

## **Colorado Mental Health Hold Task Force Final Report and Recommendations**

Prepared by The Civic Canopy  
December 31, 2016



**COLORADO**

Department of Human Services  
Reggie Bicha, Executive Director

December 30, 2016

Office of the Governor  
136 State Capitol  
Denver, Colorado 80203

Dear Governor John W. Hickenlooper,

The Mental Health Hold Task Force was established at your direction following your decision on June 9, 2016 to veto Senate Bill 16-169 concerning the emergency procedure for mental health holds. In your veto letter, you directed the Colorado Department of Human Services to create a task force to develop solutions to the underlying problems that were expressed via Senate Bill 16-169. This was not the first time concerned Coloradans had come together to address these challenges, but the recommendations in this report provide a solid foundation for moving Colorado toward addressing this complicated issue.

This task force had no easy charge. The goal of the task force was to ensure that Coloradans experiencing mental health crises have access to appropriate mental health services while preserving their fundamental rights. Specifically, the Mental Health Hold Task Force provided statutory, policy, and administrative recommendations to:

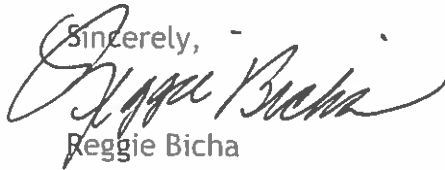
- Ensure proper mental health treatment for individuals in crisis, while satisfying individual's rights under the federal Emergency Medical Treatment and Labor Act (EMTALA) and due process standards, including exploring models used in other states.
- End the practice of confining in jail persons with mental illness who have committed no crime.
- Streamline and align regulatory oversight of the mental health hold process while ensuring necessary patient care requirements and protecting patient rights.
- Understand the need for and overcome barriers to provide inpatient psychiatric care to persons in mental health crisis.
- Maximize existing state resources, including examining potential enhancements that can be made to the current crisis services and transportation systems.
- Develop data tracking and provider communication systems to better understand the scope of the mental health hold problem in Colorado.

I want to thank you for putting together such a thoughtful group of experts to develop actionable recommendations. I want to specifically thank the members of the Colorado General Assembly for their attention to these issues. And I want to thank members of the

healthcare community, advocates for people experiencing a mental health crisis, members of law enforcement, and others who worked diligently to develop these recommendations. The Task Force's tireless efforts are reflected in these recommendations and provide a solid foundation to resolve a number of long-standing issues regarding the process of mental health holds in Colorado..

I would like to express my sincere gratitude and appreciation to the members of the Mental Health Hold Task Force for the recommendations they've made in this report to improve the mental health hold process in Colorado. It was a tough assignment, and the members of this task force worked many long hours to devise recommendations that have the potential to better serve and protect the rights of those who are experiencing a mental health crisis. I look forward to the work we will do together to implement these recommendations. I look forward to continuing this collaboration through the legislative session and beyond.

Sincerely,

A handwritten signature in black ink, appearing to read "Reggie Bicha". The signature is fluid and cursive, with a large initial "R" and "B".

Reggie Bicha

## The Mental Health Hold Task Force

On July 9, 2016, Governor John Hickenlooper vetoed Senate Bill 16-169 that would have expanded Colorado's mental health hold law, citing concerns about the due process rights of individuals experiencing mental health crisis. (See *Appendix A: Governor Hickenlooper's SB16-169 Veto Letter to Colorado Senate.*)

The Governor directed the Department of Human Services to create a task force to examine the issues and to propose recommendations that would ensure access to mental health services for individuals in crisis, while preserving their Constitutional rights. The resulting 30-member Mental Health Hold Task Force included representation from state agencies, advocacy organizations, providers, judiciary, law enforcement, and others including individuals with lived experience of mental illness.

This document is the result of the combined efforts of the individuals listed below and the stakeholders and content experts who shared their insights, knowledge, and perspectives to advance the group's work.

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*West Pines Behavioral Health*

**Nancy VanDeMark**

*Colorado Department of Human Services/Office of Behavioral Health*

**Doug Wilson**

*Colorado Public Defender*

## Task Force Mission

The Mental Health Hold Task Force was charged with making statutory, policy, and administrative recommendations to:

- Ensure proper mental health treatment for individuals in crisis, while satisfying individual's rights under the federal Emergency Medical Treatment and Labor Act (EMTALA) and due process standards. This should include exploring models used in other states;
- End the practice of confining in jail persons with mental illness who have committed no crime;
- Where appropriate, streamline and align regulatory oversight of the mental health hold process while ensuring necessary patient care requirements and protecting patient rights;
- Understand the need for, and overcome barriers to, providing inpatient psychiatric care to persons in mental health crisis;
- Maximize existing state resources, including examining potential enhancements that can be made to the current crisis services and transportation systems;
- Develop data tracking and provider communication systems to better understand the scope of the mental health hold problem in Colorado.

## Process

The Task Force met ten times between August and December 2016. All meetings were open to the public, with observers in attendance, and included opportunities for public input. The Civic Canopy, a community-based nonprofit, facilitated and documented the process. Over a twenty-week period, the Task Force worked to develop a shared understanding of: the pressures and constraints felt in the current system; best practice/lessons learned from states and localities; and opportunities to strengthen and leverage existing efforts in Colorado. A recurring theme in discussions was the extent to which regional differences affect decision-making and outcomes. To support their work, the Task Force heard presentations from the Colorado Hospital Association, the Treatment Advocacy Center, the Colorado Department of Human Services, the Colorado Behavioral Healthcare Council, and individuals with first-hand experience being placed on a mental health hold. (See *Appendix C: Summary of Task Force Meeting Agendas and Presentations*. See the [CDHS Mental Health Hold Task Force website](#) for meeting agendas, minutes, and related materials.)

The Task Force voted using a Fist-to-Five approach, raising their hands as in voting, with the number of fingers raised indicating their level of agreement. The scale was as follows:

- 5 fingers** – I am in full support of this motion.
- 4 fingers** – I support this motion.
- 3 fingers** – I'm in the middle somewhere, but can still support the motion.
- 2 fingers** – I have some concerns but will go along with the group's decision.
- 1 finger** – I have strong reservations but would not block consensus.
- 0 fingers/fist** – I object and will block consensus.

This approach allowed members to express their level of support for an idea, and provided a concrete way to test consensus within the group. This report captures three levels of support: Fully support (3-5 fingers), support with reservations (1-2 fingers) and do not support (fist / 0 fingers).

On December 21, 2016, the Task Force approved the final recommendations as a set. (See *Appendix F: Task Force Voting Tally on Final Recommendations* for details.)

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## Overview

Colorado has seen much-needed improvement to mental health services in recent years. Governor Hickenlooper's 2012 initiative *"Strengthening Colorado's Mental Health System: A Plan to Safeguard all Coloradans"* demonstrated the state's commitment to expanding access to behavioral health crisis services. In 2013, SB13-266 was signed into law, establishing the guidelines for a statewide behavioral health crisis response system to provide critical services and supports "when and where needed" with the goal that the services be accessible to all Coloradans, regardless of their ability to pay. Colorado Crisis Services, conceived as a continuum of services, launched in 2014. The system includes: 1) a 24-hour hotline/warmline for crisis assistance, staffed by trained, professional specialists and peer counselors; 2) mobile crisis response; 3) respite care; 4) crisis walk-in centers and Crisis Stabilization Units (CSUs). Since services began in 2014, over 5,000 people have been seen at walk-in centers and CSUs, and over 6,000 have received support from mobile crisis services.

But many of the system's services remain largely inaccessible in some regions of the state, particularly in Colorado's rural communities. In these areas few "designated facilities" exist that have the authority and expertise to provide evaluation and treatment. SB16-169 *"Concerning changes related to the seventy-two-hour emergency mental health procedure,"* arose out of these challenges. The bill highlighted challenges in certain regions of the state that lack adequate resources to provide proper care for some individuals who are experiencing a mental health crisis or psychiatric emergency.

## Executive Summary

In vetoing SB16-169, *"Concerning changes related to the seventy-two-hour emergency mental health procedure,"* Governor Hickenlooper made clear that while it is a priority for Colorado to ensure proper mental health treatment for individuals in crisis, doing so will not be accomplished at the expense of civil liberties.

Broadly, the Mental Health Hold Task Force was created to examine issues of concern around mental health holds in Colorado. Of primary concern was the proposal to extend the period of time permitted for the emergency detention in jails of individuals with mental illness who are not criminally charged and who await formal procedures for involuntary hospitalization. (It should be noted that Colorado remains one of only six states that still permit the use of jails in these circumstances.)

As currently implemented, mental health holds create unintended and unmanageable burdens, while still failing to meet the needs of the individual in crisis.

**Double-Bind for Law Enforcement** – Current state law allows an individual to be detained in a jail for 24 hours on a mental health hold. Within that time, the individual must be transported to a designated facility where appropriate evaluation and treatment can occur. The problem arises for law enforcement when no bed in a designated facility is available/accessible. (See *Appendix D: Overlay of Crisis Stabilization Unit and Healthcare Facility Locations Across Colorado*.) This problem is acutely experienced in Colorado's rural communities, where the law enforcement agencies tend to be small and the nearest health facility may be hours away and may or may not have the ability to provide adequate mental health evaluation and treatment. In these cases, which often require pulling a deputy off of patrol, the sheriff must choose among three options:

- Transport the individual to a designated facility (leaving the community without a public safety officer for an extended period of time);
- Detain the individual in jail (potentially safeguarding the community, but running the risk of violating the individual's rights as well as state statute if legal requirements are not met); or
- Release the individual into the community (potentially failing to safeguard the community and having provided no access to evaluation or treatment)

**Double-Bind for Emergency Departments** – Under the federal Emergency Medical Treatment and Labor Act (EMTALA), emergency departments are forbidden to turn away patients. At the same time, under current state law, they currently lack the authority to retain patients on mental health holds unless designated by CDHS. (See: 42 U.S. Code § 1395dd, C.R.S. § 27-65-102, C.R.S. § 27-65-105)

**Individual in Crisis** – Confining to jail a person who has not been charged with or convicted of a crime is a massive curtailment of liberty and may violate a person’s civil liberties afforded by the U.S. and Colorado State Constitutions if appropriate procedures are not followed. In addition, jails have indicated that they are ill-equipped to meet the needs of an individual experiencing a mental health crisis. As a result, individuals do not receive necessary support and psychiatric treatment, and are at increased risk of deterioration. Law enforcement is in a position to charge individuals with a crime, often for behaviors associated with the symptoms of their illness, thus further contributing to the criminalization of mental illness. (See: United States Constitution, Colorado State Constitution.)

**Insufficient Data** – No data exists on the frequency of M-1 holds in Colorado jails or emergency departments that are not designated because Colorado statute requiring reporting applies only to designated facilities. Because no reliable data exists to help understand the scope and nature of the problem, it is difficult to make the case for adding resources to Colorado’s behavioral health system. (See: C.R.S. § 27-65-102, C.R.S. § 27-65-105.)

The Civic Canopy, in the role of facilitator, sought to highlight the systemic nature of these challenges, acknowledging inherent interdependencies with an eye toward optimizing solutions and minimizing unintended consequences. (See *Appendix B: Mental Health Hold System Framework*). In fulfilling its mission, the Task Force engaged in an iterative process of developing and refining proposed recommendations to resolve the due process and civil rights concerns while ensuring proper treatment for individuals in crisis.

The Task Force unanimously supported ending the practice of housing in jail individuals who have been neither charged nor convicted of a crime. Their work over twenty weeks was to define and enable alternatives.

## Recommendations

The Mental Health Task Force approved the following eight recommendations on December 21, 2016. Each of the recommendations exceeded the necessary two-thirds voting threshold established by the Executive Director of the Colorado Department of Human Services.

Broadly, the recommendations focus on better use of existing resources, improved data collection and reporting, protection of civil liberties, and access to appropriate treatment for individuals in mental health crisis.

It should be noted that in addition to the eight recommendations, Task Force members consistently raised overarching themes fundamental to improving Colorado’s continuum of mental health care and to ensuring access for individuals and family members. These include:

- Reducing stigma and creating emergency services options that preserve dignity.
- Encouraging people who experience compromised mental health to seek help early.
- Increasing communication around services, supports, and use of the Crisis Response System.
- Advocating for elimination of variations in coverage and barriers to payment for behavioral health crisis services regardless of payer.



## MENTAL HEALTH HOLD TASK FORCE FINAL RECOMMENDATIONS

### **Recommendation 1: End the Use of Law Enforcement Facilities for M-1 Holds**

Amend CRS 27-65-105 during the 2017 legislative session to eliminate the use of jails, lock-up, or other place of confinement for persons placed on M-1 holds who have not been charged with or convicted of a crime.

- A. We encourage local communities to phase in this recommendation even before statutory changes have been made.\*
- B. In regions where adequate alternatives do not yet exist, implementation of this recommendation should be phased in once the services and supports outlined in subsequent recommendations are in place.\*
- C. The practice of using jails, lock-up, or other places of confinement as sites of M-1 holds for those who have not been charged or convicted of a crime should be ended no later than January 1, 2018.\*

#### Rationale and Explanation

- This is the primary objective of the Task Force and needs to drive the redesign of the mental health hold system.
- This change will lessen the criminalization associated with mental health holds and should provide greater due process protections.
- While difficult in some rural regions, eliminating the use of law enforcement facilities to hold people who have not been charged with or convicted of a crime is the right thing to do and will no longer be necessary once the following recommendations have been implemented.

#### \*Varied Task Force Support for Recommendation 1

- The first sentence of Recommendation 1 was fully supported by 19/22 Task Force members. Two members supported it with reservations. One member did not support it. Six members were not present for the vote. The Task Force member who did not support the recommendation agreed in principle, but wanted viable alternatives to be in place before ending the use of jails for M-1 holds.
- Item A was fully supported by 22/22 Task Force members. Eight members were not present for the vote.
- Item B was fully supported by 16/21 Task Force members. Three members supported it with reservations. Two members did not support it at all. Nine members did not vote. Those who did not fully support this component expressed reservations about the lack of specificity of “adequate alternatives,” and/or the lack of a phase-in date.
- Item C had the full support of 15/21 Task Force members. Six members did not support it at all. Nine members were not present for the vote. Members who did not fully support this component expressed reservations about the date: some members felt that one year was too long to wait to end the practice of using jails; others felt that one year provided insufficient time to implement viable alternatives.

### **Recommendation 2: Streamline Regulations and Establish a Stronger System of Accountability.**

Streamline the various regulatory powers delegated to the Colorado Department of Public Health and Environment (CDPHE), the Colorado Department of Human Services (CDHS), and the Department of Health Care Policy and Financing (HCPF) and establish a Mental Health Care Ombudsman Office to ensure accountability between all state agencies. This body should ensure that individuals placed on mental health holds receive proper care, that providers and regulators play their proper roles, and that grievances are impartially reviewed and resolved.

- This office should be located where it can have proper autonomy to carry out impartial reviews—perhaps in the judicial branch in a manner similar to the Office of Colorado’s Child Protection Ombudsman—and should not duplicate the efforts of any other bodies.
- The office would handle appeals and grievances from individuals with due-process concerns that were not addressed at lower levels of review and from providers with payment or regulatory concerns.
- The Ombudsman should be engaged to prevent back-to-back holds and capture data on prevalence of their use.

#### Rationale and Explanation

- The current system of M-1 holds has too many overlapping roles, responsibilities, regulatory frameworks, and potential or perceived conflicts of interest making it difficult to identify who is ultimately accountable to make sure the system works as intended and that individual dignity and rights are preserved.
- This recommendation would streamline those overlapping frameworks and provide a way to resolve grievances when they arise.

### **Recommendation 3: Establish a Tiered System for Carrying Out M-1 Holds**

Establish a three-tiered system for carrying out M-1 holds that ensures protection of individual rights throughout the M-1 hold process and acknowledges the different levels of licensed care that providers are equipped and expected to provide. Oversight for the various tiers would be shared by the Colorado Department of Public Health and Environment (CDPHE) and the Colorado Department of Human Services (CDHS) to best align with existing regulatory frameworks at the state and federal levels. Consistent data would be captured by any facility where an M-1 hold is placed. The tiers would consist of:

**Tier 1:** Current designated facilities (short- and long-term facilities)

**Tier 2:** Hospital w/mental health partnership (facility placement agreement)

**Tier 3:** General emergency department without psychiatric specialty services

- All crisis services/hospital staff will receive updated trainings on the specifics of M-1 hold processes and what is required.
- This system would set minimum standards of care for all facilities involved in mental health holds, and would allow for a broader use of facility placement and other agreements with surrounding facilities where needed.
- The Office of Behavioral Health (OBH) would shift some oversight to CDPHE where appropriate, retaining an annual review to ensure accountability.
- Define where the responsibility lies for ensuring due process protections.
- Establish data reporting requirements for each tier facility.

#### Rationale and Explanation

- The current system of designation does not take into account the different capacities of different facilities and leaves hospitals, law enforcement agencies, and people experiencing mental health crises without the supports they need.
- A tiered system would allow better coordination of care while still ensuring the protection of patients' due process rights.

### **Recommendation 4: Ensure Network Adequacy**

Ensure that each region of the state has an adequate network of providers—including the Crisis Response System workforce as well as Medicaid and private providers—to ensure the availability and coordination of a continuum of proper psychiatric care. The Office of Behavioral Health (OBH) and the Behavioral Health Transformation Council (BHTC) should convene a subcommittee to conduct a needs and capacity assessment of the Crisis Response System to ensure it is meeting demand and to identify needed enhancements such as:

- o assessing whether the initial four modalities of services are still relevant,
- o assessing workforce capacity in each region,
- o assessing crisis service capacity of Medicaid and OBH funded programs,
- o aligning distance adequacy standards across regions and payers (e.g. define the minimum distance from place in the region to a crisis facility),
- o establishing best practice response standards (e.g. having 2 responders available for calls that includes the use of peers),
- o ensuring the Crisis Response System is accessible statewide, and
- o reviewing mandated services and data collection requirements.
- The Crisis Response System should provide the first point of contact in each region for law enforcement and emergency departments to help coordinate the best response to crises and to help determine the best location for assessing someone on an M-1 hold. Since duplication of services in crisis centers and emergency departments has a large impact on cost and payment, care coordination is essential to achieve network adequacy
- Each region needs to find ways to coordinate its delivery of care between lower level and high acuity beds to make sure that people dealing with and recovering from crisis episodes can be placed in the proper facility. Crisis regions should define how to meet network adequacy guidelines in their region.
- With increased capacity in the regions, the state should explore the need to add or free up beds at Ft. Logan for individuals who are difficult to place, such as those with Traumatic Brain Injury, intellectual or developmental disabilities, or individuals with dementia and aggressive behaviors.

#### Rationale and Explanation

- In order to eliminate the use of law enforcement facilities during the M-1 hold process, each region of the state must have adequate networks of mental health care and support that include facilities that are prepared and willing to accept high-acuity patients and the ability of providers to work with people with multiple disabilities.
- More services at lower levels of intervention will keep people out of hospitals and high-acuity facilities, reduce costs, and reduce escalation of crises.
- To achieve the full continuum of care, the Crisis Response System should help coordinate among the various providers.
- Service locations might need to be added in underserved regions of the state to ensure that services are accessible.

### **Recommendation 5: Expand and Extend the Behavioral Health Workforce**

Develop a short- and long-term behavioral health workforce expansion and extension plan to ensure adequate behavioral health staffing throughout the state that includes increased use of peer support, telehealth, integrated models of care, hub-and-spoke strategies, and crisis training for relevant staff. Revise CRS 27-65 to allow Advance Practice Nurses with minimum two years' behavioral health education to release mental health holds. As warranted, review levels of licensure needed to place and release mental health holds, ensuring that all relevant professional disciplines are included in the conversation. Remove barriers that limit current workforce from operating within the fullest extent of their licensure. Ensure that staffing models address regional (not aggregate) needs.

- Clarify reporting authority of the Behavioral Health Transformation Council (BHTC).
- Engage the BHTC workforce subcommittee to convene agencies to examine the following:
  - Rely on Department of Regulatory Agencies (DORA) for workforce data.
  - Link to larger state workforce development work in State Innovation Model (SIM) workforce workgroup; Office of Economic Development and International Trade (OEDIT); Department of Labor (DOL) – for statistics.
  - Ensure telehealth is a viable, immediate workforce extension plan.
  - Develop (re-establish) collaborative agreements between the higher education system and state and local mental health departments with goal of encouraging health professionals including psychiatrists to pursue careers in community and public mental health.
  - Establish initiatives to encourage high school/college students to choose educational programs with behavioral health career paths.
  - Expand Colorado's loan repayment assistance program to include part-time and inpatient behavioral health professionals.
  - Offer paid internships incentivizing graduate students to shadow mental health professionals
  - Support and acknowledge the peer support provider certification process – ensuring adequate training, supervision and clearly defined job descriptions.
  - Develop standards for telehealth and leverage grant funded opportunities to expand the use statewide.
  - Review and align rules and regulations across state departments to ensure that all professional categories are able to operate fully within their competence based on training, education, and scope of discipline.
  - Evaluate the workforce needs related to mobile response.
  - Consider affording paramedics a distinct custodial status for the purposes of transport.
- Share examples of existing best practice among hospitals, crisis response system contractors, and other relevant stakeholders.

#### Rationale and Explanation

- Without adequate staffing, regions around the state will not succeed in eliminating use of law enforcement facilities in the M-1 hold process.
- A workforce that includes more behavioral health experts, including peers, during crises will help de-escalate episodes and require fewer law enforcement resources.
- To build that workforce, a more comprehensive review must be conducted for how to extend the reach of current staff in the short term (e.g. telehealth, peer support) and expand future recruitment efforts.

**Recommendation 6: Create a Sustainable and Reliable Data Monitoring System**

Develop a comprehensive but sustainable data tracking system for mental health holds across Colorado that includes all sites where holds are conducted as well as appropriate extrapolation methods where actual data is difficult to capture. Data should be gathered in ways that protect individual privacy and include but not be limited to:

- Mandate the Office of Behavioral Health (OBH) to report annually to ensure overall monitoring of mental health hold system and require all facilities involved with M-1 holds—including law enforcement facilities and emergency departments—to abide by the following proposed statutory change:

(a) ON OR BEFORE DEC. 31, 2017, AND EACH JULY 1 THEREAFTER, EACH FACILITY THAT RECEIVES AN INDIVIDUAL ON A MENTAL HEALTH HOLD WHICH HAS TAKEN CUSTODY OF A PERSON OR TREATED A PERSON PURSUANT TO THIS SECTION SHALL PROVIDE AN ANNUAL REPORT TO THE DEPARTMENT THAT INCLUDES ONLY AGGREGATE AND NONIDENTIFYING INFORMATION CONCERNING PERSONS WHO WERE TAKEN INTO CUSTODY OR TREATED AT THE FACILITY THAT RECEIVES AN INDIVIDUAL ON A MENTAL HEALTH HOLD PURSUANT TO THIS SECTION. LAW ENFORCEMENT FACILITIES MAY CONTACT CRISIS CENTERS FOR ASSISTANCE IN FULFILLING THE REQUIREMENTS OF THIS SUBSECTION (4.5).

THE REPORT MUST CONTAIN THE FOLLOWING:

(I) THE NAMES AND COUNTIES OF THE FACILITIES;

(II) THE TOTAL NUMBER OF PERSONS TAKEN INTO CUSTODY OR TREATED PURSUANT TO THIS SECTION, INCLUDING A SUMMARY OF DEMOGRAPHIC INFORMATION;

(III) A SUMMARY REGARDING THE DIFFERENT REASONS FOR WHICH PERSONS WERE TAKEN INTO CUSTODY OR TREATED PURSUANT TO THIS SECTION; AND

(IV) A SUMMARY OF THE DISPOSITION OF PERSONS WHETHER RELEASED FROM CUSTODY OR TRANSFERRED TO A DESIGNATED FACILITY.

**Rationale and Explanation**

- To properly monitor the number of M-1 holds and their proper usage, a consistent and reliable data tracking and review process must be implemented across the state.
- The data collected must be limited to only the most salient items to reduce the burden on providers, should utilize existing data systems, and must be reviewed annually to ensure the system is working as it should.

**Recommendation 7: Ensure Proper Payment for Treatment of Individuals on Mental Health Holds**

The presence of a substance use condition or other diagnosis should not prevent or impede a person's ability to access coverage for a mental health crisis. Toward this end,

- Crisis care should be reimbursed by the relevant payer.
- The Task Force recommends expanding funding for Medicaid to cover substance abuse and other dual diagnoses.

In addition, appropriately enforce the benefits that currently exist, identifying and removing barriers to reimbursement for services delivered during mental health holds.

- Ensure that both clients and providers have the ability to access a fair appeal process by:
  - Working with the Department of Health Care Policy and Financing (HCPF) to strengthen the accountability mechanisms currently in place to ensure payment for services currently covered by Medicaid (including both the Behavioral Health Organization (BHO) system and the future RAE (Regional Accountable Entity) system).
  - Working with the Division of Insurance (DOI) to strengthen the accountability mechanisms currently in place for private insurance plans.

**Rationale and Explanation**

- In the current system, a significant percentage of claims for mental health services provided during mental health holds, especially the highest acuity cases, are denied because the diagnosis involves substance use and hospitalization is not covered by the Medicaid capitation program. Allowing claims for mental health diagnoses for which substance use disorders or other diagnoses that are not covered by the Medicaid program are present would remove this barrier.
- If providers knew they would be reimbursed for the costs of M-1 holds, more beds would be available in the system, increasing network adequacy and reducing the need for law enforcement facilities during the M-1 process.
- Current lack of access to high-acuity psychiatric care is due, in part, to there being no appeal process for providers of highest acuity psychiatric care when they are denied payment.

### **Recommendation 8: Identify and Pilot Client Transportation Solutions that Reduce the Costs, Stigma, and Trauma Associated with M-1 Transport**

Inventory and identify methods/systems of non-emergency transportation for people on M-1 holds that ensure mental and physical health parity, alter the use of Emergency Medical Services (EMS) and law enforcement resources while reducing requirements for people on medical holds to be seen in emergency departments when not medically necessary and expand options for providing safe transport with minimal stigma attached. These transportation systems must account for both rural and urban needs and resources.

- The Office of Behavioral Health (OBH), the Colorado Department of Public Health and Environment (CDPHE), and the Behavioral Health Transformation Council (BHTC) should convene a committee to identify methods/systems of non-emergency transportation for people on M-1 holds. The committee should:
  - Review statutes and rules pertaining to the transport of individuals on M-1 holds.
  - Work with the Colorado Network of Health Alliances, EMS providers, Department of Health Care Policy and Financing (HCPF) and others to inventory existing transportation models
  - Establish clear transport best practice recommendations for regions to follow (e.g. involving peers in transport solutions).
  - Expand/develop the use of non-emergency medical, or other appropriate transportation systems where they exist and identify methods to expand those systems into areas where they currently do not operate.
  - Pilot programs, designed to introduce more suitable forms of transport in both urban and rural regions. These pilot programs could test out mechanisms to reduce costs, improve efficiency and de-escalate crises.
  - Provide training and education to law enforcement and EMS personnel to improve their ability to assess and effectively interact with clients to minimize stigma and trauma.
  - Work with local emergency medical services agencies and their physician medical directors to develop protocols that support the transportation of clients to non-acute care medical facilities when appropriate and develop cost supports accordingly.

#### Rationale and Explanation

- The current systems for transporting people on M-1 holds relies heavily on EMS and law enforcement, further traumatizing people in times of crisis and taxing public safety resources. However, CRS 27-65-105 embeds the role of law enforcement and the courts regarding the M-1 hold process and lends to the routine use of EMS and law enforcement transportation resources.
- Any savings identified during the pilot could help cover the costs of expanding the program to other regions in the state.

## Appendix A: Governor Hickenlooper's SB16-169 Veto Letter to Colorado Senate

# STATE OF COLORADO

### OFFICE OF THE GOVERNOR

136 State Capitol  
Denver, Colorado 80203  
Phone (303) 866-2471  
Fax (303) 866-2003



John W. Hickenlooper  
Governor

June 9, 2016

The Honorable Colorado Senate  
State Capitol  
200 E. Colfax Ave.  
Denver, CO 80203

Dear Members of the Colorado Senate:

Today, I vetoed Senate Bill 16-169, "Concerning Changes Related to the Seventy-Two-Hour Emergency Mental Health Procedure," at 3:29 PM P.

We agree that appropriate mental health facilities are not always readily available to treat persons having a mental health crisis. While well-intentioned, we are concerned that SB 16-169 does not provide adequate due process for individuals. The sponsors are to be commended for their commitment to solving this complex issue; we are committed to working with them in the future to address this issue in a holistic way.

Senate Bill 16-169 properly allows advanced practice nurses to determine if a person should be committed to a mental health facility longer than 72 hours. Increasing the types of providers to perform this function adds resources to solve the problem. The bill also would have generated data to help us better understand the nature of gaps in mental health services available to those in crisis.

The bill allows emergency rooms to detain a person for up to 36 hours to determine whether the he or she requires a transfer to a designated facility, but is silent on what an emergency room must do once the 36-hour period passes. No limit is placed for how long an emergency room may detain someone involuntarily while awaiting a free bed in a suitable treatment facility, and, more importantly, no mechanism is made to afford due process to a person held involuntarily in "emergency" custody. Senate Bill 16-169 expands the time for law enforcement facilities to hold someone in crisis. We have due process concerns for these individuals.

Today, I directed the Department of Human Services to create a taskforce to develop solutions to the underlying problems raised by SB 16-169 by January 1, 2017. Specifically, the taskforce will recommend policy changes to ensure proper mental health treatment and protection of federal and state constitutional rights for Coloradans experiencing mental health crises. The taskforce will make recommendations to end the practice of confining in jail persons with mental illness who have committed

no crime. The taskforce will also assess the current need for and barriers to providing inpatient psychiatric care in all regions of the State. The taskforce will consider potential proposals including inpatient bed-tracking systems, provider communications systems, and transportation systems including the funding to make that happen. Finally, the group will recommend changes in light of limited state resources, and will examine how to maximize current resources for mental health systems. This approach will better inform and guide public policy on this topic, and will better serve Coloradans experiencing the trauma of mental health crises. I would ask the sponsors of the bill to be partners to implement findings of the task force knowing we all have the same goals of providing appropriate services and treatment to the mentally ill.

Keeping Coloradans safe remains our top priority. I am confident we can work together to achieve this goal in a way that protects the fundamental rights all Coloradans hold under the U.S. and Colorado Constitutions. Accordingly, I have vetoed SB 16-169.

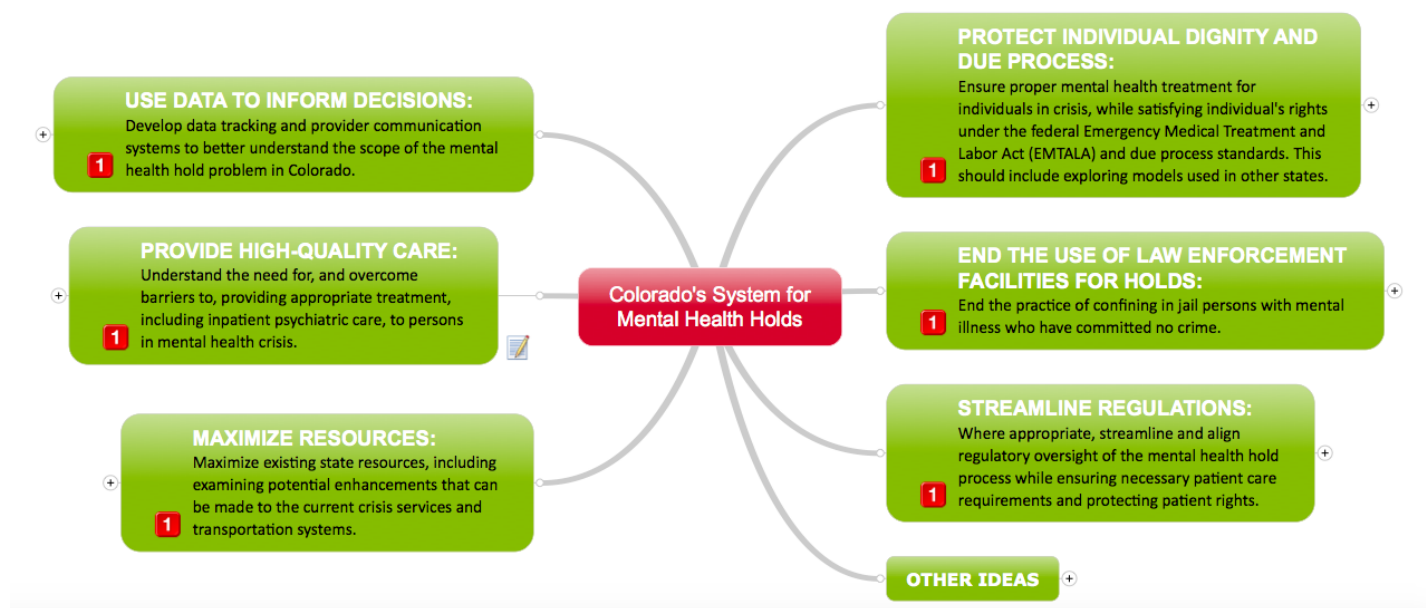
Sincerely,

A handwritten signature in black ink, appearing to read "John W. Hickenlooper", with a large, stylized initial "J" and a long, sweeping underline.

John W. Hickenlooper  
Governor

## Appendix B: Mental Health Hold System Framework

Task Force conversations were organized around a system framework comprising six primary elements tied to areas of concern expressed by Governor Hickenlooper.

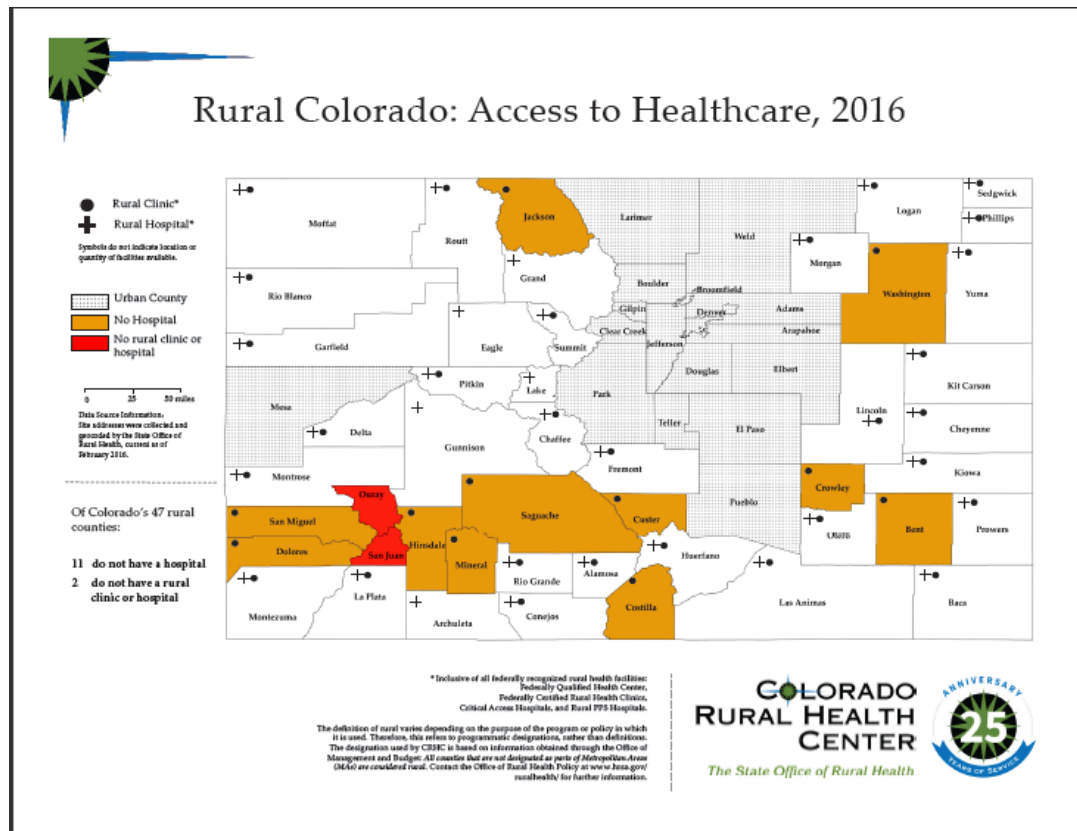




## Appendix C: Summary of Task Force Meeting Agendas and Presentations

Meetings	Task Force Meeting Objectives	Presentations to Task Force
Mtg. 1 8/4/16	<ul style="list-style-type: none"> <li>Clarify the charge of the Task Force</li> <li>Establish shared understanding of effective group working conditions</li> <li>Review process design and timeline for Task Force work</li> </ul>	Bill Fulton, The Civic Canopy <i>Working Effectively as a Task Force</i>
Mtg. 2 8/23/16	<ul style="list-style-type: none"> <li>Review working agreements of the Task Force</li> <li>Apply a systems-thinking lens to the question of mental health holds</li> <li>Review insights from Meeting 1 to build a high-level consensus on the design of a better system</li> <li>Build shared understanding of EMTALA due process considerations</li> </ul>	Katherine Mulready, CHA <i>EMTALA Overview</i>
Mtg. 3 9/7/16	<ul style="list-style-type: none"> <li>Review MHH System Framework from Meeting 2 to ensure shared understanding</li> <li>Apply a person-centered approach to the MHH process to establish a Pathway Design</li> <li>Identify critical junctures and opportunities in Pathway Design</li> <li>Update MHH System Framework with previous work and insights from this discussion</li> <li>Set an agenda for upcoming meetings</li> </ul>	Amanda Kearney-Smith, CMWN <i>A Framework for Change</i> Lacey Berumen, ER Nurse Chrissie Hodges, <i>self-identifies as having "Pure O" &amp; has experienced a mental health hold</i> Charles Steinbach, <i>self-identifies as having chronic, paranoid schizophrenia &amp; has experienced a mental health hold</i>
Mtg. 4 9/21/16	<ul style="list-style-type: none"> <li>Develop shared understanding of current draft of CO MHH System map</li> <li>Learn about and apply lessons from national examples to the design of Colorado's system</li> <li>Refine previous discussion points into potential recommendations</li> </ul>	Frankie Berger, TAC <i>Mental Health Holds: A National Perspective</i>
Mtg. 5 10/6/16	<ul style="list-style-type: none"> <li>Develop a shared understanding of how to frame discussion in non-polarized terms</li> <li>Review and revise a flow chart of the MHH process</li> <li>Review and update current proposals to improve MHH System in CO</li> <li>Refine previous discussion points into potential recommendations</li> </ul>	Todd Merendino, CDHS-OBH <i>Overview of 27-65-105, C.R.S Emergency Procedures and Designated Facility Rule</i>
Mtg. 6 10/18/16	<ul style="list-style-type: none"> <li>Develop shared understanding of CO's Crisis Response System and how it relates to task of developing a better system MHH management</li> <li>Review and revise an updated flow chart of the MHH process</li> <li>Review and update current proposals to improve CO MHH System</li> <li>Reach agreement on recommendations ready for action</li> </ul>	Nancy VanDeMark, CDHS-OBH Frank Cornelia, CBHC <i>Colorado Crisis Response System: Overview and Future Direction</i>
Mtg. 7 11/2/16	<ul style="list-style-type: none"> <li>Refine updated recommendations to improve CO MHH System</li> <li>Reach agreement on recommendations ready for action</li> <li>Define next steps and any additional info needed to reach agreement</li> </ul>	None
Mtg. 8 11/16/16	<ul style="list-style-type: none"> <li>Refine updated recommendations to improve CO MHH System</li> <li>Reach agreement on recommendations ready for action</li> <li>Define next steps and any additional info needed to reach agreement</li> </ul>	Doug Wilson Colorado Public Defender <i>CCJJ's Proposed Changes to Title 27-65</i>
Mtg. 9 12/7/16	<ul style="list-style-type: none"> <li>Review process to reach final agreement on recommendations and produce report</li> <li>Refine updated recommendations for improving the MHH system in CO</li> <li>Reach consensus/agreement on recommendations ready for action</li> <li>Define next steps and any additional info needed to reach agreement</li> </ul>	None
Mtg. 10 12/21/16	<ul style="list-style-type: none"> <li>Review remaining small group proposals around tiered designation and ownership for recommendations</li> <li>Test the set of recommendations against real-world challenges</li> <li>Reach consensus/agreement on recommendations ready for action</li> <li>Evaluate the process and gather closing reflections</li> </ul>	None

## Appendix D: Overlay of Crisis Stabilization Unit and Healthcare Facility Locations Across Colorado



## Appendix F: Task Force Voting Tally on Final Recommendations

The Task Force voted using a Fist-to-Five approach, raising their hands as in voting, with the number of fingers raised indicating each member's level of agreement.

**5 fingers** – I am in full support of this motion.

**4 fingers** – I support this motion.

**3 fingers** – I'm in the middle somewhere, but can still support the motion.

**2 fingers** – I have some concerns but will go along with the group's decision.

**1 finger** – I have strong reservations but would not block consensus.

**0 fingers/fist** – I object and will block consensus.

On December 21, 2016, the Task Force voted to approve the full set of recommendations, the table below shows the levels of agreement for each recommendation.

RECOMMENDATION NUMBER	Fully Support			Support with Reservations		Do Not Support
	5	4	3	2	1	0
<b>Recommendation 1 (First Sentence only)</b> Amend CRS 27-65-105 during the 2017 legislative session to eliminate the use of jails, lock-up, or other place of confinement for persons who have not been charged with or convicted of a crime.	18	0	1	1	1	1
<b>Recommendation 1 (Component A only)</b> We encourage communities to phase this recommendation even before statutory changes have been finalized.	20	2	0	0	0	0
<b>Recommendation 1 (Component B only)</b> In regions where adequate alternatives do not yet exist, implementation of this recommendation should be phased in once the services and supports outlined in subsequent recommendations are in place	10	3	3	3	0	2
<b>Recommendation 1 (Component C only)</b> New stand-alone bullet ending the practice of use of jails no later than January 1, 2018:	13	0	2	0	0	6
<b>Recommendation 2 (as written)</b>	12	11	1	0	0	0
<b>Recommendation 3 (as written)</b>	23	1	0	0	0	0
<b>Recommendation 4 (as written)</b>	23	1	0	0	0	0
<b>Recommendation 5 (as written)</b>	16	5	3	0	0	0
<b>Recommendation 6 (as written)</b>	21	3	0	0	0	0
<b>Recommendation 7 (as written)</b>	16	3	2	0	0	0
<b>Recommendation 8 (as written)</b>	20	2	0	0	0	0
<b>ALL RECOMMENDATIONS, AS A SET</b> Includes recommendations 2-8 and the first sentence only of recommendation #1.	9	12	0	0	0	0

## Appendix G: Definitions

An **Acute Treatment Unit (ATU)** is a facility or a distinct part of a facility for short-term psychiatric care, which may include substance abuse treatment, that provides a total, twenty-four-hour, therapeutically planned and professionally staffed environment for persons who do not require inpatient hospitalization but need more intense and individual services than are available on an outpatient basis, such as crisis management and stabilization services. (C.R.S. § 27-65-102)

A **Behavioral Health Organization (BHO)** is an entity contracting with the state department to provide only behavioral health services. (C.R.S. § 27-5-403)

The **Colorado Department of Public Health and Environment** has statutory authority to license health facilities in Colorado.

The **Crisis Hotline/Warmline** is a component of the Crisis Response System. The service is available 24/7/365 to anyone affected by a mental health, substance use, or emotional crisis. The service includes a peer support “warm-line,” texting, and chat features.

Colorado’s **Crisis Response System** was signed into law in May 2013 to provide critically needed services and supports “when and where needed” with the goal that the services be accessible to all Coloradans, regardless of their ability to pay. The system includes: 1) a 24-hour hotline/warmline for crisis assistance, staffed by trained, professional specialists and peer counselors; 2) mobile crisis response; 3) respite care; 4) crisis walk-in centers and Crisis Stabilization Units (CSUs).

A **Crisis Stabilization Unit (CSU)** provides short-term, crisis-focused intervention and treatment to people who are in psychiatric crisis. Treatment is provided 24 hours a day, 7 days a week and is available to anyone, regardless of their ability to pay.

The **Department of Health Care Policy and Financing (HCPF)** is the state agency that manages the administration of a broad-based medical care program for low-income families in Colorado.

A **Designated Facility** is an agency that has applied for and been approved by the Colorado Department of Human Services to provide mental health services. (2 CCR 502-1)

An “**M-1 Hold**” is a mental health hold that may be invoked when a qualified mental health professional determines that an individual “appears to be an imminent danger to others or to himself or herself or appears to be gravely disabled. In this circumstance, the individual can be taken into custody and placed in a facility designated or approved by the Colorado Department of Human Services for further evaluation and treatment for up to 72 hours. (C.R.S. 27-65-105) “M-1” refers to the legal document that initiates the 72-hour hold.

**Mobile Crisis** is a component of the Crisis Response System. The service is available 24/7/365, and meets individuals at their homes, other locations, or other community locations.

**Network Adequacy** is understood as ensuring that each region of the state must have adequate networks of mental health care and support that include facilities that are prepared and willing to accept high-acuity patients and the ability of providers to work with people with multiple disabilities. Network adequacy is essential to supporting emergency departments and jails, and to eliminating the use of law enforcement facilities during the M-1 hold process.

The **Office of Behavioral Health** is the state agency responsible for granting “designation” status to health care facilities in Colorado. Designation is currently optional for emergency departments.

**Peer Services** are a component of the Crisis Response System. Peer services provide opportunities for individuals to connect with others who have experienced mental health challenges.