STATE OF COLORADO

Colorado Department of Human Services
people who help people

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November 30, 2005

Ms. LouEllen Rice
Grants Management Officer
Division of Grants Management, OPS
Room 7-1091
SAMHSA
1 Choke Cherry Road
Rockville, MD 20850

Dear Ms. Rice:

Please find enclosed the Colorado's Implementation Report for FY 2005, or Year One of the approved three-year (FY 2005-2007) Community Mental Health Services Block Grant Plan.

Please do not hesitate to contact me with any questions or concerns at (303) 866-7418.

Sincerely yours,

Debra Kupfer

Debra Kupfer, MMHS
Acting Director, CO Division of Mental Health

COLORADO

COMMUNITY MENTAL HEALTH SERVICES
FY 2005-2007 BLOCK GRANT PLAN

FY 2005, Year One
Implementation Report

Division of Mental Health
Office of Behavioral Health and Housing
Colorado Department of Human Services

TABLE OF CONTENTS

Executive Summary **1**

Report Summary **2**

Summary of Areas Identified as Needing Improvement *4*

A Summary of Significant Events *11*

Sampling of Exemplary Programs *13*

Performance Indicators and Accomplishments **22**

Executive Summary

This is Colorado's FY 2005, or Year One, Implementation Report for Colorado's federal Community Mental Health Services Block Grant Plan. This report covers the first fiscal year of Colorado's new, multi-year plan that was approved without modifications for FY 2005-2007. The Report must be submitted by 1 December to meet the requirements set by federal statute and by the U. S. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. It is important to note that the failure to meet any target potentially subjects the state to the penalty of withholding of ten percent of the Block Grant award.

This report is organized into two sections: *Report Summary* and *Performance Indicator and Accomplishments*. The Report Summary begins with a letter by the Colorado's Mental Health Planning and Advisory Council commenting on this Implementation Report. Next, there is a summary of the areas that were identified in the FY 2005-2007 Plan as needing improvement. Among these areas are: consumer/family driven and focused services and systems; cultural competence; emphasis on outcomes; cross-system integration; and resources and funding.

The Report Summary continues by reviewing the most significant events of the last fiscal year. This section also includes descriptions of innovative or exemplary programs. Some of the events noted are: efforts of the Council on transformation; significant changes to children's services, including the implementation of collaborative service systems under HB 1451 and the redesign of the residential treatment program; and the restoration of a portion of the state budget dedicated to public mental health services. The Report Summary portion concludes with a report on the purposes, recipients, and activities of the block grant funds.

The Performance Indicator and Accomplishments section primarily addresses the documentation of data on the performance indicators. Included in this documentation are clear statements of whether or not each individual objective was achieved, and an explanation if it was not achieved. This section also includes descriptions of strategies and the accomplishments of Action Plan items.

Of the 28 targets in this Plan, Colorado achieved 12, and missed another two by 1.0 percent or less. Four of the remaining 14 that were missed were related to evidence-based and promising practices where the definitions of what counts as these practices changed between the time the Plan was approved and this Report. Another five would have been achieved if not for the setting of the targets with estimated FY 2004 data. That is, these targets were set using preliminary data from FY 2004 that was not final for full two months after the Plan's submission, and comparing the FY 2005 actual with the final FY 2004 data showed improvement for Colorado in these areas. Of the final five missed targets, two were missed by less than five percent and three were missed by more than eight percent. The Division and the Council have already begun discussions on those missed to determine the reasons and develop strategies, particularly for those concerning school performance, readmission to the two state Institutes and contacts with criminal or juvenile justice. Given the substantial changes in how the Division and the Council developed the original Plan and in the federal guidance/format/definitions for the Plan, this Report documents the successes that Colorado has had in implementing its Plan for FY 2005.

Report Summary

Colorado Mental Health Planning and Advisory Council Letter

1 December 2005

Ms. LouEllen Rice
Grants Management Officer
Division of Grants Management, OPS
SAMHSA
1 Choke Cherry Road
Rockville, MD 20857

Dear Ms. Rice:

The Colorado Mental Health Planning and Advisory Council (the Council) is pleased to endorse the Colorado Mental Health Services Block Grant Implementation Report for the 2005 fiscal year. The Report covers the first fiscal year of Colorado's multi-year plan that was approved for fiscal years 2005 –2007.

This past fiscal year saw the implementation of a new Plan, and this Report documents some of the achievements and challenges presented during the year:

- The state continues to recover from the budget cuts of 2003 and 2004. However, as evidenced by some of the data in this Report, the public mental health system has yet to show signs in all areas of improving outcomes.

- Council has already begun discussions about how the state performed regarding the new, redesigned goals and targets. This initial review has revealed that there are a number of challenges presented by the changes in the Block Grant itself that have impacted the outcomes, notably the changes in how evidence based programs are to be defined.

- There continues to be an emphasis on the transformation of mental health and related systems. The Council worked hard in partnership with the Colorado Division of Mental Health to create an application for the Mental Health Transformation grant, including hosting a two-day retreat on the subject. While the Council was disappointed that the application was not submitted, it is proceeding to study ways to transform itself and the systems.

- Colorado's legislative session resulted in a number of new initiatives, and some restored funding. These initiatives included approval of an outpatient substance abuse benefit under Medicaid, restoration of funding for demonstration projects for youth entering and returning from the youth correctional system, and the ability of local communities to establish mental health services districts.

- A growing number of collaborative and integrative projects continue to be created and implemented across the state. These projects include those under a 2004 law noted in the three-year Plan—HB04-1451—that have resulted in seven counties creating collaborative management projects for youth in the child welfare system.

On behalf of the Council, we trust that you will share in our belief that our State has maintained and in places improved its public mental health system, despite the numerous challenges and resource limitations we face. Be assured that the Division's staff has been instrumental in leading our plan, measuring our progress, facilitating our collaborations, and leading us toward new and proven practices for the benefit of children, adults and families across Colorado.

The Council looks forward to working with the Division and other state and local agencies and to implementing the Plan over the course of the next few years.

Sincerely,

Sharon Raggio, Chair
Colorado Mental Health Planning
and Advisory Council

Heather Cameron, Co-Chair
Strategic Planning and Monitoring Committee

Summary of Areas Identified as Needing Improvement

In its FY 2005-2007 Plan, Colorado identified a number of areas within and without the public mental health system that needed improvement. As is noted in the *Performance Indicators and Accomplishment* section below, the State made progress in most of these areas in the past fiscal year. The federal guidance for writing this Report requires the State to include those areas indicated in the Plan. Those areas needing improvement that were identified in August 2004 can be placed into the following five general categories:

- Consumer/Family Driven and Focused Services and Systems
- Cultural Competence
- Cross-System Integration
- Emphasis on Outcomes
- Resources and Funding

During the review of this Report, members of Council requested that some sort of linkage be made between the description of areas needing improvement as identified in the Plan with how the State did in its Targets. Based on this input, there are now text boxes provided below that show what Block Grant Targets are related, if any, to the areas needing improvement, and how the State did in achieving those Targets. Those Targets noted with an asterisk (*) are ones where the reader should consider achieved once the final FY 2004 data is applied. As there are a number of factors determining why a Target may have been achieved or missed, the full data and explanations are provided in the Performance Indicators and Accomplishments section of this report.

<u>Consumer/Family-Driven/Based Systems</u>
Consumers, family members and advocates should be involved in planning, designing, implementing and operating service delivery programs. Services and supports must enable individuals with serious emotional disorders and their families to have meaningful involvement in these activities. The families of children with emotional disorders must be encouraged, assisted, and entrusted to make choices and decisions about their families' lives and the direction of the service system. Consumers and families must be involved in program design, development, implementation, monitoring and evaluation. Consumer outcomes and satisfaction levels should be evaluated extensively and should continue to be used as performance indicators. Consumer choice should be an important component in designing programs. The protection of consumer rights, and consumer and family education about complaint filing mechanisms to continue to be a major responsibility of State program oversight. Individuals receiving services should be satisfied with those services and should be treated with respect and dignity. Consumers and family should be aware of the process to seek resolution, without retaliation, if they are not satisfied with services.

Related Block Grant Targets	
Criterion 1, Adult Plan	Achieved in FY 2005? (Percent Achieved)
Perception of Access	Yes (103.05)
Perception of Outcomes	No (98.42)
Criterion 1, Children Plan	
Perception of Access	No (77.39)*
Perception of Outcomes	No (66.96)*

A recovery- and resiliency-oriented service system should be supported. This type of system combines community support models for treating the illness and psychiatric rehabilitation models for improving functional abilities with the concept described by persons with mental illnesses as a way of living a satisfying, hopeful and contributing life, even with the limitations resulting from the mental illness. This is an area that the Division and the Council are committed to exploring further over the next few years. There is broad recognition of the value of consumer/peer-run services, however efforts are needed to expand these across the State. Additionally, efforts need to focus on exploring mechanisms for reporting service data for these services. Currently, consumer/peer-run services are not tracked in the State's 'encounter' data system, which is where units of service are tracked. As these services continue to expand across the State, it will be valuable to have data documenting the types and amount of consumer/peer-run services being delivered.

Colorado Cultural Competency Plan

The Division continues to recognize the critical importance of creating public mental health systems that are culturally competent and appropriate. For Colorado, such competence extends beyond ethnic issues to those of other groups not commonly seen as 'cultural', including those of consumers and families in rural and frontier communities.

Due to budgetary constraints, the Division was not able to fill a number of state vacancies during FY 2005, which impacted its ability to focus on the implementation of the Cultural Competency Plan. However, the Division has now filled some of the vacancies and by doing so can return its attention to implementation of the Cultural Competency Plan across the state. Also, the Division approved services to be provided at another clinic serving the Latino community in September 2005.

In an effort to sustain the system-wide attention on cultural competence, the Division included demographic data in its new site review monitoring process. The new process—the primary mechanism by which the Centers and Clinics are approved for licenses—uses county demographic and Division data to illustrate the extent to which each provider serves the various ethnic categories in its community.

Finally, the Division has received praise for its efforts to address the mental health needs of those Gulf Coast evacuees in a culturally competent manner. As part of its role as the state's designated disaster response agency for mental health issues, the Division, along with the Mental Health Association of Colorado and the Centers (represented by the Colorado Behavioral Healthcare Council), have convened fora with local and state faith-based and professional groups to identify issues and develop solutions to meet the needs of the thousands of evacuees that came to Colorado.

Cross-system Integration

The Division continues to lead the way in various arenas that are focusing on the integration of, and collaboration between, systems. The Division was a key player in the passage of continuation legislation for the legislature's Oversight Committee and Task Force for the Study of Persons with Mental Illness in the Criminal Justice System.

Related Block Grant Targets	
Criterion 1, Children Plan	Achieved in FY 2005? (Percent Achieved)
Percentage Improved School Performance	No (54.30)
Percentage Improved School Attendance	Yes (100.12)

It has also played a role in children's system of care collaborations. Further, the Division participates in the HB 1451 State Steering Committee. This committee is an inter-agency group designed to implement the collaborative management projects. This committee comprises representatives of the Division, the Divisions of Child Welfare and Youth Corrections within the Department of Human Services, the Department of Health Care Policy and Financing (HCPF), the Department of Public Health and Environment, the Department of Education and the State Court Administrator.

Corrections and Mental Illness

The Colorado legislature has assumed a major leadership role in addressing the growing numbers of people in correctional institutions by appointing a legislative oversight committee and task force to make recommendations about this serious problem. The Oversight Committee and its Task Force Concerning Persons with Mental Illness, with expanded membership including a representative appointed to represent the Council, continues its work.

Related Block Grant Targets	
Criterion 1, Adult Plan	Achieved in FY 2005? (Percent Achieved)
Percentage Involved with Criminal Justice	No (91.91)
Criterion 1, Children Plan	
Percentage Involved with Juvenile Justice	Yes (129.62)

The committee and task force are sponsoring two more bills for the upcoming legislative session, one addressing the gap in private insurance coverage that allows for denial of benefits that are court ordered, and the piloting of family advocacy programs across the state.

Mental Health Institutes

There is a continuing emphasis on defining the appropriate role of the state's two Institutes, and efforts are ongoing to identify ways to efficiently utilize Institute resources.

Over the past decade, there has been a national revolution in health and mental health care, involving both the types of treatment services available and the systems that deliver these services. This revolution has led to major changes in Colorado's public mental health system, and is expected to continue its impact through the foreseeable future. Along with the community mental health programs, the Institutes are major components of the state's public mental health delivery system and have traditionally used a large proportion of its resources.

Gradually, the roles of both the Institutes and the community mental health programs have changed, and this is expected to continue due to the identified need for increased community-based services as the State develops and implements its strategies that will result in consumers receiving treatment in the most appropriate, least-restrictive settings. This will be particularly important in rural and frontier areas, such as southwest Colorado, the only mental health region in the State with more than a two-hour ground transport (averaging more than seven hours) to an inpatient bed.

Currently, the Institutes have a total of 293 inpatient psychiatric beds, including a 20-bed Psychiatric Substance Abuse Program. Additionally, there is a 20-bed Residential Treatment Center and 20 general hospital beds. Of the total 293 beds, there are 178 for adults, 16 for children, 34 for adolescents, and 65 for older adults.

Data reflects some of the effects of recent changes. For instance, the average bed capacity of both Institutes (not including Pueblo's General Hospital or the Institute for Forensic Psychiatry) has decreased from 456 in FY1999-2000 to 313 in FY 2004-2005 ('average bed capacity' is pro-rated to adjust for bed closures that occurred during a fiscal year). This is a 31.4 percent decline over the six years.

Related Block Grant Targets	
Criterion 1, Adult Plan	Achieved in FY 2005? (Percent Achieved)
Rate of Readmission to Institutes, 30-days	No (69.90)*
Rate of Readmission to Institutes, 180-days	No (64.79)
Criterion 1, Children Plan	
Rate of Readmission, 30-days	No (86.59)*
Rate of Readmission, 180-days	No (79.60)

Also, the average length of stay (ALOS) as measured at discharge has decreased for most of the units (except for the geriatric services units and the residential treatment center, which is located at Fort Logan). For adults, the ALOS between FY 2000-2001 and FY 2004-2005 declined at Fort Logan from 57.4 to 46.1 days and increased at Pueblo from 59.5 to 61.5 days. Over the last two fiscal years, the ALOS at Fort Logan declined from 56.3 days to 46.1, and increased at Pueblo from 42.8 to 61.5.

These trends have resulted in the increase in the percentage of consumers with a higher acuity of illness at the Institutes. That is, as the ALOS (and the overall bed capacity) declines but the number of admissions remains virtually the same, the 'mix' of consumers at any time now comprises fewer people who are more stable (shorter lengths of stay) and more people who are not stable (continuing or increasing number of admissions despite bed reductions). This trend presents significant challenges for Institute staff. The impacts accrue to the workload for the admissions and discharge components of the Institutes, and to the attainment of performance targets. Specifically, targets for reduction of elopement (escapes), use of seclusion and restraints, and patient assaults are based on percentages of the past composition of the consumer population. Again, this trend results in a higher percentage of consumers with acute illnesses—persons who are more likely to impact these performance targets—in the total population.

Emphasis on Outcomes

In the continuing effort to improve publicly funded services and reduce costs, constituents are increasingly demanding that government measure and provide information about the performance of all human service programs. This is based on the reasonable premise that government expenditures should result in demonstrable benefits and, in particular, should provide positive outcomes for those receiving government funded services. In order to analyze and communicate the results of human service programs effectively, government must deal with a number of challenges: specifically defining the desired outcomes for every program and administrative area; designing efficient, responsive information systems that can collect, store and analyze the needed outcome data; and developing effective methods for communicating results to managers, consumers and constituents.

This effort, called for in the U. S. Surgeon General's seminal report on mental health in 1999, has been reaffirmed by President Bush's New Freedom Commission on Mental Health. The Commission's report clearly identifies that a weakness of the current system includes the fact that despite the "range of effective, state-of-the-art treatments and best practices, many interventions and supports do not reach the people who need them."[1]

The Commission recommends alleviating this situation with a goal that, in part, requires a partnership that comprises:

> "all stakeholders including providers, consumers, and families. It should guide and oversee many activities that are currently scattered throughout the public and private sectors, thus eliminating inefficient duplication and encouraging collaboration on potentially beneficial issues. This leadership is needed to bridge the gap between science and service."

Colorado's public mental health system has begun to proactively address this issue, most notably with the development of its performance indicator incentive system. However, national initiatives, such as performance partnership grants and performance-based budgeting, the Mental Health Statistics Improvement Program and the Data Infrastructure Grant, will continue to demand that the systems of care improve their efforts to measure and demonstrate positive results.

[1] New Freedom Commission on Mental Health, Achieving the Promise: Transforming the Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

Related Block Grant Targets	
Criterion 1, Adult Plan	Achieved in FY 2005? (Percent Achieved)
Number of Promising- and Evidence-Based Practices	No (61.11)
Percentage Receiving EB/PPs	Yes (1,037.29)
Criterion 1, Children Plan	
Number of Promising- and Evidence-Based Practices	No (52.94)
Percentage Receiving EB/PPs	No (50.99)

With the need to focus on evidence based and promising practices, both the Department and the Division recognize the need to provide accurate information to the legislature and other policy makers to ensure that appropriate levels of service are secured for consumers of mental health services. The information gleaned from the collection of the assessment data will also assist in the development of future plans for the provision of mental health services. Moreover, this emphasis on quality and outcomes will also serve to reinforce the need to move to consumer and family focused service delivery systems.

In an effort to begin identifying the evidence-based practices currently available in Colorado, the Division asked the Centers and Clinics to self-report on their programs. In FY 2004, 108 programs were identified as being 'evidence-based or promising practices'. 80 such practices were identified in FY 2005. The table below shows what programs are included (by federal definition) and how many exist in the State (no Center reported more than one program in each practice area). It is categorized by evidence-based or promising (self-reported by the Centers) and whether the programs collectively across the state reported serving only adults, only youth or a mixed population (some programs are appropriate for more than one age group while others are intended or proven for a specific age group):

Practice	*Population Served*	*Total Number Reported Across Colorado*
Evidence-Based		
Assertive Community Treatment	Adults	6
Family Psycho-education	Adults	4
Illness Self Management	Adults	10
Integrated Treatment for Co-occurring Disorders	Adults	12
Medication Management	Adults	6
Supported Employment	Adults	12
Supported Housing	Adults	15
Family Functional Therapy	Youth	4
Multi-Systemic Therapy	Youth	2
Therapeutic Foster Care	Youth	2
Promising		
Anger Management	Adults	1
Dialectical Behavior Therapy	Mixed	3
Eye Movement Desensitization and Reprocessing	Mixed	1
Parenting	Mixed	1
School-based Services	Youth	1

The Division expects to start evaluating and assessing the fidelity of these programs to their original models, as well as the outcomes of those programs that are promising but lack the rigorous scientific evidence. The Division recognizes that this enhanced emphasis on evaluation and outcomes will require it to reconfigure its internal structure and recommit the resources necessary to address this issue in a proactive, thoughtful manner.

Performance Indicators

Implementation of the Performance Indicators has continued through state FY 2005. However, due to the change in responsibility for the Medicaid mental health community programs, the Division only calculates data for, and makes financial awards to, the Centers. HCPF has continued to calculate the data for the Behavioral Health Organizations (or BHOs, the Medicaid contractors) and their external providers as part of its external quality review process.

Goebel Settlement

As of September 2005, all Goebel teams have met the Court Ordered service hour requirement for 28 consecutive months. This achievement ends the service hour compliance requirements for all teams. The Division and the Mental Health Center of Denver are committed to continuing to maintain this level of service for each subsequent four-month period through February of 2006 when the dismissal of the lawsuit is anticipated, to avoid any reason for later objections to the filing of the satisfaction motion with the court. The last remaining compliance requirement of the court order is continuation of the SURGE Co-Occurring substance Abuse Program at appropriate treatment levels for a minimum of 320 class members until February 2006.

The State and the Plaintiff's attorney have agreed that the service hours requirement has been met and both stipulated to the fact by signing the stipulation Document I July, 2005. It is anticipated that in February of 2006, the State will fulfill the last remaining compliance requirement of the Court Order (Surge Co-Occurring Substance Abuse Program), and a Satisfaction Motion for the entire lawsuit will be filed.

Resources and Services to the Non-Medicaid and Medicaid Eligible Populations

The past several years have seen significant cuts in state and local funding for services to those persons who are not eligible for Medicaid. These cuts totaled nearly $7 million for the fiscal years of 2002-03 and 2003-04. By some estimates, these cuts represented nearly 30% of all state funds spent on this population. Progress to restore these reductions began for FY 2004-05 when the Legislature approved half of the Division's request for $2 million. It continued in FY 2005-06 with funding for a cost of living adjustment for providers, an additional $200,000 for case management and transition services for children in residential placement, and over $700,000 for youth in and returning from juvenile detention. It should be noted that although many individuals with serious mental illnesses are Medicaid eligible, approximately 47% of the approximate 77,000 persons served in FY 2003 in the public mental health system are not eligible to receive Medicaid. As the Division and the community implement and evaluate evidence based and promising practices, it will be imperative to maintain the current level of state funding.

Related Block Grant Targets	
Criterion 5, Adult and Children Plans	Achieved in FY 2005? (Percent Achieved)
Expenditures per Capita	Yes (100.53)

Additionally, the Medicaid capitation program saw a funding cut *per capita* of approximately $7 million. In order to absorb these cuts, administrative efficiencies were implemented and new utilization restrictions were imposed on Medicaid consumers, including a limit of 45 inpatient days per year (excluding nearly all children) and 35 individual, outpatient therapy visits. The capitation program also saw a decrease in per person funding over the previous contract. Capitation program providers received an enhanced cost of living adjustment for FY 2005-06.

A Summary of Significant Events

Continuing Implementation of HB 1265

While not a specific 'event', the implementation of the statutory change of responsibility for most Medicaid community programs to HCPF continued in FY 2004-05. There has been a concerted effort on behalf of both departments to collaboratively address common issues. These efforts include the near completion of the first year of a memorandum of understanding that address the collection and sharing of data and partnership on the state steering committee for the newly created Collaborative Management projects (HB 1451) that serve children in the child-welfare system. Further, a HCPF representative has attended each Council meeting, and has presented on a number of issues of interest to the Council.

Transformation

The Division and the Council created an application for the federal Mental Health Transformation State Incentive Grant. Although the application was not submitted, the Division and the Council have committed to continuing their efforts at transformation, notably within the Council itself. The Division does intend to again develop an application for the next round of transformation grant funding.

Resources and Funding

There were various initiatives in the past fiscal year that resulted in additional resources and funding allocated to the public mental health system. First, the Colorado General Assembly restored some of the funding cut previously. This restoration took the form of:

- Cost of living adjustments for all community providers, and an enhanced adjustment for Medicaid capitation providers
- Additional funding for the Child Mental Health Treatment Act for case management and transition services
- Reimplementation of two pilot programs—now known as TurnAbout—that provide services to youth in, and returning from, juvenile detention
- Approval to add an outpatient substance abuse benefit to the Medicaid State Plan

Also, the legislature approved SB 59, 'Special Mental Health Districts', a statute that allows for local communities to form county-based districts to fund and provide mental health services. At

this writing, no counties are actively pursuing such a district, although a number are investigating the possibility.

In the private sector, the Advancing Colorado's Mental Health Care Initiative awarded funding to six communities to provide collaborative mental health programs. This effort, led by the non-profit Colorado Trust, chose the following communities in October 2005:

- Denver Public Schools Integration of School and Mental Health Systems Project
- Prowers County Behavioral Health Integration Project
- El Paso County Co-Occurring Disorders Collaboration
- Mesa County Consortium on Health
- Health District of Northern Larimer County
- Summit County Collaborative

Finally, the voters in Colorado approved a ballot measure in November 2005 that allows the state government to keep revenue it would otherwise be constitutionally required to return to the taxpayers. While this did not have a direct impact on the fiscal year covered by this report, it is a critical event that will have an impact in the future, primarily in avoiding budget cuts for the current and next fiscal year.

Children's Systems of Care

Efforts involving children and systems of care continued apace in the FY 2004-05 fiscal year. Some of those of particular note are:

- HB 1451. This legislation, passed in 2004, was implemented in July 2005. The Collaborative Management Projects, which represent binding agreements between county social/human service departments and at least five other agencies (education, health, mental health, Medicaid mental health and judicial) to serve the child welfare population, were implemented in seven counties across the state: Arapahoe, Boulder, Denver, El Paso, Larimer, Mesa and Weld. These projects are allowed by the statute to keep any 'savings' realized by these collaboration and, if they meet agreed to outcomes, additional incentives are expected to total more than $2 million in this fiscal year.

- Ending of Colorado Cornerstone. One of the original 'system of care' grantees, the Cornerstone project officially ended this year. Although the grant funding has ended, a number of the Cornerstone agencies are continuing to operate, notably the family advocacy organizations.

- Health Insurance Flexibility and Accountability Waiver. This waiver, which allows states to more quickly implement Medicaid and Child Health Plan programs that serve more persons within the current appropriations, was officially rejected by an interim committee of the legislature in August. However, most of the plan will be introduced in the next session of the legislature as a bill. The main goal of the plan is to "streamline" the state's Child Health Plan Plus program for children with Medicaid.

- Redesign of the Residential Treatment Center Program. Perhaps the most significant of the events affecting children, the federal Centers for Medicaid and Medicare Services mandated that Colorado redesign how it funds and provides services to children in residential placements. At this writing, the state continues to convene a number of committees with providers to create and detail the new system. The federal government is currently requiring this new system to be implemented by July 1, 2006.

- Colorado Department of Public Health and Environment Grant. This grant, from the federal Department of Health and Human Services, is targeted at children and maternal mental health. As one of only four such grants awarded, it is a partnership between the Department of Public Health and Environment, the Department of Human Services, the Department of Education, the Department of Public Safety, the Colorado Prevention Leadership Council, the Colorado Systems of Care Collaborative, the Colorado Chapter of the Federation of Families For Children's Mental Health, and Consultants for Systems Integration. Its mission is to promote partnerships among state agencies and key stakeholder organizations by weaving together existing efforts to create a more coordinated continuum of mental health services for Colorado youth and families. Its stated goals are to:
    1. Expand and strengthen a diverse partnership among State agencies.
    2. Build State agency capacity to support local communities in their efforts.
    3. Strengthen the capacity of Colorado's State and local Maternal and Child Health Program.

Sampling of Exemplary Programs

Family Care

Family Care involves placing a consumer in a "foster" home placement once inpatient level of care is no longer necessary and there are no other appropriate community-based options available. Family Care provides supervision and a family life setting for a consumer who, without this program, might not be able to leave the hospital setting. By living in an understanding and accepting family and with mental health services, the consumer's capacity for growth and success is fostered so that, hopefully, they may be able to one day live in an even more independent setting. Due to state budget reductions in 2003, this program was transferred from Ft. Logan to Jefferson Center for Mental Health (Jefferson Center).

Currently seven providers serve eleven consumers in the Family Care program. Jefferson Center staff (a case manager, case manager aide, nurse and psychiatrist) are specifically assigned to this population to provide continuity of care and consistency with the providers. Monthly training is provided for the direct care staff and regularly scheduled home visits are a part of the treatment plan with every Family Care consumer. Many are active in Summit Center, Consumer Run Programming, Recreational Outings, Peer Mentoring and Self-Help Groups. Staff work closely with the consumers and providers to identify community-based resources and to assist in accessing appropriate services and programs.

In the year of operation under Jefferson center, there has been growth in the program as two consumers moved out of Family Care and two new individuals were placed in a home setting.

Staff are exploring options for expanding this program to include adding one or two more homes, and are assisting one Family Care provider in obtaining ACF licensure to allow for additional resources in the program.

Early Intervention Services

Jefferson Center's Early Intervention Services (EIS) provides families a range of respite care and in-home services tailored to meet their individualized needs. In its basic form, EIS teaches the building blocks of good parenting to parents who struggle with the presence of mental health issues in the family. This includes appropriate behavior, recognizing and coping with different developmental stages including early brain development, and the value of establishing a healthy home environment. Early intervention is often the difference between abuse and neglect and a young child's safety and healthy development.

The goal of EIS is to equip parents struggling to raise young children ages 0-5 where mental health issues are present with appropriate parenting skills, to ensure the health and safety of their children. To achieve this goal the program focuses on the following objectives: 1) Prevent out-of-home placement, 2) Prevent child abuse and neglect, 3) Improve parent-child interaction, 4) Strengthen families through counseling, skills building and 5) provide community resource referrals.

EIS provides parent education, support and counseling through two approaches: Respite Care and In-Home Services. Respite Care is designed to allow the Respite Parent Educator to become the "parent" for an hour in a controlled setting, to observe the child(ren)'s behavior. This can occur in either the child's home or in a designated office within the Center. During this time, the Respite Parent Educator assesses the child's achievement of developmental milestones, as well as the child's interactions with his/her brother or sister (if applicable). These observations are used to discern what parent education/parenting skills training are most useful to improve family functioning. The Respite Parent Educator shares the observations with the parent(s) in a one-on-one session and works closely with the parent to set specific boundaries and goals related to their child's behavior. Moreover, the Respite Parent Educator helps identify appropriate parenting skills in relation to the child's certain developmental stage.

In addition to Respite Services, EIS provides two types of in-home services. A Home Visitation Case Manager (Home Visitor) works with parents who need more intensive parent education in the home setting. The Home Visitor, who is a trained case manager/parent educator, meets with families where they live to observe and identify appropriate and adverse parent/child interactions. The Home Visitor, using a variety of techniques, offers parenting skills training with a focus on existing family strengths; help in identifying available resources and information on how to access those resources as part of the service plan; and emotional support.

A master's level clinician with expertise in working with families with young children and early brain development provides In-Home Mental Health Counseling for parents who have a mental illness or severe emotional problem. By holding therapy sessions in the home, the EIS Clinician focuses on resolving issues in a parent's life that are conflicting with care for the child, and contributing to situations of abuse or neglect. By working with parents in their own home, the EIS Clinician can observe interactions and incorporate any factors in the home environment that

may contribute to dysfunctional parenting while assessing mental health needs and creating intervention strategies.

Stepping Stone (6-Bed Acute Residential Treatment Facility)
With the closing of the psychiatric unit at Mercy Medical Center in Durango, the closest inpatient psychiatric unit for consumers in southwest Colorado over the past four years became the Colorado Mental Health Institutes or St. Mary's in Grand Junction. As a result, adult consumers in need of emergency inpatient psychiatric services were transported hours by car to the Institute at Pueblo or to St. Mary's, and children were transported the same distance to the Institute at Fort Logan. These transports are both uncomfortable and difficult. They involve travel over mountain passes that are hazardous in bad weather, through very rural areas with limited convenience stops, and in shackles as required by the Sheriff's departments. Southwest Community MHC has developed an acute care crisis program in an attempt to divert hospitalizations and provide a crisis stabilization alternative in the community. Stepping Stone is a temporary solution to our sever lack of inpatient care. The program is located in a home and, because of this, somewhat limited in the acuity of the symptoms they can effectively manage. However, southwest Colorado continues to experience the long-term need for a psychiatric urgent care facility.

The process of recovery often entails the need for higher levels of care when illnesses cycle into acute phases or psychosocial stressors become overwhelming. Stepping Stone is a short-term residential care facility for individuals suffering from acute psychiatric crises. Stepping Stone provides crisis stabilization, 24 hour care and supervision (minimum 1:5 staff to client ratio), independent living skill development, social/interpersonal skill development, medication management monitoring, meals, case management linkage, advocacy and follow up monitoring, emergency services mental status examination for level of care, assessment and treatment planning, psychiatric assessment and monitoring.

The program provides three distinct types of short-term services:

- Safe-Bed – Crisis stabilization for those in crisis but who do not require immediate hospitalization.
- Transitional – Interim housing and support for consumers requiring more extensive treatment and planning for successful re-entry into the community.
- Respite – Accommodations and support for those needing respite from their roles as caregivers to those challenged by mental illness.

Pikes Peak MHC and Substance Abuse
Pikes Peak MHC works with community collaboration (Memorial Hospital, Penrose Hospital, City, El Paso County Police, Sheriff) to operate and fund a substance abuse continuum that includes detoxification, IOP, and Aftercare. A new addition is Harbor House, an eight-person recovery house.

Pro Bono Mental Health Program
Through this program, the Mental Health Association of Colorado (MHAC) delivers free mental health services to low-income youth, families, older adults and people who are homeless by

licensed professionals at more than 30 community host sites such as inner-city schools, older-adult centers and homeless shelters throughout metro Denver. Since 1986, over $7.5 million worth of services have been provided to our community.

Jefferson County Juvenile Justice Behavioral Healthcare Advisory Board

The Jefferson County Juvenile Justice Behavioral Healthcare Advisory Committee helps families and youth understand how to work within the juvenile justice system. This interagency committee represents agencies, parents and youth involved in the juvenile justice system and offers free Juvenile Justice System Training. Parents and youth participate as committee advisors and have helped to organize six trainings about the juvenile justice system and developed an informational brochure called "Juvenile Justice System, A Family Guide".

Community Mental Health and Substance Abuse Partnership of Larimer County

The Community Mental Health and Substance Abuse Partnership of Larimer County is creating significant changes at the system level. These changes are designed to improve how, where and when mental health and substance abuse services are provided. The focus is on repairing the system of care while including efforts to also maximize the quality of care. There is no mandate forcing these changes. The Partnership came together and stays together under its own impetus and because of the desire to help the 30,000 people in the community who suffer most from mental health and substance abuse. Comprising more than 70 individuals who represent more than 30 local organizations, this unique partnership crosses all sectors of the community including consumer groups, public schools, healthcare providers, mental health and substance abuse providers, government, law enforcement and the local university.

The Partnership approach to systems change includes 12 distinct strategies clustered into five broad areas:

1. Assure Adequate Connections to Services
2. Maximize Capacity for Diagnosis, Prescriptions and Treatment
3. Create and Re-create Essential Services
4. Improve Information Sharing
5. Policy Changes

By systematically implementing each of the 12 strategies The Partnership is realizing success. One of the greatest achievements thus far is the opening of Connections, a new specialized information, referral and assistance service for anyone with any level of income and with any level of need (mild mental health issues to severe, life threatening substance abuse or mental illness). This service is a true collaboration between the Health District of Northern Larimer County and the Larimer Center for Mental Health (LCMH). Housed at one of LCMH's buildings, the Connections program is staffed, funded and overseen by both organizations. All current Partnership strategies will be implemented by the end of 2006 moving the community closer to their vision of a well-integrated system of care.

The National Alliance for the Mentally Ill (NAMI) Colorado

NAMI was established in 1979 and carries forth its mission in partnership with local affiliates and numerous advocacy and consumer/family support volunteers located throughout the State.

Affiliates are located in almost every mental health center service area, with several local affiliates in some areas. NAMI of Colorado conducts annual conferences, and along with its local affiliates, publishes a newsletter and provides considerable public education and referral information. The Division has dedicated a portion of its Block Grant funds to support NAMI Colorado's Family to Family and Visions for Tomorrow training programs.

NAMI's Family to Family Education Program and the Visions for Tomorrow Program are led and taught by volunteer teams, these programs are offered at no cost to family members and direct caregivers of adults, adolescents and children with severe/persistent mental illnesses, brain disorders and emotional disturbances.

Family to Family is a free, 12-week (30-hour) curriculum endorsed by the National Institute of Mental Health (NIMH). The curriculum provides: (1) current clinical information on biologically based brain disorders and treatments; and, (2) training in coping skills so that families are more effective caregivers.

The Visions for Tomorrow curriculum was written by NAMI staff, experienced caregivers, family members and professionals to meet the growing need for education directed specifically to family and caregivers of children and adolescents with mental illness and/or serious emotional disorders. The program involves two-person teams of caregivers or family members offering the course over 8-12 weeks. The program covers 17 diagnoses, skill building, self-care, and advocacy.

The Wellness and Education Coalition and Advocacy Network (WE CAN!)
WE CAN! continues to train consumers statewide on leadership, advocacy and organizing. In 2003-2004, 25 consumers graduated from the Colorado Leadership Academy basic training and 17 from the advanced training. Graduates are leaders in their respective communities throughout the entire state. Advanced academy graduates will be working closely with the Mental Health Ombuds Program of Colorado to provide advocacy services to their peers. Five WE CAN! members who graduated from the Leadership Academy program have taken seats on the Mental Health Planning and Advisory Council and the Governor's appointed committee on 27-10 (involuntary commitment). The WE CAN! Board, which comprises over 75% consumers, includes regional consumer representatives as well as members at large. The Board determines strategic goals for the organization including education, legislative and systems advocacy and marketing and outreach.

The Mental Health Association of Colorado (MHAC)
MHAC was founded in 1953, as a non-profit organization located in Denver, Colorado. Through its many innovative programs, MHAC focuses on providing mental health advocacy, education, training, and services for young children, adolescents, their families, people who live in poverty and are homeless—all free of charge. MHAC is the Colorado affiliate of the National Mental Health Association. MHAC has three statewide affiliates located in Colorado Springs, Pueblo and Montrose with another affiliate beginning in Loveland.

The Colorado Federation of Families for Children's Mental Health
The Federation, recognized as the statewide chapter by the National Federation of Families, is a

family-driven and family-run non-profit organization. The Federation was founded in 1993 as a result of a partnership between families of youth with mental health issues, the Mental Health Association of Colorado and the federal Child and Adolescent Service System Program. Its primary focus is to provide access to appropriate and timely mental health services for children, youth and families in Colorado. The organization has four staff members, 250 active family and youth volunteers, and funding of $220,000 from a variety of sources, including Substance Abuse and Mental Health Services Administration, the State, private and corporate donors.

Crisis Intervention Teams

Created by the Memphis, Tennessee Police Department in 1987, Crisis Intervention Teams (CIT) has been replicated in over 24 major cities across the country. What is unique about the Colorado effort is that CIT is not limited to one police department; rather, CIT in Colorado began and continues to grow as a multi-jurisdictional initiative across the State. In July of 2000, the Colorado Division of Criminal Justice (DCJ) began organizing CIT by facilitating educational meetings and presentations for community leaders and stakeholders. The result of these meetings was the decision (based on community support and commitment) to pilot CIT in two of Colorado's most populated regions: Jefferson and Denver Counties.

The first CIT classes were held in May and June of 2002 for seven police and sheriffs departments in Jefferson and Denver counties. Sixty officers graduated from those first two classes. Currently, 28 Colorado law enforcement agencies have trained CIT officers: Denver, Arvada, Wheat Ridge, Westminster, Lakewood, Golden, Cherry Hills, Littleton, Englewood, Glendale, Greenwood Village, Aurora, Fountain, Colorado Springs, Pueblo and Durango Police Departments, and the Jefferson County, Douglas County, Arapahoe County, Elbert County, La Plata County, El Paso County, Pueblo County Sheriff's Departments. Police departments in Summit County (Vail and Silverthorne) have recently joined the initiative as well, and Weld and Larimer Counties have begun planning for the program with intentions of hosting their first CIT class in the fall of 2004.

Since start-up in May of 2002, the DCJ has organized 24 CIT classes. In addition, DCJ has provided technical assistance and consultation to CIT La Plata as well as CIT El Paso/Pueblo. To date, 701 law enforcement professionals have graduated from the CIT training program.

CIT officers report that their newly acquired skills and knowledge changed both their response to crisis calls as well as the outcome of the calls. The certified officers' written reports have supplied data that certainly support their claims, for example:

- Over 74% of CIT calls have resulted in transport to treatment, including hospitals, detoxification centers and mental health centers.
- Only 4.6% of mental health calls involving a CIT officer have resulted in an arrest.
- Over 98% of CIT calls resulted no injuries to officer or citizens.

Early Intervention Program

This initiative, initially supported by funding authorized by the Colorado Legislature from 1997 to 2002, provides timely and accessible mental health services to at-risk children ages' birth to eight and their families. On-site services are provided in natural environments, including childcare centers, preschools and homes. The overall goals of the Program are to reduce the

growing number of children involved with multiple systems, avoid costly and restrictive out-of-home care, and improve outcomes for children and their families. The Mental Health Center of Boulder County and the Mental Health Center of Denver (formerly the Mental Health Corporation of Denver) operate the early intervention pilots funded through this Program, in partnership with early childhood service systems.

In 2002, Colorado was the recipient of State Innovation Funds through the U. S. Department of Health and Human Services, Assistance Secretary for Planning and Evaluation. Through the anticipated three-year funding, integration of primary care and mental health will be accomplished through mental health consultation and health care screenings in childcare settings and family childcare homes.

Project Bloom

In 2002, Colorado received funding from the federal Substance Abuse and Mental Health Services agency, through its Comprehensive Community Mental Health Services for Children and Their Families Program, to develop a system of care for young children 0-5 with serious emotional disturbance and their families in four Colorado communities: El Paso, Fremont and Mesa Counties and the city of Aurora. Partners in this system include the four mental health centers in these areas; Aurora Mental Health Center, Pikes Peak Mental Health Center, West Central Mental Health Center and Colorado West Mental Health Center. Project Bloom also partners with JFK Partners at the University of Colorado Health Sciences Center, the Colorado Children's Campaign and the Federation of Families for Children's Mental Health.

Suicide Prevention

Legislation passed in the 1999-2000 session developed an Office of Suicide Prevention based at the Colorado Department of Public Health and Environment. This Department is working with other State agencies, including Division of Mental Health, as well as with local governments and organizations throughout Colorado to develop a statewide public information campaign to inform citizens about suicide risks, warning signs and interventions.

Also, the Division continues to be a major supporter of, and participant in, the Suicide Prevention Coalition of Colorado. Division staff representatives serve on the Board of Directors that sets the direction for the statewide coalition. While the rate of persons in Colorado who died from suicide in 2003 remained at 12 per 100,000 population, (a total of 700 Coloradoans), the ranking of Colorado rose from 7th place nationally to the 5th highest rate in 2002. Colorado has exceeded the national suicide rate average by 40% for the last 90 years. 9,600 Colorado citizens of all ages contemplate suicide annually. Suicide is Colorado's 9th leading cause of death between the ages of 10 and 34. The Rocky Mountain Western states of Montana, Wyoming, North and South Dakota, Utah, and Colorado have the highest regional suicide rates in the nation.

State Emergency Function—Mental Health

The State Office of Emergency Management cites the Division as the lead agency to detect and treat mental health issues following a disaster or emergency for both the victims and the responders. The Division has required the mental health centers to identify a mental health

disaster coordinator and update their mental health disaster plans. The Division participated in the federal exercise TOPOFF, which occurred at the State Office of Emergency Management, Camp George.

September 4, 2005 saw the first planeload of Hurricane Katrina Evacuees from the Gulf land in Denver, Colorado. Since then, Colorado has welcomed approximately 10,000 individual evacuees into our state. The State has provided many services to these individuals and families at the public and private level in spite of budgetary and system issues.

On September 7, 2005, Colorado was notified of its inclusion in the Mississippi Presidential Declaration of Disaster and was therefore eligible to apply for individual assistance grants such as the FEMA/SAMHSA Crisis Counseling Program (CCP) grants. On September 26, 2005, Colorado received an Immediate Services Program grant supporting the State's efforts to provide basic crisis counseling and outreach services to the evacuee population. Eight teams were developed and place strategically throughout the state to provide these basic services.

During the first weeks of the Immediate Services portion of this project, over 5,000 educational services and 400 crisis counseling services were provided to the population settling within our communities. The Division is looking forward to the transitional phase between the Immediate Services to the Regular Services portion of the project. With this transition, eight CCP teams will become five larger and more efficient and effective teams; a crisis counseling information phone line will be implemented; public service announcements will be broadcast and the CCP teams will integrate more into the larger volunteer system that is providing the basic disaster support services that are so needed by these evacuees.

Expenditure of Block Grant Funds

The Division is responsible for the distribution of the currently available resources for the public mental health system. Under Colorado Statute, appropriated funds for local mental health services are contracted through approved community mental health centers or clinics, which conform to the Division's Rules and Regulations for the Colorado Public Mental Health System. These contract agencies are authorized to provide public mental health services in their assigned service areas. An annual contract is negotiated with each Center, specifying the minimum numbers of persons in each targeted population to be served, and the various types of services to be provided. Also on an annual basis, Centers are reviewed for compliance with applicable statutes, rules and policies, which include requirements for the array of core services to be available and for the quality of those services. Funding for the Medicaid mental health capitation program are provided through contracts with BHOs, which is now conducted by HCPF.

Colorado withholds the allowable five percent of its Mental Health Block Grant funds for administration. The bulk of the remaining dollars fund community based services across the state for adults with serious mental illnesses and children with serious emotional disturbances. Colorado plans to expend its Block Grant funds to these same entities at the current rate. With the recent increases in these funds, the Division has supported numerous innovative and evidenced-based practices. Some of these activities will receive ongoing funding; while others will be re-bid every one to two years.

The table below shows the agencies and the amounts expended for community mental health services in federal FY 2004-2005, or between 1 October 2004 and 30 September 2005. The total amount listed for the Block Grant represents the net amount available after the allowed five percent for administration***. It is critical to note that these expenditures are totals across multiple state fiscal years and do not reflect the total allocation or grant to each agency for one fiscal year.*** This means that they are totals of what was officially recorded by the State as an expenditure during this time period, and do not necessarily reflect what the anticipated allocations are for a full state fiscal year.

Federal FY 2004-2005 Block Grant Expenditures
(1 October 2004 to 30 September 2005)

Arapahoe/Douglas Mental Health Network	$198,946.50
Asian Pacific Center for Human Development	$43,751.00
Aurora Comprehensive Community MHC	$172,249.00
Centennial MHC	$232,731.00
Colorado West Regional MHC	$238,368.00
Community Reach Center (formerly Adams Community MHC)	$269,065.80
Jefferson Center for Mental Health	$514,716.60
Larimer Center for Mental Health	$341,466.88
Mental Health Center of Boulder County	$56,437.93
Mental Health Center of Denver (formerly Mental Health Corporation of Denver)	$972,361.10
Midwestern Colorado MHC	$180,824.30
North Range Behavioral Health	$263,881.00
Pikes Peak MHC	$427,271.30
San Luis Valley Comprehensive Community MHC	$174,052.50
Southeast Mental Health Services	$129,462.75
Southwest Colorado MHC	$362,022.76
Spanish Peaks MHC	$369,073.80
West Central MHC	$93,257.50
Subtotal CMHCs/Clinics	$5,039,939.72
Special Purposes	
Federation of Families for Children's Mental Health--Colorado Chapter	$6,176.44
Mental Health Association of of Colorado	$100,167.90
NAMI Colorado	$30,000.00
University of Colorado	$139,028.30
Special Purposes (including Monitoring, Technical Assistance, Training and Planning Council activities)	$140,592.09
Subtotal Special Purposes	$415,964.73
Allowable (5%) Administration	$287,152.90
Total Block Grant Expenditures	$5,743,057.35

Performance Indicators and Accomplishments
Adult and Children's Plans, State Fiscal Year Data (July1 – June 30)
State Plan Implementation Report Performance Indicator Data Table, Fiscal Year 2005

The following section utilizes the Goals, Targets, Performance Indicators, Performance Measures and the data sources as outlined in Colorado's FY 2005-2007 federal Block Grant Plan. Care should be taken when reviewing these targets in noting that many are different from Colorado's previously approved Block Grant Plan for FY 2002-2004.

There are a number of significant issues that impacted whether or not individual targets were achieved. Three issues with an impact on the majority of targets are noted here:

- A number of the targets were missed (or in some cases substantially over achieved) because the targets were set before the State had the final FY 2004 data. This is a result of the Block Grant Plan being due to the federal government in September (with the Plan's targets being set by mid-August) and the state's data finalized in October.

- The State missed its targets regarding evidence-based or promising practices in large part due to changes in how the practices were reported and the relative newness of the indicators. The definition of these practices were made stricter than what was provided in the original Block Grant Plan guidance, and this is only the first year that these indicators were included in the Block Grant.

- There is a need for more analysis of some these results than what is possible prior to submission of this Report. Because these data are only complete during the month of October, the Division, Council and the providers traditionally do not have sufficient time to identify significant trends, the reasons for these trends, and strategies to address them.

In light of these factors, the Division and the Council may choose to reevaluate their original targets to determine if they will require modification for the third and final year of the Plan.

This section contains the Goals, Targets and Action Plans of the FY 2005-2007 Plan. As required by the federal government, it is separated into two parts, one each for the Adult and Children's Plans.

Criteria, Targets and Performance Indicators, **Adult Plan**
Criterion 1

Goal: Increase the availability and accessibility of appropriate public mental health services for adults with serious mental illnesses.

Target 1: Increase access to public mental health services.

Target 2: Increase the availability of evidence based and promising practices.

Criterion 1: Comprehensive Community-Based Mental Health Service System

Population: Adults with Serious Mental Illnesses (SMI)

Action Plan Accomplishments:

The State did accomplish four of the five parts of the 2005 Action Plan under Criterion 1. While the Division was unable to hire the staff necessary to commence the second phase of the Evidence Based Practices Workgroup, it was able to change its monitoring process to better focus on outcomes. Also, the Division—in partnership with the Council—did draft an application for the federal Mental Health Transformation grant. Likewise, participation by the Division and the Council continued on the Task Force on Persons with Mental Illness in the Criminal Justice System. The Division did author a report on trends in the public mental health system in February, and implemented its first memorandum of understanding with HCPF that addressed the issues arising out of the bifurcation of responsibilities for the public mental health system.

State Fiscal Year Performance Measures:

1. Perception of Access

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	73.8	71.61	72.2	74.40	103.05%	72.8	73.4
IF Rate:							
Numerator	1,893	1,793		1,779			
Denominator	2,565	2,504		2,391			

FY 2005 Findings: This target was achieved.

2. Perception of Outcomes

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	63.31	62.62	63.4	62.40	98.42%	64.2	65.0
IF Rate:							
Numerator	1,624	1,568		1,492			
Denominator	2,565	2,504		2,391			

FY 2005 Findings: This target was missed by 1.0 percent. Although the actual FY 2005 percentage was only slightly lower than that of FY 2004 (0.22 percent) indicating that the trend may be leveling out, it should be noted that an increase of 1.8 percent will be required to meet the FY 2006 target.

3. Number of EB/PP

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	N/A	108	108	66	61.11%	134	160

FY 2005 Findings: This target was missed by 38.89 percent, or by 52 evidence-based or promising practices. As noted previously, the change to a more strict, federal definition of an evidence-based or promising practice led to the decline in this indicator. Also, the Division previously used this measure for all evidence-based and promising practices, but is reflecting here only those provided to adults with serious mental illnesses. For purposes of comparison, there were a total of 80 evidence-based or promising practices reported statewide for all ages in FY 2005 versus 108 in FY 2004. Of those reported in FY 2005, only adults were served in 66, only children in nine, and a mix of ages in five. The Division will continue to focus on the identification, evaluation and provision of such practices across the state.

4. Percentage of Persons Receiving EB/PP Services

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	2.81	3.27	3.8	39.42	1037.29%	7.2	14.4
IF Rate:							
Numerator	1,014	997		12,520			
Denominator	36,028	30,491		31,763			

FY 2005 Findings: This target was achieved. As noted above, the newness of this indicator and the fact that the target was achieved by so much (over 1,000 percent) may require the Division and the Council to reevaluate the out year targets.

5a. Rate of Readmission to State Institutes at 30-days

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	6.05	9.02	6.0	8.58	69.9%	5.9	5.8
IF Rate:							
Numerator	110	199		143			
Denominator	1,817	2,207		1,666			

FY 2005 Findings: This target was missed by 30.1 percent. However, the FY 2004 data was not final at the time of the submission of the original Plan, and thus the targets were set using the incomplete data available in August 2004. Using the final FY 2004 data, it shows a slight

downward trend in this indicator (0.44 percent), which is actually greater than that anticipated in the original Plan.

5b. Rate of Readmission to State Institutes at 180-days

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	12.77	15.86	11.2	17.29	64.79%	11.1	11.0
IF Rate:							
Numerator	232	350		288			
Denominator	1,817	2,207		1,666			

FY 2005 Findings: This target was missed by 35.21 percent. While the final data for FY 2004 changed for this indicator, and fewer individuals were readmitted at 180-days, there is an upward trend in the percentage of those readmitted at 180-days. It is, at this time, unclear whether this represents a positive or negative trend. Discussions have already been initiated within Council to provide further analysis of this data.

6. Percentage of Persons Employed

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	66.05	55.89	57.0	54.07	94.86%	62.0	67.0
IF Rate:							
Numerator	14,025	6,857		6,728			
Denominator	21,235	12,269		12,443			

FY 2005 Findings: This target was missed by 3.14 percent. Given the final FY 2004 data reflected here, there was an overall decline of 1.82 percent from FY 2004 to FY 2005. The Plan anticipated a declining trend for the two fiscal years due to the anticipated lag in employment (and reemployment). There may be some relation between the increased overall acuity of those served with this decline, however, further analysis is required.

7. Percentage Involved with Criminal Justice

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	10.38	9.25	9.5	10.34	91.91%	8.7	7.9
IF Rate:							
Numerator	3,481	2,914		3,283			
Denominator	33,535	31,505		31,763			

FY 2005 Findings: This target was missed by 8.09 percent. This represents an upward trend, i.e., more adults reporting contact with the criminal justice system, between FY 2004 and 2005, and the FY 2005 percentage is nearly equal to the percentage found in FY 2003. It is possible that, as the state has restored a small percentage of the funding cut during FY 2002 and FY 2003, services have been restored to those adults most in need and thus most likely to have a recent criminal justice contact. Further, the increasing number of statewide collaborations around criminal (and juvenile) justice and mental health issues may result in a higher percentage of those served having these contacts. Further analysis is required as a decline of 1.64 percent will be required to meet the FY 06 target.

Colorado State Mental Health Plan, Adult Plan
Criterion 2

Goal: Measure and analyze changes in the public mental health system that affect children with serious emotional disturbances and their families.

Target: Increase the numbers served.

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Criterion 2: Mental Health System Data Epidemiology

Population: Adults with Serious Mental Illnesses (SMI)

Action Plan Accomplishments:

Three of the four Action Plan items were achieved during this fiscal year. The State continued to clarify and implement changes to the data requirements and collection and analysis processes brought about by HB 1265. Also, efforts continued at streamlining and consolidating data and data collection processes, notably with the Colorado Client Assessment Record. Moreover, the use of data was better integrated into the monitoring process. The only item not achieved was continuing the cooperative effort at developing a reliable measure of demand in the community.

State Fiscal Year Performance Measures:

1. Number Served

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	33,535	31,505	31,300	31,763	101.48%	33,500	35,000

FY 2005 Findings: This target was achieved.

2. Percentage Served

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	18.3	17.2	17.0	17.3	101.83%	17.7	18.4
IF Rate:							
Numerator	33,535	31,505		31,763			
Denominator	183,489	183,489		183,489			

FY 2005 Findings: This target was achieved.

Colorado State Mental Health Plan, Adult Plan
Criterion 4

Goal: Increase the availability and accessibility of appropriate public mental health services for rural and homeless populations.

Target 1: Decrease the barriers to access to services.

Target 2: Increase the availability of evidence based and promising practices.

Criterion 4: Targeted Services to Homeless and Rural Populations

Population: Adults with Serious Mental Illness (SMI)

Action Plan Accomplishments:

Three of the four Action Plan items were accomplished in FY 2005. These included ongoing, active participation by the Division in the Interagency Commission on Homelessness, as well as on select subcommittees. Also accomplished were continuing efforts toward the implementation of programs that provide alternatives to hospitalization in rural communities, and monitoring of changes regarding the Medicaid community mental health programs. As noted above, work on the evidence-based and promising practices was delayed.

State Fiscal Year Performance Measures:

1. Rural Population Receiving Services

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	24.15	21.97	22.0	23.25	105.67%	23.0	24.0
IF Rate:							
Numerator	8,098	6,923		7,384			
Denominator	33,535	31,505		31,763			

FY 2005 Findings: This target was achieved.

2. Homeless Receiving Services

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	4.6	3.65	3.55	3.72	104.65%	4.0	4.6
IF Rate:							
Numerator	1,542	1,149		1,180			
Denominator	33,535	31,505		31,763			

FY 2005 Findings: This target was achieved.

3. Number of Rural Areas with Evidence-Based or Promising Practices

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	N/A		63	32	50.79%	73	83

FY 2005 Findings: This target was missed by 49.21 percent. As noted above, this is a new indicator and will require further refinement.

Colorado State Mental Health Plan, Adult Plan
Criterion 5

Goal: Increase the available and adequate resources to manage the public mental health system.

Target: Restore mental health funding *per capita* to 2001 levels.

Criterion 5: Management Systems

Population: Population of Colorado

Action Plan Accomplishments:

The three FY 2005 Action Plan items were achieved, all of which focused on obtaining additional grants, and on enhancing data analysis and reporting.

State Fiscal Year Performance Measures:
1. Expenditure *per capita*

	FY 01 Actual	FY 02 Actual	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	$7.04	$6.35	$5.86	$5.01	$5.62	$5.65	100.53%	$6.67	$7.26
IF Rate:									
Numerator (in millions)	$29.00	$26.72	$24.74	$21.25	$24.06	$24.06		$28.70	$31.30
Denominator (in millions)	4.12	4.21	4.22	4.24	4.28	4.26		4.3	4.31

FY 2005 Findings: This target was achieved. However, it should be noted that the population estimated for the target year was higher than the final population estimate derived from the U. S. Census Bureau for 2005.

Colorado State Mental Health Plan, Children's Plan
Criterion 1

Goal: Increase the availability and accessibility of appropriate public mental health services for children with serious emotional disturbances and their families.

Target 1: Increase access to public mental health services.

Target 2: Increase the availability of evidence based and promising practices.

Criterion 1: Comprehensive Community-Based Mental Health Service System

Population: Children with SED who receive services during the designated year.

Action Plan Accomplishments:

The State did accomplish four of the five parts of the 2005 Action Plan under Criterion 1. While the Division was unable to hire the staff necessary to commence the second phase of the Evidence Based Practices Workgroup, it was able to change its monitoring process to better focus on outcomes. Also, the Division—in partnership with the Council—did draft an application for the federal Mental Health Transformation grant. Likewise, participation by the Division and the Council continued on the Task Force on Persons with Mental Illness in the Criminal Justice System. The Division did author a report on trends in the public mental health system in February, and implemented its first memorandum of understanding with HCPF that addressed the issues arising out of the bifurcation of responsibilities for the public mental health system.

State Fiscal Year Performance Measures:

1. Perception of Access

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	94.17	65.25	92.5	71.59	77.39%	94.3	95.2
IF Rate:							
Numerator	291	430		572			
Denominator	309	659		799			

FY 2005 Findings: This target was missed by 21.61 percent. However, the FY 05 actual is higher than the updated FY 04 actual by 6.24 percent. This measure—the Youth Services Survey for Families—was piloted in FY 2003, and the original targets were set using the pilot data.

2. Perception of Outcomes

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	79.34	55.1	82.8	55.4	66.96%	84.4	86.0
IF Rate:							
Numerator	242	363		443			
Denominator	305	659		799			

FY 2005 Findings: This target was missed by 33.04 percent. Like the target above, however, the FY 05 actual is higher than the updated FY 04 actual by 0.3 percent. This measure—the Youth Services Survey for Families—was piloted in FY 2003, and the original targets were set using the pilot data.

3. Number of EB/PP

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	N/A		17	9	52.94%	34	51

FY 2005 Findings: This target was missed by 47.06 percent, or by eight evidence-based or promising practices. As noted above, this is a new indicator and will require further refinement.

4. Percentage of Persons Receiving EB/PP Services

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	N/A		3.0	1.53	50.99%	6.0	12.0
IF Rate:							
Numerator				283			
Denominator				18,500			

FY 2005 Findings: This target was missed by 49.01 percent. As noted above, this is a new indicator and will require further refinement.

5a. Rate of Readmission to State Institutes at 30-days

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	8.32	10.82	8.5	9.82	86.59%	8.4	8.3
IF Rate:							
Numerator	46	83		91			
Denominator	553	767		927			

FY 2005 Findings: This target was missed by 13.41 percent. However, the FY 05 actual is lower than the updated FY 04 actual by 1.0 percent. The original target actually anticipated a small increase in this rate.

5b. Rate of Readmission to State Institutes at 180-days

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	16.64	19.69	15.8	19.85	79.60%	15.7	15.6
IF Rate:							
Numerator	92	151		184			
Denominator	553	767		927			

FY 2005 Findings: This target was missed by 20.4 percent. However, there was only a slight increase over the final FY 04 actual (0.16 percent).

Colorado State Mental Health Plan, Children's Plan
Criterion 2

Goal: Measure and analyze changes in the public mental health system that affect children with serious emotional disturbances and their families.

Target: Increase the numbers served.

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Criterion 2: Mental Health System Data Epidemiology

Population: Children with Serious Emotional Disturbances (SED)

Action Plan Accomplishments:

Three of the four Action Plan items were achieved during this fiscal year. The State continued to clarify and implement changes to the data requirements and collection and analysis processes brought about by HB 1265. Also, efforts continued at streamlining and consolidating data and data collection processes, notably with the Colorado Client Assessment Record. Moreover, the use of data was better integrated into the monitoring process. The only item not achieved was continuing the cooperative effort at developing a reliable measure of demand in the community.

State Fiscal Year Performance Measures:

1. Number Served

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	18,082	16,977	18,100	18,500	102.21%	19,100	20,800

FY 2005 Findings: This target was achieved.

2. Percentage Served

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	28.36	26.63	28.39	29.02	102.21%	29.96	32.63
IF Rate:							
Numerator	18,082	16,977		18,500			
Denominator	63,754	63,754		63,754			

FY 2005 Findings: This target was achieved.

Colorado State Mental Health Plan, Children's Plan
Criterion 3

Goal: Develop a quality and integrated system of care for children, adolescents and their families.

Target 1: Decrease the number who have contact with the juvenile justice system.

Target 2: Increase the school performance.

Criterion 3: Children's Services

Population: Children with Serious Emotional Disturbances

Action Plan Accomplishments:

Both of the Action Plan items for FY 2005 were accomplished. This includes increasing the emphasis on cross system data collection, notably through the Division's participation in the federal Other State Agency project. Also, the Division is a founding member of the State Steering Committee for HB 1451, Collaborative Management Projects.

State Fiscal Year Performance Measures:

1. Percent who have contact with juvenile justice

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	11.41	9.98	11.75	9.06	129.62%	11.25	11.0
IF Rate:							
Numerator	2,063	1,694		1,677			
Denominato	18,082	16,977		18,500			

FY 2005 Findings: This target was achieved.

2. Percent improved on school performance

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	33.21	20.68	30.8	16.72	54.30%	32.0	34.4
IF Rate:							
Numerator	6,705	2,143		2,120			
Denominato	20,188	10,365		12,676			

FY 2005 Findings: This target was missed by 45.70 percent. This measure shows a decline (reduced school performance) even with the updated FY 04 data. The Division and the Council have initiated discussions to investigate this trend.

3. Percent improved on school attendance

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	84.3	87.4	87.5	87.6	100.12%	89.0	90.5
IF Rate:							
Numerator	17,033	15,259		16,174			
Denominato	20,195	17,459		18,463			

FY 2005 Findings: This target was achieved.

Colorado State Mental Health Plan, Children's Plan
Criterion 4

Goal: Increase the availability and accessibility of appropriate public mental health services for rural and homeless populations.

Target 1: Reduce the barriers to access to services.

Target 2: Increase the availability of evidence based and promising practices.

Criterion 4: Targeted Services to Homeless and Rural Populations

Population: Children with Serious Emotional Disturbances

Action Plan Accomplishments:

Three of the four Action Plan items were accomplished in FY 2005. These included ongoing, active participation by the Division in the Interagency Commission on Homelessness, as well as on select subcommittees. Also accomplished were continuing efforts toward the implementation of programs that provide alternatives to hospitalization in rural communities, and monitoring of changes regarding the Medicaid community mental health programs. As noted above, work on the evidence-based and promising practices was delayed.

State Fiscal Year Performance Measures:

1. Rural Population Receiving Services

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	19.4	21.12	21.5	21.33	99.21%	22.5	23.5
IF Rate:							
Numerator	3,508	3,585		3,946			
Denominator	18,082	16,977		18,500			

FY 2005 Finding: This target was missed by 0.79 percent.

2. Homeless Receiving Services

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	0.68	0.57	0.55	0.52	95.33%	0.65	0.7
IF Rate:							
Numerator	123	96		97			
Denominator	18,082	16,977		18,500			

FY 2005 Findings: This target was missed by 4.67 percent. As noted above, this is a new indicator and will require further refinement.

3. Number of Rural Areas with Evidence-Based or Promising Practices

	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	N/A		63	32	50.79%	73	83

FY 2005 Findings: This target was missed by 49.21 percent. As noted above, this is a new indicator and will require further refinement.

Colorado State Mental Health Plan, Children's Plan
Criterion 5

Goal: Increase the available and adequate resources to manage the public mental health system.

Target: Restore mental health funding *per capita* to 2001 levels.

Criterion 5: Management Systems

Population: Population of Colorado

Action Plan Accomplishments:

The three FY 2005 Action Plan items were achieved, all of which focused on obtaining additional grants and enhanced data analysis and reporting.

State Fiscal Year Performance Measures:

1. Expenditure *per capita*

	FY 01 Actual	FY 02 Actual	FY 03 Actual	FY 04 Actual	FY 05 Target	FY 05 Actual	FY 05 Percent Attained	FY 06 Target	FY 07 Target
Value:	$7.04	$6.35	$5.86	$5.01	$5.62	$5.65	100.53%	$6.67	$7.26
IF Rate:									
Numerator (in millions)	$29.00	$26.72	$24.74	$21.25	$24.06	$24.06		$28.70	$31.30
Denominator (in millions)	4.12	4.21	4.22	4.24	4.28	4.26		4.3	4.31

FY 2005 Findings: This target was achieved. However, it should be noted that the population estimated for the target year was higher than the final population estimate derived from the U. S. Census Bureau for 2005.