

# STATE OF COLORADO



**Colorado Department of Human Services**

*people who help people*

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Bill Ritter, Jr.  
Governor

Karen L. Beye  
Executive Director

November 30, 2007

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 2007, or Year Three 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,

A handwritten signature in blue ink that reads '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 2007, Year Three 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 2007, or Year three, Implementation Report for Colorado's federal Community Mental Health Services Block Grant Plan. This report covers the third fiscal year of Colorado's multi-year plan that was approved without modifications for FY 2005-2007. The Report must be submitted by 1 December (3 December for 2007) 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: the continuing efforts of the Council on transformation; the first year of significant changes to children's services, notably the redesign of the residential treatment program; the first full year of the Medicaid substance abuse benefit; and a number of new legislative initiatives, including those targeting veterans' families and persons involved with the criminal and juvenile justice systems. Also, the Division of Mental Health was reorganized and placed with the Alcohol and Drug Abuse Division under a new entity named Behavioral 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 note, these data are provided as "Actual", however, there continue to be issues with the implementation in FY2006-2007 of the newly revised Colorado Client Assessment Record (CCAR 2006); changes made to the completion of the MHSIP and YSS-F, and the implementation of a web based reporting infrastructure.

Of the 28 targets in this Plan, Colorado achieved seven, and missed another five by 7.0 percent or less. Five of the remaining 16 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 Targets set) and this Report. Of the final nine missed targets, two were missed by less than ten percent. The remaining missed seven targets include: two relating to justice system (criminal for adults and juvenile for children) where there have been increased funding and services to this population (thereby increasing the numbers served); two relating to a

marked decrease in YSS-F respondents (the denominator); and three relating to potentially missing data. The Division and the Council will begin 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. Because only one year Plans were approved for FY 2008, the focus of these discussions will likely be on the new Plan.

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 2007.

## **Report Summary**

### **Colorado Mental Health Planning and Advisory Council Letter**

30 November 2007

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 2007 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 final 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. Staff changes and reductions at the Division have impacted the ability to provide this information, but the Council remains optimistic that this can still occur.
- 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.
- 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.

Community Mental Health Services Block Grant Implementation Report  
FY 2007, Year Three  
State of Colorado

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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,

A handwritten signature in cursive script, appearing to read "Sharon Raggio".

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.

Consumer/Family-Driven/Based Systems

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.



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

<i>Related Block Grant Targets</i>	
	Achieved in FY 2007? (Percent Achieved)
<b>Criterion 1, Adult Plan</b>	
Perception of Access	No (97.35)
Perception of Outcomes	No (95.03)
<b>Criterion 1, Children Plan</b>	
Perception of Access	No (72.67)*
Perception of Outcomes	No (60.61)

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 2007, 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.

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.

<b>Related Block Grant Targets</b>	
<b>Criterion 1, Children Plan</b>	Achieved in FY 2007? (Percent Achieved)
Percentage Improved School Performance	Yes (223.09)*
Percentage Improved School Attendance	No (77.20)

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.

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.

<b>Related Block Grant Targets</b>	
<b>Criterion 1, Adult Plan</b>	Achieved in FY 2007? (Percent Achieved)
Percentage Involved with Criminal Justice	No (72.40)
<b>Criterion 1, Children Plan</b>	
Percentage Involved with Juvenile Justice	No (70.68)

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.

<i>Related Block Grant Targets</i>	
<b>Criterion 1, Adult Plan</b>	Achieved in FY 2007? (Percent Achieved)
Rate of Readmission to Institutes, 30-days	Yes (104.23)
Rate of Readmission to Institutes, 180-days	Yes (109.10)
<b>Criterion 1, Children Plan</b>	
Rate of Readmission, 30-days	No (97.40)*
Rate of Readmission, 180-days	Yes (107.32)*

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."<sup>1</sup>

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.

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<sup>1</sup> 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.

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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.

<i>Related Block Grant Targets</i>	
<b>Criterion 1, Adult Plan</b>	Achieved in FY 2007? (Percent Achieved)
Number of Promising- and Evidence-Based Practices	No (43.75)
Percentage Receiving EB/PPs	Yes (266.04)
<b>Criterion 1, Children Plan</b>	
Number of Promising- and Evidence-Based Practices	No (33.33)*
Percentage Receiving EB/PPs	No (24.94)

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):

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<i>Practice</i>	<i>Population Served</i>	<i>Total Number Reported FY 2005</i>	<i>Total Number Reported FY 2006</i>	<i>Total Number Reported FY 2007</i>
<i>Evidence-Based</i>				
Assertive Community Treatment	Adults	6	7	8*
Family Psycho-education	Adults	4	1	4
Illness Self Management	Adults	10	7	6
Integrated Treatment for Co-occurring Disorders	Mixed	12	8	9
Medication Management	Mixed	6	3	5
Supported Employment	Adults	12	8	8
Supported Housing	Adults	15	12	12*
Family Functional Therapy	Youth	4	5	8*
Multi-Systemic Therapy	Youth	2	3	4*
Therapeutic Foster Care	Youth	2	0	0
<i>Promising</i>				
Anger Management	Adults	1	1	Not reported
Dialectical Behavior Therapy	Mixed	3	5	Not reported
Eye Movement Desensitization and Reprocessing	Mixed	1	0	Not reported
Parenting	Mixed	1	0	Not reported
School-based Services	Youth	1	0	Not reported
Wraparound	Youth	Not Reported	3	4*
Family Intensive Therapy	Youth	Not Reported	1	Not reported
Mentoring	Youth	Not Reported	1	Not reported
CASASTART Prevention	Youth	Not Reported	1	Not reported
QPR (Question, Persuade, Refer)	Youth	Not Reported	1	Not reported
Integrated Healthcare	Mixed	Not Reported	1	Not reported

\*Some programs reported serving consumers of mixed ages in these programs although the definition of those to be served may preclude certain ages or not traditionally report these ages as served.

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 was ended in state FY 2006.

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.

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 and FY 2006-07.

<i>Related Block Grant Targets</i>	
<b>Criterion 5, Adult and Children Plans</b>	Achieved in FY 2005? (Percent Achieved)
Expenditures per Capita	No (90.41)*

*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. HB07-1022, “Rural Health Care Needs” (Butcher/Sandoval): Created a rural family mental health pilot program, although no funds were appropriated.
2. HB07-1057, “Juvenile Justice Family Advocacy Program” (Stafford/Windels): Creates three demonstration programs for providing collaborative, juvenile justice family advocacy programs.
3. HJR07-1050, “Behavioral Health Task Force” (McGihon/Hagedorn): Created interim legislative task force charged with reviewing Colorado’s mental health and substance abuse systems.
4. SB07-001, “Generic and Non-Prescription Drug Program” (Hagedorn/Madden): Creates state pharmaceutical assistance program.

5. SB07-003, “Criminal Competency Evaluation Board” (Kester/Jahn): Creates board to advise the Department regarding standards for criminal competency evaluations (i.e., determinations of competency to proceed in criminal hearings).
6. SB07-036, “Mental Health Parity” (Keller/Stafford): Expanded types of diagnoses covered in Colorado by commercial insurance plans.
7. SB07-097, “Tobacco Settlement Monies (Offender Mental Health Services)” (Fitz-Gerald/Madden): Reallocates tobacco settlement monies to provide for offender mental health programs.
8. SB07-146, “Veterans’ Families Mental Health” (Morse/Rice): Created one local pilot program to provide mental health services to certain veterans’ families in a community mental health center.
9. SB07-230, “Child Mental Health Treatment Act Revisions” (Keller/Frangas, Kerr): Updated existing program for children with SED to receive intensive mental health services without entering the child welfare system.

### 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.

#### 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 2006. 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.”

Of note is the Division’s and Council’s concern about the apparent underutilization of this benefit.

#### 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.

Although a planned, full scale integration has not been undertaken, a number of changes have been made or begun, including work with consultants and some 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 future Block Grant Application and Plan.

#### Change in Administration

Last November, the citizens of Colorado elect a new governor, making both houses of the General Assembly and the Governor’s office held by representatives of the Democratic Party.

#### *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 severe 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 Coloradans), the ranking of Colorado rose from 7<sup>th</sup> place nationally to the 5<sup>th</sup> 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 9<sup>th</sup> 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.

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**State FY 2006-2007 Block Grant Expenditures**

Arapahoe/Douglas Mental Health Network	\$145,834
Asian Pacific Center for Human Development	\$35,685
Aurora Comprehensive Community MHC	\$134,561
Centennial MHC	\$187,635
Colorado West Regional MHC	\$152,819
Community Reach Center	\$292,771
Jefferson Center for Mental Health	\$443,257
Larimer Center for Mental Health	\$250,808
Mental Health Center of Boulder County	\$0
Mental Health Center of Denver	\$943,783
Midwestern Colorado MHC	\$139,936
North Range Behavioral Health	\$215,768
Pikes Peak MHC	\$453,995
San Luis Valley Comprehensive Community MHC	\$139,495
Southeast Mental Health Services	\$110,812
Southwest Colorado MHC	\$335,215
Spanish Peaks MHC	\$370,829
West Central MHC	\$271,642
<i>Subtotal CMHCs/Clinics</i>	<i>\$4,624,845</i>
<b>Special Purposes</b>	
Federation of Families for Children's Mental Health-- Colorado Chapter	\$25,162
Mental Health Association of Colorado--WE CAN!	\$139,936
National Alliance for the Mentally Ill--CO Chapter	\$51,389
University of Colorado	\$168,661
Mental Health Planning and Advisory Council	\$55,000
Performance Incentives	\$50,000
Monitoring, Evaluation and Other Direct Services	\$75,000
Technical Assistance and Training	\$25,000
<i>Subtotal Special Purposes</i>	<i>\$590,147</i>
<i>Subtotal Estimated FY07 Modification</i>	<i>\$447,059</i>
Allowable (5%) Administration	\$ 311,228
<b>Total Estimated Block Grant Allocations</b>	<b>\$ 5,973,279</b>

## **Performance Indicators and Accomplishments**

*Adult and Children's Plans, State Fiscal Year Data (July 1 – June 30)*

State Plan Implementation Report Performance Indicator Data Table, Fiscal Year 2007

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. Five issues with an impact on the majority of targets are noted here:

- The Division, after extensive work with community providers and other state agencies, issued a revised Colorado Client Assessment Record (CCAR 2006). The data from this streamlined version, however, was intended to be utilized through a web based upload that was not fully operational. Thus, the Division believes that some of the data provided are not final, which impacts the results. Moreover, this has impacted the time available to hold discussions regarding the results.
- Additionally, there were changes impacting the dissemination of the YSS-F that resulted in fewer responses than normal.
- 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 ongoing 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 third 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.
- 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 the state's new Block Grant Plan to be submitted in September 2008.

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 2007 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**

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	73.8	71.61	74.40	72.27	73.4	71.46	97.35%
<b>IF Rate:</b>							
<b>Numerator</b>	1,893	1,793	1,779	1,368		1,437	
<b>Denominator</b>	2,565	2,504	2,391	1,893		2,011	

FY 2007 Findings: This target was missed by 2.65 percent.

2. Perception of Outcomes

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	63.31	62.62	62.40	60.41	65.0	61.77	95.03%
<b>IF Rate:</b>							
<b>Numerator</b>	1,624	1,568	1,492	1,126		1,215	
<b>Denominator</b>	2,565	2,504	2,391	1,864		1,967	

FY 2007 Findings: This target was missed by 4.97 percent. This, however, represents a slight increase over FY 2006. The Division, the Council and the state's providers remain interested in analyzing the disaggregated (by provider) Block Grant data to better understand this possible trend and develop any appropriate strategies to address it.

3. Number of EB/PP

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	N/A	108	66	36	160	70	43.75%

FY 2007 Findings: This target was missed by 66.25 percent, or by 90 evidence-based or promising practices. This is the third 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.

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4. Percentage of Persons Receiving EB/PP Services

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	2.81	3.27	39.42	35.76	14.4	38.31	266.04%
<b>IF Rate:</b>							
<b>Numerator</b>	1,014	997	12,520	12,761		14,155	
<b>Denominator</b>	36,028	30,491	31,763	35,685		36,949	

FY 2007 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

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	6.05	9.02	8.58	9.42	5.8	5.56	104.23%
<b>IF Rate:</b>							
<b>Numerator</b>	110	199	143	138		101	
<b>Denominator</b>	1,817	2,207	1,666	1,465		1,815	

FY 2007 Findings: This target was achieved. 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

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	12.77	15.86	17.29	17.41	11.0	10.08	109.10%
<b>IF Rate:</b>							
<b>Numerator</b>	232	350	288	255		183	
<b>Denominator</b>	1,817	2,207	1,666	1,465		1,815	

FY 2007 Findings: This target was achieved. Please note the response above.

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6. Percentage of Persons Employed

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	66.05	55.89	54.07	54.71	67.0	46.40	69.26%
<b>IF Rate:</b>							
<b>Numerator</b>	14,025	6,857	6,728	8,126		9,211	
<b>Denominator</b>	21,235	12,269	12,443	14,853		19,850	

FY 2007 Findings: This target was missed by 30.74 percent, and it represents a decrease from 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 given the size of the decrease.

7. Percentage Involved with Criminal Justice

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	10.38	9.25	10.34	10.58	7.9	10.91	72.40%
<b>IF Rate:</b>							
<b>Numerator</b>	3,481	2,914	3,283	3,777		4,032	
<b>Denominator</b>	33,535	31,505	31,763	35,685		36,949	

FY 2007 Findings: This target was missed by 37.6 percent. This represents an upward trend, i.e., more adults reporting contact with the criminal justice system, between FY 2004 and 2007, and the FY 2007 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.

**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', including contracting for an extensive update of the study.

**State Fiscal Year Performance Measures:**

1. Number Served

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	33,535	31,505	31,763	35,685	35,000	36,949	105.57%

FY 2007 Findings: This target was achieved.

2. Percentage Served

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Projected</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	18.3	17.2	17.3	19.2	18.4	19.6	106.28%
<b>IF Rate:</b>							
<b>Numerator</b>	33,535	31,505	31,763	35,685		36,949	
<b>Denominator</b>	183,489	183,489	183,489	186,217		188,945	

FY 2007 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

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Target</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	24.15	21.97	23.25	23.0	23.88	24.0	19.7	82.08%
<b>IF Rate:</b>								
<b>Numerator</b>	8,098	6,923	7,384		8,521		7,279	
<b>Denominator</b>	33,535	31,505	31,763		35,685		36,949	

FY 2007 Findings: This target was missed by 17.92 percent. It is unclear as to the reasons for the decrease noted. However, it is noted that there are likely certain data missing from rural centers.

2. Homeless Receiving Services

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Target</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	4.6	3.65	3.72	4.0	3.47	4.6	3.25	70.72%
<b>IF Rate:</b>								
<b>Numerator</b>	1,542	1,149	1,180		1,240		1,202	
<b>Denominator</b>	33,535	31,505	31,763		35,685		36,949	

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FY 2007 Findings: This target was missed by 29.28 percent. However, there were only 38 fewer persons served from FY 2006. 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

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Target</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	N/A		32	73	31	83	25	30.12%

FY 2007 Findings: This target was missed by 69.88 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 2007 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	FY 07 Actual	FY 07 Percent Attained
<b>Value:</b>	\$7.04	\$6.35	\$5.86	\$5.01	\$5.65	\$6.67	\$5.94	89.02%	\$7.26	\$6.57	90.41%
<b>IF Rate:</b>											
<b>Numerator (in millions)</b>	\$29.00	\$26.72	\$24.74	\$21.25	\$24.06	\$28.70	\$25.66		\$31.30	\$28.43	
<b>Denominator (in millions)</b>	4.12	4.21	4.22	4.24	4.26	4.3	4.32		4.31	4.33	

FY 2007 Findings: This target was missed by 9.59 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. Despite missing the Target, the recent budget restorations have resulted in the fourth 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 20076 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**

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	94.17	65.25	71.59	71.92	95.2	69.18	72.67%
<b>IF Rate:</b>							
<b>Numerator</b>	291	430	572	525		321	
<b>Denominator</b>	309	659	799	730		464	

FY 2007 Findings: This target was missed by 27.33 percent. However, there was a significant decrease in the number of respondents from previous years. This measure—the Youth Services Survey for Families—was piloted in FY 2003, and the original targets were set using the pilot data.

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2. Perception of Outcomes

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	79.34	55.1	55.4	53.8	86.0	52.1	60.61%
<b>IF Rate:</b>							
<b>Numerator</b>	242	363	443	394		245	
<b>Denominator</b>	305	659	799	733		470	

FY 2007 Findings: This target was missed by 39.39 percent. This result was not found to be statistically significant. Please note the response above regarding the number of respondents. 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

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	N/A		9	11	51	17	33.33%

FY 2007 Findings: This target was missed by 67.67 percent. However, it does reflect an increase in the total number of programs available. As noted above (and for adults), this is indicator will require further refinement.

4. Percentage of Persons Receiving EB/PP Services

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	N/A		1.53	6.79	12.0	2.99	24.94%
<b>IF Rate:</b>							
<b>Numerator</b>			283	1,304		593	
<b>Denominator</b>			18,500	19,197		19817	

FY 2007 Findings: This target was missed by 75.06 percent. As noted above, this is indicator will require further refinement.

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

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	8.32	10.82	9.82	8.94	8.3	8.52	97.40%
<b>IF Rate:</b>							
<b>Numerator</b>	46	83	91	82		34	
<b>Denominator</b>	553	767	927	917		399	

FY 2007 Findings: This target was missed by 2.6 percent. However, the FY 2007 Actual is lower than FY 2005.

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

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	16.64	19.69	19.85	17.99	15.6	14.54	107.32%
<b>IF Rate:</b>							
<b>Numerator</b>	92	151	184	165		58	
<b>Denominator</b>	553	767	927	917		399	

FY 2007 Findings: This target was achieved.

**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.

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’, including the contracting for an extensive update to the 2001 study.

**State Fiscal Year Performance Measures:**

1. Number Served

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	18,082	16,977	18,500	19,197	20,800	19,817	95.27%

FY 2007 Findings: This target was missed by 4.73 percent.

2. Percentage Served

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	28.36	26.63	29.02	29.78	32.63	30.41	93.20%
<b>IF Rate:</b>							
<b>Numerator</b>	18,082	16,977	18,500	19,197		19,817	
<b>Denominator</b>	63,754	63,754	63,754	64,462		65,170	

FY 2007 Findings: This target was missed by 6.80 percent, although an additional 620 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 2007 were accomplished.

**State Fiscal Year Performance Measures:**

1. Percent who have contact with juvenile justice

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	11.41	9.98	9.06	9.89	11.0	15.56	70.68%
<b>IF Rate:</b>							
<b>Numerator</b>	2,063	1,694	1,677	1,898		3,084	
<b>Denominato</b>	18,082	16,977	18,500	19,197		19,817	

FY 2007 Findings: This target was missed by 29.32 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

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	33.21	20.68	16.72	18.65	34.4	76.74	223.09%
<b>IF Rate:</b>							
<b>Numerator</b>	6,705	2,143	2,120	2,248		3,336	
<b>Denominato</b>	20,188	10,365	12,676	12,053		4,347	



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FY 2007 Findings: This target was achieved. However, this result may reflect differences in how the indicator is measured by the new assessment tool or with the lack of complete data, as is noted by the much smaller denominator.

3. Percent improved on school attendance

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	84.3	87.4	87.6	87.5	90.5	69.86	77.20%
<b>IF Rate:</b>							
<b>Numerator</b>	17,033	15,259	16,174	16,908		3,037	
<b>Denominato</b>	20,195	17,459	18,463	19,320		4,347	

FY 2007 Findings: This target was missed by 22.8 percent. Please see above.

**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

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	19.4	21.12	21.33	19.98	23.5	16.92	94.80%
<b>IF Rate:</b>							
<b>Numerator</b>	3,508	3,585	3,946	3,836		3,353	
<b>Denominator</b>	18,082	16,977	18,500	19,197		19,817	

FY 2007 Finding: This target was missed by 5.2 percent.

2. Homeless Receiving Services

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	0.68	0.57	0.52	0.44	0.7	0.53	80.67%
<b>IF Rate:</b>							
<b>Numerator</b>	123	96	97	85		105	
<b>Denominator</b>	18,082	16,977	18,500	19,197		19,817	

FY 2007 Findings: This target was missed by 19.33 percent. However, this represents 20 more children with SED over FY 2006.

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

	<b>FY 03 Actual</b>	<b>FY 04 Actual</b>	<b>FY 05 Actual</b>	<b>FY 06 Target</b>	<b>FY 06 Actual</b>	<b>FY 07 Target</b>	<b>FY 07 Actual</b>	<b>FY 07 Percent Attained</b>
<b>Value:</b>	N/A		32	73	31	83	25	30.12%

FY 2007 Findings: This target was missed by 69.88 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 2007 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	FY 07 Actual	FY 07 Percent Attained
<b>Value:</b>	\$7.04	\$6.35	\$5.86	\$5.01	\$5.65	\$6.67	\$5.94	89.02%	\$7.26	\$6.57	90.41%
<b>IF Rate:</b>											
<b>Numerator (in millions)</b>	\$29.00	\$26.72	\$24.74	\$21.25	\$24.06	\$28.70	\$25.66		\$31.30	\$28.43	
<b>Denominator (in millions)</b>	4.12	4.21	4.22	4.24	4.26	4.3	4.32		4.31	4.33	

FY 2007 Findings: This target was missed by 9.59 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. Despite missing the Target, the recent budget restorations have resulted in the fourth straight increase in *per capita* expenditures.