League of Women Voters of Colorado (LWVCO)

Behavioral Health Task Force: Final Report - May 2014

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Introduction
In March, 2013, the League of Women Voters of Colorado (LWVCO) Board of Directors authorized formation of a Behavioral Health Task Force. Following the Aurora, Colorado, theater shootings, five local leagues – during program planning - called for study at the state level in the area of mental health; three of those asked that gun violence be included. The Board noted that this was not a strong enough recommendation for an actual statewide study, and, therefore, authorized the task force “to gather sufficient information about Colorado’s Behavioral Health system, including information available about behavioral health and gun violence, to present an overview and recommendations at LWVCO Council in May, 2014.”

In April 2013, the Behavioral Health Task Force began a year-long information gathering process. The Task Force decided on its scope of work, heard from 13 highly qualified experts in behavioral health, researched and read publications, and obtained information from other Colorado resources. Seventeen Task Force members – psychotherapists, medical professionals, a former state representative, a former chief/district judge, a county commissioner, director of a substance use prevention agency, parents of adults with mental illness, and volunteers on statewide and county boards and behavioral health organizations - represented 10 Colorado leagues.

The topics found in this report are those about which the Task Force gathered information; there are additional topics that we wish could have been included, such as medication, therapy trends, private sector services, etc. We believe we have presented a concise, and fairly complete, overview of behavioral health needs, services, challenges and promising practices in Colorado. The section of this report on pages 29-30 contains recommendations for League of Women Voters action as well as for behavioral health policy and practice.

Language in this Report:
Behavioral Health includes the areas of mental health and substance use disorder (SUD). Several years ago, the Colorado Department of Human Services, in line with national trends, brought its mental health and substance abuse treatment divisions together under a newly created Office of Behavioral Health.

“The mentally ill” is an almost automatic cliché in American society. In gathering information for this report, the Behavioral Health Task Force listened to persons in recovery from mental illness as they asked not to be labeled by their diagnoses; they are, and will always be, people first. Speakers noted that mental illness is a wide spectrum of brain disorders, from mild to severe; those with mental illness should not be grouped into one category. For those reasons, we have tried to say “people with mental illness” rather than using the above cliché.

Colorado’s Public Behavioral Health System
Office of Behavioral Health
In 2008, Governor Bill Ritter formed a Behavioral Health Cabinet consisting of the heads of various departments whose services included, or touched on, behavioral health. The cabinet received information from a Behavioral Health Transformation Council formed through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant and consisting of representatives from many service provision areas including mental health, substance use, education, criminal justice, human services, etc. In addition, the Colorado Department of Human Services consolidated mental health and addiction treatment services into the Division of Behavioral Health. In 2011, the division was renamed the Office of Behavioral Health (OBH). Its mission is “To strengthen the health, resiliency and recovery of Coloradans through quality and effective behavioral health prevention, intervention, treatment and recovery”.

The following information was gathered from a presentation to the LWVCO Mental Health Task Force by Lisa Clements, Director, Office of Behavioral Health, on August 8, 2013.
The goals of the Office of Behavioral Health (OBH) are to 1) provide quality, recovery-oriented behavioral healthcare across all public and private systems; 2) ensure access from all entry points; 3) encourage integration of behavioral and physical healthcare; 4) increase wellness through prevention/early intervention; 5) reduce stigma through public education; and 6) develop/provide policy, data and financing for a strong, transformational behavioral health system.

OBH provides oversight for Colorado’s two mental health institutes — Colorado Mental Health Institute at Pueblo and the Colorado Mental Health Institute at Ft. Logan. OBH’s current objectives for the institutes involve 1) reduced use of seclusion and restraint through implementation of trauma-informed practice; 2) reintegration of hospitalized patients into community settings; and 3) increased implementation of recovery-focused treatment (see the section of this report titled Colorado Mental Health Institutes).

OBH provides monitoring for Community Behavioral Health Services – four Behavioral Health Organizations (BHO’s) and seventeen community behavioral health centers across the state. OBH’s current objectives for community-based treatment involve 1) increased access to treatment services; 2) reduction in substance abuse; 3) reduction in symptom severity; 4) support for housing and employment access and stability; 5) development of a comprehensive crisis response system; and 6) improvement of data collection (see report section titled Public Behavioral Health Services).

OBH has strategic initiatives in five areas:

- **Community-wide Crisis Response System** – Develop a statewide behavioral health crisis response system to improve access for consumers as early as possible; to decrease unnecessary civil commitments (to hospitalization), use of hospital emergency rooms, jails and homeless programs; and to promote individual recovery. Components of a crisis response system would include: a crisis helpline; walk-in services at crisis centers; mobile services; respite and residential services and a statewide public awareness campaign.

- **Improved Community Capacity** - Address lack of funding and inability to develop the capacity for delivery of a continuum of services; provide community living for individuals currently placed in psychiatric settings, nursing homes, and jails – this involves development of a) Alternative Living Residences (ALR’s); b) housing and other subsidies; and c) wrap-around services in areas such as personal needs, mentoring and transportation.

- **Jail-based Restoration to Competency** – Restoration to Competency involves treatment of mentally ill inmates so that they are competent to stand trial; this is now done at the Colorado Mental Health Institute at Pueblo (CMHIP). Developing local jail-based Restoration programs will make more civil beds available at CMHIP. The Arapahoe County Jail now has an 18-bed program.

- **Colorado Behavioral Health Integrated Data Tool** – Develop a data base that consolidates mental health and substance use data and includes some physical health data. This tool will replace the current Colorado Clinical Assessment Record System (CCARS).

- **Mental Health Institute Treatment programs** – Improve patient outcomes through implementation of trauma-informed treatment.

The Office of Behavioral Health administers federal and state funds for community behavioral health, including prevention and intervention services, treatment and recovery services, outpatient, residential and detoxification services and evidence-based programs. OBH’s goal is to consolidate the areas of mental health and substance use into one federal block grant for Colorado. In **2012-13, Colorado’s budget – including the state general fund, various cash funds, Medicaid, Block Grant and other federal monies - for Substance Use Disorder (SUD) services totaled $52,263,065 with 149,575 persons served. In 2012-13, Colorado’s budget – same categories as SUD above - for mental health services totaled $55,450,985 with 96,000 persons served.** OBH oversees the Approved Treatment Provider Program for the Colorado Department of Corrections. This program funds community programs for offenders with mental health and substance use issues, domestic violence backgrounds, and for sex offender treatment. OBH provides some funding for Mental Health/Drug Courts (see section: Behavioral Health & Colorado’s Criminal Justice System).
Community Behavioral Health Centers
Information below is from a September 26, 2013 presentation to the LWVCO Mental Health Task Force by George Del Grosso, Executive Director, Colorado Behavioral Healthcare Council, and Moe Keller, Vice President for Public Policy and Strategic Initiatives, Mental Health America of Colorado. Additional information below is from an August 8, 2013 presentation by Lisa Clements, Director, Office of Behavioral Health and from Carl Clark, M.D., Executive Director, Mental Health Center of Denver, on December 6, 2013.

Mental Health Service Delivery
Public Mental Health services in Colorado are delivered through the state departments and divisions below (adapted from Mental Health America of Colorado); the Division of Behavioral Health is now the Office of Behavioral Health:

The Office of Behavioral Health and Colorado’s community mental health centers are under the Department of Human Services. The Behavioral Health Organizations (BHO’s) administer the state’s Medicaid contract for care of individuals with severe and persistent mental illness. Colorado’s 17 Community Mental Health Centers are members of the Colorado Behavioral Healthcare Council (CBHC), whose 28 members also include organizations providing treatment for Substance Use Disorder (SUD). All 17 mental health centers in Colorado are private non-profit organizations with community boards; there are almost 200 sites including the centers and their satellites - some, for instance, schools, are very small delivery sites. Each local community, usually at the county level, makes decisions about what programs to offer based on perceived need and budget. Boulder, Colorado, passed local funding allocations for additional services – over and above what most community mental health centers can offer. One hundred forty of the sites integrate behavioral health professionals into their physical healthcare sites and two mental health centers are federally qualified integrated healthcare centers (Durango and Adams’ Community Reach). All mental health centers are also licensed as substance use disorder (SUD) provider agencies.

Lisa Clements, Director of the Office of Behavioral Health, noted that community mental health centers must provide the following: Patient Assessment services; Clinical Treatment services; Case Management services; Rehabilitation services; Emergency services; Residential services; Inpatient services; Vocational services; Psychiatric Medication management services; Interagency Consultation; Public Education; Consumer Advocacy and Family Support; and Day Treatment, Home-based, Family Support and/or residential support services for children and adults.

Mental Health Center of Denver (MHCD) has programs for infants to seniors, including programs for young people because that is a time mental illnesses often emerge. MHCD partners with Urban Peak, an agency serving runaway and homeless youth and has programs for 16 – 26 year olds. MHCD provides services at 60 sites and measures progress in terms of recovery. An assessment is completed for each consumer; services provided depend on individual circumstances, including homelessness. Many clients come to MHCD upon discharge from prison or jail rather than go back to smaller communities, where they would be known; they need a good mental health center and a good parole officer. MHCD receives referrals from many sources; the largest number is from the police.
Integrated Physical and Behavioral Health Care

Integrated physical and behavioral health care was the topic most emphasized in presentations and information gathering about care in rural areas.

Barbara Allen Ford, Task Force member, brought information about the Colorado Beacon Consortium which consists of executive-level representation from four mission-driven, non-profit, Western Colorado-based organizations, all of which have nationally acknowledged track records of coordination to achieve superior outcomes. These are: Rocky Mountain Health Plans, Mesa County Independent Physicians' Practice Association, Quality Health Network and St. Mary's Regional Medical Center. The Colorado Beacon Consortium’s mission is: “To optimize the efficiency, quality and performance of our health care system, and integrate the delivery of care and use of clinical information to improve community health. The geographic focus of the Consortium’s activities includes the Colorado counties of Mesa, Delta, Montrose, Garfield, Gunnison, Pitkin and Rio Blanco. To learn more, visit www.coloradobeaconconsortium.org.

Nancy Ball, Task Force member, gathered the following information in a September 2013 interview with Janey Sorenson, Montrose Mental Health Center: “Colorado is "light years" ahead of other states in providing integrated (medical and physical health) care. As half of all life-time cases of mental health issues are evident by the age of 14, three quarters by age 24, the integrative (mental and physical health) programs provided by the Center catch these disorders at an earlier time in the disease where recovery is more likely.” Montrose Mental Health Center has a Colorado Health Foundation integrative medicine grant that is in its 5th year. When a youngster presents at Pediatric Associates in Montrose or Delta for care, the child is given a behavioral health assessment through the use of "patient tools" – a hand-held electronic tablet that contains behavioral health screenings that the patient or parent on behalf of the child (depending on the child’s age) completes while in the waiting room. Once completed, the report is downloaded and printed and it goes into each patient's file. If the assessment has raised a red flag for possible behavioral issues, and after the doctor has examined the patient, there is a seamless hand-off to the full-time staff therapist for further assessment and care. This same approach is used for children at the Northside Child Health Center and for patients of all ages in the Olathe Community Clinic and the Uncompahgre Medical Center in Norwood.

Dorothy Perry, CEO, Spanish Peaks Behavioral Health System, Pueblo, gave the following information in her Nov. 8, 2013 Task Force Presentation: Spanish Peaks places a heavy emphasis on health care integration as emphasized in the Affordable Care Act. Spanish Peaks has established a Care Services Tracker to help in this process. The Mt. Carmel (Spanish Peaks satellite) site in Trinidad, Colorado is a model of integrated mental and physical health care; it is also a community center with a bistro and a meditation garden. Mt. Carmel has two physicians and two nurse practitioners providing physical health care. Spanish Peaks wants to open an integrated center in Pueblo and is recruiting doctors who are invested in integrated care. Telepsych services (like telemedicine) are proving very useful for outlying areas, especially Trinidad and Walsenburg; the physician can be anywhere; the assigned nurse is on the conversation so that prescribing is immediate. Spanish Peaks has a Medicaid rural crisis care contract and must respond to crisis calls within 2 hours. The system has a crisis department that is open 24/7. Dr. Perry stated, “Behavioral health stigma is real. Everybody in a small town recognizes your car or truck. When you’re parked in front of a clinic that provides integrated care, no one knows whether you are there for physical or behavioral health services.”

Although the interviews above describe successful provision and integration of services, a 2012 Survey of Psychological and Psychiatric Care in Mesa County, with 83 of 168 Grand Junction, Colorado providers responding, found that only 22% rated mental health care above the midpoint and that 37% rated it below. No respondents rated it excellent. The survey noted that funding for care is fragmented and uncoordinated and that working poor are not generally able to purchase behavioral health services. The survey also described a pronounced lack of providers of psychiatric and substance use disorder services in rural areas of Colorado.
Colorado’s Mental Health Institutes

On Feb. 8, 1879, the Colorado legislature approved the creation of a State Insane Asylum. The Asylum opened Oct. 23, 1879 with 12 patients, a three-story farm house for the male patients and a newly built one story frame house for the women, on the northeastern edge of Pueblo. In the early 1880’s, the Asylum moved to the current “South Grounds”, in Pueblo. By 1910 there were 1,131 patients. In 1917 the Legislature changed the name to the “Colorado State Hospital.” As the census slowly grew, large buildings were built, remodeled, destroyed and rebuilt. In 1933, 247 acres (three square blocks) were purchased north of the campus and became the “North Grounds”, with more new buildings. In July 1961, Ft Logan Mental Health Center was opened in Denver on the grounds of the former Ft. Logan Army Base.

In the early 1950’s the first psychotropic drugs were introduced. For the first time, there were treatment tools besides electroshock, and this lead to what might be called the “golden age” of psychiatry. For a time, the drugs were seen as a “cure” for mental illness, rather than a “treatment”. They are now known as effective and very helpful, but they must be taken appropriately and over extended periods of time under supervision and with other appropriate treatment.

By 1959, there were 6,000 patients in the Colorado State Hospital (Pueblo). A new hospital superintendent changed the well run “custodial hospital” into one of the highest ranked state hospitals in the country. However, with the advent of health maintenance organizations and for-profit insurance companies, treatment for mental illness was not well covered. The effect of these changes and the War on Drugs was that all of the private psychiatric hospitals in Colorado closed. Mental health beds are now scarce and, in the United States, jails and prisons have become the largest mental health treatment centers, effectively criminalizing people with mental health and substance use problems.

In 1991, the names of the State Hospitals were changed to the Colorado Mental Health Institute at Pueblo, (CMHIP) and the Colorado Mental Health Institute at Fort Logan, (CMHIFL). CMHIP currently consists of the Circle Program, with 20 beds, the General Adult Psychiatric Services with 144 beds and the Institute of Forensic Psychiatry with 307 beds. Most of the buildings on the CMHIP Campus are now used by the Department of Corrections and the Youth Offender System, with some beds being used by the Pueblo County Jail for a work release program.

CMHIP is the hospital designated by law as the hospital for treatment of individuals committed by the District Courts as “Not Guilty by Reason of Insanity” or “Incompetent to Proceed”. Hence, it has been the usual facility where individuals who have entered these pleas are sent for observation. The number of incompetency examinations has increased by 351 percent (from 61 to 275) from FY 2004-05 to FY 2011-12 and to 1,283 in FY 2012-13. This is a further reflection of the criminalization of people with behavioral health issues. CMHIFL currently has 94 adult inpatient beds, and has the only unit in the state that treats mental health clients who are deaf or hearing impaired. Admission to both of the Institutes must meet the criteria of “grave disability and/or danger to self or others.” Admissions must be evaluated and approved by a Mental Health Center or ordered by the court.

Colorado’s Criminal Justice System and Behavioral Health

Problem Solving Courts - Mental Health and Drug Courts

The following information is from an Oct. 17, 2013 presentation by Brenidy Rice, State Problem Solving Court Coordinator for Colorado’s Office of the State Court Administrator.

Problem solving courts began as drug courts in Miami, Florida and are based on the rationale re-stated by Ms. Rice: “You can’t punish someone out of addiction”. Colorado now has 75 problem solving courts; 8% are adult mental health courts and 3% are juvenile; 89% are drug courts. The Problem Solving Court model works – there are 5-7 years of research and compelling evidence of effectiveness and success. Overall, money is saved and recidivism is reduced.
This is a non-adversarial model – not like traditional court where clients do not speak and lawyers argue; it integrates the treatment and judicial systems. Clients have broken the law and have addiction and/or mental health issues. If they and the court agree, they are sentenced to a Problem Solving Court rather than jail or prison, and an individualized plan is agreed upon. The client speaks directly to the judge; the team, led by the judge, is: judge, prosecutor, defense attorney, treatment provider(s), caseworker, probation officer, and, sometimes, a physician. Clients appear every week in court; the judge reviews what they are working on, whether they are on time for therapy appointments, court, etc. The judge is encouraging but must see compliance with the plan; if the client fails this, there are immediate sanctions such as jail time. Clients usually spend 18 months to 2 years in these courts before graduating.

**Behavioral Health and the Colorado Prison System**

*The following information is from a March 14, 2014 teleconference interview with Renae Jordan, Director of Clinical and Correctional Services, Colorado Department of Corrections (CDOC). Unless stated, statistics below were gathered by the CDOC on February 28, 2014.*

- **Inmates with Mental Illness**: Over 35% of the 17,708 inmates in Colorado’s prison system have a mental health diagnosis and 10% of all prisoners are considered severely mentally ill.
- **Inmates with Substance Use Disorder (SUD)**: Almost 72% of total prisoners are severe substance abusers; almost three quarters of these are male.
- **Inmates with dual diagnoses** – mental illness and substance use disorder: 27% of the total prison population is dually diagnosed; 8% of total inmates are severely mentally ill and have SUD.
- On March 14, 2014, 13,653 inmates were in state-run prisons; 3,855 were in privately-run prisons.
- Of all Colorado prisoners at this time, 145 were admitted under age 18; of those, 2 are currently under age 18.

When people enter the prison system, they are first sent to the Denver Reception and Diagnostic Center (DRDC), where, on the day they arrive, they are given a psychological assessment that includes a review of their psychological histories. Based on this assessment, they are assigned a P, or psychological, code from 1 – 5, with 1 meaning no mental illness. A P code of P3-P5 can mean serious or severe mental illness; as needed, these codes are enhanced by a functionality or behavioral code, i.e. someone with a P3 code may be a person with schizophrenia who is currently functioning well. Prisoners are also given a substance abuse code ranging from SA1 – SA5.

Prisoners are sentenced and wait in jail to be transported to a prison. If they have a mental health diagnosis, they are seen by a psychiatrist. Prior to arrival at prison, prison staff reviews all diagnoses and assessments; staff also tries to ensure that all medications are continued. When prisoners are at their permanent facilities, they are on a list to be seen by a psychiatrist based on their assigned codes; treatment should then begin immediately and continue. Psychiatrist visits to inmates are as needed.

Treatments and therapies, available to both men and women prisoners, include psychological evaluations, prescriptions, general mental health groups and transitions planning. The general mental health groups include: Seeking Safety, Anger Management, Patterns of Antisocial Behavior Disorders, Commitment to Change, and various animal therapies such as the Canine Companions program in which dogs are trained by prisoners for use by people outside of the prisons who need a canine companion. Drug and alcohol treatment programs and sex offender treatment programs are also available. Ms. Jordan noted that females’ psychological needs are generally related to trauma and that women seek treatment more readily. The Denver Women’s Prison has over 900 offenders at any one time; usually 76% of these women are participating in mental health treatment. Interestingly, no statistics about childhood abuse for men or women are kept by the Colorado Department of Corrections. Past abuse may be revealed in treatment or may be a reason for treatment.
A prisoner’s prescribed medication can usually be dispensed from the prison pharmaceutical formulary. If specific medications are not available, they may be purchased from local pharmacies; a nurse must make a note in the prisoner’s record and the prison must then go through a non-formulary process. There usually are no lags in medication, but, if lags are present, it is usually because transmission of information from a local jail is not complete. During an inmate’s parole time, there may be a gap in medication because it is difficult to monitor the condition of a prisoner on parole. CDOC is working to put offenders in touch with local treatment providers before they leave the prison.

At the present time, no prisoners with severe mental illness are in administrative segregation (solitary confinement). CDOC now has a rule that no one who is severely mentally ill will be placed in administrative segregation (severely mentally ill generally means a diagnosis of schizophrenia or schizo-affective disorder). Clinicians are available to do ongoing assessment of prisoners in administrative segregation; if a person develops mental health symptoms, they receive a new P code. This triggers monitoring and contact with primary clinicians and counselors. If a prisoner is dangerous and counseling or treatment is needed, the inmate is escorted to a table where he or she can be restrained and strapped down. Those with acute mental illness may be transported to the San Carlos Prison for severely mentally ill inmates at the Colorado Mental Health Institute at Pueblo.

CDOC is in the process of changing policies for prisoners relative to administrative segregation; there are internal initiatives now to remove individuals from administrative segregation and those with severe mental illness are the first focus. In Colorado, prisoners may be placed in Mental Health Step-Down units or sent to a mental health hospital. In addition, CDOC worked with legislators about language in SB 14-064 that deals with mentally ill prisoners and administrative segregation; CDOC doesn’t want to eliminate administrative segregation as an option. The average length of time that prisoners are in continuous administrative segregation is about 23 months, and there is no limit to how many times a prisoner may be placed in administrative segregation – this is based on behavior (if a prisoner is severely mentally ill, this doesn’t apply). Administrative segregation is used as needed depending on behavior, i.e. whether a prisoner is a risk to the general prison population. CDOC has two additional options for dealing with prisoners who are out of control: 1) an interagency agreement with the Colorado Mental Health Institute at Pueblo for treatment at San Carlos; and 2) a civil commitment option.

Rick Raemish, Director of the Colorado Department of Corrections, published a letter in The New York Times in 2013 about his experience when he asked to be placed in solitary confinement for 20 hours. He described isolation from others, even from sound and ordinary sights and noted that he felt paranoid after a few hours. As attention to the issue of placing prisoners with mental health issues into solitary confinement has increased, there is growing concern, and a growing consensus, to move away from using solitary confinement as often as has been done. Sen. Dick Durbin, D-Ill., who leads the Senate Subcommittee on the Constitution, Civil Rights and Human Rights, announced recently that the Federal Bureau of Prisons (FBP) will conduct its first review of the use of solitary confinement and that the FBP is calling for tighter rules on how long juveniles, pregnant women, and prisoners with mental illness can be held in solitary confinement.

Asked whether it would be less expensive and more appropriate to treat a person’s illness rather than incarcerate him or her when that illness has played a role in the commission of a crime, CDOC’s Renae Jordan noted this may be true, but that there is a lack of community services. She noted that prisons are the largest providers of mental health treatment in the U.S.

Privately-run Prisons
Privately-run prisons have their own policies but, by contract with the state, they must adhere to clinical standards of practice. Prisoners in private prisons are relatively mentally healthy and certain P codes cannot be sent there. The staff to prisoner ratio is different, i.e. the state-run system houses prisoners with greater mental health needs and increased custody levels, and these mean greater staffing needs.
The Affordable Care Act and Transition Out of Prison
There is no use of Medicaid or Medicare or any other federal funds in prisons - all funds are state funds; prisoners lose federal funds when they are incarcerated. Parole contracts provide for community providers, but cost is a factor and there are extensive criteria. Under the Affordable Care Act, planning for transition out of prison includes work to reinstate Medicaid benefits. CDOC has hired people who begin this navigation 30 days before a person leaves prison, and HCDF (Healthcare Policy and Financing – the administrator of Medicaid) has put these applications on a fast track; approval takes a week and prisoners leave with a Medicaid card.

Financing Behavioral Health Services
Multiple Streams of Funding for Behavioral Health Care

Behavioral health services are paid for through many sources of funding. Medicaid, which is 50:50 State and Federal funds, is the primary payer of public mental health services. However, services also are funded through 1) a federal Block Grant, 2) some Medicare - which provides health services to two categories of disabled individuals in addition to those over 65, and 3) private insurance. Counties often contribute funds in support of their own local community mental health centers, but the amount varies across the state. The Veterans Administration also contributes to behavioral health care. In addition, there is an array of funding streams - including federal, state, and foundation programs - that fund projects or programs in individual communities, often on an experimental basis, designed to shift priorities at the local level. Finally, out-of-pocket by individuals accounts for more than 10% of nationwide mental health treatment payments in a 2005 study, and about 6% of nationwide substance abuse treatment spending. (Mark, et. al. - Colorado Trust, 2011).

In 2012-13, Colorado’s budget – including the state general fund, various cash funds, Medicaid, Block Grant and other federal monies - for Substance Use Disorder services totaled $52,263,065 with 149,575 persons served. In 2012-13, Colorado’s budget – same categories as SUD above - for mental health services totaled $55,450,985 with 96,000 persons served. Office of Behavioral Health Director Lisa Clements has noted that Colorado is 48th in the nation in per capita spending for behavioral health.

State funds and the Federal Block Grant: These funding streams are the primary sources of funding for behavioral health treatment in Colorado. Historically, federal Block Grants for mental health and substance abuse have supported treatment for medically indigent populations. The Office of Behavioral Health (OBH) is working to have one block grant that includes both mental health and substance abuse. With the advent of the Affordable Care Act (ACA), Block Grant funds may be focused on unmet needs and on the needs of indigent people such as undocumented immigrants. The planning required by the Block Grant forms the basis for the allocation and distribution of the federal funds ($532,000 in 2013), and other state funds. This money was nearly 13% of one mental health center’s funding in 2013. Additionally, a defined amount of funds is allocated to the Mental Health Center of Denver by the Colorado legislature to acknowledge the disproportionate share of seriously mentally ill individuals residing in the City and County of Denver. These funds, originally allocated to respond to the settlement of the Gobal lawsuit which found that the state had not adequately provided for indigent individuals it had discharged from the Colorado State Hospital, are now a separate line item in the Colorado Long Bill (budget bill).

Private Insurance: While private insurance covers the majority of Americans, it has traditionally financed only about a quarter of spending on behavioral health care. According to one report of the US Department of Health and Human Services, about 1/3 of those covered in the individual market lacked coverage for substance use disorder services, and nearly 20% had no coverage for mental health services. This will change under ACA, as treatment for mental health and substance use disorders must now be provided by health plans as one of the ten required “essential health benefits”.

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Medicare: Medicare has not traditionally been a primary source of funding for behavioral health services because, prior to ACA and federal parity legislation, benefits were limited. Typically, 1) outpatient visits were limited to a specific number each year; 2) Medicare co-pays could be higher than for other types of care; and 3) there was a lifetime limit on the total inpatient days that would be covered. Individuals who met income requirements and were on Medicare due to disability were also on Medicaid which paid for the balance of their care. The Medicare Improvements for Patients and Providers Act addressed parity for Medicare beneficiaries separately from the ACA. The impact of parity will take its time as more and more individuals begin to realize that they have access to mental health and substance use services through their insurance carriers.

Medicaid: Medicaid is the largest source of financing for behavioral health services nationally and in Colorado. Medicaid pays for over a quarter of all expenditures nationally according to the Kaiser Family Foundation. Twenty-one states, including Colorado, have mental health services “carved out” and paid for separately from physical health services under Medicaid. Nationally, Medicaid carve-out capitation systems are designed largely to try to contain costs to redress disparities in funding for mental health and to ensure a strong provider network with specialized management expertise. They also allow for greater flexibility in service delivery to ensure consumers have access to a full array of service options, including prevention and recovery oriented services.

Colorado has used capitated contracts administered by Behavioral Health Organizations (BHO’s). Medicaid beneficiaries are assigned geographically to one of five BHO’s – Access Behavioral Care (metro Denver); Behavioral Health Care, Inc. (metro east); Foothills Behavioral Health Partners (metro west); NE Behavioral Health Partners (NE Colorado); and Colorado Health Partnerships (south, SW, west and NW Colorado). BHO’s arrange or provide medically necessary behavioral health services and pay Community Mental Health Centers based on the number of “covered lives” in their counties or service utilization. Other responsibilities include quality assurance, provider network management, usage management and data collection and analysis.

Concern with the Medicaid “carve out” for mental health, as well as with traditional “fee for service” payment for health services, is emerging because of barriers posed to physical/behavioral health service integration. A growing body of evidence documents that providing integrated services provides better quality care and can result in significant cost savings. One author has stated that savings resulting from a model of integrated care delivery (Collaborative Care) could result in a savings of $15 billion to Medicaid. Supporters of integrated care also advocate for “global payments”, i.e. shifting funding away from paying providers on a per visit basis, and moving to a single, or enhanced, payment providing for all care received over a designated period. In Colorado, the Department of Health Care Policy and Financing (HCPF) has created the Accountable Care Collaborative (ACC) as its primary vehicle for redesigning the payment and service delivery model within Medicaid. HCPF provides care coordination payments to seven Regional Care Collaborative Organizations (RCCO’s), who contract with primary care medical providers. The goals of ACC are to improve health outcomes and reduce health care costs. (Klowden, Mindy, Jefferson Center for Mental Health. Internal documents).

Medicaid Expansion and Behavioral Healthcare
As of 1/1/14, under the Affordable Care Act, Medicaid benefits are expanded.

- The Medicaid SUD benefit is expanded and is under managed care.
- Adults without dependent children are added.
- The expanded benefit serves individuals up to 133% (138% in Colorado) of poverty.
- All who come out of prison are eligible for Medicaid; previously, inmates were released with 90 days of medication.
- Colorado Connect for Care is Colorado’s health insurance exchange; applicants are screened for Medicaid eligibility and then are able to move into looking at other plans.
- People under 138% of poverty are exempt from the Affordable Care Act and are more likely covered by Medicaid.
- With healthcare expansion, providers in Colorado anticipate a workforce shortage for behavioral health.
**Silos of funding:** Each state government department and division (Department of Corrections, Division of Child Welfare, etc.) and each educational institution, etc. in Colorado has its own specific silos—specific funds to cover individuals. When an individual leaves an entity, his or her health benefits go away. Even if a provider has identified an individual as very ill and at risk for possibly violent behavior, if there is no continuing benefit, care is lost (in the case of the Aurora theater shooter who had withdrawn from school and thereby lost his coverage)(Keller presentation 2014).

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**Substance Use Disorder**

**Why we’re discussing Substance Use Disorder with Mental Health**

**Mental Illness and Substance Abuse: Scope of the Problem**

About 1 in 5 US adults suffered from a mental illness, not including a substance use disorder, in 2009, according to a report (2010) from SAMHSA (Substance Abuse and Mental Health Services Administration). However, substance abuse and dependence frequently coexisted in people with other mental illnesses. About 1 in 20 American adults aged 18 or older had a mental illness severe enough to impair major life activities in 2009. For the purposes of the SAMHSA study, the prevalence of serious mental illness was considered a subset of any mental illness, which was defined as having a diagnosable mental, behavioral, or emotional disorder with mild to serious functional impairment. Substance use disorders frequently coexisted with other types of psychiatric disorders. In adults with serious mental illness in 2009, 1 in 4 met criteria for co-occurring substance dependence or abuse. This rate (25.7 percent) was four times the rate (6.5 percent) of substance dependence or abuse in the population with no mental illness (excluding substance use disorders). Alcohol dependence or abuse was present in 1 of 5 adults with serious mental illness and was more common than illicit drug dependence or abuse. These data suggest that it is imperative to screen for and treat addiction in patients with other psychiatric disorders. ([www.samhsa.gov/data/2k12/MHUS2010/MHUS-2010.pdf](http://www.samhsa.gov/data/2k12/MHUS2010/MHUS-2010.pdf))

At least 38 million adults drink too much. Drinking too much includes binge drinking, high weekly use, and any alcohol use by pregnant women or those under age 21. It causes 88,000 deaths in the US each year and costs the economy about $224 billion. ([CDC Vital Signs; www.cdc.gov/vitalsigns](http://www.cdc.gov/vitalsigns)) When applying the national rates of substance use disorders to population estimates from the US Census Bureau (2011) it is estimated that in Colorado 135,000 young adults ages 18-25 and 257,200 adults over the age of 25 have substance use disorders, totaling nearly 400,000 adults with either substance abuse or dependence. ([2011 National Survey on Drug Use and Health](https://www.samhsa.gov/data/2k12/MHUS2010/MHUS-2010.pdf))

**Substance Abuse Treatment in Colorado**

Publicly supported substance use treatment services are partly provided through a statewide network of managed services organizations (MSO). There are over 40 providers in all MSOs and all are licensed by the Office of Behavioral Health. The range in treatment services offered includes outpatient, residential or detoxification programs. Priority is given to involuntary commitments, injecting drug users, pregnant women, and women with dependent children.

**Co-occurring substance use and any mental health disorder**

Rates of co-occurrence of substance use and mental health disorders are high. When applying national estimates to the Colorado population, 800,700 Colorado adults have a substance use disorder or any mental health condition\(^1\). Of the individuals with any substance use or mental health disorder, 226,400 have a substance use disorder only (no mental health disorder) and 165,900 have a substance use disorder along with a mental health disorder. Therefore, approximately 40% of the individuals with substance use disorders also have a mental health disorder.

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\(^1\) Any mental health disorder is defined as a diagnosis that meets the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) excluding substance use disorders.
Substance use disorders are known to commonly co-occur with a variety of mental health conditions but the most common co-occurring mental health conditions are anxiety disorders (Grant et al., 2004; Robinson, Sareen, Cox, & Bolton, 2011; Smith & Randall, 2012) and mood disorders (Grant et al., 2004; Pettinati, O’Brien, & Dundon, 2013). Estimates of Colorado adults with a substance use or mental health disorder in Colorado are shown Figure 2.

### Fig. 2: Estimates of Past Year Substance Use and Any Mental Health Disorder - CO Adults Aged 18 or Older 2011

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance use disorder and no mental health disorder</td>
<td>226,400</td>
</tr>
<tr>
<td>Mental health disorder and no substance use disorder</td>
<td>634,800</td>
</tr>
<tr>
<td>Substance use AND mental health disorder</td>
<td>165,900</td>
</tr>
</tbody>
</table>

**Note:** Chart adapted from Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings (SAMHSA, 2012)

Co-occurring substance use and serious mental health disorders

When examining the subset of individuals with a serious mental health disorders\(^2\) and substance use disorders we find that twice as many Coloradans have a substance use disorder alone than have a serious mental health disorder alone and nearly one third (27%) of the individuals with a serious mental health disorder also have a substance use disorder. In contrast, only 14% of the individuals with a substance use disorder also have a serious mental illness. See Figure 3 for the population estimates.

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\(^2\) Defined as past year diagnoses other than substance use disorders that result in significant limitations in life functioning
Theories on the interaction of substance use and mental health disorders

There are 3 primary theories about how co-occurring substance use and mental health disorders develop and interact. First, experts think that certain mental health and substance use disorders may be linked to a common factor such as genetics (Compton, Thomas, Stinson, & Grant, 2007; Smith & Randall, 2012). For example, people with a particular genetic make-up might be more likely to develop both substance use and mental health disorders.

Second, researchers maintain that people with certain mental health disorders, such as anxiety disorders or depression, may use substances to self-medicate their symptoms. Over time, this self-medication results in problem use of alcohol or drugs (Boden & Fergusson, 2011; Compton et al., 2007; Robinson et al., 2011; Wolitzky-Taylor, Bobova, Zinbarg, Mineka, & Craske, 2012). This theory suggests that in many cases, mental health problems begin before the onset of substance use disorders.

Third, researchers suggest that mental health symptoms can be caused by heavy or prolonged use of alcohol or drugs. They believe that the cycle of intoxication and withdrawal that individuals undergo as they use substances can cause mental health symptoms that would not be present in the absence of substance use (Smith & Randall, 2012).

Thus, most researchers and practitioners believe that there are a number of pathways to development of co-occurring disorders. These pathways are influenced by the genetics and history of the individual, the type of substance used and the combination of certain substances with specific mental health symptoms or diagnoses (Pettinati et al., 2013; Robinson et al., 2011). Because of these multiple pathways, a range of treatments and treatment settings are necessary including specialty substance use disorder treatment.

Conclusion
The prevalence of substance use disorders is quite high and often develops in isolation from serious mental health disorders necessitating a strong network of specialty substance use disorder prevention and treatment services. Roughly 30% of the individuals with substance use disorders have a serious mental health disorder suggesting that effective treatment for this group should include mental health interventions. Specialty substance abuse treatment coupled with mental health interventions such as psychotropic medications are likely to be effective in treating many of these co-occurring disorders (Pettinati et al., 2013).
Children’s Mental Health

Due to time constraints, the Behavioral Health Task Force was not able to schedule a presentation about children’s mental health in Colorado. The Task Force is aware that community mental health centers offer children’s treatment services as well as family and child services. Through an on-line search, we have learned that there are no published reports that provide an overview of behavioral health care for children in our state. This section, therefore, consists of 1) information on the state of children’s mental health from two national organizations: National NAMI and the National Institute for Mental Health (NIMH); 2) information from a George Washington University Center for Health and Health Care in Schools study in eleven states (Colorado is not included); 3) information about Colorado’s Child Mental Health Treatment Act of 1999; and 4) information about the Federation of Families for Children’s Mental Health, Colorado Chapter.


From the study’s Introduction: “Implementation of the Patient Protection and Affordable Care Act (ACA) is well underway, creating long-overdue opportunities for growing the capacity of child and adolescent mental health systems and meeting children’s pressing needs. The good news is that as of January 1, 2014, coverage of mental health conditions and substance use disorders will be required as part of the broad Essential Benefits package of services under the ACA...A challenge to capitalizing on the ACA opportunity, however, is the underdeveloped state of children’s mental health services across the United States.”

“Unlike children’s physical health services, for which there is a robust private and publicly funded functioning system, management and delivery of mental health services are much less well developed or coherent. From significant disconnects among the multiple institutions that serve children and their families to chronic financial instability, the children’s mental health system is fragile and at-risk. Realizing the promise of the ACA for children and adolescents will require acknowledging systemic barriers that often lead to significant disparities and gaps in care.”

National NAMI: Facts about Children’s Mental Health in America July 2010

“Reports by the U.S. Surgeon General (1999) and the New Freedom Commission on Mental Health (2013) offer great hope to the millions of children and adolescents living with mental illness and their families. Through appropriate identification, evaluation, and treatment, children and adolescents living with mental illness can lead productive lives. They can achieve success in school, in work and in family life. Nonetheless, the overwhelming majority of children with mental disorders fail to be identified, lack access to treatment or supports and thus have a lower quality of life. Stigma persists and millions of young people in this country are left behind.

Four million children and adolescents in this country suffer from a serious mental disorder that causes significant functional impairments at home, at school and with peers. Of children ages 9 to 17, 21 percent have a diagnosable mental or addictive disorder that causes at least minimal impairment (U.S. Surgeon General’s Report, 1999). Half of all lifetime cases of mental disorders begin by age 14. Despite effective treatments, there are long delays, sometimes decades, between the first onset of symptoms and when people seek and receive treatment. An untreated mental disorder can lead to a more severe, more difficult to treat illness and to the development of co-occurring mental illnesses (National Institute of Mental Health, 2005). In any given year, only 20 percent of children with mental disorders are identified and receive mental health services (U.S. Public Health Service Report, 2000).”

Consequences of Untreated Mental Disorders in Children and Adolescents

• Suicide is the third leading cause of death in youth ages 15 to 24. States spend $1 billion annually on medical costs associated with completed suicides and attempts by youth up to 20 years of age (NGA Center for Best Practices).
• Approximately 50% of students age 14 and older who are living with a mental illness drop out of high school. This is the highest dropout rate of any disability group (U.S. Department of Education, 2001).
• Youth with unidentified and untreated mental disorders end up in jails and prisons. According to a study by the National Institute of Mental Health (2005)—the largest undertaken—65 percent of boys and 75 percent of girls in juvenile detention have at least one mental illness. “We are incarcerating youth living with mental illness, some as young as eight years old, rather than identifying their conditions early and intervening with appropriate treatment.”

• When children with untreated mental disorders become adults, they use more health care services and incur higher health care costs than other adults.

• Early Identification, Evaluation and Treatment are Essential to Recovery and Resiliency

• Research shows that early identification and intervention can minimize long-term disability of mental disorders for children and teens (New Freedom Commission, 2003). These disorders are real and there is effective treatment, especially when identified early.

• Early identification and treatment prevents the loss of critical developmental years that cannot be recovered and helps youth avoid years of unnecessary suffering (National Advisory Mental Health Council Workgroup, 2001).

• Early and effective mental health treatment can prevent a significant proportion of delinquent and violent youth from future violence and crime (U.S. Surgeon General’s Youth Violence Report, 2001).

Child Mental Health Treatment Act (CMHTA) – Colorado – 1999

The Child Mental Health Treatment Act (CRS 27-67-101, et seq.) was enacted into Colorado law in 1999 and allows families to access community, residential, and transitional treatment services for their children without requiring a dependency and neglect action, when there is no child abuse or neglect. To be eligible, a child must have a mental illness, be under the age of 18, and be at risk of out-of-home placement or at risk of further involvement with a county department of human/social services. The Act applies to Medicaid eligible and non-Medicaid eligible children; the application and payment processes differ. Local and State-level appeal processes are available if services are denied.

Is the Child Mental Health Treatment Act (CMHTA) working for children and their families?

A March 2013 Legal Center for People with Disabilities and Older People letter to the Colorado Department of Human Services (CDHS) cited three cases where parents of children with mental health challenges needing treatment were not informed of the law or were pressured into being named abusive or neglectful in order to get treatment for their children. The Colorado Department of Human Services responded by committing to various actions including 1) creation of a CMHTA Advisory Committee, 2) development and distribution of information about CMHTA for parents and mental health centers, and 3) ongoing regular travel to mental health centers across the state to meet with and train staff.

Federation of Families for Children’s Mental Health – Colorado Chapter

The Federation’s mission is “to be an advocate for children, youth, and families impacted by mental health issues while striving to improve and strengthen related systems, programs, and policies across the state of Colorado.” The Federation offers no direct services but seeks to strengthen and link systems of care in Colorado, understanding that families face a complex and fragmented behavioral health system. The Federation has also published a Family Advocate Toolkit to help advocates guide families through the complexities of juvenile justice and related systems.

From the Family Advocate Toolkit: “A Family Advocate may be called by different titles, including Navigator, Family Associate, Parent Advocate, and Parent Support Partner. According to Colorado revised statutes (27-69-102) a ‘Family Advocate’ means a parent or primary care giver who 1) has been trained in a system of care approach to assist families in accessing and receiving services and supports; 2) has raised or cared for a child or adolescent with a mental health or co-occurring disorder; and 3) has worked with multiple agencies and providers, such as mental health, physical health, substance abuse, juvenile justice, developmental disabilities, education, and other state and local service systems.

A ‘Family Systems Navigator’ means an individual who 1) has been trained in a system of care approach to assist families in accessing and receiving services and supports; 2) has the skills, experience, and knowledge to work with children and youth with mental health or co-occurring disorders; and 3) has worked with multiple agencies and providers, such as mental health, physical health, substance abuse, juvenile justice, developmental disabilities, education, and other state and local service systems.”
Family-oriented Support in Colorado
The NAMI (National Alliance for Mental Illness) Family-to-Family program, and other NAMI family-oriented programs at
the state and local levels, help parents gain understanding, support and access to resources as their children begin and
continue to receive behavioral health services. Children’s behavioral health is linked with health and education services;
as children become youth and young adults, this network of services expands to include housing, employment and
training, higher education, Medicaid and at times, the juvenile and criminal justice systems. Having a family advocate or
navigator or a peer supporter to guide through these systems is highly beneficial.

Recovery
What is Recovery from Mental Illness?
To understand recovery, one might start with a basic and simple definition: a return to a normal condition or to regain
health or strength. However, mental illness is very complicated and includes a large spectrum of conditions ranging
from mild reactions to specific life events (Adjustment Reactions), then expanding to moderate changes in mental and
or behavioral functioning (Anxiety Disorders), and further expanding to include severe and major mental illness
(Schizophrenia). Because of this complexity, broad treatment approaches, conditions, actions and plans have become
incorporated into understanding recovery as a process, with multiple and individualized variables.

In studying recovery from the perspective of the Colorado Office of Behavioral Health, Colorado Wellness Network,
SAMHSA (federal Substance Abuse Mental Health Services Administration), Mental Health America of Colorado and
NAMI (National Alliance on Mental Illness), there is general agreement on the components that may be a part of a
personal and unique recovery process. The SAMHSA consensus statement is very broad and generally subsumes the
components included by other organizations. The Four Major Dimensions of Recovery are the starting points of the
SAMHSA statement: 1) Health or healthy choices; 2) Home that is stable and secure; 3) Purposeful, meaningful daily
activities and relationships; 4) Community or a social network that supports the three items above.

The following elements build on the above foundations: 1) HOPE as an essential in motivating a path to a better future;
2) PERSON DRIVEN individualized life goals and paths; 3) MANY PATHS to meet individual needs, values, goals and
history; 4) HOLOISTIC inclusion of all aspects of one’s life: biological, social and spiritual; 5) SUPPORT OF PEERS AND
ALLIES to gain and also expand knowledge, skills and community (professionals are important allies and medication can
be included); 6) RELATIONSHIP AND SOCIAL NETWORKS where hope, encouragement, empowerment and inclusion are
found; 7) CULTURAL BASED SERVICES which include attunement, congruence and individualized needs; 8) ADDRESSING
TRAUMA is an essential part of recovery; 9) INDIVIDUAL, FAMILY AND COMMUNITY STRENGTH AND RESPONSIBILITY are
the foundation for recovery; 10) RESPECT for individuals in recovery and their courage and unique identity.

Beyond these general dimensions of recovery, the Wellness Recovery Action Plan (WRAP) developed by Mary Ellen
Copeland and promoted by the Colorado Mental Wellness Network, gives seven elements which individuals can use to
develop their own specific daily path to recovery. Consumer and family groups also encourage Crisis Planning, Post Crisis
Planning and development of Advanced Directives which tell others how to respond if the individual in recovery is
unable to respond.

Understanding this broad and multi dimensional approach to recovery could help to reduce stigma and promote realism
about expectations for individuals with a Mental Illness which might not be “cured” or erased. Rather, individuals can
hope for a full and meaningful life.
Recovery from Substance Use
Recovery and Peer Recovery Support Services

Long-term recovery from addiction is a reality. Over 23 million people in the United States are in recovery from addiction. The US has historically utilized an “acute model” of care, i.e. one gets treatment for his or her disorder, and, upon discharge from the treatment facility, the person is “well” and his or her disorder is cured. This is system is not working to help people achieve long-term recovery, and the answer to this is a “Recovery Oriented System of Care”, says William L. White, Emeritus Senior Research Consultant at Chestnut Health Systems/Lighthouse Institute and past-chair of the Board of Recovery Communities United. A Recovery Oriented System of Care (ROSC) is a coordinated, person-centered network of community-based services and supports that builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

Addiction is major health concern for people in the United States, and is defined as “a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences”. Not addressing addiction as a health condition is costing the United States billions of dollars each year. One solution to addressing this major health concern is the utilization of Peer Recovery Support Services (PRSS) to meet the needs of people in or seeking recovery. PRSS are designed and delivered by people who have experienced both a substance use disorder and recovery; they include services that provide emotional (e.g., mentoring), informational (e.g., parenting class), instrumental (e.g., accessing community services), and affiliative (e.g., social events) support. PRSS are being utilized in Colorado, and data is currently being collected to show the outcomes of these services.

We must continue to work to support long-term recovery from addiction in our communities. The solution is focusing on the benefits of long-term recovery, and supporting those who are living self-directed and responsible lives. (Wheeler, Advocates for Recovery, 2014)

Persons in Recovery
The following information was gathered from a February 19, 2014 presentation by a three-person panel from the Colorado Mental Wellness Network (CMWN).

The Colorado Mental Wellness Network was incorporated as a peer-run nonprofit in 2013. The Network provides tools, not direct service. Its major emphasis is on stigma reduction; it believes that stigma is prejudice and that society “candy-coats” it as stigma. The organization’s values involve wellness and recovery education - it provides advocacy training and peer support, defining the latter as 1) using one’s expertise based on lived experience, and 2) sharing recovery in a solution-focused way, and it works for inclusion of people in recovery at various venues. The Network is part of the International Association of Peer Supporters. It also works legislatively – monitoring bills for language and working to change bills that reflect society’s often dominant view that people with mental health conditions are dangerous.

Panel members expressed the view that today’s behavioral health system is inadequate, fragmented, siloed and difficult to navigate, and that people with mental health challenges need to be able to connect with someone who is there/has been there. They stated the need for treatment for transition age youth and young adults, ages 14 – 28, because many behavioral health issues arise at that time of life, and they noted the need for age-appropriate services for this group.
CMWN advocates for self-directed treatment; the underlying principle is shared decision-making. Persons in recovery bring, and help set, goals that are incorporated into meaningful treatment. Labeling and imposing a diagnosis may be very harmful; people respond to strengths-based approaches.

CMWN advocates for, and helps people develop, individualized Crisis Plans with the following elements: 1) Daily Maintenance Plan; 2) Triggers and Action Plan; 3) Early Warning Signs and Action Plan; 4) Signs that things are getting worse and Action Plan; 5) Post Crisis time and Action Plan. Crisis Plans may be used to develop a Behavioral Health Advanced Directive which 1) describes what to do if someone is in crisis and needs hospitalization and/or treatment; 2) contains methods that work for this individual; these are stated and described ahead of the time they may be needed; and 3) is carried by the person in recovery; the PIR must make sure that families, providers, etc. have copies. Panelists noted 1) that this must be an integrated approach with friends, family, mental health professionals, etc.; 2) that each person in recovery is an individual and is truly an expert on himself or herself; 3) that, in relation to taking action when recovery isn’t going well, those regularly around persons in recovery need to be truly comfortable with what a person is asking them to do (in the Advanced Directive).

CMHN notes that there is a stereotype that people with mental illness just “go off” and that this is probably not so; instead, there is usually a series of set-backs and signs.

Panelists discussed stigma in terms also of self-stigma – that societal stigma is the basis for self-stigma that can result from something as simple but hurtful as comments from others about “the mentally ill.” Individuals create ways to deal with mental illness including denial, not talking about it, isolating from others and not making small talk. Fear and anger are involved: fear of losing one’s job, fear of losing one’s insurance, anger about mental illness and frustration about one’s own situation. Dealing with stigma needs to be worked into one’s Mental Health plan/Crisis Plan; stigma is a chronic stressor and a self-care issue. Treating people like “a diagnosis” is depersonalizing.

Recovery is individualized – it depends on the person’s life philosophy; it involves mind, body, soul and spirit. Recovery can be a lifelong struggle. A panelist said, “Throughout this process, we must treat people with unconditional regard and understand that mental health is all of us and affects all of us.”

In all of CMWN’s work, Peer Support Advocates play a key role. These Advocates are persons in recovery who have completed a comprehensive application and training program and are then able to offer regular, structured support to others in recovery. A panelist stated, “The idea is to support people – to find the human being first rather than the person with the diagnosis or label.”

Family Support
The following information was gathered from a January 19, 2014 presentation to the Behavioral Health Task Force by Scott Glaser, Executive Director of NAMI (National Alliance for Mental Illness) Colorado.

NAMI Colorado is part of National NAMI, an organization prominent nationally for its work in education, advocacy and family and consumer support. There is a network of state NAMI organizations that carries out this work at the state level. In addition, in Colorado, there are NAMI organizations serving the following counties/cities: Adams County, Arapahoe and Douglas Counties, Aurora, Boulder and Broomfield Counties, Pueblo and Fremont Counties, Colorado Springs and Denver. State and local NAMI organizations utilize and implement specific programs from National NAMI; other programs are developed to fit local needs. The mission of NAMI Colorado is to build communities of recovery and hope by educating, supporting, and advocating for individuals affected by mental illness and their families.
NAMI Signature Programs (no-cost programs)
• Family to Family is a 12-week class taught by family members for families, especially those new to behavioral health issues. The course is designed for families, partners, and friends of individuals with serious mental illness. The essence of the course focuses on the emotional responses families have to the trauma of mental illness with many family members describing their experience in the program as “life-changing”. This course has been designated an “Evidence-Based Practice”.
• Family Support Group is a standardized family group class from National NAMI. Family members share experiences and resources in a safe and nurturing environment.
• Peer to Peer is a new program in Colorado and is taught by people in recovery; Peer to Peer includes discussion of coping techniques.
• NAMI Connection Recovery Support Group is a peer-based, mutual support group program for any adult living with a mental illness. Connection groups provide a place for individuals who have in common the experience of living with mental illness, to share experiences and use them as learning opportunities. Groups are a safe space to confront the challenges that all consumers face, regardless of diagnosis.
• In Our Own Voice is a presentation by people in recovery that brings the audience from the initial dark days of illness through diagnosis and recovery; this program is often used for church and community group discussions.
• Providers Program is aimed at treatment providers who want to learn by hearing from a broad group of persons in recovery.

NAMI Colorado Programs (no-cost; NAMI Colorado trains people in local communities to teach these programs)
• Caminantes is a program for Hispanic communities; Caminantes addresses physical illness first and talks about the brain as a physical organ in order to address stigma associated with mental illness.
• Colorado Visions is a program focusing specifically on the needs of adolescents with behavioral health challenges.
• Law Line – NAMI has had a Help Line for a number of years; this new program is a Law Line with 6 volunteer attorneys; callers are screened by NAMI Colorado and are then connected with an attorney.

NAMI Colorado does not make specific referrals to individual doctors but has lists of behavioral health centers and hospitals. For legal questions, NAMI Colorado has six volunteer attorneys who can field law questions on a limited basis in the following areas: civil commitment, criminal law, special education, Social Security and PERA, Medicaid, and employment. NAMI Colorado does not locate providers for individuals, nor does it make any treatment recommendations for individuals – those decisions are between individuals and their doctors. NAMI does recommend to insurance companies and others for coverage of a broad range of treatment methods; NAMI also advises companies and others about how to include Parity. Regarding persons in treatment/recovery who don’t have families, Scott Glaser noted, “Their situations are often fragile; there are guardianship arrangements that can be made; NAMI can connect them to a lawyer but cannot offer direct services.”

Barriers to Recovery
Stigma, Prejudice and Denial
“Identify me as a person, not by my diagnosis.” (Persons in Recovery Panel members)
As articulated by several of our speakers, especially the February 19, 2014 presentation by a panel of Persons in Recovery (PIRs), words matter. They noted that the person is no longer recognized as soon as a mental illness or substance abuse problem is perceived, and that this both denigrates the individual and oversimplifies the perception and behavior of caregivers and society at large. Stigma can cause people to be ostracized, bullied, isolated, and generally treated as less than human, as panel members described from their own experiences.
People fear what they don’t understand; this is part of the origin of stigma. People have a degree of denial about any medical diagnosis; denial is increased when the diagnosis is one in which our brains - our thoughts and feelings - may be compromised. Learning that your heart is in danger is worrisome, but having your mind, your personality, in danger is terrifying. We all need to be in control; loss of control for ourselves or our loved ones is highly difficult and may encourage denial of a diagnosis of mental illness. This denial, in turn, may become the basis of the all-too-common reaction of viewing “the mentally ill” as people to be avoided and, often, blamed for not being normal.

The Persons in Recovery panel discussed “self-stigma” – stigmatizing oneself because of one’s own mental illness. Self-stigma was presented as an outgrowth of prejudice that people with mental illness experience.

Denial may also be a factor in self-stigmatization. When a person with mental illness is in a state of denial about the illness, denial can be exaggerated by the action of psychotropic medications. Although the difficult side effects of the medicine disappear shortly after medication is stopped, the mental symptoms of the illness also stop and often don’t return for several weeks. People would seem to be cured and this may lead to denial about having a mental illness. Denial, along with societal prejudice against people with mental illnesses, accounts for much of the reluctance of those with mental illness to seek or continue treatment (Saks, 2009).

Actions to reduce stigma include 1) education about the facts of mental illnesses as brain disorders; 2) recognition in law and insurance that mental illness and substance abuse are chronic illnesses; and 3) “coming out” by Persons in Recovery and their families, friends, and caregivers. Factual statements about mental illnesses – stated just as one would state a diagnosis of diabetes or heart disease - will, over time, lead others to understand that people who have a mental illness are people first, and, especially when adequately treated, they are no different than anyone else. In addition, education about the real likelihood of recovery and the ability to live a productive life must be a part of all treatment protocols.

**Housing and Homelessness**

Although the LWVCO Behavioral Health Task Force did not interview anyone on the specific topic of housing and its relationship to behavioral health, the members of the Persons in Recovery Panel from the Colorado Mental Wellness Network (see report section on Family and Consumer Work) commented on housing as follows:

- There is a total lack of adequate, affordable housing for people with serious mental illness.
- The Colorado Coalition for the Homeless (CCH) is building 78 new housing units above Denver’s Stout Street Clinic
- CCH feels safe housing is paramount – it stabilizes people so they can go to and benefit from treatment.

Dr. Carl Clark, CEO, Mental Health Center of Denver (MHCD), noted the following: MHCD accesses about 800 housing units in Denver for people with mental health issues - this is not enough to meet the need. Acquiring low cost housing is difficult because in Denver there is only a 4% vacancy rate in rental apartments - landlords who formerly provided housing under Section 8 are putting their units back into the private rental market so they can make more money.

In October 2013, the Colorado Coalition for the Homeless published a report titled *Developing an Integrated Healthcare Model for Homeless and Other Vulnerable Populations in Colorado.* The report presents the Coalition’s work to transform its current health care delivery model into an integrated system to respond more fully to the complex problems of patients and states: “In addition to physical and behavioral health services, the Coalition contends that housing stability is an essential ingredient in any population-based, integrated service delivery model. This view drives our organizational vision and shapes our programmatic decision-making. Residential instability increases risk for serious mental and physical health problems, exacerbates existing illness, and complicates treatment.
Lack of stable housing presents serious barriers to improving the health of people with acute or chronic illnesses. The daily preoccupation for securing food and shelter leaves little time for medical appointments. The pain and discomforts associated with illness and treatment side effects are compounded by a lack of privacy, risk of abuse, and theft of medications associated with living on the streets and in shelters. Clients frequently explain that they have ‘no place to lie down during the day’ to rest and heal.

Access to housing and supportive services has been shown to increase adherence to treatment, decrease arrests and incarceration that disrupt treatment, and reduce costly visits to emergency rooms. For example, the Coalition’s Housing First program documented a 72.95 percent reduction in emergency service costs, hospital stays and incarceration days, saving an average of $31,545 per participant over a 24-month period. Improvements in health status, mental health status, and housing stability were also identified. Similar results have been recorded by programs in New York, Maine, Massachusetts, Washington, and Illinois. Nevertheless, lack of affordable housing for people with very low incomes, poor housing conditions and environments, long waiting lists for transitional or permanent housing, combined with policies that exclude active substance users, and/or individuals involved in the criminal justice system, all significantly limit access to supportive housing, and impact health status and recovery from homelessness in many communities.”

**Homelessness and Parolees**

In 2009, Colorado’s Piton Foundation funded a study by the Colorado Criminal Justice Reform Coalition (CCJRC) of homelessness in relation to parolees. Homeless parolees interviewed in the study described many needs including the following psychological needs and feelings: 1) access to mental health treatment; 2) struggles with histories of substance abuse; 3) feeling set up to fail and fear of failure; 4) feeling depressed, humiliated, stressed, and/or overwhelmed.

The study’s Executive Summary states the following: “It is not known whether people who leave prison homeless have a higher failure rate on parole, but it is known that people face enormous challenges, including finding housing, when they are released. Based on our own research and interviews with parolees, CCJRC believes that paroling or discharging from prison homeless is a barrier to successful re-entry and should be avoided to the greatest extent possible.”

**Behavioral Health Challenges**

- **Advocacy** for mental health is needed; agencies doing this work in Colorado include Mental Health America of Colorado (MHAC), Colorado Behavioral Healthcare Council (CBHC), National Alliance for Mental Illness (NAMI), Federation of Families for Children’s Mental Health, Colorado (FFCMHC), Colorado Mental Wellness Network (CMWN) and Advocates for Recovery, which focuses on SUD (Substance Use Disorder). A Mental Health Caucus meets at the State Capitol and the topic is: What to do about lack of support for this area of care?

- **The Affordable Care Act (ACA) and Parity** With implementation of the ACA and the federal Parity Act, health insurance plans will have the same benefits for physical and mental health – this is parity. Lifetime caps and exclusions for pre-existing conditions will be gone. Because benefit packages now need to cover mental illness and be comprehensive, this area is being watched by Colorado’s insurance commissioner.

- **Behavioral Healthcare Providers** Colorado needs more behavioral health providers. Currently, providers are concentrated in Front Range cities with some in mountain areas, Grand Junction and southwest communities; residents of eastern and northwest Colorado have few, or no, provider options. Colorado continues to have a relatively good supply of mental health practitioners and certified addictions counselors, but has a critical shortage of psychiatrists and other prescribers. There are also needs for practitioners who specialize in children, older adults, people living in rural areas, people of minority cultures, and people who speak languages other than English. In addition, too few mental health and SUD providers are willing to serve priority populations because of current low reimbursement levels.
While there is geographic disparity across nearly all behavioral health practitioner groups, the disparity is most pronounced for the professions that require the most training. As level of training increases (number of years of graduate-level training), behavioral health providers are found disproportionately in the Denver and Colorado Springs areas. Psychiatrists across all sub-specialties are predominantly located in the Denver metro area and El Paso County. Six hundred nineteen of the 753 practicing psychiatrists (82 percent) are located in Denver and El Paso Counties alone. An even higher percentage of child psychiatrists (86 percent) are located in those two urban counties, and essentially all psychiatrists specializing in SUD treatment (95 percent) and in geriatrics (100 percent) are in the Denver and Colorado Springs areas (Colorado Trust, 2011).

• **Early Intervention is Needed for Children** Funding for early intervention is needed; some public schools are sites for child mental health services; “relief nurseries” in Oregon may be a model.

• **Fragmented Services and Systems** Moe Keller of MHAC stated that Colorado needs wiser/better use of money in all behavioral health areas; she expressed the need to bring together the fragmented portions of behavioral healthcare into one administration – one cabinet level position within Colorado government or a real Department of Public Health with a Behavioral Health Division - because “behavioral health IS public health”.

• **Funding for Care** OBH Director Lisa Clements has noted that Colorado is 48th in the nation in per capita spending for behavioral health. George Del Grosso of the Colorado Behavioral Healthcare Council stated that there is a need for additional state funds so community behavioral health services can be more equal.

• **Hospital Beds for People with Mental Illness** MHCD CEO Carl Clark noted that Colorado is 52nd (when you include U.S. territories) in the number of hospital beds available for mental health. University Hospital recently closed all of its mental health beds; other hospitals have done the same; hospitals can’t make up their costs in this area because reimbursement rates are so low.

• **Prison as the default behavioral health system** Moe Keller: “Behavioral escalation without care forces the court to order people with mental illness into prison; the prison has to take them.”

• **Silos of funding** Each state government department and division (Department of Corrections, Division of Child Welfare, etc.) and each educational institution, etc. has its own specific silos, i.e. how its specific funds will cover individuals; when an individual leaves that entity, his or her health benefits go away. Even if a provider has identified an individual as very ill and at risk for possibly violent behavior, if there is no continuing benefit, care is lost (in the case of the Aurora theater shooter who had withdrawn from school and thereby lost his coverage).

• **Stigma** is a huge challenge and often prevents people from seeking care; stigma may arise from prevailing attitudes, e.g. many in the general public think mental illness is a character problem.

**Behavioral Health and Gun Violence**
Recent events have led society to believe that all, or at least many, people with mental illness are furious and violent creatures that ought to be sought out and locked away forever. The tragic events at Sandy Hook Elementary and at the theater in Aurora were indeed perpetrated by men who had serious prior mental problems and little or inadequate treatment. However, the facts are that people with mental illness are no more likely to be violent towards others than the general population. The FBI’s National Instant Criminal Background Check data show that, from 1999-2010, mental illness accounted for less than 3% of background check denials. The incidence of mentally ill persons being violent to others is about the same as in the general population.
Persons with mental illness can be dangerous to themselves. Of the 28,700 emergency mental health holds or commitment certifications placed in 2011 in Colorado, 58% were for danger to themselves, while only 3.5% were for danger to others. (The others were because of being gravely disabled which is a form of dangerousness to oneself.) In Colorado, from 2004 to 2011, 76% of the 4,362 gun deaths were suicides, mostly related to severe depression, some to other mental illnesses while only 19% were homicides, mostly committed by people who had no mental health diagnosis. Fifty-one percent of gun deaths of children 19 and younger were suicides (Lott-Manier (2), 2011).

While mental illness alone is not a predictor of violence, the combination of alcohol use and gun ownership has been found to significantly increase the occurrence of violence. Other factors are important.

The National Epidemiology Survey, a study of 34,653 individuals interviewed twice approximately 3 years apart, showed, with a very high degree of significance, that violence towards others could be predicted among individuals who are mentally ill and have one or more other risk factors. For example, the occurrence of 3 factors (severe mental illness, substance abuse and/or dependence, history of violence) was associated with a distinctly higher than average risk of violence. The results provide empirical evidence that: 1) severe mental illness is not a robust predictor of future violence; 2) people with co-occurring severe mental illness and substance abuse/dependence have a higher incidence of violence than people with substance abuse/dependence alone; 3) people with severe mental illness report histories and environmental stressors associated with elevated violence risk; and 4) severe mental illness alone is not an independent contributor to explaining variance in multi-variate analyses of different types of violence (Elbogen, et al, 2009).

As severe mental illness itself was not shown to sequentially precede later violent acts, the findings challenge perceptions that severe mental illness is a foremost cause of violence in society at large. The data shows it is simplistic as well as inaccurate to say the cause of violence among mentally ill individuals is the mental illness itself; instead, this same study finds that mental illness is clearly relevant to violence risk but that its causal roles are complex, indirect, and embedded in a web of other (and arguably more) important individual and situational co-factors. Although alcohol and drug abuse have an effect of exacerbating violent behavior, there is a good deal of controversy as to whether it is a causal factor. There are significant differences between substances. Illegal drug addiction does lead to crime in order to support a habit. This many times leads to violence, but the use of the drug, per se, is usually not a direct cause of violence. The now legal drug marijuana is known for its mellowing effect and is rarely associated with violence. The other legal drug, alcohol, however, is certainly a factor in many instances of violence, and gun violence in particular (National Council Magazine 2012 #2).

The Parker study found that retail alcohol outlet density and violence are significantly related. The findings also showed that other factors, including narcotic drug activity, firearm availability and gang influence had significant and theoretically predicted estimated effects on youth homicide in both age groups examined. In sum, the study’s results supported the theoretical notion that alcohol availability was a significant determinant of lethal violence committed by adolescents and young adults, as the net sum of several major theoretically derived and empirically supported predictors of homicide rate variation identified in previous research. These results also add to a growing literature that shows that the relationship between outlet density and violence holds longitudinally for different types of violence in different social and national contexts (Parker, et al, 2011).

Wintemute’s study stated that from 1997 to 2009 an estimated 395,366 persons suffered firearm-related deaths, and that it is probable that more than a third of these deaths involved alcohol. This was a cross-sectional study using data from eight states with 15,474 respondents. After adjustment for demographics and state of residence, firearm owners were more likely than those with no firearms at home to have 5 drinks on one occasion, to drink and drive, and to have 60 drinks per month. Heavy alcohol use was most common among firearm owners who also engaged in behaviors such as carrying a firearm for protection against other people and keeping a firearm at home that was both
loaded and not locked away. The author concludes that firearm ownership and specific firearm-related behaviors are associated with alcohol-related risk behaviors (Wintemute, 2011).

In summary, gun violence towards others cannot be predicted by the presence of mental illness alone. Violence towards others does occur at a higher than normal rate when mental illness is combined with other factors, such as substance abuse. Alcohol abuse is associated with gun abuse. Alcohol abuse also occurs at a high rate in households with gun ownership. But, most significantly, violence is most reliably predicted by a previous history of violence.

**Behavioral Health Policy/New Legislation**

**Mental Health Parity and Addiction Equity Act (Federal)**

The following information is from a SAMHSA (Substance Abuse and Mental Health Services Administration) bulletin issued November 2013 and titled *Mental Health Parity and Addiction Equity*.

The federal Mental Health Parity and Addiction Equity Act (MHPAEA), implemented in November 2013, makes it easier for Americans without adequate health coverage to get the care they need by prohibiting certain discriminatory practices that limit insurance coverage for behavioral health treatment and services.

“The Mental Health Parity and Addiction Equity Act (MHPAEA) requires many insurance plans that cover mental health or substance use disorders to offer coverage for those services that is no more restrictive than the coverage for medical or surgical conditions. MHPAEA does not require insurance plans to offer coverage for mental illnesses or substance use disorders in general, or for any specific mental illness or substance use disorder. It also does not require plans to offer coverage for specific treatments or services for mental illness and substance use disorders. However, coverage that insurance plans do offer for mental and substance use disorders must be provided at parity with coverage for medical/surgical health conditions.

**Affordable Care Act Extension of Parity Requirements**

The Affordable Care Act (ACA) extends the reach of MHPAEA’s requirements. The ACA requires all small group and individual market plans created before March 23, 2010 to comply with federal parity requirements. Qualified Health Plans offered through the Health Insurance Marketplaces in every state must include coverage for mental health and substance use disorders as one of the ten categories of *Essential Health Benefits*, and that coverage must comply with the federal parity requirements set forth in MHPAEA. Plans created before March 23, 2010 will be "grandfathered," and will not be subject to the requirements of MHPAEA. The Department of Health and Human Services (HHS) has released guidance on how federal parity requirements will be applied to the Children's Health Insurance Program (CHIP), Medicaid managed-care organizations, and, in states that expand Medicaid, to Alternative Benefit Plans.

On Friday, November 8, 2013, the Departments of Health and Human Services, Labor and the Treasury issued the final rule to implement the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. The final rule includes specific additional consumer protections, such as 1) Ensuring that parity applies to intermediate levels of care received in residential treatment or intensive outpatient settings; 2) Clarifying the scope of the transparency required by health plans, including the disclosure rights of plan participants, to ensure compliance with the law; 3) Clarifying that parity applies to all plan standards, including geographic limits, facility-type limits and network adequacy; and 4) Eliminating an exception to the existing parity rule that was determined to be confusing, unnecessary and open to abuse.”
Colorado Behavioral Health Legislation - 2014 Colorado Legislature

HB 14 – 1271 Mental Health Duty to Warn Entities
According to the sponsor, this bill is a response to the 2012 Aurora theater shootings. The bill enlarges the duty of therapists to warn “persons identifiable by their association with a particular location or entity “of their clients only “when the patient has communicated to the mental health provider a serious threat of imminent physical violence.” It has been signed by the Governor.

HB 14 – 1253 Recommendations of the Civil Commitment Review Task Force
The Task Force recommended changes in the mental health statute regarding civil commitment to include the statutes regarding commitments for alcohol and substance abuse to standardize the procedures for placing and reporting short- and long-term commitments. The only opposition was from the National Rifle Association (NRA) and other 2nd amendment advocates, who were disturbed about the portions of the present statutes mandating the reporting of court-ordered commitments to the Colorado Bureau of Investigations for use in background checks. Although there was support in the House, there was concern that the Senate might not be able to gain enough support in light of successful recalls of legislators in 2013 and continuing opposition from gun rights groups. The bill was laid over past the end of the session, effectively killing it. A substitute bill, HB 14 -1386, was introduced by Reps. Kraft-Tharp and Gardner. This bill merely replaced “imminent” danger with “recent threats or actions” indicating danger to self or others as the Task Force had recommended as a condition that would trigger a civil commitment. Although the bill passed the House, the Senate Judiciary Committee postponed it indefinitely and it died.

SB 14-064 Concerning the Use of Long-term Isolated Confinement for Inmates with Serious Mental Illness
The original bill set out to codify several recent changes by the Colorado Department of Corrections (CDOC) in the handling of persons with serious mental illness placed in long-term isolated confinement. CDOC objected to the original bill, stating that codifying the solitary confinement process would not allow enough flexibility to address various situations. The bill was changed by striking everything below the title and replacing it with a statement that “the department shall not place a person with serious mental illness in long term isolated confinement except when exigent circumstances are present,” (no definition of exigent circumstances was given) and that a “Work Group” to advise CDOC on the handling of these inmates be established and function in an on-going manner. This new bill passed both houses with an amendment by the House Appropriations Committee, and was then re-passed by the Senate and sent to the Governor who is expected to sign it.

Moving Forward: Promising and New Practice
- **Affordable Care Act** ACA has already made significant changes with expansion of Medicaid for Colorado residents up to 138% of poverty, addition of adults without dependent children and a fast track for reinstatement of Medicaid for inmates transitioning out of prison. More changes are to come.
- **Behavioral Health Crisis Centers** A total of $22 million was allocated for crisis centers – for physical location, remote response, a 24-hour hotline and a marketing effort - by the 2013 Colorado Legislature and through Governor Hickenlooper’s Crisis Services Plan. Five or more Behavioral Health Crisis Centers would be established across the state in an effort to get people who are in crisis into treatment with trained behavioral health providers and as an alternative to using emergency rooms where there may be police involvement and potential jail time. This process is stalled in the courts due to a contested granting process. A Colorado-incorporated firm, Care Access, made up of four out-of-state companies, was initially awarded the contract and has sued the state. Mental health centers across Colorado now wish to re-apply as regional coalitions. The Hotline is being established through Metro Crisis Services in Denver.
• **Colorado Legislature Civil Commitment Review Task Force Recommendations** See Policy and Legislation Section immediately above for more complete information; the original bill was killed and a substitute bill replaced “imminent” danger with “recent threats or actions” indicating danger to self or others as the Task Force had recommended as a condition that would trigger a civil commitment.

• **Crisis Intervention Training (CIT) for police departments** CIT is a conversational technique and simulates what a person having a psychotic episode may be experiencing. CIT training equips officers in de-escalation techniques, teaching them what a person with a mental illness might be experiencing during their crisis. Police forces sponsor this 40-hour training; NAMI affiliates often assist.

• **Crisis Planning and Advanced Directives** The Colorado Mental Wellness Network helps persons in recovery develop individualized Crisis Plans with the following elements: 1) Daily Maintenance Plan; 2) Triggers and Action Plan; 3) Early Warning Signs and Action Plan; 4) Signs that things are getting worse and Action Plan; 5) Post Crisis time and Action Plan. Crisis Plans may be used to develop a **Behavioral Health Advanced Directive** which 1) describes what to do if someone is in crisis and needs hospitalization and/or treatment; 2) contains methods that work for this individual; these are stated and described ahead of the time they may be needed; and 3) is carried by the person in recovery (PIR); the PIR must make sure that families, providers, etc. have copies of the Advanced Directive.

• **First Break Psychosis Intervention** This program, described by Dr. Carl Clark, CEO, Mental Health Center of Denver (MHCD), is aimed at getting a young person into treatment immediately. Treatment is fast and heavy. This can positively affect the upcoming 10 years of young people’s lives and move them in a positive direction. Many people in the US go a long time before any diagnosis; mental illness complicates diagnosis because, for instance, one symptom of schizophrenia is the inability to recognize one’s illness - not to know you’re ill.

• **Genome Test for Medication Incompatibility** There is now a $1,200 genome test to determine the medications that people would have trouble with and also highlight combinations that would be bad for them. The test is mainly used for people not doing well on their current medications. This method helps with compliance as well because life with medication becomes easier for persons in recovery. Medicaid will pay for the genome test.

• **Mental Health First Aid** is a basic course in how to identify a mental health issue; the goal is to increase public literacy with regard to mental health issues.

• **Mental Health Parity and Addiction Equity Act of 2008 (Federal)** Rules and regulations were finally issued in 2013; this should mean that physical and behavioral health issues have equivalent coverage. Colorado chose a model pioneered by Kaiser Permanente that defines the types of treatment available and the minimum that insurance plans must offer.

• **Problem Solving Courts: Mental Health and Drug Courts** Drug Courts began in Miami, FL (Dade County). The rationale is that people cannot be punished out of addiction. This is a non-adversarial model, not like traditional court where clients do not speak and lawyers argue. Instead the client speaks directly to the judge, and there is a team, led by the judge, that includes a prosecutor, defense attorney, treatment provider(s), caseworker, and probation officer, and, sometimes, a physician. Clients have broken the law and have addiction and/or mental health issues. If they and the court agree, they are sentenced to a Problem Solving Court and an individualized plan is agreed upon. This model integrates the treatment and judicial systems and provides appropriate treatment rather than first sending clients to prison.

• **Restoration to Competency – Jail-based Restoration** A private contractor is now operating a jail-based Restoration to Competency program at the Arapahoe County Detention Center; this provides a second program in addition to the one at the Colorado Mental Health Institute at Pueblo. The contractor is part of Recovery in A Secured Environment (RISE) - a national program used in other states with high success rates. Elements of the RISE program are as follows: 1) Dedicated staff - participants have no contact with inmates; 2) Standardized criteria from the state and the contractor; 3) Treatment with medication management; 4) Follow-up after release into community. If illness is the reason for one’s unlawful act, this should be discovered at trial.

• **Wraparound Coverage and Services** The goal: provision of seamless behavioral health coverage across disciplines – training is offered to multidisciplinary teams by various groups; implementation is irregular across Colorado.
Recommendations

Recommendations to the League of Women Voters of Colorado (LWVC0)

League Advocacy:
1) LWVCO Positions in *Program for Study and Action – Positions for Action 2011-2013* should be reviewed for inclusion of Behavioral Health.
2) As part of any review and possible updating of Health Care and other relevant positions, quality Integrated Care, i.e. true parity between Behavioral and Physical Health services, should be included.
3) Local leagues should be encouraged to update their positions to include Behavioral Health.
4) Implementation of the Affordable Care Act (ACA) should be monitored to ensure true parity and true quality of services under the recently implemented federal Mental Health Parity and Addiction Equity Act.
5) LWVCO’s Legislative Action Committee (LAC) should consistently assign the area of Behavioral Health to a member.

League Education:
1) The Behavioral Health Task Force Report should be published and easily available on the LWVC0 website.
2) A list of Behavioral Health Resources should be included on the LWVC0 website.
3) A representative of each local league should be well-versed in the report and trained in how to use it for education and advocacy at the local level. Behavioral Health Task Force members will act as liaisons to their local leagues.
4) Local leagues should use the report as the basis for 1) briefings to local league membership; 2) presentations to the public; and 3) development of, or participation in, local or regional behavioral health coalitions or action groups (e.g. Community Conversations on Mental Health, presentation of Mental Health First Aid, etc.).
5) Local leagues should be encouraged to put the report on their websites and to include a list of local resources (or do this in coalition with other groups). Development and circulation of printed material should also be encouraged.
6) Local leagues need to engage with local community behavioral health centers to understand: a) whether affordable programs and treatment are available, and b) what programs are still needed in their communities.
7) The LWVC0 Behavioral Health Task Force Report should be shared with the League of Women Voters of the United States (LWVUS).

Policy and Practice Recommendations
1) Access to Care: Everyone in Colorado with a behavioral health challenge should be able to access quality care and treatment.
2) Behavioral Health Crisis Centers: Development of, and funding for, behavioral health crisis centers across the state must be implemented as soon as possible.
3) Child and Adolescent Behavioral Health:
   - Colorado must emphasize and make available, from many points of entry including physical health care, early and affordable behavioral health intervention and treatment for children and adolescents.
Policy and Practice Recommendations, cont’d.

- Colorado must provide research and consistent reporting about: a) the behavioral health of children and adolescents in our state, and b) the availability of treatment and services needed for Colorado’s children and adolescents.
- All schools should have the equivalent of a Safe Schools, Healthy Students program, with a nurse’s office with staff trained to deal with and refer both physical and behavioral health issues.

4) **Civil Commitment**: Colorado needs to increase the number of beds available across the state for civil commitments.

5) **Colorado Department of Corrections (CDOC)**: CDOC has talked about moving toward trauma-based treatment; if this is to happen, CDOC needs to collect trauma and past abuse data on prisoners upon entry into prison.

6) **Education**: School curricula need to include units on behavioral health.

7) **Re-entry to Community**: Colorado needs to provide strengthened, high quality services for people with behavioral health challenges who are re-entering communities after incarceration or civil commitment.

8) **Universal Health Care**: We support the concept of universal health care access as a means of gaining quality behavioral health services and preventing people from being incarcerated to receive treatment and care.

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Resources/References: Speakers and Publications

**SPEAKERS**

The following people made presentations to the LWVCO Behavioral Health Task Force:

**Cartwright, Anne, MD**, retired, Colorado Mental Health Institute at Pueblo, November 8, 2013

**Clark, Carl, MD**, CEO, Mental Health Center of Denver, December 6, 2013

**Clements, Lisa**, Director, Colorado Office of Behavioral Health, August 8, 2013.

**Del Grosso, George**, Executive Director, Colorado Behavioral Healthcare Council, September 26, 2013

**Glaser, Scott**, Executive Director, National Alliance for Mental Illness (NAMI) Colorado, January 17, 2014

**Guy, Matt**, Executive Director, Southeastern Colorado Area Health Education Center, November 8, 2013

**Jordan, Renae**, Director Clinical and Correctional Services, Colorado Department of Corrections, March 14, 2014

**Keller, Moe**, V. P. for Public Policy and Strategic Initiatives, Mental Health America of Colorado. September 26, 2013

**Panel from CO Mental Wellness Network** - Persons in Recovery at Mental Health America, February 19, 2014

**Perry, Dr. Dorothy**, CEO, Spanish Peaks Healthcare System, November 8, 2013

**Schut, Arthur**, CEO, Arapahoe House, June 28, 2013
PUBLICATIONS


*Child Mental Health Treatment Act – Colorado – 1999*


Elbogen, PhD, Eric B., Sally C. Johnson, M.D., *National Epidemiology Survey on Alcohol and Related Conditions*, reprinted in the Archives of General Psychiatry Feb, 2009

Federation of Families for Children’s Mental Health – Colorado Chapter


Lott-Manier, Michael, *Involuntary Commitment for Mental Illness in Colorado*, Mental Health America of Colorado, Fiscal Year 2011 Report from the Colorado Department of Human Services


National Institute of Mental Health (NIMH) Release of a landmark and collaborative study conducted by Harvard University, the University of Michigan and the NIMH Intramural Research Program (release dated June 6, 2005 and accessed at [www.nimh.nih.gov](http://www.nimh.nih.gov))


NGA Center for Best Practices, *Youth Suicide Prevention: Strengthening State Policies and School-Based Strategies*


SAMHSA (Substance Abuse and Mental Health Systems Administration) bulletin *Mental Health Parity and Addiction Equity*, November 2013
Publications, cont’d.


Wintemute, Dr. Garen G. Violence Prevention Research Program School of Medicine, University of California, *Davis Injury Prevention (2011)* gjwintermute@ucdavis.edu

Wolitzky-Taylor, Bobova, Zinbarg, Mineka, & Craske, 2012

ADDITIONAL RESOURCES

Colorado Beacon Consortium: [www.coloradobeaconconsortium.org](http://www.coloradobeaconconsortium.org)

Community Conversations on Mental Health – various Colorado communities; part of the National Dialogue on Mental Health; one Colorado website: storify.com/MentalHealthGov/community-conversation-colorado.

Endres, Mary, Chair, Women’s Mission and Education Committee, Mental Healthcare in Mesa County Study Project

Klowden, Mindy, Jefferson Center for Mental Health. Internal documents

Sorenson, Janey, Montrose Mental Health Center, Montrose, Colorado
## Appendix A: Behavioral Health & Organizational Acronyms

- **ACA**: Affordable Care Act  
- **ACC**: Accountable Care Collaborative  
- **ALRs**: Alternative Living Residences  
- **BHO’s**: Behavioral Health Organizations  
- **BHTC**: Behavioral Health Transformation Council; many Colorado governmental departments are on this Council administered by the Colorado Department of Human Services (CDHS)  
- **CBHC**: Colorado Behavioral Healthcare Council  
- **CCH**: Colorado Coalition for the Homeless  
- **CCJRC**: Colorado Criminal Justice Reform Coalition  
- **CDC**: Centers for Disease Control – Atlanta, GA  
- **CDHS**: Colorado Department of Human Services  
- **CDOC**: Colorado Department of Corrections  
- **CDPHE**: Colorado Department of Public Health and Environment  
- **CIT**: Crisis Intervention Training  
- **CMHIFL**: Colorado Mental Health Institute at Fort Logan  
- **CMHIP**: Colorado Mental Health Institute at Pueblo  
- **CMWN**: Colorado Mental Wellness Network  
- **DRDC**: Denver Reception and Diagnostic Center  
- **DSM**: Diagnostic and Statistical Manual  
- **FFCMH**: Federation of Families for Children’s Mental Health (national office)  
- **FFCMH – Colorado**: Colorado Chapter of FFCMH  
- **HCPF**: Health Care Policy and Financing  
- **HHS**: Health and Human Services (Federal Department)  
- **MHAC**: Mental Health America of Colorado  
- **MHCD**: Mental Health Center of Denver  
- **MHPAEA**: Mental Health Parity and Addiction Equity Act  
- **MSOs**: Managed Services Organizations  
- **NAMI**: National Alliance on Mental Illness  
- **NIMH**: National Institute for Mental Health  
- **OBH**: Office of Behavioral Health  
- **P Code**: Psychological Code (used by Colorado Department of Corrections)  
- **PIRs**: Persons in Recovery  
- **PRSS**: Peer Recovery Support Services  
- **RCCOs**: Regional Care Collaborative Organizations  
- **RISE**: Recovery in a Secured Environment  
- **ROSC**: Recovery Oriented System of Care  
- **SA Code**: Substance Abuse Code (used by Colorado Department of Corrections)  
- **SAMHSA**: Substance Abuse and Mental Health Systems Administration (part of Federal Department of Health and Human Services)  
- **SMI**: Serious Mental Illness  
- **SUD**: Substance Use Disorder  
- **WRAP**: Wellness Recovery Action Plan
Appendix B: Glossary

General Terms

**Mental health** is not just the absence of mental illness but is characterized by mental functions that result in productive activities, fulfilling relationships with others, and the ability to adapt to change or cope with adversity.

**Mental illness** refers to all diagnosable mental disorders, i.e., conditions characterized by alterations in thinking, mood, and or behavior.

**Recovery** implies the reduction or complete remission of symptoms and the ability to live a fulfilling and productive life despite a mental illness or addictive disorder. To many of those in the field, the important part of this is the ability to live a fulfilling and productive life with less emphasis on the complete remission of symptoms.

Community Terms

**Community mental health centers** are locally governed, not-for profit corporations who are responsible for providing mental health services in defined service areas throughout Colorado. Most mental health centers provide services for mental illnesses and substance abuse. Every part of the state is served by a community mental health center. The Centers are funded by the state, the federal government, grants, donations, and fees collected for services. For many, if not all, mental health centers, Medicaid is the largest single source of funding. Except in Denver, the community mental health center is a part owner of the Behavioral Health Organization (BHO) that serves its area. The community mental health centers vary widely in whom they will serve and how.

**Behavioral Health Organizations (BHO’s)** are responsible for implementing the Colorado Medicaid Mental Health Program. The five BHO’s operate managed-care programs serving all of Colorado’s 64 counties. Each BHO is responsible for managing the delivery of mental health services to Medicaid-eligible individuals in its assigned geographic service area. The BHO for Denver is Access Behavioral Care (ABC). The BHO’s receive a certain amount of money for each person covered by Medicaid in their area. When times are tough, like now, the number of people covered by Medicaid goes up, but the state funds available go down. The contracts between the state and the BHO’s may be renegotiated and the per-person funding (per-capita rate) may be decreased. BHO’s are required to provide appropriate services to all eligible people in their areas who request services.

Mental Illnesses

**Mood Disorders** have a disturbance in mood as the predominant feature. They include:

- **Major Depression** which includes a period of at least two weeks of either depressed mood or the loss of interest or pleasure in nearly all activities.
- **Bi-Polar Disorder** (the mental illness formerly known as Manic-Depressive Disorder) which is characterized by the occurrence of one or more manic episodes or episodes that are slightly less than manic (hypomanic) along with episodes of depression.
- **Dysthymia** which involves depressed mood for most of the day, more days than not for at least two years.
- **Perinatal Depression** encompasses major and minor depressive episodes that occur either during pregnancy or within the first twelve months following delivery.

**Schizophrenia** is a serious mental disorder involving two or more of the following symptoms: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms (restrictions of emotions, thought and speech, and goal directed behavior).

**Anxiety Disorders** are characterized by a disabling, excessive, or irrational dread of everyday situations or objects and include: Panic Disorder, Obsessive-compulsive Disorder, Post-traumatic Stress Disorder, Generalized Anxiety Disorder, and Phobias.

**Eating Disorders** may take the form of excessive reduction of food intake or overeating.

**Attention-Deficit/Hyperactivity Disorder** is characterized by a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typical for individuals at a comparable level of development.

**Substance Use Disorders** refer to the abuse of or dependence on alcohol, nicotine, illegal drugs, or prescription medications.
Appendix C: LWVCO Behavioral Health Task Force Members

**Chris Angle**, LWV Arapahoe County – BA Education; MA Foundations of Education

**Nancy Ball**, LWV Montrose and Delta Counties – Member, Awareness and Prevention Committee for a Drug-free Montrose County; interested in Drug Abuse and relationship to Behavioral Health

**Anne Courtright**, LWV Pueblo County – Psychiatrist (retired); practiced at Colorado Mental Health Institute, Pueblo.

**Karen Ericson**, LWV Estes Park – RN; has worked in mental health and psychiatric hospitals

**Barbara Allen Ford**, LWV Denver – Therapist at Jefferson Center for Mental Health; previously worked for Health Care Policy and Finance (HCPF)/Medicaid.

**Jean Fredlund**, LWV Adams County – RN; former nurse manager in acute in-patient psychiatry; mother of 49-year-old son with severe, chronic mental illness.

**Gwyn Green**, LWV Jefferson County - former Licensed Clinical Social Worker (LCSW) - work included mental health assessments and evaluations; former Colorado House representative.

**Janice Green**, LWV Arapahoe County – Ph.D., Clinical Psychology; practiced in public and private sectors in Oregon; interested in intersection of law and people with severe mental illness.

**Sharon Hansen**, LWV Montezuma County – District Judge (retired) in southwest Colorado; initiated a women’s safe house in Cortez, Colorado.

**June Hyman**, LWV Larimer County – Ph.D., Clinical Psychology; mental health therapist in private practice.

**Nancy Jackson**, LWV Arapahoe County – Arapahoe County Commissioner #4; serves on several state committees and task forces; serves on Offender Management Board and Aurora Mental Health Center Board.

**Elizabeth Kauffman**, LWV Boulder County – past President of Boulder County NAMI (National Alliance for Mental Illness); past leader for Schizophrenics Anonymous; *parent of an adult son with schizophrenia*.

**Susan Kintzle**, LWV Boulder County – Parent of a 37-year-old son with long term mental health challenges.

**Susan Meeker**, LWV Arapahoe County – Psychology degree; parent of a daughter with mental health challenges.

**Mike Nerenberg**, LWV Pueblo County – Physician (retired); interested in Behavioral Health issues.

**Elizabeth Pace**, LWV Denver - MSM and RN; CEO, Peer Assistance Services, Inc. – intervention and prevention services in workplaces and communities focusing on substance abuse and related issues; serves on Colorado Behavioral Health Transformation Council.

**Barbara Mattison**, LWV Denver – Behavioral Health Task Force Chair: M.Ed., Executive Director (retired) of several child advocacy agencies; former chair of state youth and young adult behavioral health committees; served on Colorado Mental Health Planning and Advisory Council.