STATE OF COLORADO

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November 30, 2006

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 Two 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) 866-7486.

Sincerely yours,

Janet Wood

Janet Wood, M.B.A., M.Ed.
Director, Colorado Behavioral Health Services

COLORADO

COMMUNITY MENTAL HEALTH SERVICES
FY 2005-2007 BLOCK GRANT PLAN

FY 2006, Year Two
Implementation Report

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

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Executive Summary

This is Colorado's FY 2006, or Year Two, 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 original 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 2006

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 2006 fiscal year. The Report covers the second fiscal year of Colorado's three-year plan that was approved for fiscal years 2005 –2007.

This past fiscal year saw the next year's implementation of our 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 asked for block grant data to be disaggregated by provider and Medicaid status so it can better understand areas of success and challenges.

- There continues to be an emphasis on the transformation of mental health and related systems. The Council continues to study ways to transform itself and the systems; especially with the opportunity a new governor brings.

- Colorado's legislative session resulted in a number of new initiatives, and significant 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, restoration of services targeted at early childhood mental health, and the funding for two intensive treatment facilities on the Western Slope. Additionally, funding for uninsured was restored to 2003 levels.

- 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. These projects are just starting and their full impact will most likely not be seen until 2008.

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 limitation 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 year.

Sincerely,

Sharon Raggio, Chair
Colorado Mental Health Planning and Advisory Council

Summary of Areas Identified as Needing Improvement

In its original 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 last year's Report (FY 2005), members of Council requested that a linkage be made between the description of areas needing improvement as identified in the Plan with how the State did towards achieving its Targets. The State continues this approach by including the text boxes 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 2006? (Percent Achieved)
Perception of Access	No (99.27)
Perception of Outcomes	No (94.09)
Criterion 1, Children Plan	
Perception of Access	No (76.26)*
Perception of Outcomes	No (63.69)

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. Importantly, the current and expected changes to the federal Medicaid program may have a disproportionate impact on how these consumer recovery based mental health services are to be funded and delivered through Colorado's Capitation program.

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.

The Division continues to face additional staff vacancies and the ability to fill those vacancies during FY 2006, which impacted its ability to focus on the implementation of the Cultural Competency Plan. However, the Division approved services to be provided at another clinic serving the Latino community in September 2005, and continues to review performance by community providers on cultural competency measures.

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.

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 (58.28)*
Percentage Improved School Attendance	No (98.33)

It has also played a role in children's system of care collaborations. Further, the Division participates in the HB 1451 State Steering Committee and the Department of Public Health and Environment's "LINKS" project. The HB 1451 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 (82.20)
Criterion 1, Children Plan	
Percentage Involved with Juvenile Justice	No (87.88)

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.

As is noted below in the *Performance Indicator and Accomplishments* section, the Division and the Council have noted that the failure to achieve this Target (that is, fewer persons who are served have a justice contact) might not represent failure in the system. Specifically, as funding has been restored to the public mental health system, it is possible that the State should expect to serve *more* persons who have had contact with the justice system.

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 (62.63)
Rate of Readmission to Institutes, 180-days	No (63.77)
Criterion 1, Children Plan	
Rate of Readmission, 30-days	No (93.94)*
Rate of Readmission, 180-days	No (87.25)*

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.

Also noted below, the creation and funding for two Western Slope facilities—one a psychiatric hospital and one what is expected to be licensed as an acute treatment unit—may have an impact on how often consumers from the western portion of the state are transported across the mountains to the Institute at Pueblo.

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 (36)
Percentage Receiving EB/PPs	Yes (496.67)
Criterion 1, Children Plan	
Number of Promising- and Evidence-Based Practices	No (11)*
Percentage Receiving EB/PPs	Yes (113.21)

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. Only 68 were identified in FY 2006, however, this may be primarily due to the ongoing changes to how programs are defined and counted.

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 FY 2005*	*Total Number Reported FY 2006*
Evidence-Based			
Assertive Community Treatment	Adults	6	7
Family Psycho-education	Adults	4	1
Illness Self Management	Adults	10	7
Integrated Treatment for Co-occurring Disorders	Mixed	12	8
Medication Management	Mixed	6	3
Supported Employment	Adults	12	8
Supported Housing	Adults	15	12
Family Functional Therapy	Youth	4	5
Multi-Systemic Therapy	Youth	2	3
Therapeutic Foster Care	Youth	2	0
Promising			
Anger Management	Adults	1	1
Dialectical Behavior Therapy	Mixed	3	5
Eye Movement Desensitization and Reprocessing	Mixed	1	0
Parenting	Mixed	1	0
School-based Services	Youth	1	0
Wraparound	Youth	Not Reported	3
Family Intensive Therapy	Youth	Not Reported	1
Mentoring	Youth	Not Reported	1
CASASTART Prevention	Youth	Not Reported	1
QPR (Question, Persuade, Refer)	Youth	Not Reported	1
Integrated Healthcare	Mixed	Not Reported	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 2006. 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. The Division has begun the process of redesigning the Indicators with the providers and HCPF.

Goebel Settlement

The Goebel lawsuit was finally dismissed with prejudice in March 2006 after over a quarter century of litigation. In June 2006, due largely to federal requirements, HCPF moved the Medicaid portion of the Goebel funding under the Capitation program. At this time, the Division, the providers and HCPF continue to work on addressing the impacts of this change in funding.

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	No (89.02)*

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

Legislative Issues

There are seven significant legislative issues that have risen in the past 14 months that deserve mention. The bills were:

1. HB06-1385, "Long Appropriations Bill", Representative Plant and Senator Tapia;
2. HB06-1277, "Persons with Mental Illness", Representative Clapp and Senator Sandoval;
3. HB06-1080, "Adult Criminal Competency Evaluations", Representative T. Carroll and Senator Grossman; and, HB06-1353, "Criminal Competency Evaluation Standards", Representative T. Carroll and Senator Grossman;
4. SB06-005, "Insurance Coverage for Court Ordered Treatment", Senator Windels and Representative Solano;
5. HB06-1395, "Residential Child Health Care", Representative Buescher and Senator Keller;

6. Footnote 63 (vetoed in full by the Governor), concerning a report on competency evaluations and restorations, and on allocation of civil beds; and,
7. HB06S-1023, "Restrictions on Defined Public Benefits", Representative Romanoff and Senator Fitz-Gerald (a 2006 Special Session bill).

First, and perhaps most importantly, the 2006 Colorado General Assembly 'restored' nearly all the funding cuts made to the community mental health budget in the past several years (HB06-1385). Buoyed by the passage in November 2005 of Referendum 'C', the legislature was able to appropriate over $7.6 million, including appropriating additional, supplemental funds for FY 2005-06 and provider 'cost of living adjustments' (COLA). In addition to the COLA, the two largest increases were for the: Services to the Medically Indigent (primary line item for services to the non-Medicaid), and Early Childhood Mental Health Specialists (a program initially approved in 2003, but fell victim to veto due to the budget crisis). Further, $900,000 was intended to fund programs at two new Western Slope facilities, one an inpatient psychiatric hospital in Grand Junction and the other an acute treatment unit in Durango. The Division has begun obligating the restored funding in a manner that will increase the focus paid to accountability for the system, particularly as it results in citizens accessing care who lost that access previously.

Also, the Medicaid Community Mental Health program (also known as "capitation") received an appropriation of $178.2 million for FY 2006-07, an increase of $13.1 million over the FY 2005-06 appropriation of $165.0 million.

Second, the Division wrote and successfully shepherded to passage HB06-1277, "Persons with a Mental Illness", by Representative Clapp (R-Centennial) and Senator Sandoval (D-Denver). This bi-partisan, comprehensive bill accomplished five specific goals in updating Colorado's primary mental health statute (C. R. S. 27-10):

1. Creates a new Acute Treatment Unit (ATU) licensure category where none existed previously, which will result in more community based treatment options and enhanced quality of treatment of persons with SMI/SED (and co-occurring substance abuse) in ATUs;
2. Ensures protection of Colorado citizens' civil liberties by limiting the placement of emergency holds by law enforcement to certified peace officers only, who are trained in 27-10 law and in how to deal with special populations;
3. Makes more efficient the oversight of facilities' record retention by conforming the statute with the current, appropriate community standards of practice;
4. Reduces the need for costly legal actions by simply reiterating the existing federal and state statutory authority of the governor's Protection and Advocacy program; and, perhaps most importantly,
5. Refocuses the statute on consumers and families with use of person first language and adds an emphasis on recovery and resiliency.

Third, extensive attention was given to the issue of competency evaluation and restoration. Two bills were passed, HB06-1080 and HB06-1353, regarding this. HB06-1080 gave statutory

authority for trained, licensed psychologists to perform competency evaluations. While this has been the historical practice in Colorado, the statute had not been updated to reflect this fact. HB06-1353 created a committee of the existing Advisory Task Force to the legislative Oversight Committee on Persons with Mental Illness in the Criminal Justice System (Oversight Committee) to study the issue of statewide standard setting for performance of competency evaluations. The committee, which was time limited, is expected to recommend some statutory and other initiatives in September.

Fourth, the Oversight Committee was able to pass one of its two bills for the year, SB06-005 (the other bill, HB06-1070, "Juvenile Justice Family Advocate Program", Representative Stafford and Senator Windels, failed for a lack of a defined funding source). The bill prohibits private, commercial insurance plans from denying payment for an otherwise covered mental health benefit solely because the treatment is court ordered. This bill is similar to the substance abuse prohibition bill that became law in 2003.

Fifth, the General Assembly adopted changes to the delivery system and funding structure of Colorado's residential treatment program in HB06-1395. The bill added the terms "psychiatric residential treatment facility" and "treatment residential child care facility" to statute reflecting the minor, naming changes formed after the decision by the federal Centers for Medicare and Medicaid Services' to not accept Colorado's Medicaid state plan amendment for the residential treatment program in 2005. Also, the bill reestablished the amount that counties will be required to contribute as their "share" of the residential costs for children in their custody or in their system. While opposed by the Division, the bill also allows for "provisional licensure" of certain professionals who have yet to obtain their professional license and who work in a residential facility. The Division remains concerned about the general lack of appropriate alternatives to the use of residential facilities (Colorado has as many as 1,500 children in such placements at any given time), and will continue to participate in the committee meetings in the coming year with the goal of creating a system based on outcomes, that treats seclusion and restraint as a rare, emergency intervention, and that expands the capacity of communities and families to treat children in their homes.

Sixth, the Division and the Office are committed to examining appropriate changes to how state Institute civil beds are allocated, namely whether some persons from the metropolitan area should still be sent to Pueblo for inpatient treatment. While the Governor vetoed Footnote 63, the Division expects to be able to continue planning for how to address this issue.

Finally, the seventh issue arose from the July 2006 Special Session called by the Governor to address several issues. The one of greatest potential impact on the community mental health system is HB06S-1023. This bill uses existing federal law to restrict public benefits to those individuals who are U. S. citizens or otherwise legally present in the U. S. Called by many as the toughest immigration law in the country, it took effect on August 1, 2006. However, a significant number of complex issues remain to be solved prior to the Division being able to comment on the specific impacts of the legislation. This includes the formal letter submitted by the Division to the Center for Mental Health Services for guidance regarding the law's requirements in relation to the federal Block Grant.

Transformation

In addition to other 'transformation efforts', such as ongoing participation in the HB 1451 Collaborative Management Program and the federal 'systems of care' grant Project BLOOM, the Division is reporting on information it received in preparation for the President's proposed change to federal law regarding "transformational activities". The Division, in coordination with the community mental health providers and in anticipation of a possible change to federal law, requested that each recipient of Block Grant funds provide information on: the specific services/programs (identified for federal purposes as an activity) funded by these dollars; whether these services can be categorized as "transformational activities"; and, the amount of Block Grant funds expended on each of these activities. Specifically, the Division requested:

> "Specifically, the requested report is required to include the following elements (please use the attached Microsoft Word table template for the report (Attachment A)):
>
> 1. Name of the activity;
> 2. Brief description of the activity, including a statement of why an activity is determined to be a "transformation activity", where applicable;
> 3. Demographics of consumers served by the activity, by age and severity categories;
> 4. The amount of Block Grant funds and the percentage that the Block Grant comprises of all funds expended on each activity; and,
> 5. Both the Block Grant Target and President Bush's New Freedom Commission's (NFC) goal to which the activity corresponds. (While it is preferred that individual providers identify the goal(s), the Division is prepared to assist in selecting the corresponding goal(s).)"

The Division will include the information provided in these reports in any FY 2006-07 amendments to provider contracts.

The following are brief notes from the reports provided from 17 community mental health centers, one specialty clinic and three non-profit advocacy organizations. It is noted that each contractor was given flexibility about how to report on their activities, and thus some of the reports differ in format, percentage of Block Grant funds and level of detail. Also, the Division's intent is not to create 'silo' reporting, recognizing that the capacity to blend, 'braid' and/or otherwise combine various funding sources—when paired with an appropriate amount of accountability—is critical to obtaining successful outcomes on the local level.

- **21 contractors submitted reports** (all 17 community mental health centers, the one specialty clinic that received Block Grant funds in FY 2005-06, and three non-profit advocacy organizations).

- **$3,641,346 in Block Grant funds were reported as expended on 79 "transformational activities".** These Block Grant funds were 14.74 percent of all the estimated funds spent on these activities, and represent approximately 73.18 percent of all the Block Grant dollars allocated to these agencies.

- **Over half of the programs reported were "evidence based" or "promising practices"** ($1,469,241 for 31 programs, representing 39.8 percent of all reported Block Grant dollars). These programs include for direct treatment (e.g., Assertive Community Treatment), supports (housing and employment), and recovery and resiliency (e.g., consumer recovery centers and family education programs). The remaining expenditure 'categories' of programs were:
    - $498,438 for coordination of care and/or linkages with primary health care (14 programs comprising 13.97 percent of all reported Block Grant dollars);
    - $411,021 for culturally competent services (6 programs, 11.52 percent);
    - $329,622 for telemedicine services (4 programs, 9.24 percent);
    - $298,134 for electronic health records (4 programs, 8.36 percent);
    - $258,837 for school based care (3 programs, 7.26 percent);
    - $211,480 for advocacy and education efforts (7 programs, 5.93 percent);
    - $56,823 for criminal and juvenile justice activities (3 programs, 2.25 percent):
    - $43,000 for workforce development (2 programs, 1.18 percent);
    - $29,900 for stigma reduction education (2 programs, 0.84 percent); and,
    - $9,600 for suicide prevention (3 programs, 0.27 percent).

Again, these reports should not be seen as all inclusive of the services funded by the Block Grant, rather they are indicators of the array of services made available, in part, by the flexible use of Block Grant dollars.

End of the Goebel Settlement and Lawsuit

In March 2006, the district court found the State had fully met its requirements under the Goebel lawsuit settlement, and dismissed the lawsuit "with prejudice". The successful ending of the 25 year old lawsuit has resulted in the need to make certain changes to the program. Perhaps the most significant change is that the Medicaid funding for the program was moved under the capitation program due to requirements set by the Centers for Medicare and Medicaid Services (CMS). The Division remains committed to maintaining the level of care this population has previously received, however, it also recognizes that the change in funding mechanism will likely result in additional changes.

Implementation of Medicaid Outpatient Substance Abuse Benefit

As mentioned in the Year Two Plan, HB04-1015 created the first outpatient Medicaid substance abuse benefit for Colorado. This benefit became effective on 1 July. The Council has been very active in advocating with the Department and HCPF to create a program that is integrated, allowing for seamless treatment for consumers. This activity included the passage of a resolution, reading in part:

> "…Council does hereby petition and strongly urge the Department of Healthcare Policy and Financing, the Alcohol and Drug Abuse Division and the Division of Mental Health to work together to implement regulations for the new

> Medicaid benefit in a manner that encourages providing integrated services for individuals with co-occurring disorders and discourages providing services separately and/or independently."

Reorganization of the Office of Behavioral Health and Housing

In March 2006, the Office of Behavioral Health and Housing (the Office) announced the reorganization of the Division and the Alcohol and Drug Abuse Division (ADAD) under a new structure named "Behavioral Health Services" (BHS). The Office, in making the announcement that the current ADAD Director would assume the leadership of the new entity, noted that other states that have combined the two agencies have enhanced their ability to provide consistent and cost-effective services. The BHS Director is in charge of overall leadership including planning, policy development, and oversight of contract management, monitoring and evaluation for the behavioral health system and serves as the state's Mental Health Commissioner. The Division's existing acting director position has been renamed as 'Manager', and is charged with oversight of the day to day operational functions of the Division.

Although a planned, full scale integration has not been undertaken, a number of changes have been made or begun, including restructuring resulting in the Division's finance and data and evaluation directors reporting directly to BHS. While the impacts of this reorganization will not be known for some time, it is anticipated that the impacts of this reorganization will be further discussed in Colorado's next Block Grant Application and Plan.

Change in Administration

This November, the citizens of Colorado will elect a new governor. While it is unknown which candidate will prevail (of course), it is likewise unknown in what direction either candidate will take the State in relation to mental health and the public mental health system. Either way, it is expected that Colorado's next three year Block Grant Application and Plan will be heavily influenced by whatever direction is begun with the new administration.

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, and until the recent creation of what is anticipated to be a licensed acute treatment unit, 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. Graduates of the Colorado Leadership Academy basic training and the advanced training 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.

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 also continues to operate programs under grants from the Federal Emergency Management Agency and SAMHSA.

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 2005-2006, or between 1 October 2005 and 30 September 2006. 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 state 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 2005 to 30 September 2006)

Arapahoe/Douglas Mental Health Network	$144,308.60
Asian Pacific Center for Human Development	$31,065.67
Aurora Comprehensive Community MHC	$200,551.25
Centennial MHC	$154,562.00
Colorado West Regional MHC	$410,684.00
Community Reach Center (formerly Adams Community MHC)	$275,569.00
Jefferson Center for Mental Health	$389,458.16
Larimer Center for Mental Health	$225,515.60
Mental Health Center of Boulder and Broomfield Counties	$33,949.00
Mental Health Center of Denver (formerly Mental Health Corporation of Denver)	$744,655.16
Midwestern Colorado MHC	$127,264.68
North Range Behavioral Health	$280,521.32
Pikes Peak MHC	$411,806.07
San Luis Valley Comprehensive Community MHC	$154,904.77
Southeast Mental Health Services	$143,577.49
Southwest Colorado MHC	$581,799.00
Spanish Peaks MHC	$426,966.75
West Central MHC	$244,968.00
Subtotal CMHC/Clinics	$4,982,126.52
Special Purposes	
Federation of Families for Children's Mental Health--Colorado Chapter	$47,440.46
Mental Health Association of Colorado--WE CAN!	$39,508.18
NAMI--Colorado Chapter	$44,340.66
University of Colorado	$96,183.23
Special Purposes (including Monitoring, Other Direct Services, Technical Assistance, Training and Planning Council activities)	$222,968.61
Subtotal Special Purposes	$450,441.14
Allowable (5%) Administration	$287,698.40
Total Block Grant Allocations	$ 5,720,266.06

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 2006

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 as 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 in August 2004 before the State had the final FY 2004 data. This is a result of the Block Grant Plan being due to the federal government on 1 September (with the Plan's targets being set by mid-August) and the state's data being 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 second 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.

  Despite this, on the recommendation of the community providers, the Division did review a number of the results to determine their statistical significance (where appropriate). Generally, most of the Targets that are contained in Criterion 1 (both children and adults), Criterion 3, and Criterion 4 (both children and adults) were found to have statistical significance. The exceptions were for those based on the two surveys (MHSIP and YSS-F), which were not found to be statistically significant.

- The Division and the providers have worked over the past year to identify methods and strategies to better analyze the data. To this end, the Division has committed to providing the Block Grant data disaggregated by agency and by Medicaid status. Because the Division did not have the resources to provide and analyze this data for inclusion in this Report, the results below remain as indicators of the state as a whole. It is possible that this analysis can be provided in next year's Report, and in the state's new Block Grant Plan to be submitted in September 2007.

In light of these factors, the Division and the Council may choose to reevaluate their original targets to determine which should continue in the new Plan drafted for the next three years.

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 accomplished one of the two parts of the 2006 Action Plan under Criterion 1. The Division was able further identify and implement reliable measures regarding evidence based and promising practices, although these measures will continue to require additional refinement. The Division, due primarily to its reduced staffing capacity, only minimally began work on training on fidelity and implementation.

State Fiscal Year Performance Measures:

1. Perception of Access

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	73.8	71.61	74.40	72.8	72.27	99.27%	73.4
IF Rate:							
Numerator	1,893	1,793	1,779		1,368		
Denominator	2,565	2,504	2,391		1,893		

FY 2006 Findings: This target was missed by 0.73 percent. The Division found that this difference was not statistically significant.

2. Perception of Outcomes

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	63.31	62.62	62.40	64.2	60.41	94.09%	65.0
IF Rate:							
Numerator	1,624	1,568	1,492		1,126		
Denominator	2,565	2,504	2,391		1,864		

FY 2006 Findings: This target was missed by 5.91 percent. While this difference was also found not to be statistically significant, the Division notes that the general trend has been slightly downward over the past four years and that achievement of the FY 07 Target is in jeopardy. The Division, the Council and the state's providers intend to analyze the disaggregated Block Grant data to better understand this possible trend and develop any appropriate strategies to address it.

3. Number of EB/PP

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	N/A	108	66	134	36	26.87%	160

FY 2006 Findings: This target was missed by 73.13 percent, or by 98 evidence-based or promising practices. This is the second year that the Division is reflecting only those programs serving adults with serious mental illness. The Targets were set using all programs available in the State. For the purposes of comparison, there were a total of 68 evidence-based or promising practices reported statewide for all ages in FY 2006, versus 80 in FY 2005, and 108 in FY 2004. Of all the programs reported in FY 2006, only adults were served in 36, only children in eleven, and a mix of ages in 21.

As noted previously, the ongoing changes to how these programs are defined, and to how the data are collected, continues to lead to a decline in this indicator. However, the Division expects that the steps taken in partnership with the state's provider community to better define and more accurately count these programs will provide more reliable data in the future.

4. Percentage of Persons Receiving EB/PP Services

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	2.81	3.27	39.42	7.2	35.76	496.67%	14.4
IF Rate:							
Numerator	1,014	997	12,520		12,761		
Denominator	36,028	30,491	31,763		35,685		

FY 2006 Findings: This target was achieved. As noted above, there remain issues with the definition of the programs and the collection of the data.

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

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	6.05	9.02	8.58	5.9	9.42	62.63%	5.8
IF Rate:							
Numerator	110	199	143		138		
Denominator	1,817	2,207	1,666		1,465		

FY 2006 Findings: This target was missed by 37.37 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 increase in FY 2006 over FY 2005, and that the FY 2006 Actual is higher than that of FY 2004. This result was found to be statistically significant. As noted above, the disaggregated data is anticipated to assist in better understand this result, although more research is necessary to determine the extent to which this indicator can reveal the rate of *inappropriate* readmissions.

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

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	12.77	15.86	17.29	11.1	17.41	63.77%	11.0
IF Rate:							
Numerator	232	350	288		255		
Denominator	1,817	2,207	1,666		1,465		

FY 2006 Findings: This target was missed by 36.29 percent. Please note the response above.

6. Percentage of Persons Employed

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	66.05	55.89	54.07	62.0	54.71	88.24%	67.0
IF Rate:							
Numerator	14,025	6,857	6,728		8,126		
Denominator	21,235	12,269	12,443		14,853		

FY 2006 Findings: This target was missed by 11.76 percent, although it represents an increase over FY 2005. Given the final FY 2004 data reflected here, there was an overall decline of 1.18 percent from FY 2004 to FY 2006. 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 being served, however, further analysis is required.

7. Percentage Involved with Criminal Justice

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	10.38	9.25	10.34	8.7	10.58	82.20%	7.9
IF Rate:							
Numerator	3,481	2,914	3,283		3,777		
Denominator	33,535	31,505	31,763		35,685		

FY 2006 Findings: This target was missed by 17.8 percent. This represents an upward trend, i.e., more adults reporting contact with the criminal justice system, between FY 2004 and 2006, and the FY 2006 percentage exceeds the percentage found in FY 2003. It is possible that, as the state has restored most of the funding cut during FY 2002 and FY 2003, services have been first 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.

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:

The State made some progress towards increasing the cross system data collection and analysis and further development of the 'Population In Need'.

State Fiscal Year Performance Measures:

1. Number Served

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	33,535	31,505	31,763	33,500	35,685	106.52%	35,000

FY 2006 Findings: This target was achieved.

2. Percentage Served

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	18.3	17.2	17.3	17.7	19.2	108.27%	18.4
IF Rate:							
Numerator	33,535	31,505	31,763		35,685		
Denominator	183,489	183,489	183,489		186,217		

FY 2006 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:

The State made progress towards the two parts of its Action Plan for Criterion 4. As noted above for Criterion 1, the Division was able further identify and implement reliable measures regarding evidence based and promising practices, although these measures will continue to require additional refinement. The Division, due primarily to its reduced staffing capacity, only minimally began work on training on fidelity and implementation.

State Fiscal Year Performance Measures:

1. Rural Population Receiving Services

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	24.15	21.97	23.25	23.0	23.88	103.82%	24.0
IF Rate:							
Numerator	8,098	6,923	7,384		8,521		
Denominator	33,535	31,505	31,763		35,685		

FY 2006 Findings: This target was achieved.

2. Homeless Receiving Services

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	4.6	3.65	3.72	4.0	3.47	86.87%	4.6
IF Rate:							
Numerator	1,542	1,149	1,180		1,240		
Denominator	33,535	31,505	31,763		35,685		

FY 2006 Findings: This target was missed by 13.13 percent. However, there were 60 more persons served from FY 2005. Again, the Division and the Council will analyze the disaggregated data to better identify the components of this result.

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

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	N/A		32	73	31	42.47%	83

FY 2005 Findings: This target was missed by 47.53 percent. As noted above, this indicator 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 one FY 2006 Action Plan items was achieved, including the restoration of nearly all previously reduced state general funding.

State Fiscal Year Performance Measures:

1. Expenditure *per capita*

	FY 01 Actual	FY 02 Actual	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	$7.04	$6.35	$5.86	$5.01	$5.65	$6.67	$5.94	89.02%	$7.26
IF Rate:									
Numerator (in millions)	$29.00	$26.72	$24.74	$21.25	$24.06	$28.70	$25.66		$31.30
Denominator (in millions)	4.12	4.21	4.22	4.24	4.26	4.3	4.32		4.31

FY 2006 Findings: This target was missed by 10.98 percent. 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. Also, the FY 2006 Target represented a 17.19 percent increase over the FY 2005 Target. Despite missing the Target, the recent budget restorations have resulted in the third straight increase in *per capita* expenditures.

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 accomplished one of the two parts of the 2006 Action Plan under Criterion 1. The Division was able further identify and implement reliable measures regarding evidence based and promising practices, although these measures will continue to require additional refinement. The Division, due primarily to its reduced staffing capacity, only minimally began work on training on fidelity and implementation.

State Fiscal Year Performance Measures:

1. Perception of Access

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	94.17	65.25	71.59	94.3	71.92	76.26%	95.2
IF Rate:							
Numerator	291	430	572		525		
Denominator	309	659	799		730		

FY 2006 Findings: This target was missed by 23.74 percent. However, the FY 2006 Actual represents an increase over FY 2005. 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 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	79.34	55.1	55.4	84.4	53.8	63.69%	86.0
IF Rate:							
Numerator	242	363	443		394		
Denominator	305	659	799		733		

FY 2006 Findings: This target was missed by 36.31 percent. This result was not found to be statistically significant. 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 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	N/A		9	34	11	32.35%	51

FY 2006 Findings: This target was missed by 67.65 percent. As noted above, this is indicator will require further refinement.

4. Percentage of Persons Receiving EB/PP Services

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	N/A		1.53	6.0	6.79	113.21%	12.0
IF Rate:							
Numerator			283		1,304		
Denominator			18,500		19,197		

FY 2006 Findings: This target was achieved. As noted above, this is indicator will require further refinement.

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

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	8.32	10.82	9.82	8.4	8.94	93.94%	8.3
IF Rate:							
Numerator	46	83	91		82		
Denominator	553	767	927		917		

FY 2006 Findings: This target was missed by 6.06 percent. However, the FY 2006 Actual is lower than FY 2005. The original target actually anticipated a 0.10 percent decrease in this rate.

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

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	16.64	19.69	19.85	15.7	17.99	87.25%	15.6
IF Rate:							
Numerator	92	151	184		165		
Denominator	553	767	927		917		

FY 2006 Findings: This target was missed by 12.75 percent. However, it represents a decrease of 1.86 percent decrease over FY 2005.

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:

The State made some progress towards increasing the cross system data collection and analysis and further development of the 'Population In Need'.

State Fiscal Year Performance Measures:

1. Number Served

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	18,082	16,977	18,500	19,100	19,197	100.51%	20,800

FY 2006 Findings: This target was achieved.

2. Percentage Served

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	28.36	26.63	29.02	29.96	29.78	99.40%	32.63
IF Rate:							
Numerator	18,082	16,977	18,500		19,197		
Denominator	63,754	63,754	63,754		64,462		

FY 2006 Findings: This target was missed by 0.60 percent, although an additional 697 children with SED were served.

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 2006 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 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	11.41	9.98	9.06	11.25	9.89	87.88%	11.0
IF Rate:							
Numerator	2,063	1,694	1,677		1,898		
Denominato	18,082	16,977	18,500		19,197		

FY 2006 Findings: This target was missed by 12.12 percent. As for adults, there may be an increase in this indicator as services are restored to those children with the most acute illness and who may thus have more contact with the juvenile justice system. 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.

2. Percent improved on school performance

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	33.21	20.68	16.72	32.0	18.65	58.28%	34.4
IF Rate:							
Numerator	6,705	2,143	2,120		2,248		
Denominato	20,188	10,365	12,676		12,053		

FY 2006 Findings: This target was missed by 41.72 percent. However, this measure shows an increase of 1.93 percent over FY 2005.

3. Percent improved on school attendance

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	84.3	87.4	87.6	89.0	87.5	98.33%	90.5
IF Rate:							
Numerator	17,033	15,259	16,174		16,908		
Denominato	20,195	17,459	18,463		19,320		

FY 2006 Findings: This target was missed by 1.67 percent. However, this measure reveals only a 0.1 percent decrease over FY 2005, and an increase of 0.1 over FY 2004.

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:

The State made progress towards the two parts of its Action Plan for Criterion 4. As noted above for Criterion 1, the Division was able further identify and implement reliable measures regarding evidence based and promising practices, although these measures will continue to require additional refinement. The Division, due primarily to its reduced staffing capacity, only minimally began work on training on fidelity and implementation.

State Fiscal Year Performance Measures:

1. Rural Population Receiving Services

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	19.4	21.12	21.33	22.5	19.98	88.81%	23.5
IF Rate:							
Numerator	3,508	3,585	3,946		3,836		
Denominator	18,082	16,977	18,500		19,197		

FY 2006 Finding: This target was missed by 11.19 percent.

2. Homeless Receiving Services

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	0.68	0.57	0.52	0.65	0.44	68.12%	0.7
IF Rate:							
Numerator	123	96	97		85		
Denominator	18,082	16,977	18,500		19,197		

FY 2006 Findings: This target was missed by 31.88 percent.

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

	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	N/A		32	73	31	42.47%	83

FY 2006 Findings: This target was missed by 47.53 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 one FY 2006 Action Plan items was achieved, including the restoration of nearly all previously reduced state general funding.

State Fiscal Year Performance Measures:

1. Expenditure *per capita*

	FY 01 Actual	FY 02 Actual	FY 03 Actual	FY 04 Actual	FY 05 Actual	FY 06 Target	FY 06 Actual	FY 06 Percent Attained	FY 07 Target
Value:	$7.04	$6.35	$5.86	$5.01	$5.65	$6.67	$5.94	89.02%	$7.26
IF Rate:									
Numerator (in millions)	$29.00	$26.72	$24.74	$21.25	$24.06	$28.70	$25.66		$31.30
Denominator (in millions)	4.12	4.21	4.22	4.24	4.26	4.3	4.32		4.31

FY 2006 Findings: This target was missed by 10.98 percent. 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. Also, the FY 2006 Target represented a 17.19 percent increase over the FY 2005 Target. Despite missing the Target, the recent budget restorations have resulted in the third straight increase in *per capita* expenditures.