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Colorado
Department of Human Services
Office of Behavioral Health

Needs Analysis: Current Status, Strategic Positioning, and Future Planning

Report
April 2015

WICHE
Western Interstate Commission for Higher Education
Mental Health Program

NASMHPD RESEARCH INSTITUTE, INC.

AHP
Advocates for Human Potential, Inc.

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Stakeholder survey

Provider survey

Provider inventory

Focus groups

Key informant interviews

Providing data and other information

Sharing your perspectives

And keeping us on track.

Thank you!

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Executive Summary

In February of 2014, the Colorado Department of Human Services's (CDHS) Office of Behavioral Health (OBH) released a request for proposals (RFP) to conduct a study of existing behavioral health resources in the state of Colorado and to project future needs. The intent of the study was to identify and assess existing state and community resources and to recommend strategic future planning, taking into account the many constituent variables associated with the changing behavioral health care system. The Western Interstate Commission for Higher Education Mental Health Program (WICHE), in partnership with the National Association of State Mental Health Program Directors Research Institute (NRI) and Advocates for Human Potential (AHP), formed a team of Colorado and national behavioral health experts to complete this study for OBH.

The Colorado OBH *Needs Analysis: Current Status, Strategic Positioning, and Future Planning* study began in August 2014 and concluded with the final report submission in April 2015. During this time, the project team worked on the 17 specific tasks that were part of the study. This report contains the findings from these tasks ordered by subject-matter relatedness as illustrated in the table below.

Task	Subject Areas
1	Inventory of Public Behavioral Health Agencies, Services, and Funding
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This study was informed by literature reviews; focus groups; key informant interviews; and state, regional, and national comparative data. In addition, the following data sources were created specifically for this report and are described in the introduction to this report:

- Behavioral Health Stakeholder Survey
- Office of Behavioral Health Provider Survey
- Office of Behavioral Health Provider Inventory
- State behavioral health community and inpatient utilization data

Colorado behavioral health study regions

For the most part, the data provided in the report are based on the state regions used for the Accountable Care Collaborative (ACC) program administered by the Department of Healthcare Policy and Financing (HCPF). The ACC is the state's primary-care Medicaid program. Seven Regional Care Collaborative Organization (RCCOs) provide a network of care and direct clients to providers. Unless stated otherwise, 'regions' in this report refer to these geographic areas. Data are also provided based on Behavioral Health Organization (BHO) and Community Mental Health Center (CMHC) catchment area boundaries when data were not available based on the RCCO boundaries. It is important to note that RCCO, BHO, and CMHC boundaries do not match up directly.

Brief summary of the findings

Following is a brief summary of the findings for each of the subject areas. Specific recommendations follow this Executive Summary and are embedded throughout the report.

Inventory of Public Behavioral Health Agencies, Services, and Funding

Inventory of Public Behavioral Health Agencies, Services, and Funding includes descriptions of the various state departments and programs responsible for administering and funding behavioral health services in Colorado, as well as an overview of the types of services provided by these agencies and the eligibility requirements for services. Also included is a description of the geographic regions used to provide service, funding, and inventory data for the report. Quantitative and qualitative data are presented identifying the number of individuals served and the types of services provided regionally across state. Service data indicates that OBH-funded services for non-Medicaid clients, on a statewide basis, represent 23.1 percent of Medicaid capitation services provided. The greatest variance between OBH and Medicaid capitation services is in region 7, where OBH services represent 12.9 percent of Medicaid capitation services. Agency funding and expenditures, including national comparative data are presented. Lastly, the results from an inventory completed by behavioral health providers, including each Community Mental Health Center (CMHC) along with findings obtained from stakeholder and provider surveys, inform this section and lay the foundation for the gap analysis and other sections of the report.

Service Gaps: State and Community Behavioral Health Services

Service Gaps: State and Community Behavioral Health Services brings together input from across the state about program and service variations and unmet needs, both statewide and within seven geographic regions. Service gaps for specific populations are identified across the continuum from inpatient care to community-based services and supports. There is significant variation across regions in the availability of inpatient, residential, assisted living and other intensive services, while even the regions with substantial intensive services have notable service gaps along the continuum. Services for individuals with co-occurring mental health and substance use disorders as well as other cognitive and physical disorders continue to be largely segregated, which is consistent with most of the current funding streams. Workforce vacancies— especially common for psychiatrists, nurses, both licensed and unlicensed clinicians, counselors, social workers, and peer specialists—likely contribute to many of the service gaps across the regions.

Governor's Plan to Strengthen Colorado's Behavioral Health System

Governor's Plan to Strengthen Colorado's Behavioral Health System reviews, and provides an update on, Governor John Hickenlooper's 2012 *"Strengthening Colorado's Mental Health System – A Plan to Safeguard All Coloradans"* to redesign and strengthen Colorado's behavioral health services and support system. Key elements of the plan are to:

- Enhance Colorado's crisis response system
- Expand hospital capacity
- Enhance community care
- Build a trauma-informed culture of care
- Develop a consolidated mental health and substance abuse data system.

Full implementation of most of these initiatives did not occur until FY 2014-15. The Assertive Community Treatment services, intensive case management and wraparound services, and jail-based competency restoration program were all operational before July 1, 2014. The crisis response hotline began operating statewide in August 2014. However, the two largest initiatives -- crisis response system services and community services for individuals transitioning from the state's mental health institutes -- did not begin operation until December 1, 2014. Because only preliminary utilization data are available at this time, it is not possible to report outcome data on these new and expanded services. Additionally, some outcome reporting will be limited because adequate baseline data prior to the implementation of these services are not available.

Penetration Rates and Relative Need for Services

Penetration Rates and Relative Need for Services provides a look at:

- The penetration rate of mental health and substance use services across Colorado's seven planning regions

- The current need for services, by region and by select demographic groups
- Projected needs based on population forecast data.

Two key findings stand out in the 10-year projections that are useful for planning behavioral health services: 1) regional differences in population change forecasts, and 2) the relationship between population forecasts and current service levels. Among all regions, the northeast region of the state is projected to have the greatest increase in unmet need among both children and adults. These findings indicate that this region may warrant special consideration and observation over the coming years to ensure that the amount of services grows accordingly with its projected increase in population across the lifespan.

The second finding involves the relationship between population change and the current relative need for services. Although northeastern Colorado would see the greatest increase in unmet need if service levels do not change over the next 10 years, this change is not substantial enough to overcome the current disparities in penetration rates. Despite differences across the regions in projected population growth, the same regions would still have the lowest and highest penetration rates across both OBH and Health Care Policy and Financing (HCPF) services, if the level of services remained the same through 2025. This finding indicates that region 1 (western Colorado) remains consistently the least-served and region 4 (southeastern Colorado) the most-served.

Alignment of Behavioral Health Resources

Alignment of Behavioral Health Resources includes recommendations about how to best align and maximize current OBH resources, including payer sources, in planning for existing and future behavioral health needs. Responses to the stakeholder survey identify needs in each of the 10 SAMHSA (Substance Abuse and Mental Health Services Administration) domains. Nearly 40 percent of stakeholder respondents, however, identified engagement services, community support services, and intensive support services as the three most underserved domains in the continuum of care. As for provider survey respondents, approximately 47 percent identified the following domains as the top three needs: health care including services integrated with primary care; outpatient and medication services including individual, group, and family therapy; and intensive support services.

We did not identify significant service constraints created by payer sources, holding aside estimation of unmet need for services and total state funding levels for behavioral health services. However, we make the following recommendations based on the current system financing structure:

- Implement suspension, rather than termination, of Medicaid benefits for individuals residing in institutions of mental diseases (IMD) as defined by the Centers for Medicare and Medicaid Services (CMS).
- Develop service delivery systems for individuals with significant co-occurring needs.

- Monitor affordability of care.
- Develop a strategy that includes the estimated impact of Medicaid expansion on each OBH appropriation for non-Medicaid clients, and offers proposed alternatives to repurpose these funds to meet behavioral health system needs not covered by Medicaid expansion.
- Measure the impact of crisis services on the need for inpatient psychiatric hospital beds, and adjust the population projections included in this report based on the impact, if any, from the implementation of crisis response services.

This section also describes critical barriers—multiple disconnected systems, and lack of consistent, complete, and reliable data—that inhibit the maximization of efficient and effective behavioral health service delivery. The following recommendations are provided to address these system barriers:

- ***Identify a single state behavioral health authority.*** Move the responsibility and authority for all behavioral health funding, planning, programs, and regulations into a single department. However, even with such a reorganization, a common leadership group about behavioral health would need to be in place. The Behavioral Health Cabinet and the Behavioral Health Transformation Council could serve in this role. While many of the state agencies listed earlier would still retain management of behavioral health services provided to their clients (e.g., the Department of Corrections and the Division of Probation), combining OBH and HCPF's behavioral health role would move the state forward in reducing provider confusion and burdens, and better position the state for integrating physical and behavioral health care.

- ***Explore the development of a common management information system.*** The state should consider the development of a common behavioral health data information system, or the modification of each agency system to share physical and behavioral health data using industry standard health information exchange standards (e.g., HL-7). Partners in this effort should include the Colorado Regional Health Information Organization (CORHIO), Quality Health Network (QHN) and the Center for Improving Value in Healthcare (CIVHC).

Regional Behavioral Health Service Distribution

Regional Behavioral Health Service Distribution summarizes the current allocation of mental health resources by region and provides recommendations as to the most efficient distribution of resources across rural, frontier, tribal ,and urban population centers. Medicaid capitation service rates in regions 3, 5, and 6 (generally, the urban areas of the state) range from 131 to 156 percent of the state rate, indicating services are more available and utilized more often in the urban areas of the state. Similarly, OBH (indigent) service rates range from 175 to 131 percent of the state rate. Medicaid capitation service rates in regions 1, 2, and 7 (generally the rural areas of the state) range from 49 to 79 percent of the state rate, indicating services are

less available and often utilized less often in the rural areas of the state. Suggested options for reducing the impact of the state's geography and population distribution include telehealth, increased funding for prevention and early intervention, and increased use of peer support services.

Colorado Mental Health Institutes

Colorado Mental Health Institutes covers court-ordered evaluations and restorations as well as projected civil and forensic bed needs. The discussion focuses on a trend that is occurring in Colorado and across the United States—a major increase in the number of individuals referred for court-ordered evaluations and competency restorations — and the impact of this trend on civil-bed availability at the two Colorado mental health institutes.

Referrals for inpatient competency evaluations at the Colorado Mental Health Institute at Pueblo (CMHIP) have increased 500 percent from FY 2004-05 to FY 2013-14, with an average annual increase of 24 percent. Competency restorations increased 107 percent during this same time period. Meanwhile, the number of voluntary and involuntary civil admissions to CMHIP decreased by 64 percent. On any given day, the state's mental health institutes have gone from 20 percent forensic patients (FY 2004-05) to 60 percent (FY 2011-12), limiting the number of beds available for civil admissions.

Following a 2011 federal court Settlement Agreement, a focused process improvement effort resulted in the streamlining of competency evaluations. The average length of stay for defendants admitted for competency evaluations was greatly decreased, to 35 days at CMHIP and 38 days at the Colorado Mental Health Institute at Fort Logan (CMHIFL), as compared to 102 days prior to the lawsuit. However, a side effect of the Settlement Agreement has been fewer beds available for civil commitments. The percentage of civil referrals being denied admission has increased substantially for both institutes, from 21 percent to 38 percent at CMHIP, largely due to referrals for competency evaluations. While CMHIFL has also seen an increase (from 18 percent in FY 2013 to 42 percent in FY 2014), these denials are related to medical and other reasons. However, CMHIFL is serving more individuals on civil commitments who also have competency evaluations ordered and completed during their inpatient stay.

Four bed-projection scenarios are presented in this section to address the projected rise in forensic admissions and decreased civil capacity. Scenario One projects future bed need based on state population increases and the historical increases in forensic admissions. Scenario Two reallocates 24 civil beds from CMHIP to CMHIFL, as these beds are allocated to CMHCs that are geographically closer to metro Denver and therefore CMHIFL. Scenario Three increases the overall bed capacity for adolescent and geriatric patients based on the average number of beds per 100,000 persons in seven Western states, and adds beds for these populations to CMHIFL. And Scenario Four allocates forensic beds to CMHIFL, reducing the number of forensic beds required at CMHIP. Bed projections are based on community-based services as they currently exist, and establishing or expanding additional community capacity will have an effect on the

number of inpatient beds needed.

Community Integration and *Olmstead*

Aligning and Maximizing OBH Resources and Payer Sources aims to identify strengths and weaknesses in Colorado's service delivery system related to community integration. Colorado recently revised its *Olmstead* plan, entitled *Colorado's Community Living Plan*, to create efficient and person-centered community-based care. It is important that the activities set forth in the state's plan are carried out, and that the plan remains up to date and relevant to the changing needs of the state's population to avoid a potential *Olmstead* action. On many high-level measures, Colorado's OBH ranks as well as or better than most state mental health agencies nationally in using community services, rather than institutions, to provide services to people with serious mental illnesses. However, Colorado tends to fall in the middle tier when compared to other Western states. Specifically, since 2011 the number of supported housing programs offered by OBH has declined, while the rate of homelessness among OBH consumers has increased. Given this divergence, efforts should be targeted toward ensuring that adult consumers with serious mental illnesses have access to affordable, integrated, and supported housing.

Telehealth

Telehealth provides an overview of telehealth activities in Colorado and other states, and identifies opportunities and strategies to enhance delivery of services and maximize financial and staffing resources. Using technology to connect health care providers and patients in different locations is increasingly viewed as a way of increasing the coordination of health care service demands and workforce limitations. Telehealth can be used for a variety of purposes such as consultation about patient care, assessment/evaluation/diagnostic clarification, medication management, individual/group/family therapy, supervision, and training/professional development. Telehealth in the behavioral health service sector generally occurs via video (versus texting and other technologies) because most state and federal telehealth reimbursement policies are tied to this delivery mechanism.

In Colorado, telehealth is covered in a range of ways across private insurance, Medicaid, and Medicare. Colorado is home to a number of organizations, partnerships, and experts utilizing telehealth or advocating its use across the state and between service sectors. Current legislative efforts and support to expand geographic criteria suggest that the use of telehealth will likely continue to grow. Recommendations are provided that would increase adoption, decrease restrictions, and increase care coordination across the state's behavioral health system, and for individuals with behavioral health issues who at present may be served primarily by other systems (e.g., older adults, correctional, developmental disabilities, etc.).

Housing and Employment

Housing and Employment summarizes some of the current economic and social conditions affecting mental health consumers' access to housing and employment in Colorado. While Colorado is benefitting in many ways from the economic recovery underway nationally, lower-income individuals and families are being squeezed by increased housing costs, competition for living-wage jobs, and high demand for housing subsidies and social services. Lack of affordable housing for people with disabilities is a large problem in Colorado. In addition, unmet employment-support needs for behavioral health clients is one of the barriers to affordable housing. Efforts to improve adoption and implementation of evidence-based practices (e.g., permanent supportive housing and the Individual Placement and Support (IPS) supported employment model) across the state may improve housing and employment situations for behavioral health clients. However, greater attention is needed to ensure that housing availability meets need; that reliable data are collected and shared on housing and employment issues; and that the provider workforce for this population is expanded to meet need.

Peer Mentors, Recovery Coaches, and Family Advocates

Peer Mentors, Recovery Coaches, and Family Advocates focuses on the extent to which peer mentors, recovery coaches, and family advocates are being used in the provision of Colorado behavioral health services. Topics covered include how peers are currently being used in the state and the identification of potential future opportunities. Additionally, the issue of training, support, and supervision of peer specialists is examined, along with notable support among survey respondents, interviewees, and others for establishing a statewide peer certification process. Other areas covered include the quality of work life as well as challenges and recommendations for incorporating peer services into the provision of behavioral health services and supports. Recommendations include implementing a peer certification process and instituting training and supports to better prepare and sustain this workforce.

Individuals with Mental Illness Who Are Physically Compromised

Individuals with Mental Illness Who Are Physically Compromised focuses on issues associated with consumers who have a mental illness and are physically compromised, and the significant challenges associated with finding placements for such individuals. The top service gaps identified by stakeholders for this population are 1) the inability of state facilities to care for individuals with mental illness and comorbid medical issues and 2) the inability of CMHIP and CMHIFL, specifically, to accept patients with medical/surgical concerns. Several approaches to addressing the needs of this population—in ways that are both efficient and cost-effective—are recommended, including greater engagement among local inpatient and nursing facilities, community providers, and the state.
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Behavioral Health Service Delivery for Specific Populations

Behavioral Health Service Delivery for Specific Populations analyzes the delivery of public behavioral health services in Colorado to special populations, such as persons with traumatic brain injury (TBI), dementia, serious and persistent mental illness (SPMI); children; adolescents; adults; and older adults. Special populations are categorized based on age, diagnosis, and funding source. The analysis identifies which populations have potentially unmet service needs. Colorado ranks 8th among 15 Western states in the rate of children and adolescents served by a state mental health agency. Services for children and adolescents were identified by providers and stakeholders as being underserved for mental health services, especially adolescents with co-occurring mental health and substance use disorders. Colorado ranks 6th among 15 Western states in the rate of adults with serious mental illness served by a state mental health agency, and Colorado has adopted several evidence-based practices to serve these individuals. Colorado's substance use penetration rate is fourth-highest among Western states, though it is estimated that 84 percent of persons age 12 or older with illicit drug dependence or abuse do not receive treatment.

The mental health penetration rate for older adult consumers in Colorado was less than the rate for Western states and decreased 21 percent from 2002 to 2013. Population growth among older Coloradans has outpaced the rate of growth in service capacity. Older adults were identified in the stakeholder survey as being underserved. A lack of training among providers in older-adult services and inadequate transportation were cited as the top barriers to providing better services to the older adult population.

Whole Health Integration

Whole Health Integration examines approaches to integrating primary and behavioral health care, along with barriers and facilitators from integration projects to date as a primer for strategic discussions on this topic. Whole health integration is widely understood as good practice for both systems and consumers, but implementation of these practices and even the vernacular used to discuss whole health varies. Current efforts underway in Colorado—including the highly anticipated State Innovation Model (SIM) grant, results from the global-payment pilot Sustaining Healthcare across Integrated Primary Care Efforts (SHAPE) study, and outcomes of the four-year Advancing Care Together project– will provide rich information and opportunities for continued growth in statewide integration of behavioral and primary care services. Collaboration and communication with other state agencies—in particular, HCPF—will help strengthen OBH's role in integration efforts.

Legal Marijuana and Prescription Drug Abuse

Legal Marijuana and Prescription Drug Abuse provides information on behavioral health needs in Colorado stemming from marijuana legalization and the ongoing prescription drug abuse epidemic. This section explores trends in drug use and treatment utilization, coupled with

voices from the field to identify policy and practice considerations moving forward. Comprehensive data collection and analysis efforts by the Colorado Department of Public Health and Environment (CDPHE) will provide more-definitive guidance on behavioral health services needs than is currently available. Treatment admission trends for marijuana have not seen dramatic changes, on average, but anecdotally, behavioral health providers are reporting greater need for prevention efforts. There have also not been significant increases in treatment admissions for the non-medical use of pain relievers over the last year, suggesting that existing measures to prevent prescription drug abuse are reducing the severity of this problem in the state. Evidence-based programming for substance abuse treatment and prevention is inconsistent across the state, and may benefit from targeted rollout and support from OBH. Improved communication and collaboration with other state entities, including CDPHE, the Colorado Department of Education, and drug courts, will be essential in identifying and responding to future prevention and treatment needs.

Drug Possession Sentencing Reform/Medicaid Expansion

Drug Possession Sentencing Reform/Medicaid Expansion examines how two state policies will affect the need for community-based behavioral health services for justice-involved individuals. The first policy is drug possession sentencing reform, which will increase the number of people with behavioral health disorders requiring treatment in the community. The second policy is the expansion of Medicaid, which will make health insurance available to many low-income adults without dependent children—a group that is disproportionately represented in the justice-involved population. Colorado's drug sentencing reform efforts and adoption of Affordable Care Act (ACA) resources for justice-involved individuals are both relatively new. It is clear that both will have significant impact on justice-involved populations in need of treatment, but the full impact will require more time to assess. Outcomes will depend on how successful criminal justice agencies, particularly probation offices, are at enrolling the thousands of defendants now eligible for Medicaid or appropriate health insurance, and how the courts intend to take advantage of the ACA to expand treatment opportunities to those not currently served by specialty courts. Further, it is not yet known whether treatment providers will adapt their services to meet the special needs of this population or simply demand that this population adapts to what they already offer.

Recommendations

Following are all of the recommendations embedded throughout the report. Note that there are not specific recommendations in the Inventory and Gaps sections of the report; however the information presented in these two sections informs recommendations throughout the report.

Governor's Plan to Strengthen Colorado's Behavioral Health System

Given the recent implementation of the initiatives in the Governor's Plan, it is important for OBH to continue to monitor and assess their impact on both the individuals served and the behavioral health system. Critical to substantive evaluation efforts is the accessibility of reliable baseline data. This is more feasible within existing resources for internal OBH initiatives than those involving external public and private agencies such as the statewide crisis response system.

- Evaluate the effectiveness, efficiency, and outcomes of the new crisis response services. Multiple systems are impacted by the new services—hospitals, law enforcement and jails, community mental health centers—in addition to individuals in crisis and their families. Ongoing evaluation will not only inform longitudinal analysis, but also quality-improvement and gap-identification efforts.

Penetration Rates and Relative Need for Services

Recommendations for this section are based on the relative need for services, using the 10-year projections for addressing disparities in access to services.

Two key findings stand out in the 10-year projections that are useful for planning behavioral health services: regional differences in population change forecasts, and the relationship between population forecasts and current service levels.

1. **Regional differences in population change**: Among all regions, region 2 is projected to have the greatest population increase among both children and adults. The difference in population change in region 2 compared to all other regions is substantial enough that the unmet need would grow approximately twice as much as the statewide average for children and adolescents (e.g., 24 percent vs. 12 percent for children with Serious Emotional Disturbance (SED), and 22 percent vs. 11 percent among adolescents with Alcohol and Other Drug Dependence (AOD). Similarly, among adults, the change in unmet need in region 2 is much higher than the projected statewide average (89 percent vs. 56 percent and 81 percent vs. 59 percent for mental health and substance use services, respectively). Region 3 has similarly stark projected increases in unmet need for adults for both mental health (81 percent vs. 56 percent) and substance use (106 percent vs. 59 percent), though these changes appear to be driven more by a

combination of high current penetration rates and strong, but not extreme, projected population growth. On the other end of the spectrum, regions 3 and 6 are projected to have the smallest population increase among children and regions 4, 5, and 6 are projected to have the smallest adult population increases. These findings indicate that region 2 may warrant special consideration and observation over the coming years to ensure that the amount of services grows accordingly with its projected increase in population across the lifespan.

2. **Relationship between population change and current relative need for services**: Although region 2 would see the greatest increase in unmet need if service levels do not change over the next 10 years, this change is not substantial enough to overcome the current disparities in penetration rates. There is congruence between lowest and highest penetration rates across Office of Behavioral Health (OBH) and Health Care Policy and Financing (HCPF) services in FY 2013-14. Despite differences across the regions in projected population growth, the same regions would still have the lowest and highest penetration rates across both OBH and HCPF services, if the level of services remained the same through 2025. This finding indicates that region 1 remains consistently the least served and region 4 the most served.

Aligning and Maximizing OBH Resources and Payer Sources

Payer sources

1. **Implement suspension, rather than termination, of Medicaid benefits for institutionalized individuals.** Federal Medicaid rules allow states to suspend, rather than terminate, Medicaid eligibility for individuals in institutions for more than 30 days, including state hospitals, prisons, and juvenile facilities (for individuals who emancipate). Colorado has not yet implemented this option. As a result, state mental health institute and prison staff must expend additional effort in an attempt to reapply for Medicaid on the individual's behalf. Sometimes placement options are denied because the individual has not obtained Medicaid eligibility status when they are ready to leave prison or a juvenile facility or no longer need to be in a psychiatric hospital.

2. **Develop service delivery systems for individuals with significant co-occurring needs.** A recurring theme in the stakeholder and provider survey responses centers on delays in care and lack of settings for individuals with developmental/intellectual disabilities, traumatic brain injury, primary dementia with decreasing mental illness, or substance use disorder. Providers voiced continued frustration about the institutes' admissions denials of these referrals. However, the institutes are neither appropriate settings to provide the best care for these individuals, nor are they permitted to admit individuals without a primary psychiatric diagnosis that requires inpatient psychiatric care. To do so would violate federal law and regulation and Joint Commission accreditation standards.[1]

   HCPF and OBH, along with the provider community and other state and private

agencies, are currently working toward expansion of integrated-care service delivery and health homes in the state. These efforts include the creation of the Accountable Care Organization (ACO) and regional collaborative care organizations. A later section of this report about whole health integration includes more information. Health homes offer the ability to meet the needs of individuals with complex, co-occurring needs. In addition, implementation of these service models in other states has demonstrated measurable cost savings. For example, the Missouri Health Home Initiative produced $4.2 million of savings in the first year of implementation.[2] Colorado has already demonstrated cost savings in implementing the ACO system. HCPF and the state should adopt a Medicaid State Plan amendment to facilitate the implementation of health homes as a means to integrate primary care and behavioral health service delivery.

3. **Monitor affordability of care and the ACA.** A study conducted by the Urban Institute found that adults with physical and/or mental health issues, especially those with low family income, had more difficulties obtaining and affording health care than adults who reported no health problems. Even with full-year health insurance, adults with physical and/or mental health issues were more likely to face barriers to care, especially affordability barriers, than their healthier counterparts.[3] Expanded marketplace and Medicaid coverage provided by the ACA may help mitigate some affordability concerns among the previously uninsured, especially those with physical and mental health issues. However, insurance coverage alone will not ensure that adults with such health problems receive the care they need in a timely and affordable way. Subsidized cost-sharing for visits to health care professionals and for prescription drugs may relieve some of the burden. Funding for these needs could be an appropriate use of the savings in the state's appropriation to OBH for services for non-Medicaid individuals with mental illness.

Crisis services

4. **Encourage discussion, among OBH and HCPF staff and crisis services providers, of how crisis services for Medicaid clients will be billed and reimbursed.** Crisis services are covered services under the State Medicaid Plan. Given that Medicaid behavioral health benefits are provided under a capitated, per member/per month reimbursement rather than fee-for-service reimbursement, either capitation rates need to be adjusted or providers need to be able to submit fee-for-service claims for crisis services.

5. **Encourage discussions, between OBH and crisis services providers, of processes for determining each client's ability to pay, including available payer sources, and review how providers are administering these processes.** While crisis-services contracts require all individuals who present to receive appropriate services irrespective of ability to pay, it is important that providers are diligent in identifying and billing all available payers.

6. **Attempt to measure the impact of crisis services.** It is important to develop a clearer picture of the impact of crisis services on the need for inpatient psychiatric hospital beds, and to adjust the population projections included in this report based on the impact, if any, of implementing crisis response services.

System alignment

7. **Identify a single state behavioral health authority.** Move the responsibility and authority for all behavioral health funding, planning, programs, and regulations into a single department. However, even with such a reorganization, a common leadership group about behavioral health would need to be in place. The Behavioral Health Cabinet and the BHTC could serve in this role. While many of the state agencies listed earlier would still retain management of behavioral health services provided to their clients (e.g., Department of Corrections, Division of Probation), combining OBH and HCPF's behavioral health role would move the state forward in reducing provider confusion and burdens, and better position the state for integrating physical and behavioral health care.

8. **Explore the development of a common management information system.** The state should consider the development of a common behavioral health data information system, or the modification of each agency system to share physical and behavioral health data using industry standard health information exchange standards (e.g., HL-7). Partners in this effort should include the Colorado Regional Health Information Organization (CORHIO), Quality Health Network (QHN) and the Center for Improving Value in Healthcare (CIVHC).

   Implementing these two recommendations would greatly accelerate Colorado's moving forward in the planning and delivery of publicly funded health care services over the next five to 10 years. Many providers across the state are transforming their practices through provision of integrated behavioral health and primary care services—some through affiliation with various healthcare providers, some through acquiring Federally Qualified Health Center (FQHC) status, and others by participating in growing organized networks of accountable care organizations (ACOs). The manner in which some provider organizations are transitioning their programs can offer insights into what the likely evolution of the service system will entail, and the possibility of replicating successful strategies of those who have adopted new service delivery approaches and models.

   There are significant transformations underway in how health care is being delivered, financed, and structured, and how providers are held accountable for outcomes. These changes impacting hospitals and physician practices will inevitably be extended to behavioral health. Moreover, health care providers are becoming more attuned to the importance of addressing behavioral health conditions than ever before. The use of quality measures that address behavioral health conditions, such as depression, substance use and emotional disorders in children have significantly increased

awareness, and prompted many healthcare organizations to expand capacity to deliver behavioral health services in traditional healthcare settings.

Organizational readiness to change is an extremely cogent area for analysis in assessing current behavioral health resources and in predicting how capable existing providers are of accommodating the rapidly changing environment. There are numerous objective criteria that can be used to determine the level of preparedness, and level of risk for provider organizations. These metrics will be important for planning purposes as it will be important to avoid, to the greatest extent possible, organizations finding they are falling behind the change curve such that they can no longer continue to operate. New value-based financing models will have a significant impact on traditional providers, who may have experience in fee-for-service billing, or even grant-based funding, but are unprepared to shift to risk- or performance-based models.

In January 2015, the U.S. Department of Health and Human Services announced its goal of transitioning 30 percent of traditional fee-for-service payments for Medicare to quality-driven, value-based payment models by the end of 2015, and having 85 percent of payments tied to quality and value by 2016.[4] This clearly signals a transformation of how health services will be purchased that will undoubtedly ripple through Medicaid, private insurance, and other publicly funded services. Colorado was recently awarded a $65 million State Innovation Model (SIM) grant by the Centers for Medicare and Medicaid Services (CMS). The areas targeted include value-based payment, integration of behavioral health and primary care, and enhanced use of analytics, in part to develop new payment strategies.

Clearly, these reforms will impact behavioral health providers and increase their level of financial risk. Those that are not capable of adapting will not remain viable very long. Many state behavioral health agencies have focused more attention on developing service models that embrace evidence-based practices and consumer engagement than on provider participation in integrated networks, analytics, and outcome management. Local programs have been largely responsible for adapting to changing dynamics and to managing their business operations, largely supported by relatively stable general revenue funding. Strategic planning for the Colorado behavioral health system will need to integrate across these traditional areas of focus, as well as take into account a changing environment that has an unprecedented level of attention focused on patient engagement, treatment outcomes, use of real-time clinical decision support information, and heightened expectations for care coordination and information sharing.

It is also important—with the focus of care shifting from the provider to the individual, and a better understanding of holistic health and population health—that strategic planning address the extent to which an individual's involvement in any health and human service agency increases his/her odds of needing service from another health and human service agency. While state behavioral health agencies, long underfunded,

have focused on the most seriously ill adults and children, this approach has proven less effective than proactive interventions that can offset long-term impacts of illness. Utilizing predictive analytics will provide myriad opportunities to identify at-risk individuals who could greatly benefit from early interventions and supports. Planning in this direction would have significant benefits for those individuals and for state budgets. Across the Colorado Department of Human Services (CDHS), there are many opportunities to enhance outcomes by addressing behavioral health risk issues in innovative ways. This, too, is an area where the availability of integrated, timely, and appropriate data can reduce risks to individuals and communities.

Regional Behavioral Health Service Distribution

The unique challenges faced by urban, rural, frontier, and tribal areas of the state have been presented above. Until systemic challenges such as transportation, staffing shortages, and funding issues are addressed, Coloradans in all areas of the state will continue to face barriers to receiving optimal behavioral health care. While these challenges may seem daunting, some promising practices are emerging that can be adopted to overcome obstacles.

1. **Telehealth.** Telehealth can be used to connect patients and providers and to reduce costly "windshield time." Telehealth has been found to be a cost-effective delivery method for prevention, early diagnosis, treatment, and care coordination.[56] Telehealth can assist in solving access to care issues in rural and frontier areas, in underserved communities, for individuals with mobility issues, and to provide specialty care that is not widely available.

   Colorado's parity law for private insurance allows telehealth for counties with fewer than 150,000 residents. Colorado Medicaid covers telehealth services that originate in the provider's office. Provider survey responses suggested that telehealth could extend behavioral health services to incarcerated individuals, to residents of nursing homes, or to physical health entities such as emergency rooms. Telehealth could help with the staff recruitment issues, and low-volume issues in rural clinics. Evidence-based applications have been developed that can provide a lifeline to persons at home or on waiting lists (e.g., MyStrength, Beating the Blues).[7]

2. **Primary care integration.** Primary care providers in rural/frontier areas have to be trained to function independently. Integrating behavioral health services into primary care can help reduce stigma associated with seeking behavioral health services in small communities. Training for existing providers to deliver behavioral health services to leverage existing services would be beneficial. Colorado has a grant to expand Mental Health First Aid training. Such training heightens awareness of mental illness and can help rural/frontier communities and families identify when individuals are struggling.

3. **Prevention and early intervention.** Funding for prevention and early intervention has the potential to help today and into the future.

4. **Peer support services** can be used to assist with community-based recovery and re-integration supports for both mental health and substance abuse and could be a valuable resource for tribal communities. Such supports were cited as a gap across all regions.

Colorado Mental Health Institutes

General Recommendations

1. **Develop outpatient alternatives in order to slow the trend of increased forensic admissions**. With an average of 59.4 percent forensic patients, Colorado is above the 43.2 percent average of other Western states. To keep pace with increasing forensic admissions and to maintain the current civil bed rate, the number of inpatient psychiatric beds at Colorado's two mental health institutes will have to increase by 90 percent (from 545 to 1,033 beds) by 2025.

2. **Increase the percentage of evaluations conducted in outpatient settings to decrease the number of inpatient beds being used for this purpose**. Currently, 71 percent of competency evaluations are conducted in outpatient settings. This percentage could be increased by training and retaining more evaluators, providing certification and oversight, and raising the reimbursement rate.

3. **Raise the daily reimbursement rates paid by the courts to the Colorado Mental Health Institute at Pueblo (CMHIP)**. The current rate of $35 per day is insufficient to offset the cost of an inpatient stay, and shifts the financial burden to the hospital.

4. **Create additional community-based competency restoration programs. Inpatient admissions for competency restorations are increasing by an average of 16% per year.** With nearly one-quarter of these individuals staying more than one year, CMHIP is forced to use a larger and larger portion of its civil beds to serve this population. The combination of increased admissions and longer length of stays is the driving force behind a projected shortage of beds over the next decade.

5. **Develop services at CMHIFL to serve lower security risk forensic patients**. Offering such services in the metro Denver area would reduce travel time and allow individuals to receive treatment closer to where they reside.

6. **Develop pre- and post-adjudication services** based on mental health clinics in courts, and the existing Wellness Court, to decrease the number of justice-involved individuals being referred for competency evaluations.

7. **Strengthen the continuity of care between inpatient behavioral healthcare services and jail** to reduce the likelihood that individuals will return to the hospital. Support

services for persons leaving jail and returning to community-based care should be increased, including assistance with obtaining health insurance or Medicaid to eliminate gaps in coverage.

8. **Increase inpatient services for adolescents** in either hospital or residential settings. Adding adolescent beds to CMHIFL would provide better access to inpatient services for youth residing in the metro Denver area. Developing adolescent outpatient competency restoration services would allow a larger percentage of adolescents with civil commitments to access existing inpatient beds.

9. **Increase total geriatric bed capacity** by adding beds to CMHIFL to increase access to and availability of services. Colorado is below the average rate of other Western states for geriatric beds.

10. **Leverage expanded Medicaid funding** to increase the Medicaid reimbursement rates for inpatient psychiatric services. This would provide an incentive for additional civil beds to be built in general hospitals throughout the state, alleviating the demand for civil beds at the two mental health institutes.

11. **Evaluate the effectiveness, efficiency and outcomes** of the new crisis services. An evaluation of the impact of the implementation of statewide crisis services in Texas found that the percentage of crisis service users entering state hospitals declined by about 23 percent. However, due to the larger number of people being served, the absolute number of admissions fell by only 3 to 5 percent.[8]

Recommendations/considerations related to the four bed-projection scenarios

Options to decrease the forensic demand

- Amend Colorado law to require competency referrals to meet 27-65 criteria, with alternative approval by OBH/DHS in special cases.
- Increase per-day charges to the judicial system for inpatient stays.
- Expand the RISE program, with strong behavioral health and medication management components, to reduce the potential for individuals to be transferred back to CMHIP for behavioral reasons.
- Develop outpatient restoration services for treatment-engaged persons out on bond who do not require the intensity of inpatient psychiatric services.
- Increase the number of evaluations being done on an outpatient basis
- Establish pre-and post-adjudication services for lower security risk individuals.

Considerations for special populations

- Allow flexibility in unit structure to accommodate a few swing beds for younger patients on the adolescent unit if the need arises.

- Ensure that programming, capacity, and workforce are responsive to the special requirements of the small number of patients who may present with Intellectual/ Developmental Disabilities (ID/DD) or Traumatic Brain Injuries (TBI). The low number of such cases does not warrant a designated unit.
- Occasional requests by the Division of Youth Corrections (DYC) and the Department of Corrections (DOC) that a detainee be transferred to one of the state mental health institutes should be accommodated, and a streamlined protocol for such admissions should be established. In addition, re-establish the Sol Vista program for youth with serious emotional disorders and complex behavioral needs who can be more appropriately served in a smaller specialized therapeutic treatment environment. There is a growing demand for these services, including in the metro Denver area, and the average daily bed cost the Sol Vista program was less than the cost of CMHIP inpatient beds.
- It is more cost-effective for persons with significant co-occurring medical conditions to be treated in general hospitals and provided behavioral supports than to equip the state institutes to treat significant medical conditions.
- Individuals with substance use disorders should be outside the IMD to the greatest extent possible, to make the services reimbursable through Medicaid.

Opportunities

- The new Behavioral Health Mobile Crisis Teams may help intercept persons in crisis and connect them with community-based services before their need rises to the level of requiring intensive inpatient care.
- Some private facilities have expressed interest in contracting to serve individuals with co-occurring behavioral health and medical/physical conditions (St. Mary's in Grand Junction, Lutheran–West Pines in Wheat Ridge, and Peak View in Colorado Springs).
- Add medical homes/services capacity to the ACT Teams to identify and address medical conditions, and implement FACT Teams with medical supports.
- In areas of the state that lack easy access to psychiatrists, provide telehealth services to rural emergency rooms, youth detention centers, and facilities serving geriatric populations.
- A new 92-bed inpatient facility is scheduled to open in Johnstown (Weld County) in fall 2015. The facility, which includes 36 adult/geriatric beds and 20 adolescent beds, may have an impact on civil admissions to the institutes.

Community Integration and *Olmstead*

1. **Fully implement the Colorado Community Living Plan**. It is important that Colorado's OBH continue to offer a variety of services in integrated settings, and follow the strategies outlined in Colorado's *Community Living Plan*.

2. **Improve access to housing and supports**. Based on the aggregate data, Colorado's OBH may wish to direct its most concentrated efforts toward ensuring that adult consumers with SMI have access to affordable, integrated, and supported housing .

3. **Continue to support the expansion of supported employment and ACT**. While the practices are currently in place across the state, there is variability in the breath of these programs across the regions and fidelity to the models and outcomes should be regularly monitored.

Telehealth

Telehealth is increasingly being used to increase the coordination of health care service demands and workforce limitations. Colorado is fortunate to have a cadre of individuals and organizations with significant expertise on telehealth policy, infrastructure, and implementation. Current legislative efforts and support to expand geographic criteria suggest that the utilization of telehealth will likely continue to grow.

In general, important features of good telehealth policy include: eliminating unreasonable and/or unnecessary restrictions on the telehealth practice, ensuring that telehealth services are covered to the same extent and in a similar manner as in-person services, and establishing clear priorities that are flexible enough to evolve and be updated when new clinical telehealth applications are developed and evaluated.[9]

1. **Develop a statewide telehealth strategy** that includes the operational aspects of telehealth, best practices, implementation protocols, technology guidelines, and staff training standards to guide community behavioral health providers in their telehealth efforts. The strategy should address opportunities in rural communities to increase overall broadband capabilities, especially given the affordability and scalability of telehealth.

2. **Support infrastructure, implementation, and growth of telehealth in emergency departments and crisis-response systems** (crisis stabilization units and respite) to take advantage of recently increased funding for expansion of the crisis system across Colorado. The core role of state research and evaluation networks in transporting medical services and data should be explored.

3. **Support efforts that eliminate restrictions** such as the "in-person" requirement related to prescribing via telehealth, as well as any geographic or population-based limitations to telehealth imposed on providers.

4. **Create incentives and funding mechanisms** that support the broad adoption and implementation of telehealth and other technology that supports the care provided by a broad range of healthcare providers in community mental health, substance use, and integrated-care service delivery settings.

5. **Create Current Procedural Terminology (CPT) codes and adopt reimbursement policies** that allow for telehealth services to be provided to consumers in their homes or other locations, and to not be confined to clinic-to-clinic or require staff to be present at both ends of the encounter.
6. **Expand the utilization of telehealth between the two state psychiatric institutes** (CMHIFL and CMHIP) and between the institutes and the community (e.g., for civil patients and the courts). This is especially important for specific sectors, such as nursing home settings and youth corrections facilities, where staff to address behavioral health issues is limited. Telehealth could also be used to provide consultative support to rural hospital emergency rooms that do not have psychiatric staff.
7. **Explore using telehealth between the state psychiatric institutes and the community behavioral health center and other community providers** to conduct competency evaluations (i.e., court orders to evaluate competency to proceed) in order to address the increase in these evaluations, expand capacity in the community system to alleviate backlogs at CMHIP, and increase the geographic reach of this service. CMHIP has providers with significant forensic expertise who could support the training and consultation of community providers conducting competency evaluations. Periodic and consistent training via telehealth for judges, defense attorneys, public defenders, and forensic evaluators on the conditions when the request for competency evaluations is most applicable may alleviate inappropriate requests for competency in the first place.
8. **Identify providers with specialty expertise across Colorado in high-need areas** such as gerontology, child and adolescent, and intellectual/developmental disabilities, to increase access to appropriate care that aligns with patient needs. Identify existing advanced-degree programs with a training emphasis on these specialty areas in Colorado, and explore opportunities to use interns or recent graduates to fill the gaps in high-need areas.
9. **Explore telehealth options aimed at improving coordination** between primary-care providers and behavioral health specialists. Identify ways to provide behavioral health consultation and support for primary-care practices via telehealth. While the presence of behavioral health providers in the public system (Federally Qualified Health Clinics and/or partnerships between Community Mental Health Centers and health clinics) is growing significantly, use of telehealth within these systems could be expanded. Another potential solution would be to create a cadre of behavioral health providers who could support private primary-care practices and be reimbursed for providing behavioral health consultation via telehealth for patients with psychiatric conditions or for wellness-support for patients with chronic health conditions.
10. **Expand the provision of home health services** to reimburse for behavioral health-related issues via telehealth.
11. **Expand the use of telehealth for individuals receiving rehabilitation and intellectual disability services** who have a specific need for behavioral health assessment, consultation, and treatment to complement their current care plan.

12. **Identify hubs for culturally and linguistically competent services statewide** (e.g., translation, interpretation services for refugee populations, and the deaf and hard-of-hearing etc.).
13. **Consider piloting a state licensure compact** between Colorado and bordering states to expand the provider pool and access to care, especially in rural communities.
14. **Expand the use of telehealth for workforce development-related training and supervision** through existing educational networks (e.g., AHECs, academic institutions).

Housing and Employment

Housing

1. **Implement permanent supportive housing (PSH) as an evidence-based practice.** Permanent supportive housing implementation will improve access to affordable housing and supportive services for people with behavioral health disorders. This evidence-based practice aligns well with the 159 targeted housing vouchers that became available in FY 2013-14 targeted for individuals leaving the mental health institutes and other psychiatric inpatient facilities. The results of the Public Behavioral Health System and Services Inventory suggest that some elements of the model, such as assistance finding housing and ongoing supports with independent living skills, are already available to some consumers. Wider implementation of this evidence-based practice would help alleviate the shortage of affordable housing and the lack of mental health services for low-income households. Further, it would directly address the need for effective interventions to prevent and end homelessness among people with behavioral health disorders. Implementation of this evidence-based practice must focus on core elements and meet fidelity as described in the SAMHSA Permanent Supportive Housing Evidence-based Practices KIT.[10]

2. **Recruit and train a cadre of regional housing coordinators to work with local housing providers, including PHAs, landlords, and property managers**. Regional housing coordinators would work to expand access to existing affordable housing and may assist in expanding the housing stock through strategic partnerships; they would also support and troubleshoot implementation of PSH. It is recommended that training be provided for regional housing coordinators on developing housing resources and PSH implementation and fidelity.

3. **Provide training for provider agencies on PSH. Training must focus on implementation with fidelity**. Lead regional housing coordinators could learn the process and train peers if the system supports a train-the-trainer structure.

4. **Set targets for the number of individuals to be served using PSH**. PSH should be a mandatory program for all providers serving adults, and targets should be at least 20 percent of all adults served. Targets can be phased in over a two-year period.

5. **Develop state-level strategic partnership**s with the state housing agency and other crucial partners to create new integrated housing options for people with behavioral health disorders. Explore opportunities to create a bridge subsidy program through the use of state general revenue in combination with available HUD funds.

Employment

6. **Continue the implementation and expansion of the individual placement and support model of supported employment (IPS/SE) as an evidence-based practice.** Supported employment (IPS/SE) will continue to improve access to jobs paying a living wage. The results of the Public Behavioral Health System and Services Inventory suggest that many of the agencies are already implementing this evidence-based practice for a portion of their clients. Wider implementation would help alleviate the shortage of available jobs and the lack of employment services for people with disabilities. Implementation must focus on core elements and meet fidelity as described in the SAMHSA Supported Employment Evidence-based Practices KIT.[11]

7. **Recruit and train a cadre of regional employment coordinators** to work with local workforce centers, employers, city/county employment efforts, and private nonprofit organizations focused on employment of low-income individuals. Regional employment coordinators would also support and troubleshoot implementation of SE. It is recommended that training be provided for regional employment coordinators on developing job opportunities, expanding training opportunities, and developing IPS services.

8. **Provide training for provider agencies on IPS/SE**. This training can be coordinated with housing training described above. Training must focus on implementation with fidelity. Regional employment coordinators could learn the process and train peers if the system supports a train-the-trainer structure.

9. **Set targets for the number of individuals to be served using the IPS/SE**. IPS/SE should be a mandatory program for all providers serving adults, and targets should be at least 10% of all adults served.

10. **Develop strategic state-level partnerships with the Division of Vocational Rehabilitation**. Address Order of Selection difficulties and mitigate the negative effects of this practice.

In addition, the following broad actions are recommended to support future efforts to improve housing and employment for individuals with behavioral health disorders.

11. **Improve data collection** and sharing by all state agencies to identify people in need of affordable housing, including those who are doubled up, couch surfing, or living in substandard housing. Include housing status in all client databases.

12. **Ensure that data collection is culturally sensitive** to people experiencing homelessness, and minimize paperwork and pre-authorization to rapidly link people to needed supports.

13. **Train state and regional workers in trauma-informed care principles**.

14. **Redirect spending of state funds** and mental health block grant funds on services that can be covered by Medicaid to improve housing options, provide transportation, promote employment, and other nonclinical services.

15. **Create a workforce development plan** to fund, recruit, and keep providers, especially mental health and specialty care workers.

Peer Mentors, Recovery Coaches, and Family Advocates

1. **Continue efforts to develop and implement a state certification program for peer support specialists.** Recognize and promote peer support as a unique and respected discipline. Ensure that peers are actively involved in the design, management, and oversight of this program. As part of the certification initiative, develop training, supervision, and continuing education standards for both individual peers and employing organizations. Ensure that any credentialing program has provisions for transportability to other states and recognizing certification from other states.

2. **Establish standardized ethical guidelines** as part of the certification and develop a mechanism for oversight and self-monitoring ethical violations – as done in any other professional certification and licensing process.

3. **Enhance funding to ensure access to quality training** for peer specialists and supervisors of peers across the state.

4. **Enhance and expand current training programs**. Link training to the certification and continuing education requirements. Provide funding support for curriculum development, "specialist" and "setting-specific" training opportunities, and broader access to all training. Develop a structure for an internship program that helps bridge training with employment and certification.

5. **Promote peer attendance at in-state and out-of-state conferences** for professional development, networking, and learning how other states and programs address issues faced by peers in the Colorado services system.

6. **Address workforce issues**, including compensation, access, and upward mobility. Work with both peer and provider associations and organizations to establish consistent pay scales; salary enhancement for training, education, and experience; and model job descriptions. Advocate that multiple peers be hired in a given setting to help combat tokenism.

7. **Expand opportunities within the state for peer mentors**. This would entail working with both the public and private behavioral health service systems to promote employment of certified peer specialists.

8. **Establish a standardized program for training supervisors of peers**. Include in the training information about what a "peer" is, principles of peer support, how to use peer specialists and mentors in the workplace, and how to support them in their work.

9. **Increase public awareness of peer services offered in the state**. Include easily accessible information about peer services on the public materials of institutions that offer them. Awareness of peer services could increase utilization rates among individuals who are hesitant to seek services in traditional behavioral healthcare settings, serving as a more approachable point of entry.

Individuals with Mental Illness Who Are Physically Compromised

There are often significant challenges associated with finding placements for individuals with behavioral health disorders who are physically compromised and in need of medical care. It is recommended that several approaches be taken to address the needs of this population in ways that are both efficient and cost-effective. The proposed recommendations include the engagement of local inpatient and nursing facilities, community providers, and the state.

1. **Consider operation by the state of one or more skilled nursing facilities for the treatment of individuals with behavioral health disorders requiring medical and/ or skilled nursing care. Such facilities could be part of the mental health institutes or State Veterans Community Living Centers.** Other options include contracting with private providers to either operate, or construct and operate, a facility for use by the state, or expanding the number of state nursing homes, with enhanced behavioral health supports. Options that allow for individuals requiring this level of medical and behavioral health care to be served close to their home communities should be strongly considered. Additionally, options that flexibly allow the needed level of intensive medical and/or behavioral health treatment to come to the individuals, versus having to relocate them, offers opportunities to enhance workforce competence for staff treating these individuals, and allows this population to age in place with less disruption in their care and treatment.

2. **Identify hospitals and nursing facilities across the state that already have some medical and psychiatric capacity, and develop mechanisms to enhance their capacity to treat psychiatrically challenged individuals with co-morbid physical health conditions.** This approach is more efficient and cost-effective than attempting to provide an intensive array of medical treatment and supports within a psychiatric facility. Augmenting existing services offers opportunities for individuals to be treated closer to their home communities, avoiding unnecessary transportation and separation from family and support systems. Additionally, developing the capacity to treat serious mental and physical health conditions concurrently in facilities that are not Institutions for mental diseases allows federal dollars to cover some of the cost of services for individuals who are Medicaid-eligible and under the age of 65.

3. **Develop additional state nursing home capacity to meet current and future demand attributable to population growth, individuals living longer, and the projected increase in persons with Alzheimer's disease and dementia.** The geographic location of new capacity should take into consideration regions that have significant service gaps for this population. Additionally, it may be beneficial to consider telehealth, specifically behavioral health services, to support individuals with challenging behaviors as they progress through the stages of their disease and would benefit from behavioral management interventions and supports and could reduce the need to transfer some individuals to another facility.

4. **Develop Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) team approaches that include using the medical home model of care.** Such integrated services could be added to the ACT programs that have been implemented statewide though the Governor's Strengthening Behavioral Health Initiative, which provides dedicated ACT to all 17 CMHCs. The FACT team would be available to actively support individuals residing in a variety of living arrangements from Supported Housing to assisted-living facilities to nursing homes. These evidence-based programs were originally developed to engage adults with serious and persistent mental illnesses in outpatient psychiatric treatment through the use of outreach and comprehensive services available 24 hours a day, seven days a week. FACT adds legal support and leverage for individuals such as those discharged from forensic services or on conditional release from inpatient forensic programs.

   Furthermore, staff from the ACT and FACT teams could provide additional medical services and supports to these individuals, as needed, to reduce their risk of re-hospitalization for medical or psychiatric reasons. (Aetna Mercy Maricopa Integrated Care in Arizona is implementing this model.) Given the seriousness of the offenses for which forensic individuals were charged and the reluctance of existing private facilities to serve these individuals, developing intensive community-based programs may allow many of these individuals to successfully step down from costly inpatient services and experience an enhanced quality of life.

Behavioral Health Service Delivery for Specific Populations

1. **Explore opportunities to provide services across the continuum** for the special populations with complex treatment and/or behavior-management needs identified in this section of the report. Specific options for state hospital beds are noted in the Colorado Mental Health Institutes section of this report.

2. **Expand workforce competence through training and consultation** to work with the identified special populations.

3. **Develop telehealth capacity to support the behavioral health treatment** needs of special populations, including supports for individuals in rural and frontier parts of Colorado.

Whole Health Integration

Whole health integration is exploding in Colorado, and OBH's plans moving forward should consider the status and knowledge gained through the current initiatives described above. As noted, several of these initiatives are beginning or ending, and over the next few years there should be a clearer picture of what works for integration in Colorado, and what next steps are being taken to support the implementation of best practices at multiple levels. In the meantime, OBH leadership can continue to support successful whole health integration by taking the following two key actions:

1. **Reach out to and monitor the progress of existing initiatives.** The ACT demonstration project, SIM grant, and SHAPE financing study offer promising avenues for identifying and addressing key barriers to successful whole health integration. Potential contacts include:

- ACT project: Larry Green, Larry.Green@ucdenver.edu; Deborah Cohen, cohendj@ohsu.edu
- SIM Grant: Vatsala Pathy, vatsala.pathy@state.co.us
  SHAPE Study: Benjamin Miller, Benjamin.Miller@ucdenver.edu; Patrick Gordon, patrick.gordon@rmhp.org

2. **Build relationships and communication with other Colorado state agencies.** Stakeholders within the Colorado Department of Health Care Policy and Financing were especially eager to build relationships to create efficient execution, improvement, and evaluation of programs with shared interests. Further, building these relationships now will set the stage for successful integration efforts in the future.

Legal Marijuana and Prescription Drug Abuse

Additional data on the impact of marijuana law changes is needed and will come, with time. In

the meantime, OBH leadership can take steps to facilitate greater success in allocating services for substance abuse needs as a whole.

1. **Redouble drug prevention efforts.** Prevention efforts–for youth and adults–were repeatedly recommended by stakeholders consulted for this report. Education efforts, including information for families on safe storage of marijuana and prescription drugs, are essential. Interventions targeting the perception of risk in marijuana and prescription drug abuse are needed. Both universal and selective prevention efforts targeting highest-risk regions and populations should be considered. Other state agencies, including Education and Public Health, may provide useful information on how prevention efforts can be best targeted.

2. **Review treatment and recovery practices in regions 2 and 4 to assess treatment capacity and service need.** These regions appear to have the greatest number of substance abuse treatment admissions for both marijuana and prescription opioid abuse as the primary drugs of choice, and though self-reported assessments of service availability and treatment capacity appeared positive for these regions from the inventory conducted for this report, further investigation is needed to establish a more conclusive assessment of service needs in these areas.

3. **Build stronger partnerships and communication avenues with state agencies, including those serving education, public health, Medicaid, and criminal justice interests.** There are many overlapping interests and activities across these agencies, yet state agencies appear exceptionally siloed. Collaboration with these agencies is one key to understanding and reacting to the most current marijuana use data (public health), creating and implementing drug prevention practices (education), tracking and preventing systemic prescription drug misuse (Medicaid), and meeting the treatment needs resulting from shifts in drug laws and drug court referrals (criminal justice).

4. **Support CDPHE efforts to standardize data quality and collection.** This was a major barrier to compiling current data on the impact of marijuana on service needs, and OBH should consider ways to support improvements in this area.

5. **Create policies and partnerships that encourage the use of core evidence-based practices.** The practices used to prevent, treat, and support recovery from substance abuse issues are not well defined or accessible in Colorado. Based on stakeholder reports and existing data, these services appear to vary considerably across the state. This variation limits peer support, sustainability, and quality improvement through collaboration and efficient use of funds. Building partnerships with other state agencies, along with identifying and supporting training and coaching for specific core evidence-based practices, may help to standardize and regulate the use of research-tested practices across the state.

6. **Regularly maintain and update content on the Office of Behavioral Health website.** This site can be a key resource for individuals seeking information about drug services, state initiatives, or other details relevant to marijuana and prescription drug abuse. Yet website users often find broken links and incorrect contact information throughout the OBH website. If young users of behavioral health services are to be targeted, the web presence of OBH should be improved.

Drug Possession Sentencing Reform/Medicaid Expansion

Colorado's drug sentencing reform efforts and adoption of ACA resources for justice-involved individuals are both relatively new. It is clear that both will have significant impact on justice-involved populations in need of treatment, but the full impact will require more time to assess. Outcomes will depend on how successful criminal justice agencies, particularly probation offices, are at enrolling the thousands of defendants now eligible for Medicaid or appropriate health insurance and how the courts intend to take advantage of the ACA to expand treatment opportunities to those not currently served by specialty courts. Further, it is not yet known whether treatment providers will adapt their treatment to meet the special needs of this population or simply demand this population adapts to what they already offer.

Across the nation, some insurance providers have balked at covering court-ordered treatment that is not prescribed by recognized medical authorities. This may be a particular issue if courts routinely substitute residential treatment for incarceration. Further, the Medicaid Institute for Mental Disease (IMD) exclusion has long been a barrier to the use of federal Medicaid funds to pay for services provided to patients in residential substance use disorder treatment facilities that have more than 16 beds.[12] Unfortunately, the ICD-9-CM classified substance use disorders as mental disorders.

There are strategies that administrators, staff, and other stakeholders can employ in order to maximize their efforts and ultimately succeed in realizing the full potential of the state's drug reform efforts and the ACA.

1. **The criminal justice population is unlike most other clients seeking treatment.** They are usually court-ordered and require additional resources and/or multiple treatment episodes in order to truly recover and maintain a healthy lifestyle. Their criminogenic needs must be addressed as well as clinical needs. **Behavioral health treatment providers and criminal justice stakeholders must collaborate.** This is a relatively new population for many treatment providers. If expanded treatment capacity is required, new providers will have to be included and educated on the intricacies of this population. They will also need to be aware of the separate terms that they use (e.g., offender vs. client) to foster greater understanding between the two systems and to break down preconceived notions. Together, they can press for targeted case-management programs specifically for justice-involved populations. The systems must also collaborate on funding: While not all criminogenic needs are covered by Medicaid, some such as anger management are.

2. **Healthcare and criminal justice systems are large, bureaucratic organizations that have historically remained separate.** New resources under the ACA, especially the expansion of Medicaid, create opportunities for both sets of stakeholders, but they must work together. In the past, criminal justice and healthcare systems have existed in separate "silos." To ease referrals, the two must create a mutually advantageous relationship; and to facilitate positive outcomes, all actors must be involved in planning, implementing, and sustaining programs. This will help to dispel fear or apprehension, promote cooperation, create a culture of care around individuals, and produce mutual goals for all involved. For example, behavioral health systems can educate courts and prosecutors about the benefits of community-based treatment, as opposed to residential treatment, which may be overused.

3. **Resources for treatment and healthcare providers remain low.** In order to provide the specialized supervision necessary for the increased caseload created by drug sentencing reforms, the state, drug, and specialty courts will require increased judicial resources. While the ACA makes federal resources available, in 2017 the state will begin to assume a greater burden for financing Medicaid. It is imperative that stakeholders seek other funding streams as well. Being able to prove the concept through data collection and reporting and securing additional resources is important. A sustainability plan to ensure the longevity for projects is also advisable.

4. **There are too few resources to adequately treat and serve all of those in need.** There are high needs, few resources, not enough treatment, and not enough detox services. This problem is not fully solved by Medicaid coverage. In many cases, Medicaid does not provide treatment allowances in-network for services that are court-ordered. For behavioral health services, clients must have a covered diagnosis and go to specific providers, and the treatment must be deemed medically necessary. These processes need to be simplified and streamlined to create better service.

5. **There is a disincentive for treatment providers to become Medicaid treatment providers.** As contractors with various criminal justice entities, many behavioral healthcare providers receive set rates. However, Medicaid may only pay a portion of those rates. As more probationers and parolees obtain Medicaid coverage, the courts and other administrators must be aware of and able to interpret the changes, and can adjust accordingly. It is especially important to consider treatment capacity when assigning conditions of release. Courts might wish to consider appointing an expert, or a liaison with the behavioral health system, who can determine whether court recommendations for intensive treatment are appropriate and capable of being fulfilled.

6. **Specialty courts have been primarily responsible for the management of drug offenders.** The judiciary may have to explore a broad-based strategy to handle

offenders with drug treatment needs. It is necessary to increase the capability and the utility of *all* courts and criminal justice systems. Prosecutors' offices should reassess their culture to ensure that prosecutors are recommending diversion in appropriate cases. Judges should be prepared to recommend diversion when appropriate, even when it conflicts with prosecutors' wishes. Expanding the specialized knowledge of substance use disorders not only assists in improved ability to serve, but also increases buy-in for various participants in the process.

7. **Clients are receiving care while under correctional supervision, but they may not be accessing care after discharge.** Because of the additional risk for the population after release, they need to receive special attention and involved planning for accessing care in the community. Enrollment to receive healthcare benefits is just the first step toward ensuring the long-term use of care and sustained recovery. Continuity of care and the lessening of healthcare gaps decrease relapse, overdose, and other chronic health conditions. It is necessary for criminal justice employees and treatment providers to cooperate with one another to close these service gaps. This effort can include processes on the front end through discharge planning, proactive involvement, and follow-up case management. The use of medication-assisted treatment, including injected naltrexone, will not only address the heightened risk of drug overdose deaths for re-entering inmates within the first 30 days, but also will enhance treatment outcomes thereafter.

[1] 42 CFR 424.14 and TJC Leadership Standard 04.01.01

[2] **Kansas Health Institute, 'Health home' initiative shows $4.2M savings in first year. Mike Sherry, June 25, 2013. http://www.khi.org/news/article/health-home-initiative-shows-42m-savings-first-yea/#sthash.f5YRckIB.dpuf**

[3] Health Care Access and Cost Barriers for Adults with Physical or Mental Health Issues: Evidence of Significant Gaps as the ACA Marketplaces Opened their Doors; Dana Goin and Sharon K. Long, Urban Institute Health Policy Center, April 4, 2014

[4] http://www.hhs.gov/news/press/2015pres/01/20150126a.html March 27, 2015.

[5] American Telemedicine Association, State Policy Toolkit Improving Access to Covered Services for Telemedicine, 2013.

[6] American Telemedicine Association, State Medicaid Best Practice Managed Care and Telehealth, January, 2014

[7] http://www.nrepp.samhsa.gov/

[8] **Evaluation Findings for the Crisis Services Redesign Initiative;** Report to the Texas Department of State Health Services; Page xi, January 1, 2010. Public Policy Research Institute.

[9] American Telemedicine Association (2013). State Policy Toolkit Improving Access to Covered Services for Telemedicine.

[10] Available at: http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510

[11] Available at: http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365

[12] Social Security Act, §1905(a) (B)

Introduction and Methodology

In February 2014 the Colorado Department of Human Services' Office of Behavioral Health (OBH) released a Request For Proposals (RFP) to conduct a study of existing behavioral health resources in the state of Colorado and to project future needs. The intent of the study was to identify and assess existing state and community resources and to recommend strategic future planning, taking into account the many constituent variables associated with the changing behavioral health care system. The Western Interstate Commission for Higher Education Mental Health Program (WICHE), in partnership with the National Association of State Mental Health Program Directors Research Institute (NRI) and Advocates for Human Potential (AHP), formed a team of Colorado and national behavioral health experts to complete this study for OBH.

The Colorado OBH *Needs Analysis – Current Status, Strategic Positioning, and Future Planning* study began in August 2014 and concluded with the final report submission in April 2015. During this time, the project team worked on the 17 specific tasks that were part of the study. This report contains the findings from these tasks ordered by subject-matter relatedness.

Table 1: Organization of Report

Task	Subject Area
1	Inventory of Public Behavioral Health Agencies, Services, and Funding
2	Service Gaps: State and Community Behavioral Health Services
5	Governor's Plan to Stregthen Colorado's Behavioral Health System
7	Penetration Rates and Relative Need for Services
4	Aligning and Maximizing OBH Resources and Payer Sources
12	Regional Behavioral Health Service Distribution
9 & 10	Colorado Mental Health Institutes
11	Community Integration and *Olmstead*
14	Telehealth
17	Housing and Employment
3	Peer Mentors, Recovery Coaches, and Family Advocates
8	Individuals with Mental Illness Who Are Physically Compromised
6	Behavioral Health Service Delivery for Specific Populations
13	Whole Health Integration
15	Legal Marijuana and Prescription Drug Abuse
16	Drug Possession Sentencing Reform/Medicaid Expansion

This study was informed by literature reviews; focus groups; key informant interviews; state, national, and regional comparative data; and the following, which are described below:

- Behavioral Health Stakeholder Survey
- Office of Behavioral Health Provider Survey
- Office of Behavioral Health Provider Inventory
- State behavioral health community and inpatient utilization data.

Behavioral Health Stakeholder Survey

During October 2014, the Colorado Behavioral Health System Stakeholder Survey was available to stakeholders across the state via an Internet link. The data from the survey were analyzed by geographic region.

Methodology

Quantitative data were analyzed using SurveyMonkey analytics and Microsoft Excel. Qualitative survey responses were analyzed following a content analysis approach[1] using NVivo 10 software for coding and analysis. First, the entire survey results were read through to identify emergent themes for coding. An initial list of 205 possible codes was generated. This was organized with a separate coding list for each question, resulting in duplicate codes. The initial set of codes was reviewed by the WICHE research team and organized into 15 parent themes with a total of 120 possible sub-themes or codes. We subsequently reread each response to each qualitative question, coding the responses.

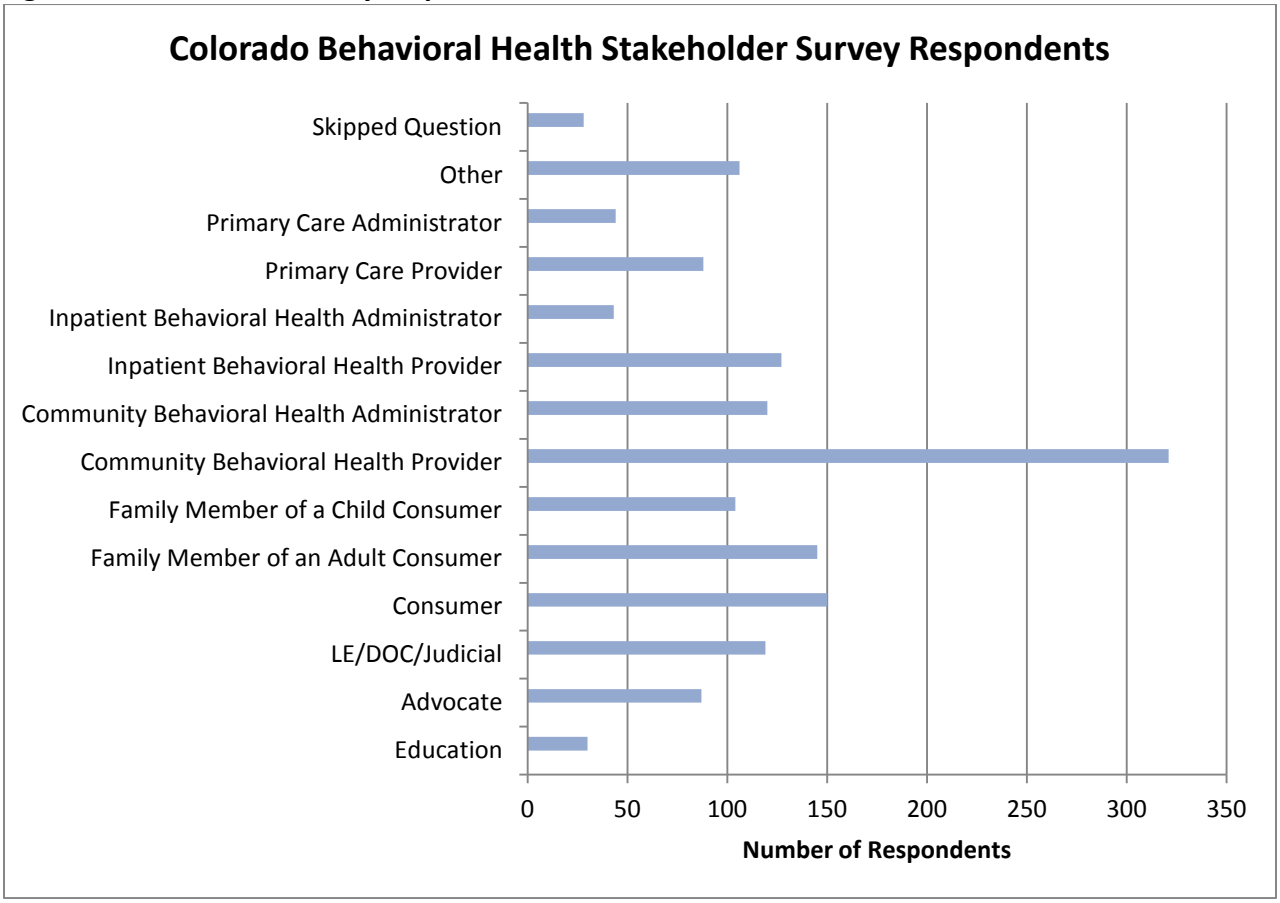
Following coding, we used NVivo to analyze the most common codes for each qualitative question to identify those response themes with the most agreement across respondents. Additionally, we employed NVivo's powerful query tools to identify code relationships for key study topics and common themes, such as co-occurring, geriatric, and serious medical illness. This allowed us to identify common issues that stakeholders discussed in relation to topics of particular interest to OBH and topics commonly raised across all survey responses and questions.

Results

The survey link was broadly shared across state and county human service agencies; public and private health and behavioral health providers; education, law enforcement, judicial, and corrections system agencies; and behavioral health advocates and individuals using behavioral health services—referred to as consumers in this report—and their families. The table below illustrates the distribution of the 1,495 of the 1,512 respondents from across Colorado who completed the survey and identified a region. Twenty-eight survey respondents skipped this item, and 106 respondents selected the "other" category—which included individuals such as non-specific community citizens, clergy, business owners, researchers, and so on.

It is important to note that the stakeholder survey allowed respondents to skip any items they did not wish to answer; therefore the number of responses varies by survey item. The chart below illustrates the distribution of the survey respondents. More than 300 respondents were community behavioral health providers, the largest group of respondents across all of the categories. There was a good distribution of other respondents across most of the remaining categories.

Figure 1: Stakeholder survey respondents



Stakeholder survey respondents: gender

More than three-quarters (76.9 percent) of the survey respondents were female.

Stakeholder survey respondents: race/ethnicity Table 2 shows the ethnicity/race distribution of survey respondents.

Table 2: Stakeholder survey respondents' ethnicity/race (note all that apply)		
Response Options	**Percent of Total Responses**	**Response Count**
American Indian or Alaska Native	1.6%	24
Asian	1.1%	16
Black or African American	2.9%	42
Native Hawaiian or Other Pacific Islander	0.03%	4
White	88.3%	1287
Hispanic or Latino	8.6%	125
Other (written comments)		25
	Total Responses	**1523**

Survey respondents were asked to identify the region in which they reside based on

theircounty. The table below shows the distribution of respondents from across the state by their identified region. These seven regions were based on the geographic regions developed by the Colorado Department of Health Care Policy and Financing (HCPF) for the Regional Collaborative Care Organizations (RCCOs) to implement Accountable Care. The geographic regional distribution was requested for this study by OBH.

Table 3: Stakeholder survey respondents' region of residence		
Response Options	**Percent of Total Responses**	**Response Count**
Region 1 -Western Counties: Archuleta, Delta, Delores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Larimer, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit	26.5%	396
Region 2 - Northeastern Counties: Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma	9.5%	142
Region 3 - Counties: East and South Metro: Adams, Arapahoe, Douglas	15.4%	230
Region 4 - Southeastern Counties: Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Lake, Las Animas, Mineral, Otero, Prowers, Pueblo, Rio Grande, Saguache	10.9%	163
Region 5 - County: Denver	17.1%	256
Region 6 - North and West Metro Counties: Boulder, Broomfield, Clear Creek, Gilpin, Jefferson	14.0%	210
Region 7 - Counties: Elbert, El Paso, Park and Teller	6.6%	98
Total Responses	**1495**	

Office of Behavioral Health Provider Survey

During October 2014, the Colorado Behavioral Health System Provider Survey was available for community mental health and substance-use providers from across the state to complete using an Internet link. The link was shared with member agencies of the Colorado Behavioral Healthcare Council. The table below indicates the number of agencies that responded from each of the seven geographic regions. For reporting purposes, an "X" is used to designate the provider responses in each of the regions throughout this report, not the specific number of responses, since there was variation in the number of providers across the regions.

Table 4: Number of Provider Respondents by Region							
Region							
Geographic Region	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Number of Respondents	2	5	5	3	5	3	1

Qualitative data from the provider survey were analyzed following content analysis procedures[2] to identify emergent themes. As there were only 20 respondents to this survey, we did not use

NVivo software. Quantitative data were analyzed using SurveyMonkey analytics and Microsoft Excel.

Office of Behavioral Health Provider Inventory

An inventory template was developed to capture the array of programs and services provided across the state. Additionally, information about service gaps, workforce, and special populations was collected. The inventory was disseminated to provider agencies with OBH contracts. The Colorado Behavioral Health Council and Colorado Providers Association distributed the inventory to their members. This inventory was conducted between November 2014 and January 2015. The findings from the inventory are presented in this report across all seven regions. Individual regional reports are included in the appendices.

Methodology

WICHE developed an inventory template to collect information about resources available for behavioral health consumers. The inventory represents a snapshot of the programs and services available across seven geographic regions. Again, these geographic regions are based on the regions developed by HCPF for the RCCOs to implement Accountable Care. These regions also reflect the inventory and analysis distribution requested by OBH.

Administration

All 17 Community Mental Health Centers (CMHCs), one specialty clinic, and two substance-use provider agencies completed all or part of this inventory during November 2014 through early January 2015. Much appreciation is extended to the staff who completed this Inventory.

Limitations

The comprehensiveness of the inventory information received varied across providers, and some did not provide information for each item. Therefore, the completeness of the data is variable from region to region. Nonetheless, the findings offer current approximations of community-based mental health programs, services, capacity, and gaps in Colorado as reported by provider agencies in each of the seven regions. The data provided in the inventory were not verified through other sources. However, when it was apparent that the data reported were from outside the providers' geographic region, the data were not included. For example, some providers identified all the nursing homes in which they place clients instead of only those located in their geographic region. Another limitation of the data is that Elbert County is located in the service area for Centennial Mental Health Center, however is located in the region 4 geographic service area used for this study.

State behavioral health utilization data

OBH and HCPF provided FY 2013-14 client and service utilization data aggregated by counties and/or the seven designated regions. In addition, the state Mental Health Institutes provided 10 years of hospital capacity and utilization data. HCPF did not provide client-level data on people receiving their services and did not separate their service data by mental health and substance use clients. The lack of client-level data from HCPF made it impossible to generate a full and unduplicated count of all clients receiving behavioral health services from OBH and HCPF. The OBH client counts include an unspecified number of clients who also received Medicaid behavioral health services during FY 2013-14; and the HCPF client counts include an unspecified number of clients who received OBH-funded services in 2014 as well. However, neither agency was able to provide client-level data.

State behavioral health fiscal data

OBH and HCPF provided FY 2013-14 appropriations and expenditure data. In addition, we used public documents available from the Colorado General Assembly to collect and compile fiscal information.

[1]Berg, , B. L. (2001). Qualitative research methods for the social sciences. Needham Heights, MA, Allyn & Bacon.
[2] Berg, , B. L. (2001). Qualitative research methods for the social sciences. Needham Heights, MA, Allyn & Bacon.

Inventory of Public Behavioral Health Agencies, Services and Funding

Introduction

This section of the report includes the following information:

- A description of the various state departments and programs responsible for administering and funding behavioral health services in Colorado
- A discussion of the types of services provided by these agencies, including eligibility requirements for services
- A description of the geographic regions used to provide service, funding, and inventory data
- The number of individuals served and the quantity of services provided
- Agency funding and expenditures, including national comparative data
- Results obtained from a services inventory completed by providers, including each Community Mental Health Center (CMHC).

State agencies with responsibilities for behavioral health services[1]

Behavioral health services in Colorado are provided primarily by two state agencies. Additional state agencies, or units of state agencies, have responsibility for population groups that may have behavioral health service needs in addition to the services for which that agency is primarily responsible (e.g., CDHS Division of Child Welfare, CDHS Division of Youth Corrections, Colorado Department of Corrections). The two state agencies with greatest responsibilities for behavioral health services are:

- The CDHS Office of Behavioral Health (OBH), which is responsible for policy development, service provision and coordination, program monitoring and evaluation, and administrative oversight of the state's public behavioral health system. Funding in this section supports community-based mental health and substance-use disorder (SUD) services for indigent individuals who are not eligible for Medicaid, as well as behavioral health prevention services.

- The Department of Health Care Policy and Financing (HCPF), which administers the joint state-federal Medicaid program that funds the majority of behavioral health services in Colorado. Services are funded through two primary mechanisms. HCPF contracts with Medicaid-eligible providers through a Medicaid mental health capitation program. In addition to the capitated model, HCPF administers a fee-for-service (FFS) mental health program and a Home and Community Based Services (HCBS) mental health services waiver program.

Behavioral health services for children, youth, and families involved in the child welfare and juvenile justice systems are provided, respectively, by the Division of Child Welfare and Division of Youth Corrections within CDHS, as well as the State Judicial Department, Office of the State Court Administrator, through both the Division of Probation Services (for youth on probation) and Youth Offender Services (for youth served in the adult system).

Services for adults in the correctional system are carried out by multiple agencies: the Department of Corrections for people in state prisons; the Department of Public Safety for people involved in community corrections; the State Judicial Department (Office of State Court Administrator, Division of Probation and Division of Parole Community Corrections) for community and residential services and regulatory oversight of community providers working with offenders; and local counties for people in jails and in some subsets of probation.

The Colorado Department of Education manages and funds special education, behavioral health programs in schools, and a positive behavioral supports program.

The Colorado Department of Public Health and Environment (CDPHE) oversees all licensing for health facility providers, including hospitals, community mental health centers, and community mental health clinics. However, CDPHE delegates regulatory programmatic oversight to OBH for any mental health-focused centers, clinics, and other specialty health facilities and agencies. OBH is uniquely responsible for the oversight and licensure of substance-use treatment agencies. CDPHE houses the Office of Suicide Prevention, which manages the state's suicide prevention programs, and the Behavioral Health Emergency Preparedness and Response Division, which coordinates statewide mental health and substance-use disorder training, preparedness, and response functions following man-made and natural disasters. OBH works collaboratively with CDPHE on these initiatives.

Many people with behavioral health issues access care through safety net providers other than community mental health centers and substance-use disorder providers. These other safety net providers include Federally Qualified Health Centers (FQHCs), Rural Health Clinics, and School-Based Health Clinics. FQHCs are major sources of primary care-based mental health and SUD treatment in Colorado. There are 15 FQHCs in Colorado operating 123 clinic sites in 33 counties. Many offer integrated behavioral health treatment, often in collaboration with community mental health providers.

Behavioral health services for members of Colorado's two American Indian Tribes (Ute Mountain Ute Tribe and Southern Ute Indian Tribe) are either provided directly by the federal Indian Health Service or purchased and delivered directly by the Tribes using tribal and federal funds. The vast majority of American Indians, Native Americans, and Alaska Natives living in Colorado reside outside of reservations and receive their care through a variety of providers, mostly in the Denver metro area.

Department of Regulatory Agencies (DORA) includes oversight of physicians and other licensed providers of behavioral health services through boards overseeing each provider group.

Mental health services provided by OBH and HCPF

Office of Behavioral Health - Mental Health Community Programs

Services for indigent individuals. OBH supports community-based mental health and substance-use disorder services for indigent adults and youth who are not eligible for Medicaid. OBH also operates the state's two inpatient psychiatric hospitals, located in Denver and Pueblo (the Colorado Mental Health Institutes at Fort Logan and Pueblo). OBH serves as the federally designated Single State Authority (SSA) for substance-use disorder prevention and treatment, and State Mental Health Authority (SMHA) to oversee distribution of two federal block grants for mental health and substance use prevention and treatment.

OBH provides funds through 17 service (catchment) areas. The residents of each of these service areas are the responsibility of a designated CMHC that receives state general funds, Mental Health Block Grant funds, federal Medicaid funds, and local funds to provide mental health services. OBH determines the distribution of state-appropriated funds for community mental health services according to the Colorado Needs Assessment Model, which determines the level of funding for each community mental health center. An annual performance contract is negotiated with each center, specifying the minimum numbers of persons in each targeted population to be served, and the amounts of various types of services to be provided. Each CMHC is responsible for providing a set of core services, including services affecting access such as 24-hour emergency and case management services.

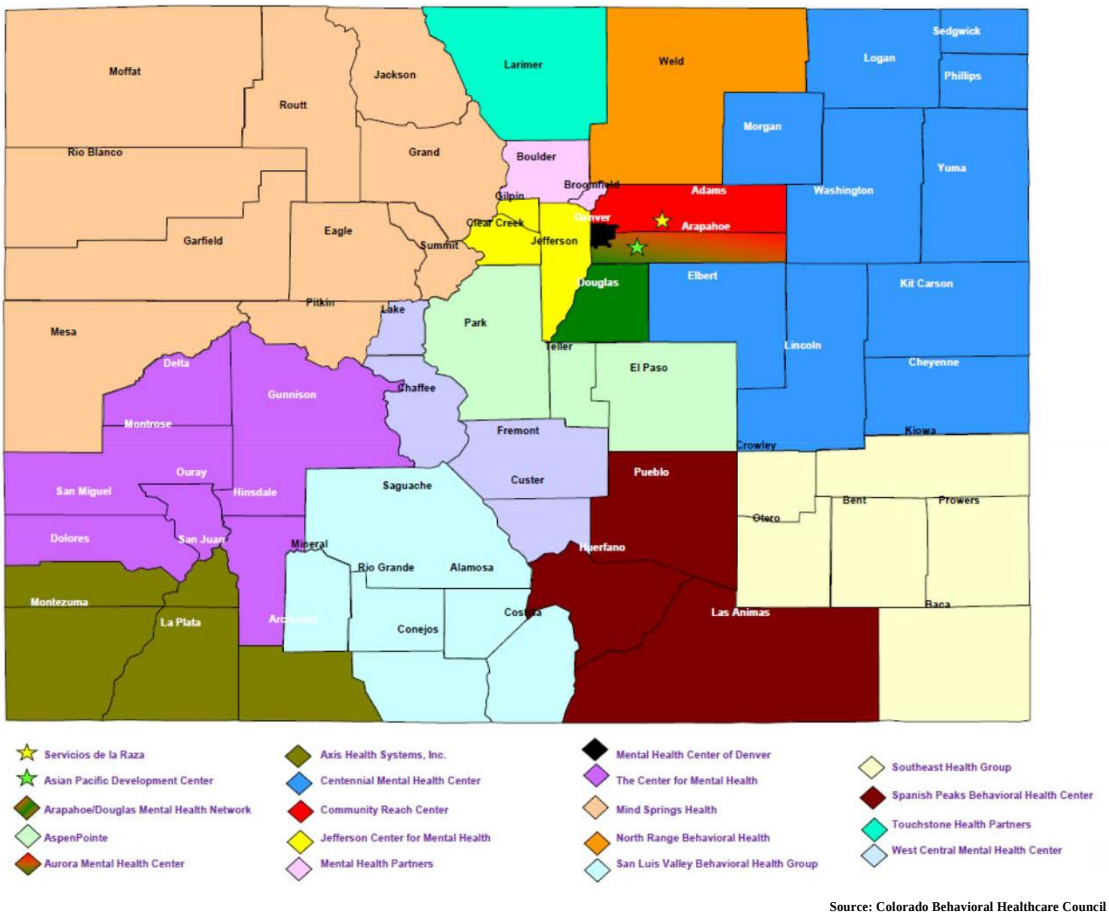
Among the many mental health providers that provide services to ethnic minorities, there are two specialty clinics that provide mental health services that take language and cultural requirements into account. Servicios de La Raza provides services to Latino/ Hispanic persons with serious mental illnesses, while the Asian Pacific Center for Human Development provides services to Asian and Pacific Islander persons with serious mental illnesses.

To quality for OBH-funded treatment services, adult and older-adult clients must have a Serious Mental Illness (SMI). Children may or may not have a Serious Emotional Disturbance (SED and adolescents must have an SED. In addition, the individual must:

- Have an income less than 300 percent of the federal poverty level
- Not be eligible for Medicaid
- Not receive mental health care from any other source.

The following map details the 17 community mental health centers and two specialty clinics.

Figure 2: Community Mental Health Centers by County Served



Source: Colorado Behavioral Healthcare Council

Each CMHC is responsible for providing a set of core services including assessment; rehabilitation; emergency services; clinical treatment services; residential services; inpatient services; vocational services; psychiatric/medication management; interagency consultation; public education; early intervention; consumer advocacy and family support; case management; and day treatment, home-based family support, and/or residential support services.

Each CMHC has designated access to inpatient beds at one of the mental health institutes, and is responsible for managing admissions to the available beds for adults within its service area. These allotted inpatient beds are funded through the Mental Health Institutes subsection of the state's Long Appropriation Bill. If a CMHC requires additional inpatient beds for adults within its service area, it must purchase the services directly from other public or private hospitals.

Categorical services for indigent individuals. In addition to a set allocation amount for services to indigent adults and youth, OBH funds CMHCs and community providers to provide various categorical services, including:

- Medications for medically indigent clients

- School-based mental health services
- Support for Acute Treatment Unit (ATU) facilities operated by two mental health centers
- Assertive Community Treatment (ACT) programs
- Intensive case-management services provided by one mental health center
- Services for adult and juvenile offenders
- Alternatives to inpatient hospitalization at a mental health institute
- Jail-based behavioral health services to county jail inmates with a substance use disorder, including a co-occurring mental health disorder
- Co-occurring behavioral health services to adolescents and adults in southern Colorado and the Arkansas Valley
- Vocational rehabilitation services
- Services for individuals who are deaf.

Other services (not limited to indigent individuals). OBH funds services that are not limited to indigent (non-Medicaid eligible) individuals, including:

- Mental health treatment services for youth without a dependency or neglect action
- Mental Health First Aid
- Crisis response services, including statewide telephone hotline/warm line, walk-in, stabilization, mobile, residential, and respite services
- Statewide marketing for crisis response services
- Community transition services to individuals served by Behavioral Healthcare Inc. for the provision of intensive case-management services to assist mental health institute patients with their transition to the community.

A more detailed discussion about the statewide crisis response services and community transition services is provided later in this report.

Office of Behavioral Health – Colorado Mental Health Institutes

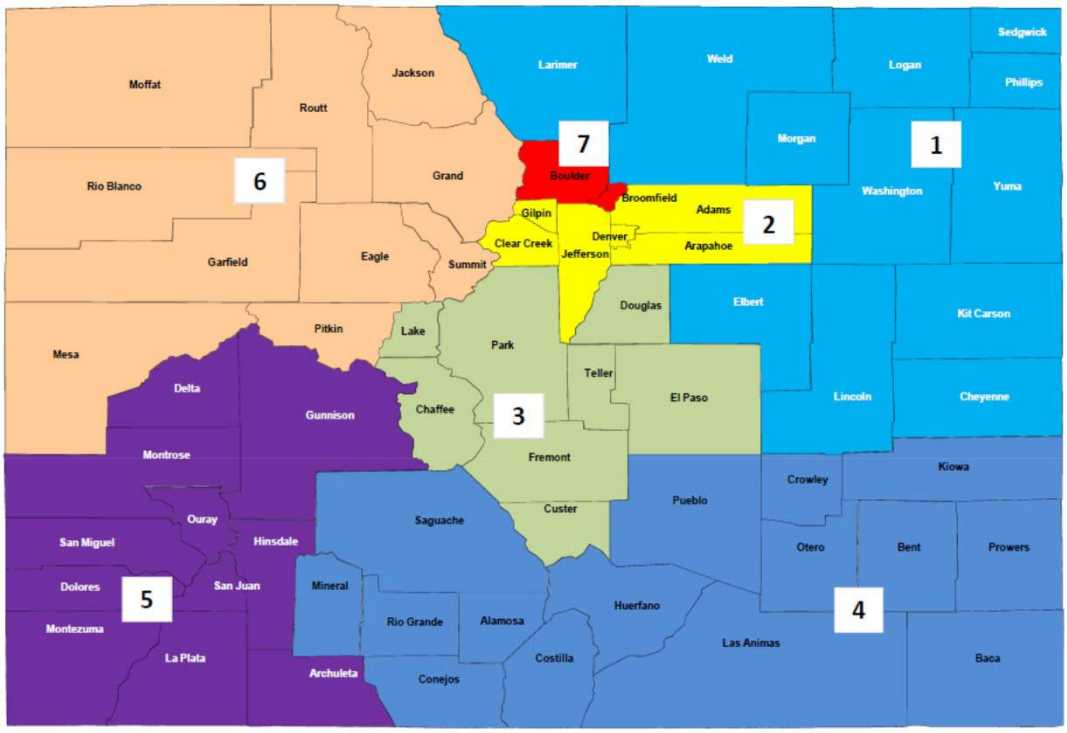
OBH operates two mental health institutes providing inpatient hospitalization for individuals with serious mental illness. The institutes serve as the state safety net provider of inpatient psychiatric services, treating primarily indigent, Medicaid-eligible, and Medicare-eligible individuals. The Colorado Mental Health Institute at Fort Logan (CMHIFL) serves adults civilly committed to inpatient care and includes four inpatient units totaling 94 beds. The Colorado Mental Health Institute at Pueblo (CMHIP) serves adolescents, adults, and older adults ordered by the courts for treatment, under a civil or forensic (criminal) commitment, and include 451 beds. (These beds were reduced to 449 in July 2014; however the most recent fiscal year data for this report are based on FY 2013-14 data.)

Office of Behavioral Health - Substance Use Services

Treatment and detoxification services. OBH contracts with four managed service organizations (MSOs) for the provision of substance-use disorder treatment and detoxification services in

seven catchment areas for indigent individuals who are not eligible for Medicaid and to provide services not covered by Medicaid. The MSOs subcontract with 40 local treatment providers in locations around the state to deliver these services. OBH requires the MSOs to place an emphasis on providing services to persons involuntarily committed by the courts, pregnant women and women with dependent children, adult and adolescent intravenous drug users, drug-dependent adults and adolescents with human immunodeficiency virus (HIV) or tuberculosis, and uninsured individuals. The map below depicts the seven MSO catchment areas.

Figure 2: Managed Service Organization Catchment Areas



MSO	SSPA
Boulder County Public Health	7
AspenPointe	3
Signal Behavioral Health Network, Inc.	1, 2, 4
West Slope Casa, LLC	5, 6

Source: Colorado Behavioral Healthcare Council

The Office of Behavioral Health arranges for non-hospital detoxification and treatment services with one contract for each catchment area. However, treatment and detoxification are two different levels of care that have separate and distinct contract admissions requirements.

- *Non-hospital detoxification services.* Individuals who are intoxicated by alcohol or drugs are evaluated and provided services necessary to protect client and public health and

safety until the blood level of the intoxicating substance(s) is zero. Detoxification and shelter services serve a dual purpose by protecting individual and public health and safety, and serving as an entry point for treatment. Detoxification services are critical for law enforcement and community protection, but do not constitute treatment for substance abuse.

- *Treatment.* Basic treatment services include: detoxification; outpatient opioid replacement treatment; individual, group, and family outpatient therapy; intensive outpatient therapy; transitional residential treatment; therapeutic community, and intensive residential treatment.

Prevention program services. OBH contracts with statewide and local prevention programs by providing partial funding for services designed to prevent the illegal and inappropriate use of alcohol, tobacco, and other drugs. Services include mentoring, tutoring, life skills training, parenting training, creative arts, education/resource centers, DUI prevention programs, and employee assistance programs. Prevention strategies used by OBH, and its contractors include:

- Information distribution regarding the nature and extent of use, abuse, and its effects on individuals, families, and communities
- Substance-free activity development for community events
- Community development, which helps groups, neighborhoods, or communities plan and implement a range of prevention services
- Prevention education, which involves a structured, formal research-based curriculum and problem identification and assessment, which determines whether substance abusing and behavior can be reversed through education
- Community-based efforts to establish or change written and unwritten community standards and attitudes influencing the incidence and prevalence of the abuse of alcohol, tobacco, and other drugs.

Department of Health Care Policy and Financing – Mental Health Capitation Program

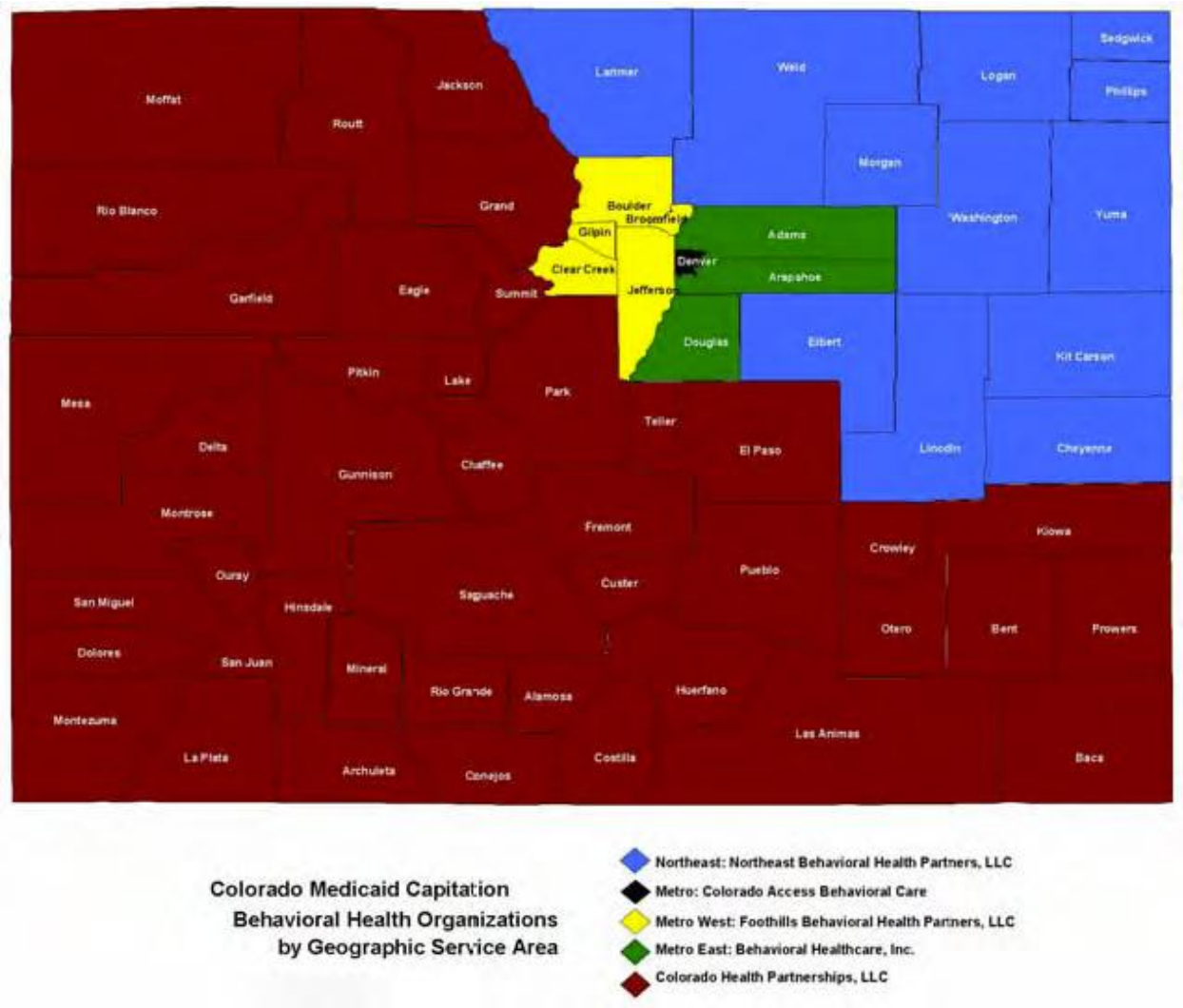
The majority of behavioral health services in Colorado are funded through the joint state-federal Medicaid program administered by HCPF. Services are funded through two primary mechanisms. HCPF contracts with Behavioral Health Organizations (BHOs) through a Medicaid mental health capitation program. In this model, HCPF pays the BHOs a specified capitation rate on a per member-per-month basis for eligible consumers who live within the geographical catchment area of the BHO. Under this system, the BHO is at risk in that it must provide services to all Medicaid-eligible consumers who are in need of and present for services. The BHOs then subcontract with a number of providers (including CMHCs) within their catchment areas.

Since January 1, 2014, BHOs have also been responsible for providing SUD services to Medicaid clients. Similar to mental health services provided by BHOs, a client must have a covered SUD

diagnosis, and receive a covered SUD service or procedure that is medically necessary. Covered services include: alcohol/drug assessment, detoxification services, individual and group behavioral health therapies, targeted case management, drug screening and monitoring, medication-assisted treatment, and peer advocate services.

The map below depicts the five regional BHOs with which HCPF contracts.

Figure 3: Behavioral Health Organizations by County Served



Other Medicaid behavioral health programs. In addition to the mental health capitation program, HCPF provides:

- A fee-for-service mental health program for individuals not included in the capitation program
- A Home and Community Based Services (HCBS) mental health services waiver program
- Fee-for-service Medicaid psychiatric residential treatment facility (PRTF) benefit for children
- Fee-for-service Colorado Child Health Plan Plus (CHP+) mental health services.

Colorado Indigent Care Program (CICP): Some clients may access care through the Colorado Indigent Care Program administered by HCPF. CICP is focused primarily on healthcare and not mental health care. It is possible that some mental health services are provided by some of the CICP providers but we are unable to determine either the types of services provided or the number of individuals receiving mental health services funded by CICP.

Mental health capitation services. Under the terms of the contract with HCPF, BHOs are required to provide the following services to BHO members with a covered diagnosis:

- Inpatient hospitalization*
- Outpatient services, including:
  - -psychiatrists
  - -rehabilitative services
  - -group behavioral health therapy
  - -individual behavioral health therapy
  - -individual brief behavioral health therapy
  - -family behavioral health therapy
  - -behavioral health assessment
  - -medication management
  - -outpatient day treatment
- Emergency services
- Crisis services, including emergency services and post-stabilization care services
- School-based services
- Targeted case management
- Alcohol and/or drug assessment
- Drug screening and monitoring
- Medication-assisted treatment
- Outpatient hospital services
- Detoxification and related services
- Covered 1915(b)(3) waiver (alternative) services, including:
  - -vocational services
  - -intensive case management
  - -prevention/early intervention activities
  - -clubhouse and drop-in centers
  - -residential services* (24-hour care provided in a non-hospital, non-nursing home setting, excluding room and board)
  - -Assertive Community Treatment (ACT)
  - -recovery services
  - -respite services

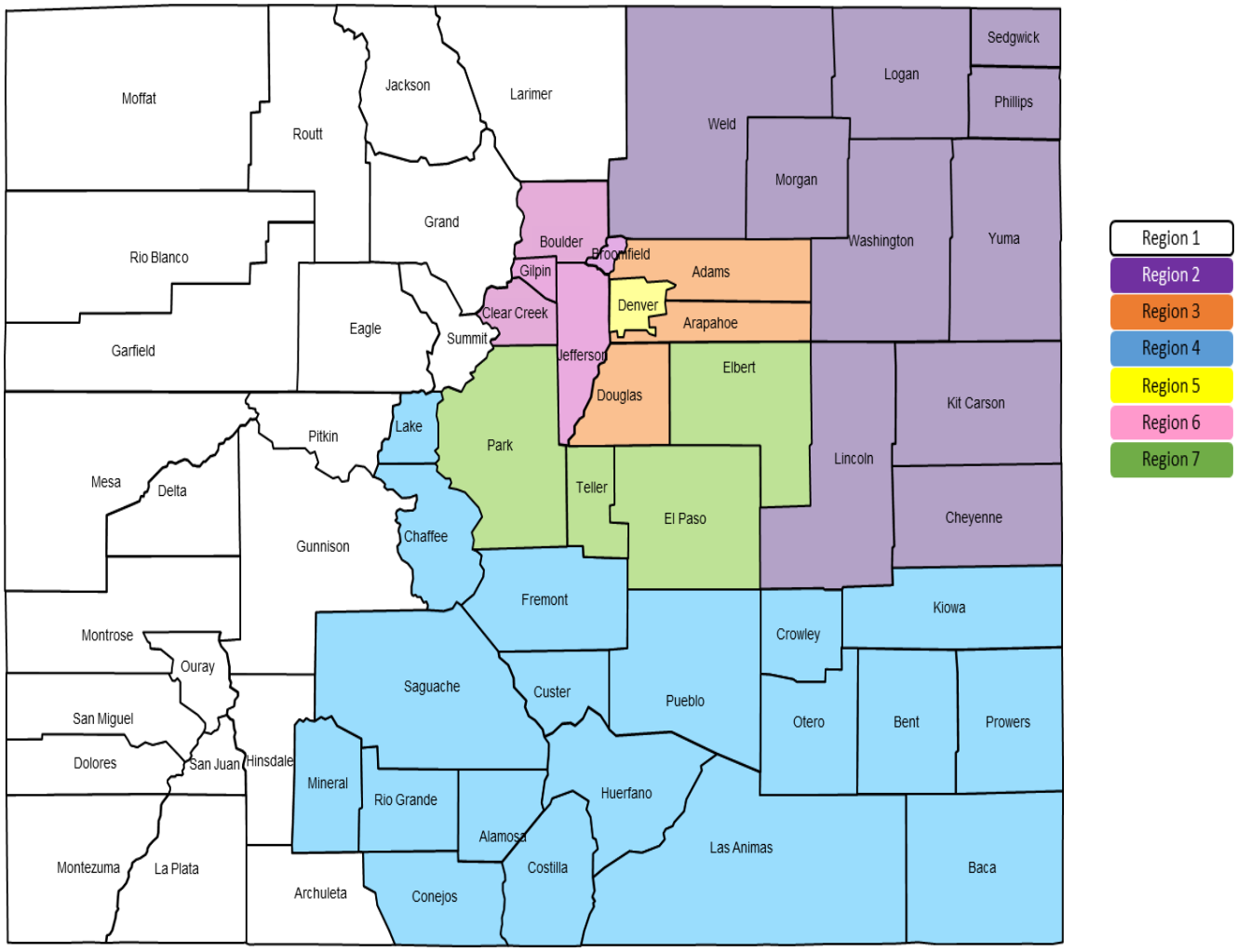
Services noted with an asterisk (*) are not covered for a client for whom the primary diagnosis is a substance use disorder (SUD). However, Medicaid covers service costs during the assessment period of the client's hospitalization even if the primary diagnosis is ultimately

determined to be a SUD.

Colorado behavioral health study regions

For the most part, the data provided in this report are based on the regions identified in the map below. These regions are also the state regions used for the Accountable Care Collaborative (ACC) program administered by HCPF. The ACC is the state's primary-care Medicaid program. Seven Regional Care Collaborative Organization (RCCOs) provide a network of care and direct clients to providers. Data are also provided based on Behavioral Health Organization (BHO) and CMHC catchment area boundaries when data were not available based on RCCO boundaries. It is important to note that RCCO, BHO, and CMHC boundaries do not match up directly.

Figure 4: Regional Care Collaboration Organizations – Regions Used for Study



The agencies that responded to the inventory are identified below, with region noted in parentheses:

- Arapahoe Douglas Mental Health (3)
- ARTS (2)
- AspenPointe Inc. (7)
- Aurora Mental Health Center (3)
- Axis Health System Inc. (1)
- Centennial Mental Health Center (2)
- Community Reach Center (3)
- Jefferson Center for Mental Health (6)
- Mental Health Center of Denver (5)
- Mental Health Partners (6)
- North Range Behavioral Health (2)
- Servicios de la Raza (5)
- San Luis Valley Behavioral Health (4)
- Sobriety House (5)
- Solvista Health (4)
- Southeast Health Group (4)
- Spanish Peaks Behavioral Health Centers (4)
- The Center for Mental Health (1) formerly Midwestern Colorado Mental Health Center
- Touchstone Health Partners (1)

The table below identified the population from the Colorado State Demography Office by region for the identified age groups.

2015 Projected Population by Age Group

Region	0-19 years	20-39 years	40-59 years	60+ years	Total
1	368,413	384,023	365,475	267,981	**1,385,892**
2	108,958	100,611	94,605	67,558	**371,732**
3	264,608	242,970	275,443	162,587	**945,608**
4	85,842	86,403	92,039	93,467	**357,751**
5	162,703	239,816	161,187	111,608	**675,314**
6	229,232	251,902	277,339	202,615	**961,088**
7	206,334	205,985	194,822	134,555	**741,696**
Colorado	**1,426,090**	**1,511,710**	**1,460,910**	**1,040,371**	**5,439,081**

Individuals served and services provided (FY 2013-14)

The following section provides data about the number of clients served, and services provided, by providers funded by OBH and HCPF.[2] It is important to note that the data on individuals served and services provided have limitations. Both HCPF and OBH data include clients served by OBH and HCPF, respectively. Also the HCPF data does not separate mental health and substance use clients receiving services.

OBH indigent (non-Medicaid) individuals served in FY 2013-14. OBH contracts with the CMHCs to provide mental health services to individuals not eligible for the Medicaid program. These contracts define the populations of "targeted" indigent individuals to be served as follows:

- Adults and older adults with serious and persistent mental illness (SPMI) - persons who have a mental illness that seriously impairs their ability to be self-sufficient, and who have been persistently ill for more than a year or have been hospitalized for intensive mental health treatment.

- Adults and older adults with serious mental illness (SMI) - persons who are diagnosed with major mental illnesses such as schizophrenia or severe affective disorders but who may not meet the definition of "persistent" because of the duration of their illness, the intensity of treatment they have received formerly, or the level of their dysfunction.

- Children with serious emotional disturbances (SED) and/or non-SED children - children defined as those ages 0-11 who have emotional or mental health problems so serious that their ability to function is significantly impaired and, as a result, their ability to stay in their natural homes may be in jeopardy.

- Non-SED children - defined as those ages 0-11 who have emotional or mental health problems that are in need of early intervention.

- Adolescents with SED - youth ages 12-17 who have emotional or mental health problems so serious that their ability to function is significantly impaired and, as a result, their ability to stay in their natural homes may be in jeopardy.

- Non-SED adolescents - defined as those adolescents ages 12-17 who have emotional or mental health problems that are in need of early intervention.

Table 1 details the number of unique individuals served in FY 13-14 by region.

Table 1: OBH Indigent Mental Health - Ever target status during FY 2013-14 (Non-Medicaid)								
	Region							
	1	2	3	4	5	6	7	TOTAL
Child SED	1,387	802	1,588	957	611	1,013	991	7,349
Child Non SED	122	66	283	145	57	207	72	952
Adolescent SED	886	606	992	526	456	723	704	4,893
Adolescent Non SED	426	241	736	362	223	614	289	2,891
Adult SPMI	765	309	549	516	503	513	391	3,546
Adult SMI	3,547	1,784	3,260	2,616	1,656	3,331	2,098	18,292
Adult Non SPMI/SMI	1,741	628	1,484	832	397	1,100	628	6,810
Older Adult SPMI	97	41	40	34	54	83	18	367
Older Adult SMI (Over age 50)	1,001	417	764	761	511	1,056	576	5,086
Older Adult No SPMI/SMI	96	44	65	44	31	158	33	471
TOTAL	**10,068**	**4,938**	**9,761**	**6,793**	**4,499**	**8,798**	**5,800**	**50,657**

OBH substance use individuals served. Table 2 below details the number of unique individuals who received substance use services during FY 2013-14, by region. Please note that some of these individuals may also be included in the Medicaid capitation program data provided in Table 3.

Table 2: Substance Use - Age Groupings by Region (OBH) FY2013-14								
	Region							
	1	2	3	4	5	6	7	TOTAL
Child/Adolescent	408*	294*	522*	349*	286*	677	263*	2,799
Adult	9,594	4,627	13,990	7,327	12,828	9,984	7,410	65,759
Older Adult (Age 50 or Over)	408	294*	522*	349	286	6772	263	2,799
TOTAL	**11,964**	**5,723**	**17,305**	**9,456**	**16,911**	**12,827**	**9,412**	**83,598**

*The data provided included age ranges where the value was less than 10 individuals and therefore not reportable due to HIPAA regulations. The total number served was derived from a different table within the spreadsheet, so it does not exactly match the data within this table.

HCPF Medicaid Capitation Program individuals served in FY 2013-14. Table 3 provides the number of unique individuals served by the Mental Health Capitation Program in FY 2013-14.

Table 3: Medicaid Capitation Program - Population Served by Region (FY 2013-14)								
	Region							
	1	2	3	4	5	6	7	TOTAL
Child/Adolescent	4,407	2,477	8,253	3,476	4,413	3,908	4,424	31,358
Adult	6,857	2,777	9,195	5,772	7,536	6,062	5,431	43,630
Older Adult (Age 50 or Over)	2,270	944	2,832	2,152	3,999	2,435	1,730	16,362
Total Served	**13,534**	**6,198**	**20,280**	**11,400**	**15,948**	**12,405**	**11,585**	**91,350**

NOTE: Some of the individuals served are counted in both of the above tables depending on changes in Medicaid eligibility—and whether, if Medicaid-eligible, they also receive services provided through OBH contracts. Therefore, the data from these tables should not be combined, as it would be a duplicated count of persons served.

Services Provided to OBH Clients. Tables 4 and 5 provide details about services provided to OBH clients in FY 2013-14.

Table 4: OBH Indigent Mental Health – Services Provided by Region (FY 2013-14)								
	Region							
Service Category	1	2	3	4	5	6	7	TOTAL
Alcohol / Drug Assessment	90	77	156	51	207	2,207	57	2,845
Alcohol / Drug Case Management	0	8	3	0	0	0	4	15
Alcohol / Drug Tx / Recovery Service	1	0	5	118	0	0	0	124
Case Management	1,243	1,129	1,363	1,395	1,706	2,457	278	9,571
Community Integration	0	0	18	0	0	0	0	18
Crisis Intervention	1,161	14	253	739	31	362	57	2,617
Domiciliary Care	0	0	0	0	0	66	0	66
Drug Screening	0	0	89	0	13	0	0	102
Hospital Care	641	0	0	0	0	0	0	641
Medication Administration	55	65	629	1,010	247	384	25	2,415
Medication Management	5	15	169	3	509	60	4	765
Mental Health Assessment	1,496	692	1,745	1,125	873	1,769	459	8,159
Multidisciplinary Evaluation	85	0	1	0	0	0	0	86

Table 4 continued: OBH Indigent Mental Health – Services Provided by Region (FY 2013-14)								
	Region							
Service Category	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**TOTAL**
Office / Outpatient Visit	741	513	798	338	988	1,799	243	5,420
Psych Testing	0	2	0	2	27	2	1	34
Res SUD Tx Program	254	19	849	176	80	110	89	1,577
Res SUD Tx Program - Long Term	277	0	71	0	2,461	467	0	3,276
Res SUD Tx Program - Short Term	0	0	111	0	545	554	0	1,210
Respite Care	0	0	0	18	0	0	0	18
Skilled Nursing Facility Care	0	0	0	0	5	3	0	8
SUD Outreach Service	65	72	329	57	1,678	398	289	2,888
SUD Prevention Education	4	58	29	1	18	834	68	1,012
Supported Housing	0	0	9	0	0	0	0	9
Treatment/Recovery Service	6,340	3,296	10,062	3,874	5,241	9,082	2,337	40,232
Tx Plan Development	7	1	204	255	613	250	73	1,403
Grand Total	**12,465**	**5,961**	**16,893**	**9,162**	**15,242**	**20,804**	**3,984**	**84,511**

Note: Does not include 704 "add on" service codes added to services to reflect case complexity

Table 5: OBH Indigent Mental Health – Services Provided by Percent of Total Services (FY 2013-14)								
	Region							
Service Category	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**TOTAL**
Treatment/Recovery Service	50.86%	55.29%	59.56%	42.28%	34.39%	43.66%	58.66%	47.61%
Case Management	9.97%	18.94%	8.07%	15.23%	11.19%	11.81%	6.98%	11.33%
Mental Health Assessment	12.00%	11.61%	10.33%	12.28%	5.73%	8.50%	11.52%	9.65%
Office / Outpatient Visit	5.94%	8.61%	4.72%	3.69%	6.48%	8.65%	6.10%	6.41%
Res SUD Tx Program - Long Term	2.22%	0.00%	0.42%	0.00%	16.15%	2.24%	0.00%	3.88%
SUD Outreach Service	0.52%	1.21%	1.95%	0.62%	11.01%	1.91%	7.25%	3.42%
Alcohol / Drug Assessment	0.72%	1.29%	0.92%	0.56%	1.36%	10.61%	1.43%	3.37%
Crisis Intervention	9.31%	0.23%	1.50%	8.07%	0.20%	1.74%	1.43%	3.10%
Medication Administration	0.44%	1.09%	3.72%	11.02%	1.62%	1.85%	0.63%	2.86%
Res SUD Tx Program	2.04%	0.32%	5.03%	1.92%	0.52%	0.53%	2.23%	1.87%

Table 5 con't.: OBH Indigent Mental Health – Services Provided by Percent of Total Services (FY 2013-14)								
	Region							
Service Category	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**TOTAL**
Tx Plan Development	0.06%	0.02%	1.21%	2.78%	4.02%	1.20%	1.83%	1.66%
Res SUD Tx Program - Short Term	0.00%	0.00%	0.66%	0.00%	3.58%	2.66%	0.00%	1.43%
SUD Prevention Education	0.03%	0.97%	0.17%	0.01%	0.12%	4.01%	1.71%	1.20%
Medication Management	0.04%	0.25%	1.00%	0.03%	3.34%	0.29%	0.10%	0.91%
Hospital Care	5.14%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.76%
Alcohol / Drug Tx / Recovery Service	0.01%	0.00%	0.03%	1.29%	0.00%	0.00%	0.00%	0.15%
Drug Screening	0.00%	0.00%	0.53%	0.00%	0.09%	0.00%	0.00%	0.12%
Multidisciplinary Evaluation	0.68%	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.10%
Domiciliary Care	0.00%	0.00%	0.00%	0.00%	0.00%	0.32%	0.00%	0.08%
Psych Testing	0.00%	0.03%	0.00%	0.02%	0.18%	0.01%	0.03%	0.04%
Community Integration	0.00%	0.00%	0.11%	0.00%	0.00%	0.00%	0.00%	0.02%
Respite Care	0.00%	0.00%	0.00%	0.20%	0.00%	0.00%	0.00%	0.02%
Alcohol / Drug Case Management	0.00%	0.13%	0.02%	0.00%	0.00%	0.00%	0.10%	0.02%
Supported Housing	0.00%	0.00%	0.05%	0.00%	0.00%	0.00%	0.00%	0.01%
Skilled Nursing Facility Care	0.00%	0.00%	0.00%	0.00%	0.03%	0.01%	0.00%	0.01%
Grand Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Note: Does not include 704 "add on" service codes added to services to reflect case complexity

Observations

- As Table 5 indicates, the majority of services provided were treatment and recovery services, at 47.6 percent, followed by case management, at 11.3 percent. Assessment services ranked third, at 9.6 percent, followed by office visits, at 6.4 percent. Treatment and recovery services include individual, family, and group psychotherapy, peer services, clubhouse services, and other miscellaneous treatment services.
- Statewide, the three most-provided services, from highest to lowest, were treatment/recovery, case management, and mental health assessment. These were also the most-provided services in all regions, except regions 5 and 6.
- In region 5, mental health assessment was the fifth most-provided service, preceded by SUD outreach and residential SUD long-term treatment.
- In region 6, alcohol/drug assessment and office/outpatient were preceded by the top three statewide.
- Office/outpatient was also a frequently provided service in regions 2 and 7.

- Region 1's next most-provided service was crisis intervention and it provided significantly more of this service than the other regions.
- Region 3's next most-provided service was residential SUD treatment.
- Region 4's next most-provided service was medication administration.
- Relatively few alcohol/drug case management, community integration, hospital care, multidisciplinary evaluation, respite, skilled nursing facility care, and supported housing services are provided in most of the regions.

Services per capita provided to OBH clients. Table 6 details per-capita services provided by region based on the number of individuals under 300 percent Federal Poverty Level (FPL) for the statewide population.

Table 6: OBH Indigent Mental Health – Services Per Capita by Region as a Percent of Individuals below 300 Percent of the Federal Poverty Level (FY 2013-14)

	Region							
	1	**2**	**3**	**4**	**5**	**6**	**7**	**Total**
Services	12,465	5,961	16,893	9,162	15,242	20,804	3,984	84,511
Pop <300% FPL	628,385	180,493	317,842	222,883	327,689	327,883	311,962	2,317,137
Services per Capita	**0.020**	**0.033**	**0.053**	**0.041**	**0.047**	**0.063**	**0.013**	**0.036**

Observation

- The statewide average number of services per capita is 0.036. Region 7 has the fewest number of services provided per capita, at 0.013 (or 35.0 percent below the statewide average) and region 6 has the highest number of services provided, at 0.063 (or 174.0 percent above the statewide average).

Services provided to Medicaid Capitation Program clients

Table 7: Medicaid Capitation – Services by Region (FY 2013-14)

	Region							
Service Category	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Total**
Alcohol/Drug Prevention Education		185	327	60	85	856	312	1,825
Alcohol or Drug Assessment	1,889		4,545		2,132	828		9,394
Alcohol or Drug Case Management		42		86		51	143	322

Table 7 continued: Medicaid Capitation – Services by Region (FY 2013-14)								
	Region							
Service Category	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Total**
Alcohol or Drug Outreach	3,473	899	250	457	1,933	1,726	558	9,296
Alcohol or Drug Treatment	241	52	122	79	259			753
Case Management	4,469		9,567		14,052			28,088
Community Integration					65			65
Crisis Intervention			3,904		4,935	569		9,408
Detox Progress Assessment							55	55
Domiciliary Care			194		160			354
Drug injection							189	189
Drug Screening		449	240		61	69	84	903
Hospital Care	1,579	1,107	1,241	1,148	4,201	483	933	10,692
Hospital Outpatient Clinic Visit			134		91			225
Lab / Medical	3,393	2,611	4,079	2,431	5,943	2,416	1,239	22,112
Med Assisted Treatment - Methadone	172							172
Medication Admin	286		579	245	1,572		234	2,916
Medication Administration	107							107
Medication Management	1,697		802	1,576	160	528	416	5,179
MH Assessment	10,569	2,332	12,250	10,445	7,952	2,177	2,814	48,539
Multidisciplinary Evaluation			164					164
Multisystemic Therapy	37			35	58			130
Office / Outpatient Visit	1,383	45	4,740	800	11,682	21,718	11,008	51,376
Psych Testing	80	135	235		48			498
Res SUD Tx Program	96		805		371			1,272
Res SUD Tx Program - Long Term			93	47	288	51		479
Res SUD Tx Program - Short Term	180	69	643	55	435	395	136	1,913
Respite Care	39			44				83
Skilled Nursing Facility Care	43	58	70		143	110	56	480
Supported Employment	143		186		463	250		1,042
Supported Housing				112				112
Transportation	51	185	54		34	64	128	516

Table 7 continued: Medicaid Capitation – Services by Region (FY 2013-14)								
	Region							
Service Category	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**Total**
Treatment Conference						223	46	269
Treatment Plan Development	1,030	2,999		3,877	435	2,465	67	10,873
Treatment/Recovery Service	16,660	11,216	29,667	11,391	26,893	31,754	13,154	140,735
Wrap-around Services			45	178	149			372
Total	**47,617**	**22,384**	**74,936**	**33,066**	**84,600**	**66,733**	**31,572**	**360,908**

Note: Does not include 5,585 "add on" service codes added to services to reflect case complexity.

Table 8: Medicaid Capitation – Services by Region - Percent of Total (FY 2013-14)								
	Region							
	1	**2**	**3**	**4**	**5**	**6**	**7**	**Total**
Treatment/Recovery Service	34.99%	50.11%	39.59%	34.45%	31.79%	47.58%	41.66%	38.99%
Office / Outpatient Visit	2.90%	0.20%	6.33%	2.42%	13.81%	32.54%	34.87%	14.24%
MH Assessment	22.20%	10.42%	16.35%	31.59%	9.40%	3.26%	8.91%	13.45%
Case Management	9.39%	0.00%	12.77%	0.00%	16.61%	0.00%	0.00%	7.78%
Lab / Medical	7.13%	11.66%	5.44%	7.35%	7.02%	3.62%	3.92%	6.13%
Treatment Plan Development	2.16%	13.40%	0.00%	11.73%	0.51%	3.69%	0.21%	3.01%
Hospital Care	3.32%	4.95%	1.66%	3.47%	4.97%	0.72%	2.96%	2.96%
Crisis Intervention	0.00%	0.00%	5.21%	0.00%	5.83%	0.85%	0.00%	2.61%
Alcohol or Drug Assessment	3.97%	0.00%	6.07%	0.00%	2.52%	1.24%	0.00%	2.60%
Alcohol or Drug Outreach	7.29%	4.02%	0.33%	1.38%	2.28%	2.59%	1.77%	2.58%
Medication Management	3.56%	0.00%	1.07%	4.77%	0.19%	0.79%	1.32%	1.43%
Medication Admin	0.60%	0.00%	0.77%	0.74%	1.86%	0.00%	0.74%	0.81%
Res SUD Tx Program - Short Term	0.38%	0.31%	0.86%	0.17%	0.51%	0.59%	0.43%	0.53%
Alch/Drug Prevention Ed.	0.00%	0.83%	0.44%	0.18%	0.10%	1.28%	0.99%	0.51%
Res SUD Tx Program	0.20%	0.00%	1.07%	0.00%	0.44%	0.00%	0.00%	0.35%
Supported Employment	0.30%	0.00%	0.25%	0.00%	0.55%	0.37%	0.00%	0.29%
Drug Screening	0.00%	2.01%	0.32%	0.00%	0.07%	0.10%	0.27%	0.25%
Alcohol or Drug Treatment	0.51%	0.23%	0.16%	0.24%	0.31%	0.00%	0.00%	0.21%
Transportation	0.11%	0.83%	0.07%	0.00%	0.04%	0.10%	0.41%	0.14%
Psych Testing	0.17%	0.60%	0.31%	0.00%	0.06%	0.00%	0.00%	0.14%
Skilled Nursing Facility Care	0.09%	0.26%	0.09%	0.00%	0.17%	0.16%	0.18%	0.13%
Res SUD Tx Program - Long Term	0.00%	0.00%	0.12%	0.14%	0.34%	0.08%	0.00%	0.13%
Wraparound Services	0.00%	0.00%	0.06%	0.54%	0.18%	0.00%	0.00%	0.10%

Table 8 continued: Medicaid Capitation – Services by Region - Percent of Total (FY 2013-14)								
	Region							
	1	2	3	4	5	6	7	Total
Domiciliary Care	0.00%	0.00%	0.26%	0.00%	0.19%	0.00%	0.00%	0.10%
Alcohol or Drug Case Mgmt	0.00%	0.19%	0.00%	0.26%	0.00%	0.08%	0.45%	0.09%
Treatment Conference	0.00%	0.00%	0.00%	0.00%	0.00%	0.33%	0.15%	0.07%
Hospital Outpatient Clinic Visit	0.00%	0.00%	0.18%	0.00%	0.11%	0.00%	0.00%	0.06%
Drug injection	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.60%	0.05%
Med Assisted Tx - Methadone	0.36%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.05%
Multidiscipline Evaluation	0.00%	0.00%	0.22%	0.00%	0.00%	0.00%	0.00%	0.05%
Multisystemic Therapy	0.08%	0.00%	0.00%	0.11%	0.07%	0.00%	0.00%	0.04%
Supported Housing	0.00%	0.00%	0.00%	0.34%	0.00%	0.00%	0.00%	0.03%
Medication Administration	0.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%
Respite Care	0.08%	0.00%	0.00%	0.13%	0.00%	0.00%	0.00%	0.02%
Community Integration	0.00%	0.00%	0.00%	0.00%	0.08%	0.00%	0.00%	0.02%
Detox Progress Assessment	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.17%	0.02%
Total	**13.19%**	**6.20%**	**20.76%**	**9.16%**	**23.44%**	**18.49%**	**8.75%**	**100.00%**

Note: Does not include 5,585 "add on" service codes added to services to reflect case complexity.

Observations

- The majority of services provided to Capitation Program clients were treatment and recovery services, at 38.9 percent, followed by office/outpatient visits, at 14.2 percent.
- Assessment services were the third most frequently provided service, at 13.5 percent, followed by case management and lab/medical services (including substance use testing and minor medical procedures) at 7.8 percent and 6.1 percent, respectively.
- Treatment and recovery services include individual, family, and group psychotherapy, peer services, clubhouse services, and other miscellaneous treatment services.

Services per capita provided to Medicaid Capitation Program clients. Table 9 details per-capita services provided by region to Medicaid capitation clients based on the number of individuals under 300 percent Federal Poverty Level (FPL) for the statewide population.

Table 9: Per Capita Services by Region - Medicaid Capitation Program as a Percent of Individuals below 300 Percent of the Federal Poverty Level (FY 2013-14)								
	Region							
	1	2	3	4	5	6	7	Total
Services	47,617	22,384	74,936	33,066	84,600	66,733	31,572	360,908
Pop <300% FPL	628,385	180,493	317,842	222,883	327,689	327,883	311,962	2,317,137
Services per Capita	**0.076**	**0.124**	**0.236**	**0.148**	**0.258**	**0.204**	**0.101**	**0.156**

Observations

- The statewide average number of services per capita is 0.156.
- Region 1 has the fewest number of services provided per capita, at 0.076, or 48.7 percent below the statewide average.
- Region 5 has the highest number of services provided, at 0.258, or 165.8 percent above the statewide average.

Services per capita – OBH and Medicaid Capitation Program clients

Table 10: Per Capita Services by Region – Medicaid Capitation and OBH Clients as a Percent of Individuals below 300 Percent of the Federal Poverty Level (FY 2013-14)								
	Region							
	1	2	3	4	5	6	7	Total
Medicaid Capitation Services per Capita	0.076	0.124	0.236	0.148	0.258	0.204	0.101	0.156
OBH Services per Capita	0.020	0.033	0.053	0.041	0.047	0.063	0.013	0.036
OBH Percentage of Medicaid Capitation Services	**26.3%**	**26.6%**	**22.5%**	**27.7%**	**18.2%**	**30.9%**	**12.9%**	**23.1%**

Observations

- OBH services, on a statewide basis, represent 23.1 percent of Medicaid capitation services provided on a statewide basis.
- The greatest variance between OBH and Medicaid capitation services is in Region 7, where OBH services represent 12.9 percent of Medicaid capitation services.
- It is important to note that the Medicaid capitation services numbers include SUD services provided in FY 2013-14, as the Capitation Program included some SUD services as a covered service beginning Jan. 1, 2014.

SUD services provided to individuals served by OBH. Based on an interpretation of federal privacy law and rules, OBH was not able to provide WICHE with data about substance use services provided to OBH clients at the time of this study.

CDHS Child Welfare clients receiving behavioral health services FY 2013-14. Table 11 shows the services provided to Child Welfare clients with a serious or moderate mental disability. It is important to note that this table does not include clients served through Medicaid Capitation, OBH funds for non-Medicaid clients, or local or grant-funded programs. Child Welfare caseworkers determine the client's disability and level of disability, which does not represent an actual medical diagnosis prepared by a medical or mental health professional.

A serious mental disability is defined as one of the following diagnoses: dissociative disorder; schizophrenia and other psychotic disorder; autism; antisocial personality disorder; bipolar disorder; conduct disorder; delusional disorder; paranoid personality disorder; psychotic disorder; schizoaffective disorder; schizoid personality disorder; schizophrenia form disorder; schizophrenia; and schizotypal personality disorder.

A moderate mental disability is defined as one of the following diagnoses: anxiety disorder (panic, obsessive-compulsive), eating disorder; mood disorder; oppositional defiant disorder; personality (paranoid, dependence, etc.); emotionally disturbed (DSM - IV); anorexia nervosa; Asperger's syndrome; bulimia; cyclothymic disorder; depressive disorder; histrionic personality disorder; pervasive developmental disorder; and post-traumatic stress disorder (PTSD).

Table 11: Child Welfare Behavioral Health Services Received – By Region (FY 2013-14)

	Region							
	1	**2**	**3**	**4**	**5**	**6**	**7**	**Total**
Out of Home	115	163	250	68	100	157	30	883
Functional Family Therapy	1	4	32	8	1	1	8	55
Intensive Family Therapy	20	10	23	16	2	12	4	87
MH Services	24	59	2	21	26	36	6	174

Table 11 continued: Child Welfare Behavioral Health Services Received – By Region (FY 2013-14)								
	Region							
	1	**2**	**3**	**4**	**5**	**6**	**7**	**Total**
Multi Systemic Therapy	1	10	8	3	5	6	8	41
Sexual Abuse Treatment	4	12	27	7	10	16	4	80
Substance Abuse Treatment	4	5	8	123	2	7	60	209
Total Services Provided	**169**	**263**	**350**	**78**	**146**	**235**	**31**	1272
Unduplicated Clients Served	**120**	**171**	**263**	**68**	**101**	**161**	**30**	**914**

Observations

- Out-of-home services are the most frequently provided service across all regions, except regions 4 and 7.
- The second most-provided service, and the most-provided service in regions 4 and 7, was substance use treatment.
- Mental health services were the third most-provided service across all regions.

OBH clients – level of functioning by percent within each region. These data are reported by providers using the Colorado Client Assessment Record (CCAR), which has been required on all admissions and discharges in the Colorado public mental health system since 1978. The CCAR is a well-established and well-researched tool that lends itself well to exploring and understanding the ability of Colorado's public mental health system to meet the needs of Colorado's indigent and Medicaid populations.[3] The "level of functioning" domain from the CCAR is reported below as functioning in activities of daily living (ADLs).

Table 12: Mental Health – Level of Functioning by Percent within each Region								
	Region							
	1	2	3	4	5	6	7	State Average
1) Functioning well in most ADLs	3.50%	2.30%	4.60%	3.40%	2.60%	5.80%	2.00%	3.70%
2) Between 1 and 3	5.90%	3.90%	8.00%	6.40%	4.90%	5.50%	2.00%	5.60%
3) Adequate functioning in ADLs	27.80%	19.10%	30.00%	20.50%	22.50%	27.10%	18.40%	24.70%
4) Between 3 and 5	20.90%	24.40%	18.80%	21.50%	24.10%	21.60%	22.60%	21.50%
5) Limited functioning in ADLs	22.50%	26.40%	17.30%	22.40%	24.80%	25.50%	26.70%	23.10%
6) Between 5 and 7	9.40%	13.30%	9.20%	12.10%	9.60%	8.30%	13.30%	10.40%
7) Impaired functioning that interferes with most ADLs	8.80%	9.50%	9.70%	12.00%	9.70%	5.30%	11.30%	9.20%
8) Between 7 and 9	1.00%	1.00%	2.00%	1.40%	1.50%	0.70%	2.60%	1.40%
9) Significantly impaired functioning may be life threatening	0.10%	0.10%	0.50%	0.30%	0.20%	0.20%	1.10%	0.30%
TOTAL	**99.90%**	**100.00%**	**100.10%**	**100.00%**	**99.90%**	**100.00%**	**100.00%**	**N/A**

Observations

- Statewide and regionally, most of the individuals served have adequate to limited functioning in activities of daily living.
- Region 7 reports serving more individuals with significantly impaired functioning.

Other populations and services data

Tables 13-16 represent aggregated responses from the service inventory completed by providers as part of this study. Please note these data are not as accurate as the population and services data provided by OBH and HCPF. However, the data do provide a perspective on relative differences in these populations among regions.

Justice-involved clients receiving behavioral health services FY 2013-14

The table below provides provider responses to the approximate number of unduplicated individuals served in FY 2013-14 who were justice-involved (probation, parole, or released from incarceration within six months of receiving services).

Table 13: Justice-Involved Individuals Unduplicated Number Served							
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**Region 7**
On probation	622 +	850 +	1130	80% = 708+	675	101 **	53
On parole	64	110+	427+	188+	10	29**	+
Released from prison or jail within 6 months of receiving services	196 + *	65 +	1190+	+	17	+ **	53
Other justice-involved	485 +	Approx. 453	1,583	+	108	168 **	+

+ Number served unknown/unsure

*Region 1: Numbers includes those served in Halfway House. *Not sure, but number of clients that had their last JBBS service in FY2014 was 240

**Region 6: Total number of criminal justice involved clients served is 1035. The numbers for parole/probation/jail released/other are not able to be calculated.

Table 14: Number of justice-involved individuals served							
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**Region 7**
Mental Health <18	10 +	+	553	47 +	232	20 *	+
Substance Use <18	11 +	+	402	+	90	+ *	+
Co-Occurring MH & SU <18	10 +	+	549	129+	417	* 3	+
Mental Health >18	184+	+	1,811	679 +	3	128*	53
Substance Use >18	185+	Approx 300 SUD or Dual +	282	89 +	0	*	+
Co-Occurring MH & SU >18	672+	+	1,123	118 +	5	147*	30

*Region 6: Total number of adults is 977, juveniles is 58. All were treated for mental health. Substance use and co-occurring are not able to be calculated.
Region 1: 2 youth <18 & 67 adults 18 and older- diagnosis deferred. The Diagnosis Deferred individuals are largely Substance Abuse Monitoring clients.

Table 15: Court-referred Individuals Number Served							
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Mental Health	86+	175+	36	17+	36	100*	10
Substance Use	128+	610 +	7	9+	0	+*	+
Co-Occurring MH & SU	119+	105+	145	69+	20	129*	6

Region 1: 14 diagnosis deferred
*Region 6: Clients were court ordered from drug court, juvenile mental health court, probation, parole, diversion and pre-trial services. The specific numbers are not able to be calculated.

Table 16: Number of Recently Incarcerated Individuals Served							
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**Region 7**
Mental Health	116+	25+	418 +	+	158	69+	53
Substance Use	89+	50 +	480	+	91	+	+
Co-Occurring MH & SU	303+	28+	1,122	30+	360	28+	30

Region 1: 6 diagnosis deferred

Behavioral health clients receiving housing assistance FY 2013-14. The table below summarizes provider responses to the number of individuals receiving housing assistance from the responding provider agency.

Table 17: Number of individuals receiving housing assistance from agency							
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**Region 7**
Mental Health	40*	84	583+ **	119+	171	498	297
Substance Use	5*	21	11+ **	+	4	50	75
Co-Occurring MH & SU	195*	20	264+ **	205+	306	211	125

+ Number served unknown
*Region 1: Approximately 125, which category(s) is unknown.
**Region 3: Disability not specified- 240

Behavioral health clients receiving employment assistance FY 2013-14. The table below summarizes provider responses to the number of individuals receiving employment assistance from the responding provider agency.

Table 18: Number of individuals receiving employment assistance from your agency							
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**Region 7**
Mental Health	126+ *	79+	Approximately 382	108+	221	912	Total Served 526 – No breakdown by diagnosis
Substance Use	3+*	10+	87+	+	3+	0	
Co-Occurring MH & SU	56+*	15+	33+	10	305	308	

* Approximately 30 per year, specific category of MH or SA or co-occurring is unknown
+ Additional served, number unknown

Observations

- Most providers do not keep accurate counts of justice-involved individuals served; therefore, comparisons are not feasible.
- Additionally, most providers, except in regions 5 and 6, do not capture data on individuals receiving housing and employment services.

Funding of services

OBH funding for mental health services. Table 19 below summarizes FY 2013-14 OBH statewide contract *allocations* for mental health services. (Note that the amounts in the table do not reflect actual expenditures.) The amount of funding for indigent clients represents "targeted" indigent individuals to be served, multiplied by an annual per-client funding amount of $3,108.

Table 19: FY 2013-14 OBH Funding for Mental Health Services

Provider	Contract Total (Includes Indigent Funding)	Percent of Total	Indigent Clients Total	Percent of Total	Indigent Clients Target #
Arapahoe/Douglas MHN	$2,236,024	4.6%	$1,680,298	5.8%	541
Asian Pacific	$77,829	0.2%	$77,829	0.3%	25
Aurora MHC	$1,929,848	4.0%	$1,316,774	4.5%	424
Mental Health Partners	$1,793,236	3.7%	$998,626	3.4%	321
Centennial MHC	$1,521,568	3.1%	$1,182,046	4.1%	380
Mind Springs Health	$3,529,889	7.3%	$1,853,200	6.4%	596
Community Reach Center	$2,638,078	5.4%	$1,839,609	6.3%	592
Jefferson Center	$4,076,726	8.4%	$2,848,289	9.8%	916
Touchstone Health Partners	$2,105,058	4.3%	$1,566,128	5.4%	504
MHC of Denver	$14,463,743	29.7%	$5,518,773	19.0%	1,776
The Center for MH (Midwest)	$935,311	1.9%	$759,939	2.6%	245
North Range BH	$2,641,527	5.4%	$2,119,796	7.3%	682
AspenPointe, Inc	$3,713,216	7.6%	$2,682,623	9.2%	863
San Luis Valley BH	$1,081,792	2.2%	$752,440	2.6%	242
Servicios de la Raza	$140,215	0.3%	$140,215	0.5%	45
Southeast Health Group	$848,671	1.7%	$680,629	2.3%	219
Axis Health Systems	$1,762,475	3.6%	$1,004,938	3.5%	323
Spanish Peaks BHC's	$2,095,579	4.3%	$1,402,333	4.8%	451
Solvista Health	$1,058,449	2.2%	$653,029	2.2%	210
SB 97 Training (DBH)	$13,738	0.0%	$0	0.0%	0
TOTAL	**$48,662,972**	**100.0%**	**$29,077,514**	**100.0%**	**9,355**

Source: OBH

In addition to funding for indigent (non-Medicaid) clients, the contract total amount includes funding for the following:

- $1,679,676 for medications for medically indigent clients
- $2,333,485 for school-based mental health services
- $1,228,899 for support of two Acute Treatment Unit (ATU) facilities

- $658,104 for Assertive Community Treatment (ACT) programs
- $6,859,100 for intensive case-management services provided by Mental Health Center of Denver
- $3,297,476 for services for adult and juvenile offenders
- $3,201,657 for alternatives to inpatient hospitalization at a mental health institute
- $200,000 for wrap-around services provided by Sol Vista Health
- $67,061 for supported employment services
- $60,000 for services for individuals who are deaf or hard-of-hearing.

In addition to categorical programs funded through provider contracts, OBH receives funding under the Child Mental Health Treatment Act ($922,172), which supports mental health treatment services for children under age 18, without the need for county department of human services involvement, when a dependency and neglect action is neither appropriate nor warranted. Services may include in-home family mental health treatment, other family preservation services, residential treatment, or post-residential follow-up services.

OBH also contracts with the Colorado Behavioral Healthcare Council to support Mental Health First Aid ($266,730), a public education program committed to training adults to identify mental health and substance abuse problems, connect individuals to care, and safely de-escalate crisis situations if needed.

OBH funding for integrated (co-occurring) services. In addition to the funding provided as indicated in Table 19, in FY 2013-14 OBH allocated funds for individuals requiring services for co-occurring mental health and substance use needs.

- **Jail-based Behavioral Health Services (JBBS) program** ($2,999,179) funds screening and treatment services for adult county jail inmates with a substance use disorder, including individuals who have a co-occurring mental health disorder.

- **Rural Co-Occurring Disorder Programs** ($324,200) funds a full continuum of co-occurring behavioral health services to adolescents and adults in southern Colorado and the Arkansas Valley. The provider of these services is Crossroads Turning Points.

- **Community Transition Services** ($2,437,827) provides funding for the provision of intensive behavioral health services and supports for individuals with serious mental illness who transition from a mental health institute to the community. Included in this funding is support for additional ACT services statewide. More information about this program is provided later in this report.

- **Crisis Response System – Walk-in, Stabilization, Mobile, Residential, and Respite Services ($0 in FY 2013-14)** includes an array of integrated services that are available 24 hours a day, seven days a week, to respond to and assist individuals who are in a behavioral health emergency. These services began operation as of December 2014

after procurement delays. More information about this program is provided later in this report.

- **Crisis Response System – Telephone Hotline** ($659,699) is a statewide 24-hour telephone crisis service that is staffed by skilled professionals who are capable of assessing child, adolescent, and adult crisis situations and making appropriate referrals.

- **Crisis Response System – Marketing** ($600,000) provides funding to market crisis services.

FY 2013-14 OBH substance use expenditures by program

Table 20: FY 2013-14 OBH Substance Use Expenditures by Program		
Program	**Amount**	**Percent of Total**
Treatment / Detoxification Services	$42,919,008	71%
Primary Prevention Services	$10,608,308	18%
Administration	$5,199,217	11%
TOTAL	**$58,726,533**	**100%**

Source: "The Costs and Effectiveness of Substance Use Disorder Programs Report" November 1, 2014, OBH.

FY 2013-14 OBH treatment and detoxification revenue by source

Table 21: FY 2013-14 OBH Treatment and Detoxification Revenue by Source		
Revenue Source	**FY 13-14 Amount**	**Percent of Total**
Substance Abuse Prevention and Treatment Block Grant	$25,550,678	44%
General Fund	$16,705,476	28%
Cash Funds	$7,756,199	13%
Other Federal Grants	$7,576,165	13%
Medicaid	$1,138,015	2%
TOTAL	**$58,726,533**	**100%**

Source: "The Costs and Effectiveness of Substance Use Disorder Programs Report" November 1, 2014, OBH.

FY 2013-14 Medicaid Capitation Program funding. Table 22 details Medicaid Capitation Program expenditures for FY 2013-14 by BHO. It is important to note that the average expenditure per client amount in the table is not comparable to the OBH FY 2013-14 funding amount of $3,108 per client for services to targeted clients. The average expenditure per client amount in table 22 represents total BHO expenditures of revenue received from HCPF, while the OBH per client funding amount represents the average allocation per client for the specific services provided by CMHC's to these clients.

Table 22: FY 2013-14 Medicaid Capitation Funding			
Behavioral Health Organization	**FY 13-14 Expenditures**	**Number of Distinct Clients Served**	**Average Expenditure Per Client**
Foothills Behavioral Health	$61,601,861	12,407	$4,965
Behavioral Health Incorporated	$94,587,793	20,275	$4,665
Northeast Behavioral Health Partners	$45,322,295	10,845	$4,179
Colorado Health Partnerships	$135,309,362	31,850	$4,248
Access Behavioral Care	$72,106,915	15,945	$4,522
TOTAL	**$408,928,226**	**91,322**	**$4,478**

Source: HCPF

FY 2013-14 HCPF mental health fee-for-service (FFS) expenditures. Total FFS expenditures amounted to $5,295,835 in FY 2013-14.

Revenue streams[4]

This section describes the current funding streams for publicly funded behavioral health services in Colorado, by state agency.

Revenue sources for services provided to non-Medicaid-eligible individuals. OBH receives funding to provide community behavioral health services to non-Medicaid-eligible individuals from the following sources:

- State of Colorado General Fund
- SAMHSA Substance Abuse Prevention and Treatment (SAPT) Block Grant
- SAMHSA Community Mental Health Services (CMHS) Block Grant
- Transfers from HCPF (Medicaid and General Fund)
  The Child Mental Health Treatment Act provides funding for mental health treatment services for children (under age 18) without the need for county department of human services involvement, when a dependency and neglect action is neither appropriate nor warranted.
- State Division of Vocational Rehabilitation (federal funds and General Fund)
- Projects for Assistance in Transition from Homelessness (PATH) Grant
- Offender Mental Health Services Fund (tobacco litigation settlement money)
- Community Prevention and Treatment Cash Fund (tobacco)
- Transfers from the State Judicial Department
  - General Fund and Drug Offender Surcharge Funds
  - Alcohol and Drug Driving Safety Program
- Persistent Drunk Driver Cash Fund
- Marijuana Tax Cash Fund.

OBH Mental Health Institute revenue. OBH receives funding for operation of the two state mental health institutes from the following sources:

- State of Colorado General Fund
- Transfers from HCPF (Medicaid and General Fund)
- Payments from behavioral health organizations (using Medicaid funds)
- Medicare and reimbursements from other insurers
- Patient payments for costs of care
- Colorado Department of Education (for educational programs)
- Colorado Department of Corrections (for services provided by state Department of Human Services staff to support prison facilities on the campus of the mental health institute in Pueblo).

The two institutes maximize non-General Fund revenue to a larger extent than in many other Western states. Colorado statute requires patients to be charged for the full cost of their stay, adjusted for need based on assessment of existing resources and any insurance (including Medicare and Medicaid) coverage. Furthermore, the unpaid patient share of billed costs for institute visits is turned over to the state's Central Collection Agency for recovery. [5] Because of this statutory requirement, the institutes are allowed to bill Medicaid (for individuals under age 22 and over age 64) for patients on a forensic commitment. Several other state hospitals do not bill Medicaid for forensic patients, as they don't use an ability-to-pay test on each patient's resources and insurance coverage(s).[6]

***Medicaid capitation revenue*.** HCPF receives federal Medicaid revenue for provision of behavioral health services in Colorado. Like every state, Colorado has a State Medicaid Plan, as required by the Center for Medicare and Medicaid Services (CMS). The plan defines the state's decisions related to eligible individuals, covered diagnoses, and covered services. CMS requires states to provide mandatory benefits and makes other benefits optional to states. Colorado operates its behavioral health Medicaid program under a 1915(b)(3) waiver approved by CMS. This allows the state to provide flexibility with the services provided to clients.

HCPF provides each behavioral health organization with a predetermined monthly amount for each Medicaid client who is eligible for behavioral health services within its geographic area. The "per-member-per-month" rates are unique for each Medicaid eligibility category in each geographic region. These rates are adjusted annually based on historical rate experience and data concerning client service utilization. Currently, the state is divided into five geographic regions for the provision of behavioral health services to the following Medicaid eligibility categories:

- Adults age 65 and older
- Children and adults with disabilities under age 65
- Parents and caretakers;
- Pregnant adults

- Adults without dependent children
- Children
- Children and young adults in or formerly in foster care (through age 26)
- Adults served through the Breast and Cervical Cancer Treatment and Prevention Program.

Every five years, HCPF uses a competitive bid process to award contracts for each region. The existing contracts went into effect July 1, 2014. Capitation rates are adjusted annually based on historical rate experience and recent encounter data (i.e., statewide average costs by diagnosis category). Capitated behavioral health program expenditures are affected by caseload changes, rate changes, and changes to the Medicaid State Plan or waiver program that affect the diagnoses, services, and procedures that are covered for Medicaid clients. Caseload changes include changes in Medicaid eligibility, as well as demographic and economic changes that affect the number of individuals eligible within each category. The state's share of expenditures is also affected by changes in the federal match rate for various eligibility categories.

The state also provides behavioral health services for small populations of individuals not included in the capitation program, using a traditional fee-for-service reimbursement system, and also administers a small Home and Community Based Services (HCBS) waiver. The HCBS waiver provides adult day care, homemaker, personal care, respite, alternative care facility, and consumer-directed attendant support services; home modifications; non-medical transportation, and specialized medical equipment and supplies for individuals with mental illness over the age of 18.

Institutions for Mental Disease (IMD). At the time Medicaid was enacted, state and local mental hospitals were viewed as primarily custodial institutions and a state responsibility—a responsibility that had the potential to significantly increase costs to the federal government. As a result, the Medicaid statute specifically precludes coverage of services for individuals age 22 to 64 in Institutions for Mental Disease (IMD). An IMD is defined as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases." The "IMD exclusion" means that federal Medicaid matching payments are available for the costs of short-term inpatient care for a Medicaid-eligible individual in a general hospital's psychiatric unit but not in a state or local mental hospital. However, the Medicaid statute does permit coverage of services for children under age 21 in psychiatric hospitals and adults age 65 and older in IMDs, as long as those institutions meet special conditions of participation.

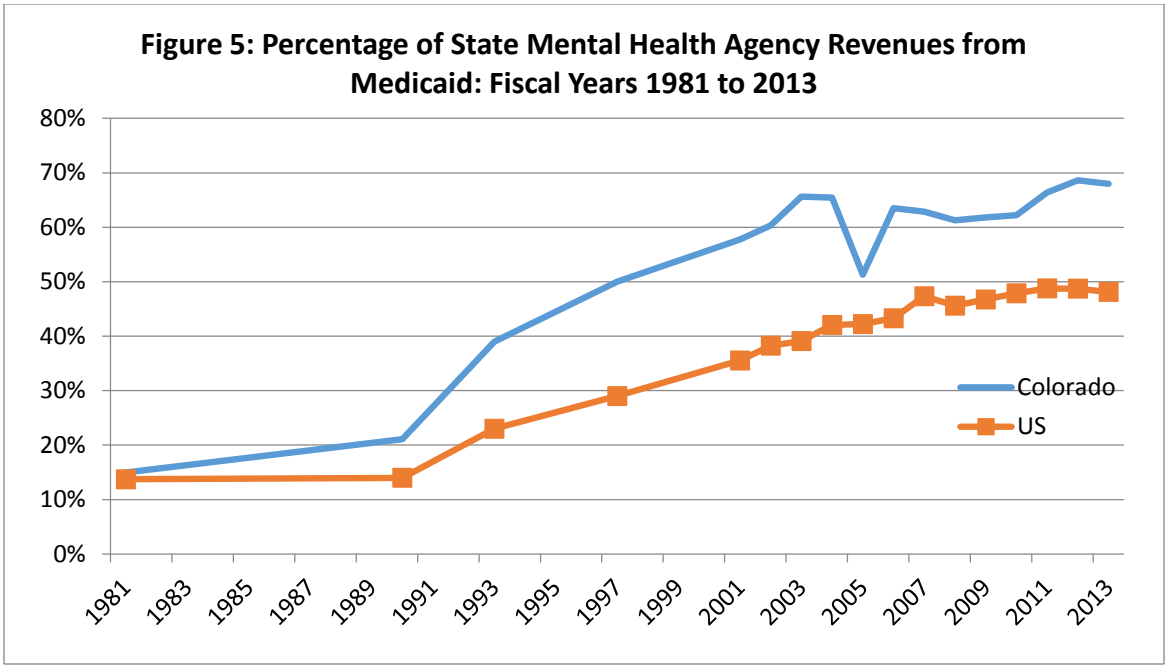
Comparative Funding Data

***Indigent care services*.** In Colorado, two sets of indigent care services are available: OBH-funded services for indigent individuals who are not eligible for Medicaid or other insurance, and the Colorado Indigent Care Program (CICP), which is largely focused on primary care and not mental

health care. This analysis primarily focuses on the OBH-funded services to persons without insurance.

State mental health agencies were established by states to provide critical behavioral health services to persons who lack insurance coverage to pay for needed services. Persons with behavioral health disorders tend to have low participation in the competitive workforce and thus often lack insurance. Until the recent passage of mental health and substance abuse parity laws, even persons with private insurance coverage often faced extreme limitations on behavioral health benefits paid by private insurance. As a result, state governments took on the responsibility to provide behavioral health services—starting with the operation of state psychiatric hospitals. The first state psychiatric hospital was opened in Virginia in 1773 and by the start of the 20th century; every state was operating at least one state psychiatric hospital funded by state general revenues. During the 1950s and 1960s, every state expanded its array of behavioral health services to include community-based behavioral health services—again, primarily funded by state general funds.

With the passage of the federal Medicaid and Medicare programs in the late 1960s, individuals who are poor and disabled were finally able to receive some insurance coverage through these public insurance programs. State mental health agencies have adapted their service system to utilize Medicaid funds and federal matching funds to leverage state dollars. Under Medicaid, every $1 of state funds is matched by at least $1 additional dollar of federal funds, resulting in $2 of service funding. As a result of shifting community-based services to Medicaid payments across the country, the portion of state mental health funding from Medicaid has grown from 14 percent of spending in FY 1981 to over 48 percent in FY 2013 (see Figure 5). In Colorado, the state mental health system has leveraged Medicaid funds at an even greater rate than most states as the percentage of state mental health expenditures that are paid for by Medicaid has grown from 15 percent in FY 1981 to 68 percent in FY 2013.



Source: NASMHPD Research Institute, Revenues and Expenditures Study: 1981 to 2013

The use of Medicaid to pay for mental health services for any person who is eligible has allowed Colorado to leverage every dollar in state funds spent through Medicaid being matched by additional federal Medicaid revenue—thus, $1 million of state dollars becomes $2 million of federal dollars. However, the reliance on Medicaid has limitations. First, relying on Medicaid to finance mental health services means that persons who are not Medicaid-eligible, either due to income or criminal justice involvement, may not qualify for services. Second, although Medicaid will pay for a broad array of mental health services and supports, Medicaid will not pay for psychiatric hospital inpatient stays for adults age 22 to 64, nor will it pay for many housing, educational, and vocational supports that persons with mental illness need to live in their own communities. Third, Medicaid is also an insurance program that generally does not pay for respite services and for education and outreach services to consumers. These supports and services are often not deemed medical services or are provided on a population/regional basis and are not billable to individual clients.

While Colorado has been successful in utilizing Medicaid to pay for the majority of its mental health service system, the state continues to rely on state general revenues and special revenues, along with federal block grants and other funds, to pay for essential services and supports for clients who are not eligible for Medicaid and for services and supports that Medicaid will not reimburse. In FY 2013, in Colorado, that meant that $141 million of state general revenues were used to fund mental health services to individuals who lacked insurance to pay for mental health services.

As Table 23 shows, only 0.4 percent of revenues to the mental health system were paid for by third-party private insurance and only 2 percent were reimbursed by Medicare. Colorado utilizes the leveraged Medicaid funding to a greater extent than the national average, but at a

rate similar to many Western states (Colorado ranked sixth out of 15 Western states in the percent of its mental health funding from Medicaid).

Table 23: SMHA Revenues from State General Revenues, Medicaid, Medicare, Other Federal and Other Sources: 2013													
	State		Medicaid (State & Federal		Medicare		Other Federal*		3rd Party (Insurance)		Other		Total
	n	%	n	%	n	%	N	%	n	%	n	%	n
AK	$55,201,725	23%	$180,102,120	74%	$3,803,500	2%	$1,466,455	1%	$150,100	0.1%	$1,827,800	0.8%	$242,551,700
AZ	151,100,000	11%	1,143,000,000	84%	400,000	0%	$14,600,000	1%	$6,300,000	0.5%	$50,500,000	3.7%	$1,365,900,000
CA	2,413,507,773	39%	2,526,254,795	41%	28,229,530	0%	$101,255,384	2%	$14,503,480	0.2%	$1,043,174,471	17.0%	$6,126,925,433
CO	**140,962,023**	**27%**	**351,316,599**	**68%**	**10,000,000**	**2%**	**$11,258,278**	**2%**	**$1,900,000**	**0.4%**	**$1,445,200**	**0.3%**	**$516,882,099**
ID	42,000,000	77%	4,800,000	9%	2,700,000	5%	$4,100,000	8%	$700,000	1.3%	$200,000	0.4%	$54,500,000
KS	107,982,000	30%	237,448,000	66%	10,700,000	3%	$3,870,000	1%	$0	0.0%	$0	0.0%	$360,000,000
MT	52,675,523	25%	155,436,622	74%	0	0%	$2,602,251	1%	$0	0.0%	$0	0.0%	$210,714,396
NE	99,597,211	60%	23,948,986	14%	3,869,044	2%	$2,649,198	2%	$8,018,802	4.8%	$29,018,870	17.4%	$167,102,111
NM	123,881,064	50%	114,228,827	46%	0	0%	$9,088,298	4%	$1,054,633	0.4%	$126,124	0.1%	$248,378,945
NV	123,881,064	$0	114,228,827	46%	0	$0	$9,088,298	$0	$1,054,633	0.4%	$126,124	0.1%	$248,378,945
OK	154,600,000	76%	30,700,000	15%	4,500,000	2%	$9,300,000	5%	$400,000	0.2%	$3,500,000	1.7%	$203,000,000
OR	286,900,000	40%	413,200,000	57%	0	0%	$5,400,000	1%	$0	0.0%	$16,300,000	2.3%	$721,800,000
UT	40,100,000	20%	142,700,000	70%	1,400,000	1%	$6,200,000	3%	$0	0.0%	$14,800,000	7.2%	$205,200,000
WA	178,700,000	23%	556,900,000	71%	20,300,000	3%	$11,700,000	1%	$6,800,000	0.9%	$12,100,000	1.5%	$786,500,000
WY	68,030,014	99%	NA	NA	0	0%	$886,235	1%	$0	0.0%	$0	0.0%	$68,916,249
US Avg.	**$301,143,697**	**40%**	$363,190,148	**48%**	*$13,554,828*	**2%**	$17,967,650	**2%**	$4,306,629	**0.8%**	$50,617,534	**6.7%**	*$752,942,729*
Western Average	**269,274,560**	**35%**	**428,161,770**	**56%**	**5,726,805**	**1%**	**12,897,626**	**2%**	**$2,725,443**	**04%**	**$78,207,906**	**10%**	**$768,448,992**

** Note: Other Federal includes the $425 million federal Mental Health Services Block Grant used by most states to provide services to uninsured clients.*
Source: NASMHPD Research Institute, Revenues and Expenditures Study: 2013

The expansion of Medicaid eligibility for adults up to 138 percent of the federal poverty level ($32,900 for a family of four in Colorado) as allowed under the Affordable Care Act (ACA) will result in many more persons with serious mental illnesses qualifying for Medicaid. The Substance Abuse and Mental Health Services Administration (SAMHSA) has estimated that, in Colorado, 3,181 individuals with a serious mental illness will be eligible for coverage under Medicaid expansion, and an additional 21,127 additional adults with a serious mental illness will be eligible for subsidized insurance through an ACA Marketplace Insurance Exchange. This expansion of adults with SMI who will be eligible for insurance through either Medicaid expansion or subsidized insurance may permit Colorado to refocus some of the $141 million of state general funds toward either indigent clients who are not eligible for new insurance coverage, or to focus on essential community support services (such as peer, housing, vocational, educational, crisis services, etc.) that are not covered by insurance.

More than half of the 100,000 persons served by Colorado's system received services that were

not reimbursed by Medicaid (primarily funded by state general revenues, state special revenues, and federal Mental Health Block Grant funds). Colorado reported that of the 100,620 persons who received OBH mental health services in FY 2013, 31,831 (32 percent) had no Medicaid reimbursement for any of their services, and an additional 22,178 (22 percent) had Medicaid pay for only some of their mental health services and supports (see Table 24).

Colorado ranked in the middle of other Western states (eighth out of 15) and ranked 20th nationally for the percent of consumers who had Medicaid pay for some or all of their care. In Colorado, patients who were white (34 percent), Asian (33 percent), and Native American (30 percent) were most likely to have no Medicaid and to rely on state general funds and Medicaid funding for their OBH mental health services.

Table 24: Number and Percentage of Persons Whose State Mental Health Services Were Reimbursed by Medicaid, 2013

	Medicaid (paid for some or all care)				No Medicaid for MH Services			
	n	%	Western Rank	US Rank	n	%	Western Rank	US Rank
Alaska	8,911	43%	11	42	11,816	57%	5	9
Arizona	142,678	74%	2	11	49,126	26%	14	40
California	338,724	51%	10	37	330,833	49%	6	14
Colorado	68,789	68%	8	20	31,812	32%	8	31
Idaho	1,915	31%	14	49	4,212	69%	2	2
Kansas	47,720	38%	12	44	79,338	62%	4	7
Montana	31,895	84%	1	6	6,126	16%	15	45
Nebraska	5,817	70%	7	17	2,442	30%	9	34
New Mexico	59,079	74%	3	12	21,231	26%	12	39
Nevada	10,304	74%	3	46	18,271	26%	12	5
Oklahoma	25,492	36%	13	47	45,869	64%	3	4
Oregon	85,006	66%	9	23	44,239	34%	7	28
Utah	32,035	72%	5	18	12,472	28%	11	33
Washington	105,704	70%	6	22	44,303	30%	10	35
Wyoming	3,386	21%	15	20	12,756	79%	1	1
US Average	4,271,155	62%			2,646,809	38%		
Western Average	64,497	58%			47,656	42%		

Medicaid Column includes clients for whom Medicaid paid for some or all of their Mental Health Services
Source: 2013 Mental Health Block Grant Uniform Reporting System

Colorado's publicly funded behavioral health system spent more than $516 million in FY 2013 to fund services to over 100,000 persons with mental illness in its state psychiatric hospital and community-based services system. Colorado ranked 23rd in total SMHA expenditures for mental

health and when adjusted for state population, OBH spent $98.80 per person in Colorado (10th in the Western states and 28th in the U.S.). (see Table 25) Colorado's expenditures of $98.80 were $25.59 lower than the U.S. average and $17.43 lower than the median per-capita expenditures of Western states.

Table 25: SMHA Mental Health Controlled Per-Capita Expenditure For State Mental Hospital Inpatient Services, Community Services (State Hospital and Other Community-Based), Research, Training and Administration, FY 2013

	State Psychiatric Hospital			Community-Based			SMHA Central Office			Total SMHA	Total	
STATE	**Inpatient**	**Rank**	**%**	**Services**	**Rank**	**%**	**Admin.**	**Rank**	**%**	**Expenditures**	**Rank**	***Notes***
Alaska	$44.50	3	13%	$287.74	1	84%	$8.83	1	3%	$341.08	1	
Arizona	$10.40	16	5%	$192.12	2	94%	$2.71	4	1%	$205.23	3	
California	$33.38	5	21%	$126.29	4	79%	$0.84	13	1%	$160.50	5	*b*
Colorado	$21.83	11	22%	$76.04	9	77%	$0.93	12	1%	$98.80	10	*ab*
Idaho	$16.35	13	50%	$14.74	16	45%	$1.68	10	5%	$32.77	16	
Kansas	$33.70	4	27%	$91.46	7	73%	$0.31	15	0%	$125.47	7	
Kentucky	$26.58	8	48%	$25.97	15	47%	$2.51	5	5%	$55.06	14	
Montana	$29.54	7	14%	$175.38	3	84%	$3.40	2	2%	$208.32	2	
Nebraska	$24.20	9	27%	$64.19	10	72%	$1.36	11	2%	$89.75	11	
Nevada	$23.80	10	27%	$63.30	11	71%	$2.31	6	3%	$89.41	12	
New Mexico	$11.73	14	9%	$119.74	6	91%				$131.47	6	
Oklahoma	$10.68	15	20%	$39.38	14	74%	$2.95	3	6%	$53.01	15	
Oregon	$60.01	2	33%	$121.50	5	66%	$2.29	7	1%	$183.80	4	
Utah	$18.48	12	26%	$51.97	13	73%	$0.41	14	1%	$70.86	13	*b*
Washington	$31.56	6	28%	$79.98	8	70%	$2.12	8	2%	$113.67	9	
Wyoming	$62.71	1	53%	$54.15	12	46%	$1.93	9	2%	$118.80	8	*a*
Western Region	$29.00		21%	$107.39		78%	$1.50		1%	$137.86		
Western Median	$25.39		26%	$78.01		73%	$2.03		2%	$116.23		
US Average	$29.49		24%	$92.22		74%	$3.11		2%	$124.39		

Source: NASMHPD Research Institute, Revenues and Expenditures Study: 2013
Note: "Community Services" includes expenditures from state mental hospitals for ambulatory and residential services.
a = Medicaid Revenues for Community Programs are not included in SMHA-Controlled Expenditures
b = SMHA-Controlled Expenditures include funds for mental health services in jails or prisons.

The distribution of Colorado's expenditures between state psychiatric hospitals and community-based services is very similar to both regional and national averages. Colorado spent 22 percent of its system funding on state psychiatric hospital inpatient expenditures—very similar to the Western regional average of 21 percent and just below the U.S. average of 24 percent of SMHA spending. Colorado's expenditures for OBH Central Office (including

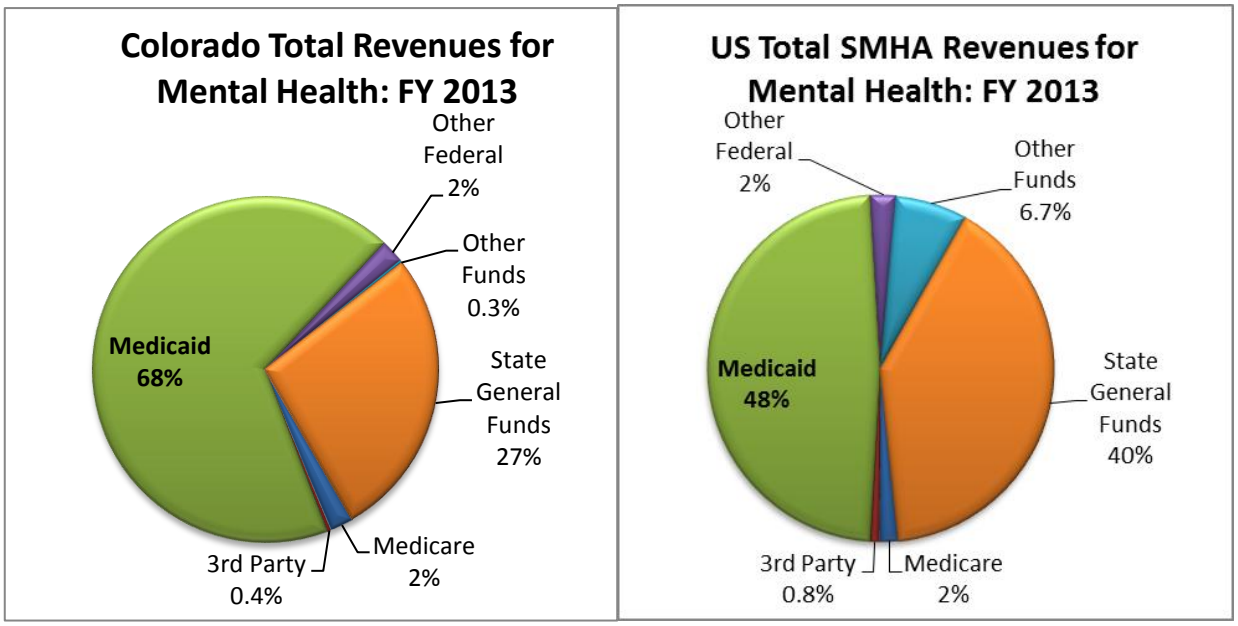
administration, data collection, training, evaluation, etc.) were just under 1 percent of total mental health spending, and ranked 10th out of 15 Western states and 40th nationally.
As described in figures below, the major funding sources were Medicaid and state general and special revenues, with Medicaid representing 68 percent of revenues.

Colorado's expenditures for OBH Central Office (including administration, data collection, training, evaluation, etc.) were just under 1 percent of total mental health spending, and ranked 10th out of 15 Western states and 40th nationally.

Within the Colorado system, there was a difference in funding sources for Colorado's state psychiatric hospitals and the community mental health system:

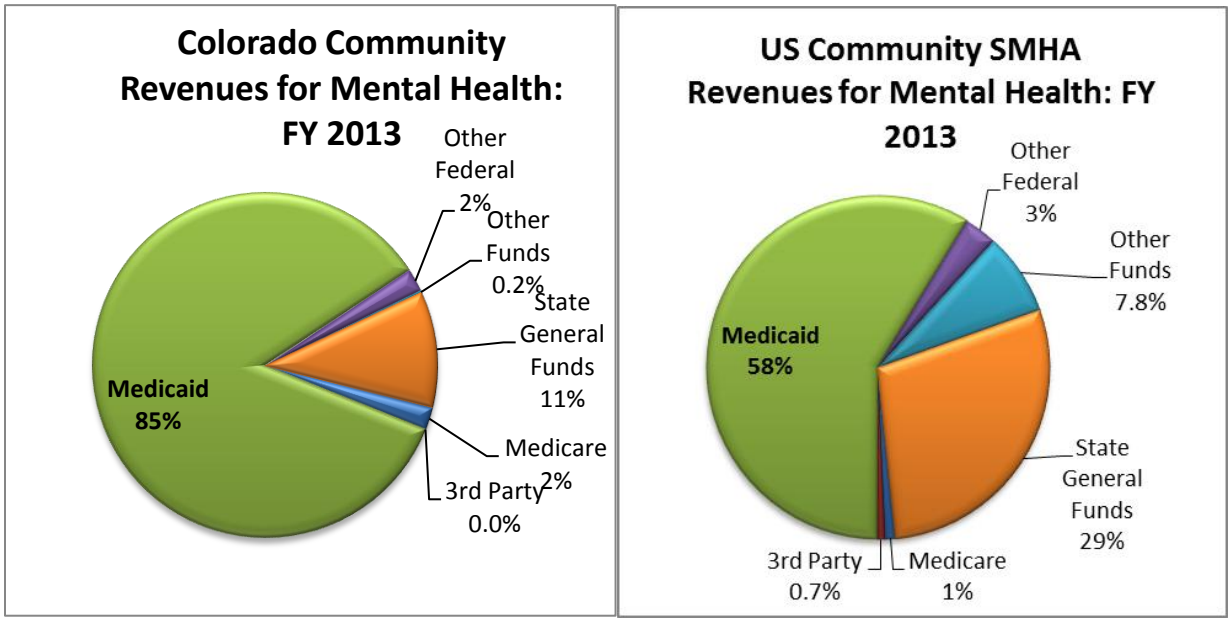
- Medicaid was the largest funding source for community mental health services. Colorado was more dependent on Medicaid funding (85 percent of revenues) for community mental health services than the U.S. average (58 percent of revenues).
- State general funds were the largest funding source for state psychiatric hospitals. Colorado was more dependent on general funds (91 percent of revenues) for hospital services than the U.S. average (68 percent).
- Colorado (27 percent) was less dependent on state general funds than Western states (43 percent) or the U.S. (40 percent).

Figure 6: Revenues Sources of Colorado and US State Mental Health Agencies (SMHAs): Fiscal Year 2013



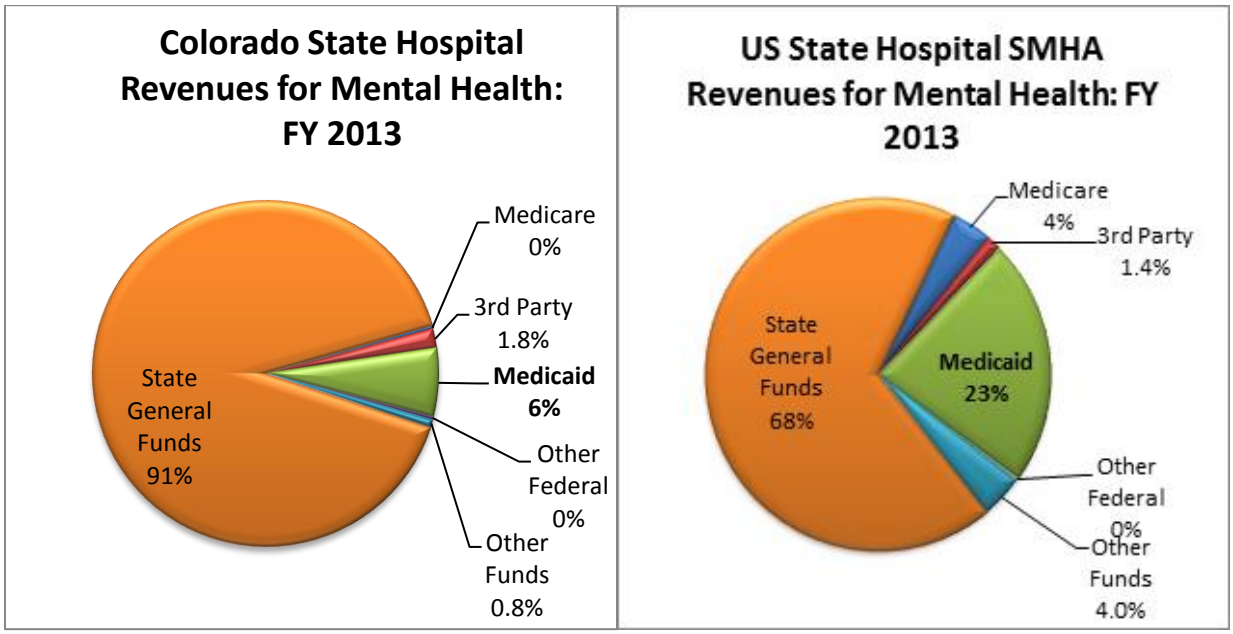
Source: NASMHPD Research Institute, Revenues and Expenditures Study: 2013

Figure 7: Community Mental Health Revenues for Colorado and US, Fiscal Year 2013



Source: NASMHPD Research Institute, Revenues and Expenditures Study: 2013

Figure 8: State Psychiatric Hospital Mental Health Revenues for Colorado and US, Fiscal Year 2013



Source: NASMHPD Research Institute, Revenues and Expenditures Study: 2013

Observations

- Medicaid was one of the largest funding sources for mental health services. Colorado was more dependent on Medicaid funding (68 percent of revenues) for mental health services than Western states (52 percent) and the U.S. (48 percent).
- Medicaid was the largest funding source for community mental health services. Colorado was more dependent on Medicaid funding (85 percent of revenues) for community mental health services than the U.S. (58 percent of revenues).
- State general funds were the largest funding source for state psychiatric hospitals. Colorado was more dependent on general funds (91 percent of revenues) for hospital services than the U.S. (68 percent).
- Colorado (27 percent) was less dependent on state general funds than Western states (43 percent) or the U.S. (40 percent).
- Colorado was more dependent on Medicare than other states, though in all states, Medicare represents a very small percentage of total revenue, typically 1 percent.

Inventory of state and community behavioral health resources

Inventory findings by region are summarized in this section. More-detailed information, including responses to additional questions related to the inventory and gap analysis, is included as separate regional appendices and some of the findings are also included in other sections of this report. Each service in the inventory is listed only once under the geographic region where it is located, regardless of the number of providers that may contract with the facility. For example, inpatient bed numbers for providers in region 5 (Denver County) are only listed in region 5, even though mental health centers from outside Denver use inpatient services there. A summary of the number of services in each region is presented below in Table 26.

Table 26: Inpatient Psychiatric and Residential Bed Capacities by Region (Excludes State Hospital Beds)

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	TOTAL
Inpatient Psychiatric beds								
Child / Adolescent	40	0	16/ 50	10	0/ 12	16	44	188
Adult / Older Adult	42	0	99	25	N/A	177	110	453
Acute Treatment Unit beds								
	15	16	16	14	0	0	16	77

Table 26 continued: Inpatient Psychiatric and Residential Bed Capacities by Region (Excludes State Hospital Beds)								
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**Region 7**	**TOTAL**
Residential								
Child and Adolescent	52	0	0	166	260	37	48	563
Child / Adol MH & SUD	0	0	0	0	65	112	0	177
Adult	433	82	159	314	116	449	0	1,553
Crisis Stabilization beds								
	11	16	55	8	0	16	25	131
Nursing Homes with Behavioral Health Services beds								
	1,971	+	204+	74 +	682	3,119+	1,586	7,767+
Substance Use Residential beds								
Child / Adolescent	0	0	0	0	0	186	0	186
Adult	432	20	0	30	0	30	0	512
Detoxification Residential beds								
	38 – 43	23	0	48+	0	84	40	233+

+ Additional beds, specific number unknown.

Observations

- Region 2 is the most lacking in inpatient psychiatric beds for all population age groups in the state.
- Regions 5 and 6 are the only regions without acute treatment units, which is notable since these have been successfully used as inpatient alternatives in other parts of the state.
- Child and adolescent mental health/substance-use residential beds are limited to regions 5 and 6.
- Child and adolescent substance use-only residential beds exist only in region 6.
- Regions 3 and 5 reported no substance-use residential or detox beds.

27-65 designated facilities

OBH is responsible for the review and designation of facilities to serve individuals with behavioral health disorders who require involuntary commitment to a treatment facility. The following CMHCs, hospitals and ATUs are designated as 72-Hour Evaluation and Treatment Facilities, Short-Term Treatment Facilities, and Long-Term Treatment Facilities, pursuant to the Care and Treatment of the Mentally Ill Act, C.R.S. 1973, 27-65-105, 27-65-107, and 27-65-109, unless specified differently below the facility name. Seventy-two hour treatment includes Saturdays, Sundays, and holidays unless noted. Psychiatric Residential Treatment Facilities and Therapeutic Residential Child Care Facilities providing mental health services are specified

PRTF and/or *RCCF*. Acute Treatment Units are specified ATU.[7]
Table 27 below identifies the 27-65 facilities in the seven regions in FY 2014-15. There are numerous caveats noted below the following table. Most of these data were provided by OBH; however, based on input during interviews with the hospitals' leadership, the current/actual bed numbers were adjusted to more accurately identify current capacity versus "designated beds." ***Note that Table 27 excludes state hospital beds.***

Table 27: 27-65 Facility Capacity by Region								
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**Region 7**	**Total**
Community Mental Health Centers								
	4	2	3	4	1	2	1	17
Substance Use Disorder (SUD) Provider Site Locations								
# of Providers	138	49	127	90	122	99	66	691
Hospitals/Community Clinics/ Emergency Centers *without* Psychiatric Beds – Number of Facilities								
	0	0	9	2	1	3	2	17
Hospitals/Community Clinics/ Emergency Centers *with* Psychiatric Beds- Number of Beds								
Child and Adolescent	8	0	50	10	12	16	44+	140
Adult	58/VA10	0	64	40/VA23	136*/VA36	147~	98**+	612
Older Adult	0	0	20	10	14	40~	36+	120
Total	66	0	134	60	167	181	76	684
Acute Treatment Unit – Number of Beds								
	15	16	16	14	0	0	16	77
Residential Child Care Facility and Psychiatric Residential Treatment Facility- Number of Beds								
RCCF and PRTF	0	0	14***	0	0	139***	24****	177

Note: VA beds, which only admit veterans, and the widows and widowers of veterans, are included in the totals.
*29 of the beds are at an eating disorders center
** Based on information provided by Cedar Springs Hospital CEO (62 not 24 Adult beds), plus 36other beds in region
***Based on staff report of actual bed availability at these facilities
**** Based on information provided by Cedar Springs Hospital CEO
~ Based on information provided by West Pines, 40 Geripsych beds and 38 SUD beds & Based on information from Boulder Community Hospital 15 adult beds (not 16)
+ Based on Peak View Behavioral Health 20 not 0 Adolescent Beds, 36 not 0 Adult beds and 36 not 24 Older Adult beds. (They will also be adding 20 swing beds before the end of 2015.)
Note: Region 2 will have 92 new psychiatric beds by the end of 2015: 20 Adolescent, 36 Adult and 36 Older Adult—Clear View Behavioral Health

Observations

- Region 2 is the most lacking in 27-65 capacity for all population age groups.
- As noted previously, regions 5 and 6 are the only regions without acute treatment units.
- Child and adolescent mental health/substance-use residential beds are limited to regions 5 and 6.
- Residential Child Care Facility and Psychiatric Residential Treatment Facility capacity does not exist in regions 1, 2, 4, and 5.
- Rural parts of the state without 27-65 capacity have an added burden of transporting individuals significant distances for needed services, away from families and support systems, or having to use jails as a safety net.

Substance use provider data

Table 28: Prevention & Reduction of Under Age 18 Alcohol, Tobacco & Other Drug Use (OBH)								
	Region							
	1	2	3	4	5	6	7	Total
Number of Providers	20	3	0	9	5	2	1	40

Table 29: Detoxification Programs by Region							
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
# of Facilities	7	2	2	4	1	3	1
County of Location	La Plata, Mesa, Eagle, Pitkin, Steamboat, Summit, Larimer	Weld	Arapahoe Adams	Alamosa Pueblo Huerfano Bent	Denver	Jefferson Boulder	El Paso
Capacity/# of Available SUD Beds	38-43	23	?	48 +?		84	40
Number of Current Clients Placed on 1st day of month	25?	17	?	?		60	3
Social or Medical	6 Social 1 Medical	Social	Social Both	Social		4 Social 1 Medical	Social
Average Length of Stay (Days)	18 hours to 2 weeks	1-2.5 days	12 hours to 3 days	2-7 days		1.5-5 days	2
Percent of SUD Residential Tx Needs Met by Available Regional Resources	20-90%	70-90%	10-70%	10-70%	90%	40-90%	90% Social No resources for Medical

? Unknown

+ Plus additional, amount unknown

Observations

- Region 1 has the most substance use providers in the state, with 20, followed by region 4, with nine.
- Regions 1 and 4 also have the most detox facilities in the state.
- The percent of SUD residential treatment needs being met varies from 10 to 90 percent, depending on the survey respondent and the regions.

State Veterans Community Living Centers

Table 30 below provides current state veterans community living center bed capacity and the number of beds by region, including designated behavioral health beds.

Table 30: Colorado State Veteran Community Living Center Beds by Region*

	1	2	3	4	5	6	7	Total
Bed Capacity	80	NA	180	165	NA	NA	NA	425
Behavioral Health DX Occupied Beds 10/2014	49	NA	112	136	NA	NA	NA	297

*2014 Data provided by CDHS staff.

Observations

- Colorado has four state nursing homes that provide skilled nursing care to veterans.
- This resource is limited to regions 1, 3, and 5.
- While these state nursing homes do not have designated behavioral health beds, a significant proportion of their residents have psychiatric diagnoses.

Wraparound services for children

Providers indicated wraparound services are available in six of the seven regions, with no services identified as available in region 7. More region-specific information is provided in the appendices for regions 1 through 6.

Assertive Community Treatment (ACT)

Table 31 below shows the number of ACT teams and caseload averages by region.

Table 31: Assertive Community Treatment Teams							
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**Region 7**
Number of teams	4	3	3	4	10	3	1
Average caseload per team	4-25	10- 40	17-50	10-52	12	12-15	40

Observations

- All seven regions have at least one ACT team. Region 5 has the most, many of which were developed as part of a class-action settlement agreement on behalf of persons with serious and persistent mental illness.
- The typical caseload for ACT teams is 80-100 individuals, with typically fewer in rural areas (up to 50). Colorado's caseloads are much lower than the evidence-based practice fidelity standards across all regions, which support a 1:10 staff/client ratio.

Peer services

The following table identifies the key areas of focus for peer services by region.

Table 32: Areas of focus for Peer Services (X)							
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**Region 7**
Assertive Community Treatment team member	X	X	X	X		X	
Housing [in-home support; landlord outreach; housing acquisition/preservation]	X	X	X			X	
Employment [job readiness, job coaching…		X	X			X	
Wellness/Recovery [e.g. informal mentoring, WRAP, WHAM, self-advocacy]	X	X	X	X	X	X	X
Education [formal information dissemination; critical skill development]	X	X	X	X		X	
Benefits support/Advocacy [e.g. acquiring housing assistance, entitlements, accommodations]	X	X	X	X	X	X	
Outreach [e.g. connecting with at-risk people not receiving services or who are registered but not involved in services]	X	X	X	X		X	
Crisis Response [e.g. Hotline, warm line, Emergency Room]	X	X	X	X		X	
Psychiatric hospital [e.g. outreach, bridging/transition]	X	X			X	X	
Community resource acquisition [e.g. linking to community resources, food banks, churches, self-help groups, recovery org's.]	X	X	X	X		X	
Criminal justice/jail liaison		X	X			X	
Family education/ support/ parenting	X	X	X	X		X	

Observations

- Peer services are available across all seven regions, however their areas of focus vary.
- There is wide variability in the use of peer specialists in the various regions, as shown in the following table.
- Additional information about peer services is provided in the inventory appendices for each region and in the peer services section of this report.

Co-occurring disorders

The table below indicates regions with intensive services for the identified populations.

Table 33: Intensive services exist for Co-Occurring Population in the Region (X)							
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**Region 7**
Individuals with Intellectual/ Developmental Disabilities	**X**	**X**	**X**	**X**		**X**	
Individuals with Traumatic Brain Injuries	**X**	**X**	**X**	**X**		**X**	
Individuals with Significant Medical/Physical Disorders	**X**	**X**	**X**	**X**	**X**	**X**	

Observations

- All providers reported not having waiting lists for individuals needing these services.
- Regions 5 and 7 do not provide intensive services for individuals with intellectual/developmental disabilities or traumatic brain injuries.
- In addition, region 7 does not provide intensive services for individuals with significant medical or physical disorders.

Primary healthcare and integration

Tables 34 – 36 identify the various mechanisms through which primary care needs are available/integrated for behavioral health clients.

Table 34: How the primary health care needs of clients are met (X)							
Primary Healthcare - Integration	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**Region 7**
We are a Federally Qualified Health Center (FQHC) and offer both primary and behavioral health services at our agency.	X						
We have fully integrated primary care into the services we provide at our location(s).		X	X	X		X	
We offer primary care as a separate service within our behavioral health center.	X		X	X	X	X	X
Our center offers behavioral health services at an FQHC or other primary care service provider(s). Described below.	X	X	X	X	X	X	
We have formal referral agreements in place with an FQHC or other primary care service provider, or have other methods for coordinating services. Described below.	X	X	X	X	X	X	
Our services are limited to meeting the behavioral health needs of our clients.		X			X		X

Other primary health integration efforts are described in the Appendices for the Regional Inventories for Regions 1, 2, 4 and 6.

Table 35: Mechanism by which primary care services are integrated or co-located (X)							
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Primary care professionals are included on our staff (e.g., physician, nurse practitioner, etc.)	X	X	X	X	X	X	
Contract with the FQHC or other provider to deliver primary care services. *Identified Below*	X	X	X		X		
MOU or other formal agreement with the following FQHC or other provider to deliver primary care services	X	X	X		X	X	

CMHC providers contract with the following FQHC(s):

Region 1

- Loveland Community Health Center

Region 2

- Sunrise Community Health provides staff at the primary care clinic operated at the North Range Main Center.
- QOL Meds to operate our pharmacy onsite.
- Sunrise Health Center to operate a primary care clinic onsite.

Region 3

- Metro Community Provider Network
- Own a pediatric practice that fully integrates BH and medical services.

Region 4

- Budgeted for physician, medical assistant and administrative support for FY 2015

Region 6

- Metro Community Provider Network

Table 36: If have formal referral agreements with primary care service provider(s):							
Referral Agreements	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Number of people referred for services in 2013/2014?	Unknown	1800	Not reported	Not reported	Not reported	Approximately 400/ unsure	Not reported
Percentage of patients referred to you by primary care providers?	Unknown	30%	100%; 1251 & Not reported	Not reported	20-25%	< 1% -15%	Not reported

Observations

- Primary-care needs of individuals are met in a variety of ways across the regions, from a provider agency in region 1 that is an FQHC to some providers that have agreements with FQHCs, and one noting that they limit their services to the provision of behavioral health services.
- The numbers of individuals receiving primary-care services are not consistently tracked and/or reported by providers.

Housing

Tables 37 through 41 provide information about housing resources and services.

Table 37: Housing programs, such as permanent supportive housing, Shelter Plus Care, supervised apartments, group homes

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Organization provides housing programs	No/ Yes	Yes	Yes	Yes/ No	Yes/ No	Yes	Yes
Housing part of the job responsibility for case managers, i.e., housing needs are addressed in treatment plans	Yes/No	Yes	Yes	Yes	Yes	Yes/No	Yes

Table 38: Tasks case manager may perform on behalf of individuals on their caseload (X)

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Housing search	X	X	X	X	X	X	X
Housing referral	X	X	X	X	X	X	X
Negotiation with landlords/program managers	X	X	X	X	X	X	X

Other tasks that case managers perform regarding housing are described in the appendices for the regional Inventories for regions 1, 2, 4, 6, and 7.

Table 39: Level of participation by your organization in community planning and advocacy regarding obtaining housing resources (X)							
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Highly involved, leadership staff	X	X		X		X	X
Highly involved, program staff	X		X	X		X	
Moderately involved (describe)	X			X	X		
Not involved	X	X	X	X			

Table 40: Housing information							
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Does your organization own and operate housing?	Yes/No	Yes	Yes	Yes/No	Yes	Yes	No
If yes, number of units	20	10/74 beds	66	39	191	87	
Organization has formal relationships with housing providers, such as the PHA, private landlords, City or County governments	Yes/No	Yes	Yes/No	Yes/No	Yes	Yes	Yes
Estimate number of units accessed through these relationships #	50	220+	200	107	600	582	Approx. 500 w/ private landlords
For individuals who live in housing programs administered or supported by your organization, are all their support/service needs provided by program staff?	Yes/No	Yes	No	Yes	Yes	Yes	No

Agency Housing Increment Count - Mental Health: This table includes data provided by the State Housing Authority and does not include county and other housing resources.

Table 41: Agency Housing Increment Count - Mental Health*								
	Region							
	1	2	3	4	5	6	7	Total
Housing Choice Voucher/Section 8	117	42	435	96	811	382	290	2,173
Shelter Plus Care Vouchers	24	39	149	31	140	196	69	648
VA Supported Housing Vouchers	0	0	0	0	0	0	109	109
State Housing Vouchers	10	5	9	31	23	21	16	115
Homeowner Vouchers	8	1	10	5	9	4	9	46
FUP01Coalition**	0	0	0	0	64	0	0	64
FUP09Coalition**	0	0	0	0	40	0	0	40
Total	159	87	603	163	1,087	603	493	3,195

* 2014 Data provided by DOLA staff.

**FUPs are Family Unification Vouchers. These are either homeless youth who aged out of the foster care system or families waiting reunification with their kids connected with the CO Coalition for the Homeless.

Observations

- At least some housing programs are available in all regions of the state, and case managers provide some housing-related services and supports.
- Providers own and operate some housing in all regions except region 7.
- Significantly more housing increments are available in urban regions of the state.

Criminal justice

Tables 42 through 44 provide information related to the criminal justice system for individual with mental health, substance use and co-occurring MH/SU disorders. The regions noted in the table 42 below have specialty courts.

Table 42: Specialty courts are in the region (X)							
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
MH Court	X		X	X	X	X*	X
Drug Court	X	X	X	X	X	X	X

Region 6: *juvenile MH court

Other Specialty Courts

Region 1:

- Care Court; Recovery Court
- Family Treatment Court

Region 2:

- Family Treatment Court – Substance Abusing Parents

Region 3:

- Drug Court exists in 18th Judicial District: treatment service performed by University of CO ARTS program
- Co-occurring juvenile specialty court, VA court- not specific to SUD or MH

Region 4:

- Juvenile Court, Sobriety DUI
- Behavioral Health Court and Veterans Court

Region 5:

- Combined court for youth/families with social services and legal involvement
- We receive referrals but we have not been successful in obtaining specific information in terms of what the courts require (mental health evaluations, parenting classes and anger management). We do not know whether we have to have a certificate or specialized training in order to provide these services. Therefore, we have referred these individuals elsewhere.

Region 7:

- Veterans/Trauma court

Table 43: Capacity exists to serve all referrals in the Region (X)							
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Mental Health Court	X		X	X	X	X	X
Drug Court	X	X	X	X	X	X	X
Other – As noted above	X	X		X	X		X

Table 44: If Drug & Mental Health Courts, co-occurring MH/SU referrals are served by (X)							
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Mental Health Court	X		X	X	X	X	X
Drug Court	X	X	X	X	X	X	

Observations

- All regions except for region 2 have both mental health and drug courts. Region 2 only has a drug court.
- Region 6 also has a juvenile mental health court.
- Adequate capacity exists to provide the specialty court services.

- Individuals with co-occurring mental health and substance use disorders are typically served in both courts.

Behavioral health workforce

The table below identifies the number of filled positions at the time the provider inventory was completed. The gaps section of this report shows a comparison of filled versus budgeted positions.

Table 45: Current Filled Positions – Full-time equivalents (FTEs)							
STAFF CATEGORY	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**Region 7**
Medical Staff	19.68	7.25	97.2	30	7	10.9	8
Psychiatrists	9.95	5	48.95	10.5	18	13.25	10.8
Psychologists	6.7	3.75	32.3	5	7	8.7	16
Nurses	14.9	7	72	24	19	30.4	16
Addictions Staff (E.g. CACs -Not Recovery Coaches)	45.7	17.4	31+	12.5	++	35.15	13
Licensed Clinicians, Counselors, Social Workers	139.5	41.75	274	71	95	218.3	100.73
Unlicensed Master's-level Clinicians, Counselors & Social Workers	84.25	56	181	58	70	80	27.84
Unlicensed Bachelor's-level Clinicians, Counselors & Social Workers	5	9.8	65*	39	193.5	45.6	44.86
Cross-trained MH/SA Behavioral Health Staff (Master's)	17.5	32	20+	23	++	3	12
Cross-trained Behavioral Health Staff (Bachelor's)	4	1	+	2	++	0	1
Case Managers (Non-Peer)	76.1	44	42.1++	29	++	52.9	10
Peer Support Specialists	24.65	13.75	23	11	4.5	21.2	6.5

Table 45 continued: Current Filled Positions							
STAFF CATEGORY	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**Region 7**
Recovery Coaches	9	0	+	4	0	16	5
Family Navigators/Advocates	12	0	9	9	1	19.4	3
Mobile Crisis Staff (Non-Peer)	32.2	8	17.3	15	`	10.15	1/0
Crisis Stabilization Unit Staff (Non-Peer)	11.5	5.65/0	23.4	0	0	2	**3**
Crisis Respite Staff (Non-Peer)	2	7.9	1	1	~	.5	2
Mobile Crisis Peer/Family/Recovery Staff	2	0	2	6	0	1.2	0
Crisis Stabilization Unit Peer/Family/Recovery Staff	3	2.04	3	0	0	0	3
Crisis Respite Peer/Family/Recovery Staff	2	3.5	2	0	0	.5	0

+information not tracked
++included in other categories
`Contracted with Denver Health
~CCC staff at Park Place

Observations

- Staffing across the regions varies significantly.
- Region 3 reported significantly more medical staff, psychiatrists, psychologists, and nurses than the other regions.
- Regions 1, 3, and 6 have the most licensed and unlicensed clinicians, counselors, and social workers.
- Regions 1, 2, 3, and 4 have the most cross-trained MH/SA behavioral health staff.
- Regions 1, 3, and 6 have the most peer/family/recovery support/coach staff.

1 All information provided in this section about state agencies, services provided, programs and facilities, was obtained from various public documents, including Colorado Joint Budget Committee staff documents and the 2014-15 Combined Behavioral Health Block Grant application submitted by OBH to the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[2] Data provided by HCPF and OBH staff.

[3] http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251581450335 . March 2, 2015

[4] SOURCE: Joint Budget Committee Staff documents: FY 2015-16 staff figure setting, Department of Health Care Policy and Financing and Department of Human Services, Mental Health Programs Only. March 4, 2015.

[5] 42 U.S.C. 1396d
[6] Informal communication with other state hospital administrators.
[7] http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%2227-65+Designated+Facilities+063014.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1252004110224&ssbinary=true.

Service Gaps: State and Community Behavioral Health Services

Introduction

This section of the report identifies service gaps between state and community behavioral health services, based on information from the following sources:

- Stakeholder Survey
- Office of Behavioral Health (OBH) Provider Survey
- OBH Provider Inventory.

The responses from these data sources are presented by region, unless stated otherwise. A look at statewide issues and gaps is followed by a look at regional issues and gaps. Stakeholder survey data with more-frequent responses are noted in **underlined bold font** in the tables.

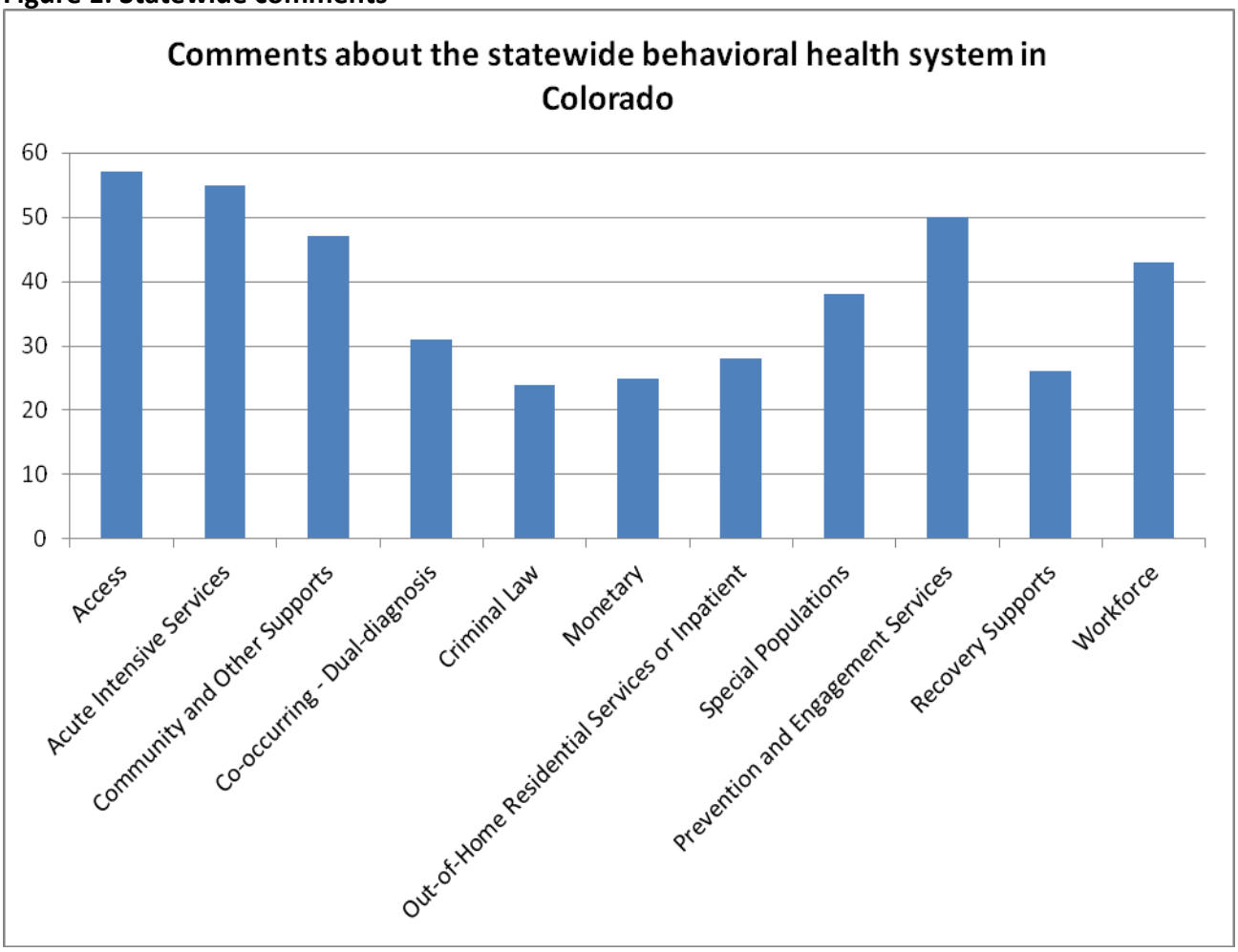
Empty cells appear in some of the provider inventory tables when there was no response from providers for specific inventory items. Similarly, not all providers shared comments for some of the inventory items.

When the two surveys and inventory had the same or similar items, the data are grouped together. The final piece of this section contains responses from the provider inventory that were not part of either survey.

Observations are noted in text boxes following the various content areas to provide a brief summary of the responses and to highlight some of the comments from providers and other stakeholders.

To begin, the following graph and comments highlight common themes of the written narrative responses we received about what is needed to improve Colorado's statewide behavioral health system. These themes were common across most of the survey and inventory items and serve as a high-level summary of the behavioral health system gaps that were identified throughout this study.

Figure 1: Statewide comments



Stakeholder comment highlights about what is needed to improve the behavioral health system in Colorado

- Access to care, statewide and especially in rural areas
- Broader implementation of evidence-based practices
- More behavioral health resources
- Skilled regional nursing facilities for individuals with behavioral health and medical conditions
- Better crisis-stabilization services
- Expanded community and inpatient services, including child, adolescent, and geriatric populations
- Development and enhancement of community-based services and other supports
- Greater emphasis on continuity of care
- [1]More public education about behavioral health disorders and how to access the behavioral health system
- Co-occurring, integrated services and supports
- Behavioral health workforce recruitment and development.

STATEWIDE BEHAVIORAL HEALTH SYSTEM INPUT

Behavioral health system comments
Specific populations not served or underserved in the behavioral health system

Stakeholder survey responses

Table 1: Are there any specific populations that you believe are not served or are underserved in the STATEWIDE behavioral health system in COLORADO, which should be served by the behavioral health system?

Stakeholder Survey	Percent/# of Respondents by Geographic Region						
Response Options	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Individuals with Traumatic Brain Injuries	**45.2%**	**44.4%**	**42.5%**	**47.4%**	**56.7%**	**52.0%**	37.0%
Individuals with Intellectual/Developmental Disabilities	42.6%	**52.4%**	**58.5%**	**51.3%**	**55.0%**	**55.0%**	**40.7%**
Individuals with Serious Medical Conditions	26.1%	27.0%	32.1%	29.5%	29.2%	27.0%	35.2%
Individuals with Dementia	43.1%	34.9%	38.7%	38.5%	**41.7%**	36.0%	**46.3%**
Veterans	**46.3%**	31.7%	**44.3%**	38.5%	29.2%	41.0%	**42.6%**
Number of Responses	188	63	106	78	120	100	54

Observations – Individuals with intellectual/developmental disabilities were the population most frequently noted as either not being served or being underserved (in six of the seven regions), followed by individuals with traumatic brain injuries (also in six of the seven regions, at a slightly lower rate), veterans (in three of the regions), and individuals with dementia (in two of the regions). Individuals with serious medical conditions were identified by 26.1- 35.2 percent of the respondents as being underserved, but were not one of the top two or three cited in any of the regions.

Additional findings from the comments included these other identified underserved populations: individuals with autism or dementia, cultural minorities, and the homeless.

Provider survey responses

Table 2: What specific populations not served or are underserved in the behavioral health system in Colorado, which should be served by the behavioral health system?							
	Responses - Providers						
Geographic Region	1	2	3	4	5	6	7
Individuals with Traumatic Brain Injuries	X	X	X	X	X	X	
Individuals with Intellectual/Developmental Disabilities	X	X	X	X	X		X
Individuals with Serious Medical Conditions		X		X	X	X	X
Individuals with Dementia	X	X	X	X	X	X	
Veterans	X	X		X	X	X	

Observations – Specific populations not served or underserved: Persons with co-occurring traumatic brain injuries, intellectual/developmental disabilities, and dementia were identified as underserved in six of the seven regions. Five of the seven regions identified individuals with serious medical concerns and veterans as underserved.

Comments from providers focus on several key areas creating gaps in the behavioral health service system. Individuals with TBI, DD, dementia, or serious medical conditions with behavioral symptoms and issues do not fit into the Community Mental Health Centers' payment reimbursement systems; they cannot be served under the Medicaid BHO contracts as these are "uncovered diagnoses," unless they also can be diagnosed with a co-occurring mental health or SUD condition. More services for veterans with behavioral health disorders are needed. Lack of specific training for behavioral health and physical health providers for individuals in these population groups is a workforce competence gap.

In addition, service system gaps were noted for undocumented clients, individuals with autism spectrum disorders, and youth aging out of child welfare and in need of transitional services.

Serious medical conditions were noted as a system gap, especially since the state hospitals no longer treat medical conditions concurrently with serious mental illness. This has created one of the biggest gaps in the state's care system according to one of the providers.

Providers generally agree that individuals in these various population groups should be served in the community whenever feasible. Public insurance should cover the cost for needed services, which is currently a system gap. The fact that the state institutes do not serve individuals with the most-complex needs creates a systemwide service gap and creates long emergency room stays for some of these individuals.

Civil (not forensic) STATE HOSPITAL inpatient psychiatric services are most needed in Colorado

Stakeholder survey responses

Table 3: What two (2) civil (not forensic) STATE HOSPITAL inpatient psychiatric services are most needed in Colorado?							
	Percent of Respondents by Geographic Region						
Answer Options	1	**2**	**3**	**4**	**5**	**6**	**7**
Acute Stay (5 or fewer days)	29.9%	35.3%	38.7%	34.1%	23.8%	23.9%	27.3%
Short-Term (6 and up to 30 days)	51.4%	44.1%	50.5%	50.0%	47.5%	55.0%	41.8%
Intermediate-Term (30 up to 90 days)	**64.5%**	**63.2%**	**61.3%**	**61.4%**	**69.7%**	**66.1%**	**63.6%**
Long-Term (90 or more days)	50.9%	50.0%	47.7%	44.3%	45.9%	45.9%	**63.6%**
Number of Responses	214	68	111	88	122	109	55

Provider survey responses

Table 4: What two (2) civil (not forensic) STATE HOSPITAL inpatient psychiatric services are most needed within Colorado?							
	Responses - Providers						
Geographic Region	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Acute Stay (5 or fewer days)	X	X		X	X	X	
Short-Term (6 and up to 30 days)		X			X		
Intermediate-Term (30 and up to 90 days)	X	X	X	X	X	X	X
Long-Term (90 or more days)	X	X	X	X	X	X	X
None - Focus should be on integrated community-based services				X			

Observations - Civil state hospital inpatient psychiatric services most needed within Colorado: Across all seven regions the most-needed state hospital inpatient services identified by stakeholders responding to the survey were for intermediate care of 30 to 90 days. Region 7 also identified long-term care of 90 days or longer as its highest need. Additionally, all seven regions identified long-term inpatient services as a higher need than acute stay. However, there was a mixed response across the regions between the short-term and long-term use of the state hospitals. Acute stay was the least needed use of the state hospitals, according to survey respondents.

Additional comments from the survey included the need for the following:

- Recovery supports including longer inpatient stays and better community integration and transitional services on discharge
- Crisis and stabilization services along with medication management
- Long-term residential inpatient placements
- Geriatric beds

Findings from the provider survey indicate the greatest need for state hospital beds was for both intermediate care long-term care. Some urban and rural providers identified acute stay (five providers) and short-term (two providers) as significant needs that should be met by the state hospitals.

Observations continued - Finally, some providers in the Inventory responses noted that beds are too far away for family- or clinician-involved recovery or transition; this was specifically noted by some providers who have to travel many hours to get to Pueblo. Access to civil Institute beds is an identified system gap. The need for state hospital beds for geriatric patients would probably be reduced if locked alternative-care facilities (ACFs) were available in the state.

Most needed civil inpatient psychiatric services

Stakeholder survey responses

Table 5: What two (2) civil (not forensic) REGIONAL inpatient psychiatric services are most needed in COLORADO?

	Percent of Respondents by Geographic Region						
Response Options	1	**2**	**3**	**4**	**5**	**6**	**7**
Acute Stay (5 or fewer days)	43.0%	43.5%	42.7%	36.8%	32.5%	36.8%	25.5%
Short-Term (6 and up to 30 days)	**56.5%**	**54.8%**	**55.5%**	**57.5%**	51.7%	**59.4%**	52.7%
Intermediate-Term (30 up to 90 days)	**59.8%**	**50.0%**	**55.5%**	**57.5%**	**63.3%**	**58.5%**	**69.1%**
Long-Term (90 or more days)	36.4%	40.3%	46.4%	36.8%	39.2%	42.5%	47.3%
Answered question	214	62	110	87	120	106	55

Provider Survey Responses

Table 6: What two (2) civil (not forensic) REGIONAL inpatient psychiatric services are most needed within Colorado?

	Region Responses						
Geographic Region	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Acute Stay (5 or fewer days)	X	X		X	X	X	
Short-Term (6 and up to 30 days)	X	X			X	X	
Intermediate-Term (30 and up to 90 days)		X	X	X	X		X
Long-Term (90 or more days)	X		X	X	X	X	
None - Focus should be on integrated community-based services			X	X			

Observations - Civil regional inpatient psychiatric services most needed: Stakeholder responses in all seven regions noted intermediate-term care as one of the most-needed regional inpatient psychiatric services, followed by short-term care in five of the seven regions. Additional comments for the survey emphasized the need for the following:

- Emergency, crisis, and stabilization services
- Better transitional services and discharge/integration
- Community resources, particularly housing.

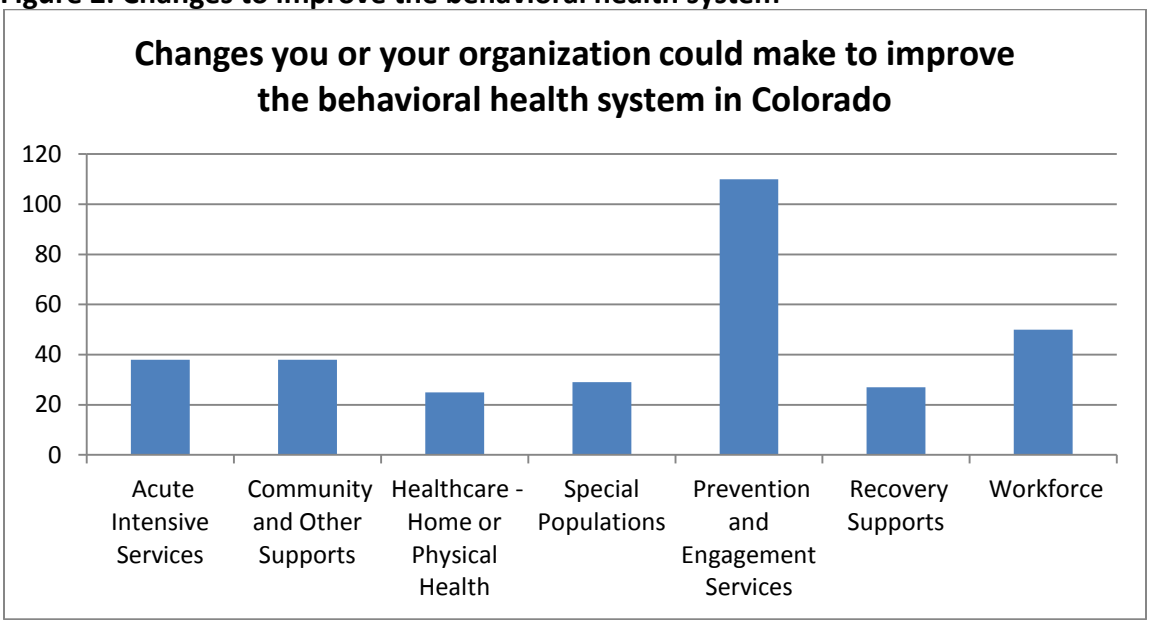
Observations continued - Findings from the provider survey indicate a mix of views about acute, short, intermediate and long-term lengths of stay. Also, providers from regions 3 and 4 noted that the focus should be on integrated community-based care versus inpatient beds. There is greater consensus on the use of state hospital beds than regional beds, which likely relates to the differences in availability within the regions. However, it is clear from both stakeholder and provider responses that there is a need for additional beds in the regions as well as in the state hospitals.

Changes you or your organization could make to improve the behavioral health system

Stakeholder survey responses

The graph below identifies several of the common themes based on qualitative analysis of write-in responses from survey respondents as personal or organization changes that could improve the behavioral health system in the State.

Figure 2: Changes to improve the behavioral health system



Observations - Changes you or your organization could make to improve the behavioral health system in Colorado: In addition to the changes noted above to improve the behavioral health system, frequent themes from stakeholders included:

- Do more prevention programming, including community education and awareness
- Better workforce education and ongoing training in best practices
- Better access for all population groups to needed services, and for populations including but not limited to individuals with autism or dementia, cultural minorities, and the homeless
- Enhance the service array from acute and crisis services to health care integration to recovery supports.

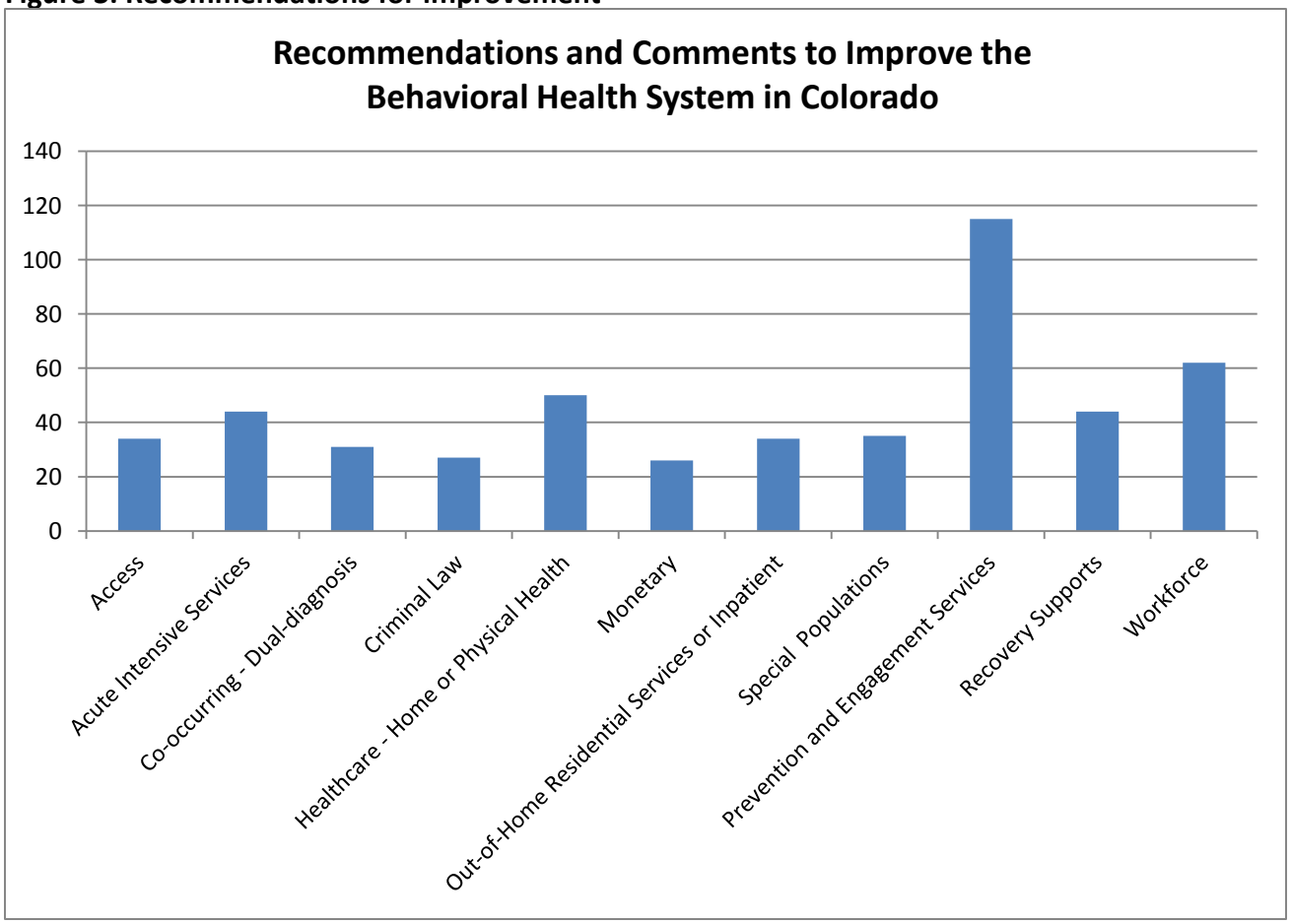
Observations continued - Prevention and engagement services was the most identified theme by stakeholders, clearly indicating it is a current gap in the system, yet one that is perceived as potentially beneficial.

Recommendations to improve the current behavioral health system

Stakeholder survey responses

Qualitative analysis of the key recommendations and comments from the Stakeholder Survey pertaining to improving Colorado's statewide behavioral health system are noted in the chart below.

Figure 3: Recommendations for improvement



Observations -Recommendations and comments from the stakeholder survey pertaining to improving Colorado's statewide behavioral health system:

Highlights from some of the frequent comments included:

• Prevention, in particular more community education

Observations continued -

• A more stable and higher-staffed workforce, with a particular emphasis on better pay and benefits to recruit qualified workforce, retain current workforce, and ensure a highly trained workforce
• Enhanced workforce, including those engaged with primary care/integration and recovery supports
• Health care homes - better integration with primary care
• Stronger crisis stabilization services, recovery supports, and transitional care
• More services for people with co-occurring diagnoses are needed, including nursing facilities for people with complex medical needs
• Competency evaluations and restorations should be more available without having to go to Pueblo
• More funding is needed to support the behavioral health system
• More inpatient beds are needed
• More public education both about behavioral health and how to access the behavioral health system as well as prevention, early intervention, and engagement efforts.

The providers' comments included themes such as streamlining behavioral health rules and regulations, and possibly combining the administrative structure of public behavioral health services, which are currently spread across three departments. Additionally, the need for better integration and collaboration of mental health and substance use services with primary care was noted frequently. Other comments included encouraging staffing/recruitment of high-quality staff and encouraging alternative settings and therapies. Additionally, efforts to enhance community awareness about behavioral health such as through Mental Health First Aid training should continue.

These themes summarize many of the comments that were shared in both the stakeholder and provider surveys, indicating some congruence in ways to reduce gaps in the behavioral health system.

REGIONAL BEHAVIORAL HEALTH SYSTEM INPUT

Population groups significantly underserved

Stakeholder survey responses

Table 7: Which three (3) specific behavioral health population groups, if any, do you believe are significantly underserved in your region?

	Percent of Respondents by Geographic Region						
Response Options	1	**2**	**3**	**4**	**5**	**6**	**7**
Children with emotional/mental health disorders	42.5%	**53.2%**	**50.8%**	38.8%	**45.3%**	**50.8%**	**50.0%**
Adolescents with emotional/mental health disorders	40.5%	**41.8%**	**57.6%**	**43.9%**	**43.1%**	**59.5%**	40.3%
Adolescents with substance use disorders	26.3%	27.8%	34.1%	32.7%	19.0%	19.0%	25.8%
Adults with mental health disorders	**46.6%**	**45.6%**	**47.7%**	**40.8%**	**43.1%**	**56.3%**	29.0%
Adults with substance use disorders	36.4%	29.1%	27.3%	30.6%	24.1%	18.3%	33.9%
Older Adults with mental health disorders	29.6%	24.1%	30.3%	26.5%	34.3%	27.8%	**43.5%**
Older Adults with substance use disorders	19.0%	13.9%	19.7%	11.2%	16.8%	12.7%	27.4%
Adolescents with co-occurring mental health and substance use disorders	**42.9%**	29.1%	34.8%	33.7%	29.2%	35.7%	**46.8%**
Adults with co-occurring mental health and substance use disorders	**44.5%**	31.6%	37.9%	**39.8%**	**43.8%**	37.3%	35.5%
Older Adults with co-occurring mental health and substance use disorders	25.1%	24.1%	25.8%	24.5%	28.5%	26.2%	32.3%
Number of Responses	247	79	132	98	137	126	62

Provider survey responses

Table 8: Which specific three (3) population groups, if any, do you believe are significantly underserved in your region?							
	Region Responses - Providers						
Geographic Region	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Children with emotional/mental health disorders	X	X		X	X		
Adolescents with emotional/mental health disorders					X		
Adolescents with substance use disorders		X	X		X	X	X
Adults with mental health disorders					X		
Adults with substance use disorders	X		X	X	X	X	
Older Adults with mental health disorders	X	X	X	X	X		X
Older Adults with substance use disorders			X	X		X	
Adolescents with co-occurring mental health and substance use disorders	X	X	X	X	X	X	X
Adults with co-occurring mental health and substance use disorders		X	X		X	X	
Older Adults with co-occurring mental health substance use disorders		X	X	X	X		

Observations - Population groups significantly underserved in your region: Findings from the stakeholder survey indicate that adults with mental health disorders were identified by stakeholders in six of the seven regions as one of the top three underserved populations. Five of the seven regions identified children and adolescents with emotional/mental health disorders as underserved. Only in region 7 were older adults with mental health disorders identified as one of the top three underserved populations. Adolescents with co-occurring mental health and substance use disorders were noted as underserved in two regions, and adults with co-occurring mental health and substance use disorders were identified as underserved in three regions.

The provider survey indicates that all seven regions believe that adolescents with co-occurring mental health and substance use disorders are underserved, followed by older adults with mental health disorders (in six regions) and both adolescents and adults with substance use disorders (in five regions). Adolescents with emotional/mental health disorders and adults with mental health disorders were only identified as underserved in one region. Some providers commented that all of the listed populations are underserved, but adolescents, older adults, and individuals with substance use disorders were more typically the populations viewed as "significantly" underserved.

Availability and adequacy of behavioral health services

Stakeholder survey

Table 9: What are your top three (3) comments about the availability and adequacy of services within the behavioral health system (mental health and/or substance use) in YOUR REGION?

	Region						
Response Options	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Access	**29**	**9**	**18**	**12**	5	9	5
Acute Intensive Services	**34**	**8**	8	7	6	5	3
Community and Other Supports	14	7	8	9	8	**15**	5
Co-occurring - Dual-diagnosis	13	5	12	7	**16**	**17**	5
Criminal Law	16	6	3	**11**	6	**16**	4
Healthcare - Home or Physical Health	4	2	1	0	9	4	1
Intensive Support Services	2	1	2	0	1	3	0
Medication	1	0	2	2	0	1	1
Monetary	6	2	10	2	8	3	4
Out-of-Home Residential Services or Inpatient	17	5	4	4	5	3	1
Outpatient Care	3	1	2	1	3	3	0
Populations	17	4	**14**	7	**21**	12	**6**
Prevention and Engagement Services	14	**10**	**15**	7	6	**19**	**7**
Recovery Supports	10	5	6	3	9	5	5
Workforce	**22**	**8**	7	**11**	7	5	2

Observations - Comments about the availability and adequacy of services within the behavioral health system in the regions: In four of the seven regions, access to services and prevention and engagement services were the most noted items regarding the availability and adequacy of services. Three regions identified populations and workforce, referring to inadequate services for individuals with a variety of disabilities and the lack of an adequate workforce to provide needed services. Highlights of the gaps identified in the stakeholder survey regarding the availability and adequacy of services in the seven regions are noted below.

Stakeholder survey regional highlights:

Region 1

- Acute: Not enough crisis and detox services
- Access: Not enough services, beds, providers
- Workforce: Not enough staff/high turnover rates.

Region 2

- Prevention: Need more early intervention for youth and better community services to support school-based services
- Access and workforce: Not enough providers/high staff turnover rates

- Acute: Need more crisis stabilization and detox beds and services.

Region 3

- Access: Although availability to services is good, there are numerous other barriers to access: need for Medicaid or private insurance, limited availability of drug-abuse providers, insufficient amount of treatment due to high caseloads, and lack of coordination/communication between services
- Co-occurring and populations: Inadequate services for people with disabilities
- Prevention: Need more outreach/education/awareness; also, school-based services are overtaxed and in need of better community and inpatient services to work with.

Region 4

- Access: Limited availability of services
- Workforce: Understaffed agencies/workforce shortage in region
- Criminal: Criminalization of substance abuse; jail often becomes placement for people with substance use disorders and mental illness.

Region 5

- Populations and co-occurring: Inadequate services for people with disabilities
- Recovery and community supports: Need for better discharge, transitional, and follow-up services (particularly for people with dual diagnoses), and better case management
- Healthcare: Stronger integration with primary care is needed, and can help improve coordination of care.

Region 6

- Prevention: Need more awareness/knowledge and early intervention
- Co-occurring: Inadequate services for people with disabilities
- Criminal law: Prisons house people with mental illness and have inadequate services for them, and the juvenile justice system is often where youth with problems end up.

Region 7

- Prevention: Need for more education, awareness, information about behavioral health, especially for youth
- Populations and co-occurring: Inadequate services for children with ID/DD/autism
- Community and recovery supports: inadequate transportation, housing, and supports for reintegration post-inpatient or jail.

Behavioral health service system gaps

Stakeholder qualitative responses

Table 10: What are the top 2-3 behavioral health service system gaps in YOUR REGION?							
	Region						
Response Options	1	2	3	4	5	6	7
Access	21	3	7	7	7	6	7
Acute Intensive Services	46	8	8	9	7	13	11
Community and Other Supports	32	9	28	14	38	25	5
Co-occurring - Dual-diagnosis	20	8	12	11	13	18	5
Criminal Law	5	2	1	2	7	7	4
Healthcare - Home or Physical Health	2	4	5	2	8	1	4
Intensive Support Services	6	0	6	6	1	1	1
Medication	3	0	1	4	2	1	2
Monetary	7	5	13	3	10	5	6
Out-of-Home Residential Services or Inpatient	23	6	14	8	7	8	3
Outpatient Care	7	3	2	1	4	2	2
Prevention and Engagement Services	15	5	17	5	11	15	5
Recovery Supports	9	6	11	9	14	11	8
Workforce	7	5	1	4	2	3	1

Observations – Top behavioral health service system gaps in regions: The behavioral health system gaps most frequently identified include community and other supports and co-occurring/dual diagnosis services, which were both noted in six regions. Five of the regions identified acute intensive services as a regional gap. Specific needs identified in several of the regions were more detox services, transportation, housing, respite care, and transitional and community integration supports. Additionally, services for co-occurring behavioral health and intellectual/developmental disorders, as well as better inpatient programs for individuals with co-occurring mental health and substance use disorders, were identified as regional gaps. Highlights of the gaps identified in the stakeholder survey regarding the availability and adequacy of services in the seven regions are noted below.

Stakeholder survey regional highlights:

Region 1

- Acute services: Detox and crisis stabilization were by far the most-cited needs.
- Community supports: A large response category, but no single consistent need mentioned. Instead there appears to be a general need for any and all types of community supports, with a few responses citing the need for housing and transportation.
- Residential and access: Common across these two categories was a strong call for more facilities (in particular, inpatient beds) and greater efforts to address the issue of access to inpatient services (within the region, as opposed to traveling far).

Region 2

- Between community support and recovery support responses, there were multiple responses identifying housing and transitional supports—as well as peer supports, mentoring, and peer groups.
- Acute services: Detox is the most-mentioned need, followed by crisis stabilization.
- Co-occurring: Services for children and adults with co-occurring ID/DD and other behavioral health needs.

Region 3

- Community supports: Overwhelmingly, the types of community supports mentioned centered on services for children and families.
- Prevention: Prevention needs similarly centered on school- and family-based services and reaching out to children.
- Out-of-home residential: A need for more inpatient beds, in particular for children/adolescents and for long-term patients.
- The focus on children and family needs was additionally emphasized in comments regarding a need for recovery supports available to families.

Region 4

- Community and recovery supports: Although two separate categories, the responses overlapped substantially. The greatest gaps mentioned are transportation, housing, and transitional and community integration supports.
- Co-occurring: More services needed for co-occurring behavioral health and ID/DD, as well as a need for better inpatient programs for co-occurring mental health and substance use clients.
- Acute services: Both crisis stabilization and detox services are mentioned multiple times.
- Although less frequent, both home-based services and longer and more inpatient services for addiction were mentioned.

Region 5

- Community supports: The primary gaps cited within this category were housing, family supports, respite care, and transportation.
- Recovery: Likewise, recovery supports were frequently cited as a system gap, particularly family supports and transitional support services.
- Co-occurring: Services for people with co-occurring ID/DD were cited as a major gap, second only to housing in frequency of being mentioned.

Region 6

- Community supports: The single most-cited need is housing, from group homes to transitional to housing-first initiatives.
- Co-occurring: Although more respondents cited community supports as an overall gap, the single most-discussed sub-theme was a lack of sufficient services for people with ID/DD co-occurring with other behavioral health needs.
- Prevention: School-based services were frequently mentioned, including screenings, early intervention, counseling, and integration of schools with community mental health.

Region 7

- Acute services needed include more crisis response and stabilization services and detox.
- Recovery support comments focus on the lack of sufficient follow-up, after-care, and transitional supports.
- Greatest access need discussed was a lack of psychiatrists and psychiatric services, as well as inpatient treatment for children and a general lack of providers in the region.

Top barriers

Stakeholder survey qualitative responses

Table 11: What are the top 2-3 barriers to providing and/or receiving services in YOUR REGION?

	Region						
Response Options	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Access	**64**	**18**	**28**	**15**	**16**	**23**	**10**
Acute Intensive Services	13	3	2	1	6	4	1
Community and Other Supports	**35**	**16**	**17**	**14**	**14**	10	7
Co-occurring - Dual-diagnosis	3	2	6	2	2	8	1
Criminal Law	2	1	2	4	3	3	1
Healthcare - Home or Physical Health	2	3	3	0	4	4	0
Medication	0	1	0	1	0	0	0
Monetary	**41**	**9**	**22**	**13**	**12**	**15**	**9**
Out-of-Home Residential Services or Inpatient	7	0	4	4	4	1	1
Outpatient Care	2	0	2	2	4	1	0
Prevention and Engagement Services	17	4	14	5	7	**14**	0
Recovery Supports	3	0	1	0	10	2	3
Workforce	**31**	10	10	**13**	8	7	4

Observations – Top barriers, identified in the stakeholder survey, to providing and/or receiving services in regions: The lack of access to services and the affordability of services were the most frequent barriers noted by respondents in all seven regions. The lack of community supports was noted as a significant barrier in five of the regions, with transportation cited as a common issue. Highlights of the gaps identified in the stakeholder survey regarding the availability and adequacy of services in the seven regions are noted below.

Highlights from the stakeholder regional responses

Region 1

- Access: Greatest issues are the lack of providers and rural geography/distance from services.
- Monetary: Many people cited the cost of services and a lack of money to pay for them.
- Community supports: The most-cited sub-theme was lack of transportation to services. This goes hand in hand with access issues.

- Workforce: A strong emphasis on services being understaffed, also related to lack of access and lack of providers.

Region 2

- Access: Lack of providers and/or distance to services.
- Community supports: Lack of transportation/ability to get to services that are not nearby.
- Workforce: Lack of providers/understaffed services stemming from issues around recruitment and retention.

Region 3

- Access: Other than general comments on access challenges, a number of respondents cited not having enough providers and agencies in the region.
- Monetary: Issues with affordability, especially for substance use services and non-Medicaid, and lack of insurance.
- Community: Transportation to services.

Region 4

- Access: Lack of availability or not enough providers, as well as distance to services.
- Community supports: Lack of transportation services and distance to services.
- Monetary: Cost of services combined with lack of insurance or concern over limitations on coverage.
- Workforce shortages.

Region 5

- Access: Lack of providers, and issues around eligibility for services.
- Community supports: Transportation to and from services, as well as insufficient case management.
- Monetary: Again, lots of comments on affordability.
- Recovery: A unique major theme for this region is problems with early discharge from inpatient settings into the community and lack of sufficient transitional supports.
- Understaffed agencies: Equal in frequency of mention to transportation and early/premature discharge.

Region 6

- Access: Lack of providers and difficulty accessing appropriate services.
- Monetary: Cost of services and lack of financial resources.
- Preventive: Lack of knowledge about what services are available and how to access them.

Region 7

- Access: Closure of juvenile facility, shortage of beds, location of providers.
- Monetary: Cost of services.
- Transportation: Lack of public transportation.

Observations - Top 2-3 barriers to providing and/or receiving services identified in the provider survey: Comments from the provider survey addressed barriers related to access, including transportation, especially in the more rural and frontier regions. Workforce availability and lack of inpatient options in some of the rural regions were also noted. Coordinating services with community partners at a level that produces true collaboration for the benefit of those in need of health care and minimizes competition was also identified as a barrier. Other common themes included the magnitude of information and documentation that is required for behavioral health services versus physical health, and the lack of coordination between the Office of Behavioral Health and Department of Health Care Policy and Financing.

Community-based behavioral health services most needed in your Region Suggestions to improve the array of services within Regions

The answer options for these survey items are from those proposed by SAMHSA in the *Description of a Good and Modern Addictions and Mental Health Service System*. As stated by SAMHSA, "a modern mental health and addiction service system provides a continuum of effective treatment and support services that span healthcare, employment, housing and educational sectors. Integration of primary care and behavioral health are essential. As a core component of public health service provision, a modern addictions and mental health service system is accountable, organized, controls costs and improves quality, is accessible, equitable, and effective. It is a public health asset that improves the lives of Americans and lengthens their lifespan."

A modern mental health and addiction system should have prevention, treatment, and recovery support services available both on a stand-alone and integrated basis with primary care and should be provided by appropriate organizations and in other relevant community settings. SAMHSA's proposed continuum used in the surveys comprises 10 domains:

- ✓ Health Homes
- ✓ Prevention and Wellness Services
- ✓ Engagement Services
- ✓ Outpatient and Medication Assisted Treatment
- ✓ Community Supports and Recovery Services
- ✓ Other Supports (such as personal care)
- ✓ Intensive Support Services
- ✓ Out of Home Residential Services
- ✓ Acute Intensive Services
- ✓ Recovery Supports

These services are not only intended for individuals with a mental or substance use disorder, but also support their families, who are critical to achieving recovery and resiliency.[1]

Stakeholder responses

Table 12: What three (3) community-based BEHAVIORAL HEALTH components are most needed in YOUR REGION?							
	Percent of Respondents by Geographic Region						
Response Options	1	**2**	**3**	**4**	**5**	**6**	**7**
Healthcare including services integrated with primary care	23.3%	21.3%	29.3%	21.3%	25.9%	27.4%	**44.3%**
Prevention/promotion including screenings	17.9%	17.3%	24.1%	31.9%	23.0%	22.6%	19.7%
Engagement Services: Assessments, specialized evaluations, service/crisis planning, consumer/family education and outreach	33.3%	**41.3%**	**42.1%**	33.0%	35.6%	**49.2%**	32.8%
Outpatient and medication services including individual, group and family therapy	30.4%	25.3%	**41.4%**	35.1%	34.8%	35.5%	**47.5%**
Community support rehabilitative services such as case management, supported employment, permanent supported housing, skill building and traditional healing services	**45.0%**	33.3%	**40.6%**	**46.8%**	**48.1%**	**47.6%**	31.1%
Other supports such as personal care, supported education, respite and recreational	20.0%	18.7%	21.1%	22.3%	20.7%	29.8%	18.0%
Intensive support services such as intensive outpatient, intensive case management, assertive community treatment, and multi-systemic therapy	**50.4%**	**36.0%**	**43.6%**	**40.4%**	**51.1%**	36.3%	37.7%
Out-of-home residential including crisis residential/stabilization, and therapeutic foster care	37.5%	**37.3%**	31.6%	30.9%	28.9%	29.8%	**41.0%**
Acute intensive services such as mobile crisis, peer-based crisis services, and medically monitored intensive inpatient	**42.5%**	32.0%	24.8%	27.7%	28.1%	28.2%	36.1%
Recovery Supports including peer supports, coaching and supports for self-directed care	24.2%	29.3%	24.8%	22.3%	24.4%	21.0%	19.7%
Number of Responses	240	75	133	94	135	124	61

Provider survey responses

Table 13: What three (3) community-based BEHAVIORAL HEALTH components are most needed in your REGION?							
	Region Responses - Providers						
Geographic Region	1	2	3	4	5	6	7
Healthcare including services integrated with primary care	X	X		X	X	X	X
Prevention/promotion including screenings	X	X	X	X		X	
Engagement including assessments, specialized evaluations, service planning, consumer/family education and outreach		X	X		X	X	
Outpatient and medication services			X	X	X	X	X
Community support rehabilitative services			X				
Other supports such as personal care, supported education, respite and recreational	X		X	X		X	
Intensive support services such as intensive outpatient, intensive case management, assertive community treatment, multi-systemic therapy	X	X	X		X	X	
Out-of-home residential including crisis residential/stabilization, and therapeutic foster care	X	X		X	X		
Acute intensive services such as mobile crisis, peer-based crisis services, and medically monitored intensive inpatient		X	X	X	X		X
Recovery Supports including peer supports and coaching		X	X	X	X		

Observations – Comments about most-needed community-based behavioral health components. The stakeholder survey findings indicate that community-supported rehabilitative services along with Intensive support services were higher needs (top 2-4) compared to the other items in the continuum in five of the seven regions. Engagement services (including assessments, specialized evaluations, service/crisis planning, consumer/family education and outreach) were higher needs in three of the seven regions.

Regions 2 and 7 identified higher needs for out-of-home residential services. Regions 3 and 7 identified outpatient and medication-assisted treatment, and only region 1 identified acute intensive services such as mobile crisis, peer-based crisis services, and medically monitored intensive inpatient as a higher need service along the continuum.

Responses for the providers survey indicate the most common needed service across six of the seven regions was healthcare, including services integrated with primary care. Additionally, five of the regions identified prevention/promotion including screenings, outpatient and medication services, Intensive support services and acute intensive services such as mobile crisis, peer-based crisis services, and medically monitored intensive inpatient.

The need for intensive support services was a common theme across both the stakeholder and providers surveys was a common theme identified in regions 1, 2, 3, and 5.

Stakeholder survey – Qualitative suggestions to improve the service array

Table 14: Suggestions to improve the array of services from physical healthcare - to early intervention and prevention - to outpatient treatment and community supports - to acute and long term residential and inpatient - to recovery supports in YOUR REGION.							
	Number of Respondents by Geographic Region						
Response Options	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Access	2	0	2	1	0	2	1
Acute Intensive Services	5	4	3	5	3	7	1
Crisis	2	1	1	4	1	3	1
Community and Other Supports	**15**	**6**	**10**	**7**	**12**	**12**	**5**
Community Support / Based Services	5	1	1	2	1	1	1
Housing - House - Shelter(s)	3	4	5	2	4	5	1
ID or DD	1	2	1	2	1	3	0
Healthcare - Home or Physical Health	5	2	6	1	6	4	4
Integrate or Integrated	2	1	3	0	3	2	0
Prevention and Engagement Services	**7**	**5**	**7**	**8**	6	**11**	3
Prevention or Preventative	1	0	2	6	3	0	0
School	3	3	1	0	0	2	1
Recovery Supports	0	0	0	2	3	4	2
Workforce	3	3	1	0	2	2	0

Note: Bolded items received the most responses statewide.

Observations – Suggestions to improve the services array: Suggestions focused on two key areas: community and other supports such as housing, and prevention and engagement services, including school-based services**.** Providers' suggestions for improving the service array are noted below.

Providers' suggestions for improving the service array:

Region 2

- Our BH state entities—including the Institutes, OBH and HCPF—need to expand their scope and vision to reaching the greatest numbers of Coloradans with an array of BH needs and improving the health of our community populations. For OBH particularly, there needs to be a continuation of recent trends to look beyond contracts based on service numbers of individuals with serious emotional disorders and mental illness, and toward population-based interventions that often don't tie well to "encounters." This would include, but is not limited to, an increased focus on collaboration and active integration with physical health care, and flexibility around current data demands such as the CCAR and DACODS, which do not play well in integrated settings.
- The biggest concern of the options listed above is a broader integration with more primary care and physical health providers. We have a very robust integrated care system with one of our FQs but the hospital systems are still mostly closed to working

collaboratively with MHCs. Otherwise, the continuum of services is comprehensive and effective. We still believe in the clubhouse model of psychosocial rehabilitation and are very involved with prevention and early intervention, i.e. infant and early childhood, suicide education and prevention and adolescent SUD prevention efforts.

- Long-term residential can be problematic at times for a limited number of individuals that need this level of care.
- Not just allow, but encourage the use of alternative therapies (art, equine), especially among the SPMI and DD populations.

Region 3

- Gap in services for high utilizers who pose a risk to the community if they are not in a supported, sometimes secure, setting.

Region 4

- It is important to address the social determinants of health, but this can't be done in a "fee for service" environment. The attempts to tie these unique programs back to traditional units of service are not helpful.
- Funding for prevention and early intervention as well as integration efforts would be money well-spent for the future of our communities. Additional primary care providers are needed throughout most of the region. Prevention education is needed for physical, mental, and substance use issues.
- Access to residential living for clients who need more assistance. An array of services can be provided; however credentialing of providers has not changed to match the codes for services available.

Region 5

- We receive requests for in-home care and therapy. There are agencies that provide case management in home but not as many for therapy.
- Substance use disorder treatment programs would benefit from having access to vocational and housing resources (i.e., housing vouchers).

Region 6

- As Medicaid expansion reduces the need for block grant and state general fund dollars to be used for indigent care, explore the potential use of those funds for care coordination, wellness/health promotion, and health coaching activities.
- Continue to work toward regulatory alignment between OBH and HCPF to minimize administrative burden on providers and streamline data collection activities.
- Facilitate billing of screening and prevention services in the physical health area by behavioral health providers and community mental health centers. Modify documentation requirements pertaining to wellness and prevention services so it is less driven by a traditional problem focused treatment plan. Facilitate information sharing across physical health and behavioral health providers, particularly in co-located settings.
- Expedite evidence-based practices for treating adolescents with onset of schizophrenia.
- Provide funding for drop-in centers for transitional services, youth/young adult programming.

- Facilitate health home provision by community mental health centers-help advocate that HCPF pursue the Medicaid state plan amendment.
- Promote availability of housing for those who have been involved in the criminal justice system.
- Develop senior-specific behavioral health resources for this fast-growing population.

Region 7

- Need medical care at state institutes.
- Need full benefit for SUD; too confusing to community providers what is versus what is not covered in partial benefit.
- Need to open up codes for behavioral health in primary care; we could be doing so much more care on the front when people are identified early. Could save major dollars later when care is more expensive.
- Medicaid benefit for housing? Other states are doing it.
- Need a medical home model for SMI/SED populations. Section 2703 of Health Homes is important to their health as well as bending the cost curve.

Substance use services most needed within Regions

Table 15: What two (2) substance use services are most needed within YOUR REGION?							
	Percent of Respondents by Geographic Region						
Response Options	1	**2**	**3**	**4**	**5**	**6**	**7**
Residential detoxification (social detox model)	**42.9%**	**43.3%**	28.7%	**40.7%**	25.5%	31.6%	30.4%
Low intensity residential services (typically transitional residential programs)	37.8%	**46.3%**	**51.5%**	32.1%	36.8%	**62.1%**	**42.9%**
Medium intensity residential services (typically a nursing home type of setting that specializes in working with people with substance use disorders)	34.1%	**41.8%**	38.6%	35.8%	36.8%	30.5%	37.5%
High-intensity residential services (typically Therapeutic Communities designed for many criminal justice involved offenders)	32.7%	25.4%	33.7%	**46.9%**	**45.3%**	34.7%	35.7%
Medically monitored intensive residential treatment (typically thought of as residential - 2-6 week stays to stabilize severe addiction that is not responding to lower levels of care)	**56.2%**	38.8%	**45.5%**	**50.6%**	**50.0%**	38.9%	**58.9%**
Number of Responses	217	67	101	81	106	95	56

Observations -Stakeholder responses regarding most-needed substance use services: Medically monitored intensive residential treatment (typically thought of as residential with 2-6 week stays to stabilize severe addiction that is not responding to lower levels of care) was noted as one of the most-needed substance use services in five of the seven regions. Four of the regions noted needing low-intensity residential services (typically, transitional residential programs). Regions 1, 2, and 4 identified residential detoxification (social detox model) as one of their higher needs. Regions 4 and 5 noted high-intensity residential services (typically, Therapeutic Communities designed for many criminal justice involved offenders) as a higher need while region 2 identified medium-intensity residential services (typically, a nursing home type of setting that specializes in working with people with substance use disorders). Additional findings from comments include:

- Across many regions, acute intensive services and detox services are indicated as either not available or having waitlists and being insufficient to meet the need.
- In some regions, longer-term inpatient residential treatment is needed.
- Other responses focused on the need for more transitional and community support services, including housing programs, supported employment, family supports, and relapse prevention.

Provider survey response

Table 16: What two (2) substance use services are most needed within your REGION?							
	Region Responses - Providers						
Geographic Region	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Clinically Managed Residential Detoxification (social detox model) ASAM III.2-D	X	X	X	X	X		
Clinically Managed Low Intensity Residential Services (typically transitional residential programs) ASAM III.1	X	X	X		X	X	X
Clinically Managed Medium Intensity Residential Services (typically a nursing home type of setting that specializes in working with people with substance use disorders) ASAM III.3		X	X	X			X
Clinically Managed High-Intensity Residential Services (typically Therapeutic Communities designed for many criminal justice involved offenders) ASAM III.5			X		X	X	
Medically Monitored Intensive Residential Treatment (typically thought of as residential - 2-6 week stays to stabilize severe addiction that is not responding to lower levels of care) ASAM III.7	X	X	X	X		X	

Provider comments from the survey

Region 2

- State supports and/or training for recovery support, including peer supports and coaching, need to be beefed up. Particularly in these days of waning access to CACs in

the workforce, recovery support is an essential and growing part of our future ability to meet treatment demand. Sustainable options to really move SBIRT-type screening and intervention into all primary-care settings for both adolescents and adults.

Region 4

- Not enough attention or resources are given to employment services.

Region 5

- Adolescent detox is specifically needed.
- Need an outpatient substance use disorder treatment program for individuals who have successfully completed therapeutic community residential treatment. The aftercare component is crucial to recovery. Outpatient therapeutic community/aftercare services are minimally funded and current funding does not cover the cost to provide the necessary services. This is an area of need and should be expanded.

Region 6

- Intensive outpatient services are needed.

Region 7

- Community has both ends of this spectrum supported—social detox and medically monitored care. Where we lack supports is in the middle, when folks are transitioning from social detox and are entering intensive outpatient (IOP) programming and outpatient (OP) programming for SUD as well as when some medical and nursing support is needed through a residential setting.

Observations - Provider responses on most-needed substance use services in regions:
Clinically managed low-intensity residential services (typically, transitional residential programs) were the most-needed substance services identified in all regions except region 4. Medically monitored intensive residential treatment and clinically managed residential detoxification (social detox model) were also the noted among the most-needed substance use services in five of the seven regions.
The provider comments noted above indicate the need for intensive outpatient services, enhanced peer and recovery supports, and greater focus on employment services.

Provider inventory responses

Given the legalization of marijuana and the current epidemic of prescription drug abuse, should services be enhanced or expanded to effectively address these challenges, and if so how?

Region 2

- These are both key areas of concern, particularly in terms of increasing access and decreasing social stigma associated with medical and, more recently, recreational marijuana in Colorado. Young people are at greater risk both in terms of brain development, and in terms of vulnerability to a perception of peer acceptance of use. Prevention and early intervention are needed. In one of our communities, our "Minor in Possession" group recently received referrals of several 10- and 11-year-olds using marijuana. Prescription drug abuse is at a critical state nationwide as well as in Colorado. Education and prevention efforts with the overall population is part of the need, as well as continuing training around physician management of high-risk medications and awareness of when patients need additional support to deal with addictive substances they may medically need. Medication-assisted treatments, such as Suboxone, are part of the answer, as well as removing system barriers that get in the way of those with behavioral health expertise bridging into physical health around services like adjunctive treatments and pain management.
- An increased emphasis on prevention is needed, not only for the reasons listed above, but because prevention services historically are not funded sufficiently. It is hard to demonstrate the fiscal benefit of these services, but it is logical that they make a difference and can have a positive impact on this issue.
- More information in the hands of the parents, teachers, and faith community.

Region 3

- Prevention for youth ages 12- 20; prevention education for parents who use drugs and have children; creation of a task force specific to each county addressing prescription drug use (Project Lazarus is one model).
- Expand buprenorphine programs, including at dispensaries.
- Expand treatment for adolescents.

Region 4

- Prevention and education programs for youth.
- Family-oriented treatment for substance use disorders.
- Enhanced child welfare training and support for families.
- The consequences of the following need to be addressed: child neglect, automobile accidents, theft, domestic violence, and more.
- More funds need to be allocated for prevention and recovery for these types of specific challenges.

Region 5

- Services should be enhanced and expanded. Education (prevention), specifically beginning in middle school and also in high schools.
- Prevention, definitely. There are such efforts underway based on the current efforts of the Prescription Drug Consortium. Additional resources for the prevention and awareness of the harms and risks of marijuana are also necessary. In order for services to be expanded/enhanced, changes need to be made to the funding streams that support these programs. For example, coverage for all levels of care needs to be examined. Additionally, some BHOs have been struggling to implement behavioral health coverage. For example, the requirement of frequent authorizations for a medication-assisted patient therapy adds to the misunderstanding of the modality of treatment. The BHOs operate independently and there is not consistency across them.
- Marijuana legalization will create the need for additional adolescent treatment/ prevention services. Educational services should be directed toward families and pregnant women, who place their unborn children at risk when they use marijuana. Marijuana use may serve to create increased relapses in individuals who have previously not used it due to its illegality. Alcohol clearly is a trigger for relapses to all classes of drugs.

Region 6

- Better systems for accessing medication-assisted therapies such as Vivitrol and Suboxone, which would include administrative support, medical personnel, adequate cost returns and outreach efforts. Availability of Narcan. Education/prevention for all substances, not just focused on marijuana.
- Need for increased treatment that manages pain without opiate or other prescription drug abuse. Similarly, need for approaches to managing anxiety without use of benzodiazepines. Integrated health approaches could be helpful both at community mental health centers and primary care practices. Education of primary care providers on addictions and alternative medications to manage pain and anxiety is needed.

Region 7

- Services should be expanded; prevention should be a big priority for school-age children. With legalization, many kids may interpret that there is also no harm medically.
- Anecdotally we hear that pot sales are getting more expensive and that many kids are turning to heroin as a cheaper alternative. This is very concerning.

Observations – Impact on services given the legalization of marijuana and the current epidemic of prescription drug abuse: Education and prevention efforts with the overall population are part of the need, as well as continuing training around physician management of high-risk medications and awareness of when patients need additional support to deal with addictive substances they may medically need. Several providers noted that prevention efforts and treatment specific to adolescents are needed in addition to educational services for families and pregnant women. Another opportunity is increased attention to the treatment of pain in order to manage pain without opiate or other prescription drug abuse.

What interest/capacity do you have to provide court-ordered competency evaluations?

Region 2

- In our portion of region 2, we have rarely been asked to provide court-ordered competency evaluations, sometimes in non-forensic and/or situations involving juveniles, but this has never been a mainstay of our service delivery. We have little capacity to expand such evaluations in our rural counties.
- With everything that we do, not much.
- Limited.

Region 4

- Yes, with additional training we would be available to provide or arrange court-ordered competency evaluations.
- We have limited capacity to provide court-ordered competency evaluations in our region. We have one provider who currently takes a limited number of referrals due to his outpatient practice.

Region 5

- We would be interested in providing court-ordered evaluations.

Region 6

- Could do if adequately reimbursed.
- Not at this time.

Region 7

- Happy to get more involved but payment usually does not cover cost for court testimony. (It is) too difficult to pull a staff member out of office all day. Must address this gap.

Observations – Providers' interest/capacity to provide court-ordered competency evaluations in regions: As noted in the comments above, there is some interest in regions 4, 5, 6, and 7 in providing court-ordered competency evaluations, if reimbursement is adequate to cover the cost of these services. If these evaluations were to be expanded across some of the regions, training for the evaluators and a peer-review process would be helpful in supporting the consistency and quality of these reviews.

Interest/capacity to provide competency restoration services

Region 2

- This is not really an area of key expertise, and doubt that we'd see numbers in our rural/frontier area that would warrant developing such services in our counties.
- We have worked well with CMHIP, in my opinion, in working with forensic clients returning to the region. I believe we have a good track record and would be willing to discuss options for the future.
- Limited.

Region 4

- We would need additional training, particularly on the legal aspects, to effectively provide competency restoration. We are interested in doing so.
- We do not have the capacity to provide competency restoration services at this time.

Region 6

- Would consider.
- Not at this time.

Region 7

- Would be open to discussing and learning more.

Observations – Providers' interest/capacity to provide competency restoration services in regions: Regions 2, 4, 6, and 7 indicate some interest in exploring the provision of competency restoration services, assuming training for this specialty area would be provided.

Telemedicine/telehealth to enhance behavioral health service delivery

Region 2

- In a nutshell, telehealth delivery should be considered and fully supported by all BH-related state entities as equivalent to "face-to-face" service delivery. It has been in development and active use in some areas of Colorado for a decade or more, to extend psychiatry services and other high-demand expertise to more individuals in need, without requiring them or the providers to waste hours and dollars in "windshield time."
- We have utilized this on a limited basis. For the rural northeastern area, it is utilized on a significant scale. I anticipate it will be utilized more through the crisis services we will provide to facilitate patient-to-doctor interaction.
- This needs to be a priority for both clinic-based and home-based services. Also, the wide variety of alternative settings (senior centers, nursing homes, and schools) could be impacted by telehealth.

Region 3

- Consultation in step-down/ disposition planning, and do telehealth from a consumer's home.

Region 4

- Create statewide efforts to recruit, credential, and train psychiatrists and psychiatric nurse practitioners who could practice via telehealth from out of state if they choose not to relocate to Colorado. Use technology to provide crisis assessments. This could be done with the patient in the hospital and master's level clinician in more rural locations. It could also include conducting assessments via secured "face-time" type applications from the patient's home to the clinician. Use technology to help monitor chronic care patients' progress. Monitoring could be done by a clinician. Self-monitoring could also be done by the patient or family.
- We are currently trying to use telehealth with our jail-based population to be more trauma-informed, provide more services, and to work with our partners around transportation issues. We discussed using telehealth for access to specialty care. Telehealth for rural communities with limited or no public transportation. Can also use telehealth for emergency needs to get those in isolated communities connected to psychiatry.

Region 5

- Telehealth can be utilized in rural areas and for families with transportation issues.
- There is a dearth of mental health and substance treatment professionals (psychiatrists, licensed mental health professionals), especially in rural Colorado. Telemedicine is a significant adjunctive support to these areas and should be encouraged and expanded.

Region 6

- Provide specialty services (including but not limited to psychiatry) not available in a particular geographic region. Provide services to individuals who are incarcerated, in nursing facilities, etc. Extend the network of crisis services, second opinions, outside

assessments, etc. Provide in-home supports to individuals who require monitoring or ongoing support Provide psycho-education and self-help services.

- This could be very helpful in serving rural and mountain communities where health services and transportation resources are limited. This could be helpful throughout the state for behavioral health services to be provided to primary care or other physical health entities.

Region 7

- Open up (billing) codes to provide more services telephonically as well as through video.

Observations – Opportunities to use telemedicine/telehealth to enhance behavioral health service delivery in Colorado: Providers from the six responding regions indicated a value of and greater opportunities to use telehealth, especially in rural areas but certainly not limited to these parts of the state. Telehealth service provision to individuals who are incarcerated, in nursing and other facilities, or receiving home-based services would be a significant enhancement to the behavioral health system. Additional opportunities to use telehealth include extending the network of crisis services, receiving second opinions, and outside assessments, as well as providing psycho-education and self-help services. Adequate billing codes are needed to support the use and expansion of telehealth services.

Barriers/gaps to serving people in the community rather than institutional settings

Table 17: Biggest barriers/gaps to serving people with mental illnesses in the community rather than institutional, settings:	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Housing	X	X	X	X	X	X	
Mental health treatment							
Substance use treatment	X		X	X	X		
Crisis services							
Residential services	X	X	X	X			
Respite care	X		X	X		X	

Other barriers/gaps identified by providers in the Inventory include:

Region 1

- Transportation; work force; small population in each of six counties makes it difficult to financially support 24/7 residential, respite, CSU, inpatient, or detox services. Total service area is 10,000 square miles – rural and frontier.
- Locked nursing home; transitional housing.

Region 2

- Safe off-site environments. The biggest barrier is engaging people with mental illness in treatment if their illness affects them in such a way that they do not want to be involved in treatment. This is largely due to paranoia, lack of trust, fear, etc. Developing ways to connect with these individuals is a major challenge.
- Another primary barrier is reducing stigma so people experiencing symptoms will seek services.

Region 4

- Transportation

Region 5

- Lack of health promotion, prevention, and early intervention services

Region 6

- Employment services, accessing benefits, providing case management to private-pay and Medicare clients, low payment/high documentation requirements for Medicare.

Region 7

- Transportation.

Observations - Barriers/gaps to serving people with mental illnesses in the community rather than institutional settings: The most prevalent identified barrier/gap to serving people with mental illnesses in the community rather than institutional settings was the lack of housing, in all regions except for region 7, which identified transportation. Substance use treatment, residential services, and respite care were all noted in four regions. Additional comments from providers included the need for employment services, health promotion and early intervention services, locked nursing homes, and transitional housing.

Greatest population challenges to serve in the community

Table 18: The following client groups pose the greatest challenge to serve in the community	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Children	X						
Adolescents	X	X					
Young adults/Transition-aged youth	X	X	X		X	X	
Older adults	X			X			X
Individuals with traumatic brain injuries	X			X	X	X	X
Justice-involved	X		X	X	X	X	
Individuals with a history of violence	X	X	X	X	X	X	

Other challenging populations to serve in the community noted by providers include:

Region 1
- Complex mental health and medical issues.
- Treatment-resistant patients.
- Substance use: Prescription drug abuse and illegal opioid abuse.

Region 2
- Dual diagnosis/developmental disability/mental illness;
- Autism spectrum/mental illness

Region 3
- Clients who are homeless
- Clients with a history of violence, simply because they often cannot access housing, which is needed to achieve any level of stability

Region 4
- Individuals and families in poverty

Region 5
- Individuals who, for whatever reason, are difficult to house. This includes those with criminal justice involvement and those with poor rental history.
- We are unable to conduct therapy with individuals who lack basic needs (food, housing, etc.). We then spend more time seeking resources than doing therapy with these clients.

Region 6
- Homeless
- Medicare clients
- Anyone with serious behavioral health concerns needing case management, housing, and employment services when their payer does not provide for these things.

Region 7
- People with developmental disabilities.

Observations - Groups that pose the greatest challenge to serve in the community: The groups identified that pose the greatest challenges to serve in the community as identified by the providers in the Inventory include; 1) individuals with a history of violence – noted in all regions except for region 7; followed by older adults, individuals with traumatic brain injuries, and individuals involved in the justice system – all noted in five of the regions. Providers also identified individuals with complex mental health and medical issues, homeless, and treatment-resistant individuals as significant challenges. Region 1 noted that there are too many layers of criminal justice, all with different rules/regulations, and funding sources. Violence is becoming more of an issue, with two recent events involving clients with weapons and having to call law enforcement.

Housing gaps

Observations: Housing gaps and waiting lists were identified as a problem across all seven regions. The estimated wait times for housing were as low as one to three months in regions 2 and 3, and as long as two or more years in regions 5 and 7, with the other regions falling in between.

The estimated percentage of unserved need for housing programs was as low as 5 to 10 percent in regions 3 and 6 and as high as 70 to 90 percent in regions 1, 4, and 7, with the other regions falling in between at around 30 to 40 percent. For individuals who do not participate in housing programs, the unserved need ranged from 20 to 90 percent.

Employment gaps

Observations: Employment service gaps were identified in at least part of all regions except region 5. The reported wait times for employment services varied but were typically one to two months. The unmet need for employment services varied from approximately 20 individuals in region 5 to 231 in region 1.

Gatekeeping who gets referred to state hospitals and serving more consumers in their own communities

Observations - Gatekeeping: The providers in the responses noted above discuss their role as gatekeepers for individuals referred to the two state hospitals. Some providers within region 1 have found access to their "allocated" beds at CMHIP to generally not be available when needed so they are using inpatient and ATU resources within their region. It was noted by region 3 providers that additional beds available at Fort Logan would allow them to serve clients closer to their communities, instead of in Pueblo. Region 3 providers also noted that they have hospital liaisons who support individuals transitioning in and out of state hospitals, but they do not function as gatekeepers. Region 5 noted that they could better serve individuals if CMHIFL had the ability to serve persons who had medical challenges in addition to their behavioral health challenges, and if they were able to routinely serve older adults.

Behavioral health workforce

Table 19: Current Filled FTE #/Total FTE Budgeted

STAFF CATEGORY	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Medical Staff	19.68/NA^	7.25/8.25	32.2/35 65/NA	**30/35**	7/7	**10.9/18**	8/8
Psychiatrists	9.95/NA^	5/5	**21.4/27.55** 21/NA	**10.5/14.5**	**18/23**	13.25/ 13.45	**10.8/15.3**
Psychologists	6.7/NA^	3.75/3.757	30.3/30 2/NA	5/5	7/7	8.7/8.7	16/16
Nurses	14.9/NA^	**7/11.5**	**25/28** 47/NA	**24/28**	19/20	**30.4/34.33**	**16/22**
Addictions Staff (E.g. CACs -Not Recovery Coaches)	45.7/NA^	17.4/18	31/8** +/NA*	**12.5/15.5**	++	**35.15/ 40.35**	13/13
Licensed Clinicians, Counselors, Social Workers	139.5/NA^	**41.75/48.75**	**172/188** 102/NA*	**71/79**	95/97	**218.3/ 249.8**	100.73/ 102.73
Unlicensed Master's level Clinician's, Counselors & Social Workers	84.25/NA^	**56/68.75**	**132/152** 49/NA*	**58/64**	70/72.5	**80/93.8**	27.84/30
Unlicensed Bachelor's level Clinician's, Counselors & Social Workers	5/NA^	9.8/4	**30/38.65** 35/NA*	39/40	193.5/ 196.5	**45.6/50**	44.86/46
Cross-trained MH/SA Behavioral Health Staff (Master's)	17.5/NA^	32/33	20/22 +/NA*	**23/27**	++	3/3	12/12
Cross-trained Behavioral Health Staff (Bachelor's)	4/NA^	1/1	0/0 +/NA*	2/2	++	0/0	1/2
Case Managers (Non-Peer)	76.1/NA^	**44/49**	42.1/47 ++/NA*	29/31	++	**52.9/57.2**	10/12
Peer Support Specialists	24.65/NA^	13.75/11.55	**18/26** 5/NA*	11/11	4.5/6.5	**21.2/28**	**6.5/10.25**
Recovery Coaches	9/NA^	0/0	+/NA 0/NA*	4/7	0/0	16/16	5/7
Family Navigators/Advocates	12/NA^	0/0	**9/13** 0/NA*	9/10	1/2	19.4/19.5	3/4
Mobile Crisis Staff (Non-Peer)	32.2/NA^	8/9	**17.3/22** NA/NA*	**15/22**	`	**10.15/21.65**	1/0
Crisis Stabilization Unit Staff (Non-Peer)	11.5/NA^	5.65/0	**23.4/36.5** NA/NA*	**0/9**	0/0	2/2	**3/6**

Table 19 continued: Current Filled FTE #/Total FTE Budgeted							
STAFF CATEGORY	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**Region 7**
Crisis Respite Staff (Non-Peer)	2/NA^	7.9/9.4	1/1.5++ NA/NA*	**1/4**	~	.5/.5	2/2
Mobile Crisis Peer/Family/Recovery Staff	2/NA^	0/0	2/3 NA/NA*	6/6	0/0	1.2/1.5	0/0
Crisis Stabilization Unit Peer/Family/Recovery Staff	3/NA^	2.04/0	3/5 NA/NA*	0/0	0/0	0/0	3/5
Crisis Respite Peer/Family/Recovery Staff	2/NA^	3.5/.5	2/3 NA/NA*	0/0	0/0	.5/.5	0/0

^There was not sufficient data among the four agencies
*ADMHC did not provide information for Total FTE budgeted
**Community Reach did not provide the Total FTE Budgeted data for this category
+info not tracked
++included in other categories
`Contracted with Denver Health
~CCC staff at Park Place

Observations – Behavioral health workforce gaps: Region 1 did not report budgeted positions (FTE) therefore it is not possible to assess workforce gaps in that region. The greatest gaps, defined as the difference between filled and budgeted positions, appear in the table above as **underlined bold.** For regions with more than one responding provider agency, FTE are combined, and therefore all of the vacancies may not be within one specific agency. The greatest workforce gaps are in regions 3, 4, and 9, which all have nine positions with notable vacancies. Regions 2 and 7 have four vacant positions, followed by region 5 with one vacant position. Some of the crisis-related programs were just rolling out at the time of the inventory, which accounts for the lack of information for these positions.
The positions with the most significant gaps across three or more regions are highlighted in gray. There are five regions with nursing gaps, and four regions with gaps in psychiatrists, licensed clinicians/counselors/social workers, and unlicensed master's level clinicians/counselors/social workers. Three regions have gaps in their peer-support positions.

Needs met and gaps identified

Table 20: Child/Adolescent Inpatient Needs Met		
Region	**Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Region.**	**Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State.**
1	40%-80%	40%-70%
2	No Response	70%-80%
3	50%-90%	50%-90%
4	50%-90%	50%-90%
5	10%-100%*	10%-100%*
6	0%-10%	0%-60%**
7	50%	90%

*10% from Servicios de Raza and 100% from MHCD

**0% from Jefferson Center and 60% from MH Partners

Table 21: Child Adolescent Inpatient Gaps			
Agency Name	**Region #**	**Gaps in Region**	**Gaps in the State**
Touchstone	1	Facilities are full or not equipped for acuity/age/diagnosis 60% of the time and a bed elsewhere must be searched out.	Rarely use Pueblo for children as it is so far away. If they have a bed, they'll admit. They are available about 60% of the time we do request admission.
Axis	1		Axis Health System placed 18 children and adolescents in inpatient care outside of its region in FY 2014.
Midwestern	1	With Crisis contract now in place, Hilltop is increasing capacity by six beds. This should resolve previously noted gap. We do not have the population to support such a facility in the Midwestern service area.	Other resources have been developed over the years due to gaps in beds in years past. Not sure how much we use state child/adolescent beds or what the gap might be.
Centennial	2	There are no child/adolescent psychiatric inpatient beds in this geographic area.	Because we hospitalize a small number of children/adolescents, we typically do not find bed capacity to be problematic for this age group.
North Range	2	There are no child/adolescent psychiatric beds in Weld County. We refer out-of-county.	The primary gap for inpatient psychiatric beds is for adolescents.

Table 21 continued: Child/Adolescent Inpatient Gaps			
Agency Name	**Region #**	**Gaps in Region**	**Gaps in the State**
Aurora	3	There are few child/adolescent inpatient beds in the metro area; beds are used across geographic regions as they are available, so the concept of enough beds in the specific geographic area is not one that fits with how we access beds when needed.	There are no child/adolescent institute beds in the metro area and due to difficulty in traveling to Pueblo for families, this resource is rarely used by AuMHC. There have been a number of alternatives to inpatient developed and are frequently used to manage the shortage. These are not locked and therefore offer a lower level of security, but are appropriate as inpatient alternatives. The two new child/adolescent CSUs coming online will provide additional access to alternatives to inpatient stays.
SLV BH	4	We do not have any available psychiatric bed space in our local area. All involuntary hospitalizations are referred out to other areas.	CMHIP has been very helpful with taking a direct admission for child/adolescent clients.
Southeast	4	There are not any child/adolescent non-state hospital psychiatric inpatient facilities in our service area. The closest would be one hour away in Pueblo or 2 hours away in Colorado Springs from our La Junta facility.	We rarely need to access inpatient psychiatric beds for our child/adolescent population; however when we do, it is always “iffy” in regard to finding placement for them as most all inpatient units are at capacity.
Spanish Peaks	4	There are no ATU beds for youth under the age of 12, which often results in hospitalization. If there are no local beds available, our clients are placed out of community and can be as far away as North Denver.	Not known
MHCD	5	No Response	No Response
Jefferson Center	6	There are no psychiatric inpatient facilities with units for youth/adolescents in our geographical area.	There are no state institute beds in our area so if a youth is appropriate for a State institute, this means a long trip for the client and family, so the state institute beds are rarely used for youth. A few times a year, all the metro-area inpatient beds for youth are full, so then we use beds in Pueblo, or youth await an opening while in an emergency room, neither of which is ideal.

Table 21 continued: Child Adolescent Inpatient Gaps			
Agency Name	**Region #**	**Gaps in Region**	**Gaps in the State**
MH Partners	6	There is the only hospital for adolescents in our geographic area, and no hospitals for children. It is a challenge to coordinate family treatment when facilities are further away. Family work is essential with this population.	One area of concern is for the children and adolescents who are dual diagnosed. Currently we only have one facility, Children's Hospital in the Denver area that is willing and able to take these clients. Often it is hard to untangle what is mental health and what is related/due to developmental delays.
Aspen Pointe	7	Beds are often full, clients 10 or younger are difficult to place	Occasional bed availability, combination MH and DD can be a problem to place.

Observations – Child and adolescent inpatient bed gaps: Providers across the regions identified the percent of child and adolescent non-state hospital beds needs being addressed as anywhere between 0 and 100 percent. Providers within region 6 identified only 0-10 percent of these needs being met within their region and 0-60 percent within the state, which represent significant service gaps. The inventory did not differentiate between children and adolescents; however, key informant interviews suggested that the need is greater for adolescents than children. A couple of providers identified gaps in resources for children and adolescents with co-occurring mental health and developmental delays/disorders. Children's Hospital Colorado is the only reported option for these individuals. The only state psychiatric hospital beds are located in Pueblo, which is a long commute from most of the regions. Many providers are hopeful that the new crisis-stabilization units will provide some relief for this population. Several key informants identified a need for additional state adolescent inpatient beds in the Denver metro area, noting there are occasional needs for additional child beds as well.

Table 22: Child /Adolescent Residential Needs Met		
Region	**Percent of Child and Adolescent Facility Needs Met by Current Available Resources in your Region.**	**Percent of Child and Adolescent Facility Needs Met by Current Available Resources in the State.**
1	30%-90%	90%
2	0%-50%	0%-90%*
3	80%-90%	50%-90%
4	0%-100%**	50%-100%
5	0%-90%***	0%
6	30%-50%	50%-70%
7	40%	80%

*0% from Centennial and 90% from North Range

**0% from SLV BH & Southeast and 100% from Sol Vista – the others were in between or did not respond

***0% from Servicios de la Raza and 90% from MHCD

Table 23: Child/Adolescent Residential Gaps			
Agency Name	**Region #**	**Gaps in Region**	**Gaps in the State**
Axis	1	Axis Health System had two children in residential treatment outside of our area in FY 2014.	
Midwestern	1	The additional six ATU beds at Hilltop should greatly assist with the additional perceived 10% gap. We do not have the population to support such a facility in our service area.	
Mind Springs	1		Difficult to place: medically fragile, ID/DD and autism spectrum youth.
Touchstone	1	70% of the time we must locate children/adolescents out of our service area.	10% of the time an appropriate placement is not available. These are high intensity, high acuity children with complex needs.
Centennial	2	There are no child/adolescent PRTF residential facilities in this region; North Range Behavioral Health offers an RCCF.	We typically do not have difficulty placing youth in PRTF or TRCCF facilities in the Metro area. Service could likely be improved if facilities were local. Placement is more difficult if youth has co-occurring DD, autism-spectrum disorder, or medical condition.
North Range	2	There are no C/A residential facilities in Weld County. We refer out.	
ADMHN	3	Client has medical needs that cannot be met by placements.	None known.
Aurora	3	When residential treatment is necessary, the appropriate services are sought in the metro area generally, not specifically in Aurora in order to best match age and need. Few children are placed at this level of care through the mental health center. The population for whom these services are difficult to obtain is developmental disabilities, hence the 90% rating.	Numbers of children and youth served in the residential system has decreased significantly, so there are typically beds available when needed. The issue is more finding appropriate services for difficult to place youth, i.e. those with co-occurring ID/DD or difficult to handle behavior who have been unsuccessful in residential treatment historically. The population for whom these services is difficult to obtain is developmental disabilities, hence the 90% rating.

Table 23 Continued: Child/Adolescent Residential Gaps			
Agency Name	**Region #**	**Gaps in Region**	**Gaps in the State**
SLV BH	4	We don't have any facilities locally. All referrals are made out of area.	We are able to make referrals to other facilities. Most of the time beds are available and wait time is acceptable.
Southeast	4	There are not any Child/Adolescent Residential Facilities in our service area.	There are no Child/Adolescent Residential Facilities in our service area. The closest would be one hour away in Pueblo or 2 hours away in Colorado Springs from our La Junta facility.
Spanish Peaks	4	There are no services available in our area for youth under the age of 10, thus resulting in having to send kids to the northern part of the state for treatment when warranted.	
Jefferson Center	6	New Vistas is licensed as a residential facility, but its treatment model is similar to that of an inpatient hospital, so for short-term treatment of acute psychiatric issues, there are very few facilities with a similar model.	
MH Partners	6	There are limited residential facilities within Boulder County that accept Medicaid. Often sending children and adolescents out of the area can be a barrier to engaging families in treatment. This can result in longer lengths of stay.	There is a gap in finding facilities that can serve both substance and mental health. Also a gap in facilities available for DD/MH children and adolescents.
AspenPointe	7	Residential facilities in our geographic area report they are unable to meet the needs of individuals with severe mentally illness who may have lower IQs, require more one-to-one staff support, dual diagnosis, or spectrum type behaviors. This makes these exceptionally high-risk clients requiring more hospitalizations and limited resources for recovery.	

Observations – Child and adolescent residential gaps: Many providers reported modest gaps in available beds for children and adolescents. Perceptions of the needs met in child and adolescent inpatient and residential beds vary significantly across the regions, and at times among the various providers within a region. Including the responses from the providers noted in the footnotes below the tables, gaps in both inpatient and residential beds for children and adolescents have been identified. This holds true for available resources within regions as well as statewide. There were noted gaps in facilities that serve children and adolescents with substance use and mental health disorders, co-occurring developmental disabilities, and autism spectrum disorders. There is also a lack of available placements for children and adolescents with serious behavioral health disorders and high acuities, needing intensive services. Many rural parts of the state have no residential facilities within 1-2 hours to treat these youth, and beds for younger children are even more difficult to access. Additionally, residential facilities that accept Medicaid are limited.

Table 24: Adult Geriatric Inpatient Needs Met

Region	Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State.
1	30%-60%	50%-60%
2	No Response	50%-60%
3	60%-80%	40%-60%
4	70%-80%	50%-80%
5	80%	90%
6	20%-40%	60%-80%
7	70%	90%

Table 25: Adult Geriatric Hospital Gaps

Agency Name	Region #	Gaps in Region	Gaps in the State
Axis	1	Axis Health System placed 43 patients in inpatient care outside of our region (Grand Junction, Pueblo, Colorado Springs, and Denver). These patients were not appropriate for the ATU available in La Plata County.	Due to shortage of beds at CMHIP and our geographic location, approximately 30 of the 43 admissions took over 24 hours to find and arrange a hospitalization. This put a burden on our local Emergency Departments (not 27-65 designated facilities) and jails.
Midwestern	1	The addition of 11 beds at Transitions, Mind Springs should greatly help to close our gap. We do not have the population to support such a facility in the Midwestern service area.	Expect there are currently more CSU beds available across the State. For those extremely complex clients that need extended stays to assess and treat complex medical and psychiatric issues, more beds are needed at CMHIP.

Table 25 continued: Adult Geriatric Hospital Gaps			
Agency Name	**Region #**	**Gaps in Region**	**Gaps in the State**
Mind Springs	1	The hospital typically turns away 10 adults a day due to being full.	West Springs has plans to expand its number of beds.
Touchstone	1	We consistently send patients out of our area as our local/regional resources are unavailable or depleted. There are 18 local/regional beds taken by private pay or other out of county patients leaving no recourse for Medicaid or indigent individuals but to look outside the area. This happens 70% of the time.	Usually we find a bed somewhere. Intensely high-acuity patients need state hospital placement, which, again, is available 0% of the time. "Wait lists" are out 6 months and are not useful – to the detriment of patients and families. 20% of all cases are high-needs individuals whose needs are not met. Crisis stabilization units are useful, but do not meet acute needs.
Centennial	2	There are no Adult/Geriatric Psychiatric inpatient beds in this geographic region.	We frequently/regularly (weekly) have difficulty placing individuals in this age group in psychiatric beds due to shortages; estimate 50% of need is met. Problem is made worse if client has medical concerns, has ID/DD or TBI.
North Range	2	There are no adult inpatient psychiatric hospital beds in Weld County. We refer out-of-county. Mountain Crest in Ft. Collins is used, as available. The NRBH ATU serves as a hospital alternative when appropriate and also as a step-down facility for earlier discharge from a psychiatric unit. The ATU is a 24 hour facility with psychiatric and nurse coverage, where we can treat acute adults at this 27-65 facility.	
ADMHN	3	There are periods of no inpatient bed capacity in the Denver metro area and clients must wait in the ER for bed to open; clients often placed in Colorado Springs instead of Denver Area; only Denver Health and Porter can handle medically complex psychiatric patients and these patients are often admitted to medical floor or remain in ER awaiting placement.	
Aurora	3	We would need 25 additional beds in our area to meet average daily demands; the current beds are used by multiple payers so do not meet our demand specifically.	We utilize any open beds in the metro area and beyond. We would need an additional 40% capacity to meet all needs easily.

Table 25 continued: Adult Geriatric Hospital Gaps			
Agency Name	**Region #**	**Gaps in Region**	**Gaps in the State**
Community Reach	3	Adams County has one geriatric hospital, in Thornton. That means that the percent of needs met within our geographic area would be close to zero. All of the hospitals that we work with for placement are outside of county.	Forensic beds
SLV BH	4	We do not have any available psychiatric bed space in our local area. All involuntary hospitalizations are referred out to other areas.	It is often very difficult to get an admission at the Adult or Geriatric unit at CMHIP. We are often told that people will be placed on a waitlist. Most are on an M1 not able to safely wait for a bed open at the CMHIP; we have difficulty finding space in private hospitals too. This puts a burden on local emergency rooms and jails, which are used to keep people until bed space opens up.
Southeast	4	There are not any adult/geriatric non-state hospital psychiatric inpatient facilities in our service area. The closest would be one hour away in Pueblo or two hours away in Colorado Springs from our La Junta facility.	We rarely are able to get an individual in CMHIP. If we are in dire need of a bed, we have to make multiple phone calls to CMHIP and even then are put on a long waiting list. The last time we got an individual in we had to call the Head of the Institutes at OBH as it was an unusual emergency situation and the state hospital still turned us down.
Spanish Peaks	4	• Lack of access to allocated state hospital beds leads to longer inpatient stays in Hospital LOC. • Hospital LOC beds full for longer periods of time. • Lack of locked facilities for difficult clients when discharged -leads to lengthier inpatient stays. • Increase in inpatient admissions for higher need SPMI clients due to saturation of out-of-county discharges from the state hospital to our community as some communities refuse to accept their clients back to their community.	Hospital LOC beds full for longer periods of time due to lack of access to CMHI-P "allocated" beds.• Unable to admit to CMHIP due to lengthy "wait lists". Longer IP stays for out of county clients due to designated counties refusing to accept clients back to originating county.
MHCD	5	If hospitals are full, consumers stay in the emergency room. Hospital ERs know the admission rate; we don't receive this data.	

Table 25 continued: Adult Geriatric Hospital Gaps			
Agency Name	**Region #**	**Gaps in Region**	**Gaps in the State**
Jefferson Center	6	In our geographical area we generally have access as needed at West Pines. Often, however, we do use beds at hospitals outside of our areas as needed.	
MH Partners	6	Overall beds for all clients as well as finding resources for dual diagnosed (MH/SA). Geriatrics is the other population that can be challenging to find intensive level of resources are for. Although BCH and West Pines will take geriatric clients, it can be rare and not the usual practice.	
AspenPointe	7	Availability vs. demand, acuity, co-morbid SUD, medical complications all impact placement.	Acuity, Medical complications

Observations- Adult and geriatric hospital gaps: Providers noted the ability to meet the inpatient needs of this population 20 to 80 percent of the time within their region (with no response from region 2) and 40 to 90 percent of the time utilizing statewide resources. Regions 1 and 6 have the greatest challenges meeting the inpatient needs of adult and geriatric behavioral health individuals. Regions 1, 2, and 3 identified the greatest unmet needs for statewide inpatient resources. For extremely complex and high-acuity clients who need extended stays to assess and treat complex medical and psychiatric issues, a gap in state hospital beds was noted in several regions. It was noted that it is often very difficult to get an admission at the adult or geriatric unit at CMHIP, and that, most often, people are placed on a waiting list. Waiting lists are sometimes very long and are detrimental to patients and families. Waiting lists put a burden on local emergency rooms and jails, which are used to keep people until beds become available. Inpatient access problems are even worse if individuals have medical concerns, developmental disabilities, or traumatic brain injuries. Longer inpatient stays were also mentioned for out-of-county clients due to designated counties refusing to accept clients back. Crisis-stabilization units are useful, but do not meet acute inpatient needs.

Table 26: Adult Residential Needs Met		
Region	**Percent of Adult Residential Facility Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Adult Residential Facility Needs Met by Current Available Resources in the State.**
1	50-80%	10-80%
2	90%	20%-90%*
3	50%-80%	50%-80%
4	90%	50%-80%
5	80%	90%
6	60%	60%-70%
7	No Response	No Response

* 10% Touchstone and 80% Mind Springs

**20% from Centennial and 90% from North Range

Table 27: Adult Residential Gaps			
Agency Name	**Region #**	**Gaps in Region**	**Gaps in the State**
Midwestern	1	There is a need for additional assisted living facilities in both Montrose and Delta.	Unaware of assisted living resources in the state.
Mind Springs	1		Difficult to place individuals in facilities; lack of locked units as well.
Touchstone	1	These residential units accept persons with mild to moderate behavioral health needs. There are no residential services in our area for serious behavioral health disorders.	It is almost impossible to move a high-needs needs individual out of county – even if the county has no appropriate resources.
Centennial	2	There are no Adult Residential facilities in the geographic area.	It is virtually impossible to find RTF level of care for adults with severe MI.
North Range	2		There is a need for a level of care that is currently unavailable in the state. This level would be characterized as an intensive residential facility that could be locked to ensure safety of the residents.

Table 27 continued: Adult Residential Gaps			
Agency Name	**Region #**	**Adult Residential Gaps in Region**	**Adult Residential Gaps in the State**
ADMHN	3	There is a wait list for ALFs and many ADMHN clients wait months for a bed.	There are many ACFs in this area, but only a few will serve clients living with mental illness.
Aurora	3	The 50% gap exists for moderate- to longer -term residential needs.	
Community Reach	3	Need secured treatment facilities for individuals with SPMI not appropriate for a nursing home. Appears to be a lower number of ALF's in Adams County taking younger consumers – only seniors. For any with history of assaultive or aggressive behavior, many ALF's will not consider them, despite duration of stability and safe behavior.	ALFs current Long Term Care functional and financial approval can take months, delaying process to be able to safely admit to residential facility. This process makes finding placements difficult resulting in lengthier inpatient stays.
SLVBH	**4**	We do not have any facilities accepting clients with major mental illness. All referrals are made out of area.	We make referrals out of area -having no local facilities puts strain on families and clients. Clients are expected to move from local supports if LOC is needed.
Southeast	4	No adult residential facilities in our service area- closest would be one hour away in Pueblo or two hours away in Colorado Springs from our La Junta facility.	Waiting lists are the biggest barriers.
MHCD	5		Of all the mental health centers, we are the only ones who will help somebody who has no income and who has no insurance. Therefore, anyone who meets that same criteria and seeks out treatment at another center experiences homelessness. Furthermore, there is a lack of facilities for people with TBI and violent criminal backgrounds.
Jefferson Center	6	No response	No response
MH Partners	6	We have a shortage of facilities that can work with dual diagnosed clients with SA as primary diagnosis and have significant mental health issues. MHP will be integrating a continuum of services for substances starting on Jan. 5, 2015.	

Observations – Adult residential gaps: All providers reported some gaps in available beds for adult and geriatric individuals with behavioral health disorders. Perceptions of the gaps in adult and geriatric inpatient and residential beds vary somewhat across the regions—with less variance by provider, however, than what were reported for child and adolescent beds. The response from Centennial, noted in the footnotes below the table, represents the most significant gap in both inpatient and residential beds for the adult and geriatric populations. (Note that region 7 did not respond to this item.) Larimer, Arapahoe, Douglas, Boulder, Broomfield, Jefferson, Clear Creek, and Gilpin counties, along with the city of Aurora, identified the greatest adult residential gaps. The need for secure adult residential facilities in the state was an identified gap. This gap often results in long waiting lists for placements, which sometimes results in longer than clinically indicated inpatient stays.

Table 28: Nursing Home Needs Met

Region	Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Nursing Home Needs Met by Current Available Resources in the State.
1	30%-90%	30%-90%
2	30%	30%
3	10%-70%*	20%-50%
4	40%-90%	90%
5	70%-90%**	90%
6	40%-80%	60%
7	50%	50%

*10% from Community Reach & ADMHC and 70% from Aurora

**Sobriety House said 70%; their primary location is Region 5, which is where they reported.

Table 29: Nursing Home Gaps			
Agency Name	**Region #**	**Gaps in Region**	**Gaps in the State**
Axis	1	Limited choices for both nursing and assisted living that take Medicaid.	
Touchstone	1	No low income housing, not enough N.Fs, need a geriatric inpatient facility with separate wings for SMI and regular population as they have different needs. Need more closed units; more master's- level social workers at nursing homes to cover mental health population and PASRR requirements. State needs entity to replace Masspro in the PASRR program. Even though the facility lists that they accept Medicaid, it may only have one or two Medicaid beds. Many secure wards are for individuals with dementia and don't accept other acting out behaviors.	Geriatric inpatient facility, support of specific training for geriatric social work in universities. Require nursing facilities to have a master's-level social worker at the facility.
Midwestern	1	No knowledge or opinion on the need for additional nursing home facilities in the geographic area or state.	
Mind Springs	1	Grand, Jackson and Summit counties do not have nursing home facilities.	Difficult to place our individuals in facilities, lack of locked units as well. Need more space for MH, dementia, and TBI.
North Range	1	Training and understanding of health care center staff to understand/tolerate mental health symptomatology.	
Centennial	2	Very few nursing facilities in the geographic region will accept residents with severe, chronic MI.	Often difficult to find nursing facility placements for MI clients anywhere in the State.
ADMHN	3	Only one locked unit in ADMHN service area and that facility primarily accepts individuals with dementia and TBIs on the unit. We struggle with SPMI placement on locked units as we are reliant on out-of-county facilities and other MHCs typically don't want to accept certification transfers. The MMI individuals currently in area facilities are not serious behavioral problems. Area facilities are typically used for short-term skilled placement.	It is questionable to 'mix populations' in SNFs. Time was recently spent to generate a proposal for locked ATUs for SPMI individuals that did not require inpatient care and were unable to be placed in SNF LOC (e.g., too violent, in need of too much supervision/monitoring, etc.). Proposal required modification of state statute – which did not occur–likely because it did not go through required policy channels. A good number of experienced mental health professionals developed the framework for this option, which remains a viable consideration for right-servicing and community safety.

Table 29 Continued: Nursing Home Gaps			
Agency Name	**Region #**	**Gaps in Region**	**Gaps in the State**
Aurora	3	Only one of the local nursing homes accepts residents who are on certifications for involuntary treatment. Less than half are equipped with locked units for residents who are at risk of wandering off grounds. Only one provides substantial opportunities for socialization outside of the nursing home. They all have fewer bilingual (English and Spanish) staff than is optimally needed.	Many nursing homes in the state do not have on-site mental health treatment providers and therefore rely on teleconferencing for psychiatric consults and treatment. In addition, many share the same gaps in service as in the Aurora area; namely, few socialization opportunities outside the nursing home, limited availability of accepting involuntary psychiatric residents, and few Spanish-speaking treatment providers.
Community Reach	3	Not enough skilled nursing facilities able to take this population.	Not enough beds or locked units in facilities able to take this population.
SLVBH	4	Evergreen Nursing Home has a locked unit that is used specifically for clients with dementia. While the nursing homes will take clients with serious behavior disorders they will shy away from taking clients with aggressive behavior or more serious mental health diagnosis. They do call for consultation, however often want a guarantee that client will not have any problems. If a guarantee cannot be given again they will sometimes shy away from taking the client.	
Sol Vista	4		Very difficult to move individuals with serious behavior management problems who do not have covered MH diagnoses from nursing homes into acute or more appropriate long term care placements.
Southeast	4		As more individuals are released from the state hospital, we will need more 27-65 certified nursing homes in the rural/ frontier areas of the state available as step-down/transition facilities before the individual fully returns to the community.
Spanish Peaks	4	Difficult time finding facilities that will accept older individuals with behavioral health concerns.	Unknown – Always have difficulty finding placement for older individuals with behavioral health diagnosis; long waiting time for placement.

Table 29 Continued: Nursing Home Gaps			
Agency Name	**Region #**	**Gaps in Region**	**Gaps in the State**
MHCD	5	For Denver nursing homes, about 40% of the bed capacity is allocated for behavioral health needs.	
Jefferson Center	6	Need more opportunities for clients who live in nursing homes to experience a continuum of activities for daily living within the nursing care center to prepare for independent living and more opportunities for clients living in secure nursing homes to move through a continuum of care outside of the nursing home rather than moving to a Colorado Choice Transitions model.	
MH Partners	6	There is a gap in facilities that will work with SMI clients needing this type of support. The most common gap is that patients in the hospitals are often waiting on beds, as they fill up quickly, which has implications for the patients and hospitals. A more serious gap is with LTC patients who have chronic psychiatric needs. Places like Mesa Vista accept a certain percentage of these patients, but there are not enough beds for these clients and if they exhibit behaviors such as aggression, suicidality or violence, it is extremely difficult to get a bed. Boulder County has an average of 127 beds per facility with a 72% occupancy rate. CO has approx. 20,000 beds with an occupancy rate of about 80%.	
AspenPointe	7	We have the resources for placement but limited MH service availability.	We have the resources for placement but limited MH service availability.

Observations – Nursing home gaps: All providers responding reported some gaps in available nursing home beds for individuals with behavioral health disorders. Perceptions vary somewhat across the regions—with similar gaps, however, noted within both the regions and statewide. Community Reach, in region 3, noted the largest gap across all of the providers for both regional and statewide nursing home beds. Many respondents noted the lack of facilities that accept Medicaid and the lack of secure beds, which are significant issues for many individuals with behavioral health disorders. The need for separate specialty MH, improved workforce competence to work with behavioral health disorders, and a shortage of Spanish-speaking staff were also identified as system gaps. Another commonly identified gap relates to the lack of a service continuum within facilities to support individuals who could be transitioned to a less-restrictive community-based setting.

Table 30: Substance Use Disorder (SUD) Residential Bed Needs Met

Region	Percent of SUD Residential Treatment Program Needs Met by Current Available Resources in your Region.	Percent of SUD Residential Treatment Program Needs Met by Current Available Resources in the State.
1	30%-70%	No Response
2	100%	No Response
3	30%-80%	No Response
4	10%-80%*	No Response
5	30%-90%**	No Response
6	20%-50%	No Response
7	0% met in area; only SUD residential service is in Bent county (out of region).	No Response

*10% from Southeast and 80% from Sol Vista- the others were 20% & 30%
**Sobriety House said 30%- their primary location is in Region 5, but also in 3 & 6.

Region 2 Comment: Community Corrections/DOC individuals in residential SUD treatment are not eligible for Medicaid if they can be charged with escape. *This is a huge need and gap in the system*. We are available to discuss this further. This also includes pregnant women and prenatal services and primary care. There is *no* Medicaid benefit for SUD residential treatment.

Observations - Substance Use Disorder (SUD) residential bed gaps: All providers responded only to regional (not statewide) needs being met for SUD residential beds. Perceptions vary significantly across providers within the regions as well as across the regions. Region 7 reported having no SUD residential beds. The responses indicate significant gaps in residential beds for individuals with SUD as reported by several providers in all regions except region 2. Also as noted by the region 2 comment, not having a Medicaid benefit for SUD residential treatment and for some individuals in Community Corrections residential placements is a significant service gap. Additionally, in a key informant interview with DOC leadership, the lack of SUD residential beds for individuals on parole was cited as the greatest community behavioral health system gap.

Table 31: Substance Use Disorder (SUD) Detox Needs Met

Region	Percent of Detox Needs Met by Current Available Resources in your Region
1	20-90%
2	70-90%
3	10-70%
4	10-70%
5	90%
6	40-90%
7	90%

Observations – SUD detox gaps: The percentage of detox needs being met varies significantly within several of the regions, the exceptions being regions 2, 5, and 7, where 70 to 90 percent of the needs are being met. Given the size of several of the more rural regions, it appears that the location within the regions may contribute to the broad ranges. It should be noted that most of the detox services available are for social, not medical detox.

[1] SAMHSA (2010). *Description of a Modern Addictions and Mental Health Service System* (draft). Retrieved from: http://www.samhsa.gov/healthreform/docs/AddictionMHSystemBrief.pdf

Governor's Plan to Strengthen Colorado's Behavioral Health System

Introduction

In December 2012, Governor John Hickenlooper announced the *"Strengthening Colorado's Mental Health System – A Plan to Safeguard All Coloradans";* a plan to redesign and strengthen Colorado's behavioral health services and support system. This section provides an update on the implementation of the plan, which includes the following elements:

Enhance Colorado's crisis response system

- Establish a single statewide mental health crisis hotline.
- Establish walk-in crisis stabilization services for urgent mental health care needs.

Expand hospital capacity

- Develop a 20-bed jail-based restoration program in the Denver area.

Enhance community care

- Develop community residential services for those transitioning from institutional care.
- Expand case management and wrap-around services in the community.
- Target housing subsidies to add 107 housing vouchers for individuals with serious mental illness.

Build a trauma-informed culture of care

- Develop peer-support specialist positions in the state's mental health hospitals.
- Provide de-escalation rooms at each of the state's mental health hospitals.

Develop a consolidated mental health/substance abuse data system.

The Colorado General Assembly appropriated $26.2 million from the General Fund for the Governor's Plan in FY 2013-14. However, due to unanticipated implementation delays, appropriations were reduced to $6.3 million and actual expenditures in FY 2013-14 only totaled $5.1 million. For FY 2014-15, the General Assembly appropriated a total of $37.2 million for these initiatives based on a full 12 months of services. The assertive community treatment services, intensive case management and wraparound services, and the jail-based competency restoration program were all operational before July 1, 2014. The crisis response hotline became statewide August 2014. However, the two largest components of these initiatives—most crisis response system services and residential services for individuals transitioning from

the state mental health institutes—did not begin operation until Dec. 1, 2014.[1]

Statewide crisis response system

The primary goals of the statewide crisis response system, as defined by Colorado's Office of Behavioral Health (OBH), are to:

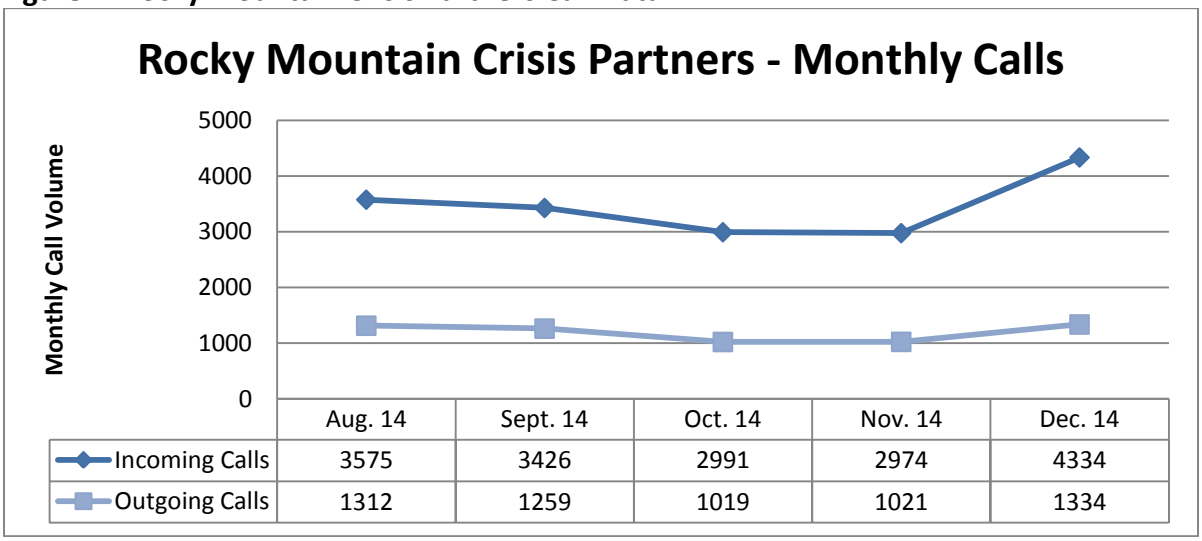
- Improve access to the most appropriate resources and services as early as possible and promote recovery for the individual
- Decrease the number of unnecessary involuntary civil commitments, and decrease the utilization of hospital emergency departments, jails, and homeless programs for individuals experiencing a behavioral health emergency.

Statewide 24-hour crisis hotline

The 24-hour crisis hotline is staffed by trained professionals and peers to assess and make appropriate referrals to resources and treatment. OBH awarded a contract to Metro Crisis Services Inc./Rocky Mountain Crisis Partners to provide hotline services, which began in August 2014. The FY 2014-15 appropriations to fund hotline services is $2,355,865.

Figure 1 shows the number of monthly calls to the hotline starting in August 2014. There was a significant spike in the number of incoming calls in December 2014, which is when the crisis-services marketing campaign began. Call data are currently available only through December 2014. Future months' data may help clarify whether the December spike in calls was related to the initiation of the marketing campaign or was possibly a temporary increase caused by the season.

Figure 1: Rocky Mountain Crisis Partners Call Data



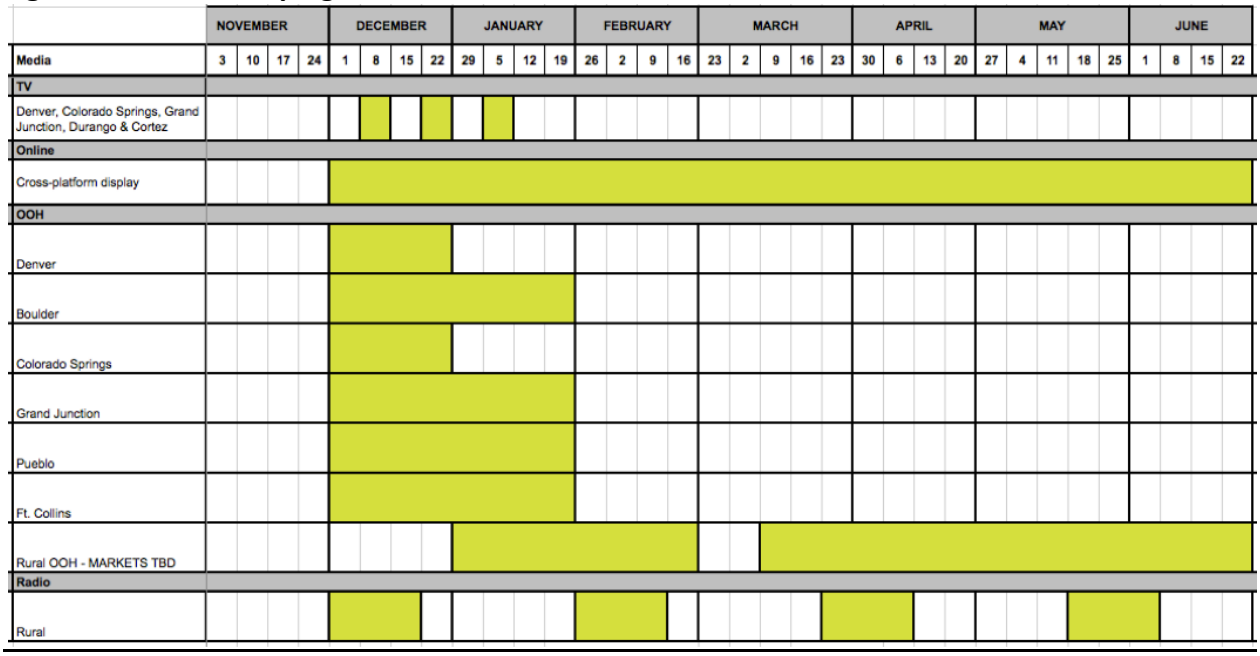
	Aug. 14	Sept. 14	Oct. 14	Nov. 14	Dec. 14
Incoming Calls	3575	3426	2991	2974	4334
Outgoing Calls	1312	1259	1019	1021	1334

Statewide awareness campaign and communication

The General Assembly appropriated $615,000 in FY 2014-15 for marketing and advertising the crisis hotline. OBH awarded a contract to Cactus Marketing Communications Inc., which launched the Colorado Crisis Services (CCS) Campaign statewide on Dec. 1, 2014, targeting primarily people in crisis and people concerned about crisis. The paid media campaign includes a mix of tactics to generate both awareness and a basic understanding of the services that CCS offers. The campaign has included:

- Television advertisements in December 2014 and January 2015 that reached individuals across the state using a combination of 15- and 30-second spots during Broncos games and NFL programming
- Out-of-Home(OOH) Media including ten billboards in metro, suburban, and rural markets, and 15 rotators
- Online digital display advertising (desktop, mobile, tablet)
- Thirty rural radio announcements.

Figure 2: Media campaign timeline



Although early in the campaign, these efforts, as reported by Cactus Marketing Communications, appear to have been successful: a 95 percent paid-media reach, with a frequency of seven in each market; 21.6 million impressions delivered; 34,811 website visits; a 61 percent increase in hotline call volume; and a click-through rate (web users clicking on a specific link) three times higher than the industry benchmark.

New regional crisis response services

In December 2014, OBH awarded contracts to the following agencies to provide crisis response services, including walk-in/stabilization services, mobile response services, and residential and respite services.

- AspenPointe Inc., dba Southern Colorado Crisis Connection ($3,889,640)
- Community Crisis Connection ($8,509,960)
- West Slope Casa ($4,403,656)
- Northeast Behavioral Health ($4,403,656)

These crisis system components are intended to provide a continuum of services from acute crisis response through stabilization and safe return to the community, when needed and with support for transitions throughout the continuum.

Walk-in crisis services/crisis stabilization unit(s): 24-hour urgent care services with capacity for immediate clinical intervention, triage, stabilization, and connection to services.

Mobile crisis services: 24-hour mobile crisis services with the ability to respond within one hour in urban and two hours in rural areas to behavioral health crises in the community, providing immediate clinical intervention, triage, stabilization, and connection to services.

Crisis residential/respite: An array of short-term crisis residential and respite services.

Given that the new and expanded regional crisis services have been operational only since December 2014, data to assess their impact are limited. The table below shows the number of individuals who received each of the new services. Northeast Behavioral Health reported the most individuals receiving crisis stabilization services (484), West Slope Casa provided the most mobile crisis services (977), and West Slope Casa also provided the most respite services (39). There has been significant variability across the four regions in the number of individuals served since these new services started.

Individuals receiving new community-based regional crisis services: Dec. 2014 – Jan. 2015

Table 1: Statewide number of individuals receiving the new crisis services (preliminary data)	
Crisis Service	**Number Served**
Walk-in crisis services / crisis stabilization unit	857
Mobile crisis services	2,477
Crisis residential/respite	108

It is important to note that crisis services were being provided prior to the implementation of the services included in the Governor's plan. Data provided by HCPF and OBH show the following services by region in FY 2013-14:

Table 2: Crisis Intervention Services (Prior to the Governor's Plan)								
	Region							
	1	2	3	4	5	6	7	TOTAL
OBH	1,161	14	253	739	31	362	57	2,617
HCPF			3,904		4,935	569		9,408
TOTAL	1,161	14	4,157	739	4,966	931	57	12,025

While preliminary data have been collected, it is premature to assess the impact of these services on psychiatric emergency room and hospital usage, including any correlated impact on referrals or admissions to the state hospitals. However, the table below shows the initial referrals for individuals receiving either crisis stabilization unit or mobile crisis services. For both of these services, there were more individuals with a psychiatric hospital admission in January 2015 than in December 2014.

The majority of the crisis stabilization unit referrals were to outpatient behavioral health services or safety planning with discharge to home, when compared with the other referral options. Most of the mobile crisis services referrals resulted in safety planning with discharge to home. Very few of the individuals receiving either of these services were referred to detox services. It will take one to two years to identify the impact these new services have on admissions to the state hospitals, and it will be dependent on adequate comparative public and private behavioral health system data prior to the implementation of these new services. Implementation of crisis services should result in a reduction in admissions to the state hospitals and presentations at emergency departments. An evaluation of the impact of the implementation of statewide crisis services in Texas found that the percentage of crisis service users entering state hospitals declined by about 23 percent. However, due to the larger number of people being served, the absolute number of admissions fell by only 3 to 5 percent.[2]

Crisis services referrals: Dec. 2014 – Jan. 2015

Table 3: Statewide crisis services referrals - Percent of total referrals (preliminary data)				
Referral type	Crisis stabilization units		Mobile crisis services	
	Dec 14	Jan 15	Dec 14	Jan 15
First responder contact	1.1%	0.4%	0.3%	0.2%
Crisis stabilization service	NA	NA	4.5%	3.3%
Respite or residential service	2.2%	3.7%	0.2%	1.6%
Medical admission/ER service	5.8%	2.2%	3.0%	2.6%
Referral to outpatient BH services	25.5%	30.9%	12.8%	16.3%
Safety planning w/ discharge, home	16.7%	24.8%	19.9%	24.9%
Safety planning with discharge, other	3.6%	4.5%	4.8%	8.3%
Admission to psychiatric hospital	5.5%	8.2%	8.2%	14.5%
Admission to Acute Treatment Unit	9.1%	9.5%	2.2%	5.0%
Admission to detox	0.4%	0.6%	1.3%	2.1%
Other referral	17.5%	6.9%	7.0%	9.8%

Improving community capacity

The primary goals of improving community capacity, as defined by OBH, are to:

- Address the current behavioral health system's lack of funding and capacity to deliver a continuum of community-based treatment services most appropriate to consumer needs, and in the least restrictive and most independent community setting.

- Provide community living for individuals currently placed in inappropriate settings, including psychiatric hospitals, nursing homes, emergency rooms, and county jails.

Initially OBH planned to develop two new residential facilities to provide short-term transition from the mental health institutes to the community for individuals needing a step-down from inpatient services before living independently. OBH later revised this approach to a "money follows the individual" concept with transition specialists who broker the needed residential and/or wraparound services for individuals close to their home community whenever feasible.

Key service components

Assertive Community Treatment (ACT) – ACT teams provide intensive, community-based, individualized services for adults with serious and persistent mental illnesses. Services provided include 24/7 case management, emergency, clinical, rehabilitation, and support with an emphasis on outreach, relationship-building, community tenure and recovery. All 17 Community Mental Health Centers in Colorado now receive specific contract funds to support ACT services. OBH reports that in FY 2013-14, 265 individuals were served and in FY 2014-15, 526 individuals are expected to be served. The funding for these services in FY 2013-14 was $1,974,982 and $4,048,711 is available in FY 2014-15.

Continuity of Care with Transition Specialists (CCTS) and "Money Follows the Individual" Program –This program provides funding for continuity of care with transition specialists (CCTS) who facilitate community reintegration for individuals leaving the state hospitals, and manage funds for wraparound services that provide intensive case management to less restrictive settings (including assisted living residences, supported/independent housing with wrap-around services and ACT services). The funding for these services in FY 2014-15 is $3,673, 687 with full funding of $5,198,520 beginning in FY 2015-16.

This initiative is intended to assist individuals ready to discharge from the state mental health institutes in ways that help them transition to the community and reduce their risk of re-hospitalization. The institutes identify individuals for placement on a discharge barriers list if they are deemed ready to discharge but still remain in the institution seven days later due to

impediments such as language barriers or needing guardianship services to manage finances. Transition specialists are to coordinate and procure community-based services not paid by other sources such as Medicaid.

The intent is for the transition specialists to begin working with individuals 30 days prior to discharge, and to continue providing assistance for up to 60 days after their return to the community.

Some clients will also receive wraparound services, including:

- individualized mentoring
- Funding for structured activities (recreation, education, and training)
- Transportation to promote engagement in treatment and community integration
- Substance use testing
- Smoking cessation
- Respite opportunities for the caretakers of clients
- Other individualized treatment services to address community placement barriers.

OBH has awarded a contract to Behavioral Healthcare Inc. (BHI) to provide CCTS services. OBH reports that during FY 2013-14, 15 individuals were served and during FY 2014-15, 350 clients are expected to be served. BHI's performance-based contract includes these two measures:

- Reduction in the average number of days on discharge-barrier waiting list (goal is 50 percent improvement, or 80 days average)
- Community engagement upon discharge; four or more days with eligible services in the first 45 days of discharge (goal is to achieve above 95 percent).

OBH is tracking these outcomes quarterly, and partial data for these outcomes look promising. Information provided by OBH shows that the CCTS program has served a total of 65 clients since July 2014. It was expected that a large proportion of eligible clients would be those on the institutes' discharge barrier list; however the CCTS program is also serving individuals not on the discharge barriers list, as indicated in Table 4.

Table 4: Referrals to the CCTS service split by members on/off the barrier wait list July 2014 – Feb. 2015.

Table 4: Referrals to the CCTS service split by members on/off the barrier wait list			
Institute	**Non-Barrier List**	**Barrier List**	**Total**
Fort Logan	22	15	37
Pueblo	9	19	28
Total	**31**	**34**	**65**

Five transition specialists have been hired, and BHI plans to hire two additional transitional specialists in April 2015; it will continue to fill positions as the program ramps up. BHI spent the first several months developing partnerships with community-based resources, educating CMHCs, assisted living facilities and behavioral health organizations about the program and its

scope; learning about the challenges CMHCs and assisted living facilities face; and contracting for guardianship services and sex offender risk assessments. Referral processes at both of the mental health institutes are in place and the program will work on increasing the number of referrals by having the transition specialists spent more time at the institutes.

Housing vouchers for behavioral health clients (Department of Local Affairs). The Governor's Plan included funding to assist individuals who are on a waiting list for federal housing vouchers to find stable homes. These subsidies are a stop-gap measure to help ensure those in need have the resources to assist with stability, independence, and the safety of housing. During FY 2013-14, 145 individuals with behavioral health disorders were successfully housed. The FY 2014-15 appropriation for these vouchers is $642,565.

Jail-based competency restoration program

The primary goals of the jail-based competency restoration program, as defined by OBH are to:

- Reduce the number of restoration patients admitted to the Colorado Mental Health Institute at Pueblo (CMHIP), thus making available 22 beds for individuals civilly committed to CMHIP
- Save county sheriff departments' time and resources by not requiring them to transport jail inmates back and forth from the Denver area to CMHIP
- Continue serving individuals requiring inpatient level of care at CMHIP.

The 22-bed jail-based restoration program—called Restoring Individuals Safely and Effectively (RISE) — is operated in a jail pod at the Arapahoe County Detention Facility. OBH contracts with Correct Care Solutions to run the RISE program, which treats defendants from county jails in: Broomfield, Denver, Jefferson, Arapahoe, Adams, Douglas, Weld, Larimer, and Boulder counties.

- The RISE program began competency restoration services in November 2013.
- The RISE program operates at a 56% lower cost per day than the state institutes.

Information provided by the RISE program indicates that from November 2013 through January 2015 the program served 106 individuals. Of these individuals, 71 were restored to competency; 19 were transferred to a state facility for long-term restoration (six months or longer) treatment due to medical, behavioral, or psychiatric destabilization; three had their charges dismissed or were released; and 13 individuals were currently receiving services at the time of the report from RISE. Eighty-four percent of the individuals in RISE were discharged within 60 days, and 96 percent within 90 days.

The FY 2014-15 funding for RISE is $2,505,495. The program is less expensive than CMHIP. In FY 2013-14, the contracted rate for RISE was $292 per patient day; the comparable cost of CMHIP's forensic unit was $636 per patient day. This resulted in a cost avoidance of $344 per patient day in FY 2013-14, or a total of $828,352. As anticipated by the program design and the types of patient referrals, the RISE program achieves competency restoration within a shorter

time frame than CMHIP: 41.1 average days per patient in FY 2013-14 compared to 117.9 average days per patient at CMHIP. As a comparison, the average time to achieve competency for the patients who receive competency restoration services at CMHIP has been reduced by 12.1 percent since FY 2009-10 (from 134.1 days to 117.9 days). [3]

The creation of the RISE program and changes within the CMHIP have increased the number of individuals receiving competency evaluations and being restored to competency, and generally reduced wait times. However, demand for these forensic services continues to grow and the anticipated goal of freeing up beds for civil patients has not been realized.

Trauma-informed care: modernizing treatment services at the Colorado Mental Health Institutes

The primary goal of this initiative, as defined by OBH, is to improve patient outcomes through the implementation of a best-practices-based, trauma- informed care approach to behavioral health services. The identified approach is endorsed by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

Trauma-informed care includes assessing individuals for trauma and adverse experiences, understanding the impact of trauma on mental health and substance use disorders, incorporating the treatment of trauma at all levels of service delivery, and utilizing peer support to improve patient outcomes within the mental health institutes as well as community behavioral health providers.

Key service components

***Trauma support staff*:** Networks of individuals who have experienced trauma are available to work with individuals in need of trauma-related supports to help them through their healing process. Dedicated trauma-informed clinicians at the state's two mental health institutes are supported through this initiative—two at Fort Logan and five at Pueblo. These staff provide trauma-specific support groups and individual therapy.

Peer support specialists: Trained peer specialists are available within the state's mental health institutes to provide support to those experiencing mental health crises. OBH contracted with Behavioral Healthcare Inc. to provide peers for both institutes.

De-escalation Rooms: Dedicated rooms at the mental health institutes are designed to calm someone experiencing an escalated crisis. The rooms include soothing colors and music and are used as an early intervention to offset the use of restraints and/or seclusion. There are three de-escalation rooms at Fort Logan and five at Pueblo.

Funding for the trauma-informed care initiative in FY 2013-14 was $911,865 and $845,284 in FY 2014-15. Efforts to evaluate the impact on patient outcomes, including quantitative measures,

such as reductions in seclusion, restraint, and assaults, as well as other quality indicators such as improved treatment outcomes, will be examined over time by the institutes. OBH does not currently have data to definitively identify the impact of this initiative in reducing seclusion, restraint, and assault (patient and staff) rates.

Both CMHIs are on the road to embracing a trauma-informed culture. Staff training has occurred and there are multiple efforts underway to keep the initiative moving forward. Patient support specialists have been hired at both of the institutes. There have been some recruitment and retention issues, primarily at CMHIP, given the narrow pool of qualified individuals in the Pueblo area coupled with the need for a higher level of security for most CMHIP programs. Experience to date indicates that allowing job-sharing instead of hiring full-time peer support specialists is less stressful and therefore more sustainable over time. The peer support staff at CMHIFL are assigned to specific treatment teams and are actively engaging with clinical staff in the milieu, treatment team reviews, and co-facilitating groups. Ongoing role definition and refinement continues at both Institutes for these positions. Additionally, staff at the Institutes report that these rooms are well-used and occasionally they have to limit the time patients can use the rooms so that they can be available for use by others.

Enhancing the behavioral health services data collection system

OBH is has funding to integrate its mental health and substance use data systems. After significant planning efforts, OBH will issue a request for proposals in spring 2015. A new data system has the potential to greatly enhance the state's capacity to report accurate and meaningful behavioral health data. We are unable to examine the impact of the implementation of this new data system on the delivery of services to consumers and examine the benefits gained from the implementation of this system to OBH, HCPF, and providers. However, a new data system holds hope that the state's capacity to report accurate and meaningful behavioral health (mental health and substance use) data will soon be realized.

Recommendations

Given the recent implementation of the initiatives in the Governor's Plan, it is important for OBH to continue to monitor and assess their impact on both the individuals served and the behavioral health system. Critical to substantive evaluation efforts is the accessibility of reliable baseline data. This is more feasible within existing resources for internal OBH initiatives than those involving external public and private agencies such as the statewide crisis response system.

- Evaluate the effectiveness, efficiency, and outcomes of the new crisis response services. Multiple systems are impacted by the new services—hospitals, law enforcement and jails, community mental health centers—in addition to individuals in crisis and their families. Ongoing evaluation will not only inform longitudinal analysis, but also quality-improvement and gap-identification efforts.

[1] Colorado General Assembly Joint Budget Committee, **FY 2015-16 Staff Budget Briefing, Department of Human Services** (Behavioral Health Services Only), Prepared By: Carolyn Kampman, JBC Staff, December 9, 2014.

[2] **Evaluation Findings for the Crisis Services Redesign Initiative;** Report to the Texas Department of State Health Services; Page xi, January 1, 2010. Public Policy Research Institute.

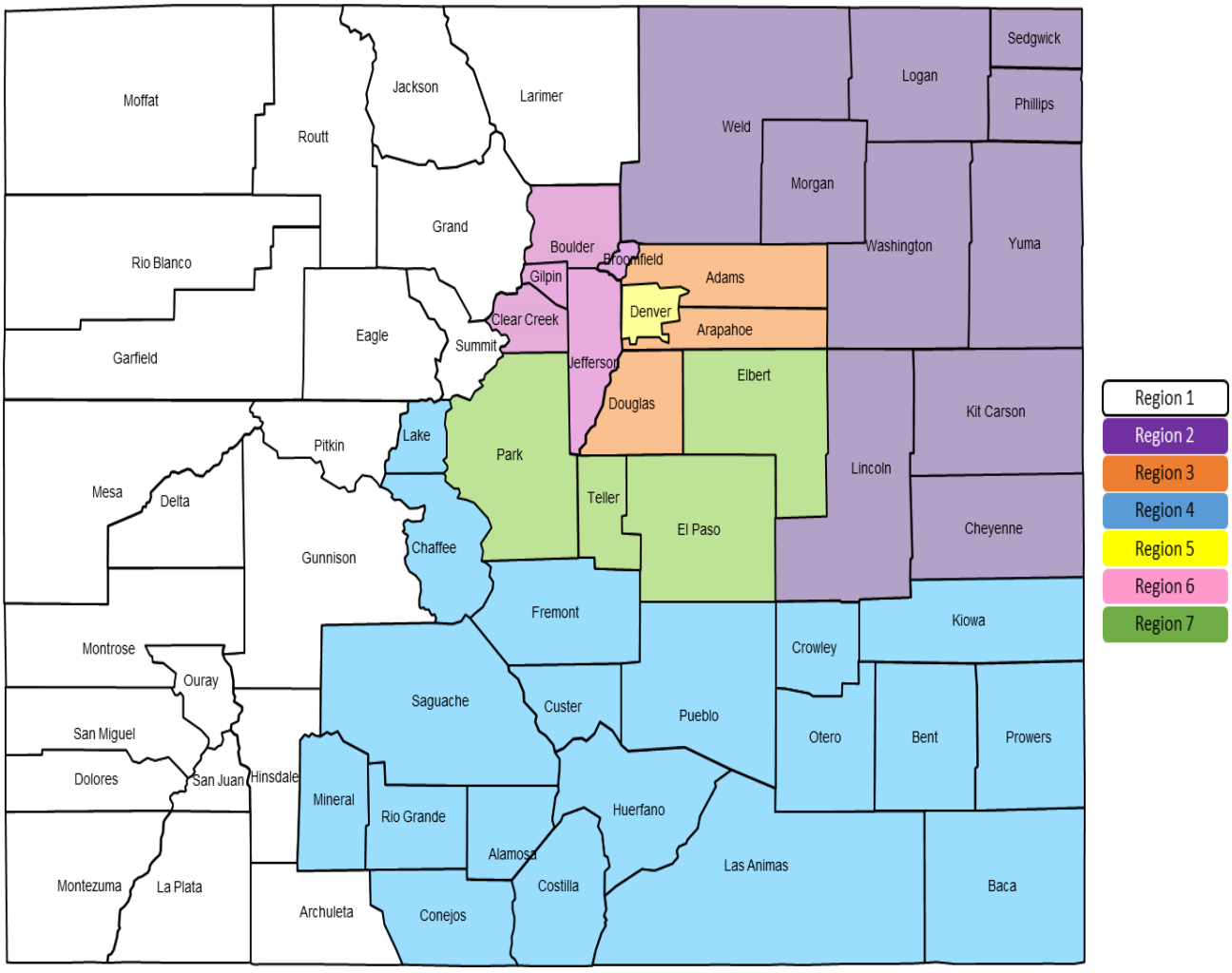
[3] Colorado General Assembly Joint Budget Committee, **FY 2015-16 Staff Budget Briefing, Department of Human Services** (Behavioral Health Services Only), Prepared By: Carolyn Kampman, JBC Staff, December 9, 2014.

Penetration Rates and Relative Need for Services

Introduction

This section of the report provides a look at the penetration rate of behavioral health services across Colorado's seven planning regions illustrated below; the current need for services, by region and select demographic groups; and a projection of needs based on population forecast data.

Figure 1: Regions Used for Study



Penetration rate is an estimate of the percentage of a population that is receiving services, most commonly calculated as the number of people served divided by the prevalence. In this report we also calculate penetration rates based on the total population; that is, the number of people served divided by the total population of a region or demographic group. The *unmet need* is defined as the number of people estimated to have need for behavioral health services who are not yet receiving services; that is, the prevalence of behavioral health challenges minus the number of people receiving services. In this report we do not provide quantitative estimates of unmet need, but instead provide relative comparison of penetration rates to identify regions and population subgroups that may be experiencing a greater unmet need.

Penetration rate estimates are particularly useful for identifying regions or subgroups of the total population that are relatively underserved. We use the information from these estimates to discuss which regions or population subgroups are less served than others, and subsequently take these disparities into account when developing recommendations for service planning.

Data sources and limitations

The table below identified the population from the Colorado State Demography Office by region for the identified age groups.

Table 1.0: 2015 Projected Populations by Age Group

Region	0-19 years	20-39 years	40-59 years	60+ years	Total
1	368,413	384,023	365,475	267,981	**1,385,892**
2	108,958	100,611	94,605	67,558	**371,732**
3	264,608	242,970	275,443	162,587	**945,608**
4	85,842	86,403	92,039	93,467	**357,751**
5	162,703	239,816	161,187	111,608	**675,314**
6	229,232	251,902	277,339	202,615	**961,088**
7	206,334	205,985	194,822	134,555	**741,696**
Colorado	**1,426,090**	**1,511,710**	**1,460,910**	**1,040,371**	**5,439,081**

Prevalence

Prevalence rates for Serious Mental Illness (SMI) among adults and Alcohol and Other Drug Dependence (AOD) among adults and adolescents are taken from the National Survey of Drug Use and Health R-DAS.[1] Prevalence estimates were generated using combined data from 2008 to 2011 for individuals under 300 percent Federal Poverty Level (FPL) for the statewide population and by gender, age group, and race/ethnicity. As prevalence rates by the seven planning regions were not available for the population under 300 percent FPL, the statewide rates were applied to regional population estimates to generate estimates of the numbers of

adults with SMI and adults and adolescents with AOD.

SED (Serious Emotional Disturbance) rates among children and adolescents are estimated as a flat rate of 10 percent. This rate was [2]calculated using the methodology for estimating prevalence of SED by state poverty levels as described in the Federal Register 98-19039.[3]

Population data was obtained from the Colorado State Demography Office. Current population estimates were provided to WICHE by the State Demography Officer, whereas 2015 and 2025 population forecasts were downloaded from the State Demography Office website. Current population by planning region and age group was estimated using the 2013 five-year ACS.[4] Current statewide population by race/ethnicity and gender was estimated using the 2013 one-year ACS Public Use Microdata Samples.[5] 2015 and 2025 population forecasts by age and gender by county were downloaded from the Colorado State Demography Office website for forecasts by age and gender.[6] 2015 and 2025 population forecasts by race statewide were downloaded from the Colorado State Demography website.[7]

Prevalence estimates were produced by applying the NSDUH statewide prevalence rate estimates by age group, race/ethnicity, and gender to the regional and statewide population data.

People served

The number of people served was provided by the Office of Behavioral Health (OBH) and the Department of Health Care Policy and Financing (HCPF). OBH provided unduplicated counts of clients who received mental health services and unduplicated counts of clients who received substance abuse services, and provided these counts by region, age group, race/ethnicity, gender, and SMI/SPMI status. HCPF provided unduplicated counts of all clients who received any type of behavioral health service by region, age, gender, and race/ethnicity.

Limitations

The estimates provided in this report have a number of limitations. Most critical, we were unable to develop complete population-in-need estimates because HCPF did not provide client-level data on the people receiving services, and did not separate service data by mental health and substance use clients. The lack of client-level data from HCPF made it impossible to generate a full and unduplicated count of all clients receiving behavioral health services from OBH and HCPF. The OBH client counts include an unspecified number of clients who also received Medicaid behavioral health services during FY 2013-14; and the HCPF client counts include an unspecified number of clients who received OBH-funded services in FY 2013-14 as well. Combining the client counts would have included duplicate counts of many individuals; therefore, we have prepared separate estimates using OBH and HCPF data.

We provide penetration rates solely on OBH service data, allowing us to look at the relative regional impact of OBH services alone. Penetration rates for OBH data represent the degree to which OBH services reach the target population of people under 300 percent FPL with serious mental illness, serious emotional disturbances, and substance use disorder (SUD). This method provides the most accurate estimate of the population in need as it is limited to the income levels of people who will access publicly funded services, and to the diagnostic categories served by OBH. However, without HCPF data these are substantial overestimates of the actual population in need. Instead, they are useful strictly for determining the relative amount of OBH services provided by regional and population subgroup.

We then provide total population-based penetration rates for HCPF services. Because HCPF data did not distinguish mental health and substance use clients, we were unable to match HCPF service data to the prevalence estimates for SMI, SED, and SUD in the target population under 300 percent FPL. Therefore, the best estimates we can provide are a comparison of the amount of HCPF clients served relative to the regional population of people under 300% FPL. This allows us to identify regions with relatively more or less HCPF-funded behavioral health services.

Additionally, we looked at the total statewide population penetration rate for each OBH and HCPF service separately, by key demographic groupings: race/ethnicity, gender, and age. Unfortunately, we were unable to generate prevalence estimates for SMI, SED, and SUD by demographic groupings for the population of people under 300 percent FPL because data on the number of people living under 300 percent FPL was not available by these demographic groups. Therefore, the penetration rates for these key demographic groups provide comparisons of the amount of OBH and HCPF services relative to the total population. Although not accurate depictions of the penetration rate to the target population of people under 300 percent FPL, they are useful to identify the relative need for services when comparing demographic groups by region.

2014 estimates of penetration rates and relative need by region

OBH penetration rates

Tables 1.1 and 1.2 below display the regional and statewide penetration rates for children and adults using OBH service data only. These figures are limited to the target population for publicly funded services of people living under 300 percent FPL. The data below highlights regional disparities in the amount of services provided by OBH relative to the need for services.

Table 1.1 highlights a disparity in penetration rate for children and adolescents needing mental health services in regions 1 and 5 (12 percent penetration rate compared to 17-26 percent in all other regions). For adolescents in need of substance use services, the penetration rates across all regions are extremely low in regions 1 and 7 (7 and 9 percent respectively), indicating either a major lack of substance use services for adolescents or the need for better data on

adolescents with SED and co-occurring substance use or dependence. The statewide average for this population is 13 percent, with region 6 reporting the highest at 24 percent.

Table 1.1: Colorado Office of Behavioral Health Penetration Rates for Children and Adolescents under 300% FPL

	Children and Adolescents with SED*				Adolescents with AOD**		
Region	**Prevalence**	**OBH Served**	**OBH Penetration**		**Prevalence**	**OBH Served**	**OBH Penetration**
1	18,479	2,273	12%		5,927	403	7%
2	5,925	1,408	24%		1,784	289	16%
3	9,936	2,580	26%		3,100	517	17%
4	6,154	1,483	24%		2,119	344	16%
5	8,728	1,067	12%		2,581	276	11%
6	8,171	1,736	21%		2,797	665	24%
7	9,839	1,695	17%		2,933	258	9%
Total	67,232	12,242	18%		21,241	2,752	13%

**Children and adolescents with diagnoses of serious emotional disturbance*
***Adolescents 12 and older with diagnoses of alcohol or other drug use or dependence*

As displayed in Table 1.2, the range of penetration rates for OBH services for adults with SMI is from 17 percent in region 5 to 44 percent in region 4, with a statewide penetration rate of 28 percent. Those regions falling below the statewide rate are regions 1, 5, and 7. For adults with SMI, we restricted the service counts to those adults with diagnoses of either SMI or SPMI. This count excludes those clients who received some level of OBH services but did not meet the diagnostic criteria equivalent to the prevalence estimates for SMI.

The range of penetration rates for OBH services for adults with substance use or dependence is from 16 percent in region 1 to 52 percent in region 3, with a statewide penetration rate of 33 percent. Those regions falling below the statewide rate are regions 1, 2, 6, and 7. For adults with alcohol abuse or dependence, all clients who received any OBH-funded substance use service were counted, including clients who receive only detox and DUI services. This inclusive pool of OBH clients was used for estimating substance use services penetration rates to best match the NSDUH's liberal estimation method for identifying people with past-year alcohol or other drug abuse or dependence.

Table 1.2: Colorado Office of Behavioral Health Penetration Rates for Adults under 300% FPL							
	Adults with SMI*				Adults with AOD**		
Region	Prevalence	OBH Served	OBH Penetration		Prevalence	OBH Served	OBH Penetration
1	22,652	4,548	20%		51,081	8,418	16%
2	6,183	2,201	36%		13,592	3,814	28%
3	11,462	4,024	35%		24,117	12,500	52%
4	7,751	3,377	44%		15,753	6,803	43%
5	12,537	2,167	17%		28,267	13,471	48%
6	12,234	4,387	36%		29,063	8,721	30%
7	11,108	2,674	24%		24,639	6,919	28%
Total	83,926	23,378	28%		186,512	60,646	33%

**Adults with diagnoses of serious mental illness or serious and persistent mental illness*
***Adults with diagnoses of alcohol or other drug abuse or dependence*

HCPF penetration rates

HCPF penetration rates are not equivalent or comparable to the OBH penetration rates. The HCPF data does not provide separate counts of mental health and substance use clients. Conversely, the NSDUH prevalence estimates do not provide a single unduplicated count of people with any behavioral health need. Therefore, there is no way to match the HCPF client counts with the NSDUH prevalence estimates.

As a work-around, we provide HCPF penetration rates based on the regional population of people living under 300 percent FPL. The result of this: rates substantially smaller than typical as they indicate the degree to which HCPF behavioral health services reach anyone in the target population, with or without need. Therefore, these penetration rates cannot be interpreted as characterizing the population in need of services. Instead, they offer only a relative comparison of the amount of HCPF behavioral health services by region.

As displayed in Table 2, the range of population-based penetration rates for HCPF behavioral health services for children and adolescents is from 2.4 percent in region 1 to 8.3 percent in region 3, with a statewide penetration rate of 5 percent. Region 1 falls substantially below the statewide average, whereas region 3 has a substantially higher penetration of HCPF services to the general population of people under 300 percent FPL.

Among adults, the range of population-based penetration rates for HCPF behavioral health services is from 2.1 percent in region 1 to 5.5 percent in region 3, with a statewide penetration rate of 3.6 percent. Region 1 falls substantially below the statewide average, whereas regions 3,

4, and 5 have substantially higher penetration of HCPF services to the general population of people under 300 percent FPL.

Table 2: Colorado Department of Health Care Finance and Policy Penetration Rates for the Total Population Under 300% FPL							
	Children and Adolescents				Adults		
Region	Pop. under 300% FPL	HCPF Served	Population Penetration		Pop. under 300% FPL	HCPF Served	Population Penetration
1	184,791	4,407	2.4%		443,594	9,127	2.1%
2	59,250	2,477	4.2%		121,243	3,721	3.1%
3	99,363	8,253	8.3%		218,479	12,027	5.5%
4	61,540	3,476	5.6%		161,343	7,924	4.9%
5	87,278	4,413	5.1%		240,411	11,535	4.8%
6	81,708	3,908	4.8%		246,175	8,497	3.5%
7	98,388	4,424	4.5%		213,574	7,161	3.4%
Total	**672,318**	**31,358**	**5%**		**1,644,819**	**59,992**	**3.6%**

Combined OBH/HCPF relative need by region

Although we cannot provide any definite accounting of the unmet need due to the lack of comparable data between HCPF service counts and OBH service counts and HCPF service counts and NSDUH prevalence estimation, we can compare the relatively least and most served regions by OBH and HCPF. The purpose of this comparison is to identify regions that are relatively underserved by any combination of OBH mental health, OBH substance use, or HCPF behavioral health.

As can be seen in Table 3 below, OBH services and HCPF services for adults and children, mental health and substance use service, all have low penetration rates in region 1. Although it is difficult to interpret this without combined data, the pattern of fewer services in region 1 relative to the prevalence and population indicates that there may be a greater unmet need in region 1, especially for substance use services.

Conversely, region 4 has relatively higher penetration rates for OBH services for children and adolescents with SED and adults with SMI and AOD. Region 4 also has higher population-based penetration rates for HCPF behavioral health services for adults. These results suggest that region 4 may be better served relative to other regions in the state, especially in the area of mental health services.

Finally, Table 3 also highlights that HCPF services reach the smallest segment of the population in region 1 for all ages, and consistently reach a larger segment of the population in region 3.

Table 3: Regions with the Lowest and Highest Penetration Rates for OBH and HCPF services				
	OBH Regions		HCPF Regions*	
	Lowest Penetration	Higher Penetration	Lowest Penetration	Highest Penetration
Children and Adolescents with SED	1, 5	2, 4	1	3
Adolescents with AOD	1	6		
Adults with SMI	1, 5	4	1	3, 4, 5
Adults with AOD	1	3, 4, 5		

** Note that the HCPF Penetration Rates are based on the total population of people under 300% FPL, whereas the OBH penetration rates are based on the prevalence of SED, AOD, and SMI. Therefore the OBH and HCPF penetration rates are not equivalent.*

Relative need by select demographic groups

To compare the adequacy of services for select demographic groups, we prepared estimates of the OBH-based penetration rates for each of the target populations. Following are the statewide summary findings for each demographic breakdown. More detailed regional-level information is available in the appendices for age groups. For race/ethnicity and gender, the State Demographer was only able to provide the statewide population under 300 percent FPL for these groupings, and hence prevalence was only available at the state level for race/ethnicity and gender. We do provide detailed service data in the appendices, by region, for all demographic breakdowns for both OBH and HCPF services.

Age groups

Tables 4.1, 4.2, and 4.3 below display the statewide penetration rates for behavioral health services by age group. Table 4.1 and 4.2 display OBH penetration rates for the actual population in need, whereas Table 4.3 displays HCPF penetration rates based on the total population by age group. Due to vastly different health insurance regulations and programs across the age groups, it is impossible to directly compare the penetration rates for children and adolescents, older adults, and all other adults. Comparing the penetration rates for adults aged 18-54 by age groups is meaningful; however, the differences are minor.

The low OBH penetration rates for children and adolescents shown in Tables 4.1 and 4.2, coupled with higher HCPF population penetration among children and adolescents shown in Table 4.3, are likely the result of child and adolescent eligibility regulations for Medicaid. Without having the ability to combine OBH and HCPF data, it is challenging to draw conclusions

as to the relative need for services among children compared to other age groups, as Medicaid eligibility differs for children and adolescents compared to adults.

Similarly, the low penetration rates for Medicaid-funded services among older adults could be due to two confounds. First, there is a substantial population of older adults receiving behavioral health services that are paid for by Medicare or Medicare Supplemental, which, therefore, are not counted in either OBH or HCPF data. Second, the prevalence of SMI and AOD are substantially lower among older adults, which a population-based penetration rate as we use for HCPF services does not take into account. For both of these reasons we would expect HCPF penetration rates as we have calculated them to appear to be very low. Without having access to data across all programs that serve the behavioral health needs of older adults separated out by mental health and substance use services, it is impossible to provide an accurate picture of the relative needs for mental health and substance use services among older adults.

Table 4.1: Statewide Penetration of OBH SED/SMI Services for the Population-In-Need Under 300% FPL by Age Group

	0-11 years	12-17 years	18-24 years	25-34 years	35-54 years	55+ years
Prevalence	47,193	20,039	12,325	23,109	37,079	11,412
OBH Served	7,349	4,893	4,428	6,281	7,583	5,086
Penetration Rate	16%	24%	36%	27%	20%	45%

Table 4.2: Statewide Penetration of OBH Substance Use Services for the Population-In-Need Under 300% FPL by Age Group

	0-11 years	12-17 years	18-24 years	25-34 years	35-54 years	55+ years
Prevalence	n/a	21,241	75,753	62,619	33,990	14,151
OBH Served	47	2,752	20,153	19,389	26,217	15,040
Penetration Rate	n/a	13.0%	26.6%	31.0%	77.1%	106.3%

Table 4.3: Statewide Population-Based Penetration of HCPF Behavioral Health Services for the Total Population Under 300% FPL by Age Group

	Under 18 years	18-24 years	25-34 years	35-54 years	55+ years
Population	672,318	300,607	372,730	514,993	456,489
HCPF Served	2,752	20,153	19,389	26,217	15,040
Penetration Rate	4.7%	3%	4%	4%	0.7%

Race/ethnicity

Table 5.1 displays the OBH penetration rates for SED/SMI and substance use services by two racial/ethnic categories (White Non-Hispanic and Minority). OBH services have substantially higher penetration among Minorities with SED/SMI at 42.6 percent, whereas the penetration rates for White Non-Hispanics with SED/SMI and White Non-Hispanics and Minorities with need for substance use services are 27 and 28 percent, respectively.

Table 5.1: Statewide Penetration of Colorado Office of Behavioral Health Services for the Population-In-Need Under 300% FPL by Race/Ethnicity					
	White Non-Hispanic			Minority	
	SMI	SUD		SMI	SUD
Prevalence	79,304	165,445		31,772	121,898
OBH Served	21,248	47,150		13,523	33,137
Penetration Rate	27.0%	28.0%		42.6%	27.0%

Table 5.2 displays the population-based penetration rate for HCPF behavioral health services by race/ethnicity. HCPF services reach a greater proportion of the total population of people under 300 percent FPL than the White Non-Hispanic Population.

5.2: Table Statewide Population-Based Penetration of HCPF Behavioral Health Services for the Total Population Under 300% FPL by Race/Ethnicity			
	White Non-Hispanic		Minority
Population	1,367,313		1,010,363
HCPF Served	40,165		42,824
Penetration Rate	2.9%		4.2%

Gender

Table 6.1 displays the OBH penetration rates for SED/SMI and substance use services by gender (male and female). OBH services have substantially higher penetration among men in need of both mental health and substance use services (40.2 percent and 37.6 percent, respectively), whereas the penetration rates for women in need of mental health and substance use services are 27 percent and 18.7 percent, respectively. This difference could be due at least partially to a greater Medicaid eligibility among low-income women than men.

Table 6.1: Statewide Penetration of Colorado Office of Behavioral Health Services for the Population-In-Need Under 300% FPL by Gender					
	Male			Female	
	SED/SMI	SUD		SMI	SUD
Prevalence	38,997	157,136		73,842	131,685
OBH Served	15,672	59,020		19,948	24,575
Penetration Rate	40.2%	37.6%		27.0%	18.7%

Table 6.2 displays the population-based penetration rate for HCPF behavioral health services by gender. HCPF services reach a greater proportion of the total population of women than men under 300 percent FPL. This finding could be due to greater Medicaid eligibility among women than men.

Table 6.2: Statewide Population-Based Penetration of HCPF Behavioral Health Services for the Total Population Under 300% FPL by Race/Ethnicity			
	Male		Female
Population	1,146,977		1,230,699
HCPF Served	39,085		52,269
Penetration Rate	3.4%		4.2%

10-year projections (2015-25) of relative need

To plan for future behavioral health needs it is critical to not only look at the relative need for services today, but to anticipate future changes as well. To anticipate future changes, we provide two separate analyses. First, we compare the projected population growth by region to the current level of services. Second, we consider projected changes in population demographic groups over the next 10 years.

Change in penetration rates by region

We applied population forecast data by county to the seven planning regions to develop estimates of future penetration rates should the level of services not change. These estimates deliberately do not project changes in the counts of clients served in order to paint a picture of how projected regional population change may exacerbate or reduce disparities in unmet need. Along with the projected penetration rates, we also present the percent change in unmet need from 2015-25. The percent change in unmet need describes the projected impact that population growth would have on relative need for services by each region. A higher percent change in unmet need corresponds directly to a greater projected population increase for the region relative to the other regions. Table 7 displays the projected penetration rates for OBH mental health and substance use services for children in 2015 and 2025.

In 2025, regions 1 and 5 would have the lowest penetration rate and regions 3 and 4 the

highest penetration rates for mental health services for children and adolescents should the amount of services provided by OBH not change. Region 2 is projected to have a substantially greater increase in unmet need for children with SED compared to other regions. Data on substance use services for children and adolescents indicates very few such services are provided explicitly for SUD as opposed to SED; therefore, penetration rates and projected changes for child and adolescent need for SUD services are difficult to interpret. Instead, the only conclusion we draw from the population-in-need data from children and adolescents with SUD is that OBH should collect more-precise data on children and adolescents receiving SUD services regardless of SED diagnosis.

Among adults, in 2025, regions 1 and 5 have the lowest penetration rates and region 4 has the highest penetration rate for OBH mental health services should the amount of services provided by OBH not change from today. For OBH substance use services, region 1 would have the lowest penetration rate and region 3 the highest penetration rate in 2025. Regions 2 and 3 would have the largest increase in unmet need for both mental health and substance use.

Table 7: Projected Penetration Rates for OBH Services 2015-2025

		Children and Adolescents				Adults		
Region		**2015 OBH Penetration Rate**	**2025 OBH Penetration Rate**	**% Increase in Unmet Need**		**2015 OBH Penetration Rate**	**2025 OBH Penetration Rate**	**% Increase in Unmet Need**
1	MH	10%	9%	17%		17%	12%	57%
	SU	3%	3%	20%		15%	10%	55%
2	MH	18%	15%	24%		29%	18%	89%
	SU	7%	6%	22%		22%	14%	81%
3	MH	25%	24%	6%		37%	24%	81%
	SU	9%	9%	-1%		52%	34%	106%
4	MH	23%	21%	11%		38%	28%	59%
	SU	10%	9%	10%		35%	25%	56%
5	MH	10%	9%	12%		16%	11%	57%
	SU	5%	4%	22%		45%	30%	87%
6	MH	18%	18%	4%		32%	25%	47%
	SU	12%	12%	-1%		29%	22%	45%

Table 7 continued: Projected Penetration Rates for OBH Services 2015-2025								
		Children and Adolescents				Adults		
Region		2015 OBH Penetration Rate	2025 OBH Penetration Rate	% Increase in Unmet Need		2015 OBH Penetration Rate	2025 OBH Penetration Rate	% Increase in Unmet Need
7	MH	17%	15%	15%		25%	17%	67%
	SU	5%	4%	13%		29%	20%	71%
Total	MH	**13%**	**12%**	**12%**		**22%**	**15%**	**56%**
	SU	**6%**	**5%**	**11%**		**25%**	**17%**	**59%**

Just as with the current 2014 penetration rate estimates, we were unable to combine HCPF service data with OBH data to generate a single estimate of unmet need for the 10-year projections. Further, because HCPF did not provide separate counts of mental health and substance use services, we were likewise unable to provide true penetration rates for the population in need of services. Instead, for HCPF projections, we use a population-based penetration rate that can only provide a rough estimate of the relative amount of HCPF services by region. Table 8 displays projected penetration rates and percent change in penetration rates for 2015 and 2025 for HCPF behavioral health services should the amount of HCPF services not change.

For children and adolescents in 2025, region 1 has the lowest and region 3 the highest population penetration rates for HCPF behavioral health services. Region 2 has the largest percent decrease in penetration rate between 2015 and 2025.

For adults in 2025, region 1 has the lowest and regions 3 and 4 the highest population penetration rates for HCPF behavioral health services. Region 2 has the largest percent decrease in penetration rate over the 10-year period from 2015 to 2025.

Table 8: Projected Population Penetration Rates for HCPF Services 2015-2025							
	Children and Adolescents				Adults		
Region	2015 Penetration Rate	2025 Penetration Rate	% Change		2015 Penetration Rate	2025 Penetration Rate	% Change
1	2.0%	1.7%	-13.4%		1.8%	1.2%	-32.0%
2	3.2%	2.7%	-16.1%		2.5%	1.5%	-38.7%
3	8.1%	7.8%	-4.1%		5.6%	3.7%	-33.8%
4	5.3%	4.9%	-8.1%		4.6%	3.3%	-26.7%
5	4.0%	3.6%	-10.0%		4.4%	3.0%	-32.4%
6	4.1%	4.0%	-2.9%		3.2%	2.4%	-24.3%
7	4.4%	3.9%	-10.8%		3.4%	2.3%	-33.4%
Total	**3.5%**	**3.1%**	**-9.3%**		**2.8%**	**2.0%**	**-30.6%**

Population forecasts by select demographic groups

Below we review expected population changes from 2015 to 2025 across select demographic groups as requested by OBH: age, gender, and race/ethnicity. These data come from the Colorado State Demography Office's population forecasts for age, gender, and race and ethnicity. The data represent expected change in the total population in the seven planning regions and statewide.

Our goal was to provide estimates of penetration rates across the demographic groups similar to the data we provide on regional penetration and relative need. However, such estimates require population forecasts for the number of people under 300 percent FPL by the demographic groups, which we were unable to obtain. Without estimates of the population by age, gender, and race/ethnicity under 300 percent FPL, we are unable to provide any meaningful estimate of the population in need of publicly funded services.

To illustrate, if we calculate a penetration rate of behavioral health services by race/ethnicity without adjusting for the income disparities between the white, non-Hispanic and minority populations, the minority population will appear to be significantly better served than the white, non-Hispanic population. Because there are a significantly higher percentage of minorities living near or below the federal poverty level, a higher percentage of the total minority population will need access to publicly funded services. Conversely, a lower

percentage of the white, non-Hispanic population needs access to and qualifies for publicly funded services. Similar differences exist across the other demographic subgroups: children and elderly populations have higher poverty rates than non-elderly adults, and women are more likely to be poor than men. The only way to control for these differences is through identifying the percentage of each population subgroup under 300 percent FPL.

As an alternate, we describe and discuss the projected population shifts across the key demographic groups. Table 9 displays the projected population in 2025 (numbers in thousands) and the percentage change from 2015 for each demographic group. We pair the discussion of each demographic group's projected population growth with current statewide prevalence estimates for the demographic groups for SMI and AOD.

Age

Statewide, the fastest-growing age group is older adults, with a projected population increase of 40.8% statewide from 2015 to 2025, which represents a change from 19 to 23 percent of the total population. Region 3 is projected to experience the largest growth in the elderly population with a projected increase of 54.7 percent from 2015 to 2025. Region 7 will likewise experience a somewhat more substantial change in the demographics of age, with an increase in the elderly population of 44.7 percent.

Table 9: 2025 Colorado Statewide Population Forecast for Select Demographic Groups

	Age Groups				Gender		Race/Ethnicity	
Region	**0-19**	**20-39**	**40-59**	**60+**	**Male**	**Female**	**Minority**	**White, Non-Hispanic**
1	426 (15.5%)	455 (18.4%)	428 (17.0%)	380 (41.9%)	854 (22.0%)	847 (23.3%)	n/a	n/a
2	130 (19.2%)	138 (36.9%)	114 (20.4%)	95 (41.2%)	244 (29.4%)	234 (30.7%)	n/a	n/a
3	276 (4.3%)	289 (19.1%)	299 (8.4%)	252 (54.7%)	549 (18.1%)	567 (18.3%)	n/a	n/a
4	93 (8.8%)	103 (18.6%)	94 (2.1%)	115 (22.8%)	208 (12.7%)	198 (14.2%)	n/a	n/a
5	181 (11.1%)	238 (-0.9%)	203 (25.6%)	142 (27.1%)	383 (13.3%)	385 (13.9%)	n/a	n/a

Table 9 Con't.: 2025 Colorado Statewide Population Forecast for Select Demographic Groups								
	Age Groups				Gender		Race/Ethnicity	
Region	0-19	20-39	40-59	60+	Male	Female	Minority	White, Non-Hispanic
6	236 (3.0%)	282 (12.0%)	268 (-3.3%)	287 (41.6%)	534 (11.4%)	541 (12.2%)	n/a	n/a
7	231 (12.1%)	255 (23.9%)	192 (-1.7%)	195 (44.7%)	430 (16.9%)	452 (20.6%)	n/a	n/a
Total	**1,573 (10.3%)**	**1,759 (16.4%)**	**1,596 (9.3%)**	**1,465 (40.8%)**	**3,199 (17.6%)**	**3,230 (18.8%)**	**2,380 (39.3%)**	**4,071 (8.6%)**

Note: The population numbers are in thousands, with percent growth from 2015-2015 provided in parentheses under the population estimates.

Table 10 below displays the prevalence for Any Mental Illness (AMI), Serious Mental Illness (SMI), and Alcohol and Other Drug Use or Dependence (AOD) among adult age groups. The prevalence of SMI is slightly lower among younger adults aged 18-25 (4.4 percent) and for older adults aged 50+ (4.9 percent) than all other adult age groups (from 5 to 6 percent). This difference in prevalence of SMI, though, is minor compared to the difference in projected population growth, indicating that the state behavioral health system should anticipate mental health services needing to account for a substantially increasing percent of all mental health services.

For substance use services, the expected growth in the elderly population will also result in a corresponding increase in the number of elderly in need of services. However, given that the estimated prevalence of AOD is significantly lower among the older population than the younger (see Table 10 below); the young adult age groups will continue to dominate the need for substance use services.

Table 10: Colorado Prevalence of Any Mental Illness (AMI), Serious Mental Illness (SMI), and Alcohol and Other Drug Abuse or Dependence (AOD) among adult age groups, 2008-2011 National Survey on Drug Use and Health.				
	18-25	26-34	35-49	50+
AMI	18.9%	21.7%	21.1%	13.6%
SMI	4.4%	5%	6%	4.9%
AOD	25.7%	17.2%	8.6%	3.1%

Gender

In all regions and statewide, the gender distribution between males and females is approximately even, and the projected growth in gender is likewise even. Table 11 below displays the current statewide prevalence for AMI, SMI, and AOD.

Table 11 – Colorado Prevalence of AMI, SMI, and AOD among males and females, 2008-2011 NSDUH		
	Male	**Female**
AMI	15%	20.8%
SMI	3.7%	6.6%
AOD	12%	8.8%

Race/ethnicity

The 10-year population forecast data was not available for race/ethnicity at the county level. Therefore, we can only compare the projected change in statewide population by racial and ethnic groups. Whereas Table 5 above displays the projected population change for the white, non-Hispanic population compared to all minorities, Table 12.1 below provides greater detail on the projected change across minority groups as well. All minority groups are projected to increase in population more than the white, Non-Hispanic population (39.3 percent growth for all minority groups combined, compared to 8.6 percent for the white, non-Hispanic population). The population of Hispanic and non-Hispanic Asian/Pacific Islander cultural groups is expected to increase the most (41.9 percent and 46.4 percent, respectively).

Table 12.1: 2015 to 2025 Colorado Statewide Population Forecast for Racial and Ethnic groups			
Race/Ethnicity	**2015 Population**	**2025 Population**	**% Growth**
White, non-Hispanic	3,748	4,071	8.6%
Hispanic Origin	1,230	1,746	41.9%
Black, non-Hispanic	228	282	23.5%
Asian/PI, non-Hispanic	197	288	46.4%
Am. Indian, non-Hispanic	54	65	20.3%

Note: Population numbers in thousands.

Table 12.2 displays the prevalence of AMI, SMI, and AOD among adults in Colorado by a simplified four-category race/ethnicity grouping. Due to small sample sizes among some racial/ethnic groups, the NSDUH could only provide prevalence estimates for white non-Hispanic, black non-Hispanic, other or multiple non-Hispanic, and Hispanic groupings. SMI is most prevalent among the other or multiple race non-Hispanic population, whereas AOD is most prevalent among the Hispanic population. Given the projected rise in the Hispanic population over the next 10 years, these prevalence estimates indicate that substance use services for people of Hispanic ethnic identity will become increasing critical to serving Colorado's population in need. Although specific prevalence data on the Asian/Pacific Islander population is not available for Colorado, the projected increase in their population should also inform the development of more culturally indicated services for this population.

Table 12.2: Colorado Prevalence of AMI, SMI, and AOD among racial and ethnic groups, 2008-2011 NSDUH

	White, non-Hispanic	Black, non-Hispanic	Other or multiple, non-Hispanic	Hispanic
AMI	18.5%	16.8%	22.7%	14.2%
SMI	5.4%	4.3%	11.3%	2.5%
AOD	9.8%	9%	7%	13.8%

Recommendations

Recommendations for this section are based on the relative need for services, using the 10-year projections for addressing disparities in access to services.

Two key findings stand out in the 10-year projections that are useful for planning behavioral health services: regional differences in population change forecasts, and the relationship between population forecasts and current service levels.

1. ***Regional differences in population change***: Among all regions, region 2 is projected to have the greatest population increase among both children and adults. As displayed in Table 7, the difference in population change in region 2 compared to all other regions is substantial enough that the unmet need would grow approximately twice as much as the statewide average for children and adolescents (e.g., 24 percent vs. 12 percent for children with SED, and 22 percent vs. 11 percent among adolescents with AOD).

Similarly, among adults, the change in unmet need in region 2 is much higher than the projected statewide average (89 percent vs. 56 percent and 81 percent vs. 59 percent for mental health and substance use services, respectively). Region 3 has similarly stark projected increases in unmet need for adults for both mental health (81 percent vs. 56 percent) and substance use (106 percent vs. 59 percent), though these changes appear to be driven more by a combination of high current penetration rates and strong, but not extreme, projected population growth. On the other end of the spectrum, regions 3 and 6 are projected to have the smallest population increase among children and regions 4, 5, and 6 are projected to have the smallest adult population increases. These findings indicate that region 2 may warrant special consideration and observation over the coming years to ensure that the amount of services grows accordingly with its projected increase in population across the lifespan.

2. ***Relationship between population change and current relative need for services***: Although region 2 would see the greatest increase in unmet need if service levels do not change over the next 10 years, this change is not substantial enough to overcome the current disparities in penetration rates. Table 3 displayed the congruence between lowest and highest penetration rates across OBH and HCPF services in 2014. Despite differences across the regions in projected population growth, the same regions would still have the lowest and highest penetration rates across both OBH and HCPF services, if the level of services remained the same through 2025. This finding indicates that region 1 remains consistently the least served and region 4 the most served.

[1] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Substance Abuse and Mental Health Data Archive. *National Survey on Drug Use and Health: NSDUH 2-Year R-DAS File*. Access on March 15, 2015 http://www.icpsr.umich.edu/icpsrweb/content/SAMHDA/rdas.html.

[2]

[3] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (1998). *Children with Serious Emotional Disturbance; Estimation Methodology.* Federal Register 98-19039, Vol 63, No. 137.

[4] 2013 U.S. Census Bureau 5-years ACS: Estimates of the Colorado County Population under 300% Federal Poverty Level by age group. File provided to WICHE by the Colorado State Demography Office.

[5] 2013 U.S. Census Bureau 1-year ACS Public use Microdata Samples: Estimates of the Colorado population under 300% Federal poverty Level by gender and race. File provided to WICHE by the Colorado State Demography Office.

[6] Colorado State Demography Office. Population Data, Age and Gender: Population estimates and forecasts by age and gender for Colorado, Sub-State Regions and Counties. Accessed online March 15, 2015 from http://www.colorado.gov/cs/Satellite?c=Page&childpagename=DOLA-Main%2FCBONLayout&cid=1251593300446&pagename=CBONWrapper

[7] Colorado State Demography Office. Population Data, Race and Hispanic Origin: U.S. and States Forecasts for years 200 – 2040. Accessed online March 15, 2015 from http://www.colorado.gov/cs/Satellite?c=Page&childpagename=DOLA-Main%2FCBONLayout&cid=1251593300475&pagename=CBONWrapper

Aligning and Maximizing OBH Resources and Payer Sources

Introduction

This section of the report includes statewide survey responses and recommendations about how to best align and maximize Office of Behavioral Health (OBH) resources and payer sources in planning for current and future behavioral health needs. Given findings from the stakeholder and provider surveys that none of the state's publicly funded behavioral health system service domains are adequately funded or integrated to meet client needs, no reallocation of existing funding or services is proposed. However, we do identify ideas for revenue maximization to provide potential funding sources for additional services.

Using stakeholder and provider survey results, along with inventory/services data, the three most-identified service domains from SAMHSA's *Description of a Good and Modern Addictions and Mental Health Service System* are identified and proposed as areas of prioritization for OBH resources. Similarly, the three most-identified underserved populations, including specific co-occurring populations, are also identified and discussed in the context of OBH resources. A discussion about applying excess funding for non-Medicaid mental health services to the service domains identified as most in need is included. Services provided under the Governor's *Strengthening Colorado's Mental Health System – A Plan to Safeguard All Coloradans"*, and revenue opportunities from services currently funded by the state's General Fund, are also examined as a potential vehicles to maximize resources for current and future system needs.

Please note that this report does not include a detailed staffing analysis of OBH; nor does it include an assessment of OBH's physical infrastructure, most specifically the two Institutes. Funding resources are examined using FY 2013-14 amounts, with note of increased funding in FY 2014-15 and FY 2015-16 as the Colorado General Assembly funds full-year operation of several of the items included in the 2013 Governor's Strengthening Behavioral Health Plan and continues to estimate and fund the impact of Colorado Medicaid expansion (under the Affordable Care Act).

SAMHSA's continuum of services[1]

As stated by SAMHSA (Substance Abuse and Mental Health Services Administration), "a modern mental health and addiction service system provides a continuum of effective treatment and support services that span healthcare, employment, housing, and educational sectors. Integration of primary care and behavioral health are essential. As a core component of public health service provision, a modern addictions and mental health service system is accountable, organized, controls costs and improves quality, is accessible, equitable, and effective. It is a public health asset that improves the lives of Americans and lengthens their lifespan. These

services are not only intended for individuals with a mental or substance use disorder, but also support their families who are critical to achieving recovery and resiliency."

A modern mental health and addiction system should have prevention, treatment, and recovery support services available both on a stand-alone and an integrated basis with primary care and should be provided by appropriate organizations and in other relevant community settings. SAMHSA's proposed continuum used in the surveys comprises of 10 domains including:

- ✓ Health Homes
- ✓ Prevention and Wellness Services
- ✓ Engagement Services
- ✓ Outpatient and Medication-Assisted Treatment
- ✓ Community Supports and Recovery Services
- ✓ Other Supports (such as personal care)
- ✓ Intensive Support Services
- ✓ Out of Home Residential Services
- ✓ Acute Intensive Services
- ✓ Recovery Supports

Survey responses about service and population needs

Top three service continuum domains

Responses to the *stakeholder* survey identify statewide needs in each of the 10 domains. Nearly 40 percent of respondents (1,070 of 2,773, or 39.3 percent) identified these domains as the top three most in need:

- *Engagement Services* – provision of assessment, specialized evaluations, service/crisis planning, and consumer/family education and outreach to assist clients and their families to engage in services (11.9 percent).
- *Community Support Services* – provision of community-based programs that enhance independent functioning (13.6 percent).
- *Intensive Support Services* - intensive, therapeutic, coordinated, and structured support services to help stabilize and support individuals and their families (13.8 percent).

Responses to the *provider* survey identify three different domains as the top three areas of service need. Approximately 47 percent of provider respondents (when weighted by provider to eliminate multiple responses from the same provider) identified these areas in the top three:

- *Healthcare,* including services integrated with primary care (20.6 percent)
- *Outpatient and medication services,* including individual, group, and family therapy (14.6 percent)
- *Intensive Support Services* (11.5 percent).

Service and inventory data available to inform the stakeholder and provider identification of

the top three services most in need are limited, as the number of services provided alone doesn't inform the degree to which the need for services is met, or if the service provided met the client's needs. The data are very informative, however, in identifying the total number of services provided to non-Medicaid vs. Medicaid clients. As presented in the inventory of this report, in FY 2013-14 an average of 0.036 services were provided on a per-capita basis to non-Medicaid clients below 300 percent of the Federal Poverty Level (FPL). In contrast, an average of 0.156 services were provided on a per-capita basis to Medicaid clients below 300 percent of the FPL. Thus, on average, Medicaid clients received 4.3 more services than non-Medicaid clients. These per-capita amounts indicate that non-Medicaid clients are underserved in comparison to Medicaid clients.

On average, Medicaid clients received 4.3 more services than non-Medicaid clients.

Top three underserved populations

General populations

Responses to the *stakeholder* survey identify these three populations as the most underserved:

- Children with emotional/mental health disorders (13.5 percent)
- Adolescents with emotional/mental health disorders (13.6 percent)
- Adults with emotional/mental health disorders (13.2 percent)

Responses to the *provider* survey identify these three populations as the most underserved:

- Adolescents with co-occurring mental health and substance use disorders (22.3 percent)
- Adolescents with substance use disorders (15.3 percent)
- Adults with substance use disorders (14.4 percent)

Specific populations

Responses to the stakeholder survey identify these three specific populations as the most underserved:

- Individuals with Traumatic Brain Injuries (19.2 percent)
- Individuals with Intellectual/Developmental Disabilities (20.4 percent)
- Other (16.6 percent)

Responses to the provider survey identify these three specific populations as the most underserved. The same percentage of respondents indicated other populations as individuals with dementia:

- Individuals with traumatic brain injuries (19.2 percent)
- Individuals with intellectual/developmental disabilities (20.4 percent)
- Other (16.6 percent)
- Individuals with dementia (16.9 percent)

Survey responses about funding impacts on service delivery

Both stakeholder and provider survey responses included numerous general comments about the need for more funding for behavioral health services. Other comments were specific and focused on specific populations for which funding streams create barriers to care.

- Several provider comments were received about individuals with a traumatic brain injury (TBI), developmental disabilities (DD), dementia, or other medical conditions who present in emergency departments and behavioral health provider settings. Providers noted that reimbursement is not available from behavioral health organizations for these individuals unless they are also diagnosed with a co-occurring mental health or substance-use disorder. One provider responded:

  All of these areas remain very complicated cases for the behavioral health system as they cross different funding lines or are poorly funded in general, which means there are few supports that serve this population. Many of the identified areas are what keep folks stranded in emergency rooms for days on end as there are few placement opportunities for them. TBI, intellectual/DD, and dementia have multiple funding steams which trap the patient in the middle between large systems who are trying their best to confirm that there is in fact a covered diagnosis.

- Some comments noted that there are funding challenges involving various levels of care for adolescents, including county departments ending treatment and funding for adolescents if they relapse.

- Providers commented that current substance use treatment program funding is fragmented, bundled, differential, and very difficult to execute. “The costs to substance treatment programs to manage the billing associated with these variations in funding are crippling,” one provider said. “There needs to be an increased understanding of funding necessities by HCPF (Health Care Policy and Financing) to effectuate full funding of necessary substance treatment services. Behavioral health organizations should provide the same contracts to providers rather than differential interpretations of HCPF regulations.”

- Providers also recommended the creation of health/medical homes and the facilitation of data and other information across physical health and behavioral health providers, including use of behavioral health service codes by primary care providers.

- Some commenters said that many of the new Affordable Care Act (ACA) insurance plans have high deductibles and copayments that do not fit for behavioral health needs.

- Regarding the administrative entities responsible for behavioral health services, providers suggested continued work toward regulatory alignment between the Office of

Behavioral Health (OBH) and HCPF to minimize the administrative burden on providers and to streamline data collection activities.

Impact of OBH non-Medicaid mental health funding on service gaps

With the exception of revenue sources and grants earmarked by statute for targeted populations, the majority of funding for services for non-Medicaid individuals is provided by the state General Fund and the SAPT and CMHS block grants. The funds are allocated to community providers using an annual contract. The only restriction imposed by OBH on the use of the funds is that providers must prioritize funding for individuals with a serious mental illness, serious and persistent mental illness, or serious emotional disturbance. No comments were received in the stakeholder and provider surveys regarding service gaps created specifically by this funding stream. As a result of the implementation of the Affordable Care Act, the Colorado Legislature has made annual reductions in the amount of General Fund money appropriated for non-Medicaid services, in response to increased numbers of individuals who are now Medicaid-eligible and were previously served with OBH non-Medicaid funds.

Revenue maximization

Services for indigent clients with mental illnesses. As a result of the estimated impact of expanded Medicaid eligibility on clients served by OBH funding for non-Medicaid clients, the General Assembly reduced these appropriations by $651,875 in FY 2012-13 and an additional $3,045,125 in FY 2013-14.[2] In addition, OBH staff indicates that providers receiving these funds for FY 2014-15 may not be able to meet their target numbers for adults and children, indicating the impact of Medicaid expansion continues to reduce the need for these funds as currently allocated (individuals not eligible for Medicaid with an income at or below 300 percent of the FPL). A corresponding reduction in the need for funding medications for indigent clients could also be expected. OBH staff indicates they use a methodology, with input from HCPF staff, to estimate reductions in the need for these funds due to the impact of Medicaid expansion.

Crisis services. OBH contracts with: four providers to provide statewide crisis response services, including walk-in, stabilization, mobile, residential, and respite services; one provider for a 24/7 statewide hotline; and one provider to market the hotline and crisis services. The FY 2014-15 legislative appropriation for crisis response services totals $22.6 million Crisis services funding is currently 100 percent General Fund. The fiscal requirements of each contract require the provider to "offset payments received from other payer sources against the contract not-to-exceed budgeted costs" of the contract. The contracts define cost-offset payments to include, but not be limited to: "Medicaid, Medicare, private insurance, co-payments or other patient revenue, grants, etc." The contract directs providers to submit a monthly invoice for incurred expenses, less any cost-offset payments.[3]

Implementation of crisis services should result in a reduction in admissions to the Institutes

and presentations at emergency departments. An evaluation of the impact of the implementation of statewide crisis services in Texas found that the percentage of crisis service users entering state hospitals declined by about 23 percent. However, due to the larger number of people being served, the absolute number of admissions had fallen only 3 to 5 percent.[4]

Assertive Community Treatment (ACT). OBH receives an annual General Fund appropriation of approximately $5.5 million for providers to provide ACT services. In addition, the appropriation to OBH for Services for Mentally Ill Clients includes approximately $650,000 for ACT services. ACT is an evidence-based service delivery model for providing comprehensive community-based treatment to adults with serious and persistent mental illness. ACT services are a Medicaid covered service under HCPF's Section 1915(b) waiver and are included in the BHO contracts.

"Money Follows the Individual." OBH receives an annual General Fund appropriation of approximately $5.1 million for the provision of intensive case management services to assist mental health institute patients with their transition to the community. Funding is also provided for residential and wrap-around services that are not covered by Medicaid or other payer sources such as: individualized mentoring; funding for structured activities (recreation, education, and training); transportation to promote engagement in treatment and community integration; substance use testing; smoking cessation; respite care for the caretakers of clients; and other individualized treatment services to address other community placement barriers. Intensive case management is a Medicaid-covered service under HCPF's Section 1915(b) waiver and is included in the BHO contracts.

OBH and providers should ensure that the General Fund appropriation for ACT services and for "Money Follows the Individual" is used to provide services to non-Medicaid clients.

Medicaid maximization efforts. OBH and HCPF are assessing ways to maximize the use of federal Medicaid resources to offset state General Fund for the provision of behavioral health serves. In light of the Affordable Care Act and the increasing number of individuals eligible for Medicaid-funded behavioral health services in Colorado, these agencies are meeting regularly to examine changes in the numbers of persons receiving serves and the types of services received. Historical contracts with providers on a cost per person basis are being evaluated to see if this is still a viable approach or if this needs to be modified. The desire is to identify opportunities to cover needed services through Medicaid, while at the same time directing the General Fund to cover programs and services that are outside of the State Medicaid Plan. Such programs include some of the new crisis services, and wraparound and assertive community treatment, which are evidence-based practices that may have some reimbursable components but not all parts of the program are currently reimbursable.

OBH and HCPF plan to continue to assess the service trends both statewide and across the various regions to determine the best funding priorities and strategies for serving individuals with behavioral health disorders in Colorado. Urban and rural considerations are being

examined as well as both mental health and substance use services, including detox. Waiver options and, or a State Plan amendment may also be considerations as potential mechanisms to provide appropriate cost effective services. The hope is to maximize the Medicaid funded services and direct state general funds to support other critical programs and services that support clinical outcomes and help individuals with behavioral health disorder thrive in their communities. Another consideration is enhanced early intervention and prevention efforts to improve the overall health of Coloradans, as good behavioral health investment for the state.

System Barriers and Alignment

Two major barriers—multiple disconnected systems, and lack of consistent, complete, and reliable data for accountability and planning—inhibit the maximization of efficient and effective behavioral health service delivery.

These barriers represent high-level categories of issues identified through our own review and analysis of system and information issues, as well as by survey respondents. It should be noted that none of the identified system barriers is insurmountable, and none is the "fault" of individuals within each system. Instead, the current system has evolved in an incremental manner, rather than through an overall system design with a common vision, leadership, administration, and expectations for behavioral healthcare for Coloradoans.

Multiple disconnected systems

Colorado has multiple systems at the state and sub-state levels, with overlapping jurisdictions and requirements for funding, managing, overseeing, authorizing and/or providing behavioral health services. These systems include:

- The CDHS Office of Behavioral Health
- The Department of Health Care Policy and Financing
- The CDHS Division of Child Welfare
- County Departments of Social Services
- The CDHS Division of Youth Corrections
- The State Judicial Department, Division of Probation Services
- The Department of Corrections
- The Department of Public Safety, Division of Criminal Justice
- The Colorado Department of Education
- The Colorado Department of Public Health and Environment
- Federally Qualified Health Centers
- Rural Health Clinics
- School-Based Health Clinics.

These various systems operate in "silos," with each system having its own structure and organization; goals and purpose; eligibility requirements; service definitions; payment rates; payment mechanisms; financial reporting system or systems; client eligibility and service utilization data tracking system; standards; program requirements; provider or practitioner

registration and/or credentialing process; contract requirements; and criteria for quality or success.

This situation creates system inefficiencies; ineffective use of public resources; inability to account for overall system impacts on services, funding, and provider capacity; strains on providers and practitioners trying to navigate the various systems and requirements; difficulty for clients and families trying to obtain access to services and sometimes file complaints about services; inefficiencies in the quality monitoring and oversight of provider performance and service delivery; and inability to plan for or meet Colorado's behavioral healthcare needs in a coherent, organized and coordinated fashion.

Because of the multiple systems, there is no identifiable behavioral health system leader with responsibility or authority across all the behavioral healthcare systems in the state. Each system leader tries to develop and improve services in his/her area of responsibility.

As detailed in a 2013 study completed by Magna Systems Inc. for OBH (*The Future is Now: Strengthening and Sustaining the Colorado Office of Behavioral Health's Implementation of the Affordable Care Act*) in response to this system fragmentation, Colorado's governmental efforts to promote collaboration between the mental health and substance use disorder systems go back several years. In 2006, a focus on collaboration was developed, leading to the Legislature's creation in 2007 of a Behavioral Health Task Force and, in 2008, to an executive order creating a Behavioral Health Cabinet composed of leaders of several state departments. In 2010, the Legislature created a Behavioral Health Transformation Council (BHTC) to work in collaboration with the Behavioral Health Cabinet toward specific cross-cutting goals, such as:

- Developing shared outcomes
- Aligning service areas to improve access
- Establishing joint monitoring to ensure accountability across systems
- Creating integrated policies
- Reforming finances
- Utilizing shared screening tools, assessments, and electronic health records
- Creating workforce development strategies
- Developing a comprehensive behavioral health service system that includes services to persons with mental illness, substance use disorders, disabilities, and co-occurring issues.

In addition to the Behavioral Health Cabinet and the BHTC, the Behavioral Health Planning and Advisory Council (BHPAC) is charged with advising and consulting with OBH on issues and services for persons with or at risk of mental health and substance use disorders. The BHPAC focuses on the service dollars derived from the federal Community Mental Health Services and Substance Abuse Prevention and Treatment block grants.

As the Magna study notes, *"Even with these efforts, as noted in the Colorado 2012-13*

application for the federal block grants, OBH's desire to create a highly collaborative behavioral health system is affected by a history of fragmentation and "siloed" services characteristic of virtually all public mental health and substance use disorder service systems nationwide. It is therefore the task of the OBH to redefine the parameters of the publicly funded behavioral health system and to take leadership of the process to establish an inclusive and comprehensive single state authority. Fortunately, for OBH, it can now build upon collaborative work."[5]

Lack of consistent, complete, and reliable data for accountability and planning

Each state agency involved in providing or contracting for the provision of behavioral health services appears to have its own management information system(s). Because of these multiple data systems, there is no current way to count the number of unduplicated persons served or to identify all the behavioral health services that a unique individual or family has received. Because these data are not available, it is difficult if not impossible to do systemwide analysis or planning in a comprehensive way. The OBH Treatment Management System and the Judicial Eclipse system were able to address issues of interoperability and data governance and have been sharing data through a web system for several years, although they do not share any clinical or medical information.

The current behavioral health data system is not designed to collaborate with other systems' data sets. OBH currently operates two data systems, one for substance use providers to record services and client data and another for mental health providers to do the same. OBH has received funding to integrate these two data sets, which should improve OBH's ability to report valuable behavioral health data. The experiences from other states that have integrated data systems could help inform OBH during this effort, including ways to maximize the utilization of substance use data while complying with federal regulations.

OBH anticipates compatibility with HL-7 specifications and 837 encounters by the end of 2016. Other CDHS systems include TRAILS, used by the Divisions of Child Welfare and Youth Corrections within CDHS. There is little system-level or data-system communication among the multiple systems. Therefore, there appear to be assumptions made about what portions of systems are serving what portions of other systems' clients, without any way to verify those assumptions. We encountered examples of these data challenges and assumptions in attempting to obtain client and service data for this study.

Recommendations

Payer sources

1. ***Implement suspension, rather than termination, of Medicaid benefits for institutionalized individuals.*** Federal Medicaid rules allow states to suspend, rather than terminate, Medicaid eligibility for individuals in institutions for more than 30 days, including state hospitals, prisons, and juvenile facilities (for individuals who emancipate). Colorado has not yet implemented this option. As a result, state mental health institute and prison staff must expend additional effort in an attempt to reapply for Medicaid on the individual's behalf. Sometimes placement options are denied because the individual has not obtained Medicaid eligibility status when they are ready to leave prison or a juvenile facility or no longer need to be in a psychiatric hospital.

2. ***Develop service delivery systems for individuals with significant co-occurring needs.*** A recurring theme in the stakeholder and provider survey responses centers on delays in care and lack of settings for individuals with developmental/intellectual disabilities, traumatic brain injury, primary dementia with decreasing mental illness, or substance use disorder. Providers voiced continued frustration about the institutes' admissions denials of these referrals. However, the institutes are neither appropriate settings to provide the best care for these individuals, nor are they permitted to admit individuals without a primary psychiatric diagnosis that requires inpatient psychiatric care. To do so would violate federal law and regulation and Joint Commission accreditation standards.[6]

   HCPF and OBH, along with the provider community and other state and private agencies, are currently working toward expansion of integrated-care service delivery and health homes in the state. These efforts include the creation of the Accountable Care Organization (ACO) and regional collaborative care organizations. A later section of this report about whole health integration includes more information. Health homes offer the ability to meet the needs of individuals with complex, co-occurring needs. In addition, implementation of these service models in other states has demonstrated measurable cost savings. For example, the Missouri Health Home Initiative produced $4.2 million of savings in the first year of implementation.[7] Colorado has already demonstrated cost savings in implementing the ACO system. HCPF and the state should adopt a Medicaid State Plan amendment to facilitate the implementation of health homes as a means to integrate primary care and behavioral health service delivery.

3. ***Monitor affordability of care and the ACA.*** A study conducted by the Urban Institute found that adults with physical and/or mental health issues, especially those with low family income, had more difficulties obtaining and affording health care than adults who reported no health problems. Even with full-year health insurance, adults with physical and/or mental health issues were more likely to face barriers to care, especially affordability barriers, than their healthier counterparts.[8] Expanded marketplace and

Medicaid coverage provided by the ACA may help mitigate some affordability concerns among the previously uninsured, especially those with physical and mental health issues. However, insurance coverage alone will not ensure that adults with such health problems receive the care they need in a timely and affordable way. Subsidized cost-sharing for visits to health care professionals and for prescription drugs may relieve some of the burden. Funding for these needs could be an appropriate use of the savings in the state's appropriation to OBH for services for non-Medicaid individuals with mental illness.

Crisis services

4. ***Encourage discussion, among OBH and HCPF staff and crisis services providers, of how crisis services for Medicaid clients will be billed and reimbursed.*** Crisis services are covered services under the State Medicaid Plan. Given that Medicaid behavioral health benefits are provided under a capitated, per member/per month reimbursement rather than fee-for-service reimbursement, either capitation rates need to be adjusted or providers need to be able to submit fee-for-service claims for crisis services.

5. ***Encourage discussions, between OBH and crisis services providers, of processes for determining each client's ability to pay, including available payer sources, and review how providers are administering these processes.*** While crisis-services contracts require all individuals who present to receive appropriate services irrespective of ability to pay, it is important that providers are diligent in identifying and billing all available payers.

6. ***Attempt to measure the impact of crisis services.*** It is important to develop a clearer picture of the impact of crisis services on the need for inpatient psychiatric hospital beds, and to adjust the population projections included in this report based on the impact, if any, of implementing crisis response services.

System alignment

7. ***Identify a single state behavioral health authority.*** Move the responsibility and authority for all behavioral health funding, planning, programs, and regulations into a single department. However, even with such a reorganization, a common leadership group about behavioral health would need to be in place. The Behavioral Health Cabinet and the BHTC could serve in this role. While many of the state agencies listed earlier would still retain management of behavioral health services provided to their clients (e.g., DOC, Division of Probation), combining OBH and HCPF's behavioral health role would move the state forward in reducing provider confusion and burdens, and better position the state for integrating physical and behavioral health care.

8. ***Explore the development of a common management information system.*** The state

should consider the development of a common behavioral health data information system, or the modification of each agency system to share physical and behavioral health data using industry standard health information exchange standards (e.g., HL-7). Partners in this effort should include the Colorado Regional Health Information Organization (CORHIO), Quality Health Network (QHN) and the Center for Improving Value in Healthcare (CIVHC).

Implementing these two recommendations would greatly accelerate Colorado's moving forward in the planning and delivery of publicly funded health care services over the next five to 10 years. Many providers across the state are transforming their practices through provision of integrated behavioral health and primary care services—some through affiliation with various healthcare providers, some through acquiring FQHC status, and others by participating in growing organized networks of accountable care organizations (ACOs). The manner in which some provider organizations are transitioning their programs can offer insights into what the likely evolution of the service system will entail, and the possibility of replicating successful strategies of those who have adopted new service delivery approaches and models.

There are significant transformations underway in how health care is being delivered, financed, and structured, and how providers are held accountable for outcomes. These changes impacting hospitals and physician practices will inevitably be extended to behavioral health. Moreover, health care providers are becoming more attuned to the importance of addressing behavioral health conditions than ever before. The use of quality measures that address behavioral health conditions, such as depression, substance use and emotional disorders in children have significantly increased awareness, and prompted many healthcare organizations to expand capacity to deliver behavioral health services in traditional healthcare settings.

Organizational readiness to change is an extremely cogent area for analysis in assessing current behavioral health resources and in predicting how capable existing providers are of accommodating the rapidly changing environment. There are numerous objective criteria that can be used to determine the level of preparedness, and level of risk for provider organizations. These metrics will be important for planning purposes as it will be important to avoid, to the greatest extent possible, organizations finding they are falling behind the change curve such that they can no longer continue to operate. New value-based financing models will have a significant impact on traditional providers, who may have experience in fee-for-service billing, or even grant-based funding, but are unprepared to shift to risk- or performance-based models.

In January 2015, the U.S. Department of Health and Human Services announced its goal of transitioning 30 percent of traditional fee-for-service payments for Medicare to quality-driven, value-based payment models by the end of 2015, and having 85 percent of payments tied to quality and value by 2016.[9] This clearly signals a transformation of

how health services will be purchased that will undoubtedly ripple through Medicaid, private insurance, and other publicly funded services. Colorado was recently awarded a $65 million State Innovation Model (SIM) grant by CMS. The areas targeted include value-based payment, integration of behavioral health and primary care, and enhanced use of analytics, in part to develop new payment strategies.

Clearly, these reforms will impact behavioral health providers and increase their level of financial risk. Those that are not capable of adapting will not remain viable very long. Many state behavioral health agencies have focused more attention on developing service models that embrace evidence-based practices and consumer engagement than on provider participation in integrated networks, analytics, and outcome management. Local programs have been largely responsible for adapting to changing dynamics and to managing their business operations, largely supported by relatively stable general revenue funding. Strategic planning for the Colorado behavioral health system will need to integrate across these traditional areas of focus, as well as take into account a changing environment that has an unprecedented level of attention focused on patient engagement, treatment outcomes, use of real-time clinical decision support information, and heightened expectations for care coordination and information sharing.

It is also important—with the focus of care shifting from the provider to the individual, and a better understanding of holistic health and population health—that strategic planning address the extent to which an individual's involvement in any health and human service agency increases his/her odds of needing service from another health and human service agency. While state behavioral health agencies, long underfunded, have focused on the most seriously ill adults and children, this approach has proven less effective than proactive interventions that can offset long-term impacts of illness. Utilizing predictive analytics will provide myriad opportunities to identify at-risk individuals who could greatly benefit from early interventions and supports. Planning in this direction would have significant benefits for those individuals and for state budgets. Across the state Department of Human Services, there are many opportunities to enhance outcomes by addressing behavioral health risk issues in innovative ways. This, too, is an area where the availability of integrated, timely, and appropriate data can reduce risks to individuals and communities.

[1] SAMHSA (2010). *Description of a Modern Addictions and Mental Health Service System* (draft). Retrieved from: *http://www.samhsa.gov/healthreform/docs/AddictionMHSystemBrief.pdf*

[2] SOURCE: Joint Budget Committee Staff documents: FY 2015-16 Staff Figure Setting, Department of Health Care Policy and Financing and Department of Human Services, Mental Health Programs Only. March 4, 2015.FY 2014-15

[3] See Page 4, Exhibit F Fiscal Requirements, Contract #15IHJA17203 between the Colorado Department of Human Services and AspenPointe, Inc.

[4] **Evaluation Findings for the Crisis Services Redesign Initiative;** Report to the Texas Department of State Health Services; Page xi, January 1, 2010. Public Policy Research Institute.

[5] Page 10, Magna Systems Inc. "The Future is Now: Strengthening and Sustaining the Colorado Office of Behavioral Health's Implementation of the Affordable Care Act."

[6] 42 CFR 424.14 and TJC Leadership Standard 04.01.01

[7] **Kansas Health Institute, 'Health home' initiative shows $4.2M savings in first year. Mike Sherry, June 25, 2013. http://www.khi.org/news/article/health-home-initiative-shows-42m-savings-first-yea/#sthash.f5YRckIB.dpuf**

[8] Health Care Access and Cost Barriers for Adults with Physical or Mental Health Issues: Evidence of Significant Gaps as the ACA Marketplaces Opened their Doors; Dana Goin and Sharon K. Long, Urban Institute Health Policy Center, April 4, 2014

[9] http://www.hhs.gov/news/press/2015pres/01/20150126a.html March 27, 2015.

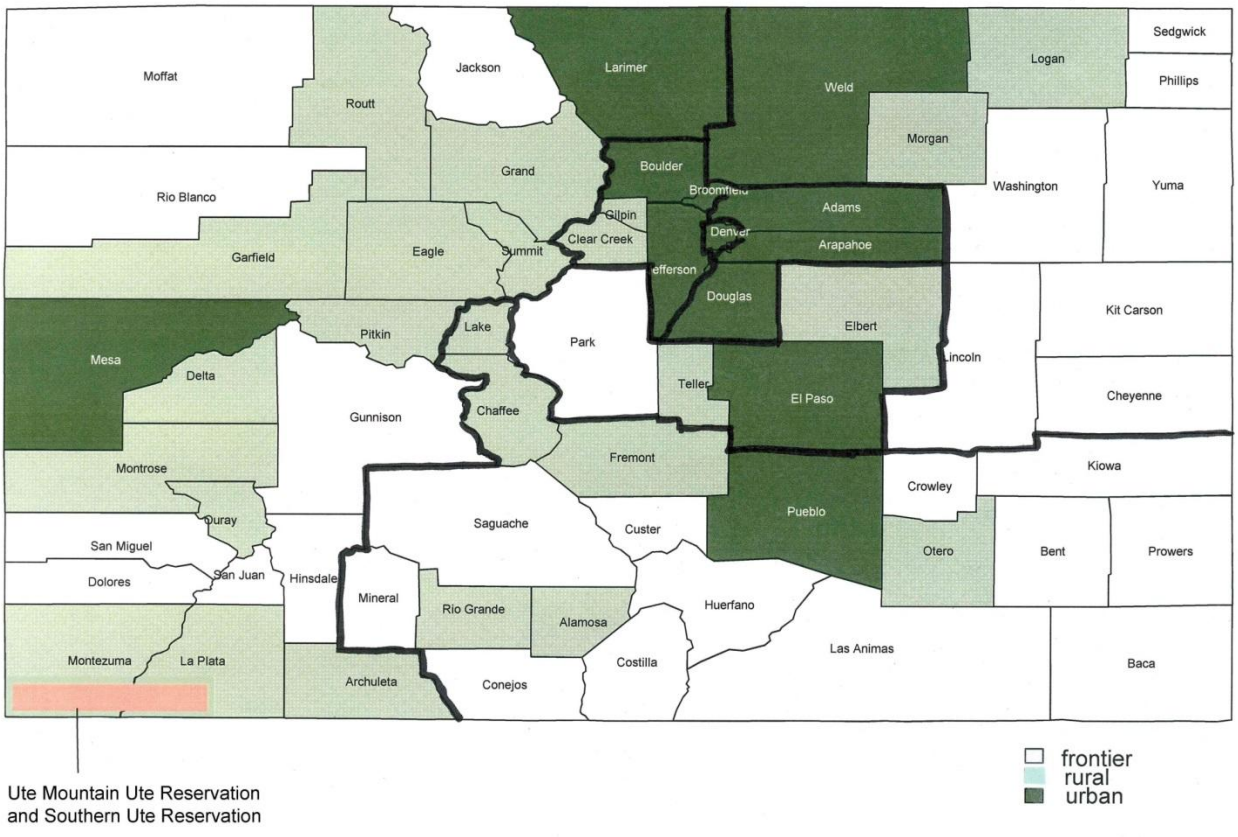
Regional Behavioral Health Service Distribution

Introduction

This section summarizes the current mental health resource allocation by the seven geographic regions and provides recommendations as to the most efficient distribution of resources across rural, frontier, tribal, and urban population centers. Data to inform the review came from Office of Behavioral Health (OBH) service data, a gap analysis, population figures and projections, and qualitative information from surveys of stakeholders and providers.

Much of Colorado's population is concentrated in 12 Front Range counties that meet the U.S. Census Bureau definition of urban areas having 50,000 or more people. Of the state's 52 other counties, 24 are classified as rural, with less than 10,000 people, and 28 meet the definition of frontier areas, with seven or fewer people per square mile (see map below). This geographic and demographic diversity creates challenges for equitable resource allocation across the state. The unique needs of each area are presented in this section and recommendations are also provided.

Figure 1: Colorado map of frontier, rural, and urban areas within the seven regions



Regional differences in service utilization

Table 1 below illustrates the regional differences in service utilization across the state.

- Medicaid capitation service rates in regions 3, 5, and 6 (generally the urban areas of the state) range from 131 to 156 percent of the state rate, indicating services are more available and utilized more often in the urban areas of the state. Similarly, OBH indigent service rates range from 175 to 131 percent of the state rate.
- Medicaid capitation service rates in regions 1, 2, and 7 (generally the rural areas of the state) range from 49 to 79 percent of the state rate, indicating services are less available and utilized less often in the rural areas of the state.
- Region 4 has service rates closest to the state rates, at 95 percent of the state rate for Medicaid capitation services and 114 percent of the state rate for OBH indigent services.

Table 1: Per Capita Services by Region – Medicaid Capitation and OBH Clients as a Percent of Individuals below 300 Percent of the Federal Poverty Level (FY 2013-14)

	Region							
	1	**2**	**3**	**4**	**5**	**6**	**7**	**Total**
Medicaid Capitation Services per Capita	0.076	0.124	0.236	0.148	0.258	0.204	0.101	0.156
Percent of State Total	49%	79%	151%	95%	165%	131%	65%	100%
OBH Services per Capita	0.020	0.033	0.053	0.041	0.047	0.063	0.013	0.036
Percent of State Total	56%	92%	147%	114%	131%	175%	36%	100%

Urban areas

Regions 3, 5, and 6 are composed mainly of urban areas. Responses to the stakeholder survey suggest that services are generally available in urban areas, but many people do not know about them. More outreach and education are needed to provide maximum awareness among Coloradans living in urban areas. Similarly, there is a need for increased health promotion, prevention, and counseling for school-age youth. Early intervention for psychosis is an emerging area and was cited in region 6 as a need[1].

Once individuals identify needed services, many face financial barriers to accessing care. There are large numbers of individuals who lack insurance or who are ineligible for Medicaid. Without public assistance, services are not affordable for these people.

The lack of care coordination was a major theme among stakeholder survey responses in urban areas. Transition supports between inpatient and outpatient services are either poor or nonexistent, particularly for persons with co-occurring medical conditions. Region 5 responses suggested that civil patients are being

In **urban areas,** challenges are focused on awareness, engagement, affordability of services, inadequate public transportation, and care coordination.

discharged from inpatient care prematurely, and the necessary transition, care, and recovery supports are not in place to help prevent inpatient readmissions. Similarly, individuals who have successfully completed residential substance use treatment face a dearth of outpatient therapeutic services. Region 5 responses suggested that vocational resources would greatly benefit these individuals. While stakeholders in urban areas felt that services were generally available, there were some provider types with high caseloads. Stakeholders in the urban regions feel that there is limited availability of drug abuse treatment providers, with adolescent detox topping the list. Region 3 identified a need for more child and adolescent inpatient beds, and a gap in services for "high utilizers" who also pose a risk to the community.

Region 6 is projected to have the smallest population increase among children and regions 5 and 6 are projected to have the smallest adult population increases.

Urban areas, particularly regions 3 and 6, have vacant staff positions that contribute to high caseloads. Positions with the greatest number of vacancies include master's-level clinicians, counselors, and social workers; nurses; peer support specialists; and mobile crisis staff. There is a shortage of medical staff in region 6; half of the 18 positions are open. Regions 3 and 5 are experiencing a shortage of psychiatrists, with five to six vacant positions.

Rural areas

Regions 1, 2, 4, and 7 are largely made up of rural and frontier areas. A major theme from the stakeholder survey is the lack of providers and the long distances that clients must travel to access services. Region 7 is in closer proximity to urban areas, so a barrier to accessing care is poor or nonexistent public transportation, rather than great travel distances. Inpatient services are lacking in these regions—inpatient psychiatric services and substance use residential detoxification services. The small population in rural areas makes it difficult to financially support programs that operate around the clock. Region 1 showed very low penetration rates for both children and adults receiving OBH services.

Follow-up after a person leaves residential care, inpatient hospitalization, or jail is cited as a gap in rural areas. Community-based recovery and re-integration supports for both mental health and substance use are needed. Stakeholders in region 2 suggested that these supports can be provided through peer mentoring and peer groups. The peer specialist portion of this report includes additional recommendations on the use of peer supports.

Challenges in **rural areas** include long travel distances to access services, lack of inpatient or residential services, re-integration/recovery supports, and recruitment and retention of staff.

Recruitment and retention of staff are particularly problematic in rural and frontier areas of the state. With a high turnover rate in behavioral health care staff, unfilled positions place additional pressure on existing staff who already carry large caseloads. Region 4, made up of mostly frontier counties, reported nine staff categories with large differences between filled and budgeted positions. Licensed clinicians, including medical staff, psychiatrists, nurses,

addictions staff, and master's-level clinicians/counselors/social workers, are in great demand in frontier areas.

Region 2 responses cited a need for prevention and early intervention services for youth. Given that region 2 is projected to have the largest percent decrease in penetration rate for OBH services to children and adolescents over the next 10 years, investment in youth services in this region is critical.

There are unique challenges to providing behavioral health services in rural and frontier areas. With longer travel distances and higher insurance rates, persons living in rural or frontier areas enter care later when their behavioral health issues have often resulted in a significant stage of decline of overall functioning. With fewer care options, the population is generally less able to recognize mental illnesses in their early stages and understand care options that are available.[2] A stakeholder in region 2 suggested that OBH look toward improving the health of rural communities through population-based interventions, instead of through billable encounters. Integration with primary care is critical in areas with limited access to behavioral health care providers. In addition, creative therapies such as art and equine therapy could be investigated as supplements to traditional services.

Frontier areas

A general lack of availability of providers continues to be a large concern for frontier areas of the state. Critical services such as inpatient psychiatric care, detox, and intensive community-based care are often 100 miles or more away.[3] Residential arrangements for clients who need more assistance are also in short supply.

Shortages of behavioral health care providers in less-populated areas have been an ongoing issue in Colorado and other states. A 2010 report, "The Behavioral Healthcare Workforce in Colorado," identified 40 Colorado counties that do not have even one psychiatrist.[4] Even if providers were available, it is difficult for them to maintain services with a low volume of clients. Rural areas tend to have high no-show rates, likely due to lengthy travel times, which are increased even more in winter weather. The lack of availability of providers yields a higher reliance on informal supports and primary care providers to deliver behavioral health care services.[5]

An earlier section of this report noted that region 4 has relatively higher penetration rates for OBH services for children and adolescents with SED and adults with SMI. Region 4 also has higher population-based penetration rates for Medicaid behavioral health services for adults. These results suggest that region 4 may be better served relative to other regions, especially with respect to mental health services. However, the stakeholder and provider survey responses underscore that while region 4 has better penetration rates than the other regions, there remains a widespread shortage of services.

In **frontier areas,** the general lack of providers is a major challenge. Sparse population makes it difficult to sustain a level of service and recruitment and retention of qualified staff is problematic. Transitional services, community and recovery supports are also largely unavailable in frontier areas.

Issues that cut across all regions

> Access to housing, transportation, and employment are key social determinants of health that cannot be addressed in a fee-for-service environment.

All regions identified housing as a major issue. Group homes, transitional housing, and housing-first initiatives were all cited as needs from stakeholders. One respondent commented, "Prison is where people with mental illnesses that don't have housing wind up." The estimated percentage of unserved need for housing programs was as low as 5 to 10 percent in urban areas (regions 3 and 6) and as high as 70 to 90 percent in rural/frontier areas (regions 1, 4, and 7). The inventory section of this report lists the types of housing services and the number of housing units available by region. All areas also cited access to services as a barrier to receiving care. In urban areas, inadequate public transportation prevents many clients from being able to travel to and from appointments. In rural and frontier areas, the long distances to providers are a major impediment to seeking care. Finally, a common theme among all regions was the need for transitional services. Individuals completing inpatient care, residential treatment, or incarceration do not receive the necessary supports to help them be successful in their recovery. The lack of care coordination among providers is a substantial barrier to holistic treatment.

Tribal communities

Colorado has two tribal communities, located in the southwest corner of the state in region 1: the Ute Mountain Ute Reservation and Southern Ute Reservation. Native American communities experience high rates of alcohol and substance use, mental health disorders, suicide, and behavior-related chronic diseases. Native Americans are significantly more likely to report past-year alcohol and substance use disorders than any other race, and suicide rates are 1.7 times higher than the national rate.[5]

Behavioral health services for members of the two tribal communities are either provided directly by the federal Indian Health Service or purchased and delivered directly by the Tribes using Tribal and federal funds and through federal SAMHSA SAPT block grant funds. [6]

> The Ute Tribal Communities cite the need for additional residential treatment, and care coordination among inpatient and outpatient substance abuse services should be strengthened.

The Tribal Health Center located on the Ute Mountain Ute Reservation in Towaoc provides primary care and behavioral health services, which include adult, adolescent, and child psychiatry, pharmacy services, and tobacco cessation counseling.[7] Certified counselors are on staff for assistance in enrolling in private insurance (Qualified Health Plans in the Marketplace), CHIP, Medicaid, and Medicare. Ute Mountain Ute Counseling Services has indicated that there is a great need for residential treatment services.[8]

The behavioral health program of the Southern Ute Tribal Health Service provides services to

children and adults that include evaluation, diagnosis, and the management of mental, behavioral, chemical dependency, or emotional conditions. Psychological assessments, tests, and individual psychotherapy are also provided. If a person requires services not available through Tribal Health Service, the Referral Services Division uses the Tribal Resource Pool and Federal Contract Health Services (CHS) funds to pay for referrals.[9]

While the Southern Ute Tribal Health Service receives some OBH substance-use prevention funding, the staff cited a need for more resources for prescription pain pills and to provide treatment for indigent clients. They would like to see better collaboration with West Slope Casa, the managed service organization serving their region that provides substance-use disorder treatment and detoxification services for indigent individuals who are not eligible for Medicaid.

The vast majority of American Indians and Native Americans living in Colorado reside outside of reservations and receive their care through a variety of providers. Three providers in the Denver metro area provide much of this health care: Denver Indian Family Resource Center, Denver Indian Health and Family Services Center, and the Denver Indian Center.[10]
The Denver Indian Family Resource Center advocates for family reunification following the standards of the Indian Child Welfare Act. The center provides culturally appropriate services and intensive case management using a strengths-based and empowerment-oriented approach. Behavioral health services are a component of the programs that are offered.[11]

The Denver Indian Center serves American Indians and Native Americans through a food bank, youth empowerment, and a work program. The center is a popular location for the community to gather for powwows and various other activities held at the facility throughout the year.[12]
Denver Indian Health and Family Services provides culturally sensitive services for mental health, behavioral, and substance use problems.[13] American Indian/Alaska Natives ages eight and older who are enrolled members of federally recognized tribes are eligible for services. This organization does not provide emergency services, and individuals with serious psychiatric conditions must be referred to county mental health providers or other local resources.

The University of Colorado, Anschutz Medical Campus, Department of Psychiatry operates a National Center for American Indian and Alaska Native Mental Health Research. The program is sponsored by the National Institute of Mental Health and is the only program of this type in the country focusing specifically on American Indian and Alaska Native populations. The mission for the Center is to promote the health and well-being of American Indians and Alaska Natives of all ages, by pursuing research, training, continuing education, technical assistance, and information dissemination that recognize the unique cultural contexts of this special population. The program conducts research projects focusing on behavioral health issues of American Indian and Alaska Native populations.[14]

Individuals residing in the Ute Tribal Communities receive their behavioral health services largely from the tribal health centers or the Indian Health Service. When more-intensive

services are needed, or American Indians and Native Americans are not residing on a reservation, OBH-funded services may be utilized. Table 2 shows that American Indian/Alaska natives represented less than 2 percent of all persons served in Colorado.

Table 2: Unduplicated Count of American Indian/Alaska Native Persons Served by OBH in FY 2014, by Region

Region	Number of persons	Percent of total person served in region
1	195	2.2%
2	70	1.6%
3	137	1.5%
4	113	1.9%
5	51	1.3%
6	112	1.4%
7	94	1.8%
Total	772	1.7%

Source: OBH

OBH also provides grant funding to the Ute Tribal communities for special initiatives. For example from 2009-2012 OBH funded the Southern Ute Community Action Programs. This program provided ASIST and Safe TALK gatekeeper training to community members throughout La Plata County, with an emphasis on their Native American Population and older adults.

Recommendations

The unique challenges faced by urban, rural, frontier, and tribal areas of the state have been presented above. Until systemic challenges such as transportation, staffing shortages, and funding issues are addressed, Coloradans in all areas of the state will continue to face barriers to receiving optimal behavioral health care. While these challenges may seem daunting, some promising practices are emerging that can be adopted to overcome obstacles.

1. ***Telehealth.*** Telehealth can be used to connect patients and providers and to reduce costly "windshield time." Telehealth has been found to be a cost-effective delivery method for prevention, early diagnosis, treatment, and care coordination.[1516] Telehealth can assist in solving access to care issues in rural and frontier areas, in underserved communities, for individuals with mobility issues, and to provide specialty care that is not widely available.

   Colorado's parity law for private insurance allows telehealth for counties with fewer than 150,000 residents. Colorado Medicaid covers telehealth services that originate in

the provider's office. Provider survey responses suggested that telehealth could extend behavioral health services to incarcerated individuals, to residents of nursing homes, or to physical health entities such as emergency rooms. Telehealth could help with the staff recruitment issues, and low-volume issues in rural clinics. Evidence-based applications have been developed that can provide a lifeline to persons at home or on waiting lists (e.g., MyStrength, Beating the Blues).[17]

2. ***Primary care integration.*** Primary care providers in rural/frontier areas have to be trained to function independently. Integrating behavioral health services into primary care can help reduce stigma associated with seeking behavioral health services in small communities. Training for existing providers to deliver behavioral health services to leverage existing services would be beneficial. Colorado has a grant to expand Mental Health First Aid training. Such training heightens awareness of mental illness and can help rural/frontier communities and families identify when individuals are struggling.

3. ***Prevention and early intervention.*** Funding for prevention and early intervention has the potential to help today and into the future.

4. ***Peer support services*** can be used to assist with community-based recovery and re-integration supports for both mental health and substance abuse and could be a valuable resource for tribal communities. Such supports were cited as a gap across all regions.

[1] RWJ Foundation Early Detection and Intervention for the Prevention of Psychosis Program: http://www.rwjf.org/en/about-rwjf/newsroom/newsroom-content/2014/07/edippp-intervention-reduces-conversion-to-full-blown-psychosis-a.html
[2] SAMHSA-HRSA Center for Integrated Health Solutions: Webinar on Reaching Rural: Best Practices in Integrating Behavioral Health, February 26, 2015.
[3] The Status of Behavioral Health Care in Colorado. Advancing Colorado's Mental Health Care: 2001 Highlights
[4] WICHE Mental Health Program (2010). The Behavioral Healthcare Workforce in Colorado: A Status Report.
[5] Indian Health Service's Behavioral Health fact sheet. Retrieved from http://www.ihs.gov/newsroom/factsheets/behavioralhealth/
[6] 2014-2015 Combined Behavioral Health Block Grant Application
[7] http://www.ihs.gov/Albuquerque/healthcarefacilities/utemountainute/
[8] 2014-2015 Combined Behavioral Health Block Grant Application
[9] http://www.southernute-nsn.gov/tribal-health/behavioral-health/
[10] 2014-2015 Combined Behavioral Health Block Grant Application
[11] http://difrc.org/
[12] http://www.denverindiancenter.org/aboutus
[13] http://www.dihfs.info/Behavioral-Health.html

[14]http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/NCAIANMHR/Pages/ncaianmhr.aspx
[15] American Telemedicine Association, State Policy Toolkit Improving Access to Covered Services for Telemedicine, 2013.
[16] American Telemedicine Association, State Medicaid Best Practice Managed Care and Telehealth, January, 2014
[17] http://www.nrepp.samhsa.gov/

Colorado Mental Health Institutes

Introduction

This section of the report focuses on a trend that is occurring in Colorado and across the United States — a major increase in the number of individuals referred for court-ordered evaluations and competency restorations — and the impact of this trend on civil-bed availability at the two Colorado mental health institutes. A full review of the impact was accomplished through key informant interviews, focus groups at each of the institutes, a review of pertinent literature, and analysis of historical and projected national and state trend data on evaluations and competency restorations.

When a judge, prosecutor, or defense attorney questions the competency of a defendant, a judge may initiate a court order for a mental evaluation. According to Colorado statute, these evaluations may be performed on an inpatient or outpatient basis by a licensed doctoral-level psychologist or psychiatrist[1]. The location of the evaluation is at the sole discretion of the judge and is determined by court order.

There are three types of evaluations that can be ordered by the courts:

- **Competence to proceed to trial evaluations** address whether or not the defendant is able to understand what he/she is charged with, and whether he/she can work with the defense attorney to communicate about the case and assist with the defense.

- **Sanity evaluations** address whether the defendant was legally insane at the time of the commission of the crime. The evaluation ultimately answers the legal question as to whether, as a result of mental illness, the defendant could tell the difference between right and wrong as it applies to the offense with which he/she is charged.

- **Mental condition evaluations** address whether the defendant had a specific condition present at the time of the commission of the crime that could have affected his/her mental state enough to question whether the crime was committed with intent and premeditated motive.

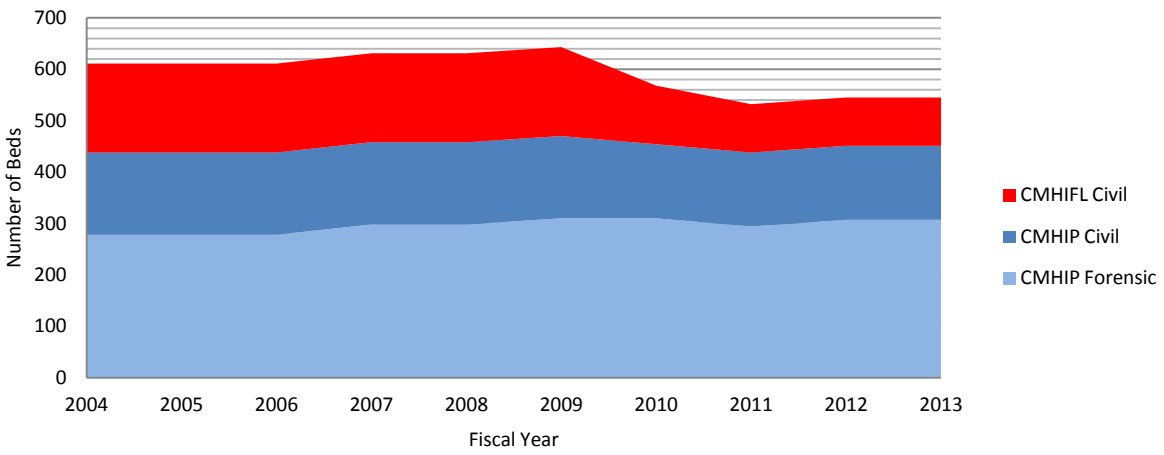
If the court finds the defendant incompetent to proceed (ITP), the defendant is ordered to treatment to restore competency. The duration of the treatment commitment may equal the maximum term of the sentence had the defendant been found guilty of the offense charged.

Trend data on inpatient psychiatric bed utilization

The Colorado Office of Behavioral Health (OBH) operates two psychiatric hospitals, the Colorado Mental Health Institute at Pueblo (CMHIP) and the Colorado Mental Health Institute at Fort Logan (CMHIFL). CMHIP is the state's only forensic hospital for defendants with mental illnesses and criminal involvement. The vast majority of inpatient competency evaluations are conducted at CMHIP; however, due to high demand in recent years, CMHIFL has had to complete 26 inpatient evaluations (2011-14), which has historically been used solely for civilly committed patients.

Bed capacity at the two mental health Institutes has undergone some modifications in recent years. Today the 94 beds at CMHIFL are solely for adults after the January 2010 closings of the 16-bed children's unit, 18-bed adolescent unit, 25-bed geriatric unit, and the closing of the 20-bed Therapeutic Residential Child Care Facility (TRCCF) in July 2011. CMHIP has a total of 144 civil and 307 forensic beds for adolescent, adult, and geriatric patients. CMHIP closed its 20-bed medical unit in fiscal year (FY) 2010. Figure 1 shows the trend in bed capacity at the institutes over time.

Figure 1: Bed Capacity Over Time: CMHIP and CMHIFL

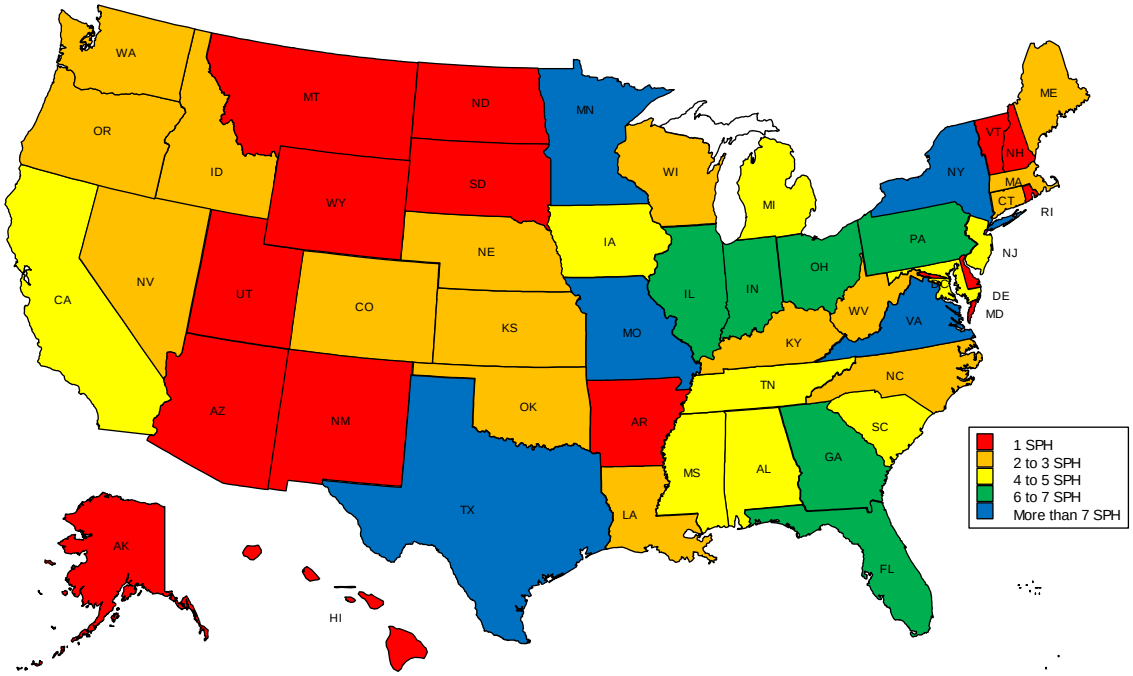


The community mental health centers (CMHCs) throughout the state control entry into CMHIFL and CMHIP for civilly committed adult patients. Each CMHC receives a bed allocation for adults with a civil commitment at their designated institute, but these allocations are loosely followed. The agreement with the CMHCs provides an allocation of 64 adult beds at CMHIP and 91 adult beds at CMHIFL. Available beds can be filled by patients from any CMHC based on need. Prior to 2011, patients at CMHIP were assigned to a unit based on their commitment status - forensic or civil. Based on a 2010 consultant report recommendation, CMHIP restructured the delivery of treatment services to serve patients on units based on clinical need and level of risk rather than commitment status. Because of this change, referring to Colorado's existing civil or

forensic bed capacity is a bit misleading since every adult bed at CMHIP can theoretically be filled by a client meeting the criteria for admission[2].

The 2013 national average penetration rate for state hospital beds (civil plus forensic) was 438 per 100,000 of population, with a range of four to 2,502[3]. Colorado's state hospital penetration rate in 2013 was 273 per 100,000 persons. Rather than comparing Colorado to the rest of the United States, it is more informative to compare Colorado's inpatient psychiatric care system to states in the West. Unlike the Eastern and Midwestern regions of the country, the majority of Western states have only one to three state hospitals, which can create accessibility challenges. Greater distances between consumers' homes and treatment services require state governments to examine outpatient resources in rural areas and diversified mix of patient populations in centralized hospitals (see Figure 2).

Figure 2: Number of State Psychiatric Hospitals: 2013



Source: 2013 State Mental Health Agency Profiling System, NRI

Colorado currently ranks 12th out of 15 Western states on state hospital beds and residents per 100,000 persons (see Tables 1 and 2). In 2012, Colorado had 9.09 residents per 100,000 persons. (South Dakota had the highest penetration rate among Western states, with 26.82, and Arizona had the lowest at 3.6.)

At the end of FY 2012, the Colorado state hospital population was 59.4% forensic, which was above the average of 43% for the other Western states.

Table 1: Western State Psychiatric Hospitals, FY 2012										
State	Number of State Hospitals	State Pop.	Residents (Start of Year)	Residents per 100,000 pop	Forensic Percent of Residents	Civil Percent of Residents	State Hospital Admissions	Admissions per 100,000 Pop	Forensic Percent of Admissions	Civil Percent of Admissions
Alaska	1	722,718	70	9.69	0.1%	99.9%	1,630	225.54	5.4%	94.7%
Arizona	1	6,482,505	235	3.63	50.5%	49.5%	75	1.16	62.0%	38.0%
California	5	37,691,912	6,016	15.96	92.0%	8.0%	3,388	8.99	N/A	N/A
Colorado	**2**	**5,116,796**	**465**	**9.09**	**59.4%**	**40.6%**	**1,776**	**34.71**	**20.9%**	**79.1%**
Hawaii	1	1,374,810	178	12.95	80.0%	20.0%	277	20.15	93.0%	7.0%
Idaho	2	1,583,750	128	8.08	12.0%	88.0%	854	53.92	6.0%	94.0%
Montana	1	998,199	149	14.93	31.0%	69.0%	732	73.33	0.8%	99.2%
Nevada	3	2,723,322	252	9.25	57.0%	43.0%	3,956	145.26	71.0%	29.0%
New Mexico	1	2,082,224	171	8.21	N/A	N/A	963	46.25	N/A	N/A
North Dakota	1	683,932	141	20.62	35.0%	65.0%	624	91.24	7.0%	93%
Oregon	2	3,871,859	657	16.97	66.5%	33.5%	821	21.20	53.3%	46.7%
South Dakota	1	824,082	221	26.82	9.0%	91.0%	1,922	233.23	N/A	N/A
Utah	1	2,817,222	290	10.29	45.0%	55.0%	388	13.77	40.0%	60.0%
Washington	3	6,830,038	1,142	16.72	32.9%	67.1%	2,120	31.04	32.9%	67.1%
Wyoming	1	568,158	115	20.24	35.0%	65.0%	223	39.25	35.0%	65.0%
Western Avg	**2**	**4,958,102**	**682**	**13.56**	**43.2%**	**56.7%**	**1,317**	**69.27**	**35.6%**	**64.4%**

N/A : Not Available
Sources: NRI's 2012 State Mental Health Agency Profiling System and SAMHSA Uniform Reporting System

Table 2: Western State Psychiatric Hospitals, 2014				
State	Total Inpatient Beds	2014 State Population	Beds per 100,000 persons	Rank beds per 100,000 persons
Alaska	80	735,132	10.88	11
Arizona	260	6,626,624	3.92	15
California	6,036	38,332,521	15.75	7
Colorado	545	5,268,367	10.34	12
Hawaii	202	1,404,054	14.39	8
Idaho	190	1,612,136	11.79	9
Montana	174	1,015,165	17.14	4
Nevada	241	2,790,136	8.64	14
New Mexico	199	2,085,287	9.54	13
North Dakota	200	723,393	27.65	2
Oregon	659	3,930,065	16.77	5
South Dakota	270	844,877	31.96	1
Utah	329	2,900,872	11.34	10
Washington	1,161	6,971,406	16.65	6
Wyoming	103	582,658	17.68	3
Western States			**14.04**	

Source: WPSHA Benchmarking Data

Like many states, Colorado is experiencing a large increase in the percentage of patients in state hospitals with a forensic commitment status, and the percentage of state hospital expenditures dedicated to forensic patients (See Figures 3 and 4).

Figure 3: State Mental Health Agency-Controlled Forensic and Sex Offender Expenditures As a Percentage of State Psychiatrc Hospital Expenditures, All States FY83 to FY12

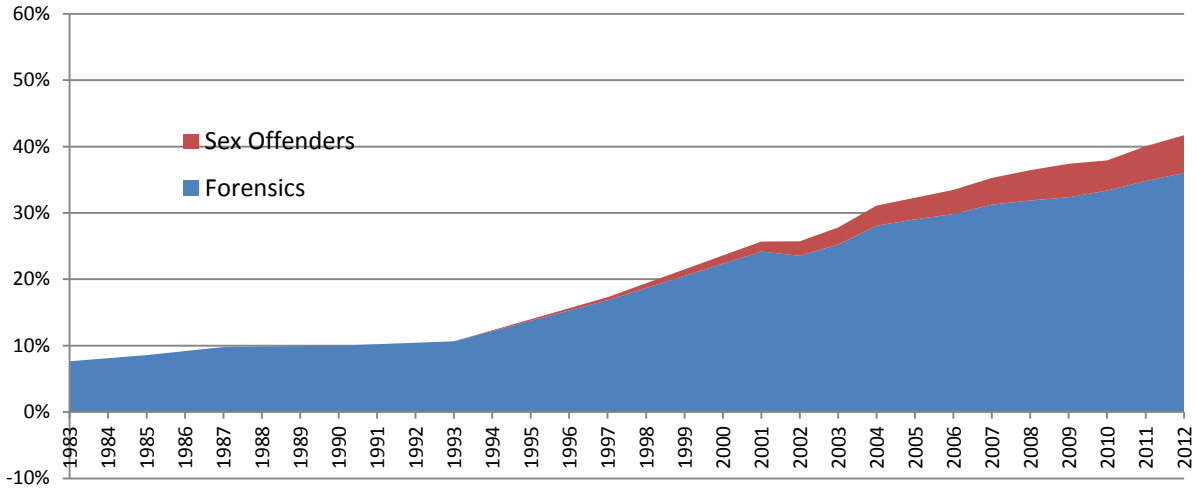
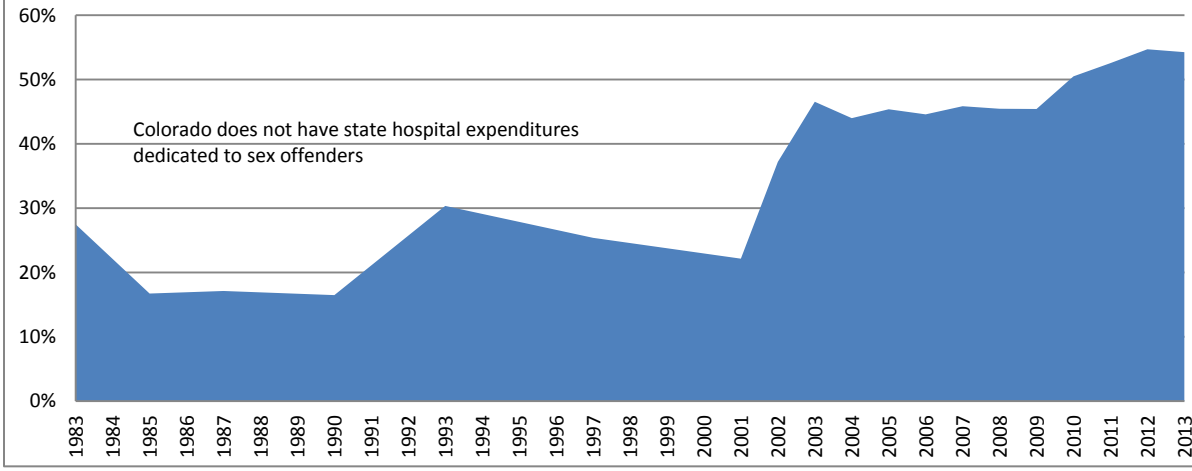


Figure 4: State Mental Health Agency-Controlled Expenditures for Forensic Services as a Percentage of State Psychiatric Hospital Expenditures in Colorado, FY83 to FY13



Source: NRI 2012 State MH Agency Revenues and Expenditures Study

Tables 1 and 2 above show comparative data on inpatient services. Another measure of the degree to which clients are being served by the public mental health system in Colorado is to look at comparable data on persons served in community-based services. Table 3 shows that

Colorado had a rate of 16.2 per 1,000 adult persons in 2013, ranking 10th among Western states. Colorado's rate is below the overall rate of Western states (18.2) and the U.S. rate (21.0).

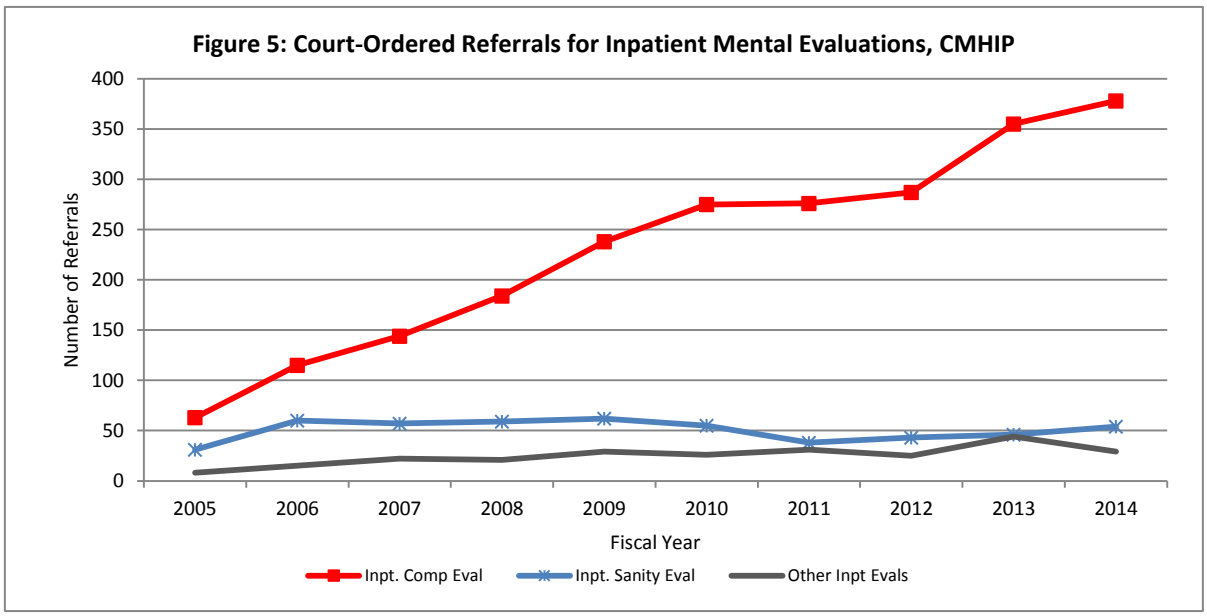
Table 3: Adults Served in Community-based Programs

State	Adults in community mental health programs	Adult Population	Rate of adult in community programs per 1,000 persons	Rank
Alaska	13,045	544,349	24.0	6
Arizona	97,329	4,932,361	19.7	8
California	433,873	28,801,211	15.1	11
Colorado	**63,935**	**3,956,224**	**16.2**	**10**
Idaho	9,277	1,169,075	7.9	15
Kansas	92,653	2,161,601	42.9	1
Montana	22,094	783,161	28.2	2
Nebraska	18,284	1,392,120	13.1	13
New Mexico	42,429	1,571,096	27.0	5
Nevada	25,413	2,095,348	12.1	14
Oklahoma	65,108	2,877,457	22.6	7
Oregon	83,902	3,038,729	27.6	4
Utah	28,913	1,967,315	14.7	12
Washington	100,203	5,312,045	18.9	9
Wyoming	12,229	440,922	27.7	3
U.S.	5,035,947	240,185,952	21.0	
Western States	1,108,687	61,043,014	18.2	

Source: 2013 Uniform Reporting system

Trends in inpatient competency evaluations and restorations in Colorado

Since FY 2005, the number of referrals for sanity and mental evaluations has remained somewhat consistent in Colorado; however, referrals for inpatient competency evaluations at CMHIP have increased 500 percent, from 63 in FY 2005 to 378 in FY 2014, with an average annual increase of 24 percent. Competency restorations (commonly referred to as Incompetent to Proceed to trial restorations, or ITPs) have increased 107 percent, from 135 in FY 2005 to 279 in FY 2014. Seventy-four percent of competency evaluations are being completed on an outpatient basis. Figure 5 shows the trend in CMHIP court-ordered mental evaluations from FY 2005 to FY 2014.



The vast increase in the number of referrals depicts the number of cases processed through CMHIP throughout the year. Not all referrals result in an admission, and some individuals have more than one referral. Therefore, we chose to focus data analysis on the number of admissions, rather than referrals, to measure the impact on beds. The number of admissions for competency evaluations has had a threefold increase in 10 years (from 42 admissions in FY 2005 to 175 in FY 2014), but in the past three years the percentage change has been steady at +/- 7 percent. ITP restoration admissions are up by 145 percent (from 123 in FY 2005 to 301 in FY 2014; see Figure 6 and Table 4). Meanwhile, the number of civil admissions has decreased 64 percent in the same time period (voluntary and involuntary civil admissions were 2,463 in FY 2005 and 885 in FY 2014). The percentage of admissions with a civil commitment went from 80 percent in 2005 to 20 percent in FY 2014, with much of this decrease in civil commitments being due to the closing of 46 percent of the beds at CMHIFL during this time period. Since bed closings, the average annual change in civil admissions for both institutes is -14.6 percent.

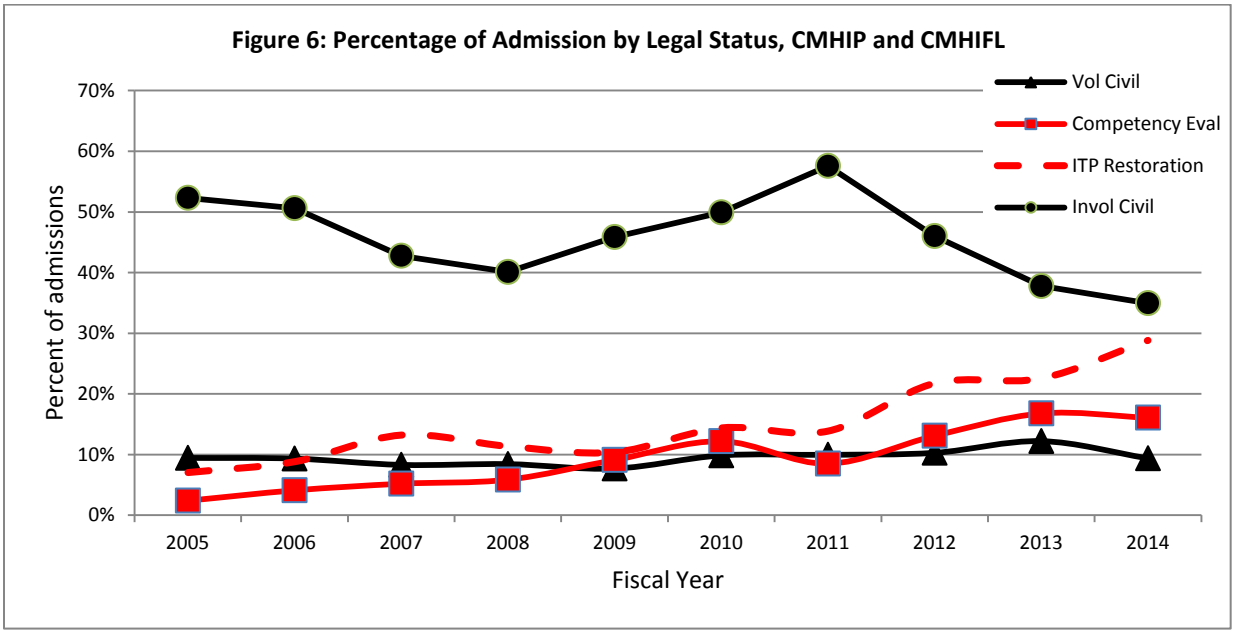


Table 4: Number of Admission by Legal Status				
		2005	**2014**	**% change**
Competency Eval	Pueblo	42	168	300%
	Fort Logan	0	7	
	Total	42	175	317%
ITP Restoration	Pueblo	123	301	145%
	Fort Logan	0	0	
	Total	123	301	145%
DOC Transfers	Pueblo	430	24	-94%
	Fort Logan	0	0	0
	Total	430	24	-94%
Invol Civil	Pueblo	913	365	-60%
	Fort Logan	1,362	392	-71%
	Total	2,275	757	-67%
Vol Civil	Pueblo	165	98	-41%
	Fort Logan	186	33	-82%
	Total	351	131	-63%
Other admissions[1]	Pueblo	72	88	-18%
	Fort Logan	0	4	100%
	Total	72	92	-27
Total admissions	Pueblo	1,745	1,044	-40%
	Fort Logan	1,548	436	-72%
	Total	3,293	1,480	-55%
Percentage forensic admissions	Pueblo	38%	56%	
	Fort Logan	0%	3%	
	Total	20%	40%	

[1] All other types of admissions are forensic admissions (mental condition evals, sanity evals, other evals, NGRI)

On any given day, the two Colorado mental health institutes have gone from 20 percent forensic patients (FY 2005) to 60 percent (FY2012)[4]. Across the U.S., state hospitals serve 36 percent forensic patients, on average. Colorado ranks fourth out of 15 Western states in 2012 for the percentage of residents with a forensic status.

Focus group participants commented that the number of individuals that court-services personnel at CMHIP handle in a given month is "daunting." Although they have developed a system to process the large caseload, staff members feel that they struggle to keep up with the increased demand for inpatient competency evaluations. While CMHIFL has not historically processed competency evaluations (only four were completed between FY 2005 and FY 2011), 26 individuals have been admitted for competency evaluations since 2012 to meet the demand.

A recent survey by the National Association of State Mental Health Program Directors (NASMHPD)[5] asked state mental health authorities about their services for competency evaluations and restorations. Ten Western states responded to the survey, as presented in Table 5. While there is a large range of responses to each item, reviewing comparable data is still informative. Colorado is among the top Western states for ITP patients and ITP lengths of stay.

NASMHPD Survey Responses -

Table 5: Competency Evaluations and Restoration Services: Western States, 2014

State	Estimated # competency evaluations done annually	Estimated % evaluations completed on an outpatient basis by inpatient staff	Estimated # defendants annually referred for ITP restoration	% Referred for inpatient ITP restoration	Average daily census of inpatients receiving ITP restoration services	Average LOS for ITP restoration inpatients
Alaska	240	98%	60	60%	10	60 days
Arizona			21	21%	3	257 days
Colorado[a]	1,466	74%	389	72%	208	279 days
Hawaii	1,300	0%	200	75%	75	176 days
Idaho	60	0%	60	100%	7	75 days
Montana	20-30	5%				90 days
Nevada	475	85%	245	95%	75	80 days
Oregon	777	23%		"a high		
South	28	5%	38	70%		180 days
Utah	550	0%	100	83%	85	180-240 days

Source: NASMHPD Survey responses: Forensic Mental Health Services in the United States, 43 States responded

[a] Colorado data was updated with current Office of Behavioral Health/CMHI data

Factors influencing the data trends

In August 2011, the Legal Center for People with Disabilities and Older People filed a lawsuit concerning delays in the system for providing court-ordered competency evaluations and restorative treatment to pretrial detainees[6]. Effective July 1, 2012, part of the settlement agreement included a stipulation that the Department of Human Services is required to admit a pretrial detainee to CMHIP within 28 days of the court determining the need for an evaluation or restorative treatment and receipt of all collateral documentation by CMHIP. Competency evaluations performed in county jails must be completed within 30 days. The Department is required to maintain a monthly average wait-time for admission of no more than 24 days for all patients admitted to CMHIP for evaluation or treatment. The court settlement has limited the lengths of inpatient stay for defendants admitted for competency evaluations. Following the court settlement, the length of stay for defendants admitted for competency evaluations now averages 35 days at CMHIP and 38 days at CMHIFL, as compared to 102 days in FY 2012.

An issue was identified during the focus groups concerning the amount of time an individual remains in jail prior to receiving an evaluation. Despite the terms of the settlement agreement, representatives from the Boulder County Sheriff's office indicated they believe that the wait clock starts ticking for defendants when the judge writes an official evaluation order. CMHIP staff indicated that they cannot begin processing an evaluation until all paperwork has been completed and received. Paperwork can be delayed due to workload demands at district attorneys' and public defenders' offices due to uncertainty about how much privileged information should be shared with evaluators. The difference between these two time periods can range from several days to several months (according to both sides), resulting in individuals remaining in jail for increased lengths of time until all parties are ready to begin the evaluation. Awaiting mental health treatment, the behavior of these individuals remains volatile, often forcing county sheriffs to place them in isolation or restraints for their own protection. Arapahoe County Detention Center data show that inmates with a mental health disorder stay in jail three times longer and cost 44 percent more to incarcerate[7].

A side effect of the settlement agreement is a limited number of beds available for civil commitments at CMHIP. As one focus group member stated, "Civil patients at CMHIP get triaged because the settlement agreement mandates that competency evaluations are processed within restricted timeframes." From March 2013 to September 2014 there were 1,403 civil admission requests at CMHIFL and 698 at CMHIP; for every civil admission at an institute, there were three admission requests at CMHIFL and 1.5 at CMHIP. Figures 7 and 8 show that 50 percent of these individuals were eventually admitted at CMHIFL, and 30 percent at CMHIP.

Figure 7: Civil Admission Requests at CMHIFL: 3/2013 - 9/2014
Total = 1,403

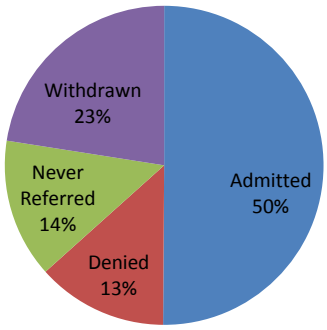
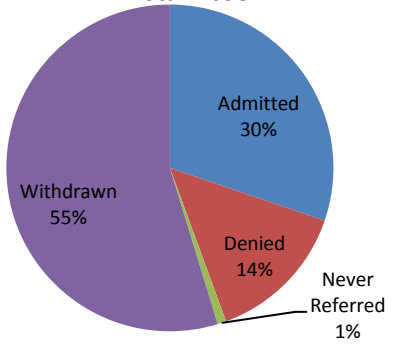


Figure 8: Civil Admission Requests at CMHIP: 3/2013 - 9/2014
Total = 698



The average amount of time spent on a waiting list prior to hospital admission for civil patients in FY 2014 was 2.7 days at CMHIFL and 6.3 days at CMHIP (See Table 6). Members of the focus groups reported that not only has the number of persons on the civil waiting list increased, but the amount of time spent on the list has also increased. Waiting list data for prior years were not available at the time of this report. The range in number of days on the waiting list for civil patients who were eventually admitted varied greatly, from 0 to 10.1 days at CMHIFL and 0 to 150 days at CMHIP. The settlement agreement stipulates maximum allowable wait times *for persons in jails* to receive competency evaluations – it does not include persons out on bond, who are now on separate lists. Civilly committed persons compete with these other waitlists for inpatient beds at CMHIP.

Table 6: Average Number of Days on Civil Waitlist Prior to Admission
March 2013 – September 2014

	Acute Treatment Units	ER	Inpt. Psych or ICU	Jail	Supervised Living	Other	Total
CMHIFL							
# people	40	308	257	25	54	19	703
Max days on waitlist	150	14	71	25	8	40	
Avg Days on waitlist	2.0	.54	5.9	3.8	.2	1.1	2.7
CMHIP							
# people	37	34	91	43	1	5	211
Max days on waitlist	10	43	65	19	7	10	
Avg Days on waitlist	6.9	2.1	8.1	4.7	8.0	10.8	6.3

The percentage of civil referrals being denied admission has increased substantially for both institutes, from 18 percent in FY 2013 to 42% in FY 2014 at CMHIFL, and from 21 percent to 38 percent at CMHIP (See Table 7).

Table 7: Number of Civil Referrals and Admission Denials FY 2013 and FY 2014

	FY 2013	FY 2014
CMHIFL		
# referrals	495	730
# denials	87	305
% denied	18%	42%
CMHIP		
# referrals	675	744
# denials	140	281
% denied	21%	38%

The number of referrals is the number of admissions plus denials.

The top reason for denial at both institutes is that the patient stabilized during the wait time and was able to be served with less-intensive treatment. At CMHIFL, a large proportion of denials is due to the patient having a medical condition that cannot be treated at the facility. At CMHIP, there has been a fourfold increase (from 14 to 76) since FY 2013 in the number of individuals denied admission due to a civil bed not being available. The top reasons for admission denials are presented in Figures 9 and 10. The inability to admit a patient requiring inpatient care creates difficulty for the referring CMHCs as well as acute care hospitals. It also disrupts or delays the patient's recovery process by not providing the necessary services at the time of need.

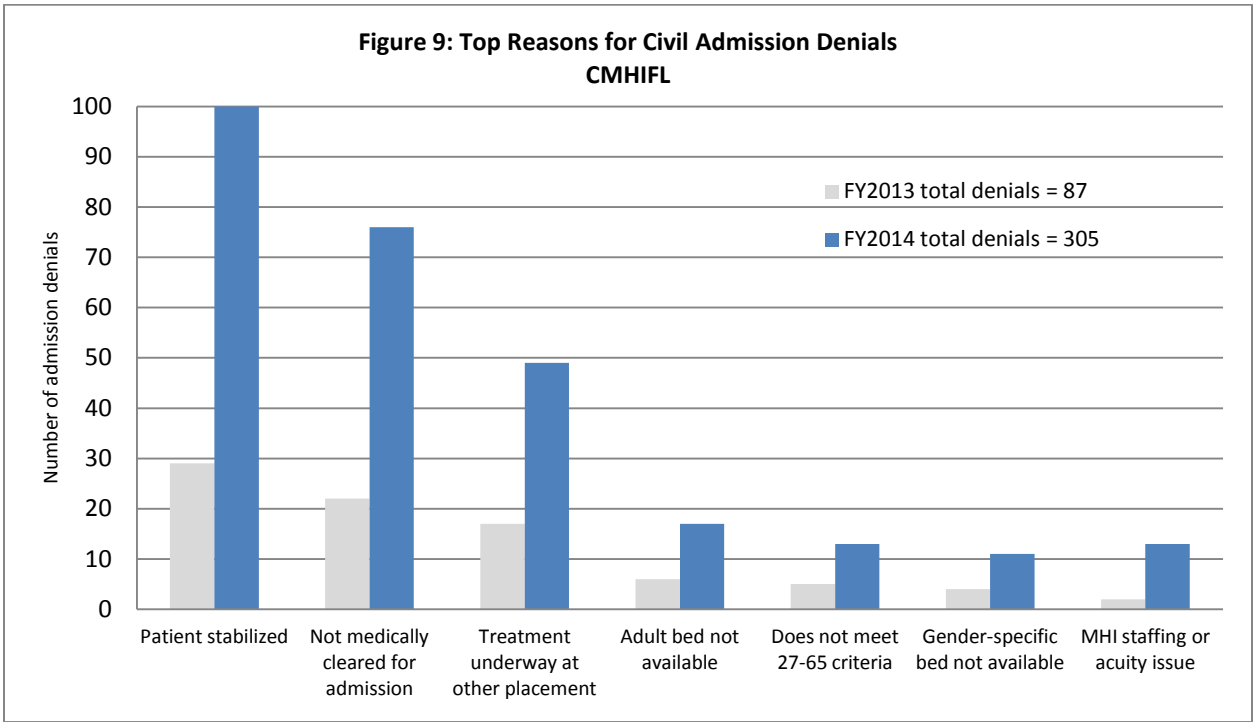


Figure 9: Top Reasons for Civil Admission Denials
CMHIFL
Number of admission denials
100
90
80
70
60
50
40
30
20
10
0
FY2013 total denials = 87
FY2014 total denials = 305
Patient stabilized
Not medically cleared for admission
Treatment underway at other placement
Adult bed not available
Does not meet 27-65 criteria
Gender-specific bed not available
MHI staffing or acuity issue

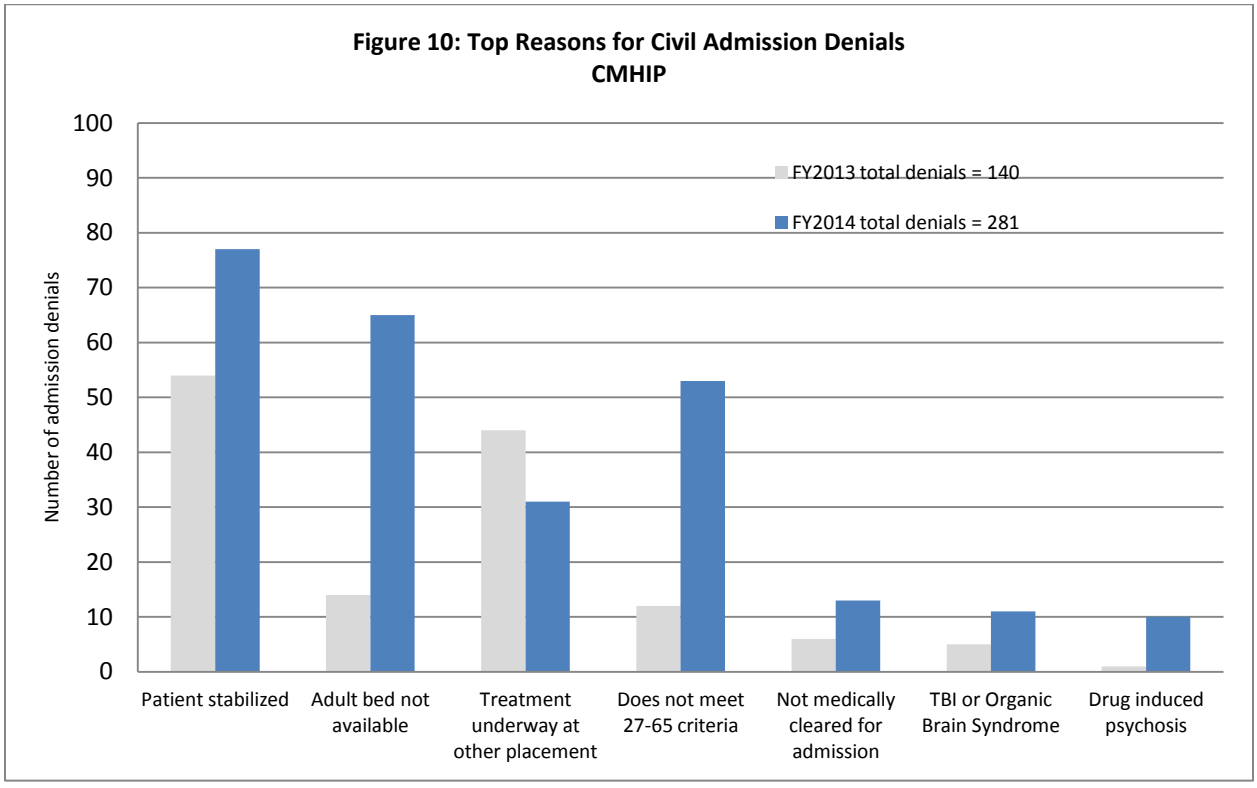


Figure 10: Top Reasons for Civil Admission Denials
CMHIP
Number of admission denials
100
90
80
70
60
50
40
30
20
10
0
FY2013 total denials = 140
FY2014 total denials = 281
Patient stabilized
Adult bed not available
Treatment underway at other placement
Does not meet 27-65 criteria
Not medically cleared for admission
TBI or Organic Brain Syndrome
Drug induced psychosis

The Office of Behavioral Health anticipated that the 2012 settlement agreement would have a negative impact on the availability of civil beds. In November 2012, the Department of Human Services (DHS) submitted a decision Item requesting funding for a 20-bed jail-based restoration program for defendants who have been determined incompetent to stand trial[8]. The innovative RISE program (Restoring Individuals Safely and Effectively) was opened in November 2013 at the Arapahoe County Detention Center. The program, operated by Correct Care LLC under contract to OBH, represents an important first step toward developing outpatient restoration services in Colorado. The goals of RISE are to restore individuals to competency in 30 to 45 days, and provide continuity of care and case management for medication adherence once the individual returns to his/her originating jail. RISE accepts individuals who are voluntarily taking their medications and who have no imminent medical conditions. RISE was intended to reduce the number of ITP patients occupying beds at the two institutes, thus opening up beds that are allocated to the state's community mental health centers for civil commitments.

The RISE program has been successful in its first year of operation. The average daily census is consistently around 16. A criterion for admission to RISE is treatment compliance. Patients would not be eligible for the RISE program and would stay at CMHIP if they posed an imminent risk to themselves or others, a risk of self-neglect, an increased likelihood of emergency psychiatric or medical services, or a potential need for involuntary medications. Some reasons that patients transfer out of the program back to CMHIP include medical, behavioral, or psychiatric decompensation. The November 2013-January 2015 RISE Outcome Data Report showed 106 total admissions with 71 defendants being restored by the program. Nineteen individuals were transferred to CMHIP for medical, behavioral, and psychiatric destabilization reasons. The average length of stay is 43.42 days, which translates into a significant cost savings on a reduced length of stay for competency restoration.

RISE is expected to have an impact on bed availability at CMHIP; however, the actual impact is yet to be determined. One of the original intents was to free up beds for civil patients by offering an alternative to inpatient ITP restorations. The program has only been open one year and it is too early to determine if the beds are being used by civil patients, or to accommodate the continued increase in referrals for competency evaluations. The data are not yet available to fully assess the impact on civil-bed availability.

Summary

- CMHIP has experienced a large increase in the number of forensic cases coming through the system. Specifically, the number of referrals for inpatient competency evaluations has increased 500 percent and referrals for inpatient competency restorations have increased 107 percent in the past 10 years.
- The rate of change in admissions for inpatient competency evaluations seems to be decreasing and has shown a change of +/- 7 percent each year for the past three years.
- Admissions for inpatient competency restorations are increasing every year (24 percent last year).
- Civil admissions at both institutes are decreasing by an average rate annually of 14.6 percent.
- The number of denials for civil admission is increasing at a rapid pace.
- For every civil admission at CMHIFL, there are three additional people on the waiting list, and at CMHIP there are 1.5 individuals waiting per bed.
- The new outpatient restoration RISE program is showing early signs of success, but solid data on its impact on civil-bed availability are not yet available.

Projected bed need for the institutes

Forensic admissions are increasing at a pace that is unsustainable; specifically, the rise in competency evaluations and restorations at CMHIP. Alternatives to inpatient competency evaluations and restorations, or additional bed capacity, or a combination of both, must be developed to avoid eliminating the capacity to serve civil patients at the state hospitals. Bed projections are based on community-based services as they currently exist. Expanding community capacity would have an effect on the number of inpatient beds needed.

Accurate quantitative data on the demand for inpatient beds is unavailable. Responses to the stakeholder survey indicated that CMHCs stopped making referrals to the state hospitals because beds simply aren't available. Hence, we compromised and based our projections on existing supply and comparable data from other states.

Bed projections are based on community-based services as they currently exist. Establishing or expanding additional community capacity will have an effect on the number of inpatient beds needed.

A review of the data determined that each legal status category does not equally contribute to bed utilization patterns. As previously stated, the percentage of admissions for competency evaluations and restorations is growing each year. Even though beds are not divided up by type of forensic legal status, we found it most useful to project bed need based on utilization patterns of each civil and forensic category.

Four scenarios are presented as options for bed availability at each of the two institutes.

- **Scenario One** takes current bed capacity and projects future bed need based on state population increases and the rise in forensic admissions.
- **Scenario Two** reallocates 24 civil beds from CMHIP to CMHIFL, as these beds are allocated to CMHCs that are geographically closer to CMHIFL.
- **Scenario Three** increases the overall bed capacity for adolescent and geriatric patients based on the average number of beds per 100,000 persons in seven Western states, and adds beds for these populations to CMHIFL.
- **Scenario Four** allocates forensic beds to CMHIFL, reducing the number of forensic beds required at CMHIP.

Scenario One

With the exception of Addictions Dual Diagnosis bed projections (served by the 20-bed CIRCLE program at CMHIP), civil-bed projections (including adolescent, adult, and geriatric) are based on total state population and not age-specific population figures. Data from other Western states is based on total state population, so we used the same methodology to maintain comparability.

Adolescent beds at CMHIP

- CMHIP has 20 beds to serve adolescent patients, or 0.37 per 100,000 persons. Therefore, we projected the future number of beds needed to maintain this rate at CMHIP, although the rate has been cited as insufficient, as discussed later in this report.

Adult civil beds

Since 2010, CMHIFL has had 94 inpatient beds dedicated to serve civilly committed adults with serious mental disorders. CMHIP has 64 beds allocated to the CMHCs for adult civil commitments; however, forensic patients are increasingly occupying these beds to keep up with requirements of the 2012 settlement agreement and the increase in court-ordered admissions. Absent historical waiting list data, we made the assumption that the current number of allocated civil beds represents a minimum number of civil beds required to serve as a safety net for persons with mental illnesses who require the most-intensive treatments offered in an inpatient setting. The 158 civil beds in Colorado (not including adolescent, geriatric, and addictions dual disorder beds) is a rate of 2.94 beds per 100,000[9].

- For CMHIP, 64 civil beds equate to 1.19 beds per 100,000 persons. The rate was held constant to project the future civil-bed need.
- For CMHIFL, 94 beds equal a rate of 1.75 beds per 100,000 adult persons. The rate was held constant for future years.

Geriatric beds at CMHIP

For more than a decade, CMHIP has maintained two geriatric treatment units with a total of 40 beds.

- Forty beds at CMHIP represent a bed rate of 0.75 per 100,000 persons. The rate was held constant to project future bed need.

Addictions Dual Diagnosis beds at CMHIP

The number of Addictions Dual Diagnosis beds at CMHIP has remained at 20 for over 10 years, or a rate of 0.59 beds per 100,000 adult persons (age 18-64).

- A bed rate of 0.59 per 100,000 adult persons was held constant for future years.

Forensic beds at CMHIP

Projecting future beds needed to meet the rising demand for forensic admissions was based on trends in admissions by patients' legal status. Since each legal status category did not contribute equally to the trend, each was analyzed separately.

Competency evaluations – The rate of admissions for competency evaluations is increasing every year and the projection model considered this factor. Data show that FY 2009 marked the beginning of the upward trajectory in forensic admissions. We used the annual percent change from FY 2009 to FY 2014 to project the number of future admissions for competency evaluations. The 7 percent average percent increase in admissions over the past five years already incorporates population changes; therefore, we did not specifically add population increases into the model. The average length of stay (LOS) has been consistently around 35 days since the settlement agreement, which was factored into the bed-need projections based on estimated admissions.

- The 7 percent average annual percentage change in admission for competency evaluations was held constant for future years to determine the expected number of admissions. The number of admissions was multiplied by the average LOS, and the product was divided by 365 to determine the bed need.

Competency (ITP) restorations – In terms of admissions, this group has been increasing by an annual average rate of 16 percent since the settlement agreement. Discharged ITP patients had an average LOS of 261 days in FY 2014 with 87 percent having an LOS of less than one year. Current patients average 394 days, with about 70 percent staying one year or less. Using this LOS data, we split the ITP group into two separate analyses: admissions with an expected LOS of less than one year, and over one year. Historical data suggest that approximately 78 percent of admissions would have an LOS of 117 days. The additional 22 percent of admissions are estimated to have an LOS of 878 days.

ITP patients with average LOS <365 days

The RISE program was established to divert ITP admissions from CMHIP and to restore competency on an outpatient basis. The program has been in existence only one year and the exact impact on admissions cannot be determined from historical data. The intended impact was to divert 116 ITP admissions away from CMHIP, so the model assumes that the RISE program will continue at its current capacity over the next 10 years. The number of admissions projected for the ITP group with an expected LOS of less than one year was adjusted based on the expected impact of RISE. However, we caution the reader that the methodology may yield an underestimate of the demand for inpatient ITP restoration, because the demand of both inpatient and outpatient services has been increasing each year.

- The total number of adult ITP admissions to CMHIP in FY 2014 was 282. Approximately 78% of these admissions (n=220) are estimated to stay less than 365 days. An average annual increase of 16 percent was held constant for future years. The RISE program is expected to divert 116 admissions per year, so this amount was subtracted from each year's estimated number of admissions to CMHIP. The number of expected admissions was multiplied by the average LOS, and the product was divided by 365 to determine the bed need.

ITP patients with average LOS >365 days

Determining the bed need for long-stay ITP patients required a different estimation methodology. Several factors affect the number of required ITP beds; for example, the resources available in the community to serve this population. Admission decisions are determined by the justice system based not solely on clinical need but also on public safety concerns. Most of these factors cannot be plugged into a mathematical model to project beds, so the numbers represent our best estimates.

We were unable to estimate the rate of increased admissions separately for the shorter- versus longer-stay ITP groups; however, applying a 16% rate of increase for long-stay ITP patients would yield over-inflated estimates of bed need. As an alternate methodology, we requested additional data and reviewed the actual number of patients who were at CMHIP for restoration, instead of the overall number of ITP admissions. One caveat to keep in mind is that patients' legal status can change throughout their admission. For example, they may be admitted for a competency evaluation, then stay at the hospital for competency restoration, and eventually change to a civil patient if the court eventually drops the ITP commitment. The data included all patients who were at the hospital for restoration, regardless of their final legal status because that yields a truer picture of the driving force behind the ITP bed need.

Using the additional data, the average percentage change in number of ITP patients having an LOS greater than 365 days at the end of each fiscal year was reviewed. Since there has been a large increase in ITP patients since the 2011 CMHIP restructuring to serve patients based on clinical need rather than legal status[10], we chose to compute averages from 2011 to 2014 to reflect a more accurate depiction of bed utilization by ITP patients.

- The average percentage change in number of ITP patients having an LOS greater than 365 days is 10.7 percent. Average LOS for this group is not factored into the model below because it is based on trends in the actual number of ITP patients occupying a bed at the end of each fiscal year. With an average LOS over 365 days, one bed will accommodate only one patient for that entire year.

Mental condition evaluations, sanity evaluations and other evaluations - Data on the number of admissions of these legal statuses have remained steady over the past five years (-0.02 percent average annual change FY 2009 to FY 2014) averaging 50 admissions per year. The average LOS for this group is 45 days so these patients occupy approximately six beds. Patients with these

legal statuses represent five percent of admissions. Bed projections for this patient group are based on state population increases since trends in admission have remained steady.

- Six beds at CMHIP represent a bed rate of 0.11 per 100,000 persons. The rate was held constant to project future bed need.

Not Guilty by Reason of Insanity (NGRI) – There have been, on average, 28 NGRI admissions per year to CMHIP for the past five years without much variation. The LOS for patients with an NGRI legal status ranges greatly, from eight days to 15,713 days. However, even the lowest LOS quartile averages 348 days, meaning that it is safe to assume that most NGRI admissions will occupy a bed for a year or longer. In FY 2014 there were 109 NGRI patients who had been at CMHIP for over one year; an additional 10 beds accommodated the other 19 NGRI patients based on their LOS (totaling 119 beds), and this model holds true based on FY 2013 data as well.

- A total of 119 beds equates to 3.5 beds per 100,000 adult persons. The projections model held this bed rate constant in future years.

Behavior Management Unit (formerly Department of Corrections transfers) – The number of patients admitted with this legal status has been declining by an average of 28% since FY 2010. Our model assumes that the trend in admissions will continue to decline at a slower pace (the rate of change between FY 2013 and 14 was -14%). Average LOS varies greatly (from 12 to 6,657 days in FY 2013). Patterns in LOS over the previous few years were reviewed and it was determined that five beds accommodated this patient group since 2010.

- There have been fewer admissions with this legal status, but average LOS has been increasing (i.e., those who are admitted are staying longer) therefore we project that five beds in 2020 and four beds in 2025 are needed.

Scenario One: Projects future institutes' bed capacity based on current civil bed rates per 100,000 persons, and trends in forensic admissions and ITP patients at end of year.

Scenario One Table 8: Bed Projections for Colorado Mental Health Institute Pueblo (CMHIP)			
	FY2013-2014 Actual	Projected 2020	Projected 2025
Adolescent Beds			
Population[2]	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons	0.37	0.37	0.37
Beds	20	22	24
Adult Civil Beds			
Population[2]	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons	1.19	1.19	1.19
Beds	64[3]	71	77
Geriatric Beds			
Population[2]	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons	0.75	0.75	0.75
Beds	40	45	48
Addictions Dual Diagnosis Beds			
Population ages 18-64	3,404,433	3,670,495	3,895,734
Bed rate per 100,000 persons	0.59	0.59	0.59
Beds	20	22	23
Adult Competency Evaluations			
Average annual % increase in admissions	7%	7%	7%
Average LOS	35	35	35
# Admissions	150	225	316
Beds	*a*	22	30
Adult ITP Restorations (staying < 365 days)[4]			
Average annual % increase in admissions	16%	16%	16%
Average LOS	117	117	117
# Admissions	220	506	1,190
Beds	*a*	162	381
Adult ITP Restorations (staying >365 days)[5]			
Average annual % increase in ITP patients with LOS >1 year	10.7%	10.7%	10.7%
# patients at end of year	62	114	190
Beds	62	114	190

Table 8 Continued: Bed Projections for Colorado Mental Health Institute Pueblo (CMHIP)			
	FY2013-2014 Actual	Projected 2020	Projected 2025
Adult Other Types of Evals			
Population	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons	.11	.11	.11
Beds	*a*	7	7
Adult NGRI			
Population ages 18-64	3,404,433	3,670,495	3,895,734
Bed rate per 100,000 persons	3.50	3.50	3.50
Beds	*a*	128	136
Behavior Mgmt Unit (formerly DOC transfers)[6]			
Beds	8[7]	5	4
TOTAL BEDS *(# beds added to current capacity)*	**451**[8]	**598** *(+147)*	**920** *(+469)*
Adolescent	20	22	24
Adult Civil	64	71	77
Geriatric	40	45	48
Addictions Dual Diagnosis	20	22	23
Forensic	307	438	748

[a] CMHIP beds are not allocated by legal status; however, basing bed projections on utilization patterns of each civil and forensic category yielded the most accurate estimations.
[2] Data from other Western states is based on total state population not age-specific population figures, so we used the same methodology to maintain comparability.
[3]Many civil beds are occupied by forensic patients. CMHIP has 144 civil beds, but census in early Dec 2014 showed 49 civil patients; 2/3 of civil beds were occupied by forensic patients at that time.
[4]78% of competency restoration admissions are estimated to stay less than 365 days.
[5]Based on actual # ITP patients with average LOS >365 in FY 2014.
[6]Methodology for projecting Behavior Management Unit beds are described on page 21.
[7]Data are based on census of the Behavior Management Unit in FY 2014. Unit capacity was recently reduced to 6 beds.
[8]Represents FY 2014 capacity.

Scenario One Table 9: Bed Projections for Colorado Mental Health Institute Fort Logan (CMHIFL)			
	FY2013-2014 Actual	Projected 2020	Projected 2025
Adult Civil Beds – Current Allocation			
Population	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 pop	1.75	1.75	1.75
Beds *(# beds added to current capacity)*	94	104 *(+10)*	113 *(+19)*

Scenario Two

Data presented earlier in this report show that civil beds at CMHIP are increasingly being occupied by forensic patients, thereby reducing the overall number of available civil beds. Some of the CMHIP civil beds are allocated to CMHCs that are geographically closer to CMHIFL. Reallocating these beds to Fort Logan would reduce patients' travel time and allow them to receive treatment closer to their homes. In the provider survey done for this report, distance was cited as a barrier to family and home clinician involvement with patients while hospitalized. The following CMHCs currently have civil beds allocated to CMHIP. Scenario Two reallocates these beds to CMHIFL and estimates the civil bed projections for 2020 and 2025 (see Map 3 in the Attachment). The total state rate of civil beds stays the same at 2.94 beds per 100,000 persons. Map 4 in the Attachemnt shows the number of civil admissions to the Institutes, by county, FY 2013-14.

Community Mental Health Centers (CMHCs) with Civil Bed Allocations at CMHIP in closer proximity to CMHIFL		
CMHC	**Serving Counties**	**Number Beds**
Arapahoe/Douglas Mental Health Network	Arapahoe, Douglas	10
Centennial Mental Health Center	Cheyenne, Elbert, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Yuma	4
Touchstone Health Partners	Larimer	8
North Range Mental Health Center	Weld	2
Total	**14 counties**	**24 Beds**

Scenario Two: Reallocation of 24 civil beds from CMHIP to CMHIFL. All other projections are the same as Scenario One.

Scenario Two Table 10: Bed Projections for Colorado Mental Health Institute Pueblo (CMHIP) after Civil Bed Reallocations			
	2014 Reallocation	Projected 2020	Projected 2025
Adolescent Beds			
Population[2]	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons	0.37	0.37	0.37
Beds	20	22	24
Adult Civil Beds – Allocation Reduced to 40 beds			
Population	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 pop	.74	.74	.74
Beds	40	44	48
Geriatric Beds			
Population[2]	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons	0.75	0.75	0.75
Beds	40	45	48
Addictions Dual Diagnosis Beds			
Population ages 18-64	3,404,433	3,670,495	3,895,734
Bed rate per 100,000 persons	0.59	0.59	0.59
Beds	20	22	23
Adult Competency Evaluations			
Average annual % increase in admissions	7%	7%	7%
Average LOS	35	35	35
# Admissions	150	225	316
Beds	*a*	22	30
Adult ITP Restorations (staying < 365 days)			
Average annual % increase in admissions	16%	16%	16%
Average LOS	117	117	117
# Admissions	220	506	1,190
Beds	*a*	162	381
Adult ITP Restorations (staying >365 days)			
Average annual % increase in ITP patients with LOS >1 year	10.7%	10.7%	10.7%
# patients at end of year	62	114	190
Beds	62	114	190

Table 10 Continued: Bed Projections for Colorado Mental Health Institute Pueblo (CMHIP) after Civil Bed Reallocations				
		2014 Reallocation	Projected 2020	Projected 2025
Adult Other Types of Evals				
Population		5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons		.11	.11	.11
Beds		*a*	7	7
Adult NGRI				
Population ages 18-64		3,404,433	3,670,495	3,895,734
Bed rate per 100,000 persons		3.50	3.50	3.50
Beds		*a*	128	136
Behavior Mgmt Unit (formerly DOC transfers)				
Beds		8	5	4
CMHIP TOTAL BEDS				
	Current Number of Beds	Proposed Reallocation	Projected 2020	Projected 2025
(# beds added to current capacity)	**451**	**427** *(-24)*	**571** *(+120)*	**891** *(+440)*
Adolescent	20	20	22	24
Adult Civil	64	40	44	48
Geriatric	40	40	45	48
Addictions Dual Diagnosis	20	20	22	23
Forensic	307	307	438	748

[a] CMHIP beds are not allocated by legal status; however, basing bed projections on utilization patterns of each civil and forensic category yielded the most accurate estimations.
[2] Data from other Western states is based on total state population not age-specific population figures, so we used the same methodology to maintain comparability.

Scenario Two Table 11: Bed Projections for Colorado Mental Health Institute Fort Logan (CMHIFL) Based on Civil Bed Reallocations				
	Current Number of Beds	Proposed Reallocation	Projected 2020	Projected 2025
Adult Civil Beds – New Allocation				
Population		5,363,689	5,946,128	6,449,955
Bed rate per 100,000 pop		2.20	2.20	2.20
Beds	94	118	131	142
(# beds added to current capacity)		*(+24)*	*(+37)*	*(+48)*

Scenario Three

Responses to the CMHC and stakeholder surveys indicated that additional adolescent beds and locked geriatric units are needed in the state. In an effort to determine unmet need, waiting list and admission denials were reviewed as well as comparable bed rates of other Western states.

Geriatric beds

In FY 2014, there were seven admission denials to either institute due to a geriatric bed not being available. Sixty-five geriatric patients were wait-listed, with 28% being denied admission (for multiple reasons), 25% being admitted, and 47% withdrawing their admission request.

Data from the Western Psychiatric State Hospital Association (WPSHA) show that seven states have geriatric beds. In 2014 the rate for geriatric beds ranged from 0.10 in California to 6.86 in South Dakota. South Dakota's rate is significantly higher than other Western states, so it was removed from the average calculation. The average rate for geriatric beds is 1.61 per 100,000 persons[11]. With a rate of 0.75, Colorado ranks sixth out of the seven states. Increasing Colorado's bed rate for geriatric patients from 0.75 to 1.61 per 100,000 persons would increase the current total number of beds from 40 to 86 (46 additional geriatric beds). These 46 new geriatric beds were added to CMHIFL in Scenario Three as a basis for future projections.

Adolescent beds

In FY 2014 there were six admission denials at CMHIP due to an adolescent bed not being available. Seventy-one adolescents were wait-listed, with 24 percent eventually being admitted, 21 percent being denied admission (for multiple reasons) and 55 percent withdrawing their admission request. Adolescent beds are only at CMHIP, so counties far from Pueblo may not be admitting adolescents there.

WPSHA data show that seven Western states have adolescent beds, with rates per 100,000 persons ranging from 0.37 in Colorado to 6.04 in South Dakota. Excluding South Dakota, the average rate is 0.91. Increasing Colorado's bed rate for adolescent patients from 0.37 to 0.91

would increase the current total number of beds from 20 to 49 (29 new adolescent beds). These 29 new adolescent beds were added to CMHIFL in Scenario Three as a basis for future projections.

In Scenario Three:

- Civil reallocations are the same as Scenario Two.
- Geriatric bed rate was held constant at 1.61 per 100,000 persons for both institutes to align with the average for Western states. The total state rate was broken out between the two institutes. New geriatric beds were added to CMHIFL.
- Adolescent bed rate was held constant at the Western state average of 0.91 per 100,000 persons for both Institutes. The total state rate was broken out between the two Institutes. New adolescent beds were added to CMHIFL.

Scenario Three: Increases the overall bed capacity for adolescent and geriatric patients and adds beds for these populations to CMHIFL. All other projections are the same as Scenario Two.

Scenario Three
Table 12: Bed Projections for Colorado Mental Health Institute Pueblo (CMHIP) after Civil Bed Reallocations
(These Projections are the same as Table 10)

	Proposed Reallocation	Projected 2020	Projected 2025
Adolescent Beds			
Population[2]	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons	0.37	0.37	0.37
Beds	20	22	24
Adult Civil Beds – Allocation Reduced to 40 beds			
Population	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 pop	.74	.74	.74
Beds	40	44	48
Geriatric Beds			
Population[2]	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons	0.75	0.75	0.75
Beds	40	45	48
Addictions Dual Diagnosis Beds			
Population ages 18-64	3,404,433	3,670,495	3,895,734
Bed rate per 100,000 persons	0.59	0.59	0.59
Beds	20	22	23
Adult Competency Evaluations			
Average annual % increase in admissions	7%	7%	7%
Average LOS	35	35	35
# Admissions	150	225	316
Beds	*a*	22	30

Table 12 Continued: Bed Projections for Colorado Mental Health Institute Pueblo (CMHIP) after Civil Bed Reallocations				
		Proposed Reallocation	Projected 2020	Projected 2025
Adult ITP Restorations (staying < 365 days)				
Average annual % increase in admissions		16%	16%	16%
Average LOS		117	117	117
# Admissions		220	506	1,190
Beds		*a*	162	381
Adult ITP Restorations (staying >365 days)				
Average annual % increase in ITP patients with LOS >1 year		10.7%	10.7%	10.7%
# patients at end of year		62	114	190
Beds		62	114	190
Adult Other Types of Evals				
Population		5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons		.11	.11	.11
Beds		a	7	7
Adult NGRI				
Population ages 18-64		3,404,433	3,670,495	3,895,734
Bed rate per 100,000 persons		3.50	3.50	3.50
Beds		a	128	136
Behavior Mgmt Unit (formerly DOC transfers)				
Beds		8	5	4
CMHIP TOTAL BEDS				
	Current Number of Beds	Proposed Reallocation	Projected 2020	Projected 2025
(# beds added to current capacity)	**451**	**427** ***(-24)***	**571** ***(+120)***	**891** ***(+440)***
Adolescent	20	20	22	24
Adult Civil	64	40	44	48
Geriatric	40	40	45	48
Addictions Dual Diagnosis	20	20	22	23
Forensic	307	307	438	748

[a] CMHIP beds are not allocated by legal status; however, basing bed projections on utilization patterns of each civil and forensic category yielded the most accurate estimations.

[2] Data from other Western states is based on total state population not age-specific population figures, so we used the same methodology to maintain comparability.

Scenario Three Table 13: Bed Projections for Colorado Mental Health Institute Fort Logan (CMHIFL) Based on Civil Bed Reallocations, and adding new Adolescent and Geriatric Beds				
		Proposed Reallocation	Projected 2020	Projected 2025
Adolescent Beds				
Population		5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons		.54	.54	.54
Beds		29	32	35
Adult Civil Beds – New Allocation				
Population		5,363,689	5,946,128	6,449,955
Bed rate per 100,000 pop		2.20	2.20	2.20
Beds		118	131	142
Geriatric Beds				
Population		5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons		.86	.86	.86
Beds		46	51	55
CMHIFL TOTAL BEDS				
	Current Number of Beds	Proposed Reallocation	Projected 2020	Projected 2025
(# beds added to current capacity)	**94**	**193** ***(+99)***	**214** ***(+120)***	**232** ***(+138)***
Adolescent	0	29	32	35
Adult Civil	94	118	131	142
Geriatric	0	46	51	55

Scenario Four

CMHIP is the only facility that provides inpatient psychiatric services for persons with a forensic legal commitment. In the view of focus group members, it does not make sense for all individuals to travel to Pueblo to receive such services, when programs could be established at CMHIFL to serve lower security risk persons who reside closer to Denver and require less-intensive forensic services. Map 5 in the Attachment shows the number of forensic admissions to the institutes, by county, FY 2013-14.

Focus group members were clear in their message that these forensic beds could be established *in addition to* the existing civil beds at Fort Logan – *not to replace* civil beds. Establishing forensic services at CMHIFL would reduce travel time, and increase connectivity with families, attorneys, and the community.

We used Scenario Three as a starting point to allocate forensic beds to CMHIFL. Over the past five years, approximately 65% of admissions for evaluations and ITP to CMHIP were from the 21 counties shaded in Map 3 in the Attachment We estimated the proportion of beds utilized by

these admissions and reallocated these beds from Pueblo to Fort Logan. The remaining forensic beds at Pueblo would be used for higher security risk patients, and all NGRI patients.

Scenario Four: Allocates forensic beds to CMHIFL, reducing the number of forensic beds required at CMHIP. This scenario builds upon Scenario Two, which reallocated some civil beds from CMHIP to CMHIFL, and Scenario Three, which added adolescent and geriatric patients to CMHIFL.

Scenario Four Table 14: Bed Projections for Colorado Mental Health Institute Pueblo (CMHIP)			
	Proposed Reallocation	Projected 2020	Projected 2025
Adolescent Beds			
Population[2]	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons	0.37	0.37	0.37
Beds	20	22	24
Adult Civil Beds – Allocation Reduced to 40 beds			
Population	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 pop	.74	.74	.74
Beds	40	44	48
Geriatric Beds			
Population[2]	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons	0.75	0.75	0.75
Beds	40	45	48
Addictions Dual Diagnosis Beds			
Population ages 18-64	3,404,433	3,670,495	3,895,734
Bed rate per 100,000 persons	0.59	0.59	0.59
Beds	20	22	23
Adult Competency Evaluations			
Average annual % increase in admissions	7%	7%	7%
Average LOS	35	35	35
# Admissions	52	79	111
Beds	a	8	11
Adult ITP Restorations (staying < 365 days)			
Average annual % increase in admissions	16%	16%	16%
Average LOS	117	117	117
# Admissions	77	177	417
Beds	a	57	134
Adult ITP Restorations (staying >365 days)			
Average annual % increase in ITP patients with LOS >1 year	10.7%	10.7%	10.7%
# patients at end of year	22	40	67
Beds	22	40	67

Table 14 Continued: Bed Projections for Colorado Mental Health Institute Pueblo (CMHIP)			
	Proposed Reallocation	Projected 2020	Projected 2025
Adult Other Types of Evals			
Population	5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons	0.04	0.04	0.04
Beds	a	2	3
Adult NGRI			
Population ages 18-64	3,404,433	3,670,495	3,895,734
Bed rate per 100,000 persons	3.50	3.50	3.50
Beds	a	128	136
Behavior Mgmt Unit (formerly DOC transfers)			
Beds	8	5	4

CMHIP TOTAL BEDS				
	Current Number of Beds	Proposed Reallocation	Projected 2020	Projected 2025
(# beds added to current capacity)	**451**	**329** ***(-122)***	**373** ***(-78)***	**498** ***(+47)***
Adolescent	20	20	22	24
Adult Civil	64	40	44	48
Geriatric	40	40	45	48
Addictions Dual Diagnosis	20	20	22	23
Forensic	307	209	240	355

[a] Institute beds are not allocated by forensic legal status; however, basing bed projections on utilization patterns of each civil and forensic category yielded the most accurate estimations.
[2] Data from other Western states is based on total state population not age-specific population figures, so we used the same methodology to maintain comparability.

Scenario Four Table 15: Bed Projections for Colorado Mental Health Institute Fort Logan (CMHIFL)				
		Proposed Reallocation	Projected 2020	Projected 2025
Adolescent Beds				
Population		5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons		.54	.54	.54
Beds		29	32	35
Adult Civil Beds				
Population		5,363,689	5,946,128	6,449,955
Bed rate per 100,000 pop		2.20	2.20	2.20
Beds		118	131	142
Geriatric Beds				
Population		5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons		.86	.86	.86
Beds		46	51	55
Adult Competency Evaluations				
Average annual % increase in admissions		7%	7%	7%
Average LOS		35	35	35
# Admissions		98	146	205
Beds		9	14	20
Adult ITP Restorations (staying < 365 days)				
Average annual % increase in admissions		16%	16%	16%
Average LOS		117	117	117
# Admissions		143	329	774
Beds		46	105	248
Adult ITP Restorations (staying >365 days)				
Average annual % increase in ITP patients with LOS >1 year		10.7%	10.7%	10.7%
# patients at end of year		40	74	123
Beds		40	74	123
Adult Other Types of Evals				
Population		5,363,689	5,946,128	6,449,955
Bed rate per 100,000 persons		0.6%	0.6%	0.6%
Beds		3	3	4
CMHIFL TOTAL BEDS				
	Current Number of Beds	Proposed Reallocation	Projected 2020	Projected 2025
(# beds added to current capacity)	**94**	**291** ***(+197)***	**410** ***(+316)***	**627** ***(+533)***
Adolescent	0	29	32	35
Adult Civil	94	118	131	142
Geriatric	0	46	51	55
Forensic	0	98	196	395

Factors that will influence inpatient bed need

Children's beds

CMHIFL closed its 16-bed children's unit in 2010, and so there are currently no inpatient beds for children at either institute. However, there are five facilities in the state that serve children: Children's Hospital Colorado, Denver Health Medical Center, Highlands Behavioral Health, Cedar Springs Behavioral Health System, and Parkview Medical Center. According to a key informant, child and adolescent beds continue to be built in the private sector as demand increases. Stakeholder survey respondents indicated that there is still a need for additional children's beds, but a major barrier to establishing inpatient services for children is the shortage of child psychiatrists in Colorado. Exploring telepsychiatry opportunities to fill this gap are presented in the telehealth section of this report.

We do not recommend establishing a children's unit at CMHIFL, primarily because outcomes for children are better when they are served closer to their homes and support systems[12]. Creating a small children's program is not cost-effective because of the need for specially trained staff. Alternatively, two to three beds on the adolescent unit may be a consideration for use by children under the age of 13 in extenuating circumstances, especially if flexible swing beds are developed.

Adolescent beds

Our methodology for determining adolescent bed projections held the rate of adolescent beds constant over time; however, the number of inpatient adolescent beds statewide is cited as being insufficient by focus group members and stakeholder survey respondents. Scenario Three raised the rate of adolescent beds in the state to the average among Western states, 0.91 per 100,000 persons, which would increase the number of beds from 20 to 49.

In 2013, the number of adolescent ITP restoration admissions was up 111 percent, from nine to 19, and civil admissions were down 42 percent (from 285 to 165). Inpatient hospitalization is considered to be less restrictive than a juvenile detention center, and CMHIP is the only formal ITP restoration site available for adolescent offenders.

One suggestion is to increase inpatient civil adolescent beds by providing adolescent beds at CMHIFL, and develop alternatives to inpatient competency restoration for adolescents.

Inpatient services for special populations

Other sections of this report examine admission referrals to the institutes that are denied due to significant medical conditions (including dementia) in combination with an active mental illness, as well as individuals ready for discharge from the institutes but facing a system barrier or unavailability of a critical service, such as housing. Such issues may pose an Olmstead threat

to Colorado, and suggestions for addressing such issues are provided in the *Olmstead* section of this report.

It is not cost-effective to establish separate units for special populations that may be added to the institute; for example, ID/DD, TBI, or persons with medical conditions. Instead, we recommend allowing flexibility in unit structure to accommodate a few swing beds for these patients if the need arises.

Civil commitments at other designated facilities

In addition to the two state institutes, there are 64 hospitals, community clinics, emergency centers, and residential facilities designated as 72-hour evaluation and treatment facilities located throughout the state (see Map 1 in the Attachment).

These facilities are known as "27-65 designated facilities," which refers to the Colorado Revised Statutes specific to institutions (Title 27) and the Care and Treatment of Persons with Mental Illness (Article 65). The criteria for an involuntary 72-hour hold are "when any person appears to have a mental illness and as a result of such mental illness appears to be an imminent danger to others or to himself or herself or appears to be gravely disabled."[13] The CMHCs serve as the gatekeeper for 27-65 admissions to CMHIFL and CMHIP. No designated facility is required to admit someone on a 72-hour hold unless mandated by the court. Focus group members indicated that CMHCs generally refer individuals who are from their catchment area; therefore, transient persons are often overlooked.

Colorado statute dictates that a professional person (a person licensed to practice medicine or a psychologist licensed to practice in Colorado) may conduct a 72-hour mental health evaluation and order an individual to be released or certify them for short-term involuntary treatment.[14] Short-term treatment is defined as up to three months, but may be extended to five months. At that time, if the person is still considered to be a danger to themselves or others as a result of a mental illness or is gravely disabled, a petition for long-term treatment can be filed.[15] Table 16 lists the types of facilities that are 27-65 designated facilities and the current number of beds available for civil commitments.

Table 16: 27-65 Designated Facilities (Excludes CMHIP and CMHIFL)			
Type of Facility	Number of Child/Adolescent Beds	Number of Adult Beds	Number of Geriatric Beds
Hospital	140	543	120
Residential Child Care with Mental Health Treatment/Psychiatric Residential Treatment	177	0	0
Acute treatment unit	0	77	0
Total	**317**	**620**	**120**

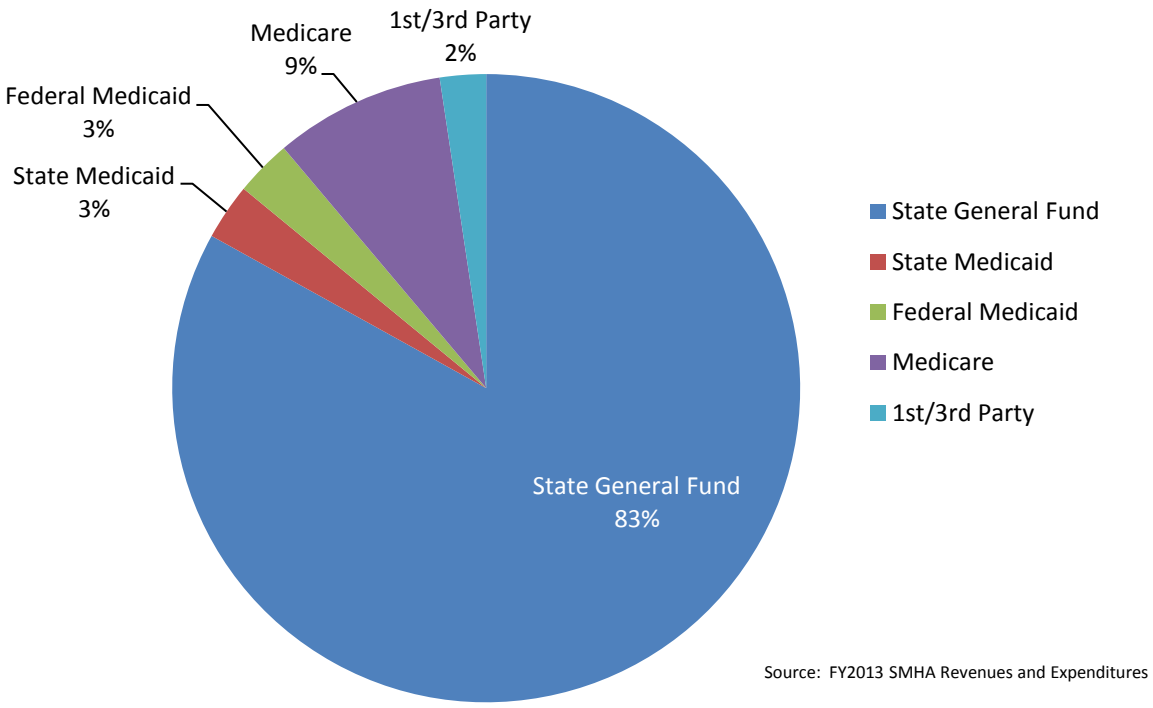
In FY 2013, there were 17 states that reported[16] having policies to require or encourage the use of general hospital psychiatric units as an initial admission location (for civil-status patients) prior to the use of a state psychiatric hospital; usually courts can directly send forensic-status patients to a state psychiatric hospital for an evaluation or treatment. Of these 17 states, seven Western states use general hospitals as gatekeepers for civil admissions to state hospitals, including Alaska, Arizona, Idaho, Oregon, South Dakota, Utah, and Washington. Arizona, for example, requires a 25-day stay in a community-based acute psychiatric unit prior to state hospital admission. Washington State reported that patients must spend at least 14 days in a community-based psychiatric hospital. And Oregon reported that individuals are admitted to acute care hospitals to rule out any physical health issues that may be causing their presenting symptoms prior to admission to Oregon State Hospital.

Both of Colorado's state psychiatric hospitals are exempt from receiving Medicaid reimbursement under the Institution for Mental Disease (IMD) Exclusion rule. This rule states that any hospital having over 16 beds, in which more than 50 percent of the beds are occupied by persons with a primary diagnosis of a mental disorder, is excluded from Medicaid reimbursement for care provided to patients ages 21 to 64.[17] Payment for a civil commitment to one of the state hospitals in Colorado is made by the state general fund (83% in FY 2013); Medicaid for persons under the age of 21 or over age 64 (6%); Medicare, if the patient has not exhausted his/her lifetime limit for inpatient psychiatric care (9%); and a small portion of first- or third-party payments (2%) (See Figure 11).[18] The CMHCs do not share the financial burden of the referred patients' inpatient hospitalization (for patients in the IMD age range), nor therefore there is any incentive for them to divert admissions from the state hospitals.

A result of the IMD rule is that psychiatric inpatient care for adults in a general hospital (in either a psychiatric unit or a scatter bed) qualifies for Medicaid, while the same care in a private psychiatric hospital or state psychiatric hospital would not be eligible. While inpatient psychiatric services provided in a state psychiatric hospital to patients in the IMD age range may require the use of 100 percent state general funds, the same care in a general hospital (for

a Medicaid-eligible adult) can be billed to Medicaid with the state match rate, meaning the federal government pays 51.1 percent and the state of Colorado pays 48.9 percent of the care. The IMD rule and Medicaid eligibility for care in general hospitals may be a major factor in several states emphasizing the use of general hospitals over state psychiatric hospitals for acute psychiatric care. For example, in California, the six state psychiatric hospitals are almost entirely oriented to providing services to forensic-status and sex offender-status patients (more than 89% of state hospital patient days were for forensic and sex offender patients). California's county mental health authorities reported expenditures of $378 million (much of it Medicaid-reimbursable) for psychiatric inpatient services. Missouri recently closed all of its state psychiatric hospital acute care units and now uses its state psychiatric hospitals for long-term care and for individuals with complex mental health issues. In Missouri most of the psychiatric acute care is now provided by general hospitals that can bill Medicaid since they are not IMDs. California and Missouri are two examples of states that have had success leveraging Medicaid funds to increase inpatient psychiatric beds for civil patients in general hospitals. The experience has been that if the Medicaid reimbursement rate is high enough, there will be an incentive to develop such capacity in the community.

Figure 11: Revenues For State Psychiatric Hospitals, By Source, FY 2013 (in millions)
Colorado Total = $114.2 million



Source: FY2013 SMHA Revenues and Expenditures

Statutes for inpatient commitment

The criterion for civilly committing an individual to inpatient psychiatric emergency treatment in Colorado is "when any person appears to have a mental illness and, as a result of such

mental illness, appears to be an imminent danger to others or to himself or herself or appears to be gravely disabled."[19] However, when a person is found incompetent to proceed (ITP) to trial, a court can order inpatient treatment, and the usual placement for these commitments is CMHIP or the RISE program. The criteria for ITP commitment lacks the dangerousness criteria.[20] In Colorado, and 33 other states,[21] the courts may commit defendants found ITP without meeting additional commitment criteria. These individuals would not be committed in civil commitment proceedings, verifying the perception that it is easier to have a person placed for inpatient treatment through the ITP evaluation and commitment process than through the civil commitment process. Focus group member comments regarding the criteria for requesting a competency evaluation included "*criteria are very low,*" "*seems like a fad – everyone gets one,*" "*seems like lawyers use it as a delay tactic.*"

Inpatient vs. outpatient evaluations

The 2014 NASMHPD Survey of Forensic Mental Health Services in the United States[22] found that 19 of the 32 responding states conduct the majority of competency evaluations on an outpatient basis (i.e., in jails or mental health centers while the individual is on bond). In Colorado, 71% of evaluations were conducted in outpatient settings in 2014, up from 67% in 2010. In Colorado, the reimbursement rate for an outpatient competency evaluation is capped at $1,000. Most evaluations can be completed with one or two interviews with the defendant.[23] The average length of stay for competency evaluations in CMHIP was 33 days in FY 2014, so the cost for inpatient evaluations is exponentially more expensive than the cost for outpatient evaluations.

When a person is referred by the courts for an inpatient competency evaluation, Colorado courts reimburse CMHIP $35 per day for the inpatient stay, which is only a small fraction of the total cost.[24] In a recent national survey, 84% of responding states indicated that inpatient evaluations for competency to stand trial were the financial responsibility of the state, and 65% of respondents indicated that outpatient evaluations were the financial responsibility of the state.[25] There is a increasing trend in states for the courts to pay for outpatient evaluations. During the focus groups on the increase in court-ordered competency evaluations and restorations in Colorado, experts discussed some of the major barriers to decreasing the number of inpatient evaluations:

- Barrier #1: *Low reimbursement rate for outpatient competency evaluations*

  The current reimbursement rate for outpatient competency evaluations is capped at $100 per hour for 10 hours. National data on the compensation rates to community-based evaluators ranges from $300 to $3,000; however, the response rate was quite low. Seventeen states responded that they pay between $500 and $1,000, and four states reported paying more than $1,000.[26] Completing a competency evaluation for a person who is cognitively impaired takes a considerable amount of time. Experts reported that the reimbursement caps are insufficient to attract qualified staff. Similarly, the topography of Colorado poses travel challenges, especially during winter

months, which increases the amount of time an evaluator must dedicate to conducting a face-to-face meeting with individuals. Experts also reported that juvenile evaluations pose unique challenges because there are more people involved. Communication through multiple family members, school officials, and other professionals takes time to coordinate.

In response to the CBHC survey, respondents from four of the geographic regions in Colorado indicated that with training and adequate reimbursement for time spent out of the office to conduct evaluations and to testify in court, they would be interested in providing competency evaluation services.

- Barrier #2: *Shortage of qualified evaluators*

  Recognizing the need for a training program specific to competency evaluations, the University of Denver has an innovative, integrative approach to developing new professionals. Experts cite this program as exemplary in the state, and capable of replication at other universities.

  Colorado, like many states, is experiencing a shortage of qualified behavioral healthcare staff; it is especially pronounced in rural areas. In 2010, more than 1,300 graduate-level behavioral health clinicians were being trained in Colorado; however, these professionals are either not choosing to practice in rural communities or are not staying in-state.[27]

  A separate issue is that once evaluators are hired, there is a lack of enforcement of the regulations regarding standardized, systematic training and centralized oversight of the community-based evaluators.[28] Evaluators whom we spoke with commended the lead forensic evaluator at CMHIP for striving to provide training and input on reports, but without a commitment from the Department of Human Services to dedicate resources to enforce the existing regulations, the increasing demand for evaluations will overshadow his efforts. Various models exist to provide good training on forensic evaluations,[29] and a few states, such as Massachusetts, Georgia, Oregon, and Virginia, which require a formal certification procedure, are experiencing positive results.

- Barrier #3: *Lack of standardization among evaluation reports*

  Recipients of competency evaluation reports (i.e., public defenders, prosecutors, judges, and mental health treatment providers) indicate that there is a lack of standardization among reports — "*Some reports are six pages, and others are 25 pages.*" Having quality-assurance procedures among evaluators through peer review has been shown to significantly increase the reliability of findings.[30] Experts stated that the lack of standardization was a larger issue with outpatient evaluations than with inpatient evaluations. At CMHIP, the lead forensic evaluator has gone to great lengths to provide quality oversight, ongoing training, and mentoring to in-house evaluators. Such practices need to be spread to community-based evaluators in Colorado.

- Barrier #4: *Belief that inpatient evaluations yield more accurate results than outpatient evaluations*

  Outpatient competency evaluations can typically be completed in one or two visits with a defendant; inpatient evaluations result in significantly more interaction between the individual and mental health professional. Focus group participants from the justice system stated that outpatient evaluations are considered a "snapshot" compared to those done on an inpatient basis, which yield the "real answers." A common perception is that there is no realistic path for civil commitments for these individuals, so filing for an inpatient competency evaluation and having the defendant receive even a short hospital stay is better than no treatment.

  Once the issue of competency is raised by the court, some perceive the defendant as dangerous and posing a threat to others in the community. Such perceptions may make the courts reluctant to allow evaluations to happen in the community, resulting in many low-risk individuals needlessly occupying beds at CMHIP.

  Addressing these barriers is anticipated to create a shift toward increased outpatient competency evaluations, interrupting the unsustainable increase in the number of inpatient competency evaluations.

Among suggestions for addressing the above barriers:

1. Raise the reimbursement rate for community-based evaluations to attract more qualified staff and provide sufficient time for quality evaluation reports to be written.
2. Raise the daily reimbursement rates paid by the courts to cover a greater proportion of the CMHI costs.
3. Prioritize existing regulations regarding training and quality oversight of forensic evaluations. Ideally, a certification program for forensic evaluators should be established.
4. Provide quality oversight for forensic evaluation reports.
5. Provide incentives to retain qualified staff.
6. Encourage additional graduate-level training programs in forensic services, throughout Colorado, that incorporate internships as a mandatory part of the curriculum.

Pre-adjudication services

Behavioral Health Mobile Crisis Teams were established in December 2014 across the state in an effort to get people who are in crisis into appropriate community behavioral health treatment as an alternative to using emergency rooms where there may be police involvement and potential jail time. Another model to divert persons with mental illness away from jails involves placing a mental health evaluator in the court system. Such a model exists in Massachusetts, where each court has a mental health clinic in which licensed psychologists provide preliminary evaluations of defendants whose competency to stand trial is questioned.

If the examiner opines that the defendant's competency cannot be determined, he or she can suggest the individual be transferred to outpatient mental health treatment or the state hospital, if stricter security is required.[31]

The Arapahoe/Douglas Mental Health Network is the first CMHC in Colorado to offer a Wellness Court post-adjudication, similar to mental health courts in other states. The program began in 2009 and provides a community-based alternative to incarceration for individuals with mental illness who are charged with misdemeanors, municipal offenses, and some non-violent felony offenders.

One suggestion is to consider pre- and post-adjudication services for lower security risk persons with mental illness who are involved with the justice system to reduce the number of persons coming into the system on a forensic status.

Revolving-door forensic admissions

Time and again, patients who come into the behavioral health system from the justice system are caught in a revolving door of admissions. Focus group members cited the lack of standardization in medication formularies as a major contributor to this phenomenon. Once competency has been restored and a detainee returns to jail, his/her psychiatric medications may be changed. Medication formularies are different between jails and mental health facilities. Stabilizing psychiatric medications takes time, and changing medications disrupts the recovery process, contributing to a revolving door between inpatient services and jail.

Once individuals are discharged from jail, there needs to be a greater effort to get them registered with Medicaid or other health insurance to continue their psychiatric medications. The Affordable Care Act and Colorado's expanded Medicaid coverage offers this opportunity. The expansion makes people below 138% of the federal poverty level Medicaid-eligible. Persons released from prison are eligible for Medicaid; previously, inmates were released with 90 days of medication. CMHCs have established jail-based behavioral health services, transitional services for incarcerated individuals with mental illness who are returning to the community, to address issues such as medication adherence. These services currently cover 36 of Colorado's 64 counties. Focus group members felt that these transition services work better in metro areas, as people in rural areas are often overlooked. Sometimes, transient, homeless, or undocumented persons with no fixed address are not affiliated with a CMHC and are left without behavioral health services.

Suggestions include:

- Aligning the formularies of county jails and the Office of Behavioral Health, as well as aligning the prescribing practices of psychiatric hospitals and referring jails.

- Strengthening existing community-transition services for persons with mental illness and/or substance use services who have been incarcerated.

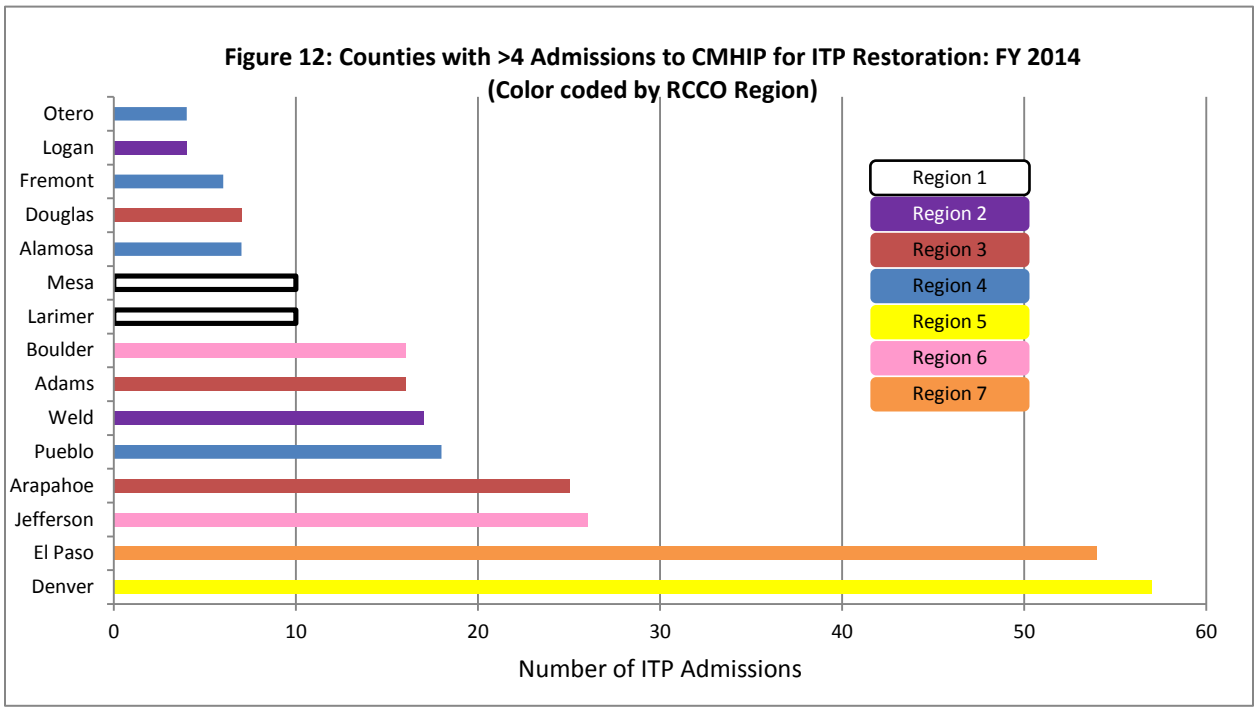
Inpatient versus outpatient competency restorations

Focus group participants unanimously agreed that the RISE program is exemplary and should be replicated in other areas of the state in future years, as dictated by demand. Some believed that additional programs should be developed outside the jail setting for detainees with less-serious criminal infractions, as well as programs that serve males and females. The RISE program serves only males, leaving hospitalization at CMHIP as the only inpatient competency restoration option for females. Focus group members said that CMHCs may be well-positioned to establish outpatient restoration programs, although the contracts to do so would have to be clearly articulated. Participants expressed some concern that since CMHCs are not directly operated by OBH and typically choose the types of individuals to whom they provide services, CMHCs may opt to not establish such programs for persons involved with the justice system.

As an example, when Minnesota was establishing community-based forensic services a few years ago, some providers resisted assimilating them into their services because of the stigma associated with justice-involved individuals and their perceived dangerousness.[32]

As part of this report, CMHCs were asked about their interest in providing competency restoration services. Respondents from four regions expressed interest in exploring options for outpatient restoration services. One person responded, "*We have strong interest in competency restoration and it could free up forensic beds at the institute.*"

Figure 12 shows the number of admissions to CMHIP for ITP restoration, by county. The RISE program is located in Region 3 and accepts patients from Douglas, Boulder, Adams, Weld, Arapahoe, Jefferson, Denver, and a few other counties. Region 5 accounted for 19% of all ITP admissions to CMHIP in FY 2014 and Region 6 had 14%, so these locations would be the first places to consider expanding outpatient competency-restoration programs.



Colorado has a track record of successfully linking offenders with mental illnesses to community services.[33] OBH funds 11 community mental health service programs for juvenile and adult offenders that could serve as a model for contracting with outpatient providers for forensic services.

While across the country the vast majority of defendants referred for competency restoration are committed to inpatient facilities, several states have developed community-based restoration services. Only one state, Arkansas, reports that the majority of such services are done in an outpatient setting.[34] In 2013, 35 states had a statutory allowance for outpatient competency restoration, and 17 of them had operating programs in place[35] (See Map 2 in the Attachment). Some common themes across these programs are that they utilize the state's community mental health system, the state mental health agency assumes sole responsibility for ITP persons, violent charges and many felonies are excluded, and specialized professionals are involved in restoration. While these programs have experienced longer lengths of stay than inpatient restoration programs, states have found that they operate at a fraction of the cost, typically about one-fifth the cost of an inpatient stay, and that individuals returned to inpatient settings infrequently.

A tiered approach to serving forensic clients

Several experts who were consulted during the writing of this report suggested that ideally, competency evaluations and restorations would be conducted outside the hospital. Competency evaluations should be done on an outpatient basis. Defendants should only be referred to an inpatient setting under special, limited circumstances. In an ideal approach, CMHIP would continue to serve higher security risk forensic patients or severely impaired

individuals who require the most-intensive psychiatric services. Civil beds would continue to be available at CMHIP, as there is already a shortage of inpatient civil beds and closing them would create strain on an already-constrained system.

Experts suggested that outpatient restoration programs be established in additional locations in the state. In sparsely populated areas like the Western Slope — where a jail-based restoration program like RISE likely wouldn't be a good fit — outpatient restoration services should be developed for treatment-engaged persons out on bond, who do not require the intensity of inpatient psychiatric services.

General Recommendations

1. **Develop outpatient alternatives in order to slow the trend of increased forensic admissions**. With an average of 59.4 percent forensic patients, Colorado is above the 43.2 percent average of other Western states. To keep pace with increasing forensic admissions and to maintain the current civil bed rate, the number of inpatient psychiatric beds at Colorado's two mental health institutes will have to increase by 90 percent (from 545 to 1,033 beds) by 2025.
2. **Increase the percentage of evaluations conducted in outpatient settings to decrease the number of inpatient beds being used for this purpose**. Currently, 71 percent of competency evaluations are conducted in outpatient settings. This percentage could be increased by training and retaining more evaluators, providing certification and oversight, and raising the reimbursement rate.
3. **Raise the daily reimbursement rates paid by the courts to CMHIP**. The current rate of $35 per day is insufficient to offset the cost of an inpatient stay, and shifts the financial burden to the hospital.
4. **Create additional community-based competency restoration programs. Inpatient admissions for competency restorations are increasing by an average of 16% per year.** With nearly one-quarter of these individuals staying more than one year, CMHIP is forced to use a larger and larger portion of its civil beds to serve this population. The combination of increased admissions and longer length of stays is the driving force behind a projected shortage of beds over the next decade.
5. **Develop services at CMHIFL to serve lower security risk forensic patients**. Offering such services in the metro Denver area would reduce travel time and allow individuals to receive treatment closer to where they reside.
6. **Develop pre- and post-adjudication services** based on mental health clinics in courts, and the existing Wellness Court, to decrease the number of justice-involved individuals being referred for competency evaluations.
7. **Strengthen the continuity of care between inpatient behavioral healthcare services and jail** to reduce the likelihood that individuals will return to the hospital. Support services for persons leaving jail and returning to community-based care should be increased, including assistance with obtaining health insurance or Medicaid to eliminate gaps in coverage.
8. **Increase inpatient services for adolescents** in either hospital or residential settings. Adding adolescent beds to CMHIFL would provide better access to inpatient services for youth residing in the metro Denver area. Developing adolescent outpatient competency restoration services would allow a larger percentage of adolescents with civil commitments to access existing inpatient beds.

9. **Increase total geriatric bed capacity** by adding beds to CMHIFL to increase access to and availability of services. Colorado is below the average rate of other Western states for geriatric beds.
10. **Leverage expanded Medicaid funding** to increase the Medicaid reimbursement rates for inpatient psychiatric services. This would provide an incentive for additional civil beds to be built in general hospitals throughout the state, alleviating the demand for civil beds at the two mental health institutes.
11. Evaluate the effectiveness, efficiency and outcomes of the new crisis services. An evaluation of the impact of the implementation of statewide crisis services in Texas found that the percentage of crisis service users entering state hospitals declined by about 23 percent. However, due to the larger number of people being served, the absolute number of admissions fell by only 3 to 5 percent.[36]

Recommendations/considerations related to the four bed-projection scenarios

Options to decrease the forensic demand

- Amend Colorado law to require competency referrals to meet 27-65 criteria, with alternative approval by OBH/DHS in special cases.
- Increase per-day charges to the judicial system for inpatient stays.
- Expand the RISE program, with strong behavioral health and medication management components, to reduce the potential for individuals to be transferred back to CMHIP for behavioral reasons.
- Develop outpatient restoration services for treatment-engaged persons out on bond who do not require the intensity of inpatient psychiatric services.
- Increase the number of evaluations being done on an outpatient basis
- Establish pre-and post-adjudication services for lower security risk individuals.

Considerations for special populations

- Allow flexibility in unit structure to accommodate a few swing beds for younger patients on the adolescent unit if the need arises.
- Ensure that programming, capacity, and workforce are responsive to the special requirements of the small number of patients who may present with ID/DD or TBI. The low number of such cases does not warrant a designated unit.
- Occasional requests by DYC/DOC that a detainee be transferred to one of the state mental health institutes should be accommodated, and a streamlined protocol for such admissions should be established. In addition, re-establish the Sol Vista program for youth with serious emotional disorders and complex behavioral needs who can be more appropriately served in a smaller specialized therapeutic treatment environment. There is a growing demand for these services, including in the metro Denver area, and the

average daily bed cost the Sol Vista program was less than the cost of CMHIP inpatient beds.
- It is more cost-effective for persons with significant co-occurring medical conditions to be treated in general hospitals and provided behavioral supports than to equip the state institutes to treat significant medical conditions.
- Individuals with substance use disorders should be outside the IMD to the greatest extent possible, to make the services reimbursable through Medicaid.

Opportunities

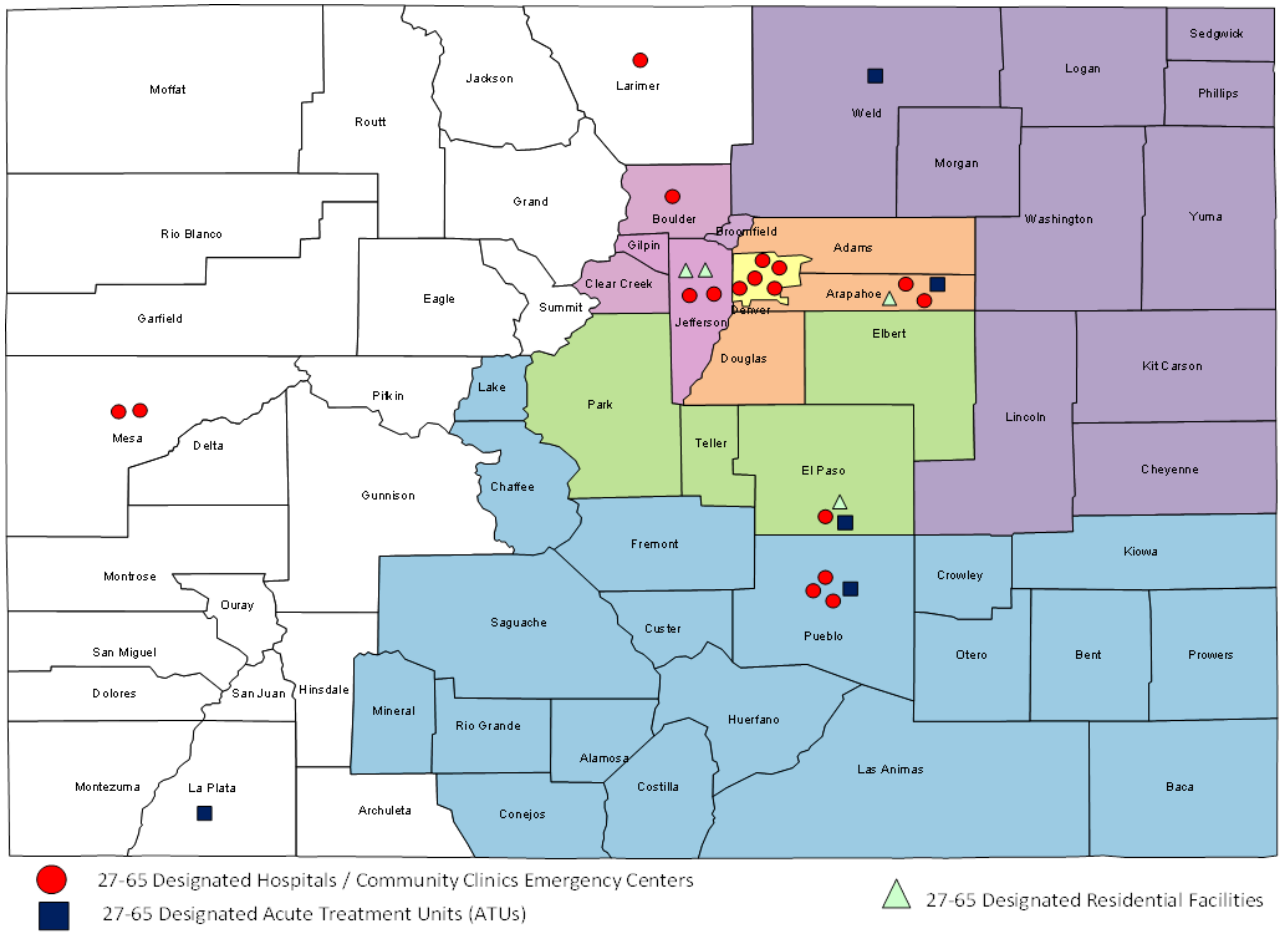
- The new Behavioral Health Mobile Crisis Teams may help intercept persons in crisis and connect them with community-based services before their need rises to the level of requiring intensive inpatient care.
- Some private facilities have expressed interest in contracting to serve individuals with co-occurring behavioral health and medical/physical conditions (St. Mary's in Grand Junction, Lutheran–West Pines in Wheat Ridge, and Peak View in Colorado Springs).
- Add medical homes/services capacity to the ACT Teams to identify and address medical conditions, and implement FACT Teams with medical supports.
- In areas of the state that lack easy access to psychiatrists, provide telehealth services to rural emergency rooms, youth detention centers, and facilities serving geriatric populations.
- A new 92-bed inpatient facility is scheduled to open in Johnstown (Weld County) in fall 2015. The facility, which includes 36 adult/geriatric beds and 20 adolescent beds, may have an impact on civil admissions to the institutes.

Attachments

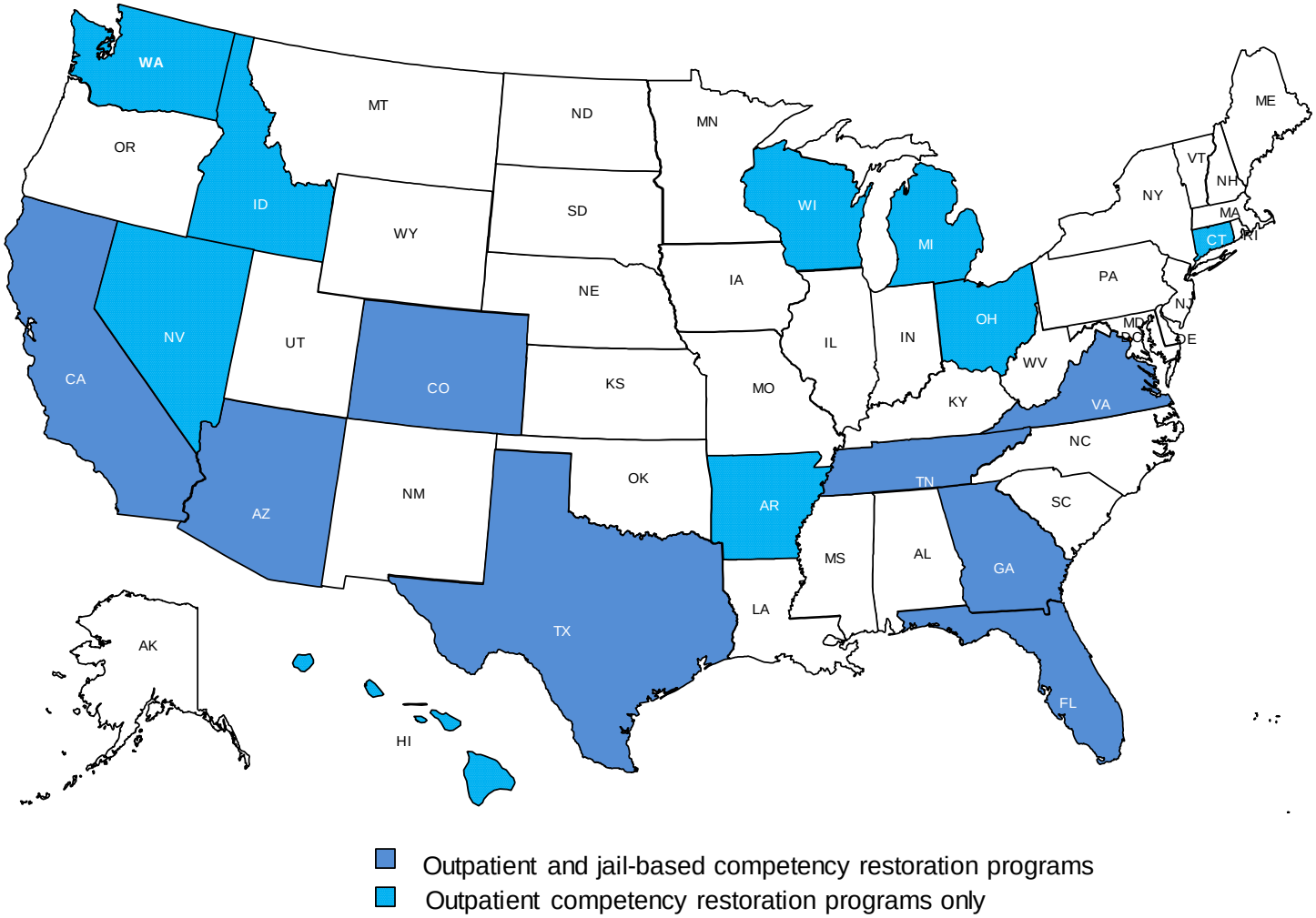
- Map 1: Map of 27-65 Designated Facilities with Psychiatric Beds in Colorado
- Map 2: National Map of States with Outpatient Competency Restoration Programs
- Map 3: Current Counties Served by Fort Logan and Counties Reallocated to Fort Logan for Bed Projection Scenario Two
- Map 4: Civil admissions to the Institutes, by County, FY2013-2104
- Map 5: Forensic admissions to the Institutes, by County, FY2013-2104

Map 1: Map of 27-65 Designated Facilities with Psychiatric Beds in Colorado

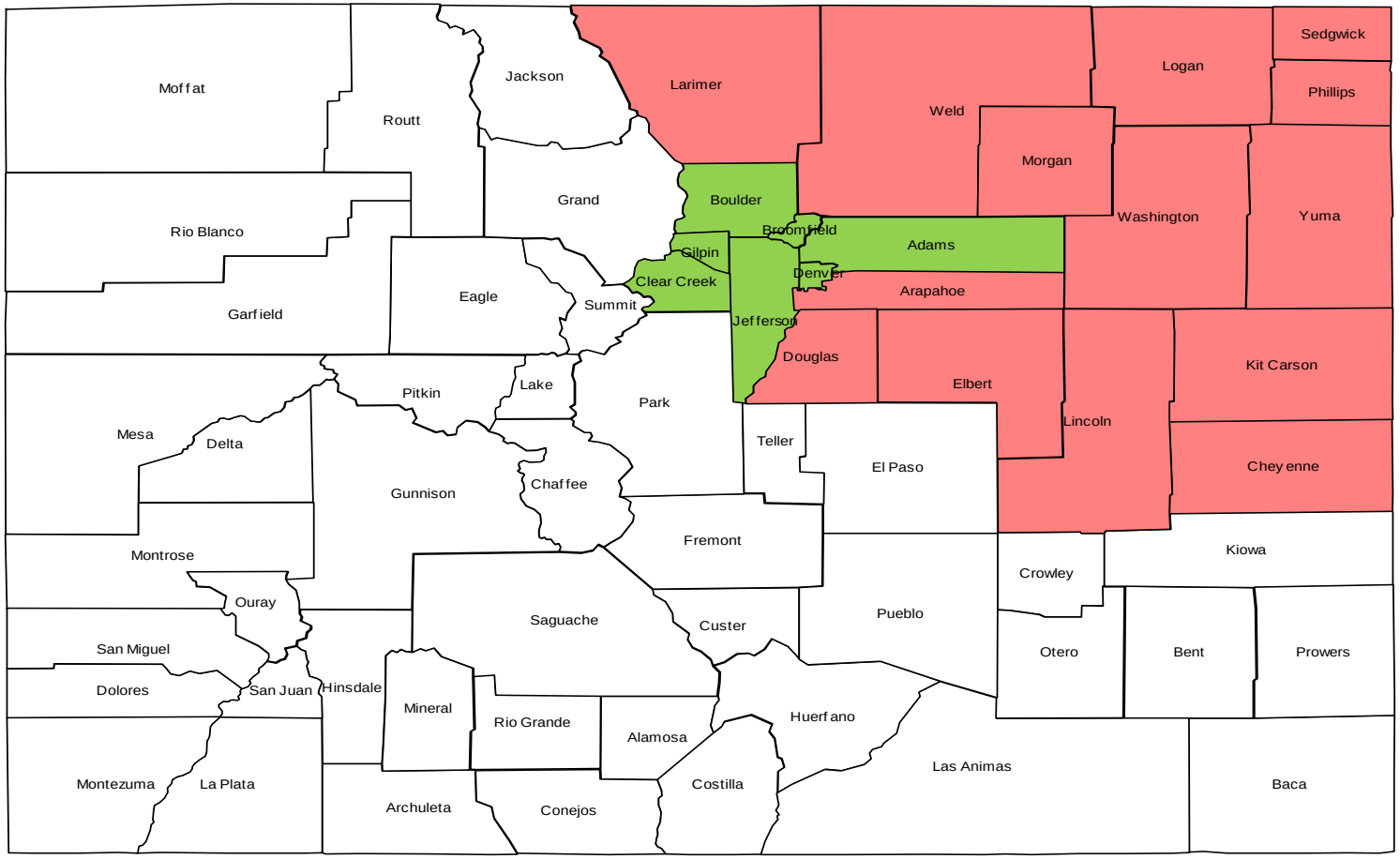
27-65 Designated Facility Beds *(excluding VA facilities)*			
County	Child/ Adolescent	Adult	Older Adult
Hospitals/ Community Clinics/ Emergency Centers			
Arapahoe	50	64	20
Boulder	16	71	0
El Paso	44	98	36
Denver	12	136	14
Larimer	8	16	0
Mesa	0	42	0
Pueblo	10	40	10
Jefferson	0	76	40
Total	**140**	**543**	**120**
Acute Treatment Units (ATUs)			
Arapahoe	0	16	0
La Plata	0	15	0
El Paso	0	16	0
Weld	0	16	0
Pueblo	0	14	0
Total	**0**	**77**	**0**
Residential Child Care Facilities			
Arapahoe	14	0	0
El Paso	24	0	0
Jefferson	139	0	0
Total	**177**	**0**	**0**
Grand Total	**317**	**620**	**120**



Map 2: National Map of States with Outpatient Competency Restoration Programs



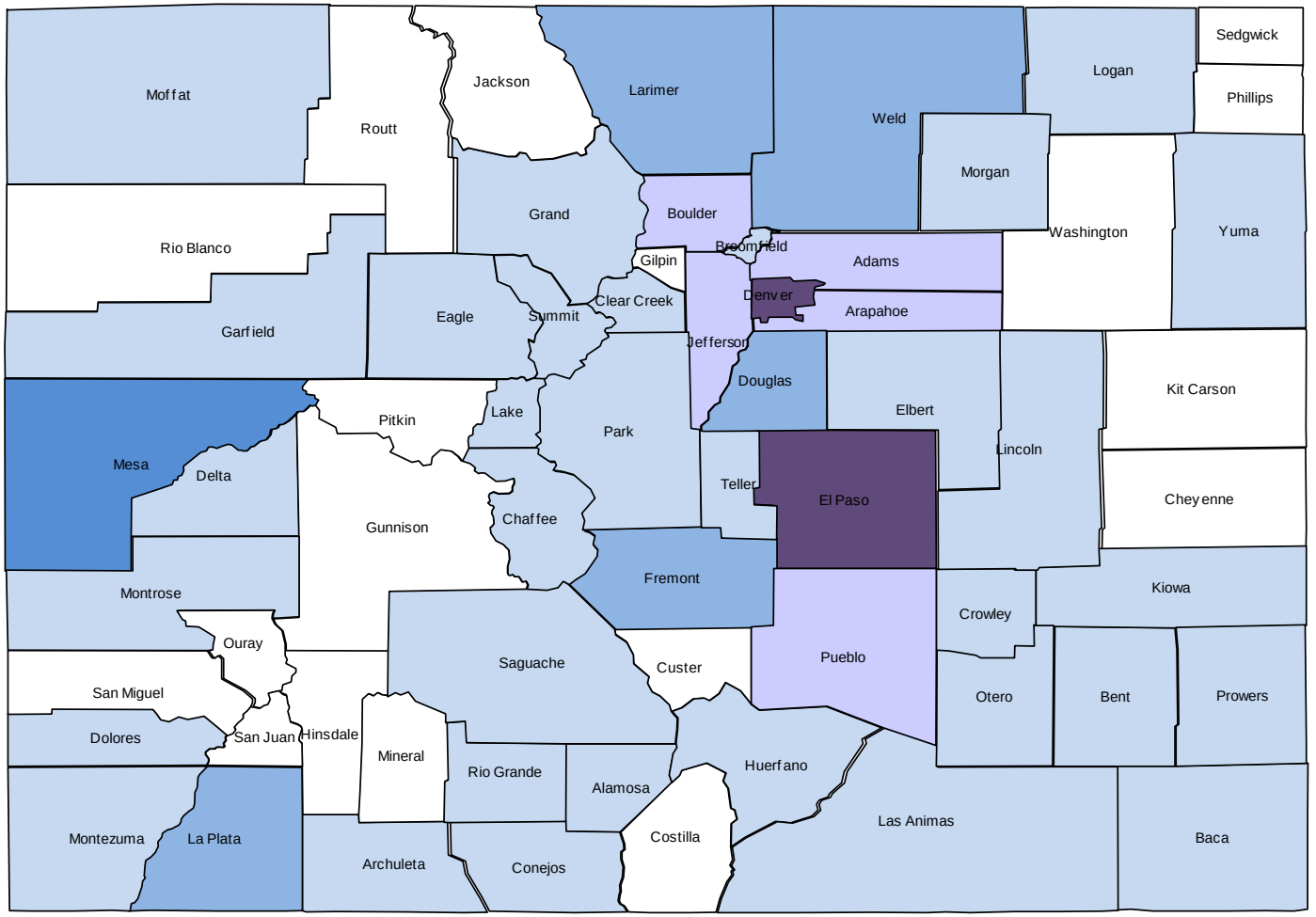
Map 3: Current Counties Served by Fort Logan and
Counties Reallocated to Fort Logan for Bed Projection Scenarios Two, Three and Four



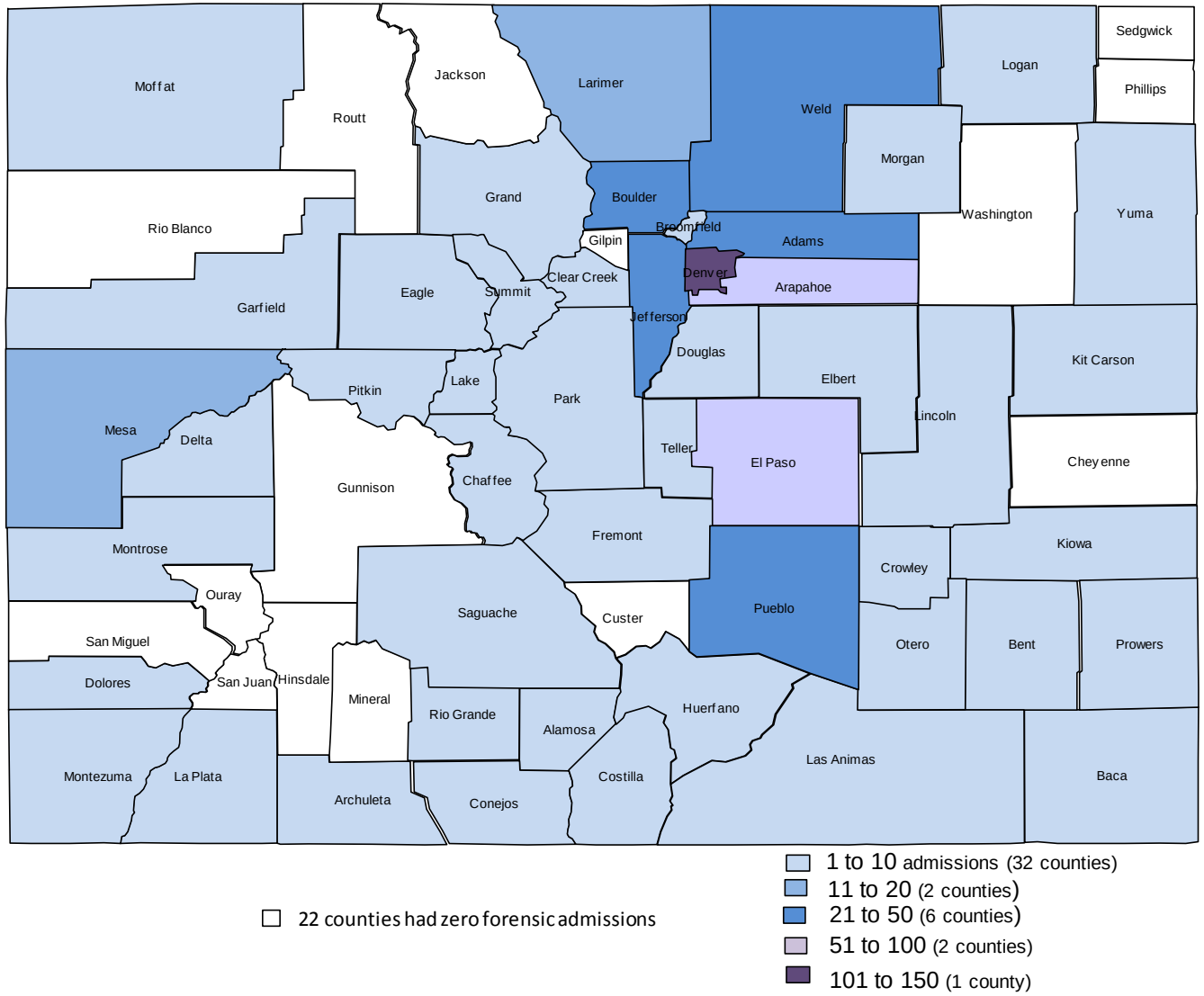
Counties moved to Ft Logan with Bed Reallocation

Counties in Ft Logan catchment area

Map 4: Total Civil Admissions to Mental Health Institutes, by County FY13-14



Map 5: Total Forensic Admissions to Mental Health Institutes, by County FY13-14



[1] See Colorado Revised Statutes (C.R.S.) 16-8.5-105
[2] One confounding factor is that the criteria for admission differ for these two commitment statuses, which will be discussed later in this report.
[3] 2013 Uniform Reporting System, NRI
[4] Source: FY 2013 State Mental Health Agency Revenues and Expenditures Study, NRI
[5] Fitch, W.L. Forensic Mental Health Services in the United States: 2014. A report from the National Association of State Mental Health Program Directors, Alexandria, VA.
[6] The Legal Center for People with Disabilities and Older People v. Reggie Bicha, in his official capacity as Executive Director of the Colorado Department of Human Services, and Teresa A. Bernal, in her official capacity as Interim Superintendent of the Colorado Mental Health Institute at Pueblo, No. 11-cv-02285-BNB (D. Colo.). http://www.rplaw.com/wp-content/uploads/2012/04/Settlement-Agreement-651345-v-1.pdf
[7] Retrieved from http://www.admhn.org/Services/CriminalJustice/CourtTreatmentServices/MentalHealthCourt.aspx
[8] Colorado Department of Human Services FY2013014 Funding Request. Retrieved from: http://www.colorado.gov/cs/Satellite?c=Page&childpagename=OSPB%2FGOVRLayout&cid=1251634296046&pagename=GOVRWrappr
[9] We caution the reader to not use this rate to compare civil bed rates in other states. Other states may include beds for adolescent, geriatrics, medical-surgical, dual disorders in their total number of civil beds.
[10] See page 4 for a description of the 2011 CMHIP policy change.
[11] Western states' bed rates are only available based on total state population, not age-specific population.
[12] Bruns, E. J., Walker, J. S., & The National Wraparound Initiative Advisory Group. (2008). Ten principles of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), The resource guide to wraparound. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.
[13] C.R.S. 27-65-105
[14] C.R.S. 27-65-107
[15] C.R.S. 27-65-109
[16] 2013 State Mental Health Agency Profiling System
[17] 42 U.S.C. §1396d.
[18] Source: FY2013 SMHA Revenues and Expenditures Study, NRI
[19] C.R.S. 27-65-105
[20] C.R.S. 16-8.5-101
[21] Fitch report
[22] Fitch report
[23] Fitch report
[24] Colorado responses to a 2014 NASMHPD survey on forensic services
[25] Fitch report
[26] Fitch report
[27] WICHE Mental Health Program (2010). The Behavioral Healthcare Workforce in Colorado: A Status Report.
[28] Regulations regarding forensic evaluators are found in C.C.R. 502-1 21.900.
[29] Frost, L.E., deCamara, R.L., & Earl, T.R (2006). Training, certification, and regulation of forensic evaluators. Journal of Forensic Psychology Practice, 6, 77-91.
[30] Gowensmith WN, Murrie DC, Boccaccini MT. (2012) Field reliability of competence to stand trial opinions: How often do evaluators agree, and what do judges decide when evaluators disagree? Law and Human Behavior, 36(2):130-9
[31] Massachusetts General Law, Chapter 123, Sections 15a and 15b
[32] Personal communication with Alan Radke, M.D., former DHS/SOS Medical Director for the State of Minnesota
[33] Colorado Dept. of Human Services (2013). *Offender Mental Health Services Initiative Annual Report*. Retrieved from http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251615383886
[34] Fitch report.

[35] N. Gowensmith presentation at the 2013 American Psychological Association's National Convention: "Community-Based and Jail-Based Competency Restoration."
[36] **Evaluation Findings for the Crisis Services Redesign Initiative;** Report to the Texas Department of State Health Services; Page xi, January 1, 2010. Public Policy Research Institute.

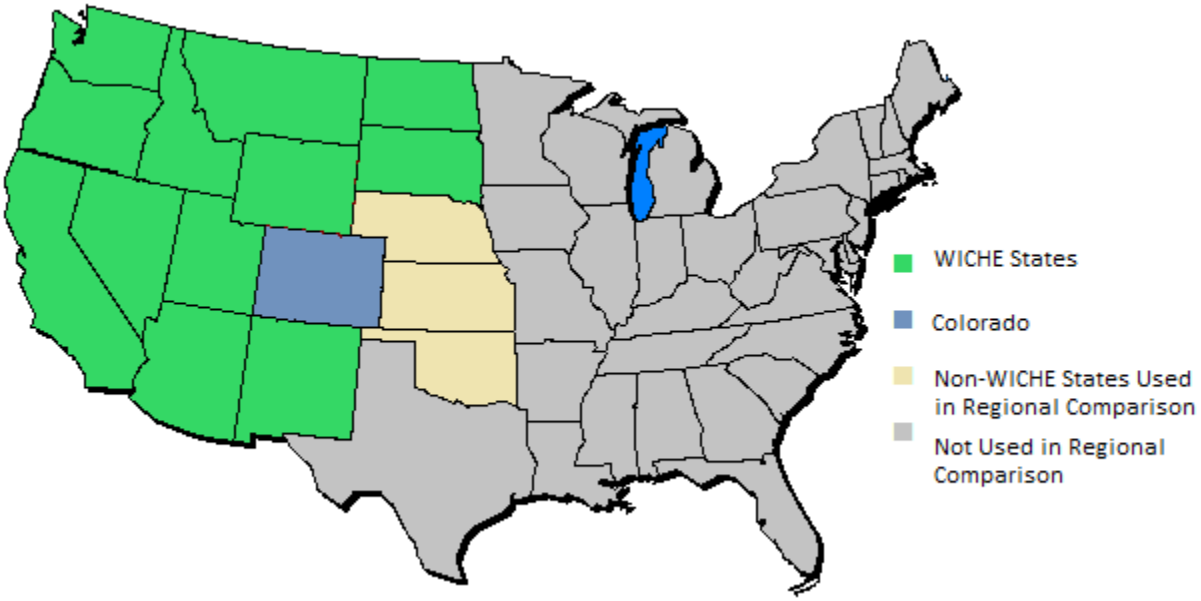
Community Integration and *Olmstead*

Introduction

This report aims to identify strengths and weaknesses in Colorado's service delivery system related to community integration and the *Olmstead* mandate so that the state's Office of Behavioral Health (OBH) can develop an *Olmstead*-compliant continuum of services that best meets the needs of people receiving public mental health services. A variety of methods were used to inform this report.

To give OBH a sense of how it aligns with national and regional averages, national-level data were used. National and state-level data were gleaned from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Uniform Reporting System (URS), SAMHSA's Revenues and Expenditures Project, and NRI's State Profiling System. Individual state mental health authority (SMHA) data for Western Interstate Commission for Higher Education (WICHE) states (with the exception of Alaska and Hawaii), as well as those states neighboring Colorado that are not WICHE states, were used to provide regional comparisons. These states include Arizona, California, Idaho, Kansas, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, and Wyoming (see Figure 1). When available, data from 2003 through 2013 were used to allow for trend analysis. Population data to calculate 2013 rates are from 2012 due to a delay in reporting by the U.S. Census Bureau.

Figure 4: States Used in Regional Comparisons



Data indicators used in this report to determine levels of community integration were derived from SAMHSA's Community Integration Self-Assessment Tool. These indicators were identified and developed by a group of technical experts who considered recent *Olmstead* case law and settlement agreements, and a review of the literature on community integration. The

indicators were then tested and refined by a group of pilot states that provided feedback on the effectiveness of the measures.[1]

A review of the *Docket of Cases Related to Enforcement of the ADA Title II "Integration Regulation"*[2] was also conducted. Results from this review provide examples of recent *Olmstead* litigation that may be relevant to Colorado's current situation, and might provide insight into where the state is at risk. In addition to reviewing data and information from national and state sources, a key informant interview was held with Charlie Smith, Ph.D., a former OBH commissioner who is the current SAMHSA regional administrator for Colorado's region, and is also the director of the *Olmstead* Regional Initiative.

Background

Title II of the Americans with Disabilities Act (ADA) prohibits state governments from denying people with disabilities the benefits of their programs, services, or activities, or to otherwise discriminate against them.[3] A Department of Justice (DOJ) regulation implementing Title II requires state governments to administer services "in the most integrated settings appropriate to the needs of qualified individuals with disabilities."[4] In the landmark 1999 case *Olmstead v. L.C.*, the U.S. Supreme Court interpreted the ADA to mean that unjustified institutionalization of individuals with disabilities constitutes illegal discrimination on the basis of disability.[5] The right to receive services in the most integrated setting possible is not unqualified. According to the National Disability Rights Network (NDRN):

> Although the ADA requires states to make "reasonable accommodations" to comply with the statute, states are not required to make accommodations that would be a "fundamental alteration of its system for providing care for individuals with disabilities." To assert a "fundamental alteration" defense to an integration mandate claim, a state must demonstrate that, "in the allocation of available resources, immediate relief for the Plaintiffs would be inequitable, given the responsibility the state has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities."[6]

Since 1999, at least 45 states have been involved in litigation related directly or indirectly to *Olmstead,* most of which was brought by Protection and Advocacy agencies or private plaintiffs.[7] The DOJ has been engaged at some level in *Olmstead* legal activities in more than half of the states. DOJ engagement may include initiating its own investigation and issuing a "findings letter," joining existing litigation as a party to the litigation, filing amicus ("friend of the court") briefs to support plaintiffs in existing litigation, or filing claims directly against a state alleging violations of the ADA.[8]

Most state *Olmstead* litigation involving DOJ results in a settlement agreement, rather than a court decision or mandate. Although settlement agreements vary significantly from state to state, many are comprehensive blueprints for system reform, requiring increased access to integrated services in the community, such as scattered-site supportive housing; programs that

expand access to competitive employment; Assertive Community Treatment (ACT); accessible crisis services, such as 24/7 hotlines, mobile crisis services, and respite programs; and peer support. For example, settlement agreements in Delaware and Georgia require increased access to supportive housing, supported employment, and a broad range of crisis services, setting performance targets for the states to meet in implementing services (such as a specific number of new supported employment slots or a percentage of housing that must be scattered-site, permanent supportive housing).

Olmstead plans

In the *Olmstead v. L.C.* decision, the Court recommended that states "demonstrate that [they have] a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings" as one activity necessary to be in compliance with Title II of the ADA.[9] In response to this recommendation, many states have developed, or are developing, *Olmstead* plans that structure priorities and set timelines to ensure that persons with disabilities have access to the most-integrated care appropriate. These plans are living documents that require periodic updates, and are developed by a group of state agencies with input from consumers, family members, advocacy organizations, service providers, and other experts. Among the 16 states used for regional comparisons, a brief Internet search indicates that 13 either have *Olmstead* plans (AZ, CA, CO, MT, ND, NM, NV, OK, OR, UT, WA, and WY), or are in the process of developing one (NE).

In July 2012, Colorado Governor John Hickenlooper mandated the creation of the Office of Community Living, an advisory committee within the Department of Healthcare Policy and Financing (HCPF). This committee—composed of consumers, advocates, and representatives from the Division of Housing, Department of Public Health and Environment, and the Department of Human Services—is tasked with "redesign[ing] all aspects of the long-term services and supports delivery system, including service models, payment structures, and data systems to create efficient and person-centered community-based care."[10] Part of its charge was to develop a revised state *Olmstead* plan. This plan, entitled *Colorado's Community Living Plan*, was released in July 2014.

Colorado's *Olmstead* plan identifies nine goals designed to improve community integration for people with disabilities, including people with mental illnesses. The nine goals are:[11]

1. Proactively identify individuals in institutional care who want to move to a community living option, and ensure successful transition through a person-centered planning approach.
2. Proactively prevent unnecessary institutionalization of people who, with the right services and supports, could successfully live in the community.
3. Increase availability and improve accessibility of appropriate housing options in the most integrated setting to meet the needs of people moving to the community.

4. Support successful transition to community settings, ensure a stable and secure living experience, and prevent re-institutionalization through the provision of responsive community-based services and supports.
5. Increase the skills and expertise of the Direct Service Workforce to increase retention, improve service quality, and better meet the needs of consumer groups.
6. Improve communication strategies among long-term services and supports (LTSS) agencies to ensure the provision of accurate, timely, and consistent information about service options in Colorado.
7. Integrate, align, and/or leverage related systems' efforts to improve plan outcomes, eliminate redundancies, and achieve implementation efficiencies.
8. Implement an evaluation plan that supports an objective and transparent assessment of implementation efforts and outcomes.
9. Ensure successful plan implementation and refinements over time through the creation of an *Olmstead* Plan Governance Structure and supportive workgroups.

Charlie Smith, Ph.D., SAMHSA's regional administrator for Colorado's region and former commissioner of Colorado's OBH, praised the state's updated *Olmstead* Plan. The collaborative effort across three state agencies in developing the plan, and their commitment to community integration, results in great synergy among the state agencies and a broad group of stakeholders. But Dr. Smith said a major challenge will be to ensure that the effort remains collaborative, and that natural interagency competition does not become an issue.

While the existence of a state *Olmstead* plan helps ensure compliance with the ADA's Integration Mandate, it does not guarantee that a state is not at risk of litigation. Even states with robust *Olmstead* plans have faced litigation, and been found in violation of the mandate. It is important that the activities set forth in the state's plan are carried out, and that the plan remains up to date and relevant to the changing needs of the state's population. Table 1 provides a brief overview of the goals and priorities identified by each of the Western states in their *Olmstead* plans. Only those states with identified *Olmstead* plans are listed in the table.

Table 1: Western States' Olmstead Plan Priorities

State	Status of State's Olmstead Plan	Olmstead Plan Priorities
AZ	Updated March 2003. Available online. [12]	▪Person-centered care management ▪Consistency of services ▪Available and accessible services ▪Most integrated settings ▪Collaboration with stakeholders
CA	Updated November 2012. Available online. [13]	▪State commitment through consistency and financing ▪Assessment and transition ▪Diversion ▪Data and research
CO	Released July 2014. Available online. [14]	▪Identify Individuals Ready to Transition ▪Prevent Unnecessary Institutionalization ▪Housing ▪Transition Planning ▪Workforce

State	Status of State's Olmstead Plan	Olmstead Plan Priorities
		▪Improve Communication ▪Evaluation Plan ▪Oversight of Plan Implementation
MT	Updated July 2006. Available online. [15]	▪Self-Directed Care ▪Prevent/Eliminate Unnecessary Institutionalization ▪Improve Access to and Availability of Community Services ▪Informed Choice ▪Quality Assurance
NE	Plan in development.	N/A
NV	Updated March 2014. Available online. [16]	▪Service Sufficiency ▪Access to Care ▪Seamless Service Delivery System ▪Information and Education
NM	Plan exists. Date of latest version unknown.	Unknown.
ND	Updated September 2011. Available online. [17]	▪Infrastructure ▪Increased Funds to Community Services ▪Informed Choice ▪Coordination of Care ▪Transition Planning
OK	Updated April 2010. Not available for download. [18]	▪Employment ▪Screening ▪Self-Directed Care ▪Healthcare ▪Housing ▪Transportation ▪Mental Health
OR	Released August 2013. Available online. [19]	▪Preventing State Hospitalization ▪Reducing Length of Stay ▪Appropriate Residential Services ▪Housing ▪Expanding the Quality and Availability of Community Supports
UT	Updated 2011. Not available for download.	Unknown
WA	Developed 2005. Not available for download. [20]	▪Housing ▪Transportation ▪Integration ▪Employment ▪Systems Change
WY	Plan exists. Date of latest version unknown. Not available for download.	Unknown

Interagency and interstate collaboration on *Olmstead* issues

Interagency collaboration is crucial to minimizing the state's risk of violating the *Olmstead* mandate. Collaborative efforts enable the SMHA to identify persons who may require OBH services, but have not yet interacted with the behavioral health system. And they help OBH

ensure that a broad range of community-level, integrated services is available to persons with behavioral health needs that may be beyond the scope of the SMHA's and OBH's responsibilities (e.g., housing, education). Persons with behavioral health needs who are at risk of institutionalization may have had no prior interaction with OBH or HCPF, and may be receiving services from other state agencies such as the Department of Corrections or Veterans Affairs, so identifying the state's at-risk population is extremely challenging without broad and effective interagency collaboration.

The creation of Colorado's Office of Community Living is a step in the right direction to prevent fragmentation and ensure that service delivery systems are aligned and easier to navigate for persons requiring long-term services and supports in the community. In addition to its role in the Office of Community Living, Colorado's OBH is responsible for the creation of the *Olmstead* Regional Initiative, a regional collaborative of federal and state agencies, and consumer and advocacy organizations.

The *Olmstead* Regional Initiative began in 2011 when OBH reached out to the U.S. Housing and Urban Development (HUD) offices in Denver to better understand *Olmstead*-related housing issues. HUD recruited the U.S. Health and Human Services Department's Office of Civil Rights (OCR) to help respond to the inquiries. This resulted in the development of the *Olmstead* Housing Coalition. The following year, a number of agencies with a stake in *Olmstead* issues were invited to participate in 2012, as was Dr. Smith of SAMHSA. The agencies included the HHS Administration for Community Living, Centers for Medicare and Medicaid Services (CMS), SAMHSA, Social Security Administration (SSA), and the Department of Veterans Affairs. As needed, this coalition can bring in representatives from other agencies, including the U.S. Department of Education and the U.S. Department of Justice. Inquiries from consumer organizations and advocacy groups in the region led to the coalition expanding its reach and services to other states in the region.

In addition to its participation in the *Olmstead* Regional Initiative, Colorado is also participating in SAMHSA's *Olmstead* Community of Practice, an initiative that encourages states to learn from one another how to better understand and improve community integration.
OBH's collaborative efforts across state and federal agencies, and with other states in the region, demonstrate a strong commitment to ensuring that integrated services are available to persons with behavioral health needs, even those who may not have prior interaction with OBH's service system.

Colorado's use of institutions versus community services

On many high-level measures, Colorado's OBH ranks as well as or better than most SMHAs nationally in using community services rather than institutions to provide services to people with serious mental illnesses. However, Colorado tends to fall in the middle tier when compared to other Western states. Table 2 provides a snapshot of how Colorado ranks on indicators used to assess a state's level of community integration.[21]

Table 2: Indicators of Community Integration, 2013[22]

Indicator	Desired Direction	Colorado	Regional Avg./Range	National Avg./Range	Colorado's Regional Ranking	Colorado's National Ranking
Percentage of SMHA Expenditures for Community Services	↑	76.96%	77.9%	72.1%	3rd largest (n=14 states)	12th largest (n=48 states)
Percentage of SMHA Expenditures on State Hospital	↓	22.09%	21.1%	25.8%	4th smallest (n=14 states)	13th smallest (n=48 states)
Penetration Rate (per 1,000)	↑	19.4	21.1	22.8	10th highest (n=16 states)	32nd highest (n=51 states)
State Hospital Utilization Rate (per 1,000)	↓	.34	.37	.46	6th lowest (n=16 states)	18th lowest (n=51 states)
Community Services Utilization Rate (per 1,000)	↑	18.87	20.4	22.1	10th highest (n=16 states)	32nd highest (n=51 states)
Median Length of Stay, Adults Discharged from State Hospital During the Year	↓	47 days	10 days to 693 days (n=15 states)	5 days to 693 days (n=50 states)	9th shortest length of stay (n=15 states)	29th shortest length of stay (n=50 states)
Median Length of Stay, Adults Continuing Services at End of Year with LOS Greater than One Year	↓	1,600 days	482 days to 2,234 days (n=15 states)	408 days to 3,420 days (n=46 states)	12th shortest length of stay (n=15 states)	38th shortest length of stay (n=46 states)
Median Length of Stay, Adults Continuing Services at End of Year with LOS Less than One Year	↓	63 days	10 days to 118 days (n=15 states)	5 days to 160 days (n=49 states)	8th shortest length of stay (n=15 states)	26th shortest length of stay (n=49 states)

It is important to note that the utility of these data are limited in a few ways. First, states did not necessarily report uniformly in these domains. For example, while all states are required to include forensic patients (including those who are classified as not guilty by reason of insanity (NGRI), and those who are receiving services to restore competency) in their total number of patients in state hospitals, three states did not in 2013. These differences affect both the utilization rate and lengths of stay reported as part of SAMHSA's Uniform Reporting System (URS). In addition, states vary significantly in how they set eligibility criteria for SMHA services. For example, Colorado's penetration rate of 19.4 per 1,000 people is somewhat lower than the national rate of 22.8 per 1,000. This may help to explain why Colorado's community services utilization rate of 18.87 per 1,000 is slightly lower than the regional and national rates.

Data regarding community versus institutional expenditures reported above includes only spending by the SMHA. Within Medicaid, Colorado spent 58 percent of its funding for long-term services and supports (LTSS) for home- and community-based services, rather than on nursing home or other institutional services in 2012. Only eight states (OR, MN, AK, VT, AZ, WA, CA, WI) and the District of Columbia spend a higher percentage of LTSS funding on home- and community-based services.[23]

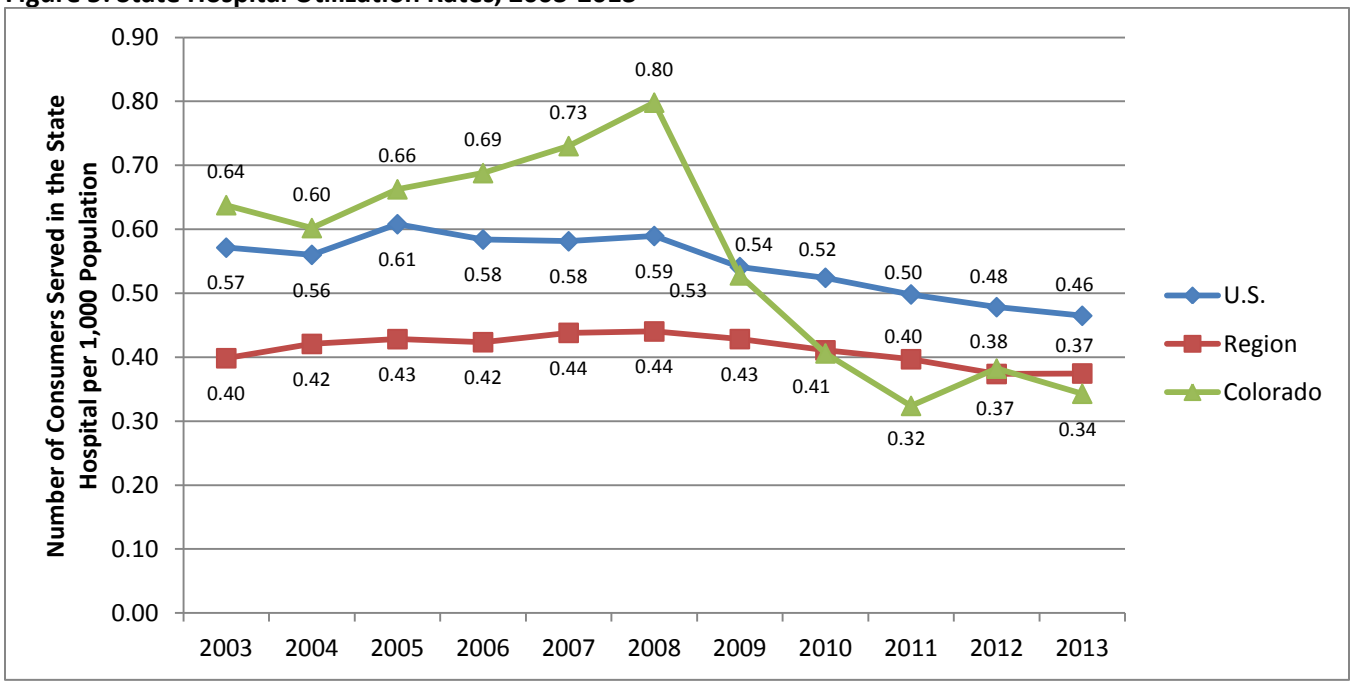
Institutional utilization

State hospital utilization – current facilities

Colorado has two state hospitals, the Colorado Mental Health Institute at Fort Logan (CMHIFL) and the Colorado Mental Health Institute at Pueblo (CMHIP). CMHIFL has 94 beds dedicated to serve persons admitted voluntarily with serious mental illnesses (SMI) who are referred by community mental health centers. CMHIP has 451 inpatient psychiatric beds, including 144 beds for civilly committed individuals, and 307 beds for individuals involved in the criminal justice system.

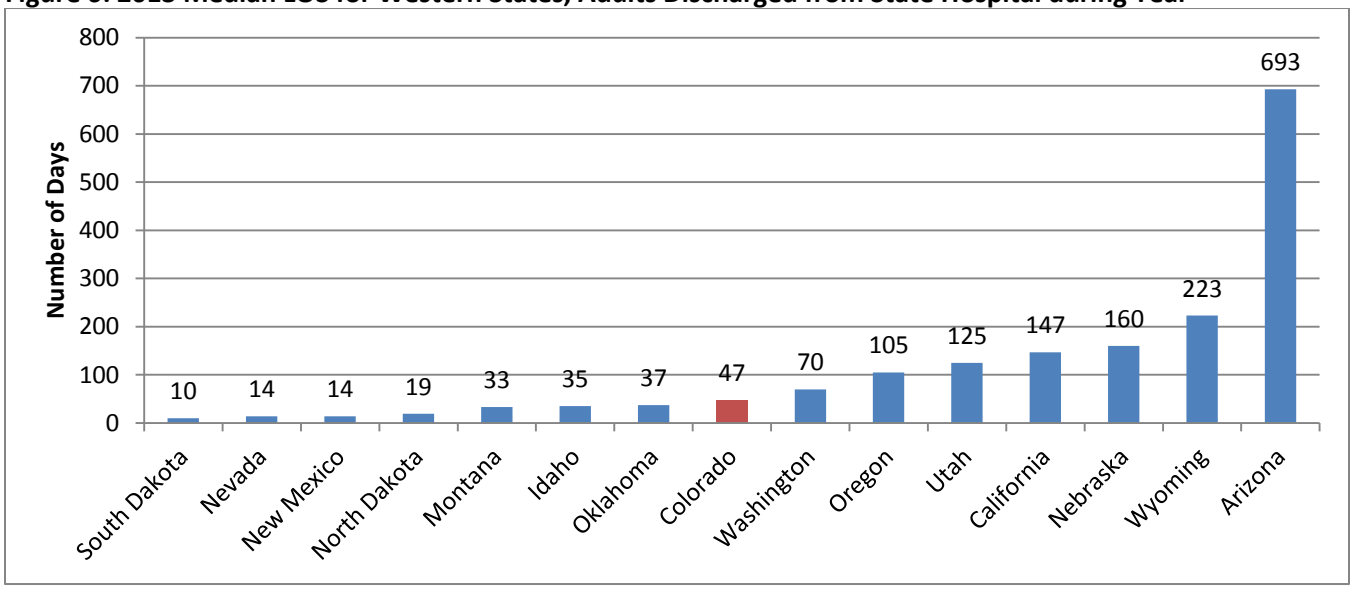
Colorado's 2013 state hospital utilization rate of .34 per 1,000 of the population is lower than the national average of .46 per 1,000 of the population, and is also slightly lower than the regional average of .37 per 1,000 of the population. Since 2009, Colorado's state hospital utilization rate has been consistently lower than the national average, and has been less than or equal to the regional average. See Figure 2.

Figure 5: State Hospital Utilization Rates, 2003-2013[24]



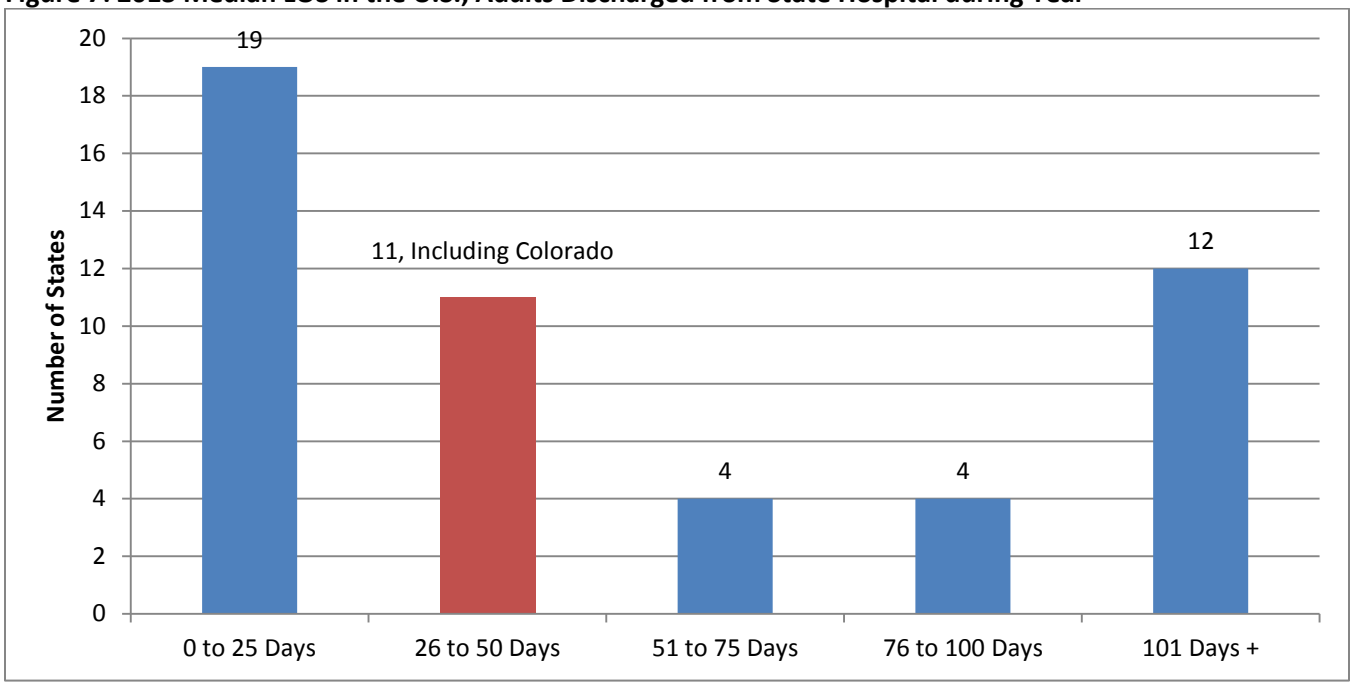
In addition to low rates of hospital utilization, Colorado's median length of stay (LOS) of 47 days for adults discharged from the state hospital during the year places it eighth among the Western states used for regional comparisons (n=15 states; Kansas did not report). The range in Western states was 10 days in South Dakota to 693 days in Arizona.[25] Figure 3 shows Colorado's regional ranking in LOS for adults discharged from the state hospital in 2013.

Figure 6: 2013 Median LOS for Western States, Adults Discharged from State Hospital during Year[26]



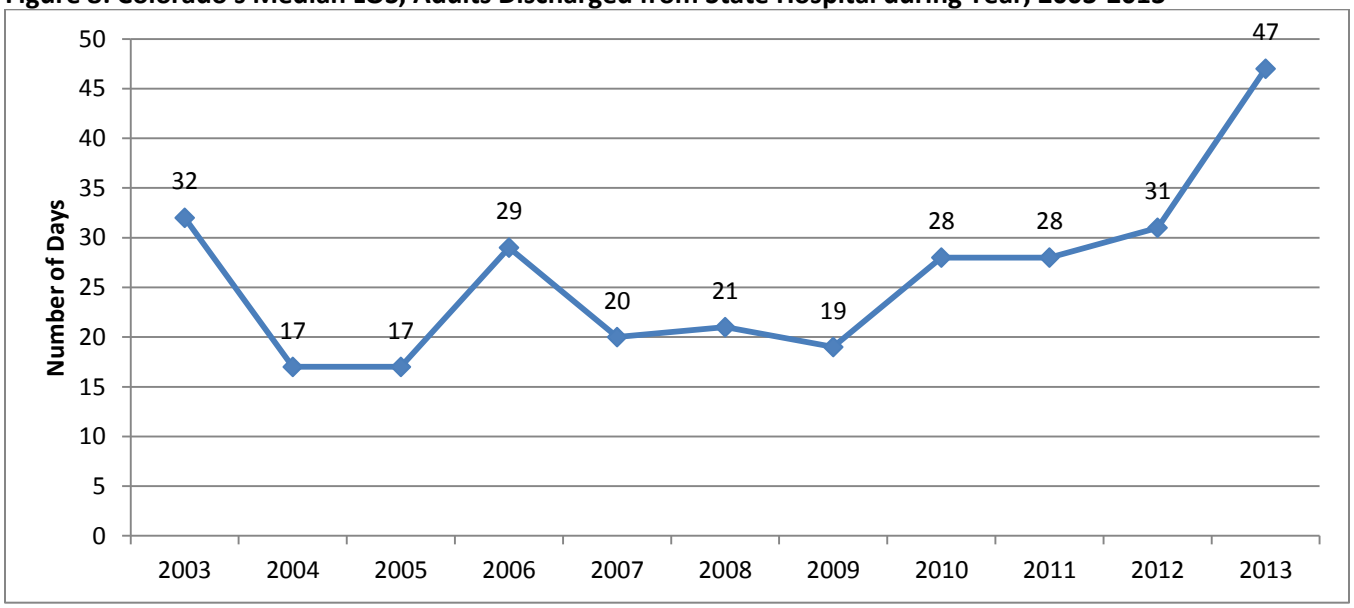
Nationally, Colorado's median LOS for adults discharged from the state hospital during the year ranks 29th among 50 states. The median LOS for adults discharged from the hospital in the U.S. ranges from five days in Alaska, Rhode Island, and Tennessee to 693 days in Arizona. Figure 4 shows the distribution of LOS for all reporting states (n=50 states responding)

Figure 7: 2013 Median LOS in the U.S., Adults Discharged from State Hospital during Year[27]



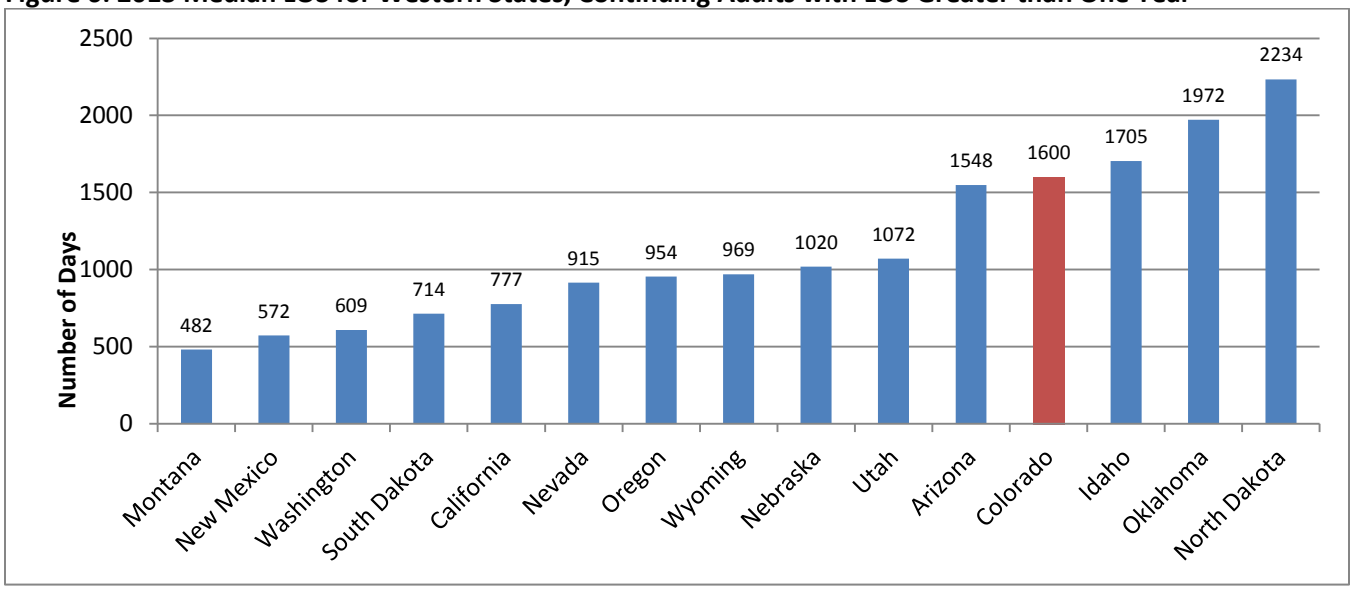
While Colorado's median LOS for adults discharged during the year falls in the middle of regional and national ranges, it has increased each year since 2009. See Figure 5.

Figure 8: Colorado's Median LOS, Adults Discharged from State Hospital during Year, 2003-2013[28]



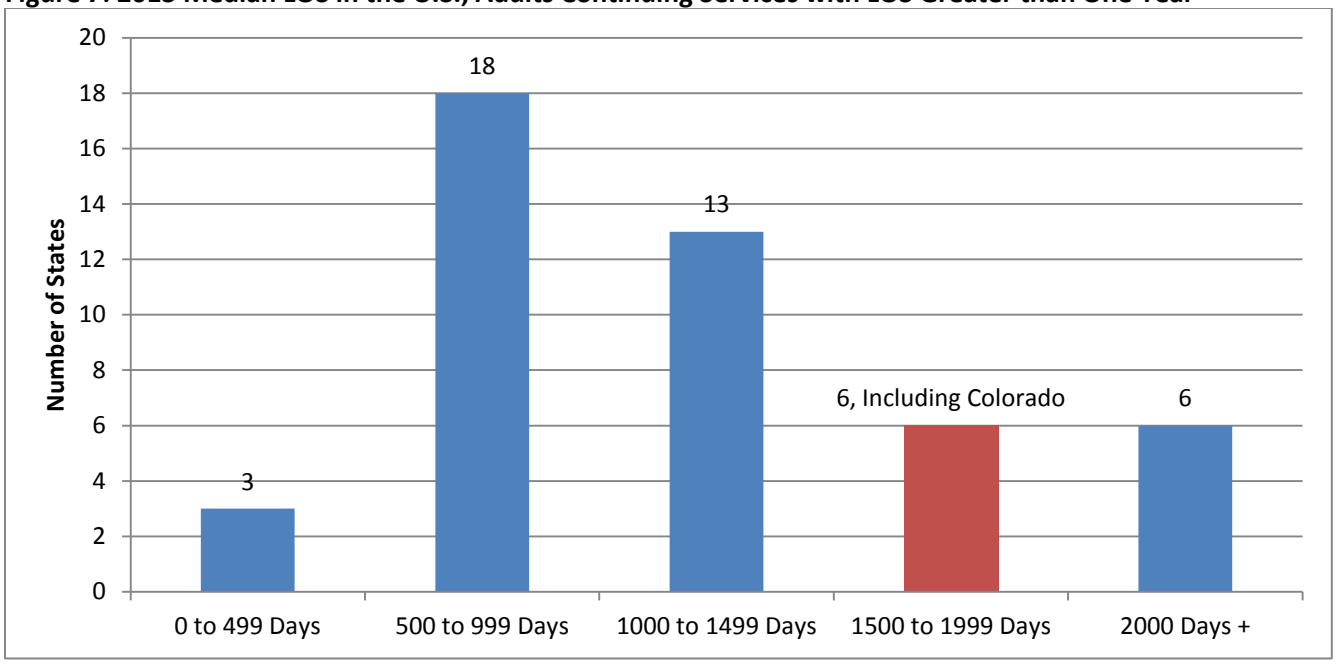
When evaluating LOS for adult consumers with a length of stay greater than one year, continuing at the end of the year, Colorado ranks 12th among the 15 regional states, with a median length of stay of 1,600 days. See Figure 9.

Figure 6: 2013 Median LOS for Western States, Continuing Adults with LOS Greater than One Year[29]



Nationally, Colorado's median LOS in 2013 for adults continuing services with an LOS greater than one year ranks 38th in the nation among 46 reporting states. The national median length of stay for adults continuing services with an LOS greater than one year ranged from 408 days in Minnesota to 3,420 in the District of Columbia. See Figure 10.

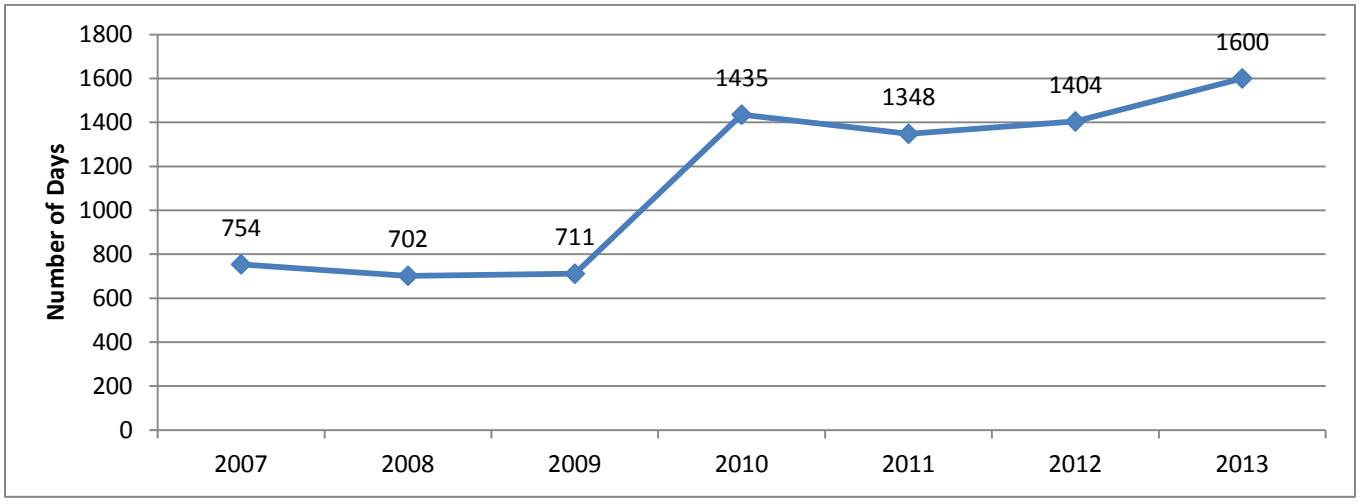
Figure 7: 2013 Median LOS in the U.S., Adults Continuing Services with LOS Greater than One Year[30]



Similar to the upward trend seen in the median LOS for adults discharged during the year, the median number of days for adult consumers continuing services at the end of the year with an LOS greater than one year has increased each year since 2009. Reliable data for this indicator

are only available from 2009. Colorado's OBH may wish to investigate what accounts for this steady increase. See Figure 8.

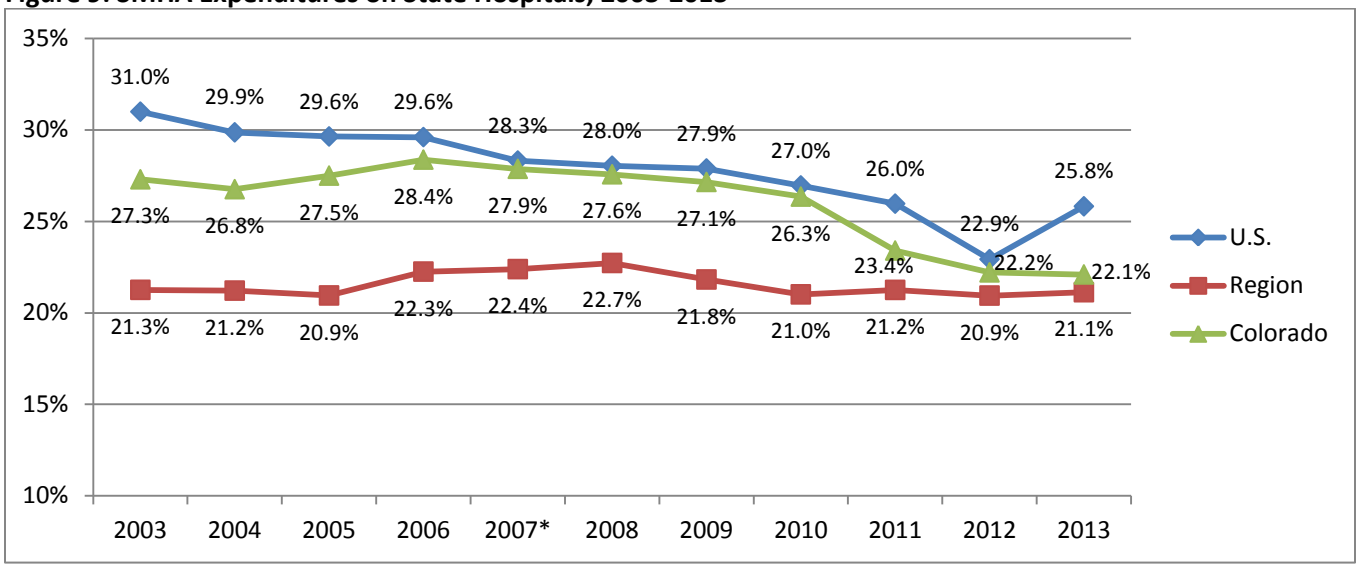
Figure 8: Colorado's Median LOS, Adults Continuing Services with LOS Greater than One Year, 2003-2013



Expenditures on state psychiatric hospitals

In 2013, Colorado spent slightly less of a percentage of its funds (22.1 percent) on state hospital expenditures than the national average (25.8 percent), and slightly more than the regional average (21.1 percent). Although this trend has remained consistent since at least 2003, Colorado's percentage of expenditures on state hospitals has been decreasing steadily since 2006, indicating that most new funds have been allocated to providing community services. See Figure 9.

Figure 9: SMHA Expenditures on State Hospitals, 2003-2013[31]



Potential of building new state hospital facilities

Colorado is considering building new hospitals to replace the aging facilities in Pueblo and Denver. In 2013, at least six other states (AL, KY, MA, NC, OR, and VT) reported building a new hospital or replacing existing state hospital beds.[32]

There is no inherent violation of the ADA associated with the use of funds to build new or replacement hospital beds, so long as it does not result in increased reliance on hospitals to serve persons with mental illness who could effectively be served in the community. In a 2009 case, a federal district court judge dismissed on procedural grounds the claims of advocates who opposed the development of a replacement residential facility for an aging institution serving people with developmental disabilities in Virginia.[33] In that case, *The ARC of Virginia v. Kaine,* the court found that the case was not ripe for review because individuals had not yet been selected for placement in the facility. In its decision, the court quoted from *Olmstead:*

> [We] recognize… the States' need to maintain a range of facilities for the care and treatment of persons with diverse mental disabilities, and the States' obligation to administer services with an even hand.[34]

The court indicated this passage from the *Olmstead* decision was important because "the Supreme Court recognized the inevitability that States are obligated to maintain facilities that enable them to provide care and services for a diverse population of persons with mental disabilities…"[35] The court also noted the replacement facility would have only half the number of beds as the original facility and that it was "but one part" of the state's plan to serve people with disabilities, which also included building new community-based facilities.[36]

In *ARC v. Kaine,* the court ruled on procedural grounds because the people to be served in the replacement facility had not yet been identified, and thus, the court found, there could be no claim that they were being unnecessarily segregated. However, the decision to build a new facility may make it more difficult for the state to defend against an *Olmstead* claim should people who are appropriate for discharge allege that they are institutionalized because of a lack of community services. Under those circumstances, a court might consider whether developing new or replacement hospital beds violates the ADA because those resources could have been used instead to provide community services. In an amicus curiae brief filed in the *ARC v. Kaine* case, DOJ argued:

> The State has not raised a fundamental alteration defense, and indeed by spending additional funds on another segregated facility, the State would be hard pressed to raise this defense. … Rather than building community capacity, the State is exacerbating its existing failure to comply with *Olmstead* by choosing to allocate its resources in a way that ignores the needs of the individuals with disabilities which it serves and perpetuates the institutional bias that the Court recognized in *Olmstead.* … Such allegations state a claim for a Title II violation under the ADA.[37]

Taking into consideration Colorado's increasing median length of stay, the state may be more vulnerable to a claim that investing in community capacity, rather than institutional services, is a reasonable accommodation required under the ADA to ensure that people who receive services in the most integrated setting appropriate for their needs.

The location of Colorado's two state hospitals does present some challenges to ensuring appropriate levels of community integration. Civil psychiatric beds in each of the state hospitals have been distributed for use based on the regions of the community mental health centers and bed availability. Because the largest number of beds are available at CMHIP, it is not uncommon for consumers to have to drive two hours south, past CMHIFL, to receive services at CMHIP. This strategy of bed allocation means that even consumers who require hospitalization are receiving treatment further from their families and other community supports—far from the most integrated setting appropriate for their care. As suggested elsewhere in this report, the reallocation of 24 civil beds from CMHIP to CMHIFL would help to reduce this risk.

Forensic patients

Many states face political and other challenges in discharging forensic patients from state hospitals, even when it is determined that those individuals can be effectively served in community settings. The challenges typically include a lack of community providers willing to assume the perceived risk associated with serving people who have histories of interaction with the criminal justice system and, often, histories of violence or sexual misconduct. In some cases, this reflects a tension among competing policy priorities within the state, including cost containment, census reduction, community integration, and public safety.

Despite these challenges, the requirements of the ADA and the *Olmstead* decision apply to forensic patients. In a 2008 DOJ findings letter to the state of Oregon, for example, DOJ wrote:

> Within the limits of court-imposed confinement, federal law requires that OSH [Oregon State Hospital] actively pursue the timely discharge of patients to the most integrated, appropriate setting that is consistent with patient needs.[38]

Forensic patients have been included in "targeted classes" identified in *Olmstead* settlement agreements between states and the DOJ. For example, the Delaware *Olmstead* settlement agreement includes as a priority population "[p]eople who are currently at Delaware Psychiatric Center, including those on forensic status for whom the relevant court approves community placement."[39]

Increased demand for forensic beds in Colorado has led to a shortage of civil beds at CMHIFL. The number of referrals for inpatient competency evaluations has increased 500 percent in the past 10 years, and referrals for inpatient competency restorations have increased 107 percent during the same period. This trend has resulted in a rapidly increasing number of denials for civil admissions to both state hospitals; for every civil admission at CMHIFL, there are three additional people on a waiting list for services, and 1.5 per civil admission at CMHIP. Although the demand for forensic beds has led to a shortage of civil beds, the need for forensic beds is still not being met. According to 2011 data, inmates waited an average of 75 days in jail for admission to CMHIP for evaluation or restoration services.[40] A 2012 settlement agreement stipulated that the state Department of Human Services is required to admit a pretrial detainee to CMHIP within 28 days of the court's determining the need for an evaluation or restorative treatment, and receipt of all collateral documentation by CMHIP. Competency evaluations performed in county jails must be completed within 30 days.

Programs aimed at decreasing forensic demand for state psychiatric hospital inpatient beds may be helpful at limiting the shortage of civil beds, mitigate the risk of *Olmstead* litigation targeted toward the forensic population in Colorado, and reduce the need for creating additional inpatient beds at the state hospitals. Establishing these programs will require collaboration with the state's corrections department, as laws and the culture of correctional facilities may need to be changed.

One initiative, the RISE (Restoring Individuals Safely and Effectively) program, was implemented at the Arapahoe County Detention Center in November 2013. The purpose of this program is to "provide competency restoration treatment to individuals found incompetent to proceed to trial by the courts and deemed suitable for jail-based restoration by [OBH]."[41] RISE provides 22 beds to individuals who may otherwise have been referred to CMHIP for similar treatment services. Additional benefits of this program are that individuals receiving these services are "closer to family and other supports," length of time in treatment is reduced, and the continuity of care is improved; all factors that are critical to ensuring services are provided in the most integrated setting possible.[42]

Use of nursing homes and adult care homes

Under *Olmstead,* the state's obligation is to provide its services in the most integrated setting appropriate for the person's needs—defined as a "setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."[43]
Recent case law confirms that even settings often considered to be "in the community," such as nursing homes and adult homes, may not meet this definition. For example, in *Disability Advocates Inc. v. Paterson,* a federal court ruled that adult care homes for individuals with mental illness in New York, which are unsecure but highly regimented congregate settings, constituted unnecessary segregation when individuals could be served in their own apartments by supported housing.[44]

Similarly, in a consent decree entered to settle the case *Williams v. Quinn,* the state of Illinois agreed to specific actions designed to support transitions from Institutions for Mental Disease (IMDs) into settings that are more integrated.[45] The IMDs that were the focus of the lawsuit were privately owned nursing homes and adult care homes with more than 16 beds serving primarily people with mental illnesses. In a statement supporting the consent decree in the *Williams* case, the DOJ pointed out that the IMDs did not prepare residents for community living and that discharge planning was "virtually nonexistent."[46] DOJ also cited a recent report indicating that "[e]xperts in this case agree that 99 percent of IMD residents have no medical reason to remain in institutions and could be safely served in the community."[47]

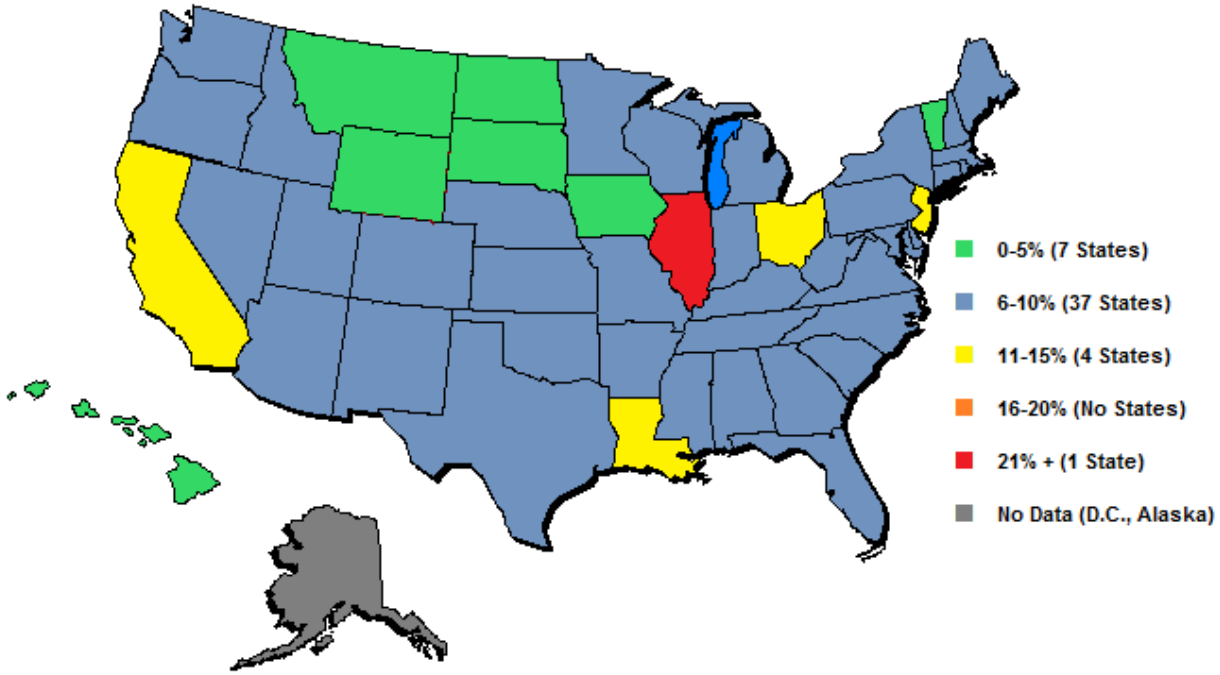
Colorado has in place several programs designed to prevent nursing home admissions and support transitions into the community for people with serious mental illnesses. Since 2002, Colorado has administered a 1915(c) waiver for people with mental illnesses, providing homemaker, personal care, respite, adult day health, environmental modifications, transportation, and other services for adults with chronic mental illnesses requiring nursing facility level of care. Additional services, including caregiver education, intensive case management, home-delivered meals, and peer mentorship may be available under Colorado Choice Transitions, a Medicaid Money Follows the Person initiative.

In addition, Colorado recently modified its approach to Preadmission Screening and Resident Review (PASRR), a federal Medicaid requirement designed to reduce inappropriate nursing home placements and ensure that people residing in nursing homes receive the services they need. Colorado's modification is designed to assess individuals for transition potential, and promote development of a transition plan where appropriate.[48]

While these strategies exist to prevent unnecessary use of nursing homes for persons with SMI, nursing homes may be the only alternative for geriatric consumers requiring intensive supports because of a lack of available geriatric beds in the state hospitals. In FY 2014, there were seven admission denials to either institute due to a geriatric bed not being available; 65 older adults were placed on waiting lists, of whom 28 percent were denied admission, 25 percent were admitted, and 47 percent withdrew their admission inquiry. It is unknown where these

individuals sought services, but some may have turned to nursing homes for care.
In 2010, 8.01 percent of all nursing home residents in Colorado had a diagnosis of bipolar or schizophrenia, slightly less than the national average of 10.5 percent. Among the Western states, seven states had lower prevalence rates than Colorado (ID, MT, NE, NV, ND, SD, and WY), and eight states had higher prevalence rates than Colorado (AZ, CA, NM, OR, UT, WA, KS, and OK). Prevalence rates in the Western states ranged from 5.24 percent in South Dakota to 11.53 percent in California.[49] See Figure 10.

Figure 10: Percentage of Persons with Bi-Polar or Schizophrenia Residing in Nursing Homes, 2010[50]



As recommended elsewhere in this report, increasing the number of psychiatric beds from 0.75 to 1.61 per 100,000 persons may help ensure that older adults are not unnecessarily receiving services in nursing homes. However, state psychiatric hospital beds cannot be relied upon to ensure acceptable levels of community integration among older adults. It is crucial that Colorado's OBH continue to pursue programs, such as the 1915(c) waivers for home- and community-based services, which allow older adults to remain in their own communities by providing appropriate levels of community supports.

In 2013, Colorado spent $620,727,684 of Medicaid funds dedicated to LTSS on nursing homes. Colorado ranked 39th in the nation, with only 12 states spending less on LTSS for nursing homes. Of these 12 states, seven are from the Western region (AZ, CA, NM, NV, OR, UT, and WA). [51]

Availability of community services

It is important that states have a wide variety of community services available to persons transitioning out of institutions, as well as to those at risk of institutionalization. Many *Olmstead* actions now focus on assuring that a comprehensive array of evidence-based practices are available in the community, especially those focused on housing, employment,

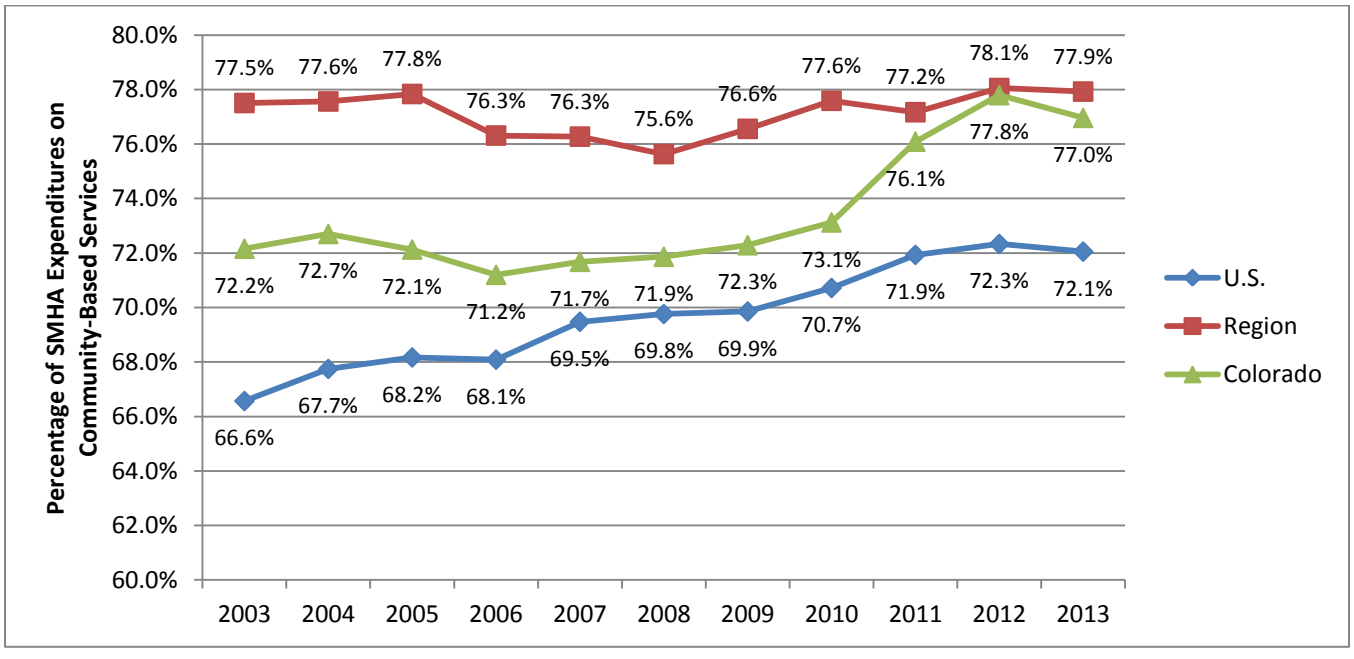
and crisis support.

Based on a review of court cases related to enforcement of the Integration Mandate, states may put people at risk of institutionalization when they make cuts to state programs that provide community-based services, do not move people off waiting lists at a reasonable pace, and develop policies that favor institutionalization over community services.[52] In June 2014, the federal government filed a Statement of Interest against the Commonwealth of Pennsylvania, claiming it put individuals "at serious risk of institutionalization by reducing funding for ACT 150, a state-funded program" that provides attendant care services in the community.[53]

SMHA expenditures on community services

In 2013, Colorado spent 77.0 percent of its funds on community-based services, slightly less than the regional average of 77.9 percent, but nearly five percentage points higher than the U.S. average of 72.1 percent. While the percentage of SMHA expenditures for community services has increased in Colorado since 2006, this figure dipped slightly in 2013. It appears this decrease is due to an increase in administrative expenses from 2012 to 2013, rather than an actual decrease in funds for community services. In FY 2012, Colorado reported administrative costs of zero dollars, due to the blending of mental health and substance use funds; the state was able to report this figure for FY 2013, reducing the percentages allocated for state hospital expenditures and community expenditures. The actual amount dedicated to community services increased by nearly $17 million between FY 2012 and 2013.

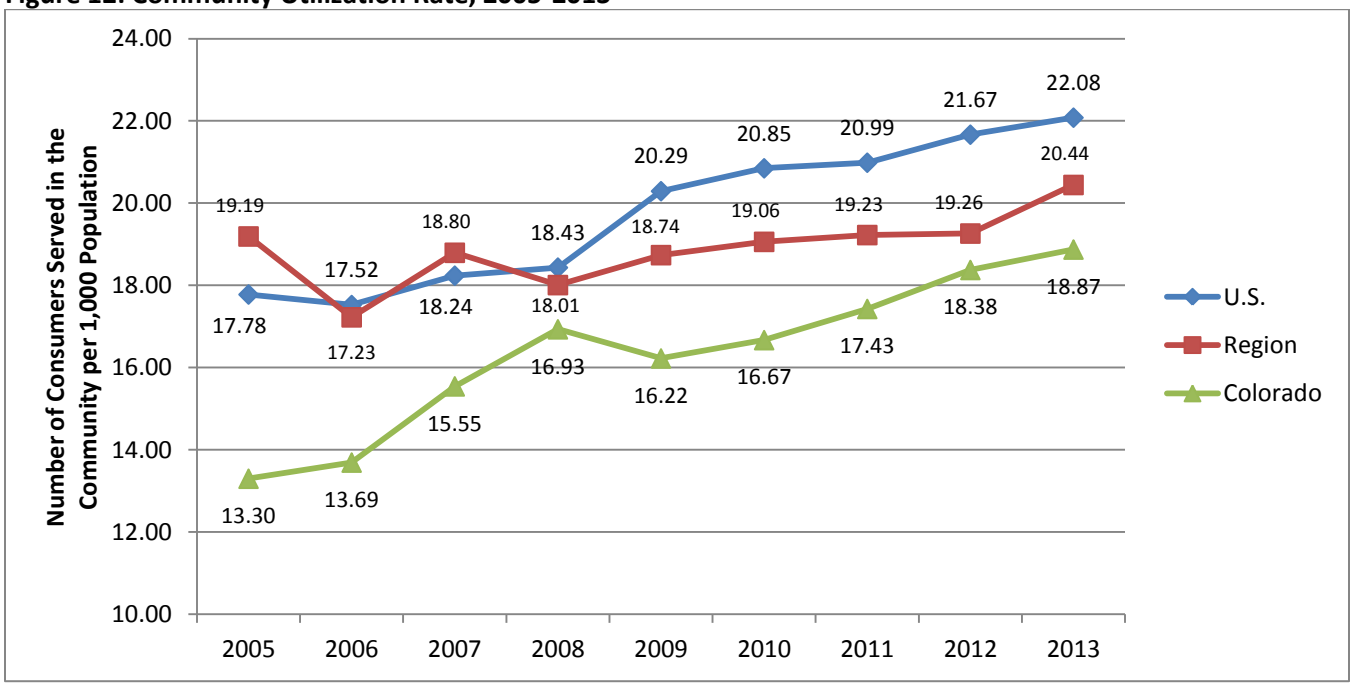
Figure 11: SMHA Expenditures on Community-Based Services, 2003-2013[54]



Community utilization rate

The community utilization rate shows how many people, per 1,000 of a state's population, receive SMHA-funded mental health services in the community. In 2013, Colorado's community utilization rate was 18.87 per 1,000, less than both the regional (20.44 per 1,000) and national averages (22.08 per 1,000). As discussed in the overview at the beginning of this section, this smaller number may be associated with the smaller overall penetration rate of Colorado (19.40 per 1,000) when compared to regional (21.28 per 1,000) and national (22,77 per 1,000) figures, and may not necessarily indicate insufficient availability of community services. Colorado's state hospital utilization rate of .34 per 1,000 supports this theory, as it is less than both the national (.46 per 1,000) and regional (.37 per 1,000) averages. Colorado's community utilization rate has also increased each year since 2005 (first year of available data), with the exception of a slight decrease in 2009 (See Figure 12).

Figure 12: Community Utilization Rate, 2005-2013[55]



Living situation

Living situation is a critical element of compliance with the *Olmstead* mandate. Consumers who are able to live on their own must have access to integrated housing. The DOJ emphasizes that

> Segregated settings include, but are not limited to: 1) congregate settings populated exclusively or primarily with individuals with disabilities; 2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits in individuals' ability to engage freely in community activities and to manage their own activities of daily living; or 3) settings that provide for daytime

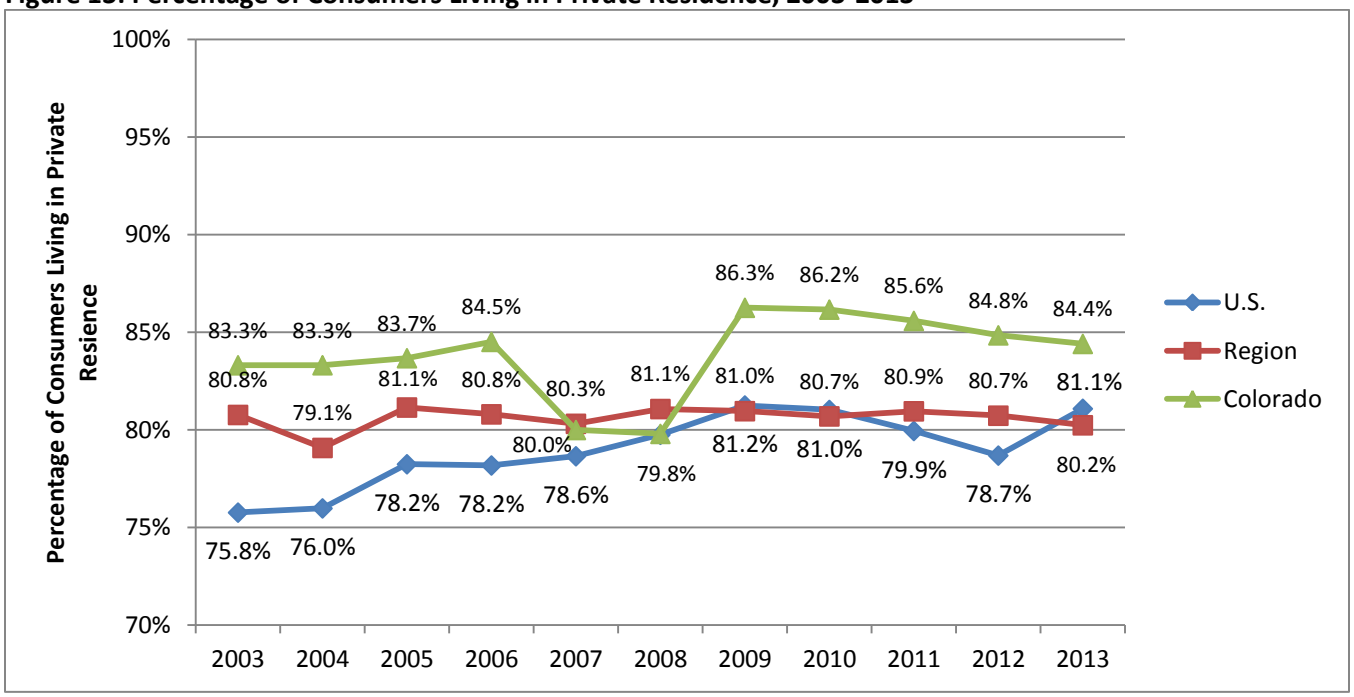
activities primarily with other individuals with disabilities.[56]

Colorado has implemented a variety of vouchers, tax credits, and Medicaid programs to help ensure that people with disabilities have access to integrated, affordable, and supportive housing in the community. At a minimum, these programs collectively provide approximately 33,000 housing vouchers, 3,000 housing units, 200 subsidies and a variety of other housing supports to persons with disabilities.[57] While most of these programs do not distinguish between the type of disability they serve (e.g., physical, developmental, or mental), some do specifically target their services toward persons with mental illnesses. The State Housing Vouchers program provides just less than 160 housing subsidies for persons with behavioral health disorders who are either residents in one of the state psychiatric hospitals or are chronically homeless. The Second Chance Housing and Reentry Program provides supportive services to 30 ex-offenders with co-occurring behavioral health disorders to facilitate transition from prisons and jails to independent living.[58]

SMHA consumers living in private residences

Colorado's rate of SMHA consumers living in a private residence while receiving treatment has consistently been above regional and national averages since 2009, a trend that continued into 2013. Only during 2007 and 2008 was Colorado's rate less than the regional average. See Figure 13.

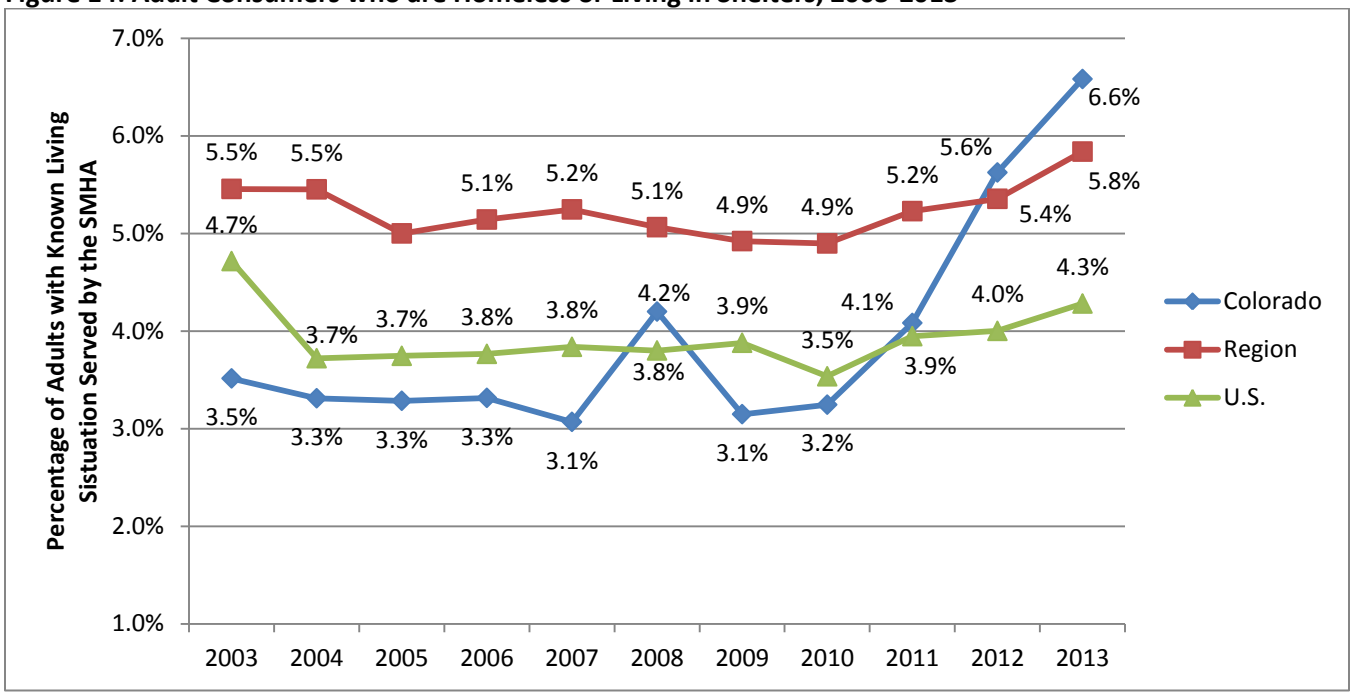
Figure 13: Percentage of Consumers Living in Private Residence, 2003-2013[59]



SMHA consumers who are homeless or living in shelters

For many years, Colorado's rate of homelessness among adult consumers of public mental health services has been far less than the regional and national averages. Although historically Colorado has had low rates of homelessness among SMHA consumers, and has several programs dedicated to providing housing supports specifically to persons with behavioral health disorders, its rate of homelessness among adults served by the SMHA with a known living situation has increased since 2009, and was more than 50 percent higher than the national average in 2013. In the Western region (n=16 states), Colorado's SMHA had the 10th-lowest rate of homelessness in 2013 (with rates ranging from 1.6 percent in Nebraska to 10.7 percent in Idaho). To mitigate this upward trend, OBH should examine how it can better ensure that persons with behavioral health issues have access to the other affordable housing programs available in the state to persons with disabilities.

Figure 14: Adult Consumers who are Homeless or Living in Shelters, 2003-2013[60]



SMHA consumers living in correctional facilities

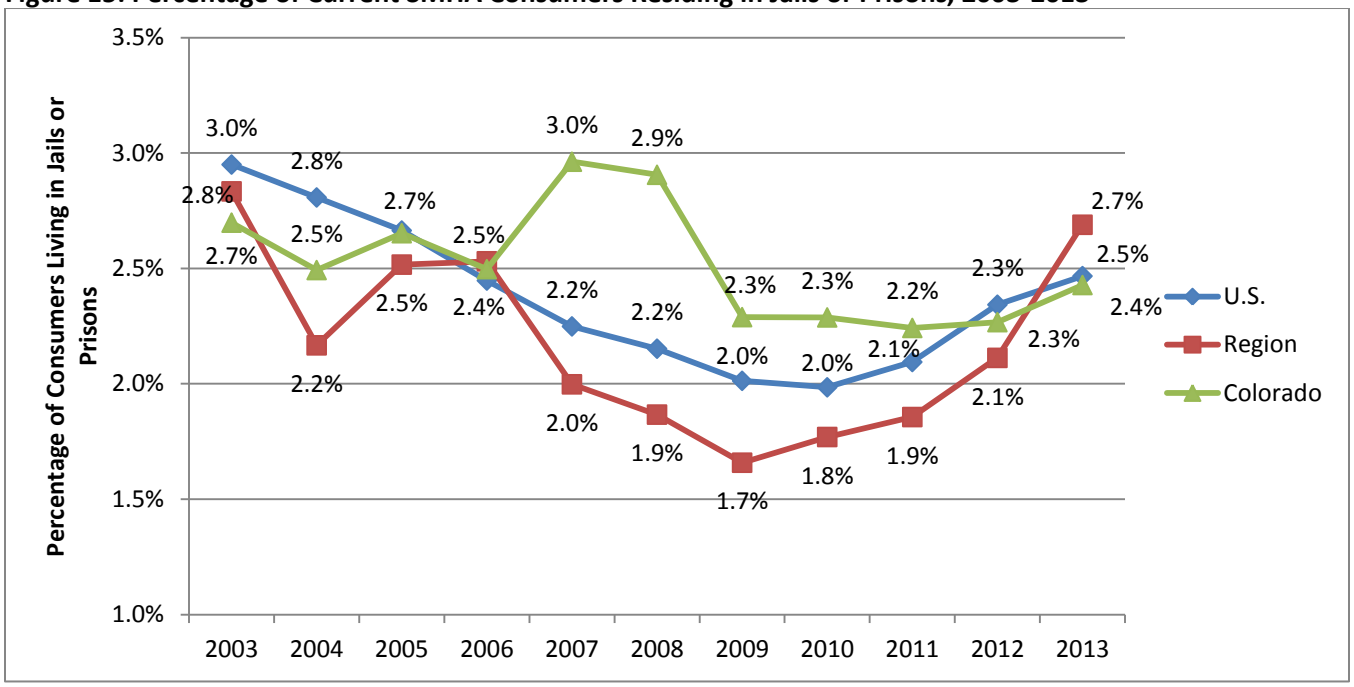
The number of adult consumers of SMHA services living in correctional facilities may indicate a lack of available community programs available to serve them. A 2003 class-action lawsuit filed in New York alleged that

> Parole violators with mental illness are incarcerated longer than violators without mental illness [due to them having to] wait until a spot opens in one of very few programs for individuals with mental illness. Plaintiffs argued that this practice violates the integration mandate because incarceration can exacerbate mental illness, making

recovery and a successful transition back to the community even more difficult for parolees with serious mental illness.[61]

The rate of current adult SMHA consumers living in jails and prisons does not significantly differ among Colorado, the region, and the nation; during any given year between 2003 and 2013, there is no more than 1 percent difference between the three groups (See Figure 15).

Figure 15: Percentage of Current SMHA Consumers Residing in Jails or Prisons, 2003-2013[62]



It appears that Colorado is committed to providing necessary crisis support services and jail diversion programs that prevent inappropriate institutionalization in jails and prisons. Colorado's *Community Living Plan* outlines the state's strategy to improve its crisis support system. This includes implementing a statewide 24-hour crisis help line, providing walk-in crisis services/crisis stabilization units, mobile crisis services within a two-hour radius of anyone in the state, crisis respite and residential services, and a statewide awareness campaign.[63]

According to the 2012 SMHA Profiles, Colorado's OBH also: ensures that patients discharged from the state hospitals back to jail are sent with treatment recommendations and prescriptions (when appropriate); conducts competency and sanity evaluations in local jails to ensure inmates receive appropriate services in the most appropriate setting; supports community mental health centers in the development and implementation of evidence-based and innovative programs in collaboration with courts, sheriff departments, and criminal justice stakeholders to provide early intervention, diversion, and transitional services; funds jail-based behavioral health screening, assessment, and treatment for co-occurring substance abuse and mental health disorders to inmates; and oversees a jail-diversion program that focuses on veterans with trauma spectrum disorders.[64]

Although the rate of current SMHA consumers in jails or prisons remains low, there may be unique cases where consumers residing in correctional facilities are deprived of the opportunity to receive services in the community. It is important to note that these data only provide information about current SMHA consumers who reside in jails or prisons, and do not identify the actual number of inmates in the state who may have a mental illness and are not receiving services from the SMHA. The SMHA may wish to reach out to the state Department of Corrections to identify and adequately serve this population.

Availability of evidence-based practices (EBPs)

The use of EBPs is an important indicator to determine the level of community integration, as EBPs "aim at increasing community integration and promoting maximum social and economic independence."[65] Among the most critical EBPs for community integration are Supported Housing, Supported Employment, and Assertive Community Treatment (ACT). URS data from 2008 to 2013 are used to show trends; earlier data are not used, as the submissions may not be reliable due to early reporting errors.

Supported housing

Supported housing provides safe, affordable housing options in conjunction with supportive services designed to meet the needs of persons with disabilities. The combination of private residences and support services increases the likelihood a person with a disability will be successful living in the community. In 2013, Colorado's OBH provided supported housing services to 202 consumers, 0.4 percent of adults with SMI, much lower than the national rate of 2.3 percent (38 states responding), and the regional rate of 1.6 percent (11 states responding). The rate of consumers receiving supported housing services in Colorado has declined by nearly 90 percent since 2009 when 2,052 consumers received supported housing services. The decline in supported housing services since 2011 may be attributed to data error, and over reporting of services in fiscal years 2008 through 2011. A note in Colorado's 2012 URS data submission addresses the sharp decline, stating that "the total N for supported housing is significantly reduced from [FY 2011]. After reviewing the raw, original data from providers, the current N is accurate for the data that [OBH] has received; however, we believe the actual numbers are higher and that there was a coding error at the level of the providers. [OBH] is in contact with providers in order to rectify this to obtain more accurate numbers." Similarly, in the 2013 URS data submission, Colorado indicated that "the total number of individuals receiving supported housing [in 2013] has dropped from [FY 2012]. The same agencies are providing the services, but the number of clients at each agency has decreased. We are working with each CMHC to better understand the change in numbers for this EBP." [66] (See Figures 16 and 17.)

Figure 16: Percentage of Adults with SMI Receiving Supported Housing Services[67]

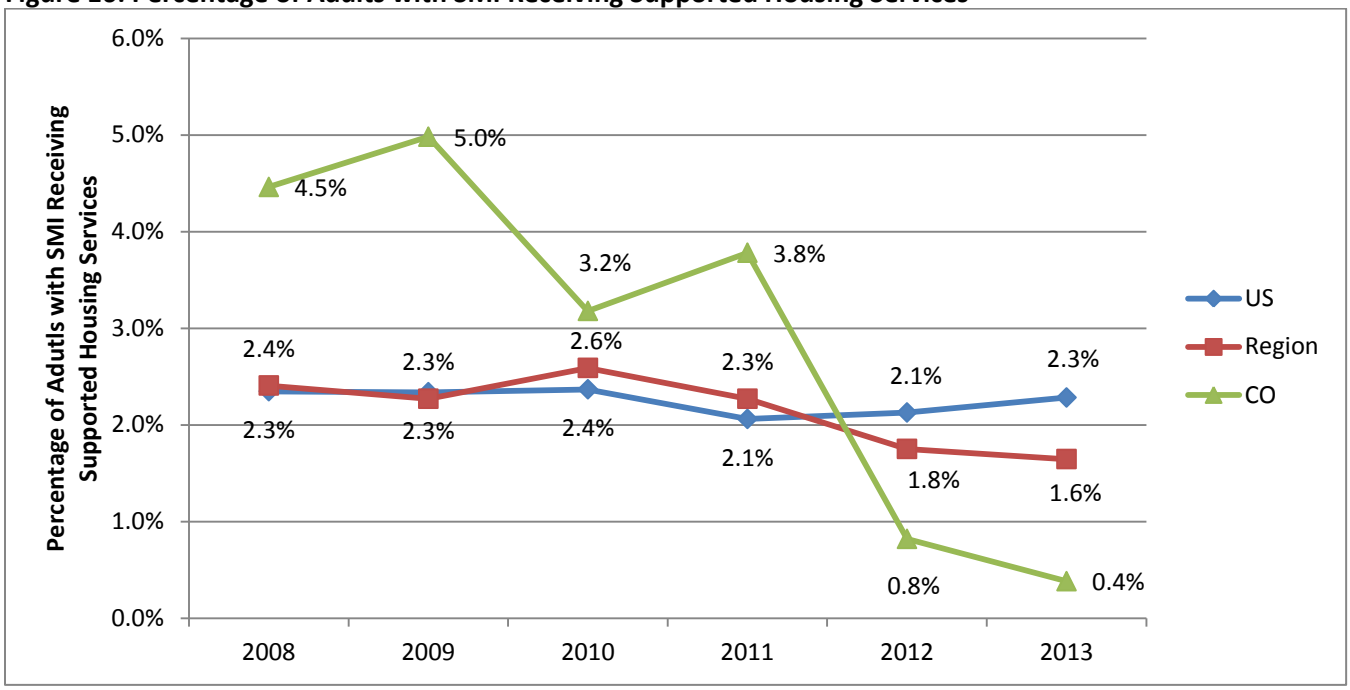
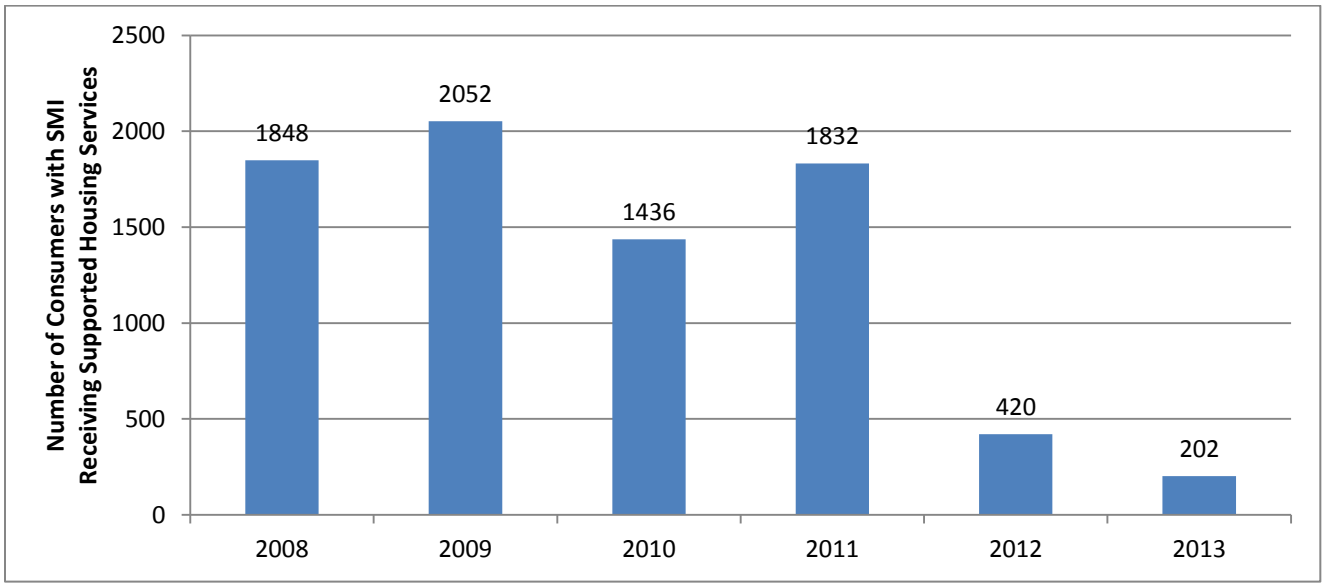
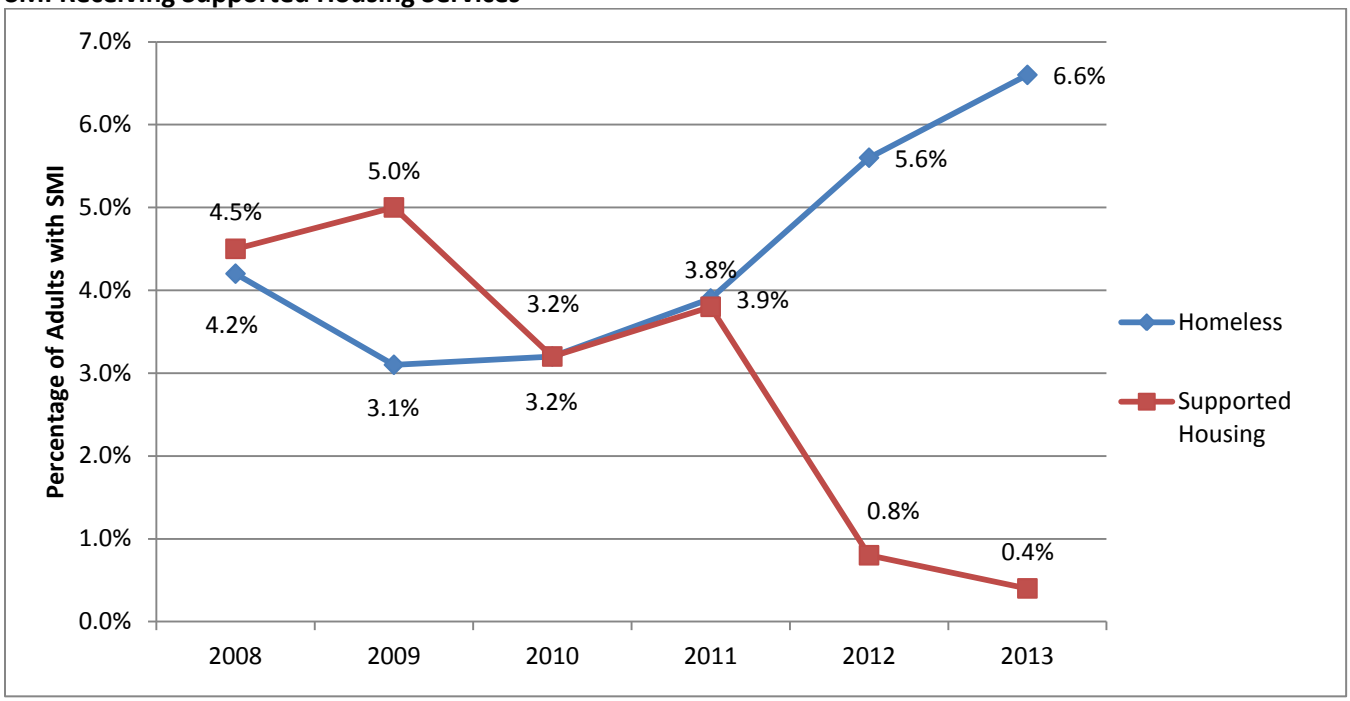


Figure 17: Number of Adult Consumers in Colorado Receiving Supported Housing Services, 2008-2013[68]



Keeping the caveat of data error in mind, this decrease in consumers receiving supported housing services coincides with the steady increase since 2009 in adult consumers who are homeless or living in shelters. See Figure 18.

Figure 18: Percentage of Adults with SMI who are Homeless Compared to Percentage of Adults with SMI Receiving Supported Housing Services[69]

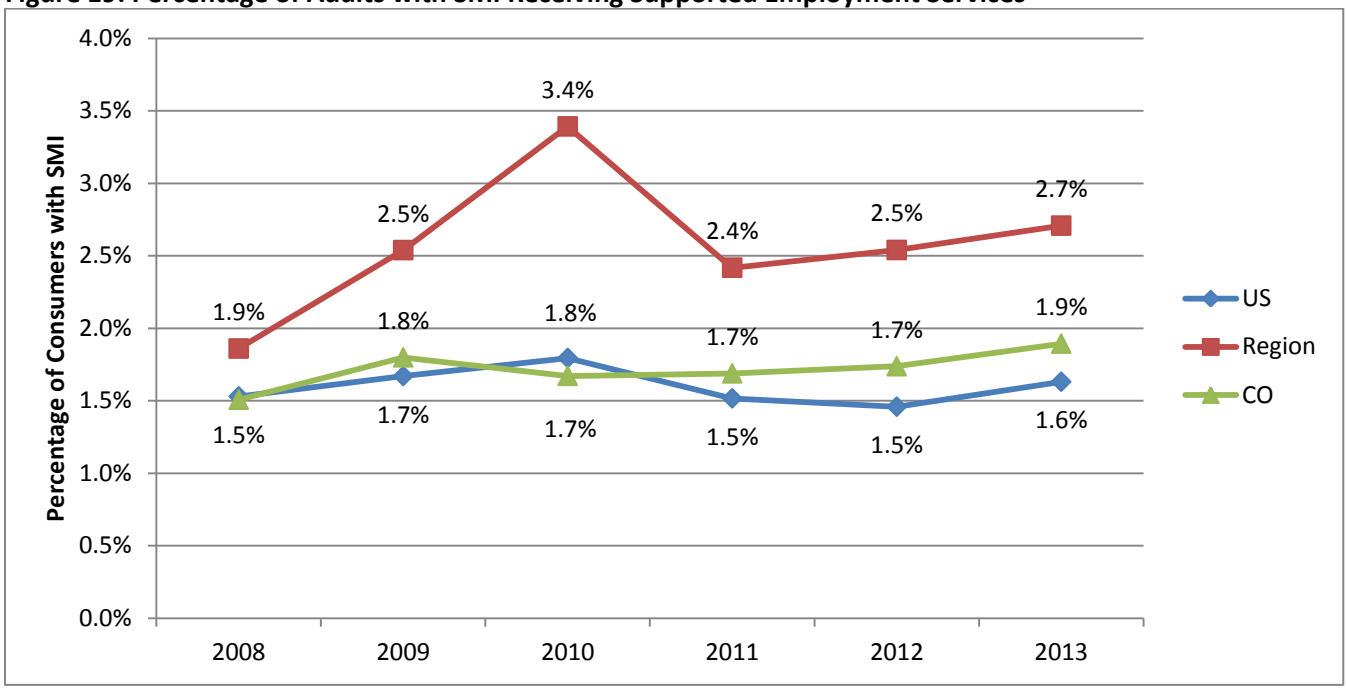


Given this divergence, Colorado's OBH may wish to examine how it can better provide supported housing services to a greater number of consumers with SMI.

Supported employment

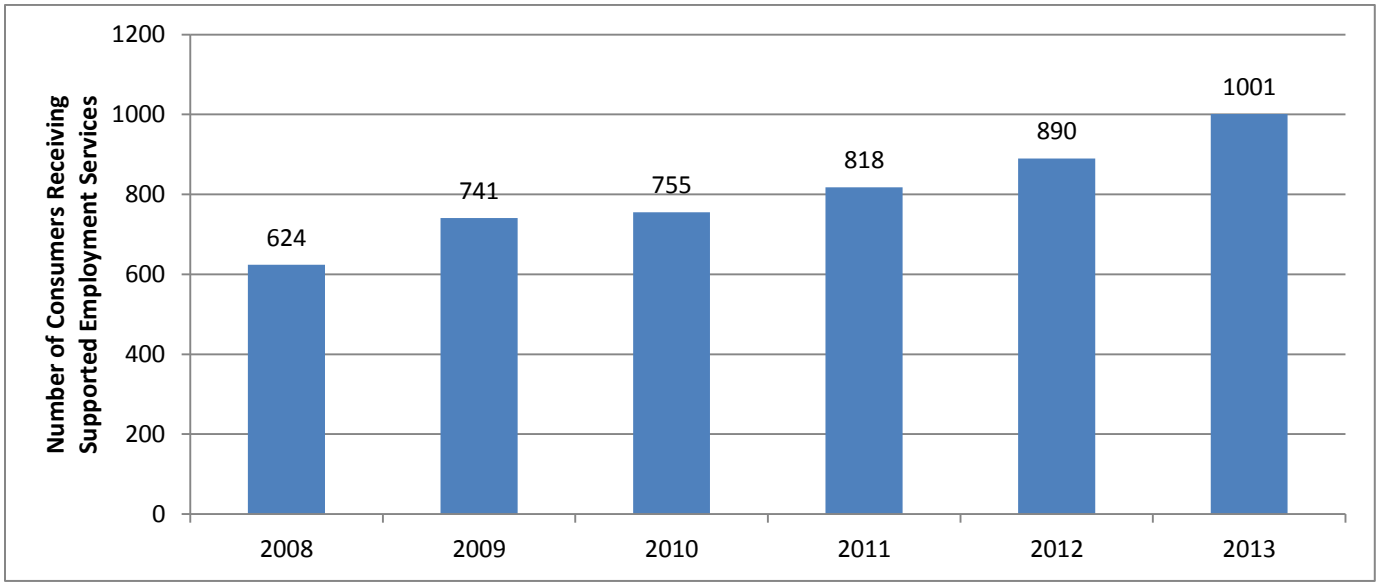
Supported employment provides consumers assistance in finding "meaningful jobs that fit their preferences, promoting the integration of consumers in the competitive job market."[70] In 2013, Colorado's OBH provided supported employment services to 1,001 (1.9 percent) adults with an SMI receiving services from the SMHA, which is slightly higher than the national rate of 1.6 percent (42 states responding), but less than the regional rate of 2.7 percent (10 states responding). The regional average is skewed higher by Arizona and Kansas, which reported rates of 25.3 percent and 16.3 percent, respectively. Removing these two states from comparison, the regional average is 0.7 percent. See Figure 19.

Figure 19: Percentage of Adults with SMI Receiving Supported Employment Services[71]



Although the increases have been modest, Colorado's OBH has increased the number of consumers receiving supported employment services each year for which reliable data are available. Since 2008, Colorado has increased the number of consumers receiving supported employment by nearly 400 individuals. See Figure 20.

Figure 20: Number of Adults with SMI Receiving Supported Employment Services in Colorado, 2008-2013[72]

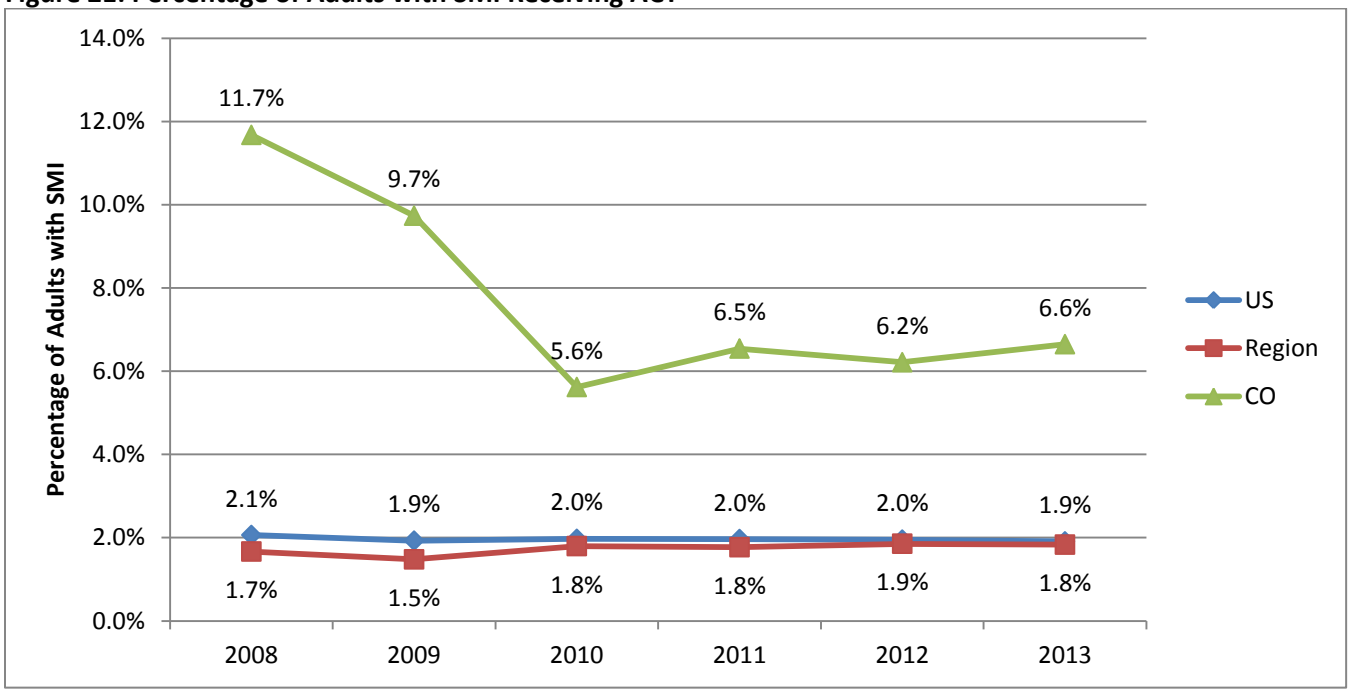


Assertive Community Treatment (ACT)

ACT relies on a multidisciplinary team approach to providing intensive community-based services. These community-based services "focus on assistance with daily living skills that help consumers maximize their independence and level of functioning in the community."[73] ACT has proven especially helpful at reducing hospitalization and homelessness, two other critical indicators of community integration.

In 2013, Colorado's OBH provided ACT services to 6.6 percent of adults with SMI who received services from the SMHA. This is far higher than the national rate of 2.0 percent (40 states responding), and the regional rate of 1.8 percent in 2013 (11 states responding). Colorado's OBH has consistently provided ACT services to a greater portion of its consumers since 2008. See Figure 21.

Figure 21: Percentage of Adults with SMI Receiving ACT[74]



Summary of findings

Based on a review of national and regional data, Colorado appears to be successful at ensuring consumers receive services in the most integrated setting appropriate for their care. Colorado's OBH performed better than national and regional averages in 2013 in the following areas:

- State hospital utilization rate: Colorado's state hospital utilization rate of 0.34 per 1,000 of the population was lower than both the regional (0.37) and national (0.46) rates.

Colorado had the sixth-lowest state hospital utilization rate in the region (16 states responding), and the 18th-lowest state rate in the nation.

- Percentage of consumers living in private residence: In 2013, Colorado's OBH had a greater percentage of adult consumers residing in private residences (84.4 percent) when compared to national (81.1 percent) and regional averages (80.2 percent).
- Percentage of consumers residing in jails or prisons: In 2013, only 2.4 percent of Colorado's adult consumers were residing in jails or prisons, less than the national and regional averages of 2.5 percent and 2.7 percent, respectively.
- Percentage of consumers receiving ACT: Colorado has consistently provided ACT services to a greater percentage of its population when compared to national and regional averages. In 2013, Colorado provided ACT services to 6.6 percent of its adult consumers, a far greater portion than national (1.9 percent) or regional (1.8 percent) averages.

While not leading the regional average, Colorado's OBH surpassed the national averages in the following areas:

- SMHA expenditures on state psychiatric hospitals: In FY 2013, Colorado expended 22.1 percent of its funds on state psychiatric hospitals, slightly less than the national average of 25.8 percent. A lower rate of expenditures on state psychiatric hospitals may indicate the state has more to spend on community-based services.
- SMHA expenditures on community-based services: In FY 2013, Colorado expended 77.0 percent of its funds on community-based services, slightly less than the regional average of 77.9 percent, but nearly five percentage points higher than the national average of 72.1 percent.
- Percentage of nursing home residents with a diagnosis of bipolar disorder or schizophrenia: In FY 2010, 8.01 percent of all nursing home residents in Colorado had a diagnosis of bipolar disorder or schizophrenia, less than the national average of 10.5 percent. While a lower rate is better, it does not necessarily indicate that the state is not violating *Olmstead.* States that have come under *Olmstead* investigation for unnecessarily serving persons with SMI in nursing homes have had rates ranging from 6.5 percent (South Carolina) to 21.05 percent (Illinois).
- Percentage of consumers receiving supported employment services: In FY 2013, Colorado provided supported employment services to 1.9 percent of adult consumers with SMI, greater than the national average of 1.6 percent, but less than the regional average of 2.7 percent.

While these aggregate data indicators seem to indicate that Colorado's OBH is excelling at providing integrated services to its consumers, they cannot tell where individual anomalies may be occurring. Specific areas OBH may wish to investigate further are the areas where the state performed worse than national and regional averages, or has experienced a decline in recent years:

- Homelessness among consumers: While Colorado's rate of consumers living in private residences exceeds the national and regional averages, a greater portion of the remaining population is homeless or living in shelters. In 2013, the rate of homelessness among adult consumers of mental health services in Colorado was 6.6 percent, far higher than the national average of 4.3 percent, and the regional average of 5.8 percent. Since 2003, Colorado has had the lowest rate in both the nation and the region for seven of the 11 reporting years; however, this percentage has increased each year since 2009.
- Percentage of consumers receiving supported housing services: The percentage of adults with SMI receiving supported housing services in Colorado in 2013 was 0.4 percent, and has decreased since 2009. This percentage is less than both the national (2.3 percent) and regional (1.6 percent) averages. The decrease in supported housing services coincides with an increase in homelessness among adult consumers.

Recommendations

1. **Fully implement the Colorado Community Living Plan**. It is important that Colorado's OBH continue to offer a variety of services in integrated settings, and follow the strategies outlined in Colorado's *Community Living Plan*.

2. **Improve access to housing and supports**. Based on the aggregate data, Colorado's OBH may wish to direct its most concentrated efforts toward ensuring that adult consumers with SMI have access to affordable, integrated, and supported housing .

3. **Continue to support the expansion of supported employment and ACT**. While the practices are currently in place across the state, there is variability in the breath of these programs across the regions and fidelity to the models and outcomes should be regularly monitored.

[1] SAMHSA. (2013). Olmstead Community Integration Self-Assessment Tool.
[2] Priaulx, E. (2014). *Docket of Cases Related to Enforcement of the ADA Title II "Integration Regulation."* National Disability Rights Network through SAMHSA Contract HHSS2832012000021.
[3] 42 U.S.C. §§ 12101.
[4] 28 CFR § 35.130(d).
[5] *Olmstead v. L.C.*, 527 U.S. 581 (1999).
[6] Priaulx, E., *Docket of Cases Related to Enforcement of the ADA Title II "Integration Regulation,"* Nov. 12, 2014.
[7] Id. Although Colorado was involved in at least one case raising *Olmstead*-related Medicaid issues in connection with its system for serving people with developmental disabilities (*Rossert v. Developmental Pathways* (D.Co. 2007). Case No.: 06CV4479), we are not aware of any past or current litigation under the ADA or *Olmstead* challenging Colorado's services for people with mental illnesses.
[8] See http://www.ada.gov/olmstead.
[9] Postal, S.W. (2014). *Olmstead at 15: The Legacy of a Landmark Case.* American Bar Association. http://www.americanbar.org/publications/aba_health_esource/2014-2015/september/olmstead.html.
[10] https://www.colorado.gov/pacific/hcpf/office-community-living
[11] Colorado's Community Living Plan

[12] Arizona Health Care Cost Containment System, et al. (2003). *Arizona's Olmstead Plan*. https://www.azahcccs.gov/reporting/Downloads/OlmsteadPlan.pdf.
[13] California Health and Human Services Agency. (2012). *California Olmstead Plan Update on its Implementation.* http://www.chhs.ca.gov/OLMDOC/California%20Olmstead%20Plan%20Update-%20November%202012.pdf
[14] Colorado Department of Health Care Policy and Financing, et al. (2014). *Colorado's Community Living Plan.* https://www.colorado.gov/pacific/sites/default/files/Colorado%20Community%20Living%20Plan-July%202014.pdf.
[15] Montana.Gov. (2014). *Olmstead Plan Update: July 2006.* http://www.dphhs.mt.gov/SLTC/communityservicesbureau/hcbswaiverprogram/OlmsteadPlan.aspx.
[16] Nevada's Aging and Disability Services Division. (2014). *Nevada's Strategic Plan for Integration of Developmental Services and Early Intervention Services into the ADSD.* http://adsd.nv.gov/uploadedFiles/agingnvgov/content/Home/ADSDStrategicPlan-2014Integration.pdf
[17] North Dakota Department of Human Services. (2011). *North Dakota Olmstead Plan 2011 Update.* Available for download through http://www.nd.gov/dhs/info/olmstead-commission.html.
[18] Information gathered from Oklahoma's participation in SAMHSA's 2012 *Olmstead* Community Integration Self-Assessment Pilot.
[19] Oregon Department of Human Services, et al. (2013). *The Olmstead Decision and Oregon's Olmstead Plan.* http://www.oregon.gov/oha/amh/amhpac/amhpac%20meeting%20docs/The%20Olmstead%20Decision%20and%20Oregons%20Olmstead%20Plan%20Rev%208.2.13.pdf.
[20] Information gathered from Washington's participation in SAMHSA's 2012 *Olmstead* Community Integration Self-Assessment Pilot.
[21] Data indicators derived from SAMHSA's 2013 Community Integration Self-Assessment Tool. Additional information can be found online at http://www.nri-inc.org/#!olmstead/cd9n.
[22] 2013 URS Data
[23] Eiken, S. et al. (2014). *Medicaid Expenditures for Long-Term Services and Supports in FFY 2012.* Truven Health Analytics. Complete report is available online at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-2012.pdf.
[24] URS Data, 2003-2013
[25] The high median length of stay in Arizona is attributed to a small number of clients who have been enrolled for a long period of time, and were discharged during the reporting year.
[26] 2013 URS Data
[27] 2013 URS Data.
[28] Id.
[29] 2013 URS Data
[30] 2013 URS Data
[31] SAMHSA's Revenues and Expenditures Data Set, 2003 through 2013
[32] NRI Profiles Data
[33] *The ARC of Virginia v. Kaine, Order to Dismiss* (E.D.Va. 2009).
[34] Id. at 16, citing *Olmstead* at 597.
[35] *The ARC of Virginia v. Kaine, Order to Dismiss* (E.D.Va. 2009).
[36] Id. at 5.
[37] *The ARC of Virginia v. Kaine* (E.D.Va.), United States' Memorandum of Law as Amicus Curiae in Opposition to Defendant's Motion to Dismiss, filed Nov. 24, 2009. Available at http://www.ada.gov/briefs/virginia_olmsteadbr.pdf.
[38] Available at http://www.justice.gov/crt/about/spl/documents/oregon_state_hospital_findlet_01-09-08.pdf.
[39] *United States v. Delaware,* Consent Decree entered July 6, 2011. Available at http://www.ada.gov/Delaware.htm/
[40] http://nationaldialoguesbh.org/wp-content/uploads/2014/11/K.-Cole-Presentation-2014.pdf
[41] http://www.correctcarers.com/rise-program-at-arapahoe-county-detention-center/
[42] Id.
[43] 28 C.F.R. Pt. 35, App. A (2010) (addressing § 35.130).
[44] The decision in *Disability Advocates, Inc.* was vacated on procedural grounds by the Second Circuit, but that court did not question the findings that adult homes can be institutions and that placement in these settings may violate the ADA.
[45] Priaulx at 23-24
[46] *Williams v. Quinn,* Statement of Interest of the United States, (N.D. Ill. 2012) Case No. 05C4673.
[47] *Williams v. Quinn,* Statement of Interest of the United States, (N.D. Ill. 2012) Case No. 05C4673 at 9.
[48] *Colorado's Community Living Plan* (2013) at 9.
[49] Data available from www.ltcfocus.org.

[50] Brown School of Public Health. (2010). *Long-Term Care: Facts on Care in the U.S.* http://ltcfocus.org/map/50/percent-schizophrenic-or-bi-polar-prevalence#2010/US
[51] Eiken, S. et al. (2014). *Medicaid Expenditures for Long-Term Services and Supports in FFY 2012.* Truven Health Analytics. Complete report is available online at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-2012.pdf.
[52] Priaulx, E. (2014). *Docket of Cases Related to Enforcement of the ADA Title II "Integration Regulation."* National Disability Rights Network through SAMHSA Contract HHSS283201200002I.
[53] Id at 31-32.
[54] 2003-2013 Revenues and Expenditures Data
[55] 2003-2013 URS Data
[56] www.ada.gov/olmstead/q&a_olmstead.htm
[57] *Colorado's Community Living Plan* (2013) at 10-12.
[58] Id.
[59] 2003-2013 URS Data
[60] 2003-2013 URS Data
[61] Priaulx at 64-65
[62] 2003-2013 URS Data
[63] Colorado Community Living Plan at 13-14.
[64] 2012 State Mental Health Agency (SMHA) Profiles
[65] Bond, et al. (2004). *How Evidence-Based Practices Contribute to Community Integration.*
[66] 2012 URS Data
[67] 2008-2013 URS Data
[68] 2008-2013 URS Data.
[69] Id.
[70] Bond, et al. (2004) at 578.
[71] 2008-2013 URS Data
[72] 2008-2013 URS Data
[73] Bond, et al. at 578.
[74] 2008-2013 URS Data

Telehealth

Introduction

This section of the report provides an overview of telehealth activities in Colorado and other states, and identifies opportunities and strategies in the field of telehealth to enhance the delivery of services and maximize financial and staffing resources. Findings were derived from a review of literature, information from the Colorado Behavioral Health Provider Survey, and key informant interviews.

The potential of telehealth to expand access to behavioral health services

Telehealth uses technology to connect health care providers with patients in different locations. The terms telemedicine and telehealth are often used interchangeably. There are no standard definitions for either term, although *telemedicine* often refers to the delivery of clinical services between different locations while *telehealth* typically refers to a broader scope of remote health-related services including clinical care, education, supervision, and administration.[1]

Increasingly, telehealth is being used to diminish health-care delivery problems, lessen costs, increase care coordination, and alleviate provider shortages.[2] Telehealth is not itself a treatment or unique service but a means of providing services via technology over distances. A foundational principle of telehealth is that the benefits to the patient via telehealth must meet the same standard of care as in-person care. In that vein, providers should approach care the same way they would if they were face to face with their patients, in terms of such tenets of good patient care as informed consent, securing privacy, confidentiality and security of information, and creating emergency protocols, to name a few.
Despite research suggesting that telehealth generally can provide the same quality as, and in some cases even higher quality than in-person services, skepticism and barriers still exist.

> *"It's [services provided via telehealth] not different or substandard care. The idea for telehealth and telemedicine is to add another tool to the clinician's and the educator's toolbox."*
>
> *- Fred Thomas, Director of Telemedicine, Children's Hospital Colorado.*

States and most payers have historically imposed a variety of restrictions on telehealth, such as requiring:

- Specific geographic or distance parameters (e.g., populations below a certain level, or within a certain number of miles from a service provider)

- An established patient-provider relationship or in-person session/exam prior to services via telehealth
- Specific provider types (e.g., physician) and specific patient settings (hospital or clinic), and explicit types of technology (e.g., video-only versus video and/or telephone).[3]

These restrictions, many of which were arbitrary and not tied to medical reasons, often did not take into consideration realities such as provider shortages (e.g., in rural areas or in specialty care domains) and patient limitations (e.g., transportation, long distances to services, individual mobility).

The three most common forms of telehealth used today include:

- Video sessions that connect patients and providers in different locations for various purposes, such as consultation about patient care, assessment/evaluation/diagnostic clarification, medication management, individual/group/family therapy, supervision, and training/professional development
- Transmission of medical information (e.g., X-rays) between providers or between patients and their provider, otherwise known as "store-and-forward"
- Remote monitoring of patient health information (e.g., blood sugar levels) through automated information about an individual's physical and mental health status.[4]

These types of communication and health-information exchange occur on secure networks so that the information is available to the providers and the patient. Health care systems sometimes create their own virtual private networks (VPNs) so that providers at different service sites within a given system work on the same network. Other providers and systems use cloud-based telehealth platforms that send encrypted transmissions to create virtual clinical spaces where patients, providers, and other supports in care can communicate.[5]

Telehealth policy advocates argue that services should be covered to the same extent as in-person services (i.e., parity). The telehealth-related health care costs are paid by private insurance, Medicaid, and Medicare. There have been some who claim that telehealth coverage will increase costs for health plans. However, telehealth has been found to be a cost-effective delivery method for prevention, early diagnosis, treatment, and care coordination.[6] [7]

Telehealth can assist in improving access 1) in rural, frontier, or other areas with geographic barriers; 2) for underserved communities and for those who have typically been less likely to seek care for behavioral health-related issues because of stigma, cultural, or financial reasons; 3) for individuals with mobility issues that limit their ability to travel to services; and 4) to specialty care that is not widely available.

Telehealth in the behavioral health service sector occurs generally via video (versus texting and other technologies) because most state telehealth use and reimbursement policies are tied to this mechanism. In the United States, the most commonly covered behavioral health services via telehealth include mental health assessments, individual therapy, psychiatric diagnostic

interview exams, and medication management.[8]

National trends in 2014 indicate growth in the industry marked by an enormous increase in the global market for telehealth, the proliferation of mobile solutions, increased employer and payer adoption, increased legislative support for telehealth initiatives, and efforts to create cross-state compacts for licensure. Specific to the status of tele-mental health, some experts conclude that it has:

- The least complex technology needs of any medical specialty
- A robust empirical base
- Adoption by consumers
- Practitioners who are clustered in urban settings
- Vast needs in settings with limited access to providers and services
- Limited interstate practice due to licensing issues.[9] [10]

With the convergence of these trends and the proliferation of technology in our everyday lives, telehealth is a potential solution for Coloradans who are looking for new and easy ways to access care in or close to their homes and communities.

[*Note: For the purposes of this section, the term telehealth will be used except where language from a specific program uses the term "telemedicine."*]

Telehealth in Colorado: a few highlights

2001 - Colorado Private Insurance Parity Law

In 2001, Colorado's partial parity law for private insurance was enacted, calling for all health benefit plans for individuals residing in a county with 150,000 or fewer residents to offer telehealth options if the county had the necessary technology to provide telehealth, effective Jan. 1, 2002. Telehealth was defined to include the delivery of health care services using advanced technology such as interactive audio, interactive video, or interactive data communication.

2006 – Medicaid coverage for telehealth in Colorado

As of July 1, 2006, in-person contact between a health care or mental health care provider and a patient shall not be required under the state's medical assistance program for health care or mental health care services delivered through telehealth that are otherwise eligible for reimbursement under the program.

2010 – Medicaid coverage for at-home telehealth services in Colorado

On Aug. 11, 2010, at-home telehealth services became eligible for reimbursement under

Colorado's medical assistance program. At-home telehealth in Colorado is defined as "the remote monitoring of clinical data through electronic information processing technologies," thereby excluding video conferencing. The 2010 reform was made on the premise that technology-enabled care, in lieu of in-person care, would save the state money. The fiscal note estimated a 10% decrease in hospital visits and $8,779/per month total savings as a result of home telehealth services delivered over 12 months. Additional projections in annual reduced emergency room visits and savings were also attributed to home telehealth utilization.[11] [12] [13] [14]

2015 Legislative Session – Expansion of telehealth coverage outside of rural areas for private insurance and Medicare

In January 2015, HB15-1029, Healthcare Delivery via Telemedicine Statewide, was introduced. The bill language was recently amended from "telemedicine" to "telehealth" to allow practitioners other than licensed physicians to provide services through technology. An important component of the bill is removal of the urban/rural restriction for Medicare and private insurers, in addition to possibly expanding coverage to asynchronous telehealth services (e.g., store-and-forward). The bill requires all health benefit plans in Colorado to provide beneficiaries with telehealth options beginning Jan. 1, 2017. The bill does not require telehealth services to be provided should a health care provider determine that telehealth is not the most appropriate standard of care. Health insurance carriers must reimburse providers for telehealth services on the same basis of in-person care for diagnosis, treatment or consultation. Insurance carrier payments for telehealth services must include reasonable compensation for the transmission costs of telehealth care, except for situations when the originating site is the private residence of the covered person. The bill was sent to Governor John Hickenlooper for his signature on March 12, 2015.

State comparisons

The American Telemedicine Association (ATA) put together a comparison of telemedicine policies across the 50 states.[15] The report provides an overview of each state's telemedicine coverage and reimbursement standards, and provides information related to how each state compares to other states in the nation related to policies that promote telemedicine adoption. It also provides recommendations related to the improvement of policies related in this area. Telemedicine coverage and reimbursement policies were examined based on aspects of health plan parity and Medicaid conditions of payment.

Health plan parity refers to the extent to which coverage for telemedicine-provided services are comparable in coverage and reimbursement to in-person services. State policies that enable or impede parity for telemedicine-provided services were examined as they relate to private insurance health plans, Medicaid, and state employee health plans.

Medicaid coverage and conditions of payment were compared across states by examining patient settings approved for Medicaid telemedicine coverage, eligible technologies for the

exchange of medical information from one site to another, distance or geographical restrictions, eligible providers, physician-provided telemedicine services, mental and behavioral health services, rehabilitation services, home health services, and telepresenter requirements.

Forty-seven states have Medicaid programs that provide some type of coverage for telehealth.[16] In the ATA report, states were given individual report cards based on the telemedicine policies currently in place. Please refer to the full report for a more in-depth description of each state. For the purposes of this report, Colorado was compared with four other states that have demonstrated a level of innovation related to telemedicine practices (see Table 1 on the following page).

Additionally, the Center for Connected Health Policy (CCHP) houses a live, continuously updated, interactive map that describes individual state telehealth policies and reimbursement schedules.[17] Information is provided on a variety of topics, including but not limited to reimbursement for live video, store-and-forward, and remote patient monitoring; consent; cross-state licensing; and private payers. Individual state information from the CCHP map and 2014 report on state telehealth policy and reimbursement schedules is also included in Table 1.

Table 1. State comparison of telehealth policy and reimbursement information					
Note: Letter grades are obtained from the ATA State Telemedicine Gap Analysis					
	Alaska	**Montana**	**Oklahoma**	**Oregon**	**Colorado**
Private Insurance					
	F; No private insurance parity law currently exists.	A; Private insurance parity law enacted in 2013	A; Private insurance parity law enacted in 1997.	C; Private insurance parity law enacted in 2009. One of three states that cover interactive audio-video *only* as a condition of the parity law.	B; Partial parity law for private insurance was enacted in 2001, and only includes coverage for rural populations. There is current proposed legislation to remove the rural population restriction.
Medicaid					
Patient Setting	A; Telemedicine coverage under the Medicaid plan is broad and the least restrictive compared to other states.	A	C; Coverage limited to originating sites located in rural areas	A	F; Patient originating setting restricted to provider's office, Federally Qualified Health Clinic, and Rural Health Clinic

Table 1 continued: State comparison of telehealth policy and reimbursement information					
Note: Letter grades are obtained from the ATA State Telemedicine Gap Analysis					
	Alaska	**Montana**	**Oklahoma**	**Oregon**	**Colorado**
Eligible Technologies	B; Excludes the phone as an eligible technology	F; Coverage for interactive audio-video only	C; Coverage for interactive audio-video only	C; Coverage for interactive audio-video, telephone, and online/email consultations	C; Coverage for interactive audio-video only for physician and mental/behavioral health services
Distance or Geography Restrictions	A	A	C; Coverage limited to originating sites located in rural areas	A	A
Eligible Providers	B	F	C; Coverage limited to originating sites locating in rural areas	A	F; Coverage limited to physician and mental/behavioral health services
Physician-Provided Services	A	B	B	B	B
Mental/Behavioral Health Services	A	B	B; One of 3 states providing services for a behavioral analyst	B	B; Coverage for Physician (e.g., psychiatrist), psychologist, and masters level psychologist

Table 1 continued: State comparison of telehealth policy and reimbursement information					
Note: Letter grades are obtained from the ATA State Telemedicine Gap Analysis					
	Alaska	**Montana**	**Oklahoma**	**Oregon**	**Colorado**
Rehabilitation Clinically, this includes a range of rehabilitation such as assessment, monitoring, prevention, intervention, supervision, education, consultation, and counseling.	A	F	N/A	F	F
Home Health	A	F	F	F	F; Coverage only for Remote patient monitoring for chronic disease management under the home health benefit
Informed Consent Requirements for written or verbal informed consent or unspecified methods of informed consent before a telehealth encounter can be performed.	A	A	F; Requires written informed consent	A	F; Requires written informed consent

Table 1 continued: State comparison of telehealth policy and reimbursement information					
Note: Letter grades are obtained from the ATA State Telemedicine Gap Analysis					
	Alaska	**Montana**	**Oklahoma**	**Oregon**	**Colorado**
Telepresenter Requirements regarding the presence of an individual or health care provider on the premises during a telehealth encounter.	C – Medicaid does not require a telepresenter as a condition of payment; the Medical Board identifies this as a practice standard requirement.	A	C; Requires a telepresenter	A	A

Some states have implemented telehealth in specific settings or for targeted populations for whom care coordination is a significant issue. For example, some managed-care organizations (MCOs) have included medical home and dual-eligible coordination via telehealth to reduce costs related to emergency room use and hospital admissions. Illinois included the coverage of telemonitoring as a service in its primary care-behavioral health integration efforts for older adults and adults with disabilities with chronic health conditions.[18] [19]

In some more-progressive Medicaid managed-care markets, such as Georgia, the use of telehealth by MCOs has been used to further collaborate and integrate behavioral health care within the Patient Centered Medical Home (PCMH). Increasing access to behavioral health services for the Medicaid population is a critical need and can be integrated within the PCMH more effectively via the application of telehealth.

Table 2: Colorado Medicaid and telehealth at-a-glance	
Private Insurance	
Distance or Geography Restrictions	Partial parity law for private insurance was enacted in 2001, and reimburses if patient is in a county of 150,000 or less. There is current proposed legislation to remove the rural population restriction.
Reimbursement	Reimbursement is the same for same service in-person or via telehealth.
Medicaid	
Patient Setting (Originating Sites)	Patient originating setting restricted to provider's office, Federally Qualified Health Clinic, and Rural Health Clinic.
Eligible Technologies	Coverage for interactive audio-video only for physician and mental/behavioral health services.
Distance or Geography Restrictions	Reimburses regardless of geographic location.
Eligible Providers	Physician, osteopath, psychologist, MA psychologist, physician assistant, nurse practitioner.
Mental/Behavioral Health Services	Coverage for physician (e.g., psychiatrist), psychologist, and master's-level psychologist.
Home Health	Coverage only for remote patient monitoring for chronic disease management under the home health benefit (CO Medical Assistance Program). Reimburses a flat fee to home health agency if patients meet very specific criteria.
Patient Setting (Originating Sites)	Offices of a physician or practitioner, hospitals, critical access hospitals, community mental health centers, skilled nursing facilities, Rural Health Clinics, Federally Qualified Health Centers, hospital-based or critical access hospital (CAH)-based renal dialysis centers (including satellites).
Eligible Technologies	Coverage for real-time, interactive audio-video only for physician and mental/behavioral health services.
Distance or Geography Restrictions	Reimburses if originating site is a Health Professional Shortage Area OR non- Metropolitan Statistical Area county.
Eligible Providers	Physicians, nurse practitioners, physician assistants, nurse-midwives, clinical nurse specialists, registered dietitians or nutrition specialists, clinical psychologists, and clinical social workers.

Colorado Medicaid and telehealth (Colorado Medical Assistance Program)

In October 2007, the Colorado Medical Assistance Program (CMAP) began accepting telemedicine claims. This enabled Colorado Medicaid providers to be reimbursed for selected services provided via telecommunications equipment. Colorado Medicaid providers who use telemedicine are expected to follow the same quality-of-care and client confidentiality guidelines as in-person services. Secure and encrypted lines of transmission should be used and should include authentication and identification procedures at both the sending and receiving ends of care (CMAP Telemedicine Manual Reference).

The reimbursement rate for a telehealth service in the Colorado Medicaid program is set at the same rate, at a minimum, as the medical assistance program rate for a comparable in-person service (C.R.S. 25.5-5-320 - 2014). Home health care or home- and community-based telehealth services are covered by and reimbursed by the Medicaid program.

The Colorado Medical Assistance Program (CMAP) Telemedicine Manual provides general information and details on billing, coding, and reimbursement procedures for Medicaid clients. Within Colorado, telemedicine involves two collaborating providers: an "originating provider" and a "distant provider." The provider where the client is located is the "originating site" or "originating provider." For services to be reimbursed, the originating site must be located in a provider's office, Federally Qualified Health Center (FQHC), or a Rural Health Clinic (RHC). The "distant provider" is a clinician who acts as either a consultant to the originating provider or as the only provider of a service (e.g., a distant provider of mental health services may be the only provider involved in the service). Telemedicine services are only reimbursed for providers who are enrolled in CMAP at the time of service. Providers may only bill procedure codes for which they are already eligible to bill at the time of service.

Managed-care organizations enrolled in CMAP may waive the Medicaid requirement for face-to-face contact between a provider and a client prior to treating the client for the first time. The provider must obtain signed documents that the client has received, and understands, the following statements:

1. The client retains the option to refuse the delivery of health care services via
2. telemedicine at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of any benefits to which the client would otherwise be entitled. All applicable confidentiality protections shall be taken into account.
3. The client shall have access to all medical information resulting from the telemedicine services as provided by applicable law for client access to his or her medical records.

Only telemedicine services provided through live audio-video are reimbursable through CMAP. Colorado Medicaid does not pay for consultations provided by telephone, or for provider or

patient education when that is the only service being provided.

According to the CMAP Telemedicine Manual, the originating provider may bill for an office, outpatient, or inpatient Evaluation & Management (E&M) service that precedes a telemedicine consultation and for other Medicaid-covered services. In some cases, the originating provider site will not be providing clinical services, but only providing a site and telecommunications equipment. If the originating provider is making a room and telecommunications equipment available but is not providing clinical services, the originating provider bills Q3014, the procedure code for the telemedicine originating-site facility fee. If the originating provider also provides clinical services to the client, the provider bills the rendering provider's appropriate procedure code and bills Q3014. The originating provider may also bill, as appropriate, on the UB-04 paper claim form or as an 837I transaction for any clinical services provided on-site on the same day that a telemedicine originating-site claim is made. The originating provider must submit two separate claims for the client's two separate services. The following provider types may bill procedure code Q3014 (telemedicine originating-site facility fee): Physician 05, Clinic 16, Osteopath 26, Federally Qualified Health Center 32, Psychologist 37, MA Psychologist 38, Physician Assistant 39, Nurse Practitioner 41, Rural Health Clinic 45.

If practitioners at both the originating site and the distant site provide the same service to the client, both providers submit claims using the same procedure code with modifier 77 (i.e., repeat procedure by another physician). All distant-site rendering providers bill the appropriate procedure code using modifier GT (interactive communication) on the Colorado 1500 paper claim form or as an 837P transaction. The previously listed provider types may bill using modifier GT. A list of approved procedure codes that may be used with telehealth services is included as Table 2.

Medicaid pays a flat fee for remote monitoring at patients' homes for chronic conditions, including asthma, congestive heart failure, chronic obstructive pulmonary disease, and diabetes.

Table 3. Colorado Medicaid-approved telehealth procedure codes	
Note. The procedures codes should be billed with modifier GT (interactive communication) when billing telehealth services	
Outpatient Mental Health Services	
90791	Diagnostic Evaluation
90832	Psychotherapy, 30 min
90833	Add on Psychotherapy, 30 min
90834	Psychotherapy, 45 min
90836	Add on Psychotherapy, 45 min
90837	Psychotherapy, 60 min
90838	Add on Psychotherapy, 60 min
90863	Add on Pharmacologic management code
90846	Family therapy – patient not present
90847	Family therapy – patient present
Evaluation and Management	
99201	Office or other outpatient visit, new patient, 10 minutes
99202	Office or other outpatient visit, new patient, 20 minutes
99203	Office or other outpatient visit, new patient, 30 minutes
99204	Office or other outpatient visit, new patient, 45 minutes
99205	Office or other outpatient visit, new patient, 60 minutes
99211	Office or other outpatient visit, established patient, 5 minutes
99212	Office or other outpatient visit, established patient, 10 minutes
99213	Office or other outpatient visit, established patient, 15 minutes
99214	Office or other outpatient visit, established patient, 25 minutes
99215	Office or other outpatient visit, established patient, 40 minutes
76801	Ultrasound, pregnant uterus, real time first trimester
76802	Each additional gestation
76805	Ultrasound, pregnant uterus, real time after first trimester
76810	Each additional gestation
76811	Ultrasound, pregnant uterus, real time plus detailed fetal anatomical exam, single or first gestation
76812	Each additional gestation
76813	Ultrasound, pregnant uterus real time first trimester fetal nuchal translucency measurement
76814	Each additional gestation
76815	Ultrasound, pregnant uterus, real time, limited, one or more fetuses
76816	Ultrasound, pregnant uterus, real time, follow-up
76817	Ultrasound, pregnant uterus, real time, transvaginal
Other	
96116	Neurobehavior status exam

20

Licensure

Currently, in Colorado there are no special licenses or certificates available related to telehealth that would allow for an out-of-state provider to render services via telemedicine within Colorado.

Barriers to Telehealth

Reimbursement

> "*People think technology is the barrier. Let us assure you that it is not the barrier. It's well defined. We have good tools. … Reimbursement in this country is a barrier*," Samantha Lippolis, Telehealth Manager, Centura Health.[21]

One of the biggest issues in telehealth is reimbursement policy. Current reimbursement policies are not consistent (e.g., some insurers apply geographical restrictions while others do not) or comprehensive across states and health care payers.[22] Telehealth advocates often say that reimbursement should be allowed for services provided to consumers in their homes or other locations and should not be confined to clinic-to-clinic only, or to require staff to be present at both ends of the encounter. Currently, all reimbursable behavioral health care must occur via live audio-visual interaction, which can create a technical barrier for individuals who do not have broadband in their homes.[23]

Privacy

Despite technological advancements, federal patient privacy requirements hamper collaborations between rural and urban providers. Wider use of telehealth is obstructed by administrative challenges on how to pay health professionals for the services they provide one another outside of, but related to, direct patient care.[24]

Prescribing

Current Colorado Medical Board (CMB) policy 40-09 states "that it is unprofessional conduct for a physician to provide treatment and consultation recommendations, including issuing a prescription, via electronic or other means, unless the physician has obtained a history and physical evaluation of the patient adequate to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided. Issuing a prescription on the basis of a questionnaire, Internet-based consultation, or a telephonic consultation, all without a valid pre-existing patient/practitioner relationship does not constitute an acceptable standard of care."[25]

The Colorado Telehealth Working Group (CTWG) submitted a letter to the CMB in September 2014 regarding this policy. The letter referenced recently released draft model language from

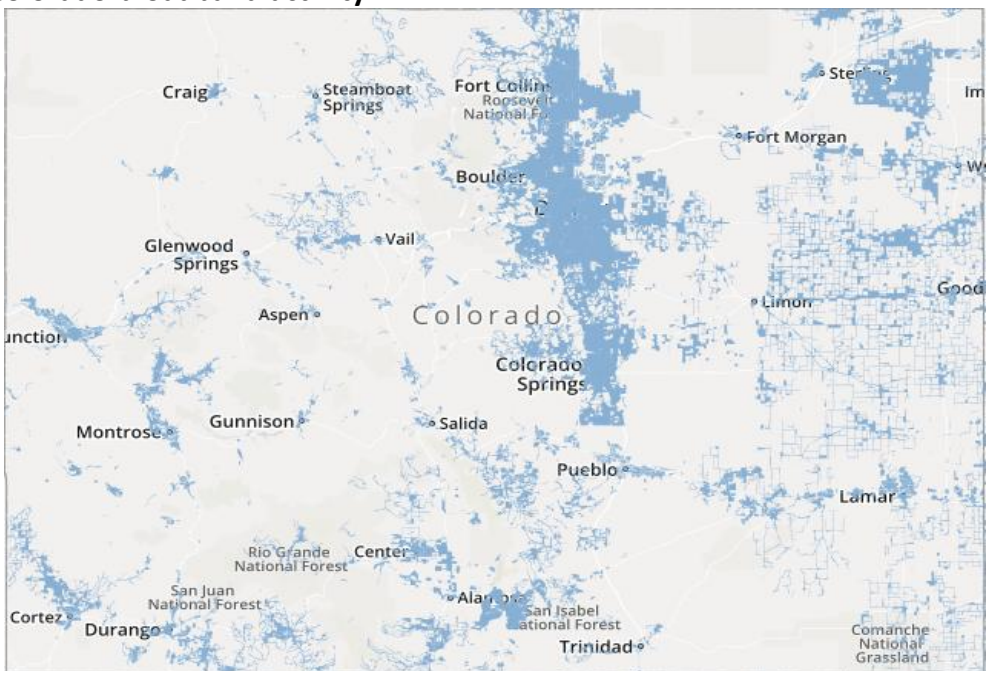
the Federation of State Medical Boards' (FSMB) for telemedicine that allows for the "*appropriate use of emerging technologies and guidelines for establishing physician-patient relationships while maintaining appropriate safeguards and protections.*" The letter also noted that the Colorado Medical Society (CMS) adopted a policy in 2014 that is consistent with FSMB policy. CTWG encouraged CMB to consider the following updates to the existing policy: establishment of the physician-patient relationship through telemedicine and enabling appropriate prescribing through telemedicine.

Important Colorado telehealth initiatives

Colorado Telehealth Network

The Colorado Telehealth Network (CTN) was formed in 2008 by the Colorado Hospital Association (CHA) and the Colorado Behavioral Health Council (CBHC) as a result of two Federal Communications Commission (FCC) grant awards to set up a statewide health care broadband network. The mission of CTN is to maximize access to health care services, especially in underserved regions of the state, through information and communications technology.[26] Today, CTN continues to provide subsidized broadband connectivity across Colorado on a secure, high-speed network. All traffic within CTN's self-contained private network is encrypted. CTN also houses several initiatives aimed at dissemination of information and resources related to telehealth and advancing telehealth policy. The blue-gray shading on the following map indicates areas with the highest broadband activity. Other data can be found at the National Broadband Map website (www.broadbandmap.gov), which provides tools to search, analyze, and map broadband availability across the United States.

Figure 1: Colorado broadband activity



CTN provides low-cost, high-capacity digital bandwidth that enhances communications systems such as electronic health records, televideo, telephone services using the Internet (VoIP), and the transmission of high-resolution images in trauma situations. This is especially important in rural areas of Colorado where broadband costs are significantly higher (three or more times higher) due to low demand and limited availability. CTN currently provides access to broadband connectivity in two ways: the CTN private network and the Net Connect initiative noted in the image below.

Figure 2: Broadband services

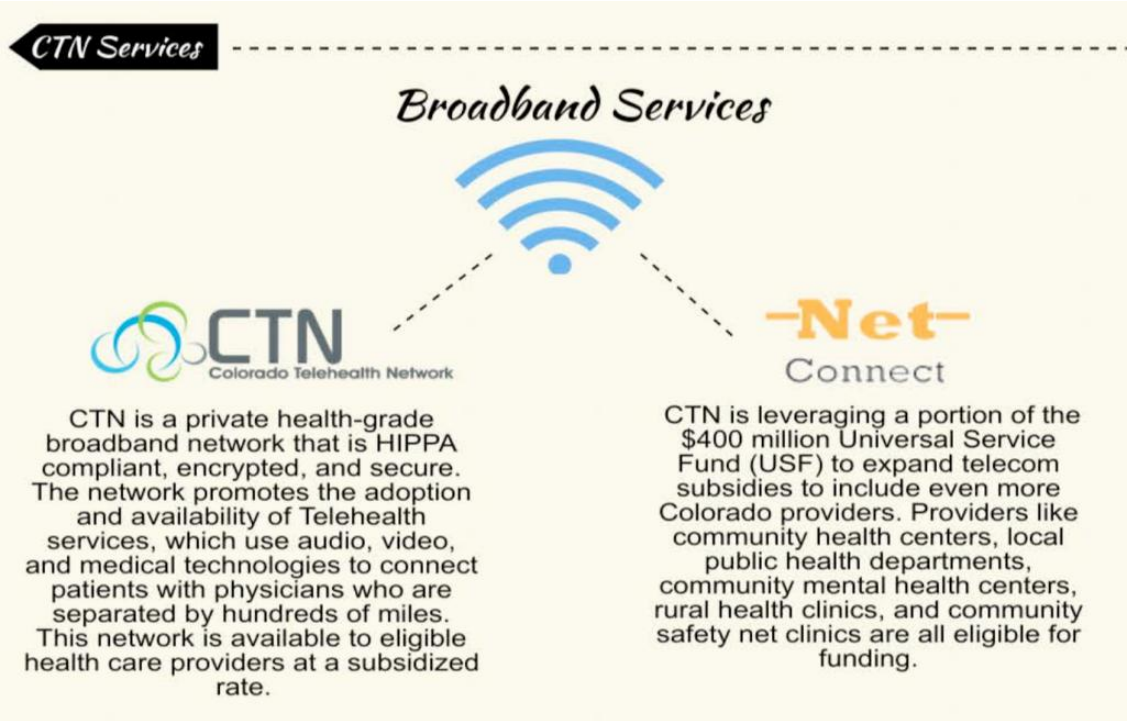
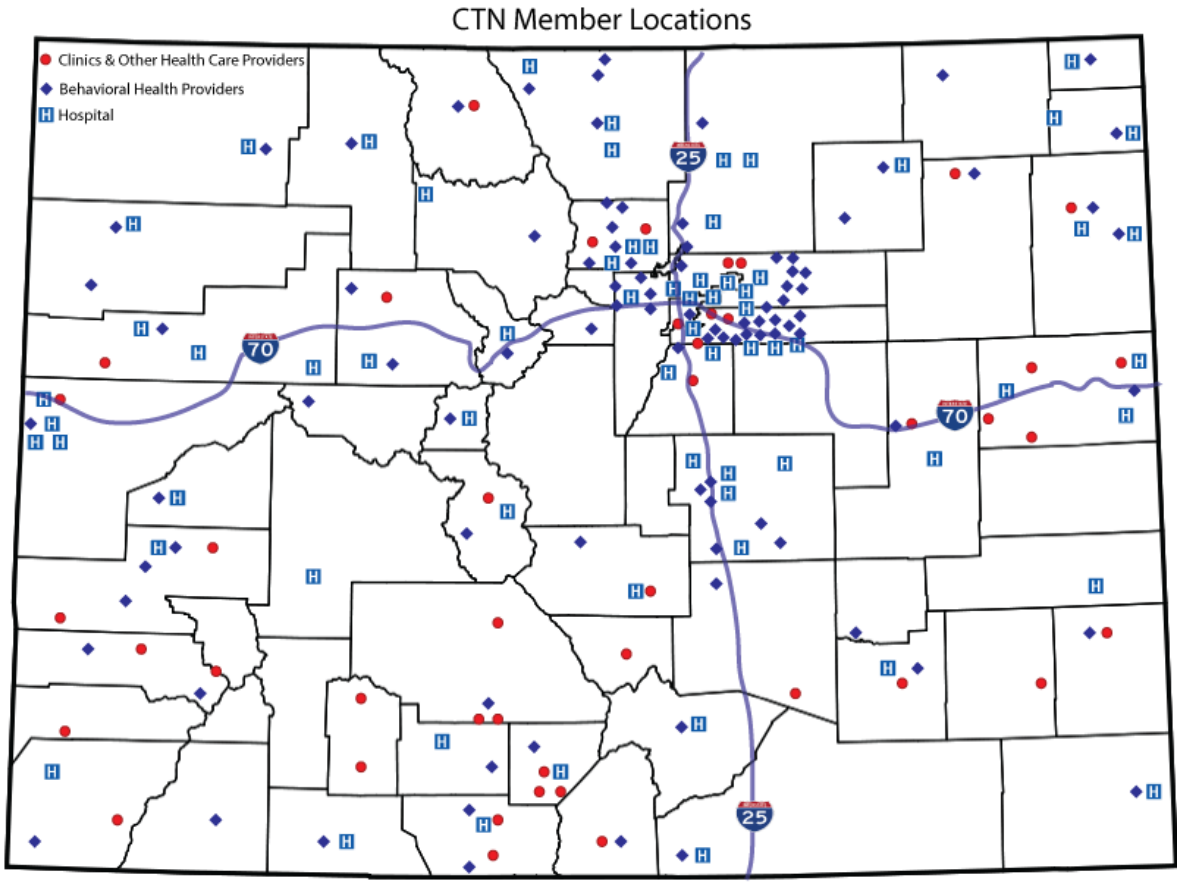


Image accessed at: http://www.cotelehealth.com/CTNASPX/media/CTN-Media/CTN-Know-the-Facts-(6)-infograpgh-for-web_1.pdf

CTN presently provides broadband connectivity to 200 behavioral and physical health care sites in Colorado. CTN's website features an interactive map of all member sites including hospitals, behavioral health care providers, and clinics and other health care providers.[27]

Figure 3: CTN member locations



Sixty-one percent of CTN members are rural and approximately 54 percent are behavioral health providers. Of the 108 current behavioral health members of CTN, Community Mental Health Centers (CMHCs) are the most common type. Other CTN members include 35 health clinics - 15 rural clinics and 20 Federally Qualified Health Centers (FQHCs) – where individuals often show up for behavioral health care.

Figure 4: CTN Members

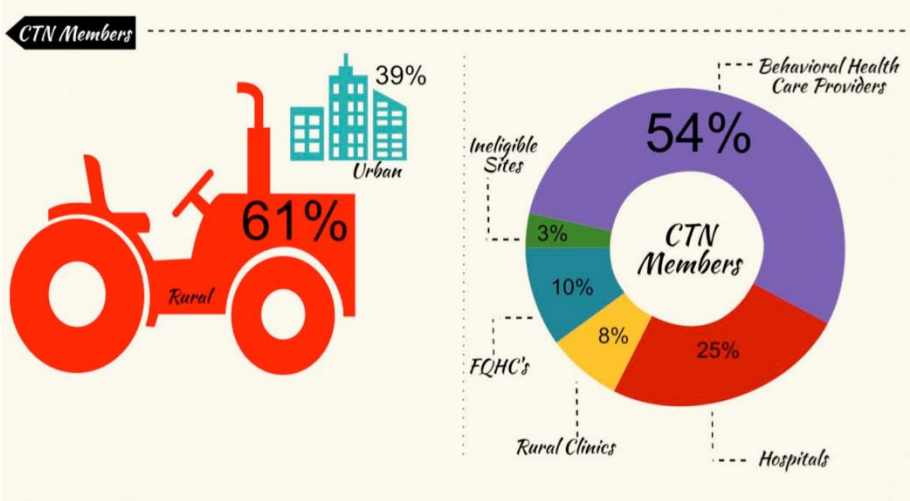


Image accessed at: http://www.cotelehealth.com/CTNASPX/media/CTN-Media/CTN-Know-the-Facts-(6)-infograpgh-for-web_1.pdf

CTN utilizes a cloud-based telehealth platform called AVEO built specifically around digital clinical interaction (e.g., CPT codes built into the system, multi-point video).
CTN has been successful in responding to specific provider requests to increase telehealth capacity. For example, CTN worked with 11 Colorado hospitals to create a secure image exchange that would reduce the duplication of testing of patients and to improve the image-transfer process, especially in medical trauma cases.

Figure 5: CTN Telehealth services

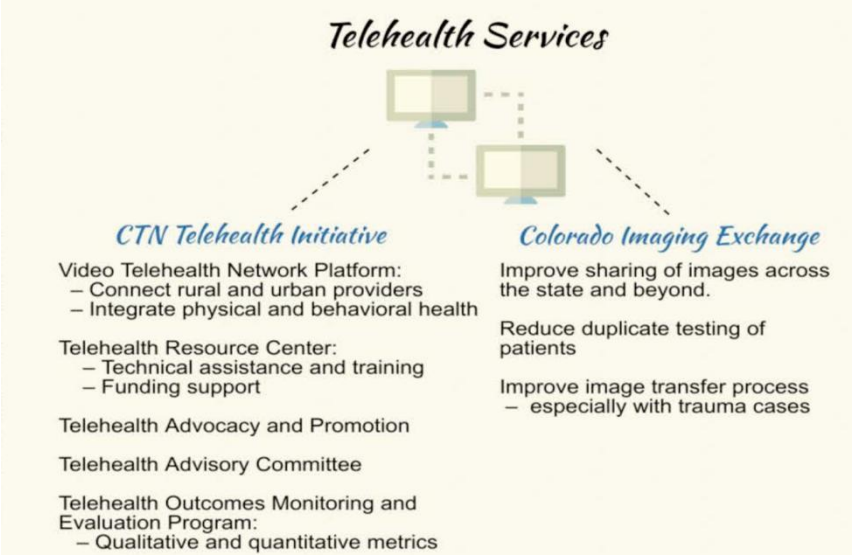


Image accessed at: http://www.cotelehealth.com/CTNASPX/media/CTN-Media/CTN-Know-the-Facts-(6)-infograpgh-for-web_1.pdf

CTN is active in advocating policy changes to improve telehealth in Colorado.

> *"In the grand sense, we're trying to make telehealth encounters equal to in-person (visits), regardless of whether the patient is on Medicare, Medicaid, or private insurance. That means developing and advocating legislation that would set up a 'super bill' program allowing providers to bill for the administration of telehealth as they would in-person consultations and for online specialty consultation like they might bill lab work. That kind of regulation is being discussed, but it's certainly not an issue state lawmakers will tackle anytime soon. Legislation that would make FaceTime with your favorite nurse practitioner private, secure, and a regular part of her job may be a year or so off — and would require potentially drawn-out federal action, as well. "*
>
> *- Ryan Westberry, Colorado Telehealth Network, regarding legislative priorities for telehealth*

CTN collaborates with other systems in Colorado to maximize efficiency of telehealth efforts. For example, CTN is partnering with Colorado Access, a Health Maintenance Organization (HMO), to create a telehealth resource center to assist service sites in rolling out the meaningful use of telehealth in Colorado. In addition, CTN is a founding member of the Western Telehealth Interstate Collaborative (WESTIC), a regional consortium of telehealth networks in the western United States.

Figure 6: The current health care access model (service is central) compared to the future health care access model using telehealth (patient is central).

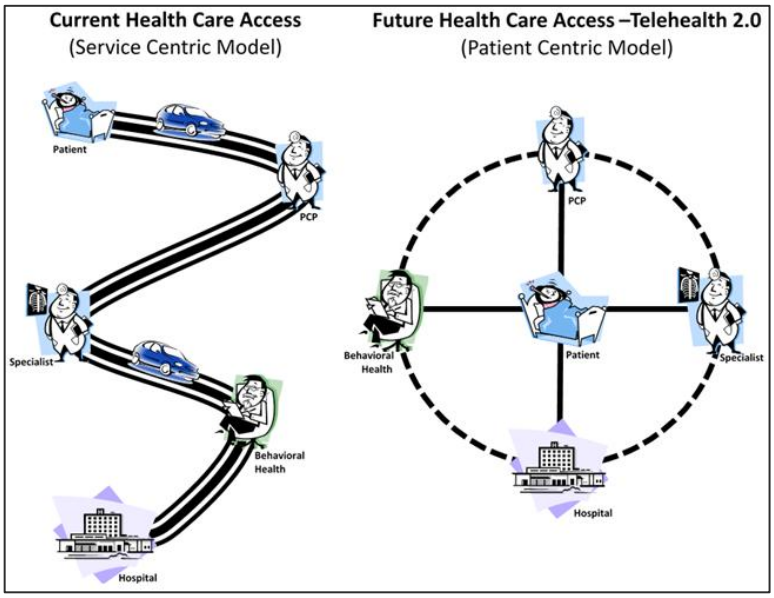


Image accessed at: http://www.cotelehealth.com/Programs/Telehealth.aspx

Colorado Telehealth Working Group (CTWG)

The Colorado Telehealth Working Group (CTWG) is a coalition of stakeholders with the mission to promote fair and practical telemedicine polices and informs policymakers on the current state of telemedicine in Colorado. Representing statewide provider associations, hospitals and health systems, individual physicians, telemedicine technology companies, private health payer organizations, funding foundations, and the state of Colorado, the group believes medical and communications technologies are critical tools that can improve service delivery and increase access to care for patients throughout the state.

Colorado Telehealth Working Group Participants

University of Colorado Health • HealthONE/ HCA • CCMCN/ CACHIE • United Health Group • Governor's Office • Centura Health • Anthem • Colorado Association of Health Plans • Colorado Medical Society • TCHF • Colorado Hospital Association • CBHC • Exempla • Anthem Blue Cross and Blue Shield • COPIC • Colorado Access/ AccessCare Technology • Colorado Access • Children's Hospital Colorado • HCPF • NCSL • DORA • Colorado Prevention Alliance • Kaiser Permanente • CRHC

The Colorado Regional Health Information Organization (CORHIO)

CORHIO is a nonprofit, public-private partnership that works to improve health care quality for all Coloradans through cost-effective and secure implementation of health information exchange (HIE). CORHIO is designated by the state of Colorado to facilitate HIE.

CORHIO was awarded two grants from the Rose Community Foundation to improve HIE for behavioral health practitioners and patients, to offer personal health records for individuals with behavioral health conditions, and to improve care coordination for Coloradans being treated by behavioral health care providers. HIE can decrease gaps in the continuity and accuracy of care to patients who see multiple providers for several conditions.

CORHIO has facilitated the exchange of clinical information for three million unique patients, more than half of the population of Colorado. All of the major hospitals and laboratories in the state are sending data into the HIE, or are in the process of doing so. In addition, there are 17 behavioral health facilities on the CORHIO network accessing the physical health clinical data on their patients, with additional facilities in queue to be connected. Using CORHIO, behavioral health providers can view laboratory and pathology results and radiology reports to see exactly what happened with a patient during a hospital stay or at a specialist visit.

CORHIO identified three ways to enhance its HIE technical infrastructure and better meet the needs of the behavioral health community: 1) create a Behavioral Health Information Exchange Coordinator position at CORHIO to manage both the system upgrades and partnerships with behavioral health organizations and stakeholders in Colorado; 2) implement a “granular

consent" model for behavioral health, which allows patients to decide whether to keep more-sensitive aspects of their health records private and excluded from CORHIO's health information exchange (addressing regulatory barriers and creating a bidirectional flow of clinical information between behavioral health and physical health providers, so they can care for patients as a coordinated team; and 3) implement a personal health record that provides behavioral health patients the opportunity to manage their health records via a secure online portal. This would be particularly helpful for patients with co-occurring diseases or who visit multiple providers throughout disparate networks.[28]

Colorado's State Health Innovation Grant

In December 2014, Colorado was awarded $65 million in State Innovation Model (SIM) funding from the Centers for Medicare & Medicaid Services to create a coordinated, accountable system of care that gives Coloradans access to integrated primary care and behavioral health. The SIM initiative provides federal funding to 25 states to develop and test their own state-based models for multipayer payment and health care delivery system transformation. Colorado's plan includes expanding telehealth infrastructure in 300 sites in rural and underserved communities under strategies to improve Health Information Technology and Health Information Exchange. Part of the planned expansion includes leveraging telehealth technologies to enhance collaboration and more effectively use specialists participating in Medical Neighborhood models of the Accountable Care Collaborative (ACC) network. Additionally, the model includes expanding the Colorado Telehealth Network's telehealth connectivity coverage from 200 to 400 hospitals, clinics, and community health centers in 2015.

Telehealth and provision of care in Colorado

Technology plays an increasingly critical role in Colorado's community behavioral health system. Providers statewide have made significant investments in advanced electronic health record systems, high-speed broadband connectivity, and telehealth technology. Large hospital networks such as HealthONE, Centura, Banner Health, and Children's Hospital Colorado, as well as closed systems such as the Veterans Administration and the Department of Defense, currently utilize telehealth to connect patients to some behavioral health-related services. However, services are not comprehensive or consistent due to a lack of regulations to ensure patient privacy, geographic coverage, and that the services are reimbursed.[29]
Multiple technology platforms are currently used across Colorado. HIPAA-compliant televideo platforms utilized for patient care include Access Care Technologies (Aveo), LifeSize, Vidyo, Visimeet, and Polycom. Other televideo products used for administrative purposes include GoToMeeting and Skype.

State Hospitals

At this point, the Colorado Mental Health Institute at Pueblo (CMHIP) is using telehealth mostly for administrative purposes in connecting leadership and staff with the Colorado Mental Health

Institute at Fort Logan. Any telehealth strategy for these entities would need to conform with state IT systems and structures.

Given the enormous increase in the number of court-ordered evaluations of competency to stand trial that cycle through CMHIP, telehealth solutions in conjunction with outpatient competency and restoration programs may be worth exploring in order to connect forensic evaluators in the community to individuals needing an evaluation in order for the legal process to move forward in a more timely way. In addition, telehealth could reduce the time and resources involved when coordinating transportation of civil patients to court appearances.

Colorado Behavioral Healthcare Council System

The Colorado Behavioral Healthcare Council (CBHC) — the organization representing the statewide network of 17 Community Mental Health Centers (CMHCs), five Behavioral Health Organizations (BHOs), four Managed Service Organizations (MSOs), and two Specialty Clinics — spearheaded the creation of the Colorado Telehealth Network (CTN), as noted previously. In partnership with the Colorado Hospital Association, more than 200 healthcare delivery sites across the behavioral health system and hospital system now have access to high-speed, affordable broadband across urban, rural, and frontier Colorado. Since 2008, CTN has served as the backbone for various technologies that improve access, enhance client experience, and reduce costs. The value generated is ubiquitous across Colorado, though particularly impactful for the state's rural and frontier communities.

Telehealth specifically is an effective and efficient care option that Colorado's CMHCs, BHOs, and MSOs give to clients, and that directly addresses access and workforce issues for the healthcare system. While the degree of implementation and use varies, all CMHCs have adopted the use of televideo.

Examples of how telehealth is currently being deployed by CBHC members include:

- Provider-to-provider consultation via televideo
- Care coordination via televideo and health information exchange
- Direct psychiatric and specialty services using live interactive video
- Technology-enabled, self-care health management solutions
- Provider education and training delivered via televideo and advanced online learning management systems
- Integration of healthcare through digital exchange of health care information.

CBHC is working with its members to move toward greater standardization and, at a minimum, ensure interoperability across televideo platforms. The use of televideo and telehealth is expanding within the crisis system. Examples of current uses or planned uses include telepsychiatry for competency evaluations in emergency departments and crisis stabilization units; medication evaluation; translation/interpretation services or the direct provision of

services in various languages; provider consultation in "living rooms" and other crisis respite models. Additional support for infrastructure and implementation costs to expand this would be highly beneficial as the system matures.

Telehealth helps mitigate the workforce and access challenges facing urban, rural, and frontier communities statewide. For example, the 10-county northeast region of Colorado covers nearly 18,000 square miles. Centennial Mental Health Center addresses a shortage of psychiatrists available to serve this vast area by giving patients the choice to receive psychiatric services via televideo. Travel costs and time-to-care are reduced while providing a care option that clients consistently rate very highly. This same scenario is playing out in rural areas statewide.

The following examples are already demonstrated as applications of telehealth by CBHC members, and should be strategic focal points for broader expansion:

- Ensuring culturally and linguistically competent services are available statewide. Translation, interpretation services, and culturally sensitive services for refugee populations, deaf and hard-of-hearing community, and others
- Psychiatric assessments in emergency departments and crisis response systems (CSUs and respite)
- Online and personalized eLearning programs for clients (MyStrength has been broadly adopted by CMHCs).

Moving toward an integrated-care model, it is important to note that access and workforce issues extend beyond behavioral health and affect primary care, specialty care, and emergency medicine statewide. Facilitating the greater adoption and expansion of telehealth will bolster the state's efforts to integrate care.

Televideo is a powerful tool for provider consultation, direct clinical care, online learning collaboratives, and eLearning. For patient care, CMHCs leverage their respective expertise (e.g., co-occurring BH/autism spectrum disorders, certain evidence-based practices, refugee populations, culturally/linguistically appropriate services) to create a sort of virtual mental health center that ensures the service needs of all populations are met statewide. For education and training, CBHC members collaborate using televideo to share subject-matter expertise and are closely tied to broader virtual learning community initiatives such as Project ECHO. In terms of electronic health records (EHRs), many CMHCs are on their second or third generation of electronic health records (EHRs). The majority use or are committed to transitioning to NetSmart, and several use Qualifacts. Mindlinc and UniCare Profiler are also used.

Depression Center – University of Colorado

The Depression Center recently launched a telehealth service from AccessCare Technology that allows in-home, completely secure patient-to-provider video communication. This telehealth platform features point-to-point high-definition video, integrated scheduling, an electronic medical record, and the ability to have multiple providers at different locations. The Depression

Center is also engaged in a trial with the A.F. Williams Family Medicine practice to evaluate the platform for use in other integrated settings (i.e., primary care and behavioral health). The Depression Center is underwriting the cost of the primary care trial due to constraints in reimbursement for services provided via telehealth.

Children's Hospital Colorado

Children's Hospital telehealth efforts include the implementation of pilot projects to support an integrated behavioral health strategy, obesity and nutrition consults to collaborative care organization practices and others, and school-based health consults/support (asthma management, allergy education, behavioral health support, post-visit follow-up and care coordination plans with the school nurse program).

Nighthorse Campbell Native Health Building

The TeleHealth/TeleEducation Program Office was created in 1996 with the primary purpose of coordinating and providing the necessary support services required by the numerous campus telehealth and teleeducation program activities. In order to generate the media source materials necessary to support teleconsultative Native American health care activities and to facilitate both the technology training and program assessment services to be provided by the center, studio and media production support space is included in this building.

Criminal Justice System - Department of Corrections

The Colorado Department of Corrections (DOC) generally utilizes telehealth to connect adult inmates to psychiatric consults, mostly for medication management. A therapist who is connected to contracted psychiatrists from the University of Colorado is present with the inmate during these sessions at the remote site. For inmates with serious mental illness who are preparing to transition back into the community, DOC contacts the Community Mental Health Center in the region to which the inmate is returning in an effort to maintain continuity of care and supports in the community. Finally, some institutions provide inmates group access to educational modules (e.g., relapse prevention) through a treatment television channel.

Project ECHO

Developed at the University of New Mexico, this model uses telehealth to link primary-care providers with advanced training from academic institutions via patient case presentations, and best practices in managing chronic conditions.

Four Corners Telehealth Consortium

The Four Corners Telehealth Consortium was formed by New Mexico, Arizona, Utah, and Colorado to serve as a model for regional telehealth collaboration in the U.S., unconstrained by

geographical or jurisdictional barriers.
Representatives of telehealth and health information initiatives in the four states have been developing specific initiatives including:

- Establishment of an interstate licensure process
- Coordination of a virtual "eHealth" university for distance learning
- Coordination of provision of telehealth clinical services representing best practices
- A process for interstate disaster response.

Telehealth and workforce development in Colorado

The Colorado Area Health Education Centers Program (COAHEC) works to build statewide network capacity and strengthen academic-community linkages in four core mission areas: health careers and workforce diversity, health professions student education, health professions continuing education, and public health and community education. While COAHEC is not currently using technology to provide training and education in behavioral health, this is an area that could be expanded to align with provider education needs in Colorado.

Recommendations for telehealth in Colorado

Telehealth is increasingly being used to increase the coordination of health care service demands and workforce limitations. Colorado is fortunate to have a cadre of individuals and organizations with significant expertise on telehealth policy, infrastructure, and implementation. Current legislative efforts and support to expand geographic criteria suggest that the utilization of telehealth will likely continue to grow.

In general, important features of good telehealth policy include: eliminating unreasonable and/or unnecessary restrictions on the telehealth practice, ensuring that telehealth services are covered to the same extent and in a similar manner as in-person services, and establishing clear priorities that are flexible enough to evolve and be updated when new clinical telehealth applications are developed and evaluated.[30]

1. ***Develop a statewide telehealth strategy*** that includes the operational aspects of telehealth, best practices, implementation protocols, technology guidelines, and staff training standards to guide community behavioral health providers in their telehealth efforts. The strategy should address opportunities in rural communities to increase overall broadband capabilities, especially given the affordability and scalability of telehealth.

2. ***Support infrastructure, implementation, and growth of telehealth in emergency departments and crisis-response systems*** (crisis stabilization units and respite) to take advantage of recently increased funding for expansion of the crisis system across Colorado. The core role of state research and evaluation networks in transporting medical services and data should be explored.
3. ***Support efforts that eliminate restrictions*** such as the "in-person" requirement related to prescribing via telehealth, as well as any geographic or population-based limitations to telehealth imposed on providers.
4. ***Create incentives and funding mechanisms*** that support the broad adoption and implementation of telehealth and other technology that supports the care provided by a broad range of healthcare providers in community mental health, substance use, and integrated-care service delivery settings.
5. ***Create Current Procedural Terminology (CPT) codes and adopt reimbursement policies*** that allow for telehealth services to be provided to consumers in their homes or other locations, and to not be confined to clinic-to-clinic or require staff to be present at both ends of the encounter.
6. ***Expand the utilization of telehealth between the two state psychiatric institutes*** (CMHIFL and CMHIP) and between the institutes and the community (e.g., for civil patients and the courts). This is especially important for specific sectors, such as nursing home settings and youth corrections facilities, where staff to address behavioral health issues is limited. Telehealth could also be used to provide consultative support to rural hospital emergency rooms that do not have psychiatric staff.
7. ***Explore using telehealth between the state psychiatric institutes and the community behavioral health center and other community providers*** to conduct competency evaluations (i.e., court orders to evaluate competency to proceed) in order to address the increase in these evaluations, expand capacity in the community system to alleviate backlogs at CMHIP, and increase the geographic reach of this service. CMHIP has providers with significant forensic expertise who could support the training and consultation of community providers conducting competency evaluations. Periodic and consistent training via telehealth for judges, defense attorneys, public defenders, and forensic evaluators on the conditions when the request for competency evaluations is most applicable may alleviate inappropriate requests for competency in the first place.
8. ***Identify providers with specialty expertise across Colorado in high-need areas*** such as gerontology, child and adolescent, and intellectual/developmental disabilities, to increase access to appropriate care that aligns with patient needs. Identify existing advanced-degree programs with a training emphasis on these specialty areas in Colorado, and explore opportunities to use interns or recent graduates to fill the gaps in high-need areas.
9. ***Explore telehealth options aimed at improving coordination*** between primary-care providers and behavioral health specialists. Identify ways to provide behavioral health consultation and support for primary-care practices via telehealth. While the presence of

behavioral health providers in the public system (Federally Qualified Health Clinics and/or partnerships between Community Mental Health Centers and health clinics) is growing significantly, use of telehealth within these systems could be expanded. Another potential solution would be to create a cadre of behavioral health providers who could support private primary-care practices and be reimbursed for providing behavioral health consultation via telehealth for patients with psychiatric conditions or for wellness-support for patients with chronic health conditions.

10. ***Expand the provision of home health services*** to reimburse for behavioral health-related issues via telehealth.
11. ***Expand the use of telehealth for individuals receiving rehabilitation and intellectual disability services*** who have a specific need for behavioral health assessment, consultation, and treatment to complement their current care plan.
12. ***Identify hubs for culturally and linguistically competent services statewide*** (e.g., translation, interpretation services for refugee populations, and the deaf and hard-of-hearing etc.).
13. ***Consider piloting a state licensure compact*** between Colorado and bordering states to expand the provider pool and access to care, especially in rural communities.
14. ***Expand the use of telehealth for workforce development-related training and supervision*** through existing educational networks (e.g., AHECs, academic institutions).

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Housing and Employment

Introduction

This section summarizes some of the current economic and social conditions affecting mental health consumers' access to housing and employment in Colorado. While Colorado is benefitting in many ways from the economic recovery underway nationally, lower-income individuals and families are being squeezed by increased housing costs, competition for living-wage jobs, and high demand for housing subsidies and social services.

Among the terms used in this section are:

Affordable housing: Household pays no more than 30 percent of income toward housing costs (including gas, electric, and water).

Cost-burdened: Household pays more than 30 percent of income toward housing costs (including gas, electric, and water).

Severely cost-burdened: Household pays more than 50 percent of income toward housing costs.

Fair market rent (FMR): Allowable rent (including basic utilities) for certain subsidized housing, calculated annually by HUD and based on the 40th percentile of the local rental market.

Housing wage: Wage that enables a full-time worker to afford a two-bedroom unit at FMR.

Living wage: Wage that enables a full-time worker to meet basic necessities, based on family size, without public assistance.

Food insecurity: At least one household member had to reduce or change eating due to lack of resources.

Findings

Affordable housing

People with limited means struggle to obtain affordable housing in Colorado. Mental health consumers in Colorado face economic barriers to housing that are similar to barriers faced by people with low incomes nationwide. With an economic recovery taking place and jobseekers moving to the state, Colorado is growing rapidly, creating new demand for housing. According

to the U.S. Census Bureau, Colorado's population increased by 4.8 percent from April 1, 2010, to July 1, 2013, double the U.S. rate of 2.4 percent. Certain counties experienced especially high growth rates, including Denver County (8.2 percent), Douglas County (7.2 percent), and Weld County (6.7 percent).[1]

Construction of housing, particularly affordable housing, is not keeping pace with population growth.[2] The U.S. Census Bureau estimated that the Denver-Aurora metropolitan area had a rental vacancy rate of only 2.5 percent in the third quarter of 2014, which was the fifth-lowest vacancy rate among the nation's 75 largest metropolitan areas. Statewide, the vacancy rate of 4.3 percent was the fourth-lowest vacancy rate of any state.[3] When vacancy rates are low and population is growing, landlords are able to increase rents. As middle-income households are priced out of neighborhoods, they turn to historically lower-income neighborhoods, in turn pricing out many people with long-term connections to those neighborhoods.

As defined by the U.S. Department of Housing and Urban Development (HUD), housing is affordable to a household if it spends 30 percent or less of its income on housing plus basic utilities (water, electricity, and gas). A household is considered cost-burdened if it spends more than 30 percent of its income on housing costs and severely cost-burdened if it spends more than 50 percent. In Colorado, 14 percent of households, including 23 percent of renters, were severely cost-burdened in 2012, according to the most recent report by the National Housing Conference.[4] An additional 18 percent of households were cost-burdened, including another 23 percent of renters. Thus nearly half (46 percent) of households that rent are either cost-burdened or severely cost-burdened. Many homeowners are also cost-burdened or severely cost-burdened, and although foreclosures have decreased since 2013, about 2 percent of home loans in Colorado are seriously delinquent.[5]

Public benefits

People who have disabilities and rely on public benefits face especially difficult housing prospects. The count of households that are cost-burdened or severely cost-burdened includes many working families. However, for people who have disabilities and do not work, the need for affordable housing is particularly acute. For people who rely on Supplemental Security Income (SSI), which provides $758 per month in Colorado, an affordable rent (including utilities) would be $227, based on 30 percent of income.

Actual rents are much higher. Each year, HUD publishes Fair Market Rent (FMR) standards for metropolitan areas and for non-metropolitan areas by county.[6] These standards are based on actual rents, with the FMR representing the 40th percentile for units of a particular size. In Denver, for example, FMR for a studio apartment in 2015 is $723 per month, while FMR for a two-bedroom unit is $1,156. In the most expensive metropolitan area, Boulder, these figures are $857 and $1,232, respectively. Among non-metropolitan areas, only two counties (Logan and Otero) have an FMR for a studio of under $400, while six counties have a studio FMR of over $700. There are no areas in which the FMR for a studio apartment meets the SSI

affordability standard of $227, and in many areas the FMR is higher than the entire SSI amount.

As a result, people who rely on SSI as their sole source of income need access to housing assistance in order to afford housing. Unfortunately, many Public Housing Agencies (PHAs) have long waiting lists for programs such as Housing Choice Vouchers (formerly Section 8), Public Housing, and other HUD-funded housing offering affordable rents.[7] A review of PHA websites reveals that numerous Colorado PHAs do not even have their waiting lists open to new applicants. Some people who need housing may be turned away because of past criminal convictions or evictions from PHA housing.

The public mental health system provides limited housing support to the individuals whom it serves. According to National Outcome Measures data for 2013, 85.4 percent of persons served reside in a private residence. Supportive Housing services are provided to only 0.4 percent of individuals, while 4.4 percent of the individuals served are reported as homeless.[8] Information obtained from the Public Behavioral Health System and Services Inventory conducted in connection with this report reveals that many behavioral health agencies do have some housing resources available to consumers, but that they can serve only a small portion of their clients, and waiting lists are long. Although some agencies reported several hundred clients receiving housing assistance, others had no clients receiving housing assistance. Waiting lists typically were a year or more, although some reported waits as little as 90 days. Several agencies reported that between 50 and 90 percent of clients with housing needs were not having those needs met.

In all, agencies reported a total of 1,968 clients receiving housing assistance. However, not all agencies reported numbers. The most common form of housing assistance was a HUD Housing Choice Voucher (58.2 percent), followed by Shelter Plus Care (21.0 percent), project-based HUD funding (4.9 percent), State Housing Vouchers (3.1 percent), and HUD Section 202 Elderly (1.1 percent). (Miscellaneous or unspecified funding sources accounted for 11.5 percent of housing placements.)

Some of the housing options identified through the Public Behavioral Health System and Services Inventory can be considered Permanent Supportive Housing (i.e., linking clients to a housing voucher or subsidized unit and providing voluntary services that are not linked to the housing). Many of the agencies reported that they provided support to clients who were housed through the local Public Housing Agency (PHA), either with a voucher or a subsidized unit. Agencies offer the following services to clients who do not receive housing from the agency:

- Helping clients identify and apply for housing, including HUD-funded housing, and get onto appropriate waiting lists
- Helping clients understand their responsibilities and retain housing, including advocating with landlords and ensuring that rent is paid
- Assisting with independent living skills such as housekeeping and budgeting

- Providing financial assistance for security deposits, furniture, etc., as well as transportation for housing search
- Assisting with employment and income supports as a means of paying for housing.

Other housing options are more institutional in nature and may require individuals to share a room or a kitchen with other individuals who have disabilities; may be of a transitional or short-term nature; and/or may require participation in treatment as a condition of residency. Of the 17 agencies responding, 12 reported owning and/or operating housing for their clients.

The lack of affordable housing contributes to the problem of homelessness. According to the point-in-time (PIT) estimate conducted in January 2014, over 10,000 people were homeless in Colorado.[9] However, because of the difficulty in locating people who are homeless, as well as people who are "doubled up," "couch surfing," or living in substandard housing, the PIT estimate significantly understates the number of people who need housing and cannot afford it.

Advocates for affordable housing express their frustration with the situation. They describe a lack of revenue sources to develop new affordable housing for very low-income people. They also perceive that communities are less tolerant of people without housing. Denver is currently in the final year of its 10-year plan to end homelessness, but significant challenges remain both in Denver and across the state. The Governor is looking at funding permanent supportive housing from the revenue from legal marijuana sales, but this might not be popular because that revenue stream is currently earmarked for education.

The current job market

The current job market presents limited opportunities for low-income people to improve their housing options. The gap between the wealthy and poor has increased significantly in Colorado. While many jobs are available, the job market continues to drive disparities. Manufacturing jobs that pay a living wage to blue-collar workers are disappearing. Most jobs either pay well but require significant qualifications (such as high-tech or energy sectors) or require limited qualifications but do not pay well enough to enable the worker to afford housing and childcare. Furthermore, job opportunities are not located close to affordable housing, and the public transportation system is not adequate to make job opportunities accessible. Although the state has enacted policies that improve employment prospects for ex-offenders, they still face difficulties finding suitable employment. These conditions create a dilemma for people with limited skills, experience, and/or education, because housing costs are driven up by demand created by people with high-paying jobs, while wages in low-paying jobs remain stagnant.

The Alliance for a Just Society advocates for workers to be paid a living wage —a sufficient wage to allow the worker to meet basic necessities without public assistance, based on family size. In its 2013 Job Gap Report, the organization calculated a living wage that ranged from $15.88 per hour for a single adult to $30.66 an hour for a single adult with two children.[10] The report noted that 44 percent of job openings paid less than a living wage for a single adult,

while 79 percent paid less than a living wage for a single adult with two children. Further, for each job paying a living wage for a single adult, there were five people looking for work, and for each job paying a living wage for a single adult with two children, there were 14 people looking for work. The high competition for jobs that pay a living wage increases the difficulty of escaping poverty in Colorado. The state has a poverty rate of 13.2 percent, according to the U.S. Census Bureau,[11] and a food insecurity rate of 13.9 percent, according to the U.S. Department of Agriculture.[12]

The National Low Income Housing Coalition (NLIHC) advocates for workers to be paid a "housing wage"—a sufficient wage to make housing affordable. NLIHC bases this theoretical wage on HUD FMR for two-bedroom units. According to NLIHC's latest report for Colorado, the average statewide two-bedroom FMR is $916, and a single worker would need to earn $17.61 hourly, working full-time, for this rent to be affordable (i.e., no more than 30 percent of income).[13] Currently, Colorado's minimum wage is $8.23 an hour, a gap of $9.38 below the housing wage. A minimum-wage worker would need to work 86 hours per week for 52 weeks in order for the two-bedroom FMR to be affordable. Given the difference between minimum wage and the housing wage, the statistics on cost-burdened and severely cost-burdened households (described above) are understandable.

Barriers to securing housing through employment

People with disabilities face additional barriers in securing housing through employment. For people with disabilities, the housing and employment situation is even more difficult. Many people with disabilities, particularly those with developmental disabilities, are not even earning minimum wage, instead participating in sheltered work activities rather than competitive employment. For mental health consumers, systemic barriers interfere with effective employment supports. Although the relationship between the behavioral health and employment/vocational sectors appears to be improving, the perception is that a stronger relationship could boost employment outcomes.

Agencies responding to the Public Behavioral Health System and Services Inventory reported employing 58.25 FTE who work solely on employment, and reported providing employment services to 3,060 clients. In almost all agencies, case managers are supposed to address employment as part of a care plan, and in most cases they follow up on clients' progress in employment supports. Further, agencies consistently reported developing relationships with employers and providing ongoing support (such as job coaching and social-skills training) to clients who obtain employment.

Some but not all of the employment services provided by the agencies follow evidence-based or promising practices. According to National Outcome Measures data for 2013, 1.9 percent of individuals served by Colorado's public mental health system receive evidence-based Supported Employment services.[14] Several agencies responding to the Inventory reported offering Supported Employment according to the Individual Placement and Support model, and some

clients have access to psychosocial clubhouses, which promote employment through a structured day and various vocational supports. In one agency, for example, a clubhouse had 77 members, of whom 56 were working. Another promising program is providing sector-based employment training in industries such as construction, culinary arts, and landscaping. Such approaches can be successful when they are keyed to high-demand industries.

However, many agencies provide informal supports such as assistance with job searches, job readiness, etc., which may not be sufficient to help people with intensive needs obtain employment. Other clients receive services in sheltered or transitional settings, rather than in natural workplace settings.

Further, resources are not available to provide employment supports to everyone who could benefit from them. Of the 17 agencies responding to the Public Behavioral Health System and Services Inventory, 15 provided their clients with help applying for benefits such as Supplemental Security Income (SSI), but only seven reported helping their clients find a job. A number of agencies estimated that a significant percentage (up to 100 percent) of their clients had unmet employment support needs. Agencies reported helping 980 people find employment; however, it is unclear how many of these jobs were competitive, full-time, or paid a living wage. In several agencies, only a handful of clients are finding employment.

Although the Colorado Division of Vocational Rehabilitation (DVR) is funded to help people with disabilities enter or remain in the workforce, the demand for the agency's services outpaces its resources. As a result, the agency has implemented an Order of Selection—a process by which people who qualify for services are prioritized according to need. People with the most significant disabilities have the top priority. This determination is based on an evaluation of the functional limitations that a person has, the number of services required to address those limitations, and the time required to provide those services.

In part because DVR must give priority to those who require a higher level of service, the number of people whom the agency can serve is limited. Many mental health consumers fall into the lower priority groups that cannot currently receive services under the Order of Selection. It is estimated that between 3,000 and 4,000 people, many of whom cannot be located, are waiting to receive vocational services. A further barrier to serving people effectively is the high turnover rate among employment counselors.

The state has recently made a policy change to enable all centers in Colorado to use state general-fund money for the IPS supported employment model. So far, 12 of the 17 centers have opted to expand or begin IPS supported employment in conjunction with the state vocational rehab program.

Just as the availability of employment services is limited for mental health consumers, there is also an unmet need for mental health treatment for very low-income and low-income workers. Despite health care reform, access to behavioral health services remains a problem for many

Coloradans, especially in rural areas, according to a report by the Advancing Colorado's Mental Health Care Project.[15] Inpatient treatment capacity has decreased and providers see paperwork requirements as detracting from patient care. Low-income workers may also have difficulty accessing needed mental health services for their children, as services may be difficult to access even for children covered by insurance.[16] The system may be getting better in terms of providers and availability of resources, but it means nothing if patients are not able to access the care.

Summary of Findings

- The supply of affordable housing is insufficient, as evidenced by the percentage of households that are cost-burdened or severely cost-burdened.
- Low vacancy rates keep housing prices high.
- People with disabilities who rely on SSI cannot afford housing without additional assistance.
- Many people who need housing assistance cannot obtain it from PHAs.
- Behavioral health agencies are providing housing to a portion of their clients through various funding streams, but many people have unmet housing needs.
- Agencies provide a variety of services to clients who live independently (i.e., in housing not provided by the agency), including help finding housing, ongoing support, and financial assistance.
- An accurate count of people who need housing assistance is not available.
- A significant percentage of available jobs do not pay enough for workers to afford market-rate housing.
- Behavioral health agencies generally provide employment supports, but these supports range from informal to following evidence-based models.
- A significant percentage of clients do not have their employment support needs met.
- Of those who do receive services, only about one in three obtain employment, and it is not clear how many of them, if any, are able to earn a living wage.
- Low-income families have difficulty obtaining behavioral health services.

Best Practices

A number of evidence-based and promising practices are used throughout the nation to improve housing and employment outcomes for people with mental illnesses.

Housing

In recent years, the Permanent Supportive Housing (PSH) model has emerged. PSH for people with disabilities is affordable housing with full rights of tenancy, and with access to voluntary, flexible support services needed to choose, obtain, and keep housing that is integrated into the community. Permanent Supportive Housing programs can serve not only people who are homeless, but also people leaving institutional settings or otherwise needing support in order to live independently. High-fidelity PSH programs use a Housing First approach when assisting people who are homeless. A Housing First approach means offering people who are homeless rapid access to housing, with no preconditions such as completion of residential treatment —

and no requirements once housed other than what is found in a standard lease.

Federal agencies have actively promoted the PSH model and Housing First approach. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) has issued a comprehensive toolkit[17] on implementing PSH, while the U.S. Interagency Council on Homelessness (USICH) promotes Housing First through a checklist[18] for determining whether the approach is being followed. The reason behind federal support for PSH and Housing First is that people with disabilities have a right to services in the least restrictive setting that is appropriate to their needs, as recognized by the Supreme Court's 1999 *Olmstead v. L.C.* decision.

As a U.S. Senate committee noted, *Olmstead* means that "individuals with disabilities should have access to housing other than group homes, other congregate arrangements, and multi-unit buildings or complexes that are primarily for people with disabilities. They should have access to 'scattered site' housing, with ownership or control of a lease. Housing should not be conditioned on compliance with treatment or with a service plan."[19]

Research Base on Permanent Supportive Housing

The evidence base on PSH continues to emerge.[20] One of the problems with earlier research into PSH is that housing was described without much precision or consistency. The adoption of tools like the PSH Fidelity Scale in the SAMHSA toolkit and the USICH Housing First Checklist have made it possible to conduct research that links outcomes to how closely a housing program complies with key elements of these preferred approaches. For example, a study of over 6,500 residents of 86 programs in California found that programs with greater fidelity to the Housing First approach, particularly with regard to client choice and incorporation of client goals in the planning process, produced better results in keeping people housed.[21]

The outcome most solidly associated with PSH is housing stability. People with serious mental illnesses and/or addictions who have experienced chronic homelessness can succeed in PSH, even though the model does not require a demonstration of sobriety or participation in treatment. In fact, studies comparing PSH using a Housing First model to "treatment-first" housing have found the Housing First approach more effective at keeping people housed.[22]

Other outcomes associated with PSH include reduced hospitalizations and emergency room visits.[23] Access to stable housing also improves criminal justice outcomes.[24] Some evidence also suggests that PSH using a Housing First approach can be effective at reducing substance use, particularly for a subgroup of people unwilling to participate in treatment.[25]

Research shows that high-quality programs can eliminate the key concerns about PSH and the Housing First approach. These concerns relate to their departure from traditional models, many of which: (a) link residency to participation in mandatory services, (b) require a showing of "readiness," (c) mandate sobriety either before or after program admission, and/or (d) require

people to complete transitional steps before receiving permanent housing. Providing access to housing coupled with support services can increase the use of mental health and substance abuse treatment, even though those services are voluntary.[26] Direct comparisons of Housing First to treatment-first programs have shown superior outcomes with the Housing First approach.[27] Further, comparison of the Housing First approach to a stepwise approach reveals that the stepwise approach imposes higher costs but does not produce better long-term outcomes.[28]

Employment

Employment of people with serious mental illnesses is a crucial part of service planning. A high percentage of people with serious mental illnesses are unemployed, even though a number of approaches are available to help people obtain employment. In addition to economic benefits, meaningful employment has psychosocial benefits.[29] However, these benefits might not be generated by lower-quality employment situations.[30] It is thought that ongoing support and workplace accommodations are crucial to improving employment outcomes such as job satisfaction.[31]

Often, employment supports are offered informally, such as a case manager or social worker offering advice or help with specific tasks such as filling out job applications. These services might be obtained either through the mental health system, vocational rehabilitation agencies, the U.S. Department of Labor's workforce system, or community-based nonprofits. Based on comparison studies[32] and the high unemployment rate among mental health consumers, these informal approaches are unlikely to produce positive results.

Three model programs, described in greater detail below, have been subjected to a significant amount of research that indicates that they are more effective than informal approaches:

- *Supported Employment*,[33] in particular the Individual Placement and Support (IPS) model, de-emphasizes pre-vocational activities in favor of rapid assistance with a search for competitive employment (i.e., a job not set aside for a candidate who has disabilities) and follow-along supports for as long as needed.
- *Social Enterprises*,[34] sometimes called social firms, have the dual purpose of generating revenues and employing people with barriers to employment, such as a thrift shop or café that employs people with disabilities.
- *Clubhouses*[35] are based on an international model that relies on a "work-ordered day," in which members follow a traditional work schedule helping staff to operate the clubhouse. Members have access to pre-vocational training, along with two major types of employment—transitional jobs, in which they work alongside other members and staff, and independent employment, which may be based on a supported employment model.

Supported Employment

SAMHSA considers Supported Employment to be an evidence-based practice. SAMHSA makes freely available a comprehensive toolkit for implementing the Individual Placement and Support (IPS) model of Supported Employment.[36] This resource offers guidance on planning, funding, and implementing IPS; materials for training direct-service staff; and a tool for evaluating fidelity to core elements of the intervention. IPS has the following core principles:

- Eligibility is based on consumer choice.
- Services are integrated with comprehensive mental health treatment.
- Competitive employment is the goal.
- Personalized benefits counseling is important.
- Job search starts soon after consumers express interest in working.
- Follow-along supports are continuous.
- Consumer preferences are important.

Considerable evidence supports the effectiveness of IPS Supported Employment. A recent article identified 12 systematic reviews and 17 randomized controlled trials supporting numerous positive effects of the IPS model of Supported Employment.[37] Multiple randomized controlled trials confirm that IPS is more effective than traditional vocational approaches, such as group skills training, vocational rehabilitation, and psychosocial rehabilitation, regardless of participant characteristics such as age, ethnicity, education level, prior work history, substance use history, and other factors.[38]

Social Enterprise

As described by the Social Enterprise Alliance, a social enterprise that employs people who face barriers to employment serves multiple purposes, including reducing burdens on public service systems, improving neighborhoods, creating economic opportunities, and promoting social justice by helping those in need.[39] The Alliance offers on its website a library of resources on planning, funding, and running social enterprises, including examples of successful ventures.

Following are links to the websites of several social enterprises that hire people who are homeless and/or have behavioral health disorders:

- Project HOME, Philadelphia: https://projecthome.org/our-work/social-enterprises
- Chrysalis Enterprises, Los Angeles: http://www.changelives.org/hire
- TROSA, Durham, NC: http://www.trosainc.org/index.php/trosa-businesses

Social enterprises can take many forms, from helping people obtain and retain employment in fields with modest earning potential such as food service and retail, to training people in high-demand fields such as renewable energy.[40] While there are successful programs scattered throughout the United States, the model appears to be widespread in Europe and the United

Kingdom.[41] People who work in social enterprises seem to value the supports that they receive on the job and value their role in the workforce.[42]

It is important to note that social enterprises can be thought of as compatible with many features of the IPS approach, such as rapid placement, follow-along supports, etc., even though they hire primarily or exclusively disadvantaged jobseekers.[43] Additionally, when social enterprises are used as transitional employment, in conjunction with other principles of IPS, participants can improve their long-term employment outcomes.[44]

Clubhouse Model

The Clubhouse model of psychosocial rehabilitation is firmly established, and there are more than 300 certified clubhouses nationwide. The parent organization, Clubhouse International, offers training, consultation, and accreditation. Extensive information about the clubhouse model is available on the organization's website.[45] Participants in services are referred to as "members," and they are involved in the operations of the clubhouse. A key feature of the clubhouse is the "work-ordered day," which is intended to simulate a working environment along with several different employment options. In transitional employment, members work for employers in the community, but the clubhouse staff agrees to cover any employee absences, the employment is for a defined time period, and the positions are reserved for clubhouse members.[46] Clubhouses also offer help with placement into permanent, competitive employment, including offering supported employment options.

Evidence suggests that clubhouses are effective in promoting employment, as compared to less-intensive interventions such as Assertive Community Treatment teams offering vocational services.[47] One study identified the work-ordered day as a pre-vocational service that can promote longer employment tenure and higher wages.[48] However, a potential concern about the clubhouse model is that some services are provided in a setting in which members are interacting primarily with other people with disabilities and clubhouse staff, which may raise concerns under the U.S. Supreme Court's 1999 decision in *Olmstead v. L.C.*, which affirmed the right of people with disabilities to receive services in a setting that allows them to interact with people who do not have disabilities. A U.S. Senate committee in fact singled out the clubhouse model as a potential example of a "segregated program," noting that "Individuals with disabilities should have the opportunity to be employed in non-segregated, regular workplaces."[49]

Recommendations

In light of the above findings, full implementation of the two housing and employment evidence-based practices described below are recommended.

Housing

1. **Implement permanent supportive housing (PSH) as an evidence-based practice.** Permanent supportive housing implementation will improve access to affordable housing and supportive services for people with behavioral health disorders. This evidence-based practice aligns well with the 159 targeted housing vouchers that became available in FY 2013-14 targeted for individuals leaving the mental health institutes and other psychiatric inpatient facilities. The results of the Public Behavioral Health System and Services Inventory suggest that some elements of the model, such as assistance finding housing and ongoing supports with independent living skills, are already available to some consumers. Wider implementation of this evidence-based practice would help alleviate the shortage of affordable housing and the lack of mental health services for low-income households. Further, it would directly address the need for effective interventions to prevent and end homelessness among people with behavioral health disorders. Implementation of this evidence-based practice must focus on core elements and meet fidelity as described in the SAMHSA Permanent Supportive Housing Evidence-based Practices KIT.[50]

2. **Recruit and train a cadre of regional housing coordinators to work with local housing providers, including PHAs, landlords, and property managers**. Regional housing coordinators would work to expand access to existing affordable housing and may assist in expanding the housing stock through strategic partnerships; they would also support and troubleshoot implementation of PSH. It is recommended that training be provided for regional housing coordinators on developing housing resources and PSH implementation and fidelity.

3. **Provide training for provider agencies on PSH. Training must focus on implementation with fidelity**. Lead regional housing coordinators could learn the process and train peers if the system supports a train-the-trainer structure.

4. **Set targets for the number of individuals to be served using PSH**. PSH should be a mandatory program for all providers serving adults, and targets should be at least 20% of all adults served. Targets can be phased in over a two-year period.

5. **Develop state-level strategic partnership**s with the state housing agency and other crucial partners to create new integrated housing options for people with behavioral health disorders. Explore opportunities to create a bridge subsidy program through the use of state general revenue in combination with available HUD funds.

Employment

6. **Continue the implementation and expansion of the individual placement and support model of supported employment (IPS/SE) as an evidence-based practice.** Supported employment (IPS/SE) will continue to improve access to jobs paying a living wage. The results of the Public Behavioral Health System and Services Inventory suggest that many of the agencies are already implementing this evidence-based practice for a portion of their clients. Wider implementation would help alleviate the shortage of available jobs and the lack of employment services for people with disabilities. Implementation must focus on core elements and meet fidelity as described in the SAMHSA Supported Employment Evidence-based Practices KIT.[51]

7. **Recruit and train a cadre of regional employment coordinators** to work with local workforce centers, employers, city/county employment efforts, and private nonprofit organizations focused on employment of low-income individuals. Regional employment coordinators would also support and troubleshoot implementation of SE. It is recommended that training be provided for regional employment coordinators on developing job opportunities, expanding training opportunities, and developing IPS services.
8. **Provide training for provider agencies on IPS/SE**. This training can be coordinated with housing training described above. Training must focus on implementation with fidelity. Regional employment coordinators could learn the process and train peers if the system supports a train-the-trainer structure.

9. **Set targets for the number of individuals to be served using the IPS/SE**. IPS/SE should be a mandatory program for all providers serving adults, and targets should be at least 10% of all adults served.

10. **Develop strategic state-level partnerships with the Division of Vocational Rehabilitation**. Address Order of Selection difficulties and mitigate the negative effects of this practice.

In addition, the following broad actions are recommended to support future efforts to improve housing and employment for individuals with behavioral health disorders.

11. **Improve data collection** and sharing by all state agencies to identify people in need of affordable housing, including those who are doubled up, couch surfing, or living in substandard housing. Include housing status in all client databases.

12. **Ensure that data collection is culturally sensitive** to people experiencing homelessness, and minimize paperwork and pre-authorization to rapidly link people to needed supports.

13. **Train state and regional workers in trauma-informed care principles**.

14. **Redirect spending of state funds** and mental health block grant funds on services that can be covered by Medicaid to improve housing options, provide transportation, promote employment, and other nonclinical services.

15. **Create a workforce development plan** to fund, recruit, and keep providers, especially mental health and specialty care workers.

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Peer Mentors, Recovery Coaches, and Family Advocates

Introduction

This section focuses on the extent to which peer mentors, recovery coaches, and family advocates are being used in the provision of Colorado behavioral health services. During November and December of 2014, key informant interviews and focus groups were used to gather information about the roles and needs of peer mentors, recovery coaches, and family advocates. Additionally, during November and December of 2014, community mental health service providers under contract to the Office of Behavioral Health (OBH) completed an inventory of their services, including items directly related to peer services. Some of the key findings pertaining to training and supervision are included in this section of the report and other data were placed in the inventory section of the report.

Participants in the interviews and focus groups primarily represented individuals with mental health or co-occurring mental health and physical health or addiction challenges. Most worked in a variety of service settings across the state, including hospitals, community centers, behavioral health services, VA centers, homelessness programs, jails, FQHCs, and addiction recovery centers. A few participants were not working in any service setting at the time of the review. Gender, age, and other demographic information about the participants were not collected.

A standard discussion protocol was used for all interviews and focus groups, addressing five key themes:

1. Ways that peers are currently working in the Colorado behavioral health service system
2. Ways that peers could potentially be more involved in the Colorado behavioral health service system
3. Training and support for peer staff
4. Quality of worklife
5. Ways that CO OBH could improve or better support peer services.

It should be noted that while this review was underway in December 2014, the Colorado Mental Wellness Network (CMWN) published “Report on Colorado’s Behavioral Health Peer Provider Workforce.” Funded by the Colorado Trust, the CMWN conducted a number of statewide focus groups and strategy sessions about the development of the peer support workforce in Colorado. Their report offers contextual background and a set of definitions in addition to findings that largely parallel the findings of this needs assessment. It is our recommendation that the CMWN report be reviewed in conjunction with the information provided here.

Overall impressions and findings

Status and Potential

Over the past several years, Colorado has made great strides in developing peer specialists, peer mentors, and recovery coaches; helping to support their training; and promoting employment opportunities. The current peer specialist training provided by the CMWN, as well as NAMI peer-to-peer training, is appreciated and positively received. While the current supervisory structure is highly variable in quantity and quality across the state, many participants were positive about their experiences with supervisors. However, it is apparent that further support and continuing education opportunities would greatly benefit the peer workforce.

All participants were enthusiastic about the potential for the peer workforce in Colorado and identified a number of settings in which incorporation of peer specialists, mentors, and recovery coaches would benefit and enrich services in a variety of areas: behavioral health, medical/primary health, legal/justice, housing/social services, colleges, professional training settings, and assisted living homes.

Key areas for development

Several key challenges emerged in the discussions. First and foremost, there was a loud and consistent call across informants to establish a statewide certification process and standards, continuing education opportunities, and setting-specific training opportunities. Participants are concerned about ensuring quality of peer services, but also establishing it as a recognized and respected discipline. Important areas for growth and development include better training for supervisors of peer specialists; creation of peer-to-peer supervision vehicles; clear, standardized job descriptions; and improved integration of peer specialists within the staff of their respective institutions.

While peers are working in a wide variety of settings and in multiple capacities within the Colorado behavioral health service system, they often experience perceptions of tokenism, feelings of loneliness, and lack of collegial support.

Priority recommendations for improving peer services in the state include: a statewide certification process, standardized ethical guidelines, expansion of current training opportunities, the promotion of peer attendance at conferences, and standardized training for peer supervisors.

Ways peers are currently working in Colorado's behavioral health system

Focus group and key informants identified a wide range of settings in which there are at least some peers employed as specialists or recovery coaches. These include the following.

- Behavioral health agencies
- Integrated FQHC/mental health services
- Local psychiatric and addictions inpatient treatment settings
- Crisis stabilization units
- Statewide Peer Crisis Intervention Program

- VA treatment and service settings
- Social services, such as unemployment programs
- Colorado Coalition for the Homeless
- Nursing homes
- Walk-in clinics such as the Community Reach Center
- Drop-in centers
- Transitional housing programs
- Jail and criminal justice services.

Within these settings, peers may work with trauma-informed care teams, case management teams, housing support, outreach, crisis support, and empowerment programs. They may provide health coaching, group facilitation, education classes, individualized support and other services. There were also examples of peers working as supervisors, coordinators, administrators, program developers, and trainers.

While peers are involved in a wide variety of settings and in multiple capacities within the Colorado behavioral health system, participants indicated that often only one or two peers are employed in any one setting, often part-time, and with a limited scope of work. Further, not all settings of a given type hire peers. For example, not all behavioral health agencies have peer specialist programs or identified peers on staff. While there is breadth, there is little depth at this time.

Ways peers could potentially be more involved in Colorado's behavioral health system

During the focus groups and interviews, participants were exceptionally enthusiastic about the potential of peer support services. They underscored the need to strengthen and expand current peer capacities in the kinds of settings where peers are currently working, but also identified additional settings that would benefit from engaging peer specialists, recovery coaches, and family advocates, and particular ways in which they may be helpful. These include the following.

Behavioral health

- All community behavioral health treatment and support services
- All inpatient psychiatric services, including state hospitals
- Emergency units
- Peer-run respite programs
- Recovery coach work for substance abuse (especially for those individuals with co-occurring behavioral health issues)
- Developmental/intellectual disability services (especially for those individuals with co-occurring behavioral health concerns)
- Substance use/abuse treatment programs.

Medical/primary health

- All hospital emergency rooms
- Health centers, dialysis centers, cancer treatment centers, and other medical settings to support people with co-occurring health and mental health issues
- All rehabilitation services (not just psychiatric rehabilitation)
- Peer specialists to assist families of an identified patient
- Patient navigators
- Palliative care/hospice
- Family advocates to help support the full family, not just identified patient
- Pregnancy resource centers.

Legal/justice

- Re-entry following incarceration
- Problem-solving court, drug court
- Probation/parole
- Homelessness courts
- County jails
- Police departments and police training programs.

Housing/social services

- Navigators and advocates
- Child protection
- Support for women losing children to system
- Peer experts on wellness and respite
- Low-income housing/social disability services
- Warming centers and rescue missions
- Vocational skills training and education services.

Colleges, academic settings

- Campus counseling and support services
- High school mentors
- Recovery schools.

Professional training, education, support

- Educators of new professionals in medicine, behavioral health, social services
- Employee assistance programs (EAP).

Training and support for peer staff

Discussions about training and support for peer staff focused on the strengths of existing training and the kinds of additional training most needed by peers to be prepared, employable, and effective in their work.

Current training opportunities

Participants in the focus groups and key informant interviews were overall positive about the quality of existing training for peer support specialists. In particular, the training offered by the Colorado Mental Wellness Network was cited often and positively. The NAMI peer-to-peer training and conferences were also recognized as helpful. A number of settings provide in-house training for peer employees, but the availability and quality of such training varies from organization to organization. Several common concerns emerged from the discussions:

- Overwhelming support for establishment of a recognized statewide certification program for peer specialists.
- Expanded availability of training across the state.
- Expansion of training to include more individuals. This includes using virtual training approaches to help reach peers in rural areas.
- A rich array of continuing education opportunities that include face-to-face training, virtual training, conferences, and in-house training.
- "Specialist" or "setting-specific" professional development opportunities. Peers working in settings such as jails and emergency services want more training on how to meet the demands and expectations of those specific settings.
- Development of and training for expanded roles for peer staff.
- Transferability of existing training to meet certification requirements of other states.
- Development of an "internship" structure that would allow individuals to develop experience and setting-specific knowledge and skills. This would be accompanied by ongoing support and supervision from internship supervisors both within and external to the internship site.

Behavioral health provider inventory: peer specialist training before and after employment

The information below was provided through the Inventory completed by the providers of public behavioral health services in Colorado through contracts with OBH. The Inventory results are presented by the seven geographic regions of Colorado as described at the beginning of this report. The bulleted items in the tables represent responses by the various providers that completed the Inventory for each region.

Table 1: Number of training hours required before employment		
Region	**Hours**	**Training peer staff receive before employment**
1	16-40 hrs.	• Georgia Peer Specialist Training model is used.
2		• Peer specialist training provided by BHO; ethical guidelines, advocacy, relationship building, conflict resolution, workplace preparedness, HIPAA, sexual harassment.
3	3 months 80-96 hrs.	• Peer specialists come from a variety of training programs, some as long as a year, others for just two months. We require some type of peer specialist training to be completed as a condition of employment prior to hire date. • Peers receive training in accordance with the Colorado Combined Core Competencies for Peer Providers. Peers are involved in training for 4 -8 hours per week for 12 weeks before employment. Peers also receive training on Mental Health First Aid (Adult /Youth) Crisis Prevention Intervention. • Attend Colorado Mental Wellness Network training.
4	120 0 40	• Our peer specialist has been with our organization for a very long time. We will require peer specialist training with our new programmatic changes. • All are degreed. One completed intensive training with the RATC program 15 years ago. • Peers receive their training after being hired, not before. • Training created by International Association of Peer Specialists with additional sections included to ensure all core competencies for peer specialists are addressed. Additional training is provided on suicide prevention, basic knowledge of mental illnesses, and self-care.
5	0	• Training starts after employment begins. Eight-hour orientation followed by 20 hours of job shadowing, followed by 80 hours of peer specialist training.
6	0 35	• All our peer specialists undergo 36 hours of training to address core competencies. Training occurs after they are hired by Jefferson Center. • A 35-hour class taught by Value Options Peer Trainer Clarence Jordan, modeled on the Colorado Combined Core Competencies for Peer Providers. In addition, peers hired by Mental Health Partners receive a new-employee orientation that introduces them to the center and to the work of the peers.
7	18	• In-house training provided by the ACCESS Center based on Georgia Peer Certification Model. Three six-hour days, for a total of 18 hours and/or training through NAMI (typically 10-week courses or volunteer experiences).

Table 2: Number of training hours required after employment		
Region	**Hours**	**Training peer staff receive <u>after</u> employment**
1	NA-80	• Weekly and as needed individual supervision. Monthly group supervision • Curriculum based on the Georgia Peer model and Intentional Peer Support. Each peer support person receives weekly individual supervision and bi-weekly group supervision, of one hour duration. Peer staff are required to meet all the mandated class requirements set out by Touchstone.
2	15-20	• Approximately 20 hours in first 6 months, then ongoing training (Solution – Focused Interventions, Motivational Interviewing, Group Facilitation Skills, MH First Aid, Recovery Principles, etc.); Clinical boundaries, MHFA, CPI, and online training.
3	8 hours monthly 32	• Peer specialists are encouraged and supported to attend ongoing training offered through our BHO (BHI) and other organizations. • After a peer is employed, it is up to the program to send peer to training to continue enhancement of skills for workplace settings. We do provide ongoing training monthly with guest speakers that is open to all employees. Peers have monthly meetings after employment to discuss concerns about the workplace and achievements or accomplishments. • Wrap Training (16 hours) and Mental Health First Aid training (8 hours) offered to all peer specialists, and training specific to their professional growth and development.
4	20-80 3 hours a month	• We provide ongoing training through Relias and other local or state trainings. • New-staff orientation and training. • Training is provided by our chief operating officer, who has a background in working with peers and a doctorate emphasizing integration. Training focuses on the culture of the citizens in our six counties, our agencies' requirements for employees, and the rules and regulations we must follow through our BHO. The peers also go through an orientation process that takes approximately 30 days and is designed for all employees at Southeast Health Group. • Training on variety of topics to include expanding on topics provided in initial training, topics that peer specialists request, or topics that a supervisor feels the peer specialists need more training on.
5	80	• Three-week peer specialist training.
6 666	36 24	• Ninety minutes a week of group supervision, which includes a clinical presentation on some domains of recovery. • Nineteen hours of annual online training required by the Center. • Miscellaneous trainings of the staff's choosing or directed by the program manager. Examples include spirituality, motivational interviewing, safety, workplace violence, de-escalation, suicide prevention, Mental Health First Aid etc. • 24 hours per year in monthly two-hour meetings with various guest speakers and invitation to center-wide staff trainings on various topics, depending on position and supervisor approval.

Table 2 Continued: Number of training hours required after employment		
Region	**Hours**	**Training peer staff receive after employment**
7	16	• Still developing our internal on-boarding process for peer specialists, but at this stage it will include eight hours of Mental Health First Aid Training and eight hours of other training specific to the paraprofessional role and beyond the basic employee orientation trainings. These include trainings on solution-focused conversations, self-care for helpers, trauma-informed care, professional boundaries, and crisis de-escalation/CPI.

Training needs

Structured training programs provide a good grounding in the concepts of recovery, but participants also called for a deeper understanding of how recovery principles can be translated into everyday practice. This is of particular concern when peers work in organizations that are not fully on board with recovery-oriented philosophy and practices. Peers are often called upon to be advocates for recovery practices, but often lack concrete knowledge about what may need to change, models for more effective practice, or how to change organizational culture and norms. Typically, too few peers are hired by an organization to create sufficient momentum for change unless there is also strong leadership will and support for such change.

While there was strong emphasis on not turning peer staff into "mini-clinicians" and ensuring that peer staff are well grounded in peer support values, participants identified several specific areas where existing training could be augmented or expanded to provide greater contextual and clinical understanding. These include:

- Richer understanding of the clinical context of diagnosis, symptomology, and treatment, including commonly used medical/psychiatric terminology
- Mental Health First Aid
- Crisis prevention/intervention
- Suicide intervention
- Substance use/abuse
- Integrated health and wellness.

Like many staff, peers feel unprepared for the documentation demands in the workplace and need greater orientation and training in this area, including CMHS coding requirements and electronic health records.

Some participants also requested more skill development in specific content areas. These include:

- How to mentor or coach others
- Building professionalism
- Shared decision making

- Solution-focused problem solving
- Ethics and boundaries
- Self-care.

While not a specific training issue, some participants mentioned that peers with a history of justice involvement may find it difficult to be hired as peer support specialists in some settings due to background checks. This is a particular concern when hiring peers to work in justice settings. Yet at the same time, this personal experience may be crucial to peer staff's being accepted and effective in these settings.

Quality of worklife

Discussions about the quality of worklife included topics such as acceptance by non-peer staff, supervision, and challenges experienced by peer staff in the workplace.

Supervision

All focus group participants who are currently employed indicated that they receive supervision within their agencies and are generally satisfied. The structure and quality of the supervision varies across employers, often dependent on the commitment and understanding by the supervisor of the peer support role and the special supervisory needs of peer staff. Some peers receive formal, weekly one-to-one or group supervision; others have bimonthly or monthly meetings with a supervisor. Some supervisors have an open-door, check-in-anytime approach, and some informally touch base with peer staff daily. Participants working within recovery coach positions reported having more informal supervisory experiences, much of which includes peer-to-peer consultation. Peers working in warm-line and crisis service settings typically have on-demand access to supervisory support.

This inconsistency reflects different organizational cultures and service demands, as well as a lack of established standards or guidelines for supervising peer staff in Colorado. There seems to be little or no training or support for supervisors overseeing peer staff. In some cases, the responsibility for supervising peer staff is assigned to clinical interns with little or no experience in supervision, let alone peer support. The VA offers annual training on supervising peer staff, but there is high demand and insufficient access for this training. However, it is a model with an established curriculum that could be expanded to benefit peer staff supervisors in other behavioral health settings.

Opinions were mixed about whether supervision of peer staff should be primarily focused on administrative issues (e.g., timesheets, documentation, scheduling), clinical concerns (e.g., how to approach or work with a specific person), or employee support and development (professionalism, reasonable accommodations, managing personal challenges in the workplace, self-care). In general, all these elements were recognized as important components of supervision of any staff person, and essential for peer staff. There was also a request for more-experienced peers to assume supervisory roles for peer staff and receive training for these new roles as needed. This sentiment was particularly strong among participants working in peer recovery coach roles.

It was noted that there are few opportunities for peer-to-peer supervision external to the organization. One participant stated that, on occasion, peers from two or more institutions have peer-mentor meetings that were quite helpful. It may be beneficial to establish a structure for regular opportunities for peer staff from multiple organizations or even statewide to have monthly or quarterly teleconferences to address common concerns. Another peer supervisor recommended the establishment of a peer-to-peer, as well as a peer supervisor, listserv or newsletter.

Behavioral health provider inventory: peer specialist supervision

As noted above, the following information was provided through an Inventory completed by the providers of public behavioral health services in Colorado through contracts with the Office of Behavioral Health. The bulleted items in the tables represent responses by the various providers that completed the Inventory for each region.

Table 3: Average number of hours and brief description of peer specialist supervision

Region	Hours/Mo	Brief descriptions
1	2-4	• Direct supervision, ongoing consultation with clinicians. • Individual supervision is scheduled; documentation is reviewed; ad-hoc supervision as issues arise; group supervision monthly; staff meetings, • Group and individual supervision • We set up 1:1 meetings to review caseloads, problem-solve, and follow up on goals.
2	2-4	• Group supervision monthly (one hour); individual supervision with clinical and administrative supervisors (approximately three hours per month. • Monthly supervision meetings (more, if asked or required); check-in phone calls; yearly reviews.
3	4-6	• Each peer specialist is supervised by a clinical supervisor on a weekly basis. Peer specialists also attend a monthly peer specialist supervision group that is run by a peer specialist for supportive interventions from their peers on cases. Each peer receives approximately four hours of individual supervision a month, which doesn't include group supervision provided in team meetings (approximately four hours a month). • Peer staff are paired with a master's-level therapist for weekly or biweekly supervision, as well as group supervision/consultation among peers on a monthly basis (two hours). • Each peer is provided four hours of individual supervision by an LCSW and then four hours of group supervision with an LPC focusing on secondary trauma and self-care.

Table 3 Continued: Average number of hours and brief description of peer specialist supervision		
Region	**Hours/Mo**	**Brief descriptions**
4	4-8	• Peer staff are supervised by the clinical supervisor responsible for case management services. Our entire peer structure is undergoing change. • Individually scheduled meetings with licensed outpatient supervisor, in addition to availability of supervisor as needed. Group supervision. • Peer staff are supervised by a peer supervisor who meets with them individually and as a team to help them develop their skills and meet the objectives of their position. • Staff receives individual supervision one hour a week and group supervision one hour a week. A supervisor is available in person or by phone during all working hours.
5	2	• Supervision is provided weekly in a team meeting and monthly on an individual basis by discussing caseloads and providing support.
6	As needed in addition to group 3-4	• New staff receive supervision for one hour a week as long as needed. More-seasoned staff receive individual supervision as needed or upon request. • Staff receive individual supervision as well as group supervision. The individual supervision is with a licensed staff member who reviews cases and provides clinical direction. Group supervision is used to work with issues that peers face globally.
7	3.5	• A dual relationship must be balanced if the peer is a previous AspenPointe client. Otherwise, additional support should be available to all peers as they integrate into the system. Once on board, supervision for peers looks the same as it does for all employees.

Challenges

- *Acceptance*. Participants had mixed experiences with being accepted by non-peer staff. Some non-peer staff, especially younger staff members, see peer support as a respected emerging discipline and value the peer staff as important members of a service team. Others have little understanding or confidence in peer support, viewing peer staff members as threatening and cheapening their professional role and expertise. Some peers reported that non-peers felt that peers were taking over the part of the work they most enjoyed – the person-to-person support work. The more peers talked and acted like non-peer staff (i.e., more like a clinician), the more they are accepted. Yet such absorption into the clinical viewpoint diminishes the special perspective and qualities that peer staff can bring to a service array. Several participants voiced the potential benefits of familiarizing non-peer clinical staff with the peer specialist training curriculum as a means of increasing peer credibility and highlighting peers' unique contributions to treatment settings.
- *Tokenism*. Often only one or two peers are employed by an agency. Some peers reported working in isolation, and feeling lonely and undervalued. Part-time schedules magnify this problem for some.

- *Unclear job descriptions*. A number of participants reported that their job descriptions were vague and unclear. Without a clear job description, peers felt they did not have a well-defined role or fully understand what was expected of them.
- *Low salaries/few advancement opportunities*. Across the focus groups and interviews, there was a call for opportunities for professional development, career paths, and upward mobility. Participants recognized that state funding would be needed to address these issues across the state.
- *Disclosure and stigma*. This not unique to peer staff, but is an important challenge. One type of disclosure is talking with a supervisor about personal issues and needs, such as those that may attend a request for reasonable accommodations. Some supervisors have difficulty separating clinical concerns from performance issues of peer staff, responding to work-related issues as a therapist rather than as a supervisor. One participant stated that when she disclosed her mental health challenges to a supervisor, she was fired.
- *Managing self-care*. A number of participants identified the challenge of working as an employee in mental health settings and simultaneously managing personal self-care and recovery. For some, the work itself can be triggering on occasion. This was a critical issue, especially for peer staff working in isolation from other peers and those lacking good supervisory support.
- *Boundaries*. Peer staff members have unique and sometimes complex relationships with the individuals they mentor. Further, a number of peer staff have been clients of their employing agencies. These circumstances can lead to sticky boundary issues that may be tough to navigate, even with supportive supervision.

Recommendations to improve and better support peer services

The final theme discussed in the focus groups and interviews involved identifying priority recommendations for how the Colorado Office of Behavioral Health could improve or better support the peer workforce and peer support services. Participant responses were similar across the groups, and are included in the recommendations that follow.

1. ***Continue efforts to develop and implement a state certification program for peer support specialists*.** Recognize and promote peer support as a unique and respected discipline. Ensure that peers are actively involved in the design, management, and oversight of this program. As part of the certification initiative, develop training, supervision, and continuing education standards for both individual peers and employing organizations. Ensure that any credentialing program has provisions for transportability to other states and recognizing certification from other states.

2. ***Establish standardized ethical guidelines*** as part of the certification and develop a mechanism for oversight and self-monitoring ethical violations – as done in any other professional certification and licensing process.

3. ***Enhance funding to ensure access to quality training*** for peer specialists and supervisors of peers across the state.

4. ***Enhance and expand current training programs.*** Link training to the certification and continuing education requirements. Provide funding support for curriculum development, "specialist" and "setting-specific" training opportunities, and broader access to all training. Develop a structure for an internship program that helps bridge training with employment and certification.

5. ***Promote peer attendance at in-state and out-of-state conferences*** for professional development, networking, and learning how other states and programs address issues faced by peers in the Colorado services system.

6. ***Address workforce issues***, including compensation, access, and upward mobility. Work with both peer and provider associations and organizations to establish consistent pay scales; salary enhancement for training, education, and experience; and model job descriptions. Advocate that multiple peers be hired in a given setting to help combat tokenism.

7. ***Expand opportunities within the state for peer mentors.*** This would entail working with both the public and private behavioral health service systems to promote employment of certified peer specialists.

8. ***Establish a standardized program for training supervisors of peers.*** Include in the training information about what a "peer" is, principles of peer support, how to use peer specialists and mentors in the workplace, and how to support them in their work.

9. ***Increase public awareness of peer services offered in the state.*** Include easily accessible information about peer services on the public materials of institutions that offer them. Awareness of peer services could increase utilization rates among individuals who are hesitant to seek services in traditional behavioral healthcare settings, serving as a more approachable point of entry.

Individuals with Mental Illness who are Physically Compromised

Introduction

This section of the report discusses the issues associated with serving consumers who have a mental illness and are physically compromised. Finding placements for these individuals often presents significant challenges.

Comorbidity between medical and mental conditions is very common. In the 2001–03 National Comorbidity Survey Replication (NCS-R), a nationally representative epidemiological survey, more than 68 percent of adults with a mental disorder reported having at least one general medical disorder, and 29 percent of those with a medical disorder had a comorbid mental health condition.[1] Additionally, a study on the impact of comorbid mental illness on the diagnosis and management of patients hospitalized for medical conditions in a general hospital found that conditions such as diabetes, hypertension, dyslipidemia, and obesity are underdiagnosed and undertreated in hospitalized psychiatric patients compared with the non-psychiatric population. Patients with mental illness have significantly less preventive intervention during hospitalization.[2] Findings such as these raise questions about how well behavioral health providers assess and treat physical health conditions. The integration of behavioral health and primary care holds out the promise of treating individuals as a whole, with consideration for both mental and physical health needs. The literature review included in the appendix provides additional information about mental and physical health comorbidity.

Until "whole health integration" is actualized, however, there remain significant challenges that impact the care and treatment of individuals with comorbid conditions, especially those requiring significant supports for both conditions. Key informant interviews suggest that state hospitals typically do not have the medical capacity to serve individuals needing significant medical care. Such services often require specialized medical equipment and staff, and given the relatively small numbers of individuals needing high levels of physical care at any given time, it is not efficient to provide such services.

Colorado Mental Health Institute admission denial data

Data were provided from the two Colorado Mental Health Institutes (CMHIs) for FY 2013 and 2014 on referrals for admission that were subsequently denied or withdrawn for a variety of reasons. One of the reasons for denial was that individuals were not medically cleared for admission. The CMHIs require medical clearance prior to admission due to their limited medical services and costs incurred when patients are transferred to a general hospital for medical care.

As noted previously in this report, the CMHIs are exempt from receiving Medicaid reimbursement under the Institution for Mental Disease (IMD) Exclusion rule.[3] A result of the IMD rule is that psychiatric inpatient care for adults in a general hospital qualifies for Medicaid,

while the same care in a private psychiatric hospital or state psychiatric hospital would not be eligible. This exclusion of Medicaid covered services includes medical care provided to individuals transferred from the CMHIs to a general hospital. Therefore, if the CMHIs admit individuals who later require medical care at a general hospital, state general funds, not Medicaid funds, pay for the medical care. Consequently, the CMHIs require medical clearance for both medical treatment capacity and cost containment reasons.

The table below identifies the number of individuals denied admission for these two years by geographic region.

Table 1: CMHI admission denials by region			
Geographic Region	**FY 2013**	**FY 2014**	**Total**
1	1	3	4
2	2	0	2
3	6	28	34
4	0	1	1
5	4	12	13*
6	12	35	47
7	3	6	9
Total	**28**	**85**	**110**

* Some of these individuals were admitted by Access Behavioral Health, which covers regions 2 and 5, however CMHIFL admissions staff noted that most of these individuals were from region 5, but a few could be from regions 3 or 6.

Note: This admission denial count excludes one individual referred from a county jail, from an unknown county.

Overall, admission denials at the two institutes have increased significantly, from 227 in FY 2013 to 586 in FY 2014. However, even with this increase there was also an increase in the percent of denials due to individuals not receiving a medical clearance, from 12.3 percent in FY 2013 to 14.5 percent in FY 2015.

Colorado Mental Health Institute discharge barriers

Discharge barriers data from the mental health institutes at Fort Logan and Pueblo do not specifically identify any barriers related to physical health reasons. However, the January 2015 C-STAT identifies "Current Civil Patients Ready for Discharge Except for Barriers." CMHIFL data indicate 609 bed-days for one or more individuals needing "assisted-living and nursing home placement." CMHIP data indicate 1,126 days for one or more individuals with "absence of guardianship and requires nursing home" and 320 days for "absence of appropriate residential setting – needs nursing home placement outside of Denver vicinity." Across both institutes, this totals 2,055 days for persons ready for discharge without an available assisted-living or nursing home placement.

Individuals with behavioral health needs in the State Veterans Community Living Centers

Colorado has four State Veterans Community Living Centers with a combined total of 425 beds. These nursing homes are located in the following areas, which represent three of the seven geographic regions identified for this study:

- Region 1: Rifle, located in Garfield County
- Region 3: Fitzsimons, located in Adams County
- Region 4: Florence, located in Fremont County, and Homelake, located in Rio Grande County

The table below shows the distribution of the 425 beds and a point-in-time number of individuals with behavioral health diagnoses being served in each of these facilities. Many individuals have more than one diagnosis. Across all of these facilities, dementia accounts for 276 patients and is the most common diagnosis, including many individuals with Alzheimer's disease. Substance use-related diagnoses were noted in 14 of the 297 diagnoses, which included seven individuals with alcohol-induced dementia.

Table 2: CO State Veterans Community Living Center Beds							
	Region						
	1	2	3	4	5	6	7
Bed Capacity	80	NA	180	165	NA	NA	NA
10/2014 BH DX	49		112	136			

When facility administrators were asked about service gaps for individuals with behavioral health disorders needing a nursing home level of care, the most commonly identified gap was a lack of beds. Administrators said that when the CMHIs stopped admitting individuals with dementia diagnoses many years ago, it had a big impact on their ability to utilize the CMHI geriatric beds. The most common problem identified was residents with dementia who have aggressive or threatening behaviors. They stated it would be beneficial if CMHIP (their designated institute) accepted dementia residents who require inpatient care and if they would provide follow-up case management to maintain a structure for success when individuals transition back to the state nursing homes. The administrator of one facility did not identify any current service gaps, and said that Parkview, Porter Behavioral, Haven Behavioral, and Cheyenne VA in Wyoming are used when a backup facility is needed.

Growing population with dementia

Of all Medicare beneficiaries age 65 and older with Alzheimer's disease and other dementias, 31 percent reside in a nursing home. Of all Medicare beneficiaries residing in a nursing home, 64 percent have Alzheimer's disease and other dementias.[4]
The table below illustrates the projected increases in persons with Alzheimer's in Colorado

based on unpublished data provided to the Alzheimer's Association.

Table 3: Projected increases in persons with Alzheimer's in Colorado			
	Projected Number w/Alzheimer's 2014	**Projected Number w/Alzheimer's 2025**	**Percentage w/Alzheimer's Change 2014-2025**[5]
Colorado	63,000	92,000	46%

Given the significant projected growth in individuals with Alzheimer's in Colorado in the next decade, and given that approximately one-third of this population currently resides in nursing homes, cost-effective options for the care and treatment of this population should be thoughtfully addressed.

Stakeholder survey findings

Data from the stakeholder survey indicated that individuals with serious medical conditions were less likely to be identified as an unserved or underserved population when compared with individuals with traumatic brain injuries, intellectual/developmental disabilities, individuals with dementia, and veterans. However, individuals with behavioral health disorders and serious medical conditions were identified by more than 25 percent of the respondents from each geographic region. The items that are in bold and underlined represent the most-frequent responses.

Table 4: Specific populations stakeholders believe are not served or are underserved in the STATEWIDE behavioral health system in COLORADO, which should be served by the behavioral health system.								
	Percent/# of Respondents by Geographic Region and All Combined							
Response Options	1	**2**	**3**	**4**	**5**	**6**	**7**	**All**
Individuals with Traumatic Brain Injuries	**45.2%**	**44.4%**	**42.5%**	**47.4%**	**56.7%**	**52.0%**	37.0%	47.4%
Individuals with Intellectual/Developmental Disabilities	42.6%	**52.4%**	**58.5%**	**51.3%**	**55.0%**	**55.0%**	**40.7%**	50.4%
Individuals with Serious Medical Conditions	26.1%	27.0%	32.1%	29.5%	29.2%	27.0%	35.2%	28.7%
Individuals with Dementia	43.1%	34.9%	38.7%	38.5%	**41.7%**	36.0%	**46.3%**	40.1%
Veterans	**46.3%**	31.7%	**44.3%**	38.5%	29.2%	41.0%	**42.6%**	39.8%
Number of Responses	188	63	106	78	120	100	54	709

Individuals with intellectual/developmental disabilities was the population most frequently identified as either not being served or being underserved in six of the seven regions. This was closely followed by Individuals with traumatic brain injuries (identified in six of the seven regions as unserved/underserved, at a slightly lower rate) veterans (three of the regions), and individuals with dementia (two regions). Individuals with serious medical conditions were

identified by 26.1-35.2 percent of the respondents; however, they were not one of the top two or three identified in any of the regions.

One of the items included in the provider survey was to "identify any intensive services for specific co-occurring populations in your geographic service area that accept Medicaid/indigent individuals with serious behavioral health disorder." As highlighted in the table below, findings from this item indicate that intensive services for individuals with co-occurring behavioral health and medical/physical disorders exist in six of the seven regions. For example, in region 2, North Range Behavioral Health (NRBH) works collaboratively with Sunrise Health Center, a Federally Qualified Health Center (FQHC) to provide integrated physical and behavioral health treatment in four locations in Weld County. Additionally, Sunrise operates a primary-care clinic at the main NRBH clinic.

Table 5: Availability of intensive services

Note if Intensive services exist for Co-Occurring Population in the Region (X)	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Individuals with Intellectual/ Developmental Disabilities	X	X	X	X		X	
Individuals with Traumatic Brain Injuries	X	X	X	X		X	
Individuals with Significant Medical/Physical Disorders	X	X	X	X	X	X	

Highlights from stakeholder survey comments

Top system gaps

- The state facilities are unable to care for mentally ill patients with comorbid medical issues.
- Inability of the institutes to accept patients with medical/surgical concerns.

Recommendations

- Regional skilled nursing facilities would be a huge asset to the mental health system.
- Provide the ability for the Institutes to take patients with medical/surgical issues.

Other comments

- Individuals with medical conditions and serious mental illness need support for their behavioral health problem instead of having it ignored.
- Teens with depression and serious medical conditions need ongoing counseling and support in managing their medical conditions. Also need support for their family to help

manage the teens' medical condition; and need counseling and respite care for family members who need a break from the strain of caring for a teen or child with depression and a serious medical condition.

- We find it very difficult if not sometimes impossible to obtain appropriate post-discharge care for clients with Intellectual/developmental disabilities. If a disability was not identified while school-age, they are typically turned down. Individuals with serious medical conditions and mental health issues often have no private insurance. Our facility is not set up for medical issues. These clients often receive minimal care.
- Individuals who develop serious medical conditions at Fort Logan and/or Pueblo require transport to a neighboring hospital. In most instances, patients with a serious medical condition will not be admitted to Fort Logan. This results in admission to Pueblo as the only alternative in the public system for chronic medical conditions, as well as long-term care. I don't believe that any of the private psychiatric facilities that accept Medicaid clients can provide long-term care.
- Individuals with dementia and serious medical conditions can be excluded from inpatient facilities where they could benefit from both medical and behavioral health interventions. They should be able to receive treatment in an integrated or at least coordinated manner to address the needs of the whole person.
- For individuals with serious medical conditions, there are very poor wrap-around services that integrate medication prescribing and management, day programs, therapy, and community support services.
- Those with serious medical conditions have behavioral health issues that are overlooked in large part. This should be a focus, even if they don't meet specific mental health diagnostic criteria.
- Due to serious medical conditions, this population can often be underserved in the behavioral health system because of the medical complexities, so being able to integrate some of the needs becomes a challenge for the member/guardian and providers/systems.

State-operated nursing facilities and residential programs in other states

State-operated skilled nursing facilities in three states were reviewed to identify possible options for addressing the needs of individuals with serious mental illness and physical health conditions. The programs summarized below include programs for individuals with both forensic and civil legal statuses.

New Mexico. The New Mexico Behavioral Health Institute at Las Vegas has a 19-bed specialty psychiatric unit for adults and older adults with a serious mental illness who are medically frail. The institute is careful not to admit individuals requiring significant active medical treatment, including intravenous therapy or other interventions that require close monitoring. When individuals' physical health conditions deteriorate and cannot be managed by the institute, patients are transferred to general medical facilities for continuing care. Institute officials said that it is important for them to have collaborative relationships with these other hospitals to

ensure appropriate care is provided. The institute does sometimes assist with discharge planning in order to accommodate the behavioral health needs of the individuals they transfer. Additionally, the institute operates a licensed nursing home, which currently has 155 beds, although it is licensed for up to 178 beds and will be expanding to this capacity soon. The nursing home serves individuals from across the state; most do not have a serious mental illness. Any referrals/admissions for individuals with a mental illness have to follow the Pre-Admission and Resident Review (PASRR) process. Given that the majority of the individuals served in the nursing home do not have a serious mental illness, New Mexico is able to bill Medicaid for the services provided to eligible individuals. The facility is dually certified for Medicaid and Medicare participation, and is accredited by The Joint Commission (TJC). A portion of the facility is accredited by TJC as a Dementia Special Care Unit.

Arkansas Health Center. The Arkansas Health Center (AHC), located in Benton, Ark., is a 290-bed medical and psychiatric nursing home licensed by the Office of Long-Term Care. The facility comprises six secure units, which include a segregated male and female unit. AHC serves the needs of adults, some only in their 30s or 40s, with significant medical conditions (including those requiring ventilators), and/or psychiatric disorders who require specialized services or programs that are not generally available through community nursing facilities. In addition to serving individuals with medical conditions, AHC serves as the state safety net for the provision of services to individuals with complex psychiatric and behavior management needs, including individuals with cognitive dysfunction, substance use-related disorders, and dementia including Alzheimer's. Behavior management interventions typically include medications and/or one-to-one staff supervision. At times AHC has as many as 36 individuals on one-to-one supervision, and occasionally some individuals require this level of supervision for their safety and the safety of others for years. Services are available to all residents of Arkansas, provided individuals meet admission criteria. AHC is not an Institution for Mental Diseases (IMD), since fewer than 50 percent of the residents have a psychiatric or substance use disorder. Therefore it is able to receive Medicaid and Medicare reimbursement for the services provided to eligible residents.

South Dakota Human Services Center (HSC). The Human Services Center (the state's psychiatric hospital) operates a 69-bed intermediate-care geriatric program within the hospital. The program provides inpatient diagnostic and therapeutic services for individuals who, in addition to psychiatric treatment needs, have medical and/or physical care needs that require the level of care provided by a nursing home. The geriatric program is surveyed annually by the South Dakota Department of Health to ensure compliance with Centers for Medicare and Medicaid Services (CMS) standards for Medicare and Medicaid reimbursement. CMS certification allows HSC to bill for covered services for individuals over the age of 64 (under the CMS IMD rules). All of the individuals served at this facility are not over the age of 64; therefore, their services cannot be covered by Medicaid due to the IMD exclusion. Based on utilization data from Oct. 1, 2010, through January 2015, 22.1 percent of the individuals served were 64 years or younger, and based on a February 2015 point-in-time review, the figure was 25 percent, which represents the proportion of individuals who were not Medicaid-eligible while receiving inpatient services.

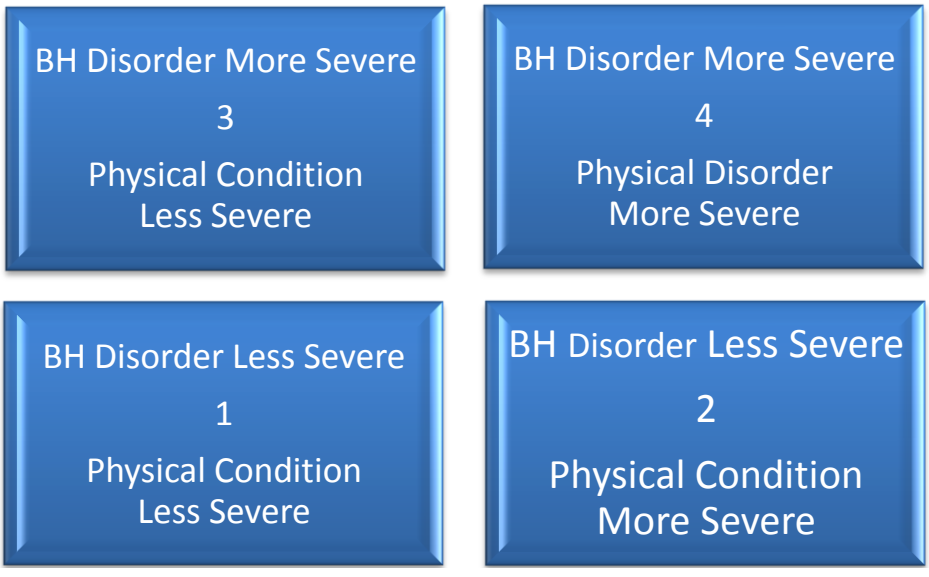
The HSC also has six designated acute geriatric beds on one of its units that are used for some admissions and screenings to determine if the nursing home level of care criteria is met when transfer to the nursing facility is a consideration. Additionally, HCS has the capacity to complete pre-screenings for referrals to rule out possible medical causes for behavior changes, and it is also able to provide behavior management consultation when it is determined that admission to HSC is not necessary.

The HSC nursing facility ran at a 98 percent occupancy rate for 2014, with an average discharged length of stay of 173 days. Some residents have resided at the facility for several years. Most individuals served have multiple diagnoses. Eighty-nine percent of the persons served had a diagnosis of dementia and some had a co-occurring serious and persistent mental illness. HSC does not have the capacity to do ventilation therapy and some other medical interventions. However, it is able to provide intravenous therapy for medication and fluids (not artificial nutrition), support for incontinence, pressure ulcers, and related conditions, as well as for end-of-life needs.

South Dakota has also developed two Challenging Behavior Units with a total of 26 beds (15 + 11) within other nursing facilities. The state provided some funds for construction and physical plant changes to accommodate this population, and provides a higher Medicaid reimbursement rate for individual served on the units. A multidisciplinary clinical review process for admission to these units has been implemented. The team that completes the review consists of a physician, psychiatrist, nurse, social worker, and therapeutic recreation specialist.

Discussion

When considering recommendations for treatment of individuals with mental illnesses and physical health conditions, it is helpful to consider the "quadrants of care" model illustrated below.



Typically individuals with behavioral health disorders in Quadrants 1 and 3 are able to be served by most community-based behavioral health programs. Similarly, most individuals in Quadrant 2 can be served by the primary care system. Individuals who fall within Quadrant 4 present the greatest treatment challenges and are most in need of collaborative, integrated behavioral and physical health treatment and supports. These treatment needs can potentially be addressed through inpatient services, intensive residential services, or intensive community-based outpatient services, depending on specific circumstances of the individuals.

Key informant interviews were conducted with leadership staff from six private and not-for-profit hospitals across Colorado. Interviewees all identified the growing need for serving individuals with serious behavioral health needs and co-occurring serious physical/medical needs. All informants believe it is more efficient to serve this co-occurring population within medical facilities, ideally through specialty programs—or when not available, to weave necessary behavioral health treatment and supports into the medical hospital setting.

Recommendations

There are often significant challenges associated with finding placements for individuals with behavioral health disorders who are physically compromised and in need of medical care. It is recommended that several approaches be taken to address the needs of this population in ways that are both efficient and cost-effective. The proposed recommendations include the engagement of local inpatient and nursing facilities, community providers, and the state.

1. **Consider operation by the state of one or more skilled nursing facilities for the treatment of individuals with behavioral health disorders requiring medical and/ or skilled nursing care. Such facilities could be part of the mental health institutes or State Veterans Community Living Centers.** Other options include contracting with private providers to either operate, or construct and operate, a facility for use by the state, or expanding the number of state nursing homes, with enhanced behavioral health supports. Options that allow for individuals requiring this level of medical and behavioral health care to be served close to their home communities should be strongly considered. Additionally, options that flexibly allow the needed level of intensive medical and/or behavioral health treatment to come to the individuals, versus having to relocate them, offers opportunities to enhance workforce competence for staff treating these individuals, and allows this population to age in place with less disruption in their care and treatment.

2. **Identify hospitals and nursing facilities across the state that already have some medical and psychiatric capacity, and develop mechanisms to enhance their capacity to treat psychiatrically challenged individuals with co-morbid physical health conditions.** This approach is more efficient and cost-effective than attempting to provide an intensive array of medical treatment and supports within a psychiatric facility. Augmenting existing services offers opportunities for individuals to be treated

closer to their home communities, avoiding unnecessary transportation and separation from family and support systems. Additionally, developing the capacity to treat serious mental and physical health conditions concurrently in facilities that are not Institutions for mental diseases allows federal dollars to cover some of the cost of services for individuals who are Medicaid-eligible and under the age of 65.

3. **Develop additional state nursing home capacity to meet current and future demand attributable to population growth, individuals living longer, and the projected increase in persons with Alzheimer's disease and dementia.** The geographic location of new capacity should take into consideration regions that have significant service gaps for this population. Additionally, it may be beneficial to consider telehealth, specifically behavioral health services, to support individuals with challenging behaviors as they progress through the stages of their disease and would benefit from behavioral management interventions and supports and could reduce the need to transfer some individuals to another facility.

4. **Develop Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) team approaches that include using the medical home model of care.** Such integrated services could be added to the ACT programs that have been implemented statewide though the Governor's Strengthening Behavioral Health Initiative, which provides dedicated ACT to all 17 CMHCs. The FACT team would be available to actively support individuals residing in a variety of living arrangements from Supported Housing to assisted-living facilities to nursing homes. These evidence-based programs were originally developed to engage adults with serious and persistent mental illnesses in outpatient psychiatric treatment through the use of outreach and comprehensive services available 24 hours a day, seven days a week. FACT adds legal support and leverage for individuals such as those discharged from forensic services or on conditional release from inpatient forensic programs.

   Furthermore, staff from the ACT and FACT teams could provide additional medical services and supports to these individuals, as needed, to reduce their risk of re-hospitalization for medical or psychiatric reasons. (Aetna Mercy Maricopa Integrated Care in Arizona is implementing this model.) Given the seriousness of the offenses for which forensic individuals were charged and the reluctance of existing private facilities to serve these individuals, developing intensive community-based programs may allow many of these individuals to successfully step down from costly inpatient services and experience an enhanced quality of life.

[1] Mental Disorders and Medical Comorbidity. Benjamin G. Druss MD, MPH, Rosalynn Carter Chair and Professor of Health Policy and Management, Emory University; Elizabeth Reisinger Walker, MAT, MPH, Doctoral Candidate, Emory University. Robert Wood Johnson Foundation – Research Synthesis Report NO. 21 February 2011.

[2] Impact of co-morbid mental illness on the diagnosis and management of patients hospitalized for medical conditions in a general hospital. Briskman I, Bar G, Boaz M, Shargorodsky M.; Int J Psychiatry Med. 2012;43(4):339-48.
[3] 42 U.S.C. §1396d.
[4] http://www.alz.org/downloads/Facts_Figures_2014.pdf: Unpublished tabulations based on data from the Medicare Current Beneficiary Survey for 2008. Prepared under contract by Julie Bynum, M.D., M.P.H., Dartmouth Institute for Health Policy and Clinical Care, Dartmouth Medical School; November 2011.
[5] http://www.alz.org/downloads/Facts_Figures_2014.pdf: Unpublished tabulations based on data from the Medicare Current Beneficiary Survey for 2008. Prepared under contract by Julie Bynum, M.D., M.P.H., Dartmouth Institute for Health Policy and Clinical Care, Dartmouth Medical School; November 2011.

Behavioral Health Service Delivery for Specific Populations

Introduction

This section of the report analyzes the delivery of public behavioral health services in Colorado to special populations, such as persons with traumatic brain injury (TBI), dementia, serious and persistent mental illness (SPMI); children; adolescents; adults; and older adults. Special populations are categorized based on age, diagnosis, and funding source. The analysis identifies which populations have potentially unmet service needs.

The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates the percent of adults age 18 and older in each state with any mental illness and with a serious mental illness.[1] According to the latest estimates, 17.6 percent of adult Coloradans (or approximately 902,000 individuals) had a mental illness and 4.4 percent (223,000 persons) had a serious mental illness. The mental health needs of these adults may be served through private insurance, by a state program, or not at all. State behavioral health services may be offered through programs such as the Office of Behavioral Health (OBH), Medicaid, Medicare, the criminal justice system and schools and universities. The total number of adult Coloradans receiving mental health services from all sources is unknown, and therefore the size of the underserved population is also unknown. Based on the methodology described below, potentially underserved populations have been identified.

Methodology

To assess the degree to which current resources are used effectively to serve specific populations, we used information derived from the following sources:

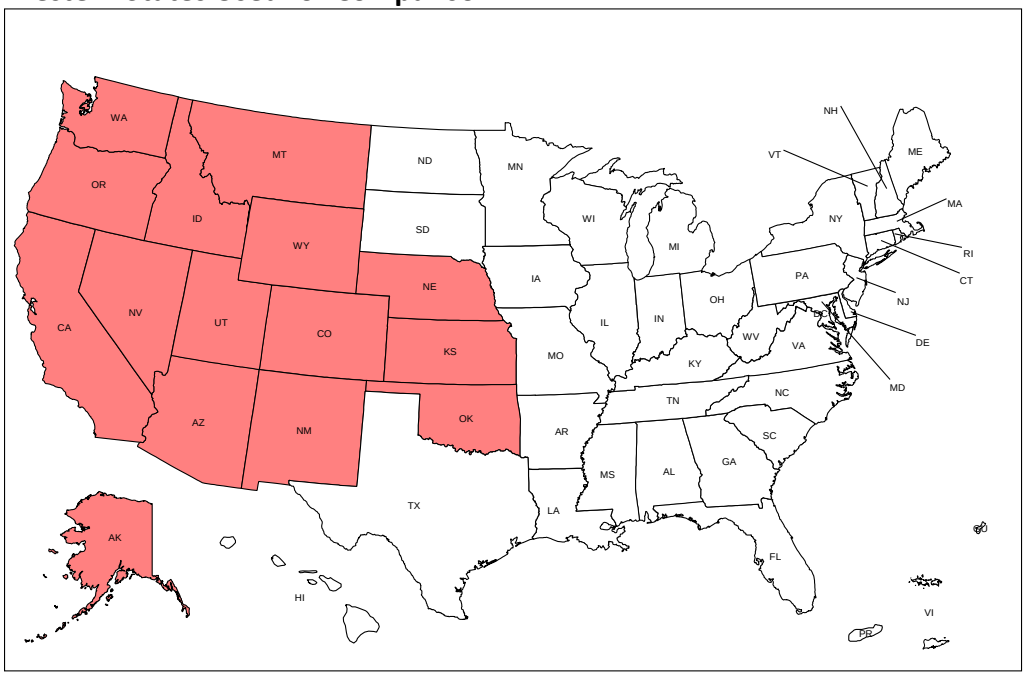
- Colorado Office of Behavioral Health
- Colorado's Behavioral Health Providers
- SAMHSA's Uniform Reporting System (URS)
- SAMHSA's National Survey on Drug Use and Health
- NRI's State Mental Health Agency Profiling System.

These sources provide the most up-to-date data available about services in Colorado and other Western states, and provide valuable insight into mental health service delivery in Colorado.

Some data used in this analysis were from OBH and from the reports of SAMHSA's mental health block grant reports. These data use the State Mental Health Agency (SMHA) as the unit of measurement; therefore, Medicaid recipients in other states not served by their SMHA may not be included in the analysis. It is important to keep in mind that not all SMHAs are alike. SMHAs across the country differ in the populations they are charged to serve, their relationships with state Medicaid programs, their use of managed care, the level of funding provided by state legislatures, and the income and illness eligibility criteria for their service

population. The comparisons of Colorado to the U.S. as a whole and to the Western states are imperfect, but still useful in highlighting potential service gaps. The Western states in the analysis included Alaska, Arizona, California, Colorado, Idaho, Kansas, Montana, Nebraska, Nevada, New Mexico, Oklahoma, Oregon, Utah, Washington, and Wyoming.

Map 1: Western States Used for Comparison



Service gaps identified by the stakeholder survey

Colorado's Department of Health Care Policy and Financing maintains seven Regional Care Collaborative Organizations (RCCOs) that help connect Medicaid clients with Medicaid providers, including providers of mental health services. The providers and other stakeholders of these regions were surveyed to identify gaps in services, and highlight which population groups were being underserved. The surveys were administered to a convenience sample, and consisted of open-ended questions. Because of this approach, data from the surveys can only provide insight, rather than surety, about specific service gaps in the system. An identified gap may only be the perception of a gap among the small number of people who responded to the survey. Summary results pertinent to special populations are presented below. A more complete discussion of survey results is presented in the inventory and gaps sections of this report.

Underserved population groups as identified by stakeholders

The most prevalent population groups identified as being underserved through the stakeholder surveys are listed below, separated by survey respondent groups (providers or other stakeholders).

Table 1: Identified underserved populations	
Provider-Identified Underserved Populations	**Stakeholder-Identified Underserved Populations**
Co-occurring mental health and substance use disorders	Intellectual/Developmental disabilities
Youth and adolescents	Traumatic brain injury
Older adults	Individuals with Dementia
Traumatic brain injury	Veterans
Intellectual/Developmental disabilities	Individuals with a serious medical condition
Dementia	Adolescents with emotional/mental health disorders
Veterans	Children with emotional/mental health disorders
Individuals with a serious medical condition	Adults with mental health disorders
	Individuals with Serious Medical Conditions

Most prominent service gaps identified by region

Survey responses were also sorted by region. The most prevalent gaps identified by all of the regions, in order of prevalence, are:

1. Waiting times for services
2. Inpatient services — all regions identified a greater need for short-term and intermediate-term inpatient services (six to 90 days) than either acute (zero to five days) or long-term (more than 90 days) services.
3. Co-occurring mental health and substance abuse services
4. Services for older adults
5. Crisis services
6. Services for youth and adolescents.

Service gaps identified by each region, in order of reporting, are highlighted below.

Table 2: Regional identified service gaps					
Region	**First Area of Need**	**Second Area of Need**	**Third Area of Need**	**Fourth Area of Need**	**Fifth Area of Need**
1	Older Adults	Co-occurring MH and SA	Crisis Services		
2	Inpatient Services	Crisis Services	Older Adults	All Age Groups	
3	Inpatient Services	Co-occurring MH and SA	Developmental Disabilities	All Age Groups	
4	Inpatient Services	Co-occurring MH and SA	Youth and Adolescents	Older Adults	Crisis Services
5	Youth and Adolescents	Excessive Wait Times	Co-Occurring MH and SA	Inpatient Services	
6	Excessive Wait Times	Youth and Adolescents	Inadequate Staffing/Training		
7	Excessive Wait Times	Insurance Gaps/Ability to Pay	Community Transition Services		

Data from behavioral health provider inventory

The information below was provided through the Inventory completed by the providers of public behavioral health services in Colorado through contracts with OBH. The Inventory results are presented by the seven geographic regions identified by OBH as described in the beginning of this report. All of the regions reported that there is no waiting list for services for these populations.

Table 3: Approximate number/percent of clients served during the last 12 months with the following co-occurring physical health problems

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Traumatic brain injury	<20/4%+	+	888+	5%+	3+	126+	+
Obesity	+	+	+	15-75%+	+	+	+
Diabetes	+	+	+	20 - 50%+	+	+	+
Deaf or hard of hearing	<1-10%+	+	172+	3 - 10%, unsure	133 adults/ 162 children	24+	+
Blind	<5/<1%	+	172+	<1% +	88 adults/ 3 children	37+	+
Mobility impairment	+	+	+	3 - 40%+	+	+	+
Intellectual/developmental disability	40/4%+	+	1,369+	5 - 15%+	1+	150+	+
+Number/percent unknown							

Some providers indicated the types of resources that would help them better meet the needs of special populations. Their responses are provided below.

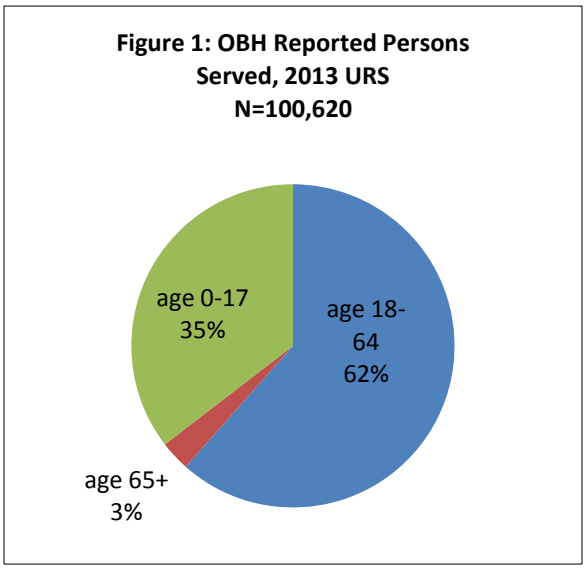
Region 5: We are unable to see clients with developmental delays or severe TBIs as they require specialized interventions/trained staff. This is beyond our scope of expertise.

Region 6: We serve all of the above with co-occurring physical health problems. The largest barrier in serving these various populations, especially TBI and DD, is not having a primary mental health diagnosis. We can be denied payment due to the client not having a primary mental health diagnosis. This occurs in many settings but especially with adolescents in the inpatient setting. It can be difficult to flush out the etiology of behaviors.

The clients who are deaf or hard of hearing are provided interpreters so they can utilize services. In using interpreters in a therapeutic session we have found that some things can be lost in translation. This can impact the overall quality of treatment.

As for obesity or diabetes or any medical condition, people with serious emotional and behavioral issues tend to struggle with managing their medical needs. Many of the clients we serve have episodes of distorted thinking or delusional thinking, which can impact their ability to manage physical/mental issues effectively. We monitor clients with serious medical conditions closely to ensure they are taking their medications and taking care of themselves.

Service delivery by age



Colorado's OBH provided mental health services to 100,620 individuals in 2013 or just under 2 percent of the state's population, according to the 2013 Mental Health Block Grant Uniform Reporting System (URS). Of those served, 61,938 were adults between the ages of 18 and 64; 3,025 were age 65 and older; and 35,657 were under age 18. Eighty-three percent of the reported persons served (including Medicaid) had a serious mental illness (SMI).

One way to assess the degree to which services are meeting the needs of the population is to examine the penetration rates for those services. Penetration rates for this section of the report are expressed as the number of persons receiving specified services per 1,000 state residents of that age range. This methodology allows for comparing penetration rates among similar states and/or populations, which may help identify populations that are being underserved.

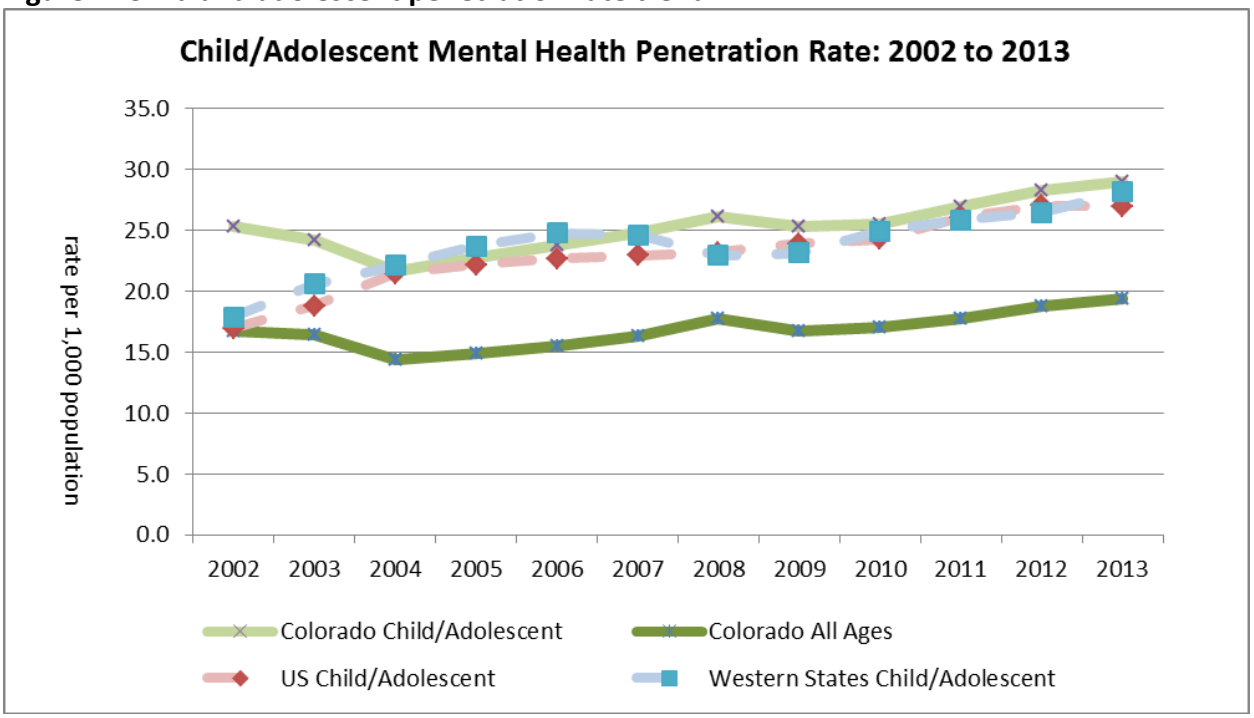
Children and adolescents, ages 0 to 17

From 2002 to 2013, the penetration rate of child and adolescent consumers in Colorado increased from 25.3 to 29.0 per 1,000 of the Colorado population ages 0 to 17, a 15 percent increase, from 28,538 youth to 35,657 (see Figure 2). During the same period, the penetration rate for all Colorado consumers increased from 16.7 to 19.4, a 16 percent increase. The rate for Colorado children and adolescents was higher than the rate for either the Western states or the U.S.

In Western states, from 2002 to 2013, the rate of child and adolescent consumers receiving mental health services from SMHAs increased from 17.9 to 28.1 per 1,000 ages 0 to 17, a 57 percent increase. Excluding California, which represents 47 percent of the child and adolescent population of the Western states, the average rate was higher, 30.9. In the U.S., from 2002 to 2013, the penetration rate of child and adolescent consumers receiving mental health services from SMHAs increased from 16.9 to 27.0 per 1,000 of the population ages 0 to 17, a 60 percent increase.

It is important to note that this penetration rate methodology is different from the one used in the *Penetration Rates and Relative Need for Services* section of this report, which were generated using combined Colorado data from 2008 to 2011 for individuals under 300 percent Federal Poverty Level (FPL) for the statewide population and by gender, age group, and race/ethnicity.

Figure 2: Child and adolescent penetration rate trend



Source: 2002 to 2013 Mental Health Block Grant Uniform Reporting System

Colorado ranked 8th among 15 Western states in the rate of children and adolescents served by a state mental health agency. OBH serves children and adolescents at a greater rate than the U.S. and Western states. Table 3 below shows great variation in the rate of child/adolescent services by state mental health agencies in the West. Some variation may be due to the fact that the SMHA shares responsibility for services to children and youth with another state agency[2].

Table 3: 2013 Child and Adolescent Mental Health Penetration Rate Ranking

State	Child/Adolescents Served	Child/Adolescent Population	Child/Adolescent Penetration Rate Per 1,000 Population	Rank
AK	6,688	187,100	35.7	7
AZ	62,788	1,620,894	38.7	5
CA	231,465	9,240,219	25.0	10
CO	**35,657**	**1,231,358**	**29.0**	**8**
ID	1,944	426,653	4.6	14
KS	36,113	724,304	49.9	4
MT	15,398	221,980	69.4	2
NE	1,965	463,405	4.2	15
NM	37,732	514,442	73.3	1
NV	3,787	663,583	5.7	13
OK	11,343	937,363	12.1	12
OR	43,086	860,624	50.1	3
UT	16,600	887,972	18.7	11
WA	44,708	1,584,967	28.2	9
WY	4,902	135,490	36.2	6
US	1,992,968	73,728,088	27.0	
Western States	554,176	19,700,354	28.1	

Source: 2013 Mental Health Block Grant Uniform Reporting System

Child and adolescent inpatient services

The Colorado Mental Health Institute at Pueblo (CMHIP) has 20 inpatient beds for adolescents. Western Psychiatric State Hospital Association data show that seven Western states' mental health departments have adolescent inpatient beds, with rates per 100,000 persons[3] ranging from .37 in Colorado to 6.04 in South Dakota. Excluding South Dakota, the average rate was .91. Increasing Colorado's bed rate for adolescent patients from .37 to .91 would increase the current total number of beds from 20 to 49 (29 additional adolescent beds). The number of inpatient adolescent beds statewide is cited as being insufficient by focus group members and stakeholder survey respondents. Adolescent inpatient bed needs are explored further elsewhere in this report.

In 2013, the number of adolescent Incompetent to Proceed (ITP) restoration admissions was up 111 percent, from nine to 19. Inpatient hospitalization is considered to be less restrictive than a juvenile detention center, and CMHIP is the only formal ITP restoration site available for adolescent offenders. This suggests that there is a need for alternatives to inpatient competency restoration for adolescents.

The Colorado Mental Health Institute at Fort Logan (CMHIFL) closed its 16-bed children's unit in January 2010, so there are no inpatient beds for children at either of the institutes. However, there are five facilities in the state that serve children (Children's Hospital Colorado, Denver Health, Highlands Behavioral Health, Cedar Springs, and Parkview). According to a key informant[4] we spoke with, there is not a shortage of inpatient beds for children in Colorado. In fact, there is a trend to build these beds because they are reimbursable by insurance. Since insurance dictates which facility a child may be admitted to, it causes frustration for families who have to travel to that facility, which may account for stakeholder responses that there is a shortage of inpatient beds for children.

Evidence-based practices for children and adolescents with a serious emotional disturbance

In 2012, Colorado provided more types of evidence-based practices (therapeutic practices with a strong evidence base) for children and adolescents with a serious emotional disturbance (SED) — 12 — than other Western states (an average of 6).[5] In 2013, 359 children and adolescents in Colorado with SED received Family Functional Therapy, a program in which each step builds on another to enhance protective factors and reduce risk by working with the child and his/her family. In 2013, 163 children and adolescents in Colorado with SED received Multi-Systemic Therapy, which is an intensive family and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders.[6]
Additional evidence-based practices for children and adolescents that could be adopted and/or reported by Colorado are:

- Therapeutic Foster Care: The needs of children and adolescents are met in a supportive family setting until they can either be reunited with their natural family or adopted.
- Dialectical Behavior Therapy: A 16- to 18- week program for adolescents that combines psychotherapy and group skills training.
- Motivational Interviewing: A counseling approach for eliciting behavior change.
- Wraparound: Provides individually tailored services to children and their families that are community-based and focused on strengths.

Table 4A: 2012 Child and Adolescent Evidence-Based Practices

State	Multisystemic Therapy (conduct disorder)	Therapeutic Foster Care	Functional Family Therapy	Incredible Years	Parent-Child Interaction Therapy	Parent Management Training	Brief Strategic Family Therapy
AK		X	X				X
AZ	X	X	X	X	X		X
CA	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
CO	X		X	X	X	X	X
ID		X	X				
KS			X			X	
MT		X					
NE	X				X		
NM	X	X	X		X		
NV					X		
OK					X		X
OR		X		X	X	X	X
UT	X	X	X				X
WA	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
WY	X	X	X				X
Total	**6**	**8**	**8**	**3**	**7**	**3**	**7**

Table 4B: 2012 Child and Adolescent Evidence-Based Practices

State	Problem Solving Skills Therapy	Coping Power	Cognitive Behavior Therapy for Depression	Cognitive Behavior Therapy for Anxiety	Trauma-focused Cognitive Behavior Therapy	Interpersonal Therapy for Depression
AK	X		X	X	X	X
AZ	X		X	X	X	X
CA	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
CO	X	X	X	X	X	X
ID						
KS						
MT						
NE					X	
NM			X	X	X	X
NV					X	
OK					X	
OR	X		X	X	X	X
UT	X		X	X	X	
WA	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
WY	X		X	X	X	X
Total	**6**	**1**	**7**	**7**	**10**	**6**

Source: Substance Abuse and Mental Health Services Administration, Funding and Characteristics of State Mental Health Agencies, 2012

Child and adolescent substance abuse services

Colorado ranked 13th among 15 Western states in the rate of children and adolescents receiving publicly funded substance abuse services. Colorado serves children and adolescents at half the rate of the U.S. and Western States. Table 4 below shows great variation in the rate of child/adolescent substance abuse services by agencies in the West. If OBH increased the rate at which it served children and adolescents to the average of all Western states (from the current rate of 1.2 to 2.5), Colorado would serve approximately 1,500 additional children/adolescents. The rate of illicit drug use among Coloradans aged 12-17 in 2011-12 was 13.2 percent, or about 49,000, which was higher than the U.S. rate of 9.8 percent. The mean ages for first use of substances were 13.9 years old for marijuana, 13.7 years for the nonmedical use of psychotherapeutics, 12.8 years for cigarettes, and 13.2 years for alcohol. However, 84 percent of persons aged 12 or older with illicit drug dependence or abuse did not receive treatment.[7]

Table 5: 2013 Child and Adolescent Substance Abuse Penetration Rate Ranking

State	Child/Adolescents Served	Child/Adolescent Population	Child/Adolescent Penetration Rate Per 1,000 Population	Rank
AK	430	188,132	2.3	7
AZ	5,324	1,616,814	3.3	3
CA	23,116	9,174,877	2.5	5
CO	**1,452**	**1,237,932**	**1.2**	**13**
ID	700	427,781	1.6	11
KS	1,656	724,092	2.3	6
MT	437	223,981	2.0	9
NE	232	464,348	0.5	14
NM	30	661,605	0.0	15
NV	1,038	507,540	2.0	8
OK	1,712	947,027	1.8	10
OR	5,824	857,606	6.8	1
UT	1,116	896,589	1.2	12
WA	4,824	1,595,795	3.0	4
WY	610	137,679	4.4	2
US	184,912	73,585,872	2.5	
Western States	48,071	19,473,666	2.5	

Source: 2014 SABG Behavioral Health Report - Table 12 - Unduplicated Count of Persons

Key points and observations

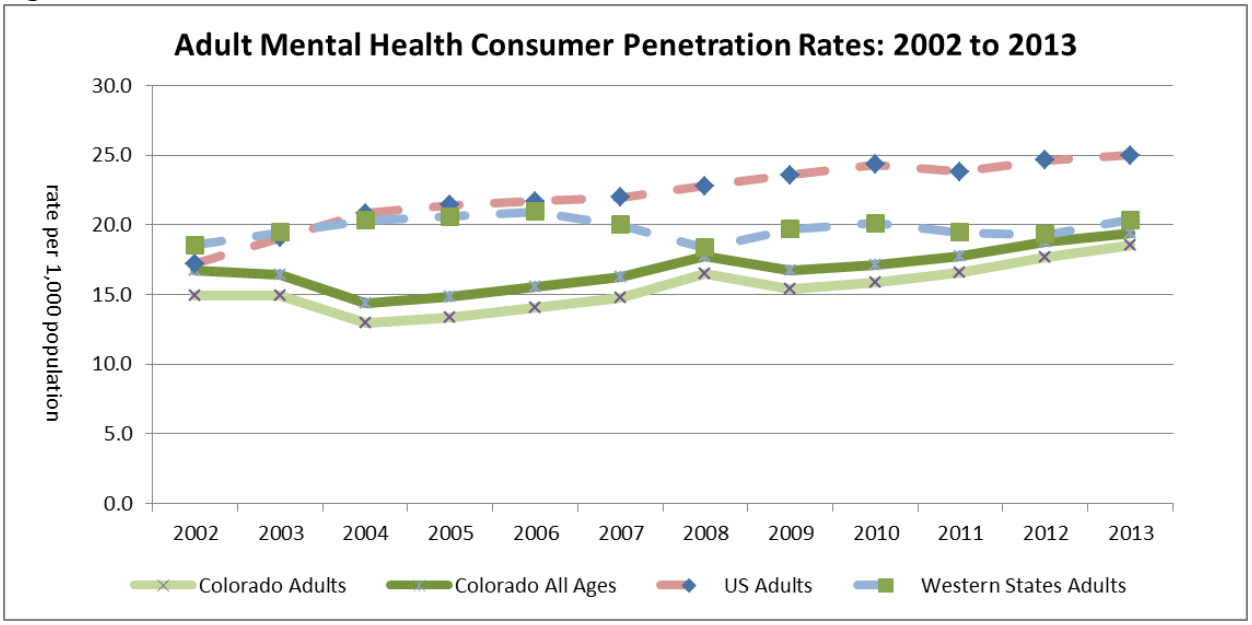
- Colorado ranked 8th among 15 Western states in the rate of children and adolescents served by a state mental health agency.
- The penetration rate for child and adolescent mental health consumers (both inpatient and outpatient services) in Colorado (29.0 per 1,000 children and adolescents) was higher than the U.S. rate (27.0), the rate for Western states (28.1), and for Coloradans of all ages (19.4).
- Services for children and adolescents were identified by surveys of Regional Care Collaborative Organization (RCCO) providers and stakeholders as being underserved for mental health services in regions 4, 5, and 6 (Denver, Boulder, and the southeastern plains), especially in regard to adolescents who had co-occurring mental health and substance abuse disorders.
- There has been a large increase in the number of adolescents admitted to CMHIP as Incompetent to Proceed (up 111 percent in 2013), suggesting that there is a need for alternatives to inpatient competency restoration for adolescents.
- Colorado ranked 13th among 15 Western states in the rate of children and adolescents receiving publicly funded substance abuse services. Colorado serves children and adolescents at half the rate of the U.S. and Western states even though they have higher rates of illicit drug use.

Adults, age 18 to 64

SAMHSA estimates that 17.6 percent of Coloradans over the age of 18 had a mental illness, or approximately 583,000 individuals. In 2013, OBH served 61,938 adults ages 18 to 64, or approximately 11 percent of the total estimated need.

From 2002 to 2013, OBH enlarged the reach of its services by 24 percent as measured by the penetration rate, or the number of individuals served per 1,000 of the population for their age group. In 2002, OBH served 14.9 adults per 1,000 adults, or 43,056 persons, while in 2013 it served 18.5 per 1,000, or 61,938 adults. This rate of increase was greater than the penetration rate increase for the entire Colorado population (16 percent). Between 2002 and 2013, the adult penetration rate for the entire U.S. increased by 45 percent (17.2 to 25.0 per 1,000 of the adult population), and for the Western states it increased by 22 percent (17.8 to 21.7 per 1,000 of the adult population). Excluding California, which represents 48 percent of the adult population of the Western states, the average rate was higher, 25.5 percent.

Figure 3: Adult Mental Health Consumer Penetration Rates



Source: 2002 to 2013 Mental Health Block Grant Uniform Reporting System

Colorado ranked 10th among 15 Western states in the rate of adults served by a state mental health agency. If OBH increased the rate at which it served adults with mental illness to the average of all Western states (from the current rate of 18.5 to 21.7), Colorado would serve approximately 10,500 additional adults.

Table 6: 2013 Adult Mental Health Penetration Rate Ranking

State	Adults Served	Adult Population	Adult Penetration Rate Per 1,000 Population	Rank
AK	13,838	481,852	28.7	7
AZ	122,864	3,960,828	31.0	6
CA	425,005	24,201,126	17.6	11
CO	**61,938**	**3,342,983**	**18.5**	**10**
ID	9,566	956,497	10.0	15
KS	86,903	1,767,332	49.2	1
MT	20,165	624,872	32.3	4
NE	19,531	1,134,766	17.2	12
NM	41,332	1,276,263	32.4	3
NV	24,792	1,734,434	14.3	14
OK	64,301	2,343,210	27.4	8
OR	80,616	2,457,110	32.8	2
UT	26,846	1,695,896	15.8	13
WA	92,822	4,403,628	21.1	9
WY	11,600	365,414	31.7	5
US	4,933,254	197,040,596	25.0	
Western States	1,102,119	50,746,211	21.7	

Source: 2013 Mental Health Block Grant Uniform Reporting System

Adult substance abuse services

Colorado ranked fourth among 15 Western states in the rate of adults receiving publicly funded substance abuse services, as Table 6 below shows. Colorado serves adults at a significantly higher rate than the U.S. and Western states. Excluding California, which represents 48 percent of the adult population of the Western states, the average rate was 10.9, still lower than that of Colorado.

The rate of illicit drug dependence or abuse among persons age 12 or older in Colorado was 3 percent, higher than the U.S., 2.7 percent. It is estimated that 84 percent of persons over the age of 12 with illicit drug dependence or abuse did not receive treatment.[8]

Table 7: 2013 Adult Substance Abuse Penetration Rate Ranking

State	Adults Served	Adult Population	Adult Penetration Rate Per 1,000 Population	Rank
AK	5,684	480,911	11.8	6
AZ	74,374	3,990,948	18.6	2
CA	112,077	24,365,913	4.6	14
CO	**43,019**	**3,383,044**	**12.7**	**4**
ID	7,357	961,213	7.7	7
KS	10,890	1,764,802	6.2	12
MT	4,792	626,416	7.6	8
NE	13,860	1,140,160	12.2	5
NM	2,659	1,747,631	1.5	15
NV	9,512	1,271,086	7.5	9
OK	16,399	2,354,420	7.0	10
OR	55,128	2,465,064	22.4	1
UT	10,345	1,720,648	6.0	13
WA	29,875	4,424,527	6.8	11
WY	6,724	366,290	18.4	3
US	1,563,517	197,838,893	7.9	
Western States	402,695	51,063,073	7.9	

Source: 2014 SABG Behavioral Health Report - Table 12 - Unduplicated Count of Persons

Adults with serious and persistent mental illness and serious mental illness

Serious mental illness (SMI) is defined in the Federal Register as

> "… adults with a serious mental illness are persons 18 years and older who, at any time during a given year, had a diagnosable mental, behavioral, or emotional disorder that met the criteria of DSM-III-R and … that has resulted in functional impairment which substantially interferes with or limits one or more major life activities…."[9]

Individuals with serious mental illness whose illness is chronic are considered to have a serious and persistent mental illness (SPMI).[10]

SAMHSA estimates that 4.4 percent of adult Coloradans, age 18 and older, had a serious mental illness, or approximately 144,000 adults. In 2013, OBH served 54,098 adults with SMI, or approximately 37 percent of the total estimated need.

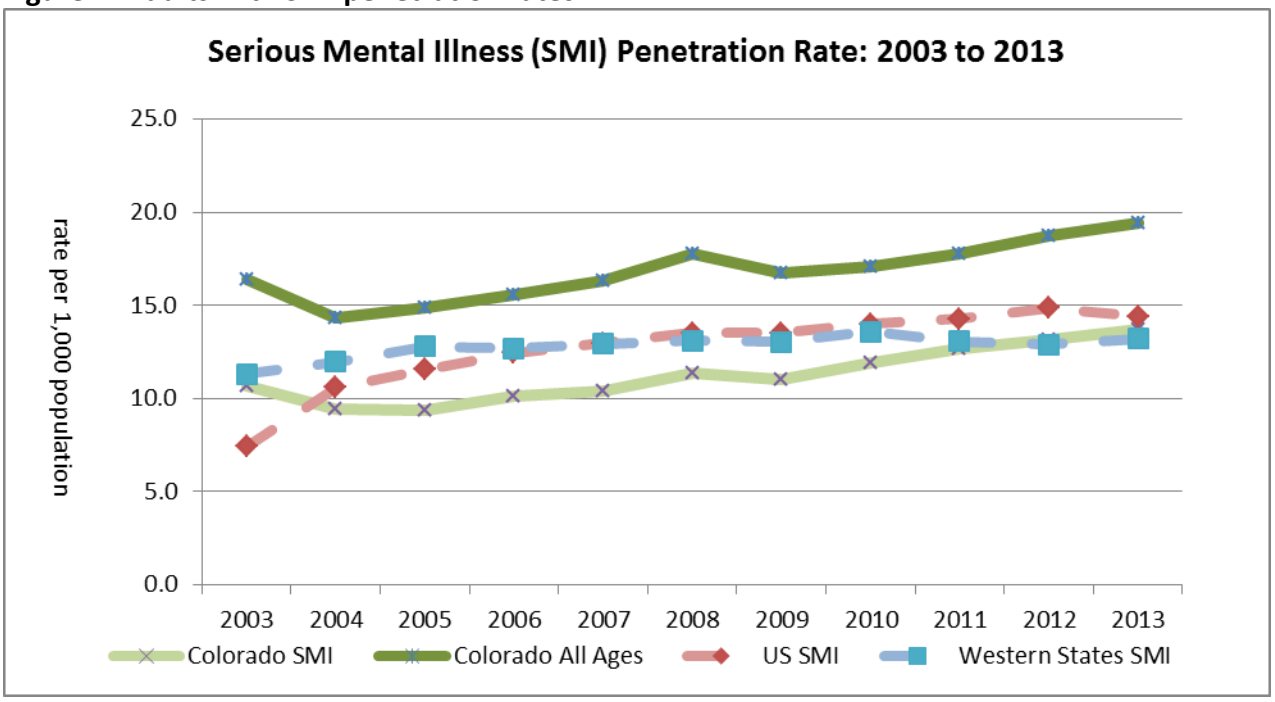
From 2003 to 2013, the rate of adult consumers with SMI increased 28 percent from 10.7 to 13.7 per 1,000 of the adult Coloradan population, from 36,025 persons served to 54,098. During the same period, the penetration rate for all consumers increased from 16.4 to 19.4 per 1,000 of the population of Colorado, an 18 percent increase[11].

In Western states, from 2003 to 2013, the rate of adults with SMI receiving mental health

services from SMHAs increased from 11.3 to 13.2, a 17 percent increase. In the U.S., from 2003 to 2013, the rate of adult consumers with SMI receiving mental health services from SMHAs increased from 7.4 to 14.4 per 1,000 of the adult U.S. population, a 95 percent increase.

The rate of Severe and Persistent Mental Illness (SPMI) among mental health consumers served by the seven regions was 14 percent in 2013[12]. Region 5 (Denver) had the highest rate (23 percent), while also serving the smallest population. Regions 3hree and 6ix had the lowest rates (11 percent) while serving the largest populations.

Figure 4: Adults with SMI penetration rates



Source: 2003 to 2013 Mental Health Block Grant Uniform Reporting System

In 2013, Colorado ranked sixth among 15 Western states in the rate of adults with SMI served by a state mental health agency.

Table 8: 2013 Adults with SMI Penetration Rate Ranking

State	SMI Adults Served	Adult Population	SMI Adult Penetration Rate Per 1,000 Population	Rank
AK	12,158	544,349	22.3	3
AZ	47,938	4,932,361	9.7	12
CA	377,914	28,801,211	13.1	7
CO	**54,098**	**3,956,224**	**13.7**	**6**
ID	6,107	1,169,075	5.2	15
KS	21,486	2,161,601	9.9	11
MT	22,633	783,161	28.9	1
NE	13,963	1,392,120	10.0	10
NM	28,016	1,571,096	17.8	4
NV	14,030	2,095,348	6.7	14
OK	44,801	2,877,457	15.6	5
OR	70,225	3,038,729	23.1	2
UT	18,589	1,967,315	9.4	13
WA	69,272	5,312,045	13.0	8
WY	5,137	440,922	11.7	9
US	3,468,888	240,185,952	14.4	
Western States	806,367	61,043,014	13.2	

Source: 2013 Mental Health Block Grant Uniform Reporting System

In 2012, Colorado provided more evidence-based practices (therapeutic practices with a strong evidence base) for adults with SMI — seven — than other Western states (an average of six).[13]

Table 9: Colorado Adults with SMI Receiving Evidence-Based Practices

Evidence-Based Practice	Description	Number Served
Medication Management	The optimization of pharmacotherapy	4,176
Integrated Mental Health and Substance Abuse Services	Mental Health and Substance Abuse Services are integrated at the clinical level	3,584
Assertive Community Treatment	A multidisciplinary clinical team approach to providing intensive community treatment, support and rehabilitation services	3,514

Evidence-Based Practice	Description	Number Served
Supported Employment	Assistance in obtaining competitive employment	1,001
Supported Housing	Services that assist individual in finding and maintaining appropriate housing	202
Family Psychoeducation	Helps individuals achieve the best possible outcome through the involvement of family members in treatment	13

Source: 2013 Mental Health Block Grant Uniform Reporting System

Table 10A: Adoption of Adult Evidence-Based Practices by Western States

State	ACT	Supported Employment	Medication Algorithms (schizophrenia)	Medication Algorithms (Bipolar disorders)	Family Psychoeducation
AK	X	X			X
AZ	X	X	X	X	X
CA	Unknown	Unknown	Unknown	Unknown	Unknown
CO	X	X			X
ID	X	X			
KS		X			
MT	X	X			
NE	X	X			
NM	X	X			
NV	X	X	X	X	X
OK	X	X			
OR	X	X	X	X	X
UT	X	X			X
WA	Unknown	Unknown	Unknown	Unknown	Unknown
WY	X	X			X
Total	**12**	**13**	**3**	**3**	**7**

Table 10B: Adoption of Adult Evidence-Based Practices by Western States

State	Integrated Mental Health/Substance Abuse Services	Self-Management	Supported Housing	Consumer Operated Services
AK	X	X	X	X
AZ	X	X	X	X
CA	Unknown	Unknown	Unknown	Unknown
CO	X	X	X	X
ID	X	X	X	X
KS	X		X	X
MT	X	X		X
NE	X	X	X	X
NM	X		X	X
NV	X		X	X
OK	X	X	X	X
OR	X		X	
UT	X	X	X	X
WA	Unknown	Unknown	Unknown	Unknown
WY	X		X	X
Total	**13**	**8**	**12**	**12**

Source: Substance Abuse and Mental Health Services Administration, Funding and Characteristics of State Mental Health Agencies, 2012

Key points and observations

- Though Colorado increased by 24 percent the rate at which it serves adults with mental illness from 2002 to 2013, it was still 10th among Western states, with a penetration rate of 18.5 per 1,000 adults as opposed to 21.7 for Western states and 25.0 for the U.S.
- The penetration rate for adult consumers with SMI in Colorado (13.7 per 1,000 of the adult Colorado population) was greater than the rate for than Western states (13.2 per 1,000 of the adult population of the Western states).
- In 2013, Colorado ranked sixth among 15 Western states in the rate of adults with SMI served by a state mental health agency.
- Colorado's substance abuse penetration rate (12.7 per 1,000 adults) was fourth-highest among Western states and was also higher than the U.S., though it is estimated that 84 percent of persons over the age of 12 with illicit drug dependence or abuse did not receive treatment.
- Region 5 (Denver) had the highest percentage of clients with SPMI (23 percent), far higher than the state average (14 percent) and the Boulder and suburban Denver regions (11 percent).

Adults over the age of 65

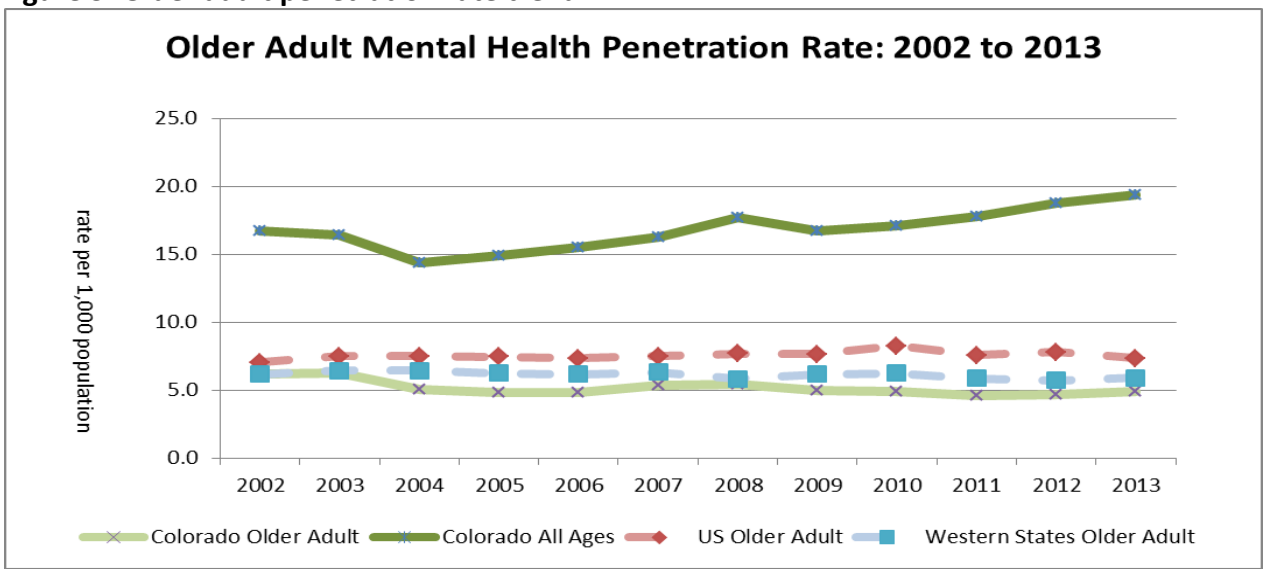
SAMHSA estimates that 17.6 percent of Coloradans age 65 and older had a mental illness, or approximately 102,000 individuals. In 2013, OBH served 3,025 adults age 65 and older, or approximately 3 percent of the total estimated need.

From 2002 to 2013, the rate of older adults receiving mental health services from OBH decreased from 6.21 to 4.9 per 1,000 of the Colorado population ages 65 and older, a 21 percent decline, even though the number of older adults served increased from 2,623 to 3,025; population growth in this age group outpaced service capacity. During the same period, the penetration rate for all consumers increased from 16.7 to 19.4, a 16 percent increase.

From 2002 to 2013, the rate of geriatric consumers receiving mental health services from SMHAs in Western states decreased from 6.2 to 5.9 per 1,000 of the Western state population age 65 and older, a 5 percent decrease. Excluding California, which represents 45 percent of the older adult population of the Western states, the average rate was higher, 7.1. From 2002 to 2013, the rate of geriatric consumers receiving mental health services from SMHAs across the U.S. increased very slightly, from 7.0 to 7.4 per 1,000 of the U.S. population age 65 and older, a six percent increase.

The provider and stakeholder surveys identified a lack of training among providers in older-adult services and inadequate transportation as the top barriers to providing better services to the older adult population.

Figure 5: Older adult penetration rate trend



Source: 2002 to 2013 Mental Health Block Grant Uniform Reporting System

In 2013, Colorado ranked 10th among 15 Western states in the rate of older adults served by a state mental health agency. If OBH increased the rate at which it served older adults with

mental illness to the average rate of the Western states, it would serve 500 additional older adults.

Table 11: 2013 Older Adult Penetration Rate Ranking

State	Older Adults Served	Older Adult Population	Older Adult Penetration Rate Per 1,000 Population	Rank
AK	604	62,497	9.7	4
AZ	6,161	971,533	6.3	8
CA	20,498	4,600,085	4.5	11
CO	**3,025**	**613,241**	**4.9**	**10**
ID	354	212,578	1.7	15
KS	5,749	394,269	14.6	2
MT	2,468	158,289	15.6	1
NE	538	257,354	2.1	13
NM	1,708	294,833	5.8	9
NV	669	360,914	1.9	14
OK	1,765	534,247	3.3	12
OR	5,464	581,619	9.4	5
UT	2,065	271,419	7.6	7
WA	9,006	908,417	9.9	3
WY	640	75,508	8.5	6
US	317,324	43,145,356	7.4	
Western States	60,714	10,296,803	5.9	

Source: 2013 Mental Health Block Grant Uniform Reporting System

Inpatient psychiatric services for older Coloradans

For more than a decade, CMHIP has maintained two geriatric treatment units with a total of 40 beds, a bed rate of 0.75 per 100,000 persons.

Data from the Western Psychiatric State Hospital Association (WPSHA) show that seven states have geriatric beds.[14] In 2014, the rate for geriatric beds ranged from 0.10 in California to 6.86 in South Dakota. South Dakota's rate was significantly higher than other Western states, so it was removed from the average calculation. The average rate for geriatric beds was 1.61 per 100,000 persons.[15] With a rate of 0.75, Colorado ranked sixth out of seven states. Increasing Colorado's bed rate for geriatric patients from 0.75 to 1.61 per 100,000 persons would increase the total number of beds from 40 to 86 (46 additional geriatric beds). Inpatient bed needs for older adults are explored elsewhere in this report.

Older adult substance abuse services

Colorado ranked fifth among 15 Western states in the rate of older adults receiving publicly funded substance abuse services, as Table 12 below shows. Colorado serves older adults at a higher rate than the U.S. and Western states. Excluding California, which represents 45 percent of the adult population of the Western states, the average rate was 0.5, still lower than that of Colorado.

Table 12: 2013 Older Adult Substance Abuse Penetration Rate Ranking

State	Older Adults Served	Older Adult Population	Older Adult Penetration Rate Per 1,000 Population	Rank
AK	58	66,089	0.9	3
AZ	904	1,018,862	0.9	2
CA	1,339	4,791,731	0.3	9
CO	**480**	**647,391**	**0.7**	**5**
ID	43	223,142	0.2	11
KS	77	405,063	0.2	12
MT	64	164,768	0.4	6
NE	95	264,008	0.4	7
NM	53	380,900	0.1	15
NV	86	306,661	0.3	8
OK	93	549,121	0.2	14
OR	588	607,395	1.0	1
UT	53	283,635	0.2	13
WA	224	951,084	0.2	10
WY	66	78,689	0.8	4
US	24,466	44,704,074	0.5	
Western States	4,223	10,738,539	0.4	

Source: 2014 SABG Behavioral Health Report - Table 12 - Unduplicated Count of Persons

Key points and observations

- The mental health penetration rate for older adult consumers in Colorado (4.9) was less than the U.S. (7.4) and less than the rate for Western states (5.9), and that rate decreased 21 percent from 2002 to 2013. Population growth among older Coloradans has outpaced the rate of growth in service capacity.
- In 2013, Colorado ranked 10th among 15 Western states in the rate of older adults served by a state mental health agency.
- Services for older adults were identified in the stakeholder survey as being underserved, particularly in sparsely populated regions 1, 2, and 4 (the western half of the state and the northeastern and southeastern plains).

- The rate of inpatient bed availability (.75 per 100,000 Coloradoans) was lower than the average of Western states (1.61 per 100,000 persons[16]).
- Colorado ranked fifth among 15 Western states in the rate of older adults receiving publicly funded substance abuse services.
- The provider and stakeholder surveys identified a lack of training among providers in older-adult services and inadequate transportation as the top barriers to providing better services to the older adult population.

Dementia

Patients with a primary, secondary, or tertiary diagnosis of dementia are rare among persons served by OBH. According to 2013 data from Colorado's regions, only 113 persons were identified as having a primary, secondary, or tertiary diagnosis of dementia, representing less than 1 percent of consumers receiving OBH services. According to the 2013 State Mental Health Agency Profiling Survey, Organic Brain Syndrome (a diagnosis category that includes dementia) is not a responsibility of the SMHA in Colorado, similar to 39 other states. Geriatric consumers had a higher rate of dementia diagnoses (1.5 percent) than children and adolescents ages 0 to 18 (0.01 percent) and adults age 18-64 (0.1 percent).

The provider and stakeholder surveys identified a lack of training among providers in services for older adults with dementia and the premature discharge of patients with dementia from crisis and emergency room settings.

Table 13: Dementia Diagnosis: Mental Health Consumers: 2013

Age Category	Number of Consumers with Dementia	Total Number of Consumers Served	Percentage of Consumers Served with Dementia
Youth & Adolescents (ages 0 to 17)	2	35,615	0.01
Adults (Ages 18 to 64)	61	64,407	0.09
Older Adults (Ages 65+)	50	3257	1.54
Total	113	103,279	0.11

Source: 2013 Data Provided by Colorado's Office of Behavioral Health.

A comprehensive source describing specialized services for individuals with dementia is not readily available or easily accessed. This is largely due to the wide variance of programs from state to state and the lack of resources to compile such data. However, a review of relevant literature and resources provides a foundation for the unique demands of persons with dementia within mental healthcare systems and serve as a guide to meet the service needs of this population.

Individuals living with dementia present unique demands within public mental health systems. The World Health Organization's 2012 publication, "Dementia: A Public Health Priority," estimates that the number of individuals living with dementia will double by 2030 and more than triple by 2050.[17] Thus, the development of programs to address the needs of this

population is vital.

Some promising programs do exist. For example, the Wisconsin Department of Health Services Division of Long Term Care implemented a statewide redesign of its care for individuals living with dementia.[18] The plan's strategies are divided into five main groups: Community Awareness and Services (to foster better understanding and early identification of dementia); Facility Based Long Term Care (to address the shortage of facilities admitting dementia patients); Care for Individuals with Significant Changing Behavior (to expand crisis response and stabilization programs); Dementia Care Standards and Training (to catalogue and publicize existing dementia training and develop standards of care); and Research and Data Collection (to inventory providers and analyze costs of strategies). Given that OBH does not have the lead responsibility for serving persons with dementia, and less than 1 percent of patients present with this diagnosis, we do not recommend that OBH tailor additional service resources to meet demand, but rather that OBH work closely with other agencies that provide services to for these individuals.

Key points and observations

- Few consumers receiving mental health services from OBH have a diagnosis of dementia.
- Services for individuals with dementia were identified by a few stakeholders as being insufficient, though this was not one of the most prevalent service gaps identified.
- The provider and stakeholder surveys identified a lack of training among providers in services for older adults with dementia and the premature discharge of patients with dementia from crisis and emergency room settings.

Traumatic brain injury

According to data provided by Colorado's OBH, 3 percent of clients served by the regions had TBI, though none of these clients were provided mental health services under the auspices of OBH. The 2013 State Mental Health Agency Profiling Survey results indicated that OBH is not the primary state agency to serve persons with TBI, similar to 31 other states. Individuals with TBI typically receive care from state health departments when receiving public services. Very few (approximately 1 percent) of clients treated for substance use disorders had a traumatic brain injury.

Table 14:Non-Medicaid Served Identified as Having a Traumatic Brain Injury FY 13-14

Mental Health - Individuals Identified as Having a Traumatic Brain Injury (TBI) by Age by Region FY 13-14 (Non-Medicaid)							
	Region						
	1	2	3	4	5	6	7
Child/Adolescent	43	15	23	N*	4	10	5
Adult	248	165	170	69*	106	180	68
Older Adult	86	45	43	40	36	80	25
Total W/ TBI	**377**	**225**	**236**	**126***	**146**	**270**	**98**
Total Clients Served	8,951	4,483	8,928	5,986	3,860	7,998	5,237
% W/ TBI	4.2%	5%	2.6%	2.1%	3.8%	3.4%	1.9%

*The data for some age groups had <10 and was not reported, so unable to compute exact total.

Table 15: Substance Use Disorder – Traumatic Brain Injury (TBI) Served FY 13-14

Substance Use Disorder - Brain Injury by Age by Region (Non-Medicaid)							
	Region						
	1	**2**	**3**	**4**	**5**	**6**	**7**
Child/Adolescent	N*	N*	N*	N*	N*	N*	N*
Adult	218*	53*	114*	67*	70*	73*	107*
Older Adult	N*	N*	N*	N*	N*	N*	N*
Total Served	11,964	5722	17,304	9,457	16,911	12,829	9,409
W/ TBI	228	61	128	76	76	81	108
% W/ TBI	1.9%	1.1%	.7%	.8%	.4%	.6%	1.1%

*The data provided had additional age group breakouts and many of the cells were <10 and therefore not reportable. The total # served was derived from a different data table, so it does not exactly match the data within this table.

Key points and observations

- There were no consumers receiving mental health services from OBH in 2011 or 2013 with a primary, secondary, or tertiary diagnosis of TBI, though there were individuals with a TBI diagnosis receiving services from regional providers. Their care was not funded by OBH.
- Of individuals served by the seven regions, 3 percent had TBI. Region 2 had the highest rate (5 percent) and regions 4 and 7 had the lowest (2 percent).
- Individuals with TBI were identified by regional providers as being underserved.

It is estimated that the majority (roughly 90 percent) of individuals living with TBI present with co-occurring mental health disorders. A 2012 Veterans Administration study found that the average annual cost per patient was nearly four times greater for veterans diagnosed with a TBI than those without – underlining the importance of finding efficient and effective programs to meet the needs of this population.[19] Accordingly, a number of states have special programming for individuals with TBIs. For example, Vermont established a TBI program in the state's

disabilities and aging services department in 1991 to serve individuals with moderate to severe TBIs.[20] The program is community-based and includes case management, rehabilitation services, community supports, environmental and assistive technology, crisis support, 25 days a year of respite care, employment support, and long-term special-needs services to Vermont residents with traditional or long-term Medicaid.

Similarly, Illinois and New York State provide community- and home-based services to Medicaid-eligible individuals with TBI who are at risk of requiring admission to nursing homes and/or assisted living facilities.

In 2012, an expert panel was convened to discuss best practices for identification and treatment of veterans with TBI seeking care in Colorado.[21] The panel reached consensus regarding the importance of standardized screening tools, the provision of holistic care (i.e., identifying and treating both TBI and the co-occurring disorder appropriately), and the implementation of evidence-based practices when treating co-occurring TBI populations. The panel also discussed barriers to treatment for co-occurring TBI populations, including a lack of resources and a lack of specific training for mental health practitioners. While the panel focused on veteran populations, much of the content is applicable to non-veterans and is pertinent for all state agencies providing such services.

Juvenile justice

An estimated 70 percent of justice-involved youth have disabilities including psychiatric, mental health, sensory, and intellectual disabilities as well as co-occurring disorders.[22] As discussed in a report by the National Center for Mental Health and Juvenile Justice,[23] a wide variance of mental health programming exists for youth in the juvenile justice system. One example is the Bernalillo County Juvenile Detention Center (BCJDC) in Albuquerque, N.M., which initiated a comprehensive intake process aimed at screening and identifying youth with mental health disorders, and diverting them to community mental health centers. Additional funding for the community mental health centers receiving diverted youth from the detention center was provided by three of New Mexico's Medicaid providers, as about 75 percent of youth at the detention center are Medicaid-eligible. A decrease of 37 percent in BCJDC's population and a decrease in average stay from 33 days to 12 were found three years following the implementation of the program.

SAMHSA collects data on arrests of persons served by each state mental health agency, though only eight of the 15 Western states provided data in 2013. These data were collected via a standardized consumer youth survey, Youth Services for Families (YSS-F) for five of the states, including Colorado; a state-specific survey for one state; and the mental health information management system for two other states. The response rates ranged from 12 percent in Colorado to 100 percent in Oklahoma, which collected the data not from a survey but from its mental health information system.

Eight of the 15 Western states reported juvenile arrests in 2013 for youth receiving public

mental health services for at least one year. Colorado had the second-lowest rate of juveniles who were re-arrested after receiving services (27 percent), though this was only three individuals out of 11. Only Nebraska had a lower rate (14 percent). Colorado was in the middle of the Western states reporting initial arrests for juveniles in the public mental health system (2 percent). Nebraska, Oregon, and Wyoming each had rates of 1 percent. Having a lower rate of juveniles involved with the justice system after receiving mental health services is one indicator that services are having a positive effect on the clients being served.[24]

Education

The Individuals with Disabilities Education Act (IDEA) is the nation's federal special education law that ensures public schools serve the educational needs of students with disabilities. This includes the provision of at-home early intervention services for infants, toddlers, and their families. While all states offer early intervention programming, the qualification for services varies state by state. In Colorado, early intervention services are provided in cases in which a child has a diagnosed condition, has a developmental delay of 25 percent or greater, lives with a parent with a developmental disability, is the subject of a substantiated case of child abuse, or is identified as directly affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure. In Massachusetts, services can be provided to a child based on the clinical judgment of an assessment team and/or the presence of four risk factors (including birth weight is lower than two pounds, gestational age is less than 32 weeks, parental age is less than 17, maternal education is less than 10 years, parent lacking social support, inadequate shelter/nutrition).[25] In Colorado, children are assessed by school districts, and then are provided services by their local early intervention center. Services are provided at home for children and families to help children meet developmentally appropriate milestones until the age of three, when they are transferred to the school district.[26]

IDEA requires that schools provide special education services to eligible students as outlined in a student's Individualized Education Program (IEP). IDEA also provides very specific requirements to guarantee a Free Appropriate Public Education (FAPE) for students with disabilities in the least restrictive environment (LRE). FAPE and LRE are the protected rights of every eligible child, in all 50 states and in U.S. territories" (idea.ed.gov). While services are extended to all individuals with ID/DD, these services exist on a wide continuum among school districts. Many school districts provide separate specialized classrooms and/or institutions for individuals with ID/DD, while others utilize integrated classrooms. Additionally, school psychologists and/or social workers are available in most school districts for assessment, accommodation, and educational planning for individuals with ID/DD.

Significant discrepancy exists between the incidence of TBI and the identification of children with TBI for special education. As discussed in a 2013 Colorado Department of Education report,[27] approximately 145,000 children live with a persistent disability following a TBI,[28] while only 24,602 were reported as receiving special education services for the disorder.[29] In 2012, Colorado reported 497 students receiving special education for TBI, while approximately 2,392 youth (0-20 years of age) were identified by the Colorado Department of Public Health and

Environment as being discharged from the hospital with a TBI. This fact suggests that a number of students living with TBI are not receiving services, or are inappropriately diagnosed and receiving improper services.

SAMHSA collects data on school attendance of persons served by each state mental health agency, though only eight of the 15 Western states provided data in 2013. These data were collected via a standardized consumer youth survey, Youth Services for Families (YSS-F) for five of the states, including Colorado. The response rate was 12 percent in Colorado. Eight of the 15 Western states reported school suspensions in 2013 for youth receiving public mental health services for at least one year. Colorado had the highest rate of juveniles re-suspended (70 percent), though that was 57 individuals out of 82. Oklahoma had the lowest rate (18 percent), though Arizona, California, Washington, and Wyoming had rates above 60 percent. Colorado was sixth out of eight Western states, and tied with Washington, for the rate of first-time suspensions for juveniles receiving public mental health services (9 percent). Nebraska had the lowest rate (2 percent) while Arizona had the highest rate (10 percent). A high rate of school suspensions is one indicator that mental health services are not having a large enough impact on problem behavior in school.[30]

Conclusions

Various data sources were used to compare Colorado's rate of service utilization among special populations to regional and national averages. For children/adolescents, Colorado's penetration rate was similar to the Western state average. For adults and older adults, the rate was below the Western average. Another source of information on the status of service delivery in Colorado was SAMHSA's Behavioral Health Barometer, 2013[31]. The report indicates that Colorado's rate of major depressive episode among all youths (7.7 percent), not just those served by OBH resources, was similar to the national rate (8.7 percent) in 2011-12. However, only 40.4 percent, or about 13,000 youth, received treatment for their depression. Data also show that between 2008 and 2012, 43.8 percent of adults (about 293,000[32] persons) with any mental illness received treatment or counseling. With less than 50 percent of persons in need receiving treatment, there is evidence that there are opportunities to improve access to services for youth and adults.

Based on comparisons of persons served by Colorado OBH resources to public mental health services in other Western states and the nation, the following have been observed:

Children and adolescents

Colorado ranks relatively high compared to Western states and the nation in the provision of mental health services for children and adolescents, although there is room for improvement.

- While Colorado ranked eighth among Western states in the rate of children and adolescents served and had a higher penetration rate (29.0 per 1,000 children and

adolescents) than the U.S., services for children and adolescents were identified by surveys of Regional Care Collaborative Organization (RCCO) providers and stakeholders as being underserved for mental health services in regions 4, 5, and 6 (Denver, Boulder and the southeastern plains), especially in regard to adolescents who had co-occurring mental health and substance abuse disorders.

- Colorado ranked 13th among 15 Western states in the rate of children and adolescents receiving publicly funded substance abuse services. Colorado serves children and adolescents at half the rate of the U.S. and Western states, even though they have higher rates of illicit drug use.
- Given the large increase in adolescent Incompetent to Proceed (ITP) restoration admissions to CMHIP, there is a need for outpatient competency restoration for adolescents.
- The number of inpatient adolescent beds statewide is cited as being insufficient by focus group members and stakeholder survey respondents. Colorado's rate of .37 adolescent beds per 100,000 adolescents was below the average of other Western states (.91 per 100,000 adolescents).
- Implementation of additional evidence-based practices for children and adolescents would be beneficial, including Therapeutic Foster Care, Dialectical Behavior Therapy, Motivational Interviewing, and Wraparound services.

Adults

- Since 2002, Colorado has been increasing the rate at which it serves adults (from 14.9 to 18.5 per 1,000 adult), yet it was still 10th among 15 Western states in 2013. Colorado would serve an additional 10,500 adults if its penetration rate was raised to that of the Western states.
- OBH meets the needs of 11 percent of the estimated number of adults, ages 18 to 64, with a mental illness. This doesn't mean that all of the 89 percent of the estimated need is unmet. Persons can receive services through private insurance, or through other state agencies that provide mental health services such as the justice system or schools.
- The penetration rate for adult consumers with SMI in Colorado (13.7 per 1,000 adult Coloradans) was greater than the rate for Western states (13.2 per 1,000 of the adult population).
- In 2013, Colorado ranked sixth among 15 Western states in the rate of adults with SMI served by a state mental health agency.
- Colorado's substance-use penetration rate (12.7 per 1,000 adults) was fourth-highest among Western states and was also higher than the U.S., though it is estimated that 84 percent of persons aged 12 or older with illicit drug dependence or abuse did not receive treatment.

Older adults

- Colorado serves older adults at rates lower than Western states and the U.S., and the stakeholder survey identified this population as being underserved.
- The mental health penetration rate for older adult consumers in Colorado (4.9) was less than the U.S. (7.4) and less than the rate for Western states (5.9) and their rate decreased 21 percent from 2002 to 2013. Population growth among older Coloradans has outpaced the rate of growth in service capacity.
- In 2013, Colorado ranked 10th among 15 Western states in the rate of older adults served by a state mental health agency. Colorado would serve an additional 1,500 older-adult mental health clients if its penetration rate was raised to that of the Western states.
- Older adults were identified in the stakeholder survey as being underserved, particularly in the sparsely populated regions 1, 2, and 4 (the western half of the state and the northeastern and southeastern plains).
- The rate of inpatient bed availability (.75 per 100,000 Coloradans) was lower than the average of Western states (1.61 per 100,000 persons).
- Increasing Colorado's bed rate for geriatric patients from 75 to 161 per 1,000 persons would increase the current total number of beds from 40 to 86 (46 additional geriatric beds). Inpatient bed needs for older adults are explored further elsewhere in this report.

Dementia

Few consumers served by dedicated OBH resources have dementia, though the stakeholder survey did identify this group as underserved.

Traumatic brain injury

OBH does not target services to individuals with traumatic brain injury; however the stakeholder survey did identify this group as underserved.

Juvenile justice

Of the eight Western states that reported juvenile arrests in 2013 for youth receiving public mental health services for at least one year, Colorado had the second-lowest rate of juveniles who were re-arrested after receiving services (27 percent), though this was only three individuals out of 11. Having a lower rate of juveniles involved with the justice system after receiving mental health services is one indicator that services are having a positive effect on the clients being served, but the low number of individuals for whom these data are available makes it difficult to draw conclusions.

Education

Of the eight Western states that reported school suspensions in 2013 for youth receiving public mental health services for at least one year, Colorado had the highest rate of juveniles re-suspended (70 percent), though that was 57 individuals out of 82. A high rate of school suspensions is one indicator that mental health services are not having a large enough impact on problem behavior in school.

Recommendations

1. **Explore opportunities to provide services across the continuum** for the special populations with complex treatment and/or behavior-management needs identified in this section of the report. Specific options for state hospital beds are noted in the Colorado Mental Health Institutes section of this report.

2. **Expand workforce competence through training and consultation** to work with the identified special populations.

3. **Develop telehealth capacity to support the behavioral health treatment** needs of special populations, including supports for individuals in rural and frontier parts of Colorado.

[1] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010, 2011, and 2012 (2010 Data - Revised March 2012).
[2] The following Western states share responsibility for services to children and youth: MT, NE, NM, NV, and OK.
[3] Western States' bed rates are only available based on total state population, not age-specific population.
[4] Key informant, Doug Novins, M.D., Psychiatrist at Children's Hospital in Denver
[5] Substance Abuse and Mental Health Services Administration, Funding and Characteristics of State Mental Health Agencies, 2012. HHS Pub. No. (SMA) XX-XX. Rockville, MD: Substance Abuse and Mental Health Services Administration, (in press).
[6] SAMHSA, Mental Health Block Grant Uniform Reporting System, 2002 to 2013
[7] Behavioral Health Barometer Colorado, 2013, SAMHSA 2013
[8] Behavioral Health Barometer Colorado, 2013, SAMHSA 2013
[9] Federal Register: June 24, 1999 (Volume 64, Number 121). Pages 33890-33897
[10] Burlingame, G. M., Seaman, S., Johnson, J., Whipple, J., Richardson, E., Rees, F., & O'Neil, B. (2006). Sensitivity to change of the brief psychiatric rating scale extended (BPRSE): An Item and Subscale Analysis. Psychological Services, 3 (3), 77-87. doi: 10.1037/1541-1559.3.2.77
[11] Data collection for SMI began in 2003 and not 2002 as with the other data, so this increase is calculated from 2003 to 2013 rather than 2002 to 2013 as in other sections of this report.
[12] Source: Data submitted by Region on OBH-funded services.
[13] Substance Abuse and Mental Health Services Administration, Funding and Characteristics of State Mental Health Agencies, 2012. HHS Pub. No. (SMA) XX-XX. Rockville, MD: Substance Abuse and Mental Health Services Administration, (in press).
[14] Western States with geriatric beds in state hospitals include: CA, CO, NM, ND, OR, SD, WA.

[15] Western States' bed rates are only available based on total state population, not age-specific population.
[16] Western States' bed rates are only available based on total state population, not age-specific population.
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[20] See http://www.ddas.vermont.gov/ddas-programs/tbi/programs-tbi-default-page
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Whole Health Integration

This section discusses approaches to integrating primary and behavioral health care, along with barriers and facilitators from integration projects to date as a primer for strategic discussions on this topic.

What is integrated care?

Strategies to advance integrated care range from freestanding coordination mechanisms, such as universal screening and patient navigators, to full service and fiscal system integration.[1] Each level of integration strategies is associated with a specific set of likely benefits, as well as likely financial and implementation challenges.[2] Traditional components of fully integrated care include cross-discipline care teams charged with coordination of the full complement of primary and behavioral health services needed by recipients; real-time access to health information among all team members; and processes for assessing and incentivizing care quality, including alignment of quality incentives across physical and behavioral health disciplines.[3] A fully integrated system stands as the ideal. Simple, stand-alone strategies, however, can yield significant gains in care quality and coordination, particularly in settings with a baseline characterized by high levels of fragmentation,[4] and a tiered or incremental approach may be the most feasible for many care systems.[5]

One of the major current concerns within the integrated-care research community is coalescing around a single framework to ground the discussion of integration. Two approaches—the continuum approach and the lexicon approach—use very different ways to create shared language about integration.

Continuum approach

In 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) introduced a Standard Framework for Levels of Integrated Care, combining multiple existing continuum-based frameworks for integration. This framework describes a continuum of six levels of collaboration and integrated care.[6]

Figure 1. Standard Framework for Levels of Integrated Care

Coordinated		Co-located		Integrated	
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Minimal collaboration	Basic collaboration at a distance	Basic collaboration onsite	Close collaboration with some system integration	Close collaboration approaching an integrated practice	Full collaboration in a transformed/ merged integrated practice
Less Integrated					**More Integrated**

As the integration categories and levels suggest, this framework focuses on interaction and collaboration between primary care and behavioral health practitioners and location of services. The continuum approach has been used by the Colorado Behavioral Healthcare Council (CBHC) since 2009 to create and maintain a map of integrated sites,[7] documenting characteristics of each site including their level of integration.

Lexicon approach

In 2009, the U.S. Agency for Healthcare Research and Quality (AHRQ), in collaboration with the University of Colorado, developed a lexicon. The lexicon already has some footing and support within the state,[8] unlike the categorical method described above. Aside from existing institutional buy-in, the lexicon is appealing in its focus on health care quality and operationalization of integration through defining clauses.

Figure 2. Lexicon for Behavioral Health and Primary Care Integration[9]

	Practice Team	Supports
Defining Clauses	1. Tailored to the needs of each patient and situation 2. Shared population and mission 3. Using a systematic clinical approach and system that enables it to function	1. A community, population, or individuals expecting that behavioral health and primary care will be integrated as a standard of care 2. Office practice, leadership alignment, and business model 3. Continuous quality improvement and measurement of effectiveness
Parameters	1. Range of care team function and expertise that can be mobilized to address needs of particular patients and target populations 2. Type of spatial arrangement employed 3. Type of collaboration employed 4. Method for identifying individuals who need integrated care 5. Protocols in place for engaging patients in integrated care, and level that they are followed 6. Proportion of patients in target groups with shared plans, and degree that care plans are implemented and followed 7. Level of systematic follow-up	1. Level of community expectation for integrated behavioral health as a standard of care 2. Level of office practice reliability and consistency 3. Level of leadership/ administrative alignment and priorities 4. Level of business model support for integrated behavioral health 5. Scale of practice data collected and used on at least the integrated medical/behavioral health aspect of the practice

While location of services and level of collaboration are included here, the lexicon includes many other characteristics of successful integration that can be used for planning and quality-improvement practices for integrated services. Further, the specific parameters are accompanied by measurement approaches, allowing integration sites to identify gaps in integration success and track improvement over time. This quantitative approach gives the lexicon practical utility beyond simply framing the integration discussion.

National perspectives on integration

Barriers to integrated care

Numerous sources on whole health integration cite siloed service systems and funding mechanisms among the top challenges to integrated care, with service system division often resulting in challenging policies and procedures at both the system and organization level.[10] The need for workforce development is also often cited as a challenge to integration,[11] as is the need for resources to support ongoing monitoring of fidelity to newly implemented practices.[12] Additionally, providers tasked with delivering integrated care must frequently overcome challenges related to time constraints and role definition, and conflict between behavioral and primary health staff. These are not challenges that are resolved through one-time solutions, but

rather require ongoing attention as collaboration initiatives grow and change.[13]

Many of these challenges were identified by programs funded through SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) initiative. Since 2009, SAMSHA has supported the co-location of primary and specialty care medical services in community-based behavioral health settings through more than 100 grants. Colorado currently has three PBHCI grantees. Past grantees have reported experiencing difficulty achieving financial sustainability, limited cross-team communication, and problems establishing an organizational culture supportive of integrated care, and they also had lower-than-expected rates of consumer enrollment in integrated services.[14] Additionally, consumers receiving services from PBHCI-funded programs in rural areas experienced lower access to integrated care than those receiving services from programs in non-rural areas.[15]

Facilitators for integrated care

While integrated care initiatives take many forms, successful initiatives share features such as a strong conceptual framework and belief in the value of whole-patient care, a focus on processes and mechanisms that support communication, and prioritization of sustainability and funding.[16] Leadership support is also a key factor in successful integration, with resource allocation, role definition, and conflict resolution being critical areas for leadership intervention.[17] Process and impact assessment is critical and requires the early establishment of measurable service model fidelity standards and outcome indicators.[18]

Buy-in can be facilitated by an organizational "integration champion" with strong advocacy skills and the capacity to relate to provider, finance, and management personnel. This individual's message should center on the evidence supporting integrated health care and real-world integrated care success stories.[19] Additionally, cross-discipline collaboration is required at the leadership as well as provider level.[20] Involvement of both primary and behavioral healthcare staff from the planning and design phases forward can both promote the development of a stronger service model and enhance cross-discipline buy-in.[21] Similarly, involvement of financial and management personnel helps to ensure that the new service model will be fiscally and administratively feasible.[22]

Technology that facilitates integration includes telepsychiatry; web-based screening; web-based provider tools (e.g., resource and referral guides); use of electronic and telecommunications to foster mentorships and other relationships between cross-disciplinary staff who are not co-located; and patient self-management tools designed for personal electronic devices.[23] Improvements in health care information sharing and health information technology capacity are important to integration,[24] and the Patient-Centered Outcomes Research Institute has identified research questions regarding the comparative utility of technology-based behavioral health services as a critical area of inquiry in support of integrated care.[25]

The Affordable Care Act (ACA) contains a number of provisions conducive to the establishment

and expansion of integrated care.[26] For example, medical homes and accountable care organizations are well suited to facilitating the management and financing of integrated health care. Integration is further supported by new infrastructure elements such as the Community-based Collaborative Care Network program and the Federal Coordinated Care Office. The ACA also mandates grant funding to expand the availability of primary health care services co-located in behavioral health care settings, as well as funding to support workforce development related to care integration and chronic-illness team management.[27]

Trends in integrated care financing

With funding among the most frequently cited obstacles to integration, financing strategies become an essential component of integration success. The following represent a selection of financing approaches currently utilized or under consideration by systems carrying out integration initiatives.

Health homes

Section 2703 of the ACA created a Medicaid State Plan Option to implement health homes for Medicaid beneficiaries with serious mental illnesses or other chronic conditions. Medicaid health homes are, at a minimum, required to provide the following: comprehensive care management, care coordination, health promotion services, transitional care and follow-up after discharge from inpatient settings, individual patient and family support, and referral to social support and community services. Additionally, health homes are expected to use health information technology to link services. At this time, 16 states have submitted and received approval to implement one or more state plan amendments (SPAs) creating health homes for a defined population of Medicaid beneficiaries,[28] but Colorado is not among the states that have received approval for a health home SPA.

Other avenues exist for supporting the transition to health homes. Since 2011, an initiative funded by HRSA has supported existing health centers in gaining and maintaining accreditation as a Patient Centered Medical Home (PCMH). In August 2014, $35.7 million in ACA funding was awarded to 147 health centers across the nation to support facility improvements, with the goal of creating space that facilitates care coordination using the PCMH model.[29] One site from Colorado – Peak Vista Community Health Center in Colorado Springs – was awarded a $250,000 grant from these funds.[30]

Maximizing Medicaid billing

Regulations regarding allowable services, staff credentials, and circumstances for Medicaid billing vary from state to state. At the provider level, Medicaid billing options can best be utilized by understanding the state's Medicaid billing policies and the degree to which current or planned integrated services match state requirements for billable services.[31] At the state level, Medicaid reimbursement to providers can be maximized by "activating" or "unlocking" federally allowable Medicaid billing codes that support reimbursement of behavioral health

services.[32]

Global payment models

Global payments or global capitation are intended to cover the costs of a comprehensive set of services that may be required by members of a population over a set period of time.[33] While all payment models are associated with both advantages and disadvantages in relation to quality of care overall and integrated care in particular, one key advantage of fully capitated models is the flexibility they allow in terms of service array, and the incentive to minimize the need for high-cost interventions through case management, prevention and wellness initiatives, and disease management.[34] One such model is currently under evaluation in Colorado; further details on the SHAPE study are described below.

Colorado perspectives

In November 2014, the Colorado Department of Health Care Policy and Financing (CDHCPF) Accountable Care Collaborative (ACC) solicited a Request for Information on multiple topics, including experiences and recommendations for whole health integration. There were 121 responses, and while results are still preliminary, the ACC did share these four key response themes:[35]

- The most significant barriers to the integration of physical and behavioral health in Colorado are different reimbursement structures, institutional divisions, data-sharing rules and capacity, the covered diagnosis list, and staff capacity.
- Behavioral health integration is occurring too slowly because physical health and behavioral health have been divided by firewalls across several domains.
- Changes are needed in payment methodologies, to the whole delivery system, and in the benefit package.
- Differences in the capture of Regional Care Collaborative Organizations (RCCOs) and Behavioral Health Organizations (BHOs) are also problematic to successful integration. Aligning RCCOs and BHOs will increase administrative efficiency and remove obstacles providing behavioral health services.

Initiatives to watch in Colorado

Colorado is at the forefront of an exciting shift within the national whole-health integration movement. Several active programs within Colorado will have an important impact on the integration of primary care and behavioral health. Activities and results from these programs have the potential to change the integration landscape in Colorado

Advancing Care Together Program

A Colorado-specific project may offer additional insights into the barriers and facilitators to integration unique to the state. Advancing Care Together (ACT) is a four-year program funded by a competitive grant from the Colorado Health Foundation. It focuses on real-life implementation of integration strategies, with the ultimate goal of identifying and disseminating best practices in whole health integration. In 2011, 11 sites received a total of $150,000 to support demonstration projects for varied approaches to delivering services meeting patients' physical, emotional, and behavioral health needs. The project concluded in 2014 and evaluation data are currently being analyzed, with a final report forthcoming. However, an initial analysis of demonstration project sites in 2013 showed that the sites shared three common barriers to integration: 1) workflow and access to care, 2) leadership and culture change, and 3) data tracking and usage.[36]

SHAPE Study

The Colorado Health Foundation also funded a study testing a global payment model for integrated care. The study, Sustaining Healthcare across Integrated Primary Care Efforts (SHAPE), is a partnership between the Collaborative Family Healthcare Association, Rocky Mountain Health Plans, and the University of Colorado Denver. SHAPE is a three-year pilot intervention currently in place in three family-practice organizations in communities on Colorado's Western Slope. These organizations receive a global payment for behavioral healthcare, with added incentives based on patient outcomes. Three control sites have been selected, and are providing services reimbursed on a fee-for-service basis.[37] The SHAPE study is now entering the final year of analyses.

State Innovation Model (SIM) Grant

In December 2014, the U.S. Centers for Medicare and Medicaid Services awarded Colorado a $65 million grant to implement its plan to innovate state health care over the next four years.[38] A major component of this grant is the implementation and testing of a model to integrate behavioral and physical health in primary-care medical homes.

Behavioral health provider inventory recommendations

The following recommendations are from the respondents to the Inventory addressing the ability to meet the primary health needs of individuals with behavioral health issues. These are described in greater detail elsewhere in this report, but highlights from these recommendations are listed below.

- Support for better billing models for truly integrated care
- Payment reform
- Bidirectional integration
- Activation of the behavioral health codes in primary care settings
- Clear definition and education regarding the role of behavioral health professionals in primary care
- Quick, easy referral processes between mental health centers and primary care

- Psychiatric consultation for primary care providers
- On-site psychiatric services in primary care
- Consistent communication among behavioral health and primary care providers
- Case management support
- Integrated care training for behavioral health providers
- Allowing Medicaid eligibility for Community Corrections individuals, which is a significant gap and need
- Pharmacies and primary care clinics embedded in community mental health centers
- Increased partnerships with primary care and pediatric facilities, and the provision of primary care services for all clients throughout the developmental spectrum
- Availability of behavioral health codes to LCSWs, LCPCs and other behavioral health professionals so they can bill for providing behavioral health services to individuals who have a primary medical condition. The true value of integration is to support patients with making behavioral change, not simply going to their primary care physician to get medications. Behavioral health professionals bring a level of expertise that can improve health and support lasting change in behaviors that impact health (i.e., addressing change in diet and exercise when the person's primary diagnosis is diabetes)
- Not following the medical model of seeing a patient every 15 minutes. We have trained our primary care providers to slow down and take a holistic approach to their assessment and diagnosis process.
- Shared electronic health record
- Funding mechanisms that support comprehensive, fully integrated mental health center-based healthcare homes as well as fully integrated primary care-based healthcare homes; no wrong door—bidirectional fully integrated whole-person healthcare.

Additional recommendations

Whole health integration is exploding in Colorado, and OBH's plans moving forward should consider the status and knowledge gained through the current initiatives described above. As noted, several of these initiatives are beginning or ending, and over the next few years there should be a clearer picture of what works for integration in Colorado, and what next steps are being taken to support the implementation of best practices at multiple levels. In the meantime, OBH leadership can continue to support successful whole health integration by taking the following two key actions:

3. **Reach out to and monitor the progress of existing initiatives.** The ACT demonstration project, SIM grant, and SHAPE financing study offer promising avenues for identifying and addressing key barriers to successful whole health integration. Potential contacts include:

- ACT project: Larry Green, Larry.Green@ucdenver.edu; Deborah Cohen, cohendj@ohsu.edu
- SIM Grant: Vatsala Pathy, vatsala.pathy@state.co.us
  SHAPE Study: Benjamin Miller, Benjamin.Miller@ucdenver.edu; Patrick Gordon, patrick.gordon@rmhp.org

4. **Build relationships and communication with other Colorado state agencies.** Stakeholders within the Colorado Department of Health Care Policy and Financing were especially eager to build relationships to create efficient execution, improvement, and evaluation of programs with shared interests. Further, building these relationships now will set the stage for successful integration efforts in the future.

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Legal Marijuana and Prescription Drug Abuse

Introduction

This section provides information on behavioral health needs in Colorado stemming from marijuana legalization and the ongoing prescription drug abuse epidemic. Beginning with the context for these needs, this section explores trends in drug use and treatment utilization, coupled with voices from the field to identify policy and practice considerations moving forward.

Legal Marijuana

In 2000, Colorado voters approved Amendment 20, legalizing the medical use of marijuana for the treatment of approved debilitating conditions, including cancer, glaucoma, HIV/AIDS, cachexia (i.e., extreme weight loss and malnutrition typically associated with chronic disease), persistent muscle spasms, seizures, severe nausea, and severe pain.[1] Colorado was the fourth state in the U.S. to legalize medical marijuana. Today, it is among 23 states (plus the District of Columbia and Guam) that have medical marijuana programs.[2]

Colorado and Washington were the first states in the country to legalize marijuana for recreational use, both in November 2012. Two additional states, Oregon and Alaska (and the District of Columbia) passed recreational marijuana legislation in 2014, and several other states appear to be considering similar action.[3] Colorado legalized recreational marijuana through Amendment 64 and has implemented a regulatory and legal framework in the years since to support his amendment. The first retail dispensaries opened in Colorado in January 2014.

With no precedent for recreational marijuana legalization within the United States and limited immediate outcome data available, studies of medical marijuana legalization and marijuana decriminalization provide initial insight into the public health and behavioral health impact expected from recreational legalization.[4] Medical marijuana legalization is largely regarded as affecting recreational marijuana use, due in part to the difficulty of enforcing medical marijuana policies.[5]

The following sections discuss our current understanding of the impact of marijuana, and its legalization and decriminalization. Available population-level, utilization, and capacity data for Colorado are discussed, and behavioral health approaches in practice to respond to client marijuana use issues are addressed. While definitive data are limited, the information described aims to facilitate discussion on behavioral health service decisions related to legal marijuana.

Literature on marijuana

Public Health Impact

It is important to consider the health impact of marijuana as a means of identifying target populations and customizing prevention and treatment efforts. The Colorado Department of Public Health and Environment (CDPHE) has systematically reviewed and documented these effects.[6] Potential target populations and areas of interest for OBH are distilled from the CDPHE report and listed below:

Pregnant women. Maternal use of marijuana during pregnancy is associated with negative effects on offspring appearing in adolescence, including decreased academic ability, cognitive functioning, and attention.

Unintentional exposure to children. More unintentional marijuana exposures of children through ingestion of products with THC occur in states with increased legal access to marijuana. Limited evidence shows that child-resistant packaging reduces these events.

Adolescent and young adult users. Regular marijuana use in adolescents and young adults is associated with negative effects on cognitive abilities, learning, memory, achievement, mental health issues, and future use of and addiction to illegal drugs.

Memory and mental health in adult users. Adult marijuana use is associated with memory impairment lasting at least seven days after use and acute psychotic symptoms immediately after use. Adult marijuana users are also more likely than non-users to have symptoms or a diagnosis of depression.

Impaired driving. Occasional marijuana users who consume 10-35 milligrams of THC via smoking, eating, or drinking are likely to experience impairment that affects ability to drive, ride a bike, or perform other safety-sensitive activities. Impairment is usually resolved after about six hours of abstinence if marijuana is smoked, and eight hours if it was ingested. Risk of motor vehicle collisions doubles among drivers with recent marijuana use compared with non-users. Combined use of marijuana and alcohol increases motor vehicle crash risk more than use of either substance alone.
The CDPHE report also notes several research gaps, including research on THC testing of current marijuana products, impairment in users with increased tolerance, impairment testing methods, health impacts of newer methods of consumption such as edibles and vaporizing, and health impact differences on occasional vs. heavy users.

Marijuana Use

A common concern of those opposed to marijuana legalization is that it will lead to increased marijuana use at the population level, leading in turn to increased public health burden and

treatment need.[7] However, studies on the impact of legal marijuana on actual use and public opinions have yielded conflicting results.[8] States with legal marijuana often have higher rates of marijuana use, abuse, and dependence overall,[9] but this cannot be taken as evidence that such policies cause higher use. Several alternative explanations exist, with a particularly compelling possibility being that pre-existing state norms drive both marijuana legalization and rates of marijuana use.[10] Friese and Grube[11] found an association between public opinion about marijuana use – but not actual medical marijuana licenses – and youth marijuana use. Choo and colleagues[12] did not find a significant increase in youth marijuana use before and after marijuana legalization, comparing states with legal marijuana with neighboring states without legal marijuana. These findings suggest that the normative environment may have a stronger relationship with youth use than increased access to marijuana. If pre-existing state norms and public opinion about marijuana are closely tied to marijuana use, abuse, and dependence, then attributing behavioral health needs to Colorado's recreational marijuana legislation may prove extremely difficult.

The association between marijuana use and later use of other illicit drugs is clearly established, as is the association between earlier initiation of marijuana use and likelihood of subsequent use of heroin and cocaine.[13] Possible mechanisms underlying this association include pre-existing propensity for drug use, initiation into the drug marketplace through marijuana purchasing, and the possibility that marijuana use causes changes in the brain that increase the likelihood of later drug use.[14] The theory that marijuana use functions as a "gateway" by introducing the user to the illegal drug marketplace was the rationale underlying the Dutch decriminalization policy.[15] Following Dutch decriminalization of marijuana, a smaller proportion of Dutch than U.S. youth reported using other illicit drugs (6.5 percent vs. 19 percent), and the proportion of Dutch individuals reporting cocaine and amphetamine use is now lower than expected given the rate of marijuana use.[16]

Outside the United States, marijuana use rates have not increased following decriminalization in the absence of active commercialization.[17] MacCoun[18] reported that while youth lifetime and recent marijuana use rates are relatively similar in the United States, Netherlands, and other European countries, there is some evidence pointing to an increase in Dutch marijuana use during the period that the coffeehouse system was rapidly expanding (1984-1996). Overall, this study did not find evidence of greater likelihood to continue regular use, heavier marijuana consumption, or longer marijuana use among the Dutch, compared to U.S. marijuana users.[19] Caution should be exercised in considering the application of the Dutch experience to states undergoing full legalization; marijuana policies in the Netherlands are more nuanced than full legalization policies, and Dutch policies have likely resulted in a more limited impact on the marijuana-related economy given that the government continues to prosecute growers and traffickers.[20]

Economic Impact

Given that both decriminalization and medical marijuana legalization are imperfect models for

recreational legalization, some researchers have turned to economic modeling to investigate the likely impact of full legalization. In work designed to assess the potential impact of legalization in California, the RAND Corporation determined that changes in consumption are likely to be a result of both price-related and non-price-related factors, the latter including changes in availability, advertising, and public perception of marijuana.[21] Changes in consumer price are likely to result from a range of factors, including changes in the cost of producing and distributing marijuana, specifics of policies regulating production and distribution, tax rates, and patterns of tax evasion. Additionally, the impact of price on consumption is in part a function of how marijuana users and potential users react to price differences. Limited data exist for many of these factors, and the model's outcomes are highly sensitive to variations in key assumptions, making prediction of the impact of legalization on consumption challenging.[22]

Marijuana dispensaries are also associated with lower cost, which tends to promote use among existing and new users. Even within a given jurisdiction, a single medical marijuana policy may change in significant ways over time.[23] These variations play a major role in the policies' impact on price, which likely impacts overall consumption and consumption patterns. Medical marijuana policies without dispensary components tend to lead to higher marijuana prices, and are therefore less likely to promote marijuana use among new users. Those that do have dispensary components (as in Colorado) tend to have lower marijuana prices, which can promote use among both existing and new users.[24]
The authors of one recent review noted that even if questions of overall rates of use could be resolved, conclusions about the impact on public health cannot be drawn based on existing knowledge.

> "It is hard to know, based on the current literature, the extent to which greater marijuana use will lead to greater harms. It will likely depend on a number of factors, including who ends up responding the most to price. If it is the casual adult user who enters the market and consumes in relatively small amounts, then the expected harms are very small. If it is new young users, more involved heavy users, or users of other substances, then the harms could be greater."[25]

Further, high cost may restrict adolescent use, as adolescents have less disposable income than adults.[26]

Population-Level Data

The Colorado Legislature tasked CDPHE with studying the potential public health impacts of marijuana. As a part of this effort, CDPHE convened a 13-member Retail Marijuana Public Health Advisory Committee, comprising primarily public health professionals and physicians. The committee released a report[27] on Jan. 30, 2015, that provides a comprehensive collection and discussion of marijuana use data, along with documentation of the health effects of marijuana. The marijuana data section of the report presents survey results from three

population-based surveys: Healthy Kids Colorado Survey (HKCS), Influential Factors in Healthy Living (IFHL), and the National Survey on Drug Use and Health (NSDUH). The assessment also included data from a one-time survey of Women, Infants, and Children (WIC) clients conducted by the Tri-County Health Department.

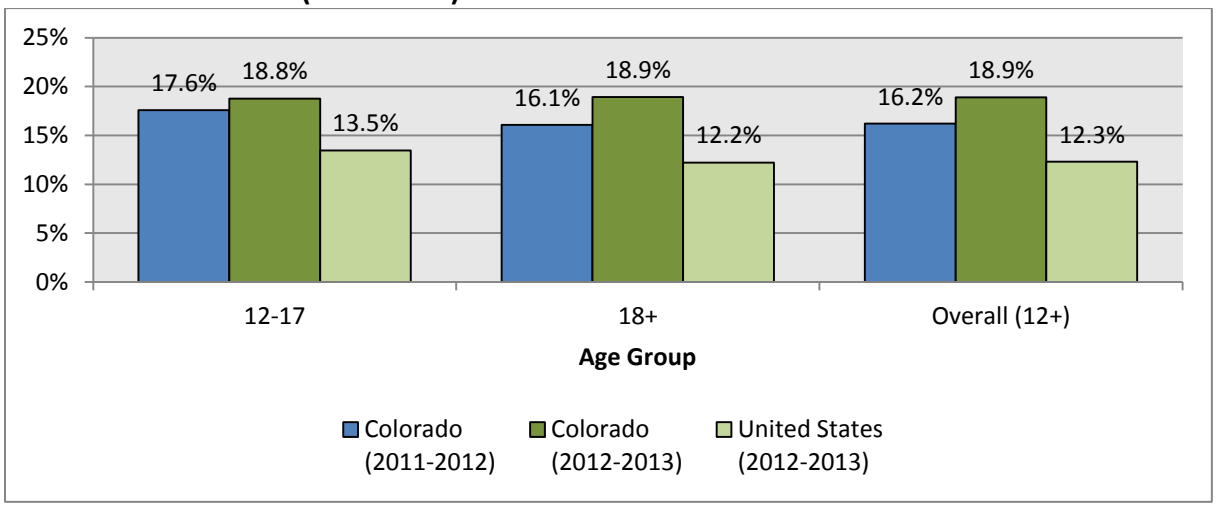
The committee cautions that the data from these sources is informative, but limited. The lag between data collection and analysis means that very little current data from the past year of active retail dispensaries asking the most relevant questions is available. The committee has made revisions to existing state data collection tools and will continue to capture and report data regularly using the survey instruments noted above. As more data are available and reported by the committee, the Office of Behavioral Health will have more insight into the impact of Amendment 64 on behavioral health needs. Until then, these general observations reported by the CDPHE committee from available data can be used to inform behavioral health service decisions.

1) Fewer middle school students than high school students use marijuana.
2) The data on marijuana use among Colorado middle school students supports prevention efforts aimed at children before they enter ninth grade.
3) There are conflicting data on adolescent marijuana use in Colorado compared to national averages and other states, likely due to variations in the methods for how data are collected.
    a. NSDUH results (2013) suggest that past 30-day marijuana use among Colorado youth (ages 12-17) is 11 percent, which is higher than the national average of 7 percent and also higher than surrounding states.
    b. HKCS results (2013) suggest that past 30-day marijuana use among Colorado high school students is 20 percent, which is lower than the national average of 23 percent.
4) There are significant racial, ethnic, and sexual orientation disparities in the prevalence of use among adolescents in Colorado.
5) NSDUH (2013) reports that adult marijuana use is higher in Colorado than in most other states.
6) Based on limited data from Colorado adult marijuana users, it appears that among those who use marijuana, 64 percent use it more than eight times per month.

Marijuana Use

Drug-specific, state-level data from the 2013-14 NSDUH was not yet released at the time of this report. However, Figure 1 below shows the most current marijuana use data for Colorado over two reporting periods, compared with the most recent national averages. While marijuana use appears to be increasing in Colorado across age groups, the increase is not statistically significant.[28] Colorado's percentages of individuals reporting past-year marijuana use remain above national numbers, but these statistics do not account for individuals using marijuana legally under medical supervision.

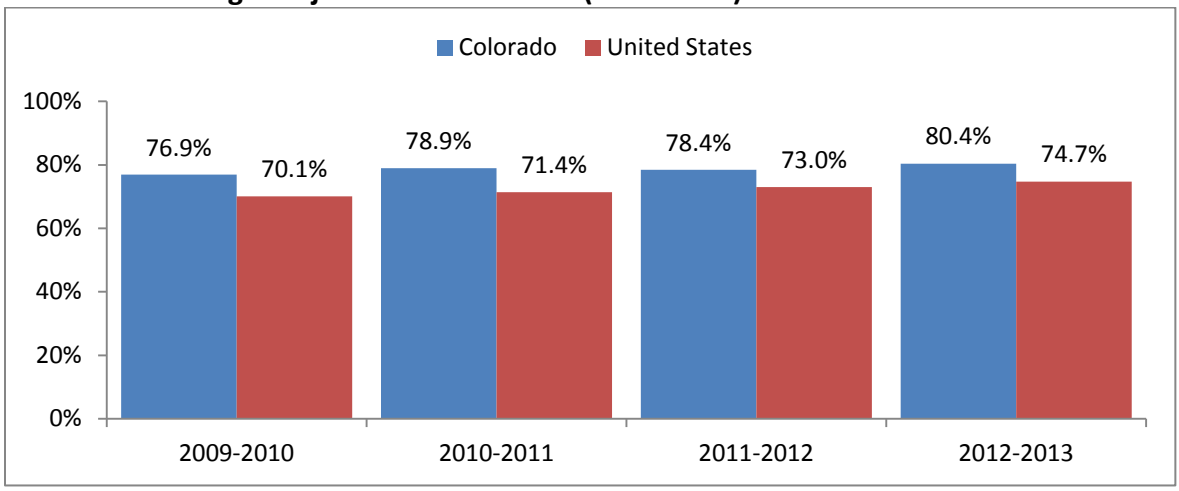
Figure 1. Percent reporting past-year marijuana use in Colorado (2011-2012 and 2012-2013) and the United States (2012-2013)[29]



Marijuana Perception of Risk

Both nationally and in Colorado, more and more adolescents perceive marijuana use as low-risk. In Colorado, that perception is paired with greater access to marijuana through both medical and recreational dispensaries and personal cultivation.

Figure 2. Adolescents aged 12-17 in Colorado and the United States who perceived no great risk from smoking marijuana once a month (2009-2013)[30]



Access to Marijuana

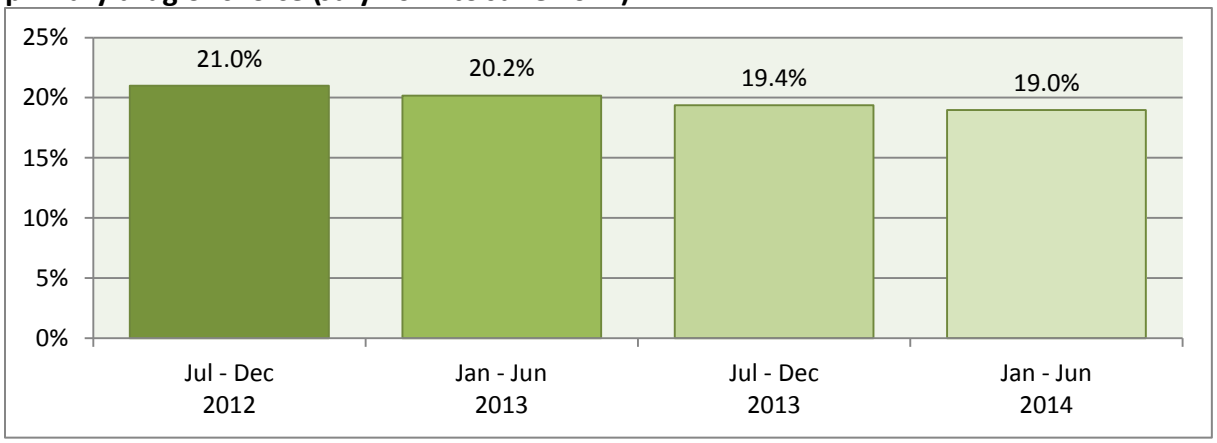
The Healthy Kids Colorado Survey conducted in 2013 found that 54.9 percent of Colorado middle and high school students think that marijuana is easy or very easy to access, and 36 percent of students know someone with a medical marijuana license. The impact of this ease of access was corroborated by our interview with two Colorado Department of Education employees who work with high-risk youth. They reported a noticeable increase in the presence of marijuana in schools following the legalization of medical marijuana—more so than with recreational marijuana.[31]

On March 17, 2014, Governor John Hickenlooper signed into law a safe-packaging bill requiring that marijuana edibles be sold in child-resistant, opaque, resealable packaging. This effort closes a loophole left by the original marijuana legalization laws, and may stem rising poison control calls and hospitalization of children due to ingestion of foods containing THC.

Treatment utilization

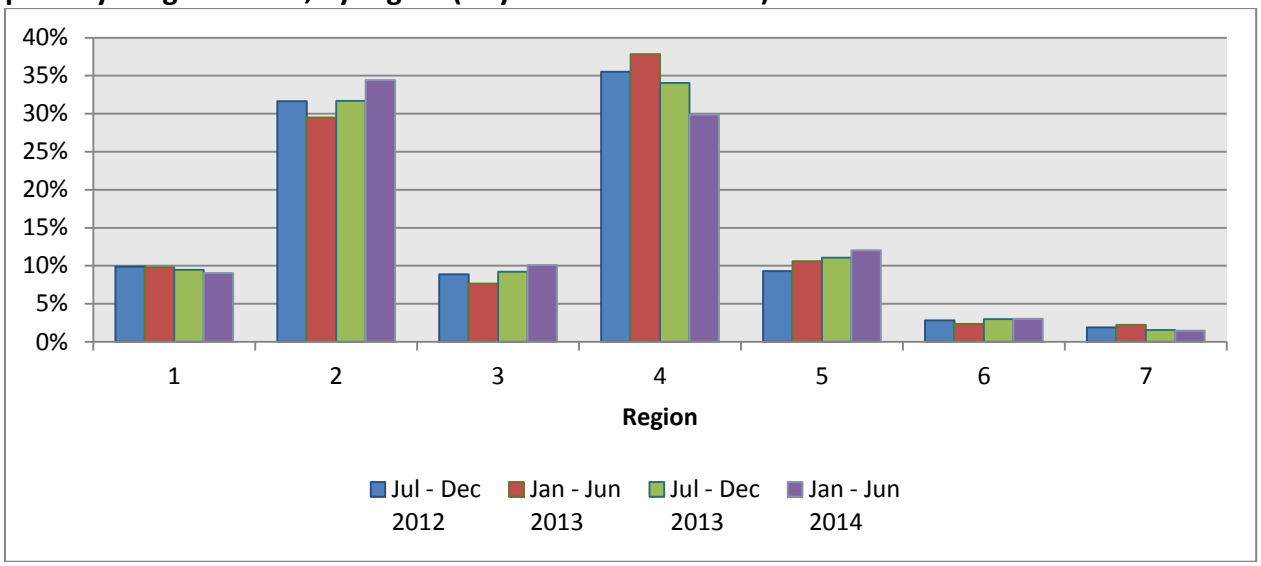
Information on primary drug of choice for individuals entering treatment within Colorado may provide more information on service needs relating to Amendment 64. Interestingly, treatment admissions for individuals identifying marijuana as their primary drug of choice have steadily decreased for Colorado as a whole since 2012.

Figure 3. Percent of Colorado treatment admissions by individuals reporting marijuana as primary drug of choice (July 2012 to June 2014)[32]



However, when we can see that some areas of Colorado—particularly Region 2 (northeastern counties) and Region 4 (southeastern counties)—have significantly higher overall rates of admissions for marijuana as the primary drug of choice, with admissions fluctuating over time depending on the region.

Figure 4. Percent of Colorado treatment admissions by individuals reporting marijuana as primary drug of choice, by region (July 2012 to June 2014)[33]



Treatment capacity

As a part of the service inventory described in greater detail earlier in this report, 20 community mental health and substance abuse centers responded to questions about a range of behavioral health services and interests. Of these, 19 sites responded comprehensively to questions about substance abuse services and capacity. Just one center reported limited capacity for marijuana-related treatment, despite treating nearly 30 percent of clients for substance abuse issues alone or co-occurring with other conditions. One additional center reported concerns with future capacity given Amendment 64, despite currently managing marijuana-related treatment sufficiently.

Evidence-Based Treatment

Evidence-based practices are a specific set of activities implemented with a standardized approach that have demonstrated positive behavioral outcomes. Prevention, treatment, and recovery funding is often tied to the use of a documented evidence-based practice, such as those listed on SAMHSA's National Registry of Evidence-based Programs and Practices.[34] While the number of evidence-based practices implemented at one site does not necessarily demonstrate improved capacity for treatment, it is also clear that a one-size-fits-all approach to substance abuse treatment does not consider the diversity of client needs. Despite this, five of the 19 sites reporting information on substance abuse treatment identified one or zero evidence-based practices in use for substance abuse treatment and recovery (see Table 1), suggesting that these sites would benefit from additional attention to programming and capacity in this area.

Table 1. Inventory respondents reporting one or fewer evidence-based practices used in substance abuse treatment and recovery

Region/Site	Evidence-based practices for substance abuse issues	% Clients in past year with substance abuse issues
1 - Touchstone	0	23.2%
1-The Center for Mental Health (formerly Midwestern_	1	19.6%
2 - Centennial Mental Health Center	1	31.9%
3 – Aurora Mental Health Center	0	15.7%
5 - Servicios de la Raza	0	4.8%

Table 2 may provide some useful options for sites seeking appropriate evidence-based programs for substance abuse issues; this table lists the most common evidence-based practices, each identified by two or more sites.

Table 2. Evidence-based practices reported by inventory respondents

Evidence-based practice	Sites	Practice reported	Sites
Seeking Safety	10	Dialectical Behavior Therapy	2
Matrix Model	6	Assertive Community Treatment	2
Cognitive Behavioral Therapy	5	Living in Balance	2
Integrated Dual Diagnosis	4	Moral Reconation Therapy	2
Strategies for Self Improvement and Change	4	MET-CBT	2
Motivational Interviewing	4	BASICS	2
Medication Assisted Treatment	4	Driving with Care	2
Solution-Focused Brief Therapy	2	Prime for Life	2

In addition to the specific programs listed above, seven sites reported using outpatient treatment (including intensive and enhanced outpatient treatment). Though outpatient treatment is an effective approach, it is not considered an evidence-based practice because one site's outpatient treatment may vary considerably from another. Site responses confusing what constitutes an evidence-based practice suggest that sites would benefit from training on evidence-based practices, including information on successful identification, adoption, and implementation of evidence-based practices to ensure good client outcomes.

Evidence-Based Prevention

There are currently statewide prevention initiatives in Colorado for workplace drug prevention for small businesses and wide-scale prescription drug abuse prevention. However, local and regional practices for the prevention of substance abuse are unclear. Under the SAMHSA substance abuse block grants,[35] 43 evidence-based practices cover a range of universal, selected, and indicated prevention areas. However, it is unclear which of these practices are actually being implemented or which of these practices are most common across the state. Many of the 43 practices listed are school-based interventions, yet discussions with

representatives of the Colorado Department of Education indicated that school and district approaches to drug prevention vary widely and are not regulated by the department.

Prescription Drug Abuse

After marijuana, prescription opioids represented the most common class of drug involved in substance abuse-related hospital discharges in Denver in 2012,[36] and prescription opioids like hydrocodone and oxycodone continue to be among the most commonly abused drugs in the nation.[37] Changes in prescribing practices are a critical feature of the prescription drug abuse landscape, with the number of opioid prescriptions dispensed tripling between 1991 and 2010.[38]

Older adults and youth are at higher risk of prescription drug abuse. Roughly a third of those abusing prescription drugs for the first time within the past year are between the ages of 12 and 17, and overall rates of prescription drug abuse are highest among those age 18 to 25.[39] Risks common among older adults include age-related changes in metabolism, greater likelihood of using multiple prescriptions and long-term prescriptions, and for some individuals, difficulty managing medications due to cognitive decline.[40] Individuals living with chronic pain also constitute a population at high risk, as long-term prescription opioid use is associated with increased drug tolerance and addiction.[41]

An October 2014 study interestingly found that in states where legal medical marijuana was available as an alternative pain management medication, a significant drop in deaths by prescription opioids and heroin overdose occurred.[42] The addition of medical marijuana as a treatment option for severe pain has been associated with significantly lower deaths by prescription opioids alone and when combined with deaths by heroin overdose.

Prescription drug monitoring programs

Prescription drug monitoring programs (PDMPs) are statewide programs that track patient-level data on dispensed prescriptions for controlled substances. PDMPs allow doctors and pharmacists to quickly identify patients with potentially dangerous prescription drug use patterns, and PDMP databases have been identified as central components in a national strategy to address the prescription drug abuse crisis.[43] PDMPs have proliferated rapidly in recent years[44] and are currently operational in 49 states and one territory.[45] PDMPs can facilitate proactive reporting of possible doctor-shopping, which can alert prescribers of possible prescription drug misuse among their patients.[46] Proactive reporting is one component of an extensive framework of PDMP best practices that has been developed based on a synthesis of available research, expert opinion, and anecdotal experience.[47]

Research and evaluation related to PDMPs suggest that these systems are associated with a number of important positive trends in controlled-substance prescribing and use.[48] Multiple states have reported that PDMP implementation and use is associated with changes in

prescribing practices and increases in drug use screening and referral to behavioral health services and pain management specialists. Numerous states have also reported significant decreases in individuals meeting doctor-shopping definitional criteria (e.g., use of five prescribers and five pharmacies within a 90-day period) following PDMP implementation or increased or mandated prescriber use of PDMPs. Declines or reduced rates of growth in controlled-substance prescribing have been noted among states with PDMPs and among states mandating prescriber use of PDMPs. In recent years, multiple states have reported that prescription drug-related deaths or emergency room visits have decreased over periods of PDMP initiation, usage increase, or mandated prescriber use implementation. Additionally, PDMPs have been used to aid in criminal-justice diversion, through such means as pre-criminal identification and monitoring of individuals engaged in doctor-shopping or coordination with drug court programs to monitor prescription drug abstinence.[49]

Insurance lock-in programs

Public and private insurance "lock-in" programs restrict controlled substance coverage for individuals meeting doctor-shopping definitional criteria to a single pharmacy and/or a single prescriber. Such programs have been associated with significant insurer savings.[50] Medicaid lock-in programs in particular have been identified as a promising tool for reducing states' population-level prescription drug abuse, given the volume of people served through Medicaid programs and the higher rates of opioid overdose among Medicaid enrollees, compared to those who are covered by private insurance.[51]
At least 46 states currently operate Medicaid lock-in programs.[52] Colorado's Client Overutilization Program (COUP) allows the state to restrict Medicaid recipients to a single provider and a single pharmacy for a 12-month period, if they are found to overuse services within a three-month period, as indicated by the use of three or more pharmacies, 16 or more prescriptions, three or more drugs in the same therapeutic category, or excessive emergency room visits or physician services.[53]

Despite the near-universality of Medicaid lock-in programs, limited research and evaluation of these programs has been conducted, and best practices have not been established.[54] Several innovative approaches have been identified, however, and may bear consideration. Key among these is the use of lock-in programs as a mechanism for identification of a population particularly likely to benefit from additional prevention and targeted treatment services, including both behavioral health and pain management interventions. For example, Montana Medicaid beneficiaries enrolled in the state's lock-in program receive two years of health education and coordinated care delivered by a multidisciplinary team. Such an approach may also serve to reframe lock-in policies in a more positive light, reducing recipients' sense of lock-in as a form of punishment.[55]

Combined approaches

No one approach has, in itself, been shown to curtail prescription drug misuse. In a recent report by Quest Diagnostics,[56] the five states with the highest declines in prescription drug misuse rates for 2013 (Florida, Georgia, Kentucky, New York, and Tennessee) were found to utilize a five-pronged approach to address prescription drug abuse:

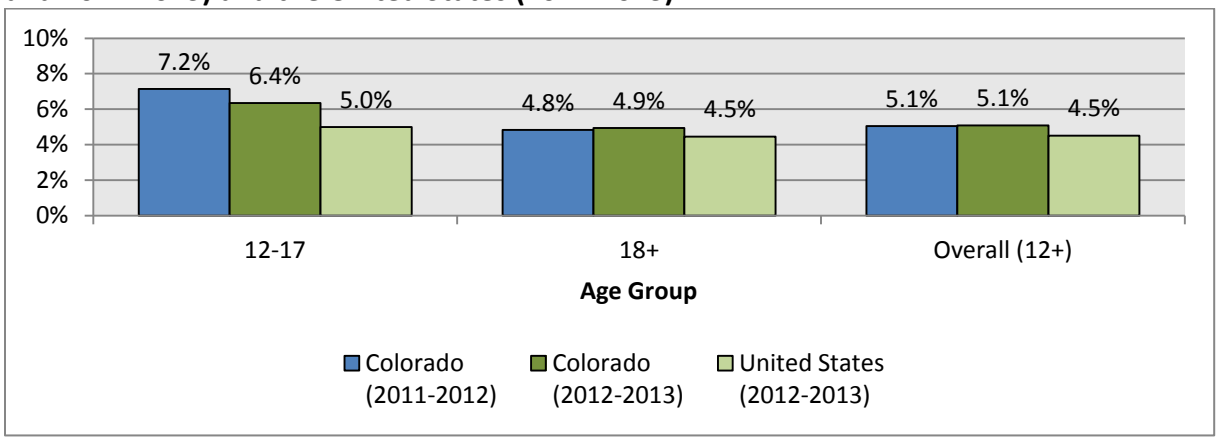
1) Active PDMP with a state prescription database
2) State legislation associated with prescription drug monitoring
3) Practitioner education requirements on prescription drug monitoring
4) Public awareness campaigns
5) Utilization of law enforcement.

Considering improvements in these areas may prove to be a useful approach to decreasing negative outcomes from prescription drug abuse in Colorado.

Population-level data

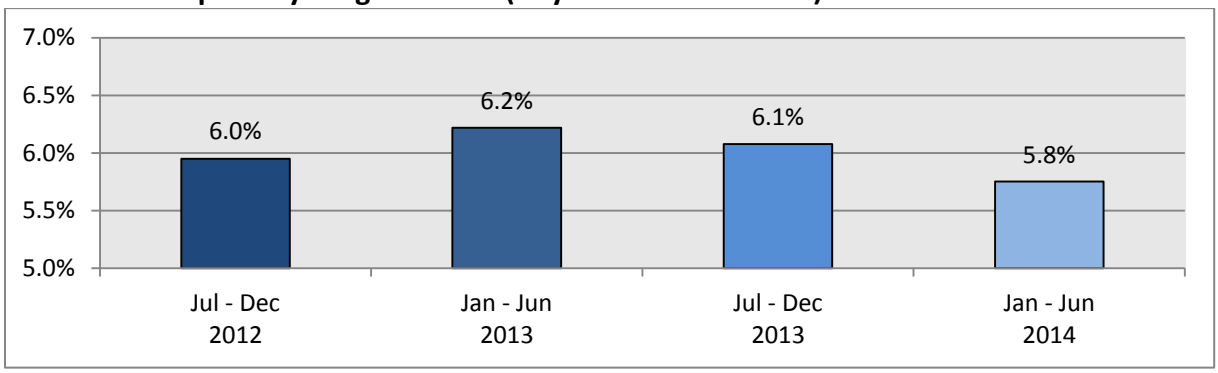
The most recent NSDUH data suggests that the abuse of prescription opioids in Colorado is comparable to national numbers and has remained steady since the last survey.

Figure 5. Percent reporting past-year nonmedical use of pain relievers in Colorado (2011-2012 and 2012-2013) and the United States (2012-2013)[57]



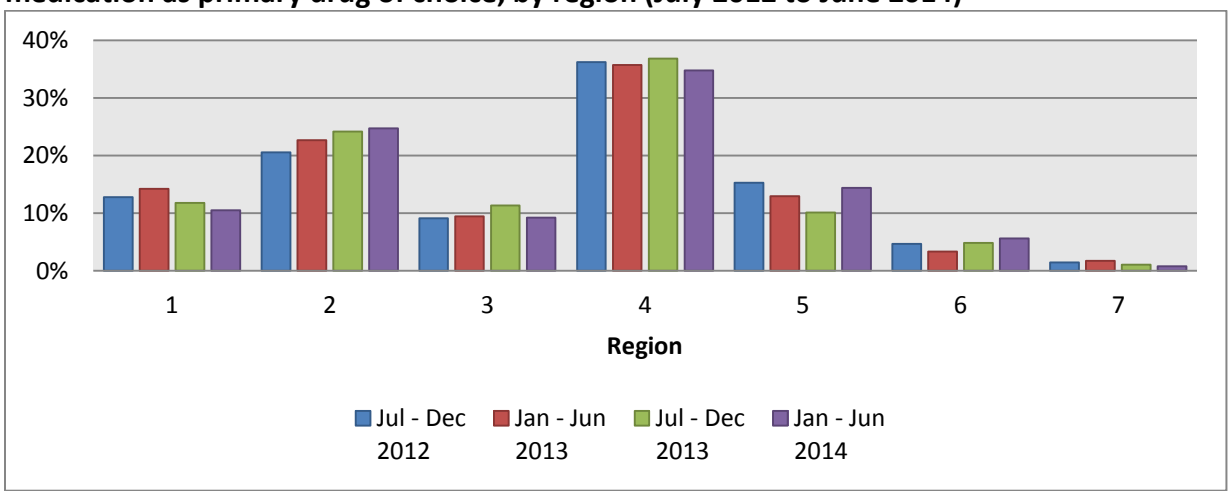
Further, admissions into treatment by individuals reporting prescription opioids as the primary drug of choice have declined slightly since 2012.

Figure 6. Percent of Colorado treatment admissions by individuals reporting prescription pain medication as primary drug of choice (July 2012 to June 2014)[58]



As with marijuana admissions, when organized by region, some areas of Colorado—particularly Region 2 (northeastern counties) and Region 4 (southeastern counties)—have significantly higher overall rates of admissions for prescription opiate abuse as the primary drug of choice, with admissions fluctuating over time depending on the region.

Figure 7. Percent of Colorado treatment admissions by individuals reporting prescription pain medication as primary drug of choice, by region (July 2012 to June 2014)[59]



Recommendations

Additional data on the impact of marijuana law changes is needed and will come, with time. In the meantime, OBH leadership can take steps to facilitate greater success in allocating services for substance abuse needs as a whole.

1. ***Redouble drug prevention efforts*.** Prevention efforts–for youth and adults–were repeatedly recommended by stakeholders consulted for this report. Education efforts, including information for families on safe storage of marijuana and prescription drugs,

are essential. Interventions targeting the perception of risk in marijuana and prescription drug abuse are needed. Both universal and selective prevention efforts targeting highest-risk regions and populations should be considered. Other state agencies, including Education and Public Health, may provide useful information on how prevention efforts can be best targeted.

2. ***Review treatment and recovery practices in regions 2 and 4 to assess treatment capacity and service need.*** These regions appear to have the greatest number of substance abuse treatment admissions for both marijuana and prescription opioid abuse as the primary drugs of choice, and though self-reported assessments of service availability and treatment capacity appeared positive for these regions from the inventory conducted for this report, further investigation is needed to establish a more conclusive assessment of service needs in these areas.

3. ***Build stronger partnerships and communication avenues with state agencies, including those serving education, public health, Medicaid, and criminal justice interests.*** There are many overlapping interests and activities across these agencies, yet state agencies appear exceptionally siloed. Collaboration with these agencies is one key to understanding and reacting to the most current marijuana use data (public health), creating and implementing drug prevention practices (education), tracking and preventing systemic prescription drug misuse (Medicaid), and meeting the treatment needs resulting from shifts in drug laws and drug court referrals (criminal justice).

4. ***Support CDPHE efforts to standardize data quality and collection*****.** This was a major barrier to compiling current data on the impact of marijuana on service needs, and OBH should consider ways to support improvements in this area.

5. ***Create policies and partnerships that encourage the use of core evidence-based practices.*** The practices used to prevent, treat, and support recovery from substance abuse issues are not well defined or accessible in Colorado. Based on stakeholder reports and existing data, these services appear to vary considerably across the state. This variation limits peer support, sustainability, and quality improvement through collaboration and efficient use of funds. Building partnerships with other state agencies, along with identifying and supporting training and coaching for specific core evidence-based practices, may help to standardize and regulate the use of research-tested practices across the state.

6. ***Regularly maintain and update content on the Office of Behavioral Health website*****.** This site can be a key resource for individuals seeking information about drug services, state initiatives, or other details relevant to marijuana and prescription drug abuse. Yet website users often find broken links and incorrect contact information throughout the OBH website. If young users of behavioral health services are to be targeted, the web presence of OBH should be improved.

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Drug Possession Sentencing Reform/Medicaid Expansion

Introduction

This section examines the issue of how two state policies will affect the need for community-based behavioral health services for justice-involved individuals. The first policy is drug possession sentencing reform, which will increase the number of people with behavioral health disorders requiring require treatment in the community. The second policy is the expansion of Medicaid, which will make health insurance available to many low-income adults without dependent children—a group that is disproportionately represented in the justice-involved population.

Background

Colorado experienced rapid growth in the prison population following the enactment of mandatory drug sentencing in 1985. In recent years, the Colorado Legislature and state government officials have implemented numerous sentencing reforms, and Colorado has seen a steady decline in the adult prison population as a result. For example, in May 2010, House Bill 10-1352 reclassified drug offenses, lowering penalties for use and possession, as opposed to manufacture and sale, of drugs.

The Colorado judicial system has addressed substance use and mental health needs through specialty courts. It has established more than two dozen adult and juvenile drug treatment courts, drunk-driving courts, veterans' treatment courts, co-occurring disorders courts, tribal healing wellness courts, and hybrid courts for substance abuse and drunk driving. Colorado has been a national leader in ensuring that justice-involved individuals receive appropriate, effective treatment without undue risk to public safety.

The most sweeping legislative reform was Senate Bill 13-250, enacted in June 2013. The law reflects Colorado's evolving criminal justice response to drug abuse, reducing sentences and emphasizing treatment in lieu of incarceration. Provisions include the following: a simplification of the current drug sentencing structure to better differentiate between drug users and drug suppliers; sentencing options that recognize individual circumstances and provide more discretion to judges; increased use of drug courts, with priority for funding those that use evidence-based practices; and the identification of drug offenders for whom rehabilitation is the priority goal of sentencing. A judge has the following options: to substitute a misdemeanor conviction for a felony if the offender successfully completes a community-based sentence (which often includes drug treatment requirements); to impose residential drug treatment as a probation condition for drug misdemeanors; and to sentence those convicted of misdemeanor drug offenses to intensive supervision probation, if appropriate.

At the same time this new law went into effect in October 2013, Colorado expanded Medicaid eligibility for all persons whose income is less than 138 percent of the federal poverty level FPL). With the availability of additional federal funds, Medicaid expansion offers an opportunity for the state to increase access to substance abuse treatment. There is a widespread consensus that Medicaid expansion will cover a significant number of justice-involved individuals. Younger, unmarried, substance-abusing males disproportionately populate Colorado prisons, as well as add to parole and probation caseloads, and many in this subpopulation will be able to obtain Medicaid under the expansion.

As a result of sentencing reform and Medicaid expansion, the demand for community-based treatment and rehabilitation services for justice-involved individuals will increase. The behavioral health and community corrections systems will need to respond to this increased demand from those who would have been imprisoned prior to sentencing reform, and Medicaid expansion offers a means of funding this expansion. The capacity of the behavioral health system will be tested in several ways, and Colorado will need to answer several key questions in order to effectively plan for the future:

- Are there enough programs and providers to meet the increased demand?
- Are the services accessible to and effective with this target population?
- What structures are in place to support collaboration among behavioral health providers and the criminal justice system to implement alternative sentences?
- What risk-management policies and practices should be in place at every level – state, regional, and provider?
- Will specialty courts be able to serve the expected increase of defendants in need of treatment?

National trends

Nationally, two major changes are taking place. The population of justice-involved individuals identified as substance and alcohol abusers is growing. For example, while the percentage of adults incarcerated in federal, state, and local correctional facilities grew by 32.8 percent between 1996 and 2006, the percentage of substance-involved offenders increased even more, by 43.2 percent.[1] Second, more than half of the states, including Colorado, have expanded state Medicaid to cover the bulk of the justice-involved population. Subsidized insurance is also now available for persons who cannot afford the full costs of private insurance.

Justice-involved population and substance abuse disorders

The vast majority of justice-involved individuals experience problems related to the use of alcohol or other substances. The National Center on Addiction and Substance Abuse (CASA) at Columbia University reported in 2010 that 1.5 million of the 2.3 million inmates in U.S. prisons and jails met the DSM IV medical criteria for substance abuse or addiction.[2] Another 458,000 had histories of substance abuse, were under the influence of alcohol or other drugs at the time

of their crime, committed their crime to get money for drugs, were incarcerated for a drug or alcohol crime, or shared some combination of these characteristics.

Table 1. Substance-involved Inmates, by Correctional Institution[3]

Institution Type	Number of Substance-involved Inmates	Percent of All Inmates
State	1,101,779	84.6%
Local	648,664	84.7%
Federal	164,521	86.2%
All	1,914,964	84.8%

In general, a prison or jail inmate is seven times more likely than an individual in the general population to have a substance use disorder.[4] Women inmates are a little more likely to have a substance use disorder (66.1% vs. 64.3%).[5] About one in four prison or jail inmates has co-occurring mental and substance use problems, including more than 40 percent of women.[6]

These statistics are of concern to community behavioral health systems, because most people who are justice-involved are not incarcerated but living in the community, on parole or probation. *Parolees* are conditionally released from prison or jail by paroling authorities before their full sentence is completed and are then supervised by parole officers. In Colorado, the Board of Parole is the paroling authority for adults, and the Division of Adult Parole Supervision of the Department of Corrections administers parole. *Probationers* are conditionally released by a judge to the community directly after trial or plea and are supervised by probation officers. The Judicial Department administers adult and juvenile probation within Colorado's 22 judicial districts. This includes 23 probation departments, with more than 50 separate probation offices throughout the state. Nationally, taking into account those on parole or probation, it is estimated that 65 percent of adults in the U.S. corrections system meet criteria for drug and/or alcohol use disorders.[7]

Justice-involved population and the Affordable Care Act

The passage of the Affordable Care Act (ACA) made Colorado's expansion of Medicaid possible. This federal law expanded the availability of health coverage by providing support to purchase insurance from state and federal exchanges, as well as giving states the option of expanding Medicaid to cover greater numbers of low-income individuals and families. Prior to the ACA's passage, as many as 70-90 percent of the approximately 10 million individuals released from prison or jail each year were uninsured, compared to 16 percent of the general population.[8] Under the ACA, many justice-involved individuals will qualify for Medicaid in states (such as Colorado) that have chosen to expand coverage, and because Medicaid is partly federally funded, states may be able to save money by diverting people into Medicaid-funded treatment rather than costly incarceration.[9]

Even before Medicaid expansion, the criminal justice system was the biggest referral source nationally for substance abuse treatment. In 2002, 655,000 of 1.9 million admissions (36%)

were criminal justice referrals.[10] Yet, in 2006, only 35.4 percent of conditionally released offenders with substance use disorders received treatment, including 55.8 percent of women and 29 percent of men.[11] The gender disparity may be attributable to differences in Medicaid eligibility, among other factors. That year (2006), Medicaid paid for treatment for 16.2 percent of female conditionally released offenders, compared with only 6.5 percent of male offenders.[12] With Medicaid coverage more widely available under ACA, criminal justice systems are likely to be more successful in referring people to treatment, and justice-involved individuals may be more likely to seek treatment on their own.

With additional federal resources available through healthcare reform, state spending on treatment will have a greater impact on other system costs. Washington State estimated that it will save $2.58 in criminal justice costs for every dollar spent on treatment, and realize an overall $3.77 offset per dollar of treatment costs.[13]

Colorado-Specific Trends

Like many states, Colorado continues its shift from punitive measures for substance abusers to a more therapeutic approach, exploring alternative criminal-justice processes and programming to advance treatment, reduce recidivism, increase public safety, and lower costs. Recent trends show that Colorado is achieving significant and positive change.

Prison population projections predict significant decline

Even before the passage of Senate Bill 13-250, the Colorado Division of Criminal Justice projected that the adult prison population in Colorado would decline by 15.8 percent from 2011 (22,610) to 2018 (19,041); by gender, the number of male inmates was expected to decrease by 15.6 percent and female inmates by 17.6 percent.[14] To the extent that SB 13-250 encourages non-incarceration of drug offenders, the division's estimates may underestimate the rate of future prison-population decline.

Colorado prison populations began to decline in 2010 and 2011. The initial decrease was explained by a variety of factors. Census data reflect a downward shift in population growth for 24-44 year-olds in Colorado in the late 2000s.[15] Felony filings in Colorado state courts declined from 2005 to 2010.[16] During FY 2009, prison admissions fell 0.4 percent, and in FY 2010 they declined an additional 2.6 percent. For all prisons in Colorado, releases exceeded admissions in 2009 and 2010. Admissions from 2007 to 2011 reflect a 22 percent decline for those sentenced with a drug crime as their most serious offense. In FY 2011, admissions of all types declined an additional 7.2 percent.[17] Still, compared to the national picture, Colorado's incarceration rate of 506 per 100,000 in 2008 was much greater than the 50-state average of 462.[18]

Probation revocations are decreasing

A decline in new court commitments is partly due to a decrease in probation revocations,

including a 23.7 percent drop from 2006 to 2010.[19] During the same period, parole technical violations (such as missing a meeting with a probation officer) increased. However, because prisoners serving time for a technical violation have a shorter length of stay, the total number of inmates still declined.[20] This decline is expected to continue as the Division of Probation Services continues its efforts to reduce technical violations and to employ evidence-based practices that reduce reliance on re-incarceration for violators.

Overall parole rates are declining

The Colorado Division of Criminal Justice Correctional Population Forecasts also project that parole rates are expected to fall, much like prison population numbers. The decline is expected to be an average of 2.9 percent per year from 2013 to 2018, or a total of 15.2 percent, amounting to a total decrease from 8,181 to 6,941.[21]

Common disorders among justice-involved populations

Substance use disorders and mental illness are common among justice-involved populations. The latest statistics (2013) from the Criminal Justice Reform Coalition reveal that 74 percent of men and 87 percent of women incarcerated in Colorado state prisons needed substance use treatment. Additionally, 31 percent of men and 69 percent of women needed mental health treatment.[22] According to a 2011-12 report of offenders within the Colorado Department of Corrections, nearly one-third of inmates have co-occurring mental health and substance use disorders: 31 percent in 2011 and 32 percent in 2012.[23]

Frequent arrestees disproportionately have alcohol, substance use, and mental disorders and are likely to be homeless. Jail officials have turned their attention to repeat offenders of lower-level crimes who require more resources due to the volume of arrests. In January 2013, the Denver County Court System collected data to track the top 299 repeat offenders. The cohort consisted of individuals with the highest number of General Sessions court cases (an average of 36 per offender) from 2006 to 2012. The average age was 49 years old, and 95 percent reported homelessness. Of the top five charge categories, 41 percent of the total arrests were due to alcohol (30%) and drugs (11%).[24] These “frequent fliers” are a strain on the system because of their high use of expensive arrest resources, despite their relatively short time in custody.

No equivalent state estimates for substance use disorders and mental illness among justice-involved populations under community supervision exist. However, as noted above, about 65 percent of the justice-involved population meets criteria for drug and/or alcohol disorders. There is no evidence that prevalence in Colorado is less than that found across the rest of the United States. The latest National Survey on Drug Use and Health reveals that 3.96 percent of Colorado adults used an illicit drug other than marijuana in the previous month, compared to 3.36 percent nationally.[25]

Available treatment does not meet need

Colorado recently has made attempts to close significant treatment gaps. In 2001, Colorado had the lowest per-capita spending on substance use disorder prevention, treatment, and research out of 46 reporting states.[26] Yet the state made further cuts, and the FY 2004 budget for alcohol and drug services was 40 percent smaller than the previous year, and as a result, many outpatient services were completely eliminated.[27]

From 2010 to 2013, to address the lack of funds, the General Assembly appropriated approximately $8 million through cost savings achieved by House Bill 10-1352.[28] However, according to the Colorado Commission on Criminal and Juvenile Justice, significant treatment gaps still exist, especially for indigent offenders. Although the number of substance abuse treatment facilities increased between 2002 and 2014 from 389 to 474,[29] there remain few existing treatment providers able to give appropriate care for special populations who require unique services. Courts frequently recommend intensive treatment, and residential treatment facilities have a critical shortage of beds.[30] Female offenders are more likely to have high treatment needs, with 43 percent identified as needing residential treatment, compared to 26 percent of male offenders.[31] To the extent that S.B. 13-250 increases the demand for residential treatment in lieu of incarceration, the bed shortage will become more acute.

Medicaid expansion under ACA will benefit justice populations

Current research suggests that the majority of justice-involved individuals who abuse substances are responsive to treatment. However, in the past many were unable to access care due to a lack of health insurance coverage. In a Denver Sheriff's Department survey of approximately 4,000 inmates, 71.7 percent reported that they did not have healthcare coverage. For the inmates who reported they had coverage, almost 50 percent cited Medicaid as their provider.[32]

The percentage of justice-involved individuals who are insured is expected to increase as a result of Colorado expanding Medicaid eligibility for those with low incomes. The U.S. Government Accountability Office estimates that as many as 90 percent of Colorado state prison inmates are likely eligible for Medicaid due to the state's Medicaid expansion.[33] Additionally, those whose income disqualifies them from Medicaid may still qualify for tax subsidies, under the ACA, to purchase private health insurance from Connect for Health Colorado.

Although Medicaid does not cover services provided inside jails or prisons, Medicaid expansion still benefits people who are currently incarcerated. People can take advantage of services after they are released, or if they require hospitalization outside the jail or prison. Colorado passed legislation to suspend, rather than terminate Medicaid, which furthers both aims.

Colorado's policy obviates the need for retroactive billing for inmates after they are released

but not yet re-enrolled in Medicaid. It also allows the inmate to bypass the task of re-submitting an application and completing new eligibility determinations, with the intention of more continuous care after release.[34] Disruption in health care services and treatment upon returning to the community has been shown to increase recidivism rates for justice-involved individuals and lead to worse health and safety outcomes. Providing justice-involved individuals with health care coverage and connecting them with care in the community will reduce the use of emergency rooms and other costly means of accessing treatment.[35]

It is estimated that Colorado prisons similarly realized $2.5 million in savings for treatment of inmates outside their walls, through Medicaid coverage of non-prison hospitalization of inmates.[36] Colorado is obtaining federal funds for treating jail inmates in some counties in which it is economically feasible to institute Medicaid enrollment efforts. For example, in Denver County, which had more than 38,000 bookings in 2010,[37] two full-time employees assist defendants in completing Medicaid applications. The jail has experienced at least $300,000 in budgetary savings by shifting costs to Medicaid.[38]

Outside of the prisons and the Denver jail system, implementation efforts to obtain Medicaid funds for inmates include hiring and training staff to complete applications and upgrading eligibility systems. However, many of Colorado's 56 jails face unique challenges in taking advantage of Medicaid expansion. Jails in general experience a high rate of turnover. Jails are also characterized by uncertainty about when an inmate will be released. In some smaller counties, the administrative costs associated with enrolling inmates and claiming funds frequently exceed the funds that are obtained.[39] Further, it does not appear that the probation and parole systems have begun to connect their populations to healthcare through the ACA.

Colorado's problem-solving courts serve only a fraction of those who could benefit

Colorado currently has a robust network of problem-solving courts. However, these courts serve a very small percentage of probationers in need of substance abuse treatment. Regina Huerter, the Treatment Working Group chair and commissioner of the Colorado Commission on Criminal and Juvenile Justice reported that, in 2014, "the Colorado drug courts served about 700 clients with 146 of them eventually graduating." The specialty courts have specific criteria for program eligibility that intentionally limits admission. Among other requirements, clients must enter a plea to gain admission and agree to follow drug-court rules. Although in need of treatment, many defendants are not willing to comply with these admission criteria.

The current model of drug courts in Colorado is not designed to serve the vast majority of probationers in need of treatment. As of Jan. 1, 2013, there were 22 probation departments in Colorado serving about 77,793 probationers, of whom 53,991 were placed in the prior year. There were 11,458 parolees, of whom 8,716 were placed in the prior year.[40] Based on national percentages, this would suggest that about 27,000 Colorado probationers have alcohol use disorders and almost 24,000 have substance use disorders. In order to serve everyone in the criminal justice population who is in need of treatment, Colorado would have to add an

additional 700 drug courts.

At least some officials involved in drug courts state that they do not think these courts have the resources to expand beyond their current capacity to absorb all of the defendants needing treatment. Although a state official declared that the drug courts do not presently turn people away, the official readily acknowledged that "drug court services are pretty maximized."

Colorado's behavioral health system serves only a fraction of justice-involved individuals who could benefit

In a Colorado Public Behavioral Health System and Services Inventory conducted by the Western Interstate Commission for Higher Education's (WICHE) Mental Health Program, 19 providers reported serving only 1,035 justice-involved clients in the last fiscal year. This reported number is far below the suspected number of justice-involved individuals who are in need of treatment. Some providers expressed concerns regarding Medicaid eligibility for prenatal services, primary care, and individuals who have been charged with escape, citing these as potential high-needs/gap areas that need to be addressed. Other providers lamented the lack of Medicaid benefits for substance-use disorder treatment in a residential setting. While all agencies participating in the WICHE inventory reported adequate capacity to treat all referrals from specialty courts, it is unclear how they might be able to accommodate an increase in referrals.

Other officials also report that the problem-solving courts in Colorado are not fully integrating their work to maximize benefits with existing healthcare systems. This may result in extreme pressure on specific treatment resources, including residential beds. According to one source, this pressure is being addressed by Denver County justice professionals, who recently entered into arrangements with major behavioral health treatment providers to build treatment capacity. Another source reported that all clients in the Recovery Court Program are enrolled in Medicaid today, compared to only about 18 percent at its inception.

Experiences in other states

In an effort to maximize positive outcomes for Colorado systems, it is advantageous to observe the process of drug sentencing reform legislation and ACA implementation in other jurisdictions. Two states' experiences may both inform future policy and suggest the future impact of Colorado's reform laws.

Drug policy reform implementation in New York City

Attempting to curb lengthy prison sentences and racial disparities for felony drug offense cases, New York enacted laws in 2009 that effectively ended the mandatory minimums of the 1973 Rockefeller Drug Laws. Much like Colorado, New York chose to increase diversion and eligibility for treatment for those possessing, using, or selling small amounts of controlled substances.

Eligibility is determined in two steps: first, through a legal evaluation and then through a clinical screening.

The Vera Institute of Justice examined the law's effects in New York City. The institute compared a sample of defendants arrested for felony drug offenses or indicted on specified property charges in 2008 with another sample with similar arrest offenses in 2010, after the drug law reform was enacted. This study revealed the following:

- Only one in five eligible defendants was actually enrolled in treatment.
    - Eligible defendants in 2010 were still more likely to receive a custodial sentence than treatment.
    - Prosecutors continued to exercise a great amount of sway over case outcomes.
    - Defendants can still refuse treatment.
- Diversion did increase, especially for those with a higher level of needs.
    - After the new laws were enacted, New York City experienced a 35 percent rise in the rate of diversion citywide.
    - Diverted defendants were more likely to self-report heroin and cocaine use and had more extensive criminal histories.
    - Prison sentences declined by 7 percent, , jail sentences declined by 10 percent, time-served sentences declined by 16 percent, and split sentences declined by 27 percent.
- In just two years, racial disparities in sentencing between blacks or Hispanics and their white counterparts were halved.
- Diversion has improved public safety.
    - About 64 percent of the treatment sample was not re-arrested over a two-year period, which translates to a 36 percent recidivism rate, vs. a 54 percent recidivism rate for those not receiving treatment.
    - Diverted defendants were arrested fewer times on average and had fewer felony arrests.
    - Only 3 percent of the treatment group in 2010 was re-arrested for a crime of violence, vs. 6 percent in a pre-drug reform group sentenced to prison, jail, or probation.
- Those who were not diverted received longer sentences in both jail and prison.
- Overall, defendants in 2010 were more likely to be indicted and convicted because prosecutors were less likely to offer a lesser charge through plea agreements.
- Drug law reform increased the number of defendants diverted to residential treatment, their average length of stay in treatment, and treatment costs.
    - Diversion from custodial sentences and reduced recidivism saved the justice system $6.4 million and $9.5 million in victims costs. However, the justice system also experienced an increase of $23.2 million in treatment costs, resulting in a net loss of $7.3 million.

- Courts may be misusing residential treatment as a punitive measure to restrict a defendant's independence instead of meeting treatment needs, and residential treatment may not be covered by Medicaid.

More information is available from the Vera Institute of Justice at:
http://www.vera.org/pubs/drug-law-reform-new-york-city

Large-scale enrollment of justice-involved populations in California

Due to a combination of legislation, new funding streams, organizational facilitation, and Medicaid expansion, California has experienced ACA enrollment in its justice system that is higher than other states. Specifics include:

- Expanding eligibility for Medicaid
- Expanding Medicaid substance abuse benefits
- A law (AB 720) allowing jail-based Medicaid enrollment
- A 2011 law (AB 109) shifting responsibility for many nonviolent offenders from the state to the counties
- Medicaid-funded wrap-around services for new and existing probationers
- Increased jail health care budgets
- Technical assistance to counties, public safety officials, and corrections officials
- A law (AB 82) supporting grants for Medicaid outreach to vulnerable populations.

California counties are currently targeting jail and probation populations for enrollment assistance. Without training and other information urging counties to specifically target the justice population, counties likely would have opted to use some of the funds for other purposes. The funding streams for these projects, alone or in combination, include:

- AB 82 grants from the state for vulnerable populations (including reentry, homeless, and substance abuse)
- Public Safety Realignment funds, which can be used for virtually anything related to local public safety
- Regular Medicaid administrative funds provided by the state
- County general funds
- Covered California (state insurance marketplace) in-person assistance program.

Some California counties are already beginning to see positive results in cost savings and their ability to connect clients to appropriate services. As of July 2014, Yolo County saved more than $100,000 through Medicaid financing of behavioral health treatment for probationers. In Sacramento County, nurses assess everyone released to probation from state prison or the local jail for eligibility and connect them to community health services. In Alameda County, the health services department connects people leaving the county jail to community clinics. More information is available from Californians for Safety and Justice at:
http://libcloud.s3.amazonaws.com/211/ac/6/484/CountyEnrollmentSurvey_singles.pdf

Recommendations

Colorado's drug sentencing reform efforts and adoption of ACA resources for justice-involved individuals are both relatively new. It is clear that both will have significant impact on justice-involved populations in need of treatment, but the full impact will require more time to assess. Outcomes will depend on how successful criminal justice agencies, particularly probation offices, are at enrolling the thousands of defendants now eligible for Medicaid or appropriate health insurance and how the courts intend to take advantage of the ACA to expand treatment opportunities to those not currently served by specialty courts. Further, it is not yet known whether treatment providers will adapt their treatment to meet the special needs of this population or simply demand this population adapts to what they already offer.

Across the nation, some insurance providers have balked at covering court-ordered treatment that is not prescribed by recognized medical authorities. This may be a particular issue if courts routinely substitute residential treatment for incarceration. Further, the Medicaid Institute for Mental Disease (IMD) exclusion has long been a barrier to the use of federal Medicaid funds to pay for services provided to patients in residential substance use disorder treatment facilities that have more than 16 beds.[41] Unfortunately, the ICD-9-CM classified substance use disorders as mental disorders.

There are strategies that administrators, staff, and other stakeholders can employ in order to maximize their efforts and ultimately succeed in realizing the full potential of the state's drug reform efforts and the ACA.

1. **The criminal justice population is unlike most other clients seeking treatment.** They are usually court-ordered and require additional resources and/or multiple treatment episodes in order to truly recover and maintain a healthy lifestyle. Their criminogenic needs must be addressed as well as clinical needs. **Behavioral health treatment providers and criminal justice stakeholders must collaborate.** This is a relatively new population for many treatment providers. If expanded treatment capacity is required, new providers will have to be included and educated on the intricacies of this population. They will also need to be aware of the separate terms that they use (e.g., offender vs. client) to foster greater understanding between the two systems and to break down preconceived notions. Together, they can press for targeted case-management programs specifically for justice-involved populations. The systems must also collaborate on funding: While not all criminogenic needs are covered by Medicaid, some such as anger management are.

2. **Healthcare and criminal justice systems are large, bureaucratic organizations that have historically remained separate.** New resources under the ACA, especially the expansion of Medicaid, create opportunities for both sets of stakeholders, but they must work together. In the past, criminal justice and healthcare systems have existed in separate "silos." To ease referrals, the two must create a mutually advantageous

relationship; and to facilitate positive outcomes, all actors must be involved in planning, implementing, and sustaining programs. This will help to dispel fear or apprehension, promote cooperation, create a culture of care around individuals, and produce mutual goals for all involved. For example, behavioral health systems can educate courts and prosecutors about the benefits of community-based treatment, as opposed to residential treatment, which may be overused.

3. **Resources for treatment and healthcare providers remain low.** In order to provide the specialized supervision necessary for the increased caseload created by drug sentencing reforms, the state, drug, and specialty courts will require increased judicial resources. While the ACA makes federal resources available, in 2017 the state will begin to assume a greater burden for financing Medicaid. It is imperative that stakeholders seek other funding streams as well. Being able to prove the concept through data collection and reporting and securing additional resources is important. A sustainability plan to ensure the longevity for projects is also advisable.

4. **There are too few resources to adequately treat and serve all of those in need.** There are high needs, few resources, not enough treatment, and not enough detox services. This problem is not fully solved by Medicaid coverage. In many cases, Medicaid does not provide treatment allowances in-network for services that are court-ordered. For behavioral health services, clients must have a covered diagnosis and go to specific providers, and the treatment must be deemed medically necessary. These processes need to be simplified and streamlined to create better service.

5. **There is a disincentive for treatment providers to become Medicaid treatment providers.** As contractors with various criminal justice entities, many behavioral healthcare providers receive set rates. However, Medicaid may only pay a portion of those rates. As more probationers and parolees obtain Medicaid coverage, the courts and other administrators must be aware of and able to interpret the changes, and can adjust accordingly. It is especially important to consider treatment capacity when assigning conditions of release. Courts might wish to consider appointing an expert, or a liaison with the behavioral health system, who can determine whether court recommendations for intensive treatment are appropriate and capable of being fulfilled.

6. **Specialty courts have been primarily responsible for the management of drug offenders.** The judiciary may have to explore a broad-based strategy to handle offenders with drug treatment needs. It is necessary to increase the capability and the utility of *all* courts and criminal justice systems. Prosecutors' offices should reassess their culture to ensure that prosecutors are recommending diversion in appropriate cases. Judges should be prepared to recommend diversion when appropriate, even when it conflicts with prosecutors' wishes. Expanding the specialized knowledge of substance use disorders not only assists in improved ability to serve, but also increases buy-in for various participants in the process.

7. **Clients are receiving care while under correctional supervision, but they may not be accessing care after discharge.** Because of the additional risk for the population after release, they need to receive special attention and involved planning for accessing care in the community. Enrollment to receive healthcare benefits is just the first step toward ensuring the long-term use of care and sustained[42] recovery. Continuity of care and the lessening of healthcare gaps decrease relapse, overdose, and other chronic health conditions. It is necessary for criminal justice employees and treatment providers to cooperate with one another to close these service gaps. This effort can include processes on the front end through discharge planning, proactive involvement, and follow-up case management. The use of medication-assisted treatment, including injected naltrexone, will not only address the heightened risk of drug overdose deaths for re-entering inmates within the first 30 days, but also will enhance treatment outcomes thereafter.

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Acronyms

ACA Affordable Care Act
ACT Advancing Care Together
ACC Accountable Care Collaborative
ACT Assertive Community Treatment
AHRQ Agency for Healthcare Research and Quality
AOD Alcohol and Other Drug Dependence
ATU Acute Treatment Unit
BHO Behavioral Health Organization
BHTC Behavioral Health Transformation Council
CBHC Colorado Behavioral Healthcare Council
CCAR Colorado Client Assessment Record
CDHCPF Colorado Department of Health Care Policy and Financing
CDHS Colorado Department of Human Services
CDOC Colorado Department of Corrections
CDPHE Colorado Department of Public Health and Environment
CMB Colorado Medical Board
CMHC Community Mental Health Center
CMHIFL Colorado Mental Health Institute at Fort Logan
CMHIP Colorado Mental Health Institute at Pueblo
CMS Centers for Medicare and Medicaid Services
CMWN Colorado Mental Wellness Network
CORHIO Colorado Regional Health Information Organization
CTN Colorado Telehealth Network
CTWG Colorado Telehealth Working Group
EBP Evidence-based Practices
EHR Electronic Health Records
FACT Forensic Assertive Community Treatment
FQHC Federally Qualified Health Center
HCBS Home and Community Based Services
HCPF Health Care Policy and Financing
HIE Health Information Exchange
HMO Health Maintenance Organization
HRSA Health Resources and Services Administration
IMD Institutions for Mental Disease

IPS/SE Individual Placement and Support/Supported Employment
JBBS Jail-based Behavioral Health Services
LTSS Long-term Services and Supports
MCO Managed Care Organization
NAMI National Alliance on Mental Illness
NASMHPD National Association of State Mental Health Program Directors
OBH Office of Behavioral Health
PASRR Pre-admission Screening and Resident Review
PATH Projects for Assistance in Transition from Homelessness
PBHCI Primary and Behavioral Health Care Integration
PCMH Patient Centered Medical Home
PDMP Prescription Drug Monitoring Program
PSH Permanent Supported Housing
RCCO Regional Care Collaborative Organization
SAMHSA Substance Abuse and Mental Health Services Administration
SED Serious Emotional Disturbance
SHAPE Sustaining Healthcare Across Integrated Primary Care Efforts
SMHA State Mental Health Agency
SMI Serious Mental Illness
SPMI Serious and Persistent Mental Illness
SSA Single State Authority
SUD Substance Use Disorder
TBI Traumatic Brain Injury
TJC The Joint Commission
VPN Virtual Private Networks

Literature Review

Continuum of Behavioral Health Services - Ideal service array

At present, Colorado has both lower penetration and utilization rates for civil inpatient and community public mental health services compared with national averages. [1] Furthermore, Colorado has slightly higher state hospital 180 day re-admission rates for both civil children and adults compared with national averages.[2] These facts indicate the importance of developing a more comprehensive service array within public mental health programs within Colorado.

The 2011 SAMHSA "Description of a Good and Modern Addictions and Mental Health Service System" serves as a starting point for policy-makers and stakeholders regarding array of services in respects to programming, reimbursement, and infrastructure.[3] It states, "A modern mental health and addiction service system provides a continuum of effective treatment and support services that span healthcare, employment, housing, and educational sectors. Integration of primary care and behavioral health are essential. As a core component of public health service provision, a modern addictions and mental health service system is accountable, organized, controls costs and improves quality, is accessible, equitable, and effective."[3] Additionally, the draft states that an array of services must incorporate the concepts of health promotion, prevention, screening and early intervention, care management, self-help and mutual support, community integration and social inclusion, provide services across the lifespan, support health literacy, and incorporate quality and performance managment.[3] Table 1. is an illustration of such an array of services, as provided in the draft report.

Table 1. Description of a Good and Modern Addictions and Mental Health Service System [3]

Healthcare Home/ Physical Health	Prevention (including Promotion)	Engagement Services	Outpatient Services	Medication Services	Community Support (Rehabilitative)	Other Supports (Habilitative)	Intensive Support Services	Out-of-Home Residential Services	Acute Intensive Services	Recovery Supports
• General and specialized outpatient medical services • Acute primary care • General health screens, tests and immunization • Comprehensive Care management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention/ Wellness Recovery Support • Warm line	• Assessment • Specialized Evaluations (psychological, Neurological) • Service planning (including crisis planning) • Consumer/Family education • Outreach	• Individual Evidenced Based Therapies * • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case Management • Behavioral management • Supported employment • Permanent Supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	• Personal Care • Homemaker • Respite • Supported Education • Transportation • Assisted Living Services • Recreational Services • Interactive Communication Technology Devices • Trained behavioral health interpreters	• Substance abuse intensive outpatient services • Partial hospital • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization service • 24/7 Crisis Hotline Services	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care • Continuing Care for Substance Use Disorders

The following paragraphs are an overview of programming which build upon these principles and can serve as examples of programming within an ideal service array. Regarding inpatient

hospitals, the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council Report recommends that state hospitals have "discrete locations for individuals requiring hospitalization for mental illness, people with criminal behavior driven by mental illness, and people with criminal and predatory behavior with no mental illness" – speaking to the need for specialized services for these distinct groups within inpatient hospitals.[4] The report further elaborates stating that psychiatric "hospitals are a vital treatment component in the healthcare system to assess, evaluate, and treat the most complex mental health and substance use conditions and should include the expectation of discharge to a continuum of a robust set of community supports."

Many states, including Colorado, have initiated Assertive Community Treatment (ACT) Programs – an evidenced based community treatment program. A number of studies have illustrated that ACT increases utilization of services and decreases dropout within public mental health settings both domestically and abroad. [5, 6, 7] A number of states including Rhode Island, Washington, and Ohio have implemented specialized versions of the ACT program including: ACT II (a less resource-intensive model for individuals who do not need the full level of ACT services) and FACT (serving individuals with serious mental illness following the release from prison). In addition, researchers have found that the implantation of ACT in concert with Integrated Dual Disorder Treatment (IDDT) significantly decreased the severity and frequency of individuals with severe mental illnesses and significantly increased these individuals stable housing.[6] These programs speak to the importance of catering public mental health programs to meet the demands of a wide range of consumer needs.

Additionally, the integration of primary care, mental health and addiction services are an essential component of a comprehensive service array.[3] A number of states including Connecticut, Maine, Maryland, Massachusetts, Minnesota, Ohio, New York, Oklahoma, and Oregon have initiated programs to address the medical needs of individuals with mental illness, recognizing the premature death rate of individuals with mental illness due to physical health conditions.[3] An example of such programming is the inclusion of nurses in community mental health institutions to screen and identify individuals with physical health symptoms such as cardiovascular disease & diabetes, as found in the state of Massachusetts.[8] These community health centers provide primary, preventative, dental, mental health, substance abuse, and other community based services. Currently, 49 community health center organizations exist in Massachusetts that "excel at providing preventive care and chronic disease management in lower cost community settings. These savings are passed onto the state's Medicaid program and other insurers."[7] Additionally, the program also links mental health and physical health records to promote more holistic and integrated care with the rise of community health centers.

A 2014 literature review found that Intensive Outpatient Services (IPO's) serving individuals with substance abuse and co-occurring mental and substance disorders are as effective as inpatient treatment for most individuals (excluding patients who required medical detoxification or 24 hour supervision).[9] The review also recommended that public and commercial health plans consider IOP services as a covered health benefit.

Other innovations in respect to continuum of care in public mental health systems include the implementation of crisis access lines, which provide 24/7 support via telephone to individuals with mental health concerns. Georgia's Crisis and Access Line (GCAL) is a single point of access for all of public mental health services that's available 24/7. [10] Callers can access both immediate assistance, via on call clinicians for mental health related crises, or be referred *and scheduled* to community-based services in their local community. The goal of these services is to assist individuals in crisis and to facilitate access to community-based services closest to consumers' residence in the least restrictive setting. Expanding upon these services, GCAL includes a statewide mechanism for tracking available psychiatric beds in real time, working with both inpatient psychiatric hospitals and emergency departments making accessing and monitoring these resources a much more streamlined process.

In addition, Peer Support Services (PSS) are an expanding part of the continuum of care. Peer Support Services have been deemed as an evidence-based reimbursable model of care by both the Centers for Medicare and Medicaid Services.[11] Peer mentorship programs offer numerous benefits including: benefits for the peer mentors, decreased substance use among co-occurring substance abuse populations, decreased utilization of emergency services, increased engagement in treatment, and reductions in overall treatment costs. [12, 13]

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Literature Review

Whole Health Integration

This review examines some of the issues associated with the integration of primary and behavioral health care. Integration takes various forms, some of which are simple, and others of which are comprehensive. Also included in this review are some of the barriers to integration, ways to overcome these barriers, and financing strategies.

Components of Integrated Care

Strategies to advance integrated care range from free-standing coordination mechanisms such as universal screening and patient navigators to full service and fiscal system integration.[1] Each level of integration strategies is associated with a specific set of likely benefits, as well as likely financial and implementation challenges.[2] Key components of fully integrated care include cross-discipline care teams charged with coordination of the full complement of primary and behavioral health services needed by recipients; real-time access to health information among all team members; and processes for assessing and incentivizing care quality, including alignment of quality incentives across physical and behavioral health disciplines.[3] While a fully integrated system stands as the ideal, simple, stand-alone strategies can yield significant gains in care quality and coordination, particularly in settings with a baseline characterized by high levels of fragmentation,[4] and a tiered or incremental approach may be the most feasible for many care systems.[5]

Tools incorporated into integration initiatives include provider education, primary and behavioral health staff co-location, advancement of patient self-management, care or case management, facilitation of staff coordination and communication, and funding integration.[6] Implementation of each of these tools may vary considerably from initiative to initiative. For example, patient navigator services are just one mechanism for achieving care management, and these services in turn may be limited to a linkage function or may be more expansive and include advocacy, support coordination, and engagement facilitation.[7] Specific strategies selected are dependent upon system characteristics and interests, including policy and funding resources and constraints, provider capacity, and features of the target population. In practice, integrated care programs tend to draw from multiple integration models rather than one single model, and as a result vary on a number of key dimensions, including degree of service co-location, systems shared across behavioral and primary service providers, and organizational culture/orientation to system integration.[8]

Barriers to Integrated Care

Siloed service systems and funding mechanisms are frequently identified among the top challenges to integrated care, with service system division often resulting in challenging policies and procedures at both the system and organization level.[9] The need for workforce development is also often cited as a challenge to integration,[10] and it is accompanied by the need for resources to support ongoing monitoring of fidelity to newly implemented practices.[11] Additionally, providers tasked with delivering integrated care must frequently overcome challenges related to time constraints and role definition and conflict between behavioral and primary health staff. These are not challenges that are resolved through one-time solutions. Rather, they require ongoing attention, as collaboration initiatives grow and

change.[12] Many of these challenges were identified by programs funded through SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) initiative. These programs reported experiencing difficulty achieving financial sustainability, limited cross-team communication, problems establishing an organizational culture supportive of integrated care, and lower-than-expected rates of consumer enrollment in integrated services.[13] Additionally, consumers receiving services from PBHCI-funded programs in rural areas experienced lower access to integrated care than those receiving services from programs in non-rural areas.[14]

Integrated Care Facilitators

Integrated care initiatives may take many forms but may still share features that facilitate success, such as a strong conceptual framework and belief in the value of whole-patient care, a focus on processes and mechanisms that support communication, and prioritization of sustainability and funding.[15] Leadership support is also a key factor in successful integration, with resource allocation, role definition, and conflict resolution being critical areas for leadership intervention.[16] Process and impact assessment is critical and requires the early establishment of measurable service model fidelity standards and outcome indicators.[17]

Buy-in can be facilitated by an organizational "integration champion" with strong advocacy skills and the capacity to relate to provider, finance, and management personnel. This individual's message should center on the evidence supporting integrated health care and real-world integrated care success stories.[18] Additionally, cross-discipline collaboration is required at the leadership as well as provider level.[19] Involvement of both primary and behavioral healthcare staff from the planning and design phases forward can both promote the development of a stronger service model and enhance cross-discipline buy-in.[20] Similarly, involvement of financial and management personnel helps to ensure that the new service model will be fiscally and administratively feasible.[21]

Technology is often cited as an integration facilitator, with specific technology-based solutions to commonly encountered integration barriers including telepsychiatry; web-based screening; web-based provider tools (e.g., resource and referral guides); use of electronic and telecommunications to foster mentorships and other relationships between cross-disciplinary staff who are not co-located; and patient self-management tools designed for personal electronic devices.[22] Improvements in health care information sharing and health information technology capacity have been offered as key recommendations for facilitating integration, [23] and the Patient-Centered Outcomes Research Institute identified research questions regarding the comparative utility of technology-based behavioral health services as a critical area of inquiry in support of integrated care.[24]

The ACA contains a number of provisions conducive to the establishment and expansion of integrated care.[25] For example, medical homes and accountable care organizations are well-suited to facilitating the management and financing of integrated health care; integration is further supported by new infrastructure elements such as the Community-based Collaborative Care Network program and the Federal Coordinated Care Office; and grant funding expands the availability of primary health care services co-located in behavioral health care settings, as well as supporting workforce development related to care integration and chronic illness team management.[26]

Trends in Financing Integrated Care

With funding among the most frequently cited obstacles to integration, financing strategies become an essential component of integration success. The following represent a selection of financing approaches currently utilized or under consideration by systems carrying out integration initiatives.

Section 2703/Medicaid Health Homes

Section 2703 of the ACA created a Medicaid State Plan Option to implement health homes for Medicaid beneficiaries with serious mental illnesses or other chronic conditions. Medicaid health homes are, at a minimum, required to provide comprehensive care management, care coordination, health promotion services, transitional care and follow-up after discharge from inpatient settings, individual patient and family support, and referral to social support and community services. Additionally, health homes are expected to use health information technology to link services. At this time, 16 states have submitted and received approval to implement one or more state plan amendments (SPAs) creating health homes for a defined population of Medicaid beneficiaries.[27] Similar activity is under consideration in other states, as well: The Michigan Workgroup on Mental Health and Physical Health Integration and Service Delivery recently recommended that Michigan pursue a Section 2703 SPA.[28]

Maximizing Medicaid Billing

Regulations regarding allowable services, staff credentials, and circumstances for Medicaid billing vary from state to state. At the provider level, Medicaid billing options can best be utilized by understanding the state's Medicaid billing policies and the degree to which current or planned integrated services match state requirements for billable services.[29] At the state level, Medicaid reimbursement to providers can be maximized by "activating" or "unlocking" federally allowable Medicaid billing codes that support reimbursement of behavioral health services.[30]

Global Payment Models

Global payments or global capitation are intended to cover the costs of a comprehensive set of services that may be required by members of a population over a set period of time.[31] While all payment models are associated with both advantages and disadvantages in relation to quality of care overall and integrated care in particular, one key advantage of fully capitated models is the flexibility they allow in terms of service array and the incentive to minimize the need for high-cost interventions through case management, prevention and wellness initiatives, and disease management.[32] In the interest of testing a global payment model for integrated care, a partnership including the University of Colorado Denver has launched the Sustaining Healthcare Across Integrated Primary Care Efforts (SHAPE) study. SHAPE is a three year pilot intervention currently in place in three family practice organizations in communities in Colorado's western slope. These organizations are provided with a global payment for behavioral healthcare, with added incentives based on patient outcomes. Three control sites are providing services reimbursed on a fee for service basis.[33]

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Literature Review

Behavioral Health Service Delivery for Specific Populations: People with Co-occurring Intellectual Disability/Developmental Disability, Traumatic Brain Injury, Dementia or being served by the Department of Corrections, Juvenile Justice, Education Systems.

A comprehensive source of specialized services for individuals with co-occurring intellectual disability/developmental disability (ID/DD), traumatic brain injury (TBI), and dementia being treated in public mental health systems is not readily available or easily accessed. This is largely due to the wide variance of programs from state to state and the lack of resources that compile these data. A review of relevant literature and resources provides a foundation of the unique demands of the above-mentioned co-occurring populations within mental healthcare systems and serve as a guide to meet the service needs of these populations.

Co-Occurring ID/DD

First, the conservative estimation of individuals with co-occurring ID/DD and other mental health disorders is 33%, with a number of sources reporting much higher rates.[1] The high rates of co-occurring ID/DD are attributable to the difficulties with communication, adaptive functioning, and social isolation experienced by many individuals with ID/DD.[1, 2] The presence of co-occurring disorders in addition to ID/DD complicate treatment, limit available services, and restrict treatment opportunities .[2]

It is estimated that approximately 5% of individuals treated in state hospitals present with ID/DD, of which 80% present with a co-occurring disorder.[3] Despite this fact, only 7% of this co-occurring population is served in state hospital units that specialize in treatment of both presenting conditions.[3] As discussed by the Oregon Technical Assistance Corporation, co-occurring ID/DD populations are divided into two major groups: people with a primary diagnosis of intellectual disability/developmental disability, with mental health as secondary; and people with a primary diagnosis of mental illness, and developmental disability as secondary.[4] Individuals with a primary diagnosis of ID/DD typically access care through community ID/DD resources, while those with mental health as the primary diagnosis, access care through more traditional community mental health resources. It is noted that individuals with co-occurring ID/DD and mental illness can at times "fall through the cracks" of these two distinct service systems which have separate financing, provider networks, and advocacy organizations.[3]

Co-Occurring TBI

It is estimated that the majority (roughly 90%) of individuals living with traumatic brain injuries present with co-occurring mental health disorders.[5] Research has indicated that the average annual cost is nearly four times greater for Veterans diagnosed with a TBI than those without.[4] Accordingly, a number of states have specialized programming for individuals with TBI's; however, very few specific programs exist for co-occurring TBI populations. Due to the unique treatment needs of individuals with TBI, treatment is typically catered towards individuals with co-occurring disorders within their TBI treatment programs, most prominently for individuals with moderate to severe TBI's. For example, the Rehab Department of Alabama provides information and resources regarding the identification of co-occurring TBI; however, does not list specific resources for this population.[6] Rather, it is recommended that

individuals contact their brain rehab injury program, or community resources to address the secondary condition (i.e. community mental health centers, counselors).

Additionally, in 2013 an expert panel convened to discuss the best practices for identification and treatment of Veterans with TBI seeking care in Colorado.[7] The panel reached consensus regarding the importance of standardized screening tools, the provision of holistic care (i.e. identifying and treating both TBI and the co-occurring disorder appropriately), and the implementation of evidence based practices when treating co-occurring TBI populations. The panel also discussed many of the barriers to treatment for co-occurring TBI populations including the lack of resources and the lack of specific training for mental health practitioners. While the panel primarily focused on Veteran populations, much of the content is applicable to non-Veterans.

Dementia

Individuals living with dementia also present unique demands within public mental health system. With the exception of individuals with severe co-occurring mental health disorders, individuals living with dementia are typically not treated within the state hospital system. Rather, this population is served in assisted living or nursing homes / long-term care facilities. [8] It is estimated that the number of individuals living with dementia will double by 2030 and more than triple by 2050.[9] As such, it is likely that rates of co-occurring dementia will also significantly increase. A variety of levels of care exist for individuals and caregivers affected by dementia; however, very few specific programs exists for co-occurring dementia populations. As discussed by the Alzheimer's Association,[10] adult day centers, in-home care, residential care, respite care, and hospital care services are available to individuals affected by dementia. Most individuals with co-occurring dementia receive care within these settings, rather than through specific programming. While not specifically designed for co-occurring dementia populations, such programming is likely to reduce the development of and decrease the symptomology of co-occurring disorders.

The Wisconsin Department of Health Services Division of Long Term Care implemented a state wide redesign of its care for individuals living with dementia.[11] The plan's strategies are divided into five main groups: Community Awareness and Services (including programs to foster better understanding of, and early identification of dementia); Facility Based Long Term Care (to address the shortage of, and barriers that deter facilities from admitting dementia patients); Care for Individuals with Significant Changing Behavior (expand crisis response and stabilization programs); Dementia Care Standards and Training (effort to catalogue and publicize existing dementia training and develop standards of care); and Research and Data Collection (inventory providers and analyze costs of strategies outlined in plan). The state of Oregon also implemented a similar plan to assist with awareness, increase ease of access (with a single point of entry), and ensure quality and cost effective care of individuals living with dementia.[9]

People with Behavioral Health Needs in Department of Corrections, Juvenile Justice, and Educational Departments

Department of Corrections

Nationally, very few specific department of corrections programming exist for individuals with co-occurring intellectual disability/developmental delay (ID/DD), traumatic brain injury (TBI), and dementia.

While most states have mental health programs within jails/prisons, most do not possess specific programming for these co-occurring populations.

To begin, an example of specific programming for inmates with ID/DD can be found within the Michigan Department of Corrections.[12] While the Adaptive Skills Residential Program (ASRP) is not exclusively designed for individuals with co-occurring disorders, it includes a number of inmates with co-occurring ID/DD. The program's goal is to "to improve the functioning and self-management of prisoners with developmental disabilities/cognitive limitations so they can adapt to the prison setting, decrease the likelihood of being victimized, becoming disruptive, or engaging in behavior which could result in a reclassification to administrative segregation, or to prepare them for community re-entry." While not specifically designed for co-occurring ID/DD populations, this support is extended to individuals with co-occurring ID/DD and is likely to reduce the risk of the development, as well as management of co-occurring symptomology.

It is estimated that the majority of individuals with TBI's and dementia's experience co-occurring disorders, however very few department of corrections institutions offer specific programming for these populations. [13, 14, 15, 16,] As such, it appears that many inmates with co-occurring TBI and/or dementia's are treated in programs that are not specifically designated for co-occurring populations. One example of a dementia specific program is the Special Needs Program for Inmate-Patients with Dementia (SNPID) in California.[19] The program consists of a standalone unit with an altered physical environment (i.e. name tags, pictorial information). The unit is staffed by individuals trained to work with this specific population and serves as a successful model for increasing independence and functioning of incarcerated individuals in the prison setting with psychosocial and environmental interventions. This in turn may decrease the development and/or symptomology of co-occurring disorders among incarcerated individuals with dementia by creating a greater sense of safety and a more comfortable living environment.

Juvenile Justice

An estimated 70% of justice-involved youth have disabilities including psychiatric, mental health, sensory, intellectual, and co-occurring disorders.[17] A wide variance of mental health programming exists for youth in the juvenile justice system; however, very few are specifically designed to meet the needs of individuals with co-occurring ID/DD and/or co-occurring TBI's. [18] In 2014, the National Center for Mental Health and Juvenile Justice released several electronic and interactive resources regarding co-occurring mental health and substance use disorders among youth involved in the juvenile justice system.[19] This resource includes a new Collaborative for Change Resource Package with information regarding the prevalence, identification, and treatment of co-occurring disorders of youth in the juvenile justice system, webinars addressing youth with co-occurring mental health and substance use disorders, and "Ask the Expert" sessions which allow providers the opportunity to ask questions of national experiments on the topic of co-occurring juvenile populations. Additionally, a number of states including Arkansas and Kentucky, have adopted screening and diversion programs for youth with co-occurring mental health and substance use disorders that come into contact with the juvenile justice system.[20] These programs have increased communication and collaboration between juvenile justice and community mental health resources, allowing for greater access to care amongst youth with co-occurring disorders that enter the juvenile justice system.

Education Department

It is estimated that 35-40% of children and adolescents with ID/DD also have a co-occurring mental health disorder;[21] however, limited specific programming exists for this population.[22] The Individuals with Disabilities Education Act (IDEA) is the nation's federal special education law that ensures public schools serve the educational needs of students with disabilities. This includes the provision of at home early intervention services for infants, toddlers, and their families. While treatment is catered to the individual child and family's needs, few programs are designated specifically for co-occurring mental health and ID/DD interventions. Additionally, IDEA requires that schools provide special education services to eligible students as outlined in a student's Individualized Education Program (IEP).[23] While services are extended to all individuals with ID/DD, including access to school psychologists and/or social workers, specific programming for individuals with co-occurring mental health and ID/DD are rarely offered.

Furthermore it is estimated that approximately 90% of individuals living with TBI's also have a co-occurring mental health disorder; however, very few services exist within educational departments for this specific population.[6] Additionally, significant discrepancy exists between the incidence of TBI and the identification of children with TBI for special education. In 2012 Colorado reported 497 students as receiving special education for TBI, while approximately 2,392 youth (0-20 years of age) were identified by the Colorado Department of Public Health and Environment as being discharged from the hospital with a TBI. While some of these children may have suffered a concussion and the symptoms cleared within a few days or weeks, there may be a number of children and adolescents living with TBI are not receiving services, or are inappropriately diagnosed and receiving improper services. Furthermore, as a large percentage of individuals with TBI present with co-occurring disorders, the lack of programming may contribute to the development and symptomology of co-occurring mental health disorders within this population.

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Literature Review

Individuals with Mental Illness Who Are Physically Compromised

Prevalence and Impact of Co-morbidity

A large percentage of individuals with mental illness are physically compromised by co-morbid medical conditions. Of the 25 percent of the adult population with mental health disorders, 68 percent experience co-occurring medical conditions; and of the 58 percent of the general adult population who suffer from medical conditions, 29 percent of those experience comorbid mental health disorders.[1] A study of 200 general medical patients, half of whom carried SMI diagnoses, found that those with mental health disorders had significantly higher rates of smoking and obesity and had significantly longer hospitalizations.[2] The National Survey on Drug Use and Health collects information from adults aged 18 or older regarding mental illnesses in the past year, including any mental illness (AMI), serious mental illness (SMI), and major depressive episode (MDE). Adults with AMI or MDE in the past year were more likely than those without these mental illnesses to have high blood pressure, asthma, diabetes, heart disease, or stroke.[3] These comorbid conditions are intertwined and complex. Druss and Walker (2011) indicate:[4] "[m]edical disorders may lead to mental disorders, mental conditions may place a person at risk for medical disorders, and mental and medical disorders may share common risk factors." (p. 6) The investigators describe childhood adversity, stress and socioeconomic status (including social supports, education, and environmental/neighborhood conditions) as risk factors that may influence medical and mental health conditions.[4]

Those with comorbid mental health and medical conditions have a greater need for services at greater cost. An analysis of Medicaid claims of a cohort of adults in fourteen southern states compared emergency department utilization of those with schizophrenia and co-morbid diabetes to that of other populations. Patients were grouped according to their condition (co-morbid diabetes and schizophrenia, schizophrenia only, diabetes only, or individuals with neither diagnosis). Emergency Room (ER) visits were categorized as those due to mental health diagnosis, due to diabetes, or those due to other medical diagnoses. The study found that patients experiencing comorbid conditions had significantly higher number of ER visits per year than all other groups.[5] Additionally, SAMHSA's National Survey on Drug Use and Health Report of 2012 indicates that adults with serious mental illnesses were more likely to use an ER (47.6 percent) or be hospitalized (30.5 percent) than adults without mental illnesses (20.4 percent and 11.6 percent respectively).[3]

Beyond emotional, time and financial costs to individuals who access intensive care, these additional services also incur costs to the healthcare system. Based on a study of inpatient and outpatient claims data representing approximately 100 private-sector payers, Melek and Norris (2008) found that healthcare costs increased an average of approximately $505 per member per month for those with comorbid depression, approximately 80 percent of which is due to medical services.[6] Further, among triads of common co-occurring disorders, Druss and Walker (2011)[4] identified that "psychiatric disorders were among seven of the top ten most frequent

diagnostic comorbidity triads in the most expensive 5 percent of Medicaid beneficiaries with disabilities." (p. 5)

In addition to impacting functioning, quality of life and cost of care, comorbidity increases the risk of premature death. The age of death of those with mental illness is 25 years younger than the general population and 60 percent of those deaths result from medical conditions.[7]

Challenges Receiving and Delivering Adequate Care

Assessment and treatment of mental health conditions, impacts of medications, service coordination and delivery issues, and lack of training and standardized care protocols all impair the ability to promote wellness for persons with comorbid conditions.

Persons with comorbid mental health and physical conditions experience challenges accessing adequate assessment and treatment for their medical needs. In a study of 120 individuals enrolled in a Veterans Affairs clinic, investigators found that, prior to participating in the study, patients had not received adequate medical care or preventive services and had medical conditions that were not documented in their records.[8] The inadequacy of care has significant and sometimes fatal consequences. Druss and Walker (2011)[4] found that "… excess mortality, like the excess mortality in general populations, is due to preventable risk factors and treatable conditions" (p. 10), yet conditions are not consistently diagnosed or addressed due to lack of screening, brief office visits, lack of training or knowledge, or discomfort of the patient or provider when addressing medical conditions of a person with mental health conditions.[4] In a study conducted by Briskman, Bar, Boaz, and Shargorodsky (2012), patients with psychiatric disorders who were admitted to the hospital for medical reasons were less likely to have been previously diagnosed with comorbid medical conditions despite having similar prevalence of these conditions as patients without psychiatric disorders. Further, they found that those with psychiatric diagnoses were less likely to receive medications for these conditions or education regarding lifestyle and medication interventions.[2]

Conversely, diagnosis of mental health conditions can be masked by physical symptoms, impacting timely access to appropriate clinical interventions. Seelig and Katon (2008)[9] estimated that, while between 50 percent to 80 percent of individuals with anxiety or depressive disorders present with physical symptoms, physicians overlook mental health causes and conduct "expensive medical testing such as MRIs, angiography, or laparoscopy that can delay arriving at the correct diagnosis and which increase direct medical costs." (p. 454)

Limited attention to the side effects of prescribed medications can also have adverse impacts to the health of individuals with mental health disorders. Treatments for medical and mental health conditions may contribute to comorbidity.[4] According to Mauer (2006)[7] "…the second generation antipsychotic medications have become more highly associated with weight gain, diabetes, dysplipidemia, insulin resistance and the metabolic syndrome, and the superiority of clinical response (except for clozapine) has been questioned." (p. 6) Ezell, Siantz, and Cabassa

(2013) conducted a study involving interviews of 21 administrators and 25 clinicians working in six mental health care organizations. They discovered that:[10]

" *…binary tension appeared to exist between providers' need to prescribe psychotropic medications, which are known to improve consumers' mental health at the potential detriment of their physical health… [I]t is possible that providers' tendency to prioritize mental health issues over medical care concerns may have contributed to some consumers' relative lack of engagement in health promotion activities and with primary care in general.*" (p. 13)

Facilitating access to services, and coordinating referrals, information and service delivery are all problematic when addressing the needs of those with comorbid mental health and medical conditions. "Geographic and organizational barriers were found to impact the care coordination loop by complicating efforts to efficiently get consumers to medical sites for appointments, establish reciprocal working relationships with primary care physicians, and obtain consumer's health records…"[10] (p. 12) The relationship between primary care and mental health providers can also impact the ability to make referrals and coordinate care[11]:

In a survey of 3375 family physicians, general internists, and obstetrician-gynecologists, respondents overwhelmingly reported being less satisfied with referrals to mental health specialists than to medical sub-specialists….[E]ven when primary care physicians did identify helpful mental health specialty colleagues, more than half of primary care physicians reported that their patients expressed reluctance to visit a mental health professional. (p. 455)

The cost of collaboration also impedes coordination of care. "The necessary system innovations described above are not universally available in part because they require extensive investment and insurers have not incentivized health care systems to develop this infrastructure. Likewise, coordination and communication between primary care and practices is not reimbursed."[9] (p. 456)

Other barriers to promoting the health of individuals with comorbidity include a lack of training, standardized practices, and adherence to those protocols that are known to have positive impacts on the well-being of this population. "…[W]hile most primary care training programs require residents to gain experience evaluating and managing depression, the degree of proficiency that residents are expected to achieve varies by discipline (e.g. family medicine, internal medicine, pediatrics, obstetrics, and gynecology."[9] (p. 455) Follow up by physicians prescribing psychotropic medications often does not meet established evidence based standards.[9] Additionally, other existing standards of care are not fully incorporated into practice. For example, the American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity guidelines on Antipsychotic Drugs and Obesity and Diabetes are often not followed due to time constraints need for change in practice.[7]

Mitigating Risk and Improving Care

Multiple approaches have been identified to better address the needs of individuals with mental illness who are physically compromised with comorbid medical conditions. These methods range from changes to policy and finance, performance measurement and quality improvement, information management, and service delivery and coordination.

Service delivery and coordination

Collaborative care, including stepped care models, co-location of services, and care management are considered to be effective approaches to impact the health of individuals with some mental health conditions. "A variety of organizational structures can support these collaborative approaches, ranging from integrated care to partnerships to facilitated referral processes."[4] Service coordination may occur via care coordination, co-location of mental health and medical services, and shared access to medical records. [4,7,9 10,12] In a randomized trial involving individuals served through Veterans Affairs integrated services in a mental health clinic (including case management, preventive and education, patient prompts and follow ups for appointments, and service collaboration), those recipients visited primary care more often, received more preventive measures, were better satisfaction, and experienced improved health as compared with those served by a general medical clinic.[8] Opportunities for co-located care can occur either in primary care settings with behavioral health services or behavioral health settings that include with primary healthcare. [12] Case managers co-located in primary care clinics improved physician satisfaction from half to 90 percent with regard to having adequate resources to treat depression, and 82 percent of physicians believed clinical outcomes improved for patients.[13]

Peer services should also be expanded to support health-related activities. Developing advocacy and support services that reduce stigma and empower individuals facilitates recovery.[7] For example, "peer-based whole health services" has been found to support improved choices related to exercise, nutrition and stress reduction.[12]

Regularly monitoring and addressing health indicators can further contribute to better outcomes for this population. "Routine monitoring should include weight, body mass index (BMI) and waist circumference, blood pressure, lipid profiles, screening for insulin resistance and diabetes, dental checks and eye health checks."[14] (p. 463) Monitoring these indicators will facilitate identification of health challenges and create opportunities for timely interventions.

Services designed to address behaviors associated with health issues are known to be effective. Mauer states[7]:

> For the general population the Centers for Disease Control and Prevention (CDC) Office of Disease Prevention and Health Promotion observed:

- Effective interventions that address personal health practices are likely to lead to substantial reductions in the incidence and severity of the leading causes of disaseses and disability in the U.S.
- Primary prevention as it relates to such risk factors as smoking, physical inactivity, poor nutrition, alcohol and other drug abuse, and inadequate attention to safety precautions holds greater promise for improving overall health than many secondary preventive measures such as routine screening for early disease…(p 38)

"There is emerging evidence that people with SMI can stop smoking, loose weight and be more physically active if interventions and lifestyle programmes are tailored to overcome the neurological, cognitive, behavioural and social deficits associated with SMI. "[14] *(p. 463)*
"Excellent tools have been developed to help consumers stop smoking and to help providers develop tobacco cessation interventions and programs. The SAMHSA-HRSA Center for Integrated Solutions website lists several useful documents, including "Smoking Cessations for Persons with Mental Illnesses: A Toolkit for Mental Health Providers" by the University of Colorado Denver. "[12] (p. 9)

As stress can be associated with both mental health and medical conditions[4], it follows that reduction of social stressors may positively impact health. "It could be argued that many of the causes of morbidity and mortality are related to the vulnerability of the population with the SMI. Efforts to address these conditions should include: safe housing;, adequate income; skills-based prevention programs to reduce vulnerability to victimization; addressing substance abuse…; and case management services."[7] (p. 38)

Standards of Care, Measurement, Training
In addition to service structure, it is recommended that infrastructure be in place to promote quality care that brings positive results. Quality is influenced by practicing under standards of care and evidenced based approaches, documenting and measuring services in a manner that supports quality management and communication, and ensuring a well-trained workforce.[7,9,10]

Mauer discusses a wide variety of strategies pertaining to standards of care, including:[7]

- Customize existing primary secondary and tertiary prevention initiatives related to obesity, diabetes and cardiovascular disease to address the needs of persons with mental illness (pp. 37-8)
- Implement standards of care for prevention, screening and treatment utilization practice guidelines (p. 39)
- Ensure consistent monitoring of individuals receiving psychotropic medications (p. 47):
    - Whenever possible, avoid use of medications that are more strongly associated with conditions such as obesity, diabetes and hyperlipidemia
    - Reduce polypharmacy
    - Prescribers should be accountable for screening to assure adequate treatment of medical risk factors such as metabolic syndrome and its consequences to the same extent that they are for Extra-Pyramidal Symptoms and Tardive Dyskinesia

- Adopt consistent use of a metabolic screening and monitoring tool

Service documentation and quality improvement processes should support implementation of practice standards and coordination of care, including appropriate screening, treatment and access to services.[4,7] Performance measures at state and national levels can assist in identifying prevalence, screening and services, outcomes, and cost of care. [7] (p. 43) Monitoring of financial and clinical data offers coordinated information about morbidity and mortality, diagnoses, treatments, and causes of death to inform service planning and system improvements.[7,12]

Workforce development facilitates consistent implementation of standards and evidence based practices.[4,7] Training should include:

- Cross training regarding medical and psychiatric needs of persons with SMI, including medical implications of side effects of psychotropic medications[10]
- Toolkits and guidelines to help providers, self-help/peer support groups and families understand how to facilitate healthy choices while promoting personal responsibility[7] (p 42)

Financing

Financial restructuring is required to transform services and processes, and expand capacity to better serve persons who have mental illness and are physically compromised. Improved outcomes resulted from the use of "additional staff resources to improve access and adherence to care, including outreach by the case manager, extra time for visits in the clinic and flexibility in scheduling appointments."[8] Financial structures should consider investment in these impactful services. Statewide efforts to support collaborative care models include strategies based off of the IMPACT model under a case rate for bundled services or local networks with primary care case management.[4] Effective financial structures will cover evidence-based strategies including care coordination, case management, education and prevention services, and smoking cessation and weight reduction treatments, and will include reimbursement rates for primary care to ensure timely access to those services for persons with mental illness.[7]

These structural and service investments are likely to result in significant savings, physically and emotionally to individuals served, and financially to the service system. Based on data collected by Melek, et al[6] (2008) regarding costs of comorbid chronic conditions and mental health disorders, Miller projects that "if a 10 per cent reduction can be made in the excess healthcare costs of patients with comorbid psychiatric disorders…$5.4 million of healthcare savings could be achieved for each group of 100,000 insured member."[12] (p 14) States and health care systems that have begun implementing integrated care strategies, they are already experiencing significant financial and clinical results. According to New York State Medicaid (as cited in Miller), Western New York experienced a 46 percent decrease in emergency room utilization and a 53 percent reduction of hospital days, lowering inpatient costs by 92 percent. "Behavioral integration efforts in a cross-section of Inter-Mountain Health System's primary care clinics increase outpatient use and medication adherence, reduced emergency department and inpatient use, lowered cost of care."[12] (p. 26)

A large percentage of persons with mental illness are also physically compromised by comorbid medical conditions. These conditions impact the quality of life and mortality rates of this population as well as the cost of care due to their need for expensive services. Researchers have identified a variety of strategies to reduce the incidence and mitigate the impacts of comorbidity, including health screening, service coordination, finance structures and other measures to promote evidence-based practices. Examination of these strategies indicates that they are likely to reduce the negative human and financial impacts of comorbidity.

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Literature Review

Peer Mentors, Recovery Coaches, and Family Advocates

The use of peer mentors is a growing trend in mental health service systems both nationally and internationally. [1, 2, 3, 4, 5, 6] The International Association for Peer Supporters (iNAPS) defines the term peer supporter as an "umbrella for many different peer support titles and roles, such as peer advocate, peer counselor, peer coach, peer mentor, peer educator, peer support group leader, peer wellness coach, recovery coach, recovery support specialist, and many more." [7] Furthermore, iNAPS state that a peer supporter is an individual who has made a personal commitment to his/her own recovery, has maintained their recovery over a period of time, has taken special training to work with others, and is willing to share his/her own experience about recovery in an inspirational way.[8]

Currently, no national certification for peer specialist training exists. [6, 9] As of 2012, 36 states had established programs that train and certify peer mentors.[7] Most states require a minimum of a high school education or GED with a minimum age of 18. [6] Additionally, some states require previous work experience in a peer role. For example, Florida requires peers to have 1000 hours of paid or volunteer work experience to gain certification. [6] In other states, including Colorado, training programs are available for peer specialists; however, none are endorsed by the state. To qualify for reimbursement from Medicaid, the Center for Medicare and Medicaid Services (CMS) requires that peer support providers receive certification as defined by the respective state.[6]

Peer mentorship programs offer numerous benefits including: benefits for the peer mentors, decreased substance use among co-occurring substance abuse populations, decreased utilization of emergency services, increased engagement in treatment, and reductions in overall treatment costs. [6, 10, 11] While having many benefits, peer mentor programs also face challenges in implementation. Peer mentors are best utilized and integrated into the treatment team of programs with a strong recovery-oriented model.[4] Programs that lack a recovery-oriented structure may encounter difficulties with integration, cohesiveness, and support for peer mentors. Furthermore, implementing peer specialist programming requires a strong programmatic commitment and clear job description. Without these factors, peer specialists may not be integrated into the treatment team and may experience conflicts with staff leading to job dissatisfaction, high turnover, and poor service delivery. [4]

In both practice and in the literature, terms referring to "peer support" services lack agreed upon operational definitions. As such, it is difficult to meaningfully distinguish the different roles of peer specialists (i.e. peer mentors, recovery coaches, family advocates) in mental health care systems. [12] Despite this fact, a growing body of literature exists regarding the utilization of peer mentors in state hospitals and community-based programs.
First, a number of states utilize peer mentor programs within state hospital programming including Idaho, Pennsylvania, Colorado, and Kansas, to name a few. Peer mentors within the

state hospital setting provide individual and group services, as well as assist with documentation for state hospital patients. Researchers have found that peer mentor programs significantly decreased rehospitalization rates amongst individuals at risk of readmission (i.e. were hospitalized three or more times in the previous 18 months).[13] Additionally, many states including Idaho and Georgia utilize peer mentors to assist patients in securing housing upon discharge. Peer mentor services within the state hospital setting help decrease costs by reducing rehospitalization and other emergency interventions.[14] Additionally, several states including Idaho utilize peer mentors to help with discharge planning including: connecting individuals with outpatient mental health services, primary health care entities, securing housing, and other mainstream services as needed (i.e. food, clothing, employment, and training).[15]

In 2012 the Department of Veterans Affairs (VA) hired 815 peer specialists across the country under a presidential executive order aimed at improving access to mental health services for Veterans.[16] Peer mentors within the VA are required to have been veterans and have been in the recovery process for a mental health and/or substance abuse issues. Additionally, peer specialists must complete a certification process to be employed at the VA. The specific roles of peer mentors in the VA vary between states and regions and include, but are not limited to: providing one on one services, facilitating groups, working on inpatient units and outpatient life skills centers within PTSD residential programs, homeless services (including outreach), and are integrated into Assertive Community Treatment (ACT) teams. Implementation of VA peer specialists has been well received in VA centers across the nation; however, continuous monitoring of the challenges of peer mentor programs, including further clarification of peer specialist roles, should be undertaken.[2]

While peer mentors are being used in jail, prison, and half-way house settings, sparse research or literature exist regarding the effectiveness of such programming. In 2008, research was conducted regarding the successful implementation of a jail based mentor program in which long-term sentenced inmates served as peer mentors, working alongside primary counselors to lead the prison-based therapeutic community program.[17] The researchers found an increase of prison based attendance and post release aftercare attendance of approximately 81%. Additionally, Recovery Innovations has trained peers while they are incarcerated and facilitate employment options following their release.[18]. Additionally, Colorado has peer mentors working in several half-way houses with promising results; [19] [20] however, formal research has not been undertaken to explore the impact of such programming. This speaks to the need for further outcome studies to explore the effectiveness of peer mentors within the judicial setting.

Next, Randle Loeb, a Denver-based advocate with the United States Interagency Council on Homelessness stated the importance of including peer mentors in outreach programming for the homeless. [21] Loeb stated that the best way to assist homeless populations "is to provide a support network that includes navigators who help establish a place to live and peer mentors who provide sustained connections with people experiencing homelessness. Peer mentors and navigators elevate the spirit, commitment, and connections that are vital to health and well-

being of people experiencing homelessness." While another promising sphere for peer programming, limited research and literature exists regarding programming for homeless populations utilizing peer mentors.

Additionally, peer specialists are utilized in mobile crisis response teams; however, research and literature regarding such programming is sparse. Peer mentors can serve an important role within mobile, community-based support services for individuals with serious mental illness.[22] Peer specialists are utilized in Colorado's mobile mental health crisis service teams, which were implemented in December of 2014. Further research should be conducted regarding the effectiveness and outcomes of such programs.

Next, parent-to-parent peer services can offer significant benefits in the provision of family mental health services.[23] The National Federation of Families for Children's Mental Health offers a national certification program for Parent Support Providers consisting of 80 contact hours across eight domains. Programs with Parent Support Providers have numerous benefits including: reduced lengths of stay in foster care, [24] increased rates of reunification, [23] and reduced rates of missed appointments and premature termination of care. [25] Parent Support Specialists are currently employed in many settings including: community mental health centers, pediatricians offices, psychiatric residential treatment centers, hospitals, schools, and family-run organizations.

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Literature Review

Housing and Employment Opportunities

Adults with serious mental illnesses have very low rates of employment, compared to adults in general. A significant portion of people who experience repeated or long-term homelessness have serious mental illnesses, often with a co-occurring substance use disorders. Studies described in this brief show that both housing and employment are crucial components of a person's recovery. The brief begins with an analysis of permanent supportive housing, which is a flexible model supported by current federal policy relating to the rights of people with disabilities. It then provides an analysis of several models of employment supports. Included at the end of this document is an annotated bibliography of the studies cited in the analysis.

Analysis of Recent Research on Permanent Supportive Housing

In recent years, the approach to providing housing for people with serious mental illnesses has undergone sweeping changes. Longstanding approaches linked residency with treatment. Examples of residential treatment include adult care homes, board-and-care homes, community residences, and supervised apartments.[1] Often, such options were offered as part of a "residential continuum," through which people passed from setting to setting as their support needs diminished or intensified.[2]

More recently, the Permanent Supportive Housing (PSH) model has emerged. PSH for people with disabilities is affordable housing with full rights of tenancy, and with access to voluntary, flexible support services needed to choose, obtain, and keep housing that is integrated into the community. Permanent Supportive Housing programs can serve not only people who are homeless, but also people leaving institutional settings or otherwise needing support in order to live independently. High-fidelity Permanent Supportive Housing programs use a Housing First approach when assisting people who are homeless. A Housing First approach means offering people who are homeless rapid access to housing, with no preconditions such as completion of residential treatment, or requirements once housed other than what is found in a standard lease.

Federal Policy

Federal agencies have actively promoted the PSH model and Housing First approach. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) has issued a comprehensive toolkit[3] on implementing PSH, while the U.S. Interagency Council on Homelessness (USICH) promotes Housing First through a checklist[4] for determining whether the approach is being followed. The reason behind federal support for PSH and Housing First is that people with disabilities have a right to services in the least restrictive setting that is appropriate to their needs, as recognized by the Supreme Court's 1999 *Olmstead v. L.C.* decision.

As a Senate Committee noted, as applied to housing, *Olmstead* means that "individuals with disabilities should have access to housing other than group homes, other congregate arrangements, and multi-unit buildings or complexes that are primarily for people with disabilities. They should have access to 'scattered site' housing, with ownership or control of a lease. Housing should not be conditioned on compliance with treatment or with a service plan."[5]

Permanent Supportive Housing Model

Permanent Supportive Housing has a number of key elements that distinguish it from other forms of housing. These elements relate to both to how housing is provided and to how services and supports are provided. SAMHSA's comprehensive toolkit includes an instrument for measuring a program's fidelity to the best practices model of housing promoted by SAMHSA. Programs can use this instrument to evaluate their fidelity to the following key dimensions:

- People have choice in housing, both in terms of where they live and with whom.
- Housing and supportive services are provided separately, so that clinical judgments do not affect a person's access to housing.
- Housing meets minimum quality standards and is affordable to the tenant, as a percentage of income.
- Housing is integrated into the community and does not isolate the individual from people who do not have disabilities.
- People have the same rights and responsibilities under a lease as any tenant living in the community.
- People have access to housing that they control, without having to demonstrate "readiness."
- People have access to flexible, voluntary services that are tailored to their needs and delivered by staff with reasonable caseloads.

Housing First Approach

High fidelity PSH programs follow a Housing First approach to housing people who are homeless. The USICH checklist contains a number of criteria with which a PSH program must comply in order to be following a Housing First approach:

- Tenants are accepted without regard to of sobriety, use of substances, completion of treatment, or participation in services.
- Tenants are not rejected for lack of housing "readiness," and are seldom rejected for poor credit or rental history or minor criminal convictions.
- The program accepts referrals from shelters, drop-in centers, and other places frequented by people who are homeless.
- Supportive services are voluntary and tenant-driven and are focused on problem solving rather than therapeutic goals.
- Alcohol and drug use are not per se grounds for eviction, which can occur only if the tenant violates the lease.

Research Base

The evidence base on PSH continues to emerge.[6] One of the problems with earlier research into PSH is that housing was described without much precision or consistency. The adoption of tools like the PSH Fidelity Scale in the SAMHSA toolkit and the USICH Housing First Checklist have made it possible to conduct research that links outcomes to how closely a housing program complies with key elements of these preferred approaches. For example, a study of over 6,500 residents of 86 programs in California found that programs with greater fidelity to the Housing First approach, particularly with regard to client choice and incorporation of client goals in the planning process, produced better results in keeping people housed.[7]

The outcome most solidly associated with PSH is housing stability. People with serious mental illnesses and/or addictions who have experienced chronic homelessness can succeed in PSH, even though the model does not require a demonstration of sobriety or participation in treatment. In fact, studies have compared PSH using a Housing First model to "treatment-first" housing have found the Housing First approach more effective at keeping people housed.[8]

Other outcomes associated with PSH include reduced hospitalizations and emergency room visits.[9] Access to stable housing also improves criminal justice outcomes.[10] Some evidence also suggests that PSH using a Housing First approach can be effective at reducing substance use, particularly for a subgroup of people unwilling to participate in treatment.[11]

Research shows that high quality programs can eliminate the key concerns about PSH and the Housing First approach. These concerns relate to their departure from traditional models, many of which: (a) link residency to participation in mandatory services, (b) require a showing of "readiness," (c) mandate sobriety either before or after program admission, and/or (d) require people to complete transitional steps before receiving permanent housing. Providing access to housing coupled with support services can increase the use of mental health and substance abuse treatment, even though those services are voluntary.[12] Direct comparisons of Housing First to treatment-first programs have shown superior outcomes with the Housing First approach.[13] Further, comparison of the housing first approach to a stepwise approach reveals that the stepwise approach imposes higher costs but does not produce better long-term outcomes.[14]

Analysis of Recent Research on Employment Supports

Employment of people with serious mental illnesses is crucial part of service planning. A high percentage of people with serious mental illnesses are unemployed, even though a number of approaches are available to help people obtain employment. In addition to economic benefits, meaningful employment has psychosocial benefits.[15] However, these benefits might not be generated by lower-quality employment situations.[16] It is thought that ongoing support and workplace accommodations are crucial to improving employment outcomes such as job satisfaction.[17]

Often, employment supports are offered informally, such as a case manager or social worker offering advice or help with specific tasks such as filling out job applications. These services

might be obtained either through the mental health system, vocational rehabilitation agencies, the U.S. Department of Labor's workforce system, or community-based nonprofits. Based on comparison studies[18] and the high unemployment rate among mental health consumers, these informal approaches are unlikely to produce positive results.

Three model programs, described in greater detail below, have been subjected to a significant amount of research that indicates that they are more effective than informal approaches:

- *Supported Employment*,[19] in particular the Individual Placement and Support (IPS) model, de-emphasizes pre-vocational activities, in favor of rapid assistance with a search for competitive employment (i.e., a job not set aside for a candidate who has disabilities) and follow-along supports for as long as needed.
- *Social Enterprises*,[20] sometimes called social firms, have the dual purpose of generating revenues and employing people with barriers to employment, such as a thrift shop or café that employs people with disabilities.
- *Clubhouses*[21] are based on an international model that relies on a "work-ordered day," under which members follow a traditional work schedule helping staff to operate the clubhouse. Members have access to pre-vocational training, along with two major types of employment—transitional jobs, in which they work alongside other members and staff, and independent employment, which may be based on a supported employment model.

Supported Employment

The Substance Abuse and Mental Health Services Administration (SAMHSA) considers Supported Employment to be an evidence-based practice. SAMHSA makes freely available a comprehensive toolkit for implementing the Individual Placement and Support (IPS) model of Supported Employment.[22] This resource offers guidance on planning, funding, and implementing IPS; materials for training direct service staff; and a tool for evaluating fidelity to core elements of the intervention. IPS has the following core principles:

- Eligibility is based on consumer choice.
- Services are integrated with comprehensive mental health treatment.
- Competitive employment is the goal.
- Personalized benefits counseling is important.
- Job search starts soon after consumers express interest in working.
- Follow-along supports are continuous.
- Consumer preferences are important.

Considerable evidence supports the effectiveness of ISP Supported Employment. A recent review article identified 12 systematic reviews and 17 randomized controlled trials supporting numerous positive effects of the Individual Placement and Support model of Supported Employment.[23] Multiple randomized controlled trials confirm that IPS is more effective than traditional vocational approaches, such as group skills training, vocational rehabilitation, and

psychosocial rehabilitation, regardless of participant characteristics such as age, ethnicity, education level, prior work history, substance use history, and other factors.[24]

Social Enterprise

As described by the Social Enterprise Alliance, a social enterprise employs people who face barriers to employment serves multiple purposes, including reducing burdens on public service systems, improving neighborhoods, creating economic opportunities, and promoting social justice by helping those in need.[25] The Alliance offers on its web site a library of resources on planning, funding, and running social enterprises, including examples of successful ventures.

Some web sites of social enterprises that hire people who are homeless and/or have behavioral health disorders include the following:

- Project HOME, Philadelphia: https://projecthome.org/our-work/social-enterprises
- Chrysalis Enterprises, Los Angeles: http://www.changelives.org/hire
- TROSA, Durham, NC: http://www.trosainc.org/index.php/trosa-businesses

Social enterprises can take many forms, from helping people obtain and retain employment in fields with modest earning potential such as foodservice and retail, to training people in high-demand fields such as renewable energy.[26] While there are successful programs scattered throughout the United States, the model appears to be widespread in Europe and the United Kingdom.[27] People who work in social enterprises seem to value the supports that they receive on the job and value their role in the workforce.[28]

It is important to note that social enterprises can be thought of as compatible with many features of the IPS approach, such as rapid placement, follow along supports, etc., even though they hire primarily or exclusively disadvantaged jobseekers.[29] Additionally, when social enterprises are used as transitional employment, in conjunction with other principles of IPS, participants can improve their long-term employment outcomes.[30]

Clubhouse Model

The Clubhouse model of psychosocial rehabilitation is firmly established, and there are over 300 certified clubhouses nationwide. The parent organization, Clubhouse International, offers training, consultation, and accreditation. Extensive information about the Clubhouse model is available on the organization's web site.[31] Participants in services are referred to as "members," and they are involved in the operations of the clubhouse. A key feature of the clubhouse is the "work-ordered day," which is intended to simulate a working environment along with several different employment options. In transitional employment, members work for employers in the community, but the clubhouse staff agrees to cover any employee absences, the employment is for a defined time period, and the positions are reserved for clubhouse members.[32] Clubhouses also offer help with placement into permanent, competitive employment, including offering supported employment options.

Evidence suggests that clubhouses are effective in promoting employment, as compared to less intensive interventions such as Assertive Community Treatment teams offering vocational

services.[33] One study identified the work-ordered day as a pre-vocational service that can promote longer employment tenure and higher wages.[34] However, a potential concern about the Clubhouse model is that some services are provided in a setting in which members are interacting primarily with other people with disabilities and Clubhouse staff, which may raise concerns under the U.S. Supreme Court's 1999 decision in *Olmstead v. L.C.*, which affirmed the right of people with disabilities to receive services in a setting that allows them to interact with people who do not have disabilities. A Senate committee in fact singled out the Clubhouse as a potential example of a "segregated program," noting, "Individuals with disabilities should have the opportunity to be employed in non-segregated, regular workplaces."[35]

Conclusion

Housing and employment are critical to the recovery of people with serious mental illnesses. Federal policy calls for providing services to people with disabilities in the least restrictive and most integrated setting possible. The permanent supportive housing model and the housing first approach attempt to fulfill these requirements by separating treatment and housing and empowering people to live in their own homes rather than in treatment facilities. Supported employment and other approaches help people not only to earn income but also to find a sense of purpose with psychosocial benefits. Recent research shows that models of providing housing and employment supports can be both less restrictive than traditional models and effective at producing desired outcomes.

Bibliography with Abstracts: Housing

Gilmer, T. P., Stefancic, A., Katz, M. L., Sklar, M., Tsemberis, S., & Palinkas, L. A. (July 12, 2014). Fidelity to the Housing First model and effectiveness of permanent supported housing programs in California. *Psychiatric Services.* doi:10.1176/appi.ps.201300447

Objectives: Permanent supported housing programs are being implemented throughout the United States. This study examined the relationship between fidelity to the Housing First model and residential outcomes among clients of full service partnerships (FSPs) in California.
Methods: This study had a mixed-methods design. Quantitative administrative and survey data were used to describe FSP practices and to examine the association between fidelity to Housing First and residential outcomes in the year before and after enrollment of 6,584 FSP clients in 86 programs. Focus groups at 20 FSPs provided qualitative data to enhance the understanding of these findings with actual accounts of housing-related experiences in high- and low-fidelity programs.
Results: Prior to enrollment, the mean days of homelessness were greater at high- versus low-fidelity (101 versus 46 days) FSPs. After adjustment for individual characteristics, the analysis found that days spent homeless after enrollment declined by 87 at high-fidelity programs and by 34 at low-fidelity programs. After adjustment for days spent homeless before enrollment, days spent homeless after enrollment declined by 63 at high-fidelity programs and by 53 at low-fidelity programs. After enrollment, clients at high-fidelity programs spent more than 60 additional days in apartments than clients at low-facility programs. Differences were found

between high- and low-fidelity FSPs in client choice in housing and how much clients' goals were considered in housing placement.
Conclusions: Programs with greater fidelity to the Housing First model enrolled clients with longer histories of homelessness and placed most of them in apartments.

Leff, H. S., Chow, C. M., Pepin, R., Conley, J., Allen, I. E., & Seaman, C. A. (2009). Does one size fit all? What we can and can't learn from a meta-analysis of housing models for persons with mental illness. *Psychiatric Services*, *60*(4), 473–482. doi:10.1176/appi.ps.60.4.473

Objective: Numerous studies have evaluated the impacts of community housing models on outcomes of persons with severe mental illness. The authors conducted a meta-analysis of 44 unique housing alternatives described in 30 studies, which they categorized as residential care and treatment, residential continuum, permanent supported housing, and nonmodel housing. Outcomes examined included housing stability, symptoms, hospitalization, and satisfaction.
Methods: Outcome scores were converted to effect size measures appropriate to the data. Effect sizes were combined to estimate random effects for housing models, which were then compared.
Results: All models achieved significantly greater housing stability than nonmodel housing. This effect was greatest for permanent supported housing (effect size=.63, $p<.05$). No differences between housing models were significant. For reduction of psychiatric symptoms, only residential care and treatment differed from nonmodel housing (effect size=.65, $p<.05$). For hospitalization reduction, both residential care and treatment and permanent supported housing differed from nonmodel housing ($p<.05$). Permanent supported housing achieved the highest effect size (.73) for satisfaction and differed from nonmodel housing and residential care and treatment ($p<.001$ and $p<.05$, respectively).
Conclusions: The meta-analysis provides quantitative evidence that compared with nonmodel housing, housing models contribute to stable housing and other favorable outcomes. The findings also support the theory that different housing models achieve different outcomes for different subgroups. Data were not sufficient to fully answer questions designed to enable program planners and providers to better meet consumers' needs. It is important to answer these questions with research that uses common measures and adheres to scientific conventions.

Mares, A. S., & Rosenheck, R. A. (2011). A comparison of treatment outcomes among chronically homeless adults receiving comprehensive housing and health care services versus usual local care. *Administration and Policy in Mental Health and Mental Health Services Research*, *38*(6), 459–475. doi:10.1007/s10488-011-0333-4

Service use and 2-year treatment outcomes were compared between chronically homelessness clients receiving comprehensive housing and healthcare services through the federal Collaborative Initiative on Chronic Homelessness (CICH) program (n = 281) and a sample of

similarly chronically homeless individuals receiving usual care (n = 104) in the same 5 communities. CICH clients were housed an average of 23 of 90 days (52%) more than comparison group subjects averaging over all assessments over a 2-year follow-up period. CICH clients were significantly more likely to report having an usual mental health/substance abuse treater (55% vs. 23%) or a primary case manager (26% vs. 9%) and to receive community case management visits (64% vs. 14%). They reported receiving more outpatient visits for medical (2.3 vs. 1.7), mental health (2.8 vs. 1.0), substance abuse treatment (6.4 vs. 3.6), and all healthcare services (11.6 vs. 6.1) than comparison subjects. Total quarterly healthcare costs were significantly higher for CICH clients than comparison subjects ($4,544 vs. $3,326) due to increased use of outpatient mental health and substance abuse services. Although CICH clients were also more likely to receive public assistance income (80% vs.75%), and to have a mental health/substance provider at all, they expressed slightly less satisfaction with their primary mental health/substance abuse provider (satisfaction score of 5.0 vs. 5.4). No significant differences were found between the groups on measures of substance use, community adjustment, or health status. These findings suggest that access to a well-funded, comprehensive array of permanent housing, intensive case management, and healthcare services is associated with improved housing outcomes, but not substance use, health status, or community adjustment outcomes among chronically homeless adults.

Montgomery, A. E., Hill, L. L., Kane, V., & Culhane, D. P. (2013). Housing chronically homeless veterans: Evaluating the efficacy of a Housing First approach to HUD-VASH. *Journal of Community Psychology*, *41*(4), 505–514. doi:10.1002/jcop.21554

Rapidly placing homeless veterans with severe mental illness into permanent housing is one important goal of the U.S. Department of Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) program; however, no research has tested whether an explicit organizational alignment of this goal with revised practices could improve outcomes. A demonstration project initiated in 2010 to reform housing placement practices in a metropolitan area enabled researchers to compare an explicit *Housing First* program—offering immediate permanent housing without requiring treatment compliance, abstinence, or *housing readiness*—with a treatment-first program for 177 homeless veterans. The Housing First initiative successfully reduced time to housing placement, from 223 to 35 days, housing retention rates were significantly higher among Housing First tenants, and emergency room use declined significantly among the Housing First cohort. The results suggest that a national Housing First model for the VA would be associated with improved outcomes for veterans experiencing homelessness.

O'Connell, M. J., Kasprow, W., & Rosenheck, R. (2009). Direct placement versus multistage models of supported housing in a population of veterans who are homeless. *Psychological Services*, *6*(3), 190–201. doi:10.1037/a0014921

This study presents information about two models of supported housing when combined with ready access to rent subsidies: a direct placement approach (where individuals are placed directly into independent housing from homelessness), and a multistage continuum approach (where individuals are placed first into a residential setting prior to independent housing). Using observational data from the national Housing and Urban Development–Veterans Affairs Supported Housing (HUD-VASH) program, which provided case management and housing subsidies to homeless veterans with psychiatric or substance abuse disorders, participants were categorized as receiving direct placement housing or multistage housing based on where they spent the majority of days prior to entry into HUD-VASH. Results indicate that multistage housing participants had significantly worse scores on baseline measures of alcohol and drug use, quality of life, and social support, and subsequently experienced significantly greater improvements over time so that, with the exception of employment outcomes, between-groups differences were not significant at later time periods. Multistage participants had health care costs that averaged more than three times those of direct placement participants during the initial period of residential care.

Padgett, D. K., Stanhope, V., Henwood, B. F., & Stefancic, A. (2011). Substance use outcomes among homeless clients with serious mental illness: Comparing Housing First with treatment first programs. *Community Mental Health Journal*, *47*(2), 227–232. doi:10.1007/s10597-009-9283-7

The Housing First (HF) approach for homeless adults with serious mental illness has gained support as an alternative to the mainstream 'Treatment First' (TF) approach. In this study, group differences were assessed using qualitative data from 27 HF and 48 TF clients. Dichotomous variables for substance use and substance abuse treatment utilization were created and examined using bivariate and logistic regression analyses. The HF group had significantly lower rates of substance use and substance abuse treatment utilization; they were also significantly less likely to leave their program. Housing First's positive impact is contrasted with the difficulties Treatment First programs have in retaining clients and helping them avoid substance use and possible relapse.

Rog, D. J., Marshall, T., Dougherty, R. H., George, P., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2013). Permanent supportive housing: Assessing the evidence. *Psychiatric Services*. doi:10.1176/appi.ps.201300261

Objectives: Permanent supportive housing provides safe, stable housing for people with mental and substance use disorders who are homeless or disabled. This article describes permanent supportive housing and reviews research.
Methods: Authors reviewed individual studies and literature reviews from 1995 through 2012. Databases surveyed were PubMed, PsycINFO, Applied Social Sciences Index and Abstracts, Sociological Abstracts, Social Services Abstracts, Published International Literature on Traumatic

Stress, the Educational Resources Information Center, and the Cumulative Index to Nursing and Allied Health Literature. The authors chose from three levels of evidence (high, moderate, and low) on the basis of benchmarks for the number of studies and quality of their methodology. They also described the evidence of service effectiveness.
Results: The level of evidence for permanent supportive housing was graded as moderate. Substantial literature, including seven randomized controlled trials, demonstrated that components of the model reduced homelessness, increased housing tenure, and decreased emergency room visits and hospitalization. Consumers consistently rated this model more positively than other housing models. Methodological flaws limited the ability to draw firm conclusions. Results were stronger for studies that compared permanent supportive housing with treatment as usual or no housing rather than with other models.
Conclusions: The moderate level of evidence indicates that permanent supportive housing is promising, but research is needed to clarify the model and determine the most effective elements for various subpopulations. Policy makers should consider including permanent supportive housing as a covered service for individuals with mental and substance use disorders. An evaluation component is needed to continue building its evidence base.

Somers, J. M., Rezansoff, S. N., Moniruzzaman, A., Palepu, A., & Patterson, M. (2013). Housing First reduces re-offending among formerly homeless adults with mental disorders: Results of a randomized controlled trial. *PLoS ONE*, *8*(9), e72946. doi:10.1371/journal.pone.0072946

Background: Homelessness and mental illness have a strong association with public disorder and criminality. Experimental evidence indicates that Housing First (HF) increases housing stability and perceived choice among those experiencing chronic homelessness and mental disorders. HF is also associated with lower residential costs than common alternative approaches. Few studies have examined the effect of HF on criminal behavior.
Methods: Individuals meeting criteria for homelessness and a current mental disorder were randomized to one of three conditions treatment as usual (reference), scattered site HF, and congregate HF. Administrative data concerning justice system events were linked in order to study prior histories of offending and to test the relationship between housing status and offending following randomization for up to two years.
Results: The majority of the sample (67%) was involved with the justice system, with a mean of 8.07 convictions per person in the ten years prior to recruitment. The most common category of crime was 'property offences' (mean = 4.09). Following randomization, the scattered-site HF condition was associated with significantly lower numbers of sentences than treatment as usual (Adjusted IRR = 0.29; 95% CI 0.12–0.72). Congregate HF was associated with a marginally significant reduction in sentences compared to treatment as usual (Adjusted IRR = 0.55; 95% CI: 0.26–1.14).
Conclusions: This study is the first randomized controlled trial to demonstrate benefits of HF among a homeless sample with mental illness in the domain of public safety and crime. Our sample was frequently involved with the justice system, with great personal and societal costs.

Further implementation of HF is strongly indicated, particularly in the scattered site format. Research examining interdependencies between housing, health, and the justice system is indicated.

Tsai, J., Mares, A. S., & Rosenheck, R. A. (2010). A multisite comparison of supported housing for chronically homeless adults: 'Housing First' versus 'residential treatment first'. *Psychological Services*, *7*(4), 219–232. doi:10.1037/a0020460

Both direct placement in supported community housing and pre-treatment with time-limited residential treatment are used as approaches to helping chronically homeless adults exit from homelessness but relative effectiveness and cost remains untested. The current observational study utilized data from a national, multi-site housing project to determine whether clients who receive residential treatment or transitional housing before being placed into independent housing achieve superior outcomes than clients who are immediately placed into independent housing, and whether they incur greater healthcare costs. A total of 709 participants (131 and 578 participants in the respective groups) were assessed every 3 months for 2 years on housing outcomes, community adjustment, work and income, mental and physical health, and health service costs. Clients who received immediate, independent housing had more days in their own place, less days incarcerated, and reported having more choice over treatment; but no differences on other clinical or community adjustment outcomes. In this observational study, there were no clinical advantages for clients who had residential treatment or transitional housing prior to entry into community housing, but they incurred higher substance abuse service costs. Studies using randomized controlled trials of these conditions are needed to establish causation.

Tsai, J., Rosenheck, R. A., Kasprow, W. J., & McGuire, J. F. (2012). Sobriety as an admission criterion for transitional housing: A multi-site comparison of programs with a sobriety requirement to programs with no sobriety requirement. *Drug and Alcohol Dependence*, *125*(3), 223–229. doi:10.1016/j.drugalcdep.2012.02.016

Background: This study examined whether homeless clients enrolled in transitional housing programs that required sobriety (SR) as an admission criterion have outcomes comparable to clients enrolled in programs that did not require sobriety (NSR) as an admission criterion.
Methods: A total of 1,062 military veterans in 40 transitional housing programs funded by the United States Department of Veterans Affairs were grouped based on whether they were in SR or NSR programs and followed over a one-year period after program discharge. Participants in SR and NSR programs were compared on their ratings of the social climate of the program, and housing and psychosocial outcomes.
Results: Participants in SR programs reported more days housed and better psychosocial outcomes than participants in NSR programs, although the differences were small and there were no differences in ratings of their social climate. Both participants in SR and NSR programs

showed improvements on most outcomes after discharge from transitional housing. There were no significant differences in outcomes between participants actively abusing substances at program entry compared to those who were not.
Conclusions: Requiring sobriety as an admission criterion in transitional housing made only a small difference in housing outcomes post-discharge. Further study is needed to determine whether requiring sobriety at admission in transitional housing is necessary for successful client outcomes.

Bibliography with Abstracts: Employment

Butterworth, P., Leach, L. S., McManus, S., & Stansfeld, S. A. (2013). Common mental disorders, unemployment and psychosocial job quality: is a poor job better than no job at all? *Psychological Medicine, 43*(8), 1763–1772. doi:10.1017/S0033291712002577

BACKGROUND: Employment is associated with health benefits over unemployment, but the psychosocial characteristics of work also influence health. There has, however, been little research contrasting the prevalence of psychiatric disorders among people who are unemployed with those in jobs of differing psychosocial quality.

METHOD: Analysis of data from the English Adult Psychiatric Morbidity Survey (APMS) considered the prevalence of common mental disorders (CMDs) among 2603 respondents aged between 21 and 54 years who were either (i) employed or (ii) unemployed and looking for work at the time of interview in 2007. Quality of work was assessed by the number of adverse psychosocial job conditions reported (low control, high demands, insecurity and low job esteem).

RESULTS: The prevalence of CMDs was similar for those respondents who were unemployed and those in the poorest quality jobs. This pattern remained after controlling for relevant demographic and socio-economic covariates.

CONCLUSIONS: Although employment is thought to promote mental health and well-being, work of poor psychosocial quality is not associated with any better mental health than unemployment. Policy efforts to improve community mental health should consider psychosocial job quality in conjunction with efforts to increase employment rates.

Campbell, K., Bond, G. R., & Drake, R. E. (2011). Who benefits from supported employment: A meta-analytic study. *Schizophrenia Bulletin, 37*(2), 370–380. doi:10.1093/schbul/sbp066

AIMS: This meta-analysis sought to identify which subgroups of clients with severe mental illness (SMI) benefited from evidence-based supported employment.

METHODS: We used meta-analysis to pool the samples from 4 randomized controlled trials comparing the Individual Placement and Support (IPS) model of supported employment to well-regarded vocational approaches using stepwise models and brokered services. Meta-analysis

was used to determine the magnitude of effects for IPS/control group differences within specific client subgroups (defined by 2 work history, 7 sociodemographic, and 8 clinical variables) on 3 competitive employment outcomes (obtaining a job, total weeks worked, and job tenure).

RESULTS: The findings strongly favored IPS, with large effect sizes across all outcomes: 0.96 for job acquisition, 0.79 for total weeks worked, and 0.74 for job tenure. Overall, 90 (77%) of the 117 effect sizes calculated for the 39 subgroups exceeded 0.70, and all 117 favored IPS.

CONCLUSIONS: IPS produces better competitive employment outcomes for persons with SMI than alternative vocational programs regardless of background demographic, clinical, and employment characteristics.

Carta, M., Sancassiani, F., Lecca, M., Pintus, E., Pintus, M., Pisano, E., … Angermeyer, C. (2013). Coping with the crisis: People with severe mental disorders acting for social change through sustainable energy. *Clinical Practice and Epidemiology in Mental Health, 9*, 214–220. doi:10.2174/1745017901309010214

Background: The aim of the study was to examine the efficacy of a vocational training program on renewable energy sources in reducing disabilities of people with chronic psychosis (CP). The innovative element was that the project could produce major advantages regarding the economic needs of the whole area involved.

Methods: Experimental Cohort, 26 subjects with CP (EC); Control Cohort1, 130 subjects with CP following pharmacotherapy plus other rehabilitation activities (CIC); Control Cohort2, 101 subjects with CP following the usual treatment (pharmacotherapy) (CUC). Study tool: Health of the Nation Outcome Scales (HoNOS). Assessment made at the start of the study (T0) and after three months (T1). Statistical analysis made by MANOVA.

Results: Improvement in HoNOS total score in both groups (F=7.574, p=0.000) with non-significant differences between groups over time (F=1.336, p=0.252) was found comparing EC vs. CIC. Greater improvement in EC vs. CIC was shown in the HoNOS “impairment" scale (F=4.910, p=0.028). EC vs. CUC: both groups improved in HoNOS total score (F=9.440, p=0.000) but the improvement was greater in EC (F = 2.273, P=0.048).

Conclusions: Work inclusion, as well as other rehabilitation treatments, reduces the social needs of people with chronic psychosis. Work inclusion in a project with real relevance for the area where these people live, produces more improvement of cognitive, physical and somatic disabilities, probably related to a better outcome in self-efficacy.

Ferguson, K. M. (2013). Using the Social Enterprise Intervention (SEI) and Individual Placement and Support (IPS) models to improve employment and clinical outcomes of

homeless youth with mental illness. *Social Work in Mental Health, 11*(5). doi:10.1080/15332985.2013.764960

Prior research reveals high unemployment rates among homeless youth. The literature offers many examples of using evidence-informed and evidence-based supported employment models with vulnerable populations to assist them in obtaining and maintaining employment and concurrently addressing mental health challenges. However, there are few examples to date of these models with homeless youth with mental illness. The purpose of this article was thus to describe a methodology for establishing a university-agency research partnership to design, implement, evaluate, and replicate evidence-informed and evidence-based interventions with homeless youth with mental illness to enhance their employment, mental health, and functional outcomes. Data from two studies are used to illustrate the relationship between vocational skill-building/employment and mental health among homeless youth. The article concludes with a discussion of the implications of conducting community-based participatory employment and clinical intervention research. The author highlights the opportunities and tensions associated with this approach.

Gilbert, E., Marwaha, S., Milton, A., Johnson, S., Morant, N., Parsons, N., … Cunliffe, D. (2013). Social firms as a means of vocational recovery for people with mental illness: A UK survey. *BMC Health Services Research, 13*, 270. doi:10.1186/1472-6963-13-270

Background: Employment is associated with better quality of life and wellbeing in people with mental illness. Unemployment is associated with greater levels of psychological illness and is viewed as a core part of the social exclusion faced by people with mental illness. Social Firms offer paid employment to people with mental illness but are under-investigated in the UK. The aims of this phase of the Social Firms A Route to Recovery (SoFARR) project were to describe the availability and spread of Social Firms across the UK, to outline the range of opportunities Social Firms offer people with severe mental illness and to understand the extent to which they are employed within these firms.

Method: A UK national survey of Social Firms, other social enterprises and supported businesses was completed to understand the extent to which they provide paid employment for the mentally ill. A study-specific questionnaire was developed. It covered two broad areas asking employers about the nature of the Social Firm itself and about the employees with mental illness working there.

Results: We obtained returns from 76 Social Firms and social enterprises / supported businesses employing 692 people with mental illness. Forty per cent of Social Firms were in the south of England, 24% in the North and the Midlands, 18% in Scotland and 18% in Wales. Other social enterprises/supported businesses were similarly distributed. Trading activities were confined mainly to manufacturing, service industry, recycling, horticulture and catering. The number of employees with mental illness working in Social Firms and other social enterprises/supported businesses was small (median of 3 and 6.5 respectively). Over 50%

employed people with schizophrenia or bipolar disorder, though the greatest proportion of employees with mental illness had depression or anxiety. Over two thirds of Social Firms liaised with mental health services and over a quarter received funding from the NHS or a mental health charity. Most workers with mental illness in Social Firms had been employed for over 2 years.

Conclusions: Social Firms have significant potential to be a viable addition to Individual Placement and Support (IPS), supporting recovery orientated services for people with the full range of mental disorders. They are currently an underdeveloped sector in the UK.

Kinoshita, Y., Furukawa, T. A., Kinoshita, K., Honyashiki, M., Omori, I. M., Marshall, M., … Kingdon, D. (2013). Supported employment for adults with severe mental illness. *The Cochrane Database of Systematic Reviews, 9*, CD008297. doi:10.1002/14651858.CD008297.pub2

BACKGROUND: People who suffer from severe mental disorder experience high rates of unemployment. Supported employment is an approach to vocational rehabilitation that involves trying to place clients in competitive jobs without any extended preparation. The Individual placement and support (IPS) model is a carefully specified form of supported employment.

OBJECTIVES: 1. To review the effectiveness of supported employment compared with other approaches to vocational rehabilitation or treatment as usual.2. Secondary objectives were to establish how far:(a) fidelity to the IPS model affects the effectiveness of supported employment,(b) the effectiveness of supported employment can be augmented by the addition of other interventions.

SEARCH METHODS: We searched the Cochrane Schizophrenia Group Trials Register (February 2010), which is compiled by systematic searches of major databases, handsearches and conference proceedings.

SELECTION CRITERIA: All relevant randomised clinical trials focusing on people with severe mental illness, of working age (normally 16 to 70 years), where supported employment was compared with other vocational approaches or treatment as usual. Outcomes such as days in employment, job stability, global state, social functioning, mental state, quality of life, satisfaction and costs were sought.

DATA COLLECTION AND ANALYSIS: Two review authors (YK and KK) independently extracted data. For binary outcomes, we calculated risk ratio (RR) and its 95% confidence interval (CI), on an intention-to-treat basis. For continuous data, we estimated mean difference (MD) between groups and its 95% (CI). We employed a fixed-effect model for analyses. A random-effects model was also employed where heterogeneity was present.

MAIN RESULTS: A total of 14 randomised controlled trials were included in this review (total 2265 people). In terms of our primary outcome (employment: days in competitive employment, over one year follow-up), supported employment seems to significantly increase levels of any employment obtained during the course of studies (7 RCTs, n = 951, RR 3.24 CI 2.17 to 4.82, very low quality of evidence). Supported employment also seems to increase length of competitive employment when compared with other vocational approaches (1 RCT, n = 204, MD 70.63 CI 43.22 to 94.04, very low quality evidence). Supported employment also showed some advantages in other secondary outcomes. It appears to increase length (in days) of any form of paid employment (2 RCTs, n = 510, MD 84.94 CI 51.99 to 117.89, very low quality evidence) and job tenure (weeks) for competitive employment (1 RCT, n = 204, MD 9.86 CI 5.36 to 14.36, very low quality evidence) and any paid employment (3 RCTs, n = 735, MD 3.86 CI -2.94 to 22.17, very low quality evidence). Furthermore, one study indicated a decreased time to first competitive employment in the long term for people in supported employment (1 RCT, n = 204, MD -161.60 CI -225.73 to -97.47, very low quality evidence). A large amount of data were considerably skewed, and therefore not included in meta-analysis, which makes any meaningful interpretation of the vast amount of data very difficult.

AUTHORS' CONCLUSIONS: The limited available evidence suggests that supported employment is effective in improving a number of vocational outcomes relevant to people with severe mental illness, though there appears to exist some overall risk of bias in terms of the quality of individual studies. All studies should report a standard set of vocational and non-vocational outcomes that are relevant to the consumers and policy-makers. Studies with longer follow-up should be conducted to answer or address the critical question about durability of effects.

Luciano, A., Bond, G. R., & Drake, R. E. (2014). Does employment alter the course and outcome of schizophrenia and other severe mental illnesses? A systematic review of longitudinal research. *Schizophrenia Research*. doi:10.1016/j.schres.2014.09.010

INTRODUCTION: This review synthesized prospective evidence to assess whether achieving employment alters the course of schizophrenia-spectrum disorder.

METHOD: Researchers identified relevant analyses for review via PubMed, expert referral, and reference review and systematically applied two levels of screening to 1484 citations using seven a priori criteria.

RESULTS: A total of 12 analyses representing eight cohorts, or 6844 participants, compared illness course over time by employment status in majority schizophrenia-spectrum samples. Employment was consistently associated with reductions in outpatient psychiatric treatment (2 of 2 studies) as well as improved self-esteem (2 of 2 studies). Employment was inconsistently associated with positive outcomes in several other areas, including symptom severity, psychiatric hospitalization, life satisfaction, and global wellbeing. Employment was consistently unrelated to worsening outcomes.

DISCUSSION: Achieving employment does not cause harm among people with schizophrenia-spectrum disorder and other severe mental illnesses. Further detailed mechanistic analyses of adequately powered long-term follow-up studies using granular descriptions of employment are needed to clarify the nature of associations between employment and hypothesized benefit.

Macias, P. D., Cathaleene, Rodican, M. S. W., Charles, Hargreaves, P. D., William, Jones, P. D., Danson, Barreira, M. D., Paul, & Wang, P. D., Qi. (2006). Supported employment outcomes of a randomized controlled trial of ACT and Clubhouse models. *Psychiatric Services, 57*(10), 1406–1415. doi:10.1176/appi.ps.57.10.1406

Objective: In a randomized controlled trial, a vocationally integrated program of assertive community treatment (ACT) was compared with a certified clubhouse in the delivery of supported employment services. Methods: Employment rates, total work hours, and earnings for 121 adults with serious mental illness interested in work were compared with published benchmark figures for exemplary supported employment programs. The two programs were then compared on service engagement, retention, and employment outcomes in regression analyses that controlled for background characteristics, program preference, and vocational service receipt. Results: Outcomes for 63 ACT and 58 clubhouse participants met or exceeded most published outcomes for specialized supported employment teams. Compared with the clubhouse program, the ACT program had significantly ($p<.05$) better service engagement (ACT, 98 percent; clubhouse, 74 percent) and retention (ACT, 79 percent; clubhouse, 58 percent) over 24 months, but there was no significant difference in employment rates (ACT, 64 percent; clubhouse, 47 percent). Compared with ACT participants, clubhouse participants worked significantly longer (median of 199 days versus 98 days) for more total hours (median of 494 hours versus 234 hours) and earned more (median of $3,456 versus $1,252 total earnings). Better work performance by clubhouse participants was partially attributable to higher pay. Conclusions: Vocationally integrated ACT and certified clubhouses can achieve employment outcomes similar to those of exemplary supported employment teams. Certified clubhouses can effectively provide supported employment along with other rehabilitative services, and the ACT program can ensure continuous integration of supported employment with clinical care.

Marshall, T., Goldberg, R. W., Braude, L., Dougherty, R. H., Daniels, A. S., Ghose, S. S., … Delphin-Rittmon, M. E. (2014). Supported employment: Assessing the evidence. *Psychiatric Services, 65*(1), 16–23. doi:10.1176/appi.ps.201300262

OBJECTIVE: Supported employment is a direct service with multiple components designed to help adults with mental disorders or co-occurring mental and substance use disorders choose, acquire, and maintain competitive employment. This article describes supported employment and assesses the evidence base for this service.

METHODS: Authors reviewed meta-analyses, research reviews, and individual studies from 1995 through 2012. Databases surveyed were PubMed, PsycINFO, Applied Social Sciences Index and Abstracts, Sociological Abstracts, Social Services Abstracts, Published International Literature on Traumatic Stress, the Educational Resources Information Center, and the Cumulative Index to Nursing and Allied Health Literature. Authors chose from three levels of evidence (high, moderate, and low) based on benchmarks for the number of studies and quality of their methodology. They also described the evidence for service effectiveness.

RESULTS: The level of research evidence for supported employment was graded as high, based on 12 systematic reviews and 17 randomized controlled trials of the individual placement and support model. Supported employment consistently demonstrated positive outcomes for individuals with mental disorders, including higher rates of competitive employment, fewer days to the first competitive job, more hours and weeks worked, and higher wages. There was also strong evidence supporting the effectiveness of individual elements of the model.

CONCLUSIONS: Substantial evidence demonstrates the effectiveness of supported employment. Policy makers should consider including it as a covered service. Future research is needed for subgroups such as young adults, older adults, people with primary substance use disorders, and those from various cultural, racial, and ethnic backgrounds.

Schonebaum, A., & Boyd, J. (2012). Work-ordered day as a catalyst of competitive employment success. *Psychiatric Rehabilitation Journal, 35*(5), 391–395. doi:10.1037/h0094499

OBJECTIVE: This purpose of this study was to determine whether participation in the Work-Ordered Day program of the Clubhouse model has a positive effect on vocational outcomes.

METHOD: The longitudinal study followed a group of individuals with severe mental illness who were randomly assigned either to a Clubhouse program or a Program of Assertive Community Treatment team. Study participants were tracked for 135 weeks. These analyses evaluated the relationship between Work-Ordered Day participation and employment duration for the 43 study participants enrolled in the Clubhouse program who were active throughout the study and competitively employed during the study.

RESULTS: Participation in the Work-Ordered Day program had a significant positive impact on average duration of employment. On average, a 1-hr increase in participation prior to employment led to an increase of 2.3 weeks in competitive employment.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: Participants with more Work-Ordered Day program participation prior to employment had significantly longer average competitive employment duration even when controlling for prior work history. Participation in the Work-Ordered Day program is likely to improve work readiness. Further research is warranted to study which elements of the program may foment employment success. This could lead to

increased implementation of the Work-Ordered Day program and its elements as precursors to employment for adults with severe mental illness.

Schonebaum, A., Boyd, J., & Dudek, K. (2006). A Comparison of Competitive Employment Outcomes for the Clubhouse and PACT Models. *Psychiatric Services, 57*(10), 1416–1420. doi:10.1176/appi.ps.57.10.1416

Objective: This study determined whether the clubhouse model of community support and psychiatric rehabilitation can produce competitive employment outcomes that are comparable or superior to those of the Program of Assertive Community Treatment (PACT) model. Methods: This longitudinal study followed a group of 170 individuals with severe mental illness who were randomly assigned either to the experimental design, a clubhouse program (N=86), or to the control design, a PACT team (N=84). Study participants were tracked for 30 months, and employment outcome data were collected. Results: After 30 months, 72 clubhouse and 76 PACT participants remained active in the project. After 30 months, 74 percent of PACT participants and 60 percent of clubhouse participants had been placed in at least one job. The average clubhouse participant worked 21.8 weeks per job and earned $7.38 per hour, whereas the average PACT participant worked 13.1 weeks per job and earned $6.30 per hour. Conclusions: Participants from both the PACT and clubhouse models achieved high employment levels, with no significant differences in weekly employment or 30-month job placement rates over the course of the study. During this time, clubhouse participants earned significantly higher wages and remained competitively employed for significantly more weeks per job than PACT participants.

Tan, B.-L. (2009). Hybrid transitional-supported employment using social enterprise: A retrospective study. *Psychiatric Rehabilitation Journal, 33*(1), 53–55. doi:10.2975/33.1.2009.53.55

Objective: This brief report examines the implementation of a hybrid transitional-supported employment program using a social enterprise model to improve work skills and work behavior of people with psychiatric disabilities. Methods: The subjects of this study included 25 consumers enrolled in a social enterprise café training program between May 2006 and December 2007. Work behavior assessments and supported employment tenure were retrospectively analyzed. Results: All training participants who completed the 20-month training program demonstrated significant improvement in work behavior before leaving the transitional training at the café. Individuals who completed the transitional training at the café went on to sustain competitive employment for an average of 44 weeks. Conclusion: The social enterprise model is deemed helpful in assisting people with psychiatric disabilities to improve their employment outcomes.

Villotti, P., Corbière, M., Zaniboni, S., & Fraccaroli, F. (2012). Individual and environmental factors related to job satisfaction in people with severe mental illness employed in social enterprises. *Work, 43*(1), 33–41. doi:10.3233/WOR-2012-1445

OBJECTIVE: The purpose of this study was to enhance understanding of the impact of individual and environmental variables on job satisfaction among people with severe mental illness employed in social enterprises.

PARTICIPANTS: A total of 248 individuals with severe mental illness employed by social enterprises agreed to take part in the study.

METHODS: We used logistic regression to analyse job satisfaction. A model with job satisfaction as the dependent variable, and both individual (occupational self-efficacy and severity of symptoms perceived) and environmental (workplace) factors (provision of workplace accommodations, social support from co-workers, organizational constraints) as well as external factors (family support) as predictors, was tested on the entire sample.

RESULTS: All findings across the study suggest a significant positive impact of both individual and environmental factors on job satisfaction. People with higher occupational self-efficacy who were provided with workplace accommodations and received greater social support were more likely to experience greater job satisfaction.

CONCLUSIONS: These results suggest that certain features of social enterprises, such as workplace accommodations, are important in promoting job satisfaction in people with severe mental illness. Further studies are warranted to expand knowledge of the workplace features that support employees with severe mental illness in their work integration process.

Williams, A., Fossey, E., & Harvey, C. (2012). Social firms: Sustainable employment for people with mental illness. *Work, 43*(1), 53–62. doi:10.3233/WOR-2012-1447

OBJECTIVE: Social firms or enterprises aim to offer sustainable employment in supportive workplaces for people who are disadvantaged in the labour market. Therefore, this study sought to explore employees' views in one social firm about the features of their workplace that they found supportive.

PARTICIPANTS: Seven employees were recruited, all of whom experienced persistent mental illness, and had worked in this social firm for between eleven months and six years.

METHODS: A semi-structured interview, the Work Environment Impact Scale (version 2.0), was used to explore participants' views of their workplace and to rate how its physical and social characteristics impacted them. Participants also rated their job satisfaction with a modified Indiana Job Satisfaction Scale.

RESULTS: Features of the social firm workplace identified by these employees as contributing to their sustained employment and satisfaction were the rewards, task demands, work schedule,

and workplace interactions with supervisors and other co-workers. From their views, guiding principles for the development of supportive workplaces and evaluation of their capacity to afford sustainable employment were derived.

CONCLUSIONS: This study adds to current knowledge about workplace supports from an employee perspective, and is of relevance for informing future social firm development, workplace design and evaluation.

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Literature Review

Legal Marijuana, Prescription Drug Abuse, and Colorado Behavioral Health Service Needs

This section provides background research on the effects of marijuana legalization and the ongoing prescription drug abuse epidemic in the United States. The focus in on national and international trends.

Marijuana Legalization

Relevant Evidence

With no precedent for full marijuana legalization, predictions of the impact of such policies are often based on studies of medical marijuana legalization and marijuana decriminalization policies. A number of arguments support the applicability of medical marijuana policy findings to recreational marijuana legalization. For example, medical marijuana legalization is largely regarded as affecting recreational marijuana use, in part due to the difficulty of enforcing medical marijuana policies.[1] Following the contention that medical marijuana regulations are not successful in restricting marijuana use to people who need it for medical purposes, some have argued that there may be substantial overlap between the population of recreational marijuana users and the population of people who obtain marijuana legally under medical use policies. By extension, studies of the public health and behavioral health impact of medical marijuana legalization may be useful in considering possible public behavioral health needs following recreational marijuana legalization.[2]

Still, while the impact of medical marijuana legalization likely is in some ways similar to that of recreational marijuana legalization, it is also likely to be different in some ways.[3] For example, medical marijuana policies are not a homogeneous group, and their differences are associated with different impacts on population marijuana use rates. Even within a given jurisdiction, a single medical marijuana policy may change in significant ways over time.[4] These variations play a major role in the policies' impact on price, which likely influences overall consumption and consumption patterns. Medical marijuana policies without dispensary components tend to lead to higher marijuana prices, and are therefore less likely to promote marijuana use among new users. Those that do have dispensary components, however, tend to lead to lower marijuana prices, which can promote use among both existing and new users.[5] Similarly, caution should be exercised in considering the application of the Dutch experience to states undergoing full legalization. Marijuana policies in the Netherlands are more nuanced than full legalization policies and likely have resulted in more limited impact on marijuana-related economy, given that the government continues to prosecute growers and traffickers.[6]

Legalization and Rates and Patterns of Marijuana Use

A common concern of those opposed to marijuana legalization is that legalization will lead to increased marijuana use at the population level, and increased use in turn will lead to increased public health burden and treatment need.[7] Studies of the impact of medical marijuana legalization on population-level marijuana use and public opinions about marijuana use have yielded conflicting results.[8] For example, Cerda and colleagues[9] reported both higher rates of marijuana use and abuse/dependence among those living in states with medical marijuana legalization, while Choo and colleagues[10] did not find evidence of an association between medical marijuana legalization and an increase in youth marijuana use. They analyzed Youth Risk Behavioral Surveillance Survey data from states that legalized medical marijuana use to determine the difference in self-reported youth marijuana use before and after medical marijuana legalization within these states and compare it to the difference in self-reported use over the same period of time in neighboring states with no medical marijuana policy. Another study found that, following the legalization of medical marijuana in Montana, county-level prevalence of medical marijuana licenses within that state was not related to youth self-reported lifetime and past-30-day use, while county-level support for medical marijuana legalization – as measured by votes for the actual legislation – was positively related to both lifetime and past 30-day use.[11] Multiple authors have noted that higher rates of marijuana use in states that have legalized medical marijuana have been found using cross-sectional data but cannot be taken as evidence that such policies cause higher use. Several alterative explanations exists, with a particularly compelling possibility being that pre-existing state norms drive both marijuana legalization and (higher) rates of marijuana use.[12]

Studies of marijuana use rates following decriminalization in other countries have generally not found evidence of increased usage in instances of decriminalization in the absence of active commercialization.[13] For example, MacCoun[14] reported that while youth (ages 15-16) lifetime and recent marijuana use rates are relatively similar in the United States and the Netherlands, as well as in a number of other European countries, there is some evidence pointing to an increase in marijuana use among youth and young adults during the period that the coffee house system was rapidly expanding (1984-1996), a period during which use among young people in other European countries was dropping. Overall, this study did not find evidence of greater likelihood to continue regular use, heavier marijuana consumption, or longer marijuana use "careers" among Dutch marijuana users, compared to U.S. marijuana users.[15]

The authors of one recent review noted that, even if questions of overall rates of use could be resolved, conclusions about the impact on public health cannot be drawn based on existing knowledge: "It is hard to know, based on the current literature, the extent to which greater marijuana use will lead to greater harms. It will likely depend on a number of factors, including who ends up responding the most to price. If it is the casual adult user who enters the market and consumes in relatively small amounts, then the expected harms are very small. If it is new young users, more involved heavy users, or users of other substances, then the harms could be greater."[16] Indeed, price reductions may have differing effects on adult and adolescent marijuana consumption patterns, particularly as adolescents have less disposable income than adults.[17]

Given that both decriminalization and medical marijuana legalization are imperfect models for recreational legalization, some researchers have turned to economic modeling to investigate the likely impact of full legalization on population-level marijuana use. In work designed to assess the potential impact of legalization in California, the RAND Corporation determined that changes in consumption are likely to be a result of both price-related and non-price-related factors, the latter including changes in availability, advertising, and public perception of marijuana.[18] Changes in consumer price are likely to result from a range of factors, including changes in the cost of producing and distributing marijuana, specifics of policies regulating production and distribution, tax rates, and patterns of tax evasion. Additionally, the impact of price on consumption is in part of function of how marijuana users and potential users react to price differences. Limited data exist for many of these factors, and the model's outcomes are highly sensitive to variations in key assumptions, complicating prediction of the impact of legalization on consumption.[19]

Adverse Consequences of Marijuana Use among Youth

In the United States, both medical and recreational marijuana legalization has been limited to adult consumers. However, a key concern about both policies is their potential impact on marijuana consumption among youth. Some studies have reported a pattern of medical marijuana diversion to adolescent consumers,[20] and there is evidence suggesting that full legalization may promote an increase in the number of youth who intend to use marijuana, as well as an increase in intention to use more frequently among youth who have used marijuana.[21] Given such findings, the long-term effects of marijuana use during youth are of particular interest.

Studies of the long-term effects of marijuana use during adolescence also face challenges in establishing that observed associations are not in part or whole a result of other factors, such as use of alcohol, tobacco, or other drugs, all of which are correlated with marijuana use. There has been some debate in the literature as to whether the methodological techniques used to control for these associations have successfully isolated the effect of marijuana use.[22] For example, while regular cannabis use and poor educational outcomes are associated, it is not clear that the relationship between the two is a simple causal one. One plausible possibility is that higher pre-existing risk contributes to both marijuana use and poor educational attainment, with regular cannabis use further contributing to poor educational outcomes through reductions in cognitive performance and increased affiliation with peers who discontinue education or perform poorly at school.[23] Similarly, studies of the neuropsychological effects of heavy cannabis use in adolescence raise important questions, but caution should be exercised in drawing conclusions based on their findings, given the difficulty and importance of controlling for a comprehensive set of potentially critical factors, including education and an array of mental health-related variables.[24]

Ultimately, given the concerns that youth may be particularly vulnerable to adverse effects of marijuana use and the potential for legal marijuana to be diverted to adolescents, some have suggested that the legalization of marijuana necessitates prevention and screening activities for

adolescents, similar to those in place for tobacco and alcohol use (e.g., screening and brief counseling conducted by primary care physicians).[25]

Adverse Consequences Related to Prenatal Exposure

There is little evidence to suggest that marijuana use among pregnant women leads to birth defects, and caution is in order in attributing the associations that have been observed solely to marijuana use, given the myriad other prenatal risk factors that are known to be more prevalent among women who use marijuana (e.g., other substance use, poorer prenatal care and nutrition).[26] Similarly, findings related to childhood behavioral and intellectual development delays among children with prenatal marijuana exposure have been inconsistent, and studies on the topic have faced significant challenges controlling for potentially confounding factors, including genetics and differences in parenting.[27]

Adverse Consequences of Acute Intoxication

Acute marijuana intoxication is associated with a number of negative behavioral health effects, including panic and anxiety, which are more likely to occur in new users, and symptoms of psychosis, which are more likely to occur in those using marijuana in very high doses.[28] While the research suggests that marijuana intoxication may pose less of a vehicle crash risk than alcohol intoxication, it does points to some reduction in driving performance under acute marijuana intoxication. At the same time, there are a number of challenges in identifying a blood THC concentration criterion to define impaired driving.[29] The lack of a clear standard poses a clear policy challenge for states developing impaired driving policies and also poses a challenge for researchers attempting to assess the impact of marijuana use and marijuana policy on public safety. A recent study found a significantly higher number of suspected impaired driving cases testing positive for THC in Washington State in the year following legalization than in the four years leading up to legalization.[30] The authors did not perform statistical tests to determine whether a significant difference existed between the number meeting the state's cutoff for impaired driving (5 ng/mL THC) in the year following legalization and the number meeting that cutoff in the years prior to legalization. It is also important to note that the increase in positive testing was noted after marijuana use had been legalized, but before the licensing and regulation of marijuana production and sale went into effect, suggesting that any impact of the full policy change may not have yet been evident in the data.[31]

Adverse Consequences of Long-term Use Related to Substance Use

Dependence

Cannabis dependence, or difficulty controlling and stopping use in the face of use-related harms, has been estimated to occur in about 9 percent of cannabis users overall, and about 17 percent of those who begin using during adolescence.[32] While at least one study has found greater overall rates of marijuana dependence in states with medical marijuana legalization than in those without such policies, the authors noted that while the rate of dependence in the population was higher in medical marijuana states, the rate of dependence among marijuana users remained the same.[33] As noted above, these findings should be interpreted with some

caution, given the difficulty in ruling out pre-policy differences in public norms as a possible cause of this finding and the challenges in applying medical marijuana policy research findings to settings with recreational marijuana legalization.

Alcohol Use

The relationship between alcohol and marijuana consumption is not yet clear, and this relationship is likely a key factor in determining the overall impact of legalization on public health. If marijuana use typically serves as a substitute for alcohol use, the public health concerns associated with increased marijuana use would be less significant than they would if marijuana use is more likely to occur alongside alcohol use.[34] Similarly, there is no consensus on the degree to which marijuana use affects tobacco use.[35]

Marijuana as a Gateway Drug

There is a clearly-established association between marijuana use and later use of illicit "hard" drugs, as well as an association between earlier initiation of marijuana use and likelihood of subsequent use of heroin and cocaine. Possible mechanisms underlying this association include pre-existing propensity for both marijuana and hard drug use, initiation into the hard drug marketplace through marijuana purchasing, and the possibility that marijuana use causes changes in the brain that increase the likelihood of later drug use.[36] Clearly these mechanisms are not mutually exclusive. No definitive consensus on the contribution of each of these mechanisms exists, with research suggesting that the pre-existing propensity or "common cause" explanation likely plays at least some role in the relationship between marijuana and harder drug use, and some studies suggesting that this may not be the only mechanism at work.[37] Some have proposed that, if marijuana does indeed function as a "gateway" drug, it does so in whole or in part by introducing the user to the illegal drug marketplace. This was the rationale underlying the Dutch decriminalization policy, and it may be important to note that a smaller proportion of Dutch than U.S. youth reported using other illicit drugs (6.5 percent vs. 19 percent), and that the proportion of Dutch individuals reporting cocaine and amphetamine use is lower than expected, given the rate of marijuana use.[38]

Adverse Consequences of Long-term Use Related to Mental Disorders

Depression and Suicide

While multiple studies have found an association between marijuana use and depression, in some cases this association has been accounted for by confounding variables, and in other cases the researchers have been unable to control adequately for confounding variables or to establish that the relationship is not a result of depression predisposing people to marijuana use.[39]

Similarly, while some studies have found an association between suicidal behavior and marijuana use, these findings have been inconsistent,[40] and research on the topic faces a number of significant methodological challenges, including difficult-to-measure individual-level confounding variables and the potential for reverse causality (i.e., individuals experiencing depression and at risk for suicide may self-medicate with marijuana).[41] Two recent studies did not find support for a relationship between medical marijuana legalization and increased

suicide rates. Anderson and colleagues[42] used state-level suicide data to examine suicide rates over a period of 18 years, during which a number of states legalized medical marijuana use. After controlling for a wide range of variables, the authors found no relationship between medical marijuana legalization and suicide rates overall, but did find a relationship between medical marijuana legalization and reduced suicide rates among younger men. Rylander and colleagues used a different approach, investigating the relationship between two proxies for medical marijuana use--number of medical marijuana registrants and number of marijuana dispensaries--and local suicide rates, controlling for a range of suicide risk factors. No relationship was found between these proxies and suicide rates, but the authors caution against wholesale optimism in response to their findings given the inconsistent findings in the research on suicide and marijuana use, as well as their own study limitations, including the use of proxy measures rather than actual medical marijuana use.[43]

Schizophrenia and Psychoses

Multiple studies have also found an association between heavy marijuana use and later schizophrenia or psychosis. Most of this research has established that marijuana use preceded the onset of psychosis or schizophrenia, and in some cases researchers have observed a relationship between cannabis use and schizophrenia even after controlling for some potentially confounding variables. At the same time, some have argued that research has yet to rule out the possibility that both marijuana use and schizophrenia are promoted by a common cause or set of predisposing factors.[44] Additionally, studies on the relationship between population-level changes in marijuana use and incidence of schizophrenia have resulted in inconsistent findings: Some have reported increases in incidence of schizophrenia following increased rates of marijuana use in the general population, as would be expected if marijuana use causes schizophrenia in people who otherwise would not have developed it, but other studies have not found such a link.[2245] Give the existing evidence, it has been argued that the strongest hypothesis is that cannabis use contributes to the onset of psychosis in some individuals who are already at risk of developing the schizophrenia or a related disorder.[46]

Marijuana use has also been associated with poorer outcomes among people diagnosed with schizophrenia, but this relationship again may not be a causal one. A systematic review of research on outcomes associated with cannabis use among people diagnosed with schizophrenia and related disorders found that while these studies were relatively consistent in their findings of an association between cannabis use and relapse or reduced treatment follow-through, associations with other outcomes were not consistently observed. Additionally, the authors noted that this body of research as a whole did not control sufficiently for confounding factors, leading them to conclude that there was not adequate support for attributing poorer outcomes to cannabis use.[47]

Adverse Consequences of Long-term Use Related to Cognitive Functioning

Heavy cannabis use is associated with subtle cognitive deficits, including those related to memory, attention, learning, and information processing. No clear consensus exists in the literature regarding whether these impairments are a result of the drug's acute, residual, or

cumulative effects; whether they are more closely related to duration or frequency of use; or the degree to which they abate following marijuana abstinence.[48]

Chronic cannabis use has been associated with changes in brain function including resting brain blood flow, brain activity levels, cannabinoid receptor activity, and reduction in hippocampus and amygdala volume.[49] Following their study of neurological differences between chronic marijuana users and non-users, Filbey and colleagues[50] suggested that some of the differences noted may represent the results of an adaptive process in response to marijuana use. As with the research on many of the other potential outcomes of marijuana use, however, studies identifying a link between marijuana use and neurological abnormalities are generally not designed to establish that the former causes the latter. Indeed, some findings point to the possibility that these neurological characteristics precede marijuana use, suggesting that they may be indicators of predisposition to use marijuana.[51]

Data Sources and Indicators

Individual-level, self-report variables commonly used in the academic and policy research on marijuana legalization include recent and lifetime marijuana use, frequency of marijuana use, marijuana dependency, age of first use, history of driving following marijuana use or riding in a vehicle driven by someone who is under the influence of marijuana, intention to use marijuana in the future, perception of the acceptability of marijuana use, and perception of the harmfulness of marijuana use. Any of these indicators may be of interest when gathered from the general public or from members of a population believed to be at particularly high risk of adverse consequences (youth, adults diagnosed with schizophrenia or related disorders, etc.). Washington's marijuana legalization policy incorporates a range of monitoring and research activities, funded in part by marijuana tax revenues.[52] Existing and new data can be leveraged to track risk and protective factors related to adverse effects of marijuana use, as well as use and perception trends overall. Two examples of particular relevance are:

Marijuana Usage Trends Monitoring:

One component of the cost-benefit analysis mandated by Washington's policy is an analysis of marijuana use over time, beginning with an analysis of use trends in the period leading up to legalization.[53] Conducted by the Washington State Institute of Public Policy (WSIPP), the initial phase of this project used 2002-2011 National Survey on Drug Use and Health (NSDUH) data to examine trends in current (past 30 days) use, lifetime use, age of first use, and abuse/dependency. Use of this dataset enabled WSIPP to compare trends observed in Washington to those in the country overall, as well as in Colorado, as the only other state with full legalization at the time of the report. NSDUH surveys both youth and adults, allowing WSIPP to conduct targeted analysis on youth as a population considered to be at high risk.

Youth Survey

The Washington policy also directs additional funding to the state's Healthy Youth Survey, a survey of a representative sample of junior and senior high school students conducted every two years by the Department of Social and Health Services (DSHS) in collaboration with several other state entities. The survey was initiated in 1988, giving the state the benefit of

considerable historical data on marijuana use and related indicators. The current survey is being used to gather information on a range of protective and risk factors related to youth well-being, as well as information on marijuana, alcohol, illicit drug, and prescription drug use; attitudes towards use; peer approval of use; and parental approval and monitoring of use. As a result of legalization, DSHS has received additional funding to expand the survey to college-age youth.[54]

Prescription Drug Epidemic

Adverse Consequences of Prescription Drug Abuse

NIDA defines prescription drug abuse as *the use of a medication without a prescription, in a way other than as prescribed, or for the experience of feelings elicited*.[55] Commonly abused classes of prescription drugs include opioid painkillers such as hydrocodone and oxycodone, central nervous system (CNS) anti-anxiety and sleep medications such as benzodiazepines and barbiturates, and stimulants such as dextroamphetamine and methylphenidate.[56] According to 2010 NSDUH data, roughly 16 million Americans reported nonmedical use of one or more prescription medications in the last year, and about seven million of those reported such use within the last month.[57] Among those reporting past-month prescription drug abuse, over five million reported nonmedical use of prescription painkillers, over two and a half million reported using sedatives and tranquilizers for nonmedical purposes, and over one million reported nonmedical use of stimulants.[58] Changes in prescribing practices are a critical feature of the prescription drug abuse landscape, with the number of opioid prescriptions dispensed tripling between 1991 and 2010, and the number of stimulant prescriptions dispensed in 2010 being 11 times that of the number dispensed in 1991.[59] Combined behavioral and pharmacological treatments are generally the most promising for many forms of prescription drug abuse.[60]

Emergency room visits and overdoses are critical outcomes of prescription drug abuse. Indeed, annual prescription opioid overdose deaths quadrupled between 1999 and 2010, and the number of 2010 overdose deaths attributed to prescription opioids was more than double that of heroin and cocaine combined.[61] The Drug Abuse Warning Network (DAWN) reported that prescription drug abuse caused roughly 1 million of the country's emergency room visits in 2009.[62] The risks associated with the use or abuse of any one prescription drug increase when the drug is taken with certain other classes of drugs (e.g., opioid painkillers and depressants) or with alcohol.[63] Additionally, structural and functional brain changes have been associated with both long-term[64] and short-term[65] prescription opioid use.

Older adults and youth are at higher risk of prescription drug abuse. Roughly a third of "new initiates" —those using abusing prescription drugs for the first time within the past year—are people ages 12 to 17, and overall rates of prescription drug abuse are highest among those aged 18 to 25.[66] Risks common among older adults include age-related changes in metabolism, greater likelihood of using multiple prescriptions and long term prescriptions, and for some individuals, difficulty managing medications due to cognitive decline.[67] Individuals living with chronic pain also constitute a population at high risk, as long-term prescription opioid use is

associated with the increased drug tolerance and addiction, as well as a paradoxical increase in pain sensitivity (hyperalgesia).[68]

Prescription Drug Monitoring Programs

Prescription drug monitoring programs (PDMPs) allow doctors and pharmacists to identify some patients with potentially dangerous prescription drug use patterns.[69] PDMPs are statewide programs that monitor patient-level data on dispensed prescriptions for controlled substances. This information is typically stored in a secure database that may only be accessed by members of authorized user groups defined by the state (e.g., medical and dental practitioners and law enforcement personnel).[70] PDMPs have been identified as central components in the Office of the President's strategy to address the prescription drug abuse crisis.[71]

PDMPs have proliferated rapidly in recent years[72] and are currently operational in 49 states and one territory.[73] PDMPs can facilitate proactive reporting of possible doctor shopping, which can alert prescribers of possible prescription drug misuse among their patients.[74] Proactive reporting is one component of an extensive framework of PDMP best practices that has been developed based on a synthesis of available research, expert opinion, and anecdotal experience.[75]

Research and evaluation related to PDMPs suggest that these systems are associated with a number of important positive trends in controlled substance prescribing and use.[76] Multiple states have reported that PDMP implementation and use is associated with changes in prescribing practices and increases in drug use screening and referral to behavioral health services and pain management specialists. Numerous states have also reported significant decreases in individuals meeting doctor-shopping definitional criteria (e.g., use of five prescribers and five pharmacies within a 90 day period) following PDMP implementation or increased or mandated prescriber use of PDMPs. Declines or reduced rates of growth in controlled substance prescribing have been noted among states with PDMPs, and among states mandating prescriber use of PDMPs. In recent years, multiple states have reported that prescription drug-related deaths or ED visits have decreased over periods of PDMP initiation, usage increase, or mandated prescriber use implementation. Additionally, PDMPs have been used to aid in criminal justice diversion, through such means as pre-criminal identification and monitoring of individuals engaged in doctor-shopping or coordination with drug court programs to monitor prescription drug abstinence.[77]

Insurance Lock-In Programs

Public and private insurance "lock-in" programs restrict controlled substance coverage for individuals meeting doctor-shopping definitional criteria to a single pharmacy and/or a single prescriber. Such programs have been associated with significant insurer savings.[78] Medicaid lock-in programs in particular have been identified as a promising tool for reducing states' population-level prescription drug abuse, given the volume of people served through Medicaid programs and the higher rates of opioid overdose among Medicaid enrollees, compared to those who are covered by private insurance.[79]

At least 46 states currently operate Medicaid lock-in programs.[80] Colorado's Client Overutilization Program (COUP) allows the state to restrict Medicaid recipients to a single provider and a single pharmacy for a 12 month period, if they are found to overuse services within a three month period, as indicated by the use of three or more pharmacies, 16 or more prescriptions, three or more drugs in the same therapeutic category, or excessive ED or physician services. [81]

Despite the near-universality of Medicaid lock-in programs, limited research and evaluation of these programs has been conducted, and best practices have not been established.[82] Several innovative approaches have been identified, however, and may bear consideration. Key among these is the use of lock-in programs as a mechanism for identification of a population particularly likely to benefit from additional prevention and targeted treatment services, including both behavioral health and pain management interventions. For example, Montana Medicaid beneficiaries enrolled in the state's lock-in program receive two years of health education and coordinated care delivered by a multidisciplinary team. Such an approach may also serve to reframe lock-in policies in a more positive light, reducing recipients' sense of lock-in as a form of punishment.[83] Additionally, integration of PDMP data and Medicaid claims data could greatly facilitate the process of identifying beneficiaries with potentially dangerous prescription drug use patterns.[84]

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Literature Review

Drug Possession Sentencing Reform

After decades of rapid growth in the prison population following the enactment of mandatory drug sentencing in 1985, the Colorado legislature and state government officials have focused considerable attention on reforming the state's criminal justice and correctional systems over the last few years. Colorado has implemented numerous sentencing reforms, resulting in a steady decline in the adult prison population.

The most sweeping legislative reform was Senate Bill 13-250, enacted into law in June 2013. The law reflects Colorado's evolving criminal justice response to drug abuse, reducing sentences and emphasizing treatment in lieu of incarceration. Provisions include a simplification of the current drug sentencing structure that better differentiates between drug users and drug suppliers; sentencing options that recognize individual circumstances and provide more discretion to judges; increased use of drug courts, with priority for funding those that use evidence-based practices; and the identification of drug offenders for whom rehabilitation is the priority goal of sentencing. For example, the law allows a judge to substitute a misdemeanor conviction for a felony if the offender successfully completes a community-based sentence (which often includes drug treatment requirements); allows a judge to impose residential drug treatment as a probation condition for drug misdemeanors; and allows defendants convicted of misdemeanor drug offenses to be sentenced to intensive supervision probation if appropriate.

At the same time this new law went into effect (October, 2013), Medicaid expansion offered a powerful impact on the treatment of substance abuse. Colorado has expanded Medicaid eligibility for all persons whose income is less than 138 percent of the federal poverty level. There is a widespread consensus that this Medicaid expansion will include a disproportionate number of justice-involved individuals, including younger, unmarried, substance-abusing males who also disproportionately populate Colorado prisons, as well as parole and probation caseloads.

As a result of these two coinciding reforms, the demand for treatment and rehabilitation services for justice-involved individuals will increase. The behavioral health and community corrections systems will need to respond to this increased demand from those who would have been imprisoned prior to sentencing reform. The capacity of the behavioral health system will be tested in several ways, and Colorado will need to answer several key questions in order to effectively plan for the future. Are there enough programs and providers to meet the increased demand? Are the services accessible to and effective with this target population? What structures are in place to support collaboration among behavioral health providers and the criminal justice system to implement alternative sentences? What risk management policies and practices should be in place at every level – state, regional, and provider?

The Colorado judicial system has established more than two dozen adult and juvenile drug treatment courts, drunk driving courts, veteran treatment courts, co-occurring disorders courts, tribal healing wellness courts, and hybrid courts for substance abuse and drunk driving. It has taken the lead nationally in addressing the special challenges and needs involved in ensuring that this population receives appropriate, effective treatment without undue risk to public safety. If the state judiciary continues to rely on its specialty courts to coordinate and oversee the treatment of Colorado's justice-involved population, will it be able to expand to serve the expected increase of defendants under community supervision in need of treatment?

To address these questions, we first looked at the research and literature that examined justice populations across the country for insights on the prevalence of individuals in need of treatment for substance abuse and the expected impact of Medicaid expansion on the justice-involved population and treatment providers. Then we looked at the research and literature that examined these issues specifically as they relate to Colorado.

Prevalence of Substance and Alcohol Use Disorders and Co-occurring Mental Illness

The population of justice-involved individuals identified as substance and alcohol abusers and those with mental illness is growing. The percentage of adults incarcerated in federal, state, and local correctional facilities grew by 32.8 percent during between 1996 and 2006, and the number of substance-involved offenders increased even more, by 43.2 percent.[1] This section examines the prevalence of behavioral health disorders among people in jail or prison, or on parole or probation.

Substance Abuse in Prisons and Jails

A majority of inmates have substance use problems. The National Center on Addiction and Substance Abuse (CASA) at Columbia University found that 1.5 million of the 2.3 million inmates in U.S. prisons and jails during 2010 met the DSM IV medical criteria for substance abuse or addiction.[2] Another 458,000 had histories of substance abuse, were under the influence of alcohol or other drugs at the time of their crime, committed their crime to get money for drugs, were incarcerated for a drug or alcohol crime, or shared some combination of these characteristics. The numbers and percentages of substance-involved inmates are broken down by type of correctional institution in the following chart.

Substance-Involved Inmates, 2006[3]

Institution	Number	Percent
State	1,101,779	84.6%
Local	648,664	84.7%
Federal	164,521	86.2%
All	1,914,964	84.8%

The numbers vary depending upon the definitions used. Limiting "substance-involved" to those diagnoses for substance use disorder, substance dependence, or merely substance abuse, the numbers are smaller but still significant. Note, the latest DSM V collapses substance abuse dependence and addiction diagnoses into one classification, substance use disorder. The

following chart breaks down the numbers and percent of inmates by both type of correctional institution and substance abuse diagnosis.

Drug Use by Inmates[4]

Institution	Drug Use Disorder	Drug Dependence	Drug Abuse Only
State	53.4% (662,712)	36.1% (448,013)	17.3% (214,699)
Local	53.5% (381,985)	35.8% (255,608)	17.7% (126,376)
Federal	45.5% (77,063)	28.7% (48,609)	16.8% (28,454)
Total	52.6% (1,121,760)	35.3% (752,230)	17.3% (369,529)

Substance use disorders are seven times more prevalent among prison and jail inmates than among the general population.[5] A quarter (24.4 percent) of prison and jail inmates have co-occurring disorders. Women inmates are a little likelier to have a substance use disorder (66.1 percent vs. 64.3 percent) and much more likely to have a co-occurring mental health problem, at a little over 40 percent.[6]

The drugs of abuse vary, but a little under a quarter of inmates report use of heroin/opiates in the past, and 13.1 percent reported "regular" use of heroin/opiates.[7] That percentage has increased since the Justice Department completed this survey in 2004.

Notwithstanding the large numbers of inmates in the nation's jails and prisons who have substance abuse disorders, only slightly more than ten percent receive any type of professional treatment or counseling or pharmacological therapy (medicated assisted treatment). State prisons are a little more likely than jails to provide any professional treatment, 14.2 percent compared to 5.2 percent, although mutual support/peer counseling is more widespread, estimated to reach 29.9 percent in prisons and 10.7 percent in jails.[8] The Bureau of Justice Administration has cut federal funding for prison and jail substance abuse treatment. This federal fiscal year, Congress provided only $8,637,752 in total for all fifty states and five U.S. territories. Colorado received only $138,662 for the fiscal year.[9]

Alcohol Abuse in Prisons and Jails

As of 2002, a little over half (51 percent) of all inmates in federal and state prisons and local jails were under the influence of alcohol at the time of their current offense.[10] Although not all necessarily had an alcohol use disorder, most did. The following chart breaks down the different alcohol use disorder diagnoses then employed among correctional facilities, state, local (county), and federal.

Alcohol Use by Inmates[11]

Institution	Alcohol Use Disorder	Alcohol Dependence	Alcohol Abuse Only
State	44.3% (549,778)	24.9% (309,017)	19.3% (239,520)
Local	46.6% (332,719)	22.8% (162,790)	23.8% (169,930)
Federal	36.3% (61,281)	18.3% (30,995)	18.1% (30,656)
Total	44.3% (943,778)	23.6% (502,802)	20.65% (440,106)

Substance and Alcohol Abuse in State Parole Populations

Most justice-involved populations are not incarcerated, but living in the community on parole or probation. The former are conditionally released from prison or jail before their full sentence is completed by paroling authorities and are supervised by parole officers, generally employees of state correctional or justice agencies. The latter are conditionally released to the community directly after trial or plea by a judge and are supervised by probation officers, generally employees of the judiciary or a state correctional or justice agency. In Colorado, the Board of Parole is the paroling authority for adults. The Division of Adult Parole Supervision of the Department of Corrections administers parole. The state Judicial Department administers adult and juvenile probation within Colorado's 22 judicial districts. This includes 23 probation departments, with over 50 separate probation offices throughout the state.

Not surprisingly, those released on parole or probation also have high rates of substance and alcohol use disorders and co-occurring disabilities. State parolees have been found consistently to have a much higher rate of substance use disorder than those in the community. In 2006, parolees were twice as likely as members of the general population age 18 and over to be either current users of illicit drugs or binge drinkers (55.7 percent vs. 27.5 percent), and four times likelier to meet clinical criteria for substance use disorder (36.6 percent vs. 9 percent).[12] The primary substance of abuse for parolees is alcohol, with almost half (45.8 percent) reporting binge drinking, compared to one quarter (24.3 percent) of the general population.[13] In 2012, adults aged 18 and over who were on parole or some form of supervised release during the past year had a higher rate of illicit drug or alcohol dependence or abuse (34 percent) than their counterparts who were not on parole or supervised release during the past year (8.6 percent).[14]

The severity of parolee substance use disorder and the challenges faced by treatment providers can be understood by two sets of statistics. The majority of parolees in need of treatment for substance use disorders had at least one prior admission to treatment for substance abuse (57.5 percent), and 18.4 percent had three or more prior admissions to treatment for substance abuse.[15] In other words, the majority failed to remain abstinent or sober notwithstanding prior treatment attempts. Further, inmates released from prison are nearly 13 times as likely to die during their first two weeks out of prison, compared to the rest of the population, and nearly 130 times as likely to die of a drug overdose in those two weeks.[16]

Colorado's mortality rate from drug overdoses is 24th among states, at 12.7 per 100,000, according to *Prescription Drug Abuse: Strategies to Stop the Epidemic*. This represents a 59 percent increase since 1999.[17] The latest National Survey on Drug Use and Health reveals that 3.96 percent of Colorado adults used an illicit drug other than marijuana in the previous month, compared to 3.36 percent nationally.[18]

Substance and Alcohol Abuse in Probation Populations

National figures indicate that parolees are more likely to receive treatment for substance abuse than inmates. In 2009, a third of male parolees, aged 18 to 49, reported receiving treatment for substance abuse in the past year.[19]

Between 2002 and 2009, 33.8 percent of probationers were diagnosed with alcohol dependence or abuse issues, and 31.1 percent with illicit drug use, in the past month. These figures compare to only 13.6 percent and 13.5 percent, respectively, for those not on probation in the past year. The total for either alcohol or illicit drug dependence or abuse was 41.7 percent.[20] As researchers commented after reviewing the 2002-2009 figures, "with surprising persistence from 2002-2009, nearly half of male probationers aged 18 to 49 needed treatment. This is about three times the treatment need found among males of the same age who were not on probation. While about half needed treatment for alcohol or illicit drug use, only about a quarter received some treatment in the past year; most of these reported receiving treatment at a specialty substance use treatment facility."[21] In 2012, the rate of substance abuse in the adult probation population was 37 percent over the prior year, which was more than three times higher than the rate in the general non-probation population (8.2 percent).[22]

All and all, approximately 65 percent of adults in the U.S. corrections system meet criteria for drug and/or alcohol use disorders.[23]

Mental Disorders among Justice-Involved Populations

Jails and prisons have replaced state mental hospitals as the largest place of institutional residency for Americans with mental illnesses. The prevalence of serious mental illness among people entering jails is estimated to be 16.9 percent, a rate three to six times higher than in the general population.[24] The U.S. Department of Justice reported that midyear 2005, more than half (56 percent) of state prisoners and two-thirds (64 percent) of jail inmates had mental health problems. Mental health problems included a recent history or symptoms of a mental health problem, including a clinical diagnosis or treatment by a mental health professional. Twenty-one percent of jail inmates and 24 percent of state prison inmates had been assessed by a professional as having a mental health problem in the year before their arrest. A quarter (24 percent) of jail inmates and over 15 percent of state prison inmates had experienced psychotic symptoms in the last 12 months.[25] Individuals in prison are diagnosed with schizophrenia at four times the rate as those in the general population.[26]

About a third of state prisoners who had mental health problems received treatment; 17 percent of jail inmates with mental health problems received treatment.[27] A little less than a quarter of these inmates in prison (22 percent) and jail (23 percent) had received mental health treatment before their incarceration, and 16 percent of these state prisoners and 17 percent of the jail inmates had been prescribed medication for their mental illness.

Mental health symptoms are common among jail and prison inmates. According to the Bureau of Justice Statistics, 43 percent of state prisoners and 54 percent of jail inmates reported symptoms of mania; 23 percent and 30 percent, respectively, reported symptoms of major depression; and 15 percent and 24 percent, respectively, reported psychotic symptoms.

Symptoms were more common among female inmates (73 percent in prison, 75 percent in jail) than male inmates (55 percent in prison, 63 percent in jail). Inmates 24 or younger have the highest rate of mental health problems; those age 55 plus have the lowest. Variations exist by race and ethnicity: 62 percent of whites, 55 percent of African Americans, and 46 percent of Hispanics are affected.[28]

Similarly, a disproportionate number of justice-involved persons supervised in the community experience mental health problems.[29] Between 2002 and 2009, 20 percent of male parolees or persons on supervised release, aged 18 to 49 years old, in the past year suffered from a serious psychological distress and 8.4 percent reported any mental illness. In 2008-2009, 33.9 percent reported any mental illness. In addition, 16.3 percent reported receiving mental health services or counseling. By comparison, only 10 percent of males of the same age who were not on parole or supervised release reported serious psychological distress.

Between 2006 and 2009, 20.7 percent of males between the ages of 18 and 49 on probation suffered serious psychological distress, and 10.4 percent had at least one major depressive episode. In 2008-2009, 34.9 percent reported any mental illness. These compare to 9.6 percent, 5.3 percent, and 18.3 percent, respectively, for the same aged males not on probation. Between 2006 and 2009, 17.5 percent reported receiving mental health services or counseling. This compares to 8.6 percent of non-probationers of the same age.[30]

Serious Psychological Distress is defined as having a score of 13 or higher on the K6 scale during the past year. The K6 scale asks about an individual's feelings of being hopeless, restless or fidgety, so depressed that nothing could cheer you up, that everything was an effort, or worthless. The scale is designed to distinguish between mental illness and non-mental illness. Major Depressive Episode is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest and pleasure in daily activities and had a majority of specified depression symptoms. Any Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than substance use disorder that met the criteria in DSM-IV.

Co-occurring Substance/Alcohol Abuse Disorders and Mental Illness

Three-quarters of state and local jail inmates who have a mental health problem also meet the criteria for substance dependence or alcohol abuse. A little less than two thirds of state inmates (both prison and jail) with mental health problems had used drugs in the month before arrest, compared to 49 percent of prison inmates and 43 percent of jail inmates without a mental health problem.[31] Three quarters of female inmates in state prisons with mental health problems met the criteria for substance dependence or abuse.[32] Among state prisoners with mental health problems, 43.8 percent were dependent on drugs and 53.9 percent were dependent on alcohol; among jail inmates with mental health problems, 56.3 percent were dependent on alcohol and 46 percent on drugs. In fact, only 24 percent of state prisoners and 19 percent of jail inmates met the criteria for substance dependence or abuse only. [33]

Among probationers and parolees, there is a similar co-occurrence of substance/alcohol use disorder and mental illness. Numerous studies have found that 72–87 percent of justice-involved individuals with severe mental disorders have co-occurring substance use disorders.[34]

Impact of Expanded Medicaid Coverage on Justice-Involved Populations

Many in the justice-involved population are in need of treatment for substance and alcohol use disorders, as well as concurrent mental health problems. Most, however, are not receiving adequate treatment in either institutional or community-based settings.[35] In the past, correctional agencies have failed to identify treatment needs, and there have been limited resources to treat this population. The largest proportion of the justice-involved population is single, non-elderly, impoverished males, unable to afford health insurance and (until recently) not eligible for Medicaid. Criminal justice agencies seeking treatment for probationers or parolees had to rely on limited free care available in the community.

Between 70 to 90 percent of the approximately 10 million individuals released from prison or jail each year are uninsured, compared to 16 percent of the general population. Lack of health insurance is associated with increased morbidity and mortality, and the high rate of being uninsured among individuals involved with the criminal justice system is compounded by the high rates of mental illness, substance use disorders, infectious disease, and chronic health conditions that are as much as seven times higher than rates in the general population.[36]

Before the Affordable Care Act (ACA) was enacted and took effect, only 8.8 percent admissions for treatment among conditionally released offenders were covered by Medicaid; 52.7 percent were covered by other government payments. Conditionally released male offenders were likelier than their female counterparts to have their admissions covered by other government payments (52.9 percent vs. 52.0 percent) or to pay for treatment themselves (13.7 percent vs. 10.1 percent), while female conditionally released offenders were likelier to have their admission covered by Medicaid (16.2 percent vs. 6.5 percent). The following chart illustrates.

Source of Payment for Treatment Admissions, Conditionally Released Offenders[37]

Financing Aftercare Rx	Male	Female	Total
Medicaid	6.5%	16.2%	8.8%
Private Health Insurance	3%	3%	3%
Other Gov't Payments	52.9%	52%	52.7%
Self	13.7%	10.1%	12.8%

Includes those on probation, parole or other restricted release; excludes those currently incarcerated, in drug court/alcohol court, referred from DWI or DUI programs, or leaving parole and probation. Percentages do not add up to 100 due to rounding. Other payments include those by federal, state, or local governments such as Department of Veterans Affairs (CHAMPUS), Temporary Assistance for Needy Families (TANF), drug courts and state health programs, and excluding Medicare, Medicaid, and Workers' Compensation.

Under the ACA, a significant portion of the justice-involved population will gain eligibility for Medicaid coverage for the first time. Some will qualify for federally subsidized health insurance

plans offered through the state health insurance marketplaces, but the majority will be newly eligible for Medicaid under the law's expansion of the Medicaid program. States that make full use of opportunities to enroll eligible individuals in their criminal justice systems in Medicaid and appropriately leverage the program to finance eligible care can realize considerable cost savings by diverting more individuals to treatment—which is significantly less costly than incarceration—and by reducing reliance on state-funded health care services for the uninsured.

Medicaid does not cover persons who are incarcerated. However, if inmates receive treatment for at least 24 hours outside of the correctional institution, they are eligible for coverage. At least 14 states, including Colorado, currently bill Medicaid for at least some eligible inpatient health services provided to incarcerated individuals. Colorado passed legislation to suspend, rather than terminate, Medicaid enrollment for its incarcerated population in 2008. This facilitates coverage for inmates receiving treatment outside prisons and jails and obviates the need for retroactive billing for inmates after they are released and re-enrolled in Medicaid.

A third or more of the individuals newly eligible for Medicaid coverage under the ACA will be justice-involved. The high rate reflects that fact that the justice-involved population is skewed toward single, younger, indigent males, historically ineligible for Medicaid in most states. Further, almost three-quarters (76.2 percent) of conditionally released offenders with substance use disorders are male. They are likelier to be younger than those without substance use disorders (31.5 percent are 18 to 25, vs. 25.5 percent without). Only 12.7 percent are married (vs. 28.5 percent without), although women with substance use disorders are more than twice as likely as males to be married (24.1 percent vs. 9.2 percent).[38] Unless these released inmates are the exception (employed or with other income), they will now be eligible for Medicaid.

Even before Medicaid expansion, the criminal justice system was the biggest referral source for substance abuse treatment. In 2002, criminal justice referrals accounted for 655,000 of 1.9 million (36 percent) of substance abuse treatment admissions. The primary type of referral by the criminal justice system was for alcohol abuse.[39] With Medicaid funding available, the criminal justice system may increase referrals, and/or justice-involved populations may seek treatment on their own. Either way, the numbers seeking substance abuse treatment will surely increase. In 2006, only 35.4 percent of conditionally released offenders with substance use disorder received any form of addiction treatment, with women likelier to receive treatment than men (55.8 percent vs. 29 percent).[40]

Further, without having to rely solely on free care, justice-involved referrals may not only increase in number but also call for more intense treatment. In the past, correctional referrals were more likely to call for less intensive treatment than were other referrals. For example, 72.9 percent of admissions with a probation, parole, or other conditional release referral called for non-intensive ambulatory care, compared to 38.6 percent of other admissions to treatment. Conversely, only 5.8 percent of admissions with correctional referrals called for short stay rehabilitation, compared to 11.7 percent of other admissions.[41]

Justice-Involved Population's Utilization of Treatment

Studies have found that more than 70 percent of inmates utilize some sort of health service in the 10 months following release.[42] They are more likely to obtain episodic, non-coordinated care, relying on emergency rooms (30 percent) and hospitalizations (20 percent). With Medicaid or insurance coverage, for the first time, justice-involved individuals are in the position to receive managed or coordinated care. However, it may take time before this population becomes "literate" in health care, taking full advantage of their coverage. Also, their ability to take full advantage of their coverage will also dependent on the availability of appropriate treatment for their special needs, including substance and alcohol use disorders and co-occurring mental health problems, as well as other criminogenic (crime causing) needs.

Massachusetts, where universal health insurance coverage began before the ACA, provides an example of what might be expected across the country. Between July 1, 2008 and Dec. 31, 2008 1,424 prisoners were released; 1,290 enrolled in MassHealth (state Medicaid program). After release, 70 percent had medical visits and 47 percent had behavioral health visits. In other words, among those who obtained medical care in those six months, two thirds had treatment for substance use disorders and/or mental health problems. The following chart breaks down the treatment visits by gender and compares it to the general population. As illustrated, the justice-involved populations are many times more likely to seek treatment for substance and alcohol use disorders than the general population: eight times for substance abuse and five times for alcohol abuse.

Behavioral Health Conditions, Re-entered Inmates vs. General Population[43]

	Alcohol (vs. General Population)	Substance Abuse (vs. General Population)
Male (Prison)	12.8% (4.7%)	35.2% (6.8%)
Female (Prison)	24.5% (2.2%)	59.2% (4.3%)
Total (Prison)	16.7% (3.3%)	43.2% (5.5%)

The needs of released offenders who have chronic conditions are particularly crucial. Although many correctional institutions provide inmates with a short-term (e.g., 30-day) supply of medications for chronic conditions at discharge, community corrections agencies are generally not obligated to provide care to people under community supervision.[44] Lack of coordination (e.g., not sharing release dates) between correctional officials and health care providers poses a threat to the health of offenders with chronic conditions such as HIV/HCV, mental and substance use disorders, asthma, and diabetes.[45]

When states expand Medicaid to cover childless adults, it should be expected that many will have criminal justice involvement. In Washington State, 30 percent of childless adults covered by Medicaid expansion had jail involvement.[46] However, because newly covered individuals tended to use expensive services prior to receiving coverage, the Mediciad expansion resulted in cost offsets. Emergency department use declined by 35 percent, which alone almost offset the cost of substance abuse treatment to the newly covered population.[47] Regardless of

whether substance abuse treatment was successful, its provision was associated in a $2,500 annual savings in medical care.[48] Re-arrest rates dropped 21 to 33 percent in the treatment group, saving local criminal justice agencies $5,000 to $10,000 for each person treated.[49] For those treated, income increased by $2,000, yielding more tax revenue and less need for welfare.[50] A similar study of the health care needs of the prisoner reentry population in California found that about two-thirds of California's reentry population reported having a drug use or dependence problem, although less than a quarter (22 percent) had received treatment while incarcerated; more than half reported a recent mental health problem, with about half of those receiving treatment.[51]

Justice-involved populations supervised in the community are more likely to be referred to treatment than those not referred by community corrections. In 2009, 26.3 percent received inpatient or outpatient treatment at a specialized substance abuse treatment facility. However, it was estimated that 42.2 percent needed alcohol/drug treatment (for dependence or abuse) and another 3.6 percent had perceived need for treatment. Therefore, 15.9 percent had unmet treatment needs.[52]

Treating Justice-Involved Populations

Treating substance and alcohol use disorders among justice-involved populations is not easy. In addition to their treatment needs, many have inadequate housing and employment to stabilize themselves in the community. In addition, many face other "criminogenic" needs, such as "criminal thinking," with poor impulse control, and little regard for the long term consequences of their behavior.

Non-completion Rates

Although individuals who complete drug court programs have been found to remain significantly more drug- and crime-free than others in the justice system, drug courts uniformly report high non-completion rates. The U.S. Department of Justice's Bureau of Justice Assistance (BJA) funds both prison/jail aftercare programs and drug courts across the country. Almost half (46.4 percent) of participants failed to complete aftercare treatment in 2013. A quarter of the participants failed as a result of new criminal charges or court revocations. Almost 10 percent failed because they dropped out of the programs before completing them. Others absconded. Less than 10 percent did not complete the programs (mostly through no fault of their own) because they were transferred out of the program, released early, administratively discharged, or had prior charges resolved. Others timed out of the program or violated other correctional requirements unrelated to the program. Finally, also reflective of the needs of this population, five of the participants died while in the program. In short, just under fifty percent (49 percent) of the participants successfully completed the programs, excluding the 160 who did not complete for reasons beyond their control.

The poor aftercare completion rates compare to those of defendants in drug courts. The evaluation of BJA drug court grantees in 2013 documented an overall graduation rate of 51 percent. BJA's target graduation rate across all BJA-funded drug court programs is only 48 percent.[53] In 2007, for example, 39.7 percent of parole population completed treatment, while 38.6 percent dropped out or were terminated from treatment.[54]

Impact of Treatment

Without treatment, substance abusing offenders are likely to repeat the same criminal behaviors.[55] Among 300,000 released in 15 states in 1994, 67.5 percent were rearrested within 3 years, and 51.8 percent were re-imprisoned. Half of them failed re-entry supervision, failing drug tests or missing appointments. [56] Other studies find substance-involved offenders are likelier to recidivate than those who are not substance-involved. Among substance-involved inmates, 52.2 percent had a previous incarceration, versus 31.2 percent of non-substance-involved inmates.[57]

The two-thirds failure rate has been consistent over the past decades. For opioid abusers, continued abuse in the community will be a prime factor for their continued cycling into and out of prison.[58] Without treatment for cocaine or opiate abuse, 60 to 75 percent of parolees will resume use within three months of release.[59]

Treatment can be cost-effective. Washington State estimates that the provision of health care will save $2.58 in criminal justice costs for every dollar spent on treatment, with an overall $3.77 offset in overall benefits per dollar spent on treatment.[60]

Colorado Specific Information

Overall Prison Populations are Decreasing.

Even before the Colorado legislature enacted Senate Bill 13-250, the Colorado Division of Criminal Justice predicted the adult prison population in Colorado to decline by a total of 15.8 percent from 22,610 to 19,041 inmates by 2018. The expected decrease of male inmates was 15.6 percent and of female inmates is 17.6 percent.[61] At the beginning of 2010, a negative growth rate was noted and continued through 2012.[62] For all prisons in Colorado, releases exceeded admissions in 2009 and 2010.

The initial decrease was explained by a variety of factors. Census data reflect a downward shift in population growth for 24-44 year-olds in Colorado during the late 2000s.[63] Felony filings declined in Colorado state courts from 2005 to 2010.[64] During FY 2009, prison admissions fell 0.4 percent, and in FY 2010 they went down an additional 2.6 percent. Admissions from 2007-2011 reflect a 22 percent decline for those sentenced with a drug crime as their most serious offense. In FY 2011, admissions of all types declined an additional 7.2 percent.[65] According to the U.S. Bureau of Justice Statistics, Colorado's imprisonment rate of 392 per 100,000 residents is lower than the U.S. rate of 480.[66]

Parole Revocations are Decreasing.

A decline in new court commitments is partly due to a decrease in probation and parole revocations, including a 23.7 percent drop from 2006 to 2010. [67] The Division of Probation Services continues its efforts to reduce technical violations and to employ evidence-based practices. However, the proportion of total admissions due to parole technical violations increased. Because prisoners serving time for a parole technical violation have a shorter length of stay, this still contributes to fewer inmates.

Overall Parole Rates are Declining.

Paroles are projected to decline by an average of 2.9 percent per year from 2013-2018, or a total of 15.2 percent, amounting in a total decrease from 8,181 to 6,941.[68] Many of these releases have been through discretionary, parole board actions. This trend is also expected to continue.

Mental Illness and SUD are Common in Colorado Prisons.

In 2008, approximately 5,600 adults incarcerated in Colorado prisons had a mental illness,[69] and 21 percent of all prisoners in Colorado had been diagnosed with a serious mental illness.[70] Drug offenses were the most prevalent crime of conviction, with 22 percent of prisoners entering on a drug conviction.[71] In 2007, 28 percent of women sent to prison were convicted of a drug offense. Of these women, 48 percent were assessed as needing mental health treatment and 82 percent were diagnosed to be in need of substance use disorder treatment.[72]

Available Treatment Does Not Meet Need.

A 2001 study found that Colorado had the lowest per capita spending on substance use disorder prevention, treatment, and research out of the 46 reporting states.[73] Unmet need for alcohol treatment in Colorado was higher than the national average. This is particularly true for Colorado residents who are 26 years old and older. The rates for unmet drug abuse treatment in Colorado were also above the national average, especially for people aged 18-25. However, the number of substance abuse treatment facilities in Colorado increased between 2002 and 2006, from 389 to 443. The increase includes the addition of 45 private for-profit facilities.[74]

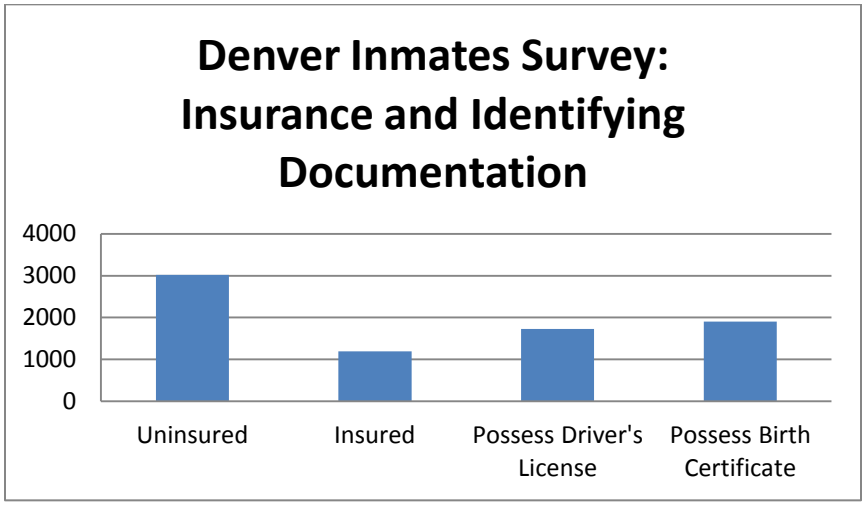
In a study of offender and parolee populations, 79 percent of offenders were identified as needing substance use disorder treatment in 2011, and 77 percent in 2012. Substance abusers who were also diagnosed with a serious mental illness made up 17 percent of the population in both 2011 and 2012. Those with any co-occurring mental illness numbered 31 percent in 2011 and 32 percent in 2012. Females were more likely to have high treatment needs, with 43 percent identified as needing residential treatment, compared to 26 percent of males. However, many are not receiving the treatment they need due to a confluence of budget cuts, high costs, and a high prevalence of Intensive Treatment recommendations. The Alcohol and Drug Services subprogram had received some of the largest cuts from FY 2003 budget reductions, and the FY 2004 budget was 40 percent smaller than the previous year. As a result, many outpatient services were completely eliminated. [75]

Medicaid/ACA Can Fill a Need for Justice Populations.

Colorado officials estimated that as many as 90 percent of state prison inmates were likely eligible for Medicaid due to the state's Medicaid expansion.[76] In a Denver Sheriff Department survey of approximately 4,000 inmates, 71.7 percent reported that they did not have healthcare coverage. Among those with coverage, almost 50 percent cited Medicaid as their provider.[77] In 2014, due to expanded Medicaid coverage, justice system officials in Colorado expected to receive an estimated $2.5 million in matching funds.[78]

Colorado is obtaining federal funds for treating jail inmates in some counties. For example, in Denver County, the jails enroll inmates at intake in order to receive matching funds. Other

implementation efforts to obtain Medicaid funds for inmates include hiring and training staff to complete applications and upgrading the eligibility systems. However, in some smaller counties, the administrative costs associated with enrolling inmates and claiming funds frequently exceed the funds that are obtained.[79] Another barrier to Medicaid enrollment is the need for obtaining identification documents necessary to the process. In Denver, many inmates do not possess a birth certificate or a driver's license.[80]



Colorado has adopted a policy to suspend inmates' Medicaid enrollment rather than to terminate upon incarceration. This allows the inmate to bypass the task of re-submitting an application and completing new eligibility determinations, leading to more continuous care after release.[81]

Summary

Nationwide, a large percentage of justice-involved individuals have substance abuse or mental health issues, and many have both. This applies to jail, prison, parole, and probation populations, and to both males and females. Many of those who need treatment have not gotten it, and lack of health insurance has traditionally been a primary barrier. The passage of the Affordable Care Act opens new opportunities for this population to receive treatment.

Colorado has expanded Medicaid, and as a result, the availability of treatment may increase. The size of Colorado's correctional population has been decreasing, raising the prospects that a smaller percentage of the population will have unmet needs.

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Appendix B – Detailed Data Tables for Prevalence, People Served, Penetration, and Population

Prevalence

Prevalence rates are taken from National Survey on Drug Use and Health for Colorado 2008-2011. Based population estimates by age group for under 300% FPL were provided by Colorado State Demography Office from 2013 population estimates. Based population estimates by gender and race/ethnicity for under 300% FPL were provided by Colorado State Demography Office from 1-year ACS PUMS population estimates.

Table 1.1: Prevalence of SED/SMI by Age Group for under 300% FPL

	0-11 years	12-17 years	18-24 years	25-34 years	35-54 years	55+ years		Total
Rate:	*10.0%*	*10.0%*	*4.1%*	*6.2%*	*7.2%*	*2.5%*		
Region								
1	12,888	5,592	3,489	6,190	9,967	3,006		41,131
2	4,242	1,683	920	1,582	2,832	849		12,108
3	7,012	2,924	1,430	3,164	5,444	1,424		21,398
4	4,155	1,999	959	1,752	3,520	1,520		13,905
5	6,293	2,435	1,734	4,028	5,278	1,496		21,264
6	5,532	2,639	2,213	3,182	5,081	1,757		20,405
7	7,072	2,767	1,579	3,212	4,956	1,360		20,946
Total	**47,193**	**20,039**	**12,325**	**23,109**	**37,079**	**11,412**		**151,158**

Table 1. 2: Prevalence of AOD by Age Group for under 300% FPL

Region	0-11 years	12-17 years	18-24 years	25-34 years	35-54 years	55+ years		Total
Rate:	*n/a*	*10.6%*	*25.2%*	*16.8%*	*6.6%*	*3.1%*		
1	n/a	5,927	21,445	16,772	9,137	3,727		57,008
2	n/a	1,784	5,658	4,286	2,596	1,052		15,376
3	n/a	3,100	8,789	8,572	4,990	1,766		27,217
4	n/a	2,119	5,893	4,749	3,226	1,885		17,871
5	n/a	2,581	10,658	10,915	4,839	1,855		30,848
6	n/a	2,797	13,604	8,623	4,658	2,179		31,860
7	n/a	2,933	9,707	8,702	4,543	1,687		27,572
Total	**n/a**	**21,241**	**75,753**	**62,619**	**33,990**	**14,151**		**207,753**

Table 1.3: Prevalence of AMI, SMI, and AOD by Race/Ethnicity for under 300% FPL

	White Non-Hispanic			Minority		
	AMI	**SMI**	**AOD**	**AMI**	**SMI**	**AOD**
Rate:	*20%*	*5.8%*	*12.1%*	*16.5%*	*3.1%*	*12.1%*
Estimate:	278,932	79,304	165,445	166,786	31,772	121,898

Table 1.4: Prevalence of AMI, SMI, and AOD by Gender for under 300% FPL

	Male			Female		
	AMI	**SMI**	**AOD**	**AMI**	**SMI**	**AOD**
Rate:	*16.4%*	*3.4%*	*13.7%*	*21.1%*	*6.0%*	*10.7%*
Estimate:	188,104	38,997	157,136	259,677	73,842	131,685

People Served in 2014

Table 2.1: Colorado Office of Behavioral Health Mental Health Clients (SED/SMI) by Age

Region	0-12 years	13-17 years	18-24 years	25-34 years	35-50 years	50+ years		Total
1	1,387	886	836	1,245	1,466	1,001		6,821
2	802	606	479	610	695	417		3,609
3	1,588	992	822	1,109	1,329	764		6,604
4	957	526	638	891	1,087	761		4,860
5	611	456	361	576	719	511		3,234
6	1,013	723	765	1,147	1,419	1,056		6,123
7	991	704	527	703	868	576		4,369
Total	**7,349**	**4,893**	**4,428**	**6,281**	**7,583**	**5,086**		**35,620**

Table 2.2: Colorado Office of Behavioral Health Substance Use Clients by Age Group

Region	0-12 years	13-17 years	18-24 years	25-34 years	35-49 years	50+ years		Total
1	5	403	3,138	2,770	3,686	1,962		11,964
2	5	289	1,615	1,308	1,704	803		5,723
3	5	517	4,283	4,184	5,523	2,793		17,305
4	5	344	2,305	2,120	2,903	1,780		9,456
5	10	276	3,154	4,021	5,653	3,797		16,911
6	12	665	3,429	2,791	3,764	2,166		12,827
7	5	258	2,230	2,196	2,985	1,739		9,412
Total	**47**	**2,752**	**20,153**	**19,389**	**26,217**	**15,040**		**83,598**

Table 2.3 HCPF Behavioral Health Clients (SED, AMI, SMI, SUD) by Age Group

Region	Under 17 years	18-25 years	26-34 years	35-49 years	50+ years		Total
1	4,407	1,580	2,335	2,942	2,270		13,534
2	2,477	700	918	1,159	944		6,198
3	8,253	2,323	3,025	3,847	2,832		20,280
4	3,476	1,371	1,886	2,515	2,152		11,400
5	4,413	1,532	2,348	3,656	3,999		15,948
6	3,908	1,273	2,019	2,770	2,435		12,405
7	4,424	1,345	1,798	2,288	1,730		11,585
Total	**31,358**	**10,124**	**14,329**	**19,177**	**16,362**		**91,350**

Table 2.4: OBH Mental Health Clients (SED/SMI) by Race/Ethnicity

Region	Amer-ican Indian / Alaska Native	Asian	Black	Native Hawaii-an / Pacific Islander	White	Other	His-panic	Multi-racial	Un-known
1	151	32	92	11	5,097	196	305	903	34
2	60	10	44	10	2,110	42	361	964	11
3	110	79	471	12	3,558	103	276	1,953	42
4	87	12	92	10	2,660	62	427	1,459	52
5	41	41	668	10	1,173	55	231	1,001	16
6	93	69	181	10	4,283	21	87	1,366	13
7	80	24	347	16	2,367	200	191	1,136	10
Total	**622**	**267**	**1895**	**79**	**21,248**	**679**	**1878**	**8782**	**178**

Table 2.4: OBH Substance Use Clients by Race/Ethnicity

Region	Amer-ican Indian / Alaska Native	Asian	Black	Native Hawaii-an / Pacific Islander	White	Other	His-panic	Multi-racial
1	223	35	142	14	9,557	174	1688	131
2	68	22	81	3	3,098	203	2156	91
3	242	250	1,305	46	8,898	1312	4382	869
4	412	12	131	10	4,014	935	3785	158
5	646	167	2,227	32	7,031	1481	4928	399

Table 2.4 continued: OBH Substance Use Clients by Race/Ethnicity

Region	Amer-ican Indian / Alaska Native	Asian	Black	Native Hawaii-an / Pacific Islander	White	Other	His-panic	Multi-racial
6	196	107	259	26	8,981	532	2298	430
7	126	82	774	31	5,571	83	1511	1231
Total	**1913**	**675**	**4919**	**162**	**47,150**	**4720**	**20748**	**3309**

2.5: HCPF Behavioral Health Clients (SED, AMI, SMI, SUD) by Race/Ethnicity

Region	Amer-ican Indian / Alaska Native	Asian	Black	Native Hawaii-an / Pacific Islander	White	Other	Hispanic	Un-known
1	256	51	228	31	8,200	1,784	1728	1255
2	79	n/a	105	n/a	3,046	626	1944	369
3	298	335	2,103	83	7,933	2,659	4951	1913
4	137	34	212	n/a	4,699	1,598	3686	1022
5	260	233	2,909	45	4,221	2,114	4786	1377
6	213	121	404	60	6,475	2,074	2086	974
7	191	111	1,090	69	5,591	1,532	1598	1401
Total	**1434**	**885**	**7051**	**288**	**40,165**	**12,387**	**20779**	**8311**

Table 2.6: OBH Clients served by Gender

	Mental Health Services		Substance Use Services	
Region	**Male**	**Female**	**Male**	**Female**
1	3,009	3,812	8,220	3,744
2	1,589	2,020	4,137	1,585
3	2,852	3,752	12,182	5,122
4	2,174	2,686	6,419	3,037
5	1,425	1,809	12,755	4,156
6	2,742	3,381	8,897	3,932
7	1,881	2,488	6,410	2,999
Total	**15,672**	**19,948**	**59,020**	**24,575**

Table 2.7: HCPF Behavioral Health Clients (SED, AMI, SMI, SUD) by Gender

Region	Male	Female
1	5,651	7,882
2	2,600	3,600
3	8,612	11,663
4	4,981	6,430
5	6,999	8,946
6	5,325	7,082
7	4,917	6,666
Total	**39,085**	**52,269**

Penetration Rates

Table 3.1: OBH Penetration of SED/SMI by Age Group for under 300% FPL

Region	0-11 years	12-17 years	18-24 years	25-34 years	35-54 years	55+ years		Total
1	11%	16%	24%	20%	15%	33%		17%
2	19%	36%	52%	39%	25%	49%		30%
3	23%	34%	57%	35%	24%	54%		31%
4	23%	26%	67%	51%	31%	50%		35%
5	10%	19%	21%	14%	14%	34%		15%
6	18%	27%	35%	36%	28%	60%		30%
7	14%	25%	33%	22%	18%	42%		21%
Total	**16%**	**24%**	**36%**	**27%**	**20%**	**45%**		**24%**

Table 3.2: Prevalence of AOD by Age Group for under 300% FPL

Region	0-11 years	12-17 years	18-24 years	25-34 years	35-54 years	55+ years		Total
1	n/a	6.8%	14.6%	16.5%	40.3%	52.6%		21.0%
2	n/a	16.2%	28.6%	30.5%	65.6%	76.3%		37.2%
3	n/a	16.7%	48.7%	48.8%	110.7%	158.2%		63.6%
4	n/a	16.2%	39.1%	44.6%	90.0%	94.4%		52.9%
5	n/a	10.7%	29.6%	36.8%	116.8%	204.7%		54.8%
6	n/a	23.8%	25.2%	32.4%	80.8%	99.4%		40.3%
7	n/a	8.8%	23.0%	25.2%	65.7%	103.1%		34.1%
Total	**n/a**	**13.0%**	**26.6%**	**31.0%**	**77.1%**	**106.3%**		**40.2%**

Table 3.3: HCPF Behavioral Health (SED, AMI, SMI, SUD) by Age Group Penetration Rate for Total Population under 300% FPL

Region	Under 17 years	18-25 years	26-34 years	35-49 years	50+ years		Total
1	2.4%	1.9%	2.3%	2.1%	0.4%		2.2%
2	4.2%	3.1%	3.6%	2.9%	0.5%		3.4%
3	8.3%	6.7%	5.9%	5.1%	0.9%		6.4%
4	5.6%	5.9%	6.7%	5.1%	1.0%		5.1%
5	5.1%	3.6%	3.6%	5.0%	1.2%		4.9%
6	4.8%	2.4%	3.9%	3.9%	0.7%		3.8%
7	4.5%	3.5%	3.5%	3.3%	0.6%		3.7%
Total	**4.7%**	**3%**	**4%**	**4%**	**0.7%**		**4%**

Table 3.4: Statewide Penetration of Colorado Office of Behavioral Health Services for the Population-In-Need Under 300% FPL by Race/Ethnicity

	White Non-Hispanic			Minority	
	SMI	AOD		SMI	AOD
Prevalence:	79,304	165,445		31,772	121,898
OBH Served:	21,248	47,150		14,196	33,137
Penetration Rate:	27.00%	28.00%		45.00%	27.00%

Table 3.5: Statewide Population-Based Penetration of HCPF Behavioral Health Services for the Total Population Under 300% FPL by Race/Ethnicity

	White Non-Hispanic		Minority
Population:	1,367,313		1,010,363
HCPF Served:	40,165		42,824
Penetration Rate:	2.9%		4.2%

Table 3.6: Statewide Penetration of Colorado Office of Behavioral Health Services for the Population-In-Need Under 300% FPL by Gender

	Male			Female	
	SMI	AOD		SMI	AOD
Prevalence:	38,997	157,136		73,842	131,685
OBH Served:	15,672	59,020		19,948	24,575
Penetration Rate:	40.2%	37.6%		27.0%	18.7%

Table 3.7: Statewide Population-Based Penetration of HCPF Behavioral Health Services for the Total Population Under 300% FPL by Race/Ethnicity

	Male		Female
Population:	1,146,977		1,230,699
HCPF Served:	39,085		52,269
Penetration Rate:	3.4%		4.2%

Population

Table 4.1: 2013 Estimated Population by Age Group under 300% FPL

Region	Child 0-12.9 yrs	Adolescent 12-17 yrs	Adult 18-24 yrs	Adult 25-34 yrs	35-54 yrs	Adult 55+ yrs	Total
1	128,876	55,915	85,100	99,834	138,435	120,225	628,385
2	42,418	16,832	22,451	25,511	39,340	33,941	180,493
3	70,119	29,244	34,876	51,026	75,608	56,969	317,842
4	41,553	19,987	23,384	28,265	48,884	60,810	222,883
5	62,927	24,351	42,295	64,970	73,312	59,834	327,689
6	55,320	26,388	53,983	51,325	70,576	70,291	327,883
7	70,718	27,670	38,518	51,799	68,838	54,419	311,962
Colorado	**471,931**	**200,387**	**300,607**	**372,730**	**514,993**	**456,489**	**2,317,137**

Table 4.2: 2013 Estimated Statewide Population Under 300% FPL by Race/Ethnicity and Gender

	Male	Female		White, Non-Hispanic	Minority
Population	1,146,977	1,230,699		1,367,313	1,010,363

Table 4.3: 2015 Projected Population by Age Group

Region	0-19 years	20-39 years	40-59 years	60+ years
1	368,413	384,023	365,475	267,981
2	108,958	100,611	94,605	67,558
3	264,608	242,970	275,443	162,587
4	85,842	86,403	92,039	93,467
5	162,703	239,816	161,187	111,608
6	229,232	251,902	277,339	202,615
7	206,334	205,985	194,822	134,555
Colorado	**1,426,090**	**1,511,710**	**1,460,910**	**1,040,371**

Table 4.4: 2025 Projected Population Age Group

Region	0-19 years	20-39 years	40-59 years	60+ years
1	425,613	454,503	427,788	380,133
2	129,905	137,721	113,872	95,376
3	275,930	289,400	298,526	251,501
4	93,365	102,481	93,989	114,774
5	180,809	237,624	202,505	141,858
6	236,072	282,107	268,104	286,969
7	231,431	255,119	191,512	194,638
Colorado	**1,573,125**	**1,758,955**	**1,596,296**	**1,465,249**

Table 4.5: Projected Population by Gender 2015 to 2025

	Male				Female		
Region	***2015***	***2025***	***% Change***		***2015***	***2025***	***% Change***
1	699,651	853,742	22.0%		687,070	847,027	23.3%
2	188,216	243,624	29.4%		183,500	239,784	30.7%
3	464,648	548,548	18.1%		479,661	567,485	18.3%
4	184,117	207,509	12.7%		173,683	198,304	14.2%
5	338,067	382,933	13.3%		338,216	385,074	13.9%
6	478,706	533,458	11.4%		481,755	540,650	12.2%
7	367,329	429,544	16.9%		374,652	451,838	20.6%
Colorado	**2,720,734**	**3,199,358**	**17.6%**		**2,718,537**	**3,230,162**	**18.8%**

Table 4.6: Projected Population by Racial/Ethnic Group 2015 and 2025

Group	2015	2025	% Change
White, Non-Hispanic	3,747,466	4,070,469	8.6%
Hispanic Origin	1,230,173	1,745,165	41.9%
Black, Non-Hispanic	227,991	281,600	23.5%
Asian/PI, Non-Hispanic	196,828	288,245	46.4%
American Indian, Non-Hispanic	53,608	64,476	20.3%
Total	**5,456,067**	**6,449,955**	**18.2%**
Minority	1,708,601	2,379,487	39.3%
White, Non-Hispanic	3,747,466	4,070,469	8.6%

Appendix C-1:

Colorado Public Behavioral Health System and Services Inventory – Region 1

Counties Included in Region 1
Larimer, Archuleta, Delta, Delores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Larimer, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, and Summit

Region 1

- 4 CMHCs
  - Axis Health System
  - Midwestern Colorado Mental Health Center/The Center for Mental Health
  - Touchstone Health Partners
  - Mind Springs Mental Health Center
- 1 BHO - Colorado Health Partnerships, LLC
- West Slope MSO for 3 of the 4 CMHCs.
- Signal MSO for 1 CMHC (Touchstone/Larimer County)

Number of Persons Served

Table 1: Number of Persons Served			
Unduplicated Served	**Child/Adolescents 0-17**	**Adults 18-64**	**Older Adults 65 & Older**
Mental Health (MH)/ Emotional Disorders	5,475	11,711	1,400
Substance Use (SU) Disorders	83	3,899	81
Co-Occurring MH & SU Disorders	376	7,009	154

Workforce

Table 2: Workforce	
Staff Category	**Current Filled FTE #/Total FTE Budgeted**
Medical Staff	19.68/NA^
Psychiatrists	9.95/NA^
Psychologists	6.7/NA^
Nurses	14.9/NA^
Addictions Staff (E.g. CACs -Not Recovery Coaches)	45.7/NA^
Licensed Clinicians, Counselors, Social Workers	139.5/NA^
Unlicensed Master's level Clinician's, Counselors & Social Workers	84.25/NA^
Unlicensed Bachelor's level Clinician's, Counselors & Social Workers	5/NA^
Cross-trained MH/SA Behavioral Health Staff (Master's)	17.5/NA^
Cross-trained Behavioral Health Staff (Bachelor's)	4/NA^
Case Managers (Non-Peer)	76.1/NA^
Peer Support Specialists	24.65/NA^
Recovery Coaches	9/NA^
Family Navigators/Advocates	12/NA^
Mobile Crisis Staff (Non-Peer)	32.2/NA^
Crisis Stabilization Unit Staff (Non-Peer)	11.5/NA^
Crisis Respite Staff (Non-Peer)	2/NA^
Mobile Crisis Peer/Family/Recovery Staff	2/NA^
Crisis Stabilization Unit Peer/Family/Recovery Staff	3/NA^
Crisis Respite Peer/Family/Recovery Staff	2/NA^

^There was not sufficient data among the four agencies

^^Insufficient data to include the caseloads.

Funding

Table 3: Funding	
FY 2014/2015 Funding Payer Source	**Approximate Per Cent of Total Operating Budget**
Medicaid	50%-71%
Medicare	1.00%
State General Funds/Block Grants/Path Federal Funds	14%-24%
Other Grants	.5%-7%
Funding from DOC, DYC, etc.	<1%-4%+
Privately insured	2%-3%+
Donations & other sources	<1%-18.5%
Other funds for Public Behavioral Health Services	2%-6%

+Axis did not provide data for these categories

Services Provided

Integrated Care

All four of the CBHC's in the West Slope Region offer behavioral health services at an FQHC or other primary care service provider(s). Three have formal referral agreements in place with an FQHC or other primary care service provider, or have other methods for coordinating services. One CBHC is a Federally Qualified Health Center (FQHC) and offers both primary and behavioral health services. Another intends on offering primary care on site in 2015.

Axis health owns and operates two fully integrated primary care and behavioral health care centers at Cortez (Integrated Healthcare) and a HRSA supported Community Health Center, La Plata Integrated Health Care in Durango. Axis also operates two integrated school based health centers. All centers offer full range of primary care, mental health, and substance use treatment. Axis also collaborates with SW Memorial Primary Care (a rural health center) in Cortez by providing a co-located behavioral health provider at the following clinics:

Uncompahgre Medical Clinic in Norwood (FQ); River Valley Community Clinic in Olathe (FQ); Pediatric Associates in Montrose; and, Delta School Based Kidz Clinic in Delta. Axis is also embedded in some 12 practices primary care practices.

In Larimer County, the CMHC contracts with Loveland Community Health Center (FQHC) and has a clinic located in their Loveland main office. The CMHC has formal referral agreements in place with the Loveland Community Health Center (FQHC); Touchstone Sunrise Clinic (located in the CMHC's Loveland main office); Associates in Family Medicine Medicaid Accountable Care Collaborative; and a partnership with University of Colorado Health Systems Poudre Valley Hospital.

The CMHC's in this Region report serving clients with co-occurring physical health problems, including traumatic brain injury; obesity; diabetes; hearing loss; vision loss; mobility impairment; and intellectual or developmental disabilities. Two CMHC's offer Intensive Services for individuals with co-occurring serious mental illness and intellectual or developmental disabilities or significant medical / physical disorders and one CBHC offers services for co-occurring individuals with at TBI.

The CMHC's completing the inventory did not know what percentage of clients were referred by primary care providers or how many clients they referred to primary care providers.

Special Co-Occurring Populations

Table 4: Intensive services exist for Co-Occurring Population in the Region (X)	
Individuals with Intellectual/ Developmental Disabilities	X
Individuals with Traumatic Brain Injuries	X
Individuals with Significant Medical/Physical Disorders	X

Infant/Early Childhood Services

The CMHCs in this Region reported that they have a total of 2.8 full-time equivalent (FTE) positions

- 1State funded FTE available for consultation to the entire 10 county region;

- FTE split between La Plata and Montezuma counties; and
- .8 FTE position funded by Office of Early Childhood serving Montrose and Delta Counties. This position provides primarily consultation, education, resource and referral information. Individuals needing treatment are referred to community providers including the CMHC.

The following early childhood programs and services were identified by the CMHCs in Region 1:

- Early Childhood Program: Serves children ages birth to 9, and their parents, in both outpatient and home based settings, who are exhibiting behavioral concerns and experiencing disruptions in the parent/child relationship.
- Outpatient Mental Health Treatment: Outpatient services include family therapy, play therapy with young children, group therapy, individual therapy and include family involvement with treatment.
- Family Care Coordinator: An intensive in-home therapy program designed to serve children ages birth to 17 who are at-risk for out-of-home placement and for whom there are safety concerns at home.
- The HUB Assessment Center: In collaboration with the Department of Human Services (DHS), mental health assessments, mediation and brief therapy are provided to families accessing the HUB, the single point of entry for DHS services.
- Incredible Years Parenting Series: An evidence based parenting education program designed to positively impact the relationship between parent and child.
- Intensive Care Coordination: Intensive Care Coordinators manage all inpatient services and higher levels of care for clients. This includes assessment, referral and services assisting in transition to a less restrictive environment.
- Intensive Case Management: Case Management involves activities that are intended to ensure that clients receive needed services, that services are coordinated, and that services are appropriate to the client's stated desires over time.
- Loveland Counseling Connections: An information and referral service for low and moderate income individuals, couples, children, and families in need of mental health counseling in Loveland, CO.
- Namaqua Center For Children, Community-Based Services: Offers families the individualized support and child counseling they need to raise healthy, successful children.
- Family Support Program: Relationship-based services that develop and maintain family stability when dealing with a behavioral health problem.
- Wondercamp: Skill building program for Namaqua Center children who have severe emotional disturbances, and who require structure and support during school holidays.

School-based Services that target children and adolescents with serious emotional/ behavioral health disorders

The CMHCs indicated in their surveys that the provide behavioral health services in over 60 schools, as well as two (2) school-based health centers offering integrated care.

The CMHCs in this Region reported that they have a total of 6.8 full-time equivalent (FTE) positions dedicated to school-based services:

- 1 FTE School Mental Health specialist position in La Plata County targeting one high school and 2 middle schools.
- 1 FTE at Vista Charter School in Montrose (.2 funded by OBH School Based funding)
- 1 FTE at Delta Schools (.8 funded by OBH School Based funding)
- 1 FTE at Delta School Kidz Clinic
- .2 FTE at Ridgway Schools
- .2 FTE at Ouray Schools
- .2 FTE at Telluride Schools
- .2 FTE at Norwood Schools
- 1 FTE Day Treatment therapist
- 1 FTE Behavior Specialist working in Day Treatment program

Special Programs/Services that target transitional-aged youth with serious emotional/ behavioral health disorders

CMHCs within this region noted a working relationship with Hilltop in Montrose, HB 1114 projects in Gunnison and Montrose, as well as offering home-based services. One of the CMHCs employs two (2) child and adolescent psychiatrists. Some of the specific programs and services identified in this Region that target transitional-aged youth with serious emotional/ behavioral health disorders include:

- Functional Family Therapy: An outcome-driven and evidence-based prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting-out behaviors and related syndromes.
- Multi Systemic Therapy: An evidenced based, intensive home based family therapy program designed specifically for juvenile offenders and their families.
- Tips: Transition To Independence Processing System: TIPS is an evidence based program designed to help move young people toward greater self-sufficiency and successful achievement of their goals related to relevant transition domains. The target population is 16-23 year-old individuals who are currently on Medicaid and have a persistent mental illness.

- Outpatient Mental Health Treatment: Outpatient services including family therapy, play therapy with young children, group therapy, and individual therapy including family involvement with treatment.
- Family Care Coordinator: An intensive in-home therapy program designed to serve children ages birth to 17 who are at-risk for out-of-home placement and for whom there are safety concerns at home.
- The Hub Assessment Center: In collaboration with the Department of Human Services (DHS), mental health assessments, mediation and brief therapy are provided to families accessing the HUB, the single point of entry for DHS services.
- Intensive Care Coordination: Intensive Care Coordinators manage all inpatient services and higher levels of care for clients. This includes assessment, referral and services assisting in transition to a less restrictive environment.
- Intensive Case Management: Case Management involves activities that are intended to ensure that clients receive needed services, that services are coordinated, and that services are appropriate to the client's stated desires over time.
- Loveland Counseling Connections: An information and referral service for low and moderate income individuals, couples, children, and families in need of mental health counseling in Loveland, CO.
- Family Support Program: Relationship-based services that develop and maintain family stability when dealing with a behavioral health problem.

Special Programs/Services that target children and adolescents with serious emotional/ behavioral health disorders in the Child Welfare System

CMHCs) in this Region reported a total of seven (7) dedicated FTEs that target children and adolescents with serious emotional/ behavioral health disorders in the Child Welfare System, specifically providing regional youth and family support and engagement services, for children who are at risk of out of home placement. Additionally, intensive home and community based services are provided. Also in this region, core Services funding from County Human Services Departments and Child Welfare are also used to provide some services to this population, including for the prevision of Day Treatment Program/services. The specific programs and services identified for this population include:

- Multi Systemic Therapy: An evidenced based, intensive home based family therapy program designed specifically for juvenile offenders and their families.

- Tips: Transition To Independence Processing System: TIPS is an evidence based program designed to help move young people toward greater self-sufficiency and successful achievement of their goals related to relevant transition domains. The target population is 16-23 year-old individuals who are currently on Medicaid and have a persistent mental illness.
- Outpatient Mental Health Treatment: Outpatient services include family therapy, play therapy with young children, group therapy, individual therapy and include family involvement with treatment.
- Family Care Coordinator: An intensive in-home therapy program designed to serve children ages birth to 17 who are at-risk for out-of-home placement and for whom there are safety concerns at home.
- The HUB Assessment Center: In collaboration with the Department of Human Services (DHS), mental health assessments, mediation and brief therapy are provided to families accessing the HUB, the single point of entry for DHS services.
- Intensive Care Coordination: Intensive Care Coordinators manage all inpatient services and higher levels of care for clients. This includes assessment, referral and services assisting in transition to a less restrictive environment.
- Intensive Case Management: Case Management involves activities that are intended to ensure that clients receive needed services, that services are coordinated, and that services are appropriate to the client's stated desires over time.

Special programs/services that target Veterans with serious behavioral health disorders

One CBHC identified use of a 0.4 FTE who works in Veterans Support program in Montrose and Touchstone Health Partners offers numerous trauma-informed programs.

Community Based Services

Table 5: **Approximate number/percent served during the last 12 months with the following co-occurring physical health problems.**	
Traumatic brain injury	Unsure, likely <20 ,4%
Obesity	Unsure
Diabetes	Unsure
Deaf or hard of hearing	Unsure, likely <10/1%
Blind	Unsure, likely <5,
Mobility impairment	Unsure
Intellectual/developmental disability	40, Unsure, 4%

Table 6: The biggest barriers/gaps to serving people with mental illnesses in community, rather than institutional, settings.	
Housing	X
Mental health treatment	
Substance use treatment	X
Crisis services	
Residential services	X
Respite care	X

Other: transportation; locked nursing home; transitional housing, work force; small population in each of 6 counties makes it difficult to financially support 24/7 residential, respite, CSU, inpatient or detox services. Total service area is 10,000 square miles – rural and frontier.

Table 7: Which of the following client groups pose the greatest challenge to serve in the community?	
Children	X
Adolescents	X
Young adults/Transition-aged youth	X
Older adults	X
Individuals with traumatic brain injuries	X
Justice-involved	X
Individuals with a history of violence	X

Other (Table 7): Too many layers of criminal justice, all with different rules/regulations, and funding sources. Violence is becoming more or an issue with 2 recent events involving clients with weapons and having to call law enforcement; complex mental health and medical issues; treatment resistant patients; prescription drug abuse; illegal opioid abuse.

Housing

Data provided from the Provider Inventory indicate two of the four CMHC's provide housing programs, including permanent supportive housing, Shelter Plus Care, supervised apartments, group homes. These CMHCs 1indicate providing housing assistance to 40 individuals with mental health needs, five (5) individuals with SUD needs, 195 with co-occurring MH and SU disorders, as well as another 125 for whom the breakout by type of disorder was unknown for a total of 365 individuals.

Housing assistance is an element of case managers' jobs in three of the four CMHCS and these case managers assist individuals in the following ways:

- Applying for housing vouchers and finding suitable housing, including making sure they are on appropraite housing lists and helping them find housing;
- Providing referrals to other housing resources, including HUD housing, ; assistance in completing housing applications;
- Advocating to attain or maintain housing;
- Working with landlords and managers if there are problemsto help individuals stay in their housing they have Case managers assure that clients in need of housing are on appropriate housing lists.

The level of participation by CMHC leadership in this region in community planning and advocacy regarding obtaining housing resources varies considerably from a high level of leadership engagement to no involvement.

Across the Region the following housing resources were identified by the providers completing the Inventory:

- 20 unit owned HUD Housing with dedicated case management services to the residents;
- Partnership with county housing authority to find housing;
- New S+C vouchers as well as SHP vouchers and State Housing Vouchers.
- Referred clients to the Ft. Lyons program.
- Partnered with the state to be 1 of 2 sites to have the CABHI grant from SAMSHA.
- Housing Choice Vouchers (Section 8) – 125. Scattered site HUD vouchers for people with disabilities.
- Shelter Plus Care – 20. Scattered site vouchers received through Continuum of Care competition for people who are literally homeless, disabled and in need of ongoing services.

- Transitional Housing Grant – 5, Scattered site vouchers received through Continuum of Care competition for people who are literally homeless. 2 year program with supportive services including case management.
- State Housing Vouchers – 8 – scattered site vouchers for people transitioning from state institutes.
- Supportive Permanent Housing, Loveland Apartments – 8 site based apartments received through Continuum of Care competition for people who are literally homeless and disabled. Some supportive services money, including case management.
- Access to Permanent Supportive Housing at Redtail Ponds owned by Fort Collins Housing Authority for 15 people, must be disabled and literally homeless.
- Choice House and Promise House – residential programs for Touchstone clients in need of stabilization. Temporary, usually 3 months

> Frankly, this is a large area of need on the Western Slope. Even when we have vouchers it is hard to find housing that is affordable enough to be paid for by these programs.
>
> *Regional Provider*

Table 8: Housing Information	
Does your organization own and operate housing?	Varies
If yes, number of units?	28
Does your organization have formal relationships with housing providers, such as the PHA, private landlords, City or County governments.	Varies
Estimate number of units accessed through these relationships	50
For individuals who live in housing programs administered or supported by your organization, are all their support/service needs provided by program staff?	Varies

Employment

Table 9: Number of individuals receiving employment services in the past year	
Mental Health	126 with some unknown
Substance Use	3 with some unknown
Co-Occurring MH & SU	50 with some unknown
Plus an additional 30 across all three categories	

Employment programs, such as supported employment, job preparedness, sheltered workshop, ticket to work, and /or training programs are provided by three of the four CMHCs. These programs include:

- Colorado Division of Vocational Rehabilitation (DVR) Supported Employment Program, which served 21 individuals during FY 2013-14;
- Internal vocational program providing vocational assessment, job preparedness, job development/placement/coaching, which served approximately 34 additional individuals;
- Sheltered workshop that served about 20 individuals. This program allows individuals who want to attempt work but are not ready for competitive employment to try their skills and learn in our work environment;
- Individual Placement Support (IPS) EBP vocational program. This program at one CMHC has 2 FTEs and should serve about 30-50 individuals per year. This program will help individuals find competitive employment. Full Fidelity reviews to begin January 2015.
- Accredited Clubhouse Model – Pre-employment transferable skill building, Transitional Employment, Supported Employment (IPS), post employment supports of Independent Employment, and Supported Education. Total individuals served the the past year was 77, with 56 individuals employed and 23 receiving on-going employment supports.

These employment programs do not have waiting lists however it is estimated that 231 individuals being served in this Region have a need for employment programs that is currently unmet.

Employment services are not part of the job responsibility for case managers, i.e., employment needs are addressed within a treatment plan, reported by two of the three CMHCs. For individuals who do not participate in employment programs, a case manager may provide job search, employment program referrals, Assistance with applying for public benefits such as SSI, SSDI, VA and, or support to maintain employment on behalf of individuals on their caseload regarding employment.

For individuals who do participate in employment programs, the case management responsibilities beyond referral to an employment program typically include:

- Follow up with the person's care team; continued advocacy and referral to outside community partner resources.
- In the new IPS program there are many fidelity measures that will apply to this around continued support and sustainability of the job placement.
- Monitoring of treatment / medication management, housing, health care, access to transportation, daily living skills.

For people who do not participate in the employment programs, the estimated percentage of the un-served need reported ranges from 3-50% by the various CMHCs.

Table 10: Employment Information	
Does your agency have dedicated employment staff?	2/4 do
If yes, how many staff FTEs work solely on Employment?	5
How many people were working as a result of your Employment Program in the last fiscal year?	75
Are you tracking the data of your Employment Program such as hourly wages, length of time working, part time vs. full time, types of jobs?	2/3 do
Does your agency currently have formal relationships with Employers, Employment programs, Training programs?	Yes
If yes, please indicate number of formal relationships	Approx. 100
Please estimate the percent of need for employment services at your agency.	3 -40%
If people are employed through a referral, does your agency provide on-going support to maintain employment?	3/4 Yes

On-going support to maintain employment includes the following:

- Individuals who receive DVR Supported Employment Services who maintained employment for at least 90 days and were ultimately closed successfully by DVR, are provided Extended Support Services. These include at least one contact per month in a setting desired by the individuals. The services provided are on a case-by-case basis i.e. advocacy, counseling, employer contact if appropriate, and internal referral for MH services if appropriate, and contact with DVR for Post-Employment Services if appropriate. Persons served by internal Vocational Services essentially receive the same services minus the access to DVR Post Employment Services.
- The new IPS program. Ongoing supports are built into Clubhouse Model for those choosing Clubhouse Membership; services include community support and assistance with resources/entitlements, socialization/peer support, vocational counseling: including on the job advocacy, and job rendition skill building/problem solving. Those not involved in Clubhouse, follow along will be provided by Employment Specialist and treatment clinician/case manager (unclear what types of supports the clinicians currently provide)

If individuals express no desire for employment but are rejected for public benefits have access to employment services in an effort to identify the benefits of working, care team collaboration to arrive at solutions, education or removal of barriers to working. Motivational Interviewing is used as a tool in this regard. Additionally, behavioral health services and exploration of other resources continue along with emphasizing employment training, unclear of any other “plan of action” for non-Clubhouse members.

When individuals receive different levels of assistance with housing and/or employment based on a level of service designation, these include.

- People that meet eligibility the requirement for DVR Supported Employment Services have greater resources available to achieve their employment goals than those that do not meet that DVR eligibility.
- As the level of care tool (LOCUS) indicates, we can provide more case management and peer supports to individuals as their needs change.

    - Three of the four CBHC's provide wraparound service for childen, and two CBHCs indicate that they provide intensive in home services for children and their families.

    - All four of the CBHC's have Assertive Community Treatment (ACT) teams, with caseloads ranging from 10 to 25 cases per ACT team.

Residential Substance Use Services that target adults with serious behavioral health disorders, including those related from the Department of Corrections.

- Some programs previous described accept individuals with co-occurring disorders.
- Larimer County Community Corrections: Intensive Residential Treatment focusing on an atmosphere of quality interactions which reflect: honesty, self responsibility, work ethic, and community responsibility.

The Western Region includes mobile crisis services and units that are linked to the walk-in crisis services and crisis respite. OBH entered into contracts for crisis services in the Fall of 2104, and

Inpatient

Children and Adolescents Hospital

Table 11: Children and Adolescent Hospital					
Agency Name	**Hospital Name**	**County of Location**	**# of Beds**	**Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State**
Midwestern	+		40	80%	70%
Mind Springs	West Springs Hospital	Mesa		80%	

+ None: these services are located in Mesa County; outside of Midwestern service area.

Adult- Geriatric Hospital

Table 12: Adult- Geriatric Hospital									
Agency Name	**Hospital Name**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed on 1st day of the month**	**Secure/ Lockable Facility? YES/NO**	**Indicate Adult/ Geriatric or Both (A/G/B)**	**Average Length of Stay (Days)**	**Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State**
Axis								60%	60%
Midwestern	+							60%	60%
Mind Springs	West Springs Hospital	Mesa	32 total	24	Yes	Both	7.6	40%	50%

+None: these services are available in Mesa County

Residential

Child- Adolescent Residential

Table 13: Child- Adolescent Residential											
AGENCY NAME	Facility Name	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month	Indicate Child, Adolescent or Both (C/A/B)	Secure/ Lockable Facility? YES/NO/ SS (Staff Secure)	Average Length of Stay (Days)	Percent of Child and Adolescent Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Child and Adolescent Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH						
Midwestern	+									90%	
Mind Springs	Hilltop RYS/RCCF	Mesa			52	0	B	No	Unknown	90%	90%

+ None: these services are available in Mesa County

Adult Residential

Table 14: Adult Residential												
Agency Name	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Secure/ Lockable Facility? YES/NO	Average Length of Stay (Days)	Percent of Adult Residential Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Adult Residential Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH	MH	SU	BOTH				
MIDWESTERN	+	Delta	?	?	?	?	?	?	No	Unknown	70%	
Mind Springs	Angkor West/ACF	Mesa	8			8			No	Unknown	80%	80%
Mind Springs	Family Care/ACF	Mesa	10			8			No	Unknown	80%	80%
Mind Springs	Angkor Wat East/ACF	Mesa	32			28			No	Unknown	80%	80%
Mind Springs	Bookcliff Manor/ACF	Mesa	24			18			No	Unknown	80%	80%
Mind Springs	Aspen Glen/ACF	Mesa	9			5			No	Unknown	80%	80%
Mind Springs	Blossom View/ACF	Mesa	16			15			No	Unknown	80%	80%
Mind Springs	The Oaks/ACF	Mesa	85			4			No	Unknown	80%	80%
Mind Springs	Peachtree Adult Care I & II/ACF	Mesa	31			21			No	Unknown	80%	80%

Table 14: Adult Residential Continued												
Agency Name	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Secure/ Lockable Facility? YES/NO	Average Length of Stay (Days)	Percent of Adult Residential Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Adult Residential Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH	MH	SU	BOTH				
Mind Springs	Advantage Home Care/ACF	Mesa	8			7			No	Unknown	80%	80%
Mind Springs	Pilgrim Home/ACF	Mesa	9			7			No	Unknown	80%	80%
Mind Springs	The Residence/ACF	Mesa	44			2			No	Unknown	80%	80%
Mind Springs	Retreat at Palisade/ACF	Mesa	51			2			No	Unknown	80%	80%
Mind Springs	Retreat at Harbor Cove/ACF	Mesa	76			6			No	Unknown	80%	80%

+ Delta House (ALR)-This is long-term residential placement. Delta House serves many persons who do not have a behavioral health disorder

Role in gatekeeping who gets referred to State Hospitals:

- When someone does needs inpatient level of care, we do the evaluation and making this recommendation. Unfortunately, it is very hard when we have an indigent patient and there are no beds available at CMHIP.
- There is no gatekeeping as Pueblo is always full.

- Those referred to State Hospitals are staffed. Most clients needing inpatient level of care are admitted to West Springs in Grand Junction. If West Springs unable to effectively treat, those patients referred to State Hospital.
- Utilization Management Team manages all requests for inpatient admission to CMHIP. These referrals happen in the course of an inpatient admission in which the patient displays a remarkable lack or response to hospitalization, or is unmanageable in that setting.

What would enable you to better serve consumers in their own communities?

ATU services and recently started ACT programs.

Skilled Nursing Facilities

Table 15: Skilled Nursing Facilities

Agency Name	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/ # of Available BH Beds	# of Current Clients Placed	Secure/ Lockable Facility? YES/NO	Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Nursing Home Needs Met by Current Available Resources in the State
Axis	Four Corners Nursing	La Plata	158	2	No	70%	
Midwestern	+						
Mind Springs	Blossom View Assisted Living	Mesa	16	15	No	80%	80%

Table 15: Skilled Nursing Facilities							
Agency Name	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed**	**Secure/ Lockable Facility? YES/NO**	**Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Nursing Home Needs Met by Current Available Resources in the State**
Mind Springs	Bookcliff Manor Assisted Living	Mesa	25	18	No	80%	80%
Mind Springs	Eagle Ridge at Grand Valley	Mesa	70	5		80%	80%
Mind Springs	Family Health West	Mesa	90	3	No	80%	80%
Mind Springs	La Villa Grande Care Center	Mesa	80	0	Yes one 17-bed unit	80%	80%
Mind Springs	Larchwood Inns	Mesa	130	2	Yes	80%	80%
Mind Springs	Mantey Heights Rehabilitation and Care Center	Mesa	88	3	No	80%	80%
Mind Springs	Mesa Manor Care and Rehabilitation Center	Mesa	84	0	No	80%	80%

Table 15: Skilled Nursing Facilities							
Agency Name	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed**	**Secure/ Lockable Facility? YES/NO**	**Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Nursing Home Needs Met by Current Available Resources in the State**
Mind Springs	Palisade Living Center	Mesa	84	Unknown	Yes	80%	80%
Mind Springs	Peachtree Assisted Living	Mesa	31	21	No	80%	80%
Mind Springs	Casey's Pond	Routt	No specific BH beds, 52 total			80%	80%
Mind Springs	Sandrock Ridge Care and Rehab	Moffat	None specific to BH, 83 total			80%	80%
Mind Springs	Pioneers Medical Center	Rio Blanco	None specific to BH, Licensed for 31 total beds			80%	80%
Mind Springs	Rangely District Hospital	Rio Blanco	None specific to BH, 14 total			80%	80%

Note from nursing table: + Unknown; there look to be approximately 11 nursing home facilities in the Midwestern geographic area. My understanding is that all accept Medicaid; none accept indigent and all admissions must have a physical health problem. I am not aware that any would accept a stand-alone behavioral health problem. I believe all would accept a co-occurring disorder.

Community providers work with Nursing Homes to assure they are only used for persons who need that level of care and for the minimum stays necessary through:

- Close collaboration with Single Entry Point and Home and Community Based Services.
- Use of a utilization management assessment tool called LOCUS.
- Money follows the person program, Choice transition program. However, not enough low income housing exists to allow individuals to actually move out even if they are ready. Not enough money and resources in the program to make it work. There is a waitlist of 7 months before individuals can even start the program. It does not recognize that some individuals can live independently with all the supports provided by the program. So when the supports are taken away in two years the individual will eventually need to be placed back in the nursing facility, which is not good for clients.
- The ARCH and Options for Long Team Care helps individuals and families looking for placement in to ACF and N.F. They help screen individuals.
- The PASRR program provides in depth MH and DD assessments of individuals and assesses if placement is appropriate. The nursing facilities also screen individuals for placement.

ATU

Table 16: ATU									
Agency Name	**Acute Treatment Unit Name - Not Crisis Stabilization Unit**	**County of Location**	**Capacity/# of Available BH Beds**			**# of Current Clients Placed on 1st day of the month**			**Average Length of Stay (Days)**
			MH	**SU**	**BOTH**	**MH**	**SU**	**BOTH**	
Axis	Axis Health System ATU	La Plata	15			5		2	4 days

Crisis Services

Table 17: Crisis Services									
AGENCY NAME	Acute Treatment Unit Name - Crisis Stabilization Unit	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Average Length of Stay (Days)
			MH	SU	BOTH	MH	SU	BOTH	
Mind Springs	Transitions at West Springs	Mesa	+	0		3			Too new to report; by licensure cannot be more than 5 days

+ Total of 11 beds for all ages

SUD

Table 17: SUD								
AGENCY NAME	SUD Program Res. Treatment Program Name	County of Location	Capacity/# of Available SUD Beds	# of Current Clients Placed on 1st day of the month	OBH licensed for III.1, III.5 or III.&	Male/ Female or Both	Average Length of Stay (Days)	Percent of SUD Residential Tx Program Needs Met by Current Available Resources in your Geographic Service Area.
Midwestern	+							60%
Mind Springs	Womens Recovery Center	Mesa	20	20		Female only	30 days	70%
Mind Springs	Summit View	Mesa		0-this program is a jail diversion program only		Men only		70%

+ None: these services are available in Mesa (3) and La Plata (1) Counties

Detox

Table 18: Detox							
AGENCY NAME	**Detox Provider Name**	**County of Location**	**Capacity/ # of Available SUD Beds**	**# of Current Clients Placed on 1st day of the month**	**Medical or Social detox Model? (M or S)**	**Average Length of Stay (Days)**	**Percent of Detoxification Needs Met by Current Available Resources in your Geographic Service Area.**
Axis	Axis Health System	La Plata	16	8	Social	2.5 days	90%
Mind Springs	Mind Spring Health	Mesa, Eagle, Pitkin, Steamboat, and Summit counties	Mesa has 12 beds; all others have 2-3 beds	Mesa has 10, Pitkin has 3, Eagle has 2, Summit has 1, Steamboat has 1	Social	Mesa =36 hrs; all others =18 hrs	90%
Touchstone	PVH/MCR	Larimer	Unknown		Medical	Up to 4 days	

Peer Services

All four of the CMHC's in this Region provide peer support / peer specialist services. The number of positions budgeted by each CMHC ranges from 1.2 FTE to 7 FTE. The average caseload ranges from 8 to 20 and the aggregate number of hours per week of services provided ranges from 20 to 100 hours. The three most common areas of focus for peer services are wellness/recovery [e.g. informal mentoring, WRAP, WHAM, self-advocacy], outreach [e.g. connecting with at-risk people who are not receiving services or who are registered but not involved in services], and education [formal information dissemination; critical skill development].

The average number of hours of "peer specialist" training peer staff receive before employment and training range from 16 to 40 hours. The average number of hours of peer-provider focused training peer staff receive after employment ranges from six to 80 hours and includes weekly and as needed individual weekly supervision; bi-weekly and monthly group supervision; and use of a curriculum based on

the Georgia Peer model as well as Intentional Peer Support. The average number of hours of individual supervision each peer staff member receives per month ranges from two to four hours. Independent peer-operated support or recovery organizations in the region for people with mental health or addiction disorders include AA, NA, Celebrate Recovery (faith based organization) and NAPS is a Peer run group that identifies and works on peer specialist related activities.

Criminal Justice

1. Please indicate the approximate number of unduplicated clients you served during the last fiscal year who were justice-involved (probation, parole, or released from incarceration within 6 months of receiving services). If you served clients who were justice-involved but you are unsure of the number, please enter *unsure*.

Table 19: Justice-Involved Individuals Unduplicated Number Served	
On probation	522(Probation payer and/or probation referral types), 100 +
On parole	52 (Parole payers and/or parole referrals types), 12 +
Released from prison or jail within 6 months of receiving services	196, Not sure, but number of clients that had their last JBBS service in FY2014 was 240
Other justice-involved (Includes halfway house)	64, 421 (JBBS or SB97 payers) +

+ Some additional served- numbers unknown

Table 20: Number of justice-involved individuals treated in the past year	
Mental Health <18	10 +
Substance Use <18	1 +
Co-Occurring MH & SU <18	10 +
Mental Health >18	184
Substance Use >18	185
Co-Occurring MH & SU >18	672

+ Some additional served- numbers unknown , plus 2 youth <18 & 67 adults 18 and older- diagnosis deferred. The Diagnosis Deferred individuals are largely Substance Abuse Monitoring clients.

Table 21: Court-referred Individuals treated in the past year	
Mental Health	86 +
Substance Use	128 +
Co-Occurring MH & SU	119 +

+ Some additional served- numbers unknown, plus: 14 diagnoses deferred

Table 22: Recently Incarcerated Individuals Served in the Past Year	
Mental Health	116 +
Substance Use	89 +
Co-Occurring MH & SU	303 +

+ Some additional served- numbers unknown *14 diagnosis deferred*

Table 23: Note if in the Region there are the following Specialty Courts	
Mental Health Court	X
Drug Court	X

Other Specialty Courts include: are Court, Recovery Court, and Family Treatment Court

Table 24: Capacity exists to serve all referrals in the Region (X)	
Mental Health Court	X
Drug Court	X
Other – As noted above	X

Table 25: If Drug & Mental Health Courts, which serves co-occurring MH/SU referrals in the Region (X)	
Mental Health Court	X
Drug Court	X

Marijuana Legalization

Table 26: Substance use treatment, prevention and/or recovery services are provided	
If provided mark WITH (x)	X

Table 27: Any new substance use treatment, prevention and/or recovery services that will be provided In the next 6 months	
Anticipate providing these services in the next 6 months (Yes/No)	Yes
Approximate number of people to be served in the next 6 months	950

Services that will be provided in the next 6 months: Outpatient treatment; DUI
Outpatient groups/individual SUD treatment, Crisis stabilization services including short-term inpatient stays and mobile assessments.

Table 28: Substance use treatment and recovery services	
Total number of individuals have participated in substance use treatment and recovery services in the past year	Approx. 7153
Number with co-occurring mental health and substance use disorders	2800 +
Number with marijuana use issues alone or as primary drug of choice	1044 +
Number with prescription drug use issues alone or as primary drug of choice	184 +

+ Some additional served- numbers unknown

Evidence-based programs or practices for substance use treatment and recovery services have been implemented in the past year

Evidence-based programs or practices for substance use, generally:

- Matrix program, Strategies for Self Improvement and Change, Driving with Care
- Motivational interviewing; Matrix mode;, IOP; EOP
- CDDT (an alternately titled, partial fidelity IDDT program), ACT, CBT, DBT

Evidence-based programs or practices for co-occurring mental health and substance use disorders:

- BASICS
- Seeking Safety
- Seeking Safety, CBT, Aggression Replacement Therapy
- CDDT (an alternately titled, partial fidelity IDDT program), ACT, CBT, DBT

Evidence-based programs or practices for marijuana use issues alone or as primary drug of choice: CBT and DBT

Evidence-based programs or practices for prescription drug use issues alone or as primary drug of choice: MAT, CBT, and DBT

Table 29: **Do you currently have the capacity to serve everyone who requests services at your center for: (Yes = X)**	
Marijuana use issues	X
Prescription drug issues	X

Appendix C-2:

Colorado Public Behavioral Health System and Services Inventory – Region 2

Counties Included In Region 2
Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, and Yuma

Region 2

- 2 CMHCs
  - Centennial Mental Health Center (Sans Elbert County)
  - North Range Behavioral Health
- 1 BHO – Northeast Behavioral Health Partnership (Sans Larimer)

Signal MSO

Number of Persons Served

Table 1: Number of Persons Served			
Unduplicated Served	**Child/Adolescents 0-17**	**Adults 18-64**	**Older Adults 65 & Older**
Mental Health (MH)/ Emotional Disorders	3,938	7,503	508
Substance Use (SU) Disorders	440	5,061	76
Co-Occurring MH & SU Disorders	245	3,737	249

Workforce

Table 2: Workforce	
Staff Category	**Current Filled FTE #/Total FTE Budgeted**
Medical Staff	7.25/8.25
Psychiatrists	5/5
Psychologists	3.75/3.757
Nurses	**7/11.5**
Addictions Staff (E.g. CACs -Not Recovery Coaches)	17.4/18
Licensed Clinicians, Counselors, Social Workers	**41.75/48.75**
Unlicensed Master's level Clinician's, Counselors & Social Workers	**56/68.75**
Unlicensed Bachelor's level Clinician's, Counselors & Social Workers	9.8/4
Cross-trained MH/SA Behavioral Health Staff (Master's)	32/33
Cross-trained Behavioral Health Staff (Bachelor's)	1/1
Case Managers (Non-Peer)	**44/49**
Peer Support Specialists	13.75/11.55
Recovery Coaches	0/0
Family Navigators/Advocates	0/0
Mobile Crisis Staff (Non-Peer)	8/9
Crisis Stabilization Unit Staff (Non-Peer)	5.65/0
Crisis Respite Staff (Non-Peer)	7.9/9.4
Mobile Crisis Peer/Family/Recovery Staff	0/0
Crisis Stabilization Unit Peer/Family/Recovery Staff	2.04/0
Crisis Respite Peer/Family/Recovery Staff	3.5/.5

Funding

Table 3: Funding	
FY 2014/2015 Funding Payer Source	**Approximate Per Cent of Total Operating Budget**
Medicaid	58%-65%
Medicare	5%-6%
State General Funds/Block Grants/Path Federal Funds	12%-15%
Other Grants	1%-8%
Funding from DOC, DYC, etc.	1%-3%
Privately insured	4%-9%
Donations & other sources	10%+
Other funds for Public Behavioral Health Services	1%-2%

+North Range did not provide data for this category

Services Provided

Integrated Care

Table 4: Primary Healthcare - Integration	
We are a Federally Qualified Health Center (FQHC) and offer both primary and behavioral health services at our agency.	
We have fully integrated primary care into the services we provide at our location(s).	X
We offer primary care as a separate service within our behavioral health center.	
Our center offers behavioral health services at an FQHC or other primary care service provider(s). Described below.	X
We have formal referral agreements in place with an FQHC or other primary care service provider, or have other methods for coordinating services. Described below.	X
Our services are limited to meeting the behavioral health needs of our clients.	X
Other: Described below.	X

Additional comments:

- Psychiatric consultation with Salud Health Clinic Ft. Morgan, co-located clinicians at Sterling Regional Med Center, East Morgan County Hospital, pending integrated behavioral health care provider at Peak Vista FQHC, Limon, pending co-located clinician at Hugo hospital.
- Sunrise Health Center (multiple locations) Fully integrated
- Northern Colorado Family Medicine (not an FQ – we are co-located here)
- Providers with formal referral agreements in place with an FQHC or other primary care service provider, or have other methods for coordinating services. Name of the organization(s) with formal referral agreements:
- Sunrise Community Health (FQHC)
- North Colorado Family Medicine
- Salud Health Center
- Traditional behavioral health services are provided in the medical clinics where a CMHC is co-located and also works as part of the health care team, coordinating services with medical providers, inputting treatment notes into their medical records, etc.

Table 5: If you offer primary care services that are integrated or co-located within your behavioral health center, please indicate the mechanism by which these services are provided:	
Primary care professionals are included on our staff (e.g., physician, nurse practitioner, etc.)	X
Contract with the FQHC or other provider to deliver primary care services identified.	X
MOU or other formal agreement with the following FQHC or other provider to deliver primary care services	X

Contracts with the following FQHC:

- Sunrise Community Health provides staff at the primary care clinic operated at the North Range Main Center; and an.
- Additional contractual relationship withQOL Meds to operate a pharmacy onsite.

Table 6: Funding Mechanism for Co-located services w/in BH Center	
Colorado Medicaid	X
Federal government and/or private grants	X
State funding	
Other	

***Specific federal government and/or private grants*:** *FQHC funding through Sunrise*

Table 7: Referral Agreements for Co-located services w/in BH Center	
If you have formal referral agreements with primary care service provider(s), how many people did you refer for services in 2013?	1800
If you have formal referral agreements with primary care service provider(s), what percentage of your patients were referred to you by primary care providers?	30%

Recommendations to enhance the ability to provide/meet the primary health needs of individuals with behavioral health issues:

- Allow for Medicaid eligibility for Community Corrections individuals…there is a significant gap and need;
- Improved ability to bill and document services; and
- Pharmacies and primary care clinics embedded in community mental health centers; MH professionals embedded in primary care clinics.

Special Co-Occurring Populations

Providers in this region were unable to provide the approximate number and percent of clients served during the last 12 months with the following co-occurring physical health problem: traumatic brain injury, obesity, diabetes, hard of hearing, blind, mobility impairment or intellectual/developmental disability. They have no waiting list for services for these populations.

Table 8: Intensive services exist for the following indigent/Medicaid Co-Occurring Populations in the Region	
Individuals with Intellectual/ Developmental Disabilities	X
Individuals with Traumatic Brain Injuries	X
Individuals with Significant Medical/Physical Disorders	X

- Individuals with Intellectual/Developmental Disabilities - NRBH works collaboratively with Envision, the CCB agency for Weld County to coordinate treatment for individuals with co-occurring disorders. NRBH has a full time clinician on-site at Envision. We provide psychiatric coverage for Envision clients.
- Individuals with Traumatic Brain Injuries - NRBH works collaboratively with the Greeley Center for Independence in providing therapeutic and psychiatric services as appropriate for those with TBI.
- Individuals with Significant Medical/Physical Disorders – NRBH works collaboratively with Sunrise Health Center (FQHC) in providing services as needed.

Infant/Early Childhood Services

Infant/early childhood consultation and screening are available across all 10 counties. Limited direct service for this age group is available within the one CMHC catchment area.

NRBH Young Child & Family Program includes:

- Project Launch (prenatal – 8) promotes the wellness of young children and their families by addressing the physical, emotional, social, cognitive, and behavioral aspects of development with an integrated and community-based approach.
- Early childhood MH service: Incredible Years, Positive Solutions, Parent-Child Interactive Therapy, and other parent-child therapies; screens, and psycho-education.
- Family Connects: community, pre-school, and home-based parent education, screening, and early intervention services; classroom and professional workforce development in pre-schools; HIPPY Program, and Parents as Teachers for birth to age 5.
- Psychiatric services are available/referred as appropriate.

School-based Services that target children and adolescents with serious emotional/ behavioral health disorders

- STEPS day-treatment in Brush, CO – CMHC clinician imbedded in classroom setting serving middle-school age youth with SPMI/SMI. School-Based BH specialist serves as consultant on behavioral health to all 38 school districts across CMHC catchment. No Educational Support services offered.
- Outpatient services such as individual and group therapy and psycho-education are provided in Weld County District 6 elementary, middle, and high schools for youth who are unable to access services in North Range offices. Adjunctive services include workforce development, consultation, psycho-education for parents, and engagement activities.

Special Programs/Services that target transitional-aged youth with serious emotional/ behavioral health disorders

- TIP (Transition to Independence Process) services available to this population using Case Managers trained in the model.
- Transition to Independence Process (TIP) are for youth 14-29 to help youth and young adults cope, identify strengths, and build a positive, independent future.
- Multi-Systemic Therapy (MST) is an intensive family and community-based treatment that addresses serious antisocial behaviors in juvenile offenders aged 11-18.
- Functional Family Therapy (FFT) is an intensive family-based treatment that addresses pervasive patterns of relational dysfunction that leads to conduct disorder, violent acting out, and substance use among youth 11 -18.
- Psychiatric services available as appropriate.

Special Programs/Services that target children and adolescents with serious emotional/ behavioral health disorders in the Child Welfare System

- General outpatient services (counseling, psychiatric services, mentoring, psychological testing, etc.) offered to this population across agency catchment. In-Home intensive Case Mgmt and Family treatment offered throughout the region for this population as well.
- Weld County Trauma-Informed Systems of Care (TISOC) is a collaboration of multiple community partners to provide advocacy and empowerment via a wraparound process that supports youth and families as they navigate systems; reduces the barriers to accessing care and duplication of services.
- COMPASS is a partnership with DHS that seeks to reduce DHS involvement in families with the goal of reducing out –of-home placement for children, youth, and families who are at risk of child abuse and neglect.

- Outpatient therapeutic services, Intensive Outpatient Services, MST and FFT and psychiatric services available as appropriate.

Special programs/services that target Veterans with serious behavioral health disorders

- No specialty programs for this population offered.
- "Civilians for Veterans Fund" monies are available to fund treatment for veterans who qualify.
- Four regional clinicians receive additional training on issues pertinent to veterans.

Community Based Services

Table 9: **The biggest barriers/gaps to serving people with mental illnesses in community, rather than institutional, settings are noted below.**	
Housing	X
Mental health treatment	
Substance use treatment	
Crisis services	
Residential services	X
Respite care	

Other barriers/gaps include:

- Safe off-site environments,
- Engaging people with mental illness in treatment if their illness affects them in such a way that they do not want to be involved in treatment. This is largely due to paranoia, lack of trust, fear, etc. Developing ways to connect with these individuals is a major challenge. and
- Reducing stigma so people experiencing symptoms will seek services.

Table 10: Client groups that pose the greatest challenge to serve in the community.	
Children	
Adolescents	X
Young adults/Transition-aged youth	X
Older adults	
Individuals with traumatic brain injuries	
Justice-involved	
Individuals with a history of violence	X

Other identified groups include: Dual Diagnosis Developmental Disability/Mental Illness; Autism Spectrum/Mental Illness

Housing

Table 11: Number of individuals receiving housing assistance from agency.	
Mental Health	84
Substance Use	21
Co-Occurring MH & SU	20

The following housing programs, such as permanent supportive housing, Shelter Plus Care, supervised apartments, group homes, are available and serve the following numbers of individuals (for those with available data):

- 4th Street House: 10 unit, 202/8 property for single individuals 18 + with SPMI;
- Housing Choice Voucher program;
- State Housing Voucher Program;
- Supportive Housing – Multiple rentals owned by North Range to provide housing to clients – 74
- Shelter Plus Care – 30
- Group Homes – assisted living residences – 26

These programs have waiting lists of an average of 12 months, except for independent living which has a wait of 3 months. The estimated percentage of un-served need for housing programs is 30%.

Housing is part of the job responsibility for case managers, i.e., housing needs are addressed in treatment plans. For people who do not participate in housing programs (above), case managers provide the following housing services/supports: Linkage, housing searches, referrals and advocacy to locate safe, affordable housing; payeeships, independent living skills, advocacy with landlords; rental listings and contact information, and help individuals connect with landlords and complete applications.

For people who do participate in housing programs, case management responsibilities beyond referral to the housing program include follow-up to ensure needs are met, assurance that appropriate placements are made, advocacy with landlords, and problem-solving.

For people who do not participate in housing programs, the estimated percentage the un-served need is unknown.

The level of participation by CMHC leadership in this region in community planning and advocacy regarding obtaining housing resources varies considerably from a high level of leadership engagement to no involvement.
Individuals who live in the community but not in specific housing programs supported by the organization, individuals support/service needs are met through linkages, referrals and advocacy to locate safe, affordable housing; payeeships, independent living skills, advocacy with landlords, assistance with accessing resources in the community and in governmental agencies that can assist with financing of housing.

Table 12: Housing Information	
Does your organization own and operate housing?	Yes
If yes, number of units/beds	10 units & 74 beds
Does your organization have formal relationships with housing providers, such as the PHA, private landlords, City or County governments.	Yes
Estimate number of units accessed through these relationships	220 +
For individuals who live in housing programs administered or supported by your organization, are all their support/service needs provided by program staff?	Yes

+ Plus others that cannot be quantified.

Employment

Table 13: Number of individuals receiving employment services in the past year	
Mental Health	79 with some unknown
Substance Use	10 with some unknown
Co-Occurring MH & SU	15 with some unknown

Employment programs, such as supported employment, job preparedness, sheltered workshop, ticket to work, and /or training program are provided. These programs include:

- DVR program (Employer Stipend, On Job Training, Work Adjustment Training, Job Coaching, Community Based Situational Assessments, Job seeking skills)
- Frontier House, accredited Clubhouse model of Vocational Rehabilitation, has two primary employment programs (in addition to a supported education program): Transitional Employment & Supported Employment.
- IPS (Individual Placement and Support) services. Over 100 served in the last year.

Some of these programs have waiting lists with variable wait times. Approximately 40 individuals at one CMHC have unmet employment needs and 50% at the other CMHC.

Employment services are part of the job responsibility for case managers, i.e., employment needs are addressed within a treatment plan.

Table 14: For people who do not participate in employment programs (above), the following tasks might be performed by a case manager behalf of individuals on their caseload regarding employment.	
Job Search	X
Referral to an Employment Program	X
Assistance with looking for an Employer	X
Assistance with applying for public benefits such as SSI, SSDI, VA	X
Support to maintain employment	X

For people who do participate in employment programs, the case management responsibilities beyond referral to an employment program include DVR staff providing services noted above and case managers support these efforts, monitor progress and, help problem-solve.
For people who do not participate in the employment programs, the estimated percentage of the un-served need is 25-50%.

Table 15: Employment Questions	
Does your agency have dedicated employment staff?	Yes
If yes, how many staff FTEs work solely on Employment?	3
How many people were working as a result of your Employment Program in the last fiscal year?	60+
Are you tracking the data of your Employment Program such as hourly wages, length of time working, part time vs. full time, types of jobs?	Yes
Does your agency currently have formal relationships with Employers? Employment programs, Training programs?	Yes
If yes, please indicate number of formal relationships	35+
Please estimate the percent of need for employment services at your agency.	25%
If people are employed through a referral, does your agency provide on-going support to maintain employment?	Yes

+additional unknown

On-going support to maintain employment includes the following:

- Formalized support through DVR program; informal support provided to clients by case managers, therapists; and
- Clubhouse or IPS staff; job coaching, personal adjustment assistance, vocational counseling, working with employer on additional job training.

If people express no desire for employment but are rejected for public benefits, the plan of action is referral to (limited) community support/benevolence programs and services and vocational counseling is encouraged. This doesn't happen often.

Wraparound Services

Wraparound services are provided to children. Children meeting criteria for this level of service may receive: multiple in-office contacts weekly, mentoring, family treatment, in-home case management, in home family therapy, case management, and psychiatric services. Additionally, staff work with youth, families and other service providers (DHS, Schools, etc) to ensure coordinated and continuation of services for clients.

Assertive Community Treatment

Three (3) Assertive Community Treatment teams are in the Region with caseloads ranging from 10-40 individuals.

Residential Substance Use Services that target adults with serious behavioral health disorders, including those related from the Department of Corrections include:.

- NRBH's True North program is a 20-bed facility that provides 45 days of intensive co-occurring treatment for substance dependent individuals who are 18 and older. Residential staff collaborate with the individuals, their physicians, therapists, probation/parole officers, caseworkers and families to promote recovery.
- After discharge, clients can participate in Intensive Outpatient groups to continue sobriety.
  NRBH also offers a sober living residential facility for those who have completed treatment at True North as they continue toward a life of recovery. Many of these residents attend the True North IOP groups.

Inpatient

Children and Adolescents Hospital

Table 16: Children and Adolescent Hospital					
Agency Name	**Hospital Name**	**County of Location**	**# of Beds**	**Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State**
Centennial			0		70%
North Range	+				80%

+None in Weld. Strategic Behavioral Health is building a 92 bed psychiatric hospital in Larimer County (all ages - however, it is primarily for private payers/insured)

Adult- Geriatric Hospital

Table 17: Adult- Geriatric Hospital									
Agency Name	**Hospital Name**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed on 1st day of the month**	**Secure/ Lockable Facility? YES/NO**	**Indicate Adult/ Geriatric or Both (A/G/B)**	**Average Length of Stay (Days)**	**Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State**
Centennial									50%
North Range	+								80%

+None in Weld. Strategic Behavioral Health is building a 90 bed psychiatric hospital in Larimer County (all ages - however, it is primarily for private payers/insured)

Residential

Child- Adolescent Residential

Table 18: Child- Adolescent Residential											
AGENCY NAME	**Facility Name**	**County of Location**	**Capacity/# of Available BH Beds**			**# of Current Clients Placed on 1st day of the month**	**Indicate Child, Adolescent or Both (C/A/B)**	**Secure/ Lockable Facility? YES/NO/ SS (Staff Secure)**	**Average Length of Stay (Days)**	**Percent of Child and Adolescent Facility Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Child and Adolescent Facility Needs Met by Current Available Resources in the State**
			MH	**SU**	**BOTH**						
North Range	None in Weld										90%
Centennial										50%	

Adult Residential

Table 19: Adult Residential												
AGENCY NAME	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/# of Available BH Beds**			**# of Current Clients Placed on 1st day of the month**			**Secure/ Lockable Facility? YES/NO**	**Average Length of Stay (Days)**	**Percent of Adult Residential Facility Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Adult Residential Facility Needs Met by Current Available Resources in the State**
			MH	**SU**	**BOTH**	**MH**	**SU**	**BOTH**				
Centennial												20%
North Range	Maxwell Center (ACF) (North Range)	Weld	12			8			No	400 days	90%	90%
North Range	Kinnick (ALR) (North Range)	Weld	12			8			No	85 days	90%	90%
North Range	Birch Assisted Living	Weld	42						No	?	90%	90%
North Range	Assisted Living of Greeley	Weld	16									20%

Role in gatekeeping who gets referred to State Hospitals: CMHCs exclusively place individuals at State Hospitals within our region when beds are available. North Range utilizes State Hospital beds on a very limited basis.

The following would enable us to better serve consumers in our own communities:

- Opened the first ATU in the state in 1990 and gave up state hospital beds in the process. We have developed this service to keep clients closer to home and reduce the need for admissions to CMHIP.

Skilled Nursing Facilities

Table 20: Skilled Nursing Facilities							
Agency Name	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed**	**Secure/ Lockable Facility? YES/NO**	**Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Nursing Home Needs Met by Current Available Resources in the State**
Centennial	Sunset Manor	Morgan	unknown	3	yes	30%	30%
Centennial	Sterling Living Center	Logan	unknown	2	yes	30%	30%
Centennial	Devonshire Acres	Logan	unknown	1	yes	30%	30%

Community providers work with Nursing Homes to assure they are only used for persons who need that level of care and for the minimum stays necessary as noted below:

- Because so few nursing facilities will accept/can manage clients with SMI, there is little concern that these individuals are placed unnecessarily/inappropriately; and
- North Range has strong working relationships with local nursing homes. Through this they strive to place individuals in LTC only when necessary. All residents with mental health issues are evaluated through the PASSR process to ensure their mental health needs are met and to confirm the need for LTC.

ATU

Table 21: ATU									
AGENCY NAME	Acute Treatment Unit Name - Not Crisis Stabilization Unit	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Average Length of Stay (Days)
			MH	SU	BOTH	MH	SU	BOTH	
Centennial	Crisis Stabilization Services (North Range BH)	Weld				2	2		3-4 days
North Range	ATU - the NRBH ATU will serve as a Crisis Stabilization Unit in the northeastern region (per contract with OBH)	Weld	16			12			7

Crisis Services

Table 22: Crisis Services									
AGENCY NAME	Acute Treatment Unit Name - Crisis Stabilization Unit	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Average Length of Stay (Days)
			MH	SU	BOTH	MH	SU	BOTH	
North Range	ATU - the NRBH ATU will serve as a Crisis Stabilization Unit in the northeastern region (per contract with OBH)	Weld	16			12			7

SUD

Table 23: SUD								
AGENCY NAME	**SUD Program Res. Treatment Program Name**	**County of Location**	**Capacity/# of Available SUD Beds**	**# of Current Clients Placed on 1st day of the month**	**OBH licensed for III.1, III.5 or III.&**	**Male/ Female or Both**	**Average Length of Stay (Days)**	**Percent of SUD Residential Tx Program Needs Met by Current Available Resources in your Geographic Service Area.**
North Range	North Range - True North	Weld	20	15	TRT	Both	31	100%

Detox

Table 24: Detox							
AGENCY NAME	**Detox Provider Name**	**County of Location**	**Capacity/ # of Available SUD Beds**	**# of Current Clients Placed on 1st day of the month**	**Medical or Social detox Model? (M or S)**	**Average Length of Stay (Days)**	**Percent of Detoxification Needs Met by Current Available Resources in your Geographic Service Area.**
North Range	North Range	Weld	23	15	S	2.5	90%

Peer Services

Table 25: Peer-related information	
Average case load of individual peer support staff	23-28
Typical aggregate number of hours per week of service provided across all peer specialist staff	Approx 185
Number of peer support positions budgeted for your organization	5 FTE, 11 staff
Number of peer support positions that were vacated within the last year fiscal year	.25 FTE, 2

Table 26: Areas of focus for Peer Services	
Assertive Community Treatment team member	X
Housing [in-home support; landlord outreach; housing acquisition/preservation]	X
Employment [job readiness, job coaching, etc.]	X
Wellness/Recovery [e.g. informal mentoring, WRAP, WHAM, self-advocacy]	X
Education [formal information dissemination; critical skill development]	X
Benefits support/Advocacy [e.g. acquiring housing assistance, entitlements, accommodations]	X
Outreach [e.g. connecting with at-risk people who are not receiving services or who are registered but not involved in services]	X
Crisis Response [e.g. Hotline, warm line, Emergency Room]	X
Psychiatric hospital [e.g. outreach, bridging/transition]	X
Community resource acquisition [e.g. linking to community resources, food banks, churches, self-help groups, recovery organizations]	X
Criminal justice/jail liaison	X
Family education/support/parenting	X

Other areas of focus include:

- Supervision/support at Residential Respite facility; and
- North Range employs peers with life experiences in both mental health and substance use disorder issues.

Hours	Table 27: Training Peer Staff Receive before Employment – Description
40-50	Peer Specialist training provided by BHO Ethical guidelines, advocacy, relationship building, conflict-resolution, workplace preparedness, HIPAA, sexual harassment
15-20	Approx 20 hours in first 6 months, then ongoing training (Solution –Focused Interventions, Motivational Interviewing, Group Facilitation Skills, MH First Aid, Recovery Principles, etc.) Clinical boundaries, MHFA, CPI, and online training
2-4	Group supervision monthly (I hour); individual supervision with clinical and administrative supervisors approx. 3 hours per month Monthly supervision meetings (more if asked or required); check in phone calls, yearly reviews.

Peer Support network for individuals in substance-misuse recovery (Sterling, CO) is an independent peer-operated support or recovery organizations in our area for people addiction disorders.

Criminal Justice

Approximate number of unduplicated clients served during the last fiscal year who were justice-involved (probation, parole, or released from incarceration within 6 months of receiving services):

Table 28: Justice-Involved Individuals Unduplicated Number Served	
On probation	850 +
On parole	110 +
Released from prison or jail within 6 months of receiving services	65 +
Other justice-involved	Approx. 350 (JBBS), 103

Table 29: Number of justice-involved individuals treated in the past year	
Mental Health <18	Unsure
Substance Use <18	Unsure
Co-Occurring MH & SU <18	Unsure
Mental Health >18	Unsure

Table 29 Continued : Number of justice-involved individuals treated in the past year	
Substance Use >18	Approx 300 SUD or Dual clients +
Co-Occurring MH & SU >18	Served through JBBS grant +

+ Additional served, unsure of number

Table 30: Court-referred Individuals - Number Served in FY 2014	
Mental Health	175 +
Substance Use	610 +
Co-Occurring MH & SU	105 +

+ Plus additional served – number unknown

How many recently incarcerated (i.e., in the last year) individuals in the past fiscal year were treated for the following issues by your agency?

Table 31: Recently Incarcerated Individuals - Number Served in FY 2014	
Mental Health	25
Substance Use	50
Co-Occurring MH & SU	28

+ Plus additional served – number unknown

Table 32: In the Region there is the following specialty court(s)	
Mental Health Court	
Drug Court	X

Other – In addition there is a Family Treatment Court – Substance Abusing Parents.

Capacity exists to serve everyone who is referred the specialty courts.

The Drug Court serves individuals with co-occurring mental health disorders.

Additional comment: Community Corrections/DOC individuals in residential SUD treatment are not eligible for Medical Medicaid if they can be charged with escape. This is a huge need and gap in the system. We are available to discuss this further. this also includes pregnant women and prenatal services and primary care. As mentioned previously, there is NO Medicaid benefit for SUD Residential Treatment.

Marijuana Legalization

Region 2 provides substance abuse treatment, prevention, recovery services.

Table 33: Substance use treatment and recovery services	
Total number of individuals have participated in substance use treatment and recovery services in the past year	7,333
Number with co-occurring mental health and substance use disorders	4,231
Number with marijuana use issues alone or as primary drug of choice	525 +
Number with prescription drug use issues alone or as primary drug of choice	45 +

+ Plus additional served – number unknown

Evidence-based programs or practices for substance use include: PRIME, Prime for Life, Celebrating Families, Seeking Safety, Motivational Interviewing, CBT, Matrix Model, ACT, ICCD, and MAT.

Evidence-based programs or practices for co-occurring mental health and substance use disorders include: PRIME, Prime for Life, Celebrating Families, Seeking Safety, Motivational Interviewing, DBT, Motivational Interviewing, CBT, Matrix Model, ACT, ICCD, and MAT.

Evidence-based programs or practices for marijuana use issues alone or as primary drug of choice include: PRIME, Motivational Interviewing, CBT, Matrix Model, ACT, ICCD, and MAT

Evidence-based programs or practices for prescription drug use issues alone or as primary drug of choice include: Medication Assisted Treatment, Motivational Interviewing, CBT, Matrix Model, ACT, ICCD, and MAT.

Region 2 currently has the capacity to serve everyone who requests services at your center for marijuana and prescription drug issues.

Appendix C-3:

Colorado Public Behavioral Health System and Services Inventory – Region 3

Counties Included In Region 3
Adams, Arapahoe, and Douglas

Region 3

CMHCs and SUD Providers/Program Administrators

- 3 CMHCs
  - Arapahoe Douglas Mental Health Network
  - Aurora Comprehensive Community Mental Health Center
  - Community Reach Center
- 1 BHO1
  - Behavioral Healthcare, Inc. (Adams, Arapahoe, Douglas Counties and Aurora)
- 1 MSO Provider: Signal MSO

Number of Persons Served

Table 1: Number of Persons Served			
Unduplicated Served	**Child/Adolescents 0-17**	**Adults 18-64**	**Older Adults 65 & Older**
Mental Health (MH)/Emotional Disorders	14,642	16,577	2,382
Substance Use (SU) Disorders	454	2,875	42
Co-Occurring MH & SU Disorders	378+	3,408+	103+

+Aurora did not provide data for Co-Occurring MH & SU Disorders

Workforce

Table 2: Workforce	
Staff Category	**Current Filled FTE #/Total FTE Budgeted**
Medical Staff	32.2/35 65/NA
Psychiatrists	**21.4/27.55** 21/NA
Psychologists	30.3/30 2/NA
Nurses	**25/28** 47/NA
Addictions Staff (E.g. CACs -Not Recovery Coaches)	31/8** +/NA*
Licensed Clinicians, Counselors, Social Workers	**172/188** 102/NA*
Unlicensed Master's level Clinician's, Counselors & Social Workers	**132/152** 49/NA*
Unlicensed Bachelor's level Clinician's, Counselors & Social Workers	**30/38.65** 35/NA*
Cross-trained MH/SA Behavioral Health Staff (Master's)	20/22

	+/NA*
Table 2 Continued: Workforce	
Staff Category	**Current Filled FTE #/Total FTE Budgeted**
Cross-trained Behavioral Health Staff (Bachelor's)	0/0 +/NA*
Case Managers (Non-Peer)	42.1/47 ++/NA*
Peer Support Specialists	**18/26** 5/NA*
Recovery Coaches	+/NA 0/NA*
Family Navigators/Advocates	**9/13** 0/NA*
Mobile Crisis Staff (Non-Peer)	**17.3/22** NA/NA*
Crisis Stabilization Unit Staff (Non-Peer)	**23.4/36.5** NA/NA*
Crisis Respite Staff (Non-Peer)	1/1.5++ NA/NA*
Mobile Crisis Peer/Family/Recovery Staff	2/3 NA/NA*
Crisis Stabilization Unit Peer/Family/Recovery Staff	3/5 NA/NA*
Crisis Respite Peer/Family/Recovery Staff	2/3 NA/NA*

^Insufficient data to include the caseloads.

*ADMHC did not provide information for Total FTE budgeted

**Community Reach did not provide the Total FTE Budgeted data for this category

+info not tracked

++included in other categories

Funding

Table 3: Funding	
FY 2014/2015 Funding Payer Source	**Approximate Per Cent of Total Operating Budget**
Medicaid	59%-80%
Medicare	1%-3%
State General Funds/Block Grants/Path Federal Funds	5%-7%
Other Grants	1%-7%
Funding from DOC, DYC, etc.	0%-1%
Privately insured	3%-23%
Donations & other sources	1%-10%
Other funds for Public Behavioral Health Services	2%-9%

Services Provided

Integrated Care

Table 4: Primary Healthcare - Integration	
We are a Federally Qualified Health Center (FQHC) and offer both primary and behavioral health services at our agency.	
We have fully integrated primary care into the services we provide at our location(s).	X
We offer primary care as a separate service within our behavioral health center.	X
Our center offers behavioral health services at an FQHC or other primary care service provider(s). Described below.	X
We have formal referral agreements in place with an FQHC or other primary care service provider, or have other methods for coordinating services. Described below.	X
Our services are limited to meeting the behavioral health needs of our clients.	
Other: Described below.	

The CMHCs offer behavioral health services at an FQHC or other primary care service provider(s) which include:

- Metro Community Provider Network
- Arapahoe Park Pediatrics
- Lone Tree Family Practice
- DTC Family Health & Walk-in
- Hampden Medical Group
- Doctor's Care
- Arapahoe Community College
- Englewood High School
- MCPN; 15 staff at 5 separate clinic sites
- Children's Hospital in 2 outpatient clinics
- Advanced Pediatrics Aurora site
- Rocky Mountain Youth Clinic Aurora site
- Salud, Clinica, Rocky Mountain Youth, Kids First

The CMHCs also work with formal referral agreements in place with an FQHC or other primary care service provider, or have other methods for coordinating services include:

- Arapahoe Park Pediatrics
- Lone Tree Family Practice
- DTC Family Health & Walk-in
- Hampden Medical Group
- Doctor's Care
- Arapahoe Community College
- Englewood High School
- Colorado Access through the **Colorado** Psychiatric **Access** and Consultation for Kids (C-PACK) program to provide access to PCMPs who are associated with CPACK.

Table 5: The mechanism by which these services are provided: If you offer primary care services that are integrated or co-located within your behavioral health center	
Primary care professionals are included on our staff (e.g., physician, nurse practitioner, etc.)	X
Contract with the FQHC or other provider to deliver primary care services. Identified Below	X
MOU or other formal agreement with the following FQHC or other provider to deliver primary care services.	X

Contract with the following FQHC: MCPN and also own a pediatric practice that is fully integrated BH and medical services.

Table 6: Funding Mechanism for co-located primary care services w/in BH Center	
Colorado Medicaid	X
Federal government and/or private grants	X
State funding	
Other	X

Specific federal government and/or private grants include:

- Colorado Health Foundation (grant year 11/1/10-10/31/12)
- SAMHSA PBCHI grant; MCPN has federal funding sources

***Other funding sources include*:** Uninsured clients of ADMHN, fee for service Medicaid, commercial insurance

Table 7: Referral Agreements	
If you have formal referral agreements with primary care service provider(s), how many people did you refer for services in 2013?	Not reported
If you have formal referral agreements with primary care service provider(s), what percentage of your patients were referred to you by primary care providers?	100% +

+ All CMHCs did not provide a percentage.

Recommendations to enhance the ability to provide/meet the primary health needs of individuals with behavioral health issues:

- Increased partnerships with primary care and pediatric facilities; provide primary care services within ADMHN for all clients throughout the developmental spectrum.
- Increase availability of services in behavioral health settings for those clients with significant behavioral health issues. Support efforts to ensure that services provided by behavioral health providers within primary care settings are billable so that services can be successfully sustained.
- Behavioral Health codes need to be made available so that LCSWs, LCPCs and other Behavioral Health Professional can bill for providing behavioral health services to individuals who have a primary medical condition. The true value of integration is to support patients with making behavioral change, not simply going to their PCP to get medications. Behavioral Health Professionals bring a level of expertise that can really improve health and support lasting change in behaviors that impact health (i.e. addressing change in diet and exercise when the person's primary diagnosis is diabetes.)

Special Co-Occurring Populations

Table 8: Intensive Services Exist for Co-Occurring Populations in the Region	
Individuals with Intellectual/ Developmental Disabilities	X
Individuals with Traumatic Brain Injuries	X
Individuals with Significant Medical/Physical Disorders	X

Infant/Early Childhood Services

ADMHN has Masters level licensed therapists who have expertise in early childhood services. They provide play therapy, individual therapy, and family therapy as part of our service continuum. In addition, they have a consultant who works with individuals and agencies in our community who serve the early childhood community. Their services include:

- **Screening** for behavioral health issues using ASQ-SE in community settings.
- **Diagnostic assessment** using both DC: 0-3R and DSM IV.
- **Dyadic assessment** using Marschak Interaction Method, Crowell Procedure for Parent Child Relationship Assessment and Working Model of the Child Interview.
- **Psychotherapy** including individual, family and group therapy, in-home support, crisis services, case management, individual behavioral health counseling.

- **Evidence based models include:** Parent Child Interaction Therapy, Trauma-Focused Cognitive Behavior Therapy, Child Parent Psychotherapy, Incredible Years and Nurturing Parenting Program.
- **Additional services:** Peer-led support groups, family involvement as Family Peer Specialists, wellness classes for children and for their parents.
- **Consulting services:** childcare centers and homes including center-based/home-based and child-specific; team-based consulting with Early Intervention providers.
- **Specialty services**: maternal mental health focused dyadic therapy, integrated services in pediatric clinics.

CRC also offers early childhood services. Early Childhood Services offer direct therapy; social, emotional, behavioral, and mental health concerns for children birth to age eight and their families and for children up to the age of 17 who are involved with the Department of Human Services. We are also able to offer support for mothers experiencing pregnancy related (PRD) and postpartum depression (PPD) and consultation services to schools, teachers and families regarding the promotion of positive social and emotional development for children are offered for children birth to age six in the Adam's County community. Therapy sessions are available in English and Spanish and may include; individual play therapy, family therapy, filial therapy, parent psychoeducation and parent guidance, group therapy, case management, care coordination, and intake coordination. Frequencies of service at Community Reach Center are based on the needs of the client. Parent and family therapy may also be integrated into care as needed by the client. As part of the treatment process, Community Reach Center collaborates with the child's treatment team including the family, referral sources and others as identified by the parent or guardian.

Consultations are classroom-based and child specific mental health consultations. Consultations are available to nurses and other providers at Tri-County Health Department regarding PRD/PPD. Trainings and support are provided regarding positive parent-child interactions and social/emotional development. Trainings and support are provided to PCPs, OBGYNs, and other community providers regarding PRD/PPD.

Early Childhood Services are located at their Mountainland Child Development Center in Thornton and their Brighton Outpatient office. They are also able to offer home-based services. Direct therapy is offered Monday-Thursday 8:00am-7:00pm and Friday 8:00am-5:00pm. Consultations are flexible and may include early mornings and later evenings depending on the client's needs.

School-based Services that target children and adolescents with serious emotional/ behavioral health disorders

ADMHN has a school liaison who is available to our 5 local school districts. This individual is available to assist with any barriers to treatment, communication between schools and therapists, and to provide education relation to options for services. We have therapists in our most high needs schools. These therapists see students during the school day and consult/collaborate with parents and teachers on strategies to ensure success in the classroom and at home.

Aurora Mental Health Center (AuMHC) has a longstanding partnership with Aurora Public Schools (APS) that spans nearly 30 years. Currently, school-based mental health providers are located in 26 elementary, middle and high schools in the district. They provide individual, group and family therapy, mental health assessments, crisis assessments and interventions as well as case management, classroom consultations and training and education for school staff. Most providers are bilingual in Spanish and English and all have access to phone and in-person translation services for languages other than Spanish. All services provided in APS are at no cost to the children and families served. AuMHC also provides crisis response services in APS in the aftermath of disasters such as student suicides, accidental deaths and, most notably, extensive school-based crisis services were provided for many months after the Aurora theater shooting in 2012. Aurora Mental Health Center also operates two school-based health centers in APS in partnership with Rocky Mountain Youth Clinics, which provides physical health services in the clinics and Children's Hospital, which provides dental health services. A behavioral health provider works within each clinic providing integrated behavioral health care for all clinic patients. In the fall of 2015, this partnership will expand to a new school-based health clinic at Central High School. With the opening of the clinic at Central, all APS students and their younger siblings will have access to physical, mental and dental healthcare within the network of the three clinics. AuMHC also provides school-based behavioral health services in Cherry Creek School District (CCSD) in 2 middle and 1 elementary school, and plans to add additional providers. For the past two years, Aurora Mental Health has initiated a new, innovative program in APS called HEARTS (Healthy Environments and Response to Trauma in Schools.) HEARTS aims to create school environments more sensitive to trauma and cultural diversity and therefore, more supportive of the needs of all students through training (for teachers, staff and parents), direct therapy services (for children and their families) and consultation (for teachers and staff). We currently implement HEARTS in 10 schools APS. HEARTS addresses many areas of school functioning with a primary focus of impacting the so called "School to Prison Pipeline."

School Based Services offer services to student's ages 5 to 21 years old attending grades K through 12 in Adams County School Districts 1, 12, 14 and 27J, 50 Charter Schools, and Front Range Community College.

All services are evidenced based/informed and tailored to fit populations with behavioral health needs. Frequencies of services at Community Reach Center are dependent on clinical need. Here are a few of the direct services offered through Outpatient Services:

- Direct therapy, for clients and their families experiencing social, emotional, behavioral or mental health concerns
- Consultation, prevention and early intervention services as well as assessment
- Psychotherapy
- Case Management
- Psychiatric Services
- Medication Management
- Prevention Intervention Services
- Linkage to intensive services
    - IRSS
    - Crisis Response Team
    - Adolescent DBT

School Based Services are offered on school sites in the above references school districts, services are also available as needed in the client's home. Clinicians are available for services Monday through Friday 7:00am- 6:00pm. Referrals for School Based Services are made from school staff, administrators, Juvenile Justice, Department of Social Services, Community Reach Center, or the client may self-refer.

Special Programs/Services that target transitional-aged youth with serious emotional/ behavioral health disorders

While there are no specific programs for transitional age youth, individual, group, and family therapy with these youth as they transition into adulthood are available. In addition, the BRIDGES program for substance abusing youth extends the age range up to age 25.

Special Programs/Services that target children and adolescents with serious emotional/ behavioral health disorders in the Child Welfare System

ADMHN partners with both of our Child Welfare Systems on a regular basis. We communicate treatment plans, progress towards goals and challenges. In Arapahoe County we participate as trainers for caseworkers. These trainings focus on trauma informed care and vicarious trauma. We participate in staffings and provide monthly update reports. We are also members of the team that reviews all child abuse reports.

In Douglas County, we are members of their community collaboration initiative that focuses on assessment and coordination of care for youth who are involved in both child welfare and criminal justice systems. ADMHN participates with both departments in reviewing their annual Core Service plans for families with no other fund source.

AuMHC works closely with Arapahoe County Human Services to screen and assess children for trauma exposure through a co-located staff member who specializes in this area. In addition, AuMHC offers a Child and Family Intensive outpatient program linked to ACDHS through an electronic referral system who provides intensive services for children and families receiving child welfare services. Additional services for this population include day treatment through Metro Children's Center, Hampden Academy and Intercept Center. AuMHC provides several evidence-based practices for this population including Parent-Child Interaction Therapy, Child Parent Psychotherapy, Alternatives for Families- CBT, and Nurturing Parenting Programs.

In addition to the early childhood and school based services, CRC has a liaison who works directly with Adams County Health and Human Services to link children in the foster care system with behavioral health services. Additionally, our Mountainland Pediatric Practice has a contract with Adams County HHS to provide physical health care services to children in foster care

Special programs/services that target Veterans with serious behavioral health disorders

Aurora Mental Health Center offers two veterans programs: One is transitional housing program for military veterans (Aurora Veterans Home) and the others is the hospital step-down program located at John Thomas House.

Aurora Veterans Home, is a 15 bed facility serving honorably discharged veterans struggling with homelessness, substance use disorders, and mental health issues. It is open veterans who are eligible for and referred through the Grant and Per Diem (GPD) program from the Veterans Administration. Services include structured housing with supportive case management by expert staff and community resources that help veterans make a successful transition to independent living. The goals of the program include: Connecting veterans to the VA for medical, mental health and vocational support, as well as substance use treatment services.

Assisting in rebuilding their lives, discovering their untapped resilience, harnessing their strengths, and returning their sense of self-determination. Empowering veterans to find jobs, build savings, and move to independent housing in the community.

The Veterans program located at John Thomas House offers a therapeutic hospital step-down program for both community hospital psychiatric units and the Denver VA. It is Staffed 24 hours per day by individuals formally educated in the field and provides medication education and administration, crisis counseling, treatment collaboration with VA 7th floor inpatient team, basic ADL education, including cooking skills, budgeting, and social skills, and finally transportation to psychosocial therapeutic programming at Intensive Services.

While we do not offer specialized services to Veterans, we do collaborate with the Veteran's Administration and provide behavioral health services to Veterans who cannot access services through the VA in a timely manner. We develop a treatment package that is individualized to meet the needs of the individual and family, if applicable.

Community Based Services

Providers in Region 3 serving more than 888 individuals with traumatic brain injuries during the last 12 months, however were unsure of the numbers of individuals served who were obese or had diabetes. Providers reported no waiting list for services.

Table 9: **Biggest barriers/gaps to serving people with mental illnesses in community, rather than institutional, settings.**	
Housing	X
Mental health treatment	
Substance use treatment	X
Crisis services	
Residential services	X
Respite care	X

Table 10: The following client groups pose the greatest challenge to serve in the community	
Children	
Adolescents	
Young adults/Transition-aged youth	X
Older adults	
Individuals with traumatic brain injuries	
Justice-involved	X
Individuals with a history of violence	X

Other groups that pose challenges to treat in the community include:

- Clients who are homeless
- Clients with a history of violence- Simply because they often cannot access housing, which is needed to achieve any level of stability

Housing

Table 11: Number of individuals receiving housing assistance from your agency.	
Mental Health	583 + *
Substance Use	11 + *
Co-Occurring MH & SU	264 + *

+ Plus additional who could not be reported

* Disability not specified- 240

Housing programs, such as permanent supportive housing, Shelter Plus Care, supervised apartments, group homes are provided throughout the Region. These include:

- HUD: 12 rooms (12 clients)in two different facilities where they pay 30% of their income towards rent. Each person has their own room and share common spaces such as kitchen and bathroom.
- Shelter Plus Care: 35 vouchers are currently open and receiving this service.
- CSHARP: 4 vouchers active with 6 more pending placement. These vouchers are for individuals coming out of prisons or jails

- SHV: 1 voucher active for clients that are coming out of state hospitals that choose to reside in Arapahoe or Douglas County. Voucher is triggered through the hospital.
- Aspen Leaf: 12 units (24 people) that are shared apartments for individuals in our ACT program or Wellness Court program to support them for at least a year until more permanent housing and/or vouchers are available. Individuals pay 30% of their income
- Fox Street: 6 (8 people) apartments in the community in a mixed housing area that has case management and other supportive services provided at a reduced rent rate.
- Section 8: 116 vouchers for individuals and families that have received services through ADMHN.
- Shelter Plus Care. We currently have 23 participants leased up but hope to lease up a total of 40 by approximately December 2014.
- HUD (6 two bedroom apartments), 167 section 8 housing choice voucher and 55 Shelter Plus Care Vouchers, 12 HUD 202, four home owners through section 8 and two state housing vouchers. We did not have a waitlist for a really long time, but due to shelter plus care voucher were put on a hold. Section 8 operates on a turnover system. We anticipate that we will be able to open it in the near future. Waitlist for Section 8 started in October 2009.
- Shelter Plus Care total of 120 vouchers; Housing Choice 148 vouchers; State Housing Voucher 14 total; Project Based Voucher 33 total vouchers and 2 Emergency Beds; Project Based Voucher Lafayette total of 9 vouchers; CHFA vouchers 5 total; 980 University 6 vouchers.

These housing programs have wait lists of approximately 90 days, however the wait varies. The estimated percentage of un-served need for housing programs is 5%.

Housing is part of the job responsibility for case managers, i.e., housing needs are addressed in treatment plans. Case managers provide services such as housing searches, referrals, negotiation with landlords/program managers as well as the following:

- Resources to affordable landlords in the area and connections with them. Helping to apply for other housing waitlist such as Section 8 in the counties and/property based units. Connecting them with other organizations that have housing vouchers.
- For those clients not being served by the Shelter Plus Care program, housing case management remains a common service provided to them. Case managers may assist clients in locating housing (e.g. completing applications, joining clients in the community to tour properties, etc.), securing housing (e.g. completing lease documents, assisting with background checks, etc.), and maintaining housing (e.g. advocating with landlords on clients' behalf, providing psychosocial rehabilitation

services to clients to enhance their independent living skills, etc.). Not all clients require this level of case management support, but many do, and when appropriate, goals related to this are included in a client's treatment plan.

- Work with individuals needing housing to locate appropriate housing, engage landlords, connect with funding options if need support with security deposits or ongoing supports to pay the rent. Case Managers help consumers complete housing applications as well as work with landlords to mitigate issues.
- Support in the community to help them maintain housing. Collaboration with clients current landlords to help prevent eviction. Teaching independent living skills and providing other resources such as employment and benefit acquisition services to those needing to have financial means to continue housing.
- Help to maintain placements. In Coronado program, which is a HUD program, PSR staff also support two groups which help individuals with learning or maintaining skills to live independently.

The estimated percentage of un-served need for housing programs is 20%.

The level of participation by CMHCs in community planning and advocacy regarding obtaining housing resources ranges from highly involved program staff to no involvement.

Individuals who live in the community but not in specific housing programs administered or supported by your organization get their support/service needs are met through:

- Support in the community to help them maintain housing. Collaboration with clients current landlords to help prevent eviction. Teaching independent living skills and providing other resources such as employment and benefit acquisition services to those needing to have financial means to continue housing.
- In addition to the range of mental health and case management services provided by a client's primary treatment team (therapist, case manager, psychiatrist, peer specialist, etc.), many clients living in the community also receive supportive in-home services, such as nursing care (e.g. medication administration or packing, medication education, other medical services, etc.) and homemaking supports (e.g. cleaning, cooking, organizing, etc.). These services are generally coordinated through CO Access' Home and Community Based Services (HCBS) and/or other Medicaid-funded programs.
- As part of a grant with the state of Colorado, we transitioned to offering IPS services to individuals with a SPMI. It is a supported employment program that offers competitive employment.

Table 12: Housing Information	
Does your organization own and operate housing?	Yes
If yes, number of units?	66
Does your organization have formal relationships with housing providers, such as the PHA, private landlords, City or County governments.	2 Yes/1 No
Estimate number of units accessed through these relationships	200
For individuals who live in housing programs administered or supported by your organization, are all their support/service needs provided by program staff?	No

Employment

Table 13: Number of individuals receiving employment services in the past year	
Mental Health	Approximately 272
Substance Use	87 +
Co-Occurring MH & SU	33

+ Employment counselors do not track/ data not available

CMHCs in this Region provide employment programs, such as supported employment, job preparedness, sheltered workshop, ticket to work, and /or training program. These include:

- ADMHN provides DVR (state waiting list), supported employment ("SE") (waiting list), job seeking skills training and job readiness training groups.
- Ghgfh
- Supported Employment- Through a partnership with The Division of Vocational Rehabilitation (DVR) we have assisted 122 Individuals with a primary disability of mental health obtain and maintain employment.
- Aurora Mental Health Center Vocational Program- Services include job readiness training, application assistance, resume assistance, job placement and follow along support. 48 individuals were served through this program last fiscal year.
- As part of a grant with the state of Colorado, we transitioned to offering IPS services to individuals with a SPMI. It is a supported employment program that offers competitive employment.

Table 14: Waiting Lists for Employment Programs	
Do these programs have a waiting list?	2/3 Yes
If yes, estimate of wait times	30 days
In your estimate, how many individuals being served by your program have a need for employment programs that is currently unmet	114

Employment services tend to be part of the job responsibility for case managers, i.e., employment needs are addressed within a treatment plan.

Table 15: For people who do not participate in employment programs (above), these tasks might be performed by case managers on behalf of individuals regarding employment?	
Job Search	X
Referral to an Employment Program	X
Assistance with looking for an Employer	X
Assistance with applying for public benefits such as SSI, SSDI, VA	X
Support to maintain employment	X

For people who do participate in employment programs, the case management responsibilities beyond referral to an employment program include:

- Ongoing support of their client's employment goal and collaboration with employment staff to assist with the development and implementation of an employment plan.
- Case managers are responsible for assisting clients in applying for public benefits and collaborating with the vocational team to best serve the client.
- Monitoring how things are going, support with attending to barriers that the consumer is facing that might impact his/her ability to maintain employment

a. For people who do not participate in the employment programs, what is your estimated percentage of the un-served need?

For people who do not participate in the employment programs, the estimated percentage of the un-served need is 19-46%.

Table 16: Employment Questions	
Does your agency have dedicated employment staff?	Yes
If yes, how many staff FTEs work solely on Employment?	10.5
How many people were working as a result of your Employment Program in the last fiscal year?	160
Are you tracking the data of your Employment Program such as hourly wages, length of time working, part time vs. full time, types of jobs?	Yes
Does your agency currently have formal relationships with Employers, Employment programs, Training programs?	Yes
If yes, please indicate number of formal relationships	13
Please estimate the percent of need for employment services at your agency.	19%+
If people are employed through a referral, does your agency provide on-going support to maintain employment?	Yes

+some unknown

On-going support to maintain employment includes the following:

- Job coaching and maintenance services are provided by employment specialist.
- Ongoing support and mental health services are provided by members of the treatment team.
- For as long as necessary the vocational team will provide follow along supports to maintain employment. This may include weekly meetings, meetings with the employer, job coaching, and phone check ins. When an individual expresses they are no longer in need of the intensive services that the vocational team provides, ongoing support is transitioned to the therapist. At any point if the client loses employment or needs more intensive support than the therapist can provide the client, the client can be referred back to the vocational team.
- Consumers choose if they want the ongoing support. If they do, we provide daily contacts for the first couple of weeks, weekly contact for a month or so after they start and then monthly for up to a year. If the consumer wants contact beyond the year, we will do that, but most consumers do not want that level of follow up.

If people express no desire for employment but are rejected for public benefits, the plan of action includes:

- People who do not desire to work are referred to case management for support and linkage to resources.
- Our employment program is based on client choice and we serve clients who are interested in obtaining employment. Client without public benefits who are not interested in obtaining employment are provided other resources by the treatment team to assist in meeting their needs.
- Continued encouragement for them to look at employment. Treatment teams address the issue as part of ongoing treatment.

Different levels of assistance with housing and/or employment based on a level of service designation include:

- Preferential treatment is given to ACT clients for housing services, especially if the client is affiliated with the DOC.
- Consumers receive different levels of service designation based on choice. We make recommendations, but develop the plan that is specific to needs and desire with the consumers' desire being the bigger variable.

Wraparound Services

One of the CMHCs provide **wraparound** services for children. These services include having trainers in Hi-Fidelity Wraparound, and offering this service to families. Case managers are trained routinely and incorporate principles into their work. We offer respite services in several configurations, including weekend groups, hourly services after school and on weekends, and overnight respite.

Assertive Community Treatment

Table 17: Assertive Community Treatment Teams	
Number of teams	3
Average caseload per team	17- 50

Residential Substance Use Services that target adults with serious behavioral health disorders, including those related from the Department of Corrections.

- None offered directly by AuMHC
- CRC does not offer residential substance use services. We partner with Arapahoe House when residential services are needed for the consumers we serve.

Inpatient

Children and Adolescents Hospital

Table 18: Child and Adolescent Hospital					
Agency Name	**Hospital Name**	**County of Location**	**# of Beds**	**Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State**
ADMHC	Devereux Cleo Wallace	Adams	16	90%	90%
ADMHC	Highlands Behavioral Health	Douglas		90%	90%
ADMHC	Children's Hospital Colorado	Aurora		90%	90%
Aurora	Children's Hospital	Adams		50%	50%
Community Reach	Highlands Behavioral Health	Douglas		90%	

Adult- Geriatric Hospital

Table 19: Adult- Geriatric Hospital									
Agency Name	**Hospital Name**	**County of Location**	**Capacity /# of Available BH Beds**	**# of Current Clients Placed on 1st day of the month**	**Secure/ Lockable Facility? YES/NO**	**Indicate Adult/ Geriatric or Both (A/G/B)**	**Average Length of Stay (Days)**	**Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State**
ADMHC	Highlands Behavioral Health	Douglas	54	2	Yes	B		80%	40%
Aurora	Medical Center of Aurora	Arapahoe	48	3	yes	both	6	60%	60%
Community Reach	HIGHLANDS	Arapahoe	55	1	YES	A	5-7 days		
Community Reach	MEDICAL CENTER OF AURORA	Aurora	44	1	YES	B	5-7 days		
Community Reach	+					B	7-10 days		

+None: these services are available in Mesa County

Residential

Child- Adolescent Residential

Table 20: Child-Adolescent Residential											
AGENCY NAME	Facility Name	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month	Indicate Child, Adolescent or Both (C/A/B)	Secure/ Lockable Facility? YES/NO/ SS (Staff Secure)	Average Length of Stay (Days)	Percent of Child and Adolescent Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Child and Adolescent Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH						
ADMHC	Devereux Cleo Wallace Center	Adams	Unknown			Unknown	A	Yes	Unknown	80%	80%
ADMHC	Excelsior Youth Center	Aurora	Unknown			Unknown	A	Yes	Unknown	80%	80%
ADMHC	Shiloh	Adams	Unknown			0	B	No	Unknown	80%	80%
Aurora	Jefferson Hills	Arapahoe				None by AuMHC	A	Staff secure	Unknown	90%	50%
Aurora	Excelsior Youth Center	Arapahoe				None by AUMHC	C/A (12-21)	Staff secure	Unknown	90%	50%

Table 20: Child-Adolescent Residential

AGENCY NAME	Facility Name	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month	Indicate Child, Adolescent or Both (C/A/B)	Secure/ Lockable Facility? YES/NO/ SS (Staff Secure)	Average Length of Stay (Days)	Percent of Child and Adolescent Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Child and Adolescent Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH						
Community Reach	Excelsior Youth Services, RCCF	Arapahoe					A	SS		90%	90%
Community Reach	Arapahoe House Stepwise, RCCF	Adams					A	SS		90%	90%

Adult Residential

Table 21: Adult Residential												
AGENCY NAME	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Secure/ Lockable Facility? YES/NO	Average Length of Stay (Days)	Percent of Adult Residential Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Adult Residential Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH	MH	SU	BOTH				
ADMHC	CareLink				8				NO to all		50%	
ADMHC	Manor at Sycamore				10				NO to all		50%	
ADMHC	Manor on Orchard				8				NO to all		50%	
ADMHC	Gentle Hearts				8				NO to all		50%	
ADMHC	Assisted Living at Floyd				8				NO to all		50%	
Aurora	Thomas House	Arapahoe	15			10			no	15	50%	50%
Aurora	Mrachek House	Arapahoe	15			9			no	45	50%	50%
Community Reach	Mesa	Adams	9			8			No	119	80%	80%
Community Reach	Crestone	Adams	10			10			No	437	80%	80%
Community Reach	Beaver Retreat	Adams	8			8			Yes	unsure	80%	80%
Community Reach	Sunnyslope	Adams	8			8			No	Unsure	80%	80%
Table 21 Continued: Adult Residential												

AGENCY NAME	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Secure/ Lockable Facility? YES/NO	Average Length of Stay (Days)	Percent of Adult Residential Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Adult Residential Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH	MH	SU	BOTH				
Community Reach	Angels Abode	Adams	6			6			Yes	Unsure	80%	80%
Community Reach	Mountain View Gardens	Adams	10			9			Yes	unsure	80%	80%
Community Reach	Kraft Home	Adams	12			11			Yes	Unsure	80%	80%
Community Reach	Little Patch of Heaven	Adams	14			12			Yes	Unsure	80%	80%
Community Reach	Boston House	Adams	10			10				unsure	80%	80%

Role in gatekeeping who gets referred to State Hospitals and what would enable you to better serve consumers in their own communities:

- All referrals for either state hospital go through hospital liaison. Having additional beds available at Fort Logan would allow us to serve clients in our community, instead of down in Pueblo.
- Hospital Services Team works to transition consumers out of state and private hospital beds efficiently and safely; work with metro-area bed-tracking to utilize state hospital bed across Centers to ensure capacity is effectively utilized.
- Consumers could be better served in the community by advancing the mission of residential caregivers and in-home peer specialists. The crisis system CSU and Respite beds will allow for greater community-based recovery.
- Hospital liaisons support individuals transitioning in and out of our State hospitals, but we do not function as gatekeepers.

The State hospitals produce monthly assessments of clients who are ready for discharge and these are shared with Community Providers.

Skilled Nursing Facilities

Table 22: Skilled Nursing Facilities

AGENCY NAME	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/ # of Available BH Beds	# of Current Clients Placed	Secure/ Lockable Facility? YES/NO	Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Nursing Home Needs Met by Current Available Resources in the State
ADMHC	Pearl Street Health & Rehab	Arapahoe	Unknown	3	No	10%	20%
ADMHC	Julia Temple	Arapahoe	Unknown	0	Yes	10%	20%
ADMHC	Cherrelyn Manor	Arapahoe	Unknown	6	No	10%	20%
ADMHC	Castle Rock Care Center	Douglas	Unknown	1	No	10%	20%
Aurora	Cherry Creek Nursing Home	Arapahoe	25	3		70%	50%

Table 22 Continued: Skilled Nursing Facilities							
AGENCY NAME	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed**	**Secure/ Lockable Facility? YES/NO**	**Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Nursing Home Needs Met by Current Available Resources in the State**
Aurora	Aspen Care Center	Arapahoe	48	2		70%	50%
Aurora	Summit Nursing Home	Arapahoe	36	12		70%	50%
Aurora	The Colorado Veterans Community					70%	50%
Aurora	Living Center at Fitzsimons					70%	50%
Aurora	Kindred Aurora Center	Arapahoe	41	1		70%	50%
Aurora	Shalom Park	Arapahoe	54	0		70%	50%
Community Reach	Alpine	Adams	?	9	NO	10%	50%

Table 22 Continued: Skilled Nursing Facilities							
AGENCY NAME	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed**	**Secure/ Lockable Facility? YES/NO**	**Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Nursing Home Needs Met by Current Available Resources in the State**
Community Reach	Clear Creek	Adams	?	0	NO	10%	50%
Community Reach	Elms Haven	Adams	?	6	NO	10%	50%
Community Reach	Park Forest	Adams	?	28	NO	10%	50%
Community Reach	Cottonwood	Adams	?	25	YES	10%	50%
Community Reach	Mission San Miguel	Adams	?	20	NO	10%	50%
Community Reach	Avamere at Malley	Adams	?	5	NO	10%	50%
Community Reach	Woodridge Terrace	Adams	?	10	NO	10%	50%
Community Reach	Villas at Sunny Acres	Adams	?	1	NO	10%	50%
Community Reach	Vista View	Adams	?	1	NO	10%	50%

Community providers work with Nursing Homes to assure they are only used for persons who need that level of care and for the minimum stays necessary through:

- Assessment of individuals to ensure they meet the admission criteria for available services. Additionally, through their OBRA team, assess if individuals meet the level of care need for a nursing home facility and as people focus on recovery, actively work with nursing homes to transition consumers out of the facility to who meet a lower level of care.

ATU

Table 23: ATU									
AGENCY NAME	Acute Treatment Unit Name - Not Crisis Stabilization Unit	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Average Length of Stay (Days)
			MH	SU	BOTH	MH	SU	BOTH	
ADMHC	Bridge ATU (ADMHN)	Arapahoe			16	14	0	0	3-7 days

Crisis Services

Table 24: Crisis Services									
AGENCY NAME	Acute Treatment Unit Name - Crisis Stabilization Unit	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Average Length of Stay (Days)
			MH	SU	BOTH	MH	SU	BOTH	
ADMHC	Santa Fe (ADMHN) (opened 12/1/14)	Arapahoe			15	0	0	0	3-5 days
Aurora	2206 Victor Street (Aurora Mental Health Center)	Adams			16	2			4
Aurora	Jefferson Hills Aurora	Arapahoe			8			0	4
Community Reach	CRC St. Anthony North	Adams			16			0	5

SUD

Table 25: SUD								
AGENCY NAME	**SUD Program Res. Treatment Program Name**	**County of Location**	**Capacity/# of Available SUD Beds**	**# of Current Clients Placed on 1st day of the month**	**OBH licensed for III.1, III.5 or III.&**	**Male/ Female or Both**	**Average Length of Stay (Days)**	**Percent of SUD Residential Tx Program Needs Met by Current Available Resources in your Geographic Service Area.**
ADMHC	Arapahoe House	Arapahoe						80%
ADMHC	Parker Valley Hope	Douglas						
Community Reach	Arapahoe House	Adams County				both	1 - 4 weeks	

Detox

Table 26: Detox							
AGENCY NAME	**Detox Provider Name**	**County of Location**	**Capacity/ # of Available SUD Beds**	**# of Current Clients Placed on 1st day of the month**	**Medical or Social detox Model? (M or S)**	**Average Length of Stay (Days)**	**Percent of Detoxification Needs Met by Current Available Resources in your Geographic Service Area.**
Aurora	Arapahoe House	Arapahoe	UK	UK	Social	UK	60%
ADMHC	Arapahoe House						10%
Table 26 Continued: Detox							

AGENCY NAME	Detox Provider Name	County of Location	Capacity/ # of Available SUD Beds	# of Current Clients Placed on 1st day of the month	Medical or Social detox Model? (M or S)	Average Length of Stay (Days)	Percent of Detoxification Needs Met by Current Available Resources in your Geographic Service Area.
ADMHC	CO Coalition for the Homeless						10%
ADMHC	Salvation Army						10%
Community Reach	Arapahoe House	Adams County			Both	12 hrs - 3 days	70%

Peer Services

Peer support/peer specialists provide services in Region 3. **Peer Specialist -** is a person that is grounded in their own (or family) recovery and model competency in managing symptoms and accessing resources in the community. Certified Peer specialists are fully integrated team members, who provide highly individualized services in the continuity of care, community outreach and they promote client self-determination and decision-making.
An essential role for the Peer Specialist is to share the recovery process and their own story to promote recovery, establish meaningful healing relationships and support systems, utilizes the Wellness and Recovery Action Plan (WRAP) and to encourage self-determination, self-sufficiency, therapeutic environment for recovery and engage in positive self-sustaining activities.

Aurora Mental Health Center has been a proponent of the integration of Peers on various teams throughout the agency for the past 10 years. Peer were first introduced and worked part time on the Intensive Service Community Living Program and DDMI (now known as ACLS) working alongside our front desk staff, case managers, business office and co-facilitating groups and even managing their own Clothing Thrift Store (Unique Creations Gallery).

In 2008, the Department of Health Care Policy and Finance (HCPF) established Peer Specialist Competencies, understanding the proven role that peers' play in the advancement of recovery. These competencies are to provide guidance on the basic skills and

knowledge that a peer specialist in Colorado must have. The competencies were developed in collaboration with Medicaid members, HCPF, and mental health provider staff and community advocates.

Table 27: Peer Support-related questions	
Average case load of individual peer support staff	10 - 35
Typical aggregate number of hours per week of service provided across all peer specialist staff	90-230, Part time 16 - 20 Full time 40
Number of peer support positions budgeted in the Region	37
Number of peer support positions that were vacated within the last year fiscal year	4

*not all are direct service—this is the number of hours worked

Table 28: Areas of focus for Peer Services	
Assertive Community Treatment team member	X
Housing [in-home support; landlord outreach; housing acquisition/preservation]	X
Employment [job readiness, job coaching, etc.]	X
Wellness/Recovery [e.g. informal mentoring, WRAP, WHAM, self-advocacy]	X
Education [formal information dissemination; critical skill development]	X
Benefits support/Advocacy [e.g. acquiring housing assistance, entitlements, accommodations]	X
Outreach [e.g. connecting with at-risk people who are not receiving services or who are registered but not involved in services]	X
Crisis Response [e.g. Hotline, warm line, Emergency Room]	X
Psychiatric hospital [e.g. outreach, bridging/transition]	
Community resource acquisition [e.g. linking to community resources, food banks, churches, self-help groups, recovery org's.]	X
Criminal justice/jail liaison	X
Family education/support/parenting	X

Other: Described Below:

- Milieu support in rehabilitation program. Help to manage the flow of the milieu by providing ongoing support in the activities that are planned and unplanned. Seeks member input to make decisions and changes in programming.
- In addition to the above, our Peer specialist are available at our intake office in Thornton to support consumers entering our system.

Hours	Table 29: Training Peer Staff Receive before Employment – Description
3 months	Peer specialists that work here come from a variety of training programs. Some were as long as a year while others were for two months. We do require some type of peer specialist training to be completed as a condition of employment/prior to hire date.
96	Peers receive training in accordance to the Colorado Core Competency set by the State of Colorado. Peers are involved in training for 4 -8 hours per week for 12 weeks before employment. Peer also receive training on Mental Health First Aid (Adult /Youth) Crisis Prevention Intervention
80	Attend Colorado Mental Wellness Network Training

Hours	Table 30: Training Peer Staff Receive After Employment – Description
8	Peer specialists are encouraged and supported to attend ongoing training provided to peer specialists that are offered through our BHO (BHI) and other organizations.
8 hours monthly	After a peer is employed it is dependent upon the program to send peer to training to continue enhancement of the peer skills for the workplace settings. However we do provide ongoing training monthly with guest speakers that is open to all employees. Peer have monthly meeting after employment to discuss any concerns about the workplace and achievements or accomplishments.
32	Wrap Training 16 hours, Mental Health First Aid- 8 hours, offered to all peer specialists. Additionally, individuals have attended training specific to his/her professional growth and development

Hours/Mo	Table 31: Brief Description of How Peer Staff Are Supervised
4	Each peer specialist is supervised by a clinical supervisor on a weekly basis. Peer specialists also attend a monthly peer specialist supervision group that is run by a peer specialist for supportive interventions from their peers on cases.
6	Each peer receives approximately four hours of individual supervision each month, which doesn't include group supervision provided in team meetings (approximately four hours a month). Peer staff are paired with a masters-level therapist for weekly or biweekly supervision, as well as group supervision/consultation amongst peers on a monthly basis (2 hours).
4	Each peer is provided 4 hours of individual supervision by an LCSW and then 4 hours of group supervision with an LPC focusing on secondary trauma and self-care.

Independent peer-operated support or recovery organizations in your area for people with mental health or addiction disorders include:

- Charge Program
- Colorado Mental Wellness Network
- Colorado Mental Wellness Network out of Denver, AA, NA, CMA

Criminal Justice

1. Please indicate the approximate number of unduplicated clients you served during the last fiscal year who were justice-involved (probation, parole, or released from incarceration within 6 months of receiving services). If you served clients who were justice-involved but you are unsure of the number, please enter *unsure*.

Table 32: Justice-Involved Individuals - Number Served	
On probation	1130 +
On parole	447 +
Released from prison or jail within 6 months of receiving services	1190 +
Other justice-involved	1,583

+ Plus additional – number unknown

Table 33: Number of justice-involved individuals treated in the past year	
Mental Health <18	553
Substance Use <18	402
Co-Occurring MH & SU <18	549
Mental Health >18	1,811
Substance Use >18	282
Co-Occurring MH & SU >18	1,123

Table 34: Specialty Court-referred Individuals - Number Served FY 2014	
Mental Health	36
Substance Use	7
Co-Occurring MH & SU	145

Table 35: Recently Incarcerated Individuals (in the past year)	
Mental Health	418 +
Substance Use	480
Co-Occurring MH & SU	1,122

+ Plus additional – number unknown

Table 36: The Region has the following Specialty Courts	
Mental Health Court	X
Drug Court	X

Other Courts:

- Drug Court exists in 18th Judicial: treatment service performed by University of CO ARTS program
- Co-occurring juvenile specialty court
- VA court- not specific to SUD or MH

Table 37: Note if capacity exists to serve all referrals in the Region (X)	
Mental Health Court	X
Drug Court	X
Other – As noted above	

Table 38: If Drug & Mental Health Courts, which serves co-occurring MH/SU referrals in the Region (X)	
Mental Health Court	X
Drug Court	X *

*At times serves co-occurring, but focus is on drugs

Marijuana Legalization

Table 39: Substance use treatment and recovery services in the Region	
Total number of individuals have participated in substance use treatment and recovery services in the past year	4,177
Number with co-occurring mental health and substance use disorders	2,865 +
Number with marijuana use issues alone or as primary drug of choice	139 +
Number with prescription drug use issues alone or as primary drug of choice	58 +

Evidence-based programs or practices for substance use, generally: Motivational Interviewing, IDDT, and Seeking Safety

Evidence-based programs or practices for co-occurring mental health and substance use disorders: IDDT, A-CRA, Seeking Safety, and Motivational Interviewing

Evidence-based programs or practices for marijuana use issues alone or as primary drug of choice: Motivational Interviewing, IDDT, and Seeking Safety

Evidence-based programs or practices for prescription drug use issues alone or as primary drug of choice: Motivational Interviewing, IDDT, and Seeking Safety

Region 3 currently has the capacity to serve everyone who requests services at the CMHCs for marijuana and prescription drug use issues.

Appendix C-4:

Colorado Public Behavioral Health System and Services Inventory – Region 4

Counties Included in Region 4
Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Lake, Las Animas, Mineral, Otero, Prowers, Pueblo, Rio Grande, and Saguache

Region 4

CMHCs and SUD Providers

- 4 CMHCs
  - San Luis Valley Mental Health Center
  - Southeast Mental Health Services
  - Spanish Peaks Mental Health Center
  - West Central Mental Health Center
- 1 BHO Colorado Health Partnerships, LLC
- MSO providers: Signal MSO for 3 of the 4 CMHCs; West Slope Casa MSO for 1 CMHC.

Number of Persons Served

Table 1: Number of Persons Served			
Unduplicated Served	**Child/Adolescents 0-17**	**Adults 18-64**	**Older Adults 65 & Older**
Mental Health (MH)/ Emotional Disorders	4,304	9,791	1,370
Substance Use (SU) Disorders	29	828	23
Co-Occurring MH & SU Disorders	45+	796+	69+

+Southeast did not provide data for Co-Occurring MH & SU Disorders

Workforce

Table 2: Workforce	
Staff Category	**Current Filled FTE #/Total FTE Budgeted**
Medical Staff	**30/35**
Psychiatrists	**10.5/14.5**
Psychologists	5/5
Nurses	**24/28**
Addictions Staff (E.g. CACs -Not Recovery Coaches)	**12.5/15.5**
Licensed Clinicians, Counselors, Social Workers	**71/79**
Unlicensed Master's level Clinician's, Counselors & Social Workers	**58/64**
Unlicensed Bachelor's level Clinician's, Counselors & Social Workers	39/40
Cross-trained MH/SA Behavioral Health Staff (Master's)	**23/27**
Cross-trained Behavioral Health Staff (Bachelor's)	2/2
Case Managers (Non-Peer)	29/31
Peer Support Specialists	11/11
Recovery Coaches	4/7
Family Navigators/Advocates	9/10
Mobile Crisis Staff (Non-Peer)	**15/22**
Crisis Stabilization Unit Staff (Non-Peer)	**0/9**
Crisis Respite Staff (Non-Peer)	**1/4**
Mobile Crisis Peer/Family/Recovery Staff	6/6
Crisis Stabilization Unit Peer/Family/Recovery Staff	0/0
Crisis Respite Peer/Family/Recovery Staff	0/0

^Insufficient data to include the caseloads.

Funding

Table 3: Funding	
FY 2014/2015 Funding Payer Source	**Approximate Per Cent of Total Operating Budget**
Medicaid	61%-84%
Medicare	.01%-1%
State General Funds/Block Grants/Path Federal Funds	8%-12%
Other Grants	1.1%-11%+
Funding from DOC, DYC, etc.	.5%-18.8%++
Privately insured	1%-4.62%
Donations & other sources	.1%-3.7%
Other funds for Public Behavioral Health Services	0%-6%

+Solvista Health did not provide data for this category

++Southeast put an NA for this category

Services Provided

Integrated Care

Table 4: Primary Healthcare - Integration	
We are a Federally Qualified Health Center (FQHC) and offer both primary and behavioral health services at our agency.	
We have fully integrated primary care into the services we provide at our location(s).	X
We offer primary care as a separate service within our behavioral health center.	X
Our center offers behavioral health services at an FQHC or other primary care service provider(s). Described below.	X
We have formal referral agreements in place with an FQHC or other primary care service provider, or have other methods for coordinating services. Described below.	X
Our services are limited to meeting the behavioral health needs of our clients.	
Other: Described below.	X

The CMHCs offer behavioral health services at an FQHC or other primary care service providers identified below

- Valley Wide Health Services Inc; (FQHC)
- Alamosa Family Medical Center
- Sierra Blanca Medical Clinic
- Edward M Kennedy Health Clinic
- San Luis Health Clinic
- Moffat Health Clinic
- Guadalupe Health Clinic
- Cesar Chavez Medical Clinic
- San Luis Valley Health
- Stuart Street Clinic: Family Practice and Internal Medicine
- Sierra Blanca Street: OBGYN Clinic and Pediatric Clinic
- Rio Grande Clinic and Hospital
- Del Norte Clinic

<u>Planned for 2015</u>

- Valley Wide Health Systems – FQHC
- Mt Carmel Health, Wellness and Community Center, Trinidad, Colorado (5 medical prescribers)
- Family Practice Physicians, Pueblo, Colorado (Dr. Jamie Pollock)
- Southern Colorado Family Medicine, Pueblo, Colorado (Multiple prescribers at this site)
- Mt. San Rafael Hospital Clinic, Trinidad, Colorado (9 medical prescribers)
- Grand Avenue Homeless Health Center, Pueblo, Colorado

Providers with formal referral agreements in place with an FQHC or other primary care service provider, or have other methods for coordinating services include:

- Valley Wide Health Services Inc;
- San Luis Valley Health

- Rio Grande Clinic and Hospital
- Dr. Sowards Medical Clinic (private practice)
- Care coordination to all primary care practices are co-located in Custer and Chaffee Counties.
- Valley Wide Health Systems - FQHC
- High Plains Community Health Clinic –FQHC
- Integrated Community Health Partners – our Region 4 – Southeast Health Group is both a partner and provider
- FQHC – Pueblo Community Health Center, Pueblo, CO

Other: Services are provided as quickly as possible and coordinating with existing community programs to maximize service access and promote cost effectiveness. Integration efforts focus on services to meet the behavioral health needs of community members who would benefit from behavioral health and also provide some specific care coordination to community members who have high risk physical health needs only.

Primary care professionals are included on our staff - Budgeted for Physician, Medical Assistant and Administrative Support for FY 2015.

Funding sources for Co-located services w/in BH Center include insurance and co-pays as any primary care; capital infusion from organizational reserves, third party insurance and self-pay.

To enhance the ability to provide/meet the primary health needs of individuals with behavioral health issues CMHCs will need to:

- Develop a co-located partnership to provide primary care services at our behavioral health organization. We expect to have these services within the next year.
- Increased availability of primary care providers is needed within our region
- Not follow the medical model of seeing a patient every 15 minutes. We have trained our primary care providers to slow down and take a holistic approach to their assessment and diagnosis process. They may spend 30-45 minutes with a patient depending on the issue presented. By slowing down and focusing on the holistic needs of the patient our primary care providers have, in the past year, diagnosed 6 individuals with cancer that had gone undetected.
- In 2015 Spanish Peaks will begin providing integrated primary healthcare services at the main Center in Pueblo, CO.

Special Co-Occurring Populations

Table 5: Intensive public services exist for Co-Occurring Population in the Region (X)	
Individuals with Intellectual/ Developmental Disabilities	X
Individuals with Traumatic Brain Injuries	X
Individuals with Significant Medical/Physical Disorders	X

Infant/Early Childhood Services

Work in partnership with the area Early Childhood Council and Child find. Employ an Early Childhood Specialist who provides consultation. The Early childhood mental health consultation provided in the early care and learning setting to include training/coaching for child care providers and parents. The Early Childhood Specialist is available to provide one-on-one behavioral services with the child in a community setting. When possible, individual behavioral services should include parent and provider involvement. Standardized assessments such as the PSI, DECA, and ASQ-SE at intake, update, and discharge are completed and the Pediatric Symptoms Checklist (6-8) is utilized. Prenatal and postnatal depression screenings are provided such as Edinburgh Postpartum Depression Screening as well as trauma screenings when deemed appropriate such as PCL and trauma symptom check list for young children (TSCYS).

The Early Childhood Specialist coordinate the Center's efforts to use the DECA, ASQ-SE, and other assessments to improve early identification of social-emotional problem areas and design both prevention strategies and appropriate interventions.

Consultation services may include teacher/therapist consultation and guidance on individual children, teacher/teacher interaction, teacher/child interaction, training on topics need by teachers and/or parents, unbiased observation of classroom functioning and children's behavior and suggestions for improving interactions, assistance in accessing services for children with special needs, brief individual therapy (Children needing more intensive therapeutic mental health services will be referred to the Mental Health Center), and determining the need for referrals to medical or other community services.

The Specialist also work with and provide consultation to therapist providing intensive therapy.

One CMHC has one FTE dedicated to Early Childhood Mental Health Specialty Services. A .6FTE covers Fremont and Custer Counties. A.4 FTE covers Chaffee and Lake Counties. Additionally Child and Family Clinicians with specialized early childhood training work in outpatient with young children and their families.

Early Childhood Specialists support area licensed daycare providers, Early Childhood Development Councils, Nurse Family Partnership agencies, Child Development Services agencies, pediatricians and family practitioners by offering consultation, coaching and education to their respective staffs and the families of the children they serve. Activities of the Case Manager II-Early Childhood Specialist include: Consultation to families and early care education providers, community outreach and education, and cross systems program development. The master's level Early Childhood Clinician is responsible for: Age appropriate standardized screening to determine the Functional Emotional Developmental Level and Parent Infant Relational Global Assessment Scale (PIR-GAS) for each child engaged in treatment, individual therapy, play therapy, family therapy, and arranging psychiatric consultation.

Both infant and early childhood services are available in Pueblo, Las Animas and Huerfano counties. An Early Childhood specialist works with community partners Head Start, Day Care Centers (both center based and home based), DSS, Catholic Charities, etc.) to provide services to children and their families. These services include observation, consultation, assessment, case management and in home treatment. An Early Childhood Consultant works specifically with day care providers (both centers and in home) to provide consultation and observation that is focused on the Pyramid model. Both EC Specialist and Consultant participate in the Early Childhood Council in the community. One CMHC also has outpatient clinicians trained in the DC0-3 and they are also trained in both Filio Play Therapy and Theraplay.

School-based Services that target children and adolescents with serious emotional/ behavioral health disorders

One CMHC provides behavioral health services on site at 13 of the 14 school districts in their area.

A CMHC has one FTE dedicated is to School-Based Services. A .6FTE covers Fremont and Custer Counties. A .4 FTE covers Chaffee and Lake Counties.

School-based Mental Health Specialist Position job duties include:

- Consultation for school based behavioral health needs
- Coordination of treatment services among treatment providers
- Education/prevention/early intervention/outreach services

- Direct care provider for schools, to include individual and group services
- Attendance to truancy court and HB04-1451 collaborations
- Direct services provided to children in the school, home, and office settings as needed and based on assessment and treatment planning. Direct services to include; assessment, treatment planning, case management, individual/group therapy, individual/group skills training, and facilitation of psychiatric referrals

Planned therapeutic interventions including evidence-based practices;

- Use of standard assessment, diagnostic, and treatment guidelines as well as standard treatment interventions under the supervision of an LPC and in coordination with family/guardian, school staff, and community agencies involved in treatment
- Use of EBP's such as Coping Cat, Adolescent Coping With Depression Course, TF-CBT, CBT, MI, Adolescent DBT. Use of traditional treatment approaches including skill building, individual, group and family therapy.

Spanish Peaks CMHC has 5 school based therapists and 1 School Liaison serving the two school districts in Pueblo County. With this staff is currently providing a full array of services (individual, family, group therapy, case management) to 11 schools. 9 of these schools are in Pueblo City School District 60 and 2 are in Pueblo School District 70. Our School Liaison works closely with a number of other schools, primarily elementary, to help link students and their families with services. Our school based team also provides consultation to teaching staff when requested and often sit in on the Response to Intervention (RTI) process and at times are invited to participate in the IEP process. Our school based team will also provide training to school staff when requested. Our school based team members are also a part of both school districts emergency response teams and will help the districts manage school/district wide crisis, such as a student death. Our clinicians also do crisis evaluations at the schools where they are assigned to students who express homicidal or suicidal ideation. The clinicians will evaluate and based on the evaluation they will either provide case management to the student or enroll them for services. If the client needs a higher level of care the clinicians will facilitate the process with Spanish Peaks Crisis response team. We do not currently offer these services in Las Animas County or Huerfano We have worked with the two school districts in these counties but have not been successful to date.

Special Programs/Services that target transitional-aged youth with serious emotional/ behavioral health disorders

Some providers do not have special programming that targets transitional age youth. There is a recent targeted program in Fremont/Custer County clinician and one Chaffee/Lake County clinician supervisor to receive specialized training in working with transition-aged youth. Another provider is working closely with Posada Homeless Shelter (Pueblo County) to provide case management to transition aged youth to ensure their mental health needs are being met. A case manager is going to Posada every Thursday morning to meet with clients and ensure they have appointment information, transportation and help meet any other needs they might have. They are also developing and will have in place by May, a transition aged group that will focus on life skills to include management of their mental health needs when they become adults. They will be working closely with Department of Social Services to identify clients that they both serve who would benefit from this group.

Special Programs/Services that target children and adolescents with serious emotional/ behavioral health disorders in the Child Welfare System

Children/families opened in the child welfare system are referred for trauma and other behavioral health screenings. If a child has identified needs he/she will be set up for a clinical assessment and ongoing services.

CORE services assessments and treatment through the child and adolescent team are offered in all Counties.

The Youth and Family Services Program works with children and families in rural/frontier Southeastern Colorado. The goal of the program is to assist and strengthen families experiencing disruption, family disintegration, and behavior problems by increasing positive parenting skills and developing tools with parents and children that promote harmony in the family. Through early intervention and prevention our therapists can assist families in a more effective way to build Resiliency and further focus on Recovery.

Close collaboration with the child welfare system (Department of Social Services-Pueblo County)(DSS) includes bi-monthly staffing (Care Alliance) where clinicians and DSS case workers meet and discuss the needs of clients and their families. When possible, families are included in these meetings. Also provide a Summer Intensive Outpatient Program that works with DSS to identify appropriate clients who would benefit from the structure of this program over the summer months. Have a case manager who has office hours at the DSS office to help meet the needs of clients. This Case manager is able to help families and case workers gather information about appointment times, or relay information back and forth. Work closely with DSS to identify clients who would be

appropriate for home based services. DSS is also a major partner in the System of Care work. They are active participants in this process and have sent staff to our High Fidelity Wrap Around training.

Special programs/services that target Veterans with serious behavioral health disorders

While doors are open to any veteran, one CMHC decided not to pursue the PCCC contract because the service providers are too restrictive. Another CMHC provides open access for Veterans but do not have any specialized programs or services.

The only veteran-specific program identified in Region 4 is the Stationed Home-Returning Soldiers program was started in 2008 in conjunction with the Civilians for Veterans Fund, which started as a partnership between private funders and Colorado Behavioral Healthcare Systems. Staff reach out to veterans and their families to inform them of the symptoms of depression and post-traumatic stress disorder and the availability of confidential behavioral health services. Veterans and their immediate family members accessing help through this program do not pay for the services provided.

Community Based Services

Table 6: Approximate number and percent of clients you served during the last 12 months with the following behavioral health co-occurring disorders	
Traumatic brain injury	5% +
Obesity	15 -75% +
Diabetes	20 - 50% +
Deaf or hard of hearing	3 - 10% +
Blind	<1% +
Mobility impairment	3 - 40% +
Intellectual/developmental disability	5 - 15% +

+ Plus additional individuals, numbers unknown

Wait Lists: The CMHCs in Region 4 report having no wait lists.

Table 7: The biggest barriers/gaps to serving people with mental illnesses in community, rather than institutional, settings include:	
Housing	X
Mental health treatment	
Substance use treatment	X
Crisis services	
Residential services	X

Other barriers/gaps include: Individuals and families in poverty

Table 8: The following client groups pose the greatest challenge to serve in the community include:	
Children	
Adolescents	
Young adults/Transition-aged youth	
Older adults	X
Individuals with traumatic brain injuries	X
Justice-involved	X
Individuals with a history of violence	X

Housing

Table 9: Number of individuals receive assistance regarding housing	
Mental Health	119 +
Substance Use	+
Co-Occurring MH & SU	205 +

+ Plus additional – numbers unknown

Two of the four responding organizations provide housing *programs*, such as permanent supportive housing, Shelter Plus Care, supervised apartments, group homes. These programs include:

PATH Program serving clients that are homeless and suffering from mental illness. Shelter Plus Care helps subsidize rental assistance for clients participating in treatment. Section 8 offers a subsidy to make housing affordable to clients. Contract for an efficiency apartment as short-term housing for a person with acute homeless needs. Provide short term housing assistance for single parent families. Purchase one bed in a faith-based recovery program and are in the process of adding to this number and services available at that site.

Housing Choice Voucher Programs that include: Housing Choice Voucher independent living vouchers (67), Project Based Vouchers (4), and Homeownership vouchers (4). All three of these voucher programs are administered by Spanish Peaks for the Division of Housing and provide rental or mortgage assistance to low income, disabled families or individuals in Pueblo, Las Animas, and Huerfano Counties. Spanish Peaks also administers the State Housing Voucher program for the Division of Housing serving 17 individuals and families. This program serves co-occurring mental health and substance use individuals in Pueblo, Las Animas and Huerfano counties by providing rental assistance. Operate a 9 unit independent apartment complex with funding directly from HUD through which we serve 14 individuals.

Table 10: Housing Programs	
Do these programs have a waiting list? (Yes/No)	Yes
If yes, estimate of wait times	Varies, Choice Voucher wait times are approx. 1 – 2 years, State Housing Vouchers have an unknown wait time as new vouchers are based on state funding, Spanish Peaks Apartments have approx. 3 year wait list.
Estimated percentage of un-served need for housing programs	25 - 40%, Considering lengths of waiting list unserved need is about 90%.

Housing is part of the job responsibility for case managers, i.e., housing needs are addressed in treatment plans.

For people who do not participate in housing programs (above), case managers provide housing referrals, searches, linkages with landlords/program managers, as well as the following housing related services:

- Referrals to shelter. Assistance completing housing applications. Locating affordable housing.
- Help with HUD applications, budgeting skills. Assist clients applying for housing. Work closely with local homeless shelter to find housing.
- Links to landlords with housing vacancies and various community programs that the individual can go to for information and help with housing.
- Assistance with locating housing, communicating with landlords, and ensuring rent and bills are paid.
- Complete wrap around services, employment assistance, linkages, and benefit assistance.

For people who do participate in housing programs, case management responsibilities beyond referral to the housing program include:

- Intensive case management.
- Procure Releases of Information with landlords to identify consumers at risk for eviction.
- Ensure follow through with physical and behavioral health care.

For people who do not participate in housing programs, the estimated percentage the un-served need is 30-90%

The level of participation by CMHCs in the Region concerning community planning and advocacy regarding obtaining housing resources ranges from highly involved, leadership and program staff participating to no involvement.

For individuals who live in the community but not in specific housing programs administered or supported by CMHCs, their support/service needs are met by:

- Local shelters or Department of Human services;
- Referral and linkage. Assess client to see if they qualify for HCBS services. Assist with application process. Link clients with other community resources that might help with housing options.
- Housing is very limited in our rural/frontier counties, thus most live with relatives. Support service needs are provided by our Health Navigators and Case Managers who go out to the individual's current place of residence.
- Case management and referrals for transportation services; medical and psychiatric appointment compliance; referrals and assistance with other resource agencies such as DSS, and food pantries.

Table 11: Housing Information	
Does your organization own and operate housing?	2 Yes/2 No
If yes, number of units?	39
Does your organization have formal relationships with housing providers, such as the PHA, private landlords, City or County governments.	2 Yes/2 No
Estimate number of units accessed through these relationships	117
For individuals who live in housing programs administered or supported by your organization, are all their support/service needs provided by program staff?	Yes

Employment

Table 12: Number of individuals receiving employment services in the past year	
Mental Health	108 with some unknown
Substance Use	unknown
Co-Occurring MH & SU	10 with some unknown

CMHCs in Region 4 provide employment programs, such as supported employment, job preparedness, sheltered workshop, ticket to work, and /or training program, which include:

- Fund 7 (Mental Health Supported Employment Program); contracted for 54 clients this year
- Supported employment emphasizing transition age youth 15-26. Just started this year
- We just started a vocational program in February 2014 and do not have a year's worth of data at this time.
- Supported employment, Job preparedness, National Work Readiness credential training, situational assessments, job coaching, community job development, resume building, interview skills.

Some of the CMHCs have waiting lists for employment servcies. The wait time is approximately, depends on DVR. Unmet employment needs range from 10-100%.

Employment services are part of the job responsibility for case managers, i.e., employment needs are addressed within a treatment plan.

Table 13: For people who do not participate in employment programs (above), which of these tasks might a case manager perform on behalf of individuals on their caseload regarding employment?	
Job Search	X
Referral to an Employment Program	X
Assistance with looking for an Employer	X
Assistance with applying for public benefits such as SSI, SSDI, VA	X
Support to maintain employment	X

For people who do participate in employment programs, the case management responsibilities beyond referral to an employment program include: Job coaching, skills training; employer development; assistance with resumes and applications; job interview skills Any needed services are assessed with the individual. Collaborative treatment planning, team meeting.

Table 14: Employment Questions	
Does your agency have dedicated employment staff?	3 Yes/1 No
If yes, how many staff FTEs work solely on Employment?	6.75
How many people were working as a result of your Employment Program in the last fiscal year?	38+
Are you tracking the data of your Employment Program such as hourly wages, length of time working, part time vs. full time, types of jobs?	Yes
Does your agency currently have formal relationships with Employers, Employment programs, Training programs?	2 Yes/2 No
If yes, please indicate number of formal relationships	DVR plus up to 10
Please estimate the percent of need for employment services at your agency.	20-60%
If people are employed through a referral, does your agency provide on-going support to maintain employment?	Yes

+some unknown

For people who do not participate in the employment programs, what is your estimated percentage of the un-served need ranges from 15-100%?

On-going support to maintain employment includes the following:

- Case managers provide skills training around hygiene, social skills, and symptom management to keep clients employed.
- The support is provided at the client's direction by clinician or case manager working with them. Could include supportive services and education for the client or the employer as needed and expressed wishes of the client.
- Case managers provide the on-going support by checking in with the individual to make sure that their behavioral and physical health care needs are being met while employed so unmet needs do not result in unemployment.
- Job coaching, problem solving, coordinating with care team.

If people express no desire for employment but are rejected for public benefits they may receive:

- Referral to resources in the community such as food bank and shelter.
- Case managers continue to work with clients on motivation and life skills.
- If treatment team agrees that the person has a disability and should be eligible for benefits that is pursued through the appeal process and specialized attorneys. If the person does not have a disabling condition, then motivational interviewing is used to pursue other options.
- Volunteerism
- Motivational interviewing techniques

When people receive different levels of assistance with housing and/or employment based on a level of service designation please briefly describe.

- Clients enrolled in PATH program or Mental Health Supported Employment receive wrap around services; include housing, employment, mental health and/or substance abuse treatment.

Both housing and jobs are very limited in our rural/frontier counties, thus there is no differentiation between people needing these services.

Wraparound Services

Three of four responding CMHCs report providing wraparound services. The one that does not has a county funded group that provides wraparound services to our families. They participate in a collaborative group with this entity so that our youth can benefit from these services. The high fidelity Wraparound provided uses the Vroon Vandenberg model for youth ag 8-26 and their families.

Currently High Fidelity Wrap Around services for youth and their families in Pueblo County are offered. We are a System of Care Community of Excellence and we are providing this service in conjunction with this grant. We have two wrap around facilitators who work closely with a number of community partners (DSS, HB1451, Catholic Charities) as well as internal referrals for this service. We have on staff a High Fidelity Trainer and Coach and we have offered Wraparound training to community partners and have thus far trained 13 community partners as part of our System of Care Grant. We will also be offering monthly coaching sessions for those individuals trained. The request of more training has resulted in us scheduling another training class in January. Wraparound facilitators also work closely with our Home Based clinicians and will provide Wraparound when needed for these families. Since July we have served 10 families, our targeted number per the System of Care Grant was to provide Wraparound for 12 families this year.

Assertive Community Treatment

Table 15: Assertive Community Treatment Teams	
Number of teams	4
Average caseload per team	10-52 clients

Residential Substance Use Services that target adults with serious behavioral health disorders, including those related from the Department of Corrections include:

- 90-day IRT program at SLV Community Corrections.
- The local SUD residential provider in the area is Crossroads in Pueblo and Huerfano Counties. These are social models for residential treatment usually last 28-30 days. These programs are based on 12 steps and the biopsychosocial model of care. Access is minimal, and the waiting list long. There is not a protocol set for clients from the criminal justice system. These programs do not accept the special population in the list below. Usually this group is addressed in the outpatient facilities.

Inpatient

Children and Adolescents Hospital

Table 16: Children and Adolescent Hospital

Agency Name	Hospital Name	County of Location	# of Beds	Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State
SLV BH	+		10		80%
SOL VISTA	+	Fremont		90%	90%
SOUTHEAST	+				50%
SPANISH PEAKS	Parkview Medical	Pueblo		50%	50%
SPANISH PEAKS	El Pueblo Treatment Center ATU	Pueblo		50%	50%

+None in these regions

Adult- Geriatric Hospital

Table 17: Adult- Geriatric Hospital									
Agency Name	**Hospital Name**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed on 1st day of the month**	**Secure/ Lockable Facility? YES/NO**	**Indicate Adult/ Geriatric or Both (A/G/B)**	**Average Length of Stay (Days)**	**Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State**
SLV BH	None								70%
SOL VISTA	+							80%	80%
SOUTHEAST	+								50%
SPANISH PEAKS	Spanish Peaks ATU	Pueblo	14	9-Nov 1st 9-Dec 1st	Yes	B	5-10 days	70%	80%
SPANISH PEAKS	Parkview 2 North Psychiatric	Pueblo	10 Geri 15 Adult	12-Nov 1st 4- Dec 1st	Yes	B	7-10 days	70%	80%

+None actually located within our region/service area

Residential

Child- Adolescent Residential

Table 18: Child- Adolescent Residential											
AGENCY NAME	Facility Name	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month	Indicate Child, Adolescent or Both (C/A/B)	Secure/ Lockable Facility? YES/NO/ SS (Staff Secure)	Average Length of Stay (Days)	Percent of Child and Adolescent Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Child and Adolescent Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH						
SLV BH	None										80%
Sol Vista	Southern Peaks Regional Treatment Center	Fremont				Not currentl y used for Solvista clients				100%	100%
Southeast	N/A- none in our service area										50%
Spanish Peaks	El Pueblo Treatment Center	Pueblo			166	0	Adolescent (10+ years of age)	Staff Secure	38 days (last quarters average)	50%	70%

Adult Residential

Table 19: Adult Residential												
AGENCY NAME	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Secure/ Lockable Facility? YES/NO	Average Length of Stay (Days)	Percent of Adult Residential Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Adult Residential Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH	MH	SU	BOTH				
SLV BH	None											70%
Southeast	+											50%
Spanish Peaks	Golden Gate Manor	Pueblo			16				No			
Spanish Peaks	Trinity Life Gardens	Pueblo			100				No			
Spanish Peaks	North Pointe Gardens	Pueblo			53				No			
Spanish Peaks	Oakshire Gardens	Pueblo			19				No			
Spanish Peaks	Eddie's House	Pueblo			14				No			
Spanish Peaks	Grand House	Pueblo			10				No			
Spanish Peaks	Chautard	Pueblo			10				No			
Spanish Peaks	Johnson Home	Pueblo			21				No			

Table 19 Continued: Adult Residential												
AGENCY NAME	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Secure/ Lockable Facility? YES/NO	Average Length of Stay (Days)	Percent of Adult Residential Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Adult Residential Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH	MH	SU	BOTH				
Spanish Peaks	PALs	Pueblo			15				No			
Spanish Peaks	Greenwood Manor	Pueblo			16				No			
Spanish Peaks	Villa Grove	Pueblo			16				No			
Spanish Peaks	Pueblo West Gardens	Pueblo			NK				No			

+None in our service area

Role in gatekeeping who gets referred to State Hospitals:

CMHCs currently serve as gatekeepers for who gets referred to the State Hospitals. However, State Hospital beds have not been available for several years except under rare condition, so the role of gatekeeper has not been necessary.

The following would enable us to better serve consumers in our own communities:

- Individuals would be better able to serve consumers in their own communities by:
- Making referrals and completing the M1's for involuntary hospitalizations.
- Having a local inpatient unit to refer people.
- Lack of appropriate workforce and transportation issues are always an ongoing problem for us in better serving clients in their communities.

Skilled Nursing Facilities

Table 20: Skilled Nursing Facilities							
Agency Name	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed**	**Secure/ Lockable Facility? YES/NO**	**Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Nursing Home Needs Met by Current Available Resources in the State**
SLV BH	San Luis Care Center	Alamosa			No	70%	
SLV BH	Evergreen Nursing Home	Alamosa			No	70%	
SLV BH	Home Lake (VA)	Rio Grande			No	70%	
SLV BH	Juniper Village	Rio Grande			No	70%	
SLV BH	Rio Grande Inn	Conejos			No	70%	
Solvista	Valley View Nursing Home	Fremont	30	8	Yes	90%	90%
Southeast	Pioneer Health Care Center	Otero	?	?	Yes	90%	90%
Spanish Peaks	Belmont Lodge	Pueblo County	1	19	No	40%	
Spanish Peaks	CO State Veterans Nursing Home	Huerfano County	50% of total beds	3	Yes	40%	
Spanish Peaks	Life Care Center of Pueblo	Pueblo County	0 not taking any	0	No	40%	
Spanish Peaks	Minnequa Medicenter	Pueblo County	9	19	No	40%	
Spanish Peaks	Pavilion at Villa Pueblo	Pueblo County	40% of total beds	7	No	40%	

Table 20 Continued: Skilled Nursing Facilities							
Agency Name	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed**	**Secure/ Lockable Facility? YES/NO**	**Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Nursing Home Needs Met by Current Available Resources in the State**
Spanish Peaks	Pueblo Care and Rehabilitation	Pueblo County	"no cap"	10	No	40%	
Spanish Peaks	Trinidad Inn Nursing Home	Las Animas	20 total beds		Yes	40%	
Spanish Peaks	University Park Care Center	Pueblo County			No	40%	
Spanish Peaks	Westwinds Village	Pueblo County	4	8	No	40%	
Spanish Peaks	Westwinds Horizon Heights	Pueblo County	3	5	Yes	40%	
Spanish Peaks	Sharmar Village Care Center	Pueblo County	7-Mar	4	No	40%	

Community providers work with Nursing Homes to assure they are only used for persons who need that level of care and for the minimum stays necessary through:

- Determinations made based on PASSAR and other comprehensive assessments initially; consumers are reassessed by staff providing services both at the nursing facilities as well as MHC clinics to determine need for continued stay and to advocate for least restrictive placement.
- The Nursing Homes work with and consult with a behavioral health provider as well as the OBRA coordinator; the OBRA coordinator role is to function as an independent evaluator to determine mental health diagnoses and service needs and to report sufficient information to the State to determine appropriateness of placement. This person also works with Nursing Homes to assure PASRRs, Status Changes Reviews, Depression Diversions and follow-up care is provided. The behavioral health provider working with the Nursing Homes will further provide and work with the social services director to assure

coordination of care is occurring in regards to psychiatric medication, therapy, provider consultation and transition services are available.

- Clinicians and Case Managers are trained in least restrictive care principles and specific regulations around offering individuals in nursing homes community options.
- Assurance provided by following the OBRA/PASSR guidelines.
- OBRA coordinator and OBRA clinician - the OBRA clinician is only in contact with the nursing homes in Pueblo County regarding the clients that are open to SPBHC services.

ATU

Table 21: ATU									
AGENCY NAME	Acute Treatment Unit Name - Not Crisis Stabilization Unit	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Average Length of Stay (Days)
			MH	SU	BOTH	MH	SU	BOTH	
Spanish Peaks	Spanish Peaks Acute Treatment Units	Pueblo	14	0	14	10	0	10	6.5

Crisis Services

Table 22: Crisis Services									
AGENCY NAME	Acute Treatment Unit Name - Crisis Stabilization Unit	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Average Length of Stay (Days)
			MH	SU	BOTH	MH	SU	BOTH	
North Range	ATU - the NRBH ATU will serve as a Crisis Stabilization Unit in the northeastern region (per contract with OBH)	Weld	16			12			7

SUD

Table 23: SUD								
AGENCY NAME	**SUD Program Res. Treatment Program Name**	**County of Location**	**Capacity/# of Available SUD Beds**	**# of Current Clients Placed on 1st day of the month**	**OBH licensed for III.1, III.5 or III.&**	**Male/ Female or Both**	**Average Length of Stay (Days)**	**Percent of SUD Residential Tx Program Needs Met by Current Available Resources in your Geographic Service Area.**
Solvista	+							80%
Southeast	RESADA	Bent	?	?	?	?	?	10%
Spanish Peaks	Crossroads/STI RRT Program	Pueblo (CAID, Indigent)	10-Aug	Unsure	III.1	Both	21-28 days	20%
Spanish Peaks	Crossroads	Huerfano	8	Unsure	III.1	Both	30 days	20%
Spanish Peaks	Parkview	Pueblo (CARE)	10	Unsure	III.5 (Medical)	Both	30 days	20%
Spanish Peaks	Rosada	Las Animas	12-Oct	Unsure	III.1	Both	30 days	20%

+None actually located within our four county region

Detox

Table 24: Detox							
AGENCY NAME	**Detox Provider Name**	**County of Location**	**Capacity/ # of Available SUD Beds**	**# of Current Clients Placed on 1st day of the month**	**Medical or Social detox Model? (M or S)**	**Average Length of Stay (Days)**	**Percent of Detoxification Needs Met by Current Available Resources in your Geographic Service Area.**
SLV BH	Crossroads' Turning Points	Alamosa	30		Social	2-3 days	
Spanish Peaks	Crossroads	Pueblo	10	Unsure	Social Model	3-7 days	10%
Spanish Peaks	Crossroads	Huerfano	8	Unsure	Social Model	3-7 days	10%
Solvista	+						70%
Southeast	RESADA	Bent	?	?	?	?	10%

+None actually located within our four county region

Peer Services

All CMHCs in Region 4 has Peer Specialists. One noted it is planning to increase peer services in the next 6-12 months. They have a Recovery Center called New Beginnings. Their current program is not meeting the needs of their community as well as they would like it to and have plans for increasing services and peer specialists.

Table 25: Peer-related questions	
Average case load of individual peer support staff	8-25, although some do not carry a caseload
Typical aggregate number of hours per week of service provided across all peer specialist staff	40 - 80
Number of peer support positions budgeted for your organization	14
Number of peer support positions that were vacated within the last year fiscal year	0 - 2 (immediately filled)

Table 26: Areas of focus for Peer Services	
Assertive Community Treatment team member	X
Housing [in-home support; landlord outreach; housing acquisition/preservation]	
Employment [job readiness, job coaching, etc.]	
Wellness/Recovery [e.g. informal mentoring, WRAP, WHAM, self-advocacy]	X
Education [formal information dissemination; critical skill development]	X
Benefits support/Advocacy [e.g. acquiring housing assistance, entitlements, accommodations]	X
Outreach [e.g. connecting with at-risk people who are not receiving services or who are registered but not involved in services]	X
Crisis Response [e.g. Hotline, warm line, Emergency Room]	X
Psychiatric hospital [e.g. outreach, bridging/transition]	
Community resource acquisition [e.g. linking to community resources, food banks, churches, self-help groups, recovery org's.]	X
Criminal justice/jail liaison	
Family education/support/parenting	X

Other: Peer Specialists are trained to teach coping skills that help people deal with negative situations and feelings. Peers help others recognize and use their own strengths to problem-solve. People are welcomed as fellow human beings, rather than 'patients', and the focus is on helping, not judging.

Hours	Table 27: Training Peer Staff Receive before Employment – Description
0	Our peer specialist has been with our organization for a very long time. We will require peer specialist training with our new programmatic changes.
120	All are degreed. One completed intensive training with the RATC program 15 years ago.
0	Our peers receive their training once employed, not before they are employed.
40	Training created by International Association of Peer Specialists with additional sections included to ensure all core competencies for peer specialists are addressed. Additional training is provided on suicide prevention, basic knowledge of mental illnesses and self-care.

Hours	Table 28: Training Peer Staff Receive after Employment – Description
20-30	We provide ongoing training through Relias and other local or state trainings.
80	New staff orientation and training.
40/ongoing	Training is provided by our COO who has a background in working with peers and his doctorate emphasizing integration, thus he does the training that is focused on the culture of the citizens in our 6 counties, our agencies requirements for employees, and the many rules and regulations we must follow through our BHO. The peers also go through an orientation process that takes approximately 30 days and is designed for all employees at Southeast Health Group.
3 hours/mo	Training on variety of topics to include expanding on topics provided in initial training, topics that peer specialists request or topics supervisor feels the peer specialists needs more training on.

Hours/Mo	Table 29: Brief Description of How Peer Staff Are Supervised
6	Peer staff are supervised by the Clinical Supervisor responsible for the Case Management services. Again, our entire peer structure is planning to be changed.
8	Individually scheduled meetings with licensed outpatient supervisor, in addition to availability of supervisor as needed. Group supervision.
4	Peer staff are supervised by our Peer Supervisor who meets with them individually and as a team to help them develop their skills and meet the objectives of their position as a peer.
4	Staff receives individual supervision one hour a week and group supervision one hour a week. A supervisor is available in person or by phone during all working hours.

Independent peer-operated support or recovery organizations in your area for people with mental health or addiction disorders include the Friendly Harbor Drop-In Center provides a supportive environment for people with mental illnesses to socialize with each other. There are peer staff available at all times and a few groups are run each week. Alcoholics Anonymous has several groups operating in the area.

Criminal Justice

1. Please indicate the approximate number of unduplicated clients you served during the last fiscal year who were justice-involved (probation, parole, or released from incarceration within 6 months of receiving services). If you served clients who were justice-involved but you are unsure of the number, please enter *unsure*.

Table 30: Justice-Involved Individuals Number Served	
On probation	708 +
On parole	188 +
Released from prison or jail within 6 months of receiving services	Unsure
Other justice-involved	Unsure

+ Additional served – number not known

Table 31: Number of justice-involved individuals treated in the past year	
Mental Health <18	47+
Substance Use <18	Unsure
Co-Occurring MH & SU <18	129 +
Mental Health >18	679 +
Substance Use >18	89 +
Co-Occurring MH & SU >18	118 +

+ Additional served – number not known

Table 32: Court-referred Individuals Number Served	
Mental Health	17 +
Substance Use	9 +
Co-Occurring MH & SU	59 +

+ Additional served – number not known

Table 33: Recently Incarcerated Individuals - Number Served	
Mental Health	Unsure
Substance Use	Unsure
Co-Occurring MH & SU	30 +

+ Additional served – number not known

Table 34: Note if in the Region there the following Specialty Courts	
Mental Health Court	X
Drug Court	X

Other - Juvenile Court, Sobriety DUI, Behavioral Health Court and Veterans Court

Table 35: Capacity exists to serve all referrals in the Region (X)	
Mental Health Court	X
Drug Court	X
Other – As noted above	X

Table 36: If Drug & Mental Health Courts, which serves co-occurring MH/SU referrals in the Region (X)	
Mental Health Court	X
Drug Court	X

Marijuana Legalization

The CMHCs in Region 4 provide substance abuse treatment, prevention, or recovery services.

New services that will be provided in the next 6 months at one CMHC include:
Expansion of substance abuse services in all sites, including Adult Services and the Youth and Family Services center. In the adult site we are fully integrated in the range of outpatient services, including intensive outpatient and recovery services, we have integrated both modalities individual and group counseling, with many different evidence based curriculums and provide specialize urine analysis collection and testing protocol. The Youth and Family Services center provides some substance abuse counseling via group to complement the mental health work

they do. Additionally, they provide substance use intervention and prevention (will start soon) via the school team. Adult Services provides substance use services via individual therapy.

Table 37: Substance use treatment and recovery services	
Total number of individuals have participated in substance use treatment and recovery services in the past year	1,290 +
Number with marijuana use issues alone or as primary drug of choice	29 +
Number with prescription drug use issues alone or as primary drug of choice	27 +

+ Additional served – number not known

Available evidence-based programs or practices for substance use, generally:

- IDDT, A-CRA
- Seeking Safety
- My Journey, Matrix Model
- Strategies for Self Improvement & Change-Wanberg & Milkman
- Driving with Care-DUI Treatment-Wanberg, Timken & Milkman
- MRT- Little & Robinson
- MRT – Staying Quit – Little
- Relapse Preventions Skills – Hazelden
- Outpatient, Enhanced outpatient, intensive outpatient and recovery support

Available evidence-based programs or practices for co-occurring mental health and substance use disorders:

- Moral Reconation Therapy
- Seeking Safety
- Hazelden Co-Occurring Program
- Anger Management
- Outpatient group and individual, Enhanced outpatient, intensive outpatient and recovery support.

Available evidence-based programs or practices for marijuana use issues alone or as primary drug of choice:

- Outpatient individual and group
- CYT-Cannabis Youth Treatment Series – SAMHSA
- Marijuana: CYS MET/CBT cannabis use
- Outpatient, Enhanced outpatient, intensive outpatient and recovery support.

Available evidence-based programs or practices for prescription drug use issues alone or as primary drug of choice:

- Outpatient individual and group,
- Enhanced outpatient,
- A Day without Pain,
- Intensive outpatient and
- Recovery support.

Additional SUD treatment includes:

- Men's SSIC and Women's SSIC,
- Level II education,
- Thinking for a Change,
- Early Recovery Skills,
- Relapse Prevention,
- Men's and Women's trauma,
- Level II therapy (< 21, track C & D),
- Dual Diagnosis Group,
- Living in Balance, Grief
- Loss and DBT group.
- Living in Balance,
- Matrix,
- Strategies for Self Improvement and Change
- Co-Occurring: Seeking Safety, WRAP, The Basics for co-occurring disorder, SAMHSA anger management.

The CMHCs in Region 4 currently have the capacity to serve everyone who requests services for marijuana and prescription drug use issues.

Appendix C-5:

Colorado Public Behavioral Health System and Services Inventory – Region 5

County Included in Region
Denver

Region 5

- CMHC
  - Mental Health Center of Denver
- Specialty Clinics
  - Asian Pacific Development Center
  - Servicios de la Raza
- 1 BHO
  - Access Behavioral Care – Colorado Access (Denver County Only)
- MSO Provider: Signal Behavioral Health Network

  Sobrity House Drug and Alcohol Treatment Center

Number of Persons Served

Table 1: Number of Persons Served			
Unduplicated Served	**Child/Adolescents 0-17**	**Adults 18-64**	**Older Adults 65 & Older**
Mental Health (MH)/ Emotional Disorders	3,291	5,484	463
Substance Use (SU) Disorders	3	344+	0++
Co-Occurring MH & SU Disorders	59	3,669	160
MHCD-Total Unique Consumers Served as reported by the Board Report and Annual Report	3,557 MIS + 1,717 non-MIS = 5,274	9,615 MIS + 215 non-MIS = 9830	Included in the adult category

+Includes 330 from Sobriety House- this is the only category they had data for.

++MHCD did not provide data for this category

Workforce

Table 2: Workforce	
Staff Category	**Current Filled FTE #/Total FTE Budgeted**
Medical Staff	7/7
Psychiatrists	**18/23**
Psychologists	7/7
Nurses	19/20
Addictions Staff (E.g. CACs -Not Recovery Coaches)	++
Licensed Clinicians, Counselors, Social Workers	95/97
Unlicensed Master's level Clinician's, Counselors & Social Workers	70/72.5
Unlicensed Bachelor's level Clinician's, Counselors & Social Workers	193.5/196.5
Cross-trained MH/SA Behavioral Health Staff (Master's)	++
Cross-trained Behavioral Health Staff (Bachelor's)	++
Case Managers (Non-Peer)	++
Peer Support Specialists	4.5/6.5
Recovery Coaches	0/0
Family Navigators/Advocates	1/2
Mobile Crisis Staff (Non-Peer)	`
Crisis Stabilization Unit Staff (Non-Peer)	0/0
Crisis Respite Staff (Non-Peer)	~
Mobile Crisis Peer/Family/Recovery Staff	0/0
Crisis Stabilization Unit Peer/Family/Recovery Staff	0/0
Crisis Respite Peer/Family/Recovery Staff	0/0

^Insufficient data to include the caseloads.
`Contracted with Denver Health
++included in other categories
~CCC staff at Park Place

MHCD Note*: Caseloads vary widely within positions because we have teams to serve consumers at varying levels of intensity and we use staff in different kinds of positions. For example, many of the staff doing intakes and assessments are licensed and they don't have assigned caseloads; a licensed clinician on a high-intensity treatment team could have an assigned caseload of 10, while also conducting therapy groups for 30 other*

consumers; most nurses are shared across teams and don't have caseloads assigned to them individually, so each one could work with hundreds of consumers that are assigned to other clinicians' caseloads.

Funding

Table 3: Funding	
FY 2014/2015 Funding Payer Source	**Approximate Per Cent of Total Operating Budget**
Medicaid	56.2%-70%+
Medicare	0%-.7%+
State General Funds/Block Grants/Path Federal Funds	16.7%-75%
Other Grants	0%-6.4%
Funding from DOC, DYC, etc.	0%-10%
Privately insured	0%-10%
Donations & other sources	3.1%-5%+
Other funds for Public Behavioral Health Services	0%-13.1%+

+Sobriety House did not provide data for these categories

Services Provided

Integrated Care

Table 4: Primary Healthcare - Integration	
We are a Federally Qualified Health Center (FQHC) and offer both primary and behavioral health services at our agency.	
We have fully integrated primary care into the services we provide at our location(s).	
We offer primary care as a separate service within our behavioral health center.	X
Our center offers behavioral health services at an FQHC or other primary care service provider(s). Described below.	X
We have formal referral agreements in place with an FQHC or other primary care service provider, or have other methods for coordinating services. Described below.	X
Our services are limited to meeting the behavioral health needs of our clients.	X*
Other: Described below.	

*Sobriety House

MHCD offers behavioral health services at an FQHC or other primary care service providers identified below:

- Rocky Mountain Youth Clinic and Denver Health Westside Clinic

In addition, Sobriety House,(based in Region 5 although serving individuals in surrounding regions) is in the process of contracting with medical staff. They currently make referrals for serious mental health and primary care if a client needs it. SUD treatment is their primary focus. In some ways, it makes much more sense to refer out of the agency for primary care rather than to provide it in-house by their agency as having medical staff in a substance abuse disorder program duplicates services offered elsewhere and thereby increases costs.

Formal referral agreements in place with an FQHC or other primary care service provider, or have other methods for coordinating services include:

- Denver Health primary care clinics including the Eastside and Westside clinics and Montebello campus,
- Rocky Mountain Youth Clinics, and
- South Federal Family Practice.

Table 5: If you offer primary care services that are integrated or co-located within your behavioral health center, please indicate the mechanism by which these services are provided:	
Primary care professionals are included on our staff (e.g., physician, nurse practitioner, etc.)	X
Contract with the FQHC or other provider to deliver primary care services.	X
MOU or other formal agreement with the following FQHC or other provider to deliver primary care services	X

Table 6: Funding Mechanism for Co-located services w/in BH Center	
Colorado Medicaid	X
Federal government and/or private grants	X
State funding	
Other	X

Specific federal government and/or private grants include: CMMI Grant, Children's Integrated Expansion Grant, and SAMSHA. Other funding source includes the Colorado Health Foundation.

Table 7: Referral Agreements for Co-located services w/in BH Center	
If you have formal referral agreements with primary care service provider(s), what percentage of your patients were referred to you by primary care providers?	20%-25%

Recommendations to enhance the ability to provide/meet the primary health needs of individuals with behavioral health issues:

- *Shared Electronic Health Record;*
- *More CPT Behavioral Health Codes available to use in primary care; include behavioral health codes as a covered benefit.*

Special Co-Occurring Populations

Table 8: Intensive Services Exist for Co-Occurring Populations include:	
Individuals with Intellectual/ Developmental Disabilities	
Individuals with Traumatic Brain Injuries	
Individuals with Significant Medical/Physical Disorders	X

Infant/Early Childhood Services

Right Start is a mental health program for children ages 0 to 5 years and their families. The CMHC provides help when there are concerns about a child's development or behavior or when parenting becomes difficult. The goal of our services is to help caregivers in their relationship with their babies and young children. Relationship-focused, culturally-informed interventions for young children and their families are offered.

Services Provided:

The CMHC has a team of clinical psychologists and therapists work exclusively with infants, toddlers, preschoolers and their families. They offer comprehensive, trauma-informed, family-focused interventions that can include:

- Family therapy (we work with caregivers including biological parents, foster parents, grandparents and other kinship caregivers).
- Child Parent Psychotherapy
- Parent-Child Interaction Therapy
- Case management (e.g., help with housing, food, childcare, access to community programs for enrolled families)
- Psychiatric Services

These services are available to **a**ny family with a child between the ages of birth to five years who:

- thinks your baby is unusually quiet or uninterested in you
- is concerned about your baby's sleeping or feeding
- thinks your baby is fussy or cries too much
- is worried about your young child's temper tantrums or aggressive behavior
- has a young child that is often sad or keeps to him/herself
- has a young child that has experienced a traumatic event (i.e., abuse, neglect, exposure to domestic violence, foster care placement) feels exhausted or overwhelmed by the demands of parenting.

School-based Services that target children and adolescents with serious emotional/ behavioral health disorders

School based services include: crisis intervention, mental health assessment, treatment planning, case management, individual, family and group therapy, prevention services to individuals and within groups, consultation and education, referral to other MHCD service programs including psychiatry, psychological testing, day treatment, care management.

School based therapists provide educational supports by advocating for clients and parents to school administration and teachers. They also advocate for clients and parents within school meetings such as discipline and special education. Therapists also at times participate in suicide risk review meetings and help to develop behavior plans for daily support of students. Therapists provide consultation and education to school administration and staff regarding mental health issues. The same consultation and education is also provided to clients and parents. Students are also sometimes referred for psychological testing to support the special

education process. Treatment goals many times also include educational goals that address academic success and social emotional development in school.

Special Programs/Services that target transitional-aged youth with serious emotional/ behavioral health disorders

MHCD's Child and Family Outpatient program has a specific focus on transitional-aged youth through therapy and clinical case management services provided by our Emerging Adults therapist. That therapist provides individual and family therapy as well as clinical case management, and also has working relationships with several agencies in the metro area who work with youth in this age group, including Mile High Youth Corps and Urban Peak. Youth in therapy can also participate in additional services, including psychiatry, vocational and educational rehab services and service coordination. Through a partnership with MHCD's adult services at the 2Succeed location, youth can also participate in a weekly program called The Downstairs, during which time a drop-in center specifically for transitional-aged youth is open, and provides programming and community time for the youth.

Special Programs/Services that target children and adolescents with serious emotional/ behavioral health disorders in the Child Welfare System:

The Child Welfare System is the largest referral source for our Right Start for Infant Mental Health program

Special programs/services that target Veterans with serious behavioral health disorders

Sobriety House- Two out of the last 3 years we received a Dept. of Military and Veterans Affairs grant to provide SUD treatment for veterans.

Community Based Services

1. Please indicate the approximate number and percent of clients you served during the last 12 months with the following co-occurring physical health problems. If you served clients with these physical health problems but you are unsure of the number, please enter *unsure*.

Table 9: Approximate number of client served during the last 12 months	
Traumatic brain injury	3 +
Obesity	Unsure
Diabetes	Unsure
Deaf or hard of hearing	133 adults/ 162 children
Blind	88 adults/ 3 children
Mobility impairment	Unsure
Intellectual/developmental disability	+1

+ Unable to report additional specific numbers

No waiting lists exist. The CMHC is unable to see clients with developmental delays or severe TBI's as they require specialized interventions/ trained staff. This is beyond their scope of expertise.

Table 10: The biggest barriers/gaps to serving people with mental illnesses in community, rather than institutional, settings include:	
Housing	X
Mental health treatment	
Substance use treatment	X
Crisis services	
Residential services	
Respite care	

Another gap includes the lack of health promotion, prevention and early intervention services.

Table 11: The following client groups pose the greatest challenge to serve in the community:	
Children	
Adolescents	
Young adults/Transition-aged youth	X
Older adults	
Individuals with traumatic brain injuries	X
Justice-involved	X
Individuals with a history of violence	X

Other:

- Individuals who, for whatever reason, are difficult to house. This includes those with criminal justice involvement and those with poor rental history.
- Unable to conduct therapy with individuals who lack their basic needs (food housing and etc. Spend more time seeking resources than doing therapy with these clients.

Housing

Table 12: Number of individuals receive assistance from your agency regarding housing	
Mental Health	171
Substance Use	4
Co-Occurring MH & SU	306

Table 13: Do you currently have the capacity to serve everyone who requests housing services at your center for: (Yes/No)	
Does your organization provide housing programs, such as permanent supportive housing, Shelter Plus Care, supervised apartments, group homes?	Yes *

*Sobriety House does not have the capacity.

Housing programs include:

- Shelter Plus Care Rental Assistance Program: Shelter Plus Care provides housing options for homeless persons and their families with targeted disabilities, primarily those with serious mental illness, chronic problems and/or drugs and acquired immunodeficiency syndrome(AIDS)or related diseases; last year we served 74 consumers.
- Open Doors Rental Assistance Program: The Open Doors program is designed to provide housing and supportive services on a long term basis, (not transitional)for homeless persons, or persons at risk of becoming homeless with mental illness; last year we served 40 consumers.
- State Housing Voucher Rental Assistance Program: The SHV program is designed to provide housing and supportive services for homeless persons. The program allows for a variety of housing choices, and a range of supportive services funded by other sources, in response to the needs of the hard-to-reach homeless population with disabilities; last year we served 19 consumers.
- Housing Choice Vouchers: The Housing Choice Voucher Program (HCV) provides housing opportunities to disabled individuals and their families. Participants and their families may enter this program homeless; last year we served 523 consumers.
- *Servicios de La Raza has 7 programs and one of the programs does help with housing and employment but not the Mental Health Program does not.*

The Housing Programs do have waiting lists however the estimated wait times and percentage of un-served need were not provided.

Housing part of the job responsibility for case managers, i.e., housing needs are addressed in treatment plans. Some tasks that might be performed by a case manager on behalf individuals on their caseload include: housing referral, housing search and negotiation with landlords/program managers. People are visited in their apartments, case managers advocate with landlords, refer to the HCBS waiver program for non-skilled support, and help people find furnishings.

For people who do not participate in housing programs (above), Case managers provide referrals, linkage, rental searches, assistance with application fees, where to get deposits, how to get apartment furnished, and how to make moves happen.

Level of participation by CMHC in community planning and advocacy regarding obtaining housing resources is Moderate Involvement.

Individuals who live in the community but not in specific housing programs administered or supported by your organization, get their support/service needs are met through intensive case management and assertive community treatment teams.

Table 14:Housing Information	
Does your organization own and operate housing?	Yes
If yes, number of units?	191
Does your organization have formal relationships with housing providers, such as the PHA, private landlords, City or County governments.	Yes
Estimate number of units accessed through these relationships	600
For individuals who live in housing programs administered or supported by your organization, are all their support/service needs provided by program staff?	Yes

Employment

Table 15: Number of individuals receiving employment services in the past year	
Mental Health	221
Substance Use	3
Co-Occurring MH & SU	305

Employment *programs* served 465 in FY 2014 through programs such as:

- 2Succeed in Employment: This is a supported employment program that follows an evidence based practice (IPS
- Psychiatric Rehabilitation Program

Table 16: Employment Waiting Lists	
Do these programs have a waiting list?	Yes
If yes, estimate of wait times	Approx 1 month
In your estimate, how many individuals being served by your program have a need for employment programs that is currently unmet	Approx 20

Employment services are part of the job responsibility for case managers.

Table 17: For people who do not participate in employment programs case managers perform the following on behalf of individuals on their caseload employment:	
Job Search	
Referral to an Employment Program	X
Assistance with looking for an Employer	
Assistance with applying for public benefits such as SSI, SSDI, VA	X
Support to maintain employment	X

For people who do participate in employment programs, the case management responsibilities beyond referral to an employment program include:

- Supporting the efforts of the employment program and consumer; and
- Collaboration with the Employment Specialist and consumer to problem solve.

The un-served need for people who do not participate in the employment programs was not reported.

Table 18: Employment Questions	
Does your agency have dedicated employment staff?	1 Yes/1 No
If yes, how many staff FTEs work solely on Employment?	16
How many people were working as a result of your Employment Program in the last fiscal year?	238

Table 18 Continued : Employment Questions	
Are you tracking the data of your Employment Program such as hourly wages, length of time working, part time vs. full time, types of jobs?	Yes
Does your agency currently have formal relationships with Employers, Employment programs, Training programs?	1 Yes/1 No
If yes, please indicate number of formal relationships	1,500
Please estimate the percent of need for employment services at your agency.	70%-80%
If people are employed through a referral, does your agency provide on-going support to maintain employment?	Yes

On-going support to maintain employment includes the following: Job coaches provide ongoing support for people to succeed in their employment placement.

If people express no desire for employment but are rejected for public benefits, this would be addressed in treatment planning to help the consumer determine how they will meet their basic needs and goals.

With regards to employment, 2Succeed will provide services for anyone no matter what level of services are needed.

Wraparound Services

Wraparound Services for children are provided in Region 5. These are provide pretty thoroughly between any psychotherapeutic services, service coordination, case management, psychiatry, resource center, caregiver services, etc. The wraparound process should be "strengths based," including activities that purposefully help the child and family to recognize, utilize, and build talents, assets, and positive capacities. However, we don't promote our services as Wraparound.

Assertive Community Treatment

Table 19: Assertive Community Treatment Teams	
Number of teams	10
Average caseload per team	12

Residential Substance Use Services that target adults with serious behavioral health disorders, including those related from the Department of Corrections are:

- Beeler Street and Second St; MHCD provides integrated dual disorders treatment
- Sobriety House- The CMHC has a contract with the 17th and 18th Judicial Districts to provide residential SUD services for their clients.

Inpatient

Children and Adolescents Hospital

Table 20: Children and Adolescent Hospital					
Agency Name	**Hospital Name**	**County of Location**	**# of Beds**	**Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State**
MHCD	Denver Children's Home	Denver	0	100%	100%
MHCD	Tennyson Center For Children	Denver		100%	100%
MHCD	Denver Health	Denver		100%	100%
SERVICIOS DE LA RAZA	Denver Health	Denver		10%	10%

Adult- Geriatric Hospital

Table 21: Adult- Geriatric Hospital									
Agency Name	**Hospital Name**	**County of Location**	**Capacity /# of Available BH Beds**	**# of Current Clients Placed on 1st day of the month**	**Secure/ Lockable Facility? YES/NO**	**Indicate Adult/ Geriatric or Both (A/G/B)**	**Average Length of Stay (Days)**	**Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State**
MHCD	Denver Health Medical Center	Denver		169			11	80%	90%
MHCD	Eating Recovery Center LLC	Denver		1			24	80%	90%
MHCD	Exempla St Joseph Hospital	Denver		1			7	80%	90%
MHCD	Porter Adventist Hospital	Denver		72			7	80%	90%
MHCD	PSL Medical Center	Denver		5			1	80%	90%
MHCD	Rose Medical Center	Denver		1			2	80%	90%
MHCD	Swedish Medical Center	Denver		3			1	80%	90%
MHCD	University Of Colorado Hospital	Denver		8			1	80%	90%

Residential

Child- Adolescent Residential

Table 22: Child- Adolescent Residential											
AGENCY NAME	Facility Name	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month	Indicate Child, Adolescent or Both (C/A/B)	Secure/ Lockable Facility? YES/NO/ SS (Staff Secure)	Average Length of Stay (Days)	Percent of Child and Adolescent Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Child and Adolescent Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH						
MHCD	Denver Children's Home	Denver	60				B	SS	365	90%	
MHCD	Family Crisis Center	Denver	30				B	Yes	120	90%	
MHCD	Mt. St. Vincent	Denver	60				C	No	270	90%	
MHCD	Tennyson Center	Denver	85				B	SS	180-365	90%	
MHCD	Savio House	Denver	25				A	SS	180	90%	
MHCD	Synergy	Denver			30		A	SS	150	90%	
MHCD	Third Way Center	Denver			35			No	270	90%	
SERVICIOS DE LA RAZA	Family Crisis Center	Denver									

Adult Residential

Table 23: Adult Residential												
AGENCY NAME	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Secure/ Lockable Facility? YES/NO	Average Length of Stay (Days)	Percent of Adult Residential Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Adult Residential Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH	MH	SU	BOTH				
MHCD	Ash (ALR)	Denver			8				No		80%	90%
MHCD	Franklin (ALR)	Denver	11						No		80%	90%
MHCD	Grant (ALR)	Denver	10						No		80%	90%
MHCD	Monaco (ALR)	Denver	8						No		80%	90%
MHCD	Miller (ALR)	Denver	8						No		80%	90%
MHCD	Monroe (ALR)	Denver	12						No		80%	90%
MHCD	Narcissus (ALR)	Denver	6						No		80%	90%
MHCD	New Visions (ALR)	Denver	8						No		80%	90%
MHCD	Olive (ALR)	Denver	6						No		80%	90%
MHCD	Park Place (ALR)	Denver	16						No		80%	90%
MHCD	Poplar (ALR)	Denver	6						No		80%	90%
MHCD	Second Street (ALR)	Denver	9						No		80%	90%
MHCD	Vallegos (ALR)	Denver	8						No		80%	90%

The CMHC serves as the gatekeeper for referrals to State Hospitals. MHCD could better serve our consumers if Ft. Logan had the ability to serve persons who had medical challenges in addition to their behavioral health challenges. Further, we could better serve our consumers if Ft. Logan were able to routinely serve older adults.

Skilled Nursing Facilities

Table 24: Skilled Nursing Facilities

Agency Name	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/ # of Available BH Beds	# of Current Clients Placed	Secure/ Lockable Facility? YES/NO	Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Nursing Home Needs Met by Current Available Resources in the State
MHCD	Amberwood Court	Denver	75	N/A	No	90%	90%
MHCD	Autumn Heights	Denver	125	10	No	90%	90%
MHCD	Berkeley Manor	Denver	94	0	No	90%	90%
MHCD	Franklin Park Living	Denver	86	11	No	90%	90%
MHCD	Jewell Care Center	Denver	87	7		90%	90%
MHCD	St. Paul Health Care	Denver	155	14	No	90%	90%
MHCD	Forest Compassionate Care	Denver	60	9	Yes	90%	90%
SORBRIETY HOUSE		Denver				70%	

Community providers work with Nursing Homes to assure they are only used for persons who need that level of care and for the minimum stays necessary through the direct provision of services within the nursing home. The state PASRR process is used to determine level of care, and the CMHC does weekly administrative and clinical meetings at most nursing homes.

ATU

None in this region.

Crisis Services

None in this region.

SUD

Table 25: SUD								
AGENCY NAME	**SUD Program Res. Treatment Program Name**	**County of Location**	**Capacity/# of Available SUD Beds**	**# of Current Clients Placed on 1st day of the month**	**OBH licensed for III.1, III.5 or III.&**	**Male/ Female or Both**	**Average Length of Stay (Days)**	**Percent of SUD Residential Tx Program Needs Met by Current Available Resources in your Geographic Service Area.**
MHCD	Denver Health	Denver						90%

Detox

Table 26: Detox							
AGENCY NAME	**Detox Provider Name**	**County of Location**	**Capacity/ # of Available SUD Beds**	**# of Current Clients Placed on 1st day of the month**	**Medical or Social detox Model? (M or S)**	**Average Length of Stay (Days)**	**Percent of Detoxification Needs Met by Current Available Resources in your Geographic Service Area.**
MHCD	Denver Health	Denver					90%

Peer Services

Peer support/peer specialist services are provided in Region 5.

Table 27: Peer Support Related Information	
Average case load of individual peer support staff	4
Typical aggregate number of hours per week of service provided across all peer specialist staff	340
Number of peer support positions budgeted for your organization	20
Number of peer support positions that were vacated within the last year fiscal year	3

Table 28: Areas of focus for Peer Services	
Assertive Community Treatment team member	
Housing [in-home support; landlord outreach; housing acquisition/preservation]	
Employment [job readiness, job coaching, etc.]	
Wellness/Recovery [e.g. informal mentoring, WRAP, WHAM, self-advocacy]	X
Education [formal information dissemination; critical skill development]	
Benefits support/Advocacy [e.g. acquiring housing assistance, entitlements, accommodations]	X
Outreach [e.g. connecting with at-risk people who are not receiving services or who are registered but not involved in services]	
Crisis Response [e.g. Hotline, warm line, Emergency Room]	
Psychiatric hospital [e.g. outreach, bridging/transition]	X
Community resource acquisition [e.g. linking to community resources, food banks, churches, self-help groups, recovery org's.]	
Criminal justice/jail liaison	
Family education/support/parenting	

Hours	Table 29: Training Peer Staff Receive before Employment - Description
0	Training starts after employment begins. 8 hour orientation followed by 20 hours of job shadowing, followed by 80 hours of peer specialist training.

Hours	Table 30: Training Peer Staff Receive after Employment - Description
80	Three week peer specialist training.

Hours/Mo	Table 31: Brief Description of How Peer Staff Are Supervised
2	Supervision is provided weekly in a team meeting and monthly individually by discussing caseloads and providing growth supports.

Criminal Justice

Table 32: Justice-Involved Individuals - Number Served	
On probation	675
On parole	10
Released from prison or jail within 6 months of receiving services	17
Other justice-involved	108

Table 33: Number of justice-involved individuals treated in the past year	
Mental Health <18	232
Substance Use <18	90
Co-Occurring MH & SU <18	417
Mental Health >18	3
Substance Use >18	0
Co-Occurring MH & SU >18	5

Table 34: Court-referred Individuals - Number Served	
Mental Health	36
Substance Use	0
Co-Occurring MH & SU	20

Table 35: Recently Incarcerated Individuals - Number Served	
Mental Health	158
Substance Use	91
Co-Occurring MH & SU	360

Table 36: Note if in the Region there are the following Specialty Courts	
Mental Health Court	X
Drug Court	X

Other Courts **-** Combined court for youth/families with social services and legal involvement.

Table 37: Note if capacity exists to serve all referrals in the Region (X)	
Mental Health Court	X
Drug Court	X
Other – As noted above	X

Table 38: Drug & Mental Health Courts: which serves co-occurring MH/SU referrals in the Region (X)	
Mental Health Court	X
Drug Court	X

Marijuana Legalization

The CMHC provides substance abuse treatment, prevention, or recovery services.

Table 39: Substance use treatment and recovery services	
Total number of individuals have participated in substance use treatment and recovery services in the past year	3,902
Number with co-occurring mental health and substance use disorders	3,885
Number with marijuana use issues alone or as primary drug of choice	0
Number with prescription drug use issues alone or as primary drug of choice	0

Evidence-based programs or practices for substance use, generally include: Outpatient, enhanced outpatient, education, Individual and group.

Evidence-based programs or practices for co-occurring mental health and substance use disorders include: New C-SCHARP Colorado Second Chance Housing and Reentry Program; Welcome Home for serious mental illness and substance use, and 3) PHASE Probation & Parole Accountability & Stabilization Enhancement.

No evidence-based programs or practices for marijuana use or prescription drug use issues alone or as primary drug of choice were identified.

Table 40: Do you currently have the capacity to serve everyone who requests services at your center for: (Yes = X)	
Marijuana use issues	*
Prescription drug issues	*

* Region 5: No, as this is not our target population.

Appendix C-6:

Colorado Public Behavioral Health System and Services Inventory – Region 6

Counties Included in Region 6
Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson

Region 6

CMHCs and SUD Providers

- 2 CMHCs
  - Mental Health Partners
  - Jefferson Center for Mental Health
- 1 BHO
  - Foothills Behavioral Health Partners, LLC (Boulder, Broomfield, Clear Creek, Gilpin and Jefferson)
- 2 MSO Providers: Signal MSO and; Boulder Health Department MSO for Boulder/Broomfield

Number of Persons Served

Table 1: Number of Persons Served			
Unduplicated Served	**Child/Adolescents 0-17**	**Adults 18-64**	**Older Adults 65 & Older**
Mental Health (MH)/ Emotional Disorders	4,860	8,473	1,076
Substance Use (SU) Disorders	18	51	0
Co-Occurring MH & SU Disorders	74	4,326	84

Workforce

Table 2: Workforce	
Staff Category	**Current Filled FTE #/Total FTE Budgeted**
Medical Staff	**10.9/18**
Psychiatrists	13.25/13.45
Psychologists	8.7/8.7
Nurses	**30.4/34.33**
Addictions Staff (E.g. CACs -Not Recovery Coaches)	**35.15/40.35**
Licensed Clinicians, Counselors, Social Workers	**218.3/249.8**
Unlicensed Master's level Clinician's, Counselors & Social Workers	**80/93.8**
Unlicensed Bachelor's level Clinician's, Counselors & Social Workers	**45.6/50**
Cross-trained MH/SA Behavioral Health Staff (Master's)	3/3
Cross-trained Behavioral Health Staff (Bachelor's)	0/0
Case Managers (Non-Peer)	**52.9/57.2**
Peer Support Specialists	**21.2/28**
Recovery Coaches	16/16
Family Navigators/Advocates	19.4/19.5
Mobile Crisis Staff (Non-Peer)	**10.15/21.65**
Crisis Stabilization Unit Staff (Non-Peer)	2/2
Crisis Respite Staff (Non-Peer)	.5/.5
Mobile Crisis Peer/Family/Recovery Staff	1.2/1.5
Crisis Stabilization Unit Peer/Family/Recovery Staff	0/0
Crisis Respite Peer/Family/Recovery Staff	.5/.5

^Insufficient data to include the caseloads.

Funding

Table 3: Funding	
FY 2014/2015 Funding Payer Source	**Approximate Per Cent of Total Operating Budget**
Medicaid	48%-68%
Medicare	.5%-1%
State General Funds/Block Grants/Path Federal Funds	7%-8.5%
Other Grants	2%-9%
Funding from DOC, DYC, etc.	.4%-4%
Privately insured	1.2%-10%
Donations & other sources	5%-14.1%
Other funds for Public Behavioral Health Services	5.3%-16%

Services Provided

Integrated Care

Table 4: Primary Healthcare - Integration	
We are a Federally Qualified Health Center (FQHC) and offer both primary and behavioral health services at our agency.	
We have fully integrated primary care into the services we provide at our location(s).	X
We offer primary care as a separate service within our behavioral health center.	X
Our center offers behavioral health services at an FQHC or other primary care service provider(s). Described below.	X
We have formal referral agreements in place with an FQHC or other primary care service provider, or have other methods for coordinating services. Described below.	X
Our services are limited to meeting the behavioral health needs of our clients.	
Other: Described below.	X

Behavioral health services are provided at an FQHC or other primary care service provider(s) as noted below:

- Rocky Mountain Youth Clinic and Denver Health Westside Clinic

- Metro Community Provider Network, Mountain Family Health Center, Wheat Ridge Internal Medicine, Rocky Mountain Primary Care, Altitude Family and Internal Medicine, Family Care Southwest, Belmar Family Medicine, Lakewood Family Medicine, Rocky Mountain Pediatrics, Kids First Pediatrics, Peak Pediatrics, Family Health Care Center, Practice of Gordon Fleischaker Jr, MD and and Yelena Khayut, MD
- Clinica, Salud, Broomfield Family Practice, and My Family Doctor.
- Ira Freedman and Christa Ambrose are our PCP's that are collocated at our behavioral health center.
- Providers with formal referral agreements in place with an FQHC or other primary care service provider, or have other methods for coordinating services. Name of the organization(s) with formal referral agreements:
- Coordination of care, but not formal referral agreements: Metro Community Provider Network, Mountain Family Health Center, Arapahoe House, St Anthony Hospital, Lutheran Hospital, Colorado Community Health Alliance
- Clinica, Salud, Broomfield Family Practice, and My Family Doctor.

Additionally, there is an Organized Health Care Arrangement (OHCA) in place effective January 2015 with Metro Community Provider Network, Arapahoe Douglas Mental Health Network, Aurora Mental Health Center, Jefferson Center for Mental Health and Arapahoe House.

Behavioral health services as well as complex care coordination are provided.

Table 5: If you offer primary care services that are integrated or co-located within your behavioral health center, please indicate the mechanism by which these services are provided:	
Primary care professionals are included on our staff (e.g., physician, nurse practitioner, etc.)	X
Contract with the FQHC or other provider to deliver primary care services identified.	*
MOU or other formal agreement with the following FQHC or other provider to deliver primary care services	X

* Contract with the following FQHC(s):Metro Community Provider Network, Mary Dragoo, RNP

Table 6: Funding Mechanism for Co-located services w/in BH Center	
Colorado Medicaid	X
Federal government and/or private grants	X
State funding	X
Other	X

Specific federal government and/or private grants include: Medicare, and SAMHSA PBHCI grant.

Specifically designated state funding includes the Colorado Indigent Care Program

Other funding sources include in-kind contributions and commercial insurance.

Table 7: Referral Agreements for Co-located services w/in BH Center	
If you have formal referral agreements with primary care service provider(s), how many people did you refer for services in 2013?	Approximately 400 +
If you have formal referral agreements with primary care service provider(s), what percentage of your patients were referred to you by primary care providers?	<1% - 15%

+ Additional referrals number unknown.

Recommend to enhance the ability to provide/meet the primary health needs of individuals with behavioral health issues include:

- Funding mechanisms that support comprehensive, fully-integrated mental health center-based healthcare homes as well as fully integrated primary care-based healthcare homes – no wrong door – bidirectional fully integrated whole person healthcare.
- Integrated care is a need for all clients, we find having a PCP co-located provides clients the opportunities to be introduced to this service without barriers. This is a relatively new practice and managing this type of service can be challenging from a workflow, documenting and billing perspective. The technical systems needed to make this work smoothly is a little behind the concept of the actual practice. An example is the EHR's used in behavioral health don't always support a traditional medical practice. This is changing in new products and more integrated EHR's.

Special Co-Occurring Populations

Table 8: Intensive services exist for the following indigent/Medicaid Co-Occurring Populations in the Region	
Individuals with Intellectual/ Developmental Disabilities	X
Individuals with Traumatic Brain Injuries	X
Individuals with Significant Medical/Physical Disorders	X

Infant/Early Childhood Services

JCMH has specialized early intervention programming. We provide consultation to preschools, day cares, Head Start and Jefferson County Health Department. We offer a Nurturing Parenting Program and a post-partum depression group. We offer traditional in-office therapy services as well as intensive in-home services. We will offer parent educator to families needing additional supports , such as help with parenting skills, understanding developmental milestones, appropriate discipline, the importance of early brain development, school readiness and access community resources.

MHP provides services through our program Early Childhood Services. This service is provided in the community as an educational and preventive resource. Staff collaborate with day care centers to provide support and education. Community Infant Program is also a service that is provided in the home, with some office work, to families that require support in learning how to parent in a healthy manner. Many of these families are at risk of losing their infants/toddlers to the Child Welfare system. The Community Infant Program provides a team of nurses and clinicians to work with families who at the greatest risk.

School-based Services that target children and adolescents with serious emotional/ behavioral health disorders

JCMH offers school based services in Gilpin, Clear Creek and Jefferson Counties. We have both counseling in the school programs where individual, family, group and affective education are offered and a very robust prevention program offering classroom based affective education. We are currently using Brainwise as our prevention curriculum. We have counselors in 20 schools and prevention specialist in 34 schools.

School-based services provide brief, solution focused therapy to children and families in 6 elementary/middle schools. The Family Resource Center (FRC) and The Family Resource Schools (FRS) are a part of this initiative in partnership with the COB.

The Boulder County Prevention Intervention Program (BCPIP) is also school-based and provides a variety of services: Prevention (education around mental health/substance use) as well as crisis intervention, suicide/homicide/threat assessments to individual interventions, as well as brief solution focused therapy. We are in 7 High Schools, 1 community college and 7 middle schools. This is done in partnership with BVSD, DHHS, BCPH, MHP and COB.

Day Treatment services are provided in an elementary setting and high school setting for BVSD. The high school day treatment is no longer licensed as such however they provide a separate school setting for adolescents with serious emotional/behavioral health disorders. Clinicians and behavioral specialists are available throughout the school day to provide support. A psychiatrist works with the day treatment settings and the children and adolescents in need of psychiatric services.

Special Programs/Services that target transitional-aged youth with serious emotional/ behavioral health disorders

JCMH's specialized program for transition aged youth is our award winning program the ROAD. The ROAD which is grounded in the TIP model is available for youth and young adults ages 15-22 y/o. Transition aged youths have a place they can call their own. We are located in an area high school and are open to all youth in our region. The ROAD assists young adults by fostering empowerment, leadership and responsibility. Services offered include: Job Preparation and Job Search, GED Tutoring, Independent Living Skills Class, Counseling, Wellness Workshops, Community Resource Presentations, and Drop-in Center. Youth have the opportunity to feel acceptance and learn skills needed to successfully navigation adulthood. For the last 2 summers, ROAD participants were able to experience a week long back-packing experience in partnership with Big City Mountaineers. When Medicaid members are 17 ½ we start working with them to apply for any benefits needed once they are 18 to insure they have the appropriate level of public/private insurance and assistance.

In partnership with DHHS and IMPACT, MHP offers both home based services and office based services to help support this population. Clients are able to receive therapeutic services to include psychiatric medication services. We offer educational, employment and life skills support to those clients in need.

Special Programs/Services that target children and adolescents with serious emotional/ behavioral health disorders in the Child Welfare System

Jefferson Center offers Trauma-Focused CBT services through both outpatient and home-based services. We have a Trauma focused treatment team that offers trauma services including EMDR for children and adolescents. The majority of outpatient clinicians have experience in treating reactive attachment disorder. There is a dedicated Family Services Manager that problem solves any issues with access to services for children and adolescents involved in the child welfare system. Outpatient and Intensive family treatment is also offered to help with reunification of children with caregivers. There is a trauma assessment tool that was recently added to the electronic medical record to earlier identify trauma symptoms and to be able to address these symptoms earlier in treatment. There are groups offered that will address a variety of emotional/behavioral disorders and symptoms.

MHP works in collaboration with DHHS on several programs and projects. There are specific providers who carry a lower case load to provide intensive therapeutic services to include case management. Our home based team works with several children and adolescents at risk of out of home placement. MHP is providing Functional Family Therapy and Trauma Focused CBT to effectively serve this population. MHP is also involved with partnership programs for specific populations such as Adopted youth, Transitional

age youth and the Juvenile Integrated Treatment Court. All of these partnerships involve collaborative work with DHHS, Probation, Substance Use and the Schools, to name a few.

Special programs/services that target Veterans with serious behavioral health disorders

The Jefferson Center Veteran Services program, Total Force, provides individual counseling and case management with clinicians who themselves are veterans. These services are available both at the Independence office as well as offsite locations including Red Rocks Community College and the mountain communities in Jefferson County, Clear Creek, and Gilpin Counties. The Veteran Services Manager is available for clinical consultation with other clinicians serving veteran clients. The Program provides educational opportunities within Jefferson Center and other organizations in the community about veterans and behavioral health. The Veteran Services Program has a relationship with the 1st Judicial District Veterans Treatment Court to provide consultation and clinical services to the criminal justice-involved veterans with behavioral health or substance abuse problems participating in the Court. The Veteran Services Manager also assists in the training of veteran mentors who work with Court participants. The Program provides veteran-specific training to CIT-trained law enforcement officers in Jefferson County to better assist veterans in crisis.

We do not offer any specific programs targeted at the Veteran population. MHP does however provide trauma treatment for those individuals in need. These services can be provided in an office setting, jails, homeless shelter, hospitals, and in the home.

Community Based Services

Table 9: Approximate number and percent of clients you served during the last 12 months with the following co-occurring physical health problem	
Traumatic brain injury	126 +
Obesity	Unsure
Diabetes	Unsure
Deaf or hard of hearing	24 +
Blind	37 +
Mobility impairment	Unsure
Intellectual/developmental disability	150 *

+ Additional served – numbers not available

* Primary and secondary Dx for clients from FY14 services, +

Waiting Lists - The CMHCs report no waiting lists for the populations. All of the above with co-occurring physical health problems are served. The largest barrier is serving these various populations, especially TBI and DD, is not having a primary mental health diagnosis. We can be denied payment due to the client not having a primary mental health diagnosis. This occurs in many settings but especially with adolescents in the inpatient setting. It can be difficult to flush out the etiology of behaviors.

The clients who are deaf or hard of hearing are provided interpreters so that they can utilize services. In using interpreters in a therapeutic session we have found that some things can be lost in translation. This can impact the overall quality of treatment.

As for the obesity or diabetes, or any medical condition, people with serious emotional and behavioral issues tend to struggle with managing their medical needs. Many of the clients we serve have episodes of distorted thinking or delusional thinking, which can impact their ability to manage physical/mental issues effectively. We monitor clients with serious medical conditions closely to insure they are taking their medications and taking care of themselves.

Table 10: The biggest barriers/gaps to serving people with mental illnesses in community, rather than institutional, settings are noted below.	
Housing	X
Mental health treatment	
Substance use treatment	
Crisis services	
Residential services	
Respite care	X

***Other, barriers/gaps include*:** Employment Services, Accessing Benefits, providing case management to private pay and Medicare, low payment/high documentation requirements for Medicare.

Table 11: Client groups that pose the greatest challenge to serve in the community.	
Children	
Adolescents	
Young adults/Transition-aged youth	X
Older adults	
Individuals with traumatic brain injuries	X
Justice-involved	X
Individuals with a history of violence	

***Other include*:** Homeless, Medicare, anyone with serious behavioral health concern needing case management, housing, employment services when their payer does not provide for this.

Housing

Table 12: Number of individuals receiving housing assistance from agency.	
Mental Health	498
Substance Use	50
Co-Occurring MH & SU	211

The CMHCs currently have the capacity to serve everyone who requests housing services. Specific housing programs include: Permanent Supportive Housing, Housing Choice Vouchers, State Housing vouchers.

Table 13: Housing Programs	
Do these programs have a waiting list? (Yes/No)	Yes
If yes, estimate of wait times	1 year, Varies depending on program/voucher
Estimated percentage of un-served need for housing programs	10% -40%

Housing part of the job responsibility for case managers at one of the two CMHCs. Services provided include housing search, housing referral, transportation, negotiation with landlords/program managers, and resources such as financial. All care coordinators/managers are trained to refer folks for housing when needed. We also have a staff member that is stationed at the homeless shelter to help these clients access services.

The Housing team has a more active role and goal of helping people maintain their housing. We are not only interested in helping the person but also want to ensure that bridges are not burned for further tenants. Having a centralized service delivery around Housing ensures that we are uniformly approaching the community in a consistent and mindful way. Being involved with housing we are able to know the latest resources around housing (although we learn stuff also) and are working closely with other housing providers in the community.

The estimated percentage of un-served need for housing programs is 45%+ (some providers did not provide a percent).

Leadership and program staff are highly involved in community planning and advocacy regarding obtaining housing resources.

For individuals who live in the community but not in specific housing programs administered or supported by your organization, their support/service needs are met through:

- Case management and Outpatient providers.
- Individuals in the community are monitored by either clinicians, recovery care coordinators or case managers. All of these providers are continually assessing for any specific housing needs. If the individual is struggling with housing or at risk of losing housing these providers work the individuals to gain skills to avoid this type of situation. These providers will also connect them with the housing program when clinically appropriate.

Table 14: Housing Information	
Does your organization own and operate housing?	Yes
If yes, number of units/beds	87
Does your organization have formal relationships with housing providers, such as the PHA, private landlords, City or County governments.	Yes
Estimate number of units accessed through these relationships	582
For individuals who live in housing programs administered or supported by your organization, are all their support/service needs provided by program staff?	Yes

Employment

Table 15: Number of individuals receiving employment services in the past year	
Mental Health	912
Substance Use	0
Co-Occurring MH & SU	308

Both Region 6 CMHCs provide employment programs, such as supported employment, job preparedness, sheltered workshop, ticket to work, and /or training program

Employment *programs* include:

Supported Employment (SE)-Individualized employment support to include development of a vocational profile, job exploration, resume and cover letter development, job development, application submission, on the job support and follow along services and support to learn to manage behavior health while job searching and on the job.

Summit Center-facility based continuum of vocational services. Training and support in vocational and community/work related social skills. Opportunity to participate in facility based work, Transitional-employment which is supported work inside Jefferson Center and in the community to assist a person to transition to community employment.

Boulder/Broomfield Employment Team serving Chinook, Boulder Journeys, Boulder Medical, Boulder Housing, Boulder Connections Teams with full array of supported employment services. Longmont Employment Team serving Longmont Journeys, ACT, Quest, Medical, Longmont Housing, LAOS, Longmont Connections with full array of supported employment services. WRKE Employment Specialist serving BAOS and PACE with IPS model supported employment services. All offer vocational counseling, job seeking skills training, job development, job coaching, and job retention support.

Table 16: Employment Program Waiting Lists	
Do these programs have a waiting list?	Yes/No
If yes, estimate of wait times	Supported Employment - 1.5-2 months Summit-no wait list
In your estimate, how many individuals being served by your program have a need for employment programs that is currently unmet	85 / 30%

Employment services are part of the job responsibility for case managers.

Table 17: For people who do not participate in employment programs (above), the following tasks might be performed by a case manager behalf of individuals on their caseload regarding employment.	
Job Search	
Referral to an Employment Program	X
Assistance with looking for an Employer	X
Assistance with applying for public benefits such as SSI, SSDI, VA	X
Support to maintain employment	X

For people who do participate in employment programs, the case management responsibilities beyond referral to an employment program include:

Work as a team with the Employment Specialist to provide the most appropriate individualized support to the person. To provide clinical perspective and support to the process and to provide clinical support with any behavior health challenges the person encounters throughout the employment process.

The employment program works with clients to develop job readiness skills. They practice these skills and assist the client in finding employers and employment. They offer support through job coaches and other supports to help the individual maintain their job. These providers are also assessing for other needs such as therapy, medication management, housing , education and wellness. When it is clinically appropriate the employment specialist will refer to the appropriate services. The employment specialist will also work in collaboration with these providers to insure the highest quality of care.

Table 18: For people who do not participate in the employment programs, what is your estimated percentage of the un-served need	
For people who do not participate in the employment programs, what is your estimated percentage of the un-served need?	30%

Table 19: Employment Questions	
Does your agency have dedicated employment staff?	Yes
If yes, how many staff FTEs work solely on Employment?	14
How many people were working as a result of your Employment Program in the last fiscal year?	332
Are you tracking the data of your Employment Program such as hourly wages, length of time working, part time vs. full time, types of jobs?	Yes
Does your agency currently have formal relationships with Employers? Employment programs, Training programs?	Yes
If yes, please indicate number of formal relationships	72
Please estimate the percent of need for employment services at your agency.	30%-40%
If people are employed through a referral, does your agency provide on-going support to maintain employment?	Yes

On-going support to maintain employment includes the following:

The Employment Specialist will provide job coaching, workplace communication and social interaction training and support. Any type of support needed for the person to be successful in the position. If the person wants the Employment Specialist to speak to their manager/supervisor, the employment specialist will go to the job site and meet with the person and their manager/supervisor to assist in the successful maintenance of the position. All on-going supports are provided as long as the person wants the support and will provided on an individualized basis to make sure any specific needs are addressed.

Job coaching either on-site (if client agrees to disclose disability) or off-site, Weekly groups, individual support until stability attained on job, then responsibility shifted back to primary treatment team. Some ongoing employer support offered if client agrees to disclose disability.

If people express no desire for employment but are rejected for public benefits, s the plan of action for those people includes:

- Referred to speak to our benefit/resource department to work with them to assist them to meet their needs.
- No formal systemic plan, we can refer the person to our navigator who can explore other options in the community for assistance, we encourage volunteerism, and we encourage the clinician or benefits specialist to revisit the idea of employment with the client encouraging each treatment plan cycle as a good opportunity to talk about it.

People do not receive different levels of assistance with housing and/or employment based on a level of service. All employment services are provided equally to everyone receiving services.

Wraparound Services

Wraparound Services are provided by both CMHCs in Region 6 as described below.

Jefferson Center helps youth and families access many community resources, such as recreation center passes, art and drama classes various sport teams and activities. The wraparound services are tailored to meet each family's unique needs. The length of time of the wraparound services varies according to family needs. Our Parent support-specialists also provide wraparound services for the many families The Center serves. There are several groups to support parents, especially adoptive parents and kinship caregivers. All families that Family Services sees are provided the opportunity to access a variety of wraparound services.

At MHP this is provided through our partnership with IMPACT program. This is a new service although we delivered this service in the past. The wraparound provider uses the Wraparound model.

Assertive Community Treatment

Table 20: Number of Assertive Community Treatment Teams	
Number of teams	3
Average caseload per team	12-15

Residential Substance Use Services that target adults with serious behavioral health disorders, including those related from the Department of Corrections:

Jefferson Center does not offer Residential Substance Use Services to adults.

MHP has partnered with Public Health for over 20 years for clients with dual diagnosis. MHP will be integrated the substance services on January 5, 2015. The ARC (Addiction Recovery Center) provides a 10 bed Transitional Residential Substance Use program. These clients are served at MHP for outpatient mental health services. Our providers will work with clients that have a dual diagnosis, whether substance or mental health is primary. Clients have an average length of stay of 30 days. Clients receiving services in the residential setting are provided medication assistance treatment.

Clients who are involved with the Department of Corrections have access to MH providers in the jails. MHP also has a partnership program called PACE to serve those clients with serious behavioral health disorders as the reenter the community following a stay at the Department of Corrections.

Inpatient

Children and Adolescents Hospital

Table 21: Children and Adolescent Hospital					
Agency Name	**Hospital Name**	**County of Location**	**# of Beds**	**Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State**
Jefferson Center	Blank	Blank	0	0%	0%
MH Partners	Centennial Peaks	Boulder		10%	60%

Adult- Geriatric Hospital

Table 22: Adult- Geriatric Hospital									
Agency Name	**Hospital Name**	**County of Location**	**Capacity /# of Available BH Beds**	**# of Current Clients Placed on 1st day of the month**	**Secure/ Lockable Facility? YES/NO**	**Indicate Adult/ Geriatric or Both (A/G/B)**	**Average Length of Stay (Days)**	**Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State**
Jefferson Center	West Pines	Jefferson	40	7 #	Yes	B	8.21	40%	80%
Jefferson Center	Sr Behavioral Health	Jefferson	20	0 #	Yes	B		40%	80%
MH Partners	Boulder Community Hospital	Boulder	27	0	Y	B	7.4	20%	60%
MH Partners	Centennial Peaks	Boulder	72	3	Y	A	8.9	20%	60%

Residential

Child- Adolescent Residential

Table 23: Child- Adolescent Residential											
AGENCY NAME	Facility Name	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month	Indicate Child, Adolescent or Both (C/A/B)	Secure/ Lockable Facility? YES/NO/ SS (Staff Secure)	Average Length of Stay (Days)	Percent of Child and Adolescent Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Child and Adolescent Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH						
Jefferson Center	Jefferson Hills at New Vistas (RCCF)	Jefferson	27			5*	B	Yes	4.5	50%	70%
Jefferson Center	Devereux Cleo Wallace (PRTF and RCCF)	Jefferson			112	0 *	B	Yes	Unknown #	50%	70%
MH Partners	Shiloh House	Boulder	10			0	A	SS	68	30%	50%

Adult Residential

Table 24: Adult Residential												
AGENCY NAME	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Secure/ Lockable Facility? YES/NO	Average Length of Stay (Days)	Percent of Adult Residential Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Adult Residential Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH	MH	SU	BOTH				
Jefferson Center	Haf House Adult Res	Jefferson	8			2#			no	4 *	60%	70%
Jefferson Center	Teller House Adult Res	Jefferson	15			8			no	148 ^	60%	70%
Jefferson Center	Inn Between Adult Res	Jefferson	8			4			No	116 ^	60%	70%
Jefferson Center	Acacia Assisted Living ACF	Jefferson	8			8			no	Permanent	60%	70%
Jefferson Center	Accent on Elder Care ACF	Jefferson	6			6			no	Permanent	60%	70%
Jefferson Center	Aspen Hills ACF	Jefferson	10			8			no	Permanent	60%	70%
Jefferson Center	Caring Hearts ACF	Jefferson	8			5			no	Permanent	60%	70%
Jefferson Center	Depew House ACF	Jefferson	5			4			no	Permanent	60%	70%
Jefferson Center	Eaton Terrace ACF	Jefferson	66			6			no	Permanent	60%	70%

Table 24 Continued : Adult Residential												
AGENCY NAME	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Secure/ Lockable Facility? YES/NO	Average Length of Stay (Days)	Percent of Adult Residential Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Adult Residential Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH	MH	SU	BOTH				
Jefferson Center	Fountainhead ACF	Jefferson	14			7			no	Permanent	60%	70%
Jefferson Center	The Granville ACF	Jefferson	113			2			no	Permanent	60%	70%
Jefferson Center	Helping Hands ACF	Jefferson	8			8			no	Permanent	60%	70%
Jefferson Center	Just For Seniors ACF	Jefferson	24			13			no	Permanent	60%	70%
Jefferson Center	Karen's House ACF	Jefferson	8			7			no	Permanent	60%	70%
Jefferson Center	Lakewood Terrace Assisted living ACF	Jefferson	8			1			no	Permanent	60%	70%
Jefferson Center	Marshal House ACF	Jefferson	8			6			no	Permanent	60%	70%
JEFFERSON CENTER	Our Family Care Home ACF	Jefferson	8			8			no	Permanent	60%	70%

Table 24 Continued : Adult Residential												
AGENCY NAME	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Secure/ Lockable Facility? YES/NO	Average Length of Stay (Days)	Percent of Adult Residential Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Adult Residential Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH	MH	SU	BOTH				
Jefferson Center	Retreat at Highlands ACF	Jefferson	42			4			no	Permanent	60%	70%
Jefferson Center	Silver Rose ACF	Jefferson	10			6			no	Permanent	60%	70%
Jefferson Center	Temenos Assisted Living Home ACF	Jefferson	7			4			no	Permanent	60%	70%
Jefferson Center	Temenos Elder Care Company ACF	Jefferson	8			7			no	Permanent	60%	70%
Jefferson Center	Your Second Home ACF	Jefferson	8			5			no	Permanent	60%	70%
Jefferson Center	Walden House ACF	Jefferson	8			1			no	Permanent	60%	70%
MH Partners	Warner House	Boulder	16	0	0	15	0	0	N	21.5	60%	60%
MH Partners	Alterra Wynwood at Ridgeport	Boulder	?	?	?	0	0	0	N	411	60%	60%

Table 24 Continued : Adult Residential												
AGENCY NAME	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Secure/ Lockable Facility? YES/NO	Average Length of Stay (Days)	Percent of Adult Residential Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Adult Residential Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH	MH	SU	BOTH				
MH Partners	Balfour Retirement Community	Boulder	?	?	?	0	0	0	N	unsure	60%	60%
MH Partners	Cinnamon Park	Boulder	?	?	?	1	0	0	N	519.5	60%	60%
MH Partners	Golden West Senior Center	Boulder	?	?	?	0	0	0	N	364.2	60%	60%
MH Partners	Mary Sando	Boulder	?	?	?	1	0	0	N	unsure	60%	60%
MH Partners	The Legacy	Boulder	?	?	?	1	0	0	N	unsure	60%	60%
MH Partners	980 University	Boulder	4	0	0	4	0	0	N	455.3	60%	60%
MH Partners	Sage Residence	Boulder	5	0	0	5	0	0	N	454.8	60%	60%
MH Partners	Bridge House	Jefferson	16	0	0	0	0	0	N	23.2	60%	60%

* For last 11 quarters this is a rolling average

^FY14

The CMHCs serve a gatekeeping function for who gets referred to State Hospitals. Their utilization of the State Hospitals and ways they could better serve consumers in their own communities include:

Jefferson Center tends to use our 22 allocated beds for clients with FBHP Medicaid. Clients with Medicare/Medicaid are generally placed in psychiatric facilities at general medical hospitals but sometimes we also use our allocated State beds for these clients. Youth we rarely refer to the State hospital because of capacity and because for optimum treatment, families should be involved as much as possible, and for many the long drive to Pueblo would be a barrier to this participation. For both populations above we

sometimes use stand-alone psychiatric facilities as well. We try to preserve the State beds for clients with Medicaid and for those for whom a long episode of care is needed.

For MHP's referrals to Fort Logan, all evaluations go through their Emergency team and they determine who should go to Fort Logan, where we have allocated beds. They have 14 beds and try to get folks with no insurance admitted to Fort Logan. They often go over our limit of 14 due to need. Inpatient Liaisons assist in having clients transfer from a private hospital to Ft. Logan, to include care coordination. MHP also has a liaison who works on campus at Fort Logan. He works in collaboration with the staff at Ft. Logan for care coordination and discharge planning.

MHP has no allocated beds at Pueblo and rarely if ever hospitalize clients at Pueblo. Often the clients are at Pueblo on various units due to legal issues ITP, Incompetent to Proceed, and NGRI Not Guilty by Reason of Insanity.

Often the clients that are placed at a State Hospital tend to be violent or more of a risk to the community and themselves. There are not many options of a residential setting or frankly tolerance in the community for these individuals displaying that type of behavior.

Skilled Nursing Facilities

Table 25: Skilled Nursing Facilities

AGENCY NAME	Facility Name (Indicate ACF or ALR)	County of Location	Capacity/ # of Available BH Beds	# of Current Clients Placed	Secure/ Lockable Facility? YES/NO	Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Nursing Home Needs Met by Current Available Resources in the State
Jefferson Center	Allison Care Center	Jefferson	92	0	Not for BH	80%	60%
Jefferson Center	Bethany Healthplex	Jefferson	174	21	Not for BH	80%	60%
Jefferson Center	Cedars Health Care Center	Jefferson	100	2	Not for BH	80%	60%

Table 25 Continued: Skilled Nursing Facilities							
AGENCY NAME	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed**	**Secure/ Lockable Facility? YES/NO**	**Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Nursing Home Needs Met by Current Available Resources in the State**
Jefferson Center	Cherrelyn Healthcare Center	Jefferson	0	7	Not for BH	80%	60%
Jefferson Center	Christopher House	Jefferson	75	5	Not for BH	80%	60%
Jefferson Center	Harmony Pointe	Jefferson	20 beds BH unit; 54 beds accept MH		Yes, locked and secure	80%	60%
Jefferson Center	Life Care Centers of Evergreen	Jefferson	0	8	Not for BH	80%	60%
Jefferson Center	Mapleton Care Center	Jefferson	80	1	Not for BH	80%	60%
Jefferson Center	Sandalwood	Jefferson	80	6	Not for BH	80%	60%
Jefferson Center	Sierra Health Care Community	Jefferson	29 beds BH unit; 51 beds accept MH		Yes, locked and secure	80%	60%
Jefferson Center	Villa Manor Care Center	Jefferson	0	2	Not for BH	80%	60%

Table 25 Continued: Skilled Nursing Facilities							
AGENCY NAME	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed**	**Secure/ Lockable Facility? YES/NO**	**Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Nursing Home Needs Met by Current Available Resources in the State**
Jefferson Center	Western Hills Health Care Center	Jefferson	97	6	Not for BH	80%	60%
Jefferson Center	Westlake Care Community	Jefferson	75	11	Not for BH	80%	60%
Jefferson Center	Wheatridge Manor	Jefferson	78	0	Not for BH	80%	60%
Jefferson Center	Cambridge Care Center	Jefferson	43% occupied- 100 beds for all residents- 43 max for BH	37	Not for BH	80%	60%
Jefferson Center	Arvada Care & Rehab	Jefferson	55	DATA NOT AVAILABLE	DATA NOT AVAILABLE	80%	60%
Jefferson Center	Bear Creek Nursing & Rehab Center	Jefferson	160	DATA NOT AVAILABLE	DATA NOT AVAILABLE	80%	60%

Table 25 Continued: Skilled Nursing Facilities							
AGENCY NAME	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed**	**Secure/ Lockable Facility? YES/NO**	**Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Nursing Home Needs Met by Current Available Resources in the State**
Jefferson Center	Exempla Colorado Lutheran Home	Jefferson	205	DATA NOT AVAILABLE	DATA NOT AVAILABLE	80%	60%
Jefferson Center	Mountain Vista Health Center	Jefferson	155	DATA NOT AVAILABLE	DATA NOT AVAILABLE	80%	60%
Jefferson Center	Village Care Center	Jefferson	DATA NOT AVAILABLE	DATA NOT AVAILABLE	DATA NOT AVAILABLE	80%	60%
MH Partners	Applewood	Boulder	106	5	N	40%	60%
MH Partners	Boulder Manor	Boulder	165	2	N	40%	60%
MH Partners	Broomfield Skilled Nursing	Broomfield	210	1	N	40%	60%
MH Partners	Frasier Meadows	Boulder	108	0	N	40%	60%
MH Partners	Life Care Center of Longmont	Boulder	187	1	N	40%	60%

Table 25: Skilled Nursing Facilities							
AGENCY NAME	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed**	**Secure/ Lockable Facility? YES/NO**	**Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Nursing Home Needs Met by Current Available Resources in the State**
MH Partners	Manor Care	Boulder	150	1	N	40%	60%
MH Partners	Peak's Care Center	Boulder	105	1	N	40%	60%
MH Partners	Mesa Vista	Boulder	162	8	N	40%	60%
MH Partners	Covenant Village	Jefferson	65	0	N	40%	60%
MH Partners	Lakewood Villa	Jefferson	60	0	N	40%	60%
MH Partners	LCC-Evergreen	Jefferson	100	0	N	40%	60%
MH Partners	Villa Manor	Jefferson	70	0	N	40%	60%

RED font indicates changes made to reduce duplicated counts within the region and correct bed numbers.

Community providers work with Nursing Homes to assure they are only used for persons who need that level of care and for the minimum stays necessary through:

The ULTC 100 and PASARR Level II are completed to ensure that the resident meets/needs nursing home level of care and Jefferson Center tries to exhaust all other levels of care before referring someone for nursing home placement, i.e. residential, ACF, etc. It is only after those options have been considered or consumer has tried/hasn't been successful at other level of care are they then referred to nursing home.

When consumer is living in the nursing home, focusing on least restrictive setting is always part of their treatment. The care coordinator and psychiatrist consult with the nursing home social workers, nurses, etc ., regarding this and identify barriers that

would prevent them from transitioning to less restrictive setting. Any barriers identified would be addressed in their treatment plan (and specialized care plans) and goals/objectives would be set up to help them progress toward less restrictive level of care. Care coordinator also does this through monthly coordination of care, quarterly care conferences, and pass plan meetings (if they are on locked units).

Clients in need of nursing homes, or potentially in need of nursing homes, are staffed with an interdisciplinary team. This team determines the need and attempts to keep all clients in the community whenever possible. When a client is admitted to a nursing facility they are assigned a clinician and/or a case manager to monitor their care. These providers continually assess the clients to determine their level of care and work on discharge planning to set up services in the community to provide the best possible support.

ATU

None for this region.

Crisis Services

Table 26: Crisis Services

AGENCY NAME	Acute Treatment Unit Name - Crisis Stabilization Unit	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Average Length of Stay (Days)
			MH	SU	BOTH	MH	SU	BOTH	
Jefferson Center	Jefferson Hills at New Vistas	Jefferson			16	n/a			n/a *

SUD

Table 27: SUD								
AGENCY NAME	**SUD Program Res. Treatment Program Name**	**County of Location**	**Capacity/# of Available SUD Beds**	**# of Current Clients Placed on 1st day of the month**	**OBH licensed for III.1, III.5 or III.&**	**Male/ Female or Both**	**Average Length of Stay (Days)**	**Percent of SUD Residential Tx Program Needs Met by Current Available Resources in your Geographic Service Area.**
Jefferson Center	West Pines-Adults	Jefferson	20	12-14	3.7	10-M, 10-F	14 days	50%
MH Partners	Valmont TRT-ARC	Boulder	10	10	Y	Both	30 days	20%

Detox

Table 28: Detox							
AGENCY NAME	**Detox Provider Name**	**County of Location**	**Capacity/ # of Available SUD Beds**	**# of Current Clients Placed on 1st day of the month**	**Medical or Social detox Model? (M or S)**	**Average Length of Stay (Days)**	**Percent of Detoxification Needs Met by Current Available Resources in your Geographic Service Area.**
Jefferson Center	Arapahoe House-Detox West	Jefferson	30	30	S	1.5 days	40-90%
Jefferson Center	West Pines-Adult	Jefferson	38	18	M	3-5 days	40-90%
MH Partners	Valmont-ARC	Boulder	16	12	Social	2.5	40%

RED font indicates changes made to reduce duplicated counts within the region and correct bed numbers.

Peer Services

Both CMHCs in Region 6 provide Peer Support Services.

Table 29: Peer-related questions	
Average case load of individual peer support staff	Adult Outpatient – 5, Intensive – 12 No caseload –see 6 clients on average per week
Typical aggregate number of hours per week of service provided across all peer specialist staff	612 (2.5?)
Number of peer support positions budgeted for your organization	28.5
Number of peer support positions that were vacated within the last year fiscal year	4

Table 30: Areas of focus for Peer Services	
Assertive Community Treatment team member	X
Housing [in-home support; landlord outreach; housing acquisition/preservation]	X
Employment [job readiness, job coaching, etc.]	X
Wellness/Recovery [e.g. informal mentoring, WRAP, WHAM, self-advocacy]	
Education [formal information dissemination; critical skill development]	X
Benefits support/Advocacy [e.g. acquiring housing assistance, entitlements, accommodations]	X
Outreach [e.g. connecting with at-risk people who are not receiving services or who are registered but not involved in services]	X
Crisis Response [e.g. Hotline, warm line, Emergency Room]	X
Psychiatric hospital [e.g. outreach, bridging/transition]	X
Community resource acquisition [e.g. linking to community resources, food banks, churches, self-help groups, recovery organizations]	X
Criminal justice/jail liaison	X
Family education/support/parenting	X

Other Peer Support Responsibilities:

AOP peer specialists also serve as Consumer Service Representatives. They meet every new consumer who comes in for outpatient services. They complete initial paperwork with the consumer, tell them a little about our recovery model and what peer specialists do, and assist in making new consumers feel comfortable as they anticipate meeting with a clinician to complete an intake.

Intensive peer specialists are very actively involved in outreach to hospitals, ACT, and Criminal Justice programs.

Hours	Table 31: Training Peer Staff Receive before Employment - Description
0	35 hour class taught by Value Options Peer Trainer Clarence Jordan, modeled on the Colorado Combined Core Competencies for Peer Providers. In addition, peers hired by MHP receive a new employee orientation that introduces them to the center and to the work of the peers.
35	All our peer specialists attend a 36 hours peer specialist training developed to address the core competencies of peer specialists in Colorado. This training is attended AFTER they are hired by Jefferson Center

Hours	Table 32: Training Peer Staff Receive after Employment - Description
36	One and a half hours, weekly, of group supervision which includes a clinical presentation on some domain of recovery. Nineteen hours annual online training required by the Center. Miscellaneous trainings of the staff's choosing or directed by the program manager i.e. iNAPS conference, Spirituality, Motivational Interviewing, Safety, Violence in the Workplace, De-escalation, Suicide Presentation, Mental Health First Aid, etc.
24	24 hours per year in monthly 2 hour meetings with various guest speakers and invitation to center-wide staff trainings in various topics depending on position and supervisor approval.

Hours/Mo	Table 33: Brief Description of How Peer Staff Are Supervised
As needed in addition to group	New staff receive weekly supervision for one hour as long as is needed. More seasoned staff receive individual supervision as needed or upon request.
3-4	They receive individual supervision as well as group supervision. The individual supervision is with a licensed staff who reviews the cases and provides clinical direction. Group supervision is used to work with issues that peers face globally

***Independent peer-operated support or recovery organizations include*:** NAMI, NAMI Jeffco, The Network, and Family to Family.

Criminal Justice

Table 34: Justice-Involved Individuals Unduplicated Number Served	
On probation	101 +
On parole	29 +
Released from prison or jail within 6 months of receiving services	Unsure
Other justice-involved	168+

+Total number of criminal justice involved clients served in 1035. The numbers for parole/probation/ jail released/other are not able to be calculated.

Table 35: Number of justice-involved individuals treated in the past year	
Mental Health <18	20 +
Substance Use <18	Unsure
Co-Occurring MH & SU <18	3+
Mental Health >18	128+
Substance Use >18	Unsure
Co-Occurring MH & SU >18	147+

+Total number of adults is 977, juveniles is 58. All were treated for mental health. Substance use and co-occurring are not able to be calculated.

Table 36: Court-referred Individuals - Number Served in FY 2014	
Mental Health	100 +
Substance Use	Unsure
Co-Occurring MH & SU	129 +

+ Clients were court ordered from drug court, juvenile mental health court, probation, parole, diversion and pre-trial services. The specific numbers are not able to be calculated.

Table 37: Recently Incarcerated Individuals - Number Served in FY 2014	
Mental Health	69 +
Substance Use	Unsure
Co-Occurring MH & SU	28 +

+ Additional served, number not known

Table 38: In the Region there is the following specialty court(s)	
Mental Health Court	X*
Drug Court	X

*juvenile MH court

Capacity exists to serve everyone who is referred the specialty courts.

The Mental Health and Drug Court serves individuals with co-occurring mental health disorders.

Marijuana Legalization

Both CMHCs in Region 6 provide substance use treatment, prevention and/or recovery services.

Table 39: Substance use treatment and recovery services	
Total number of individuals have participated in substance use treatment and recovery services in the past year	540
Number with co-occurring mental health and substance use disorders	382
Number with marijuana use issues alone or as primary drug of choice	79
Number with prescription drug use issues alone or as primary drug of choice	27

Evidence-based programs or practices for substance use, generally include: CBT, Motivational interviewing, Strength-Based, Solution Focused, and Seeking Safety.

Evidence-based programs or practices for co-occurring mental health and substance use disorders include: CBT, Motivational Interviewing, Strength Based, Integrated Dual Diagnosis Treatment (IDDT) TIP 42 for Co-Occurring Disorders, Strategies for Self Improvement and Change, Seeking Safety, Trauma Recovery and Empowerment Model and Seeking Safety.

Evidence-based programs or practices for marijuana use issues alone or as primary drug of choice include: CBT, Motivational Interviewing, Strength-Based, Solution Focused and Seeking Safety.

Evidence-based programs or practices for prescription drug use issues alone or as primary drug of choice include: CBT, Motivational Interviewing, Strength-Based, Solution Focused, and Seeking Safety.

Table 40: **Do you currently have the capacity to serve everyone who requests services at your center for: (Yes = X)**	
Marijuana use issues	X
Prescription drug issues	X

Appendix C-7:

Colorado Public Behavioral Health System and Services Inventory – Region 7

Counties Included in Region 7
Elbert, El Paso, Park and Teller

Region 7

CMHCs and SUD Providers

- 1 CMHC
  - AspenPointe Behavioral Health Services
- 1 BHO: Colorado Health Partnerships, LLC
- 1 MSO provider: AspenPointe

Number of Persons Served

Table 1: Number of Persons Served			
Unduplicated Served	**Child/Adolescents 0-17**	**Adults 18-64**	**Older Adults 65 & Older**
Mental Health (MH)/ Emotional Disorders	5,906	13,776	496
Substance Use (SU) Disorders	1	68	1
Co-Occurring MH & SU Disorders	5	187	0

Workforce

Table 2: Workforce	
Staff Category	**Current Filled FTE #/Total FTE Budgeted**
Medical Staff	8/8
Psychiatrists	**10.8/15.3**
Psychologists	16/16
Nurses	**16/22**
Addictions Staff (E.g. CACs -Not Recovery Coaches)	13/13
Licensed Clinicians, Counselors, Social Workers	100.73/102.73
Unlicensed Master's level Clinician's, Counselors & Social Workers	27.84/30
Unlicensed Bachelor's level Clinician's, Counselors & Social Workers	44.86/46
Cross-trained MH/SA Behavioral Health Staff (Master's)	12/12
Cross-trained Behavioral Health Staff (Bachelor's)	1/2
Case Managers (Non-Peer)	10/12
Peer Support Specialists	**6.5/10.25**
Recovery Coaches	5/7
Family Navigators/Advocates	3/4
Mobile Crisis Staff (Non-Peer)	1/0
Crisis Stabilization Unit Staff (Non-Peer)	**3/6**
Crisis Respite Staff (Non-Peer)	2/2
Mobile Crisis Peer/Family/Recovery Staff	0/0
Crisis Stabilization Unit Peer/Family/Recovery Staff	3/5
Crisis Respite Peer/Family/Recovery Staff	0/0

^Insufficient data to include the caseloads.

Funding

Table 3: Funding	
FY 2014/2015 Funding Payer Source	**Approximate Per Cent of Total Operating Budget**
Medicaid	82.66%
Medicare	0.49%
State General Funds/Block Grants/Path Federal Funds	10.63%
Other Grants	1.56%
Funding from DOC, DYC, etc.	0.15%
Privately insured	2.90%
Donations & other sources	0.89%
Other funds for Public Behavioral Health Services	0.74%

Services Provided

Integrated Care

Table 4: Primary Healthcare - Integration	
We are a Federally Qualified Health Center (FQHC) and offer both primary and behavioral health services at our agency.	
We have fully integrated primary care into the services we provide at our location(s).	
We offer primary care as a separate service within our behavioral health center.	X
Our center offers behavioral health services at an FQHC or other primary care service provider(s). Described below.	
We have formal referral agreements in place with an FQHC or other primary care service provider, or have other methods for coordinating services. Described below.	
Our services are limited to meeting the behavioral health needs of our clients.	X
Other: Described below.	

The CMHC offers behavioral health services at the following primary care service provider entities**:**

- Peak Vista Community Health Center (FQHC)
- Colorado Springs Health Partners
- Academy Women's Healthcare Associates

Table 6: Funding Mechanism for Co-located services w/in BH Center	
Colorado Medicaid	X
Federal government and/or private grants	X
State funding	
Other	

***Specific state, federal government and/or private grants**:* SAMHSA Primary Behavioral Health Care Integration Grant

Recommendations to enhance the ability to provide/meet the primary health needs of individuals with behavioral health issues include:

Increased flexibility in codes and documentation requirements to serve more people at the primary care level of care. For Example: We serve all payers in the medical clinics that we are a part of, but are only paid for the Medicaid patients (capitated adjudication). We see many uninsured who would qualify for Block Grant, but we cannot count them because we do not do a CCAR for preventative services.

The P&I codes that we are using for work in the primary care setting changed their requirement in July to require the number of minutes, rather than just the encounter. This is problematic because the physical healthcare systems' EHR's do not capture time because all services are based on encounters. So, we have had to request special build out in our partner's systems to try to meet this need and some of the other systems cannot accommodate this request.

Special Co-Occurring Populations

Intensive Services for individuals with behavioral health disorders Co-Occurring Intellectuals/Developmental Disabilities, Traumatic Brain Injuries or significant medical/physical disorders are not available in Region 7.

Infant/Early Childhood Services

- ***Play Therapy****: the early childhood team members are trained in play therapy (a developmentally appropriate therapeutic treatment modality) and is available to all young children and their families*
- ***Expressive Arts Therapy****: other expressive arts therapies are available for young children, including art therapy, movement therapy, sand tray therapy, etc.*
- ***Family Therapy****: several modalities of family therapy are available to children*
- ***Family Preservation****: intensive home-based therapeutic services for high-risk families with a goal of keeping children and families and avoiding unnecessary removal or separation from the home*
- ***Filial Therapy****: the early childhood team members are trained in filial therapy, a play based approach to family therapy*
- ***Child Care Consultations****: two early childhood specialists are available for prevention and intervention services in local child care centers; they observe children at various locations and make recommendations for the child care centers to meet the developmental, emotional and behavioral needs without needing to be removed from their current environment*
- ***Incredible Years Dinosaur School****: comprehensive prevention and early intervention treatment program for children to promote social competence, emotional regulation, recognition of positive attributions, academic readiness, and problem solving*
- ***Incredible Years Parent Group****: comprehensive prevention and early intervention treatment program for parents of young children to improve parent-child interactions, positive relationships and attachment, parental functioning, less harsh and more nurturing parenting, and increased parental social support*
- **Infant Mental Health**: specialized, therapeutic services including traditional and enhanced therapy delivered to family caregivers to address the needs of infants and toddlers with mental health or behavioral health challenges
- **Psychiatric Services/Medication Management**: psychiatric evaluation by a medical prescriber and medication management if medications are determined to be needed

School-based Services that target children and adolescents with serious emotional/ behavioral health disorders

- **School-based health clinics**: AspenPointe is present in two school-based health clinics in Colorado Springs and Cripple Creek, CO where behavioral health professionals work with primary care physicians and school personnel to meet the behavioral, emotional, physical, educational and developmental needs of children
- **REACH**: wrap-around services in partnership with a local school district

- **School-based clinicians**: AspenPointe has behavioral health providers located in several schools throughout the geographical service area
- **School advocacy**: school advocates provide services with and on behalf of families to address behavioral, emotional and developmental health needs of children and adolescents in schools
- **Incredible Years Dinosaur School**: comprehensive prevention and early intervention treatment program for children in preschool and kindergarten classrooms to promote social competence, emotional regulation, recognition of positive attributions, academic readiness, and problem solving

Special Programs/Services that target transitional-aged youth with serious emotional/ behavioral health disorders

- **Individual Therapy**: individualized, evidence-based therapeutic services offered one on one with transitional aged youth is available for those who need it to help manage serious emotional/behavioral health disorders
- **Expressive Arts Therapy**: other expressive arts therapies are available for young children, including art therapy, movement therapy, sand tray therapy, etc.
- **Family Therapy**: several modalities of family therapy are available to transitional aged youth
- **Family Preservation**: intensive home-based therapeutic services for high-risk families with a goal of keeping children and families and avoiding unnecessary removal or separation from the home
- **Group Therapy**: specialized, evidence based groups including those for anger management, trauma, social skills development, Dialectical Behavioral Therapy (DBT), managing behavioral difficulties, etc.
- **Adolescent Intensive Out Patient (IOP)**: offered afterschool and during school breaks focusing on meeting the clinical needs of children who need comprehensive supports in order to maximize and maintain their functioning level and peer connections
- **Psychiatric Services/Medication Management**: psychiatric evaluation by a medical prescriber and medication management if medications are determined to be needed
- **School advocacy**: school advocates provide services with and on behalf of families to address behavioral, emotional and developmental health needs of children and adolescents in schools
- **Career and Development Services**: resume writing, application skills, interviewing skills, workplace expectations, job placement assistance, ongoing job coaching, employment essentials, dress for success
- **Job Specific Training**: youth job training programs are available for transitional aged youth (i.e., barista training, cooking and baking program)

- **GED Preparation**: individualized services to enhance an individual's ability to obtain their GED
- **Theft Prevention**:
- **Services for Court Involved Youth**: including victim impact classes, theft prevention, conflict resolution, restorative justice-based services
- **Educational Services**: after school tutoring, skills for success in school groups, assistance for home-schooled and online students, post-secondary planning services

Special Programs/Services that target children and adolescents with serious emotional/ behavioral health disorders in the Child Welfare System

All AspenPointe services are available to children and adolescents who are a part of the child welfare system. Additionally, AspenPointe has an imbedded mental health provider located at El Paso County DHS to serve as a liaison between the child welfare system and AspenPointe to ensure an appropriate transition to care. In addition, AspenPointe provides Adoption, Foster and Kinship Care (i.e., specialized, proactive supports including traditional therapy and case management to families with needs related to adoption, foster and kinship care)

Special programs/services that target Veterans with serious behavioral health disorders

- **Peer Navigator**: helps active-duty services members, veterans and their families to plot a course through the sometimes overwhelming challenges of day to day life and the numerous complex systems available to support them
- **Peer Navigator Specialized Services**: (Veterans Integration Program) specialized service within the Peer Navigator program that focuses on connecting young, transitioning service members and veterans to employment, training and education
- **Veteran Trauma Court Peer Mentor Program**: designed for service members and veterans who have had legal contact that could result or has resulted in a lower-level felony and who are currently enrolled for could be considered for Veteran Trauma Court

Community Based Services

Table 7: Approximate number and percent of clients you served during the last 12 months with the following co-occurring physical health problems	
Traumatic brain injury	unsure
Obesity	unsure
Diabetes	unsure
Deaf or hard of hearing	unsure
Blind	unsure
Mobility impairment	unsure
Intellectual/developmental disability	unsure

The biggest barrier/gap to serving people with mental illnesses in community, rather than institutional, settings is transportation.

Table 8: The following client groups pose the greatest challenge to serve in the community?	
Children	
Adolescents	
Young adults/Transition-aged youth	
Older adults	X
Individuals with traumatic brain injuries	X
Justice-involved	
Individuals with a history of violence	

Other: Individuals with Developmental Disabilities

Housing

Table 9: Number of individuals receive assistance from your agency regarding housing	
Mental Health	297
Substance Use	75
Co-Occurring MH & SU	125

Aspen Pointe provides housing programs, such as *Permanent Supportive Housing, Housing Choice Vouchers, and State Housing vouchers.* We have 497 individual on PSH, HCV, SHV, and VASH vouchers.

Table 10: Housing Programs	
Do these programs have a waiting list? (Yes/No)	Yes
If yes, estimate of wait times	2 years
Estimated percentage of un-served need for housing programs	75%
Is housing part of the job responsibility for case managers, i.e., housing needs are addressed in treatment plans?	Yes

For people who do not participate in housing programs (above), what do case managers provide regarding housing? Referral and assistance accessing affordable housing: however, resources are scarce. Housing is our largest unmet need. Transportation is a close second.

Table 11: **Which of these tasks might a case manager perform on behalf of individuals on their caseload:**	
Housing search	X
Housing referral	X
Negotiation with landlords/program managers	X

Other: Assistance with application process.

For people who do participate in housing programs, what are the case management responsibilities beyond referral to the housing program? Assistance with landlord conflicts, basic house keeping skills, budgeting, and social skills training.

For people who do not participate in housing programs, what is your estimated percentage the un-served need is unknown.

Table 12: Level of participation by your organization in community planning and advocacy regarding obtaining housing resources	
Highly involved, leadership staff participating	X
Highly involved, program staff participating	
Moderately involved (describe)	
Not involved	

For individuals who live in the community but not in specific housing programs administered or supported by your organization their support/service needs are met through: Case management, advocacy and peer services. As noted below there are not specific housing programs and support activities supported by the provider agencies.

Table 13: Housing Information	
Does your organization own and operate housing?	No
If yes, number of units/beds	
Does your organization have formal relationships with housing providers, such as the PHA, private landlords, City or County governments.	No
Estimate number of units accessed through these relationships	~500 through private landlords
For individuals who live in housing programs administered or supported by your organization, are all their support/service needs provided by program staff?	No

Employment

Table 14: Number of individuals receiving employment services in the past year	
Mental Health	Total Served in Training and Career in FY14: **526** Do not have break down by diagnosis
Substance Use	
Co-Occurring MH & SU	

Employment programs provided include:

Construction Program: The construction program is a 120 hour (15 days at 8 hours per day), non-credit program intended to prepare individuals for entry-level work in the construction industry or to pursue additional training in a specific construction trade (HVAC, Plumbing, or Electrical Work, etc.).

Clerical Program: Our 12 hour clerical program prepares students to find employment in entry level administrative jobs.

Culinary Program: Our 16-week culinary training program trains students for restaurant and commercial food service positions and helps students acquire the foundational knowledge and skills of cooking and baking, sensory awareness, and teamwork needed to work with competence and professionalism in a commercial kitchen or related culinary field.

Maintenance Tech Training: Students learn the day-to-day operations of property management. During the program students will learn time management techniques, safety and awareness, work orders, minor electrical, minor plumbing, irrigation/grounds keeping and much more.

Landscaping Training: Students will learn how to build and implement water and environmentally conscious landscaping. In addition to planning and design, students will be taught how to limit turf areas, appropriate zoning, how to improve soil using mulch, and maintenance.

Cashier Training: Student will learn cash handling techniques and loss prevention measures which will equip the student with the knowledge to obtain employment in a retail business.

Barista Training: A 10 week training program that teaches students customer service skills while learning manual and automatic espresso machine operation.

Job Seeking Skills This training incorporates all of the classes offered by Career Services to allow a full career training to help get clients as fully prepared as possible. This training teaches lessons in: Intro to Computers, Mavis Beacon Typing, Microsoft Office Programs, Intro to Internet, Mind Mapping/Career Explorations, Employment Applications, A-Game Soft Skills Training, Resume Writing, and skills in Interviewing

Job Placement Skills: Job Placement is a separate class dedicated to offering time for those with completed resumes and JSS skills to get assistance in finding and applying for jobs

Forklift Training: The forklift training program is a two week intensive training focused on provided students with the information necessary to use a forklift safely.

Hospitality Training: Student will learn cleaning methods utilized in most hotel environments. Students learn how reset a hotel room while providing good customer service.

Table 15: Employment Waiting list and Unmet Need for Participants	
Do these programs have a waiting list?	No
If yes, estimate of wait times	
In your estimate, how many individuals being served by your program have a need for employment programs that is currently unmet	80%
Are employment services part of the job responsibility for case managers, i.e., employment needs are addressed within a treatment plan?	No

Table 16: For people who do not participate in employment programs (above), the following tasks might be performed by a case manager behalf of individuals on their caseload regarding employment.	
Job Search	
Referral to an Employment Program	X
Assistance with looking for an Employer	X
Assistance with applying for public benefits such as SSI, SSDI, VA	X
Support to maintain employment	X

For people who do participate in employment programs, what are the case management responsibilities beyond referral to an employment program? They may refer or link clients to resources but they are not directly involved in job training.

For people who do not participate in the employment programs, the estimated percentage of the un-served need is 40%.

Table 17: Employment Questions	
Does your agency have dedicated employment staff?	Yes
If yes, how many staff FTEs work solely on Employment?	3
How many people were working as a result of your Employment Program in the last fiscal year?	87
Are you tracking the data of your Employment Program such as hourly wages, length of time working, part time vs. full time, types of jobs?	Yes
Does your agency currently have formal relationships with Employers? Employment programs, Training programs?	Yes
If yes, please indicate number of formal relationships	6
Please estimate the percent of need for employment services at your agency.	90%
If people are employed through a referral, does your agency provide on-going support to maintain employment?	Yes

On-going support to maintain employment includes the following:
Assistance in maintaining MH/SU symptoms in order to stay employed, link to other needed resources as needed.

If people express no desire for employment but are rejected for public benefits, what is the plan of action for those people? Refer to case management to discern options.

If people receive different levels of assistance with housing and/or employment based on a level of service designation please briefly describe. No, every client is assessed and supported on an individual basis.

Wraparound Services

Are not provided for children in Region 7.

Assertive Community Treatment

Table 18: Assertive Community Treatment Teams	
Number of teams	1
Average caseload per team	40

Residential Substance Use Services that target adults with serious behavioral health disorders, including those related from the Department of Corrections.

Not applicable; AspenPointe does not currently offer any residential substance use services in their geographic area

Inpatient

Children and Adolescents Hospital

Table 19: Children and Adolescent Hospital					
Agency Name	**Hospital Name**	**County of Location**	**# of Beds**	**Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Child/Adolescent Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State**
AspenPointe	Cedar Springs	El Paso	44	50%	90%
AspenPointe	Peak View	El Paso		50%	90%

Adult- Geriatric Hospital

Table 20: Adult- Geriatric Hospital									
Agency Name	**Hospital Name**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed on 1st day of the month**	**Secure/ Lockable Facility? YES/NO**	**Indicate Adult/ Geriatric or Both (A/G/B)**	**Average Length of Stay (Days)**	**Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Adult Non-State Hospital Psychiatric Inpatient Bed Needs Met by Current Available Resources in the State**
AspenPointe	Cedar Springs	El Paso	38	1	Yes	A	4	70%	90%
AspenPointe	Peak View	El Paso	72	1	Yes	A	6		

Residential

Child- Adolescent Residential

Table 21: Child- Adolescent Residential											
AGENCY NAME	Facility Name	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month	Indicate Child, Adolescent or Both (C/A/B)	Secure/ Lockable Facility? YES/NO/ SS (Staff Secure)	Average Length of Stay (Days)	Percent of Child and Adolescent Facility Needs Met by Current Available Resources in your Geographic Service Area.	Percent of Child and Adolescent Facility Needs Met by Current Available Resources in the State
			MH	SU	BOTH						
AspenPointe	Cedar Springs	El Paso	24			1	A	No	45	40%	80%
AspenPointe	Emily Griffith Center	El Paso	24			0	NA	No	45	40%	80%

Adult Residential

None available in this region.

Role in gatekeeping who gets referred to State Hospitals?

AspenPointe provides the main "gatekeeper" role for admissions to one state hospital, CMHI-P. This role is defined by AspenPointe's evaluation of the individual being referred, and in delegating responsibilities that assist with the admission process. (For example, reminding the facility where the patient is located that tox screens or legal paperwork need to be provided to CMHIP admissions.) AspenPointe provides this service for to the emergency rooms, ATU, and inpatient facilities in AspenPointe's catchment area of El Paso, Park, and Teller counties, when any of these facilities make requests to admit someone to CMHI-P. Very rarely, AspenPointe

also helps the local jails in these counties by explaining the process to follow, but AspenPointe does not always provide the assessment in these cases.

What would enable you to better serve consumers in their own communities?

Enabling better service in local communities would be driven by mobile crisis, CSU, ATU, ACT teams, and hospital services.

Table 22: Discharge Readiness Information	
State hospitals produce weekly or monthly assessments of clients who are ready for discharge	Yes
These lists shared with Community Providers	No

Skilled Nursing Facilities

Table 23: Skilled Nursing Facilities							
AGENCY NAME	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed**	**Secure/ Lockable Facility? YES/NO**	**Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Nursing Home Needs Met by Current Available Resources in the State**
AspenPointe	Aspen Living Center	El Paso	84	3	No	50%	50%
AspenPointe	Cedarwood Healthcare Center	El Paso	73	12	No	50%	50%
AspenPointe	Colonial Columns Nursing Center	El Paso	72	0	No	50%	50%

Table 23 Continued: Skilled Nursing Facilities							
AGENCY NAME	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed**	**Secure/ Lockable Facility? YES/NO**	**Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Nursing Home Needs Met by Current Available Resources in the State**
AspenPointe	Cripple Creek Care Center	Teller	59	2	No	50%	50%
AspenPointe	Lauren Manor Center	El Paso	81	0	No	50%	50%
AspenPointe	Garden of the Gods Center	El Paso	45	0	No	50%	50%
AspenPointe	Life Care Center of Col Spgs	El Paso	105	0	No	50%	50%
AspenPointe	Medallion Health Center	El Paso	60	0	No	50%	50%
AspenPointe	Parkmoor Village Healthcare Center	El Paso	145	0	No	50%	50%
AspenPointe	Mount St Francis Nursing Center	El Paso	108	0	No	50%	50%
AspenPointe	Pikes Peak Care and Rehab Cntr	El Paso	210	1	No	50%	50%

Table 23 Continued: Skilled Nursing Facilities							
AGENCY NAME	**Facility Name (Indicate ACF or ALR)**	**County of Location**	**Capacity/ # of Available BH Beds**	**# of Current Clients Placed**	**Secure/ Lockable Facility? YES/NO**	**Percent of Nursing Home Needs Met by Current Available Resources in your Geographic Service Area.**	**Percent of Nursing Home Needs Met by Current Available Resources in the State**
AspenPointe	NAMASTE' Alzheimer Center	El Paso	64	0	No	50%	50%
AspenPointe	Sunny Vista Living Center	El Paso	116	1	No	50%	50%
AspenPointe	Springs Village Care Center	El Paso	91	0	No	50%	50%
AspenPointe	Terrace Gardens Healthcare Center	El Paso	108	4	No	50%	50%
AspenPointe	Sundance Skilled Nursing & Rehabilitation	El Paso	65	5	No	50%	50%
AspenPointe	Union Printers Home	El Paso	100	0	No	50%	50%

Community providers work with Nursing Homes to assure they are only used for persons who need that level of care and for the minimum stays necessary through:

A nursing home therapist who regularly reviews for appropriateness of Level of Care and works with the Colorado Choice Transitions program at the Independence Center for individuals ready to transition back to the community.

ATU

Table 24: ATU									
AGENCY NAME	Acute Treatment Unit Name - Not Crisis Stabilization Unit	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Average Length of Stay (Days)
			MH	SU	BOTH	MH	SU	BOTH	
AspenPointe	Lighthouse	El Paso	16			14			5.4

Crisis Services

Table 25: Crisis Services									
AGENCY NAME	Acute Treatment Unit Name - Crisis Stabilization Unit	County of Location	Capacity/# of Available BH Beds			# of Current Clients Placed on 1st day of the month			Average Length of Stay (Days)
			MH	SU	BOTH	MH	SU	BOTH	
AspenPointe	AspenPointe - CSU (please note this is a living room model and therefore there are no 'beds'. Capacity reflects the number of client that can be served in the designated CSU area.)	El Paso			25	8			1.5 hours

SUD

Table 26: SUD								
AGENCY NAME	**SUD Program Res. Treatment Program Name**	**County of Location**	**Capacity/# of Available SUD Beds**	**# of Current Clients Placed on 1st day of the month**	**OBH licensed for III.1, III.5 or III.&**	**Male/ Female or Both**	**Average Length of Stay (Days)**	**Percent of SUD Residential Tx Program Needs Met by Current Available Resources in your Geographic Service Area.**
AspenPointe	NA							0% met in area; only SUD residential service is in Bent county (out of RCCO region).

Detox

Table 27: Detox							
AGENCY NAME	**Detox Provider Name**	**County of Location**	**Capacity/ # of Available SUD Beds**	**# of Current Clients Placed on 1st day of the month**	**Medical or Social detox Model? (M or S)**	**Average Length of Stay (Days)**	**Percent of Detoxification Needs Met by Current Available Resources in your Geographic Service Area.**
AspenPointe	El Paso County Detox	El Paso	40	3	S	2	For Social Detox – 90% resource met. For Medical Detox – no resources for Medicaid/Indigent clients.

Peer Services: titles such as peer specialist, peer mentor, recovery coach, and family support specialist.

Peer support services are provided by a peer specialist in Region 7. Currently there are 2 peer positions and one is filled. These staff do not carry caseloads, however their one staff has served 82 clients as of the time of the survey. Typically the staff works 36 hours per week. Work activities focus on wellness/Recovery [e.g. informal mentoring, WRAP, WHAM, and self-advocacy.

Training and Supervision:

Hours	Table 28: Training Peer Staff Receive before Employment - Description
18	In house Peer Specialist Training Program provided by the ACCESS Center based on Georgia Peer Certification Model. Three 6 hour days, for a total of 18 hours and/or training through NAMI(typically 10 week courses or volunteer experiences)

Hours	Table 29: Training Peer Staff Receive after Employment - Description
16	Still developing our internal on-boarding process for Peer Specialists but at this stage it will include 8 hours of Mental Health First Aid Training and 8 hours of other training specific to the para professional role and beyond the basic employee orientation trainings. These include trainings on Solution Focused Conversations, Self-Care for Helpers, Trauma Informed Care, Professional Boundaries and Crisis De-escalation/CPI Training.

Hours/Mo	Table 30: Brief Description of How Peer Staff Are Supervised
3.5	This will involve balancing the dual relationship if the Peer was a previous AspenPointe client. Otherwise, additional support should be available to all Peers as they onboard and integrate into the system. Once onboard, supervision for Peers will look the same as it does for all employees.

Criminal Justice- The following tables provide information about the justice-involved individuals service in Region 7.

Table 31: Justice-Involved Individuals Unduplicated Number Served	
On probation	53
On parole	unsure
Released from prison or jail within 6 months of receiving services	53
Other justice-involved	unsure

Table 32: Number of justice-involved individuals treated in the past year	
Mental Health <18	unsure
Substance Use <18	unsure
Co-Occurring MH & SU <18	unsure
Mental Health >18	53
Substance Use >18	unsure
Co-Occurring MH & SU >18	30

Table 33: Court-referred Individuals - Number Served in FY 2014	
Mental Health	10
Substance Use	Unsure
Co-Occurring MH & SU	6

Table 34: Recently Incarcerated Individuals- Number Served	
Mental Health	53
Substance Use	Unsure
Co-Occurring MH & SU	30
Note if in the Region there is a	
Mental Health Court	X
Drug Court	X

Other – Veteran/Trauma Court

Table 35: Note if capacity exists to serve all referrals in the Region (X)	
Mental Health Court	X
Drug Court	X
Other – Veteran/Trauma Court	X

Table 36: If Drug & Mental Health Courts, which serves co-occurring MH/SU referrals in the Region (X)	
Mental Health Court	X
Drug Court	

Marijuana Legalization – The following tables provide some general information about substance use programs and services.

Region 7 provides substance abuse treatment, prevention, recovery services.

Table 37: Substance use treatment and recovery services	
Total number of individuals have participated in substance use treatment and recovery services in the past year	284
Number with co-occurring mental health and substance use disorders	238
Number with marijuana use issues alone or as primary drug of choice	22
Number with prescription drug use issues alone or as primary drug of choice	24

Evidence-based programs or practices for substance use, generally: There has been no new EBP program implementation for SUD services over the last year. We continue to provide OP and IOP SUD services as we have been doing for years with expanded volume of clientele. Programs are based on the ASAM level of care guidelines using Matrix model.

Evidence-based programs or practices for co-occurring mental health and substance use disorders: There has been no new EBP program implementation for SUD services over the last year. We continue to provide OP and IOP SUD services as we have been doing for years with expanded volume of clientele. Programs are based on the ASAM level of care guidelines using Matrix model.

Evidence-based programs or practices for marijuana use issues alone or as primary drug of choice: There has been no new EBP program implementation for SUD services over the last year. We continue to provide OP and IOP SUD services as we have been doing for years with expanded volume of clientele. Programs are based on the ASAM level of care guidelines using Matrix model.

Evidence-based programs or practices for prescription drug use issues alone or as primary drug of choice: There has been no new EBP program implementation for SUD services over the last year. We continue to provide OP and IOP SUD services as we have been doing for years with expanded volume of clientele. Programs are based on the ASAM level of care guidelines using Matrix model.

Table 38: **Do you currently have the capacity to serve everyone who requests services at your center for: (Yes = X)**	
Marijuana use issues	X
Prescription drug issues	X