Colorado Behavioral Health Task Force

SUBCOMMITTEES' PROCEEDINGS AND RECOMMENDATIONS

Prepared by the Farley Health Policy Center for the
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COLORADO
Behavioral Health Task Force
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About the Authors

The Farley Health Policy Center (FHPC) at the University of Colorado Anschutz Medical Campus strives to advance policy that overcomes fragmented systems and addresses the wholeness of a person – physical, behavioral, and social health in the context of family, community, and the healthcare system. The FHPC works with state agencies and policymakers to understand and inform achievable policy actions to improve the integration of behavioral health across health and healthcare systems. The FHPC was contracted by the Colorado Department of Human Services in June 2019 to facilitate the three Behavioral Health Task Force subcommittees: Children's Behavioral Health, State Safety Net, and Long Term Competency, established by Governor Polis.

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"We can and must do better to transform our system for Coloradans living with a behavioral health condition so that they have access to affordable, high-quality, and patient-centered care."

– Governor Jared Polis

Executive Summary

Introduction

Colorado is home to vibrant and diverse people, reputed to be health conscious with abundant opportunities to thrive in all types of communities. It is therefore discordant that Colorado ranks in the bottom half of all states in prevalence of mental illness and access to mental health care for both adult and youth populations.[1] With an investment of more than $1 billion annually toward Colorado's behavioral health system, the demand for improved health outcomes and accessible, high quality services is universal. Governor Polis set to address Colorado's behavioral health crisis, establishing the Behavioral Health Task Force (BHTF) to develop a blueprint to transform the state's behavioral health system. First and foremost, this process of system reform would be informed by stakeholders from across the state representing those who seek, deliver, administer, and pay for care. Four committees were created to prioritize and address behavioral health needs — a main task force with three subcommittees, Children's Behavioral Health, State Safety Net and Long Term Competency. Their charge from state leadership was to be bold and undeterred by either known or unforeseen barriers. Subcommittee recommendations for improving the behavioral health system are delivered after 12 months of committed work together. Mid-year, upon the global disruption of the COVID-19 public health crisis, subcommittees were encouraged to go forward with presenting the right solutions for reform and not be derailed by ensuing budgetary restrictions. Subcommittees recognize that budget will directly affect implementation, but suggest that these are the reforms required to ultimately address the shortfalls in the behavioral health system. The final blueprint, entitled The Remedy for Behavioral Health Reform, will strive to define and articulate recommendations to meet the behavioral health needs of Coloradans today, with a vision and implementation plan for more secure and equitable behavioral health and wellbeing in the future.

This report, developed and compiled by the Farley Health Policy Center, delineates the work of each of the three subcommittees and describes a comprehensive approach to defining focused recommendations. These recommendations were further vetted and culled by the Main Task Force to determine inclusion in The Remedy for Behavioral Health Reform.

Process

Each subcommittee included representatives from many different sectors and disciplines with experience within the behavioral health system, including direct service providers, managers and directors, system administrators, technical experts, and individuals and family members with lived experience. Subcommittees met for 3-4 hours in-person and virtually each month to discuss critical subject matter, and develop, and vote upon recommendations. Public testimony sessions were held in locations across the state. These testimonies served as a valued component to inform discussion, and to ground and validate recommendations.

The three subcommittees shared common values and guiding principles but were built upon differing mandates. The Children's Behavioral Health Subcommittee articulated the necessity of developmentally appropriate care, engagement and strengthening of family systems, and creation of supports and pathways between the child and adult system and services that specifically address the unique needs of children and youth, ages 0-26. The State Safety Net subcommittee sought to ensure that any Coloradan would have access to quality behavioral health regardless of acuity level, ability to pay, co-occurring disabilities or geographic location. The Long Term Competency subcommittee developed recommendations to address federal requirements that Colorado had previously failed to meet in providing competency evaluations and restoration services, and focused on the intersection between behavioral health and criminal justice systems.

Key Findings

Key findings fell into eight main areas: access, comprehensive continuum of services, workforce, financing, governance, quality, social determinants of health, and specific populations in need for additional focus. To improve the behavioral health and well-being of Coloradans, subcommittees discussed, wrote, and approved recommendations in each of these areas, offering solutions that are specific and tailored to the populations of focus.

ACCESS

Overwhelmingly, the common concern across the three subcommittees is access. All Coloradans deserve equitable access to a full continuum of behavioral health services needed to remain well in their own communities. Access to the right services, in the right place, at the right time. Access to services that are trauma-informed and culturally and linguistically responsive. Access to services to manage crisis, avoid intersection with law enforcement and the criminal justice system, and recover and maintain wellness in community-based settings.

COMPREHENSIVE CONTINUUM OF SERVICES

Both the Children's Subcommittee and the State Safety Net Subcommittee recommend a comprehensive continuum of services be available for children, youth, and adults. Informed by an Institute of Medicine framework[2] and Substance Abuse and Mental Health Services Administration (SAMHSA) service continuum,[3] the subcommittees developed behavioral health service arrays built on promotion, prevention, and early identification, with outpatient treatment, high-intensity treatment, in-patient treatment, crisis system and recovery. Essential supports for these service continuums include care coordination and case management, delivery of services in community-based settings, and investment in expanded access to telehealth services. The experiences and expertise of subcommittee members and stories from public testimonies indicate significant differences in the availability and quality of services across the continuum in different parts of the state. A comprehensive service gap analysis is needed to develop targeted plans to address these gaps and may be informed by the Population In Need study, being conducted for the Office of Behavioral Health (OBH)

concurrently with the work of the BHTF. Additional research may be needed to understand the gaps in publicly-funded and commercial services and future work is needed to develop and implement uniform service definitions across providers and agencies.

The Long Term Competency Subcommittee recommends the inclusion of specific service types, such as Assisted Outpatient Treatment and behavioral health services in jails. While the Long Term Competency Subcommittee had a specific and necessary focus on the competency population and the intersection of the criminal justice system with individuals with behavioral health needs, all recommendations for the subcommittee are couched in the value that the criminal justice system should not serve as the de facto behavioral health system: individuals should not have to be arrested or incarcerated to access behavioral health services. Services provided within the criminal justice system should be available and accessible within the civil behavioral health system and community behavioral health services should be available to those most at risk for incarceration to prevent and divert from detention.

WORKFORCE

The delivery of high-quality behavioral health services is dependent on a high-quality behavioral health workforce. Subcommittees offer recommendations to increase the number, type, and diversity of behavioral health professionals across the state with investments in recruitment, retention, and training. Workforce investments were identified for licensed behavioral health providers, such as psychologists and social workers, and as well as for other direct behavioral health service providers, including peers or program staff, to increase the racial and ethnic diversity of the workforce and improve geographic distribution. Workforce recommendations include strategies for training and other methods to improve the competency to care for specific populations. With an additional emphasis in the safety net systems, the State Safety Net Subcommittee recommends increasing peer support programs across the state, creating pathways for peers to bill Medicaid and other providers, and including peers as part of network adequacy requirements.

FINANCING

To ease access to behavioral health services, subcommittees recommend streamlining funding. Currently, there are over 60 funding streams for publicly funded behavioral health services, which create barriers to individuals and families accessing services. Both the Children's Subcommittee and State Safety Net Subcommittee recommend reimbursement for a set of essential services for children, youth, and adults to support the delivery of a comprehensive service array as well as flexible funding to respond to local and emerging needs.

GOVERNANCE

To inform the BHTF decision about the governance of the state's behavioral health system, discussions occurred in two subcommittees: The State Safety Net Subcommittee calls for a governance structure that streamlines an individual's access to services regardless of payer (i.e., reduces the 60+ "wrong doors"), ensures timely access, offers centralized system navigation services and establishes a core set of essential services that are readily available across the state. The Children's Subcommittee recommends a distinct infrastructure within any governance structure to oversee and be accountable for the services for all children, youth and young adults, ages 0-26. As the largest payer of behavioral health services in the state, subcommittee members call for the Department of Health Care Policy and Financing's (HCPF) alignment with the behavioral health governance structure to reduce administrative burden to providers and coordinate oversight, regulations, and policy.

QUALITY

Subcommittee members recommend a data-driven approach to continuous system improvement. However, the mixed understanding of the current metrics collected and publicly available among subcommittee members underscores the necessity to first assess existing data already collected across the system. Ideally, with an understanding of the current state of data collection and reporting, any development or prioritization of uniform metrics (i.e., a minimal data set) will be consistently defined across the system and will not add administrative

burden on providers or facilities. To enhance care coordination and continuity of care, investment in data infrastructure and health information exchange is needed across providers and systems (e.g., education and healthcare; civil and criminal systems).

SOCIAL DETERMINANTS OF HEALTH.

In all aspects of work, subcommittees considered the impact of social determinants of health including transportation barriers, access to healthy food, and social support systems as necessary components to behavioral health and well-being. Subcommittees call for permanent supported housing and supportive employment programs to ensure basic needs are met, allowing individuals to meaningfully engage in care.

SPECIFIC POPULATIONS

While the subcommittees each had a population of focus, there were specific subpopulations within and across each subcommittee that members highlighted as needing tailored approaches or additional resources to equitability deliver services and address current population-based health disparities. While this list is not exhaustive, some populations prioritized by subject matter experts and individuals with lived experience for system improvements include: individuals with cognitive or physical disabilities and co-occurring behavioral health needs; individuals with Fetal Alcohol Syndrome; children in the child welfare system; transition-aged youth; LGBTQIA+ youth; communities of color; and the forensic population, or individuals who cycle in and out of the criminal or juvenile justice system.

Legislation

On June 29, 2020, the first piece of legislation derived from work of the BHTF, Senate Bill (SB) 20-181, was signed into law by Governor Polis. SB 20-181 helps ensure individuals are not held in jail when facing low-level charges and competency is in question or when restoration is unlikely due to a severe disability regardless of the charge. The Long Term Competency Subcommittee worked with primary sponsors, Senator Pete Lee and Representative Michael Weissman, on measures to improve outcomes for defendants who may be incompetent to proceed.

Conclusion

There is no quick fix to improve the behavioral health and well-being of Coloradans. A year of focused and extensive work is reflected in the subcommittees' recommendations. Implementation will require continued commitment from diverse and committed stakeholders across Colorado to carry this work forward. The subcommittees' work informs The Remedy for Behavioral Health Reform; implementation will require more discussion, more debate, and more collaboration. Optimistic yet pragmatic leadership will be essential to continue to push stakeholders and state agencies alike towards system reform that will result in better health that includes meeting the behavioral health needs of all Coloradans.

Nancy Jackson, Arapahoe County commissioner and co-chair of the State Safety Net Subcommittee, closed the final State Safety Net Subcommittee meeting reflecting on John F. Kennedy's quote on choosing to go to the moon, likening this endeavor with the resonating truth that we will pursue global improvements in behavioral health:

> "We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win."

We are unwilling to let more Coloradans suffer and die because of inadequate access to behavioral health care. The continued work to improve the system to meet the behavioral health needs of all Coloradans will not be easy, and it is up to every one of us to continuously strive for better outcomes. Behavioral health must be at the forefront of the minds of policy makers, legislators, state agency leaders and staff, communities, service providers, and family members so that we never stop paying attention, do not accept the status quo and continuously work towards solutions that meet the behavioral health needs of people living in Colorado.

Introduction

Purpose

Colorado dedicates over $1 billion annually to its behavioral health system,[4] yet in 2020 Colorado was ranked in the bottom half of all US states in prevalence of mental illness and access to mental health care for both adult and youth populations.[1] Moreover, Colorado's suicide rates are among the highest in the country.[5] Consequently, on April 8, 2019, Governor Jared Polis directed the Colorado Department of Human Services (CDHS) to spearhead the BHTF. The BHTF includes four working groups: the governing Main Task Force, the Children's Behavioral Health Subcommittee, the State Safety Net Subcommittee and the Long Term Competency Subcommittee. The Main Task Force and three subcommittees are comprised of interdisciplinary experts representing all regions of the state who were tasked with evaluating and developing a roadmap to improve the state's behavioral health system while optimizing resources.

The strategic vision for this blueprint, to be known as The Remedy for Behavioral Health Reform, is to guide system reform in order to ensure that every Coloradan experiencing behavioral health needs can receive timely, cost effective, and high-quality services in their own communities.

This report delineates work of the three BHTF subcommittees (Children's Behavioral Health, State Safety Net and Long Term Competency), which the Farley Health Policy Center was responsible for facilitating.

Colorado Behavioral Health Task Force Composition

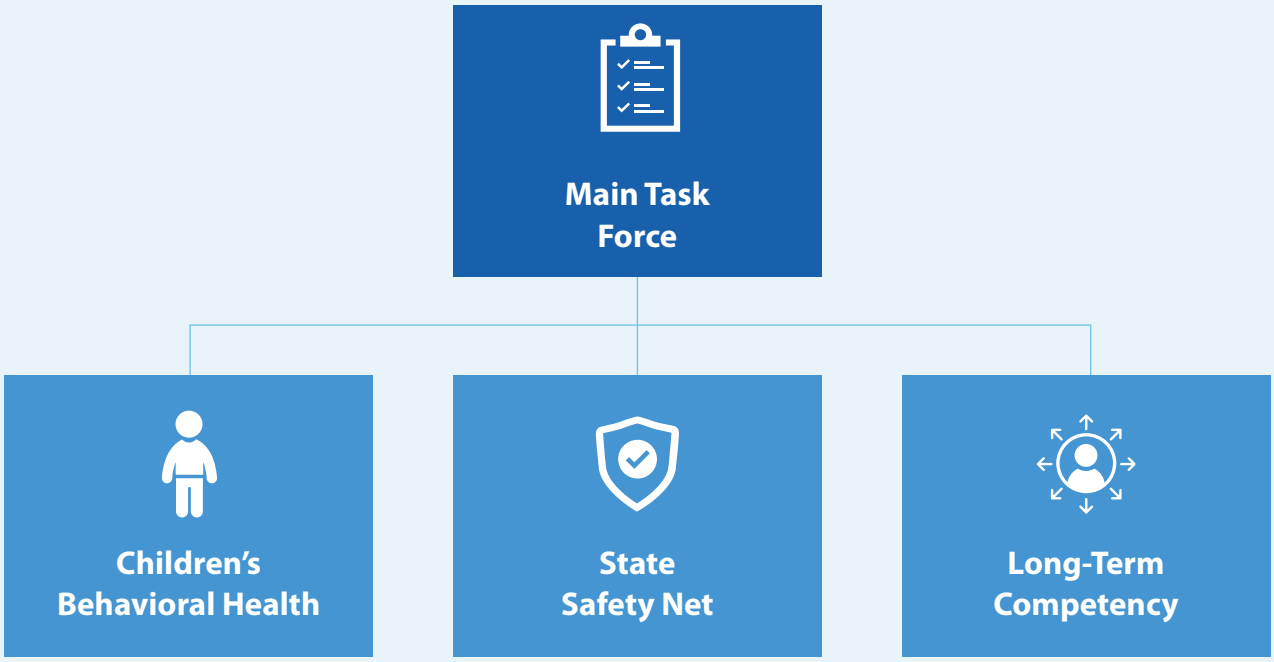
Members of the BHTF (Main Task Force and three subcommittees) were chosen from almost 500 applicants across the State of Colorado to include individuals who represent diverse, multi-disciplinary, multi-sector, and balanced perspectives with respect to behavioral health issues. Members included consumers and families, key executives representing state and local government, criminal justice experts, advocates, clinicians and subject matter experts in behavioral health.

The Main Task Force was comprised of 27 members, plus six ex-officio members. The Main Task Force was led by six Executive Committee members, including a County Commissioner, the Lieutenant Governor, and representatives from CDHS, HCPF, the Colorado Division of Insurance (DOI), the Colorado Department of Public Health and Environment (CDPHE). The Main Task

> *"This new task force will be responsible for developing a statewide, strategic blueprint to reform our system with the goal of improving the efficacy and efficiency of our behavioral health system."[4]*
>
> *– Governor Jared Polis*

Force acted as the governing entity to guide the work of three subcommittees named by Governor Polis: the State Safety Net Subcommittee (24 subcommittee members, plus three ex-officio members), the Children's Behavioral Health Subcommittee (25 subcommittee members, plus one ex-officio member), and the Long Term Competency Subcommittee (25 subcommittee members). Please see Appendix 1 for names of all members of the Main Task Force and subcommittees.

Figure 1. Colorado Behavioral Health Task Force and Subcommittees



Colorado Behavioral Health Task Force Vision

The goal of the BHTF is to provide recommendations that, when implemented, will make behavioral health services in Colorado **comprehensive, equitable,** and **effective**. These three values identified by the Main Task Force are guiding the development of the Remedy for Behavioral Health Reform and are articulated in the Main Task Force vision statement, which is to design a ***comprehensive, equitable, effective*** *continuum of behavioral health services that meets the needs of all Coloradans in the right place at the right time to achieve whole-person health and well-being.* The three BHTF subcommittees considered this overarching vision when developing their individual guiding principles to direct their work.

Subcommittees were encouraged from the start to think big and put forward bold recommendations that they believe are necessary to reform the behavioral health system in Colorado. All recommendations need review to identify whether statutory or budgetary changes will be required to effectively resource and implement.

Subcommittee Processes

Multi-stakeholder groups like the BHTF are brought together because of their differences, with the intent of multiple perspectives being presented. Subcommittees committed to group agreements, including:

- making charitable assumptions,
- allowing space for all members to participate,
- remaining tough on ideas, but soft on individuals,
- staying solution oriented,
- leaving preconceived prejudices outside of subcommittee work,
- acknowledging roles,
- using words thoughtfully, and
- using person-first language.

Members of all three subcommittees had to grapple with bringing both personal and professional experiences to the table while remaining open to listening to and exploring ideas representing very different perspectives. Conflicts arose, differences were expressed, multiple solutions were presented, driving a diverse group to make the best decisions they could with the information they had. Members of the three subcommittees, the Senior Advisor for Behavioral Health Transformation, and the facilitation team remained committed to this often challenging process in order to deliver recommendations to the Governor that they believe will improve the health of Coloradans across the lifespan.

Each subcommittee convened monthly for 3-4 hours. As work progressed, additional in-person meetings and webinars were held to facilitate the work. In-person meetings with remote participation available were held July 2019 through mid-March 2020. All subcommittee meetings April through June 2020 were held virtually due to COVID-19.

All subcommittee meetings were open to the public. Ten minutes were reserved at every meeting for public comment and members of the public were encouraged to participate in small group discussions within meetings. Public testimony opportunities were organized around the state to allow for individuals and families to share personal experiences with behavioral health services in Colorado. These recorded testimonies were often shared at subcommittee meetings to spark discussion and inform recommendations.

Agendas for all subcommittee meetings were set jointly between the Farley Health Policy Center facilitation team, the Senior Advisor for Behavioral Health Transformation and respective subcommittee co-chairs. Meetings combined subject matter expert presentations to inform subcommittee work with facilitated discussions and small group work to accomplish pre-determined meeting objectives. Voting on final recommendations required a quorum of subcommittee members or designated substitutes or proxies. Recommendations were approved with a majority of the quorum. Voting record of approved recommendations is included in Appendix 2.

Significant work occurred between meetings, including drafting and editing of recommendations and completion of surveys to provide feedback and subject matter expertise on evolving work. The Farley Health Policy Center team worked with co-chairs and the Senior Advisor for Behavioral Health Transformation to collect and synthesize data to maintain momentum of work in progress across the subcommittees and inform future agendas.

Subcommittee co-chairs provided monthly updates at the Colorado Behavioral Health Task Force meetings, where feedback on subcommittee progress and final recommendations was solicited.

Meeting minutes including formal results of voting were recorded, approved by subcommittee members and posted publicly. All agendas, recordings and supporting materials for subcommittee meetings are available on the Colorado Behavioral Health Task Force website, https://www.colorado.gov/pacific/cdhs/colorado-behavioral-health-task-force.

Please refer to Appendix 3 for overview of subcommittee meeting dates, meeting objectives, between meeting assignments and subcommittee votes.

COVID-19

In March of 2020 with the onset of the COVID-19 public health crisis and statewide stay at home orders, BHTF work was temporarily paused to support subcommittee members in prioritizing their professional time and attention to meet the needs of their individual employers, organizations and patients. From March 16 through April 18, 2020, formal BHTF meetings were suspended. During that time, subcommittee members were invited to optional web-based workgroup meetings to inform The Remedy for Behavioral Health Reform recommendations, but work on subcommittee specific objectives was paused. Upon return to virtual meetings the week of April 20, 2020, subcommittee timelines were extended by one month and BHTF leadership advised subcommittees to continue work towards drafting recommendations that would best support the redesign of behavioral health services in Colorado, in a time when behavioral health needs were becoming more relevant and urgent to even more Coloradans. Recommendations in this report reflect what the BHTF subcommittees believe needs to be done to improve access, equity, financing, and delivery of behavioral health services in the state, despite budget constraints evolving in the wake of COVID-19.

Of note though not directly addressed in this report, in May of 2020 Governor Polis directed the BHTF to create a new Covid-19 Special Assignment Committee, co-chaired by CDHS and CDPHE. The goal of this special assignment committee is to:

- Evaluate the behavioral health crisis response in Colorado to COVID-19 and provide recommendations for The Remedy for Behavioral Health Reform on improvements of behavioral health services for response during any potential future crisis.
- Create an interim report that highlights the short- and long-term impacts of COVID-19 on the behavioral health system, including access to behavioral health services, especially for vulnerable and underserved populations.

Cross-Cutting Values

Each BHTF subcommittee developed unique value statements and grounding principles, however, fundamental values related to delivery of behavioral health services were cross-cutting and established a foundation for the development of recommendations.

PROVIDE EASY ACCESS TO CARE

Provide equitable and unobstructed access to behavioral health services, including easily accessible options for behavioral health care and related supports in the community regardless of complexity of the presenting problems, ability to pay, criminal history, zip code, payer source, culture, or other factors. Provide "no wrong door" access, in which individuals will be connected to an appropriate level of care in a timely fashion.

ADDRESS SOCIAL DETERMINANTS OF HEALTH

Provide transportation and other accessibility solutions to connect individuals and families with needed services, provide accessible and inclusive housing options that prevent homelessness and rapidly re-house individuals when needed, provide access to food and clean water, and consider community resources including employment, childcare, and high-speed internet access.

PROVIDE A CONTINUUM OF SERVICES

Define and provide a continuum of behavioral health services across the lifespan, including promotion, prevention, early identification, treatment, and recovery.

PROVIDE WHOLE-PERSON CARE

Provide access to whole-person care, including access to care that integrate physical and psychological health. Provide culturally and linguistically responsive care, trauma-informed care, individual- and family-centered care, and emphasize all aspects of health, including wellness.

IMPROVE WORKFORCE

Increase the number, type, diversity, and investment in behavioral health professionals across the state.

Subcommittee Work

Each subcommittee was established based on a unique set of mandates from the Governor and the Colorado General Assembly. Guiding principles aligned the work, but very different goals drove specific efforts and required different approaches to achieve final recommendations. As presented here, each subcommittee had a different purpose and composition. The work of each subcommittee reflects their stakeholder expertise and the differences in activities that resulted in recommendations for the Main Task Force's consideration, prioritization and inclusion in the Remedy for Behavioral Health Reform.

Children's Behavioral Health Subcommittee

As reported in the 2018 Roadmap to Children's Behavioral Health 4-Year Strategic Plan,[6] Colorado ranked 48th in the country when analyzing several indicators including the prevalence of mental illness and access to care for children and youth. Suicide was reported the leading cause of death among Coloradans between 10 and 24 years old, and nearly one in three Colorado high school students reported experiencing sadness or hopelessness that impacted their usual activities for at least two weeks. Colorado ranked 47th in the US for the prevalence of youth with major depression, and was worst for rates of youth alcohol dependence and illicit drug use. The task of the Children's Behavioral Health subcommittee was to improve outcomes by developing a plan to address delivery and management of children's behavioral health.

Mandates from Governor Polis

1. Options to increase and enhance efficient and effective behavioral health services to children and youth
2. Efforts between state agencies and community partners to increase public understanding and awareness of child and youth behavioral health needs
3. Shared children and youth behavioral health policies to remove administrative barriers to facilitate collaboration between communities, Southern Ute Indian Tribe, Ute Mountain Ute Tribe and American Indian/Alaska Native-serving organizations, state departments, and political subdivisions of the state
4. Children and youth behavioral health recommendations, where appropriate, to enhance efficiency and avoid duplication of service delivery, referral, and entry point, and funding mechanisms for behavioral health services for children and youth
5. The need for comprehensive wrap-around services and case management and coordination for children and youth
6. The need for comprehensive screening and early intervention and prevention services for children, youth and families
7. Strategies to promote behavioral health for youth and adolescents in school and community settings, including strategies to protect against mental health challenges, suicide, and substance use
8. Changes in how children and youth behavioral health is governed ensuring services work seamlessly when children and their families are involved in multiple systems
9. Strategies to address the needs of children and adolescents who become "stuck" between systems, including exploring community-based services and other strategies
10. The need for comprehensive support for children and youth who are transitioning out of foster care or out of the custody of the Division of Youth Services

Legislative Mandate - Senate Bill 19-195

Senate Bill 19-195 mandates that HCPF shall seek federal authorization to provide wraparound services for eligible children and youth who are at risk of out-of-home placement or in an out-of-home placement. The act requires HCPF, in conjunction with CDHS, to develop and implement wraparound services for children and youth at risk of out-of-home placement or in an out-of-home placement. The Children's Behavioral Health Subcommittee considered this legislation in their work and aligned recommendations to support the work of HCPF and OBH.

Guiding Principles

To specialize the BHTF value statement to meet the needs of children, youth and families, the Children's Behavioral Health Subcommittee developed the following guiding principles which recognize the necessity of developmentally appropriate care, engagement and strengthening of family systems, and creation of supports and pathways between the child and adult system and services that specifically address the unique needs of children and youth, ages 0-26.

A comprehensive behavioral health system for children and youth must be:

COMPREHENSIVE

- Focuses on individuals and families, respecting the agency of the child and family in solutions and services
- Addresses social determinants of health
- Coordinates for normalization across systems and sectors: social services (housing, employment, food, etc.), public health, health care, education, criminal justice systems
- Provides a continuum of developmentally appropriate services that recognizes wellness across the spectrum of promotion, prevention, treatment, and recovery
- Increases the number, type, diversity, and investment in behavioral health professionals across the state
- Integrates physical and behavioral health services for "no wrong door" access

EQUITABLE

- Provides equitable and unobstructed access to behavioral health services (regardless of zip code, payer source, culture, etc.)
- Provides easy access to culturally and linguistically responsive services
- Insures easy access to trauma-informed care
- Supports a statewide safety-net system that provides services to all individuals regardless of complexity

EFFECTIVE

- Creates a state-wide system tailored for locally driven, community-based, timely solutions
- Ensure accountable and sustainable allocation of financial resources
- Establishes quality assurance processes to support provision of evidence-based services and monitor service outcomes
- Uses data driven continuous quality improvement and evaluation at population and individual levels
- Prevents worsening systems or involvement in the criminal or juvenile justice system

Subcommittee members worked both in small groups and as a whole to refine recommendations that they could support, always prioritizing the consumer experience and meeting the needs of children and youth in Colorado. When grappling with complex and consequential matters of policy and institutional change, such as finance and governance structures, robust debate ensued that at times challenged the group and informed how the subcommittee moved forward, managed timelines or ordered topics of discussion leading to recommendations. As mentioned previously, effective multi-stakeholder processes should be intentionally structured to elicit input from a diverse and knowledgeable group of individuals from differing perspectives. This process pushed and encouraged individuals and the organizations they represent to challenge one another, leading to recommendations that the majority of the subcommittee could ultimately support.

After discussion and debate, the subcommittee decided the population of focus would include children and youth ages 0-26. This upper age limit was decided to reduce "hard breaks" in the system that create gaps for transition-age youth, and is mainly attempting to address distinct populations like foster care youth and youth with disabilities (i.e., intellectual and developmental disabilities (IDD) or Autism Spectrum Disorder (ASD)) where parents may still be actively involved in their care. This age is not a mandate, but rather a range that is intended to dovetail into the adult system. When looking at where system breaks currently exist, and where members fall through the cracks (whether through access, funding, or otherwise), it is helpful to consider the overlaps (former foster care - up to age 26; Clubhouse services range from 15-26, insurance under a guardian stops at age 26, etc.). Additionally, SB 19-195 legislation defined youth as ages 0- 26. High school and college health clinics will deal with similar issues if students remain on their parent's insurance, and these services would benefit from being aligned and informed by a system that considers these ranges. In practice, most individuals 18 and older will seek out and engage in services with an adult system. However, for those who do not, or cannot, setting an upper age limit of 26 will help ensure proper oversight and support to eliminate as many gaps as possible.

Subcommittee work towards final recommendations was also supported by review of foundational documents from previous work completed in Colorado to support transformation of the children's behavioral health service delivery and webinar format presentations to provide context and highlight work happening in Colorado parallel to the BHTF. These provided insight to avoid duplication and optimally encourage alignment across multiple entities and efforts. These included the 2015 report completed by the Colorado Children's Campaign, Young Minds Matter: Supporting Children's Mental Health through Policy Change,[7] and presentations from HCPF and OBH on the current legislative landscape (11/12/2019), and Families First Colorado, highlighting their ongoing work to support legislation allowing local child welfare agencies to use federal funding to pay for services that prevent the removal of a child or teen from their home (1/14/2020).

OBH presented qualitative analysis of 34 public testimonies from children and youth across Colorado (6/9/2020). Outcomes indicate that the top five concerns reported by youth in the testimonies were 1) a need for increased community education, 2) access, 3) timely care, 4) a need for more early intervention, and 5) challenges with payers. These align with and are reflected in the recommendations from the Children's Behavioral Health Subcommittee.

A workgroup assembled to further identify ways to solicit youth voice regarding their experience with the Behavioral Health System created and distributed a survey through youth-serving organizations and advocates across the state. A total of 367 individuals between the ages of 12 and 26 responded. Further synthesis of survey outcomes will be available from OBH after the submission of this report, but identified concerns related to access, timeliness, and stigma support recommendations put forward by the Children's Behavioral Health Subcommittee.

Building from the Roadmap to Colorado's Behavioral Health System for Children, Youth and Families,[6] the Children's Behavioral Health Subcommittee adopted the Building Systems of Care framework[8] to organize and prioritize recommendations. This framework defines a system of care as a broad, flexible array of effective services and supports for a defined multi-system involved population, which is organized into a coordinated

network, integrates care planning and care management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and with youth at service delivery, management and policy levels, has supportive management and policy infrastructure, and is data-driven. Through small group discussions answering the questions, 1) What are the priorities or big issues this subcommittee should focus on; and 2) What will success look like for the Children's Behavioral Health Subcommittee, the subcommittee narrowed to the following categories to make actionable recommendations to the Behavioral Health Task Force: Governance, Quality, Financing, Service Array, Workforce, and Access.

Children's Behavioral Health Subcommittee Recommendations

A small workgroup within the Children's Behavioral Health Subcommittee convened to consider which recommendations passed by majority in the subcommittee should be prioritized, given the budget and implementation implications of the COVID-19 public health crisis. These recommendations have been labeled as COVID-19 priorities in blue font. New recommendations emerging from this workgroup that were not voted on in the Children's Behavioral Health Subcommittee are being presented for approval by the COVID-19 Special Assignment Committee.

GOVERNANCE

COVID-19 priority recommendation: Children and youth are not simply small adults. They have unique needs, experience unique challenges, and require unique supports and interventions. As a result, **WE RECOMMEND** that the State of Colorado design a distinct infrastructure within the Behavioral Health Governance Authority to oversee and be accountable for the services for all children, youth and young adults, ages 0-26, and their families, regardless of level of need or diagnosis. Whatever final design or locus of accountability is chosen by the BHTF, and in line with our mandate as a subcommittee, we believe reforming the current system to include a robust infrastructure, including leadership, staffing, and authority, dedicated to this population is essential.

There is a myriad of reasons why a distinct infrastructure for children and youth is appropriate.

- ***Needs.*** Children and youth require developmentally appropriate remedies and culturally responsive services. They also need high-fidelity wraparound systems. The needs of the family system should be integrated into service provision.
- ***Timeliness.*** Children and youth need a structure that is empowered to direct and respond quickly. Timely intervention is exponentially impactful for children and youth. One example, the appeals process must be simplified so no youth and/or family is left waiting or without services when they need them the most.
- ***Flexibility.*** Children and youth need a system that has adaptability as the landscape constantly changes.
- ***Distinct Systems.*** Children and youth cross multiple sectors (e.g., schools, primary care physicians, foster care, juvenile justice, child welfare, etc.). The behavioral health system needs to coordinate across these sectors and reduce complex navigation needs.
- ***Department of Education.*** The education system must be equipped, engaged, and identified as partners to ensure coordination, alignment, and resources are available to children and youth where they can most easily access help.

- ***Confidentiality and Consent.*** The age of a child/youth creates unique challenges for both parents/caregivers related to access of services and information.
- ***Advocacy.*** Children and youth often do not have a voice in the decision-making process.
- ***Funding.*** Finances can be addressed separately (i.e., different approach). We also recognize that we need to be careful about splitting funding from adult services to ensure one does not rob the other.

Addressing behavioral health wellness early in life can lead to decreases in emotional and behavioral problems, functional impairment, and contact with all forms of law enforcement. It can also lead to improvements in social and behavioral adjustment, learning outcomes, and school performance.[9] We are committed to helping all Colorado children, youth, and young adults flourish and achieve whole-person health and well-being.

The distinct children and youth infrastructure should address the recommendations made by the Children's Behavioral Health Subcommittee of the BHTF, and more broadly:

1. Be accountable for the full scope of system functions which includes, organization and financing of services, improving access, availability of services, and workforce development.
2. Streamline administrative, management, and fiscal functions that shield families from payment disputes between agencies.
3. Be focused on prevention, to earliest possible identification, and to the full range of behavioral health resources.
4. Collaborate with DOI and commercial insurers to establish coverage for an essential benefits package that reflects the Colorado Continuum of Behavioral Health for Children and Youth and supporting service array recommendations.
5. Address the widespread problem of fragmentation and siloed systems to ensure statewide consistency, alignment, and collaboration.
6. Improve collaboration, communication and joint accountability among state, regional, and local child- and youth- serving entities, including the Department of Education and local schools.
7. Reduce duplication and redundancy of work to limit bureaucracy and ensure maximum resources go to services for members and families.
8. Improve quality, outcomes, and resource utilization (e.g., blended and braided funding and maximization of federal dollars).
9. Ensure network adequacy and improve access (i.e., promoting integrated primary care).
10. Ensure adequate stakeholder involvement, including providers as well as family and youth voice in governance.
11. Ensure implementation of a robust child and youth-focused mobile crisis response system and address the intersections of behavioral health and law enforcement.
12. Support expansion of trauma-informed care practices.
13. Recognize cultural-specific needs for children and their families, and respond in culturally responsive ways, which may be different for both.
14. Ensure health equity for all underrepresented groups and those persons furthest away from power (e.g., African Americans, LGBTQIA+, Hispanic/Latino, Tribal, Unsheltered, Refugees, deaf and blind, out of home placement, dual diagnosis, IDD, etc.).

QUALITY

Establishing structures that provide data to system builders and other key stakeholders to measure whether systems are improving the lives of children, youth and families being served in Colorado is essential to measuring outcomes and determining sustainability. These include structures to measure quality, provide feedback loops, and that have response (i.e., quality improvement) capabilities.

1. **WE RECOMMEND** that the State of Colorado determine clear, reasonable, and limited metrics to measure the quality of the Children's Behavioral Health system. This effort should first evaluate existing data points already collected across the system to limit adding more administrative burden on providers/facilities, as well as identify uniform data points, consistently defined, across the system over time. This effort should include metrics to understand statewide awareness of the system, access, unmet need, impact on member functioning and caregiver wellbeing, shared decision making, cost, utilization, and be designed to direct system improvement. This effort should ensure family representation on all quality review teams/initiatives of the behavioral health system.

2. In order to measure and support Colorado's child/youth behavioral health network **WE RECOMMEND** that the State of Colorado research, develop, and publish specific standards of care for children and youth, ages 0-26, that include network adequacy and access measures, wait time/waitlist limits, and general care considerations (time between appointments/services, length of treatment, episode of care, how many touches do members need to get services, efficient use of appointments, integrating multiple appointments in one system – medications, therapy, physical health, etc.). These standards should be aligned with evidence-based best practices, be developmentally appropriate, and specific for respective places of service.

3. **WE RECOMMEND** that the State of Colorado develop and adopt an Outcomes and Performance Dashboard with selected/limited metrics to measure child, youth, and family wellbeing across the state. This effort should align with existing work being done in the Delivery of Child Welfare Services Task Force and other child- and youth-focused systems, as well as help to streamline current quality measurements, and reduce unnecessary and burdensome administrative requirements across the system.

4. **COVID-19 priority recommendation: WE RECOMMEND** that the State of Colorado create a statewide behavioral health strategic plan with clear priorities and measurable goals to help align initiatives and resources across all child and family serving efforts. This strategic plan should include a glossary of common terminology and definitions of terms to promote clarity and consistency in communication and implementation of the plan (for example, suicide prevention efforts that span across state agencies; provider network procurements; align credentialing).

5 In order to promote and ensure transparency and accountability **WE RECOMMEND** that a statewide, unblinded dashboard for payers and behavioral health provider entities be published at least annually using a clear scale/grade and informed by the standards produced by the State of Colorado. This effort should be implemented with robust stakeholder input.

6 In order to address a patchwork of different programs that serve children and families and to determine the ideal distribution of programs along the service continuum, **WE RECOMMEND** that the State of Colorado partner with local stakeholders to create a menu of evidence-informed or promising practices and determine how to invest resources and workforce training for implementation. This should include specific guidelines for early childhood (children 0-8), school-aged children, adolescents, and youth 18+. This standard/model can help inform local communities, counties, and school districts regarding staffing ratios, program offerings, and partnerships, as well as analyze their resources/programs and address gaps as identified.

7 In order to get consistent data across the system and measure true utilization and impact, **WE RECOMMEND** that the State of Colorado create/implement a single identifier for each child, as in a Master Patient Index, to measure utilization throughout the system.

8 **COVID-19 priority recommendation:** In order to remove confusion and support children and families navigating across systems, **WE RECOMMEND** that the State of Colorado publish guidance and training for caregivers and providers to promote easy access to services and protect individuals' rights. This guidance should include information to address situations where parents are necessarily involved in the care of an adult dependent, where legal guidance/practice does not easily translate (e.g., between primary care settings, schools, and behavioral health facilities, as well as HIPAA/FERPA barriers to data sharing), where parents can and cannot access records and/or consent for treatment, and youth's rights to protect their records. This guidance should also address individual/family choice and privacy rights, and help train professionals (including teachers, front line staff, etc.) about the minimum information standards when communicating about a child, youth, or family.

FINANCING

Driven by a recommendation from a 2018 report, *Roadmap to Colorado's Behavioral Health System for Children, Youth and Families: 4-year Strategic Plan*,[6] Partners for Children's Mental Health contracted with the Colorado Health Institute to conduct a financial analysis of the current children's behavioral health system in Colorado. The report was completed in April 2020 and clarifies how state and federal funds are allocated in the current system, the services that these dollars are purchasing, and opportunities to reallocate funding. Key findings of the report indicate between $404 million and $810 million in federal and state funds support child and youth behavioral health services; highlight the complexity of the delivery system and resulting challenges of who is and is not being served; offer opportunities to improve the system through consolidation of funding streams, additional leveraging of federal dollars, and new investments in data collection.[10] The financial analysis report can be found here.

In addition to the financial analysis, the financial recommendations were informed by two other reports: *Risk, Reach, and Resources: An Analysis of Colorado's Early Childhood Mental Health Investments*[11] *and Youth Behavioral Health Services in Colorado School Districts.*[12] The intent of these recommendations is to include all payers that operate within the State of Colorado when feasible and legal.

1 In order to reduce fragmentation, allow for easier system navigation, reduce duplication, increase alignment and efficiencies, prioritize funding of direct services, improve data collection, and improve quality and access to care for children and youth who need it most, **WE RECOMMEND** consolidating children's behavioral health funding streams by eligibility criteria, program size, funding flexibility, and/or services provided across 6 state agencies/offices (i.e., OBH, CDPHE, HCPF, Colorado Department of Education (CDE), Colorado Office of Early Childhood (OEC), Colorado Office of Children, Youth and Families (OCYF)) and the identified 34 distinct programs, as suggested in the financial map.[10]

2 **COVID-19 priority recommendation:** In order to streamline billing and claiming processes; to support meaningful and consistent data collection; and to remove the burden from providers and family members, **WE RECOMMEND** the State of Colorado designate a single, publicly funded, fiscal management system be used to account for funds for all publicly funded services, including HPCF, OBH, and OEC, and to allocate funds as necessary.

3 In order to maximize the use of state dollars by identifying opportunities to increase federal matching funds, **WE RECOMMEND** examining all services provided by state programs that don't get a federal match and changing those that could be provided using funding from Medicaid or Child Health Plan Plus, Individuals with Disabilities Education Act, Title IV-E, etc. while not compromising essential services within the service array. Colorado may be able to get the federal government to pay a greater portion of the cost or be able to deliver more services.

4 **COVID-19 priority recommendation:** Currently, children and youth can wait to receive care while state agencies and commercial carriers debate who is responsible to provide and pay for that care (i.e., the current Creative Solutions process). This happens when children and youth either fall into the gray area regarding populations each state agency is responsible for serving (the child or youth meets criteria for more than one state agency), or is dually insured. These negotiations should not prevent or delay the delivery of care or put at risk payment for the provision of care to the provider or family (beyond their covered benefits or maximum lifetime limits). In order to facilitate the timely provision of clinical services that meet the needs for children, youth, and families, and together with our recommendation to establish an essential services package and statewide utilization management guidelines, **WE RECOMMEND** that the State of Colorado implement a pay and chase model that identifies a single state agency to be responsible for reimbursement to a provider ("pay") for the entire cost of all services rendered up front. The identified single state agency will then be responsible for securing payment from the appropriate payer ("chase") based on an agreed upon funding hierarchy. If they are unsuccessful, this single state agency will maintain complete responsibility for the full payment for all services provided.

5 In order to maximize the dollars that are being deployed and to make informed decisions, **WE RECOMMEND** developing a systematic approach to collect information on children's behavioral health spending across the 6 state agencies/offices (i.e., OBH, CDPHE, HCPF, CDE, OEC, OCYF) to learn where dollars are going, for whom services are being provided, what services are being purchased, number and type of providers involved, where gaps remain, and how to maximize the utilization of resources across the entire array of services. This may include leveraging existing data infrastructure (i.e., Colorado Health Information Exchanges, Office of E-health, All-payers Claims Database) and/or investing in new data infrastructure.

6 In order to support primary care providers (PCPs) throughout the state with the assessment and treatment of behavioral health conditions of children, adolescents and young adults; to address statewide shortages of child psychiatrists throughout Colorado; and to potentially provide the infrastructure for consultation by other specialists related to the needs of children and families, **WE RECOMMEND** that the State of Colorado develop a sustainable funding stream for a statewide behavioral health consultation program.

This program should provide 1) Access for all Colorado families regardless of insurance status (i.e., all payers should contribute to this program), 2) Timely access for peer to peer consultation and education (telephone, e-consults or telehealth), and 3) Support to identify and connect families to local/telehealth mental health resources that provide evidence-based treatment. Based on the experience of programs in other states (e.g., child psychiatry access programs), we estimate that it would cost $2-2.50/child/year to support this program. Given the current population of Colorado, this program would require approximately $2.6-3.2M per year for sustainability.

Based on funding for other states' programs, options for sustaining this program include:

- Funding from the state general fund
- Funding from public and private payers based on proportional utilization of services over time or a per member per month fee for covered lives, ages 0-25, from both public and private payers
- Incorporation into HCPF's Accountable Care Collaborative
- Braided funding from medical, behavioral health and social service budgets
- Creation of an endowment to provide long-term support for the program

7 In order to improve access and authorization of behavioral health services across the state, **WE RECOMMEND** that the State of Colorado create a package of "Essential Services" for children's behavioral health needs that includes an annual mental health exam. The State of Colorado should conduct an annual review to determine which codes cover all essential services and ensure all payers have complied with the requirement to cover these. Additionally, the administrative processes for billing and claiming behavioral health codes should be reviewed to ensure they are at parity with physical health claims.

8 In order to maximize access to care, prevent patient escalation up the care continuum, reduce costs and promote prevention, early intervention, brief interventions, and other services that expedite the appropriate assessment and referral of patients, **WE RECOMMEND** that the State of Colorado open the Health and Behavior Assessment and Intervention codes (96150-96155), eConsult codes (99451, 99452), as well as work to make permanent any of the temporary guidelines related to telehealth services that are clinically appropriate. These codes should be allowed in as many places of service as are clinically appropriate.

9 Financial investment in prevention and promotion is needed for a robust child/youth behavioral health system. In order to support schools, PCPs, and early childhood key partners to prevent mental, emotional and behavioral health problems, **WE RECOMMEND** the State of Colorado consider the following actions:

- Include in the covered Essential Services bundle universal and targeted preventive behavioral health services that do not require a behavioral health diagnosis.
- Ensure that all communities provide access to behavioral health services through school-based providers or health centers or in partnership with other community-based services (Community Mental Health Centers, Federally Qualified Health Centers, etc.) and be required to follow legal confidentiality and consent guidelines as age appropriate.
- Enhance/expand OBH School Based Mental Health Specialist Program, the OEC Early Childhood Mental Health Specialist Program.
- Identify a statewide allocation goal for prevention dollars and move strategically toward that target. This does not have to be new funding, but rather a reallocation of existing funding to continue to invest in promotion and prevention services.

10 In order to equitably meet the needs of all Colorado students, teachers, and schools for a 21st century context that is increasingly tasked with addressing behavioral health needs of students without adequate resources, **WE RECOMMEND** that the State of Colorado evaluate the School Finance Act and modify the School Funding Formula to cover a core set of essential services for every student in the state within TIER 1 resources.

11 While data is limited, findings suggest youth ages 0 to 5 and 18 or older may be disproportionately under-funded compared with school-aged youth, and opportunities exist to reduce disparities in funding among racial, ethnic, and disability groups. In order to promote equity in behavioral health funding and to ensure funds are distributed to services for the youth populations that need them the most, **WE RECOMMEND** tracking spending based on age, gender, sexual orientation, race, ethnicity, primary language, disability, and geographic region, and developing specific programs to address any identified inequities.

12 In order to make the behavioral health system more member-focused and reduce the barriers and complexity of navigating the system, **WE RECOMMEND** that the State of Colorado adopt a single, statewide utilization management guideline for all payers, aligned with an array of essential services. This will promote transparency in the system and reduce some level of grievance and appeals related to disparity in access to services across the state and among payers. This can also address parity issues related to access to physical and behavioral health services.

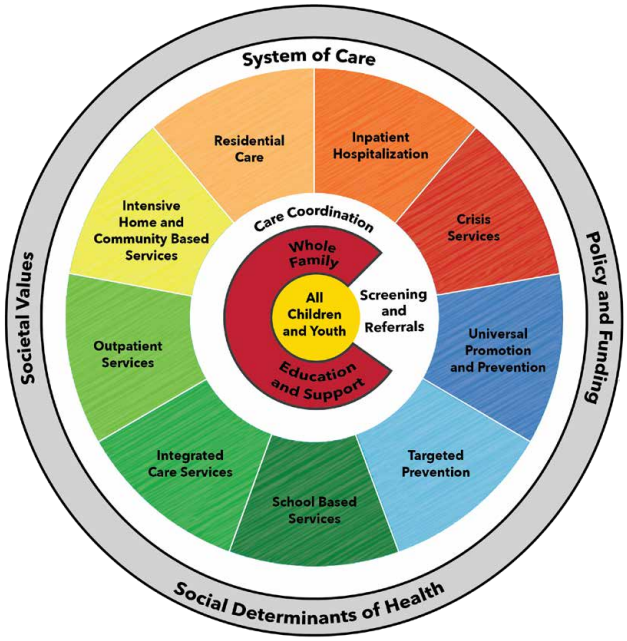
SERVICE ARRAY

To overcome the behavioral health crisis Colorado youth are experiencing, the following recommendations define and support a comprehensive continuum of care considered essential for children and youth across the state, ensuring that children have access to services where, when, and as needed.

1 ***Essential Services.*** **WE RECOMMEND** the State of Colorado adopt the Colorado Continuum of Behavioral Health for Children and Youth (See Figure 2 and Appendix 4). This Continuum defines essential services across the service array (from prevention to treatment and recovery) that should be accessible to all children across the state. The Continuum of care provides support services and interventions in a child and family focused way, across varying levels of intensity that incorporate and address the needs of both children and parents/caregivers. This includes provision of services directly to the child/youth that promote well-being and address behavioral health issues, as well as provision of services directly to adult caregivers in support of the child/youth.

- Reimbursement. **WE RECOMMEND** that essential services, as defined by the Continuum of Children's Behavioral Health Care in Colorado, be universally reimbursed at levels sufficient to cover the actual cost of care by all public and commercial insurance providers in Colorado.
- Service definition. **WE RECOMMEND** that the State of Colorado enforce fidelity of how essential services are defined.
- **COVID-19 priority recommendation:** Flexible funding. **WE RECOMMEND** that state-issued funding for essential children's behavioral health services allow for flexible allocation to respond to local and emerging needs in communities across Colorado**.**

Figure 2. Colorado Continuum of Behavioral Health for Children and Youth



2 ***Gaps.*** To understand where there are gaps in essential services as defined by the Continuum, **WE RECOMMEND** the State of Colorado complete a comprehensive service gap analysis to identify local, regional and systemic service gaps. This analysis would define and assess:

- **Timeliness.** Adequacy of timely access to essential services (timely access to be defined within context of service gap analysis), including entry points that allow services to be offered at the right level of need without requiring an outcome failure to move to the next step of services.
- **Workforce.** Adequacy of trained and competent workforce to support essential services.
- **Financing.** Level and distribution of financing to support essential services
- **Statute and Rules.** Review of legislative and regulatory policies that support or create barriers to access to essential services by all Colorado children and their families.

3 ***Prevention.*** In order to move upstream to prevent intensive and costly behavioral health problems, **WE RECOMMEND** investment in the infusion of promotion and prevention services where children and families seek support, including schools, healthcare and community settings.

4 **COVID 19 priority recommendation: *Integration.*** To support youth and families where they routinely access well-child and healthcare services, **WE RECOMMEND** investment in expanding integrated behavioral health services in primary care settings. This will increase access to screening and provide early intervention for lower acuity conditions, while ensuring strong referral mechanisms and linkages with specialty behavioral health providers for children and families in need of higher levels of care.

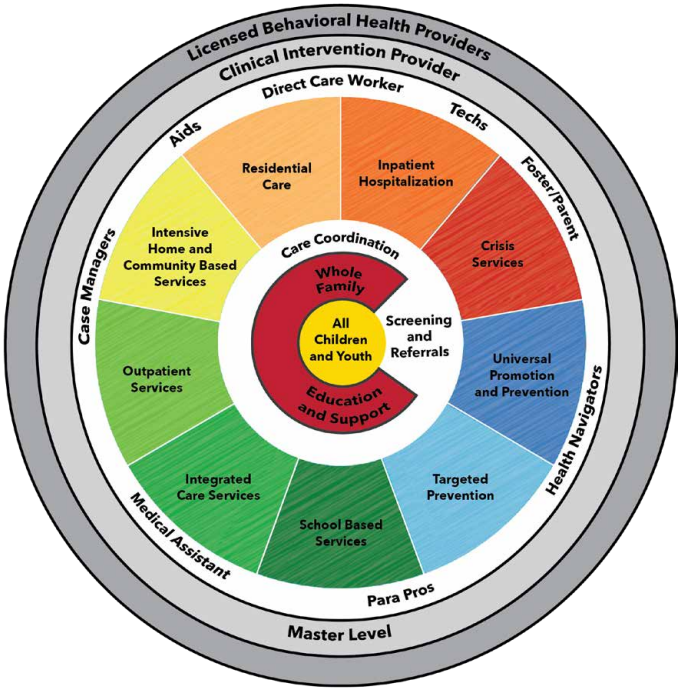
5 ***Care Coordination.*** To assure that youth and families can navigate the Continuum to access the right services at the right time, **WE RECOMMEND** investment in care coordination across the continuum.

1 **COVID-19 priority recommendation:** In order to measure and support Colorado's child/youth behavioral health network, **WE RECOMMEND** that the State of Colorado research, develop, and publish metrics and methods to determine the value and cost of behavioral health services that can inform statewide salary recommendations for the workforce. These metrics should include parity considerations and help inform reimbursement rates and caseload requirements for behavioral health providers.

2 In order to improve workforce retention and quality of care, **WE RECOMMEND** that the State of Colorado develop and adopt a spectrum of core competencies for Direct Care Workers (workers not currently monitored by Colorado Department of Regulatory Agencies (DORA), and who do not already have training and support in their workplace related to behavioral health and wellness), and align these competencies with appropriate scopes of work for each level of acuity/population. This could be modeled after the Youth Health Competency Framework which includes universal and core competencies for variety of individuals and teams working with young people.[13]

These competencies should include pediatric-specific topics such as family engagement, child development, cultural and linguistic inclusivity, and issues surrounding confidentiality and child safety. We believe this will enhance the quality of care for families by expanding the number of competent and trained staff at multiple levels throughout the workforce. We advise that this recommendation be implemented in such a way as to support the workforce and not add additional burden or barriers to participating in the workforce. See Figure 3 for examples of Direct Care Workers, and how they fit with other members of the workforce.

Figure 3. Workforce for the Colorado Continuum of Behavioral Health Care for Children and Youth



3 **COVID-19 priority recommendation:** In order to create a potential career ladder (or Tiered Workforce) that serves as a workforce pipeline, and to focus the work of licensed behavioral health providers on the highest acuity clients as they work at the top of their licensure, **WE RECOMMEND** that the State of Colorado:

- Create a series of endorsements (not certificate or license) supported by a clearinghouse of approved training modules (Motivational Interviewing, Mental Health First Aid, Trauma, Suicide Prevention, etc.) that are aligned with core competencies and best practices for Direct Care Workers, and which follow the worker across child/youth-facing health care roles. This could be modeled after the CO Association for Infant Mental Health (http://coaimh.org/) Endorsement or the Alaska Behavioral Health Aide program.
- Adopt a strong incentive program for employers and educational institutions to recognize these endorsements and support staff training in order to become the cultural expectation for entities that provide behavioral health services. (A system of core competencies or voluntary credentials will not have impact unless paired with a robust incentive system. Colorado Shines, an early childhood multi-level quality rating system, may serve as a model to adapt for behavioral health: professionals can pursue additional levels of training and organizations can achieve higher tiers of reimbursement.)

4 In order to promote/increase competency in the behavioral health workforce for specific populations (LGBTQIA+, Tribal communities, etc.) and specific conditions (Substance Use Disorder (SUD), IDD, ASD, etc.), **WE RECOMMEND** that the State of Colorado:

- Identify specific populations and their needs and identify trainings that would address these needs.
- Work with respective agencies/entities to eliminate unnecessary and duplicative requirements that create barriers to providing and being reimbursed for services to these populations (i.e., OBH certification requirements for SUD providers/services).
- Develop minimum training guidelines for licensed staff to meet and maintain core competency standards (i.e., Licensed Professional Counselors are provided an addiction-specific continuing education seminar).
- Work with DORA and other entities to review and revise requirements to allow for cross discipline supervision within the workforce to open employment opportunities for our diverse workforce.
- Work with medical professionals in primary care settings who could treat lower acuity conditions (like Attention Deficit Hyperactivity Disorder) that would open capacity for child psychiatrists to work with more complex, higher acuity conditions.
- Support the development of a statewide pediatric telepsychiatry consultation program (i.e., Colorado Pediatric Psychiatry Consultation and Access Program).

5 In order to reduce the burden on providers and allow providers to dedicate as much time to clinical care as possible, **WE RECOMMEND** that the State of Colorado consider multiple efforts to support our workforce that include the following options:

- Work with DORA to streamline/implement reciprocity procedures to better facilitate licensed professionals moving into the state from other states or countries (i.e., refugees/immigrants).
- Work with HCPF and other state agencies to simplify and streamline credentialing processes to enroll providers with payers.
- Review and take action to reduce the administrative burden on providers related to billing/claims, reporting, data tracking, etc.

6 In order to attract and retain behavioral health providers to the workforce, **WE RECOMMEND** that the State of Colorado work with the respective agencies/entities to develop incentives that include the following options:

- Improve/strengthen the Colorado Health Service Corps loan repayment program to ensure that awards adequately cover the cost of completing internships and supervised hours required for licensure, that awards incentivize at least 5 years of rural and frontier service, and that award funds can increase to meet the growing need for services.
- Explore Housing supports that could remove barriers to behavioral health providers living in rural/resort communities. This can include partnering with cities who have income-restricted/income-qualified housing programs, or working with the Colorado Housing and Finance Authority to include behavioral health professionals in their preference policy for affordable housing options.
- Use flex funds to create a matching fund to incentivize organizations to offer "sign-on bonuses" for providers in such a way that encourages retention/commitment to these communities (i.e., percentages of bonus paid out for each year a provider extends their service, etc.).
- Identify a pool of licensed behavioral health providers who will offer supervision free of charge to master's level providers in exchange for loan repayment or other cost incentives (i.e., if a Licensed Clinical Social Worker (LCSW) will provide supervision for 2 years to a Licensed Social Worker free of charge, the LCSW will receive a state funded grant of $20,000 toward student loans, or a tax incentive/housing stipend toward rent if serving in a rural/frontier county).

7 In order to support the development of a robust, statewide behavioral health workforce, **WE RECOMMEND**:

- To the extent allowable, prioritize a part of every grant application written by the State be dedicated to workforce development (i.e., training toward core competencies, training toward best practices related to pilot programs, recruiting and skill-building toward new initiatives, etc.).
- **COVID-19 priority recommendation:** Seeking workforce expansion funds (i.e., https://www.hrsa.gov/grants/find-funding/HRSA-19-089).
- Prioritize a portion of state budgets to be used to support "career ladder" efforts.
- **COVID-19 priority recommendation:** Develop and promote workforce cultivation initiatives to reach students looking for career options (i.e., campaign to attract girls in STEM, occupational outlook handbook https://www.bls.gov/ooh/).

ACCESS

Access recommendations from the Children's Behavioral Health Subcommittee are offered in categories of screening, single point of entry, assessment and outreach. Recommendations related to screening, single point of entry, and assessment support the work of SB 19-195 (Figure 4).

SCREENING

1. Because screening and identification of behavioral health needs of children and youth should happen through PCPs, **WE RECOMMEND** a standardized approach to behavioral health screening that is normed to different cultures, languages and for the deaf and blind in primary care settings and schools.

2. To determine appropriate standardized screening tools in primary care as relates to SB 19-195, **WE RECOMMEND**:

   - Convening a stakeholder group of PCPs, child and adolescent psychiatrists, and psychologists to identify a set of approved and developmentally appropriate screeners for use in primary care settings. This stakeholder group should:
     - Examine the list of 12 approved screeners from Massachusetts,14 and consider adding the Columbia-Suicide Severity Rating Scale (C-SSRS), Behavior Assessment for Children 3rd Edition, and Conner's Behavior Rating Scale.
     - Evaluate the set of tools periodically and add or remove screeners when appropriate.
     - Develop a workflow or decision tree to help PCPs determine when to use which screener.
     - Provide support / training to those within PCP offices that will be administering the screeners.
   - Requiring that public and private payers in Colorado align and reimburse PCPs for a determined set of developmentally appropriate screeners.
   - Requiring that identified screenings align with the periodicity schedule, a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence.

3. **COVID-19 priority recommendation:** Because schools play a critical role in helping identify youth that are struggling with social / emotional wellbeing, **WE RECOMMEND** developing a standardized approach to screening for social / emotional wellbeing in all Colorado schools by:

   - Establishing a system where youth ages 12-18 are offered the opportunity to electronically complete a self-report screening tool, making data reporting, tracking, and needs identification possible statewide. For example, a school screening and assessment program in Cañon City uses the Behavior Intervention Monitoring Assessment System 2 (BIMAS-2). Youth in grades 6th – 12th receive the BIMAS-2 to their school email twice per year (assumption of passive consent with an opt out policy). The BIMAS-2 takes 2.5 minutes to complete and examines social, emotional, and behavioral health. It is normed nationally and identifies youth that fall outside the normal distribution and may need help. Youth are referred to a community provider if they ask for care or if a need or risk factor is identified

through the screener. Currently two people coordinate care across nine schools for 900 youth and additional navigation support is needed.

- Convening a stakeholder group of child and adolescent psychiatrists, psychologists, and child development specialists to identify a set of approved and developmentally appropriate screeners to be used in schools.
- Evaluating the set of tools periodically and adding or removing screeners when appropriate.
- Developing a workflow or decision tree to help school professionals determine the best screener for their children and adolescents.
- Providing support / training to those within schools that will be administering the screeners.
- Developing an implementation process for standardized screening in all school districts, including resources for making referrals and warm handoffs to community providers as needed.
- Creating data infrastructure to capture self-report data, analyze data, and flag students in need of supports.
- Identifying a navigator role to help support students with positive screens.
- Identifying an embedded social/emotional curriculum (e.g., Sources of Strength).

4 Because parents are in need of resources to support the emotional and behavioral health of children and youth, **WE RECOMMEND** creating a recognized and credible source to provide parent/care giver education on how to recognize and address behavioral health needs, such as the crisis brand and system, SEE ME Colorado or Children's MD built out for behavioral health.

SINGLE POINT OF ENTRY (SB 19-195)

1 Because of the current behavioral health system's complexity, and burden experienced by children, youth, and families in identifying need and accessing services, **WE RECOMMEND** a single point of entry to help individuals (including PCPs, schools, caregivers, and parents) navigate the behavioral health system. Considerations for a single point of entry include:

- Developing a point of entry so that any service provider administering behavioral health screening has a functional place to refer children and youth for services.
- Potentially leveraging the Colorado Crisis Services Hotline to fulfill this function at a state level, or expanding Crisis Administrative Service Organizations or Care Management Entities responsible for wraparound implementation at the regional level.
- Contributing to creation of a "no wrong door" system by not requiring that all children and youth with a behavioral health need use the single point of entry; that is, if needs are clear and care is accessible, then there is no need to access the single point of entry.

2 **COVID-19 priority recommendation: WE RECOMMEND** that the single point of entry be staffed with family navigators, community health partners, and/or peer specialists as a means to provide further needs assessment and to link families to resources in the community.

3 **WE RECOMMEND** the following considerations and functions of a single point of entry:

- Screening (if not completed already)
- Referral to a consistent assessment process
- System navigation across the multiple systems based on need and eligibility
- Warm handoffs to service provider organizations
- Follow the family and create a feedback loop for 3 months to ensure the link to needed resources was accomplished
- Development of universal consent and information sharing exchanges to facilitate access to care

4 **WE RECOMMEND** extensive marketing so that providers, schools, parents, and others are aware of the single point of entry, know its purpose, and know how to use it.

5 **WE RECOMMEND** measuring the effectiveness of the single point of entry.

ASSESSMENT (SB 19-195)

1 Because standardized approaches to assessment ensure similar levels of quality, equity and access for youth and families and allow for the collection and analyses of systems level data to support data-based decisions, **WE RECOMMEND** exploration of alignment across state agencies to use a single standardized assessment.

For example, there is currently some alignment with the Child and Adolescent Needs and Strengths Assessment (CANS) tool. The CANS is being adopted by Children and Youth Mental Health Treatment Act, the Systems of Care grantees, for SB 19-195 implementation, and through the child welfare Family First Prevention Services Act implementation to access the Qualified Residential Treatment Program level of care. A single standardized assessment tool could also be used by HCPF for implementation of high fidelity wrap around, for any child or youth who receives publicly funded behavioral health treatment and requiring enhanced community-based services or higher levels of care, and as the assessment required by OBH for mental health centers.

2 **WE RECOMMEND** the assessment is re-administered every 3 to 6 months to track progress and measure outcomes.

3 **WE RECOMMEND** standards and approaches to assessment apply to both publicly and commercially insured youth.

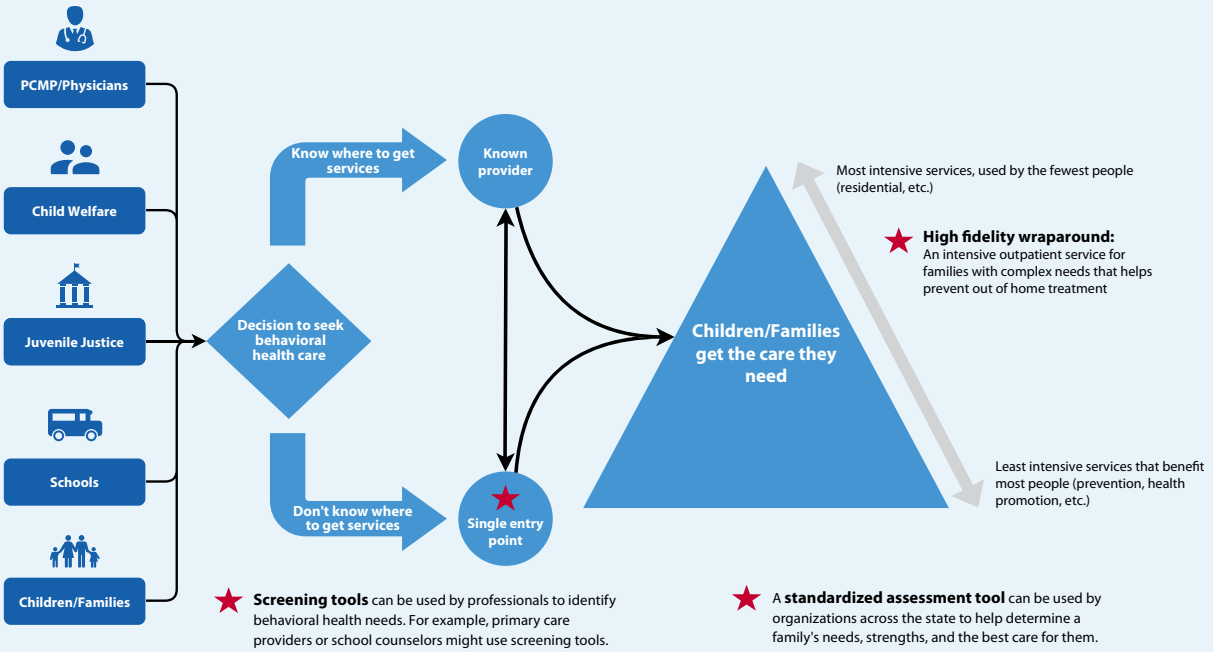
4 **WE RECOMMEND** payment for completing the assessment be required for both publicly and commercially insured youth.

OUTREACH

1 To reach communities that are underserved and underrepresented in the behavioral health system (e.g., LGBTQIA+, Hispanic/Latino, Tribal, unsheltered, refugees, deaf and blind), **WE RECOMMEND** development of specific outreach strategies, including:

- Leveraging organizations already working with these populations and talking with community providers
- Using a community-based approach
- Establishing ambassadors to develop trusted relationships with underrepresented populations and community providers
- Ensuring our care is culturally and linguistically responsive
- Ensuring our workforce reflects the populations we serve
- Analyzing data to understand the reasons that are contributing to underrepresentation (e.g., stigma, lack of a culturally diverse workforce, not enough bi-lingual providers, etc.), and develop and implement specific strategies per population
- Collaborating with underrepresented populations to understand how they would like to engage and then implementing identified strategies

Figure 4. Pathway to Behavioral Health Services For Children, Youth, and Families[15]



This pathway uses System of Care values and principles such as being youth guided, family driven, strengths based, trauma responsive, community focused, culturally competent, and integrated.

★ Denotes a component of SB19-195

State Safety Net Subcommittee

In 2020, Mental Health America ranked Colorado as 33rd in the US for adult mental health and access to mental health care.[1] As reported in the 2019 Colorado Health Access Survey: Behavioral Heath completed by the Colorado Health Institute, 15.3% of Coloradans surveyed reported poor mental health, an increase from 11.8% in 2017.[16] Twenty-seven percent of Colorado adults surveyed reported that they, a loved one, or a close friend have been addicted to alcohol or drugs in their lifetime. Of those surveyed, 72.4% of those who had not sought treatment for their behavioral health concerns reported that they were concerned about someone finding out that they had a problem, a strong indicator that stigma related to behavioral health remains a barrier to care.

Mandate from Governor Polis

This subcommittee shall offer a roadmap to ensure that every Coloradan, regardless of acuity level, ability to pay, or co-occurring disabilities, can obtain appropriate behavioral health services in their community.

Legislative Mandate - Senate Bill 19-222

- Define what constitutes a "high-intensity behavioral health treatment program"
- Understand what services and supports are needed to assist with diversion and release of individuals with behavioral health disorders from the criminal justice and juvenile justice systems

Guiding Principles

The State Safety Net Subcommittee developed a definition for the Colorado Behavioral Health State Safety Net System:

A safe, community-based behavioral health system that provides person-centered and patient-driven access to a continuum of behavioral health services and supports to all Coloradans regardless of severity of need or ability to pay.

Using this definition to guide their work, the State Safety Net Subcommittee developed the following guiding principles:

COMPREHENSIVE

- Assures no one is refused services, regardless of complexity of their presenting symptoms, ability to pay, or criminal history, with criteria and processes for when the needs of an individual exceed treatment capacity or clinical expertise of a provider (SB-222) are developed and implemented so all individuals are served by the system
- Supports locally driven, community-based, culturally informed care
- Supports of multiple pathways to well-being and the role of supportive and peer-based services
- Provides appropriate frequency, duration, and intensity for the needs of the patient

- Addresses social determinants of health
- Provides a continuum of care that recognizes wellness across the spectrum of promotion, prevention, treatment, and recovery comp

EQUITABLE

- Supports inclusive, culturally and linguistically responsive, trauma-informed services
- Provides patient autonomy (client-driven, patient choice in services and/or provider)
- Provides equitable access to behavioral health services across the state

EFFECTIVE

- Remains evidence-informed and focused on patient-centered outcomes
- Provides timely and responsive services, including responsiveness of mobile services, regardless of geographic location or past use
- Commits to the highest levels of quality and patient satisfaction

As the State Safety Net Subcommittee began their work, they reviewed the Western Interstate Commission for Higher Education (WICHE) report completed for CDHS in 2015 which identified and assessed existing state and community resources and made recommendations for strategic future planning to strengthen Colorado's behavioral health system.[17] Recommendations from the WICHE report, including examining funding allocation methodologies for all behavioral health programs and services and exploring alternative payment approaches for the use of indigent funds in Colorado, remain relevant today. WICHE report findings were presented to the subcommittee via webinar to clarify and ground recommendations and provided framing for subcommittee work.

Community Mental Health Centers had the opportunity to present current behavioral health service delivery models to the subcommittee to inform continuum of services and safety net recommendations. Five counties (Douglas, Eagle, Larimer, Park and Summit) also provided overviews of how each county has implemented local behavioral health solutions and recommendations for the subcommittee to consider. Additional readings to ground subcommittee work included The Intersection of Housing and Mental Health in Colorado; Mapping Critical Social Determinants of Health and the Statewide Needs Assessment of Primary Prevention for Substance Abuse (SNAPS) report conducted by the Colorado Health Institute on behalf of OBH.[18,19]

In the recommendations and considerations described below, subcommittee members grappled with defining context and crafting language that represented each of their individual professional organizations and personal experiences. When charged with defining "safety net", subcommittee members debated about who should be included in the definition, ultimately concluding that the safety net should include all Coloradans versus only those who have no access to health insurance. The subcommittee recognized that this increased complexity in defining essential services and program implementation. Of note, subcommittee members repeatedly and conscientiously considered the consumer perspective when refining recommendations, raising questions and having dialogue about how individuals' and families' experiences may improve should certain recommendations be put forward.

When considering potential models for consolidating financing of behavioral health, there were multiple perspectives presented to examine how to best meet the needs of Colorado's safety net population. These perspectives were respectfully considered in drafting of final recommendations and considerations. Generally, across recommendations and areas of discussion, subcommittee members indicated support of final recommendations and considerations, and members were encouraged to provide written synthesis of areas of concern or disagreement with final recommendations for inclusion as addendums to the Remedy for Behavioral Health Reform.

State Safety Net Subcommittee Recommendations

HIGH INTENSITY TREATMENT PROGRAMS

The State Safety Net Subcommittee drafted a definition of "high-intensity behavioral health treatment programs" based on language in SB 19-222, existing definitions in the literature, and subcommittee expertise. SB 19-222 included a list of representation that needed to be consulted within developing the recommendation. Of that list, counties, law enforcement, mental health centers, hospitals, physical health providers, and family advocates were represented by members on the State Safety Net Subcommittee; substance use providers and judicial districts were missing from the subcommittee, and the subcommittee recommended individuals to provide that perspective. The subcommittee identified additional expertise not listed in statute: intellectual and developmental disabilities, traumatic brain injuries, juvenile justice and high-risk youth, child welfare, and social services, including child welfare. Individuals representing these additive perspectives were invited to attend subcommittee meetings and provide revisions and suggestions to the draft definition virtually. A list of individuals who contributed to the definition is included in Appendix 5.

The subcommittee developed and voted on a working definition of high intensity treatment. Using this definition, subcommittee members offered considerations for operationalizing high intensity treatment programs as well as considerations for the state in developing a plan to increase the number of programs, as mandated by SB 19-222.

WORKING DEFINITION OF HIGH INTENSITY BEHAVIORAL HEALTH TREATMENT

High Intensity Behavioral Health Treatment (High Intensity Treatment) is a community-based, client and family centered approach that is specifically designed to engage adults and youth with severe mental health and/or substance use conditions who are at risk for or experiencing complicating problems such as physical health problems, developmental challenges and/or involvement in criminal and juvenile justice systems. This community-based approach to treatment provides individualized support to reduce risk for worsening problems, ensure continuity of care across the service system, and prevent adverse outcomes such as homelessness, criminal justice involvement and physical or behavioral health crisis. High intensity treatment has the following characteristics:

- ***Assertive outreach and engagement:*** The treatment team uses motivational enhancement and other strategies to develop rapport and provides the services that are relevant to the individual and family in order to engage them in care.

- ***Community-based:*** Although some services may be delivered in offices, in general, services are delivered in the community where the individual or family lives.
- ***Multi-disciplinary and team-based:*** The multidisciplinary treatment team needs to have the capacity to meet the needs of and defined by the client. The treatment team may include medical providers, clinicians, case managers, and peer specialists as well as employment and housing navigators and law enforcement who work together in a team-based approach to care.
- ***Recovery-focused:*** Services extend beyond traditional clinical or medical services to include housing and income assistance, employment, social support, education, and daily living skills with the ultimate goal of attaining and maintaining as much independence as possible. This should include any social determinants of health that are necessary for the sustainability of an individual's or family's recovery.
- ***Client driven:*** Service planning is focused on the needs identified by the individual and family and is responsive to their cultural, linguistic and developmental needs and preferences. Treatment is flexible to serve individuals with multiple needs and able to coordinate with other service delivery systems to meet client co-occurring needs.
- ***Flexible in duration and intensity:*** Service intensity and duration are based on the needs and risks of the individual and family; however they are generally more intensive than conventional services and extend over an indefinite period of time.
- ***Coordinates care across settings:*** The team continually assesses need, facilitates access to needed services, and provides continuity across services including emergency and intensive care, and outpatient and recovery support services. The treatment approach is adaptable to other services being provided to the individuals; such as those services related to IDD, brain injuries, etc.
- ***Natural supports:*** The treatment team includes peers and/or recovery coaches and actively works to expand and enhance the natural supports available to the individual and family.
- ***Advocacy:*** The treatment team advocates for the individual and family in accessing needed skills and resources and helps the individual build skills to advocate for themselves.

High Intensity Treatment programs are implemented with fidelity to evidence-based practices such as Assertive Community Treatment, Integrated Dual Disorder Treatment and/or High Fidelity Wrap-around programs and interface with a variety of other evidence-based interventions based on the needs of the individual and family.

To operationalize high-intensity behavioral health treatment definition and ensure services are accessible to individuals who need them, the State Safety Net Subcommittee suggests the following considerations:

1. Identify strategies to make services accessible statewide, including in rural areas, without requiring individuals/families to drive hours for services. This may include mobile services, telehealth, etc.
2. Ensure 24/7 accessibility to manage crisis situations, or ensure programs are connected to a 24/7 crisis system.
3. Connect and coordinate with crisis response systems, including mobile crisis and co-responder teams, e.g., behavioral health providers with law enforcement and paramedics. Explore non-law enforcement response to emergency and urgent mental health and social services needs by dispatching counselors and social workers directly to communities.

4 Connect services with timely access to Crisis Stabilization Units, respite, and/or other residential programs to keep individuals safe during crisis and decrease dependence on Emergency Department services in times of crisis.

5 Ensure natural support services include and are available to families and other caregivers who may need services in order to support the individual in need.

6 Connect behavioral health providers to health information exchange platforms to support compliant sharing of health records across providers and systems.

7 Ensure consumer voice is included in treatment decisions and advance directives.

8 Include in-home and out-of-home respite services when possible.

9 Include flexibility in how services are delivered for rural/mountain communities.

Mandated by SB 19-222, CDHS must create a plan to increase the number of high-intensity treatment programs across the state by November 2020. In addition to the definition and operational considerations above, the subcommittee requests the state consider the following in creation of this plan:

- Ensure culturally appropriate services in all high intensity treatment programs
- Offer guidance to local providers when services are expanded to ensure fidelity with necessary modification that are appropriate given community resources (example, guidance that could address the current differences in Assertive Community Treatment implementation across the state)
- Explore funding sustainability and alternative models, such as hub and spoke
- Support local provider organizations in maintaining service lines (i.e., rural communities may face challenges in maintaining capacity to provide Assertive Community Treatment when caseloads are low and providers may be assigned other responsibilities)
- Invest in peer services as part of high intensity treatment programs
- Include caseworkers in co-responder teams; adding behavioral health expertise and personnel leads to avoided arrests
- Increase availability of services for co-occurring needs in one care setting
- Leverage technology to supplement in-person care (e.g., use technology as a check-in tool)
- Invest in infrastructure to improve telehealth and other technology
- Consider a Housing First strategy, and how a Housing First strategy could be broadened to fund and reimburse services not included under "medical necessity"

The State Safety Net Subcommittee concluded that the definition of high intensity behavioral health services will assist with diversion and release of individuals with behavioral health disorders from the criminal justice system by providing appropriate services to meet the needs of these individuals in the community when combined with the Colorado Continuum of Safety Net Services.

COLORADO CONTINUUM OF SAFETY NET SERVICES

The State Safety Net Subcommittee created the Colorado Continuum of Safety Net Services to display the array of services that should be available as part of the state safety net to promote behavioral health and well-being. The Continuum was developed using a framework from an Institute of Medicine report that identified the need for promotion and prevention, treatment, recovery and maintenance of mental health conditions and shows how each component is interrelated.[2] The framework has been adapted by federal and state agencies, including SAMHSA.[3] The State Safety Net Subcommittee worked from the SAMHSA continuum, identifying behavioral health services necessary to meet Coloradans' needs and informed by public testimony vignettes and consumer perspectives. The continuum is depicted along with service category headers from the Colorado Continuum of Behavioral Health for Children and Youth to display a full continuum of care. In three workgroups, the State Safety Net Subcommittee prioritized the services into three tiers and re-iterated values and considerations for service continuum implementation:

- Develop standardized definitions for services to be used across systems and programs (i.e., care coordination)
- Promotion and prevention include wellness and recover and relapse prevention
- Navigation eases access to and within safety net system
- Care coordination with services to address social determinants of health, like housing, transportation, and employment
- Intensive case management spans and supports multiple service categories
- Services are available in multiple community-based settings
- Decrease wait times
- Invest in telehealth infrastructure
- Improve data sharing between providers and systems
- Address health inequities with specialized outreach, screening, and assessment to engage underserved populations in care

Figure 5. Colorado Continuum of Safety Net Services

Children's Behavioral Health Subcommittee headings	Universal Promotion/ Prevention/Targeted Prevention		Integrated Care Services	Outpatient Services		Across multiple sections of CH array	Across multiple sections of CH array	Intensive Home and Community-Based Services	Residential Care	Inpatient hospitalization	Crisis Services	Captured under in intensive home and community-based services
State Safety Net Subcommittee headings	**Prevention (including Promotion)**	**Engagement Services**	**Healthcare Home/ Physical Health**	**Outpatient Services**	**Medication Services**	**Community Supports (Rehabilitative)**	**Other Supports (Habilitative)**	**Intensive Support Services**	**Out-of-Home Residential Services**	**Inpatient Hospitalization**	**Crisis Services**	**Recovery Supports**
Tier 1 (prioritized by 2+ Safety Net Subcommittee workgroups)	- Comprehensive screening in primary care and other community-based settings - Parent/ caregiver skills training and psycho education - Mental Health First Aid - Anti-stigma campaigns - Wellness and recovery; relapse prevention	- Comprehensive case management (including outreach) - Treatment/service planning	- Primary care and behavioral health integration (in fqhcs and other primary care settings and cmhcs) - Centralized care coordination	- Telehealth / telepsych (including phone only) - Mobile services - Primary care and behavioral health integration	- Medication management in community-based settings, ers, outpatient - Pharmacotherapy (including mat) - Laboratory services	- Intensive case management - Co-responder model - Coordination with social service providers	- Interactive communication devices and apps	- Intensive outpatient for sud and mh - High-intensity treatment services, both home- and community-based (e.G., Assertive community treatment)	- Bh assisted care facilities - Cognitive nursing facilities - Step down services and transitional care support - Increased access to out of home residential placement (based on region and population type)	- Medical detox	- Co-responder - Mobile crisis - Crisis hotline - Crisis stabilization beds / units (with flexibility)	- Peer support - Recovery support coaching - Self-directed care supports
Tier 2 (prioritized by 1 Safety Net Subcommittee workgroup)	- Expanded use and access to existing programs: Safe Talk, ASSIST, Man Therapy - Screening Brief Intervention and Referral to Treatment (SBIRT) - Social determinants of health - Promotional tools for referral	- Wellness /recovery - All hotlines/ resource lines (streamlined to the extent possible) - Client- and family-centered assessments - Info/education - Specialized evaluations - Referrals and warm-handoffs - Tailored to specific populations - Assertive outreach - Crisis aftercare/ outreach (post-hospitalization) - Peer navigator programs - Safe to tell	- Integration of care with all social determinants of health services - Care navigators - Wrap around services - Peer mentorship - Intensive case management - Comprehensive case management	- Traditional outpatient services, including individual evidence based therapies; group therapy; and family therapy - Supported employment - Treatment for co-occurring disorders	-Increase capacity of med-prescribers -Medication costs -Injectable medication access -Increased used of tech for medication adherence -Psychiatric medication evaluation -Poly-pharmacy services for complex needs	Comprehensive care and intensive case management -Collaboration in schools and with local BH providers - Supports to be successful in other programs; life skills building - Permanent supported housing -Supported employment -Wrap around services -Peer support services -Recovery housing	- Respite - Adaptative rehabilitation services - Nontraditional therapeutic - Long-term supports - Trauma-informed rehabilitative care - Respite - Club houses/ drop in - Partnering with community providers - Job skills training - Care coordination across resources - Supported education - Personal care	- Treatment on demand - Secure crisis drop off centers (with no refusal) - Intensive substance abuse service - Services for idd population, regardless if waiting for other services - Intensive case management - Telehealth to support intensive - Flexibility - Partial hospitalization	- Localized residential supports (may need to be subsidized in rural communities) -Therapeutic foster care services) -Clarify differences between MH residential and SUD residential, and short-term vs long-term -Expand capacity for step down treatment -Short term, 30/60 days -Intensive case management to support transitional care and step-down services -Comprehensive SUD residential for adults and youth that is trauma informed	-Long term civil placements -Transition care (to housing, community services, etc.) -Hospital liaison to support diversion -Traditional inpatient -Centralized system for referrals (interactive bed tracking system) -Family supports -Acute treatment centers -Family supports	-First responder training/CIT -Crisis transportation -Hospital liaison -Medical detox -Intensive case management -Walk in crisis / drop off	-Continuing Care for SUD -Recovery support center services -Support groups -Quick access to intensive case management -Use of tech
Tier 3 (other services to include in a robust continuum of Safety Net services)	-Brief motivational interviews -Screening and Brief Intervention for Tobacco Cessation -Wellness and Recovery Action Planning (WRAP) -Risk reduction models -Facilitated referrals -Relapse prevention/ wellness recovery support -Warm line		-General and specialized outpatient medical services -Acute primary care -General health screens, test and immunization -Individual and family support -Comprehensive transitional care	- Consultation to caregivers		-Parent / caregiver support -Care navigators -TBI Services -Behavioral management -Therapeutic mentoring	-Recreational services (including yoga/ stress reduction/ nutrition) -Non-traditional services -Homemaker -Trained behavioral health interpreters	- Social detox - Multi-systemic therapy - Treatment on demand (Denver Health) - Dual diagnosis services	-TEAM approach to civil commitment beds -CIRCLE Program (CMHIP) -Clinically managed 24-hr care -Clinically managed medium intensity care -Therapeutic foster care		- Peer based crisis service - Urgent care services - Step-down crisis stabilization	

IMPLEMENTATION CONSIDERATIONS

Through work developing the Colorado Continuum of Safety Net Services, discussing patient/consumer experience in the system and reflections on public comment and testimonies, a list of barriers and opportunities for the safety net system emerged. To prioritize the work of the subcommittee, members were asked to vote on four "must do" and four "most attainable" opportunities to establish areas of consideration that would both drive and underlie the work of the subcommittee. The multi-vote led to the following areas of focus:

Subcommittee "most attainable" considerations:

1. Telehealth
2. Alignment of licensing
3. Define core safety net services
4. System navigation and Central governance (tied for fourth)

Subcommittee "must do" considerations:

1. Address workforce shortages
2. Central governance
3. Increase access
4. Align funding streams

Workgroups were established to focus on Telehealth, Increased Access, System Navigation, and Workforce Shortages. Subcommittee members decided to defer the work of Alignment of Licensing to DORA's review of the Mental Health Practice Act, the six behavioral health professional boards and the Behavioral Health Entity Implementation and Advisory Committee. Work on Central Governance and Alignment of Funding Streams was incorporated into discussions of CDHS' proposed model for consolidated financing of behavioral health. Defining core safety net services was completed as a full subcommittee.

Due to an increased focus of the State Safety Net Subcommittee on informing a state framework for consolidating behavioral health funding, these identified priority areas did not result in finalized recommendations from the subcommittee. However, the four workgroups drafted considerations for telehealth, system navigation, workforce shortages and increased access that the State of Colorado or a newly established governing behavioral health entity may leverage to guide implementation.

TELEHEALTH CONSIDERATIONS

Expanding the scope of telehealth services will increase access to behavioral health services, particularly to underserved populations in rural demographic and geographic regions. These considerations aim to reduce barriers to treatment for those seeking care, including but not limited to logistical challenges (e.g., schedule/availability, wait lists, transportation, payment) and perceived challenges (e.g., stigma, misconceptions of treatment, negative past experience in therapy). Further, these considerations aim to maximize capacity for clinical services for each clinician, allow for increased flexibility in delivery of services (e.g., groups, more regular brief

check-ins, ongoing periodic assessment of symptom severity) and increase immediacy of service access (i.e., "real time referral"). Most importantly, expanding telehealth may reduce or eliminate the existing health disparities related to both access and outcomes for all community members, especially the most vulnerable populations. Considerations for telehealth expansion should include:

1. Making investments in broadband technology to ensure telehealth and other telemedicine options are available statewide.
2. Considering public-private partnerships and foundation support to improve broadband capacity and pilot expansion of telehealth.
3. Developing policies and rules, as appropriate, for provider training and CME credits that can be made available using online technology.
4. Assessing payment strategies for telehealth services and make recommendations about methods and payments.
5. Maintaining and creating enhanced services using telehealth, with consideration of the following options:
    - Law enforcement co-responder model using telehealth (could also help in areas where there is limited broadband).
    - Home health providers connected to behavioral health providers, for example, psychiatrists for medication assistance.
    - Group therapy, in particular for specific populations, modeled after a successful approach in the Veterans Affairs system.
    - Video chat function for crisis line services.
    - Licensure process for out-of-state telehealth providers.
    - Text-based and app-based platforms.
6. Evaluating and making effective emergency telehealth rules enacted for COVID-19 permanent.

ACCESS CONSIDERATIONS

The primary aim of increased access is to minimize the gap between needing services and acquiring care, such that all individuals with a clinical need, be it basic or essential, receive access that is timely and matches the level of clinical severity. Motivations to expand access also include minimizing degree of distress and burden of mental illness and substance abuse, reducing the number of deaths by suicide, enhancing productivity, quality of life and well-being for all individuals, families and caregivers, and preventing downstream cost and suffering. The following considerations support increased access to behavioral health services in Colorado:

1. Expanding the Co-Responder model of criminal justice diversion. Co-Responder teams consist of two-person teams of law enforcement officers and behavioral health specialists to intervene on mental health-related police calls to de-escalate situations that have historically resulted in arrest, and to assess whether the individual should be referred to immediate behavioral health assessment.

2. Explore new response mechanisms to reduce a police/criminal response to emergency and urgent mental health and social service related 911 calls by dispatching counselors and social workers directly to community; route individuals in need to civil/social service/health systems and not to jail/correctional systems where competency to stand trial issue ever comes into question.

3. Supporting law enforcement management of individuals with behavioral health issues by requiring mental health first aid training for all first responders and law enforcement professionals.

4. Reforming regulations and contract requirements to support trauma-informed and problem-focused assessment.

5. Identifying flexible funding to support minimum intake, assessment, intervention, and referral requirements regardless of payer.

6. Reviewing and, if necessary, reforming regulations to eliminate or streamline requirements for providers to "open" and "close" clients.

7. Expanding transportation services for routine (non-emergency) behavioral health care for all populations and ensuring that transportation models are flexible to encourage behavioral health responsive operations. This includes enhancing the Non-emergent Medical Transportation benefit in Medicaid to include this type of transportation for behavioral health services.

8. Increasing reimbursement and utilization of behavioral telehealth solutions that wrap around and support other services to minimize place as a barrier to care. This includes investigating potential platforms to increase provider capacity, e.g., online forums supporting group telehealth and/or app-based platforms for individuals to engage in treatment between sessions and to allow providers to track outcomes.

9. Expanding and creating additional housing-first models that ensure an individual's basic needs are met and individuals are stabilized prior to expectations to engage in treatment.

10. Creating training opportunities for and invest in two generation (2gen) models to ensure the entire family system is adequately engaged in relevant treatment modalities.

11. Developing a Colorado-focused model of comprehensive care and cost-based reimbursement akin to the Certified Community Behavioral Health Clinic model to facilitate increased access to care, reimbursing providers for the total cost of care, and reducing administrative burden by creating a streamlined and more uniform system of data collection and reporting.

12. Requesting support from the Attorney General's Office and DOI to work with community behavioral health providers to identify access barriers for community members with private insurance, and enforcing network adequacy and parity.

SYSTEM NAVIGATION CONSIDERATIONS

The following considerations will support increased access to behavioral health services and easier navigation of the full continuum of services:

1. Systematically defining, reviewing, and cataloging existing efforts in Colorado to enhance care navigation and assess potential benefits and consequences to consolidating initiatives.
2. Supporting regional expansion of the 211 system and connecting to the 988 national suicide hotline for entry to the behavioral health system.
3. Identifying and supporting a single point of entry to behavioral health services.
4. Supporting navigators that possess knowledge of available behavioral health and developmental disability services and coordinate these services across regional systems in a culturally and linguistically appropriate manner. These navigators will also facilitate navigation in other regions if necessary and appropriate.
    - Establishing a system in which navigators are assigned to a family unit.
    - Developing a certification process for navigators and ensure that peer support is a component.
    - Developing processes for information sharing across systems that ensures compliance HIPAA, FERPA, 42 CFR part 2 (e.g., development of a single consent form).
    - Developing a process to ensure quality of navigation services.
    - Exploring technology-based solutions to support enhanced navigation (i.e., apps for smart phones).

WORKFORCE SHORTAGE CONSIDERATIONS

The issue of workforce shortages which contribute to gaps in access to care across the state was elevated by the Safety Net Subcommittee, identifying the following priorities:

1. Invest in a continuum of workforce strategies, from cultivation (i.e., scholarships and tuition costs to incentivizing supervisors) to retention (i.e., loan repayment programs and care progression opportunities).
2. Modernize the workforce to meet current and future behavioral health needs:
    - Seek feedback from tomorrow's workforce and develop jobs and systems where they want to work
    - Allow more flexibility in funding to respond to community, cultural and market expectations
    - Create training, certification, and reimbursement structures to support peers and non-traditional community health workers
    - Develop workforce for prevention and promotion, and to strengthen integrated care
    - Ensure providers are trained to provide culturally competent care to diverse populations

3. Address low salaries and cover cost of care to ensure value matches priority.
4. Consider workforce needs in the design of any proposed behavioral health authority model to prevent clinician burnout from administrative responsibilities by aligning requirements (credentialing, reimbursement, quality report, documentation standards) with Medicaid.
5. Invest in peer support programs across the continuum of services and create pathways for billing Medicaid and other payers.

The Children's Behavioral Health Subcommittee voted on a set of workforce recommendations as the Safety Net Subcommittee prioritized and began to address safety net workforce needs. In addition to the priorities specified above, State Safety Net Subcommittee members reviewed the Children's Behavioral Health Subcommittee package of workforce recommendations and support those recommendations to invest, build, and retain a robust workforce of licensed and unlicensed behavioral health providers and staff necessary to ensure all Coloradans may access high quality behavioral health services and supports.

PROPOSED SAFETY NET MODEL

Significant meeting time was dedicated to reacting and providing revisions to a proposed Safety Net model developed by CDHS. The proposed model was first introduced to the subcommittee on 1/16/2020 in response to previous discussions of the system's complexity and multiple funding streams. Lessons learned from other states' efforts to redesign their behavioral health systems were also presented. Subcommittee members' input was incorporated for presentation to the full task force and subcommittees on 1/24/2020. The next State Safety Net Subcommittee meeting then focused on discussing further considerations for the proposed model, including consumer experiences captured in public testimony. The Colorado Behavioral Healthcare Council also presented a proposed model to re-appropriate and integrate behavioral health resources. These discussions resulted in the following considerations for CDHS in the redesign of Colorado's behavioral health system.

Highlighted opportunities a new administrative structure should consider:

- Individuals should receive services regardless of payer (reduce the 60+ "wrong doors")
- Care coordination
- Opportunity to establish a minimum set of services
- Timely access
- Centralized navigator that is accessible to individuals/families

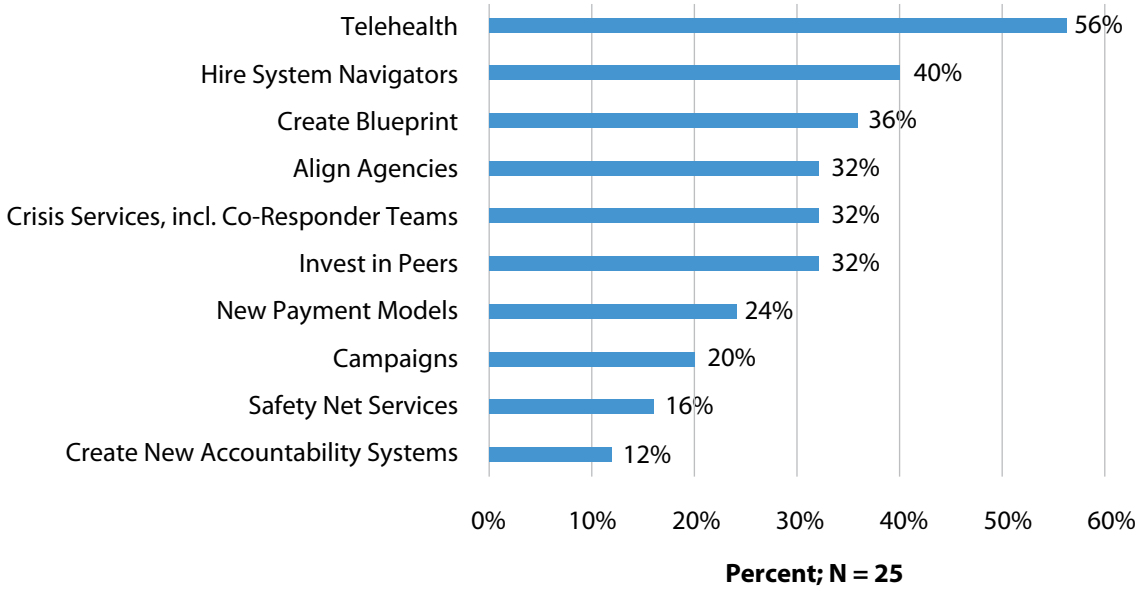
In offering guidance and identifying areas of concern, the State Safety Net Subcommittee suggests the new administrative structure needs to:

- Be integrated with HCPF and the Regional Accountable Entities
- Develop standards and measures for care delivery and provider accountability
- Assure that resources are not taken from direct services to support administrative costs
- Create an external appeals process and accountability system
- Establish a process to ensure the administrative service organization does not become a "dumping ground" for insurance companies
- Define system "guardrails" that are mandates, not guidelines
- Address the experience for individuals with intellectual and developmental disabilities (IDD)

PRIORITIES FOR NEXT 12 MONTHS

Since many of the recommendations proposed by the State Safety Net Subcommittee will require significant time to implement and demonstrate outcomes, members were asked to prioritize actions that could be executed in the next 12 months that would lead to immediate improvements in the behavioral health system. Via survey and in-meeting polling, subcommittee members prioritized actions that were most feasible to implement in the next 12 months and that would yield positive impact for individuals and families.

Figure 6. State Safety Net Subcommittee Priorities for Immediate Focus



Note: percentages reflect number of subcommittee members that indicated this priority in their top three.

Long Term Competency Subcommittee

CDHS is legally responsible for providing competency evaluation or restoration services to individuals who have been court ordered to receive an evaluation of competency to proceed or found incompetent to proceed and are to receive competency restoration treatment. Between FY 2000-01 and FY 2018-19, Colorado has seen a 664% increase in the number of court orders for competency evaluations and a 1,634% increase in the number of court orders for competency restoration services. CDHS has been unable to meet the ever-growing demand for inpatient competency evaluation and restoration services, despite significantly increasing treatment capacity. In 2011, Disability Law Colorado sued the state in federal court alleging the length of time defendants were waiting in jail to receive services violated their constitutional rights. After eight years of litigation, the two parties entered into mediation in March 2019 and reached a Consent Decree, which outlines a comprehensive approach to addressing this crisis.[21]

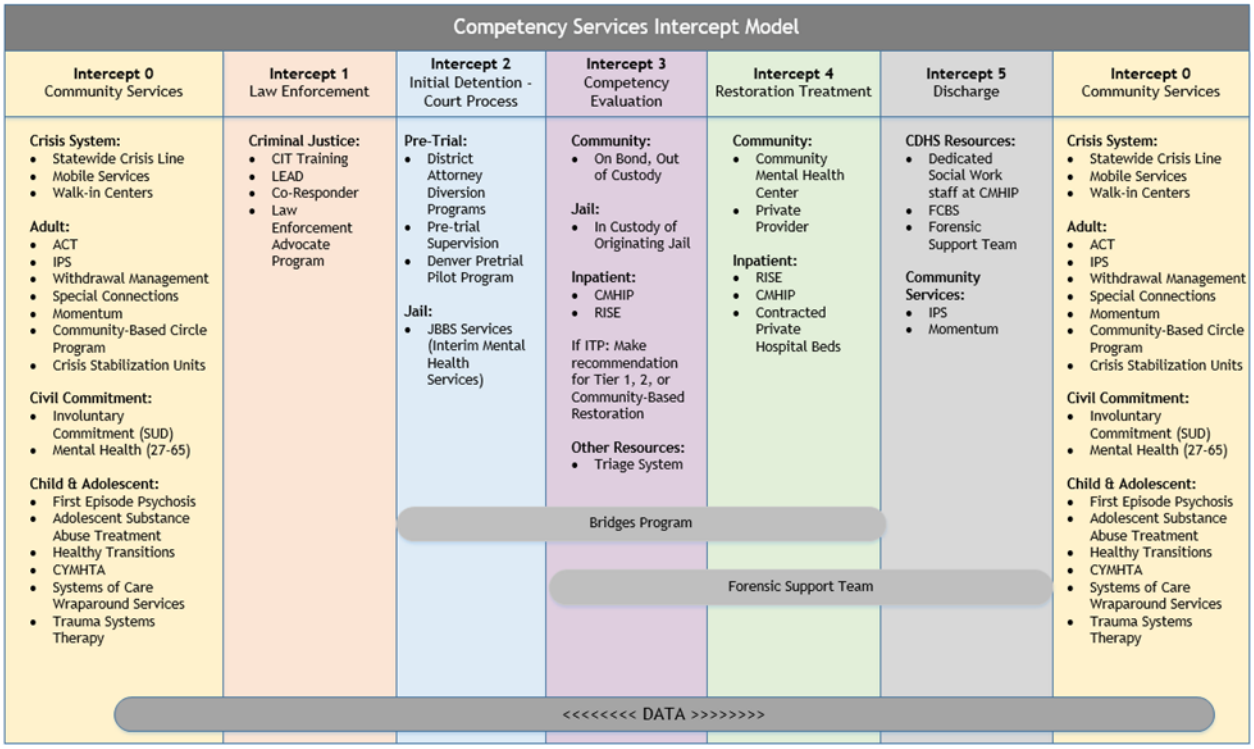
In response to an initial Comprehensive Plan for Compliance submitted in 2018, the Consent Decree required revisions to provide a more comprehensive and cohesive plan by or about January 2020. This second plan, the Long Term Comprehensive and Cohesive Competency Plan,[20] was to result from a long-term visioning process with Disability Law Colorado, the court appointed Special Masters and stakeholders to consolidate pieces of the current plan, along with legislative initiatives into a cohesive package for courts, administrators, service providers and legislators to consider. The aforementioned stakeholder group is represented by members of the Long Term Competency Subcommittee.

Per the Consent Decree, the revised Long Term Comprehensive and Cohesive Competency Plan will address each of the following points:

1. Reducing the emphasis on inpatient beds and increasing the emphasis on community beds
2. Further prioritizing outpatient competency restoration treatment
3. Prioritizing a triage approach (i.e. prioritizing inpatient admissions based on acuity) over a traditional waitlist approach
4. Making better use of data and ensuring reliable access to data
5. Creating a central system of easily accessible information for stakeholders
6. Prioritizing quality, even amid quantity and time pressures

The Long Term Comprehensive and Cohesive Competency Plan uses the framework of the Sequential Intercept Model, a strategic planning tool used to develop a comprehensive picture of how people with behavioral health issues and SUD flow through the criminal justice system along distinct intercept points: Intercept 0: Community Services, Intercept 1: Law Enforcement, Intercept 2: Initial Detention – Court Process, Intercept 3: Competency Evaluation, Intercept 4: Restoration Treatment, Intercept 5: Discharge.[22] Figure 7 describes competency specific services across the Intercept Model. Subcommittee recommendations were made and prioritized across these six individual intercepts of the Sequential Intercept Model, with Intercept 0 (Community Services) represented at both the beginning and the end of the model.

Figure 7. Competency Services Intercept Model



Mandates from Governor Polis

Consistent with a recent consent decree entered into by the Department of Human Services, this subcommittee should address the following:

1. The development of a comprehensive picture of the system of services and resources available for individuals in the criminal justice system who have been found incompetent to proceed (ITP);
2. The framework of a statewide strategic blueprint for competency and the first set of recommendations that aligns with the CDHS' consent decree, to include:
   - A priority emphasis on prevention and diversion efforts;
   - Recommendations on restoration services specifically designed for persons with intellectual or developmental disabilities;
   - Recommendations for short-term and long-term solutions, with an emphasis on expanding community-based solutions first, when appropriate;
   - Projections of competency evaluation and restoration needs over the next 20 years, and an understanding of the trends that impact need;
   - Legislative recommendations (if needed) to implement the plan, along with removing barriers or providing support to aspects of the plan;
   - Costs associated with implementation; and
   - Possible funding mechanisms, including leveraging non-state dollars.

Legislative Mandate - Senate Bill 19-223

Colorado Senate Bill 19-223 addresses issues related to competency to proceed in a criminal trial. When a defendant's competency to proceed is raised, the act:

- Changes the timing of various matters;
- Clarifies where restoration services are to be provided;
- Expands the requirements for a competency evaluation report; and
- Clarifies when defendants are to be released following an evaluation or restoration services.

The act requires the department of human services to:

- Develop an electronic system to track the status of defendants for whom competency to proceed has been raised;
- Convene a group of experts to create a placement guideline for use in determining where restoration services should be provided; and
- Partner with an institution of higher education to develop and provide training in competency evaluations.

On and after January 1, 2020, except for certain certified or certification-eligible evaluators, competency evaluators are required to have attended training. District attorneys, public defenders, and alternate defense counsel are also to receive training on competency to proceed.

The act also provides that a competency evaluator is not liable for damages in any civil action for failure to warn or protect a specific person or persons against the violent behavior of a defendant being evaluated.

The act appropriates general fund dollars to pay for fines, liquidated damages, costs, attorney fees, and special master compensation due to a consent decree agreed to by the state. It also appropriates additional money from the general fund and from reappropriated funds to the department of human services and the judicial department to implement the act.

This legislation guided the work of the Long Term Competency Subcommittee as they considered recommendations to address competency concerns across the Competency Services Intercept Model.

Guiding Principles

The Long Term Competency Subcommittee drafted the following statement of values for inclusion in the Long Term Comprehensive and Cohesive Competency Plan to guide their work and recommendations:

The subcommittee submits the recommendations within our duties and obligations as a subcommittee to the Behavioral Health Task Force to review and recommend solutions to improve the systems related to individuals who are arrested for crimes and present issues of competency. In so doing, the subcommittee prioritized the requirement that CDHS provide the federal court with a cohesive comprehensive plan pursuant to its obligations from the Consent Decree in which Disability Law Colorado sued CDHS over its failings to individuals in the competency process. Thus, this report (Long Term Comprehensive and Cohesive Competency

Plan) focuses on CDHS-directed action steps to resolve the problems identified throughout the course of the lawsuit. We acknowledge the strengths and limitations of such a focused purpose while also advocating for a collaborative, strategic vision to end the criminalization of people living with behavioral health disorders, no matter one's age or identity. Resolution and change toward this vision must be systemic, and the subcommittee discussed the following broad reforms in various areas warranting ongoing improvement and advocacy:

- Early identification of behavioral health concerns (across the lifespan) and criminogenic risk factors, paired with a systems-oriented response to provide preventative healthcare and social support services;
- Guaranteed and easily accessible options for behavioral health care and related supports available in the community prior to and after involvement in the criminal justice system;
- Accessible and inclusive housing options that prevent homelessness and rapidly re-house individuals when needed;
- Transportation and other accessibility solutions to connect individuals and families with needed service, be they healthcare oriented or otherwise, to promote health and wellbeing;
- Telehealth and strong information sharing via health information exchanges to improve access to care and sharing of information between providers; and,
- Collaborations with public health, public safety, corrections, and a wide variety of funding systems to develop a cohesive, health-promotion, recovery oriented, statewide approach.

While these topics generated debate and critical dialogue, the subcommittee finds it important to acknowledge that, despite diverse representation, there are limitations to the scope of what could be accomplished and or addressed. Furthermore, the subcommittee recognizes that such systematic solutions will require cross-departmental collaboration within Colorado's multi-governmental structure and will not always be actionable for CDHS alone.

In acknowledging the importance of the need for strong community-based mental health services to limit the need for criminal justice involvement, the subcommittee is committed to continuing study of these opportunities, engaging with the appropriate stakeholders, and promoting action that is inclusive and reflective of all voices in Colorado beyond the submission of this report. The subcommittee recognizes that for many individuals where competency has been raised, there is an opportunity to divert them away from the criminal justice system with systemic solutions, therefore reducing the demand on the competency services system. To this point, the subcommittee recognizes that the intensity and quality of behavioral health services in the criminal justice system should be matched or exceeded by community-based services to avoid a pipeline to the criminal justice system to obtain essential services.

Additional learning opportunities to support and align recommendations were presented to the subcommittee including a presentation from the court-appointed Special Masters who would review and approve the Long Term Comprehensive Plan, and a webinar to provide an overview of the approach that Los Angeles County is taking to support mental health courts to address delays in competency evaluations and restoration treatment.

Subcommittee members worked diligently together to reach agreement and approval of final recommendations. This group hosted rigorous and respectful debate, reflecting multiple perspectives, including a judge, a district attorney, a public defender, members of law enforcement, consumers of services, and representatives from several advocacy organizations and state agencies. Through thoughtful discussion, this diverse group of individuals focused on client-centered solutions that

considered the rights of those at risk for interaction with the criminal justice system. To this end, the subcommittee heard from a consumer panel prior to the submission of the Long Term Comprehensive and Cohesive Competency Plan to hear directly from individuals who have experienced incarceration or hospitalization on how recommendations and resulting policy directly affect the health and well-being of individuals and families. The subcommittee focused not only on behavioral health services that occur after arrest, but also on how to prevent high risk individuals from entering the criminal justice system by enhancing services available in the community.

The Long Term Competency Subcommittee identified additional priorities to more comprehensively address community-based solutions related to minimizing the likelihood that individuals with behavioral health issues and SUD would interact with the criminal justice system, explicitly focusing on how to appropriately treat these individuals in the community to prevent interactions with law enforcement and the judicial system. The subcommittee also drafted concepts that led to the development of Colorado Senate Bill 20-181, to help ensure that people are not held in jail when competency is in question and they have a low-level crime or if, regardless of charge, due to severe disability, restoration is unlikely.

Long Term Competency Subcommittee Recommendations

LONG TERM COMPREHENSIVE AND COHESIVE COMPETENCY PLAN

In September, October and November of 2019, the Long Term Competency Subcommittee voted on and approved 38 recommendations across the intercept model to be included in the Long Term Comprehensive and Cohesive Competency Plan.[20] At the request of the main Task Force, the subcommittee revisited and prioritized these recommendations in June 2020. Below, recommendations are listed by intercept as prioritized by the subcommittee members. The original recommendation numbers as indicated in the Long Term Comprehensive and Cohesive Competency Plan is reflected within parentheses. The complete Long Term Comprehensive and Cohesive Competency Plan is available here.

INTERCEPT 0: COMMUNITY SERVICES

1. **(Recommendation 1)** Expand and enhance the crisis services system, including crisis drop-off centers, to ensure we are diverting people with behavioral health issues from the criminal justice system to the behavioral health system.

2. **(Recommendation 2)** Enhance, expand, and connect services for individuals at risk of institutionalization or criminal involvement, such as co-responder models, wraparound services, and ACT, to facilitate behavioral health interventions before these individuals come into contact with law enforcement.

3. **(Recommendation 3)** The Department shall ensure that contracts for competency services are bundled with other needed safety net services, and explore opportunities to further fund needed ancillary services that support good restoration outcomes.

INTERCEPT 1: LAW ENFORCEMENT

1. **(Recommendation 6)** The Department shall evaluate models and seek appropriate resources and legislation if necessary to develop secured treatment settings and Behavioral Health Adult Assessment Centers where adults, upon arrest, can be assessed/screened for behavioral health needs and criminogenic risk, and then placed in the appropriate system of care/intervention.

2. **(Recommendation 5)** The Department shall work with the Department of Public Safety and other state agencies to secure resources to expand CIT training (or similar training) for Colorado first responders, court security, and corrections staff, and provide continuing education to ensure officers are well equipped to safely intervene in a mental health crisis and to divert those in crisis to the behavioral health system and away from additional, unnecessary charges and further incarceration.

3. **(Recommendation 7)** The Department shall engage jails to understand and respond to feasibility concerns to developing community-driven and locally responsive interim jail mental health services for defendants.

4. **(Recommendation 4)** The Department shall continue to work with the Long Term Competency Subcommittee to ensure recommendations for legislation so that effective, appropriate, timely and continuous behavioral health services, including medication management, are provided for individuals who are currently in jail.

5. **(Recommendation 8)** The Department shall consider asking the legislature for increased funding for jail-based behavioral services, including medication management and services to maintain competency, to accompany potential legislation to be recommended by the Long Term Competency Subcommittee.

INTERCEPT 2 – INITIAL DETENTION/COURT PROCESSES

1. **(Recommendation 9)** The Department shall explore requesting resources for all jails to have in-person or tele-capacity to conduct screenings and behavioral health services upon intake by qualified behavioral health providers. The Department shall develop standards as to what qualifies as a behavioral health provider. While it is preferred for pretrial defendants to have in-person services, the Long Term Competency Subcommittee recognizes that resource and access limitations may require services to be delivered via tele-health. The Department shall seek to coordinate with other legislative bodies exploring improved telecommunication systems for jail so as not to duplicate efforts and funding.

2. **(Recommendation 10)** The Department shall work with the State Court Administrator's Office to consider seeking additional resources to create and/or expand pretrial supervision and case management services for defendants requiring competency services in an effort to provide services in the least restrictive setting. Services to include court reminders, appointment reminders, and transportation.

3. **(Recommendation 13)** The Department will explore collaborations with local courts to better integrate the availability, access, and delivery of mental health and collateral services by utilizing a community justice center model, where appropriate, in part to divert people with mental illness away from the criminal justice system where their needs can be met and risks mitigated through other community-based resources.

4 **(Recommendation 12)** The Department shall continue to use the Sequential Intercept Model to guide decision making and resource allocation for efforts to enhance the interface and outcomes of the behavioral health and criminal justice systems, and cooperate with the Office of the State Court Administrator and local judicial districts and other state agencies in the use of the model.

5 **(Recommendation 11)** Expand Bridges and Forensic Support teams to provide competency navigation support and stability in the community to meet the needs of released individuals and defendants with potential for release such that judicial officers will increase release decisions. Continue to engage with attorneys in the criminal justice community to maximize the efficacy of Bridges and FST.

6 **(Recommendation 15)** The Department shall continue to work with The Long Term Competency Subcommittee in identifying the need for potential legislation to eliminate unnecessary competency evaluations for people determined Permanently Incompetent to Proceed, those with Intellectual or Developmental Disabilities or Traumatic Brain Injury, or other conditions which result in permanent incompetence.

7 **(Recommendation 14)** The Department shall work with key stakeholders to explore legislation to monitor and continue care for individuals to ensure s/he maintains competency through the court process after a finding that individual is competent or competency has been restored.

8 **(Recommendation 16)** The Department will work with the Long Term Competency Subcommittee in identifying any need for potential legislation for alternatives to the competency process for those with low-level offenses. Any legislation shall address how to meet the behavioral health needs of these individuals.

INTERCEPT 3: COMPETENCY EVALUATION

1 **(Recommendation 17)** The Department shall provide universal training to Judicial Officers, District Attorneys, Defense Attorneys and Guardians Ad Litem to increase understanding of the competency assessment and restoration process, including the availability and extent of services and supports that can be provided in the community versus in jail, and the consequences and cost of using jails to treat and warehouse persons living with mental illness.

2 **(Recommendation 18)** The Department shall collect data, including stakeholder input, on community-based referrals to understand drivers of low referral rates and resources needed to increase court referrals for community restoration.

3 **(Recommendation 20)** The Department shall implement a mandatory annual training in accordance with 16-8.5-122 for evaluators contracted by or managed by the Department in an effort to increase the quality and consistency of evaluations.

4 **(Recommendation 21)** The Department shall continue to provide more information and education to the local courts regarding competency evaluations and community-based options in an effort to increase the number of individuals referred to community-based services if appropriate.

5 **(Recommendation 19)** In an effort to explore opportunities to stabilize an individual prior to the initial court hearing, the Department shall begin by providing subcommittee members with existing jail-based services funding contracts and related statute to facilitate a recommendation to identify individuals who are at risk of being deemed incompetent to proceed as soon as possible.

6 **(Recommendation 22)** The Department shall explore and implement an information sharing process that ensures complete privacy and HIPAA compliance to allow key stakeholders to access information about an individual ordered for competency services.

INTERCEPT 4: RESTORATION TREATMENT

1 **(Recommendation 23)** The Department shall develop comprehensive outpatient restoration treatment programs able to serve higher-risk and higher-need defendants to include a continuum of behavioral health interventions and medication management. Comprehensive programs may include housing, transportation, and other social supports. (Recommendation 29) The Department shall design and implement a quality improvement process for inpatient restoration services that addresses their efficiency, optimum length of stay, and individualized treatment plans.

2 **(Recommendation 25)** The Department shall collect and analyze data to understand the prevalence of housing issues as barriers to success in the community to inform recommendations to the legislature for funding, as appropriate.

3 **(Recommendation 26)** The Department shall actively engage efforts to remove housing as a barrier to completing community restoration services in the community. The Department shall leverage work of the Taskforce Concerning Treatment of Persons with Mental Health Disorders in the Criminal & Juvenile Justice Systems (MHDCJJ) and others in the state, such as Mental Health Center of Denver's pilot program, to develop a strategy for housing for defendants ordered to competency services and for whom housing is the key barrier to success in the community.

4 **(Recommendation 27)** Based on the outcomes of the Denver Pilot, the Department shall request the necessary resources for these services to be available statewide, and, if necessary, the Department shall approach State Court Administrator's Office (SCAO) about jointly seeking resources so that all judicial districts have pretrial services to serve this population. Work with SCAO to ensure pretrial case managers are provided training to work with individuals with mental health needs. The model for outpatient restoration services shall include outpatient competency restoration services such as the Assertive Community Treatment (ACT) model (or similar evidence-supported intensive case management models) and pretrial supervision services.

5 **(Recommendation 24)** The Department shall, with appropriate awareness of civil beds in the state, contract with community or non-state hospitals to provide competency services for individuals with high clinical acuity in order to ensure people are getting the right level of care while the Department retains and provides proper oversight.

6 **(Recommendation 29)** The Department shall design and implement a quality improvement process for inpatient restoration services that addresses their efficiency, optimum length of stay, and individualized treatment plans.

7 **(Recommendation 28)** The Department shall work with HCPF and other stakeholders to explore the development of community-based services and programs dedicated to specific populations in need (IDD, dementia, etc.) to ensure their unique needs are being met and to reduce the number of individuals deemed incompetent to proceed ordered for inpatient services.

8 **(Recommendation 32)** The Department shall encourage judicial districts' interest in developing and piloting court dockets specific to competency (Competency Dockets) to increase the flexibility of court dates so individuals can have their court hearing quickly after being opined competent to proceed or incompetent to proceed. The Department shall support interested judicial districts in developing these specialized dockets, with emphasis on those judicial districts that have the greatest amount of competency examination referrals.

9 **(Recommendation 30)** The Department shall assess the availability of existing transportation services to ensure that individuals in community-based restoration services are able to attend appointments for restoration services, mental health treatment, and court related appointments. Based on this assessment the Department shall consider the request of the necessary resources to eliminate transportation barriers to make these appointments, including the availability to utilize telehealth as an option for individuals to receive services as needed.

10 **(Recommendation 31)** The Department shall work with the Long Term Competency Subcommittee to explore state administered services to fulfill the continuum of care that is less restrictive than inpatient level of care, more restrictive and intensive than outpatient services, and has some security features to account for public safety. This secure treatment level of care should be available for both civil and forensic populations.

11 **(Recommendation 33)** The Department shall work with the court and parties to identify an upcoming discharge date and initiate the discharge process for each patient as early as possible to decrease the time a CMHIP patient waits to discharge due to discharge barriers.

12 **(Recommendation 34)** The Department shall consider legislation that ensures that all safety net providers contracting with the Department have the resources and workforce to provide Community-Based Restoration Treatment and behavioral health services as needed. Specifically, based on the outcomes of the Denver Pilot, that behavioral health services and restoration services shall be paired together in a singular treatment plan and service delivery. The goal is to coordinate restoration services and behavioral health services to restore persons faster while also providing for their ongoing health and maintenance of competency.

INTERCEPT 5: DISCHARGE

1 **(Recommendation 36)** The Department shall collaborate with HCPF to seek resources to expand Assertive Community Treatment (ACT) if clinically indicated for competency individuals being discharged from a psychiatric hospital to ensure they are receiving the support and treatment they need to be successful after discharge. The Department shall develop a workforce strategy to staff ACT teams.

2 **(Recommendation 35)** Based on the outcomes of the housing program with Colorado Coalition for the Homeless, the Department shall seek resources to extend and, based on need, expand housing services and other collateral services beyond the already funded initial five years. The Department shall request funds to evaluate the efficacy and cost of the program and shall consider any such program in future housing strategy.

3 **(Recommendation 38)** The Department shall collaborate with HCPF to seek resources to expand Assertive Community Treatment (ACT) if clinically indicated for competency individuals being discharged from a psychiatric hospital to ensure they are receiving the support and treatment they need to be successful after discharge. The Department shall develop a workforce strategy to staff ACT teams.

4 **(Recommendation 37)** Every three years, the Department shall assess the accessibility and effectiveness of a continuum of treatment services, including for co-occurring disorders, for individuals receiving competency services in the community and assess the impact to non-justice involved citizens requiring community-based care.

As the Long Term Competency Subcommittee drafted recommendations to support equitable access to behavioral health services in jails, the following was approved to improve the efficiency of competency processes. **WE RECOMMEND** a multi-stakeholder process, including behavioral health providers, competency evaluators, judicial representatives, and individuals with lived experience, to develop a more efficient competency process, such as a competency court or docket, or a standard competency report (report from BH providers/comp evaluator) that focuses on increasing quality and decreasing burden, that judges and courts approve in each jurisdiction.

LEGISLATIVE OPPORTUNITIES

On June 29, 2020, the first piece of legislation derived from work of the BHTF, SB 20-181, was signed into law by Governor Polis. SB 20-181 helps ensure individuals are not held in jail when facing low-level charges and competency is in question or when restoration is unlikely due to a severe disability regardless of the charge. The Long Term Competency Subcommittee drafted concepts that were approved by the BHTF, and then worked with primary sponsors, Senator Pete Lee and Representative Michael Weissman, on SB 20-181: Measures to improve outcomes for defendants who may be incompetent to proceed.

CONCEPT 1 (MUNICIPAL COURT):

When a person has been arrested and charged with a municipal offense and competency has been found by the court or where the defendant is civilly committed, the court shall dismiss the charge. These are very low violations, typically traffic offenses.

CONCEPT 2 (MISDEMEANOR CHARGES):

A person who is in jail on a misdemeanor charge and is found ITP and does not meet an inpatient level of care should be ordered for outpatient restoration treatment; the court must presume releasing the individual on a Personal Recognizance bond or demonstrate by clear and convincing evidence why it is an extraordinary circumstance for not doing so. A bond hearing must take place within seven days of being found incompetent.

CONCEPT 3 (MISDEMEANOR CHARGES):

In addition, this legislation expands the current provisions for non-victims' rights misdemeanors to victims' rights misdemeanors, specifically the provisions that state if the defendant is found incompetent, detained on a misdemeanor, and restoration efforts fail after six months, the court shall dismiss the charges. The legislation also allows a court to dismiss charges against a defendant if they are found ITP and are civilly committed, even if the charges involved victim's rights crimes.

CONCEPT 4 (NO PROBABILITY OF RESTORATION):

If a person is arrested, charged with a crime, competency is raised, the court orders a competency evaluation and an evaluator opines the person is incompetent and it is unlikely that the person will be restored within the reasonably foreseeable future based on:

- An evaluation completed in the last 5 years that determined the person is unlikely to be restored within reasonably foreseeable future OR
- A diagnosis of a moderate to severe cognitive disability (IDD, brain injuries, dementia), that alone or together with a co-occurring mental health issue impacts a person's ability to attain or maintain competency OR
- A person who has been found ITP 3 times in the prior 3 years on the current case or another, even if regaining competency at portions of time, but who slips back to incompetency.

Then, the court shall presume that the individual is unlikely to be restored to competency and maintain competency and shall dismiss the pending criminal charges and order the person's release from criminal custody. If the court finds after a hearing that despite the evaluator's findings, there is clear and convincing evidence that the individual may regain and maintain competency and makes findings of fact on record to support that, the court may order restoration services for a maximum period of 91 days. After 91 days of restoration education, if the individual has not been restored, it will be presumed that the individual is unlikely to regain and maintain competency in the reasonably foreseeable future and the individual shall be presumed to be released. If they are not released, periodic reviews will resume, always carrying the presumption of incompetency and dismissal.

DIVERSION

Diversion recommendations are being put forward from the Long Term Competency Subcommittee to support prevention of reoccurring interaction with law enforcement and the criminal justice system for individuals at high risk because of behavioral health concerns.

PRE-ARREST/PRE-CHARGE

1. In order to prevent reoccurring interaction with law enforcement by individuals whose clinical conditions put them at high risk (e.g., those with high intensity needs, medication non-adherence, persistent and severe mental illness, continuous criminal engagement) and connect individuals in need with treatment before a behavioral health crisis begins or at the earliest possible stage of system interaction, **WE RECOMMEND** investment in

a sustainable safety net continuum of behavioral health services that ensures cohesion between substance use and mental health stabilization services that provide timely access to appropriate services and keep individuals engaged in those services, which shall include:

- A full continuum of services as laid out by Substance Abuse and Mental Health Services Administration and supported by State Safety Net Subcommittee, includes supported work, day treatment and comprehensive case management to provide follow up and support adherence.
- Expansion and modification of current crisis stabilization units and withdrawal management licensure requirements that address the bifurcation between the two systems and allow for treatment of individuals experiencing a co-occurring crisis.
- Investment in crisis line expansion and response resources to reduce mental health crisis response wait times. This includes an expanded capacity of crisis line to manage re-routed 911 calls that require a Co-Responder response or does not require a law enforcement or paramedic response.
- In instances in which a law enforcement response is necessary, a statewide expansion of the Co-Responder model of criminal justice diversion to more communities. Co-Responder teams consist of two-person teams of law enforcement officers and behavioral health specialists to intervene on mental health-related police calls to de-escalate situations that have historically resulted in arrest, and to assess whether the individual should be referred to immediate behavioral health assessment.

PRE-PLEA

1. To support individuals to successfully navigate the judicial system and match up the appropriate risk and need to the appropriate supervision and services, **WE RECOMMEND** intensive case management and pre-trial supervision as outlined by recommendation 10 in the Long term Comprehensive and Cohesive Competency Plan to seek additional resources to create and/or expand pre-trial supervision and case management services for defendants requiring competency services in an effort to provide services in the least restrictive setting. Services to include court reminders, appointment reminders, and transportation.

2. In alignment with the Long Term Comprehensive and Cohesive Competency Plan to consistently support diversion to community services when appropriate and not contrary to public safety concerns, **WE RECOMMEND** a safety net system that is required to serve this high risk pre-plea population and provide an adequate level of support, have a defined process by which law enforcement and courts can interact with the safety net system as described above and be assured and informed of services available to help this population to survive and be successful in the community.

3. In lieu of jail, to provide safe alternatives for the appropriate placement of an individual interacting with law enforcement for those that are experiencing behavioral health symptoms and are not appropriate for immediate return into the community and need secure assessment, **WE RECOMMEND** investment in behavioral health assessment centers; secure treatment centers in lieu of jail that provide a mechanism for law enforcement to consult with professionals to stabilize, screen, assess and determine the optimal placement of individuals that may not belong in jail.

4 **WE RECOMMEND** offering an outpatient treatment diversion option pre-plea, with successful completion of treatment plan resulting in dropped charges, per the following Assisted Outpatient Treatment (AOT) pathway produced by the Equitas Model Law Workgroup:

- A petition for involuntary civil commitment for either inpatient treatment or AOT when it is determined that the person meets criteria for involuntary treatment and continues to be unable to participate in needed treatment on a voluntary basis. The decision whether to seek involuntary civil commitment on an inpatient or outpatient basis shall be based on an assessment of the level of care and supervision required by the individual as well as the availability of resources to provide such care. If a civil commitment petition for involuntary inpatient or outpatient mental health treatment for an individual is filed, the individual may remain in the treatment facility pending a hearing (set timeframe). Treatment should continue as allowed by state law.

POST-PLEA

1 In order to effectively process individuals with identified behavioral health concerns through the judicial system and match risk with need with appropriate level of supervision, **WE RECOMMEND** creation or expansion of behavioral health court/dockets with a focus on high risk/high need defendants. Mental health courts provide higher levels of intervention in both misdemeanor and felony charges and based on level of risk to support individuals who may be at risk for incarceration due to underlying behavioral health diagnoses.

2 To provide continuity of behavioral health services post-plea, **WE RECOMMEND** processes be put in place to support a timely warm hand-off to and from Jail-based Behavioral Health Services (JBBS), including case management services with mechanisms for ongoing process improvement with all relevant stakeholders to ensure coordination and collaboration.

CIVIL COMMITMENT

1 Because the under-utilization of involuntary outpatient treatment is likely related to the reliance on the criminal justice system as a mechanism to get treatment, **WE RECOMMEND** reviewing the requirements for pursuing civil commitment filings in Colorado to consider if modifying the standard for civil commitment is needed to minimize the reliance on the criminal justice system. Any consideration for changes to outpatient involuntary treatment should include diverse stakeholder groups, including representation of consumers and consideration of other state models.

ASSISTED OUTPATIENT TREATMENT

As defined by the Treatment Advocacy Center and Northeast Ohio Medical University, October 2019 white paper, Implementing Assisted Outpatient Treatment: Essential Elements Building Blocks, and Tips for Maximizing Results,[23] Assisted Outpatient Treatment (AOT) is the practice of providing community-based behavioral health treatment under civil court commitment, as a means of: (1) motivating an adult with mental illness who struggles with voluntary treatment adherence to engage fully with their treatment plan; and (2) focusing the attention of treatment providers on the need to work diligently to keep the person engaged in effective treatment. AOT has been demonstrated to reduce hospitalization, homelessness, arrests and incarceration, violence, crime, and victimization. It has also been demonstrated to improve treatment compliance, substance abuse treatment outcomes, and caregiver stress.

An AOT program is defined by its "essential elements," as a systematic, organized effort to:

1. identify individuals within the service area who appear to be persistently non-adherent with needed treatment for their behavioral health diagnosis and meet criteria for AOT under state law;
2. ensure that whenever such individuals are identified, the behavioral health system itself takes the initiative to gather the required evidence and apply to the court for AOT, rather than rely on community members to do so (although community members should not be impeded from initiating an AOT petition or investigation where permitted by state law);
3. safeguard the due process rights of participants at all stages of AOT proceedings;
4. maintain clear lines of communication between the court and the treatment team, such that the court receives the clinical information it needs to exercise its authority appropriately and the treatment team is able to leverage the court's powers as needed;
5. provide evidence-based treatment services focused on engagement and helping the participant maintain stability and safety in the community;
6. continually evaluate the appropriateness of the participant's treatment plan throughout the AOT period, and make adjustments as warranted;
7. employ specific, treatment-based protocols to respond in the event that an AOT participant falters in maintaining treatment engagement;
8. evaluate each AOT participant at the end of the commitment period to determine whether it is appropriate to seek renewal of the commitment or allow the participant to transition to voluntary care;
9. ensure that upon transitioning out of the program, each participant remains connected to the treatment services they continue to need to maintain stability and safety.

The following recommendations will support efforts in Colorado to provide and support AOT as defined by these essential elements and ten building blocks of a sustainable AOT program.

WE RECOMMEND

1. Utilizing the Treatment Advocacy Center's, Implementing Assisted Outpatient Treatment: Essential Building Blocks, Elements and Tips for Maximizing Results framework to explain what AOT is and how it can benefit communities, provide a view into the variability of AOT programs, and identify practices considered promising for successful systematic implementation. If a psychiatric advance directive (PAD) exists for the participant, ensure treatment plan incorporates stipulations in the PAD. The model is only effective if adequately resourced to ensure all the appropriate parties and services can be engaged.

2. Continuation of the convening of a multi-disciplinary team building from the Colorado Behavioral Health Task Force Long Term Competency Subcommittee, including the public mental health authority, civil court judge and personnel, mental health professionals representing community-based, inpatient and psychiatric crisis, attorneys representing petitioners and respondents, Sheriff or police agencies, and peer mentors and consumer/family advocates (Building Block 1) to:

   - Explore other state and county models where AOT has been successfully implemented and studied to identify a programmatic mentor to consult and collaborate with as Colorado develops AOT programs across the state (Building Block 10)
   - Review and recommend changes in legislative statute to support the addition of AOT in Colorado to the current structure of civil commitment options (Building Block 2)
   - Develop clear clinical standards based on evidence-based best practices (eliminate variation) for when an individual is eligible or appropriate for AOT services (both through civil and criminal justice avenues)
   - Create written policies, procedures and forms to ensure key elements and principles of AOT are maintained (Building Block 5)
   - Meet periodically for purposes of program improvement and evaluation (Building Block 6)
   - Actively engage stakeholders who may have concerns or opposition to AOT as a violation of civil rights
   - Determine the appropriate level of judicial engagement, for example a specialized court handling AOT (Building Block 3)
   - Empower judges, prosecutors, and defense attorneys to assist in identifying persons appropriate for off-ramping from criminal justice to AOT
   - Provide the appropriate level of funding to provide the capacity to implement the treatment plans that an AOT order would include at a community level.

3. Establishing a mechanism at the state level to provide participants with standardized printed materials to inform them of their rights and responsibilities (Building Block 7) and for monitoring of participants ordered for involuntary treatment to avoid punitive legal measures, as the best outcomes are those that use motivational approaches. (Building Block 4)

4. Tracking data for purposes of program evaluation and improvement, including participant feedback, re-incarceration rates, rehospitalization rates and Emergency Department utilization rates. (Building Block 9)

5 Educating stakeholders and the community at large on AOT processes, procedures, and overview, including healthcare facilities staff, NAMI, peer support, professional organizations, law enforcement, and judicial system stakeholders. (Building Block 8)

INDIVIDUALS WITH COGNITIVE DISABILITIES

Population of focus for these recommendations includes persons with cognitive disabilities, including but not limited to individuals with intellectual and developmental disabilities (IDD), neurodevelopmental disorders (including autism and fetal alcohol syndrome (FAS)), acquired brain injury, and dementia. Hereafter, this population is referred to as "individuals or population with cognitive disabilities."

IMPROVED DATA COLLECTION AND TRANSPARENCY

1 To understand the prevalence of individuals with cognitive disabilities who are arrested and involved in competency evaluations and restoration, **WE RECOMMEND** OBH collects data from jails and other entities within the competency system and publicly report on data collection processes, outcomes, and at what points these individuals are being identified within the system.

- Reports should identify the number of individuals deemed permanently incompetent to proceed who have cognitive disabilities
- Additional data collection and reporting is needed to understand the populations experiences and outcomes at each intercept
- Data will be aggregated as needed based on small numbers
- To support cross-system evaluation, if possible, align with existing codes used by Department of Corrections and other state agencies

INTERCEPT 0: COMMUNITY SERVICES

1 To enable an increased understanding and knowledge of this population and available resources, **WE RECOMMEND** planned and facilitated opportunities for individuals with cognitive disabilities, law enforcement and first responders, and other partners to interact in non-crisis situations. Facilitated opportunities, such as interactive trainings, will be developed with intentional plans to outreach and involve communities of color and majority non-English speaking communities.

2 **WE RECOMMEND** the State create a committee be established to identify partners and develop or review trainings and organized events for best practices.

3 **WE RECOMMEND** Colorado Crisis Services provide the education and infrastructure for individuals, families, and Community Centered Boards and other case management agencies to develop and file crisis plans and register with Smart911.

INTERCEPT 1: LAW ENFORCEMENT

1. **WE RECOMMEND** confirming that Crisis Intervention Team education components include a focus on identification and interaction skills with individuals with cognitive disabilities.

2. **WE RECOMMEND** developing educational opportunities for law enforcement, judges, and court officials to have better understanding and work with populations with cognitive disabilities. Educational opportunities should include best practices to address language and racial disparities. WE RECOMMEND reviewing available trainings through various state and national advocacy partners and experts for opportunities to scale and spread. Trainings will be reviewed and/or developed by a committee with subject matter expertise in law, mental health and behavioral health, and cognitive disabilities.

3. To maximize effectiveness of co-responder teams, **WE RECOMMEND** co-responder teams have access to behavioral health and community centered boards and other case management agencies information to effectively intervene, to respond appropriately, refer to appropriate agenda, and/or divert to appropriate services when necessary.

4. To ensure the co-responder model is effectively interacting with individuals with cognitive disabilities, **WE RECOMMEND** developing uniform and improved data collection, evaluation, and reporting of co-responder model programs and outcomes across the state.

5. **WE RECOMMEND** the expansion and funding of diversion programs to consider and attend to the needs of individuals with cognitive disabilities.

INTERCEPT 2: INITIAL DETENTION - COURT PROCESS

1. **WE RECOMMEND** a study is conducted with a public report to identify which jails are accredited and provide behavioral health and cognitive disabilities screenings and services across the state to better assist the department and legislature in expending JBBS and other similar funds.

2. **WE RECOMMEND** development of screening standards (based on the current accreditation standards of the National Commission on Correctional Health Care and American Correctional Association) and a system for all jails to have access to screening, either in-person or via tele-health services.

3. **WE RECOMMEND** all individuals are initially screened, preferably by JBBS or other health care professionals, at the time of medical/mental health intake or as soon as practical. Screening tools should include measures to identify cognitive disabilities. Screening tools should be culturally competent and available in multiple languages, and attend to common but less likely identified conditions such as FAS and ASD. To support screening efforts, OBH should provide jails with technical assistance to gain access to health care professionals to conduct screenings.

4. **WE RECOMMEND** all individuals are screened for health care coverage at the time of medical/mental health intake or as soon as practical so benefits (Medicaid) can be suspended or eligible unenrolled individuals can also be identified.

INTERCEPT 3: COMPETENCY EVALUATION

1. **WE RECOMMEND** the state conduct assessment of and publicly report on the wait times for competency evaluation, and identify if individuals with cognitive disabilities experiences different lengths of wait times

2. **WE RECOMMEND** a system is developed so that individuals with cognitive disabilities who are deemed ITP and not likely to be restored on the current charge do not have to undergo further restoration efforts. (Note: this recommendation supports following up SB 19-223 with SB 20-181.)

3. **WE RECOMMEND** an independent study of the competency evaluation process to ensure the guidelines and practices currently in place for individuals with cognitive disabilities are equitability being enacted across the state.

INTERCEPT 4: RESTORATION TREATMENT

1. **WE RECOMMEND** OBH contract with restoration providers that have access and ability to provide specialized restoration curriculums for individuals with cognitive disabilities and recognize when curriculum is not "working" because they will not be restored. This includes the ability to individualize curriculum to a person's needs based on core components of restoration curriculum to ensure quality.

INTERCEPT 5: DISCHARGE

1. **WE RECOMMEND** the Forensic Support Team and Bridges navigators be current on available services for individuals with cognitive disabilities, including Community Centered Boards, Community Mental Health Centers, case management agencies, and medical services, so they can navigate clients appropriately.

2. **WE RECOMMEND** the state provide a continuum of placement options to include less restrictive options than hospitals or jails that may include regional centers, group homes, assisted care facilities, etc.

3. **WE RECOMMEND** OBH, for the purpose of promoting a less restrictive setting than hospitals or jail, explore the use of technology for supervision.

BEHAVIORAL HEALTH SERVICES IN JAIL

The following recommendations are presented to assure that individuals currently in jail or transitioning between jail and the community have access to behavioral health services that consider and meet their needs.

1. Because decisions about behavioral health service provision and providers are at the discretion of individual county-run jails, **WE RECOMMEND** statutory changes crafted in collaboration with stakeholders, including law enforcement and JBBS providers, to a) promote uniformity of JBBS standards available across the state and b) ensure the quality of services provided by private correctional corporations and nonprofits are comparable and delivered to fidelity and c) promote collaboration among JBBS, Adult Diversion, Juvenile Diversion, Bridges, and other related state entities.

2. Because jail facilities across Colorado have different space and workforce capacity to deliver behavioral health services in jails, **WE RECOMMEND** that any statutory changes from recommendation number one include flexibility at the jail level to adapt approaches to delivery of behavioral health services in jails based on available resources and assets to deliver uniform goals/standards with technical assistance and consultation from OBH to deliver programming.

3. To improve quality and continuity of care for inmates, **WE RECOMMEND** enhanced collaboration and coordination between services and community resources, or a single provider, to provide behavioral health, physical health and substance use disorder services within a specific facility or county.

4. To support inmates to continue to manage behavioral health conditions upon discharge from jail, **WE RECOMMEND** OBH work with individual vendors and amend contracts as needed to ensure each individual experiences a seamless transition to community services and support continuity of care. Enhancement of transition services may include transition clinics that coordinate with community services to provide medication management, and bridge to community primary care, behavioral health services, and other community resources to address social determinants of health

5. **WE RECOMMEND** continued investment and collaboration between necessary entities to foster health information exchange, both between jails and between jails and community providers, to provide HIPAA-compliant data sharing supporting continuity of care, faster access to lab results and radiology reports, streamlined access to patient histories and discharge summaries, and automated physician referral and consult processes.

6. **WE RECOMMEND** OBH and JBBS work with county jails to develop and implement protocols to screen, assess, treat, and monitor for triage purposes inmates while in custody and in preparation for successful community re-entry. We recommend OBH provide technical assistance and resources that enable jails to meet the basic standards for interim behavioral health services as well as ensure compliance and quality assurance.

CONCLUSION

Three different subcommittees, three different populations, similar priorities, similar calls for action. Across the lifespan, and across a multitude of settings and circumstances, including communities and the criminal justice system, it is clear that reform is needed to better meet the behavioral health needs of Coloradans. And though there are specificities to meet those needs that cannot be ignored, specificities spelled out in the individual subcommittee recommendations, unifying themes sweep across the Children's Behavioral Health, the State Safety Net and the Long Term Competency Subcommittees, demonstrating that opportunities to strengthen the behavioral health system in Colorado are more alike than different across populations.

ACCESS

All Coloradans deserve equitable, locally driven access to the full continuum of behavioral health services they need to remain well in the communities where they live. Access to the right services, in the right place, at the right time that is trauma-informed and culturally and linguistically responsive preserves the opportunity to manage crisis, avoid intersection with law enforcement and the criminal justice system and maintain wellness in the setting of community.

PREVENTION

Coloradans are best served when behavioral health issues are addressed early or even before they present, in such a way that preserves and supports optimal wellness.

WORKFORCE

In order for Coloradans to have access to the behavioral health services that they deserve, behavioral health providers, across the spectrum of licensure and training, must find ways to connect with all communities across the state.

QUALITY

State and local solutions to provide behavioral health services across Colorado should be data informed and maintain a rigorous and transparent process of continuous quality improvement.

SOCIAL DETERMINANTS OF HEALTH

Both the physical and behavioral health of Coloradans are directly tied to the basic needs that allow them to thrive in their communities, including access to food, safe housing in safe neighborhoods, transportation, economic stability and education.

SPECIFIC POPULATIONS

The needs of Coloradans with cognitive or physical disabilities and co-occurring behavioral health needs; individuals with dual diagnoses; children in the child welfare system and foster care; transition-aged youth; LGBTQIA+ youth; communities of color; and the forensic population should be considered in development and implementation of programs and policies to assure that their unique needs are considered and ultimately met.

DIVERSION FROM CRIMINAL JUSTICE SYSTEM

The criminal justice system should not serve as the de facto behavioral health system. Any services provided within the criminal justice system should be available within the civil behavioral health system, and community behavioral health services should be available to those at risk for interface with law enforcement secondary to behavioral health issues to prevent incarceration.

Underpinning these tenants of whole person health that support wellness of both the body and the mind, is the need for statewide infrastructure that provides governance and directs financing for behavioral health services in Colorado. Subcommittees recognized the essential need for these foundations and entered into challenging discussions about how to design an infrastructure that meets the needs of individuals across the state. Both the State Safety Net and Children's Behavioral Health Subcommittees discussed governance and accountability, highlighting the need for integration across state agencies. Both also provided guidance to develop standards and measures for high fidelity services that do not add burden to service providers or take resources away from direct service delivery to support administrative costs. The Children's Behavioral Health Subcommittee in particular emphasized that any reform to the current behavioral health system consider the unique needs of children and youth, highlighting the need for specific staffing, leadership and authority dedicated to this population. Ultimately, it is the hope that the subcommittee recommendations and considerations provide guidance as the Main Task Force continues its work towards designing and implementing a new behavioral health governance structure for the State of Colorado.

The three subcommittees represented a wide array of subject matter expertise from across the State of Colorado, including consumer and family advocates. The groups were high functioning, and members recognized their individual responsibility to participate and contribute. Racial and ethnic diversity across the three subcommittees was limited, and future efforts to engage stakeholders should assure that the diversity of our state is reflected in representation in discussions that guide policy decisions. Focused discussions on specific populations or services highlighted some limitations of the subcommittee membership. On occasion, there simply were not the right people with the right expertise in the room to inform highly actionable recommendations. These instances are reflected in recommendations that ask for future stakeholder processes with the right subject matter experts to focus on specific topics.

A year of focused and extensive work is reflected in the contents of this subcommittee report, but by no means does this represent the end of the work. In fact, the real work starts now. It will require continued commitment from diverse and committed stakeholders across Colorado to carry this work forward. The Remedy for Behavioral Health Reform will represent an implementation plan that will require more discussion, more debate, and more collaboration. Optimistic yet pragmatic leadership will be essential to continue to push stakeholders and state agencies alike towards system reform that will result in better health that includes meeting the behavioral health needs of all Coloradans. Assuring equitable access to high quality behavioral health services when and where Coloradans need them represents work that will never really be complete. Behavioral health must be at the forefront of the minds of policy makers, legislators, state agency leaders and staff, communities, service providers, and family members so that we never stop paying attention, do not accept the status quo and continuously work towards solutions that meet the behavioral health needs of people living in Colorado.

APPENDICES

Appendix 1. Colorado Behavioral Health Task Force Members

*denotes a committee member who had to step down from the BHTF at some point during the course of the year or replaced a subcommittee member

Main Task Force

Executive Committee

Director Michelle Barnes, Colorado Department of Human Services

Lt. Governor Dianne Primavera

Deputy Manager Barbara Drake, Douglas County

Director Jill Hunsaker Ryan, Colorado Department of Public Health & Environment

Director Kim Bimestefer, Colorado Department of Health Care Policy and Financing

Commissioner Michael Conway, Division of Insurance

Ex-Officio Members

*Greg Dorman, Department of Military and Veterans Affairs – Denver

Kate Greenberg, Colorado Department of Agriculture – Denver

*Brey Hopkins, Colorado Department of Military and Veterans Affairs

*Mickey Hunt, Department of Military and Veterans Affairs - Denver

Nancy Ingalls, Douglas County Schools – Douglas County

Debbie Oldenettel, Colorado Department of Public Safety – Denver

Patty Salazar, Colorado Department of Regulatory Agencies – Denver

Dean Williams, Colorado Department of Corrections – Denver

Task Force Members

*Vincent Atchity, Mental Health Colorado – Denver

*Della Cox-Vieira, Alamosa County Public Health – Alamosa

Daniel Darting, Signal Behavioral Health Network – Greenwood Village

Raul De Villegas-Decker, RDV Executive Consulting – Grand Junction

Jill Derrieux, Mesa Youth Services, Inc. dba Mesa County Partners – Grand Junction

Rebecca Ela, Delta County Memorial Hospital – Hotchkiss

C. Neill Epperson, University of Colorado School of Medicine – Aurora

Jennifer Fanning, Grand County Rural Health Network – Hot Sulphur Springs

Michael Fields, Colorado Rising Action – Parker

Rana Gonzales, Colorado Workers for Innovative New Solutions – Manitou Springs

Deidre Johnson, Center for African American Health – Denver

Tracy Kraft-Tharp, General Assembly – Denver

Lois Landgraf, General Assembly – Denver

Glenn Most, Sisters of Charity of Leavenworth Health System – Wheat Ridge

Cory Notestine, Colorado Springs School District 1 – Colorado Springs

Patricia Oliver, Oliver Behavioral Consultants – Broomfield

Byron Pelton, Commissioner Logan County – Sterling

Valerie Schlecht, Colorado Cross-Disability Coalition – Denver

Meg Taylor, Rocky Mountain Health Plans – Greenwood Village

Laura Teachout, National Alliance on Mental Illness, Colorado Springs Board Member – Colorado Springs

Brian Turner, Solvista Health – Cañon City

*Nancy VanDeMark, Mental Health Colorado - Denver

Selwyn Whiteskunk, Ute Mountain Tribe – Towaoc

Children's Behavioral Health Subcommittee

Co-Chairs

John Laukkanen, Colorado Department of Health Care Policy & Financing – Denver

Shannon Van Deman, Children's Hospital Colorado – Aurora

Ex-Officio Member

Jamie Murray, Cañon City School District – Cañon City

Members

Morgan Bruss, Harrison School District 2 – Colorado Springs

Megan Burch, Eagle County Department of Human Services – Eagle

Sarah Davidon, Davidon Consulting – Denver

Samantha Field, Mental Health Professional – Denver

M. Cecile Fraley, Pediatric Partners of the Southwest – Durango

Brook Griese, Judi's House/JAG Institute – Denver

Jennifer Grote, Denver Health – Denver

Camille Harding, Colorado Department of Human Services – Denver

Rebecca Hea, Denver Children's Home – Denver

Melissa Janiszewski, Office of Children's Affairs – Denver

Dawn Khederian, the Vanguard School – Colorado Springs

*Adrianne Maddux, Denver Indian Health & Family Services – Denver

Carol Meredith – The Arc Arapahoe & Douglas Counties – Centennial

Dafna Michaelson Jenet, Colorado General Assembly – Denver

Aaron Miltenberger, Boys & Girls Clubs of the San Luis Valley – Alamosa

Lindsey Myers, Colorado Department of Public Health & Environment – Denver

Leslie Patterson, Envida – Colorado Springs

Jessica Peck, Peck Law Colorado – Denver

Lindsay Reeves, Catholic Charities Diocese of Pueblo – Pueblo

Lenya Robinson, Jefferson Center for Mental Health – Wheat Ridge

Shannon Secrest, Colorado Cross-Disability Coalition – Aurora

Stephanie Villafuerte, Office of Colorado's Child Protection Ombudsman – Denver

Kathryn Wells, Kempe Center for the Prevention and Treatment of Child Abuse and Neglect – Aurora

Lisa Zimprich, Fountain-Fort Carson School District 8 – Fountain

State Safety Net Subcommittee

Co-Chairs

Nancy Jackson, Arapahoe County – Littleton

Robert Werthwein, Colorado Department of Human Services – Denver

Ex-Officio Members

Kristina Daniel, Valley-Wide Health Systems, Inc. – Alamosa

Rickey Gray, Cedar Springs Hospital – Colorado Springs

*Kiara Kuenzler, Jefferson Center for Mental Health – Wheat Ridge

*Jennifer Leosz, Mental Health Partners - Boulder

Members

Aubrey Boggs, Behavioral Health Ombudsman of Colorado – Denver

Traci Bradford-Walker, Aurora Municipal Courts – Aurora

Frank Cornelia, Colorado Behavioral Healthcare Council – Denver

Kevin Duffy, Douglas County Sheriff's Office – Castle Rock

Melissa Eddleman, Colorado Department of Health Care Policy & Financing – Denver

Marilyn Fausset –Family Advocate, Boulder

Alison George, Colorado Department of Local Affairs – Denver

Kimberly Gonzales, Las Animas Huerfano Counties District Health Department – Trinidad

Joy Hart, Colorado Department of Corrections – Denver

*Levon Hupfer, Galvenize Counseling, Commerce City

Carl LoFaro, Clinical Social Worker – Aurora

Meighen Lovelace, Family Advocate – Avon

Tom Manzione, Attention Homes – Boulder

Mike Nugent, Colorado Department of Public Health & Environment – Denver

*Amber Pace, Centura Health Physician Group – Denver

*Kyle Phillips, Valley-Wide Health Systems, Alamosa

*John Pickett III, Larimer County Human Services – Loveland

Aisha Rousseau, Denver Office of Disability Rights – Denver

Deb Ruttenberg, Grand County Department of Human Services – Hot Sulphur Springs

Jessica Schart, Kit Carson County Department of Public Health and Environment – Burlington

Richard Simms, Richard S Simms PC – Littleton

Lauren Snyder, Mental Health Colorado – Denver

*Danette Swanson, Colorado Rural Health Center, Aurora

Sarah Vaine, Summit County Government – Breckenridge

Eva Veitch, Region 10 Low-income Energy Assistance Program – Montrose

Long Term Competency Subcommittee

Co-Chairs

Alison Butler, Disability Law Colorado – Denver

Robert Werthwein, Colorado Department of Human Services – Denver

Members

Lacey Anne Berumen, TRACKtech LLC – Greenwood Village

*Kyle Brown, UC Health – Aurora

Su Coffey, Family Advocate – Denver

Alexis Giese, Colorado Access – Aurora

Brian Gonzales, University of Denver Graduate School of Social Work – Denver

Ravid Moshe "Moses" Gur, Colorado Behavioral Healthcare Council – Denver

Ben Harris, Colorado Department of Health Care Policy & Finance – Denver

Joy Hart, Colorado Department of Corrections – Denver

Daric Harvey, Cañon City Police – Cañon City

Peggy Heil, Colorado Department of Public Safety – Denver

Tim Lane, Colorado District Attorney's Council – Denver

Richard Martinez, University of Colorado School of Medicine – Denver

Lucienne Ohanian, Colorado State Public Defender – Denver

Brenda Pace, Pueblo County Attorney's Office – Pueblo

Sasha Rai, Denver Health – Denver

Cordelia Rosenberg, University of Colorado – Aurora

Jessica Russell, Health Solutions – Pueblo

Carleigh Sailon, Mental Health Center of Denver – Denver

Jonathan Shamis, State of Colorado Judge – Leadville

Rana Shaner – Consumer Advocate, Olathe

Juan Silva, Denver District Attorney's Office – Denver

Cali Thole, SummitStone Health Partners – Fort Collins

Mary Thomas, Consumer Advocate – Longmont

*Laura Warner, San Juan Basin Public Health – Durango

Appendix 2. Subcommittee Voting Record

Long-Term Competency Subcommittee

11/18/2019 LTC Comprehensive Plan – Recommendations Vote (Numbering reflects order in Comprehensive Plan)				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
1. Intercept 0-1	23	23	0	0
2. Intercept 0-2	23	23	0	0
3. Intercept 0-3	23	23	0	0
4. Intercept 1-1	23	23	0	0
5. Intercept 1-2	23	23	0	0
6. Intercept 1-3	23	23	0	0
7. Intercept 1-4	23	23	0	0
8. Intercept 1-5	23	23	0	0
9. Intercept 2-1	23	23	0	0
10. Intercept 2-2	23	23	0	0
11. Intercept 2-3	24	24	0	0
12 Intercept 2-4	24	24	0	0
13. Intercept 2-5	24	24	0	0
14. Intercept 2-6	24	24	0	0
15. Intercept 2-7	24	22	2	0
16. Intercept 2-8	24	22	1	1
17. Intercept 3-1	24	24	0	0
18. Intercept 3-2	24	24	0	0
19. Intercept 3-3	24	24	0	0
20. Intercept 3-4	24	24	0	0
21. Intercept 3-5	24	24	0	0
22. Intercept 3-6	24	24	0	0
23. Intercept 4-1	24	23	0	1
24. Intercept 4-2	24	22	0	2
25. Intercept 4-3	24	24	0	0
26. Intercept 4-4	24	24	0	0
27. Intercept 4-5	24	24	0	0
28. Intercept 4-6	24	24	0	0
29. Intercept 4-7	24	24	0	0
30. Intercept 4-8	24	24	0	0
31. Intercept 4-9	24	24	0	0
32. Intercept 4-10	23	23	0	0
33. Intercept 4-11	23	23	0	0
34. Intercept 4-13	23	23	0	0

35. Intercept 5-1	23	22	0	1
36. Intercept 5-2	22	22	0	0
37. Intercept 5-3	21	21	0	0
38. Intercept 5-4	21	17	0	4

2/10/2020 LTC
Legislative Concepts Vote

Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Municipal Charges	19	17	2	0
Misdemeanor Charges, part 1	19	18	0	1
Misdemeanor Charges, part 2	19	16	2	1
PITP	19	19	0	0

5/27/2020 LTC
Cognitive Disabilities, including Intellectual and Developmental Disabilities Recommendations Vote

Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Improved data collection and transparency	19	19	0	0
Intercept 0-1	20	20	0	0
Intercept 0-2	20	18	1	1
Intercept 0-3	20	20	0	0
Intercept 1-1	20	20	0	0
Intercept 1-2	20	19	1	0
Intercept 1-3	20	19	0	1
Intercept 1-4	20	12	6	2
Intercept 1-5	20	20	0	0
Intercept 2-1	20	20	0	0
Intercept 2-2	20	20	0	0
Intercept 2-3	20	18	0	2
Intercept 3-1	20	20	0	0
Intercept 3-3	20	20	0	0

6/8/2020 LTC Votes Remaining IDD Recommendations; Diversion and AOT Recommendations				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
IDD 2-4	17	16	0	1
IDD 3-2	18	18	0	0
IDD 4-1	18	18	0	0
IDD 4-2	19	11	2	6
IDD 5-1	19	18	0	1
IDD 5-2	19	19	0	0
IDD 5-3	18	18	0	0
Diversion pre-arrest/pre-charge	18	18	0	0
Diversion pre-plea 1	18	18	0	0
Diversion Pre-plea 2	17	17	0	0
Diversion Pre-plea 3	17	17	0	0
Diversion Pre-plea 4	17	17	0	0
Diversion Post-plea 1	17	16	1	0
Diversion Post-plea 2	17	17	0	0
Diversion Civil Commitment	17	17	0	0
AOT #1-5	18	18	0	0

6/22/2020 LTC Votes Behavioral Health Services in Jails Recommendations				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
1	19	18	0	1
2	19	18	0	1
3	18	11	6	1
4	17	14	1	2
5	18	17	0	1
8	18	17	0	1

State Safety Net Subcommittee

3/5/2020 State Safety Net Subcommittee Drafted Recommendation to Present to Main Behavioral Health Task Force				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Telehealth Draft Recommendation	20	20	0	0
System Navigation Draft Recommendations	20	19	0	1
High Intensity Treatment Program Draft Definition	20	20	0	0

5/21/2020 State Safety Net Subcommittee High Intensity Treatment Program Definition				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
High Intensity Treatment Program Definition	13	12	0	1

Children's Behavioral Health Subcommittee

2/13/2020 Children's Behavioral Health Subcommittee Service Array, Access, and Workforce Recommendations				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Service Array Recommendations	16	15	0	1
Access Recommendations	18	18	0	0
Workforce Recommendations	18	18	0	0

5/28/2020 Children's Behavioral Health Subcommittee Finance Recommendations				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Finance 1: Consolidate Funding Streams	18	18	0	0
Finance 2: Fiscal Management System	19	19	0	0
Finance 3: Federal Match	18	18	0	0
Finance 5: Systematic Approach to Collect Data	19	19	0	0
Finance 6: State-wide Consultation Program	18	18	0	0
Finance 7: Essential Services Package	19	19	0	0
Finance 8: Open H&B Codes	18	17	0	1
Finance 9: Investment in Prevention and Promotion	19	19	0	0
Finance 10: School Finance Act	19	18	0	1
Finance 11: Track Spending Based on Demographics	19	19	0	0
Finance 12: Utilization Management	18	17	1	0

6/11/2020 Children's Behavioral Health Subcommittee Remaining Finance Recommendation				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Finance 4: Pay and Chase Model	14	14	0	0

6/15/2020 Children's Behavioral Health Subcommittee Governance and Quality Recommendations				
Recommendation or package of recommendations	Voting members present	Approved	Opposed	Abstained
Governance Recommendation	15	15	0	0
Quality Recommendations	16	16	0	0

Appendix 3. Subcommittee Meeting Dates and Objectives

Children's Behavioral Health Subcommittee

8/9/19 — 3 HR MEETING

MEETING OBJECTIVE

3 Welcome and introduce members of the Children's Behavioral Health Subcommittee

4 Grounding/level-setting for the work ahead: Discuss priorities and focus for the Children's Behavioral Health Subcommittee

HOMEWORK

Read the following documents and review recommendations to determine if they resonate as a potential starting point for the subcommittee: *Young Minds Matter report and Roadmap to Colorado's Behavioral Health System for Children, Youth, and Families: 4-year Strategic Plan*

VOTE

None

FINAL DOCUMENTS/ OUTCOMES

None

8/23/19 — 2 HR MEETING

MEETING OBJECTIVE

1 Continued work on defining value statements

2 Children's Behavioral Health Governance Structure

HOMEWORK

Refining values

VOTE

1 Input on vision and values (to align with BHTF and add child/youth focus)

2 Feedback on support for Governance and Systems Management recommendations from the Roadmap to Colorado's Behavioral Health System for Children, Youth, and Families: 4-year Strategic Plan

3 Ask for service continuum examples

FINAL DOCUMENTS/OUTCOMES

Values

9/12/19 — 2 HR MEETING

MEETING OBJECTIVE

Governance Structure Discussion-Part 2

HOMEWORK

Survey before next meeting

VOTE

What three transformational ideas would you prioritize for the Children's Behavioral Health Subcommittee?

FINAL DOCUMENTS/OUTCOMES

Draft Governance recs

10/10/19 — 3 HR MEETING

MEETING OBJECTIVE

1. Revisit operating agreements and decision-making process
2. Review Children's Behavioral Health Subcommittee Scope of Work
3. Introduce Children's Behavioral Health Subcommittee Roadmap
4. Small workgroups – System of Care Functions

HOMEWORK

Submit preferences for workgroups

VOTE

None

FINAL DOCUMENTS/ OUTCOMES

None

10/24/19 — 2.5 HR MEETING

MEETING OBJECTIVE

1. Building on existing work
2. Workgroups Session 1: Service Array, Access, Workforce

HOMEWORK

Ongoing homework to refine workgroup recs

VOTE

Input from Workforce, Service Array, and Access workgroups

FINAL DOCUMENTS/ OUTCOMES

Draft workforce and access recommendations

11/14/19 — 3.5 HR MEETING

MEETING OBJECTIVE

Explore a governance structure for children's behavioral health in Colorado

HOMEWORK

Ongoing homework to refine workgroup recs

VOTE

Straw polls for following:

1. As a foundation for this subcommittee's governance recommendations, do we affirm that this list reflects an accurate picture of the needs of the current system, and which we intend our recommendations to address?
2. What population of kids we want to govern. What are the functions that we want to fall under the purview of the governance structure?
3. Decentralized or centralized governance structure?
4. What authority do we want the body to have?
5. Governance Membership and ensuring stakeholder involvement – what group of stakeholders do we want to propose to be engaged?

FINAL DOCUMENTS/OUTCOMES

None

12/12/19 — 4 HR MEETING

MEETING OBJECTIVE

1. Continued work on defining value statements for the BHTF Children's Behavioral Health Subcommittee
2. Children's Behavioral Health Governance Structure

HOMEWORK

Ongoing homework to refine workgroup recs

VOTE

1. Governance – pros and cons of different models
2. Governance – what components are unique to the kid population?

FINAL DOCUMENTS/OUTCOMES

None

1/9/2020 — 2 HR MEETING

MEETING OBJECTIVE

Workgroup time

HOMEWORK

Ongoing homework to refine workgroup recs

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

1/23/2020 — 2 HR MEETING

MEETING OBJECTIVE

Workgroup time

HOMEWORK

Ongoing homework to refine workgroup recs

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

2/13/2020 — 3 HR MEETING

MEETING OBJECTIVE

1. Wrap-up recommendations/debrief Main TF
2. Quality Refresher
3. Connecting proposed finance model to proposed Children's Governance Model

HOMEWORK

Ongoing homework to refine workgroup recs

VOTE

Service Array, Access, Workforce Recommendations

FINAL DOCUMENTS/OUTCOMES

Service Array, Access, Workforce Recommendations

2/27/2020 — 2.5 HR MEETING

MEETING OBJECTIVE

Member level - Quality

HOMEWORK

1. Review of recommendations and proposed financing model from consumer perspective, based on case studies from pubic testimonies
2. Ongoing homework to refine quality recommendations

VOTE

None

FINAL DOCUMENTS/ OUTCOMES

None

3/12/2020 — 3 HR MEETING

MEETING OBJECTIVE

System level – Quality

HOMEWORK

Ongoing homework to refine quality recommendations

VOTE

None

FINAL DOCUMENTS/ OUTCOMES

None

4/23/2020 — 3 HR MEETING

MEETING OBJECTIVE

1. Presentations to inform finance recommendations from Children's Subcommittee
2. Launch discussion to begin drafting finance recommendations
3. Update on SB19-195

HOMEWORK

Ongoing homework to refine quality recommendations

VOTE

Discussion regarding parity and finance recommendations

FINAL DOCUMENTS/ OUTCOMES

Finance recommendations

5/14/2020 — 3 HR MEETING

MEETING OBJECTIVE

1. Continue editing finance recommendations
2. Update on service array, access, and workforce recommendations

HOMEWORK

Ongoing homework to refine quality recommendations

VOTE

Refining recs developed in response to financial reports

FINAL DOCUMENTS/ OUTCOMES

Updated finance recommendations

5/28/2020 — 3 HR MEETING

MEETING OBJECTIVE

1 Refine and vote on finance recommendations

2 Revisit governance recommendations and prime for finalizing

HOMEWORK

Provide feedback on finance recommendation #9 and review the governance 1-pager

VOTE

Finance Recommendations

FINAL DOCUMENTS/ OUTCOMES

Finance Recommendations

6/9/2020 WEBINAR — 1 HR MEETING

MEETING OBJECTIVE

Children's Testimony Qualitative Analysis Overview

HOMEWORK

None

VOTE

None

FINAL DOCUMENTS/ OUTCOMES

None

6/11/2020 — 3 HR MEETING

MEETING OBJECTIVE

1 Finalize finance recommendation

2 Revisit governance recommendations

3 Introduce quality recommendations

HOMEWORK

Provide feedback on governance and quality recommendations

VOTE

None

FINAL DOCUMENTS/ OUTCOMES

None

6/25/2020 — 3 HR MEETING

MEETING OBJECTIVE

1 Finalize and vote on governance recommendations

2 Finalize and vote on quality recommendations

3 Child and Youth Survey results

4 Update from COVID-19 workgroup

HOMEWORK

None

VOTE

Governance and Quality recommendations

FINAL DOCUMENTS/ OUTCOMES

Governance recommendation

Quality recommendations

State Safety Net Subcommittee

7/18/19 — 3 HR MEETING

MEETING OBJECTIVE

1. Welcome and introduce members of the Safety Net Subcommittee
2. Grounding/level-setting: Discuss priorities and focus for the Safety Net Subcommittee

HOMEWORK

None

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

8/15/19 — 2 HR MEETING

MEETING OBJECTIVE

1. Review Operating Agreements and Person-First Language
2. Refine definition of "safety net"
3. Overview of SB 222 and work of the subcommittee

HOMEWORK

SN definition survey

VOTE

Feedback and Review of Safety Net definition

FINAL DOCUMENTS/OUTCOMES

Draft definition of "Safety Net"

9/5/19 — 2 HR MEETING

MEETING OBJECTIVE

1. Finalize "safety net" definitions
2. Safety Net Subcommittee roadmap; work ahead
3. Introduce continuum of care examples

HOMEWORK

None

VOTE

Feedback on Safety Net definition

FINAL DOCUMENTS/OUTCOMES

Updated Safety Net definition

9/19/19 — 2 HR MEETING

MEETING OBJECTIVE

Small group discussion: Safety Net service continuum

HOMEWORK

Provide input on continuum of care

VOTE

Adding details to "protractor" spectrum of care

FINAL DOCUMENTS/OUTCOMES

List to add to continuum of care

10/3/19 — 2 HR MEETING

MEETING OBJECTIVE

1. Synthesis of continuum work to date
2. Small group discussion: Safety Net service continuum

HOMEWORK

None

VOTE

Identify existing, existing but insufficient, and redundant systems in continuum of care

FINAL DOCUMENTS/OUTCOMES

Updated continuum of care

10/17/19 — 2 HR MEETING

MEETING OBJECTIVE

Presentations: Community Mental Health Centers' Role in the Continuum

HOMEWORK

Service continuum from perspective of Colorado families (discussion of case studies)

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

11/7/19 — 3.5 HR MEETING

MEETING OBJECTIVE

1. Discuss Colorado's financing structure
2. Overview of Ombudsman Office
3. Report out – Service continuum from perspective of Colorado families
4. CMHC presentation
5. Multi-vote: Prioritize work for recommendations

HOMEWORK

Vote on priorities for subcommittee work leading to recommendations and pre-readings

VOTE

Multi-poll: prioritize work for rec's

FINAL DOCUMENTS/OUTCOMES

Prioritized categories for subcommittee recommendations

11/21/19 WEBINAR — 2 HR MEETING

MEETING OBJECTIVE

Counties webinar

1. Overview of five counties that have implemented behavioral health solutions at the local level
2. Learn what is going well
3. Hear recommendations counties think SN subcommittee should consider

HOMEWORK

None

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

12/5/19 WEBINAR — 1 HR MEETING

MEETING OBJECTIVE

WICHE report webinar

HOMEWORK

None

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

12/19/19 — 3.5 HR MEETING

MEETING OBJECTIVE

1. Discuss key takeaways from counties and WICHE report webinars
2. Present results of November multi vote on priorities
3. Begin prioritized workgroup discussions

HOMEWORK

None

VOTE

Prioritize top 3 solutions/strategies in workgroups

FINAL DOCUMENTS/OUTCOMES

Prioritization of solutions and strategies

1/16/2020 — 3 HR MEETING

MEETING OBJECTIVE

Overview of state models to consolidate behavioral health financing and structure

HOMEWORK

None

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

2/6/2020 — 4 HR MEETING

MEETING OBJECTIVE

1 Debrief 1/24 all BHTF and subcommittees meeting

2 Discuss consumer experience in the proposed model

HOMEWORK

Survey: high intensity treatment program definition and recommendations feedback

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

3/5/2020 — 3 HR MEETING

MEETING OBJECTIVE

1 High Intensity Behavioral Health Treatment Program definition

2 Feedback on recommendations: Telehealth, System Navigation, Access

HOMEWORK

None

VOTE

Feedback and vote on recommendations

FINAL DOCUMENTS/OUTCOMES

Drafted recommendations for Telehealth and System Navigation

5/7/2020 — 4 HR MEETING

MEETING OBJECTIVE

1 Reorient to Subcommittee Work and Timeline

2 Presentation and Discussion of Safety Net Models

HOMEWORK

None

VOTE

Input on model from each individual subcommittee member

FINAL DOCUMENTS/OUTCOMES

Video for main BHTF with input from each safety net subcommittee member

5/21/2020 — 2 HR MEETING

MEETING OBJECTIVE

1 Define high intensity behavioral health services

2 Discussion entities providing behavioral health services in Colorado

HOMEWORK

High intensity behavioral health services

VOTE

Definition high intensity behavioral health services

FINAL DOCUMENTS/OUTCOMES

Definition high intensity behavioral health services

6/4/2020 — 3 HR MEETING

MEETING OBJECTIVE

1. High intensity behavioral health services from consumer perspective
2. Revisit safety net continuum of services

HOMEWORK

Identifying subcommittee priorities

VOTE

Identifying subcommittee priorities

FINAL DOCUMENTS/OUTCOMES

Safety net continuum of services

6/18/2020 — 2 HR MEETING

MEETING OBJECTIVE

1. Connecting Persons in Need Study findings with high intensity behavioral health services
2. Revisiting parking lot items
3. Refining subcommittee priorities

HOMEWORK

None

VOTE

Identifying subcommittee priorities

FINAL DOCUMENTS/OUTCOMES

Subcommittee priorities

Long Term Competency Subcommittee

7/10/19 — 2 HR MEETING

MEETING OBJECTIVE

1. Welcome and introduce members of the Long Term Competency (LTC) Subcommittee
2. Grounding/level-setting for the work ahead for the BHTF
   - Determine how we would like to work together
   - Define the role of the LTC Subcommittee
   - Provide historical narrative of how Subcommittee came to be

HOMEWORK

None

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

7/22/19 — 2 HR MEETING

MEETING OBJECTIVE

1. Operating Agreements
2. Timelines/deliverables
3. Outpatient Restoration

HOMEWORK

None

VOTE

None

FINAL DOCUMENTS/OUTCOMES

Operating agreements

8/12/19 — 2 HR MEETING

MEETING OBJECTIVE

1. What is the function of this subcommittee - is it just to help improve the competency process to get someone well enough to stand trial or is there more of a role to help improve access to mental health resources in Colorado?
2. What are the priorities or big issue areas this subcommittee should focus on?

HOMEWORK

None

VOTE

Function and priorities of LTC Subcommittee and Competency Evaluation Recommendation

FINAL DOCUMENTS/OUTCOMES

Identification of functions and priorities of LTC Subcommittee and updates for Competency Evaluation Recommendations

8/29/19 — 3 HR MEETING

MEETING OBJECTIVE

1. Special Master's Report - overview and clarification
2. Wrap up discussion - Intercept 3: Competency Evaluation

HOMEWORK

Review and edit recommendations in Intercept 3

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

9/6/19 — 2 HR MEETING

MEETING OBJECTIVE

Intercept 4 – Restoration Treatment Overview and Discussion

HOMEWORK

Review and edit recommendations in Intercept 4

VOTE

Review Recommendations 1, 2, 3, and 16

FINAL DOCUMENTS/OUTCOMES

Updates for recommendations 1,2,3, and 16

9/23/19 — 3 HR MEETING

MEETING OBJECTIVE

1. Defelonizing Symptoms of Mental Health Conditions
2. Cont. Intercept 4 – Restoration Treatment Overview and Discussion
3. Intro Intercept 5

HOMEWORK

Cont. review and edit recommendations in Intercept 4

VOTE

Review Recommendations in Intercept 4

FINAL DOCUMENTS/OUTCOMES

Updated Recommendations in Intercept 4

10/8/19 — 4 HR MEETING

MEETING OBJECTIVE

1. Intercept 5 – Discharge
2. Intercept 1 – Law Enforcement
3. Intercept 2 – Court Process

HOMEWORK

None

VOTE

Review Recommendations in Intercepts 1 and 5

FINAL DOCUMENTS/OUTCOMES

Updated Recommendations in Intercepts 1 and 5

10/9/19 — 4 HR MEETING

MEETING OBJECTIVE

Intercept 0/6 – Community Services

HOMEWORK

Review and edit recommendations in Intercepts 5, 1, 0, 2, 6

VOTE

Review Recommendations in Intercepts 0, 2, and 4

FINAL DOCUMENTS/OUTCOMES

Updated Recommendations in Intercepts 0, 2, and 4

10/28/19 — 2 HR MEETING

MEETING OBJECTIVE

1. Revisit recommendations after subcommittee survey
2. Value Statements to include in LTC Plan
3. Legislative Recommendations from subcommittee

HOMEWORK

Final review of all recommendations to be included in Comprehensive Plan

VOTE

Review of Recommendations post survey

FINAL DOCUMENTS/OUTCOMES

Updated Recommendations post survey

11/7/19 — 1 HR MEETING

MEETING OBJECTIVE

Legislative Webinar

VOTE

None

HOMEWORK

None

FINAL DOCUMENTS/OUTCOMES

None

11/18/19 — 3 HR MEETING

MEETING OBJECTIVE

Voting on Final Recommendations for Long Term Comprehensive and Cohesive Competency Plan

VOTE

Final recommendations for LTC and Cohesive Competency Plan

HOMEWORK

None

FINAL DOCUMENTS/OUTCOMES

Final recommendations for LTC and Cohesive Competency Plan

12/9/19 — 2 HR MEETING

MEETING OBJECTIVE

Consumer Panel

VOTE

None

HOMEWORK

None

FINAL DOCUMENTS/OUTCOMES

None

1/13/2020 — 2 HR MEETING

MEETING OBJECTIVE

1. Review and discuss plans for legislation related to LTC subcommittee work
2. Wrap up input to Comprehensive Plan
3. Orient and reset for LTC subcommittee Phase 2 work

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

HOMEWORK

None

1/27/2020 — 2 HR MEETING

MEETING OBJECTIVE

1 Debrief 1/24 meeting and legislative small group

2 Phase 2 Workgroups

HOMEWORK

Review legislative language Google Doc to prepare for vote on 2/10/2020

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

2/7/2020 — 1 HR MEETING

MEETING OBJECTIVE

Legislative webinar

HOMEWORK

Ongoing review legislative language

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

2/10/2020 — 2 HR MEETING

MEETING OBJECTIVE

1 Legislative Update

2 Phase 2 Workgroup Time – draft recommendations

HOMEWORK

None

VOTE

Vote on proposed legislative concepts to move forward to BHTF

FINAL DOCUMENTS/OUTCOMES

Proposed legislative concepts

2/24/2020 — 2 HR MEETING

MEETING OBJECTIVE

Phase 2 Workgroups – draft recommendations

Group 1: IDD

Group 2: Diversion and AOT

HOMEWORK

Ongoing review and edits to IDD, Diversion and AOT recs

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

3/9/2020 — 2 HR MEETING

MEETING OBJECTIVE

Cont. Phase 2 Workgroups – draft recommendations

Group 1: IDD

Group 2: Diversion and AOT

HOMEWORK

Ongoing review and edits to IDD, Diversion and AOT recs

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

4/27/2020 — 2 HR MEETING

MEETING OBJECTIVE

Final work group time for AOT/Diversion and IDD

HOMEWORK

Review the recommendations submitted to the Federal Court

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

5/11/2020 — 2 HR MEETING

MEETING OBJECTIVE

1. Transition to jail-based services work
2. Final preparations before voting on IDD, Diversion, and AOT recommendations

HOMEWORK

IDD Recommendations: Review, Prioritizing Comprehensive Plan Recommendations: Survey, and AOT and Diversion Recommendations – continue to refine in Google doc

VOTE

None

FINAL DOCUMENTS/OUTCOMES

None

5/27/2020 — 2 HR MEETING

MEETING OBJECTIVE

1. Final review and vote on IDD recommendations
2. Review and discussion of JBBS recommendations
3. Progress on prioritization of Comprehensive Plan recommendations

HOMEWORK

Review and provide edits to JBBS recommendations and take Prioritizing Comprehensive Plan Survey

VOTE

Recommendations

FINAL DOCUMENTS/OUTCOMES

IDD Recommendations

6/8/2020 — 3 HR MEETING

MEETING OBJECTIVE

1. Vote on remaining IDD recommendations
2. Finalize and vote on Diversion and AOT recommendations
3. Introduce JBBS recommendations

HOMEWORK

Refine and finalize behavioral health services in jails recommendations
Review and provide edits to JBBS recommendations and take Prioritizing Comprehensive Plan Survey

VOTE

Remaining IDD Recommendations, Diversion, AOT recommendations

FINAL DOCUMENTS/OUTCOMES

Final IDD Recommendations, Diversion and AOT recommendations

6/22/2020 — 3 HR MEETING

MEETING OBJECTIVE

1. Finalize and vote on behavioral health services in jails recommendations
2. Prioritize comprehensive plan recommendations

HOMEWORK

None

VOTE

Behavioral health services in jails recommendations

FINAL DOCUMENTS/OUTCOMES

Behavioral health services in jails recommendations

Prioritized comprehensive plan recommendations

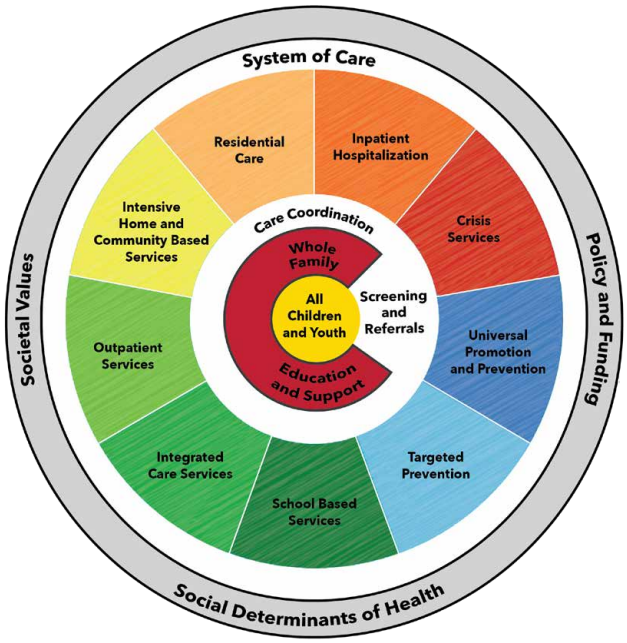
Appendix 4. Colorado Continuum of Behavioral Health for Children and Youth

System of Care: Core Values and Principles

A "system of care" is defined as a spectrum of effective services and supports, organized within a coordinated community network, that partners with individuals and families to meet their cultural and linguistic needs while helping them function better in all aspects of their life.[24] A system of care operates within its larger societal context and is only successful when there is ample public and legislative support for the prioritization and funding of a full continuum of prevention and intervention services. The system relies upon meaningful collaboration and cooperation amongst all agencies and departments, including early childhood, education, human services, child welfare, housing, transportation, public health, law enforcement, corrections, and health and behavioral health care insurers and providers.

The Colorado Behavioral Health Task Force Children's Behavioral Health Subcommittee views the following core values and principles as essential to an inclusive and effective approach to meeting the needs of our state's youth and families:

- Developmentally appropriate services that are individualized and support the whole family through meaningful partnership and collaboration
- Culturally, socially, and linguistically competent and responsive services to reach communities that require additional outreach and those underrepresented in the behavioral health system (e.g., LGBTQIA+, Hispanic/Latin, Tribal, unsheltered, refugees, deaf and blind)
- Trauma-informed services that address the impacts of adverse childhood experiences (ACEs) and other potentially traumatic events
- Accessible, affordable, and inclusive services regardless of diagnostic status
- Strengths-based, resilience, and wellness approaches that include upstream promotion and prevention rather than a singular focus on illness and disorder
- Effective and evidence-informed community-based services that address the full range of social, emotional, physical, and educational needs, including both traditional and nontraditional modalities and informal supports
- Integrated and coordinated care across settings with seamless care transitions and provision of services within the least restrictive environments deemed clinically appropriate
- Advocacy and protection of the rights of all children, adults, and families, with continuous tracking of quality and accountability metrics at the system and practice level



Behavioral Health Service Array

The graphic above is a representation of the comprehensive continuum of care that the Colorado Behavioral Health Task Force Children's Behavioral Health Subcommittee (BHTFCS) deems essential for children and youth across the state to have access to where, when, and as needed. This visual representation highlights the importance of all children and families having access to the right service at the right time through careful assessment and care coordination, with the continuum progressing from lower to higher levels of intensity of need and corresponding service—from promotion and prevention to crisis services. This is not a linear or mutually exclusive continuum, as many youth would benefit from multiple services within the array simultaneously. Rather than continuing to be forced to spin the roulette wheel and land where they might, families should be guided in "dialing in" to the most appropriate and effective services for their children in a timely, accessible, and affordable way.

Below are descriptions of each element of the recommended service array, along with key examples:

All Children and Youth

ALL YOUTH IN COLORADO AGED 0-26 YEARS

For the purpose of addressing the behavioral health needs of Colorado's young people, the Children's Behavioral Health Subcommittee defines "children" as ALL youth, from birth to 26 years old, in line with Colorado Senate Bill 19-195, brain development research, insurance coverage policies, and recent trends in the parenting and living arrangements of young adults. Given alarming increases in behavioral health problems and suicide attempts for youth of all backgrounds, the service array must be accessible to all and not limited to high risk populations. Essentially, all youth are "at risk" during this time in our society's development when technology, social media, and other stressors are contributing to a youth suicide and behavioral health crisis.

WHOLE FAMILY EDUCATION AND SUPPORT

- Psychoeducation on youth's behavioral health issues
- Parenting skills and support

In order for an individual to effectively manage their own behavioral health, it is imperative that their surrounding support system have the knowledge and tools to help provide positive scaffolding for wellbeing. This is particularly true for the young people in our state. Children and youth live, learn, and grow within a family system that profoundly impacts their social, emotional, and behavioral development. Given indisputable evidence of how critical the health, wellbeing, and awareness of parents and caregivers are to the behavioral health of their children, the value and importance of whole family education and support is central to a successful system of care. This includes psychoeducation and parenting support for all caregivers.

EASY ACCESS TO SCREENING AND REFERRALS

- Screening and assessment
- Referral services

Across the board there needs to be increased awareness of and access to screening and referral services in our state—for those in immediate crisis, but also for youth and families who simply need assistance determining what kind of support they need and where to find it. Without broad awareness of resources and ready access to information and early identification services, we will continue to see the startling increase in behavioral health problems and youth suicide rates in our state. Standardized screening assessments are recommended to aid in communication and coordination of care as well as prevention efforts.

CARE COORDINATION

- Care coordination and navigation

Navigating the behavioral health care landscape can be incredibly daunting. Many spend several months trying to find the right service, during which difficulties often worsen, further disrupting lives and developmental trajectories. Timeliness of identification and intervention is particularly crucial for children given how rapidly their brains and behavior patterns are developing. There is a tremendous need for easily accessible and highly trained care coordinators who help individuals and families navigate the system, connect with the right service at the right time, and aid in ensuring continuity of care and collaboration among providers with seamless care transitions. Care coordination is an essential service that should be covered by insurance and other funding sources. This should include linkages and warm hand-offs to services that address social determinants of health, such as food, housing, and transportation. There are opportunities to consider training or certification in care coordination for individuals who do not have advanced degrees in behavioral health.

UNIVERSAL PROMOTION AND PREVENTION

- Awareness campaigns (e.g., public service announcements, behavioral health information and tips shared via media, internet, printed materials, and presentations in schools, primary care offices, and other community settings)
- Safe community spaces and afterschool programs that promote positive youth development
- Social-emotional learning and coping skills development

Intentional integration of social emotional learning and behavioral health education throughout our communities—in classrooms, doctors' offices, workplaces, and the media—can help promote awareness and actions that support mental and physical wellness across the lifespan. In particular, children, adolescents, and young adults are in a critical period of developing social emotional skills and coping strategies that promote lifelong resilience and wellbeing. Providing youth and those who educate and care for them with knowledge and tools is a powerful and cost-effective way to help prevent behavioral health issues from developing or progressing. Awareness building and education should be happening in all settings where youth and families spend their time—especially schools, youth agencies, and primary care settings. Ensuring access to safe community spaces and afterschool programs for children and teens is another important way to promote resilience and support positive youth development.

Upstream prevention efforts begin with universal approaches that are designed for an entire population regardless of individual risk factors. These strategies are generally provided through easily accessible platforms, such as web-based written resources and training, as well as large group outreach and education efforts. These approaches can often be provided at low cost and by trained lay people rather than behavioral health professionals. For example, many schools are implementing resilience and suicide prevention programs, such as Sources of Strength (sourcesofstrength.org), which train students and caring adults to facilitate peer education and support.

TARGETED PREVENTION

- Selective prevention services
- Indicated prevention services/early intervention
- Trauma-informed psychoeducation, coping skills training, and preventive interventions following exposure to potentially traumatic events or other adverse childhood experiences (ACEs), regardless of diagnostic status
- Peer support
- Exercise programs
- Nontraditional therapies
- Group counseling
- Home visitation (e.g., for new or at-risk parents)
- Comprehensive family programs
- Parenting education for caregivers specific to the child's experiences or condition

Targeted prevention includes both "selective" and "indicated" prevention strategies. Selective prevention targets at-risk populations regardless of identified symptoms or problems. For example, providing trauma-informed psychoeducation and supportive services for those who have been exposed to potentially traumatic events or adverse childhood experiences (ACEs). Indicated prevention includes early interventions aimed at individuals with identified behavioral health issues and needs that are designed to reduce symptoms and prevent additional difficulties and life disruption. These are often less intensive and more cost-effective therapeutic approaches, such as

group counseling or peer support, that can help prevent the need for services that are more expensive or difficult to access. Targeted preventive services should be readily accessible and covered by insurance or other funding whether or not the impacted individuals have a diagnosable condition or disorder. We need to move towards including a strengths-based wellness approach to behavioral health and resilience rather than limiting our scope to illness and medical models of care.

SCHOOL BASED SERVICES

- Screening, Assessment, and Referral services
- Social-emotional learning and coping skills development
- Suicide prevention training
- Parenting education and training
- Psychoeducation
- Educational supports and accommodations
- Peer support
- Group counseling
- Individual counseling

As most children and youth are enrolled in an educational setting, early childhood centers, schools, and colleges are key locations for providing behavioral health screening, prevention, and intervention. Students who have unaddressed trauma, loss, and behavioral health needs are less likely to be able to engage successfully in school—academically or socially. In order to fulfill their commitment to whole child education, schools need to have the funding and resources to provide tiered services that meet the diverse needs of their students—whether through behavioral health professionals employed by the school or in close and coordinated partnership with providers in their community. These services should include social emotional and coping skills education, suicide prevention training, behavioral health screening and assessment, individual and group counseling, and referral and care coordination. Training of teachers and school personnel is also key to an informed and supportive environment for all children and families.

INTEGRATED CARE SERVICESS

- Integrated primary care
- Integrated specialty care
- Screening, Assessment, and Referral for behavioral health and substance use issues
- Psychoeducation and coping skills training
- Parenting education and skills training
- Individual counseling/therapy
- Medication management

Increasing the amount of primary care and other health care settings that have behavioral health providers imbedded in the practice is central to attending to mental health and substance abuse needs in a timely manner by removing barriers to this support, such as stigma and lack of understanding of behavioral health needs. Early identification is key to prevention and effective intervention. At a minimum, health care settings need to be trained and equipped to provide screening assessments that help them direct their patients to appropriate care, including warm hand-offs and ongoing care coordination with affordable and accessible behavioral health providers. Given that a large percentage of psychiatric medication management is already provided by primary care physicians, it is essential that continuing education and training in psychiatric care is required. To aid in care integration efforts, behavioral health needs must be covered by insurance at parity with other health conditions.

OUTPATIENT SERVICES

- Screening, Assessment, and Referral services
- Psychoeducation and coping skills training
- Clubhouse Services
- Parenting education and training
- Individual counseling/therapy
- Group counseling/therapy
- Family counseling/therapy
- Substance use disorder treatment (e.g., MAT)
- Psychiatric medication management
- Telehealth (for all of the above services)

A successful system of care requires ample access to outpatient providers with training and specialization in varied behavioral health issues and with demonstrated cultural, developmental, social, and linguistic competence. This includes private practitioners, group practices, nonprofit organizations, and behavioral health organizations. Outpatient providers offer such services as assessments, psychoeducation, parenting support, individual and group counseling or therapy, family therapy, substance abuse treatment, and medication management. There is a particularly large gap in availability of providers in rural and mountain communities in Colorado, requiring financial incentives for professionals to practice in these areas. Telehealth approaches are also a very helpful way to expand access to outpatient care for those who are not able to get to a physical location for services.

INTENSIVE HOME AND COMMUNITY BASED SERVICES

- Frequent psychotherapy sessions
- Frequent medication management sessions
- Intensive family therapy
- Functional Family Therapy (FFT)
- Multisystemic Therapy (MST)
- High Fidelity Wraparound
- Ancillary home-based services, home health care, habilitation
- Rehabilitation and recovery services
- Therapeutic preschools and schools
- Partial hospitalization/day treatment
- Peer support
- Exercise programs
- Nontraditional therapies
- Respite

Youth with behavioral health issues that warrant several hours of intensive community-based services each week need a comprehensive and coordinated treatment plan to prevent escalation to more restrictive and costly levels of care. Youth who are transitioning back from residential or inpatient care to living at home or in the community need services that aid in successful adjustment and maintenance of health in addition to continued behavioral health treatment. Youth and families with this level of need must have access to intensive services, such as frequent psychotherapy and medication management sessions, ancillary home-based services, intensive family therapy, high fidelity wraparound services, peer support, exercise programs, non-traditional therapies, rehabilitation and recovery services, and respite for parents and caregivers. Therapeutic schools, partial hospitalization programs, and day treatment facilities are also essential for those in need of care and supervision throughout the day.

RESIDENTIAL CARE

- Residential psychiatric and substance use disorder treatment facilities
- Therapeutic and rehabilitation group homes
- Therapeutic foster care
- Juvenile justice/corrections therapeutic facilities (e.g., trauma-informed individual and group therapy, substance use disorder treatment, life skills training, social-emotional learning and coping skills development, whole family psychoeducation)

Short- and long-term residential behavioral health care must be available to youth who are not able to live safely in their homes due to mental health, developmental disability, and/or substance abuse issues. This includes treatment facilities, therapeutic and rehabilitation group homes, and therapeutic foster care. For youth who are incarcerated or in juvenile justice facilities, trauma-informed therapeutic services, life skills training, social emotional learning, and whole family education and support are all vital to rehabilitation and prevention of reoffending or exacerbated mental health and substance abuse issues.

INPATIENT HOSPITALIZATION

For individuals who are a danger to themselves or others or whose symptoms are too severe to be managed in the home or community, there must be an adequate number of accessible inpatient beds and providers to accommodate their needs. In particular, our state has seen a tremendous increase in youth arriving at emergency rooms with suicidal ideation and behaviors, and without a corresponding increase in inpatient services we will continue to see our youth suicide rates skyrocket.

CRISIS SERVICES

- 24/7 crisis hotlines
- Mobile crisis services
- Crisis assessment, intervention, and stabilization services
- Co-responder units (police paired with behavioral health and IDD professionals)
- Integrated emergency departments
- Detox services

It is essential that youth and families have ready access to crisis services across the state. These must be effective services that ensure that those in crisis receive the care they need in the moment and ongoing support for continued stabilization. These include 24/7 crisis hotlines, mobile crisis services, co-responder units (police paired with behavioral health and intellectual and developmental disabilities professionals), integrated emergency departments, detox services, and crisis assessment, intervention, and stabilization services. Given disturbing increases in youth anxiety, depression, substance abuse, co-occurring diagnoses, and suicide attempts—with younger and younger children dying by suicide, it is critical that all children, adolescents, young adults, educators, parents and caregivers are aware of crisis services that are easily and immediately accessible throughout Colorado.

Appendix 5. External Experts Who Reviewed the State Safety Net Subcommittee Definition of High Intensity Behavioral Health Services

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Appendix 6. Common Acronyms

AOT - Assisted Outpatient Treatment

ASD - Autism Spectrum Disorder

CDE - Colorado Department of Education

CDHS - Colorado Department of Human Services

CDPHE - Colorado Department of Public Health and Environment

DOI - Division of Insurance

DORA - Department of Regulatory Agencies

FAS - Fetal Alcohol Syndrome

HCPF - Department of Health Care Policy and Financing

IDD - Intellectual and Development Disability

ITP - Incompetent to Proceed

JBBS - Jail-based Behavioral Health Services

LCSW - Licensed Clinical Social Worker

LGBTQIA+ - Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, Plus other identities

OBH - Office of Behavioral Health

OCYF - Colorado Office of Children, Youth and Families

OEC - Colorado Office of Early Childhood

PCP - Primary Care Provider

SAMHSA - Substance Abuse and Mental Health Services Administration

SUD - Substance Use Disorder

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