

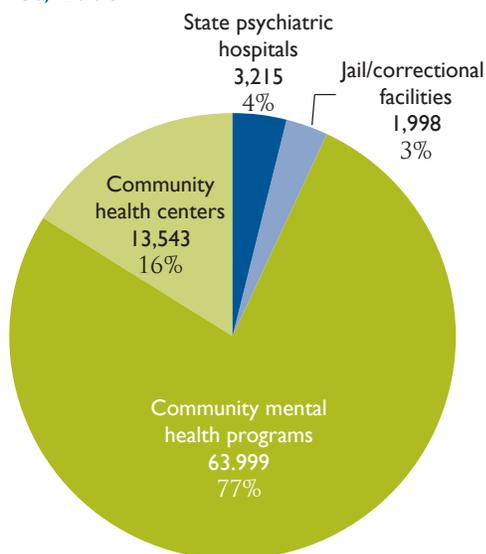
COLORADO'S MENTAL HEALTH SAFETY NET

Introduction

A mix of systems and providers, including community mental health centers (CMHCs), community health centers (CHCs), hospitals, schools, correctional facilities and other community-based organizations serve as Colorado's de facto mental health care system. Many of these providers act as the *mental health safety net* for low-income and medically indigent individuals. For individuals who are eligible because of their income and who are otherwise uninsured, enrollment in the Medicaid program provides a major payment source for out-patient mental health care providers and in-patient treatment facilities. Many low-income medically indigent individuals, however, have no source of insurance coverage for mental health treatment.

According to a 1999 United States Surgeon General report, good mental health most often results in a productive life with fulfilling relationships and the ability to adapt to change and cope with adversity.¹

Graph 1. Patient distribution of mental health care sites representative of Colorado's mental health safety net, 2006²



This definition of positive mental health functioning is consistent with the World Health Organization's definition of overall health as a "state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." Colorado has been moving its mental health system toward this broader definition of health by recognizing the importance of wellness and prevention services as integral to positive mental health outcomes. Consistent with the national and international dialogue on policy and service integration, Colorado is also progressing toward an integrated behavioral health model that incorporates mental health care, substance abuse treatment and physical health care services into coordinated care systems.

For many individuals with a diagnosed mental health illness, including those with a co-occurring diagnosis of substance abuse, having access to a full continuum of services from prevention and early intervention to diagnosis and treatment to long-term therapeutic care management can substantially improve their quality of life. When individuals with serious mental illness do not have access to this full continuum of care, untreated symptoms are often exacerbated, resulting in unnecessary hospitalizations and/or incarceration.

The Colorado Health Institute (CHI) established the *Safety Net Indicators and Monitoring System (SNIMS)* in 2006 to inform communities and policymakers about the changing dynamics of Colorado's safety net system that provides primary health, mental and oral health care to the state's most vulnerable residents, and to arm them with the information needed to ensure the system's sustainability. CHI recently published an updated safety net primer³ that describes the providers, users, financing and public programs that make up Colorado's safety net system. This primer is devoted exclusively to the providers, users and financing for Colorado's mental health safety net.

National context

In 1999, the mental health status of Americans received focused attention when the U.S. Department of Health and Human Services released the landmark report, *Mental Health: A Report of the Surgeon General*. According to this report, mental illness, including substance abuse disorders, was estimated to affect one in five Americans each year—regardless of age, gender, race, ethnicity, religion or economic status. The report noted that although the system of care that existed at the time functioned well for many people, individuals with the most complex needs and the fewest financial resources faced a fragmented system that was difficult to access and use appropriately.⁴

In 2002, President George W. Bush established a Commission on Mental Health as part of a broader New Freedom Initiative for people living with disabilities.⁵ The New Freedom Initiative funded programs to increase access to educational and employment opportunities for people with disabilities. In 2003, recommendations emanating from the commission's work included increasing consumer-directed service options, mitigating health disparities, increasing screening and referral programs, expanding the use of technology to access services and increasing the public's understanding of the role that mental health plays in an individual's overall health. Soon thereafter, the National Institute of Mental Health estimated that mental health disorders were the leading cause of disability in the U.S and Canada for people ages 15-44.⁶

Colorado context

Findings from a 2005-06 National Survey on Drug Use and Health administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that approximately one in 10 Coloradans 18 years and older reported serious psychological distress and 8 percent experienced at least one major depressive episode in their lifetime. One in four young adults (ages 18-25 years) reported alcohol or illicit drug dependence or abuse and one in five of these reported needing but not receiving treatment for alcohol abuse.⁷

For low-income populations, the gap between available behavioral health services and the numbers in need is even higher. In 2002, the Colorado Department of Human Services' Division of Mental Health (now the Division of Behavioral Health) released a legislatively authorized study, *Population in Need of Mental Health Services and Public Agencies' Service Use in Colorado*.⁸ The study estimated the number of individuals with serious mental illnesses who qualified for publicly funded services, identified where they were receiving services, estimated the unmet need for mental health and child welfare services and assessed the service capacity of the juvenile justice, criminal justice and educational systems.

The study found that most individuals with serious mental illnesses were receiving services outside the mental health system and that approximately 66,500 (39%) were not receiving any services. A 2008 follow-up report issued by the Division of Behavioral Health had consistent findings with the 2002 report, finding that six in 10 individuals with a serious mental illness received services in such places as the corrections and social services systems.⁹

The state is currently updating these estimates and has found that approximately 215,200 Coloradans living at or below 300 percent of the federal poverty level (FPL), which in 2009 was \$32,490 for an individual and \$66,150 for a family of four, have a serious mental illness, substance abuse problem or both. Of this combined group, 40,000 are children and youths (0-17 years) with a serious emotional disorder, 84,000 are adults with a serious mental illness, 67,000 are adults with a serious substance abuse problem and close to 14,000 are adults with a co-occurring serious mental illness and substance abuse problem.¹⁰ The final report is expected to be released in mid-2009.

In 2003, eight Colorado foundations formed the Mental Health Funders Collaborative and conducted an extensive assessment and analysis of mental health needs and services in Colorado, the results of which culminated in a report, *The Status of Mental Health Care in Colorado*.¹¹ This report found growing needs, shrinking resources and often inaccessible mental health care services.

Mental health care issues were elevated in visibility in Colorado in 2005 when the General Assembly established a bipartisan Mental Health Caucus. In 2006, gubernatorial candidate Bill Ritter included a set of mental health policy goals in his platform known as *The Colorado Promise*.¹² During the 2007 and 2008 legislative sessions, several laws affecting mental health service delivery and reimbursement for mental health services were passed. HB 07-1050 created a legislative task force to study and make recommendations to the legislature to improve Colorado's entire behavioral health care system. The Ritter Administration established the Division of Behavioral Health within the Colorado Department of Human Services, merging two existing divisions—the Division of Mental Health and the Alcohol and Drug Abuse Division.¹³

Colorado's mental health care safety net

A wide array of providers and systems, often but not always working together, constitutes Colorado's mental health care safety net. Because community innovation informs and shapes local mental health care systems, it is difficult to generalize about providers and agencies that serve low-income individuals and families and the ways in which they configure service delivery at the local level.

CHI has adopted the Institute of Medicine's (IOM) definition of core safety net providers as those: 1) that offer care to patients regardless of their ability to pay for services based on either a legal mandate or explicitly adopted in their mission; or 2) for whom a substantial share of their patient mix is made up of uninsured, Medicaid or other vulnerable patients. While it is clear that many other service providers offer mental health care, including social service agencies, juvenile and criminal justice systems and private therapists, this primer focuses primarily on the community-based mental health care system.

Behavioral Health Organizations (BHOs) are Medicaid managed mental health care organizations designated by the Colorado Department of Health Care Policy and Financing (HCPF) that represent five geographic service areas encompassing the entire state. BHOs contract for services under the Community Mental Health Services (CMHS) program—the state's Medicaid mental health program

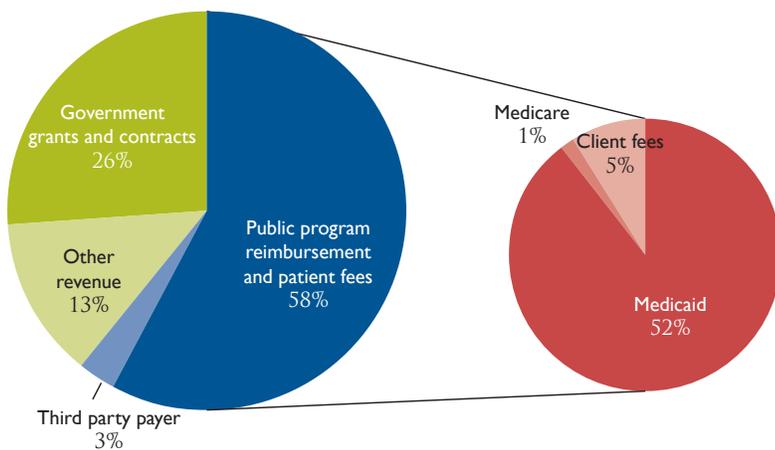
administered and funded by HCPF. Core services include psychiatric inpatient hospitalization, outpatient hospital services, psychiatry, rehabilitation, psychosocial rehabilitation, case management, medication management, emergency services and residential treatment services.¹⁴ BHOs also must ensure the availability of one additional optional service beyond those listed above, which may include assertive community treatment, multi-systemic therapy, vocational services, clubhouses and drop-in centers, respite care, home-based family services or intensive case management. (See *The Status of Mental Health Care in Colorado*, TriWest Group, for a discussion of these therapies.)

BHOs are required to maintain a network of service providers that includes community mental health centers (CMHCs), other essential community providers such as federally qualified health centers (FQHCs), private facilities, specialty clinics, physicians and other mental health care professionals including clinical psychologists and social workers. BHOs are responsible for ensuring that patients have access to multicultural/multilingual providers as needed. Finally, involuntary in-patient services are provided at two state-operated mental health institutes, the Colorado Mental Health Institutes at Ft. Logan and at Pueblo.

Community Mental Health Centers (CMHCs) are nonprofit or publicly operated clinics providing or arranging for core services to low-income individuals residing in designated geographic service areas. There are 17 CMHCs in Colorado offering a range of individualized services;¹⁵ contracts between the State of Colorado and CMHCs do not prescribe the specific service mix to be provided. In 2008, CMHCs served 89,213 adults and children.¹⁶

Although CMHCs receive funding from various sources, an increasing proportion of their revenue is derived from the Medicaid program. In 2007, 34 percent of the individuals served in CMHCs were enrolled in the Medicaid program. Another 34 percent were uninsured and paid for services based on a sliding-fee scale.¹⁷ Services provided to uninsured individuals are subsidized with state General Fund dollars and the federal mental health block grant administered by SAMHSA.

Graph 2. Distribution of CMHC primary revenue sources, 2007



*Other revenue includes foundations support and other donations
SOURCE: Colorado Behavioral Healthcare Council

Colorado has seven Mental Health Specialty Clinics.¹⁸ The state contracts with these specialty clinics, including the Asian Pacific Development Center and Servicios de la Raza, to serve the needs of special populations. An important objective of these clinics is to provide comprehensive mental health services that are tailored to the cultural needs and preferences of ethnic and racial minority populations.¹⁹

Hospital emergency departments have increasingly become de facto sites of mental health care for individuals with chronic and serious mental illness and substance abuse problems who find themselves in crisis. The Emergency Medical Treatment and Active Labor Act (EMTALA) specifies that as a condition of receiving Medicare funds, hospitals must provide emergency stabilization services to individuals seeking treatment in an emergency department regardless of their insurance status or ability to pay.

For the years 2004-05, eleven Metro Denver hospitals reported more than 16,600 emergency department visits involving individuals with behavioral health problems. Of these, approximately 1,300 were children and adolescents. According to Mental Health America of Colorado, during this time period 75 percent of all police Crisis Intervention Team contacts resulted in individuals being transported to a Metro Denver area hospital for psychiatric stabilization.²⁰

Federally qualified health centers (FQHCs), also known as community health clinics (CHCs), provide comprehensive primary health care services to low-income populations of all ages. FQHCs receive an annual grant from the federal government to subsidize care for uninsured or underinsured people once they have met certain criteria, including being located in a federally designated medically underserved area (MUA) or serving a medically underserved population (MUP). A large proportion of FQHC patients are enrolled in the Medicaid program, particularly children. Some FQHCs also provide mental health and oral health care services. If they do not provide these services directly, they work closely with

CMHCs through referral arrangements. In recent years, FQHCs receiving Amendment 35 Primary Care Funds have used these dollars to provide mental health services.

In some cases, FQHCs contract with a BHO to receive Medicaid capitation dollars to provide mental health services to their patients. In 2007, Colorado's FQHCs provided 59,271 mental health visits to 16,502 individuals. These numbers represent 3.5 percent of all center visits and 4 percent of the individuals receiving services from FQHCs in 2007.²¹

As far back as 1981, the Colorado General Assembly issued an advisory statement requiring that state appropriations for mental health services provided by CMHCs be prioritized for serious and chronically mentally ill persons, those considered to be in greatest need. Since that time, CMHCs have been required to prioritize services to individuals with serious and persistent mental illness or in psychiatric crisis. As a result, CMHCs are limited in their ability to serve any but the most severely mentally ill. Individuals enrolled in the Medicaid and the Child Health Plan Plus (CHP+) programs often have better access to mental health services than non-Medicaid low-income individuals who also get prioritized according to their diagnoses, medications and services needed but have no reimbursement source.²²

Rural health clinics (RHCs) are federally designated clinics that receive cost-based reimbursement for

Medicare and Medicaid patients and are located in non-urban areas with documented shortages of health care providers or who serve medically underserved populations. RHCs provide basic primary care services. Some RHCs provide limited mental health services, but they are generally not comprehensive and the services offered differ from clinic to clinic. Many RHCs refer their patients with mental health needs to local mental health providers or a CMHC that serves the same geographic area as the RHC.

Other community-based clinics include nonprofit clinics and community-based programs, free clinics, faith-based clinics, clinics staffed by volunteer clinicians and family practice residency clinics that provide free or low-cost primary care services to low-income uninsured and underinsured families and individuals. Many of these clinics, including RHCs, are affiliated with a nonprofit membership organization called ClinicNET which represents their policy and programmatic interests. In addition to offering primary physical health care services, many of these clinics are staffed with behavioral health care professionals to address their patients' mental health care needs.

School-based health centers (SBHCs) link low-income children to comprehensive coordinated health care services. The vast majority of SBHCs arrange for mental health services through collaborating community organizations that include CMHCs and other public and private mental health care providers. SBHC services include clinical assessment and diagnosis as well as individual, group and family therapy for a range of diagnoses including depression, anxiety and attention deficit disorder. In 2007, SBHCs provided nearly 67,000 visits to almost 21,000 Colorado students.²³ Sixty percent of SBHC visits were primary care visits, 16 percent were mental health visits and 11 percent were substance abuse visits. At present, there are 45 SBHCs in Colorado.²⁴

SBHCs also work closely with school psychologists, social workers and counselors to identify children and youth who need clinical assessment and intervention services. Schools without a SBHC may have mental health or substance abuse counselors on site at the school through a partnership with a local CMHC or substance abuse provider.

Funding for SBHCs varies. Often it is a mix of local CMHC and/or school district dollars, state funding through the Colorado Department of Public Health and Environment, foundation funding and in-kind support from other community providers. SBHCs also bill Medicaid, the CHP+ program, the Colorado Indigent Care Program (CICP) and private insurance. For children who are un- or underinsured, SBHCs may charge families on a sliding-fee basis for the cost of services.

Mental health triage centers operate in certain areas of the state to provide an alternative to hospital emergency departments and jails for individuals experiencing a mental health crisis or requiring urgent care. Centers provide 24-hour access to a range of crisis and psychiatric urgent care services including intervention, assessment, stabilization and linkage to community resources. Current triage centers are in place in Colorado Springs, Grand Junction, Durango and Ft. Collins. A center is currently being planned for the Denver Metro Area.

Veteran's mental health resources include veterans' organizations that provide mental health services in some Colorado communities to individuals who otherwise would have no access to such services. In many cases, these organizations are staffed by volunteer clinicians or non-licensed staff that provide mental health counseling and services for low-income and uninsured individuals who have a range of mental health issues from situational depression to serious mental illness.

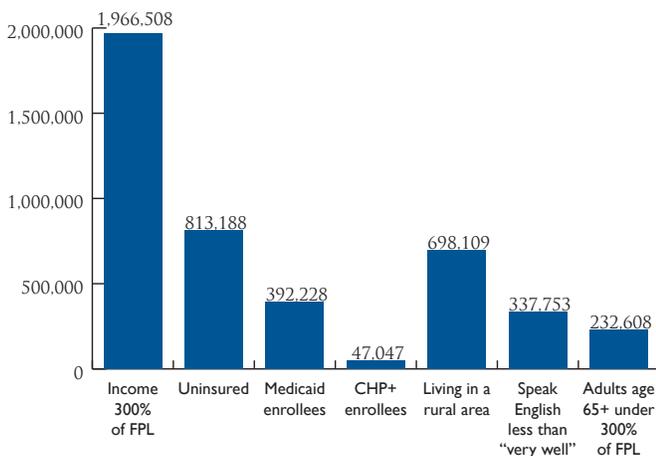
Users of mental health safety net services

Users of the mental health safety net include some of Colorado's most vulnerable residents (see Graph 3). Vulnerability as defined by CHI's Safety Net Indicator and Monitoring System (SNIMS) is first defined by low-income status and then combined with other factors that increase the likelihood that an individual in need of mental health care services will not get the care they need when they need it. Low income is defined as individuals and households living below 300 percent of. Other factors such as being uninsured, geographically isolated or having cultural, linguistic and other social barriers increase one's probability of being vulnerable.

Vulnerability from a mental health perspective also includes individuals who are homeless, returning war veterans who may or may not have mental health benefits depending on their military status, and emancipated children and youth from the foster care system. Another dimension of vulnerability for individuals with mental illness is the discrimination and stigma that often accompanies their diagnosis.

A large number of Colorado's low-income children are eligible for coverage under the state's Medicaid and CHP+ programs which are jointly funded by the state and federal governments. Far fewer low-income adults are currently eligible for Medicaid, although low-income elders and adults who have been deemed permanently and totally disabled by the state's disability determination program are eligible for Medicaid benefits. This group includes a significant number of adults with serious and persistent mental illness.

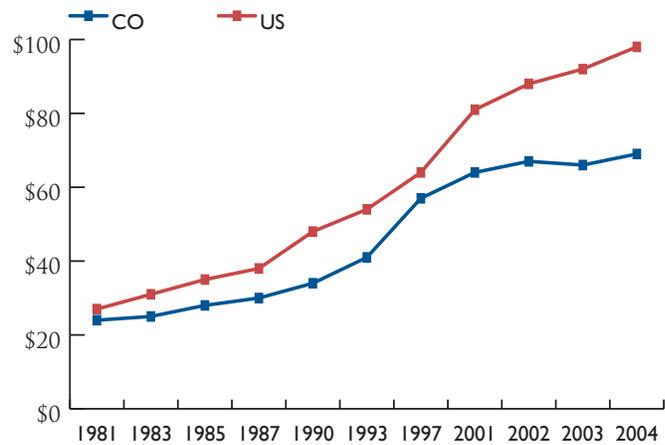
Graph 3. Number of Coloradans by low-income status and other dimensions of vulnerability



Financing of mental health safety net services

In 2004, Colorado ranked 33rd in the United States in terms of public mental health per-capita spending.²⁵ Graph 4 illustrates that Colorado's public spending per capita on mental health services steadily increased between 1981 through 2004; during this same period, however, Colorado consistently lagged behind the U.S. average.

Graph 4. State mental health agency per-capita expenditures for mental health services, Colorado and U.S., 1981-2004



SOURCE: Centers for Disease Control & Prevention (2007). Health, United States, 2007, Table 147. Available at: <http://www.cdc.gov/nchs/data/hus/hus07.pdf> (retrieved from the Web 4/23/09).

Of the various federal and state funding streams, the following are important for ensuring the viability of the mental health safety net because they are ongoing rather than time-limited, and they are large enough in scope to benefit large numbers of people and/or support key services. Both the Medicaid and the CHP+ programs meet these criteria and include a mental health benefit.

Medicaid is a state/federal partnership providing health care coverage to low-income children, some parents, pregnant women, elders and individuals with permanent disabilities. In FY 2008-09, the Colorado budget allocated funds to serve 362,754 Medicaid enrollees eligible for mental health services.²⁶ In Colorado, the federal government provides one dollar for every dollar the state spends on Medicaid services. To participate in Medicaid, states must cover certain population groups while they have the discretion to cover others.

Although Medicaid eligibility has been extended to a few optional populations in Colorado, the program has relatively lean coverage compared to other states.²⁷ HB 1293, signed into law by Governor Bill Ritter in April 2009, will expand Colorado's Medicaid coverage to childless couples and single adults up

Table I. Medicaid mental health program caseload and expenditures, FY2003-09

Fiscal year	Total capitation expenditures	Total fee-for-service (FFS) expenditures	Total capitation and FFS expenditures	Medicaid mental health caseload	Percent change in Medicaid mental health caseload
FY 03-04	\$151,328,728	\$3,509,845	\$154,838,573	348,140	NA
FY 04-05	\$164,540,442	\$1,379,580	\$165,920,022	388,254	11.5%
FY 05-06	\$176,727,920	\$1,231,390	\$177,959,310	382,734	-1.4%
FY 06-07	\$184,640,568	\$1,367,867	\$186,008,435	375,045	-2.0%
FY 07-08	\$196,546,508	\$1,315,785	\$197,835,293	360,765	-3.8%
FY 08-09	\$208,102,155	\$1,323,040	\$209,425,195	362,754	0.6%

SOURCE: Colorado Department of Health Care Policy and Financing: FY 08-09 Budget Request: Medicaid mental. <http://tinyurl.com/HCPFbudget>

to 100 percent of the FPL, many of whom are living with significant mental illnesses and substance abuse problems.

In Colorado, the Medicaid mental health benefit is capitated and managed by the five BHOs described earlier on a per-member, per-month basis, that is, BHOs receive a fixed monthly payment for each Medicaid enrollee residing in their designated geographic region. This monthly payment is based on the expected cost of providing services for each eligibility group based on historical claims data. In other words, historic Medicaid caseloads determine the annual funding allocations received by BHOs to contract for a full continuum of community mental health services authorized by the legislature for eligible Medicaid enrollees.

Medicaid is an important funding source for meeting the mental health needs of children and adolescents in the foster care system. Medicaid also has a targeted Home and Community-based (HCBS) waiver for adults with significant and persistent mental illness known as the HCBS Waiver for Persons with Mental Illness. This waiver covers services such as:

- Adult day services
- Alternative care facilities
- Consumer-directed attendant support
- Personal emergency response system
- Home modifications
- Homemaker services

- Non-medical transportation
- Personal care
- Respite care

Child Health Plan Plus (CHP+) is a publicly financed health insurance program providing health insurance coverage to low-income children up to age 18 and pregnant women with incomes at or below 205 percent of FPL. The federal government pays 65 percent of the costs of services provided and Colorado pays for the remaining 35 percent. CHP+ covers a range of benefits similar to the private insurance standard health plan available to small employer groups in Colorado. Until 2008, the mental health benefit in CHP+ was limited to 20 visits per year. With the enactment of SB 08-160, mental health benefits in CHP+ will be expanded to the same coverage level as Medicaid.

Medicare funds may be used to enhance the provision of primary care services provided by FQHCs in underserved urban and rural communities and RHCs in non-urban areas. Therapeutic services furnished by clinical social workers and clinical psychologists are subject to an outpatient mental health treatment limitation (50% co-pay of the all-inclusive encounter rate) under Part B of the Medicare program. Medications covered under Part D of Medicare qualify for reduced pricing available through the 340B Drug Pricing Program when prescribed by an FQHC provider.

Graph 5 provides a snapshot of how safety net patients are distributed by payer source across the various types of safety net providers and how they compare to Colorado's population below 300 percent of FPL.

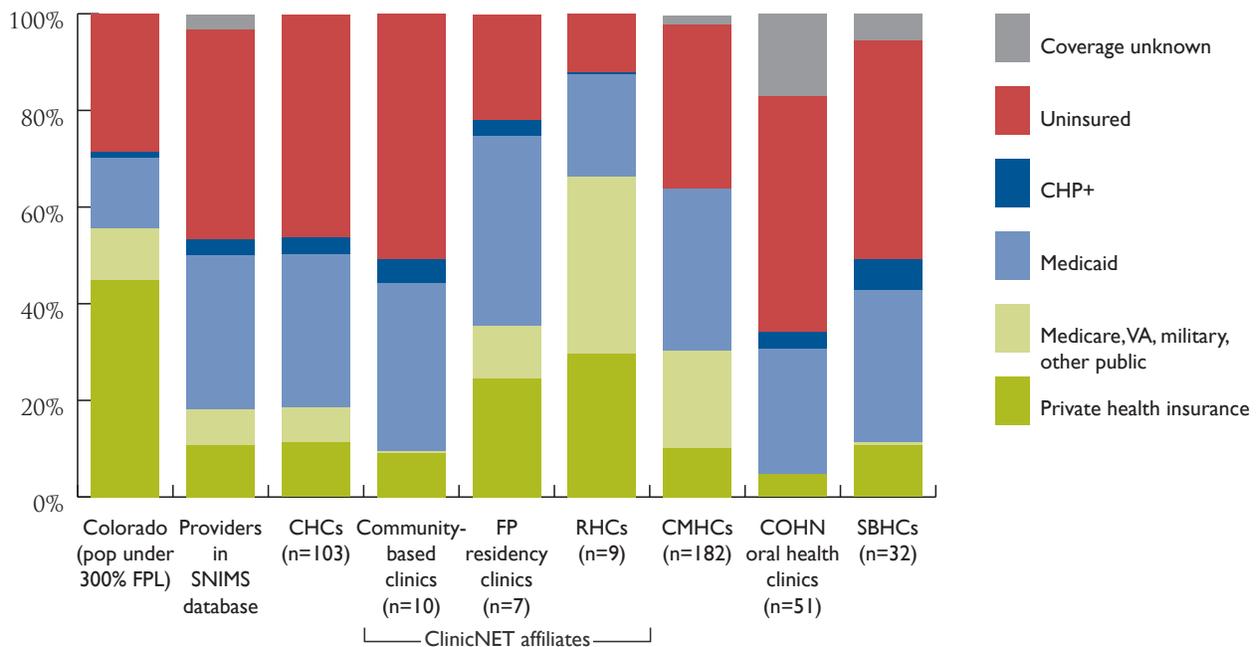
Other state funds are available for mental health services for low-income individuals who do not qualify for Medicaid or CHP+. The Division of Behavioral Health administers funding for non-Medicaid community mental health and substance abuse services for people with serious emotional disturbances or serious mental illness of all ages through contracts with the seven specialty clinics and 17 CMHCs.

- The Child Mental Health Treatment Act (CRS 27-10.3-101, et seq.) was enacted into Colorado statute in 1999 through HB 99-1116. The act allows families to gain access residential treatment services for their children without requiring a dependency and neglect action when there is no official complaint of child abuse or neglect. To be eligible, a child must have a mental illness and require the level of care provided in either a Therapeutic

Residential Child Care Facility or Psychiatric Residential Treatment Facility. The act covers both Medicaid eligible and non-Medicaid eligible children.

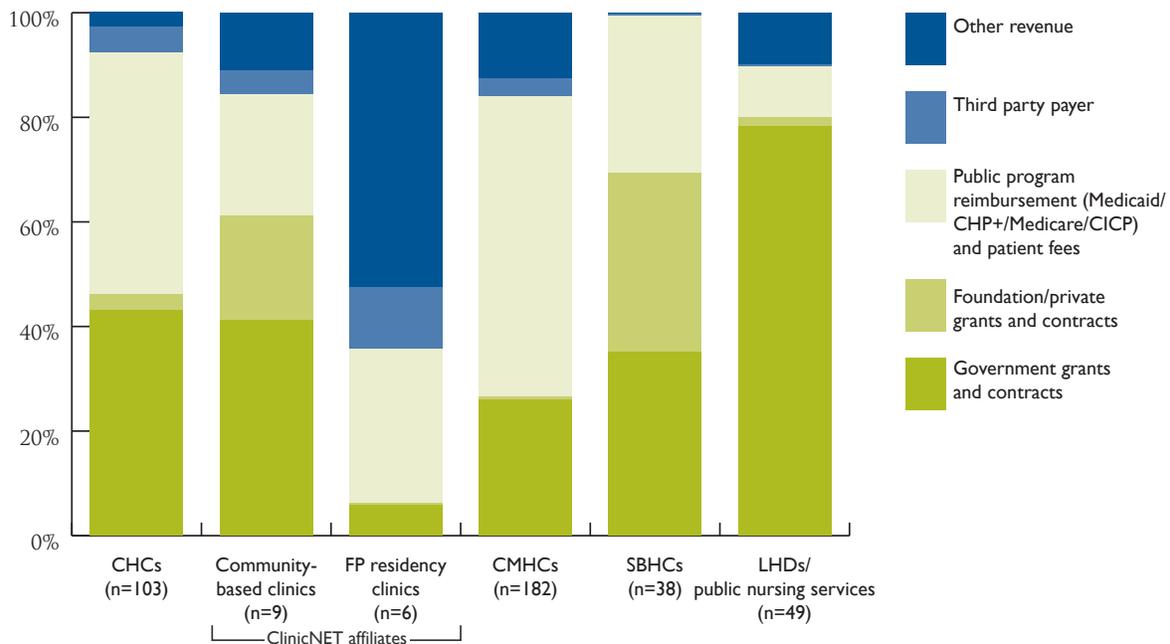
- The Assertive Community Treatment (ACT) program offers intensive mental health services based on a clinical team model. The team assumes responsibility for providing all necessary clinical services, including emergency as well as rehabilitation and support services. The program is designed to emphasize outreach, relationship building and individualized services. In 2000, the Colorado General Assembly appropriated General Fund dollars for the expansion of ACT programs to non-Medicaid eligible adults with serious and persistent mental illness who are at risk of becoming involved in the criminal justice system. The Colorado Division of Behavioral Health contracts with three CMHCs, selected through a competitive bid process, to provide ACT services. These centers currently include the San Luis Valley Comprehensive Community Mental Health Center, the Mental Health Center of Denver and the Mental Health Center Serving Boulder and Broomfield Counties.

Graph 5. Distribution of patients by third-party payer source and type of clinic compared to Colorado's population below 300% of FPL, 2007



NOTE: Safety net providers in Graph 5 reported data to the Colorado Health Institute which was entered into the Safety Net Indicators and Monitoring System database. See: Colorado Health Institute (2009), *The State of Colorado's Health Care Safety Net*.

Graph 6. Distribution of revenue sources by type of provider, 2007*



*The “other revenue” category includes hospital-based support and any other receipts that are not related to charge-based services. This may include interest income, rent from tenants, etc., it does not include Graduate Medical Education (GME) funding for family practice residency clinics. CICP revenue is included as revenue from the state. The CHC data does not include SBHC revenues from CHC-sponsored SBHCs.

SOURCE: Colorado Health Institute (2009). *The State of Colorado’s Health Care Safety Net*.

- SB 07-097 was passed in response to Colorado’s growing demand for community-based mental health services for individuals with mental illness involved in local and state criminal justice systems. Through new funds authorized by the Colorado General Assembly (HB 07-1359), which was a complementary bill to SB 07-097, the Division of Behavioral Health funded the development of six mental health service programs within CMHCs during FY 2008 for juvenile and adult offenders with mental health problems who are involved in the criminal justice system. Five additional CMHCs are scheduled for funding in 2009.

The Colorado Indigent Care Program (CICP) is a reimbursement mechanism to partially compensate qualified health care providers such as some high-volume hospitals and clinics that provide discounted health services to indigent patients who are uninsured, have limited assets and incomes at or below 250 percent FPL and who are not Medicaid eligible. CICP reimburses for some outpatient mental health

services if they are provided on site by a CICP-designated provider.

The Community Mental Health Block Grant is a federal grant administered by SAMHSA intended to assist states in providing comprehensive services to children and adults with serious mental illness. Dollars may be allocated in five target areas—comprehensive community-based mental health services, epidemiologic data systems, services to children and youth with serious emotional disturbance, rural homeless individuals with serious mental illness and enhancing electronic management information systems. In Colorado, these funds are primarily distributed to the community mental health centers.

Limited local public funding also is available to fill some of the resource gaps. The Mental Health Special Tax District legislation was passed in 2005 to allow communities to create a mental health special district in order to generate tax revenues to be used to address local mental health care treatment needs.

Although a few communities have attempted to pass this special tax, none has been successful to date.

Colorado foundations also provide financial support to safety net providers through grants and contracts. This funding is often directed at addressing the specific health care needs of a local community and/or special population.

Endnotes

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