LEAGUE OF WOMEN VOTERS®

OF COLORADO

Behavioral Health Task Force Report: August 2015
for the
LWVCO Behavioral Health Study

An Overview of Colorado's Behavioral Health System

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League of Women Voters of Colorado (LWVCO)

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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 called for study at the state level in the area of mental health; three of those asked that gun violence be included. The LWVCO Board asked 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 gathering information, the Behavioral Health Task Force listened to 13 highly qualified experts in behavioral health, researched and read publications, and obtained information from other Colorado resources. 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 state, county and behavioral health organization boards - represented 10 Colorado Leagues. In the May 2014 report, the Task Force made a number of recommendations, one of which was that the League of Women Voters of Colorado update its Health Care position to include Behavioral Health. The LWVCO Board approved the recommendation and called for a Behavioral Health Study to complete the process. Local Colorado Leagues overwhelmingly approved the recommendation during their Program Planning meetings in spring 2015; delegates to the May 2015 LWVCO Convention gave final approval for the study.

The original Task Force report is now updated for use with the Behavioral Health Study. This updated report includes a more complete section on child and adolescent behavioral health, information on re-entry into community for persons coming out of correctional facilities, and information on Colorado's new behavioral health crisis care system. The Task Force has striven to present a concise and fairly complete overview of behavioral health needs, services, challenges and promising practices in Colorado. *The section of this report on pages 37-39 contains the original recommendations made by the Task Force for League of Women Voters action as well as for behavioral health policy and practice; in that updated section, the current status of each recommendation is noted.*

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; "**persons in recovery**" is the preferred term. 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.

Brain Disorders - Speakers noted to the Task Force that mental illness is a wide spectrum of brain disorders, from mild to severe; those with mental illnesses/brain disorders 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. Thomas Insel, M.D., Director of the National Institute of Mental Health, prefers the term "brain disorder" rather than "mental Illness." And in substance use disorder, addiction means a brain change – a brain disorder.

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 Behavioral Health Task Force by Lisa Clements, then-Director of the Office of Behavioral Health, on August 8, 2013. The information was updated in May 2015 by Chris Habgood, Director of Policy and Planning, Office of Behavioral Health.

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 report section titled Colorado Mental Health Institutes, pages12-13).*

OBH provides monitoring for Community Behavioral Health Services – seventeen community behavioral health centers and specialty mental health clinics 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 Community Behavioral Health Centers, pages 5 - 8*).

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 2013-14, Colorado's budget for its Medicaid mental health capitation program was $397,201,020; Colorado's budget for mental health programs including the state general funds, various cash funds, Block Grant and other federal monies was $49,724,713 with 113,269 persons served. For Substance Use Disorder (SUD) services, this combination of funds totaled $44,666,681 with 74,556 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 report section titled Colorado's Criminal Justice System & Behavioral Health, pages 13 - 15).*

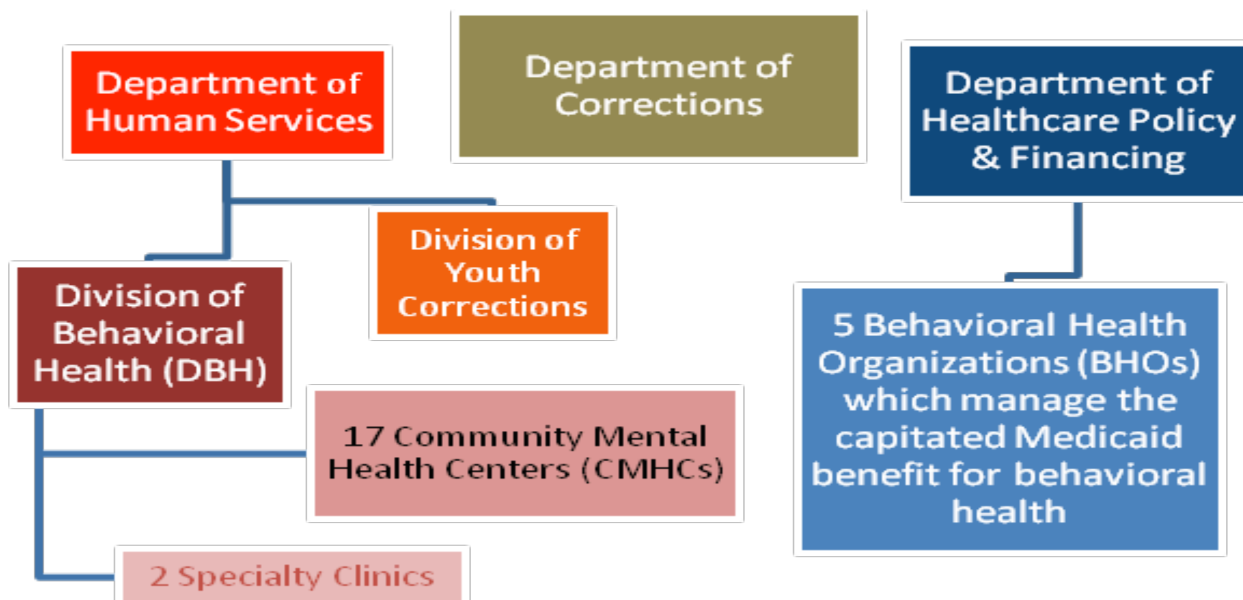
In April, 2015, the Colorado Office of Behavioral Health released the findings of its *OBH Needs Analysis: Current Status, Strategic Positioning, and Future Planning.* The Western Interstate Commission for Higher Education Mental Health Program (WICHE), in partnership with the National Association of State Mental Health Program Directors Research Institute (NRI) and Advocates for Human Potential (AHP), formed a team of Colorado and national behavioral health experts to complete this study. The 700-page document lays the foundation for direction for public behavioral health services in Colorado for the next decade. It makes numerous recommendations, chief among them that Colorado should align and maximize OBH resources and payer sources with respect to payer sources, crisis services and system alignment. It also makes recommendations for regional behavioral health service distribution; for the Colorado Mental Health Institutes; for community integration, telehealth, housing and employment, peer mentors, recovery coaches and family advocates, individuals with mental illness who are physically compromised, whole health integration, drug possession sentencing reform and Medicaid expansion.

Community Behavioral Health Centers

Information below is from a September 26, 2013 presentation to the LWVCO Mental Health Task Force, and updated April 28, 2015, by George Del Grosso, Chief Executive Officer, 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, then-Director, Office of Behavioral Health. Carl Clark, M.D., Executive Director, Mental Health Center of Denver, provided information on Mental Health Center of Denver (MHCD) on December 6, 2013; Kristi Mock, Vice President for Adult Services at MHCD, provided additional information on May 21, 2015.

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 5 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 funding allocations for additional services - above what most community mental health centers can offer. One hundred forty of the sites integrate behavioral health professionals into physical healthcare sites; 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.

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. Services beyond this list depend on local fund raising.

Urban Behavioral Health Services: Mental Health Center of Denver

Mental Health Center of Denver (MHCD) has programs for infants to seniors, including programs for young people – important because youth and young adulthood are the stages of life when 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. MHCD emphasizes that people need to be in some form of treatment and then MHCD can engage with them. 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's largest number of referrals comes from the police.

At any one point in time, MHCD is providing case management for about 6,500 adults. In 2014, MHCD provided services for 14,498 adults and children. MHCD emphasizes a unique approach to case management: People can't work on their mental health issues unless they have their daily requirements covered (food, housing and other fundamental needs). About 850 adults are in MHCD's High Intensity Case Management program at any one time; most of these clients have spent time homeless or in hospitals or in the criminal justice system (typically for crimes relating to homelessness such as urinating publicly). These clients receive a high level of services for 12 -18 months. Case managers connect them with community supports and work toward the life that clients want; this may involve housing, jobs, education, health and dental services. When clients are regularly meeting with psychiatrists, have community support and a place to live, they can move to less intensive services and then gradually to much less intensive services, such as outpatient therapy by phone and coming into the office only for quarterly follow-up and medication.

MHCD has an extensive housing program that includes group homes, apartments and beds in additional buildings where clients live aided by federal subsidies; the agency also has 100 Section 8 certifications – these are attached to the person so clients can use them in any facility. Housing in Denver is now so expensive that the Section 8 certification will not cover rent adequately.

Please see page 30 for more information about MHCD's housing program.

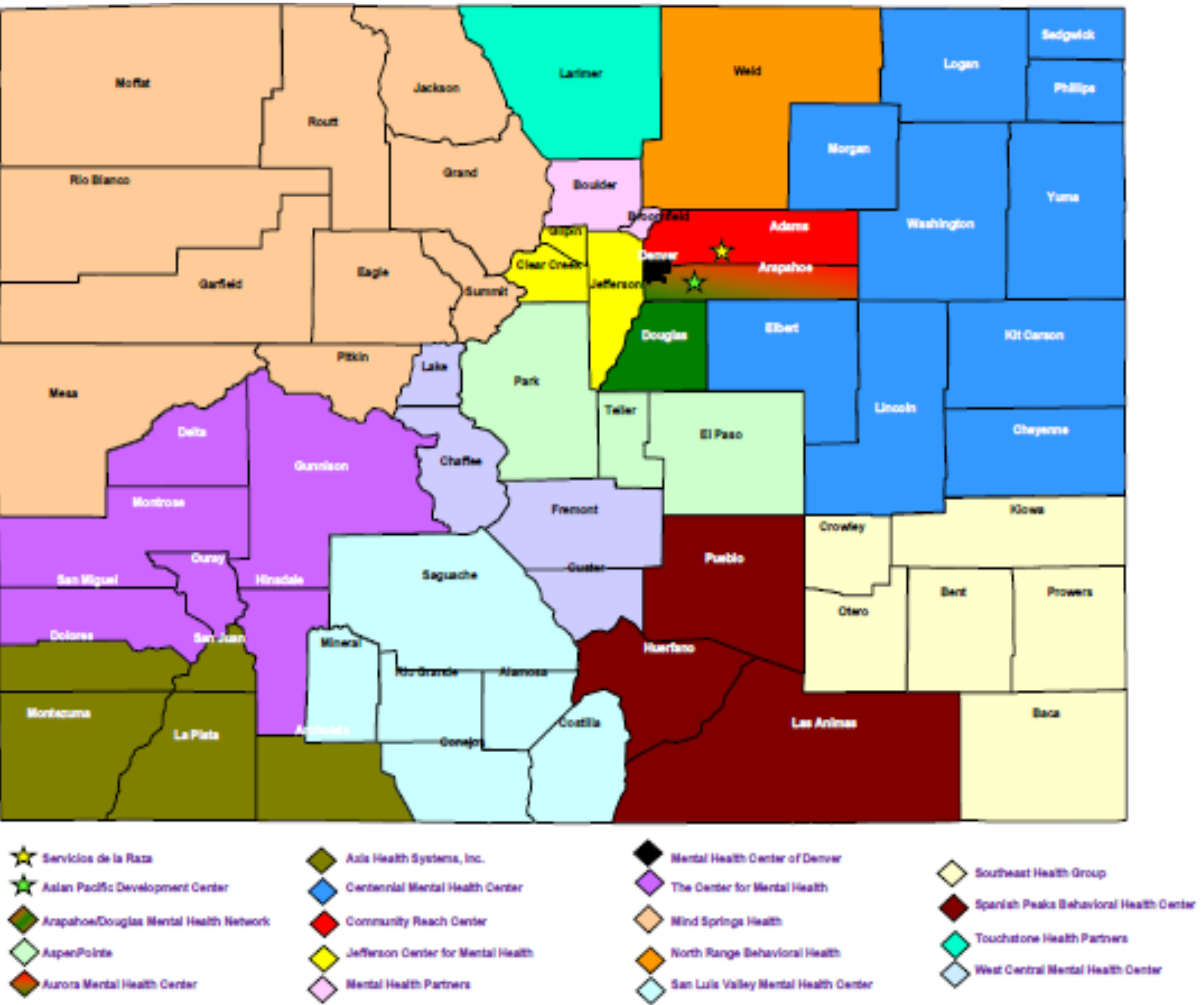
Rural Colorado Behavioral Health Care: Mind Springs Health - Western Slope

Mind Springs Health, a public behavioral health center with its main office in Grand Junction, serves 23,000 clients annually. Mind Springs has been able to increase services and staff due to more funding through legislation. Mind Springs now has 14 offices in 10 Western Slope counties for out-patient treatment. In-patient care is offered in conjunction with West Springs Psychiatric Hospital, the only such hospital between Salt Lake City and Denver. West Springs has 32 beds for adults, children and adolescents; these beds are at a premium and more are needed.

Because of Colorado's new funding for crisis services, Mind Springs has expanded its services to include a Crisis Team - utilized 24/7 - and a Crisis Stabilization Unit, Transitions, located at West Springs Hospital. This new unit has 11 beds for people in need of short-term patient stay.

Mind Springs is remodeling its building in Grand Junction to be more usable for clients and counselors; there is a full activity schedule as well as peer support and a pharmacy. The agency is also opening a medical clinic at this facility to begin to integrate physical and behavioral health care. At present, Mind Springs' behavioral health personnel are embedded in several family practice clinics in the area. Mind Springs is also partnering with Rocky Mountain Health Plans to provide a payment reform pilot project for Colorado.

Please see Integrated Physical and Behavioral Health Care (pages 10-12) & Child and Adolescent Behavioral Health (pages 21-25) in this report for additional information about community behavioral health services.



Colorado Community Mental Health Centers by County Served

Colorado's Crisis Centers for Behavioral Health Care

Moe Keller, Vice President for Public Policy and Strategic Initiatives at Mental Health America of Colorado, stated, "Mental Health is the only physical illness where we wait until stage four to do anything." She noted that if a person went to his or her doctor with a suspicious spot, and if the doctor said, "Well, it may be cancer but let's wait until stage four before we do anything", the person would be outraged. Ms. Keller stated, "(People) should be outraged with our lack of investment in prevention, early intervention and recovery for mental health conditions. We can change that!"

Colorado Governor John Hickenlooper unveiled his plan for statewide behavioral health crisis centers in December 2012. In 2013, legislation was passed allowing $25 million for crisis responses including these components: 1) a 24/7 statewide behavioral health crisis hotline; 2) walk in behavioral health crisis services; 3) a marketing campaign; 4) mobile crisis services; and 5) residential respite care.

These programs must: 1) be based on *evidence-based practices; 2)* be innovative; 3) coordinate with existing systems; 4) include peer support and community participants. Programs must operate 24/7; they must be accessible irrespective of ability to pay. Programs meet needs across the state and have the flexibility to tailor to individual community needs.

The Crisis Hotline contract was awarded to Metro Crisis Services, now "Rocky Mountain Partnerships," in August 2014; the crisis stabilization contract was awarded December 1, 2014 to five regional organizations now called "Colorado Crisis Services," (CCS). These two arms of Crisis Response must work together to form a seamless crisis network. Now, anywhere in Colorado, there is a single Crisis Hotline number to call: Rocky Mountain Crisis Partners (RMCP): 1-844-493-8255 (talk). RMCP triages calls for the whole state; Colorado Crisis Services, or the regional crisis response centers, have more face-to-face, in-person response capabilities.

The Crisis Stabilization statewide and regional organizations are: 1) Statewide Hotline: Rocky Mountain Crisis Partners; 2) Community Crisis Connection: Denver Metro Area; 3) Northeast Behavioral Health LLC; 4) Southern Colorado Crisis Connection; and 5) West Slope CASA.

Although in operation for only a few months at the time of this report, each organization above has a "dashboard" that citizens can look at that posts real time data on how many clients have been served, demographics for these clients, and performance measures for the organization. <u>The objective of the crisis stabilization organizations is to ensure that people are treated appropriately and to avoid emergency rooms by creating region-wide partnerships among sheriffs' departments, police, mental health centers, hospitals, and human services departments.</u> While regional differences must be acknowledged, each organization has created practical, evidence based protocols that help citizens receive the care and treatment they need. *(From Behavioral Health Task Force member Nancy Jackson, PhD, from a presentation by Patrick Fox and Lisa Tupa, PhD, at the University of Colorado April 22, 2015.)*

<u>The Hotline: Rocky Mountain Crisis Partners (RMCP)</u>

The Crisis Hotline has two main components: 1) a masters level clinician crisis response, assessment and triage, and/or 2) a peer specialist for support and ongoing discussion. The assessment is for a wide scope of mental health and substance abuse issues, and triage to other components. In addition, the therapists do suicide/safety screenings, referrals and offer resource links. Peer support line services, on the other hand, offer peer support, shared experiences, in-the-moment or ongoing support. Their goal is to promote wellness and recovery, triage to crisis line as appropriate, and offer referral and resource linkages. RMCP is the front door to the state wide crisis response system. It promotes a seamless state system, provides education about the crisis system, manages expectations regarding services available, bridges communication between regions and helps people understand protocols.

(From Behavioral Health Task Force member Nancy Jackson, PhD, from presentation by Cheri Skelding, Clinical Director,RMCP, and from RMCP website. http://www.metrocrisisservices.org/.)

Walk-in Crisis Stabilization Centers

- Metro Region Crisis Response is operated through 6 community mental health centers and offers in-person services through 7 walk-in centers in the Denver Metro area and 5 stabilization centers. The average length of stay is 3 days. In addition, there are 6 mobile crisis units. There are no boundaries between cities and counties. Services operate 24/7. Respite care offers a 7-day stay for people in need of rest. Services are designed to be convenient, friendly, with access to professionals and referrals, and to offer access to follow-up with partners. From its inception in December, 2013, the program had served about 1,000 clients by March 2015. *(Information from presentation given by John Talbot, April, 2015. See dashboard and website for current information http://www.communitycrisisconnection.org/)*
- Northeast Crisis Response System is operated through 3 mental health centers in 12 counties. The system has 2 walk-in centers that are 24/7, 2 crisis stabilization units, mobile crisis response units, and 2 respite centers. *(Information from Deanna Ryerson, April 2015, and website, http://www.northrange.org/crisis-support-services/)*
- South Eastern Colorado Crisis Response serves mostly rural counties and is available 24/7. It has 2 inpatient facilities, mobile crisis units, and community living centers staffed by peer specialists. This system also has care coordinators who refer and connect, and licensed evaluators. Respite options are available. http://www.southerncoloradocst.com/)
- Western Slope CASA is a collaboration among 3 mental health centers in Durango, Grand Junction, and Montrose. Their service area is 21 counties with 40,000 square miles and half a million people. This collaboration includes a 32-bed psychiatric center, a mobile crisis unit and 22 walk-in units over the region. They have recently added an 11-bed crisis stabilization unit, 12 respite beds, in-home respite, peer services, transportation services, aftercare visits televised for providers and crisis clinicians, designated crisis staff and emergency room consultations. They are currently planning a peer respite house. *(Dale Wright, presentation on April, 2015, and Westslopecasa.org)*

Colorado providers and citizens are involved in a steep learning curve about this new crisis response system. Challenges include: how to expand services; how to measure success; implementation of "no wrong door" considering number, severity and types of clients; hiring of qualified therapists and nurses statewide; coordination among centers; glitches with an electronic health records system; and getting the word out to the public about these services.

Integrated Physical and Behavioral Health Care

Integrated care occurs when an individual receives his or her physical and behavioral health care in one location from a provider team. Colorado health care reform is focused on treating the "whole patient." Colorado is a leader in providing integrated behavioral health and primary care within coordinated community systems. In the next four years, plans are for a majority of insured Coloradans to begin getting care that provides behavioral health and primary care integration.

National studies have shown people are more likely to start and complete mental health therapy when it is offered in the same place as their primary physical health care. Treatment drops off dramatically when patients are referred to separate mental health clinics. Absence of integrated care results in inefficient utilization of medical and behavioral health expertise. Studies have found that presently 50 % of behavioral health disorders are treated in a primary care clinic. When the primary care provider refers a client to a behavioral health outpatient clinic, only 50% of referrals keep the first behavioral health outpatient clinic appointment. At present, only 67% of people with behavioral health disorders receive treatment, but 80% of people with a behavioral health disorder will make a visit to a primary care clinic at least once a year. Further, individuals with dual diagnoses of a behavioral health condition and a physical health

condition are far more costly to treat. It is more efficient, and the quality of care improves, when their conditions are treated at one location – a medical home, where a team of professionals work collaboratively to provide care.

In January, 2014, Colorado advanced toward integrating care as the Colorado Department of Health Care Policy and Financing (HCPF) expanded substance use disorder treatment services within Medicaid and decided that these should be managed by the Behavioral Health Organizations (BHOs). Previously, BHOs worked closely with the community mental health centers (CMHCs) providing mental health services. CMHCs are now being looked to for substance use disorder treatment in addition to traditional mental health services. Previously, substance use disorder benefits offered under Medicaid were paid on a fee-for-service basis and administered separately from the BHO system. A new expanded benefit includes patient assessment, detox services for people coming off drugs and away from addiction, outpatient treatment services, targeted case management, peer support and medication. Colorado has now committed heavily to progress in integrated care with 5 health care innovation challenge projects for behavioral health integration.

Colorado's New State Innovation Model (SIM)

The following information is from June 2015 interview with Alicia Caldwell, Director of Communications, Colorado Department of Human Services, on behalf of Vatsala Pathy, Colorado SIM Director, Colorado Office of the Governor.

In December, 2014, the State of Colorado was awarded $65 million over 4 years by the Center for Medicare-Medicaid Innovations (CMMI) for the Colorado State Innovation Model (SIM). The CMMI provides federal funding for states to develop and test state-based models for multi-payer payment and health care delivery system transformation to improve health system performance for state residents. The overarching goal of the Colorado SIM is to provide access to integrated primary care and behavioral health services in coordinated community systems, with value-based payment structures, for 80% of state residents by 2019. Many partners are involved including private health care practitioners and private insurance providers; over 150 people are involved in planning and implementation committees. The Governor's office is administering the grant; the University of Colorado Medical Center serves as fiscal agent. Contracts with various entities for the purpose of developing tools and for training and coaching integrated health and behavioral health care at the consumer level will total $14.5 million/year. There will be more than 400 primary care delivery sites with 1600 providers. Contracts will also be let for information technology and development of payer reform models.

Payment Reform within Integrated Care

Accountable Care Organizations (ACOs) are a vehicle for payment reform and are designed to disrupt the traditional fee-for-service system by holding providers accountable for the costs and quality of care for whole populations of people, and by providing clinicians with more financial flexibility when it comes to how they treat patients. Colorado's Accountable Care Collaborative (ACC), developed by HCPF in 2011, ensures that Medicaid enrollees have the benefits of being members of a care system that provides "the right care at the right time in the right place." The ACC, which has demonstrated significant cost savings, operates through seven Regional Care Collaborative Organizations (RCCOs) that manage care for Medicaid members in a geographic area. HCPF is considering encouraging coordination of care between the RCCOs and Behavioral Health Organizations (BHOs) to further integration of primary care and behavioral health.

Integrated Care within Colorado's Community Behavioral Health System

The Colorado Beacon Consortium 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.

From a September 2013 interview with Janey Sorenson, The Center for Mental Health in Montrose, Colorado: "Colorado is "light years" ahead of other states in providing integrated (behavioral and physical health) care. As 50% of all life-time cases of mental health issues are evident by the age of 14, and 75% by age 24, the integrative programs provided by the Center catch these disorders at an earlier time in the disease where recovery is more likely." This 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 November 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."

The interviews above describe successful integration of services, but a 2012 Survey of Psychological and Psychiatric Care in Mesa County, with 83 of 168 Grand Junction providers responding, found that 22% rated mental health care above the midpoint and 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 usually able to purchase behavioral health services. The survey noted a lack of providers of psychiatric and substance use disorder services in rural Colorado. S*ee Rural Colorado Mental Health Care: Western Slope, p. 7, for information about strengthened Western Slope services.*

Colorado's Mental Health Institutes

On February 8, 1879, the Colorado legislature approved the creation of a State Insane Asylum. The Asylum opened October 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 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 1,758 in FY 2013-14. This is a further reflection of the criminalization of people with behavioral health issues.

CMHIFL currently has 94 adult inpatient beds, and, according to a July 7, 2015 Denver Post article, can admit only patients with the most severe illnesses. Major cuts at Ft. Logan in 2010 and 2011 closed units for children, adolescents and geriatric patients, as well as a day program. 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.

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. Ms. Rice updated the information June 1, 2015.

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 79 problem solving courts; eight are adult mental health courts and seven are juvenile; 27 are adult drug courts, six are Veterans' courts, thirteen are family drug courts, and sixteen are DUI courts. Courts may completely drop some charges and these won't appear on one's record; this can depend on the court and a person's criminal history, i.e. charges where there has been a conviction remain on the record.

The Problem Solving Court model works – there are 20 years of research in adult drug courts and 5-7 years of research and compelling evidence of effectiveness and success in mental health courts. Overall, money is saved; recidivism is reduced. This is a non-adversarial model – not like traditional court where clients do not speak and lawyers argue; it integrates treatment and judicial systems. Clients have broken the law and have addiction and/or mental health issues.

If they and the court agree, clients 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 and to a team consisting of the 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 Department of Corrections (CDOC)

The following information is from a March 14, 2014 teleconference interview with Renae Jordan, Director of Clinical and Correctional Services, Colorado Department of Corrections. Ms. Jordan updated the information in May 2015.

- **Inmates with Mental Illness**: 36% of the 17,708 inmates in Colorado's prison system have a mental health diagnosis and 10% of that 36% have serious mental illness.
- **Inmates with Substance Use Disorder (SUD**): 73% of prison inmates have moderate to severe substance use needs; almost three quarters of these are male.
- **Inmates with dual diagnoses (mental illness and substance use disorder)**: 38.7% of prison inmates are dually diagnosed.
- 14,185 inmates are in state-run prisons; 3,816 are in privately-run prisons.
- There are 81 inmates (currently incarcerated) who were originally sentenced to the CDOC prior to their 18th birthday.
- There are 5 inmates (currently incarcerated) who are currently 18 years of age.
- There are currently no incarcerated inmates younger than 18 years of age.

When offenders enter the prison system, they are first sent to the Denver Reception and Diagnostic Center (DRDC) where they are given a psychological assessment that includes a review of their psychological history. Based on this assessment, they are assigned a P (psychological) code ranging from 1-5. A P code is a combination of need levels (demands for services) and current symptom severity. For example, a P code of 1 indicates no current identified mental health needs and no historical evidence of specific mental health problems. Assigned P codes of 3-5 must have an accompanying qualifier that indicates the classification in which their mental illness falls. For example, an offender with Schizophrenia would have a P code that describes his level of stability/impairment and an M qualifier to indicate a category of serious mental illness.

Prior to entering the prison system, health care information is communicated to CDOC clinic staff for continuity of care purposes. This includes mental health information such as diagnoses, assessments, and current medications. Medications are continued, uninterrupted, until the inmate is evaluated by psychiatry. When inmates are transferred to permanently-assigned facilities, they are initially assessed and then evaluated and monitored thereafter based on assigned P codes and qualifiers. In addition to routine monitoring, a process exists to evaluate inmates experiencing mental health symptoms that interfere with their daily functioning and treatment is adjusted accordingly. Psychiatrist visits to inmates are as needed or as scheduled by the psychiatrist.

Offenders diagnosed with a mental illness achieve success through individual and group therapy. The Department understands medication compliance in combination with therapy is the most effective means of promoting recovery. Besides providing these two essential services - psychiatry and psychosocial treatments to offenders - the behavioral health department offers specialized interventions to promote wellness. These services include alcohol and drug treatment, sex offender treatment and discharge transition planning. As Ms. Jordan noted, it is believed female offenders have different psychological needs than the male population.
As such, group therapy integrates gender-specific and evidence-based practices as means of treating a wide range of psychological treatment issues. Female offenders can attend groups relating to trauma (seeking safety), anger management, criminogenic thinking (commitment to change) and skill building treatment (Dialectical Behavioral Therapy) to name a few. The Denver Women's Correctional Facility (DWCF) has over 900 inmates at any one time; approximately 76% are participating in mental health treatment. Interestingly, no statistics about childhood abuse for men or women are kept by the CDOC. Past abuse may be revealed in treatment or may be a reason for treatment.

Prescribed medications for inmates are dispensed from the Department's centralized pharmacy and delivered to facility clinics for administration by clinic nurses. Prescriptions are ordered in accordance with the approved pharmaceutical formulary; however, there is a process for approving non-formulary medications. Inmate-specific medications are transferred with the inmate when transferred to another prison facility. When inmates leave the system, e.g. they are placed on parole, a supply of medication is provided. With the assistance of parole mental health coordinators and other transition services (such as in-reach appointments), gaps in mental health treatment and/or medication are closed. To help facilitate a seamless transition to the community, transition plans are created by therapists within the institution that identify treatment needs before inmates leave the prison.

Rick Raemisch, Director of the CDOC, 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 inmates 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 from Illinois, who leads the Senate Subcommittee on the Constitution, Civil Rights and Human Rights, announced recently that the Federal Bureau of Prisons (FBOP) will conduct its first review of the use of solitary confinement and that the FBOP is calling for tighter rules on how long juveniles, pregnant women, and inmates with mental illness can be held in solitary confinement.

CDOC has changed policies for inmates relative to restrictive housing maximum security status (solitary confinement). The average length of time that inmates are in continuous restrictive housing (maximum status) is about 9 ½ months. Inmates in restrictive housing are psychologically evaluated a minimum of every 30 days. Those experiencing mental health symptoms are evaluated by psychiatry in concert with treating therapists. Recommendations for appropriate placement are made; this may mean, for example, placement in one of the Department's residential treatment programs. There are additional interventions for inmates currently incarcerated whose mental illness requires a higher level of treatment: 1) transfer to the San Carlos Correctional Facility and 2) transfer to the Colorado Mental Health Institute at Pueblo through an intergovernmental agreement. A civil commitment option is also available upon release if needed. Additionally, there are internal initiatives to restrict inmates with serious mental illness from restrictive housing maximum security, with very few exceptions. Colorado inmates with serious mental illness are housed according to level of treatment needs. There are currently no inmates with serious mental illness in restrictive housing maximum security.

Privately-run Prisons

Privately-run prisons have their own policies but, by contract with the state, they must adhere to clinical standards of practice. Inmates in private prisons are relatively mentally healthy and inmates with greater psychiatric needs are not housed in private facilities.

The Affordable Care Act and Transition out of Prison

Since the implementation of the Affordable Care Act in January 2014, CDOC nurse case managers have submitted Medicaid applications on behalf of eligible incarcerated individuals during hospitalization and prior to transition into the community. This transition begins 30 days prior to re-entry. Applications are quickly reviewed for approval by the Department of Health Care Policy and Financing (HCPF), most often within one week. Since its implementation and up to May 15, 2015, a total of 7,302 applications have been processed, resulting in 6,360 approvals.

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. Services also are funded through 1) a federal Block Grant, 2) Medicare to provide 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 local community behavioral health centers, but the amount varies. 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 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 (2005 study), and about 6% of nationwide substance abuse treatment spending. (Mark, et. al. - Colorado Trust, 2011).

In 2013-14, Colorado's budget – including the state general fund, various cash funds, Medicaid, Block Grant and other federal monies - for Substance Use Disorder services totaled $44,666,681 with 74,556 persons served. In 2013-14, Colorado's budget for its Medicaid mental health capitation program totaled $397,201,020; Colorado's budget for mental health services - including the same categories as SUD above - totaled $49,724,713 with 113,269 persons served. **Colorado's Office of Behavioral Health notes that Colorado has risen to 27th from 48th in the nation in per capita spending for behavioral health (http://kff.org/other/state-indicator/smha-expenditures-per-capita/).**

State funds and the Federal Block Grant: These funding streams are 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 implementation 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 ($35,139,629 in 2013-14). 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 one-third 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 continue to 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".

Silos of funding: Colorado government departments and divisions as well as educational institutions each have specific silos of funding, i.e. their own 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) (Moe Keller presentation 2014).

Medicare: Medicare has not traditionally been a primary source of funding for behavioral health; prior to ACA and federal parity legislation, benefits were limited. Typically, 1) outpatient visits were limited to a specific number per year; 2) Medicare co-pays could be higher than for other types of care; and 3) there was a lifetime limit on total inpatient days 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 time as more individuals realize that they have access to behavioral health services through their insurance carriers.

Medicaid: Medicaid is the largest source of financing for behavioral health services. Prior to the Affordable Care Act (ACA) Medicaid paid for over a quarter of all expenditures, 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. The carve-out systems 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) that 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).

The Affordable Care Act (ACA): Current Coverage

With implementation of the Affordable Care Act (ACA), Colorado's uninsured rate has fallen from 17% to 11%. HCPF expects these statistics to continue to improve. Between November 15, 2014 and February 15, 2015, nearly **220,000** Coloradans enrolled in healthcare coverage for 2015, either in private plans purchased through the health insurance Marketplace or with Medicaid or Child Health Plan *Plus* (CHP+). HCPF's March 2015 newsletter reported that as of February, 2015, there were 1,194,129 enrolled in Medicaid and 53,331 enrolled in CHP+.

During the three-month open enrollment period, **139,652** people enrolled in private coverage through Connect for Health Colorado; another **76,194** in Medicaid and **3,720** in CHP+. Connect for Health Colorado also enrolled **24,884**

individuals in dental plans. Among Connect for Health Colorado customers, **54 %** qualified for financial assistance. In 2014, the Marketplace enrolled more than 150,000 Coloradans in private insurance and helped nearly 100,000 gain access to new tax credits that made their health coverage more affordable. Coloradans who purchased coverage through the Marketplace received more than $250 million in tax credits to help lower the cost of their health insurance.

The Affordable Care Act: Medicaid Expansion and Behavioral Health Care

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. The Colorado Department of Corrections and Healthcare Policy and Financing now collaborate to ensure that offenders have a Medicaid card upon release.
- 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.

Substance Use Disorder

Why we're discussing Substance Use Disorder with Mental Health

Mental Illness and Substance Abuse: Scope of the Problem

About one in five 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 one in twenty American adults aged eighteen 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, one in four met criteria for co-occurring substance dependence or abuse. This rate (25.7%) was four times the rate (6.5%) of substance dependence or abuse in the population with no mental illness (excluding substance use disorders). Alcohol dependence or abuse was present in one of five 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)

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) 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)

Substance Abuse Prevention

The following information is from Natalie O'Donnell Wood, MA , Peer Assistance Services, Inc., May 15, 2015.

Prevention has been proven to be a valuable, low-cost tool in combating risky or harmful substance use. It can take many forms, including public education campaigns, community-based programs, or school-based services. These last programs are especially important because research has found that people who begin drinking at an early age are more

likely to experience alcohol dependence in their lifetime, to develop that dependence within ten years of beginning drinking,and to become dependent before age 25 (Hingson, et. al). Prevention, along with early intervention, is not aimed at those struggling with dependence, rather it is targeted at educating and increasing awareness among the 65 to 70 million people whose behavior wavers between "use" and "harmful use" of substances.

According to Dr. Tom McLellan, a former deputy director for the White House Office of National Drug Control Policy, "harmful use," so named because it affects an individual's health, productivity or relationships, can be effectively addressed with convenient, attractive, potent but brief interventions to reduce use and prevent problems from becoming worse.

An example is Screening and Brief Intervention (SBI), an evidenced-based practice implemented in Colorado primary health care settings since 2006. Screening involves a few short questions that allow a health care provider to assess risk associated with substance use. Brief intervention is a short motivational conversation to educate and promote behavioral changes in situations where a patient has indicated moderately risky behavior. Nearly 30% of adult Americans engage in unhealthy use of alcohol and/or other drugs, yet very few are identified or participate in a conversation that could prevent injury, disease or more severe use disorders (from "Helping Patients Who Drink Too Much: A Clinician's Guide," U.S. DHHS).

SBI is a Colorado success story. 1) It is cost effective. Estimates show that alcohol SBI yields a 400% return on investment within one year and that screening alone ranks fourth in saving costs – ahead of screening for hypertension, high cholesterol and cancers. 2) It is a useful tool in detecting problems, leading to the identification of substance abuse as a contributing factor to more than 70 medical conditions. 3) It is effective in motivating significant, lasting changes in substance use behavior. It can reduce how much a person drinks on any occasion by as much as 25% (from "Vital Signs, Alcohol Screening and Counseling: An Effective but Underused Health Service" Centers for Disease Control and Prevention. January 2014. http://www.cdc.gov/VitalSigns/alcohol-screening-counseling/). Six months after SBI began in Colorado, data revealed a 51% decrease in alcohol use and a 36% decrease in illegal drug use. 4) SBI is a reimbursable expense through Medicaid. For information, visit www.improvinghealthcolorado.org.

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. 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;

[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.

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

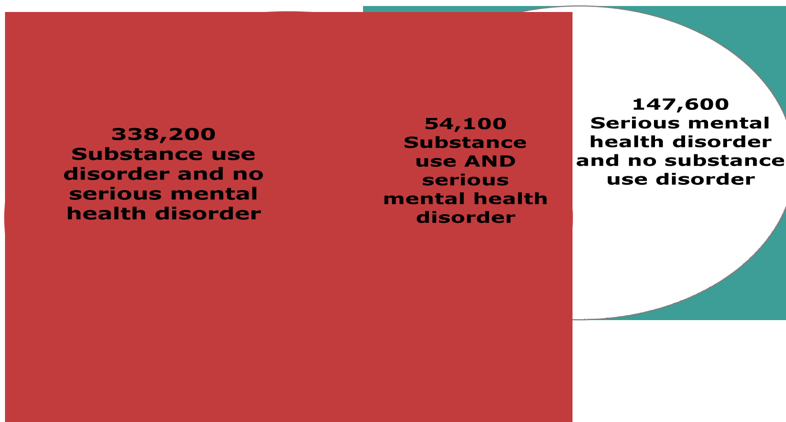
Note: *Chart adapted from Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings (SAMHSA, 2012)*

Co-occurring substance use and serious mental health disorders

When examining the subset of individuals with 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.

Fig. 3: Estimates of Past Year Substance Use & Serious Mental Health Disorder - CO Adults Aged 18 or Older 2011

[2] Defined as past year diagnoses other than substance use disorders that result in significant limitations in life functioning



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

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).

Child and Adolescent Behavioral Health

Colorado now has established, and continues to originate, significant behavioral health work for children; this updated section on Children's Behavioral Health contains information about ongoing and new efforts.

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.

Family-oriented Support in Colorado

The National Alliance on Mental Illness (NAMI)

NAMI's 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.

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, fragmented behavioral health system. The Federation has 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."

Colorado's Office of Early Childhood (OEC)

The Office of Early Childhood was established in 2012 and now has a Mental Health Unit. The following information is from a February 26, 2015 interview with Jordana Ash, Director of the Mental Health Unit. Mary Martin, Director of the Division of Community and Family Support, and Lindsay Dorneman, Projects Specialist, also participated.

The Office of Early Childhood's **Mission** is: To provide collaborative leadership and resources for children and families and early childhood professionals to best prepare Coloradoans for future success through access to coordinated and quality early childhood programs and family support. Specific focus areas include: 1) school readiness, 2) safe, stable and nurturing environments, and 3) resilience in early childhood. The target population is children prenatal through age 8. Children with Autism Spectrum and Autism-like behaviors are included in OEC's target group. Colorado has 31 Early Childhood Councils (each serves one or more counties) whose goal is systems coordination and the improvement and strengthening of early childhood services for children and families. OEC 's **goals** are 1) to align and coordinate efforts underway in early childhood and 2) to bring various programs and funding streams together.

The Early Childhood Mental Health Unit (ECMH) was created in January 2014; Ms. Ash was hired as Director in May 2014. Initial goals are: 1) to provide internal and external expertise about early childhood mental health, and 2) to develop a Colorado strategic plan for early childhood mental health.

ECMH works in prevention and capacity-building: 1) Kids need to be resilient and ready for school; 2) Providers and families need tools to promote development and respond to children's developmental and mental health needs; and 3) A two-generation approach involves focus on adults in children's lives and support for their behavioral health.

ECMH recommends use of screening tools at the pre-school level and recommends standardized screening tools such as the Ages and Stages Questionnaire – Revised (ASQ3) and the Devereux Early Childhood Assessment Tool (DECA Tool). **The ASQ Social and Emotional tool has a protocol about how to refer and how to find help; the DECA Tool looks at** resiliency and protective factors and helps guide support in classrooms so providers have specific strategies to promote protective factors and reduce challenging behaviors.

Early identification is an important part of a continuum of services and impacts how mental health specialists help teachers and work on what can be done in the classroom. Twenty-five Early Childhood Mental Health Specialists across the state observe on-site and help create a plan. These specialists, based at community behavioral health centers, are most effective when they are brought in before a child is expelled from day care or pre-school. It can be challenging to respond in metro areas where there may be hundreds of day care centers and homes and also in rural/remote areas with vast geographical coverage. The OEC supports the Nurse Family Partnership; 62 of Colorado's 64 counties have this service for first-time moms. The service continues until a child's second birthday, and nurse visitors can call on mental health consultants for case consultation. The Affordable Care Act created a Maternal Infant and Early Childhood Home Visiting Program; this program operates in the highest risk counties in Colorado (i.e. highest numbers of citizens with high risk factors) and clients are targeted by risk factors (poverty, developmentally disabled parent(s), etc.).

Additional information: 1) Poverty plays a huge role in health and well-being; people in poverty have any barriers to quality care; 2) Stigma influences whether parents will seek and accept mental health care for their children; 3) Society needs to continue to reduce barriers to access to care; 4) Child data collection in Colorado is segmented with state departments, offices and agencies collecting different data; information is not uniform or informing at this time. This should be addressed.

Community Behavioral Health: Services for Children and Adolescents at Aurora Mental Health Center, Aurora, CO

Community behavioral health centers in Colorado offer a range of services for children and adolescents. The following information is from a May 7, 2015 interview with Kathie Snell, Deputy Director, Family Services and Integrated Care, at Aurora Mental Health Center (AUMHC).

In fiscal year 2014, AUMHC served 6, 810 children and adolescents (ages 0-17). AUMHC's diverse service population includes immigrants and refugees; 60% of this population receives Medicaid and the remainder are either uninsured or have private insurance. The number of uninsured has now declined with more coverage under the Affordable Care Act; undocumented families are not eligible for ACA coverage unless their child(ren) have been born in the US. If people have no insurance, AUMHC contracts with the Colorado Office of Behavioral Health for funding. AUMHC has a sliding fee scale. The Aurora Public Schools have an Uninsured Students fund and AUMHC has some grants for funding for uninsured clients. Ethnicity of AUMHC's population is 60% white, 29% Hispanic, 20% Asian and other - less than 5%.

Most common child and adolescent diagnoses at AUMHC are: anxiety disorders, mood disorders, depression, bipolar disorder, trauma, and disruptive behavior disorder. Ms. Snell noted that diagnosis with children is often an art and takes time. Treatment services range from early childhood programs and group case management to helping families connect with other entities and services. AUMHC has three outpatient teams that provide traditional, evidence-based services and therapies throughout the city of Aurora. There are intensive outpatient teams for kids at risk for hospitalization or out-of-home placement, and 40 Aurora schools have comprehensive school-based programs. AUMHC works closely with the school staffs.
There are school-based health centers at Laredo and Crawford Elementary Schools, and these staff people serve ten additional schools. A behavioral health clinic will open in fall 2015 at Aurora Central High School and AUMHC is part of a new program called HEARTS (Healthy Environments and Response to Trauma in Schools) aimed at dealing with school trauma situations. Three Cherry Creek schools have AUMHC staff and will add more and AUMHC has three day-treatment programs for kids not able to be in school --- usually kids are in this program from six to nine months.

AUMHC also has a hospital liaison program where staff meets families in the hospital before a child's release and helps determine the appropriate level of outpatient services. AUMHC staff members are integrated in various private clinics; AUMHC staff work with Human Services staff to do assessments within trauma situations; AUMHC also has a mobile trauma team that can serve the new crisis centers. AUMHC is involved in suicide prevention partly through Mental Health First Aid for Teens – AUMHC now has a large cohort of trainers and is doing six to eight classes per month.

AUMHC staff has conversations with each family about what particular diagnoses mean and about what families can expect. These include a discussion of treatment options and how service provision works, the family's role, and various support groups and peer support. <u>Family involvement is primary in a child's treatment and recovery.</u> Medication is not generally prescribed for children. Over 50% of AUMHC kids are seeing a psychiatrist. AUMHC first evaluates and looks at treatment options with parents. The emphasis is on psycho-social treatment over medication.

Ms. Snell noted that child and adolescent services such as comprehensive early childhood services, home- and school-based services, evidence-based and trauma-informed assessment and treatment, and integrated primary and behavioral health care in pediatric settings are not consistently available across Colorado. She also noted that there is better understanding of the needs of "transition age youth" ages 16-24. Their needs differ from either the child or adult populations, and they need a different approach. Youth and young adults ideally would have specialized services that provide the necessary supports in a casual environment that can be accessed as needed. A system of care would include housing, educational/vocational support, support accessing Medicaid and other state programs, and social supports. Many community behavioral health centers are moving in this direction.

<u>Additional Colorado Behavioral Health Efforts for Children and Adolescents</u>

- **University of Colorado's JFK Center** completed a Scan of Early Childhood Mental Health in Colorado in 2013. From the Scan: "Early childhood mental health is the capacity of children from birth to five years to form close and secure adult and peer relationships, experience, manage, and express a full range of emotions, and explore the environment and learn—all in the context of family, community, and culture… To support the healthy development of our young children, it is essential to create a comprehensive system that supports a continuum of mental health services and has the capacity to deliver those services statewide. Despite a growing awareness of the importance of mental health to future wellness and recent progress to address gaps in its current system, Colorado's early childhood mental health system remains inadequate to promote the healthy development of its young children, prevent problems for those at risk, and treat the symptoms of children with diagnosed mental health disturbances." Challenges include: 1) "the current workforce is insufficient, and there is a notable lack of incentives and supports for professionals to seek specialized training and remain in the field;" 2) "while quality programs and services exist, availability is often unequal and limited to certain geographic areas;" 3) "despite the importance of early identification and treatment, screening for childhood social and emotional difficulties is inconsistent among providers;" and 4) "current Medicaid policies are often not flexible enough to cover treatment appropriate for young children. The accompanying full report includes recommendations for funders to address these and related challenges as they work with other funders, government, social service agencies, and mental health professionals to find enduring, systemic solutions."

- **Colorado Department of Public Health and Environment (CDPHE)** is part of a national program: Essentials for Childhood: Safe, Stable and Nurturing Relationships. The premise of this program is that child maltreatment is a public health problem and safe and stable relationships are important to prevent maltreatment. In Colorado, a collaborative CDPHE socio-emotional workgroup is working to develop and implement a statewide plan.
- **CDPHE's Colorado 9 to 25** is a group of youth and adults working to align efforts and achieve positive outcomes for all youth. Goal areas include safety; physical and mental health; quality education; connection to caring adults, schools and communities; and contribution to communities. Colorado 9 to 25 is especially aware of transitions during adolescence, including mental health challenges, and the need for positive decision-making. See **http://CO9to25.org,** a clearinghouse for "all things adolescent health."
- **Youth and Young Adults ages 14 – 25** From the Colorado Department of Human Services website: "…there has been growing attention concerning youth and young adults with mental health challenges (and) there has been a significant amount of information developed on best practices in working with this group. Young people with mental health challenges, defined here as individuals between the ages of 14 to 25, have unique needs and strengths that often transcend services provided in traditional youth and adult service systems. Service approaches that are proving to be effective offer an array of services and supports in addition to behavioral health services. Leadership provided by young people is also having an impact on program and policy development. Youth-run organizations are an example of this growing movement among young people with lived experience in human service systems. Service models such as the evidence-informed Transition to Independence Process (TIP) are examples of youth-centered approaches that focus on the various life domains of young people. Family connections and other types of lasting relationships are also being viewed as necessary transition supports. Many Colorado communities have undertaken creative efforts to serve this population. These efforts are supported by diverse systems such as behavioral health prevention and treatment, child welfare, juvenile justice, education, vocational rehabilitation, employment, and community-based organizations."

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). SAMHSA (federal Substance Abuse and Mental Health Services Administration) defines recovery as "a process of change through which individuals improve their health and wellness, live self directed lives, and strive to reach their full potential." Mental Health America (MHA) broadly describes recovery as a journey of healing and transformation, enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. MHA strongly believes that any person with a behavioral health problem can recover.

In studying recovery from the perspective of the Colorado Office of Behavioral Health, Colorado Wellness Network, SAMHSA, 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) HOLISTIC 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 (CMWN), gives seven elements which individuals can use to develop their own specific daily path to recovery including a Wellness Toolbox, Daily Maintenance Plan, Identifying Triggers and an Action Plan, Identifying When Things are Breaking Down and an Action Plan, and Crisis Planning and Post Crisis planning. Some consumer and family groups also encourage 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

The following information was contributed by Tonya Wheeler, Executive Director, Advocates for Recovery, 2014.
Long-term recovery from addiction is a reality. Over 23 million people in the United States are in recovery from addiction. The U.S. 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 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.

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 created by individuals who seek wellness and recovery from mental health issues. It was incorporated as a peer-run nonprofit in 2013 to provide individuals with tools and self-help information to achieve their goals while changing community perceptions of mental illness through advocacy. The Network does not provide 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. CMWN works for inclusion of people in recovery at various venues. The Network is part of the International Association of Peer Supporters, and it also works legislatively, often 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 1) the need for specialized treatment for transition-age youth and young adults, ages 14–28, because many behavioral health issues arise at that time, and 2) 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 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.

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 Person in Recovery (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).

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. Mr. Glaser updated this information in May 2015.

NAMI Colorado is affiliated with NAMI National, a grassroots organization known for work in education, advocacy and support. 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. There are fourteen local NAMI affiliates throughout the state: NAMI Adams County, NAMI Arapahoe/Douglas Counties, NAMI Aurora, NAMI Boulder/Broomfield, NAMI Colorado Springs, NAMI Denver, NAMI Jeffco, NAMI Larimer County, NAMI Roaring Fork Valley (Glenwood Springs and surrounding areas), NAMI Heart of the Rockies (Salida), NAMI Southeast Colorado (Pueblo/Canon City and surrounding areas), NAMI Southwest Colorado (Durango and surrounding areas), NAMI Western Slope (Grand Junction and surrounding areas), and NAMI Weld County.

NAMI National creates curriculum for classes and support groups that are used by NAMI Colorado to train volunteers to conduct those programs in the local affiliates. NAMI Colorado has developed additional programs for Colorado.

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 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; many family members describe this program experience "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 taught by people in recovery and including 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 from a broad group of persons in recovery.

<u>NAMI Colorado Programs</u> (*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 six volunteer attorneys; callers are screened by NAMI Colorado and are then connected with an attorney.

NAMI Colorado does not make referrals to individual doctors. NAMI Colorado directs people to local community mental health centers and hospitals and gives guidance to the new Colorado Crisis Services system.
NAMI Colorado has six volunteer attorneys who field law questions on a limited basis in these 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 Colorado is currently advocating for parity across all insurance plans and following the roll-out of the Colorado Crisis Services system.

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 speakers, especially the February 19, 2014 presentation by a panel of Persons in Recovery (PIR), 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; that 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 the prejudice that people with mental illness experience. A study has shown that an individual with a mental illness may incorporate societal stigma into one's sense of self, and, then, lower one's self-esteem. Individuals with a psychological challenge who attribute their condition to a physical, medical, or biological condition will be more satisfied with their social relationships and life in general than those individuals who see

themselves as responsible for their mental illness. Individuals who perceive themselves as responsible also perceive a greater degree of stigma than those attributing their disorder to a cause outside of their control. (Mechanic et al. 2002)

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 symptoms of the mental 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 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

The Colorado Coalition for the Homeless (CCH) states that safe housing is paramount because it stabilizes people so they can go to, and benefit from, treatment. The Coalition has opened 78 new housing units above its Stout Street Clinic. Members of the Persons in Recovery Panel from the Colorado Mental Wellness Network stated that there is a total lack of adequate, affordable housing for people with serious mental illness.

Kristi Mock, Mental Health Center of Denver's (MHCD) Vice President for Adult Services, noted in a May 21, 2015 interview that housing is a critical component of MHCD's adult case management program. Clients may live in their own housing or in MHCD housing that includes 144 beds in 16 group home facilities (6 - 16 people per facility). Medicaid will pay for people in facilities up to 16 beds. MHCD also has 64 apartments in 3 buildings that the agency owns or leases. Case managers work with the landlords to adjust the level of care needed for each client. In addition, MHCD has 60 beds in 3 other buildings owned by a corporation that is part of MHCD.

MHCD also has 100 Section 8 certifications - these are attached to the <u>person</u> so clients can use them in any facility. This method of subsidizing housing is very difficult now because housing is so expensive that the Section 8 certification will not cover the rent adequately. MHCD has 600 additional housing subsidies or vouchers that can be used in various entities and people can apply these to the housing of their choice.

Kristi Mock said, "It is paramount to have housing." In Denver, the housing vacancy rate is the lowest she's seen; MHCD has trouble placing people. A one-bedroom costs at least $1,000 per month; a subsidy maximum is about $827. Case managers work intensively with landlords to keep people in existing housing; homeless people may share housing - this upsets landlords. MHCD can arrange to have social security checks come to MHCD, which then pays the rent directly.

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* that 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

barriers to improving the health of people with acute or chronic illnesses. Daily preoccupation with securing food and shelter leaves little time for medical appointments. Pain and discomfort associated with illness and treatment side effects are compounded by lack of privacy, risk of abuse, and theft of medications. Clients frequently explain that they have 'no place to lie down during the day' to rest and heal."

In 2005, Denver's Commission to End Homelessness established Denver's Road Home and a 10-year plan to end homelessness. This comprehensive plan blends a "housing first" solution with responsibility, self-reliance and accountability. Housing assistance is the first priority, followed by case management, mental health and substance abuse counseling, employment and other services that help sustain stability and self-sufficiency. Goals include the development of almost 3,200 permanent and transitional housing opportunities and provision of better access to supportive services that promote long-term stability and improved functioning.

Re-entry to Society after Incarceration

In 2008, the Colorado Department of Corrections (CDOC) proposed a top-to-bottom overhaul of parole operations that included more resources for preparing prisoners for their release and for helping them cope with life after prison. Although the Behavioral Health Task Force has not been able to reach a CDOC representative to learn about the status of the proposed plan, a search of the department's website revealed that CDOC has designed, and is implementing, extensive Pre-Release and Community Re-Entry Programs. The overall goal is to provide "*a continuum of transition services from facility into the community through statewide partnerships*".

The CDOC website states, "The mission of the Pre-Release Program is to provide a consistent continuum of services between facilities and the community, accessible to all incarcerated adults preparing for release, in order to target the known predictors of recidivism and increase opportunities for successful re-entry. The goal of the Pre-Release Program is to assist individuals to identify critical barriers to successful community re-entry and to identify internal strengths and external resources in order to expand individual networks of support. This is accomplished through the development of a transitional action plan in the areas of identification, housing, employment, transportation, money management, education, healthy lifestyles, family, relationships and support systems, victim awareness and restorative justice and living under supervision. .. Community Re-Entry provides brokered services through state and federal agency partnerships, faith and community based collaborations, case management, and direct support services that afford the division strategies and interventions for a balanced approach to offender management."

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."

In 2014, Colorado's legislature passed bills that funded a Wrap-around Re-entry Services Grant to provide services for adults on parole. The CCJRC website states, "The Work and Gain Education and Employment Skills (WAGEES) initiative is a community re-entry grant program created in 2014 by the Colorado General Assembly as part of House Bill 14-1355, and funding was included in the Department of Corrections' (DOC) budget." Four grants were awarded in January 2015 to agencies in Denver, Aurora, Pueblo and Boulder. In 2015, the legislature increased funding for expansion into new

areas: Colorado Springs, Ft. Collins/Greeley and Grand Junction. CCJRC website states, "This … program is intended to improve success by strengthening community-based wrap-around services to people on parole and building a strong partnership between grantees and CDOC." Wrap-around services include help in finding housing and employment, identification acquisition, family reunification, and mentoring.

CCJRC has produced a book on re-entry titled Getting On After Getting Out: A Re-Entry Guide for Colorado. CCJRC states that the book "… provides extensive information to help people prepare for release and successfully reintegrate back into their families and communities" and is designed for use by parolees, their families, community service providers and criminal justice professionals. Twenty chapters cover topics from planning for release to understanding parole and the parole board, from legal matters including child support to one's first days out and places to find help and services and housing, and from identification needed to how to search for jobs, how to apply for benefits, how to manage money and credit, and eligibility for voting. The density of the book is a testimony to the complexity of re-entry.

Are parole services working? The Problem-Solving Courts' Coordinator for Colorado's 7th Judicial District (Montrose, CO) provided the following response: "Re-Entry programs are pretty limited to being assigned a parole officer, at least in our part of the state. It is an area full of potential to do good… If someone is struggling on parole, they represent an alternative to re-incarceration."

Re-entry from jail to community: Jail-Based Behavioral Services (JBBS)
The Office of Behavioral Health (OBH) has budgeted $3,066,446 for the Jail Based Behavioral Health Services Program. JBBS supports **c**ounty **s**heriffs in providing screening, assessment and treatment for substance use disorders and co-occurring substance use and mental health disorders for people who need such services while they are in jails. In October 2011 (HB 10-1352), OBH contracted with **c**ounty sheriffs' departments to serve 23 counties to provide behavioral health and transition support services for offenders in jails. In October 2012 (SB 12-163), the Correctional Treatment Board voted to fund and expand the Jail-Based Behavioral Health Services Program to additional counties across the State. An additional 13 counties have JBBS programs effective July 1, 2013.

The JBBS program funds provision of evidence-based behavioral health services, with continuity of care extending into the community. Sheriff departments have partnered with local community provider(s) who are currently licensed by OBH to provide services within the jail and have the capacity to provide free or low-cost services in the community to inmates upon release. Most programs have at least a clinician position to offer screenings, assessment and treatment in the jail, and a case manager position dedicated to transitional care and a seamless re-entry in treatment services. Treatment providers screen all inmates for presence of substance use disorders, mental health disorders and trauma and traumatic brain injury. County jails with a JBBS program: Adams, Alamosa, Arapahoe, Baca, Bent, Boulder, Cheyenne, Clear Creek, Conejos, Crowley, Delta, Denver, Douglas, Eagle, Elbert, El Paso, Hinsdale, Garfield, Grand, Gunnison, Jefferson, Kiowa, Kit Carson, La Plata, Larimer, Logan, Morgan, Montrose, Montezuma, Mesa, Otero, Ouray, Phillips, Pueblo, Routt, San Miguel, Washington, Weld and Yuma.

Re-entry from jail to community: FOCUS Reentry, Boulder, Colorado
"It is critical to keep people with mental illness out of jail – the system can eat them alive. Jails are the new repository for people dealing with mental illness – there is hardly any place to take people other than the jail." (Nicky Marone, Executive Director, FOCUS Reentry) The following information is from an April 23, 2015 interview with Ms. Marone.

The mission of FOCUS Reentry, a private non-profit organization that contracts with the Boulder County Jail to provide re-entry services, is: To reduce recidivism and enhance community safety in Boulder, Colorado. FOCUS Reentry usually has 20 – 25 volunteer mentors who are matched with inmates/offenders coming out of the Boulder County Jail. Research shows that if an offender coming out lacks basic needs such as housing, food, clothing, etc., they will recidivate within 72 hours. The volunteer mentors usually work with the inmate from six to eight weeks prior to release to form a

trust bond. The inmates chosen are men and women ages 18 – 55 (inmates above 55 usually don't recidivate) who are recommended by the jail; offenders must formally request a mentor because FOCUS Reentry wants them to be invested. FOCUS Reentry does not serve people who are habitually violent, sex offenders or critically mentally ill people – those for whom medications are not working. These three categories require more training than FOCUS Reentry can provide for its mentors. FOCUS Reentry will serve inmates with domestic violence charges.

Mentors accompany clients to court hearings; mentors are often an objective set of eyes and ears. For instance, if there is erratic behavior, a mentor can note that this mentee may be off his or her medications and re-entry faces challenges when people do not take their medications.

Some offenders come out of jail with post-traumatic stress disorder (PTSD) and can't make decisions; no decisions are needed in jail because everything is ordered or prescribed, and this can be traumatic and also produces learned helplessness. FOCUS Reentry utilizes the services of a psychotherapist and also works with mental health partners and services in the community. Mentors also have a "mentor advisor" that they can call with questions. Fifty percent of FOCUS Reentry mentees have a mental health diagnosis, and there is an overlap between mental illness and addiction; addiction may also drive someone to commit a crime. Colorado's recidivism rate is 55%; FOCUS Reentry's recidivism rate (for those in the program for a year) is 17%. Successful re-entry means keeping someone out of jail and out of the criminal justice system.

Additional Barriers to Recovery

- **Need for Advocacy** for mental health is ongoing; agencies doing this work in Colorado include Mental Health America of Colorado (MHAC), Colorado Behavioral Healthcare Council (CBHC), National Alliance on 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 Substance Use Disorder (SUD). A Mental Health Caucus has met at the state capitol; the topic has been: What to do about lack of support for behavioral health care?
- **The Affordable Care Act (ACA) and Parity:** With ACA and federal Parity Act implementation, *some* 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. However, health insurance plans are falling short in coverage of mental health and substance abuse conditions according to a report issued April 1, 2015 by the National Alliance on Mental Illness (NAMI), based on a survey of 2,720 consumers and an analysis of 84 insurance plans in fifteen states. A federal "parity" law enacted in 2008 requires mental health benefits in some employer-sponsored plans to be provided on the same terms as other medical care. Coverage was expanded under the Affordable Care Act (ACA) in 2010. "Despite the law, discrimination still exists toward mental health and substance use conditions," said NAMI Executive Director Mary Giliberti. " NAMI's report identifies areas where insurance companies need to improve…"
- **Need for Behavioral Health 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 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. Too few mental health and SUD providers are willing to serve priority populations because of low reimbursement levels. There is geographic disparity across nearly all behavioral health practitioner groups; the disparity is most pronounced for professions that require the most training. As level of training increases (# 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).

- **Fragmented Services and Systems:** Moe Keller, Mental Health America of Colorado, stated that Colorado needs better use of money in all behavioral health areas; she expressed the need to bring together 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".
- **Need for Early Intervention 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.
- **Hospital Beds for People with Mental Illness:** MHCD CEO Carl Clark noted that Colorado is 52nd (including U.S. territories) in the number of hospital beds available for mental health. The University of Colorado Hospital has closed all of its mental health beds. Other hospitals have done the same. Hospitals cannot 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).

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. This belief is furthered by the media. "The vast majority of news stories on mental illness either focus on other negative characteristics related to people with the disorder (e.g., unpredictability and unsociability) or on medical treatments. Notably absent are positive stories that highlight recovery of many persons with even the most serious of mental illnesses" (Wahl, et al., 2002).

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 three 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 three 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).

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 controversy as to whether this abuse is a causal factor, and there are significant differences between the two 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 (in Colorado) 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 summary, 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 five 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 <u>cannot</u> 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 <u>is</u> 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

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 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 care by prohibiting discriminatory practices that limit insurance

coverage for behavioral health treatment. "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.
In 2013, the departments of Health and Human Services, Labor, and the Treasury issued the final rule to implement the 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."

Moving Forward: New Practice

- **Affordable Care Act:** ACA has 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 (*see ACA, pages 15, 17-18, 33)*.
- **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. This system is now operational *(see pages 9-10 of this report).*
- **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,** 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. According to Dr. Clark, this can positively affect the upcoming 10 years of young people's lives and move them in a positive direction.

- **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 about mental health issues. Many community behavioral health centers offer or help sponsor this training.
- **Mental Health Parity and Addiction Equity Act of 2008 (Federal):** Rules and regulations were finally issued in 2013. Although this should mean that physical and behavioral health issues have equivalent coverage, only some insurance coverage offers this *(see Parity Act, pages 33 and 35-36).*
- **Problem-Solving Courts: Mental Health and Drug Courts:** Drug Courts began in Miami, FL (Dade County). The rationale is that people can't be punished out of addiction. This is a non-adversarial model, not like traditional court where clients do not speak and lawyers argue. Here, the client speaks directly to the judge, and a team, led by the judge, includes a prosecutor, defense attorney, treatment provider(s), caseworker, 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 a 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 **s**eamless behavioral health coverage across disciplines – training is offered to multidisciplinary teams by various groups; implementation is irregular across Colorado.

Recommendations

In its May 2014 report, the LWVCO Behavioral Health Task Force made recommendations 1) to the League and 2) for behavioral health policy and practice. The current (June 2015) status of those recommendations is presented below.

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

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.

Current Status: This LWVCO Behavioral Health Study is a result of the above recommendation; information about Parity is included in the study materials; local Leagues will use the updated state position; information on Parity and quality of service is included in these updated materials; the Legislative Action Committee has a member specifically following behavioral health.

League Education:

1) The Behavioral Health Task Force Report should be published and easily available on the LWVCO website.
2) A list of Behavioral Health Resources should be included on the LWVCO 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 LWVCO Behavioral Health Task Force Report should be shared with the League of Women Voters of the United States (LWVUS).

Current Status: The Task Force Report is on the LWVCO website (http://www.lwvcolorado.org/behavioral-health.html); a list of resources is not yet included; a representative of each League still needs to be trained to educate about the report at the local level; most local Leagues have had briefings presentations, and several are participating in coalitions or committees to improve behavioral health services; several local Leagues have helped sponsor Mental Health First Aid courses; local Leagues have the report on their websites or have a link to the LWVCO website (above); the LWVCO Behavioral Health Task Force Report is on the LWVUS Clearinghouse for all leagues in the US to view and use.

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.

Current Status: *Implementation of the Affordable Care Act (ACA), Medicaid Expansion in Colorado and the Parity Act have made it possible for increasing numbers of Coloradans with behavioral health issues to obtain and receive care (Please see pages 16-18 and 35-36 of this report for more on ACA and Parity).*

2) **Behavioral Health Crisis Centers**: Development of, and funding for, behavioral health crisis centers across the state must be implemented as soon as possible.

Current Status: *The Crisis Centers opened January 1, 2015 (see pages 9-10 of this report).*

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.
    - 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.

Current Status: *The Colorado Office of Early Childhood Mental Health Unit (OECMHU) was staffed in May 2014 and is working to define and educate about services for children pre-natal through age eight; the OECMHU is working on a strategic plan for Early Childhood Mental Health by updating a 2008 framework.*

4) **Behavioral Health Inpatient Treatment**: Colorado needs to increase the number of beds available across the state for behavioral health inpatient treatment.

Current Status: ***Increased public behavioral health beds are still not available.***

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.

Current Status: *Unknown.*

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

Current Status: *this needs to be accomplished.*

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 behavioral health inpatient treatment.

Current Status: *The Colorado Department of Corrections and various non-profit agencies are working to strengthen re-entry services for offenders on parole; Colorado's jails provide services as county budgets allow; Colorado has a Jail-based Behavioral Services program available for local jails; Focus Reentry in Boulder, Colorado has developed an effective program with the Boulder County Jail.*

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.

Current Status: *The League of Women Voters of the US includes support for universal health care in its health care position and LWVCO and all local Leagues use this position. Various Colorado organizations are considering legislative action.*

Resources/References: Speakers, Publications and Contributors

SPEAKERS

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

Ash, Jordana, Director, Mental Health Unit, Colorado Office of Early Childhood (OEC), Feb. 26, 2015 (Additional participants f*rom the Office of Early Childhood: Mary Martin, Director, Division of Community and Family Support; Lindsay Dorneman, Projects Specialist.*

Caldwell, Alicia, Director of Communications, Colorado Department of Human Services, on behalf of Vatsala Pathy, Colorado SIM Director, Colorado Office of the Governor.

Courtright, 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 (OBH), August 8, 2013 (Ms. Clements has retired; updated information provided by Chris Habgood, OBH, May 2015)

Del Grosso, George, Executive Director, Colorado Behavioral Healthcare Council (CBHC), September 26, 2013 (updated information provided by Joseph Councilman, CBHC, May 2015)

Glaser, Scott, Executive Director, National Alliance for Mental Illness (NAMI) Colorado, January 17, 2014 (updated information provided May 2015)

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 (updated information provided May 2015)

Keller, Moe, V. P. for Public Policy and Strategic Initiatives, Mental Health America of Colorado, September 26, 2013 (additional information provided May 2015)

Marone, Nicky, Executive Director, Focus Reentry, Boulder, Colorado, April 23, 2015

Mock, Kristi, Vice President for Adult Services, Mental Health Center of Denver (MHCD), May 21, 2015

Panel from CO Mental Wellness Network - Persons in Recovery at Mental Health America Colorado, February 19, 2014
Perry, Dr. Dorothy, CEO, Spanish Peaks Healthcare System, November 8, 2013
Schut, Arthur, CEO, Arapahoe House, June 28, 2013
Snell Kathie, Deputy Director, Family Services and Integrated Care, Aurora Mental Health Center (AUMHC), May 7, 2015

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ADDITIONAL RESOURCES

Colorado Beacon Consortium : 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.

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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; Colorado governmental departments are on this Council administered by 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 following treatment for 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 behavioral health centers are locally governed, not-for profit corporations that are responsible for providing behavioral health services in defined service areas throughout Colorado. Most behavioral health centers provide services for mental illnesses and substance abuse. Every part of the state is served by a community behavioral health center. The Centers are funded by the state, the federal government, grants, donations, and fees collected for services. For many, if not all, behavioral health centers, Medicaid is the largest single source of funding. Except in Denver, the community behavioral health center is a part owner of the Behavioral Health Organization (BHO) that serves its area. The community behavioral 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

Carol Anderson, LWV Denver – Interested in and involved with issues surrounding homelessness and behavioral health.

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.

Mary Endres, LWV Mesa County – Chaired a Mesa County group that developed and carried out a survey of providers; survey stimulated public health action.

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 (retired); former nurse manager in acute in-patient psychiatry; mother of 49-year-old son with severe, chronic mental illness.

Gwyn Green, LWV Jefferson County - Licensed Clinical Social Worker (LCSW) (retired)- 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.

Sally Olsen, LWV Mesa County - Psychiatric nurse (retired); taught college level community mental health; a writer of Mesa County Mental Health Survey (2012); serves on the Board of NAMI Western Slope.

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; 2015 – President, League of Women Voters of Colorado.