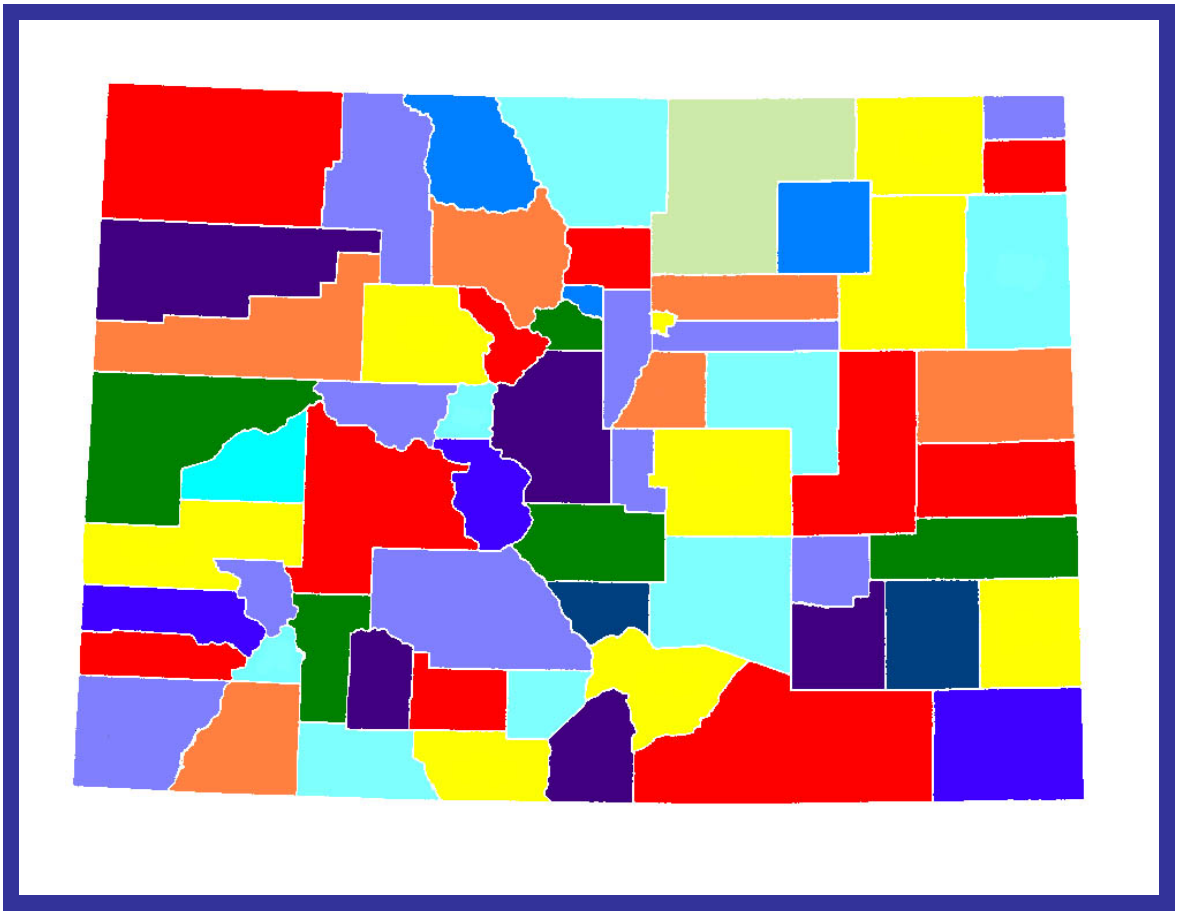
Colorado HJR 07-1050 Behavioral Health Task Force Report



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Acknowledgements

In 2007, the Colorado Legislature passed House Joint Resolution 07-1050 to create a task force (1050 Task Force) for the study of behavioral health funding and treatment. This final report is the result of the 1050 Task Force's efforts to study mental health and substance abuse services in order to coordinate the efforts of state agencies, streamline the services provided, and maximize federal and other funding sources. The final report could not have been completed without the leadership, guidance, commitment, and knowledge of the individuals and organizations listed below.

1050 Task Force Members

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Senator Betty Boyd, Vice Chair

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The Office of the Governor, Screening, Brief Intervention, Referral to Treatment
The Colorado Institute of Public Policy

The Federation of Families for Children's Mental Health ~ Colorado Chapter was designated as the nonprofit or private organization to be the custodian of the funds for the 1050 Task Force.

1050 Task Force Committee Members:

A full list of participants in the 1050 Task Force's committees is included in Appendix B.

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Executive Summary

In 2007, the Colorado Legislature passed House Joint Resolution 07-1050, creating a task force for the study of behavioral health funding and treatment in Colorado ("1050 Task Force"). The 1050 Task Force's charge was to study mental health and substance abuse services in order to coordinate state agency efforts, streamline services provided, and maximize federal and other funding sources. The 1050 Task Force focused its efforts on the public systems that provide behavioral health services and did not address behavioral health services through the private insurance system. For purposes of this report, behavioral health is defined as encompassing both mental health and substance use (use, abuse, and dependence/addiction) disorders.

The 1050 Task Force Structure and Process

The 1050 Task Force members consisted of six legislators, a representative of the Governor's Office, a representative from the Colorado Chapter of the Federation of Families for Children's Mental Health, and representatives from the following key departments of state government: Human Services; Health Care Policy and Financing; Public Health and Environment; Corrections; Public Safety; Education; and Law. (Please see Appendix A for a copy of the enabling resolution and list of Task Force members.)

The 1050 Task Force created three committees – Program; Budget and Funding; and Streamline and Coordinate Services - to assist it in meeting its goal. Overall, 90 individuals participated on the committees, representing all perspectives of behavioral health including consumers and family members, providers, state agencies, and other interested parties. (Please see Appendix B for a copy of the Task Force Committee members.)

The Final Report

The research process that led to the 1050 Task Force's final report, including its key findings and recommendations, consisted of: planning and consensus building; reviewing and analyzing Colorado and national research; conducting and analyzing Colorado and national key stakeholder interviews; and presenting research findings. The research process and content is described in detail in sections three through five. The 1050 Task Force disseminated a draft report for review and comment and received comments from over thirty individuals, representing Task Force members, state agencies, advocacy organizations, providers, law enforcement, interagency policy councils and committees, and others. All comments and feedback received are included in Appendix I. A revised final report was then disseminated for final review, comment, and approval by 1050 Task Force members.

The 1050 Task Force Final Report contains:

- Section 1. Introduction and Background
- Section 2. Planning Together: The Recommendations
- Section 3. Q-Sort Survey Results
- Section 4. Colorado's Behavioral Health System Themes
- Section 5. Colorado's Behavioral Health System: Behavioral Health Related Funding Streams

The Vision and Guiding Principles

There is no single behavioral health system in Colorado. Instead, adult, youth, and child consumers with behavioral health disorders and their families receive services from a number of different public systems, including behavioral health, child welfare, juvenile and criminal justice, education, higher education, and others. Interagency planning and coordination is therefore essential for Colorado to be responsive to the behavioral health needs of adult, youth, and child consumers and their families.

In planning together, the 1050 Task Force members developed a shared vision for behavioral health care in Colorado and a set of principles to guide Colorado's efforts as the state acts upon the 1050 Task Force's recommendations to achieve Colorado's vision. The vision and principles are intended to guide the state infrastructure development, coordination of efforts, and maximization of funding needed to create an integrated behavioral health system for all Coloradans.

Colorado's Vision and Guiding Principles:

Adult, youth, and child consumers and their families receive quality behavioral health care that is individualized and coordinated to meet their changing needs through a comprehensive integrated system. They also have timely access through multiple points of entry to a full continuum of culturally responsive services, including prevention, early intervention, crisis response, treatment, and recovery provided by the integrated system.

State level leadership supports the integrated behavioral health system to ensure that the system is streamlined, funding is maximized, and uses cost-effective, evidence-based, and promising practices resulting in favorable outcomes for Colorado's adult, youth, and child consumers and their families, and the communities in which they live.

Public education emphasizes the importance of behavioral health as part of overall health and wellness for all Coloradans in order to build public understanding and the will to invest in and support an integrated behavioral health system in Colorado.

The Guiding Principles for an integrated behavioral health care system in Colorado are:

- Equal, Timely Access to a Full Continuum of Services
- Equal Partners: Mental Health, Substance Abuse, and Primary Care:
- Health and Wellness Promotion
- Data Driven
- Sustainable Change and Leadership
- Adult, Youth, and Child Consumer and Family Participation
- Culturally Responsive System and Services

The Recommendations

The 1050 Task Force recommendations create opportunities for significant changes in many key areas. Though they do not address all possible issues in the envisioned behavioral health system, collectively these eleven recommendations would bring Colorado closer to an integrated system.

The 1050 Task Force therefore proposes as ***Recommendation #1***, that Colorado establish a Behavioral Health Commission ("Commission") with leadership from the three branches of state government, adult and youth consumers and families, providers, and communities. The Commission's charge would be to implement the 1050 Task Force's and its own recommendations and provide oversight and support to Colorado's vision for an integrated behavioral health system.

The remaining recommendations are based on the themes that emerged through the research process and 1050 Task Force and Committee discussions. Recommendations #2 through #6 specifically describe alignment opportunities for Colorado's integrated behavioral health system.

- ***Recommendation #2, Shared Outcomes*** proposes developing and implementing a set of shared outcomes across key systems to enable joint accountability and to improve the lives of Colorado's adult, youth, and child consumers with behavioral health issues, their families, and the communities in which they live.

- ***Recommendation #3, Alignment of Service Areas*** proposes the alignment of service areas across systems so that adult, youth, and child consumers and their families have equitable, timely access to a full continuum of services provided through an integrated behavioral health system regardless of where they live in Colorado.

- ***Recommendation #4, Joint Auditing across Systems*** recommends the expanded use of joint auditing across systems, which could include fiscal and/or programmatic audits.

- ***Recommendation #5, Joint Budget Planning across Systems*** addresses the need for a multi-year joint budget and strategic planning process across departments to support long term and cross-system needs.

- ***Recommendation #6, Integrated Behavioral Health Policies, Rules and Regulations*** addresses the barriers created by state and federal funding requirements that make collaboration and integration of mental health and substance abuse services difficult at the local level. It recommends developing integrated behavioral health fiscal policies, rules, and regulations that align with integrated behavioral health service delivery.

- ***Recommendation #7, Financing Reform to Support an Integrated Behavioral Health System*** addresses financing reform to maximize and efficiently utilize funds to support an integrated behavioral health system.

- ***Recommendation #8, Electronic Cross-System Data Collection, Sharing, and Evaluation*** proposes the use of electronic cross-system data collection, sharing, and evaluation, including an electronic health record and shared screening tools, assessments, and evaluations.

- ***Recommendations #9, Cultural Competency*** and ***Recommendation #10, Adult, Youth, and Child Consumer and Family Involvement*** recommends that Colorado adopt consistent cross-system standards for cultural competency/responsiveness and for adult, youth, and child consumer and family involvement.

- ***Recommendation #11, Work Force Development*** addresses the need for workforce development strategies for an integrated behavioral health system.

Conclusion

The 1050 Task Force's final report prepares Colorado for an integrated behavioral health system by providing the foundation for coordinated efforts across systems. Task Force members recognize that the report does not include important issues that still need to be addressed. The Behavioral Health Commission may need to consider such things as the role of and support to local communities, including rural and frontier communities; the need for statewide crisis stabilization services; the adequacy of specific types of services such as police transport and statewide availability of behavioral health beds; the remaining elements of the vision and principles that have not been specifically covered by recommendations, such as the partnership between behavioral and physical health; and the need for a shared framework based on a combination of models like systems of care, medical home, principles of recovery, etc.

Section 1. Introduction and Background

In 2005, an estimated 19.7 million Americans were classified as current illicit drug users, and 126 million individuals aged twelve or older were current drinkers (HJR07-1050). Nationally, approximately 57.7 million people aged eighteen or older suffer from a diagnosable mental health disorder in a given year. In addition, mental health disorders are the leading cause of disability in the United States for individuals ages fifteen through forty-four.

In Colorado, six out of ten people receiving mental health services receive them outside of the mental health services in such systems as Corrections and Human Services/Social Services. For example, in FY 2006 43% of youth receiving mental health treatment were referred by the justice system. Further, Colorado spends just over $64 dollars per capita on publicly funded mental health care, which is 21% below the national average. Due to a lack of appropriated resources in FY 2006, 17,300 individuals with serious mental illness did not receive treatment (HJR07-1050).

Nationwide, $27 dollars per United States resident is spent on publicly funded substance abuse treatment compared to $7.50 spent per resident in Colorado. Yet, Colorado ranks 19% higher than the national average in per capita consumption of alcoholic beverages and an estimated 30,000 youth living in Colorado are substance abusers (HJR07-1050).

As a result, the Colorado Legislature passed House Joint Resolution 07-1050, creating a task force for the study of behavioral health funding and treatment in Colorado ("1050 Task Force"). The 1050 Task Force's charge was to study mental health and substance abuse services in order to coordinate state agency efforts, streamline services provided, and maximize federal and other funding sources. The 1050 Task Force focused its efforts on the public systems that provide behavioral health services and did not address behavioral health services through the private insurance system. For purposes of this report, behavioral health is defined as encompassing both mental illness and substance use disorders.

The 1050 Task Force Structure and Process

The 1050 Task Force met eight times starting in the late summer of 2007 through early winter of 2008. The work of the 1050 Task Force and its committees resulted in this final report, including key findings and recommendations to improve Colorado's behavioral health systems.

The 1050 Task Force members consisted of six legislators (three Representatives and three Senators), a representative of the Governor's Office, a representative from the Colorado Chapter of the Federation of Families for Children's Mental Health, and representatives from the following key departments of state government: Human Services; Health Care Policy and Financing; Public Health and Environment; Corrections; Public Safety; Education; and Law. Representative Anne McGihon chaired the task force and Senator Betty Boyd was its Vice-Chair. (Please see Appendix A for a copy of the enabling resolution and list of 1050 Task Force members.)

The 1050 Task Force created three committees – Program; Budget and Funding; and Streamline and Coordinate Services - to assist it in meeting its goal. The Budget and Funding, and Streamline and Coordinate Services became a joint committee given the overlap in membership and relatedness of charges. Overall, 90 individuals participated on the

committees, representing all perspectives of behavioral health including consumers and family members, providers, state agencies, and other interested parties. (Please see Appendix B for a copy of the 1050 Task Force Committee members.)

The Program Committee was charged with the identification of national and Colorado experts to inform the 1050 Task Force about behavioral health system building and improvement efforts. The Committee met five times between September and November 2007 to identify national and Colorado presenters and key questions for panel presentations at the 1050 Task Force meetings. Thirty-two experts representing state departments, provider associations, advocacy organizations, behavioral health initiatives, and others presented on a range of topics on behavioral health. Topics included behavioral health system planning efforts, leadership and vision, consumer and family involvement, infrastructure, financing reform, contracting, and other topics. (A complete list of presenters can be found in Appendix C.)

The Budget and Funding Committee's charge was to: inventory funding available at the local, state, and federal levels to pay for behavioral health services; determine the various agencies that administer such funding; consult with experts in Colorado and out-of-state regarding the financing of behavioral health services; identify those funding streams that are or are not fully utilized by our state; and prioritize those funding streams that appear to have the most positive impact on the delivery of behavioral health services. It did so by expanding and analyzing a funding matrix developed by Behavioral Health Services in the Division of Mental Health. The matrix catalogued 82 different federal and state funding streams that can be used to pay for behavioral health prevention, early intervention, treatment, and recovery services for adults and children. Of the 82, forty-five were prioritized for further study because they were ongoing rather than time-limited funding (such as grants) and sufficient in scope to benefit large numbers of people needing behavioral health services or key services needed by that population. (A further description of the funding matrix can be found below in Section Five and Appendix D.)

The Streamline and Coordinate Services Committee worked as a joint committee with the Budget and Funding Committee to fulfill its charge: to identify the primary state agencies with a role in the administration or delivery of behavioral health services that need to be coordinated; categorize the various mandates of the state agencies related to behavioral health; identify and describe the primary service delivery system(s) utilized by the state agencies to provide behavioral health services; describe the priority populations served by each agency and identify any underserved or over-represented populations; inventory the collaborative or coordination efforts that currently exist; identify any perceived overlap or gaps in the continuum of services; consult with experts in Colorado and out-of-state regarding efforts to streamline and coordinate services; and describe any known barriers to coordinating and streamlining services. A major focus of the committee was mapping the different service regions used by the various state systems. Many of the committee's charges were covered by the research process described below. Based on its work, the joint committee made several recommendations that were adopted by the 1050 Task Force described below in Section Two.

The Research Process

The 1050 Task Force's fiscal agent, the Federation of Families for Children's Mental Health ~ Colorado Chapter (The Colorado Federation), contracted with the Center for Systems Integration (CSI) to conduct national and Colorado research, provide staff support, and write the final report in partnership with NPM Consulting (NPM) and the Western Interstate Commission for Higher Education (WICHE). The research process and content is described in detail in

sections three through five. The following are the key components of the research process that led to the 1050 Task Force's final report, including its key findings and recommendations:

- *Planning and Consensus Building.* Conduct a Q-Sort survey and analysis to determine common interests in improving Colorado's behavioral health system;
- *Colorado Research.* Review and analyze Colorado reports, plans, studies, and other documents to learn about Colorado's behavioral health system;
- *National Research.* Review and analyze national trends and system building/improvement efforts in behavioral health and their applicability to Colorado;
- *Colorado Key Stakeholder Interviews.* Conduct and analyze key stakeholder interviews with the state agencies involved in Colorado's behavioral health system;
- *National Stakeholder Presentations and Interviews.* Analyze presentations and interviews with states and communities identified through the national research on behavioral health (Please See Appendix H for a list of States and Organizations Interviewed); and
- *Research Findings.* Present interim and key findings for input and development of legislative recommendations and other policy/practice changes to improve Colorado's behavioral health system.

The Final Report

The 1050 Task Force disseminated a draft final report for review and comment on December 21st, 2007. Over thirty individuals commented on the draft report, representing 1050 Task Force members, state agencies, advocacy organizations, providers, law enforcement, interagency policy councils and committees, and others. Many of the comments were incorporated into the narrative of the report. All comments and feedback received, however, are included in Appendix I. After the initial review, a revised final report was disseminated for final review, comment and approval by 1050 Task Force members on January 18, 2008.

The 1050 Task Force Final Report is divided into the following sections:

- **The Executive Summary** summarizes the work of the 1050 Task Force, including its key findings and recommendations;
- **Section 1. Introduction and Background** addresses the 1050 Task Force's process and structure leading up to the preparation of the final report;
- **Section 2. Planning Together: The Recommendations** describes the 1050 Task Force's vision and guiding principles for an integrated behavioral health system in Colorado and recommendations to achieve it;

- **Section 3. Q-Sort Results** provides a summary of the results of the survey conducted early in the research process to help identify where the broader stakeholder community in behavioral health has consensus on changes needed and where conflicts exist;

- **Section 4. Colorado's Behavioral Health System Themes** provides an overview of Colorado's current behavioral health system along with guidance from the national and Colorado research on how to improve it;

- **Section 5. Colorado's Behavioral Health System: Behavioral Health Related Funding Streams** summarizes the sources of funding to support behavioral health services in Colorado;

- **Appendices A through J** contain the Enabling Resolution, a list of 1050 Task Force members, a list of 1050 Task Force Committee members, a list of presenters to the 1050 Task Force, a funding streams matrix, descriptions of the state agencies as they relate to behavioral health, the 1050 Task Force Framework, a list of the Substance Abuse and Mental Health Services Administration's (SAMHSA) national outcome measures, a list of the interviews conducted with states and agencies outside of Colorado, a list of comments to the first draft of the report, and a bibliography.

Section 2. Planning Together: The Recommendations

There is no single behavioral health system in Colorado. Instead, adult, youth, and child consumers with behavioral health disorders and their families receive services from a number of different public systems, including behavioral health, child welfare, juvenile and criminal justice, education, higher education, and others. Interagency planning and coordination is therefore essential for Colorado to be responsive to the behavioral health needs of adult, youth, and child consumers and their families. In planning together, the 1050 Task Force members developed a shared vision for behavioral health care in Colorado. They also identified a set of principles to guide Colorado's efforts as the state acts upon the 1050 Task Force's recommendations to achieve Colorado's vision.

The Vision and Guiding Principles

The 1050 Task Force used a consensus-building process to develop a vision statement and guiding principles, essential elements to an effective system building process (Pires, 2002). The vision and principles are intended to guide the state infrastructure development, coordination of efforts, and maximization of funding needed to create an integrated behavioral health system for all Coloradans.

Colorado's Vision:

Adult, youth, and child consumers and their families receive quality behavioral health care that is individualized and coordinated to meet their changing needs through a comprehensive integrated system. They also have timely access through multiple points of entry to a full continuum of culturally responsive services, including prevention, early intervention, crisis response, treatment, and recovery provided by the integrated system.

State level leadership supports the integrated behavioral health system to ensure that the system is streamlined, funding is maximized, and uses cost-effective, evidence-based, and promising practices resulting in favorable outcomes for Colorado's adult, youth, and child consumers and their families, and the communities in which they live.

Public education emphasizes the importance of behavioral health as part of overall health and wellness for all Coloradans in order to build public understanding and the will to invest in and support an integrated behavioral health system in Colorado.

Colorado's Guiding Principles:

Guiding principles also emerged from discussions among members and participants at the 1050 Task Force and Committee meetings. These discussions were initiated by information presented by national and Colorado experts and research findings, and then scrutinized for applicability to Colorado. Most importantly, the 1050 Task Force's vision and guiding principles focus on an integrated behavioral health system that is designed and implemented to benefit consumers and families with behavioral health disorders, and that is caring and accepting of them.

The Guiding Principles for an integrated behavioral health care system in Colorado are:

- **Equal, Timely Access to a Full Continuum of Services:** All Coloradans seeking behavioral health support have equitable, timely access to a full continuum of effective services from multiple points of entry (i.e., "No Wrong Door") which includes prevention, early intervention, treatment, recovery, and crisis stabilization services at all levels of care regardless of where they live in Colorado;

- **Equal Partners: Mental Health, Substance Abuse, and Primary Care:** Mental health, substance abuse, and primary care are treated equally in terms of policy, practice, and funding in order to holistically treat individuals with behavioral health disorders;

- **Health and Wellness Promotion:** Wellness, resilience, and recovery efforts and activities are promoted by the integrated behavioral health system;

- **Data Driven:** The integrated behavioral health system:
    - Uses evidenced-based and promising practices demonstrating positive outcomes for adults, youth, children, and families and the communities in which they live, and
    - Conducts high quality, outcome-oriented data gathering, evaluation, and information sharing;

- **Sustainable Change and Leadership:** State leadership is in place to oversee and support the coordination and implementation of policies, regulations, funding, and programming of an integrated behavioral health system across Colorado;

- **Adult, Youth, and Child Consumer and Family Participation:** Adult, youth, and child consumers and their families are fully engaged and participate in meaningful ways at the system and service delivery levels of an integrated behavioral health system; and

- **Culturally Responsive System and Services:** Services provided by the integrated behavioral health system are culturally responsive in addressing the needs of consumers, children, youth, and families based on their own unique strengths, values, and culture including but not limited to race/ethnicity, language, place of origin, gender, religious affiliation, sexual orientation, and other characteristics that help to form one's cultural identity and cultural community.

The Recommendations

The eleven recommendations that follow are first steps to creating the integrated behavioral health system envisioned by the 1050 Task Force. The recommendations begin to address the issues raised in the guiding principles and create opportunities for significant changes in many key areas. Though they do not address all possible issues in the behavioral health system, collectively, these eleven recommendations would bring Colorado closer to an integrated system.

National experts that presented to the 1050 Task Force as well as the literature emphasize that state level leadership is critical to system building and reform efforts. The 1050 Task Force therefore proposes as its first recommendation that Colorado establish a Behavioral Health Commission ("Commission") with leadership from the three branches of state government, adult and youth consumers and families, providers, and communities. The Commission's charge

would be to implement the 1050 Task Force's and its own recommendations and provide oversight and support to Colorado's vision for an integrated behavioral health system.

The remaining recommendations are based on the themes that emerged through the research process and 1050 Task Force and Committee discussions. They are:

- Recommendations #2 through #6 describe alignment opportunities for Colorado's integrated behavioral health system;
- Recommendation #7 addresses financing reform to maximize and efficiently utilize funds to support an integrated behavioral health system;
- Recommendation #8 proposes the use of electronic cross-system data collection, sharing, and evaluation, including an electronic health record and shared screening tools, assessments, and evaluations;
- Recommendations #9 and #10 recommend that Colorado adopt consistent cross-system standards for cultural competency/responsiveness and for adult, youth, and child consumer and their families' involvement; and
- Recommendation #11 addresses the need for workforce development strategies for an integrated behavioral health system.

Recommendation #1: Leadership Structure

Governors, legislative leaders, and chief judges must provide leadership for an integrated behavioral health system (Join Together, 2006). Such leadership must also be structured and institutionalized if it will sustain over time as changes in leaders occur. States across the country have selected different structures to house their leadership function, from behavioral health cabinet level positions to an interagency collaborative and committees.

The 1050 Task Force recommends that Colorado establish a Commission with decision-making authority to implement the 1050 Task Force's recommendations in a timely manner to achieve Colorado's vision for an integrated behavioral health system in accordance with its guiding principles. This leadership structure in Colorado would offer transparency across systems and encourage joint prioritization, planning, implementation, and monitoring. The integration of behavioral health policy, funding, and operations through the Commission would also reduce duplication across systems and help to maximize and effectively utilize funding.

The Commission would serve as a central coordinating leadership structure for behavioral health, with defined tasks and timelines. As such, it would coordinate and collaborate with other task forces, councils, and policy bodies charged with addressing a specific topic area within behavioral health. The Commission would work to align the efforts of cross-systems behavioral health prevention, early intervention, treatment, and recovery as well as address other consumer and family needs such as housing, education, and employment.

It is recommended that the Commission's membership would include representatives at the executive level from all three branches of state government who have the authority to commit their agency:

- Legislature;

- Judiciary; and
- Executive Branch:
  - Governor's Office
  - Colorado Department of Corrections;
  - Colorado Department of Education;
  - Colorado Department of Health Care Policy and Financing;
  - Colorado Department of Human Services;
  - Colorado Department of Law;
  - Colorado Department of Public Health and Environment;
  - Colorado Department of Public Safety; and
  - Colorado Department of Local Affairs.

The Commission would also include representatives from:

- Adult and youth consumers, families, and advocacy organizations representing adult, child, and youth consumers and their families;
- Provider associations representing mental health, substance abuse, and primary health care; and
- Communities.

Each branch of government would appoint their own representatives to serve on the Commission. The representatives from advocacy organizations, providers, and communities would be appointed jointly by the Governor and the Colorado State Legislature. Additional members, not limited to the list above, may also be identified by the Commission as needed. The Commission would regularly review, monitor, evaluate, and adjust as needed the implementation of its directives and progress made.

Recommendation #2: Shared Outcomes

The 1050 Task Force identified shared outcomes at the state level as a means toward a more streamlined and coordinated system for adult, youth, and child consumers and their families, which will ultimately lead to shared funding and responsibilities across systems. To be able to measure shared outcomes across systems requires planning and implementation, management, and evaluation on the part of systems. However, according to Kathryn A. Power, M.Ed., Director of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration: "What gets measured gets done and if you don't measure results, you can't judge success from failure." Shared outcomes have been a priority in other states and nationally, with examples already being collected by the Substance Abuse and Mental Health Services Administration (included in Appendix G).

The 1050 Task Force therefore recommends that the Commission develop and implement a set of shared outcomes across key systems to enable joint accountability and to improve the lives of Colorado's adult, youth, and child consumers with behavioral health issues, their families, and the communities in which they live. (Please see Appendix G, which provides information about National Outcome Measures through the Substance Abuse Mental Health Services Administration.)

Recommendation #3: Alignment of Service Areas

Currently, each system providing behavioral health services has its own geographic regions or service delivery areas. Depending on the system, funds are allocated for service provision by

county, judicial district, school-district, statewide, or system-specific regional areas such as mental health, developmental disability, or special healthcare needs catchments areas. Examples of the multiple service area boundaries include:

- 64 counties;
- 22 judicial districts;
- 17 mental health service areas and 5 behavioral health organization service areas;
- 7 treatment regions and 6 prevention regions of Colorado's Alcohol and Drug Abuse Division;
- 6 child and family service review regions;
- 8 education regions; and
- 4 Division of Youth Corrections regions.

Regional catchment areas for some systems can limit the services consumers are able to access, while other systems with custody of adult, youth, and child consumers and their families are able to transfer them to the programs anywhere within the state that can best meet their behavioral health needs. Coordination across systems may be challenged by different service areas and the fiscal and administrative structures that accompany them.

Accordingly, the 1050 Task Force recommends that the Commission plan and implement an alignment of service areas across systems so that adult, youth, and child consumers and their families have equitable, timely access to a full continuum of services provided through an integrated behavioral health system regardless of where they live in Colorado. A comprehensive alignment of service areas can also increase local collaboration across systems and define integrated service sectors.

Recommendation #4: Joint Auditing Across Systems

Alignment of auditing requirements that address state and federal requirements from each system may help providers who report to multiple Departments and agencies within Departments to more efficiently meet their reporting requirements. Examples are already underway in Colorado between Community Corrections in the Colorado Department of Public Safety, State Judicial, the Colorado Department of Corrections, and other partners.

The 1050 Task Force recommends that the Commission expand the use of joint auditing across systems, which could include fiscal and/or programmatic audits, keeping in mind that each system does have different contractual reporting requirements to state, federal, and other funders. Any development of common reporting requirements from providers therefore would have to be inclusive of each system's existing reporting requirements.

Recommendation #5: Joint Budget Planning Across Departments

The independent processes that each Colorado Department undertakes to create separate budget requests to the Joint Budget Committee results in competition for dollars to oversee and provide behavioral health services. State agency staff from multiple departments encouraged the 1050 Task Force to reconsider this process so that budgets can be created to support cross-system needs.

The 1050 Task Force recommends that the Commission design and implement a multi-year joint budget and strategic planning process across departments to support long term and cross-system needs. Such planning could also help to identify areas where additional funding is

needed to support the full continuum of behavioral health services and reduce any redundancies.

Recommendation #6: Integrated Behavioral Health Policies, Rules, and Regulations

Reimbursement structures for substance abuse and mental health currently create barriers to integrated service delivery. With substance abuse services in a fee-for-service structure and most mental health services in a capitated model, providing integrated services can be challenging for clients with co-occurring disorders. Local providers reported that the fear of "double dipping" may keep them from meeting their clients' co-occurring needs within a single session.

The barriers created by state and federal funding requirements, including multiple codes and inconsistent reimbursement rates, make collaboration and integration of mental health and substance abuse services difficult at the local level. The 1050 Task Force recommends that the Commission address these barriers by developing integrated behavioral health fiscal policies, rules, and regulations that align with integrated behavioral health service delivery.

Recommendation #7: Financing Reform to Support an Integrated Behavioral Health System

Financing reform is needed in Colorado to support a behavioral health system that is integrated across all relevant state departments. Such reform should address maximizing federal funding and effectively utilizing current funding in order to support a full continuum of behavioral health services, from prevention through treatment and recovery. It should also address the inequity in rates between the different systems providing behavioral health services. These inequities should be addressed at the same time since they are interdependent. Reducing rates in some regions in community-based services may lead to higher rates of use of resources in child welfare, youth corrections, or adult corrections. Some reform efforts may be achieved quickly. Others may take longer to achieve.

Current opportunities to maximize federal funding that present an early win for Colorado to increase funding to support behavioral health services are:

- Adopting CMS codes for screening, brief intervention, and referral to treatment;
- Pursuing federal substance abuse funding for Native Americans through a waiver application; and
- Increasing the number of eligible children enrolled in CHP+ (Child Health Plan *Plus*) as proposed in the Governor's 2008 budget.

The 1050 Task Force further recommends that the Commission develop and implement a financing reform plan and structure that: supports the full continuum of behavioral health services statewide; minimizes the barriers and effects of funding silos; maximizes the use of cross-system funding; reduces barriers that currently hinder Medicaid and CHP+ enrollment and significantly reduces the length of time to become eligible for Medicaid or CHP+; addresses the cost resulting from consumers with behavioral health disorders not receiving any treatment or adequate treatment; and recognizes that new additional funding will be needed, as well as looking at shifting existing funding, for the planning and initial stages of implementation. As the

Commission's implementation plan yields efficiencies, the Commission will address how to shift resources to the most appropriate needs at that time.

Recommendation #8 Electronic Cross-System Data Collection, Sharing, and Evaluation

The 1050 Task Force members prioritized Colorado developing the ability to collect, share, and evaluate behavioral health information electronically across systems. The development and implementation of an electronic health record, shared across systems while still protecting privacy rights, would result in better decisions and efficiencies leading to improved outcomes for adult, youth, and child consumers, their families, and the systems. The development and implementation of an electronic health record would also support the use of shared screening tools as well as assessments and evaluations across systems.

Currently, some systems are already using the same screening tools, such as the shared tool used by local law enforcement, corrections, and community corrections. However, due to a lack of electronic records and inconsistent implementation of the tool in some systems, the screening information does not follow a consumer through the systems. This may result in repetition of the screening process, a lack of identification of needs, or other problems.

As consumers enter and exit different systems, they also often repeat the process of assessment and evaluation to triage their needs. The repetition creates multiple issues that may result in unnecessary expenditures of resources and delays in treatment as consumers move between systems if the new system does not engage services until the triage process is completed.

The 1050 Task Force recommends that the Commission and other appropriate partners, such as the Office of Innovation and Technology, investigate and develop recommendations for utilization of an electronic, cross-system data collection, sharing, and evaluation system to better serve and meet the needs of adult, youth, and child consumers with behavioral health needs and their families. The electronic system would include an electronic health record and technical standards with a common consent form for the release of information and treatment plan including any advance directives from the consumer. The benefits of such an electronic health record for consumers and providers would be numerous, and particularly advantageous in emergency situations where emergency/crisis services are often provided at locations other than where primary care is provided.

Recommendation #9: Cultural Competency

In Colorado, cultural competency definitions, requirements, and reporting are inconsistent across the behavioral health and related systems in Colorado. Some contracted providers address cultural competency on their own initiative, but it is not a universal practice. Cultural competency training for staff has been found to be sporadic at the state and community level, which may be due to a lack of state requirements. Standards are also lacking for translation and interpretation services. As a result, inequitable treatment of culturally diverse adult, youth, and child consumers and their families may exist, depending on the community and program they access.

There is inconsistent reporting of racial and ethnic outcomes and needs across systems, including the need for linguistically competent services. Some systems are collecting and reporting the data, some are collecting data but not reporting it, and other systems may not be

consistently collecting any outcome data related to race and ethnicity. Efforts like those at the Office of Health Disparities have made advances in this area, but have not focused heavily on behavioral health. If efforts to develop shared outcomes or reporting requirements are undertaken, incorporating racial and ethnic data into those efforts may address this problem. Partners in this effort could include leaders in cultural competency such as the Interagency Health Disparities Leadership Council or the Western Interstate Commission for Higher Education.

The 1050 Task Force recommends that the Commission develop and implement cultural competency standards, definitions, and requirements, including training and reporting, to provide equitable treatment of culturally diverse adult, youth, and child consumers with behavioral health issues and their families.

Recommendation #10: Adult, Youth, and Child Consumer and Family Involvement

Like cultural competency, Colorado does not have consistent definitions, standards, and requirements around adult, youth, and child consumer and family involvement. Representatives from family and consumer advocacy organizations urge that adult and youth consumers and their family members are in the unique position to be able to offer historic knowledge of program and policy, personal accounts of program successes or misfires, and cultural reflections. In addition, their support and "buy-in" for program and policy implementation increases after being engaged as a valued voice in the planning effort.

At the policy level, most systems have requirements or have voluntarily chosen to involve adult and youth consumers and their families in their planning and policymaking processes. However, the extent of adult and youth consumer and their families' involvement varies greatly at the state level, creating the potential for state policy to be established without sufficient input. The extent to which local providers choose to or are required to involve adult and youth consumers and their families in their boards also varies.

Similarly, cross-system Councils and Task Forces are inconsistent in their involvement of adult and youth consumers and their families. Currently systems with the most extensive involvement by adult and youth consumers and their families appear to be where federal requirements are in place. Few systems have recognized and engaged the youth voice as part of their consumer involvement efforts.

At the service delivery level, few requirements are made of behavioral health providers to use adult, youth, or child consumer or family driven processes, or to have adult or youth consumer or family advocates on staff, or to provide peer-based services. This results in inconsistent use of these approaches throughout the state and across systems.

Colorado needs to ensure consistent adult, youth, and child consumer and family involvement across systems at both the system and service delivery levels. Therefore, the 1050 Task Force recommends that the Commission develop and implement standards for the meaningful involvement of adult, youth, and child consumers and their families. In doing so, it should also address barriers to involvement, such as reimbursement for travel and other expenses related to participating in policymaking efforts.

Recommendation #11: Workforce Development

As Colorado develops its envisioned integrated behavioral health system, it will need to develop an appropriate workforce to address the behavioral health needs of Coloradans by providing Colorado's workforce with opportunities to develop the necessary skills and competencies through a variety of strategies. Colorado will also need to address the lack of certain specialty providers, such as child psychiatrists and providers for underserved cultural and linguistic groups.

The 1050 Task Force recommends that the Commission develop and maintain an appropriate workforce plan to ensure capacity to meet the behavioral health needs of Coloradans across the state. Strategies considered at 1050 Task Force meetings include: standards for co-occurring training curricula and cross-training on mental health and substance abuse; the use of telemedicine; the availability of consultation services for primary care physicians; addressing compensation levels; and providing tuition reimbursement for needed behavioral health specialists in underserved areas of the state.

Conclusion

The 1050 Task Force's final report prepares Colorado for an integrated behavioral health system by providing the foundation for coordinated efforts across systems. 1050 Task Force members recognize that the report does not include important issues that still need to be addressed. The Behavioral Health Commission may need to consider such things as the role of and support to local communities, including rural and frontier communities; the need for statewide crisis stabilization services; the adequacy of specific types of services such as police transport and statewide availability of behavioral health beds; the remaining elements of the vision and principles that have not been specifically covered by recommendations, such as the partnership between behavioral and physical health; and the need for a shared framework based on a combination of models like systems of care, medical home, principles of recovery, etc.

Section 3. Q-Sort Survey Results

A survey was conducted early in the research process to help identify where the broader stakeholder community in behavioral health has consensus on changes needed and where conflicts exist. The survey contained 42 statements describing the ideal state infrastructure for a successful behavioral health system. The statements were developed by 1050 Task Force members and other key stakeholders. Survey results were then used to inform discussions and decisions made by the 1050 Task Force, identify questions for the interview process, and help in assessing themes emerging from the interviews. The following is an overview of key survey findings that help to describe the priorities that different stakeholders have for an integrated behavioral health system in Colorado.

Survey of Stakeholders' Priorities for State Infrastructure

Q-methodology was used as the survey instrument, as it uncovers how people come together in "clusters" around beliefs. Each survey respondent was asked to rank the 42 statements from best describes to least describes their ideal state infrastructure for the behavioral health system. The survey was available on the Internet for approximately three weeks. Q-methodology does not require a random or large sample of participants in order for the analysis to be successful. Rather, it is important that participants represent the wide range of perspectives on the issue. For this reason, the survey was disseminated through a variety of system leaders, recruiting involvement from many sectors. Eighty-eight of the participants in the survey completed it and were included in the analysis. An additional 27 people took the survey, but were not included in the analysis because they either did not complete it or completed it with contradictory responses indicating a lack of understanding about current state infrastructure. The 27 individuals largely represented line level service providers who may not have much experience with state infrastructure.

Analysis of the data revealed four "clusters" that participants fell into related to their beliefs about how the ideal state infrastructure should look. Each cluster is described below. The participants were also asked to share any additional thoughts. Quotes from the participants in each cluster are included to better understand the clusters.

Cluster 1: Integrated Behavioral Health Authority

The "Integrated Behavioral Health Authority" cluster has the largest number of members in it of all of the clusters. The members also have more in common with each other than any other cluster. They strongly support the integration of funding and administrative structures, including one parallel behavioral health authority, coordinated budget proposals, coordinated planning, and a governor appointed leader for the system. They support, at varying levels, every statement related to the integration of behavioral health services from their current systems into the single behavioral health authority. They do not support continuing distinct funding, outcomes, screening and assessment tools, and data management systems among the various behavioral health systems. They believe the state has a role in ensuring local communities undertake coordinated case planning and provide a continuum of services.

Demographics of Cluster 1 Members: Five Task Force members are included in this cluster. The 47 members of this cluster represent many different interests and types of agencies:[1]

- 20% are from state agencies;
- 23% are consumer or family advocates, higher than any other cluster;
- 13% are from community mental health centers, lower than any other cluster;
- 6% are from public health, both community level and state agencies;
- 16% are from corrections, public safety, law enforcement, or judicial;
- 6% are legislators, which represents all of the legislators who took the survey; and
- 9% are racially or ethnically diverse.

Quotes from Cluster 1 Members:

"A collaborative and integrated systems infrastructure is needed, that includes the consumer and family voice."

"Performance incentive systems for providers -- common development of outcome measures across the state."

"Counties and other structures do not operate consistently. This hinders access to care."

"We need to bring together the child and adult mental health services systems to provide a continuum of care for transitional youth and young adults ages 14 - 25 who currently fall through the cracks."

"I believe we need a cabinet level position for behavioral health, where all parallel systems are merged and where funding streams are braided or blended."

Cluster 2: Improved Fiscal Policies and Accountability

Members of the "Improved Fiscal Policies and Accountability" cluster strongly believe that the behavioral health system should ensure that a continuum of services is available for every adult and child, and that populations currently falling through the cracks should be included in the behavioral health system. They prioritize fiscal policies as a means of accomplishing this vision, with strong agreement that the behavioral health system should manage the Medicaid and Medicare behavioral health dollars. They envision a system where agencies are not penalized for being efficient with their funds. They want blended funding, increased substance abuse funding, aligned auditing requirements, and joint budget planning.

Quotes from Cluster 2 Members:

"Combined or braided funding between medical and mental health Medicaid for children with autism and TBI (Traumatic Brain Injury)."

"My main concern is that too much energy goes into trying to restructure things and not enough energy goes into making things work. Accountability is important, but there are few really effective measures of complex services. A simplified accountability system with easy access to services/dollars across systems is what is needed."

Demographics of Cluster 2 Members: One 1050 Task Force member is included in this cluster. The 16 members of this cluster represent many different interests and types of agencies:

- 37.5% are from state agencies, higher than any other cluster;

[1] The percentages do not add up to 100% as the bullets represent answers to a number of different questions. For complete demographic breakdowns in each cluster, please see the methodological appendix.

- 12.5% are consumer or family advocates;
- 25% are from community mental health centers, higher than any other cluster;
- 13% are from public health, both community level and state agencies;
- 25% are from corrections, public safety, law enforcement, or judicial; and
- 7% are racially or ethnically diverse.

Cluster 3: Successful Service Delivery

Members of the "Successful Service Delivery" cluster believe state agencies should align or integrate data management systems, screening and assessment tools, and funding streams. To achieve this, they want state departments to coordinate budget planning and increase substance abuse funding. They envision local communities who provide culturally competent services, work in partnership with consumer and family organizations, expand services without compromising the existing service array, and provide more prevention services. Consumer and family organizations have a leadership role in their ideal system. The participants of this cluster prioritized many of the same values as presented by Barbara Huff and Trina Osher at the October 9th, 2007 1050 Task Force. The presentation highlighted the need for consumer and family experiences to drive policy and practice. It also described a variety of state models that have a great deal in common with the vision of Cluster 3 members, such as the New Jersey, Kansas, and Arizona family leadership and involvement models.

Demographics of Cluster 3 Members: No 1050 Task Force members are included in this cluster. The 16 members of this cluster represent many different interests and types of agencies:

- 7% are from state agencies, much lower than any other cluster;
- 19% are consumer or family advocates;
- 19% are from community mental health centers;
- 13% are from public health, both community level and state agencies;
- 0% are from corrections, public safety, law enforcement, or judicial, the lowest of any cluster;
- 19% are from substance abuse, higher than any other cluster; and
- 26.7% are racially or ethnically diverse, the highest of any cluster.

Quotes from Cluster 3 Members:

"There must be a menu of evidence based programs that are available to all."

"The legislature needs to establish a multidisciplinary, provider- and non-provider forum to hear issues and recommendations from the public."

"Local providers, families, and state staff often know a great deal about what works and simply need more funding to take these programs and strategies to scale."

"Funding for all services needs to increase."

Cluster 4: Coordinated Behavioral Health Systems

Members of the "Coordinated Behavioral Health Systems" cluster described a behavioral health system similar to the current system in many ways. Mental health and substance abuse are integrated and planning is driven by state-adopted guiding principles and values. But they prioritize each system continuing to have its own outcomes, funding streams, screening and assessment tools, and data management systems. They are not interested in mandating that

local communities have a continuum of services, and they do not want to see the behavioral health system managing services in the other systems. Unlike the previous three clusters, the quotes from the cluster members did not match their description of the ideal system using the statements in the survey.

Demographics of Cluster 4 Members: One 1050 Task Force member is included in this cluster. The nine members of this cluster represent a number of different interests and systems:

- 33% are from state agencies;
- 11% are consumer or family advocates, the lowest of any cluster;
- 22% are from community mental health centers;
- 11% are from public health, both community level and state agencies;
- 44% are from corrections, public safety, law enforcement, or judicial, the highest of any cluster;
- 11% are from substance abuse; and
- 18% are racially or ethnically diverse.

Quotes from Cluster 4 Members:

"The state can provide the structure, financing mechanisms, and policies that can bring about efficiencies across departments, funding streams, and systems"

"I believe that the current structures are driven by special interest, not by objective research outcomes."

"Community mental health treatment is lacking and the offenders leaving state facilities have little to follow-up on."

Comparisons Between Clusters

Table 1.1 explores the differences and similarities between the clusters. Members of each cluster have different visions of what Colorado's state infrastructure should look like, but there are some statements that are supported or not supported by multiple clusters. There are also some statements that were not a priority for any of the clusters.

Table 4.1: Strong Support For and Against Survey Statements, by Cluster. A smiley-face indicates that the mean for the statement within that cluster is greater than or equal to 1.0. A down arrow indicates that the mean for the statement within that cluster is less than or equal to -1.0. If neither a smiley-face or down arrow are present, the statement was not a strong priority for the cluster members. For example, Cluster 4 neither strongly supports nor opposes state departments working together to prepare coordinated budget proposals.

Survey Statements: **Cluster Number:**	**1**	**2**	**3**	**4**
State departments work together to prepare coordinated budget proposals to the Joint Budget Committee	☺	☺	☺	
Expansion of new services to fill gaps occurs without compromising the existing services	☺	☺	☺	
Funding for substance abuse services is in parity with funding for mental health services	☺	☺	☺	⇩
Local reporting and auditing requirements from the state are non-duplicative and aligned across systems	☺	☺	☺	

Survey Statements: **Cluster Number:**	**1**	**2**	**3**	**4**
State policies ensure a continuum of appropriate services is available to meet adult and child needs	☺	☺	☺	⇩
The behavioral health system manages the Medicaid and Medicare behavioral health dollars	☺	☺	⇩	
Integrated mental health and substance abuse funding/administrative structures reduce administrative costs	☺	☺		☺
Current funding streams expand eligibility to allow for increased prevention/early intervention services	☺		☺	⇩
Consumer/family advocacy organizations have a formal, state supported leadership role	☺		☺	⇩
State policies require local systems to work in partnership with consumer/family advocacy organizations	☺		☺	
A governor appointed position coordinates the behavioral health system	☺		⇩	⇩
Parallel behavioral health systems in different state departments are consolidated under one authority	☺			
Ongoing system planning and oversight are led by a commission representing all affected Departments	☺			⇩
Ongoing system planning is driven by evaluations of consumer/family outcomes and cost efficiency	☺			
The behavioral health system manages behavioral health services provided in the criminal justice system	☺			
The behavioral health system manages behavioral health services provided in the juvenile justice system	☺			⇩
The behavioral health system manages behavioral health services provided in the child welfare system	☺			⇩
STATE agencies that do not fully expend their funds are allocated decreased future budgets	⇩	⇩	⇩	☺
LOCAL agencies that do not fully expend their funds are allocated decreased future budgets	⇩	⇩	⇩	☺
State level funding streams remain distinct and separate, not braided or combined	⇩	⇩	⇩	☺
The state public health system manages the behavioral health system	⇩	⇩	⇩	
Each system continues use of their separate screening and assessment tools	⇩	⇩	⇩	☺
Each state agency maintains their existing, separate data management systems	⇩	⇩	⇩	☺
State policy grants autonomy to local communities over whether to address cultural competency needs	⇩	⇩	⇩	
A fee for service model replaces managed care as the primary state supporting funding model	⇩	⇩	⇩	
Each system identifies its own outcomes and the incentives for local providers to achieve them	⇩	⇩		☺
Without restructuring, state level collaboration is effective and roles are clearly defined	⇩		⇩	⇩
State policy grants autonomy to local communities over whether to undertake coordinated case planning	⇩		⇩	☺

Survey Statements: **Cluster Number:**	**1**	**2**	**3**	**4**
The state manages mental health and physical health Medicaid dollars together ("carve-in")	⇩			⇩
State policy grants autonomy to local communities over whether to use a "no wrong door" service model	⇩			
State policy grants autonomy to local communities over whether they undertake cross-system training	⇩			☺
State policy grants autonomy to local communities over whether to integrate behavioral and physical health	⇩			
State certification and other workforce policies allow rural communities flexible options for staffing services		☺		
The behavioral health system includes autism, FAS [Fetal Alcohol Syndrome], and other needs that currently "fall through the cracks		☺		
Ongoing system planning efforts are driven by state adopted guiding principles and values				☺
Without increasing overall funding, funding specifically for prevention and early intervention increases				
Local level funding accountability is tied to child and adult intervention and treatment outcomes				
Local communities develop the outcome measures they will be held accountable to by the state				
The behavioral health system manages behavioral health services provided in the education system				
State policies use incentives to increase local use of preferred models to improve outcomes				
State policies mandate local use of preferred models to improve outcomes				
Outcome measurement and quality improvement efforts are expanded to include the private pay system				

Conclusion

Each cluster has its own priorities, but areas of alignment do exist. Most survey participants agree that state departments should prepare coordinated budget proposals and ensure a continuum of services are available. Most survey participants also want to see expansion of new services occur without comprising the existing array and increasing substance abuse funding to be in parity with mental health funding. The majority of survey participants want the systems managing behavioral health services to braid their funding and to have shared data management systems, screening and assessment tools, and auditing requirements. There is also agreement that the state should ensure cultural competency is available in all communities. Survey participants do not want to see behavioral health moved under public health or a fee for service model implemented more widely. They also do not want state or local agencies to be penalized for not fully expending their funds. These areas of general agreement among most survey participants suggest key areas where change is recognized as necessary by many people.

Other statements in the survey elicited a combination of strong support from some participants, but largely neutral responses from others. For example, Cluster 1 prioritized both a governor-

appointed leader for the system and a planning and oversight commission of representatives of each Department with a role in the behavioral health system. These statements align with the priorities outlined by Governor Dukakis in his October 9th, 2007 presentation to the 1050 Task Force, where he stated that consistency with implementation starts with the Governor and with those who report directly to the Governor. Other speakers also emphasized similar leadership models, such as Fran Randolph's description of the different leadership structures among the state's with Mental Health Transformation grants (October 30th, 2007). Although other clusters did not equally prioritize this issue, most survey participants were either neutral or positive for both structural changes, with only a few participants in cluster 4 disagreeing with the statements.

Other issues have less consensus surrounding them, particularly those related to restructuring the state system. There is not agreement across the clusters on whether Medicaid and Medicare behavioral health dollars should be managed by the behavioral health system or whether a governor appointed position should coordinate the behavioral health system. These conflicts suggest that more discussion and learning is needed to understand the value of or need to significantly change state management structures.

Section 4. Colorado's Behavioral Health System: Themes

This section describes the themes that were identified, as part of the research process, from interviews with agencies within Colorado State Departments and a review of state plans. These themes were reviewed and discussed by the 1050 Task Force and led to many of its recommendations. Appendix E contains the summaries of the State Agency interviews. Incorporated within each theme's description are examples from other state system reform efforts that can provide guidance as Colorado seeks to build the integrated behavioral health system envisioned by the 1050 Task Force. It is important to note that not all of the agencies with a role in the behavioral health system were available for interview within the short timeline of the 1050 Task Force. Consequently, some themes may not reflect the issues experienced by those agencies. Future efforts may wish to complete the research process by engaging the remaining state agency partners.

Themes Identified from State Agency Interviews and Plans

- Relationships with Service Providers: Cross System Alignment
  - Contracting
  - Auditing
  - Rate Setting
  - Reimbursement for Co-Occurring Services
  - Research-based Practices in Behavioral Health
- Information Collection and Sharing
  - Shared Screening Tools
  - Assessments and Evaluations
  - Reporting Requirements
  - Outcome Measures
  - Use of Data
- Cultural Competence
  - Standards and Contracts
  - Provision of Services
  - Training
  - Data and Reporting
- Consumer, Family, and Youth Involvement
  - Involvement at the System Level
  - Involvement at the Service Level
- Service Areas and Regions
- Approaches to Behavioral Health
- Professional Certifications
  - Certification Requirements
  - Rural Challenges

Budget and Funding

- Budget Planning
- Systems Change Resources

Relationships with Service Providers: Cross System Alignment

Contracting:

Currently, providers of behavioral health services may hold contracts with multiple Departments or agencies within Departments in Colorado. Alignment of contract requirements and language may create a more efficient process and more consistent service expectations across service systems. Development of aligned contracts may require staff from each agency to work together to develop a template contract.

For example, ***New Mexico*** contracts have alignment of language, billing codes and consistent reimbursement rates across all systems. Pam Sanchez, Planning and Community Engagement Manager/Transformation Grant Project Director at the New Mexico Behavioral Health Collaborative, cited in her presentation to the 1050 Task Force that contract management is a key issue in improving relationships with providers and creating a more sustainable service network.

Auditing:

Alignment of auditing requirements or development of a master audit that addresses state and federal requirements from each system may help providers who report to multiple Departments and agencies within Departments to more efficiently meet their reporting requirements. Examples of this are already underway in Colorado with Community Corrections, State Judicial, Department of Corrections, and other partners. Cross-system auditing may work for programmatic and/or financial audits.

In ***Mississippi***, the Department of Mental Health ensures implementation of minimum standards for community programs in organization, management, and in specific service areas to assure the delivery of quality services. Service expectations and prescribed minimum standards are evaluated through an ongoing certification and joint site review process. Reviews are conducted by representatives from the Division of Community Services, the Division of Children and Youth Services, the Division of Alcohol and Drug Abuse Services, and the Division of Accreditation and Licensure.

Rate Setting:

Each system in Colorado has a different approach to setting rates, with the state and federal requirements and service delivery needs driving the approaches. Rates for behavioral health services consequently vary across the systems, which may be inevitable due to the ability of different systems to cover 100% or less than 100% of costs. Additionally, services are not always defined the same across systems, making it difficult to compare rates for like services.

Differences in rates can have many consequences, one of which is unequal competition for qualified staff between systems with higher and lower rates, resulting in different salaries. Additional examination of this issue may identify opportunities for improvements in the

transparency of current rate setting processes. As mentioned above, ***New Mexico*** has consistent reimbursement rates across all systems.

Reimbursement for Co-Occurring Services:

As noted by Carmelita Muniz in her October 9th, 2007 presentation to the 1050 Task Force, not only has the integration of substance use and mental health services been shown to be effective in research (e.g. Mental Health Treatment, 2004; Drake, Essock, Shaner, Carey, Minkoff, Kola, Lynde, et al., 2001) and prioritized by state and federal plans (e.g. Colorado Juvenile Justice State Plan; Colorado Division of Mental Health, 2004; Colorado Department of Human Services' Title IV-B Child Welfare Plan) New Freedom Commission on Mental Health, 2003), the approach also reflects the values of a family-focused and individualized service delivery system emphasized by Barbara Huff and Trina Osher, two other speakers at the 1050 Task Force on the same day.

However, reimbursement structures for substance abuse and mental health currently create barriers to integrated service delivery. With substance abuse services in a fee for service structure and most mental health services in a capitated model, providing integrated services can be challenging for clients with co-occurring disorders in Colorado. The fear of "double dipping" may keep local providers from meeting their clients co-occurring needs within a single session.

Other states are also addressing issues related to reimbursement for co-occurring services that are in different stages of development. ***Alaska*** has been developing integrated regulations as part of its Behavioral Health Integration Project. It includes a single set of behavioral health reimbursement and services rules and development of "integrated" Medicaid regulations. The recommended rule changes are currently being formalized into regulation format for upcoming public hearing and eventual review by the Department of Law.

As of July 2008, ***Florida*** will require all agencies contracting for public funds to be "co-occurring capable" within one year. Co-occurring capable is defined as having an established provider network relationship to treat co-occurring disorders if such services are not performed in-house.

Wraparound Milwaukee has demonstrated that changing reimbursement structures can open the door to improved service delivery. As Bruce Kamradt described in his December 4th, 2007 presentation to the 1050 Task Force, a vital component of the Wraparound Milwaukee model has been the changes in reimbursement structures, blending of funds, and flexibility at the local level so that the dollars follow the case and family, not the system. The model has demonstrated that addressing reimbursement issues can go far beyond just improving co-occurring services to building a more integrated and comprehensive system. ***Oregon*** is now proposing to take the Wraparound Milwaukee financing structure to the state level (Oregon's Statewide Children's Wraparound Initiative, 2007).

Research-Based Practices:

Colorado is inconsistent across the behavioral health system, particularly in mental health services as to the encouraged use of research-based practices. The standards developed by the Alcohol and Drug Abuse Division have led to the dissemination of research-based approaches to service delivery in many systems, but the Division of Mental Health's efforts around research-based practices have not similarly disseminated to mental health providers in

some systems such as Corrections and Community Corrections. Coverage of research-based practices through Medicaid also poses challenges (Colorado Juvenile Justice Plan).

Resources to identify, implement with fidelity, and evaluate the success of research-based practices are also lacking for many providers and systems. Colorado would benefit from an outcome based behavioral health intervention strategy that maximizes the current use of existing strategies showing positive outcomes to integrate across multiple systems, enhancing the expertise of each. Colorado's plan for prevention, intervention, and treatment services for children and youth through the Prevention Leadership Council calls for the adoption of uniform minimum standards as a means for promoting "best practices/best processes"' and fostering rigorous program evaluation.

Other states have encouraged the use of research-based practices through a variety of strategies. ***Nebraska*** mandates state agencies to show percentage of funding for Evidence Based Practices (EBPs). This percentage increases by 25% each year up to a total of 75% so that funding will still be available for non-EBP's. Currently, 50% of its funding is dedicated to EBPs.

South Carolina has recognized that the cost of EBPs poses a significant challenge for some communities since they are designed for a narrow segment of the population and apply to only a few types of people in need. In response, South Carolina is working with communities that implement Assertive Community Treatment (ACT), a best practice model, to collect data identifying the most important aspects of the EBP. It has asked these sites to propose an "ACT like" program that would contain not all, but just these essential elements. The state has offered grants to sites that wanted to use the "paired down" version and is gathering data on these ACT like programs.

Information Collection and Sharing

Colorado's multiple service systems are collecting, using, and sharing different behavioral health data. This has impact at the case and aggregate levels. Multiple presenters to the 1050 Task Force, both from Colorado and other states, emphasized the need for timely information sharing at the case level. They suggested that common consent and information sharing tools are needed to ensure a better balance between confidentiality and meeting the needs of adult, youth, and child consumers and their families (Carmelita Muniz, Barbara Huff, and Trina Osher's October 9th, 2007 presentations to the 1050 Task Force; Chuck Ingoglia, December 4th, 2007 presentation to the 1050 Task Force). Interviews with state agencies allowed for a more comprehensive understanding of these information collection and sharing issues, with the resulting themes building on the ideas shared by the presenters.

Shared Screening Tools:

Some systems are already using the same screening tools, such as the one used by local law enforcement, Corrections, and Community Corrections. However, due to a lack of electronic records and inconsistent implementation of the tool in some systems, the screening information does not follow a consumer through the systems. This may result in repetition of the screening process, a lack of identification of needs, or other problems.

Efforts to expand the use of common screening tools in Colorado have included the dissemination of the MAYSI-2 throughout the juvenile justice system, a process that is still

underway, and the more recent efforts of the Screening, Brief Intervention, and Referral to Treatment Grant (SBIRT). SBIRT is working with healthcare providers throughout the state to establish screening for people at risk for a substance use disorder, using a common screening tool. The project is partnering with HCPF to develop Medicaid billing codes to support physicians who implement the screening tool along with brief interventions and referrals to treatment.

States that have addressed the issue of shared screening tools include ***Missouri***, ***South Carolina***, ***Washington***, and ***Alaska.*** Alaska has a standardized co-occurring screening tool tied to statutorily mandated co-occurring standards for all mental health centers and substance abuse providers. Similarly, Washington's legislature has mandated a collaborative effort to identify, provide training for, and implement a shared screening tool for mental health and substance abuse to be used by providers throughout the state, including those in juvenile justice, aging and disabilities, corrections, children's services, and Temporary Assistance to Needy Families (TANF). The state law also includes sanctions for providers who fail to implement it within the proscribed timeline.

In ***South Carolina***, each mental health consumer has a state identification number so that the state can review consumer information, service utilization, and outcome data across all human services agencies systems. No release is needed by employees in the system to obtain records from another provider in the state mental health system.

Assessments and Evaluations:

As consumers enter and exit different systems in Colorado, they repeat the process of assessment and evaluation to triage their needs. The repetition creates multiple issues:

- It is a duplication of efforts that may result in unnecessary expenditure of resources; and
- It may delay treatment as a consumer moves between systems if the new system does not engage services until the triage process is completed.

This has been found to be an issue for Department of Corrections inmates who are transitioning over to substance abuse and mental health services in the community. Delays in treatment with this population have the potential to result in increased recidivism rates. Although repeat triaging has negative consequences, it does occur for multiple reasons:

- When a consumer transitions to a new system, the financial liability for meeting the consumer's needs also transitions, and it is not unexpected that the new system would prefer to assess what services are needed themselves;
- Some state agencies and local providers have protocols in place that require specific information to be collected as part of the triage process. This information may or may not be easily available from the previous system; and
- Protocols for information sharing between systems, and sometimes within a system, are lacking. Without information following the consumer through systems, triage based on a previous system's assessment and evaluation cannot happen.

Responses to this challenge could include changes in protocols, changes in information sharing, changes in the timing of triage, to occur earlier in the system transition process, or other solutions. Some work in child welfare specifically around the transition of children and youth from residential to community services may result in a model that could be built upon.

Reporting Requirements:

As noted above in the section on relationships with providers, providers are currently required to report different information in different forms to different Colorado Departments and agencies within Departments. This may be unnecessarily time consuming. However, each system does have different reporting requirements to the federal government, so any development of common reporting requirements from providers would have to take into account the federal requirements.

Wyoming has a new emphasis on data and quality monitoring. All contracts with the state have data reporting requirements. Each provider has its own data system with an upload to the state for annual data tracking. On-line data reporting is also available.

Outcome Measures:

Different systems in Colorado have defined the same outcomes in different ways. The measure of recidivism, for example, is not the same for Community Corrections as the Department of Corrections. Different measures have served internal purposes, such as allowing the Department of Corrections to track recidivism into their system. However, a shared definition across systems might help with cross-system planning. The Mental Health Planning and Advisory Council also notes that such outcome data can be used for performance improvement as well as strategic planning (Colorado Community Mental Health Block Grant, 2004). Shared outcomes that are tied to the information collection systems would create an opportunity for shared accountability.

David Wanser, Executive Director of the National Data Infrastructure Improvement Consortium, emphasized to the 1050 Task Force on November 15th, 2007 that common, cross-system outcomes are a key element to strategically targeted resources to make the greatest impact, as did Chuck Ingoglia at the 1050 Task Force's December 4th, 2007 meeting.

The concept of cross-system outcomes was also highlighted by interviewees in ***North Dakota*** and ***Wyoming***. Wyoming tracks high-end users, specific services, and the cost associated with both as part of their reporting process to policymakers and other planning bodies. The collection, analysis, and reporting of comprehensive data allows for outcome-based planning. ***Tennessee*** has focused on an additional cross-system outcome, consumer satisfaction. The state developed a cross-system consumer satisfaction survey that meets federal reporting requirements for many different agencies while also providing data for system planning.

Use of Data:

Currently, each system prepares their independent reports to meet federal and state requirements. No systems are required to or are undertaking cross system reporting to create a more comprehensive picture of the needs and opportunities in the behavioral health system. More comprehensive analysis may enable more effective resource allocation and cross-system planning. David Shern, presenting at the October 30th, 2007 1050 Task Force meeting, emphasized this point, describing how Florida's collection of behavioral health prevalence data

across all relevant systems allowed the state to address its behavioral health treatment needs while also meeting the individual goals of each system. ***Wraparound Milwaukee*** has also benefited from this type of cross-system data analysis, something that is possible in their system due in part to a single, internet based IT system and a strong evaluation program.

Cultural and Linguistic Competence

Cultural competency definitions, requirements, and reporting are inconsistent and lacking throughout the behavioral health and related service systems in Colorado.

Standards and Contracts:

The standards set by boards like the Community Corrections Boards and the contracts with providers throughout the system lack cultural competency requirements for racial and ethnic minorities. Programming for women and girls has been addressed in some systems, which is one type of cultural competency.

Provision of Services:

Some contracted providers and state personnel are addressing cultural competency on their own initiative, but this is not a universal practice. The result may be inequitable treatment of culturally diverse consumers, dependent on the community and program they access.

Translation and Interpretation:

Translation and interpretation standards are lacking, resulting in inconsistent approaches in local communities to provision of linguistically competent services. Additionally, it is unclear whether translators and interpreters in any system are certified or regulated at a level sufficient to ensure competency to work in a service delivery setting.

Training:

Cultural competency training for staff is sporadic at the state and community level, which maybe due to a lack of requirements from state Departments.

Data and Reporting:

There is inconsistent reporting of racial and ethnic outcomes and needs across systems, including the need for linguistically competent services. Some systems are collecting and reporting the data, some are collecting data but not reporting it, and other systems may not be consistently collecting any outcome data related to race and ethnicity. Programs like the Office of Health Disparities have made advances in this area, but have not focused heavily on behavioral health. If efforts to develop shared outcomes or reporting requirements are undertaken, incorporating racial and ethnic data may address this problem. Similarly, Colorado's Juvenile Justice and Delinquency Prevention Plan recommends that Colorado focus on the utilization of data to meet its goal of reducing the over representation of minority youth in contact with the juvenile justice system.

Other states also face challenges in the area of cultural and linguistic competency. One state that has made efforts to address cultural competency in a comprehensive and systemic way is

Arizona. Arizona has conducted a self-assessment of cultural competency activities using the National Association of State Mental Health Program Directors (NASMHPD) Tool. Results from the self-assessment were incorporated into the Division's annual Cultural Competency Plan. The Division's Cultural Competency Committee also meets monthly to implement their Plan. The Committee, in conjunction with consultants from the Centers for Substance Abuse Treatment (CSAT), developed two types of cultural competency training. The first training addressed the application of an organizational assessment tool within behavioral health agencies and the second training addressed the integration of culturally competent services into daily clinical practice.

Finally, Arizona's Data Subcommittee created a Language Capacity Reporting form, which is completed by the Tribal and Regional Behavioral Health Authorities (T/RBHAs) annually, the primary behavioral health service administrators. The form is used to collect data on bilingual capacity for the four most prevalent languages within the region, including American Sign Language. Data is reported for all levels of behavioral health professionals, physicians, technicians, and paraprofessional staff in the T/RBHA systems.

Consumer and Family Involvement

Consumer and family leadership and involvement in systems was discussed by the 1050 Task Force early in the process. Barbara Huff and Trina Osher, at the October 9th, 2007 Task Force meeting, defined family driven care as families having a primary decision-making role in the care of their own children, as well as in the policies and procedures governing care. They referenced the President's New Freedom Commission report as an example of the national push to transform mental health systems to be consumer and family driven (New Freedom Commission on Mental Health, 2003).

Consumer and Family Involvement at the System Level:

Most Colorado systems have requirements or have voluntarily chosen to involve consumers and families in their planning and policymaking processes. However, the extent of consumer and family involvement varies greatly at the state level, from officially appointed consumers and family members on decision-making boards to rulemaking that includes community meetings for input and feedback. Similarly, the extent to which local providers choose to or are required to involve consumers in their boards also varies. Few of the systems have recognized and engaged the youth voice as part of their consumer involvement efforts.

In response, the Colorado LINKS Action Plan calls for the development of standards to ensure consistent and institutionalized participation of families and youth with behavioral health issues on state and local boards. Similarly, one of the priorities of the Mental Health Planning and Advisory Council is to strengthen consumer and family member voice and participation at the systems level (Colorado's Community Mental Health Block Grant, 2004).

The different systems also vary in their level of reimbursement, if any, for consumer and family members' time, travel, child care, and other expenses related to participating in policymaking efforts. At the December 4th, 2007 1050 Task Force Meeting, LaVerne Miller of the Peer Advocacy Center in New York strongly advised the 1050 Task Force not to underestimate the importance of providing reimbursement. The systems with the most extensive involvement appear to be those where federal requirements ensure a high level of consumer and family involvement. Similarly, cross-system Councils and Task Forces are inconsistent in their

involvement of consumers and families, creating the potential for the development of rules, regulations, and draft legislation without consumer or family input.

Other states have undertaken efforts to include consumers and families at the system level, including ***Oregon, Nebraska,*** and ***Wyoming.*** Oregon's first step has included developing a team to identify criteria for community readiness for system change with regard to consumer and family involvement. In Nebraska, legislation was passed guaranteeing consumer involvement by requiring consumers make up at least 20% of the membership of any behavioral health taskforce, workgroup, or policy body. Wyoming has a cross system consumer survey of all state funded programs, resulting in an annual report that is broadly disseminated, including to legislative bodies.

Consumer and Family Involvement at the Service Level:

Much like cultural competency, few requirements are made of behavioral health providers in Colorado to use consumer or family driven processes, have consumer or family advocates on staff, or provide peer-based services. This results in inconsistent use of these approaches throughout the state and across systems.

In 2005, ***Nevada*** enacted legislation requiring facilities providing services to persons with mental illness, developmental disabilities, or related conditions to obtain the input and participation of the client, or the client's parent or guardian, in developing and modifying that client's individualized plan of services. This legislation marks a major step for Nevada to legally require consumer and family member input into their treatment plans.

Many states have created formal certifications, programs, and other supports to ensure peer-services and/or peer advocacy are widely available. For example, Family Voice of ***New Jersey***, which is in every county, assigns a family advocate and educator for every child enrolled in mental health services to work with the child's family including diagnoses, classes, support groups, attending meetings with parents, and advocating in schools. Intensive work with families occurs during the first six months to make sure families know how to get the services they need. After that, as families are ready, they are transitioned to groups, classes, and other less intensive support services, instead of one-on-one activities with their advocate. Similarly, ***Utah*** has a contract with a consumer advocacy organization, NAMI, to provide services in schools and for families, ensuring peer services are widely available.

Florida, ***Alabama***, and ***Pennsylvania*** all offer some form of certification for peer specialist and family peer specialists. Additionally, Pennsylvania has provided technical assistance to the counties in the state to prepare their work environment for peer support services. The use of peer specialists is also a priority in, where they have specifically created a credentialing process for people who are recovering from a mental illness and wish to work directly with other mental health consumers. ***North Dakota*** and ***Connecticut*** have parent partners actively involved in providing on-going support to parents negotiating services for their children, including life skills training and other programs in Connecticut.

Service Areas and Regions

Each system in Colorado has its own service regions or service delivery areas and these jurisdictional boundaries do not align across systems. Depending on the system, funds are allocated for service provision by county, judicial district, school-district, statewide, or system-specific regional areas such as mental health, developmental disability, or special healthcare needs catchments areas. Regional catchment areas for some systems can limit the services consumers are able to access, while other systems that have custody of consumers are able to transfer them to programs anywhere within the state that can best meet behavioral health needs. Coordination across systems may be challenged by the different regional boundaries and fiscal and administrative structures that accompany them. This issue has been noted by previous system reform efforts, including being specifically mentioned in the Juvenile Justice State Plan. (Please see Appendix J for maps of the various service regions and areas in Colorado).

Missouri addressed this issue by moving to a regional model of service delivery. ***New Mexico*** eliminated multiple regions and jurisdictions by agreement to use the judicial districts to build the service regions of the State. In ***Texas***, eleven regions consolidated into eight regions that include the 40 community mental health centers that oversee the behavioral health networks across the state (inclusive of substance abuse providers).

Approaches to Behavioral Health

Each Department and system in Colorado has developed behavioral health programming based on their areas of expertise, populations served, federal mandates, and historical approaches. Different models with different jargon can create barriers to coordinating across systems. It also creates inconsistencies in the types of services that consumers receive, with some services more heavily focused on strength-based, recovery, or early intervention models, while others are not using similarly research-based approaches. State staff encouraged broad visioning on behalf of all Departments and the development of a cross-system framework. An example of a cross-system framework is the integration of the Positive Behavior Supports (PBS) from the education system with the System of Care approach developed by the mental health system (Way to Go, 2006).

Multiple state plans recommend that the state build capacity, including financing of an integrated system, to address the needs of consumers and families, including those with behavioral health issues, through a full continuum of services from prevention, early intervention to treatment and recovery.

Workforce Development

Certification Requirements:

Most systems have adopted the Alcohol and Drug Abuse Division's licensure for their substance abuse providers. This has created some consistency in services across the state and across systems. Based on the state interviews conducted, there appears to be no comparable requirements for the public mental health system.

The ***Mississippi*** Department of Mental Health has a training and credentialing program for staff who work in the public mental health system and are not covered by any other credentialing

programs, including direct service providers, public mental health administrators, and case managers. The state works with the University of Mississippi Medical Center's Department of Psychiatry and Human Behavior on cooperative psychiatry training programs available at Mississippi State Hospital and in community-based service settings.

Similar to Mississippi, ***North Dakota*** has recognized the need for case managers to be certified. The state created a certification process and training curriculum that ensures a consistent framework for case management and care coordination across mental health, child welfare, and juvenile justice.

Rural Challenges:

Certification and licensure requirements from ADAD and other agencies have created challenges for the delivery of substance abuse, domestic violence, and other specialized services in rural areas. Departments report that some rural areas are unable to recruit certified or licensed personnel or unable to release their current personnel from their duties in order to receive training only available outside their communities to earn their certification of licensure.

Budget and Funding

Budget Planning:

The independent processes that each Colorado Department undertakes to create separate budget requests to the Joint Budget Committee results in competition for dollars to provide behavioral health services. State agency staff from multiple Departments encouraged reconsideration of this process to create budgets that support cross-system needs. Further, Colorado could benefit by reforming budget, funding, and financing practices in order to develop long-term, consistent, and flexible funding streams. A previous cross-system planning effort focused on children and youth also identified this issue (Colorado LINKS Action Plan, 2006).

Many of the speakers who presented to the 1050 Task Force emphasized the importance of coordinated, blended, or even braided funding processes. For example, Jim Haveman described the importance of integrating funding in Michigan, a vital step in the process of developing an integrated health and mental health system (October 30th, 2007).

Systems Change Resources:

State agency personnel recommend that funding be provided for the time-intensive planning and implementation of systems change efforts. State agencies with tight budgets are unable to dedicate staff time to research, implement, and evaluate changes to the system. Multiple state plans have recommended this to their governing bodies as well. Past systems change efforts have depended on federal and foundation grants to provide planning support.

Section 5. Colorado's Behavioral Health System: Behavioral Health Related Funding Streams

In 2006, Colorado ranked 33rd in the country in terms of mental health spending per capita spending. According to The National Alliance on Mental Illness, "this lack of financial support for community-based mental health services continues to have devastating impacts on other systems that pick up the slack for underfunded services, including the criminal justice system." (Grading the States, 2006). Colorado also faces challenges in funding substance abuse prevention and treatment, which impacts other state departments as well (Shoveling Up, 2001). In her November 30, 2007 presentation to the 1050 Task Force and the State Methamphetamine Task Force, Susan Foster from The National Center on Addiction and Substance Abuse at Columbia University noted that Colorado is spending $845.9 million on substance abuse costs. Of that amount, only a fraction is spent on prevention and treatment with the remaining $845.4 million representing costs to other state systems.

Financing reform is therefore needed to support an integrated behavioral health system in Colorado to reduce the social and economic consequences of untreated substance use and mental health disorders. As a beginning step, one of the Budget and Funding Committee's charges was to inventory funding available at the local, state, and federal levels to pay for behavioral health services and prioritize those funding streams that appear to make the most positive impact on the delivery of behavioral health services. It did so by using and expanding a funding matrix of federal and state funding streams that can be used to pay for behavioral health prevention, early intervention, treatment, and recovery services for adults and children developed by Behavioral Health Services – Division of Mental Health.

Overall, 82 funding streams were inventoried. Of the 82, forty-five were prioritized for further study because they were ongoing rather than time-limited funding such as grants, and they were sufficient in scope to benefit large numbers of people needing behavioral health services and/or supported key services. Of these prioritized funding streams, approximately twenty can support prevention services, twenty can support early intervention services, and thirty can support treatment services. As one the Commission's charges, further study and analysis, however, is required to determine whether these funding streams are being fully maximized and utilized effectively, and whether there are other opportunities to maximize funding to support an integrated behavioral health system.

Prioritized Funding Streams

Alcohol & Drug Driver Fund
Asset Forfeiture Funds
Department of Public Safety – Division of Criminal Justice Funding
Child Mental Health Treatment Act House Bill 1116, and subsequently SB 230
Children's Basic Health Program (CHP+)
Community Based Grants for the Prevention of Child Abuse and Neglect (CBCAP)
Community Mental Health Block Grant
Comprehensive Family Treatment Services
Core Services
Detoxification Services
Division of Vocational Rehabilitation Funding
Division of Mental Health Community Program Child - Alternative to Inpatient

Hospitalization
Division of Mental Health Early Childhood Specialist
Division of Mental Health Indigent Line
Department of Corrections Funding
Drug Courts
Drug Offender Surcharge Fund
Early Periodic Screening Diagnosis & Treatment (EPSDT)
Family Violence Prevention and Services
Federally Qualified Health Center
Gambling- Casino Tax
Head Start/ Early Head Start
IDEA Part B - Preschool
IDEA Part B - State Grants
Indian Health Care Improvement Act
Juvenile Justice Formula Grants
Law Enforcement Assistance Fund
Medicaid
Mental Health Districts
Native American - Substance Abuse funding
Persistent Drunk Driver Fund
Promoting Safe & Stable Families
Safe & Drug Free Schools and Communities
Senate Bill 94
Screening, Brief Intervention, Referral to Treatment (SBIRT)
Social Services Block Grant
State Judicial - Division Of Probation Offender Services Fund
Substance Abuse Prevention and Treatment Block Grant
Temporary Assistance for Needy Families (TANF)
Temporary Assistance for Needy Families (TANF) Transfer
Title IV-B
Title IV-E
Title V Incentive Grants for Local Delinquency Prevention
Title XX IV-B
Tobacco

Appendix D contains a chart with more detail on each of these funding streams, including:

- The purpose;
- The population served and eligibility requirements;
- The allowable services;
- The state agency administering the funding; and
- The local agency receiving the funding

Appendix A: Enabling Resolution and Members of the Task Force

HJR 07 – 1050 Behavioral Health Task Force Enabling Resolution

HOUSE JOINT RESOLUTION 07-1050

BY REPRESENTATIVE(S) McGihon, and Labuda; also SENATOR(S) Hagedorn, Boyd, Groff, and Williams.

CONCERNING THE CREATION OF A JOINT TASK FORCE FOR THE STUDY OF BEHAVIORAL HEALTH ISSUES.

WHEREAS, Mental disorders are common in the United States, with approximately 57.7 million people age 18 or older suffering from a diagnosable mental disorder in a given year; and

WHEREAS, Mental disorders are the leading cause of disability in the United States for ages 15 through 44; and

WHEREAS, Colorado ranks 19% higher than the national average in per capita consumption of alcoholic beverages; and

WHEREAS, In 2005, an estimated 19.7 million Americans were classified as current illicit drug users and 126 million aged 12 or older were current drinkers; and

WHEREAS, In Colorado, there are 17,300 people with a serious mental illness who are left untreated due to a lack of appropriated resources; and

WHEREAS, Children and adolescents in Colorado experience over one-third of the severe mental health disorders in the state, yet only approximately half of the children from low-income families receive care for such disorders; and

WHEREAS, There are an estimated 30,000 adolescent substance abusers in Colorado; and

WHEREAS, Colorado spends just over $64 per capita on publicly funded mental health care, which is 21% below the national average; and

WHEREAS, Nationwide, $27 per United States resident is spent on publicly funded substance abuse treatment compared to $7.50 spent per resident in Colorado; and

WHEREAS, Six out of ten people receiving mental health services in Colorado are receiving services outside of the mental health system, and instead must seek care in other systems such as Corrections and Social Services; and

WHEREAS, In fiscal year 2006, 43% of the youth in mental health treatment had been referred by the criminal justice system; and

WHEREAS, Several state agencies are involved in the treatment of persons with mental health and substance abuse disorders; and

WHEREAS, Many other states have organized departments and state agencies to coordinate and create single behavioral health service systems for mental health and substance abuse treatment resulting in the maximization of public funding streams for services and treatment and a better coordination of efforts to treat those in need; and

WHEREAS, In order to best serve Coloradans, these state agencies need to coordinate their efforts to serve all persons in need and to maximize public funding for mental health and substance services; now, therefore,

Be It Resolved by the House of Representatives of the Sixty-sixth General Assembly of the State of Colorado, the Senate concurring herein:

(1) That there is hereby created a task force for the study of behavioral health funding and treatment, whose duty shall be to study mental health and substance abuse services in order to coordinate the efforts of state agencies and streamline the services provided and to maximize federal and other funding sources;

(2) The task force shall consist of fourteen members as follows:

(a) Three members of the House of Representatives, of whom two shall be appointed by the Speaker of the House of Representatives and one shall be appointed by the minority leader of the House of Representatives;

(b) Three members of the Senate, of whom two shall be appointed by the President of the Senate and one shall be appointed by the minority leader of the Senate;

(c) One representative of the governor's office, who shall be appointed by the Governor;

(d) The executive director of the department of human services or his or her designee;

(e) The executive director of the department of health care policy and financing or his or her designee;

(f) The executive director of the department of public health and environment or his or her designee;

(g) The executive director of the department of corrections or his or her designee;

(h) The executive director of the department of public safety or his or her designee;

(i) The executive director of the department of education or his or her designee; and

(j) The executive director of the department of law or his or her designee;

(3) That the Speaker of the House of Representatives shall designate a chairperson of the task force from among the members appointed from the House of Representatives, and the President of the Senate shall designate a vice-chairperson of the task force from among the members appointed from the Senate;

(4) That the task force shall consult with interested parties to assist the task force in its work, which parties may include community mental health centers, mental health institute administrators, the Colorado mental health planning and advisory council, mental health and substance abuse service users, county commissioners, parole and probation officers, school district representatives, substance abuse treatment providers, law enforcement representatives, hospital representatives, developmental disability representatives, representatives of the judicial system, residential treatment providers, and other persons whose assistance the task force may find helpful;

(5) That the task force shall receive information and testimony and shall present a report to the Health and Human Services Committees of the Senate and the House of Representatives on or before January 31, 2008, regarding any findings and legislative recommendations.

(6) That the Speaker of the House of Representatives and the President of the Senate shall designate a nonprofit or private organization as the custodian of funds for the task force for the study of behavioral health issues. The organization is authorized to receive and expend any funds necessary for the operation of the task force. The organization shall prepare a budget for the operation of the task force. Prior to the expenditure of any moneys received, the organization shall transmit a copy of the operating budget to the Speaker of the House of Representatives and the President of the Senate and shall certify that there is adequate funding available to cover the expenses identified in the operating budget.

(7) That any staff needed to assist the task force in conducting its duties shall be provided by nonprofit agencies or private groups.

(8) That the members of the task force shall not be compensated for services or reimbursed for expenses associated with their service on the task force.

(9) That the task force may contract with an outside consultant to prepare a report for presentation to the General Assembly.

(10) That all costs incurred while conducting the study on behavioral health issues, including, but not limited to, the direct or indirect costs associated with the duties of the task force, the costs of research and analysis, compensation for any nonprofit agency or private group that assists the task force by supplying staff support, and costs for contracting with an outside consultant to prepare a report for the General Assembly shall be paid by contributions, grants, services, and in-kind donations from private sources.

Andrew Romanoff
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Joan Fitz-Gerald
PRESIDENT OF THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Karen Goldman
SECRETARY OF THE SENATE

Members of the 1050 Behavioral Health Task Force

- Representative Anne McGihon, Chair, Colorado State House of Representatives
- Senator Betty Boyd, Vice-Chair, Colorado State Senate
- Senator Bob Hagedorn, Colorado State Senate
- Senator Tom Wiens, Colorado State Senate
- Representative Jeanne Labuda, Colorado State House of Representatives
- Representative Debbie Stafford, Colorado State House of Representatives
- Tom Dillingham, Executive Director, Federation of Families for Children's Mental Health ~ Colorado Chapter
- Joan Henneberry / Ginny Brown, Colorado Department of Health Care Policy and Financing
- Leslie Herod, Office of the Governor
- Cynthia Honssinger Coffman, Chief Deputy Attorney General, Office of the Attorney General
- Joanie Shoemaker, Colorado Department of Corrections
- Jeanne Smith, Colorado Department of Public Safety
- Ed Steinberg, Colorado Department of Education
- Karen Trierweiler, Colorado Department of Public Health and Environment
- Janet Wood, Director, Behavioral Health Services, ADAD, Colorado Department of Human Services

Appendix B: 1050 Task Force Subcommittee Members

Joint Budget and Funding and Streamline / Coordinate Services Committee Members

Representative Anne McGihon, Co-Chair. Colorado House of Representatives
Senator Betty Boyd, Co-Chair. Colorado State Senate
Janet Wood, Co-Chair. Behavioral Health Services, Colorado Department of Human Services
Dyan Alexander, AstraZeneca
Lacey Berumen, National Alliance on Mental Illness ~ Colorado
Ginny Brown, Colorado Department of Health Care Policy and Financing
George DelGrosso, Colorado Behavioral Healthcare Council
Doyle Forrestal, Colorado Behavioral Healthcare Council
Chris Habgood, Mental Health America of Colorado
Leslie Herod, Office of the Governor
Tracy Kraft-Tharpe, Federation of Families for Children's Mental Health ~ Colorado Chapter
Deb Kupfer, Western Interstate Commission for Higher Education
Michael La Rue, Signal Behavioral Health Network
Patti Marqui-Hilker, National Alliance on Mental Illness ~ Colorado
Denise McHugh, Center for Systems Integration
Ellen McMillan, Colorado Access
Carmelita Muniz, Colorado Association of Alcohol and Drug Services Providers
David Murphy, Arapahoe House
Phoebe Norton, National Alliance on Mental Illness ~ Colorado
Sharon Raggio, Pikes Peak Behavioral Health Group
LeNore Ralston, Colorado Access
Chief Joseph Russell, Silverthorne Police Department
Kyle Sargent, Western Interstate Commission for Higher Education
Joanie Shoemaker, Colorado Department of Corrections
Representative Debbie Stafford, Colorado House of Representatives
Ed Steinberg, Colorado Department of Education
Ann Terry, Colorado Department of Public Safety
Jeff Thormodsgaard, Mendez Steadman
Karen Trierweiler, Colorado Department of Public Health and Environment
Deborah Trout, Colorado Department of Human Services

Program Committee Members

Tom Dillingham, Chair. Federation of Families for Children's Mental Health ~ Colorado Chapter
Dyan Alexander, AstraZeneca
Doyle Forrestal, Colorado Behavioral Healthcare Council
Chris Habgood, Mental Health America of Colorado
Tracy Kraft-Tharpe, Federation of Families for Children's Mental Health ~ Colorado Chapter
Denise McHugh, Center for Systems Integration
Carmelita Muniz, Colorado Association of Alcohol and Drug Services Providers
Elizabeth Pace, Peer Assistance Services
Sharon Raggio, Pikes Peak Behavioral Health Group
LeNore Ralston, Colorado Access

Appendix C: Presenters to the 1050 Task Force

Presentation to the August 28th, 2007 1050 Task Force Meeting

1. Jose Esquibel, Prevention Leadership Council and the Colorado Department of Public Health and Environment. Title: Colorado Prevention Leadership Council Presentation

Presentations to the September 13th, 2007 1050 Task Force Meeting

1. Sharon Raggio, Pikes Peak Behavioral Health Group. Subject: *The Colorado Perspective*
2. Anne-Marie Braga, Colorado Department of Public Health and Environment. Subject: *Colorado LINKS ~ Linking Interagency Networks for Kids Services*
3. Bruce Guernsey, Colorado Department of Public Health and Environment. Subject: *School Based Health*
4. Barb Beiber, Michael Ramirez, and Kiki McGroff, Colorado Department of Education. Subject: *CDE's Positive Behavior Support*
5. Claudia Zundel, Division of Mental Health. Subject: *Early Childhood Mental Health*
6. Karen Trierweiler and Ginny Brown, Subject: Medical Home

Presentations to the October 9th, 2007 1050 Task Force Meeting

1. Barbara Huff and Trina W. Osher, Huff Osher Consulting, Inc. Title: *Family-Driven Care: Setting the Standard for Practice in Colorado*
2. Governor Michael Dukakis, former Governor of Massachusetts
3. Carmelita Muniz, Colorado Association of Alcohol and Drug Service Providers
4. George Delgrosso, Colorado Behavioral Healthcare Council

Presentations to the October 30th, 2007 1050 Task Force Meeting

1. David Shern, Ph.D., President / CEO of Mental Health America. Title: *State and National Trends in Public Behavioral Health*
2. Deb Kupfer, MHS, WICHE, National Association of State Mental Health Program Directors Research Institute. Title: *State Profiles System*
3. Frances Randolph, Ph.D., Center for Mental Health Services, Substance Abuse Mental Health Services Administration. Title: *Transforming the Mental Health System*
4. James Haveman, President, Haveman Group. Title: *Behavioral Health: The Beginning of a Navigable System Leading to Integrated Health Care*
5. John Hudgens, Innovation Center Director, Oklahoma. Title: *Transformation: the Vision for a Healthy Oklahoma*

Presentations to the November 15th, 2007 1050 Task Force Meeting

1. Brie Reimann, BA, Screening, Brief Intervention, Referral to Treatment (SBIRT) Colorado Program Manager, Peer Assistance Services; Jim Adams-Berger, PhD,

President, OMNI Institute; Marjie Harbrecht, MD, Medical/Executive Director, Colorado Clinical Guidelines Collaborative; Kerry Broderick, MD, Fellow of the American College of Emergency Physicians, Emergency Department Attending Physician, Denver Health Medical Center. Title: *Screening, Brief Intervention, Referral and Treatment (SBIRT)*

2. Robert Glover, Ph.D., Executive Director, National Association of State Mental Health Program Directors. Title: *National Perspectives: Maximizing Resources Through State Partnerships*
3. William Hogan, Deputy Commissioner, Alaska Department of Health & Social Services. Title: *Alaska's Behavioral Health System*
4. David Wanser, Ph.D., Visiting Fellow, Lyndon B. Johnson School of Public Affairs, Texas. Title: *Improving the Health of Colorado's Citizens*

Presentation to the November 30th, 2007 Joint Meeting of the 1050 Behavioral Health and Methamphetamine Task Forces

1. Susan E. Foster, Vice-President of the Center for Addiction and Substance Abuse at Columbia University. Title: *Assessing the Impact of Substance Abuse on State Systems and Recommendations to Improve Policy and Practice*

Presentations to the December 4th, 2007 1050 Task Force Meeting

1. Heather Cameron, Project Director, Mental Health America Colorado Chapter; Chief William Kilpatrick, Golden Police Department; John Bridges, MD, Medical Director, Porter Hospital. Title: *Metro Denver Crisis Triage Project*
2. Bruce Kamradt, Director, Wraparound Milwaukee. Title: *Wraparound Milwaukee: A Model for Serving Children with Serious Emotional or Mental Health Needs and Their Families*
3. Chuck Ingoglia – Vice President of Public Policy, National Council for Community Behavioral Healthcare
4. Leslie Schwalbe – Behavioral Health Consultant, Arizona. Title: *Financing and Contracting Strategies: Developing a Mental Health and Substance Abuse Services System That Works*
5. LaVerne D. Miller, Esq – Director Peer Advocacy Center New York, national consultant for the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration. Title: *The New Frontier: Effective Strategies for Promoting and Sustaining The Meaningful Involvement of Consumers, Families, and Youth in State Mental Health Transformation Activities*
6. Pamela Sanchez – Planning and Community Engagement Manager and Project Director, New Mexico Behavioral Health Collaborative. Title: *New Mexico Behavioral Health Collaborative: Progress of Transformation*

Presentation to the December 13th, 2007 1050 Task Force Meeting

1. Janet Wood, Director of the Behavioral Health Services Division, Colorado Department of Human Services. Title: *Colorado Service Area Mapping*

Appendix D: Funding Streams Matrix

The Funding Streams Matrix begins on the next page.

	Funding Matrix	Purpose	Population	Examples of Services	Local Agency Receiving Funds	State Funds	Federal Funds	Local	CRS / CFDA
1	**Alcohol and Drug Driver Safety (ADDS) Fund**	Fines assessed to drunk drivers	legal driving age requirements	Level I programs are short term, didactic education programs. Level II programs are therapeutically oriented education, long term outpatient, and comprehensive residential treatment programs.	State Judicial collects fees and utilizes them for alcohol evaluators, operation of the ADDS program, and provides funding to ADAD for FTE who license DUI treatment programs.	X			C.R.S. 43-4-1307(10)
2	**Asset Forfeiture Dollars**	Provides funding for local treatment and detox	Not specified	Room and board, group counseling, urinalysis with treatment	Managed Services Organizations and their Contracted Treatment Providers			X - Funds collected as assets from drug dealers upon arrest or conviction	C.R.S. 16-13-311 (3) (a) (VII) (B)
3	**Child Mental Health Treatment Act House Bill 1116** (DMH - CDHS)	Access to residential treatment for children without requiring a dependency and neglect action	Children w/ SED requiring RTC level care	RTC and community-based services to prevent and transition children from RTC placement.	Mental Health Centers evaluate; RTC get treatment dollars	For Match	X	parental fees	Title 27 Article 10.3; 2 CCR 502-3
4	**Children's Basic Health Program (CHP+)** (HCPF)	Health Insurance for low income children. Population: Children	Children to age 19 under and pregnant women not eligible for Medicaid and under 200% of FPL	Inpatient and outpatient health care	Health Care Providers enrolled in CHP+	For Match	X		
5	**Community Based Grants for the Prevention of Child Abuse and Neglect** (CDPHE)	Develop statewide network of family support programs to decrease child abuse and neglect	Children and families	Community-baed prevention services; services to strengthen and support children and families (e.g., fatherhood education, child care, job training, parenting education, home visitation)	Local grantees or family centers	For Match	X		CFDA # 93.590
6	**Community Mental Health Block Grant** (BHS - CDHS)	Assist states in providing services for SED children	Adults w/ SMI and children w/ SED who are not on Medicaid	Outpatient services	Community Mental Health Centers	For Maintenance of effort	X		

	Funding Matrix	Purpose	Population	Examples of Services	Local Agency Receiving Funds	State Funds	Federal Funds	Local	CRS / CFDA
7	**Comprehensive Family Treatment Services (formerly AFS)**l	Provides funding for substance use disorder treatment of clients with open child welfare cases	Not specified	Room and board, group counseling, urinalysis with treatment	Managed Services Organizations thru ADAD; services purchased from local substance abuse treatment providers	X	X SAPT Block Grant		N/A
8	**Core Services** (Div. of CW/ CDHS)	To provide services to children at risk of out of home placement, including funding for substance use disorder treatment of clients with open child welfare cases	Children 0-18 yrs of age who could be maintained at home or in a less restrictive out of home placement w/ core services	Home based intervention; intensive family therapy; life skills; day treatment; substance abuse treatment; aftercare services; group counseling, urinalysis with treatment	County Departments of Social Services (Counties who contract with Managed Services Organizations; services purchased from local substance abuse treatment providers)	X	X		CRS 19-1-116
9	**Department of Corrections** l	Provides funding for treatment of clients referred by the Department of Corrections	Clients referred by DOC	Treatment while in placement and in the community	Local approved treatment providers (ATP)	X			N/A
10	**Department of Public Safety, Division of Criminal Justice**	Provides funding for treatment of offenders referred by the Department of Public Safety (Community Corrections clients)	Community corrections serves adult offenders who have been convicted of felony offenses. There are two major groups of community corrections offenders: diversion and transition. Diversion offenders are sentenced directly by the courts or in rare instances have been sentenced as a condition of a probation placement for up to 30 days.	Provide services for offenders convicted of less severe offenses who are diverted from prison, offenders in transition between prison and parole, parolees released by the CO board of parole	Local treatment providers	X			
11	**Detox services funding**	Funding for local detoxification services	Not specified	Counseling, testing, treatment, and early intervention services for substance abusers at risk for the human immunodeficiency virus (HIV disease)	Local agencies providing detox services (ADAD thru MSO) and local municipalities	X	X	X	93.959

	Funding Matrix	Purpose	Population	Examples of Services	Local Agency Receiving Funds	State Funds	Federal Funds	Local	CRS / CFDA
12	**Div. of Voc.Rehab.**	Supported Employment (Fund 7) provides specialized vocational services that will result in competitive employment for those DVR clients who have severe mental health issues that result in significant barriers to getting or keeping a job.	A person must have a physical or mental impairment that constitutes an impediment to employment. There must be a reasonable expectation that upon completion of services the person will be able to engage in work and benefit from work. The person must have financial need.	Comprehensive assessment, education, transportation, job finding, job coaching.	15 local mental health centers	23% state match	77% federal match (federal funds currently capped for our state)		
13	**Division of Mental Health Community Programs Child Alt to Inpatient Hosp.**	Mental Health Services for Adolescents	Adolescents	Funding for community programs	Mental Health Centers	X			
14	**Division of Mental Health Community Programs Early Childhood Specialist**	Mental Health Services and Technical Assistance for Children 0-5	Young children	services and technical assistance	Mental Health Centers	X			
15	**Division of Mental Health Community Programs Indigent Budget Line Item**	Mental Health services for non-Medicaid children 0-11	Non-Medicaid population	treatment services	Mental Health Centers and Clinics	X			

	Funding Matrix	Purpose	Population	Examples of Services	Local Agency Receiving Funds	State Funds	Federal Funds	Local	CRS / CFDA
16	**Drug Courts**	Provides funding for treatment of people involved in specialty courts such as drug court, family court, etc.	Not specified	Not specified	Local treatment providers	X	X	X	
17	**Drug Offender Surcharge (DOS) Fund**	Provides funding for research, training, assessment, and treatment of adult offenders in the criminal justice system	adult offenders	research training assessment and treatment services	Managed Services Organizations and Contracted Treatment Providers thru ADAD, State Judicial, Dept of Corrections, Division of Criminal Justice	Funds collected as a part of the fees leveed upon offenders with felony drug charges			C.R.S. 18-19-(103)(4),16-11.5-(101)
18	**EPSDT** (HCPF)	Comprehensive screening and treatment for Medicaid eligible children. This program is just another name for Children's Benefits on Medicaid. For that reason there is no funding formula or funding available, it is a direct entitlement to the eligible child.	Eligible for Medicaid Children up to 6 whose income does not exceed 133% of Federal Poverty Level (FPL) and resources do not exceed maximum. Children born after September 30, 1983, and under the age of 19, whose income does not exceed 100% of FPL and resources under maximum. Children under the age of 18 or who graduate before their 19th birthday, whose income does not exceed the 1931 income standard and resources under maximum.	The EPSDT benefit, in accordance with section 1905® of the Act, must include the following services: Screening Services: Comprehensive health and developmental history Comprehensive unclothed physical exam Appropriate immunizations Laboratory tests Health Education Vision Services Dental Services Hearing Services Other Necessary Health Care	Medicaid Providers.	For Match	X		
19	**Family Violence Prevention and Services** (CO Works/CDHS)	Activities to prevent or intervene in domestic violence	Three different areas under this act- a) discretionary grants, b) grants to States for providing assistance to victims and c) to the state domestic violence coalition for direct and coordinated activities.	Emergency shelters, counseling to victims and children, advocacy, and community education.	Domestic Violence Agencies		X	For Match	

	Funding Matrix	Purpose	Population	Examples of Services	Local Agency Receiving Funds	State Funds	Federal Funds	Local	CRS / CFDA
20	**Federally Qualified Health Centers (FQHC)**	Medicare funding used to enhance the provision of primary care services in underserved urban and rural communities. All therapeutic services furnished by clinical social workers and clinical psychologists are subject to the outpatient MH treatment limitation (50% copay of the all-inclusive encounter rate). Can purchase prescription and non-prescription medications at reduced pricing (340B Drug Pricing Program).	Low income	Primary care, therapeutic services, medications	Safety net providers such as community health centers, public housing centers. Outpatient health program funded by the Indian Health Service, and programs serving migrants and the homeless. FQHC can provide or contract for substance abuse and mental health services.				Sec 1861 (AA) of the SS Act was amended by Sec. 4161 of the Omnibus Budget Reconciliation Act of 1990.

Funding Matrix		Purpose	Population	Examples of Services	Local Agency Receiving Funds	State Funds	Federal Funds	Local	CRS / CFDA
21	**Gambling-Casino Tax** (Dept. of Local Affairs)	Reduce the impact of gaming	As mentioned on the Colorado Labor Administration's website, the local Government Limited Gaming Impact was created in statute in 1997 to provide financial assistance to local governments in addressing documented gaming impacts stemming from limited stakes gaming in the communities of Cripple Creek, Black Hawk and Central City.	The geographic eligibility area for the program includes the counties of Gilpin and Teller, as well as the eight counties contiguous to these two counties: Boulder, Clear Creek, Douglas, El Paso, Fremont, Grand, Jefferson, and Park. In addition, counties that contain tribal lands where limited gaming occurs are included within the geographic eligibility area. Tribal gaming counties include: Archuleta, La Plata, and Montezuma. The types of local governments eligible to receive assistance include: counties, municipalities (with the exception of the three gaming cities: Black Hawk, Central City, and Cripple Creek) and special districts that provide emergency services. In addition, eligible local governments may apply on behalf of private nonprofit agencies that are impacted by gaming.	Local government in affected areas			X	
22	**Head Start/ Early Head Start**	Comprehensive child development services to low income children and their families	Prenatal to age five 100% Federal Poverty Guideline, age (10% of enrolled slots can be above the FPG). 10% of enrollment must be allocated for children with disabilities.	Education, Health Care (general, oral, mental), Parent Involvement, family support services , Center & Home-Based services (Early Head Start-Prenatal services)	Local grantees		X	For Match	

	Funding Matrix	Purpose	Population	Examples of Services	Local Agency Receiving Funds	State Funds	Federal Funds	Local	CRS / CFDA
23	**IDEA Part B - 611** (CDE)	Funding to administrative units to provide a free appropriate public education to children with disabilities.	Children and youth ages 3 to 21 with disabilities	Special education and related services for children	Administrative Units-school districts and BOCES		X		
24	**IDEA PartC Preschool** (CDHS)	To enhance child development or avoid long-term impacts of developmental delay	Provide early intervention services to eligible infants, toddlers and families.Children with significant delays (significantly outside range of normal) or children with a diagnosed physical or mental condition known to have a high probability of resulting in a significant developmental delay.	27-10.5-102 (12) "Early intervention services and supports" means education, training, and assistance in child development, parent education, therapies, and other activities for infants and toddlers and their families, which are designed to meet the developmental needs of infants and toddlers including, but not limited to, cognition, speech, communication, physical, motor, vision, hearing, social-emotional, and self-help skills.	Community Centered Boards		X		
25	**Indian Health Care Improvement Act**	To provide health related services to Urban Indians	Urban Indians residing in the urban centers in which the organization is located.	1) Alcohol and Substance Abuse Prevention, Intervention, After-Care and Education for Youth and Families; (2) Therapeutic Counseling; (3) Comprehensive Chemical Dependency Project; (4) Mental Health Needs Assessment; (5) Mental Health Services; (6) Immunization Services; and (7) Diabetes Prevention/Education and Obesity Control.	Indian Organizations		X		

	Funding Matrix	Purpose	Population	Examples of Services	Local Agency Receiving Funds	State Funds	Federal Funds	Local	CRS / CFDA
26	**Juvenile Justice Formula Grants** (Office of JJ, DPS)	To assist communities to respond to juvenile delinquency/violence through prevention and treatment	Youth ages (10-18 who are at risk of entering the juvenile justice system, or are involved in the justice system, and professionals and laypersons who work with those juveniles.	Federal law allows for programs such as community-based services for the prevention and control of juvenile delinquency, group homes and halfway houses, screening and intake services to permit increased diversion from juvenile court processes, law enforcement training, expanded use of probation and training for related personnel, and those activities which would remove status offenders from secure detention, separate juveniles from adults in institutions where they have contact with incarcerated adults, or remove juveniles from adult jails or lockups. In Colorado examples are: crisis intervention, minority family advocates, gender specific programs.	Grantees		X		CFDA 16.54
27	**Law Enforcement Assistance Funds (LEAF)**	Fines assessed to drunk drivers	Not specified	prevention services	State Judicial collects fees and a portion of the funds are for increased enforcement activities through CDOT,as well as prevention programs through ADAD, and	X			C.R.S. 43-4-402(2)

	Funding Matrix	Purpose	Population	Examples of Services	Local Agency Receiving Funds	State Funds	Federal Funds	Local	CRS / CFDA
28	**Medicaid** (HCPF) Ginny Brown	Health services for low income persons	Federal: Mandatory populations: 1) children up to age 19 100% FPL 2) adults in families with children 3) States MUST cover pregnant woman and children up to age 6 in families with incomes up to 133% of FPL. 4) Disabled SSI beneficiaries 5) Certain working disabled 6) Elderly SSI beneficiaries 7) Medicare buy-in groups	Inpatient and outpatient health care, including specialty care, prescription drugs, home health services, behavioral health, dental care.	Medicaid Providers. Licensed treatment providers who are enrolled as Medicaid providers under the SA Outpatient Benefit and Special Connections. Mental health services for Medicaid eligible clients are provided through 5 BHOs (Behavioral Health Organizations)	For Match	X		C.R.S. 25-1-212 thru 25-1-213, 25.5-5-202 (1)(r)
29	**Mental Health Districts**	Support mental health programming	Community identifies the eligible population	Community identiffies the mental health services to be provided	Local mental health districts			X	
30	**Persistent Drunk Driver (PDD) Fund** I	Pays the costs of the Department of Revenue regarding persistent drunk drivers, and to support programs that are intended to deter persistent drunk driving or intended to educate the public, with particular emphasis on the education of young drivers, regarding the dangers of persistent drunk driving	Juveniles	intervention and or treatment services	Contracted prevention providers thru ADAD	Funds collected as a part of the fees leveed upon DUI offenders			C.R.S. 42-3-303

Funding Matrix		Purpose	Population	Examples of Services	Local Agency Receiving Funds	State Funds	Federal Funds	Local	CRS / CFDA
31	**Promoting Safe & Stable Families** (Div. of CW/CDHS)	Community based family support programs that assist families involved with child welfare or help prevent involvement.	Children 0-18 Meet program requirements for Program Area 4, 5 or 6 and meet Colorado Out of Home Placement criteria at the time of provided service and require a more restrictive level of care, but may be maintained at a less restrictive out-of-home placement or in home with core services.	Home-based, intensive family therapy, sex abuse treatment, mental health, drug/alcohol treatment, life skills, special economic assistance, day treatment and county designed Family Therapy and mental health services.	Departments of Social Services-may contract	For Match	X	X	
32	**Safe and Drug Free Schools and Communities**	Support programs to prevent violence in and around schools; to prevent the illegal use of alcohol, tobacco, and drugs; and that involve parent and communities; and that are coordinated with related federal, state, school, and community efforts and resources to foster a safe and drug free learning environment that suports academic achievement.	Students, families, and communities	violence prevention efforts	School districts				NCLB-Title IV-A, Section 4002: Purpose
33	**Screening, Brief Intervention, Referral and Treatment (SBIRT) Grant**	Demonstration grant to implement SBIRT in primary health--provides small amount of funding for treatment	At risk of substance use	screening, brief intervention	Local treatment providers		X		93.243
34	**Senate Bill 94**	Provides funding to treat adolescents who are involved with diversion services through local SB 94 committees	juveniles on diversion	treatment services	Division of Youth Corrections contracts with treatment providers	X			C.R.S. 19-2-303
35	**Social Services Block Grant** (CDHS)	To enable states to furnish social services based on needs of state	Determined by programs that funding goes to.	Childcare assistance, child welfare services	Department of Social Services		X		

	Funding Matrix	Purpose	Population	Examples of Services	Local Agency Receiving Funds	State Funds	Federal Funds	Local	CRS / CFDA
36	**State Judicial-Division of Probation-Offender Services Fund**	Provides funding for offenders on probation	Adults and juveniles age 10 and up. Must be on probation with an identified need	sex offender, substance abuse, and mental health treatment	Local probation depts contract with treatment providers	X			
37	**Substance Abuse Prevention and Treatment Block Grant** (BHS/CDHS)	Substance Abuse prevention and treatment services.	List of priority populations as specified in block grant: pregnant women, women with dependent children and families with open child welfare cases.	Mentoring programs, and parenting programs Specialized and general treatment in outpatient and residential settings	Substance Abuse agencies as determined by ADAD (Managed Services Organizations, Contracted Treatment Providers thru ADAD)	For Maintenance of effort	X		93.959 Partnership Grants: 93.575
38	**TANF** (CO Works/CDHS)	To assist needy families to become self - sufficient	Eligibility is limited to needy families with dependent children or parent(s) with an unborn child. A needy family is defined as a family consisting of children who are living with a caretaker relative whose income and resources are below the standard. All dependent children must live with a caretaker relative or a parent, except for children receiving family preservation services or children receiving services as outlined in Colorado's approved Title IV-A State Plan	Cash payments and childcare assistance. County departments of social services may pay additional benefits and incentives to recipients above the basic benefit level. The types of additional benefits and amounts thereof are described in each county plan.	Local Departments of Social Services	For Maintenance of effort	X		

	Funding Matrix	Purpose	Population	Examples of Services	Local Agency Receiving Funds	State Funds	Federal Funds	Local	CRS / CFDA
39	**TANF Transfer**(CO Works/CDHS)	TANF funds transferred to childcare	see above	• Quality childcare programs • Childcare capacity building such as facility start up costs • Increased resource and referral services • Increased licensing coverage through contracts with the State • Grants to providers • Provider training • Provider recruitment • Implementing early childhood care and education councils • Minor remodeling of childcare facilities	County Departments of Social Services	For Maintenance of effort	X		
40	**Title IV-B** (Div. of CW/CDHS)	Provides support and services to children in need of services to keep in their homes. Partnership Grants: Provides funding to establish partnerships between regional child welfare and substance use disorder treatment agencies	Children and families in need of child welfare services. In some cases children can be served through their 21st birthday.	Services that are provided through this block may include but are not limited to: prevention and protective services; pre-placement; out-of-home placement, including foster care, residential care, and treatment; reunification; adoptions; subsidized adoptions; subsidized adoption case services payments; child welfare-related child care and burials; county case management and administration; and the administration of the interstate compact on the placement of children for children who are either moving to Colorado from another state or are being placed by Colorado in another state.	County Departments of Social Services. Parnership Grants: County Departments of Human/Social Services, Substance Abuse Treatment Providers, other local partners		X	Parntership Grants: 10% match for first year	

Funding Matrix		Purpose	Population	Examples of Services	Local Agency Receiving Funds	State Funds	Federal Funds	Local	CRS / CFDA
41	**Title IV-E**(Div. of CW/CDHS)	Provides support and services to children placed out of home	Up to 18 as long as child is in care; or up to 19 if child is in school or educational equivalent and is expected to graduate by 19; up to 21 for adoption assistance payment if child has mental or physical disabilities.	Foster care maintenance payments when the foster care provider is fully licensed or certified. Subsidized adoption for children with special needs. Statuary protections. Training and administration	County Departments of Social Services and other licensed facilities	For Match	X	For Match	
42	**Title V Incentive Grants for Local Delinquency Prevention** (Off. Of JJ/DPS)	Prevention of Delinquency	Ages 0-18. Communities who have used a risk and protective factor model to develop a comprehensive three-year Delinquency Prevention Plan and have established an oversight committee.	Mentoring, after-school alternative activities, and tutoring.	Local Units of Government	For Match	X	For Match	
43	**Tobacco** (CDPHE)	Any purpose generally to improve the health of Coloradoans	Not specified	Not specified	Depends			From tobacco companies	

Appendix E: Colorado's Behavioral Health System: Descriptions of State Agencies

This section provides a summary of the information that was gathered from the six state agency stakeholder interviews conducted within the timeframe required in order to prepare the final report. Although other agencies also provide or oversee behavioral health services, scheduling difficulties prevented their inclusion in this portion of the report. Future efforts may wish to specifically document the work of the agencies not included in this appendix. The analysis of these interviews yielded the cross-cutting themes mentioned above. The agencies or divisions within Departments that were interviewed were: Department of Corrections; Department of Education [to be inserted]; Department of Health Care Policy and Financing; Department of Human Services; Department of Public Health and Environment; and Department of Public Safety. Each of these departments has a representative that sits on the 1050 Task Force. Given the time limitations, it was not always possible to have all key staff present at these interviews. Therefore each agency may have additional activities and efforts underway that are not reflected in these summaries. We want to thank everyone who participated in these interviews and/or provided information.

The state summaries cover a variety of areas as they relate to behavioral health, to the extent that the information was available. These areas were based on the framework originally developed to help guide the 1050 Task Force's efforts as well as a way to categorize information received through the research process in a consistent way. The framework can be found in Appendix F.

The areas covered include:

- Role in the behavioral health system
- Governance structures
- Quality monitoring, use of data, reporting
- Screening and assessment
- Service array
- Service entry and exit, and service planning, management and operations
- Service delivery
- Training and professional development
- External and internal communications
- Cultural competence
- Consumer, family, youth involvement

Colorado Department of Corrections (DOC)

Overview:

About 75 to 80% of Colorado offenders have a substance abuse issue. There is a range of estimates as to the percentage with co-occurring mental health and substance abuse disorders. DOC estimates that 20 to 25% have co-occurring disorders based on Colorado standards. Federal estimates are higher at 35 or 40% based on federal standards. Eighteen percent of those with a substance abuse disorder have a serious mental illness. Eighty percent of those with a mental illness have a substance abuse disorder as well.

Governance, Management, and Planning:

The Office of Clinical Services within the Division of Prison Operations oversees the mental health and substance abuse services provided to offenders in both publicly and privately operated DOC facilities. The office also oversees sex offender treatment and physical health services.

Mental Health: Each publicly or privately run facility has a health service administrator responsible for all clinical services in the facility and a mental health supervisor who directly oversees the mental health services. Clinical oversight of the mental health supervisor and services within facilities is the responsibility of the Office of Clinical Services. Mental health services include clinical treatment and psychiatric services, crisis intervention, medication and medication monitoring, hospital placement, and other services.

Substance Abuse: The substance abuse treatment services in DOC are overseen by the Office of Clinical Services, but do not follow the same management model as mental health services. Substance abuse services are contracted out to private providers who bid on specific programs of service. The service array available through the private providers is determined by DOC and is comprised of recommended, research-based practices identified in partnership with the Alcohol and Drug Abuse Division (ADAD) in the Department of Human Services. All substance abuse providers are required to be certified through ADAD.

Mental Health and Substance Abuse in Community Corrections: The Division of Adult Community Service Operations oversees referrals to mental health and substance abuse services for offenders who are in community corrections or on parole through the Office of Community Mental Health Services, which is staffed with one Licensed Psychologist, the Manager for Community Mental Health Services. Additionally, the Division has one coordinator for the Approved Treatment Provider Board and an Offender Programs unit that consists of 34 staff focused on re-entry efforts for offenders.

Budget, Funding, and Finance Structures:

Mental Health: DOC's mental health funding goes primarily into personnel, as DOC employees directly provide the majority of the services to offenders who are inmates in public facilities. DOC also oversees the provision of services in private facilities, which are provided by contractors. Additional mental health funding includes Community Mental Health Services and the Psychotropic Medication program, both in community corrections. The Psychotropic Medication program provides 30 days of psychotropic medication to offenders (this does not include parolees) who are released to the community. DOC has been in contact with the Governor's Office of State Planning and Budget to explore ways to maximize treatment funding for use by community corrections, including how to make it more flexible with fewer restrictions.

Substance Abuse: DOC's substance abuse funding goes primarily into contracts with treatment providers. In the past, DOC was able to subsidize the cost of substance abuse treatment. Due to past budget cuts that DOC and other departments experienced, DOC can no longer subsidize such treatment. Instead, offenders are expected to work and a portion of their pay can go towards substance abuse treatment, which is on a fee-for-service basis.

At the federal level, a great deal of attention has been given to the need for and innovative approaches to the integration of mental health and substance abuse services. In Colorado, funding for substance abuse and mental health services is administered separately. However,

DOC has received grants to pilot demonstration integration projects and funding to research those programs. Also, in the 1970's the Treatment Accountability for Safer Communities (TASC) program was developed by the federal Office of Justice programs, which manages and funds drug and alcohol treatment services. Seventy-five percent of the funding is for prison programs and twenty-five percent for parole and community programs. The TASC case managers frequently work with clients who have co-occurring substance abuse and mental health disorders. Despite these grant dollars, additional funding is still needed for fundamental services while offenders are incarcerated and as they transition to the community to ensure continuity of care.

Medicaid Eligibility: DOC is charged with putting in place ongoing services before an offender is released from prison. The Romanoff Bill sets up a defined process mandating that other agencies work with DOC in this regard.

DOC now tracks offenders based on whether they were receiving Medicaid or SSI benefits. One hundred and twenty days prior to an offender's release, DOC reviews offender files and clinical staff tries to identify those that might be eligible for Medicaid or SSI so as to begin the application process and have the offender qualified by the time of release. There are many challenges associated with this process. If an offender is being released to a county different than the one in which the prison is located, DOC must make sure that the application is processed in the county where the offender will be released.

Another challenge is that in Colorado, many stakeholders have reported that applications for SSI are typically denied on the first round triggering a lengthy appeal process. This may be more restrictive than in other regions of the country.

This legislative session one of the bills sponsored by the Legislative Oversight Committee for the Mentally Ill in the Justice System Task Force will address the suspension of benefits rather than the termination of benefits while a person is incarcerated. This may address the needs of some offenders by making it easier to restart the benefit process.

Service Array/Benefit Design:

Mental Health: DOC provides mental health services including clinical treatment and psychiatric services, crisis intervention, medication and medication monitoring, hospital placement, and other services. DOC provides three levels of mental health care:

- Level 1: Each major DOC facility has an out-patient mental health office, with generally one psychologist, two social workers, and limited psychiatric services (One and a half to two days per week).

- Level 2: DOC provides acute care, generally about a two-week stay, at its infirmaries located in Denver and in Centennial where acute stabilization and management of risk occurs.

- Level 3: DOC also provides intermediate care at its San Carlos facility involving longer-term treatment for those who are not able to function in the general prison population. San Carlos has 255 beds for male offenders. There is an intake and evaluation process. Unless an offender is there for evaluation only, offenders stay at San Carlos for six months to a year.

The service array at each of these levels is based on the judgment of the facility's treatment team and resource availability. These decisions are guided by prioritizing the highest needs first with DOC's first priority being suicide prevention. Its second is to prevent violence towards others. In those facilities designated for offenders with mental health needs, DOC provides crisis management and monitoring.

DOC's mentally ill population has continued to grow. Resources and funding, however, have not increased at the same rate to address increased needs. DOC has therefore had to prioritize providing services to those whose screening results are at a "P3" score or higher, considered most in need. For example, when San Carlos was built DOC had approximately 600 offenders with a mental illness. DOC now has upwards of 3500 offenders with a mental illness. There has also been a change in this population. About eighteen percent of offenders have P3 level or above signifying that they are seriously mentally ill. Approximately, 40% of the females in DOC have a serious mental illness compared to sixteen percent of males. Providing services in a prison setting can be challenging because of the routine counting and safety requirements. However, it is a contained environment where if someone needs immediate attention their appointment can be moved up.

Substance Abuse: DOC contracts with alcohol and substance abuse treatment providers to provide a range of services in their facilities. Similar to the mental health services, offenders are assigned a treatment level based on results from screening and assessments. The levels are:

- Level 1: No Treatment.
- Level 2: Drug and Alcohol Education and Increased Urinalyses
- Level 3: Weekly Outpatient Therapy
- Level 4a: Enhanced Outpatient Therapy
- Level 4b: Intensive Outpatient Therapy.
- Level 4c: Intensive Residential Treatment (IRT)
- Level 4d: Therapeutic Community (TC).
- Level 5: Medical/Mental Health Referral.

Also similar to the mental health services, the number of offenders requiring substance abuse treatment has also increased. Given the scarce resources, DOC has maximized its resources by providing treatment towards the end of an offender's sentence when the treatment will do the most good to ensure community safety. This contrasts with the ongoing treatment approach for mental health needs. DOC adopted ADAD's standards in the 1980s and DOC offers the different types of services that ADAD standards address. In prison, most services provided to clients are enhanced outpatient, available 4 days a week, and therapeutic services available 24 hours, 7 days a week, for 6 to 12 months. DOC has also found that group work is an efficient way to serve those with substance abuse issues. Each facility has its own array of substance abuse services, with different specialized programs in the different facilities. Offenders' needs are matched with the capacities of the facility in which they are placed.

As continuity of care has been shown to be effective in decreasing recidivism, DOC hires parole case managers who are experienced and skilled with substance abuse disorders. When offenders are transitioning out of DOC and back into the community, Managed Services Organizations (MSOs) oversee substance abuse treatment services. Like mental health, although the offender's substance abuse needs are screened, assessed, and managed within DOC, that information is not used by MSOs to triage offenders directly into necessary services. As a result, offenders may be asked to pay an upfront screening and assessment fee for $65 or more. To address this situation, DOC has developed relationships with individual providers in

the community who will work with offenders prior to the assessment and screening process being completed, to ensure continuity of care.

Mental Health and Substance Abuse in Community Corrections: The Division of Adult Parole, Community Corrections, and Youthful Offender Services is responsible for the oversight of all mental health programs/services provided to offenders who are on parole, in community corrections, or on the Youthful Offender Services phase III. This monitoring includes the scope of behavioral health services necessary for risk management as well as continuity of care for offenders with generally complex needs including (but not limited to): sex offender treatment and management, substance abuse, mental illness, education, housing, and vocational assessment/training.

When offenders transition to parole, they are connected to public or private mental health services as available. A summary form based on, but separate from, the clinical record is sent to parole officers responsible for monitoring parolees' behavior outside prison. The form lists the treatment services parolees have received so that the officers understand the type of treatment that the parolees require and should receive. Specific program monitoring includes, but is not limited to, approved DOC treatment providers, behavioral health programs funded through the Division of Criminal Justice and Department of Human Services/Division of Mental Health for inmates and parolees (e.g., Mental Illness and Chemical Abuse program, John Eachon Re-entry Program), and transitional operations necessary for offenders moving from prison placement into the community or offenders triaged from the community back into a prison setting.

Offenders who are referred to the publicly funded mental health centers face similar waiting lists as any other client of the mental health centers. After approximately 30 days, they have an opportunity to meet with a screener at the mental health center who triages the offender, identifying services needed including psychiatric care. An appointment with a psychiatrist is made for approximately two to three weeks after the triage date.

One of the barriers to successfully maintaining the offender's mental health treatment is the difference between the length of time it takes an offender to access a psychiatrist and medication management and the thirty days of medication provided upon exit from a corrections facility. Although the offender's mental health and substance abuse needs are screened, assessed, and managed within DOC, currently the information available from DOC is not used by the mental health centers to triage offenders directly into necessary services. The duplication of screening and assessments results in a gap in services. Sometimes, DOC and parole officers find private providers to treat the parolee in the interim.

Data Collection and Use:

Screening and Assessment: When an offender enters the custody of DOC, state law mandates that local law enforcement has already screened the offender for substance abuse and mental health needs using a standardized screening tool, SOA-R (Standardized Offender Assessment – Revised), that is tied to the "p-code." However, statewide implementation of the screening tool is not yet consistent. DOC addresses this issue by undertaking the screening with the standardized tool with every new inmate and additionally providing a short, clinical interview with a mental health specialist located at the Denver Reception and Diagnostic Center where all new inmates are processed and receive their initial p-code status. This interview happens within the first few weeks of the offender's entry into the system. The screening and interview are used to identify the level of service needed and select the best facility able to meet the offender's needs.

Case Level Data Collection: DOC monitors those offenders with a "P3" score or higher while in prison. Offenders also have a drug and alcohol code, dental code, and medical code allowing DOC to know important information about them without compromising private medical information. There is a matrix that is reviewed periodically to ensure that DOC is placing offenders in appropriate facilities given their behavioral health needs.

Research and Evaluation: DOC has research studies showing the effectiveness of substance abuse treatment provided by DOC and its impact on recidivism. DOC defines recidivism differently than the Department of Public Safety, as is further explored in that agency's write-up.

Training and Professional Development:

All DOC personnel working in corrections facilities are trained to recognize mental health and substance abuse issues as they emerge.

Colorado Department of Education (CDE)

Organization: Colorado Department of Education, Exceptional Students Leadership Unit (ESLU) and Prevention and Early Childhood

Overview:
Behavioral health is integrated across all programs within CDE. ESLU and the Prevention and Early Childhood initiatives work parallel together. Positive Behavior Supports (PBS) is an initiative that crosses both units (described below).

Governance, Management, and Planning
The Commissioner of Education reports to the State Board of Education. CDE works with local school districts that by statute have local decision-making. Colorado is broken up into eight regions. CDE consultants are assigned to different regions, including liaisons that specialize in mental health and behavior issues. CDE has monitoring responsibilities for compliance with IDEA and other requirements.

At the local level, school districts participating in different programs or initiatives have policy bodies such as the Colorado Preschool and Kindergarten Program (CPKP) district advisory councils that manage the local CPKP programs and Early Childhood Councils are community-based collaboratives working to build a comprehensive early childhood system in education, health, mental health, and family support.

At the state level, CDE participates in a number of interagency groups related to mental health and behavioral issues such as the Behavioral Health Task Force, Colorado LINKS Advisory Council, Mentally Ill in the Justice System Task Force, Prevention Leadership Council, Mental Health Planning and Advisory Council, and others.

Budget, Funding, and Finance Structures
Funding to support student social, emotional, and behavioral health comes from a variety of different federal and state funding sources. These include: Special Education, Expelled and At-Risk Students, Safe and Drug Free Schools, Coordinated School Health, School Medicaid Program, and CPKP. Colorado's State Improvement Grant for PBS is used for training and technical assistance. Some of these funding streams are grants and others such as Safe and

Drug Free Schools are formula grants. Early childhood funding goes to school districts that can then disseminate it to private entities for services.

Service Array/Benefit Design

Overall, CDE's vision is to promote the use of evidence based practices to support student social, emotional, and behavioral health. It does so through training/technical assistance and dissemination of information, including its website that lists best practices in several areas and a guide to school mental health services. The following are a summary of some of CDE's initiatives and efforts.

Positive Behavior Supports: PBS is receiving increased attention as an integrated approach for promoting the social and emotional well-being of students, which includes those with mental health and behavioral health issues. Based on the three-tier public health prevention model, PBS includes: (1) universal interventions focused on creating a positive school-wide environment; (2) targeted interventions for students identified as having at-risk behaviors; and (3) intensive individualized interventions for students whose behaviors are dangerous, highly disruptive and/or may result in social or educational exclusion. Colorado's Statewide PBS Initiative is recognized nationally. At the district level, CDE supports the implementation of PBS through training/technical assistance and professional development activities.

Over 35% of the schools in this state (638 schools) are implementing PBS. CDE is also linking behavior, academics, and mental health within the school through Response to Intervention (RTI) and PBS. RTI is a multi-tiered, problem-solving approach that addresses academic and behavioral difficulties of all students. It is an integrated school improvement model that is standards-driven, proactive and incorporates both prevention and intervention. Research clearly shows that there is a connection between academic achievement and behavior.

Mental Health: Schools deliver mental health services through school psychologists, school social workers and counselors, indirect services to families, special education, and collaboration with community and mental health agencies. These services range from school-wide prevention efforts to individualized and intensive interventions. Most schools have suicide prevention programs in place. Some schools have co-located staff from the local community mental health center at their school; others have school based health centers that can address the mental and behavioral health issues.

CDE also approves the education programs within Division of Youth Corrections and eligible facilities (e.g., Psychiatric Residential Treatment Facilities (PRTF) and Therapeutic Residential Child Care Facility (TRCCF)) that serve children with behavioral health issues. CDE also monitors the special education component. CDE and Division of Child Welfare are working together to address the education of children in the foster care system and their social/emotional development.

Early Childhood: Behavioral issues are a priority within Prevention and Early Childhood Units. Several of the early childhood initiatives have a focus, among others, on children's social/emotional development and mental health such as Colorado's Early Childhood Councils described above, Results Matter System, and Smart Start Colorado. The purpose of Results Matter is to positively influence the lives of children and families by using child, family, and system outcomes to inform early childhood practices and policy. Smart Start Colorado provides the framework for comprehensive early childhood system. It is based on a vision of a connected, integrated network of early care and education, health, mental health, and family

support and parent education using Smart Start's eight goals to guide collaborative systems building work.

CPKP addresses the needs of children who lack overall learning readiness due to significant family risk factors, such as drug or alcohol abuse in the child's family, and children served by Social Services as neglected or dependent children.

Evaluation/Data Collection and Use
CDE collects data and outcomes in a variety of different areas (see www.cde.state.co.us for data) some of which is dictated by the different funding streams that supports and informs Colorado's public education system. For example, ESLU monitors compliance with identified emotional disabilities. Other evaluation efforts include the PBS SIG grant, Coordinated School Health, Results Matter, Project BLOOM, an early childhood system of care initiative, and others that are used to improve services and systems related to mental health and behavioral health. CDE and the Colorado Department of Public Health and Environment also administer the Youth Risk Behavior Survey through a sampling statewide. In early childhood, the BASC and the DECA are used.

Cultural Competency/Consumer Family Involvement
Cultural Competency is woven throughout its training and everything that CDE does. Examples are cultural mediators in the English Language Learners program who train districts in working with families, special education's cultural competency component, and work with the Southern Ute Reservation to train teachers on the Native American culture. CDE also monitors for disproportionate representation of minority children in special education. Through PBS – SWIS (the evaluation component), CDE monitors the race/ethnicity of those disciplined. PBS training is provided to families in both English and Spanish.

Family Involvement has been a key component of the PBS Initiative since its inception. CDE partners with the Peak Parent Center to provide training and in other areas. Also, family representatives are required on a number of CDE and local district advisory councils, such as the Special Education Advisory Council, Early Childhood Councils, CPKP Advisory Councils and others.

Training/Professional Development

CDE's PBS Initiative has a strong training and professional development component. Trainings and conferences are held periodically throughout the year as well technical assistance in the form of coaching. PBS also trains families on how to use PBS strategies at home.

Two school districts that are the recipients of a federal grant (Integration of Schools and Mental Health Systems) have identified training as a key issue for CDE could to help address in terms of the role and responsibilities of schools and mental health systems, including the different outcomes measured by these systems, and to help develop shared values and outcomes and language across systems.

In the area of early childhood, Project BLOOM has identified training as a key need as well.

Colorado Department of Health Care Policy & Financing (HCPF)

Overview:

HCPF has multiple behavioral health programs and governance structures. They include:

1. A fee-for-service Medicaid program for substance abuse services;
2. A capitated and a fee-for-service Medicaid program for mental health services; and
3. Contracts with HMOs as part of the CHP+ program that includes some behavioral health services.

Substance Abuse: HCPF's Medicaid program did not include substance abuse services until July 2006 when services were expanded to include an outpatient substance abuse benefit with a limited array of 'a la carte' services. These substance abuse services, managed by HCPF's acute-care benefits section, are available to any Medicaid client that has a covered diagnosis. ADAD certifies Medicaid funded inpatient substance abuse facilities as well as facilities providing services for specialized populations.

Mental Health: Colorado's Community Mental Health Services (CMHS) program is a statewide capitated managed care program operated under a 1915(b) waiver. Currently, five Behavioral Health Organizations (BHOs) function as the managed care organization for five discreet geographic service areas. Client enrollment is mandatory; clients are assigned to a BHO based on their county of residence. To receive services, clients must be Medicaid eligible and have a covered diagnosis.

Governance, Management, and Planning:

HCPF's Medical Services Board approves the department's rules. For most benefits or programs, HCPF develops rules and then brings them to the board. Recently, HCPF has developed a formalized process for bringing proposed rules before stakeholders in an open forum prior to their adoption by the board. The Board meetings are also open forums.

Additionally, for the mental health capitation program, HCPF has an informal advisory committee made of consumers, advocates, providers, and other departments and agencies. HCPF staff facilitates the meetings, which are an opportunity to bring and discuss rules, plans for quality improvement activities, issues with stakeholders, and other matters. Although the board has formal requirements related to representation of key stakeholders, it is an advisory board only and has no formal voting process or authority over decisions. It was established in the summer of 2004.

HCPF also participates as a member of the Mental Health Planning and Advisory Council (MHPAC). HCPF generally presents information on requests that they have received from the MHPAC. Recently, HCPF and MHPAC have structured a more responsive process to MHPAC requests. When MHPAC has an issue, it notifies HCPF and HCPF then responds with a presentation within a month or two.

Budget, Funding, and Finance Structures:

Mental Health: HCPF has tried to align state requirements with federal regulations and mandates so that they are not in conflict. Colorado has a lot of flexibility with regard to mental health services because it has a waiver. Mental health services are provided by fee for service providers and through managed care contracts. Continuity of care between the two is maintained in part through the partnership of Community Mental Health Centers (CMHC) and the Behavioral Health Organizations (BHOs). The CMHCs are also the entities that receive

funding for indigent care, aiding in the continuity of care when a client goes on and off Medicaid. However, disconnects still occur as eligibility changes.

Substance Abuse: Since HCPF has implemented the fee for service arrangement with regard to substance abuse benefits. Reimbursement for substance abuse services is set by a fee schedule for the HCPCS (Healthcare Common Procedure Coding System) and the CPT (Common Procedural Terminology) code. HCPF also has a Medicaid fee schedule.

Fee setting for medical benefits has occurred over time. Some billing codes have been updated, but funding has been insufficient to update all billing codes. HCPF has looked at how its rates compared to the federal fee schedule, to determine what billing codes to update. In the last few years, HCPF has increased several rates. Rate increases are intended to align with current commercial rates, which included doing analysis of competitive rates in the private sector. HCPF has received feedback that the current rates are still not adequate. It also resulted in a range of rates for different types of services. HCPF has requested funding to increase rates for substance abuse services provided through the outpatient substance abuse treatment benefit and the Special Connections program.

Substance Abuse and Mental Health: The fee-for-service model, which differs from the mental health capitated model, can create challenges for providers who provide integrated mental health and substance abuse services. This has raised questions about CMHCs billing for mental health services and substance abuse services.

Service Array/Benefit Design:

Mental Health: Services provided as part of Colorado's Community Mental Health Services (CMHS) program are those required by the State Plan, including psychiatric inpatient hospitalization, outpatient hospital services, psychiatry, rehabilitation, psychosocial rehabilitation, case management, medication management, emergency services, school-based services, and residential treatment services. Each BHO must also provide Alternative Services, which may include Assertive Community Treatment (ACT), vocational services, clubhouses and drop-in centers, respite care, home-based family services, and intensive case management. Each BHO is required to maintain a network of service providers that includes CMHCs, other essential community providers (e.g. Federally Qualified Health Centers), and individual facilities, physicians and practitioners. Services are also provided by two JCAHO-accredited state institutions of mental disease (IMDs): Colorado Mental Health Institute at Ft. Logan and Colorado Mental Health Institute at Pueblo.

Substance Abuse: State Plan services provided as a part of HCPF's outpatient substance abuse treatment benefit include assessment, individual and family therapy, group therapy, alcohol/drug screening and monitoring, targeted case management, and social/ambulatory detoxification. Providers who seek reimbursement through Medicaid for substance abuse services are required to be nationally certified in addiction medicine if providing substance abuse services as an individual practitioner or certified as a facility by ADAD.

Integration of Physical Health and Behavioral Health: Physical health care and mental health care are not integrated under Medicaid. The BHOs cover mental health and physical health services are provided through a separate system. The BHO contracts require coordination of care with physical health and this is an area that HCPF is continuing to look at for improvements. For example, there is a Performance Improvement Project where the HMOs and BHOs are discussing how to improve care and integration. This started in July 2007.

These discussions have led to the identification of a specific population where they could make the biggest impact. Some concerns raised include the lack of incentive for doctors under a fee for service arrangement to participate in the project. In January or February 2008, HCPF will have more information on this project.

Integration of Behavioral Health and Developmental Disabilities (DD): HCPF's Long Term Care Division is responsible for the developmental disabilities waiver. In 2006, HCPF asked the BHOs to work with the DD system to determine their roles and responsibilities when individuals have co-occurring mental health and DD issues. HCPF's contract managers have been partnering with a workgroup that includes BHOs to develop guidelines under which the contractors would coordinate and provide services. A subset of these guidelines was made operational by contract. HCPF is monitoring the implementation of these guidelines.

Evidence-based Practices: Although not contractually required, HCPF encourages BHOs to pursue evidenced-based and best practices. Some BHOs are doing their own research to identify best practices or evaluate their services. The majority of BHOs probably have in place one or two of the most commonly used evidenced-based practices. With regards to mental health services, Colorado has flexibility because of its mental health waiver as to the services it can provide. This decreases the barriers to the implementation of evidenced based practices.

Services in Rural Areas: ADAD certification requirements can create barriers to provision of substance abuse services in rural communities. There are an insufficient number of qualified providers who choose to live in rural areas. Solutions to this could include expanded use of telemedicine.

CHP+ and Medicaid: The benefits under CHP+ for behavioral health services are very limited. Currently, CHP+ limits services for mental health to 20 visits, using a model similar to most commercial insurance plans. No common assessment tools are required as the CHP+ programs resemble private insurance services more than the public service model HCPF is looking at possible pilots that include some children with SED (serious emotional disturbance).

Although HMOs would like to provide mental health services as well as health services, they are concerned about their financial risk exposure in providing them. As an alternative, the HMOs have suggested that mental health services could be provided outside of the risk-based rate that they accept for physical health services. If the HMOs were to take the financial risk, they have concerns that the BHOs might shift more services over to the HMOs, increasing costs. HCPF has not yet determined how to address this issue. HCPF is also waiting to see what happens on the federal level with the SCHIP Reauthorization.

It is difficult to compare CHP+ to the Medicaid model as the programs are set up in very different ways. Some efforts have been made to increase the continuity of care for children who move between these two very different programs. HCPF has addressed this problem by determining that once a child is on CHP+ they stay on CHP+. CHP+ has a 12-months guaranteed issue. The continuity of care is a more efficient way of providing services than switching children between the two systems. Another challenge for children's mental health services is the lack of child psychiatrists in Colorado and nationally.

Data Collection and Use:

Data Collection: The BHO's are required to use the Colorado Client Assessment Record (CCAR), an assessment tool with mental health and substance abuse components. Both HCPF

and DHS collect data related to the CCAR tool and endeavor to work together to share information where appropriate and necessary. For example, HCPF shares encounter data with DHS for purposes of federal reporting. There were some technology challenges this summer with the electronic record keeping related to the CCAR, but the issue is being resolved. HCPF requires that the BHOs report encounter data and is working on developing a system to allow BHOs to input that encounter data directly into their data system. HCPF collects limited outcome data through the CCAR, which clinicians use to assess clients' "change in problem severity" and through a member satisfaction survey, the Mental Health Statistics Improvement Program (MHSIP), which queries clients on their satisfaction with their own treatment outcomes. It also collects and reports on several other measures of client satisfaction through the MHSIP survey that all providers are implementing.

Performance Measurement: Several new performance measures have been established beginning FY 07-08 evaluating psychiatric hospital admissions and lengths of stay; hospital recidivism; follow-up after hospitalization; emergency department usage; and penetration rates by age, service category and eligibility category.

Performance Improvement: HCPF has been working on a performance improvement project as part of its efforts to improve the coordination of physical health and mental health care. HCPF has less control over individual physicians than it has with the BHOs to manage quality, creating a need for the mental health system to build relationships with individual physicians. Additional data collection projects include working with DHS on two client satisfaction tools and on how to collect penetration rates in mental and physical healthcare.

Cultural Competence/Responsiveness:

The BHO's have a list of covered services and diagnoses: service providers must be culturally competent, but not necessarily culturally specific. HCPF has pursued culturally specific funding in the past, through a waiver for Native American substance abuse services. The department secured legislative authority to pursue the waiver along with a second program, an extension of Special Connections, a program for pregnant women and 3—12 months post-partum. HCPF rolled the Special Connections program and the Native American program together and submitted a waiver for both to the federal government. The federal Centers for Medicare and Medicaid Services (CMS) required that the Department remove the Native American component of the waiver. HCPF complied with the CMS directive to remove the Native American component from the waiver. Although Native Americans can receive services through the BHOs or through Indian Health Services, the state has not chosen to expand its coverage to culturally specific services such as sweat lodges. Determination of what is a Medicaid covered benefit is done at the federal level, but states can go beyond mandatory services and provide optional services allowed by the feds, including culturally specific services.

Colorado Department of Human Services (CDHS)

Overview:

The newly formed Behavioral Health Services (BHS) is under the Office of Behavioral Health and Housing (OBHH). It is comprised of the Alcohol and Drug Abuse Division (ADAD) and Division of Mental Health (DMH). OBHH also includes the two state hospitals and supported housing and homeless programs.

Substance Abuse: BHS-ADAD is the designated State Substance Abuse Authority providing leadership and oversight of the public, community substance abuse prevention and treatment system. It does so by overseeing the development of State policies, standards, rules and regulations; setting licensing requirements for programs; certification and licensing requirements for addiction counselors; planning, contracting and allocating State resources; monitoring programs and contracts; providing technical assistance; conducting program and outcome evaluations; and developing and maintaining management information systems. ADAD contracts for services through four Managed Service Organizations (MSOs) who then subcontract with community providers.

Mental Health: BHS-DMH is the designated State's Mental Health Authority providing leadership and oversight of the public, community mental health system. It does so by overseeing the development of State policies, standards, rules and regulations; planning, contracting and allocating State resources; monitoring programs and contracts; providing technical assistance; conducting program and outcome evaluations; and developing and maintaining management information systems. DMH contracts with all 17 of the State's community mental health centers (CMHC).

Governance, Management, and Planning:

The newly developed BHS is still forming and determining its structures. Recently, BHS went through an organizational development process and training, and formed work groups to focus on three leverage points selected by staff:

- *Mission/Vision/Values:* This work group is developing a shared vision and mission, making sure it's aligned with the Department of Human Services mission and vision, the Governor's as well as DMH and ADAD.
- *Staff Development Work Group:* This work group is canvassing all ADAD and DMH staff with regard to such things as job skills and passions that will lead to integrative work groups that may cross division boundaries. Initially these groups may form teams that are project oriented. Collecting the data is proving more difficult than originally planned. Once collected, BHS plans to conduct some research and analysis based on the data.
- *Staff Morale Work Group:* This work group is addressing staff morale issues, physical environment concerns, and other staff issues related to the new structure. It is looking into such things as staff appreciation, resources and barriers to good collaboration, and work conditions.

Ongoing issues that the workgroups and leadership of BHS will address include the need to co-locate staff in the two Divisions. Currently, both Divisions are on the same campus, but are not in the same building, creating barriers to alignment.

Budget, Funding, and Finance Structures:

Substance Abuse: ADAD receives federal funding through a substance abuse prevention and treatment block grant and other discretionary federal grants, state general fund dollars, and cash funds from stated generated miscellaneous surcharges. Twenty percent of the federal block grant must be spent on prevention services. For state fiscal year 2008, $3,826,230 of the block grant is allocated to prevention. $33,829 is general funded prevention dollars. For substance abuse treatment, ADAD braids general fund dollars with block grant dollars and contracts with the MSOs throughout the state who in turn subcontract with approximately 40 treatment providers statewide. Since 1992, ADAD has also managed the high-risk substance abuse pregnancy program called Special Connections.

Treatment rates are established for the services to be provided. ADAD only reimburses 1/12 of the total contract per month for the MSOs. ADAD funding is not meant to pay for 100% of the cost of the services. To cover the remaining costs of services, Medicaid, local funding, third party pay, grants, client fees, and other funding as available are combined however possible. Reimbursement is broken down between modalities of treatment services, based on what each MSO is qualified to provide. ADAD informs the MSOs as to the services they expect them to provide.

Mental Health: DMH receives federal funding (mental health block grant and other discretionary federal grants), state general funded dollars, and cash funds. General funded dollars make up the vast majority of DMH's budget of $51.4 million for state fiscal year 2008 (approximately $36.7 million is allocated to the state's medically indigent population).

Combined, ADAD and DMH also receive approximately $2.5 million from the new tobacco settlement funds. DMH funds are contracted out to six community mental health centers to develop enhanced capacity to serve juvenile and adult offenders. ADAD's funding of $514,867 was used to restore funding cuts to prevention, treatment, and detoxification services. The yearly amount is expected to grow to $5 million by 2009.

Medicaid Funded Services: HCPF (Department of Health Care Policy and Financing) manages the Medicaid mental health benefit and the substance abuse outpatient Medicaid benefit. The substance abuse Medicaid benefit is a state plan benefit that allows any willing Medicaid provider who is also licensed by ADAD to provide the service.

Service Array/Benefit Design:

Populations Served: DMH is charged with serving two populations: (1) adults and older adults with serious and persistent mental illness or with serious mental illness; and (2) children and adolescents with serious emotional disturbance. ADAD is charged with serving those populations prioritized by federal and state law.

There is a great deal of overlap between the populations served by ADAD and DMH. Many consumers and families receive services from both systems because they have co-occurring substance abuse and mental health disorders. Some, however, receive services from only one system. ADAD and DMH have had some concerns given its new structure that the BHS not lose its focus on those clients that require just substance abuse services or require just mental health services while still acknowledging that there are resources to be shared across the divisions.

Substance Abuse: ADAD's service array includes prevention and treatment services. Traditionally prevention and treatment have been separate categories, but BHS and ADAD are trying to view them together through the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) that funds 14 counties and the Mountain Ute tribe. The framework's hallmark is building a community coalition and it prioritizes building a continuum of care model from early intervention to prevention to treatment as its vision. BHS and ADAD are now looking to replicate that process with the ADAD prevention block grant funds. The SPF-SIG grant is a five year grant process and currently Colorado is in year four.

Primary health care is impacted by substance abuse. Substance abuse and primary health care, however, are not well connected, resulting in medical professionals lacking the knowledge

to screen for substance use. Through the federal SBIRT grant (Screening, Brief Intervention, Referral to Treatment), ADAD is trying to include substance use in the screening protocol for primary health, an approach that has been shown to prevent the further development of substance use problems. ADAD, the Colorado Department of Public Health and Environment (CDPHE), and the Prevention Leadership Counsel are jointly implementing the SBIRT grant, in partnership with the Governor's Office, who is the recipient of the grant.

Many of the publicly funded substance abuse treatment services in the state are tied to the ADAD licensure. HCPF has adopted ADAD treatment provider licensure as a requirement for the provision of Medicaid funded services. Similarly, ADAD licensure is used by other systems that provide substance abuse, including DOC, DUI programs, and other publicly funded services. County departments of social services also utilize ADAD licensed providers. Privately provided and paid for substance abuse services are not required to be ADAD licensed unless they also dispense controlled substances. Private prisons are also currently not required to maintain ADAD licensure.

BHS recommends that all public and private substance abuse service providers should be required to have ADAD certification in an effort to increase the consistency of services provided throughout the state.

DMH/Mental Health: Like ADAD, DMH contracts include both block grant and general funded dollars. Contracts with the mental health centers are based on a per client basis. DMH contracts with all 17 of the community mental health centers. The community mental health centers are expected to provide all core services including assessment, case management/service coordination, outpatient and inpatient treatment, specific evidence based practice models, medication monitoring, and crisis intervention services. Beyond that mental health centers can customize additional services such as clubhouses and respite care. The contracts between DMH and the mental health centers do not proscribe a specific service mix and some mental health centers receive funding for specific services that are not provided by other mental health centers. Additional contracts with specialty clinics require provision of all the core services except residential, vocational, and emergency services. There are some other areas that DMH funds, such as inpatient facilities, alternatives to inpatient hospitalization for adults, assertive community treatment programs, and the HB 1116 program (child mental health treatment act - treatment program for youth).

DMH is also focused on early intervention and prevention with young children and infants zero to six through Project BLOOM, a federally funded early childhood system of care initiative. Additionally, each of the community mental health centers now has a state general funded allocation to support an early childhood mental health specialist.

Evidence Based Practice: Substance abuse prevention services are required to be evidence-based. With regard to mental health, each mental health center is required by contract with DMH to choose an evidence-based practice, implement it, and then monitor it for three years and report on it. Other mental health center services per the contract are not required to be evidence-based. However, the contracts contain language strongly encouraging the use of evidence-based practices. Similar language is also contained in the substance abuse block grant and general fund contracts encouraging the use of evidence-based practices.

Data Collection and Use:

Both ADAD and DMH report nationally standardized outcome measures. DMH has a data collection system for all mental health services provided to Medicaid and indigent clients. Data is collected monthly and compiled annually to show service utilization and the amount of services provided each time the client accesses services. Some of the types of data collected include CCAR forms, utilization reports, encounter reports, client and family satisfaction data. There are also informal processes by which the division receives feedback such as through work groups focused on service issues.

Beyond regular reporting requirements from providers, BHS is undertaking a number of data and research efforts. For example, BHS-DMH is supporting a statewide Population-in-Need (PIN) study to project the prevalence of mental health, substance use, and co-occurring disorders. They are also looking at fidelity in the implementation of evidence-based practices, including the challenges of implementation in rural versus urban areas.

BHS and ADAD also want to be able to measure proximal outcomes and set targets for evidence-based programs. One of the challenges involved with measuring outcomes in evidence-based programs is the difficulty in measuring the degree of fidelity to the model. BHS therefore, must continue to collect and analyze data to determine if these practices are having an impact.

Performance Based Contracting: BHS is working towards performance measures in its contracts. It is a slow process, however, because historical data is needed to create a baseline and adjust for case mix so that there is not a perverse incentive to serve only those consumers with the greatest likelihood of success.

BHS assembled a steering committee to lead a Statewide Performance and Management initiative whose overall objective is to develop standardized performance measures across the state for mental health and substance abuse. The steering committee involves the Mental Health Planning and Advisory Council, Colorado Behavioral Healthcare Council, and HCPF representatives, including consumer and family advocacy participants. The initiative is just getting started and has collected a number of different documents that people throughout the state have generated to develop performance measures.

Cultural Competency/Consumer Family Involvement:

Consumer and family involvement efforts include:

- Mental Health Planning and Advisory Council's membership is required to consist of at least 51% consumer and family members.
- DMH in partnership with the Division of Criminal Justice is overseeing the family demonstration grant program established by House Bill 07-1057.
- DMH provides funding for family advocacy organizations through the Community Mental Health Block Grant.
- ADAD regularly consults with Advocates for Recovery, a consumer run organization of persons in recovery from addiction.
- BHS addresses cultural competency and consumer/family involvement as part of the regular monitoring processes.

Colorado Department of Public Health and Environment (CDPHE)

Overview:

CDPHE has several initiatives through its offices related to behavioral health services:

- The Interagency Prevention Systems Program is the lead agency with the Prevention Leadership Council (PLC). The PLC is an interagency council linked to state statute by Memoranda of Understanding between state departments that fund prevention, intervention and treatment services for children and youth, and oversee the operations of child prevention and treatment services among these five state departments (Colorado Departments of Education, Human Services, Public Health and Environment, Public Safety and Transportation). MOUs are in place requiring the departments to comply with the rules and regulations that have been developed by the group. Once agreement is reached, CDPHE can run the regulations through its departmental process. A State Plan for Prevention, Intervention and Treatment Services for Children and Youth (2004-2009) is also in place.
- Office of Suicide Prevention serves as the lead entity for statewide suicide prevention and intervention efforts, collaborating with communities to reduce the number of attempts and suicides in Colorado.
- Colorado LINKS for Mental Health promotes partnerships among state agencies and other stakeholder groups by weaving existing efforts to create a more coordinated mental health system for children and families.
- Colorado School-Based Health Center Program funds local communities to plan, establish and maintain school-based health centers to provide primary care, mental health services, substance abuse counseling, oral health, and other services.
- Children and Youth with Special Health Care Needs (HCP) focuses on care coordination rather than providing direct services. There are fourteen regional offices and three county nursing offices for HCP. Each of the offices is looking to work more closely with the community mental health centers, including the early childhood specialists located at the centers.
- Smart Start Colorado has four components one of which is early childhood behavioral health. In Colorado, a significant number of young children are being kicked out of child care settings due to their behavior. The Blue Ribbon Policy Council for Early Childhood Mental Health (BRPC) is connected to the work of Smart Start. BRPC is currently working on a statewide strategic plan for early childhood behavioral health. Kid Connects, HARAMBE, Division of Mental Health, and Project BLOOM are the four leaders and conveners of the BRPC. Part of the strategic planning process is to review other state plans to ensure that all areas related to early childhood are covered.
- The Medical Home Initiative is a primary care focused project that has incorporated behavioral health into its planning efforts. It is housed in the Health Care Program for Children with Special Needs. The Medical Home Advisory Board is assisting with the development of standards for Medical Home practice. The development of these standards was mandated by SB07-130, which gives a formal definition of a Medical Home that includes mental health as well as health care.

Additionally, CDPHE has representation on the state level steering committee for HB 1451 (Collaborative Management Program) as do other departments, collaborates with HCPF on the Medical Home initiative recently enacted into state law, and participates in the Screening, Brief Intervention, Referral and Treatment (SBIRT) grant, focused on universal screening for early

identification and intervention with the non-dependent alcohol and other drug user. Also, CDPHE identified mental health as a high priority for its Maternal Child Health block grant.

Governance, Management, and Planning:

The Prevention Services Division has multiple units within it that are involved in behavioral health efforts. The Child, Adolescent, and School Health unit oversees the LINKS initiative, the Colorado School-Based Health Center Program, and Smart Start, an early childhood initiative. All three have advisory groups who help guide the efforts and identify policy changes and other system improvements. Also within the Prevention Services Division is the Health Care Program for Children with Special Needs, the Office of Suicide Prevention, and the Interagency Issues for Prevention Services unit, where the Prevention Leadership Council is housed.

Budget, Funding, and Finance Structures:

Generally, CDPHE's public health funding does not pay for direct services. Instead, funding is used to build capacity. In the past, HCP for example, used to pay for direct services like an insurance company. Now, HCP pays for care coordination. HCP's funding consists of general funded dollars, prenatal plus, maternal health, and HCP funding. CDPHE is encouraging its HCP offices to work with their community center boards on the diagnostic codes when mental health is related to developmental disabilities. There is a funding formula that is reviewed every five years based on community resources, needs, and population. The majority of the funding is spent on physical health. The offices are just starting to collaborate around behavioral health, particularly autism and fetal alcohol syndrome.

Funding for the Interagency Prevention Systems Program is from general funds and multiple federal grants. The office is the lead agency on a number of interagency grant projects.

The Colorado LINKS for Mental Health Initiative was originally funded by a federal grant and is now funded by a combination of general funds (Interagency Prevention Systems) and foundation dollars.

School Based Health Center Program funds a grant program created by state statute to support local communities in planning, establishing and maintaining school based health centers. Funding consists of $500,000 in general funds and $285,000 from the federal Maternal and Child Health Block Grant. The program has also received substantial funding from Colorado foundations.

The Office of Suicide Prevention, which is housed in the Injury, Suicide and Violence Prevention Unit, provides funding for several initiatives using a combination of general funds and federal grant dollars:

- Ten small community grants. Funding comes from state general fund dollars. SAMHSA dollars for Project Safety Net go to five Colorado counties and to the University of Colorado at Boulder.
- Gatekeeper trainings through state dollars.
- Pueblo Suicide Prevention Resource Center that provides data to CDPHE on the calls to the hotline.
- Evaluation of a school based prevention program call Yellow Ribbon program through state funds.

The Injury, Suicide and Violence Prevention Unit provides funding for several initiatives:

- Youth Violence Prevention Project, which provides mentoring.
- Strategic plan through a contract with four agencies.
- Sexual assault program, adolescent leadership development project, a school-based violence prevention project, trainings, child abuse and neglect through a nurturing parent program supported by The Colorado Children's Trust Fund.

Service Array/Benefit Design:

School Based Health Center services consist of primary care, oral health, mental and behavioral health care, and outreach and enrollment in CHP+. Although not required by statute, CDPHE requires its grantees to provide both physical and mental health services. Statewide, about a quarter of school based health center visits are for behavioral health—primarily direct services that include: individual, group family therapy; assessments; and substance abuse intervention and treatment.

HCP pays for care coordination, including mental health, although the state definition is much narrower focusing on IQ. HCP is building collaborative efforts rather funding specific direct services with the exception of its specialty clinics. Currently, most of the services from HCP are not directed at behavioral health, but it is increasingly an area of focus.

Medical Home Initiative is a system of care approach for children and families that includes mental health as well as physical health. Senate Bill 07-130 requires that children covered by Medicaid and CHP+ have a medical home to coordinate health services. Although the law itself is directed at public pay, the vision is to expand the requirement of a medical home to private insurance as well.

Data Collection and Use:

Screening and Assessment: SBIRT is federal demonstration grant where an initial substance abuse screening is performed by a health care professional to alert a client early on that they are engaging in high risk behavior in an effort to change that behavior. The screening tool used is called the ASSIST. Currently, this program is in place at six hospital settings and it is being expanded to four others. Funding is also available for conducting screenings at school-based health centers. Work is currently being done with Medicaid to get the federal billing codes approved in Colorado so that this service is reimbursable under Medicaid. Work is also being done with insurance companies to make this a billable service as an accepted modality.

School Based Health Centers: Colorado Association for School Based Health Care is working on the development of a uniform data collection system with the Colorado Health Institute, including definition of terms, units of service, online data collection, duration of intervention, measurements of improvements.

Medical Home: The first four standards governing a medical home have been formulated and will be reviewed by stakeholders in the coming months. CDPHE is working with HCPF on a measurement system to hold providers accountable.

Training and Professional Development:

School Based Health Centers use the ADAD requirements. There are no comparable requirements for mental health. The Colorado Department of Regulatory Agencies (DORA)

does not require that mental health professionals be licensed. Medicaid and CHP+, however, require certification for reimbursement.

Consumer, Family, and Youth Leadership and Support:

CDPHE's units have actively engaged the youth and family voice in a number of their efforts including:

- School Based Health Centers: Communities involve youth when they are planning a school based health center depending on their age. Most high school programs use youth in an adjunct capacity within the health center. Family and youth involvement and cultural competency must be addressed in the scope of work that is a part of the community's contract with CDPHE.
- HCP: Each of the regional offices has a family coordinator that works with HCP. HCP is developing a family leadership database to identify what families need to feel competent and have useful leadership skills.
- Colorado LINKS: Its action plan prioritizes youth and family involvement, support, and leadership as a top priority. Development of the plan included family and youth focus groups and the advisory board includes a family advocacy organization. The budget for the project has included stipends and expenses for family members participating in the project. The vision of LINKS is to weave together existing efforts in this area as well as collaboration and financing.

The Department has an ongoing forum for engaging the youth voice, the Youth Partnership for Health. The partnership was recently evaluated and found to have had an impact across a number of different health programs in the Department and with community partners. The youth receive stipends and travel expenses for their time.

Department staff is also actively involved in two efforts that have representation from family organizations:

- HB 1451, Collaborative Management Program: Family members are on the state steering committee.
- Medical Home: Family organizations have been involved in planning.

Cultural Competence/Responsiveness:

CDPHE has some activities around cultural competence, but staff report that this is an area where further work could occur. Efforts include:

- Prevention Leadership Council's cultural responsiveness guide;
- Office of Suicide Prevention's translation of some of its resources into Spanish and current efforts to develop Spanish language gatekeeper trainings;
- A committee looking at health disparities issues within the Prevention Services Division.
- HCP efforts with the Developmental Disabilities Council including a one day training held last summer on cultural and linguistic competency. HCP staff have also been involved with a community of learners through Georgetown University on cultural and linguistic competency.
- Within CDPHE, but not within the Prevention Services Division, is the Office of Health Disparities. Currently, the office has not identified behavioral health as a priority area, but it is working on disparities in other healthcare needs.

Colorado Department of Public Safety – Division of Criminal Justice (DCJ)

***Overview*:**

DCJ is comprised of seven units. They are:

1. *Research Unit*. The unit provides support to the other units, conducts evaluations, and prepares reports. It is funded by a combination of state general fund dollars and grants for specific projects.
2. *Sex Offender Management Board*. DCJ staffs the board and provides direction. The board is responsible for setting the standards for sex offender treatment. These standards are focused primarily on the treatment providers rather than the offenders themselves in an effort to set Evidenced Based Practices (EBP) and Best Practices (BP) for treatment. The board also reviews complaints filed against treatment providers.
3. *Domestic Violence Board*. DCJ staffs the board and provides direction. The board is response for setting the standards for Domestic Violence Offender treatment and provider approval. Complaints go through DORA (Department of Regulatory Agencies) and DORA refers these complaints to the board. The board determines whether someone should be an approved provider. (Note: There is limited overlap between providers who are certified through these two boards.)
4. *Grants Management Unit*. This unit oversees boards that funnel through federal and state funding like justice assistance and Byrne grants. This unit is involved on the policy side not direct services. The Juvenile Justice/Delinquency Prevention Council that is staffed by this office awards direct service grants to local communities to address mental health issues in the juvenile justice system. The office also staffs a joint subcommittee of the Mentally Ill in the Justice System Task Force that looks at mental health and juvenile justice. Finally, the office is the lead on a new MacArthur Foundation Grant that is focused on mental health in juvenile justice. It is a policy level grant that is partnering with the City and County of Denver to implement changes related to research-based practices and integration.
5. *Victim Services Unit.* This unit manages funding through VALE, VOCA, VAWA and staffs the grant boards responsible for awarding money, and supervises the grants. The unit is responsible for handling complaints under the Victims Rights Act (Colorado law) and conducts trainings throughout the state.
6. *Community Policing Unit.* This unit's main function is to conduct trainings with law enforcement. They provide Crisis Intervention Training (CIT) as well as juvenile CIT, human trafficking, and anti-bias training.
7. *Community Corrections.* This unit funds substance abuse, mental health, and life skills treatment through Community Corrections, and sets standards and policy. The details to follow primarily cover the Community Corrections unit, where the greatest amount of behavioral health oversight and management occurs.

Governance, Management, and Planning:

The Office of Community Corrections is responsible for staffing the Governor's Community Corrections Advisory Council and auditing and analyzing community corrections programs to determine compliance with the standards developed by the Council. The advisory council has broad based representation including ex offenders, community corrections board members, policy experts, and providers. The standards, which have been well accepted as reasonable, are continually reviewed, modified, and published as required.

Community Corrections has a shared governance function. Local Community Corrections boards are governed by statute, and they contract with one or more of the thirty-four providers statewide. The providers may be units of local government, non-for-profit organizations or for-profit entities.

Budget, Funding, and Finance Structures:

Funding for Community Corrections primarily comes from the Office of Community Corrections at DCJ. Some funding for ISP (Intensive Supervision and Parole) comes from DOC.

Rate setting for services begins with the determination of cost and then goes through the budgetary process where rates may be decreased and/or determined that offenders should pay more for services. Facilities sometimes do not require offenders to pay the full amount allowed by law ($17/day) because they want the offender to pay for their treatment instead as a way to increase their personal investment in that treatment. At the federal level, the proposed Second Chance Act addresses the issue of payment by offenders, noting that there is a point at which it becomes easier for offenders to re-offend and return to prison rather than to pay all the financial costs that they are responsible for once they are released. In Colorado, the combined total fees that an offender is required to pay across programs and systems is not tracked, making it difficult to determine if the offender might be reaching the point at which it is easier to re-offend than pay off their debts to the systems.

Service Array/Benefit Design:

Community Corrections serves three different groups of clients: Diversion, Transition, and Condition of Parole. These clients are placed in one of several types of community facilities based on their situation. Typically those that are placed through Community Corrections fare better than those that are discharged to the street.

Diversion clients are those who are sentenced directly to Community Corrections for felony offenses. Often these sentences are in lieu of prison sentences.

Transition clients are those who have spent time in prison and who are placed in Community Corrections by the DOC before they are released to parole supervision.

Condition of Parole beds are for individuals on parole who have made mistakes, but are not returned to prison.

All three types of clients are overseen by Community Corrections and providers are held to the standards developed by the Community Corrections Advisory Council.

There are some programs that offer specialized services for special-needs offenders in community corrections. These specialized services fall into the categories of include Intensive Residential Treatment beds, Therapeutic Community Beds, and Residential Mental Health Beds.

IRT (Intensive Residential Treatment) beds are for substance abuse offenders. They are short term beds (45 days). Offenders who are placed in these beds could be in transition, diversion, or on parole.

Specialized services includes a therapeutic community model, which may be unique to Colorado. It is operated principally by the University of Colorado, Health Sciences Center. Community Corrections and ADAD work together to develop, oversee, and certify these specialized substance abuse treatment programs. These are long term treatment programs that may house and treat an offender for a year or more.

Mental Health Services: Historically, substance abuse programming has been the focus of Community Corrections specialized treatment programs. More recently, funding for mental health has allowed for an enhanced mental health focus in some of the programs. Additionally, life-skills training classes are provided to offenders as part of their service array Additional mental health services are noted in CDPS report.

Substance Abuse Certification: Community Corrections has incorporated ADAD standards in its contracts and enforces them.

Referral to Services: Local Community Corrections screening committees evaluate and determine the fitness for Community Corrections placement and refer that information to the judge or DOC. Once approved, Community Corrections tries to find a program with the appropriate level of clinical care within a community that the client will be able to transition back into. For example, Community Corrections considers race and ethnicity of clients when placing them in urban or rural settings. Community Corrections clients can be placed anywhere in the state. If a local community correction's provider is full, programs in other communities are considered.

All specialized programs must have criteria for accepting clients to ensure that they only accept clinically appropriate clients. A client can be from Fort Collins, for example, and be placed with a San Luis Valley IRT facility as opposed to an IRT in Greeley if the client needs warrant it.

Some facilities work better with certain types of clients. Based on their screening and assessment processes, Community Corrections can determine where clients might do well and where they will not. Sometimes a client might be a good fit for intensive or specialized services, but cannot pay for the services required. As a result, they are placed in a lower level of treatment that they can afford. Some programs waive part of the $17/day fee, and others provide programs in-house at no cost. Clients therefore are sometimes placed in facilities where they can afford the treatment.

Data Collection and Use:

Case Level Information Sharing: As required by state law, Community Corrections uses the same risk assessment and substance abuse needs assessment tools as probation and DOC. However, assessment information does not follow offenders between these systems. There is some sharing of information when an offender goes from DOC to Community Corrections and there is a process is in place to support it. Whether information is shared, however, often depends on the particular parole officer or case manager involved. To make it more universal, electronic forms are needed as well as a simplified process to transfer information among DOC, the courts, probation, and Community Corrections.

Community Corrections reports that federal regulations often pose a barrier to the sharing of some information between law enforcement entities and non-law enforcement entities such as local boards or programs where there have to be contracts in place and the redaction of certain information. The electronic systems that could be set up to share information may still face

barriers because of HIPAA (Health Insurance Portability and Accountability Act) or other state and federal privacy laws as well as an unwillingness to share information that occurs sometimes between agencies.

Community Corrections standards do not require that information be shared between entities. Contracts for specialized programs do require that treatment programs accept only placements that come with clinical information. Examples of more effective information sharing do exist within Colorado. In southern Colorado, there is an Intensive Residential Treatment facility that has built a good relationship and has effectively shared information with the local board and Community Corrections.

Auditing: Many providers contracting with Community Corrections have reporting requirements to other systems including ADAD and DOC. DCJ is currently collaborating with DOC, State Judicial, and the Department of Human Services to conduct joint audits of providers. This collaboration arose from the Interagency Advisory Committee focused on adult and juvenile corrections treatment. The committee helped bring these departments together to conduct their joint audits and to build relationships among them. This is an area where further cross-Department policy development could occur.

Tracking Outcomes: Recidivism is a key outcome that is tracked and monitored to understand the reason for its occurrence. The cause can be a supervision-related issue as well as a treatment issue. Recidivism, however, is tracked differently by different agencies. For example, DOC defines recidivism as the occurrence when an offender returns to DOC. Community Corrections defines recidivism based on a 24-month standard length of time for determining whether a client is a recidivist.

Community Corrections is starting to find providers that are in violation of the standards where the treatment provided does not seem to be appropriate based on the client's assessment. Community Corrections would like to have better data to determine the very best treatment for their clients.

Training and Professional Development:

Community Corrections trains between 400 and 600 people a year on the standardized assessment and needs assessment tools. The significant majority of the trainees are from the Community Corrections system with the remainder coming from DOC, probation, and treatment providers. This year Community Corrections expects to train about 100 licensed therapists in Cognitive Behavioral Treatment from programs or half-way house for criminal conduct and substance abuse.

Community Corrections requires 40 hours of training for program staff. Community Corrections assists programs in training their staff through state-sponsored trainings.

Consumer, Family, and Youth Leadership and Support:

Each provider and local Community Corrections board determines the appropriate role for consumers to play on such things as policymaking boards. For some provider organizations, consumer involvement happens through recovering addicts who may or may not be ex-offenders.

Cultural Competence/Responsiveness:

The Community Corrections standards do not address cultural competency. Community Corrections does fairly well with its gender specific programs and there have been some studies on it to support it. Recidivism is tracked by race and ethnicity, but it is not reported in that way. Currently, this is done by hand, but in a year or so Community Corrections will be in a position to report it because it is moving to an electronic system.

The Community Corrections leadership has identified three levels of cultural competency and feels that current programming addresses some of these levels. Overall, cultural competency is generally left to the provider since they are dealing directly with the clients:

- Level 1: The corrections/prison culture dominates, subsuming some of the other cultural issues, and ignoring others.
- Level 2: Culture is defined more similarly to the traditional definitions, related to race, ethnicity, gender, etc. Programs choose whether and how to address this type of cultural competency. Some programs focus on hiring diverse staff to increase their cultural competency.
- Level 3: Programs themselves develop their own cultures, with some being very defined and distinct.

Appendix F: Framework

Name of Initiative:					
Jurisdiction (State or Local):					
Overall Description, including scope (e.g., Public; Public/Private; Mental Health and Substance Abuse; Continuum-Early Intervention, Prevention, Treatment, Recovery):					
Population Focus (e.g., Adults with Mental Health and/or Substance Abuse Issues; Children with Mental Health and/or Substance Abuse Issues & Families; and/or Special Populations or Priority Populations with Mental Health and/or Substance Abuse Issues):					
Contact Info:					
SYSTEM FUNCTIONS **Address where applicable**	Specific Description (Parties Involved, Activities/Steps & Timeline)	Goal / Benchmark of Success – Guiding Principles	Policy Change (Legislation, Regulation, State Practice Change)	Key Elements (e.g. Leadership, collaboration, resources)	Lessons Learned (What worked well, What didn't, Challenges)
Consensus Building/Planning					
Governance & Decision-Making (Policy/System Level)					
Budget, Funding & Financing (e.g., revenue generation/maximization, provider reimbursement rates)					
Consumer/Family & Youth Leadership, Support & Development					
Cult. Competence/ Responsiveness					
Management & Operations					
Service Array/Benefit Design					
Quality Monitoring/Data & Evaluation					
System Entry and Exit					
Screening, Assessment/Testing					
Service Planning (e.g., case management, care coordination)					
Service Delivery					
Training & Professional Development					
External & Internal Communications					
Other					

Appendix G: The Substance Abuse and Mental Health Services Administration's National Outcome Measures (NOMs)

SAMHSA
Substance Abuse & Mental Health Services Administration
U.S. Department of Health and Human Services

National Outcome Measures (NOMs)

Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs)

DOMAIN	OUTCOME	MEASURES		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ▶	30-day substance use (non-use/reduction in use) ▶
				Perceived risk/ harm of use ▶
				Age of first use ▶
				Perception of disapproval/attitude ▶
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/ Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ▶	Increase in/no change in number of employed or in school at date of last service compared to first service ▶	Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment ▶
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ▶	Alcohol-related car crashes and injuries; alcohol and drug-related crime ▶
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ▶	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ▶	NOT APPLICABLE
Social Connectedness	Increased Social Supports/Social Connectedness[1]	Under Development	Under Development	Family communication around drug use ▶

Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ▶	Unduplicated count of persons served; penetration rate-numbers served compared to those in need ▶	Number of persons served by age, gender, race and ethnicity
Retention	Increased Retention in Treatment - Substance Abuse	**NOT APPLICABLE**	Length of stay from date of first service to date of last service ▶ Unduplicated count of persons served ▶	Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message ▶
	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ▶	**NOT APPLICABLE**	**NOT APPLICABLE**
Perception of Care	Client Perception of Care[2]	Clients reporting positively about outcomes ▶	Under Development	**NOT APPLICABLE**
Cost Effectiveness	Cost Effectiveness (Average Cost) [2]	Number of persons receiving evidence-based services/number of evidence-based practices provided by the State	Number of States providing substance abuse treatment services within approved cost per person bands by the type of treatment	Services provided within cost bands
Use of Evidence-Based Practices	Use of Evidence-Based Practices [2]		Under Development	Total number of evidence-based programs and strategies

[1] For ATR, "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.
[2] Required by 2003 OMB PART Review.

National Outcome Measures (NOMs) for Children and Families

March 2007

Overview

The mission of the Substance Abuse and Mental Health Services Administration (SAMHSA) is to build resilience and facilitate recovery for people with or at risk for substance use and/or mental disorders. In 2001, SAMHSA created a matrix management system that outlines and guides the agency's activities in pursuit of this mission. The matrix includes 12 program priority areas, one of which addresses the unique needs of children and families with or at risk for mental and/or substance use disorders. The matrix also includes a set of cross-cutting principles, including one recognizing the critical need for data for performance measurement and management. SAMHSA is in the process of developing and implementing a data strategy in order to measure the agency's success in meeting its mission. The National Outcome Measures (NOMs) is a key component of the data strategy. The NOMs have introduced a set of 10 measurable outcomes for three key areas: mental health services, substance abuse treatment, and substance abuse prevention. As part of this effort, SAMHSA's activities and data have been reviewed to determine what outcomes could be measured for each NOMs domain.

The highlights contained here represent the best summary information about NOMs currently available from national-level SAMHSA data sets for the children and families program priority area. Since this is a preliminary overview, these national-level data are used to describe possible baselines or starting points from which to measure changes in the future. These baseline data on children and families are available for 7 of the 10 NOMs domains: Reduced Morbidity, Employment, Stability in Housing, Access/Capacity, Retention, Social Connectedness, and Perception of Care. Further work is under way to identify potential data sources for use as measures of outcomes for the remaining domains. While not the focus of this summary, it is equally important to mention that SAMHSA's grant programs have demonstrated success and effectiveness in improving the lives of children and families throughout the country. SAMHSA initiatives have reduced alcohol and other drug use, improved emotional and behavioral functioning, increased attendance and performance at school, and reduced law enforcement contacts.

SAMHSA's Action Plan for the children and families program priority area is available at http://www.samhsa.gov/Matrix/SAP_children.aspx.

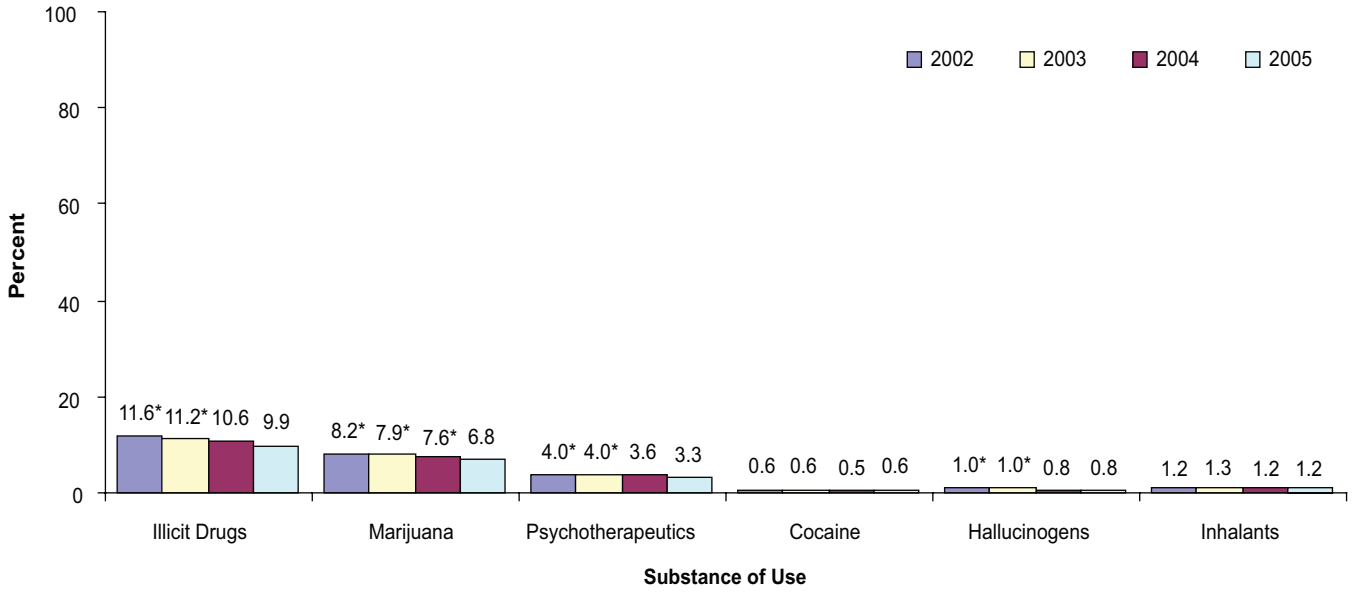
National Outcome Measures Overview

SAMHSA has developed these 10 NOMs domains in collaboration with the States. These domains are designed to embody meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and work, learn, live, and participate fully in their communities. The development and application of NOMs is a key component of the SAMHSA initiative to set performance targets for State and Federally funded initiatives and programs for substance abuse prevention and mental health promotion, early intervention, and treatment services. The NOMs domains and their associated outcome measures are as follows:

- Reduced Morbidity (for substance abuse—decreased use of substances of abuse, nonuser stability, increasing perceived risk, increasing disapproval, increasing age of first use; for mental health—decreased mental illness symptomatology)
- Employment/Education (getting and keeping a job; workplace drug and alcohol policy; alcohol, tobacco, and other drug school suspensions and expulsions; or enrolling and staying in school)
- Crime and Criminal Justice (decreased criminality, incarcerations, and alcohol-related car crashes and injuries)
- Stability in Housing (increased stability in housing)
- Social Connectedness (family communication about drug use, increasing social supports and social connectedness)
- Access/Capacity (increased access to services/increased service capacity)
- Retention (for substance abuse—increased retention in treatment, access to prevention messages, evidence based programs/strategies; for mental health—reduced utilization of psychiatric inpatient beds)
- Perception of Care (or services)
- Cost Effectiveness
- Use of Evidence-Based Practices

Current data regarding substance abuse among the children and families population are available from several of SAMHSA's national-level data sets, including the

Figure 1. Percent of Adolescents (Aged 12–17) Reporting Past Month Use of Selected Illicit Drugs: 2002–2005



* Difference between estimate and 2005 estimate is statistically significant at the 0.05 level. See notes at end.
Source: SAMHSA, OAS, (2006), *Results from the 2005 National Survey on Drug Use and Health: National findings* [Figures 2.5 and 2.6].

National Survey on Drug Use and Health (NSDUH), the National Survey of Substance Abuse Treatment Services (N-SSATS), the Treatment Episode Data Set (TEDS), and the Uniform Reporting System (URS). However, it must be noted that TEDS data are primarily drawn from substance abuse treatment facilities that receive some public funding. In addition, URS, which is the major source of mental health reporting for SAMHSA's Center for Mental Health Services (CMHS), consists of data collected voluntarily by the States. These data tend to have large ranges in the values reported because of important variations in State data systems, reporting capacity, means of instrumentation, data collection methods, and variable definitions, as well as in the number of States reporting any data for a specific variable. Finally, the URS data set represents only individuals who have been seen through a publicly funded mental health system served by the State Mental Health Authority. The URS data set does not include individuals seen by private providers or individuals receiving their mental health services from other agencies such as the criminal and juvenile justice systems, homeless programs, and child welfare. CMHS is working to refine its data and expand its data sets.

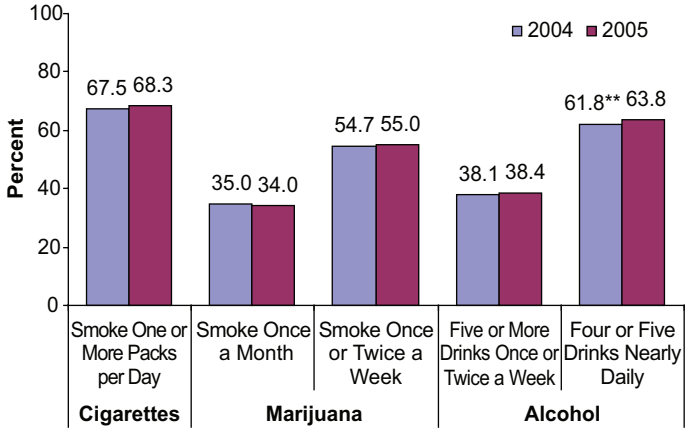
Recognizing that there are challenges to critically examining the NOMs in the children and families program priority area, SAMHSA is striving to develop more in-depth and comprehensive data (e.g., detailed age intervals particularly for children younger than 12, child-parent relational data, and complete/consistent data for all States) and to fine-tune strategies to effectively collect data on children. SAMHSA is also making continuous efforts to elaborate the definitions of the outcomes. As SAMHSA refines and implements the data strategy for performance measurement and management, additional NOMs data for children and families will be developed.

Substance Abuse Prevention NOMs for Children and Families

Within the substance abuse prevention area, NOMs for children and families are available from SAMHSA's national-level data sets under the domains of Abstinence from Drug/Alcohol Use, Retention, Social Connectedness, and Employment. Much of these data come from NSDUH.[1, 2, 3]

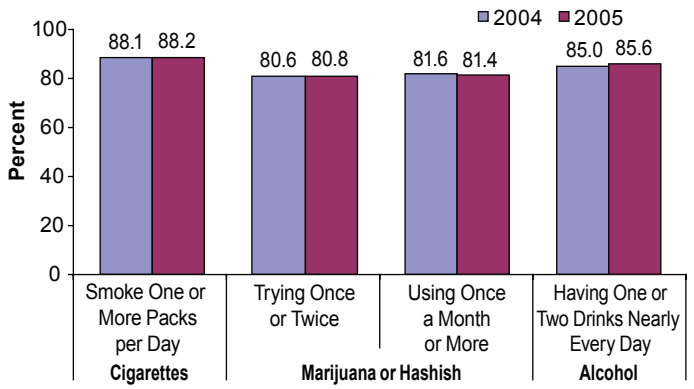
Under the Abstinence from Drug/Alcohol Use domain, data are available for the following measures: 30-day substance use, perceived risk/harm of use, perception of disapproval/attitude, and age of first use. The declines in past month usage over a four-year period show that national efforts are having an impact across the board in reducing 30-day use of multiple kinds of drugs (Figure 1). Figure 2 documents the desired effect of increasing adolescents' perception of great risk of harm. For measures of cigarette, marijuana, and alcohol use, perceptions of great risk of harm increased from 2004 to 2005 in all cases, except for smoking marijuana once a month. Similarly, Figure 3 shows a general increase in adolescents' disapproval of peers using cigarettes, marijuana, and alcohol. Figure 4 represents baseline

Figure 2. Percent of Adolescents (Aged 12–17) Perceiving Great Risk of Harm from Use of Cigarettes, Marijuana, and Alcohol: 2004 and 2005



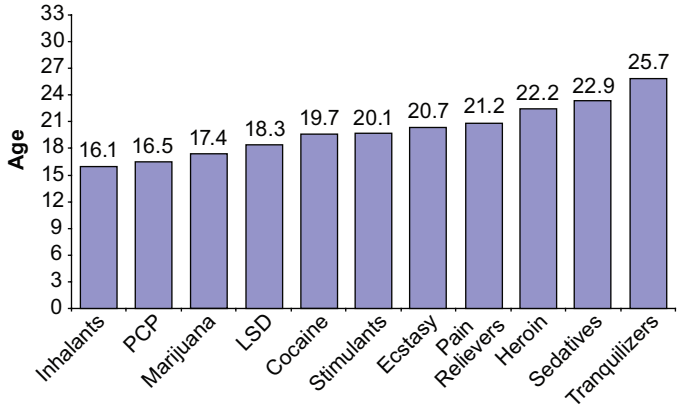
** Difference between estimate and 2005 estimate is statistically significant at the 0.01 level. See notes at end.
Source: SAMHSA, OAS, (2006), *2005 National Survey on Drug Use and Health: Detailed tables* [Table 3.1B].

Figure 3. Percent of Adolescents (Aged 12–17) Feeling Strong/Somewhat Disapproval about Peers Using or Trying Cigarettes, Marijuana or Hashish, and Alcohol: 2004 and 2005



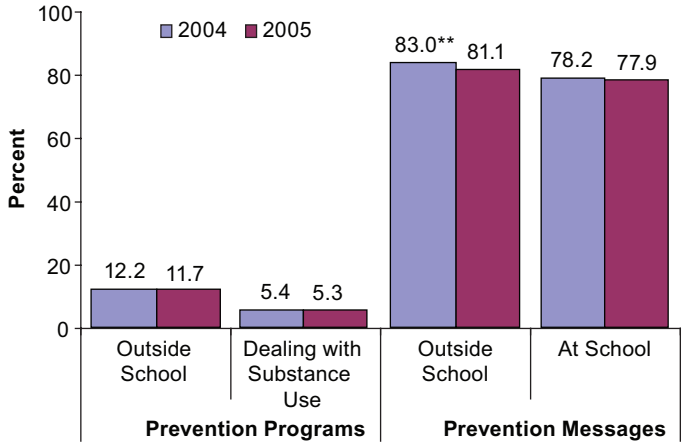
See notes at end.
Source: SAMHSA, OAS, (2006), *2005 National Survey on Drug Use and Health: Detailed tables* [Tables 3.30B, 3.31B, 3.32B, 3.33B].

Figure 4. Mean Age at First Use for Past Year Initiates Aged 12 to 49, by Illicit Drug: 2005



Source: SAMHSA, OAS, (2006), *Results from the 2005 National Survey on Drug Use and Health: National findings* [Figure 5.2].

Figure 5. Percent of Adolescents (Aged 12–17) Who Participated in Prevention Programs or Were Exposed to Prevention Messages in Past Year: 2004 and 2005



** Difference between estimate and 2005 estimate is statistically significant at the 0.01 level. See notes at end.
Source: SAMHSA, OAS, (2005), *2004 National Survey on Drug Use and Health: Detailed tables* [Tables 3.36B, 3.37B, 3.40B, 3.41B].

data on the mean age of first use among past year initiates aged 12 to 49 for a number of substances. Other available baseline data reveal that, among adolescents, the average age of first use of cigarettes, alcohol, and marijuana was 17, 16, and 17 years, respectively.[4]

One of the Retention domain measures in the substance abuse prevention area is the percentage of youth seeing, reading, watching, or listening to a prevention message. Figure 5 shows that adolescents were more likely to see or hear prevention messages than to participate in prevention programs.

Data related to the Social Connectedness domain are provided in Table 1, which shows some improvements in family communication about the dangers of drug, tobacco, or alcohol use.

Under the Employment/Education domain are measures related to perception of workplace policy on alcohol or other drug use. Data from the 2005 NSDUH show that approximately 29 percent of adolescents aged 15 to 17 who were employed were willing to work for an employer who does employee drug tests on a random basis.[4]

Table 1. Number and Percent of Adolescents Who Talked with at Least One Parent in the Past Year about the Dangers of Drug, Tobacco, or Alcohol Use, by Age Category: 2004 and 2005

	2004		2005	
Age Category	Number	Percent	Number	Percent
Total	15,063	60.3	15,002	59.8
12–13	5,188	62.9	4,969	61.5
14–15	5,194	60.4	5,233	60.6
16–17	4,681	57.4	4,800	57.3

See notes at end.
Source: SAMHSA, OAS, (2006), *2005 National Survey on Drug Use and Health: Detailed tables* [Tables 3.39A–B].

Crime and Criminal Justice domain measures concern alcohol-related car crashes and injuries and alcohol- and drug-related crime. While not directly applying to these measures, the 2005 NSDUH provides supplemental information—it found that only 3 percent of adolescents had driven under the influence of alcohol in the past year.[5]

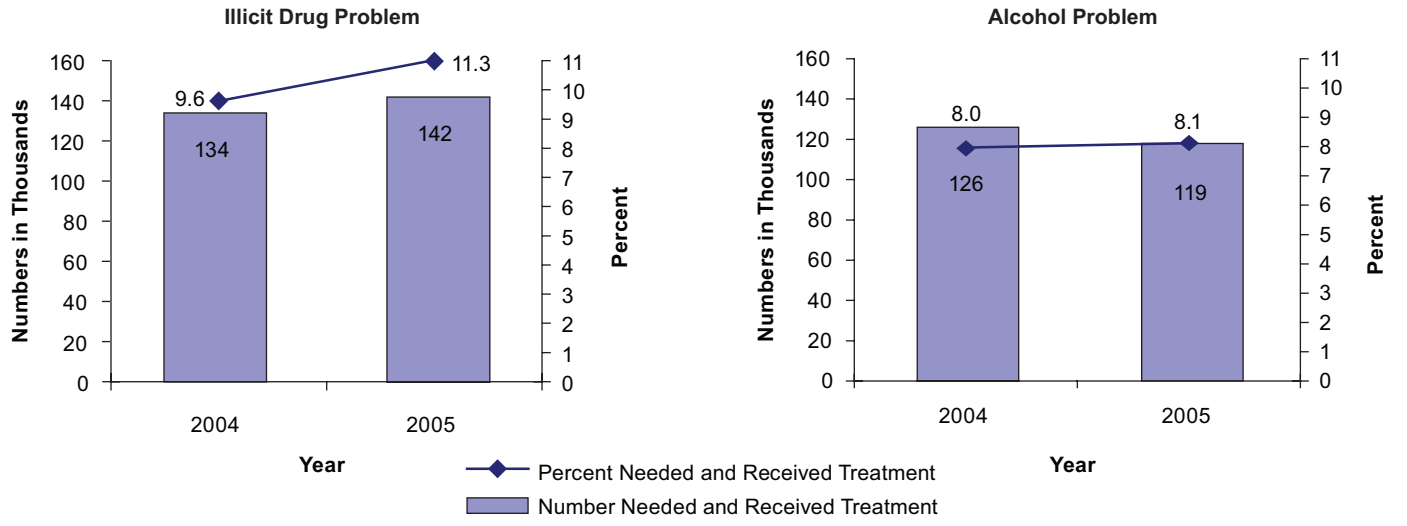
Thus, for Crime and Criminal Justice as well as the three remaining NOMs prevention domains (Access/Capacity, Cost Effectiveness, and Use of Evidence-Based Practices), information specific to the children, youth, and families population cannot be isolated from SAMHSA's national-level data sets and looked at independently from the broader population; thus, outcomes appropriate to the children, youth, and families population cannot be reported from SAMHSA's national-level data sets. However, SAMHSA's adolescent substance abuse prevention grant programs currently collect these data for use at the local provider level. In addition, some NOMs for substance abuse prevention will be obtained from data sets developed by other agencies such as the Departments of Transportation, Justice, and Education.

Substance Abuse Treatment NOMs for Children and Families

For substance abuse treatment, national-level data are available for children, youth, and families under the Access/Capacity and Retention domains. NSDUH[2] and N-SSATS[6, 7] provide access/capacity data, while retention data are provided by the Treatment Episode Data Set (TEDS).[8]

The Access/Capacity domain measures are concerned with obtaining an unduplicated count of persons served and determining the penetration rate—numbers of clients served compared to those in need. N-SSATS, an annual census of facilities providing substance abuse treatment, provides data for the number of clients in treatment as well as information on types of services offered by these facilities. In 2005, data show that 87,611 clients younger than age 18 were in treatment on March 31; of these, 87 percent were receiving outpatient care, 12 percent residential care, and 1 percent hospital inpatient care.[9, 10] Most of these clients were adolescents, but this population also encompasses children younger than 12 years old in treatment, including infants exposed prenatally to substances. N-SSATS data also show that in 2005, half of all facilities accepted adolescents,[7] and 32 percent offered programs or groups for adolescents.[11] Among services offered by N-SSATS facilities, some were directly

Figure 6. Number and Percent of Adolescents (Aged 12–17) Who Needed and Received Treatment at a Specialty Facility, by Type of Problem: 2004 and 2005



See notes at end.
Source: SAMHSA, OAS, (2006), *2005 National Survey on Drug Use and Health: Detailed tables* [Tables 5.61A and 5.67A].

related to the children and family area. These services included family counseling (76 percent of all facilities), domestic violence—family or partner violence services (32 percent), child care for clients' children (9 percent), and residential beds for clients' children (4 percent).[12]

Penetration rate data come from NSDUH. In 2005, approximately 11 percent or 142,000 of all adolescents needing treatment for illicit drug use received it (Figure 6). NSDUH documents that roughly 1,112,000 adolescents overall needed but did not receive treatment for an illicit drug problem in 2005. Similarly, approximately 8 percent or 119,000 of all adolescents needing treatment for an alcohol problem in 2005 received it. In that year, there were about 1,341,000 adolescents overall who needed but did not receive treatment for an alcohol problem.

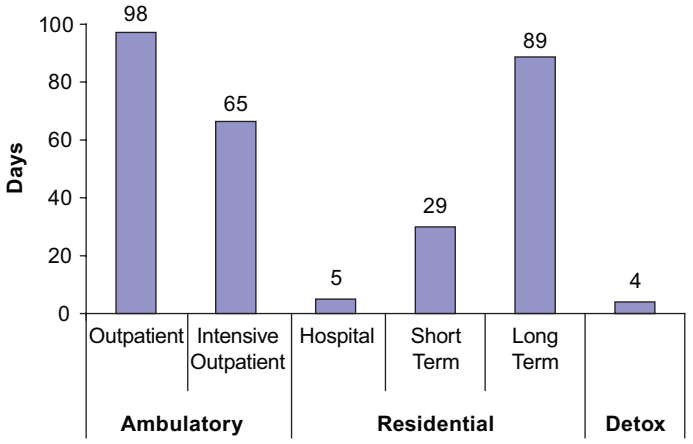
An available Retention domain measure is length of stay in treatment, which is reported by TEDS. In 2004, the median length of stay for discharges younger than 18 who completed their treatment varied by the type of service received: within ambulatory services, the median length of stay for outpatient care was 98 days and for intensive outpatient care 65 days; within residential services, median lengths of stay were 5 days for hospital care, 29 days for short-term care, and 89 days for long-term care; and the median length of stay for those completing detoxification services was 4 days (Figure 7).

Data on outcomes for four of the substance abuse treatment domains (Abstinence from Drug/Alcohol Use, Employment/Education, Crime and Criminal Justice, and Stability in Housing) will be available when the State Outcomes Measurement and Management System (SOMMS) data set is fully implemented in fiscal year (FY) 2008. For the remaining substance abuse treatment domains (Social Connectedness, Perception of Care, Cost Effectiveness, and Use of Evidence-Based Practices), information specific to the children, youth, and families population cannot be isolated from SAMHSA's national-level data sets and looked at independently from the broader population; thus, outcomes appropriate to the children, youth, and families population cannot be reported from SAMHSA's national-level data sets. However, SAMHSA's adolescent substance abuse treatment grant programs currently collect relevant data for use at the local provider level. For example, the Center for Substance Abuse Treatment (CSAT) program data indicate that the number of adolescents served in CSAT's Discretionary Services Program has grown fourteenfold from FY 2001 to FY 2006 (Figure 8).

Mental Health Services NOMs for Children and Families

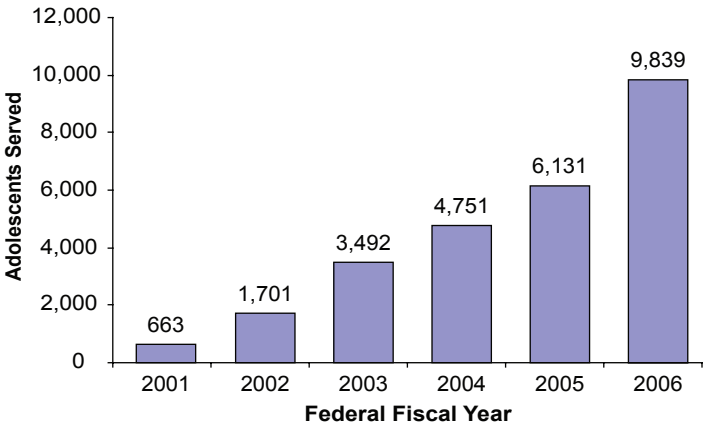
National-level mental health services data are available for 4 of the 10 domains (Stability in Housing, Access/Capacity, Reduced Utilization of Psychiatric Inpatient Beds, and Perception of Care). Data measuring Access/Capacity are from NSDUH.[2] In 2005, more than 5.5 million adolescents aged 12 to 17, over one fifth of this age group, received mental health treatment/counseling in the past year according to NSDUH data (Figure 9). Data measuring Stability of Housing, Reduced Utilization of Psychiatric Inpatient Beds, and Perception of Care are found in URS.[13] According to State mental health agencies, a majority of mental health

Figure 7. Median Length of Stay for Discharges Younger than 18 Who Completed Substance Abuse Treatment, by Type of Service: 2004



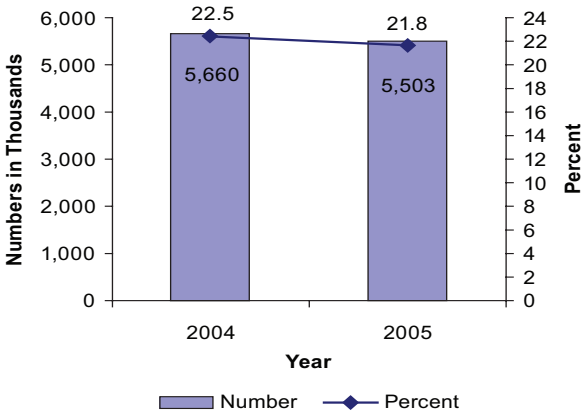
See notes at end.
Source: SAMHSA, OAS, 2004 TEDS [Data file—discharge data not released; for SAMHSA internal use only].

Figure 8. Number of Adolescents Served in CSAT's Discretionary Services Program: FY 2001–FY 2006



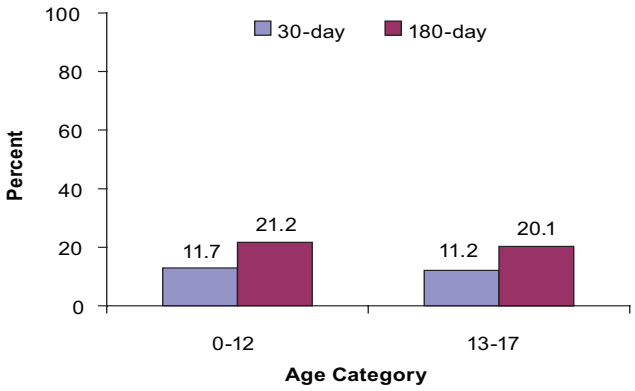
Source: SAMHSA, CSAT, 2006 Discretionary Services Program data.

Figure 9. Number and Percent of Adolescents (Aged 12–17) Who Received Mental Health Treatment/Counseling in Past Year: 2004 and 2005



See notes at end.
Source: SAMHSA, OAS, (2006), *2005 National Survey on Drug Use and Health: Detailed tables* [Tables 6.36A-B].

Figure 10. Rates of Readmission within 30 and 180 Days to Any Psychiatric Inpatient Bed in the State Mental Health Authority System, by Age Category: FY 2005

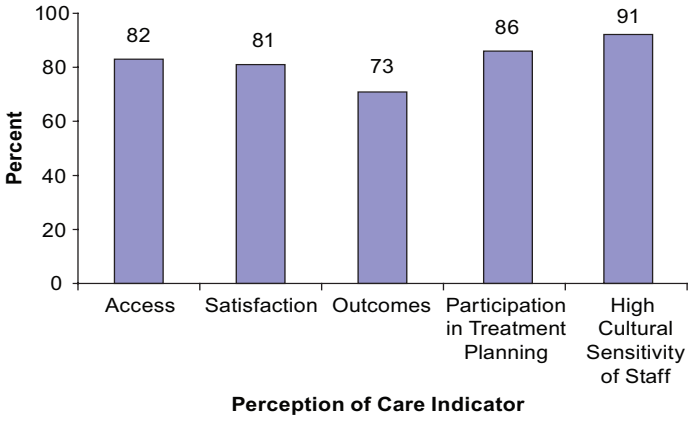


See notes at end.
Source: SAMHSA, CMHS, 2005 URS [Outcomes Domain Table 6].

consumers younger than 18 years old—71 percent—were living in private residences.[14] State mental health agencies also reported that only about 20 percent of children overall were readmitted within 180 days of discharge, with lower rates for readmission within 30 days of discharge (Figure 10). States' Mental Health Service Consumer Surveys found that most family members of child or adolescent mental health consumers reported positively about treatment. Generally, high proportions of these consumers—80 to 90 percent—were satisfied when asked about five indicators of care (Figure 11).

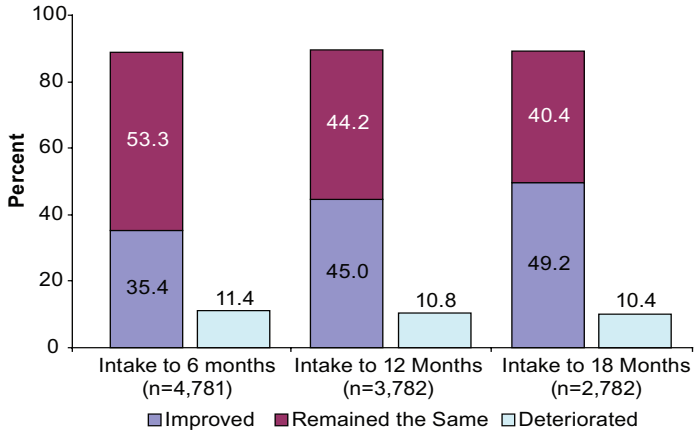
For the other six NOMs mental health services domains (Decreased Mental Illness Symptomatology, Employment/Education, Crime and Criminal Justice, Social Connectedness, Cost Effectiveness, and Use of Evidence-Based Practices), information specific to the children, youth, and families population cannot be isolated from SAMHSA's national-level data sets and looked at independently from the broader population; thus, outcomes appropriate to the children, youth, and families population cannot be reported from SAMHSA's national-level data sets at this time. However, many mental health grant programs do collect

Figure 11. Percent of Mental Health Service Consumers Reporting Positively about Services/Treatment for Children, by Perception of Care Indicator: FY 2005



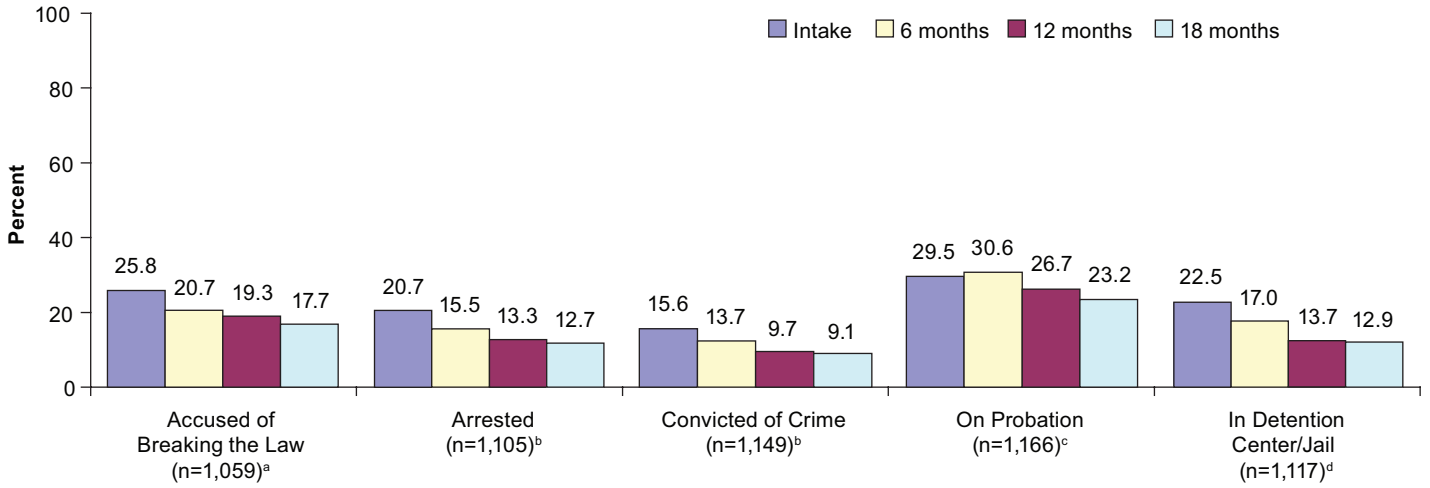
See notes at end.
Source: SAMHSA, CMHS, 2005 URS [Outcomes Domain Table 2].

Figure 12. Change in Children's Overall Behavioral and Emotional Problems, from Intake to 6 Months, Intake to 12 Months, and Intake to 18 Months



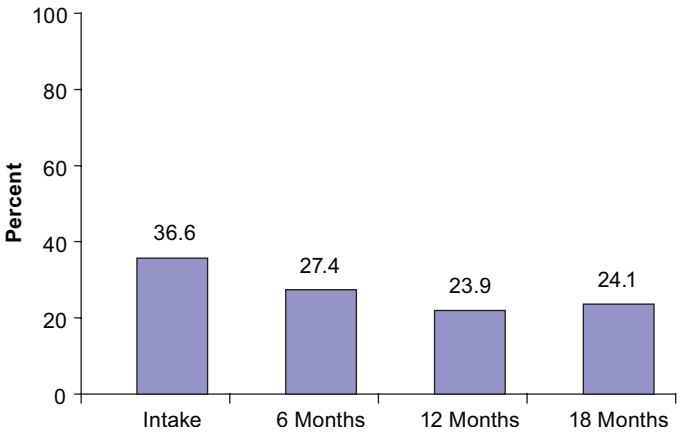
Source: SAMHSA, CMHS, (2007), Comprehensive Community Mental Health Services for Children and Their Families Program [Unpublished raw data].

Figure 13. Law Enforcement Contacts at Intake, 6 Months, 12 Months, and 18 Months



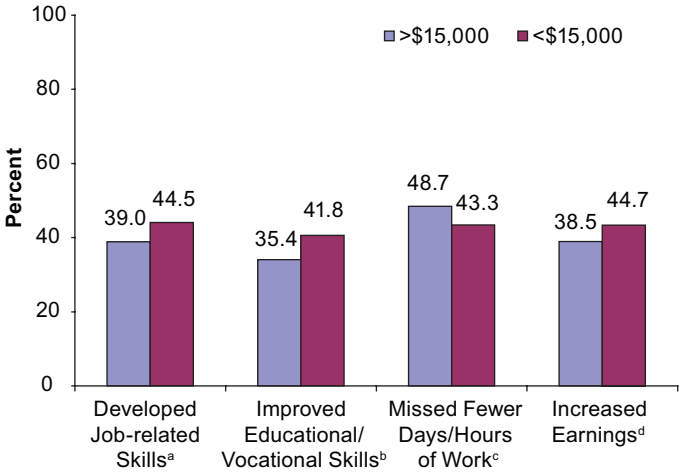
Source: SAMHSA, CMHS, (2007), Comprehensive Community Mental Health Services for Children and Their Families Program [Unpublished raw data].
[a] z = -4.61, $p < .001$.
[b] z = -5.38, $p < .001$.
[c] z = -3.93, $p < .001$.
[d] z = -6.41, $p < .001$.

Figure 14. Percent of Children Living in Multiple Settings at Intake, 6 Months, 12 Months, and 18 Months



Number of children = 2,238.
Source: SAMHSA, CMHS, (2007), Comprehensive Community Mental Health Services for Children and Their Families Program [Unpublished raw data].

Figure 15. Percent of Improvement in Economic Outcomes of Caregivers from Intake to 18 Months After Entering Systems of Care for Caregivers with Incomes Above and Below $15,000 per Year



Number of caregivers = 2,732.
[a] z = 2.75, $p < .01$.
[b] z = 3.26, $p < .01$.
[c] z = -2.67, $p < .01$.
[d] z = 3.11, $p < .01$.
Source: SAMHSA, CMHS, (2007), Comprehensive Community Mental Health Services for Children and Their Families Program [Unpublished raw data].

specific evaluation data related to NOMs. For example, in the Comprehensive Community Mental Health Services for Children and Their Families Program, data indicate improvements in behavioral functioning, reduced contacts with police, increased stability in living situations, and improvements in parental employment status (Figures 12–15).[15] Further, the National Child Traumatic Stress Initiative is working to achieve higher levels of functioning for children and adolescents exposed to different types of trauma, improved school performance, and the introduction of evidence-based practices that are trauma-informed.

Table Note:

Table 1: Respondents with unknown data were excluded (NSDUH Tables 3.39A–B).

Figure Notes:

Figure 1: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

Figure 2: Respondents with unknown data were excluded (NSDUH Table 3.1B).

Figure 3: Respondents with unknown data were excluded (NSDUH Tables 3.30B, 3.31B, 3.32B, 3.33B).

Figure 5: The substance prevention program refers to "a Drug, Tobacco, or Alcohol Prevention Program Outside School in the Past Year" (Table 3.36B); the program dealing with substance use refers to "a Program in the Past Year for Dealing with Drug or Alcohol Use" (NSDUH Table 3.37B); the exposure to prevention messages refers to "Saw or Heard Drug or Alcohol Prevention Messages from Sources" outside of or at school in the past year (NSDUH Tables 3.40B and 3.41B). Respondents with unknown data were excluded.

Figure 6: Respondents were classified as needing treatment for an illicit drug problem if they met at least one of three criteria during the past year: (1) dependent on illicit drugs; (2) abuse of illicit drugs; or (3) received treatment for an illicit drug problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers) (NSDUH Table 5.61A). For the definition of Illicit Drugs, see note for Figure 1. Respondents were classified as needing treatment for an alcohol problem if they met at least one of three criteria during the past year: (1) dependent on alcohol; (2) abuse of alcohol; or (3) received treatment for an alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers) (NSDUH Table 5.67A).

Figure 7: These are preliminary estimates based on data received through February 1, 2006, from the 28 States or jurisdictions that had linked discharge to admission records for 2004. This age group (younger than 18) included newborns with a substance dependency problem. The service categories exclude records where methadone treatment was planned (TEDS data file).

Figure 9: Mental Health Treatment/Counseling for youths is defined as having received treatment or counseling from any of 10 specific sources (e.g., private therapist, school counselor, special school program) for emotional or behavioral problems NOT caused by drug or alcohol use. Youths who answered none of the source of treatment questions with a "yes" and answered "no" four or fewer times were excluded from this analysis (NSDUH Tables 6.36A-B).

The 10 categories are defined in NSDUH Table 6.40. Note that respondents could indicate multiple sources; thus, these response categories are not mutually exclusive: 1) private therapist, psychologist, psychiatrist, social worker, or counselor; 2) school counselor, school psychologist, or having regular meetings with a teacher; 3) mental health clinic or center; 4) in-home therapist, counselor, or family preservation worker; 5) pediatrician or other family doctor; 6) overnight or longer stay in any type of hospital; 7) special education services while in a regular classroom or in a special classroom or placement in a special program or special school; 8) partial day hospital or day treatment program; 9) overnight or longer stay in a residential treatment center; and 10) overnight or longer stay in foster care or in a therapeutic foster care home. (Respondents who did not report their school enrollment status or who reported not being enrolled in school in the past 12 months were not asked about receipt of mental health treatment/counseling from sources 2 and 7.)

Figure 10: Data on the 30-day readmission counts/rates for 0- to 12-year-olds were reported by 13 States or jurisdictions and for the 13- to 17-year-olds by 14 States or jurisdictions. Data on the 180-day readmission counts/rates reported by 12 and 14 States or jurisdictions, respectively, for the two age groups (URS Outcomes Domain Table 6).

Figure 11: Consumer Survey results are reported in URS Outcomes Domain Table 2. The five indicators relevant to children and families were phrased in the Customer Survey, respectively, as follows: Reporting Positively about Access (42 States reported); Reporting Positively about Satisfaction (41 States reported); Reporting Positively about Outcomes (42 States reported); Family Members Reporting on Participation in Treatment Planning (43 States reported); and Family Members Reporting High Cultural Sensitivity of Staff (38 States reported).

References:

1. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006). *2005 National Survey on Drug Use and Health: National Findings* (NSDUH Series H-30, DHHS Publication No. SMA 06-4194—Figures 2.5, 2.6, 5.2). Rockville, MD. Retrieved Dec. 11, 2006, from http://www.oas.samhsa.gov/NSDUH/2k5NSDUH/2k5results.htm
2. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006). *2005 National Survey on Drug Use and Health: Detailed tables* (Tables 3.1B, 3.30B, 3.31B, 3.32B, 3.33B, 3.36B, 3.37B, 3.39A-B, 3.40B, 3.41B, 5.61A, 5.67A, 6.36A-B, 7.89B). Retrieved Dec. 11, 2006, from http://www.oas.samhsa.gov/NSDUH/2k5NSDUH/tabs/TOC.htm
3. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *2005 National Survey on Drug Use and Health* [Data file].
4. Data calculated from 2005 NSDUH restricted-use data file.
5. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006). *2005 National Survey on Drug Use and Health: Detailed tables* (Table 7.89B). Retrieved Dec. 11, 2006, from http://www.oas.samhsa.gov/NSDUH/2k5NSDUH/tabs/TOC.htm
6. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2005. Data on substance abuse treatment facilities* (DASIS Series: S-34, DHHS Publication No. SMA 06-4206—Tables 2.5, 3.5, 4.10B). Rockville, MD. Retrieved Dec. 11, 2006, from http://wwwdasis.samhsa.gov/05nssats/nssats2k5web.pdf
7. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *2005 National Survey of Substance Abuse Treatment Services* [Data file].
8. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *2004 Treatment Episode Data Set* [File of data received through Feb. 1, 2006—discharge data not released; for SAMHSA internal use only].
9. N-SSATS collects capacity information according to the type of care offered within a facility. In 2005, facilities were asked for the number of clients in non-hospital residential and hospital inpatient care as of the census date—March 31; however, facilities offering outpatient care were asked about the number of active clients—individuals who were seen at the facility for a substance abuse treatment or detox service at least once during the census month, and who were still enrolled in substance abuse treatment services as of the census date.
10. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2005. Data on substance abuse treatment facilities* (DASIS Series: S-34, DHHS Publication No. SMA 06-4206—Table 3.5). Rockville, MD. Retrieved Dec. 11, 2006, from http://wwwdasis.samhsa.gov/05nssats/nssats2k5web.pdf
11. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2005. Data on substance abuse treatment facilities* (DASIS Series: S-34, DHHS Publication No. SMA 06-4206—Table 2.5). Rockville, MD. Retrieved Dec. 11, 2006, from http://wwwdasis.samhsa.gov/05nssats/nssats2k5web.pdf

12. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2005. Data on substance abuse treatment facilities* (DASIS Series: S-34, DHHS Publication No. SMA 06-4206—Table 4.10B). Rockville, MD. Retrieved Dec. 11, 2006, from http://wwwdasis.samhsa.gov/05nssats/nssats2k5web.pdf

13. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (2006). 2005 CMHS Uniform Reporting System output tables (Outcomes Domain Tables 2 and 6, Appropriateness Domain Table 4). Retrieved March 12, 2007, from http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/urs2005.asp

14. Data on the percentage of children younger than 18 years old living in private residences were provided by 45 States or jurisdictions (URS Appropriateness Domain Table 4). Retrieved March 12, 2007, from http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/urs2005.asp

15. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (2007). [Analysis of data from the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program]. Unpublished raw data.

Appendix H: List of States Interviewed, with Organizations

State	Agency or Organization
Alabama:	Alabama Department of Mental Health and Mental Retardation; Division of Mental Illness
Alaska:	Alaska Division of Behavioral Health
Arizona:	Arizona Department of Health Services; Division of Behavioral Health Services
Connecticut:	Connecticut Behavioral Health Partnership
Florida:	Department of Children and Families; Alcohol, Drug Abuse and Mental Health
Idaho:	Idaho Department of Health and Welfare; Division of Behavioral Health
Illinois:	Illinois Department of Human Services; Division of Mental Health; Strategic Planning, Evaluation and Systems Analysis
Maryland:	Maryland Mental Hygiene Administration; Office of Planning, Evaluation & Training
Mississippi:	Mississippi Department of Mental Health
Missouri:	Missouri Department of Mental Health; Quality Improvement Section
Nebraska:	Nebraska Department of Health and Human Services; Division of Behavioral Health
Nevada:	Nevada Division of Mental Health and Developmental Services
New Jersey:	Family Support Organization of Burlington County
	New Jersey Division of Mental Health Services; Office of Planning and Evaluation
North Dakota:	North Dakota Department of Human Services
Pennsylvania:	Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services
South Carolina:	South Carolina Department of Mental Health; Office of Evaluation, Training and Research

Tennessee:	Tennessee Department of Mental Health and Developmental Disabilities; Recovery and Planning Services
Texas:	Texas Department of State Health Services
Utah:	Utah Department of Human Services, Division of Substance Abuse and Mental Health
Vermont:	Vermont Department of Health; Division of Mental Health Adult Services
Washington:	Office of the Governor; Washington State Mental Health Transformation Project
Wyoming:	Wyoming Department of Health, Mental Health and Substance Abuse Services Division

Appendix I: Comments on the Draft Final Report

Intro and Background: 1050 Task Force Structure and Process

Does there need to be anything added, changed, modified, or removed?

- "No": 7
- I would encourage you to add a few sentences about the underlying problems/issues that led to legislature seeing need for a TF (could be taken from enabling legislation language)
- I would like to see if there is a way to include the early childhood mental health work completed by the Blue Ribbon Policy Council. Is there some way to include the special issues of early childhood?
- The description was accurate and complete
- No, however, I am concerned that this report is geared toward the State level of system delivery and does not adequately discuss the lower levels of service delivery where the true services are provided to a majority of the State of Colorado. I think this report misses a major perspective that is not being explored and reported adequately.
- The structure is well-designed in its committee responsibilities and membership.
- The Program Committee's was charged-take out was
- Western Interstate Commission for (not "on") Higher Education
- At the end of the Introductory paragraph you define "behavioral health" as both mental health and substance abuse. You may want to adjust some wording so readers don't think you mean that substance abuse is healthy.

Do you have any other comments on this section?

- "No": 5
- "Good synopsis": 2
- Well written, easy to understand.
- Need to title the sections consistently.
- Amazing amount of work was accomplished in a short time
- See two descriptions of what is in appendix B: The 1050 Task Force created three committees – Program, Budget and Funding, and Streamline and Coordinate Services - to assist it in meeting its goal. The Budget and Funding, and Streamline and Coordinate Services became a joint committee given the overlap in membership and relatedness of charges. Overall, 90 individuals participated on these committees representing all perspectives of behavioral health including consumers and family members, providers, state agencies, and other interested parties. (Please see Appendix B for a copy of the 1050 Task Force Committee members.) The Program Committee's was charged with the identification of national and Colorado experts to inform the 1050 Task Force about behavioral health system building and improvement efforts. The Committee met five times between September and November 2007 to identify these national and Colorado presenters and key questions for panel presentations at the 1050 Task Force meetings. Twenty-five experts representing state departments, provider associations, advocacy organizations, behavioral health initiatives, and others presented on a range of topics on behavioral health. Topics included behavioral health system planning efforts, leadership and vision, consumer and family involvement, infrastructure, financing reform, contracting, and other topics. A complete list of presenters can be found in Appendix B. The Budget and Funding Committee's charge was to inventory funding

Intro and Background: The Research Process

Does there need to be anything added, changed, modified, or removed from this section?

- "No": 6
- This is a general comment: there are publications cited in various places in the document: will there be a bibliography at the end?
- The process was described very accurately. It was easy to follow the process used.
- I believe that the survey tool that was used was designed for state level agencies. I do not think it was user friendly and frankly the comments I received was that it was confusing and not easy to use regarding the identification of issues, outcomes and areas of change for the entire system. I commend the efforts, but I believe that the parameters placed upon the project from the beginning left certain segments of the critical needs and discussion biased.
- Yes- explain more in depth why the 27 people were removed. Isn't there some way to save their feedback? For many it was the sorting process not their lack of knowledge that was a barrier.
- Appendix D regarding DOC states that some facilities provide crisis management. While this is a technically correct statement, it could be misleading. It could lead one to believe that not all mentally ill inmates have access to crisis management. While we do not have crisis management at all facilities, those are facilities that do not have mentally ill inmates. A, more accurate statement might be that "All facilities that have mentally ill inmates provide crisis management".
- The enabling legislation is HJR 1050, not JR 1050 (in the header).

Is anything in this section difficult to understand or needing further explanation?

- "No": 5
- Even the reporting of the survey in this is difficult to understand regarding what it is telling the reader and the result of the survey overall.

Do you have any other comments?

- "No": 2
- "Good job!", "good synopsis", "looks fine": 3
- In reviewing the speakers and topics, I am left wondering if there was attention paid to inpatient hospitalization issues: state hospitals, private hospitals, or ACUs in Community Settings? This seems under-represented and is a critical issue in Colorado.
- Family and consumer involvement were important themes that ran throughout the process and were discussed at every meeting. I would like to see this addressed as stronger threads throughout the document. So it is not swallowed up and minimized.

Intro and Background: Contents of the Final Report

How can this section be improved?

- "No suggestions": 2
- This is confusing-says that section 1 is the executive summary but on the next page it says that Section 1: Planning Together: The Recommendations. same with other sections
- Still incomplete - the exec summary will help
- Do we have a recommendation for wraparound? As the integrated process at the family and child level and then the integrated structure in the county or region supports that service delivery model.

- I believe that there are several points that have been left out and should be addressed. Overall the report is complete for the state service level, however, the problems that exist and that need to be addressed are only slightly mentioned. The need for a different level of crisis stabilization is only briefly mentioned and yet is not mentioned as a point of major concern for law enforcement. The challenges facing the rural areas of Colorado are only mentioned with no real recommendation for change or adjustment. I believe that having adequate bed space to house individual in a crisis is not even mentioned in the report. There were other recommendations made as well regarding juvenile crisis stabilization and housing them in a detention facility until the crisis has passed. I believe that the commission recommended should have broad power and ability to hold hearings about certain events and episodes that overlap with mental health issues in Colorado. For example, the Columbine Incident should have been looked at from the mental health perspective. The recent church shootings in Arvada and Colorado Springs should be looked at from the mental health perspective along with law enforcement to determine better ways of dealing with these issues, make recommendations and learn how we can better serve the mental health community, the public and educate the public about these issues for the outcome of better funding and making these issues a higher priority in our community. At the last meeting in December when there was extensive testimony provided that helped to tweak the information presented to the group, I feel that this information was not provided. There is no discussion about the state wide triage system, special difficulties for the rural population areas and such. There was discussion about recommendations for the commission having rural representation. On another note, I am concerned that the make up of the commission is all state level agency appointments. I have found this to be limiting, as these individuals although well intended have a state level perspective that at times seems to miss the local level perspective of how things are operated and run. The state level is to ask the local level how things are going, but this is often very selective and does not translate well from the local level to the state level. I think this is one of my concerns about this report. It seems to hover at the state level very well, but it does not truly get into the translation from the local level where the true service contact is occurring. Once they get to the state level they are people with numerous issues identified and then the issues is how to best deal with them in the most cost effective way. I believe in what is being done here, and I commend everyone for giving it their best effort, but I believe that this report is not at the level of identification of issues and recommendations to truly overhaul a system that is broken and desperately needs repair. I will be glad to speak with you about my comments if you like. You know I am truly interested in this product and the overall hope for change that it will bring. Thank you for this opportunity and I appreciate your efforts greatly!!!
- With no executive summary yet, it seems incomplete. Not sure this is necessary, since the index includes the same information.
- (1)While joint budgeting and auditing has many useful purposes, it is essential to recognize the different mandates of various state agencies and how that impacts the ability to deliver mental health care. As an example, due to security issues in DOC, a mental health provider would not be able to see inmates who are patients with the same efficiencies that someone in a community mental health center would. It would be a mistake to compare apples and oranges in the budget process. It would be more appropriate to look at national standards for mental health staffing for DOC and evaluate DOC's staffing based on those standards ...than to compare DOC staffing with community mental health centers. (2)I laud the makeup of the recommended Commission with decision making capacity. However, it will be important for the leadership provided by the commission with decision making capacity to recognize that while some state agencies might have only one member on the committee, the number of mentally ill covered by that agency and the impact of that agency's ability to deliver care appropriately has far reaching effects on other agencies. (3)While consumer

involvement is always important, in DOC, due to security issues, the consumer involvement may not be able to meet the same community standards.

Vision and Guiding Principles

Does the vision resonate with you? And other comments on the vision.

- "Yes" (The vision resonates): 8
- Vision is well crafted and certainly in harmony with core principles being pursued by NAMI Colorado
- I would like to see a vision that includes an explicit commitment to the "Recovery Model", which is really a framing philosophy of recovery and hope -- It is a model that would push thinking beyond just health care services into community support, housing, employment, etc. -- it is consumer (and family) driven -- and there are precedents in states like Ohio. Without a commitment to this (or some other) framing vision of what is possible in terms of actual outcomes for people with mental illnesses, I do not see how we can achieve real change and realignments at the service delivery level where the rubber hits the road, and hard budget decisions will need to be made.
- The vision was reflective of what the group decided as the overall vision
- Under the "Planning Together" section - are we talking about the whole system or the public system only?
- The vision describes an ideal system with ideal results, which is as a vision should be. With mental illnesses, consistently high attainment may not be possible. This seems to be acknowledged by including crisis and levels of need.
- Paragraph 2 after Colorado Vision, I suggest the addition in caps: ----to ensure that the system is streamlined, funding is maximized, ADMINISTRATIVE COSTS ARE MINIMIZED, and uses cost-effective, evidence-based and ------
- This should be reflected in the recommendations Consumers and families receive quality behavioral health care that is individualized and coordinated to meet their changing needs through a comprehensive integrated system. They also have timely access through multiple points of entry to a full continuum of culturally responsive services from prevention, early intervention, crisis response, treatment and recovery provided by the integrated system.
- Not sure where to put this comment: The first paragraph of Section I references consumers being served by a "behavioral health" system. As CO does not have such a system, I'd suggest breaking out that term into "mental health and substance abuse systems".
- Great vision
- On page 7 you list several areas where consumers receive behavioral health services. Given the large number of people in the criminal justice system, it would seem appropriate to include them.

Do the guiding principles resonate with you? And other comments on the guiding principles.

- "Yes" (The guiding principles resonate): 9
- Having worked with a System of Care grant, I found the guiding principles familiar and comfortable. As a provider and supervisor of those who provide direct mental health services, I find the voice of providers missing. I suggest a principle such as "Direct service providers are engaged in and participate in meaningful ways at the system as well as the service delivery level". Providers need to be held to high standards of professionalism and then need the support of the system in the areas of reimbursement and benefits as well as working conditions that support professionalism.

- They are lofty though...
- The only suggestion I have is to discuss more fully the thoughts behind agencies being able to request joint monies. It may require more discussion about the existing process and then the concept of joint requests.
- It makes sense to set vision & principles for the whole system, not just the public system. I also wonder, even though we did not discuss it - realistically, every person cannot access every possible benefit due to the prohibitive cost so we really need to set up a system that also has some limits in place.
- Make family and consumer participation throughout the development and implementation process stronger
- Page 8 under Data Driven (suggested additions in caps) Conducts high quality, OUTCOME-ORIENTED, data gathering, evaluation, and information sharing; AND: Under Sustainable Change and Leadership: State leadership is in place to oversee and support the implementation of policies, regulations, funding, MINIMIZATION OF ADMINISTRATIVE COSTS, and programming ----
- The principles should be reflected in the recommendations. Most are but you're missing "comprehensive integrated system." Needs more recommendations…"timely access through multiple points of entry". Needs recommendations... "crisis response" we need a state wide crisis response system recommendation!
- The recommendations need to follow the guiding principles.
- I believe the most important is sustainable leadership. Being a family member, I am heartened to see that consumer/family involvement is critical. And equal partnerships among mental health, physical health and substance abuse.

The Recommendations

Are these recommendations as a whole an accurate reflection of the consensus reached by the 1050 Task Force?

- "Yes" (Recommendations are an accurate reflection): 6
- Having not attended most meetings I cannot comment on this. However, I would observe that while issues of employment and housing are mentioned in the vision and guiding principles, I do not see those concerns, which are central to sustainable recover, addressed in the recommendations or in the proposed composition of the Commission.
- OK, I think we are missing certain items and perspective as previously mentioned.
- I would like to see consumer and family worded stronger
- Not having been on the Task Force, I can't comment on this.
- I would add a recommendation titled Comprehensive Integrated System which is talked about in the vision but is not a recommendation except in relation to funding. This would allow you to speak about no wrong door, wrap around services, a statewide crisis system, etc.
- I think the commission has done a terrific job in identifying the recommendations. It is a very comprehensive list, and I believe the recommendations capture the needs of our system.

Recommendation #1: Leadership Structure

- "Communities" is too vague a term. Do you mean cities and counties? How would the specific representatives be selected?
- It is a hopeful recommendation. The silos and splitting of services and oversight creates intractable problems for consumers and providers.

- Suggest discussion the role of BHS, as the recognized state BH authority, and how its role may change based on the recommended Commission...Who is in charge? Who is responsible?
- The recommendation should stress the commitment from each agency to send someone who can speak for the agency in decision making processes
- I believe that this area could be improved to include more local representation and not state agency participation only.
- I'm wondering if we need to specify that the Commission's role is for the public system...insurance companies may be opposed to this structure because they will be concerned about legislative mandates regarding benefits...I'm also concerned about too many political appointments to the Commission - it can sharply hamper progress in administrations that do not value public benefits.
- yes- make sure families and consumer do have an active voice on the commission
- While a cabinet level position would raise the importance of behavioral health to its needed status, a Commission, though large and perhaps unwieldy, is a good first step following the good work of the Task Force, given the complexity of the changes envisioned. Requiring the involvement of consumer and family advocacy groups is essential.
- Paragraph 2, bottom line: (suggested addition in caps) --effectively utilize funding, and reduce ADMINISTRATIVE COSTS and duplication across systems. And: Paragraph, second and third sentences: I suggest making the role of the Commission stronger by changing these sentences to: As such, it will coordinate other task forces, councils, and policy bodies charged with addressing a specific topic area within behavioral health. The Commission will help to combine or integrate the efforts of cross-systems behavioral health.
- I laud the makeup of the recommended Commission with decision making capacity. However, it will be important for the leadership provided by the commission with decision making capacity to recognize that while some state agencies might have only one member on the committee, the number of mentally ill covered by that agency and the impact of that agency's ability to deliver care appropriately has far reaching effects on other agencies.
- The recommendation needs to clearly state that the commission would report to the Governor. I am not clear who implements the decisions that the commission recommends.
- I'd suggest that the Department of Regulatory Agencies (and/or Division of Insurance) be included due to workforce, licensing, etc. issues in the public system. Also, I'd suggest separately noting counties, and perhaps law enforcement, in the "communities" line for "other representatives". Also, the Dept. of Labor and the Commission on Higher Education (or other Higher Ed) representative should be at least noted, again particularly for workforce issues.
- I embrace the idea of a Behavioral Health Commission. We must have state level leadership structured as you have described, for the commission to succeed.
- This isn't a comment on your wording of the report, but more of a question on the role of the Commission as outlined on page 9. It seems to me this is an area that needs a lot more thought. I can understand the interest of having a Commission with some clout, but also understand the technical, organizational and legal difficulties of having a Commission with that broad representation to be able to make decisions that commit the various agencies and organizations. For instance, I doubt anyone representing the legislature could make commitments for the entire legislature. Perhaps what is needed is just some further clarifying language about what authority/commitment ability/etc. is meant.
- The proposed Commission should provide the authority to move things forward diligently.
- I think there is a tremendous opportunity for this Task Force to develop a place of responsibility and authority for a Commission to be developed to that has the ability to hold hearings about certain events or incidents to fact find and provide lessons learned or make

adjustments regarding the delivery or services being provided regarding mental health issues in Colorado. For example, having the authority to have a hearing about the recent church shootings. Find out the facts, and then present them to the State of Colorado regarding the education, lessons learned, and what can we learn from this that can we use to provide better services to the community if any. Having the ability to have this type of fact finding commission with the ability to make recommendations can lead to better education, public dialogue, shared information with the public about the factual basis of what occurred, instead of conjecture and greater stigma about a "crazy person" who did something. I believe the potential gain for having this type of authority and place for it to reside state wide could be very important for the transparency and health of the state when these things happen. I also admit that legally there may be better avenues for this to occur that has more or better advantages legally, politically and for the benefit of mental health. I am sure that Ms. Coffman from the AG's Office would be able to make some recommendations and provide guidance and feed back to these two issues.

Recommendation #2: Shared Outcomes

- "Ok", "Looks Fine", "No comment": 3
- Strongly agree.
- Not enough info to comment.
- Shared outcomes, if they do not continue to include agency-specific outcomes as well, will drop down to the lowest common denominators and may not stretch the measurement of important measures for various agencies.
- I believe that one of the major outcomes of this TF should be education of the public to include a mandate that this occur and the ability to hold hearings on certain events etc, that overlap with other agencies such as law enforcement and mental health agencies in an effort to learn from and develop better ways of dealing with an preventing certain issues from occurring again in the future.
- This statement needs the additional work suggested for the January meeting in order for it to resonate with me. However, there must be measurable outcomes with accountability or nothing significant will improve or change.
- I am not totally sure where to put this, but wanted to share that the concept of using evidence based practices is a good one it is important to note that in the area of Mental Health and Substance Abuse services there are really very few Evidence Based Practices that have emerged, there are promising practices based on research that are on the way, and others that are just beginning to get the data pathway developed to measure them (yet, they appear to be affective). I don't want folks to think we have enough established EBP's in this career field to cover everything. A fear is that the State could move towards only funding EBP's and right now that would be a mistake. On the other hand, we should be measuring outcomes on what services are being provide, and then using practices more universally that show they are achieving those outcomes clinically, and with cost effectiveness. As a provider organization our members really want to do more data collection and outcome measurement. One problem we are facing is the funding to do this. Almost all of our funding is interested in paying for the specific service delivery, but not in paying for research and data development. I hope as we get the state to look at making changes to brining what resources we currently have in the area of data and outcome measurement together to make best use of those current resources, and that they consider getting funding to help us expand our data collection and outcome measurement. A recent example of this is where Aurora Mental Health Center is facilitating a joint meeting of both local and state level data folks to work together in the area of criminal justice. I can get you a contact if you need it.

- I'd suggest noting that any shared outcomes should be integrated / coordinated with federally mandated ones. Most existing "outcomes" measures for mental health and substance abuse are federally based.

Recommendation #3: Alignment of Service Areas

- "Looks fine", "No comment": 2
- This would be very helpful - consumers and providers alike get very confused about where to go and who has limits and who doesn't.
- I believe that this is critical in helping to streamline the service delivery that is needed. I also believe that state regional crisis stabilization units are needed. Having them in three main areas or the state is not helpful, and puts a tremendous strain on local service providers in the rural areas of Colorado.
- very important
- This is a challenging recommendation. However, it bodes well for rural areas if it can be accomplished if funding is adjusted to be equitable for these rural areas
- The reality is that County based alignment is the most logical and proven successful.
- I hope this can be accomplished.

Recommendation #4: Joint Auditing Across Systems

- "No issues", "Looks fine", "No comment": 3
- Somewhere within the recommendations is there embedded the concept of 'joint accountability?", as well as joint planning, auditing, etc.?
- Very important. Accountability needs to be real and effective. We spend too much time trying to meet various audit requirements that are incongruent. This wastes resources.
- The concept may need more explanation. The criteria being reviewed in the audit would need to be clearly defined prior to auditing.
- Also important
- Joint auditing sounds reasonable; this recommendation may need further explanation of who does them and how such audits are envisioned.
- (1)While joint budgeting and auditing has many useful purposes, it is essential to recognize the different mandates of various state agencies and how that impacts the ability to deliver mental health care. As an example, due to security issues in DOC, a mental health provider would not be able to see inmates who are patients with the same efficiencies that someone in a community mental health center would. It would be a mistake to compare apples and oranges in the budget process. It would be more appropriate to look at national standards for mental health staffing for DOC and evaluate DOC's staffing based on those standards ...than to compare DOC staffing with community mental health centers.
- Both this and #11 are very important in an additional way. On the provider and BHO level the varied requirements in both auditing, and other rules and regulations creates a huge amount of extra paperwork and administrative overhead that could be reduced and the $ better used to increase service capacity and work force development.
- I'd suggest defining the term "auditing" as both fiscal and clinical/compliance. Depending on a person's view point, this term might not resonate. For example, fiscal folks see "audit" differently than monitoring/compliance staff. Integrating both fiscal and clinical/compliance functions would be recommended.

Recommendation #5: Joint Budget Planning Across Departments

- Yes, yes and yes - families should not have to struggle with where funds come from and where to go for what. That should be taken care of at a macro level.

- The comment may need to be made that this would be a future goal or that any new monies requested would be done in this manner
- I believe we can do a better job with this process in many areas to include mental health issues.
- You may have to do away with the crosswalk process for this to happen but it will result in increased communication and decreases in cost
- Definitely needed. The problems at present are well explained.
- looks fine
- Add a five year strategic budget planning process to the recommendation. Often savings for a new program are not seen for several years and this would be a way for long range benefits to be part of the discussion and process. MHAC has a piece of legislation that, if passed, would make this possible.
- I could not agree more with the competition for funding, and the necessity to change this process.

Recommendation #6: Integrated BH Policies, Rules, & Regulations

- "No comment", "no issues", "looks fine": 4
- Again, strengthen consumer family involvement here
- The problem is described accurately. Did the Task Force take into account that HCPF is due to renew contracts for Medicaid mental health providers and that these contracts are for multiple years?
- Statewide crisis system needs to be incorporated
- Seems important and helpful.
- I would love to see something included in the report about finding a way to have HCPF support at DC:0-3R crosswalk. When Claudia Zundel, Division of Mental Health's early childhood specialist presented to the council she explained that a more appropriate diagnostic system for young children called DC:0-3R has been developed. In order to be reimbursed for using the DC:0-3R codes a crosswalk to ICD-9 codes has been developed. It would be helpful to have HCPF support this crosswalk. This would further the appropriate diagnosis and treatment of young children. This recommendation comes from 6 years of work completed under Project BLOOM, a federal system of care grant.

Recommendation #7: Financing Reform to Support an Integrated Behavioral Health System

- "No issues": 1
- Again, I think it is very important to create a financing structure that minimizes the barriers and silo effects and maximizes the use of the funding we have across systems. We really worked on understanding this with Project BLOOM and ended up with such a complex maze of funding streams, each with separate parameters and requirements that interfered with good system development from the family or service provider perspective.
- The discussion needs to stress that new monies must be added to make some changes possible. Shifting of existing dollars will only change where the critical needs are.
- I think we should be cautious about using Medicaid or CHP+ expansions as the answer. While Medicaid waivers are popular, they are extremely labor intensive and come with an extensive set of evaluation requirements that might not be in alignment with the system's shared outcomes. These waivers/expansions really pit the advocacy groups against a more comprehensive effort and leads to more siloing of benefits according to "diagnosis" which does not benefit the overall health of the population. Each new Medicaid waiver creates a "new" class of limited benefits for specific populations (increases the administrative burden

substantially) versus creating a reasonable baseline level of benefits for all. The advocacy groups really foster this approach.
- Without funding the greatest plans are never implemented
- This recommendation sounds good; equal always seems desirable. However, given the high cost in human lives ad the cost to the state for untreated or under-treated severe mental illnesses and/or substance abuse, the past emphasis on treating those most in need with available funds still has merit. I understand that the Task Force did not spend much time on determining which groups of persons (children, adults, substance abuse, mental illness, etc.) received services from each funding entity. Nor did they look at those who have never received services or treatment, but still cost the state large amounts of money as a result of lack of treatment. I believe this is the elephant in the room that is consistently overlooked or minimized. The new Population in Need Study and its additional data that is forthcoming will identify a huge number of untreated persons with mental illnesses and/or substance abuse. A myth, in my opinion, is that only 1/3 of those who need services will accept them. The state cannot afford to accept this myth or to ignore the impact of these untreated persons, both for humane reasons and for financial ones. The Commission should be given full disclosure of this reality.
- First paragraph, third sentence: Suggested addition is in caps. It also should address the inequity in rates between the different systems providing behavioral health services. THESE INEQUITIES SHOULD ALL BE ADDRESSED AT THE SAME TIME SINCE THEY ARE INTERDEPENDENT. REDUCING RATES IN SOME REGIONS IN COMMUNITY BASED SERVICES MAY LEAD TO HIGHER RATES OF USE OF RESOURCES IN CHILD WELFARE, YOUTH CORRECTIONS OR ADULT CORRECTIONS.
- Loosening the Medicaid enrollment standards to both streamline the process and to make more people eligible.

Recommendation #8: Electronic Cross-System Data Collection, Sharing, and Evaluation
- "No comment": 2
- "Good / Excellent Idea": 2
- This is a laudable and important goal. It will however be vexing to achieve. With that in mind, I would hope interim agreements could be implemented to insure consumers will not loose services as they move from system to system. Perhaps there needs to be a 'hold harmless' period where the receiving agency agrees to accept the evaluation and service plan of the sending agency and provide services under that plan for a period of time (1 or 2 months) until it can complete its own triage and evaluation process.
- Very difficult to maintain a balance between confidentiality for consumers and families and a good sharing of data - an important issue to tackle as the experience for the client is so fragmented and repetitive.
- Please stress the electronic health records more
- okay as long as process is really explained to families and consumers- they need to realize the potential benefits
- I understand and appreciate the benefits of such date sharing, both for efficiency and for best results in treatment. A concern is the effect that knowledge of such sharing may have on a person's willingness to become involved in systems. While there are benefits for identifying a child or even an adult early, stigma, stereotyping, lowered expectations can have a negative effect and must be considered.
- Paragraph 4, second sentence: suggested addition is in caps. The electronic system would include and electronic health record with a common consent form for the release of information and treatment plan INCLUDING ANY ADVANCE DIRECTIVES FROM THE CONSUMER.

- I hope this can be accomplished. I think it would create a much more effective system.
- I have only a few items to be considered. Under Recommendation #8, pages 12-13, I suggest a revision and addition to the recommendation language. In particular, I suggest avoiding the language of "developing and implementing an electronic...." since the state now has a new office of technology that will need to be involved in any discussion about development of technology systems. Instead, consider this language: "The 1050 Task Force recommends that the Commission investigate and develop recommendations for utilization of an electronic cross-system data collection, sharing, and evaluation system to better serve and meet the needs of consumers and families with behavioral health needs. The electronic system would include an electronic health record with a common consent form for the release of information and treatment plan and should follow the technical standards for the operation of health information exchange being established by the Office of the National Coordinator of Health Information Technology in the U.S. Department of Health and Human Services. The benefits of such an electronic health record for consumers and providers would be numerous and particularly advantageous in emergency situations where emergency/crisis services are often provided at locations other than where primary care is provided."
- I think there is an opportunity to talk with the Police Officer Standards and Training P.O.S.T. group about having new police officers who go through the POST certification training at an academy obtain Critical Incident Training (CIT) of how to deal and handle calls regarding the mentally ill or people in a crisis. This training is widely available now, and comes in tow forms, an 8 or 16 hour version, and a 40 hour version. The level of training required from the academy could be up for debate, but i think this could be an important recomendation for the group to discuss and work with the POST board on.

Recommendation #9: Cultural Competency

- "No comment", "Looks fine": 2
- A difficult area to set measurable goals - I think the thing that helps the most in this area is diversifying the workforce.
- This is needed to provide services to all segments of the population regardless or origin and status in the country when services are needed in a crisis.
- Worthwhile, important and challenging. No argument with this goal.
- [Our organization] totally agrees with the Commission to develop and implement cultural competency standards, definitions, and requirements, including training and reporting in order to provide equitable treatment of culturally diverse consumers and families with behavioral health issues. While we believe [our organization] has the expertise and experience in this area, we do lack adequate resources such as funding and manpower to totally immerse ourselves in this area. Therefore, any support in resources would be helpful.
- It would be good to have something about disparities in rural and frontier areas but I wasn't sure where to put it.
- Also, consider adding this language under Recommendation #9: “The 1050 Task Force recommends that the Commission work in collaboration with the Colorado Health Disparities Leadership Council to develop and implement cultural competency standards, definitions, and requirements, including training and reporting, to provide equitable treatment of culturally diverse consumers and families with behavioral health issues.”

Recommendation #10: Consumer, Family and Youth Involvement

- "No comment", "Looks fine": 2
- There are three pieces to this that perhaps need to be more clearly defined. One has to do with consumer, family and youth participation in planning. This is well addressed. The other

two issues I think are important include 1) cross system consumer and family evaluation of services on a regular basis, widely reported; and 2) more systematic use of consumers and family members as peer educators, resources, and participants in actual service deliver.

- It would be great to have support for strong consumer, family and youth involvement. This has been one of the best parts of working with a System of Care grant and we will be losing the funding to support meaningful family involvement. It needs to be required, funded and supported with training for the consumers/families/youth and administrators and providers to be successful.
- I would like to see money attached to family involvement and for it to be spelled out so it becomes real.
- I believe that the definition of consumer should be expanded to include the local agencies that interface with these agencies for services from time to time. Communicating with local law enforcement and other entities that access the mental health services from time to time would be very helpful. I believe that this is often ignored and has lead to the need for this type of discussion and need for change to be so strongly asked for.
- The money needs to follow the consumer and many of these issues will self resolve. This is very important and needs some more build out
- I appreciate the recognition that, like cultural competency, involvement of consumers and family members of both children and dependent adults is often considered a burden and a nuisance for many providers. What is provided is often token. Standards and requirements are essential. I applaud the frequent emphasis throughout the report on the need and the value of the consumer and family voice of experience and as a reality check.
- While consumer involvement is always important, in DOC, due to security issues, the consumer involvement may not be able to meet the same community standards.
- Family members and consumers know better than anyone what works, what doesn't work, and what is needed.

Recommendation #11: Workforce Development

- "No comment": 2
- "Very Important / critical": 3
- Colorado lags, in general, in its licensing and continuing education requirements of health care professionals. Such requirements not only enhance the skills, but also the prestige associated with these important jobs.
- I would like to see a more concrete recommendation that all providers be licensed and regulated and required to have CEUs. The requirement of CEUs pushes the training and educational system to offer more opportunities and develop the capacity to reach out to rural areas, etc. I would like to see specific endorsements required for specialty areas as well.
- I would like to see wraparound and SOC values and principles part of workforce development.
- Opportunity to discuss higher education link & disconnect with preparing folks to work in the public sector.
- There is a greater need for more CIT training to be provided to law enforcement. I believe that this task force could work with POST to mandate new police officers receive CIT training in the police academy before they even hit the streets.
- Obvious consequence of the other recommendations if the need for experienced and committed staff trained in best practices and promising practices. Incentives for students to become such providers are essential and valuable.
- Very important addition to paragraph two in caps: ---services for primary care physicians; COMPENSATION FOR COMMUNITY BASED BEHAVIORAL HEALTH PROVIDERS AT

LEAST EQUAL TO THEIR COUNTERPARTS IN STATE EMPLOYMENT, and tuition reimbursement----

- Colorado is faced with a shortage of psychiatrists...especially outside of Denver. Tuition reimbursement is an excellent area to address. While DOC is not a region that is solely classified as rural, DOC is traditionally considered an underserved population in other states...regardless of what city the workforce is in.
- While we feel workforce development is a critical component toward an integrated behavioral health system, this recommendation and strategies could potentially limit [our organization's] ability to fully serve the system based upon our current resources.
- Rural and Frontier communities have a severe problem in this regard
- Please see comment about including DORA in the Commission. I don't feel as strongly about the Department of Labor, but perhaps they can be mentioned.

Q-Sort Survey Results

Do you have any comments on the Q-Sort Results?

- "No": 1, 1, 1
- "Good": 1
- I found the distinctions between groups 1, 2, and 3 kind of fuzzy to follow as currently written and in the case of group 4; the quotes do not align with the description of a group supporting current structures. Tee chart, however, was very helpful.
- How do the q-sort results relate to the recommendations in the report?
- Interesting - I think the results would be stronger if there had been more participation. Difficult to get a lot of people to respond to system-type questions, but still it is a limited sample.
- First 2 paragraphs talk about mental health; do you want it to be behavioral health?
- No easy to read and understand. I am unsure what it is really saying, and one of the rules of any graph or chart is that it should be easy to read and understand. I find this one to be confusing, not sure what it is really saying and what message I should be taking away from the data collected. I also found this tool to be geared to the state agencies, and was not useful for the local agency or individuals to provide feedback on what the real problems are and how to discuss changing them.
- You need to explain that this was a very challenging process and folk's inability to complete this task should not negate the value of 27 people's ideas.
- Describing by clusters was easy to understand and showing the groups who responded in each cluster was informative. The comparative responses by survey question were a little difficult to understand, i.e. value is greater than or less that 1. What was the significance when there was no smiley face of arrow? Could this be better explained? It helped to have the commonalities highlighted after this section. Giving numbers of respondents and percentages of categories who agreed with individual clusters was very helpful in seeing how opinions fell and in understanding the recommendations, which fell primarily within clusters 1-3.
- Maybe match up with recommendations?
- I appreciated that you were able to identify respondents who had a lack of knowledge, and were able to not include those responses. I had been concerned about that. I loved all of the information about the clusters.

Colorado's Behavioral Health System: Themes

Themes and Opportunities Identified from State Agency Interviews and Plans:

- "No comment": 2
- As noted earlier, and I do not know where to place this comment, two areas of service need seem to be overlooked in the report: 1) housing and employment and 2) inpatient hospital care providers, (including long term care providers such as nursing homes)
- May want to organize so that the themes are clear and may need to describe some of the opportunities.
- The perspective from state agencies is important, but I would like to see this TF also include local discussion of how to improve the system. The state perspective does not necessarily translate into a true collaboration with all of the service providers and making sure they are being heard as well.
- Please make this document a true agent of change that include many perspectives and true collaboration from taking comments that have a differing point of view than from an agency head.

Relationships with Service Providers: Cross System Alignment:

- "Yes": 2
- Do you want the opportunity for Research Based Practices to be limited to mental health?
- I feel this is too one sided again. No real feedback from the local service provider.
- I like the way that you did the section on evidence-base strategies...I think it will be important that we move in the direction of evidence-based work and put some intermediate steps in place to get there. (it will be important that rural interests don't derail this objective.) I also like that you have infused the experiences from other states into each category.
- Good seems to match with recommendations
- Use of the term "behavioral health providers" is confusing. While there are some providers that provide both mental health and substance abuse services, there is no current "behavioral health" provider system. This is, of course, part of the problem.
- List mental health and substance abuse providers separately. Define auditing as both fiscal and clinical/compliance/monitoring.

Information Collection and Sharing:

- "Yes", "good", "no issues": 5
- It will be critical to articulate clear, transparent systems outcome objectives. Information collecting and sharing need to relate directly back to these outcomes (not just process outcomes, but impact/recovery outcomes)
- Seems to match with recommendations
- The problem is identified.

Cultural and Linguistic Competence:

- "Yes", "Good", "No issues": 4
- Are we thinking about statewide standards for all service delivery, not just BH?
- Seems to match with recommendations

Consumer and Family Involvement:

- "Yes", "Good": 4
- The point about supporting transportation, child care, or other expenses related to family, youth, and consumer participation is very real. It is not just a 'nice to have' but essential in order to have sustained participation that is more than just window dressing. I would argue

that 20% requirement is a MINIMUM and perfectly reasonable if we accept the statistic that 20% of population will experience a mental illness in their lifetime.
- Extremely important. It will be critical to make sure that policies/systems changes are not made on the basis of one person's consumer/family experience. (Always the danger of the personal anecdote and the "n" of 1!
- I think this is the one area that can be added to and built up.
- Explanation made in previous comments
- Descriptions from other states makes this strong
- See previous comments regarding DOC population and consumer involvement.
- I believe that family and consumer involvement is not at all near the level that it should be within any of the behavioral healthcare organizations.
- Strengthen roles and importance of involvement in recovery process.

Service Areas and Regions:
- "Yes", "good": 3
- Good job of suggesting alignment versus realignment - great use of state examples.
- A bit confusing but so are all the boundaries
- Stronger if includes mapping info on the different systems to show is broader than juvenile justice
- As previously noted, DOC is considered an underserved region in other states, regardless of which city DOC services are provided in...and how rural that city is.
- I think it will be important to define what alignment may be. I understand the need to be vague on this right now, but for example, doing a county by county realignment may be going too ar. In some rural areas you almost have to do a regional approach to have enough resources and workforce to meet the needs.
- The problems are identified.

Approaches to Behavioral Health:
- "Yes", "no issues", "ok": 4
- Does this align with recommendations?
- I know some substance abuse providers are very cautious about this because they do not want to lose their funding and specialty. On the other hand, service delivery needs to be integrated.
- An integrated system is essential to effective treatment.
- "State staff encouraged broad visioning on behalf of all Departments and the development of a cross-system framework."-would be stronger IF there were a recommendation from the task force on this.

Professional Certifications:
- "No issues", "Yes", "ok": 3
- Address items in recommendations: standards for co-occurring training curricula and cross-training on mental health and substance abuse; use of telemedicine; availability of consultation services for primary care physicians; and tuition reimbursement for needed behavioral health specialist in underserved areas of the state.
- Maybe name this section workforce development to align with recommendation
- It is not accurate to state that DORA does not require licensing; this is most of what they do. I'd suggest eliminating that sentence as the differences between why substance abuse professionals are generally not licensed might be too in depth for this brief section. Alternatively, you could write about how most mental health professionals are licensed thus

do not require additional certification. Or, note the differences between certification and licensing generally, which would require changing the title to this section.
- I was very surprised to read that there are no "ADAD like" requirements for mental health.
- Statement: The Colorado Department of Regulatory Agencies (DORA) does not require that mental health professionals be licensed is not accurate-The legislature requires licensure not DORA, and mental health professionals are required to be licensed or unlicensed are required to be in database.

Budget and Funding:
- "Yes", "ok", "Good": 4
- Good suggestion for planning funding. Although, we never seem to get past planning and into implementation. You might add the importance of a commitment and funding source to actually do the hard work of implementing these changes. State systems are used to competing with each other in the budget process so this is a major shift.
- Isn't the LINKS plan focused on kids and families? Perhaps it can be noted as an (process) example but not suggested as an existing plan that covers all populations.
- I like that you have included resources for systems change.

Colorado's Behavioral Health System: Behavioral Health Related Funding Streams

Do you have any comments on Section 4: Behavioral Health Related Funding Streams?
- "No comment": 4
- "Good": 1
- "I am eager to see the matrix": 2
- The priority funding streams lean heavily to those for children. How will combining these streams allow for funding for all age groups?
- It is a massive amount of info though
- Any discussion about the use of the Inventory?

Appendices

Do you have any comments on the Appendices?
- "No comment", "good": 2
- Lots of good information here. Worth completing the section on the key agencies.
- I felt like some of the recommendations made in the last December meeting are not included here? Crisis stabilization, rural issues, triage centers spread across the state. Bed space for individuals. Co existing mental health and substance abuse issues and follow up after release, etc. Commission having the power to hold hearing and make recommendations for change and improving the system. More training for LE in the police academy.
- Very helpful information that I will keep and refer to often in my advocacy efforts.
- Page 50, 2nd paragraph – Screen for substance abuse should read screen for substance use. Also, there is no mention of Peer Assistance Services, Inc. or OMNI however it may be the intent to cite state agencies only which is fine.
- Page 53, 1st paragraph – Describes SBIRT as brief screening of high-risk substance user - should be described as universal screening focusing on early identification and intervention with the non-dependent alcohol and other drug user. 4th paragraph – for clarification,

SBIRT was awarded to the office of the Governor, is administered by the Alcohol and Drug Abuse Division, and is managed by PAS. Jose Esquibel (CDPHE) is the chair of the SBIRT Colorado Policy Steering Committee.
- Also, we noted that there is no mention of the presentation by Susan Foster from Columbia University which was a joint presentation to the Meth Task Force and the 1050 Task Force.
- We did not really have sustentative changes to the report but a clarification was suggested for page 46: "Although HMOs contracted for CHP+ would like to provide mental health services as well as health services, they are concerned about their financial risk exposure in providing them. ...".

Overarching Questions (on the report as a whole)

Does the report resonate or conflict with what you know?
- "Yes", "Resonates": 5
- It is honest about many of the problems.
- CO needs to clearly decide the degree of integration it wants, both for MH & SA as well as across agencies. Some states report that although integration for co-occurring services makes good sense...over integrating may dilute Mental Health & Substance Abuse, provides less 'face' time with policy makers and the term 'behavioral' may further promote the mentality that MH & SA are behaviors versus disorders.
- See comments above for conflict and greater hopes.
- I am surprised and the quality of the report did address many of the key areas we talked about. We have numerous gaps and need everything to fix the fragmented system that we try to function to full capacity under.
- I am so pleased with how comprehensive the report is. I am not a professional, and my expectations were greatly exceeded by the work of this commission. I think you have identified the problems within the Colorado system.

From your perspective are the vision and guiding principles appropriate for Colorado?
- "Yes": 8
- Include service providers.
- I feel that the issue of education and prevention was not emphasized enough.
- Long overdue
- Hopeful and positive, yes. Realistic, perhaps not, given the funding limitations Colorado must operate within.

From your perspective are the recommendations appropriate for Colorado?
- "Yes": 7
- I feel they fall short and are not inclusive of the total bigger picture as discussed in December.
- I think we need to make certain that it is clear that we are talking about reforming the public system not the entire system. (Unless I am not thinking about this correctly…)
- Needs a little more in system changes like crisis services and system.

How can the report be improved?
- I wonder if the group has considered committing itself to a "recovery model" as the conceptual framework for services across the board? An example: Ohio. In the absence of a framing philosophy guiding every agency at every level, I fear that it will be very difficult to get agreement on EBPs across systems, for example. Also, the recovery model (which is

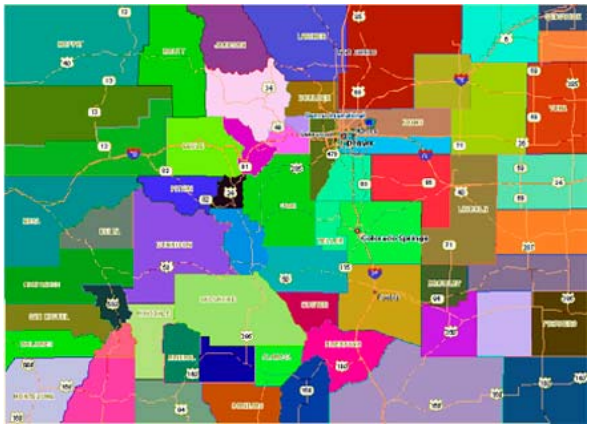
really a philosophy, not a 'service model' in the traditional sense) truly empowers consumers to take responsibility and leadership, to the extent that they can, in every step of their treatment and life.

- It is a huge job and I can't review it in detail!
- As I mentioned earlier I think we need to connect with the early childhood work
- Add timelines and a budget (Ha!)
- Great job you all - thanks and congrats!
- I am very impressed with the amount of good data collected and research done in the amount of time the Task Force had. This important undertaking is the most positive and hopeful step that Colorado has taken in the last 20 years. Thank you all for your very hard and very important work.
- Since report comes from the task force I would suggest that the Task force members be on the cover page rather than "prepared by" as well as footer in report be HJR 1050 Task Force Report
- I have already completed the survey. I failed to say how much I appreciate the opportunity to respond to the report. I also greatly appreciate the time and commitment of the Task Force.
- I have some feedback regarding the 1050 draft report—I believe that in addition to looking at integrated systems within state government we need to look at the non state-funded services that are part of the mental health system of care. In particular we need to look at community based psychiatric hospital services that are used by unfunded clients from both an integrated service of care and financing/funding view points.

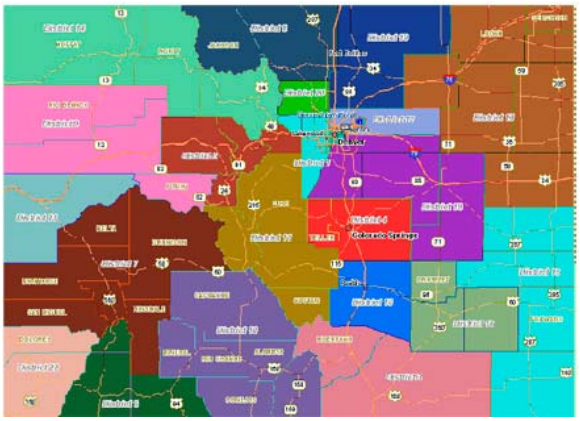
Appendix J: Maps of Service Areas and Regions

State of Colorado

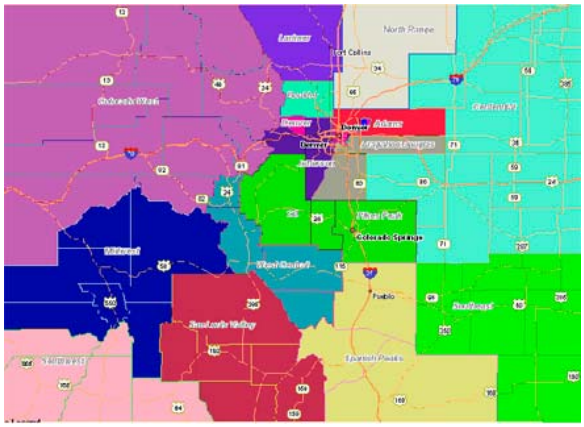
Colorado Counties [64]



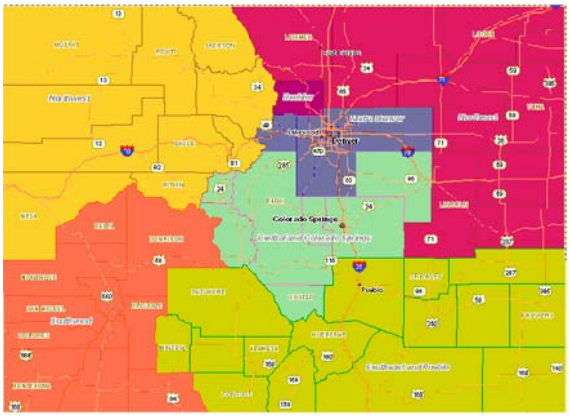
Judicial Districts [22]



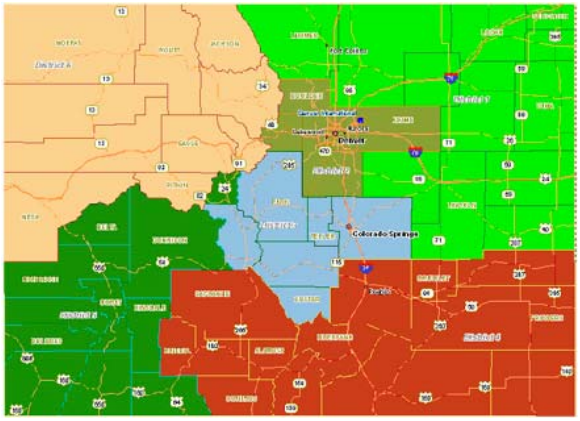
Mental Health Service Areas [17]



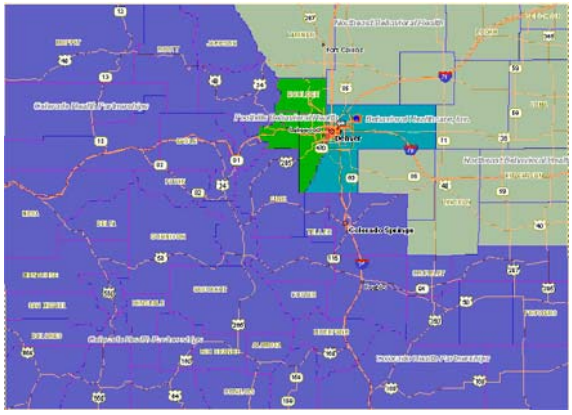
ADAD Planning Areas [7]



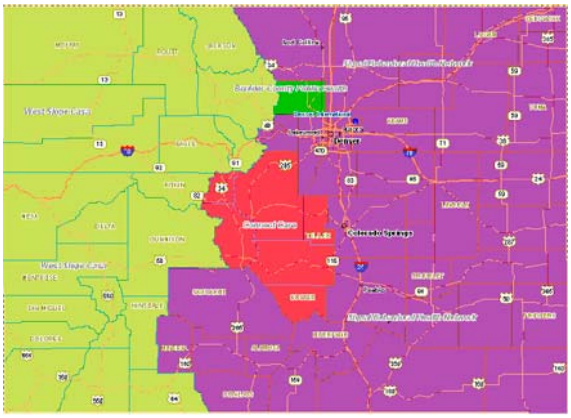
Prevention Regions [6]



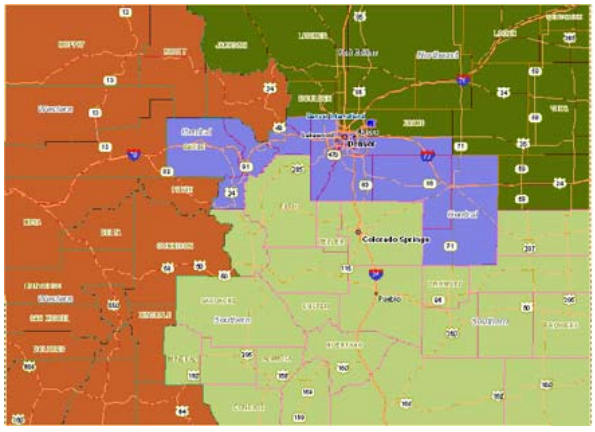
BHO Service Areas [5]



MSO Service Areas [4]

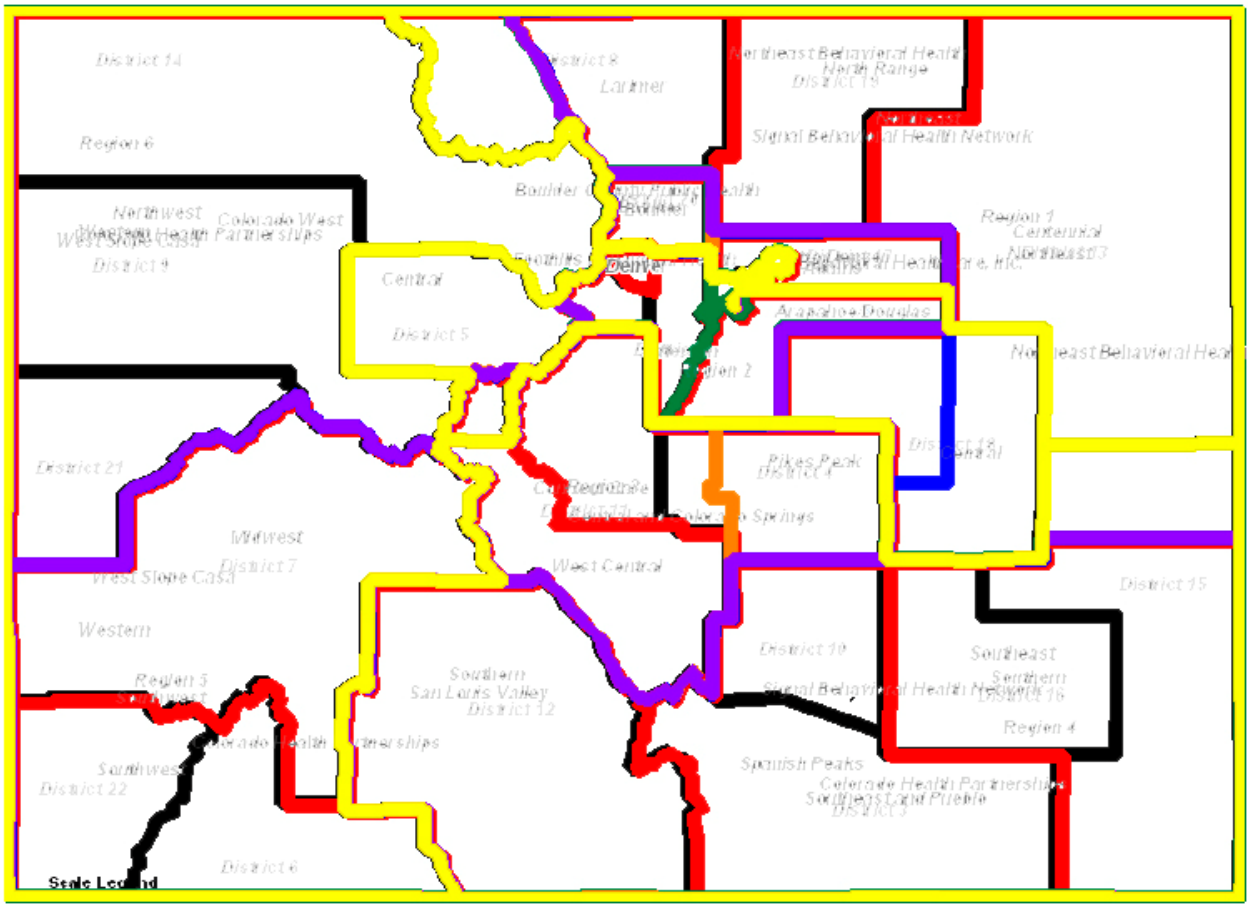


DYC Service Areas [4]



Education Districts [8]

Combined Service Area Map



Key:

Judicial Districts	**[Black]**
DYC Areas	**[Yellow]**
Mental Health	**[Red]**
ADAD	**[Blue]**
BHO Areas	**[Green]**
MSO Areas	**[Orange]**
Prevention Regions	**[Purple]**

Appendix K: Bibliography

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