MEADOWS
MENTAL HEALTH
POLICY INSTITUTE

Strategies for Increasing Access to Quality Mental Health Care

for Children and Youth in Colorado

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Contents

Introduction

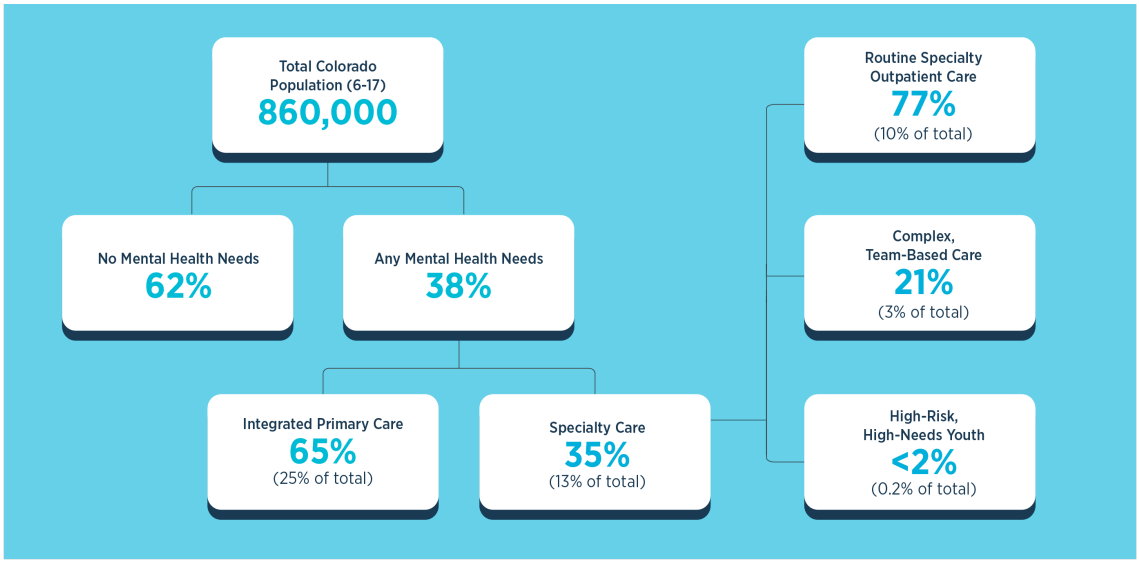
With generous support from the Penner Family Foundation, the Meadows Mental Health Policy Institute (Meadows Institute) conducted a comprehensive analysis of Colorado's child and youth mental health landscape. This strategic analysis of existing and potentially impactful levers across policy, philanthropy, and industry—as well as opportunities for transformational investment—spotlights the vital work of organizations across the state, identifies existing challenges and obstacles, and pinpoints promising opportunities for improving mental health resources and support for Colorado's children and youth across public and private sectors.

Prioritizing The Mental Health Needs of Colorado's Children and Youth

This report is grounded in the very urgent current mental health needs of the children and youth of Colorado. These are examined in detail in Appendix D, but overall:

Needs are great, but most are mild to moderate. About two in five (38% of Colorado school-aged children and youth ages 6–17) have a mental health need.[A,1,2,3] However, the vast majority (80%) of these young people exhibit mild to moderate symptoms, and most (65%) pediatric mental health needs could be optimally treated by evidence-based primary care models. The remaining third require more complex treatment, with a small group—less than one in every 50 of those with needs—requiring intensive services, including crisis supports. See Figure 1.

Figure 1. Mental Health Treatment Needs Among Colorado Children and Youth (2022)[4,5,6]



[A] All Colorado population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%.

Across levels of need, the primary diagnosis (and optimal care) varies. The most common conditions include attention deficit hyperactivity disorder (ADHD), major depression, and anxiety disorders. More severe disorders, such as post-traumatic stress disorder and bipolar disorder are less common, though 16,000 and 10,000 Colorado youth (ages 12 to 17), respectively, suffer from them. Only about 300 Colorado youth experience schizophrenia. There are roughly 150 new cases of first-episode psychosis[B,7] occurring each year, as these conditions tend to present in late adolescence and early adulthood. See Table 1 below.

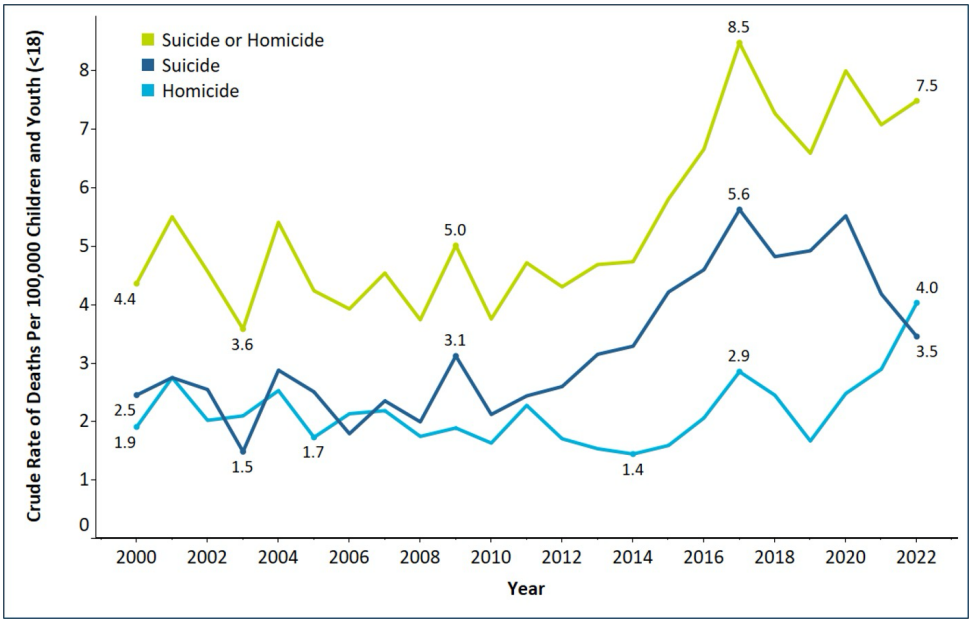
Table 1. Mental Health Prevalence Among Colorado Youth (2022)

Attention Deficit Hyperactivity Disorder[8]	Depression[C,9,10]	Non-PTSD Anxiety Disorders[11]	Post-Traumatic Stress Disorder[12]	Bipolar Disorder[13]	Schizophrenia[14]	First Episode Psychosis[D,15]
110,000 (13% of children and youth 6–17 yrs.)	100,000 (23% of youth 12–17 yrs.)	90,000 (10% of children and youth 6–17 yrs.)	16,000 (4% of youth 12–17 yrs.)	10,000 (2% of youth 12–17 yrs.)	300 (<1% of youth 12–17 yrs.)	150 (<1% of youth 12–17 yrs.)

Rates of death from suicide and homicide among youth are rising. In 2022, the most recent year with complete and final data, about 150 Colorado youth died from violence (suicide and homicide) or substance-related deaths.[16] As seen in Figure 2, while deaths from suicide have declined for Colorado youth from their pre-pandemic highs (the reverse of national trends), the homicide rate increased by more than 50%. The per capita trends for both are elevated compared to the rest of the nation, with more children and youth in Colorado dying from suicide and homicide compared to the national rates (suicide: 3.5 deaths per 100,000 in Colorado versus 2.2 per 100,000 nationally; homicide: 4.0 deaths per 100,000 in Colorado versus 3.3 per 100,000 nationally).[17]

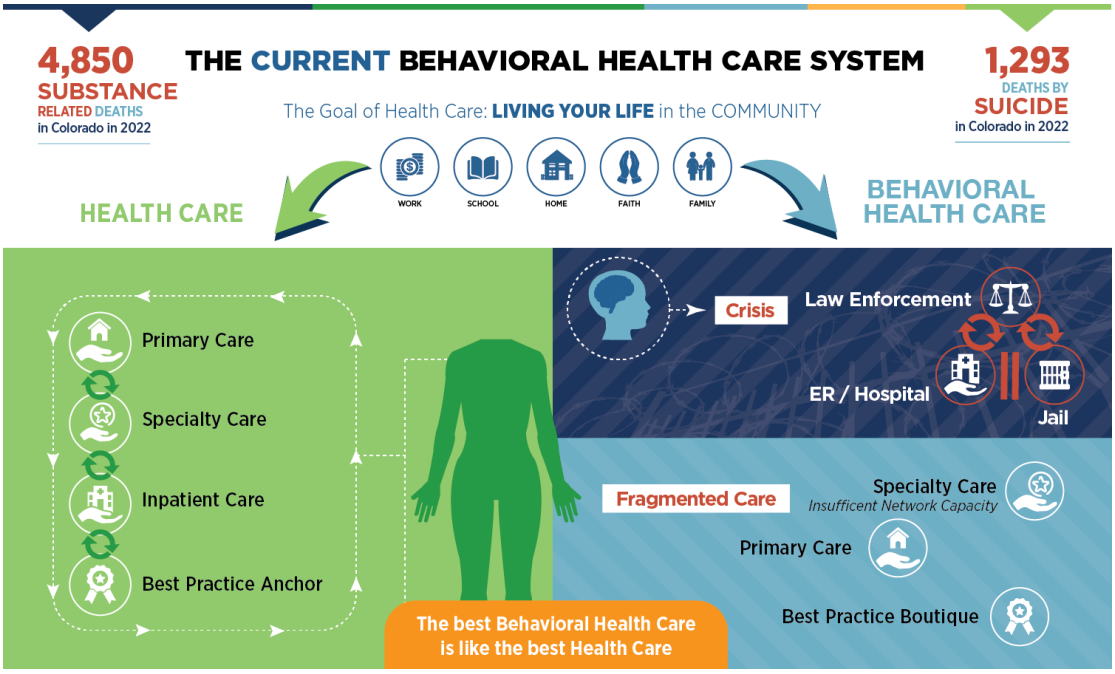
[B] Psychosis is caused by a multitude of factors. It may be the symptom of specific mental illnesses such as schizophrenia, bipolar disorder, or severe depression; it also may be caused by a mix of genetics, brain development and exposure to stress and trauma.
[C] An estimated 8,400, or 2%, of Colorado children between the ages of 6-11 suffer from major depression.
[D] First episode psychosis data reflects incidence—or new cases—that occurred during the 12-month timeframe only. As noted above, the Meadows Institute opted to use the most conservative estimates that provide a baseline for decision making and action.

Figure 2. Suicide and Homicide Death Rates Among Colorado Children and Youth



Colorado's Mental Health System is Systemically Flawed (Like in Every Other State). Even more tragically, this crisis is not a result of ineffective care: treatment for mental health conditions works 80% of the time.[18] Instead, Colorado's youth mental health crisis is primarily driven by more broadly mis-designed, poorly resourced health systems that generally fail to detect and treat people in need until symptoms reach a crisis point, as depicted in Figure 3.

Figure 3. The Current Behavioral Health Care System[19]



Mental health care delivery in Colorado—and every other state in America—is generally fragmented and segregated from the health care system. As a rule, care is not received until suffering becomes obvious to the person or the people around them, too often through a crisis that leads to an emergency room, hospital, or law enforcement. Because of this, fewer than one in 15 Coloradans with depression each year receive the care needed for symptom remission,[20] and nearly 1,300 people in Colorado die annually from suicide,[21] even though available depression treatments have over a 60% efficacy rate.[22,23]

While it can at times feel like the mental health system in Colorado is "broken," the problem is more deep-seated. Decades of policies purposefully designed behavioral health care delivery so that the average length of time between the initial onset of symptoms and access to needed care for children ranges from eight to 10 years.[24] Americans previously faced this same problem for heart disease and cancer. Until the 1980s, medical systems typically identified heart disease primarily when a person had a heart attack and began treatment then, after the heart was damaged, to resuscitate the person and prevent a recurrence. Health systems also used to wait to detect cancer until it resulted in functional impairment—a broken bone, coughing up blood—with devastating consequences and higher mortality rates.

Today, there are systems in place in primary care and in the community that detect most heart diseases and many cancers much earlier, when they are easier to treat successfully, much less likely to be disabling and burdensome to the person receiving care, and less costly to society. Health conditions are also treated proactively in primary care, routinely tracking early symptoms and titrating care in response. Additionally, there are health systems across Colorado that are routinely able to provide best practice assessment and treatment for heart disease and cancer, and Coloradans can travel within one to two hours from most places in the state (longer for the most remote areas, though) to find hope for these diseases.

This is not the case for behavioral health in Colorado today or in most parts of the nation; people living outside of the Northeast United States or the West Coast must travel thousands of miles to receive top-rated care,[25] and the best care is too often reserved for people able to pay tens of thousands of dollars out of pocket.

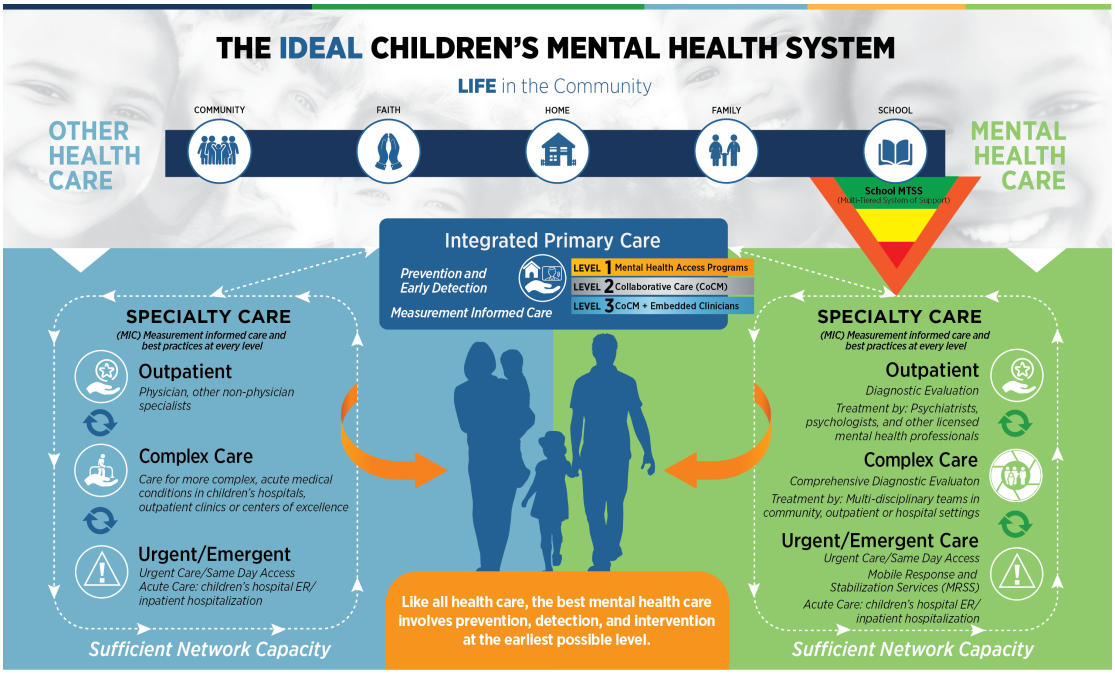
Envisioning an Ideal System of Care

This report posits a systemically reformed mental health system, and its underlying principle is simple: **The best behavioral health systems should mirror the best health systems for other conditions, with a focus on early detection and access to best-practice care**.[26] This centers on two core principles:

- **The earlier mental health conditions can be identified and treated, the better**. The average length of time between the initial onset of symptoms and access to needed care should be measured in months, not years.[27] Half of all mental health conditions manifest by age 14, and 75% manifest by age 24.[28] Early identification and treatment provide an opportunity to improve outcomes for all people with mental illness, particularly for young people and their families.
- **Given that mental illnesses are generally pediatric in origin, we must rethink and redesign health systems serving children, youth, and their families.** To more efficiently connect young people to the care they need, mental health needs must be identified where young people are, including the family doctor or pediatrician (through integrated health care approaches) and schools.

Rather than the current fragmented system where mind and body are treated separately, we envision an **ideal system** (Figure 4) in Colorado and beyond where mental health is integrated into the rest of the health care system, and, like the rest of health care, emphasizes prevention, early detection, and early intervention at the appropriate level of treatment.

Figure 4. Ideal System of Care



Integrated primary care and measurement-informed care play a critical role, with schools acting as important places to identify and connect youth to appropriate care. Additionally, in an ideal behavioral health system, substance use disorder (SUD) services must be integrated into a person's overall treatment.

Methodology: A Systematic, Data-Driven Analysis

In January 2024, the Meadows Institute initiated an assessment of Colorado's mental health service delivery systems for children and youth, including systems for school mental health support, aiming to understand and improve services and enhance the state's capacity to meet their needs. To understand what is and is not currently working in Colorado's systems, the Meadows Institute completed five assessment workstreams.

- **Interviews with Experts and Leading Coloradans across the Public and Private Sectors:** We interviewed 90 leaders from across the state representing a diverse group of investors, entrepreneurs, healthcare systems, school-based mental health leaders, mental health provider associations, advocacy groups, academics, elected officials, state agencies, and officials from local agencies.
- **Research Literature, Reports, and Policy Review:** We analyzed more than 100 sets of secondary data, research articles, reports, and state policies, including in-depth analyses by organizations in Colorado examining state and regional needs and proposed ways to continue to improve available care. We provide our analysis of three key reports in Appendices E-G: Behavioral Health Administration's Children and Youth Behavioral Health Implementation Plan, Colorado Health Institute's Solutions to Strengthen Colorado's Youth Mental Health Ecosystem, and Mental Health America's state ranking for Colorado.
- **Quantitative Data Analysis:** We collected and analyzed mental health and demographic data, including insurance coverage, education levels, and socioeconomic data.
- **Philanthropic Exploration:** We undertook a scan of the philanthropic field to determine the key funders in the mental health space, cataloged which organizations and programs are currently being funded, and identified noticeable gaps and/or underleveraged opportunities.

Actionable Policy and Practice Recommendations

This analysis provides actionable recommendations for near- and longer-term systemic change to substantially improve and, over time, fundamentally transform the delivery and efficacy of mental health care for children and youth in Colorado. They focus on helping leaders across philanthropic, governmental, and other private sector settings drive meaningful and sustainable improvements in behavioral health outcomes of the state's children and youth. Near-term strategies focus on immediate interventions and capacity building, while longer-term approaches aim at systemic changes and the development of sustainable policies and financing.

Table 2 below summarizes the recommendations in this report. Appendix A provides an in-depth explanation of each recommendation by domain.

A note regarding the role of philanthropy and the recommendations in this report: While philanthropy cannot (and should not) replace funding for public and commercially funded health services, we believe the private sector—both through philanthropy and private investment—can play a unique role in driving strategy, demonstrating innovation, de-risking system change, and uniting public and private sector leaders behind a shared vision and comprehensive strategy.

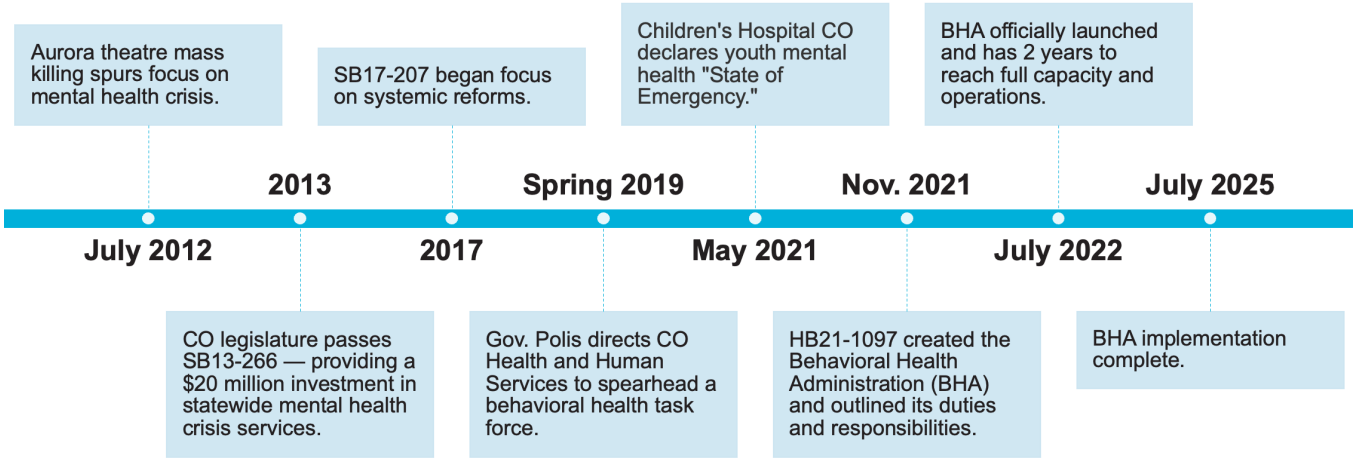
Table 2. Summary of Recommendations

Recommendation Areas	
Mental Health Care Delivery: Opportunities for mental health delivery system change and improvement across five key subdomains.	**14 recommendations**
Mild to Moderate Mental Health Services: Addressing mild to moderate needs in primary care settings by scaling best practice, sustainable interventions.	**4 recommendations**
Complex and Intensive Mental Health Services: Addressing serious and complex mental health needs through coordinated, evidence-based interventions, preferably in community settings.	**3 recommendations**
Crisis Care: Expanding the continuum of best practice crisis services in Colorado to improve the outcomes of crisis encounters.	**3 recommendations**
Maternal Mental Health Services: Addressing maternal mental health as a crucial step in improving child and youth outcomes.	**3 recommendations**
Grief and Trauma Services: Improving and expanding Colorado's evidence-based, scalable trauma- and grief-focused services.	**1 recommendation**
School Mental Health: Positioning Colorado schools to address mental health needs through prevention, early detection, and connection to appropriate mental health services.	**2 recommendations**
Workforce and Innovation: Helping Colorado develop the necessary workforce and expand the use of digital solutions to optimize workforce deployment to decrease mental health professional shortages.	**4 recommendations**
Systemic Cross-Cutting: Making systemic changes in state policy, financing, and national policy to realize the full potential of these recommendations through a scalable public-private partnership model.	**2 recommendations**

Chapter 1: Colorado's Mental Health Policy and Financing Context

Colorado, like many states, has been reforming its mental health system for more than a decade, frequently in response to high-profile crises (see Figure 5). Almost every aspect of the treatment system has experienced some degree of change, with the most recent being the establishment of the Behavioral Health Administration in 2022.

Figure 5. Evolution of Public Sector Behavioral Health Services



Policymakers' focus has now shifted from spurring transformation to overseeing implementation as unprecedented federal investments recede and legislative reforms come online in communities. With growing budgetary pressures (described in more detail below) and behavioral health needs remaining high across the state, Colorado policymakers are facing growing pressure to balance the need to meet the expectations of its residents while a host of other worthy interests compete for resources and legislative attention.

Colorado's Behavioral Health Funding Landscape

The Taxpayer Bill of Rights (TABOR) Shapes Colorado's Public Funding Options

Colorado's governmental funding structure is fundamentally shaped by the restrictions set forth in a constitutional amendment, known as the Taxpayer Bill of Rights (TABOR). Adopted in 1992, TABOR restricts government spending by placing revenue retention limits on all levels of government (state, county, and municipal) using a set formula based on inflation and population. If revenues collected by state and local governments exceed the prior year's revenues by more than inflation plus population growth, the excess must be refunded, regardless of any separate financial or programmatic needs otherwise identified by policymakers. Voter approval via referendum is required to increase taxes or the government debt beyond that which TABOR allows. In interviews, the Colorado Fiscal Institute explained that the required language "applies the lessons of human psychology" to make voting for a tax increase unattractive to voters—regardless of the ultimate proposed use of funding.

Beyond these restrictions, TABOR also limits the ongoing growth of state programs, as any expansion effectively takes up a larger portion of an otherwise unchanged financial "pie." Similarly, as any new program is introduced, those expenditures must also compete for a portion of existing revenue. In practice, this can make it especially challenging for the state to

adopt any new programs that require significant upfront spending, even if doing so would reduce future cost expenditures.

The restrictive nature of TABOR has been criticized for hampering the state's ability to invest in infrastructure and needed capital improvements and to respond to emergent challenges such as housing affordability or environmental issues, like the historic drought in the Colorado River Basin. At the same time, the resource restrictions of TABOR have encouraged the use of a novel set of alternative funding strategies, described in more detail in Appendix H.

State Agency Expenditures

Colorado has used a combination of state and one-time federal funding to invest in mental health services and system reorganization in recent years, including the $114 million Behavioral Health Recovery Act in 2021 (which included $100 million in federal American Rescue Plan Act COVID-19 relief dollars) and $450 million of federal COVID-relief funds to address rising mental health needs.[29] Because many of the state's investments leveraged one-time federal funding, there are concerns related to the ongoing sustainability of Colorado's investments in mental health.[30] The Colorado Behavioral Health Administration (BHA), established in 2022, is tasked with overseeing these funds and coordinating behavioral health care across the state and will be responsible for managing the transition away from the one-time federal COVID-19 funding.[31] See Table 3 for details.

Table 3. Colorado State Mental Health-Related Expenditures, FY 24-25

Colorado State Agencies	FY 24-25 Expenditures
Behavioral Health Administration (BHA)	
Agency Expenditures	$23,455,819
Children's Mental Health	$23,923,972
Children's Substance Use Disorder	$81,349,745
Community Services	$130,266,458
Information Technologies	$889,090
Justice Services	$31,046,277
Total BHA Expenditures	***$290,931,361***
Department of Health Care Policy and Financing (HCPF)	$1,040,269,703
Department of Human Services (CDHS)	$310,669,068
Department of Education (CDE)	$17,571,886
Other Agencies	$93,955,799
Total Departments and Agencies Expenditures	***$1,753,397,817***

Additionally, the state is pursuing entry into the federal Certified Community Behavioral Health Clinic (CCBHC) demonstration grant program. The CCBHC model provides a standardized framework to enhance federal funding for essential services that form the backbone of behavioral health systems, particularly for people with the most severe and complex needs. Colorado was awarded a $1 million, one-year CCBHC planning grant in January 2025. The planning grant will allow the state to take the necessary steps to join the CCBHC demonstration grant program, including preparing an application to the four-year demonstration program, developing their in-state CCBHC certification process, and expanding the prospective payment systems for Medicaid-reimbursable services to include CCBHC services. See Appendix I for a detailed explanation of the role of CCBHCs in the behavioral health system.

Colorado's Public Behavioral Health Care Delivery System is in Transition

Behavioral Health Administration

Prior to 2023, the Office of Behavioral Health (OBH) in the Department of Human Services (CDHS) oversaw the provision of public behavioral health services in the state. On July 1, 2022, House Bill (HB) 21-1097[32] and HB 22-1278[33] created the Behavioral Health Administration (BHA), which is now responsible for the administration of the state's public behavioral health system. In 2023, this public mental health system served 33,930 children and youth.[34] The BHA is also responsible for coordinating with and reporting on all the behavioral health programs and funding for 14 state agencies.[35]

Roughly two years after its creation, the BHA's contracting and reimbursement structure is shifting. Under the previous structure, the BHA contracted with:

- Eighteen Community Mental Health Centers (CMHCs) that provided community-based mental health and inpatient services.
- Managed Service Organizations (MSOs) who subcontracted for SUD services.
- Administrative Service Organizations (ASOs) who subcontracted for crisis response services.

The new contracting structure is changing from these CMHCs, MSOs, and ASOs to Behavioral Health Administration Service Organizations (BHASOs), with a final implementation date of July 1, 2025. Under the new structure, the BHA contracts with BHASOs who, in turn, subcontract with safety net providers for services.[36] Behavioral health safety net providers subcontracting with BHASOs can choose to subcontract to become licensed as a comprehensive or an essential provider. This change opens the opportunity to be part of the safety net—historically the purview of CMHCs—to other providers. Please see Appendix J for more details. Note that final implementation of the BHA is expected on July 1, 2025.

Transformation Process Spotlight

Children and Youth Behavioral Health Implementation Plan

In 2024, the BHA released its comprehensive *Children and Youth Behavioral Health Implementation Plan* to address the unique needs of children and youth. The planning process involved collaboration among multiple state agencies, including the BHA, CDHS, Department of Health Care Policy and Financing (HCPF), Department of Early Childhood, Department of Education, and Department of Public Health and Environment.[37] The plan identifies nearly 100 action items and highlights immediate priorities to be addressed within one to two years. An analysis of the recommendations is provided in Appendix E.

Along with this implementation plan, Senate Bill (SB) 19-195[38] required the HCPF to outline recommendations for a statewide child and youth behavioral health delivery system pilot program that integrates funding for behavioral health intervention and treatment services. HCPF contracted with the Farley Health Policy Center (FHPC) at the University of Colorado's Anschutz Medical Center to conduct the analysis, which recommended that HCPF focus on aligning with funding and initiatives that are already underway rather than implementing a new pilot.[39]

Prospective Payment System

In July 2024, the Department of Health Care Policy and Financing (HCPF) implemented a new Medicaid prospective payment system (PPS) for comprehensive, safety net providers,[40] putting the core of the public mental health system in flux as it adjusts to changing reimbursement and payment structures. The main changes include:

- **Changing the basis of payment for Medicaid service.** The PPS now reimburses them based on the number of people they serve in a day (i.e., an encounter rate) instead of the number of services they deliver. This is a very large change.
- **Quarterly instead of monthly payments.** The former CMHCs will receive quarterly payments rather than a per-member-per-month rate, creating cash flow concerns.[41]
- **Disrupted enrollment.** The organizations previously designated as CMHCs had to re-enroll in Medicaid as a comprehensive provider by December 31, 2024.

Medicaid Unwinding

Adding to the strain placed on essential safety net providers is the end of COVID-era policies that boosted Medicaid enrollment during the public health emergency (PHE). In 2023, the PHE ended, concluding these flexibilities. As a result, states across the country—including Colorado—had to disenroll people no longer eligible for Medicaid in a process known as "unwinding."[E,42]

[E] The Consolidated Appropriations Act, 2023, ended the connection between Medicaid's continuous enrollment condition and the COVID-19 public health emergency. According to Medicaid.gov, "the expiration of the continuous enrollment condition authorized by the Families First Coronavirus Response Act (FFCRA) presents the single largest health coverage transition event since the first open enrollment period of the Affordable Care Act." When continuous enrollment ended in March 2023, states – including Colorado – resumed normal operations like Medicaid eligibility renewals and terminations for people who were no longer eligible.

Stakeholders expressed concerns that the State's process for enacting these required cuts was problematic and led to a larger reduction than was appropriate. From May 2023 to May 2024, Colorado's Medicaid enrollment declined by over 575,000,[43] resulting in a massive increase in the number of uninsured Coloradans.[44]

The Cumulative Impact on Providers is Threatening the Public Safety Net

Providers previously designated as CMHCs shared that these collective changes pose substantial challenges. To date, at least three of the 18 former CMHCs have made significant cuts to their workforce due to budget shortfalls. It is too soon to know the impact of the new PPS on safety net providers. The Colorado Behavioral Healthcare Council (the membership association for Colorado CMHCs) has expressed concerns that the new PPS and the increased number of uninsured people have resulted in budget deficits and staffing cuts in an effort to achieve sustainability.[45,46]

2024 Settlement Agreement Related to Intensive Behavioral Health Services

Another activity influencing the Colorado policy landscape is the 2024 settlement of a federal lawsuit, *A.A. v Kim Bimestefer,* alleging that Colorado failed to provide Medicaid-eligible children with necessary intensive behavioral health services (IBHS). The plaintiffs and the State of Colorado reached a settlement agreement in February 2024, under which HCPF must develop an implementation plan for delivering IBHS to Medicaid members, defined to include at a minimum: intensive care coordination services; intensive in-home and community services; and mobile crisis intervention and stabilization services. HCPF must implement the plan by February 2029, but only if the Colorado General Assembly appropriates adequate funding.

Chapter 2: Mental Healthcare System

The ideal mental health care system described in the previous chapter includes strategies and evidenced based practices to support needs ranging from mild to complex and intensive to crisis.[F] While Colorado's continuum of care includes examples of most of these components, multiple gaps remain, and the components are not functioning as a coordinated system.

Mild to Moderate Mental Health Services for Children and Youth

Children and youth with mental health conditions that are mild to moderate in severity represent multiple diagnostic groups, including anxiety, depression, attention issues, and other behavior challenges that providers can address with adequate supports in primary care and other low acuity settings. Early intervention and support can prevent these mild to moderate issues from escalating into more severe mental health problems.

[F] For a an overview of mental health evidence-based best practices, see Appendix K.

Behavioral Health Integration

Behavioral health integration (BHI) combines mental health care with primary care and provides a holistic approach to managing a child's overall health. Integrating behavioral healthcare into the pediatric primary care setting means allowing children and youth to receive routine medical care, as well as treatment of mild to moderate mental health needs, in the same location, and it enables early detection (through universal screening) and treatment of mental health needs. Studies show that the use of an integrated primary care model improved outcomes for children and youth and was feasible in a variety of settings.[47,48,49]

The **Collaborative Care Model (CoCM)** CoCM is the most financially sustainable integrated behavioral health model with the strongest evidence-base,[50,51,52,53] including strong support for its use with children and youth.[54] CoCM is covered by Medicare,[55] nearly all commercial payers,[56] and 33 state Medicaid programs,[57] making it the only BHI model reimbursed in primary care with dedicated billing codes. CoCM has been shown to be effective for various behavioral health problems across diverse populations and treatment settings.[58] For example, a randomized controlled trial of CoCM for adolescents with depression found that the CoCM group had greater improvement at 12 months in depression symptoms (68% vs. 39%) and remission (50% vs. 21%) than the control group,[59] a finding that is consistent with the dozens of rigorous studies of CoCM across diverse populations. Importantly, CoCM is proven to work just as well for Black, Hispanic, and other communities of color, as well as people living in poverty more generally.[60] CoCM is also a workforce extender, leveraging psychiatrist time up to eight-fold over other models.[61] For in-depth detail on CoCM, see Appendix L, Figure L-2.

Colorado has long been at the forefront of implementing integrated mental health care in primary care settings for adult populations; [62] however, efforts have often resulted primarily in co-location,[63] a less effective and less sustainable BHI model that is easier to implement, absent larger grants and more substantive technical assistance.[64] More recently, HB 22-1302 allocated $31 million to fund larger grants of up to $400,000 (averaging $200,000 per award), with technical assistance through the CU Anschutz School of Medicine,[65] and The Colorado Health Foundation currently has an initiative focused on supporting practices implementing a range of models, including CoCM. However, as in most states, relatively few Colorado primary care providers have implemented CoCM with fidelity, with most practices across the state continuing to focus on co-located models that have substantially less potential to improve outcomes.[66] Historically, pediatric and perinatal care settings have not been a primary focus, in large part due to the absence of Medicaid coverage.

Program Spotlight	***Children's Hospital of Colorado's BHI/CoCM Pilot Program***
	CHCO's Pediatric Care Network (PCN) includes 33 pediatric practices across the state, and CHCO's Pediatric Mental Health Institute is partnering with eight early adopter PCN practices to design, pilot, and evaluate an effort to accelerate adoption of CoCM through implementation support, technical assistance, and a learning collaborative.

Recommendations for Mild to Moderate Mental Health Services

Rec. 1	**To increase mental health treatment for mild to moderate conditions, Colorado's Medicaid program should cover and reimburse primary care providers for CoCM.**

Why take this on? The greatest current barrier to pediatric CoCM implementation in Colorado is the failure of the state's Medicaid program to reimburse for the practice. Medicaid covers one in three Colorado children,[67] making Medicaid a crucial component of the payer mix for any large pediatric primary care provider, particularly safety net providers.[68]

How can Colorado move this forward? Colorado's Department of Health Care Policy and Financing has taken steps to cover CoCM billing codes by submitting a budget request to the Governor. [69] Given CoCM's proven benefits and costs savings, the Colorado General Assembly should move forward with this budget request to increase general fund spending by $686,000 ($2.9M total funds) annually to expand CoCM coverage and amend the Colorado Medicaid State Plan to add the national CoCM codes in alignment with Medicare rates and rules.

Rec. 2	**To increase mental health treatment for mild to moderate conditions, philanthropy should invest in technical assistance and implementation support to defray CoCM "start-up" costs in pediatric practices, catalyzing uptake across the state.**

Why take this on?

The primary barriers to implementation of CoCM are start-up costs and technical assistance:

- **Start-up** implementation costs and financial sustainability questions have been generally recognized as the primary impediment to wider adoption of CoCM, estimated to be a median of $160,000 per clinic across a diverse nationwide sample.[70] CoCM requires significant changes to clinical and administrative processes and requires hiring new team members and implementing new data infrastructure.
- **Technical assistance** during and after CoCM implementation has been associated with improved patient outcomes and with enhanced implementation support resulting in substantially better depression treatment outcomes than clinics that received only basic implementation support. Implementation support can be scaled efficiently and effectively through technical assistance accelerators with CoCM expertise.[71]

Unfortunately, many pediatric offices lack access to technical assistance and are often unable to incur the upfront costs involved in starting CoCM.[72] While Colorado has invested in CoCM implementation for the adult population, little has been done for the pediatric population. While House Bill 22-1302 also provides such support, it is not pediatric in its focus. With ARPA funding ending and TABOR constraints, the state is unlikely to be able to expand much needed start-up assistance to reach pediatric settings. In the absence of state resources, philanthropy can play a strategic role in investing in expanding CoCM, as the General Assembly focuses on Medicaid funding for CoCM to make the investment sustainable over the long-term.

How can Colorado move this forward? Philanthropic, state, and federal sources have all helped provide systematic investments for CoCM, but the pediatric population has generally been left out. CHCO's new effort highlighted above is an example of what is needed, as the Anschutz Foundation supported both start-up costs and substantial technical assistance. Additionally, the Colorado Health Foundation also has a substantial program focused on CoCM start-up costs and technical assistance, though it is not focused on pediatric settings. Colorado philanthropy is well positioned to develop a coordinated, collaborative effort to increase funding to offset startup costs and initial and ongoing technical assistance need in pediatric settings.

Rec. 3	**To support pediatric practices as CoCM capacity ramps up, the Colorado General Assembly should establish permanent funding for CoPPCAP.**

Why take this on? While the best practice for access to mental health care in pediatric settings is CoCM, scaling of CoCM across the state will take years, and children and families in Colorado need help today. The Child Psychiatry Access Programs (CPAP) model is a well-established approach to provide consultation directly to primary care providers.[73] It was first developed in Massachusetts in 2003[74] and has been implemented partially in many states (including Colorado) and fully in a few states (such as Texas[75]). Colorado has built out a base of such a program through the Colorado Pediatric Psychiatry Consultation & Access Program (CoPPCAP), funded in 2022 by the General Assembly with one-time funding of $4.6 million under SB22-147, plus additional private insurance funding of $1.8 million. CoPPCAP currently reaches 96 primary care practices (including school-based health centers) with over 1,000 primary care providers serving over 670,000 Colorado children, but sustained funding is needed.

Program Spotlight	***Colorado Pediatric Psychiatry Consultation & Access Program (CoPPCAP)***
	Based on the Child Psychiatry Access Programs (CPAP) flagship model, Colorado developed CoPPCAP to help pediatricians manage mental health issues through direct access to child and adolescent psychiatrists, licensed mental health professionals, and care coordinators.[76] Pediatricians consult with specialists for real-time guidance on diagnosing and managing mental health conditions, enabling them to provide comprehensive care within their practices. See Appendix M for more detail.

How can Colorado move this forward? The Colorado General Assembly should prioritize making CoPPCAP funding permanent. Given the TABOR limitations, philanthropy could play an important role in supporting the expansion of CoPPCAP into regional hubs, helping maximize the state's existing investments.

Rec. 4	**To improve I Matter's program quality and outcomes, increase the use of evidence-informed practices by funding measurement-informed care initiatives, improving clinical training, and addressing gaps in diagnostic assessments and data collection.**

Why take this on? While I Matter represents an important step to expand access to mental health care for families and youth, the program would benefit from increasing the use of evidence-informed practices and incorporating measurement-informed care into its on-line platform. Measurement-informed care (MIC) is a best practice employed by where clinical outcomes are measured at regular intervals using standardized tools, and it has been clearly linked to better outcomes.[77] While all leading digital mental health providers incorporate MIC, less than 20% of behavioral health providers actively employ MIC.[78] Currently, the I Matter program contracts with community providers across the state, but specific therapeutic modalities are not specified, data collection is lacking, and MIC is not practiced. Standardized training in evidence-based models (including trauma and grief specific treatment) and MIC could enhance the quality of I Matter services substantially.

Program Spotlight	***I Matter Program*** In response to rising youth mental health needs during the COVID-19 pandemic, the state developed the I Matter program to allows caregivers and youth over age 12 to access up to six free therapy sessions to any youth online.[79] 2024 legislation (SB 24-001) made the program permanent with a $5 million annual budget. For more information about I Matter, see Appendix N.

How can Colorado move this forward? Collaboration between BHA, who runs I Matter, and external partners to help support the integration of MIC into I Matter could improve the quality of the program's services across the state. This could also include targeted investments to create standardized protocols for clinicians who are delivering services through the program and specialized training for clinicians to deliver MIC and short-term, evidence-based trauma therapies. Incorporating a partnership with strong clinical providers could provide the expertise needed to accomplish these quality improvements. Additionally, partnerships with tech-enabled partners could allow I Matter to leverage the existing infrastructure of the private sector rather than build a new platform from scratch.

Complex and Intensive Mental Health Services for Children and Youth

Children and youth with more serious and complex mental health needs have significant challenges functioning in daily life that require intensive and specialized interventions. Examples include severe anxiety disorders, major depressive disorders, bipolar disorder, schizophrenia, severe autism spectrum disorders, and complex trauma-related disorders. These children and their families benefit most from evidence-based interventions that keep them in their homes, schools, and communities, reduce crisis system use, and improve functioning. (See Appendix O for a broad, but by no means comprehensive, list of such services.)

Intensive Community-Based Services

Intensive community-based services can address the behavioral health needs of the child and their family before they reach a point of crisis, or their mental health deteriorates to a point where they require hospitalization. Providing services in the home and community allows a clinical team to observe family dynamics, understand cultural factors, assess support systems, and identify essential needs. This enables them to connect families with resources and services that help children and youth thrive.

However, navigating the mental health care system can still be challenging, particularly when children and youth are transitioning between different levels of care. Especially for those with complex needs, it is vital to ensure a smooth transition from hospital to community-based care. This requires support to guide the process, integrating resources, and streamlining care across multiple providers to ensure continuity and better outcomes.

Best Practice for Youth at Risk of Violence and Justice System Involvement: Multisystemic Therapy (MST)

Violence has driven most of the increase in death among Colorado youth recently, and MST is the only evidenced-based intervention proven to reduce violence. The efficacy of MST has been established through 28 highly rigorous random control trials carried out over the last thirty years.[80] MST helps youth ages 12-17 with juvenile offenses and severe behavioral problems, including violence and substance use.[81,82,83] MST acknowledges that problems are multi-determined, and, to be effective, treatment must have an impact on multiple systems, including the youth's family and peer group.[84] Accordingly, MST is designed to increase family functioning by helping caregivers improve their capacity to provide supervision and support and to reduce conflict, and it is effective over 60% of the time (as documented across a large body of evidence, including 74 studies across 57,000 diverse families and over 140 peer-reviewed citations, as documented in Appendix P). Colorado is incorporating MST as a key component of its new system of care, in response to *A.A. vs Kim Bimestefer* settlement (see Chapter 1). It should be noted that Colorado MST providers have had challenges sustaining the model historically due reimbursement issues, especially in rural areas of the state.

Best Practice for First Episode Psychosis: Coordinated Specialty Care (CSC)

Psychosis is a condition that affects a person's thoughts and perceptions, making it harder to distinguish between what is real and what is not,[85] and a first episode of psychosis typically occurs between late teens and mid-twenties.[86] Early connection to the right treatment can significantly improve a person's future;[87] however, most people who experience psychosis do not receive care until five years after the onset of symptoms.[88] Coordinated Specialty Care (CSC) is the most clinically proven and cost-effective best practice focused on those in the early stages of psychosis.[89] Tailored to the individual, CSC includes typical treatments such as medication and illness management, and it actively engages the family to support recovery and engages key community entities to support educational and employment opportunities to restore a health developmental path. Additionally, CSC can help reduce violence, as people with untreated psychosis are at a higher risk of committing homicide, and effective treatment like CSC eliminates this risk.[90,91] CHCO and other community-based providers across the state offer CSC and play an important role in helping youth experiencing psychosis get the care they need.

Recommendations for Complex and Intensive Mental Health Services

Rec. 1	**Navigation programs, such as CHCO's Care Transitions Team, should be invested in as a best practice model that can be replicated in other health systems across the state.**

Why take this on? CHCO currently operates one of the best navigator programs in the state, assisting with care coordination and addressing barriers to care between providers and families.[92] The BHA committed $4.8 million for a three-year pilot to support implementation, but delays shortened the spending window to just one year. Despite this, initial results are impressive, and the goal is to optimize the navigation team to meet the needs of over 8,000 people once fully operational, serving as a best practice model for the state.

How can Colorado move this forward? Short-term philanthropic support could help stabilize programs such as these to build momentum and support proof of concept. Building on this, a policy-focused effort to identify long term financing could then sustain and expand the model statewide.

Rec. 2	**The BHA, with funding prioritized by the Colorado General Assembly, should expand access to Multisystemic Therapy (MST) to serve children and youth outside of the justice system, including those most at-risk of violence.**

Why take this on? The Meadows Institute estimates that there are about 1,600 high-need youth in Colorado who could benefit from care to reduce their risk of violence and other adverse outcomes, and they have also been documented to use a disproportionate amount of hospital capacity and other intensive state resources.[93] Approximately 80% of these young

people are at-risk due to serious behavioral disorders best addressed by MST, preferably available prior to formal involvement in the juvenile justice system.

How can Colorado move this forward? As part of the *A.A. vs. Kim Bimestefer* settlement (see Chapter 1), Colorado has proposed an Intensive Behavioral Health Services framework aimed at improving access to mental health care for Medicaid-enrolled children and youth with complex behavioral health needs. Colorado Medicaid reimburses MST for youth ages 12-17, but only if they are justice-involved. To be proactive, philanthropy could fund policy work to enact sustainable funding for additional MST capacity that expands services to a broader population. Philanthropy could go further by supporting research to identify sustainable funding models for additional MST capacity.

Rec. 3	**The BHA, with funding prioritized by the Colorado General Assembly, should include Coordinated Specialty Care (CSC) as part of the Intensive Behavioral Health Services framework to better serve all youth with First Episode Psychosis.**

Why take this on? Early connections to the right care, particularly CSC, can significantly improve the life trajectory of a young person experiencing psychosis.[94] Approximately 150 youth experience first episode of psychosis each year in Colorado, and about 300 need treatment for early psychosis at any one time. While Colorado has some CSC teams, increased capacity is needed.

How can Colorado move this forward? BHA has not included CSC in its IBHS framework, meaning there are currently no plans to expand this beneficial program. CSC typically utilizes a mix of federal block grants, state general revenue funds, and Medicaid to cover the cost of operating a program. The Colorado General Assembly should prioritize the establishment of CSC teams as a key component of its intensive behavioral health services redesign and develop a multi-year plan to build sufficient, financially sustainable capacity to reach all youth in need.

Crisis Care Services for Children and Youth

A robust mental health service system includes a crisis response and ongoing care management structure that provides support for children, youth, and their families who are affected by a single traumatic event as well as those struggling with complex mental health challenges.[95] While crisis services should not be the default entry point for care in an ideal system, today in systems across the nation, crisis care too often serves as the front door to mental health treatment, making the availability of a quality crisis care continuum especially important.[96]

An ideal crisis continuum works best when youth receive care close enough to home to maintain ties to their community and family.[97,98] This requires a range of services, including a well-functioning 988 system integrated with 911, mobile response teams that can be

dispatched to the full range of youth and family crisis (from urgent to acute), walk-in centers, crisis stabilization units (CSUs) to support children and youth at-risk of psychiatric hospital admission, and psychiatric hospitals for children and youth at the highest level of acuity. See Appendix Q for an overview of crisis services and their descriptions.

It is important to remember that the ideal crisis continuum exists within a broader system of care that identifies and responds to individual mental health needs within the community. Without the availability of community-based mental health services that address needs ranging from mild to serious, the crisis end of the services continuum becomes the default point of entry for care. In the ideal system, most people would have their mental health needs identified long before reaching a point of crisis. Developing a strong community-based services continuum that people can access prior to being in crisis is critical to preventing crises and maximizing efficient use of the available crisis services. When meaningful community-based alternatives to inpatient treatment are absent, many people in crisis have nowhere to turn but to the most restrictive, disruptive, and expensive care.

Crisis Services in Colorado

In Colorado, multiple mental health providers and emergency response teams operate programs as part of the continuum of crisis services (see Appendix R for more detail, including gaps). Colorado stakeholders repeatedly highlighted the lack of crisis services for the state's children and youth. Several gaps stand out:

- There are no mobile crisis teams dedicated to serving only children, youth, and their families.
- There is a lack of crisis transportation services in the state.
- There is only one youth-focused crisis stabilization unit in the state. (CHCO has plans to build two crisis stabilization units, but the plans are not yet a reality.)
- Uneven and inadequate services create disparities, even within urban areas, but multi-hour waits are typical in rural and mountain areas.
- Post-crisis, youth too often return to the same pre-crisis services that were not adequate to support them originally (or they must find new services, which are generally lacking).

There are, however, strong programs to build on. CHCO has enhanced a range of supports including mobile response and crisis stabilization as part of their five-year strategic plan and can be a resource statewide. In rural areas, both the Aspen Hope Center and the Your Hope Center in Eagle County offer best practice continuums, including enhanced mobiles responses that

incorporate many of the best practices noted below and a continuum of crisis stabilization and acute care options.[G]

Best Practice: Youth Crisis Outreach Team

Youth Crisis Outreach Teams (YCOT) is a home and community-based crisis intervention model that works with families and community supports to provide rapid urgent and crisis response and stabilization services with the goal of helping youth and their families get effective care ideally before a situation escalates, a placement is disrupted, or behaviors become unsafe. YCOTs are also able to provide follow-up care post-crisis to connect young people and their families with ongoing care, prevent reoccurrences, maintain their home and school placements, and get on track to recover and thrive. Best practice indicates that teams remain connected to families for at least eight (and ideally 12) weeks to ensure warm connections for ongoing, community-based services and to help families establish support systems. YCOTs are multidisciplinary, but they are staffed differently from traditional mobile crisis teams that focus on all ages (but primarily adults) and focus on managing access to inpatient care. While Colorado stakeholders broadly agree that the addition of YCOT teams is a critical component to crisis care, and last session HB 24-1019 would have taken initial steps toward establishing the youth crisis outreach team model, the legislation did not advance. See Appendix S for more detail on the YCOT model.

Recommendations for Crisis Care Services

Rec. 1	**CHCO should accelerate its timeline for creating two crisis stabilization units, providing Colorado with a more appropriate, evidence-based setting for youth experiencing a mental health crisis.**

Why take this on? CHCO estimates its system will have more than 19,000 crisis visits by 2026. CSUs can stem the tide of emergency room encounters, offering immediate, short-term stabilization and support to ensure children in crisis receive timely and appropriate care. By way of example, CHCO incorporates CSUs in its strategic plan and is currently raising funding to support development at Denver and Colorado Springs locations. The CSUs will be located across from CHCO's emergency departments, allowing for emergency department diversions when appropriate. This model could be adopted by other health systems.

How can Colorado move this forward? Philanthropy could help accelerate the development and funding of sustainable CSUs. As an example, CHCO already has a sustainable plan in place and is in the process of fundraising to address both capital and start-up staffing needs.

[G] More information on these essential centers can be found at https://www.aspenhopecenter.org/programs#mobile-crisis and https://www.yourhopecenter.org/.

Rec. 2	**The BHA should partner with local health systems to build regional behavioral health campuses with crisis stabilization services that connect to specialty resources in urban areas.**

Why take this on? While best practice programs have been developed in wealthier mountain communities able to leverage their seasonal tax base, access to needed crisis care is generally lacking in rural and mountain communities or highly. As a result, children and youth often forego care or rely on emergency departments and inpatient units often located hundreds of miles away. The too-frequent result is inpatient admission or discharge without appropriate behavioral health follow-up. Integrating facility-based services into strategically located behavioral health campuses in rural areas can offer more appropriate and effective treatment for the young person while mitigating emergency room overcrowding and the overuse of inpatient admissions. In a campus model, young people can access crisis care designed to quickly triage, assess, and initiate treatment in a safe and supportive environment.

How can Colorado move this forward? The BHA should work with the Colorado General Assembly to develop a multi-year plan for financing and implementing at least three behavioral health campuses in rural areas, each offering outpatient clinics, crisis respite, crisis residential, and crisis stabilization services for children and youth. These campuses should provide rapid triage, early intervention, treatment initiation, and continuous observation. Following a thorough needs assessment, children and youth can return to the community, avoiding unnecessary and costly hospitalization. This model should mirror best practices in treating other severe health conditions, allowing for more routine cases to be managed locally and more complex cases to be referred to metropolitan centers with advanced resources.

Rec. 3	**The BHA should create and deploy Youth Crisis Outreach Teams (YCOT) across Colorado, in partnership with best practice partners such as CHCO, Aspen Hope Center, and Your Hope Center.**

Why take this on? Colorado has mobile crisis teams, and Medicaid covers many components of crisis intervention services; however, these services are not focused on children and youth and lack the capacity to respond to urgent needs pre-crisis or help the youth and family connect to necessary care post-crisis. Investment is needed to establish a fully dedicated YCOT focused on responding to young people experiencing behavioral health crises in the community. These programs are especially important in a state like Colorado, where inpatient resources are often located far away, as a well-functioning YCOT can provide most of the stabilization services that drive families to emergency rooms. Moreover, YCOTs can provide ongoing care for up to three months to bridge access to ongoing care.

How can Colorado move this forward? Philanthropy can play a critical role by supporting a three-year YCOT proof of concept pilot for Colorado General Assembly to consider. The costs to implement and run a YCOT vary depending on the region and the services included. The core team costs just over $1,100,000 to operate annually, plus an additional $275,000 in start-up costs for vehicles and equipment, including telehealth and technical assistance. Once a YCOT is fully implemented, some service components can be reimbursed for Medicaid-enrolled young people, helping with teams' financial sustainability. Colorado could also consider a tiered staffing model to match the needs of individual communities. Please see Appendix T for YCOT average costs and tiered staffing options.

Maternal Mental Health

While the correlation between maternal mental health and children's mental health is well-established, access to maternal mental health care continues to be inadequate in Colorado and across the nation. Addressing maternal mental health is a crucial step in improving children and youth behavioral health outcomes. Less than 20% of women are screened for depression during pregnancy and the postpartum period,[99] and only 22% of women who screen positively are connected to care.[100] In Colorado, there are 54.7 deaths per 100,000 live births (significantly higher than the national rate), with the rate for Black mothers nearly double.[101,102] The leading causes of pregnancy-related deaths in Colorado include suicide, unintentional overdose, and obstetric complications,[103] and suicide and unintentional overdose are the leading causes of maternal deaths first year postpartum.[104] The Maternal Mortality Review Committee found that 90% of these deaths were preventable.[105] About 40% of Colorado counties[106]—most in rural regions—are classified as lacking essential maternal health care, including essential maternity care and hospitals providing obstetric services and prenatal care. A few women's health clinics in Colorado offer integrated mental health care services, but they are the exception. Stakeholders report that about 70% of community providers do not accept commercial insurance or Medicaid, resulting in high out-of-pocket costs for women seeking care.

Several organizations and initiatives are actively working to bridge the care gap and enhance maternal mental health support. In particular, CU Anschutz School of Medicine's Colorado Women's Behavioral Health and Wellness (CoWBHW) Center is an important behavioral health resource for women across the lifespan, providing comprehensive services across the care continuum.

Program Spotlights

Connections Program for High-Risk Infants and Families

This CoWBHW program offers comprehensive support from pregnancy complications through kindergarten, addressing a wide spectrum of care needs including mental health and development services for infants, parenting support, development and behavioral assessment, and broader supports to healthy child development and overall family

	wellbeing. The program leverages technology to meet needs and provides virtual and in-person support.
	Perinatal Resource Supporting Obstetric Screening, Psychiatric Education, Equity, and Referral (PROSPER) PROSPER improves perinatal mental health care by supporting obstetric providers with resources and education to screen for and manage mental health conditions during pregnancy and the postpartum period. This program emphasizes the importance of early identification and treatment of perinatal mood and anxiety disorders, which can have significant impacts on both maternal and child health. PROSPER provides obstetricians and other perinatal care providers with access to psychiatric consultations, training on mental health screening tools, and education on best practices for managing mental health conditions in pregnant and postpartum patients. By equipping obstetric providers with these resources, PROSPER ensures that mental health care is integrated into routine perinatal care, making it more accessible to expectant and new mothers. See Appendix U for more detail.

Recommendations for Maternal Mental Health

Rec. 1	**To identify and address the mental health needs of Colorado mothers before, during, and after pregnancy, CU School of Medicine should identify sustainable funding to continue and expand programs such as PROSPER.**

Why take this on? Colorado's maternal mortality rate is more than double the national average, with suicide and unintentional overdose as some of the leading causes of death. By providing psychiatric consultation supports to perinatal providers, programs such as PROSPER can expand access to mental health care, improving the mental health of mother and child and addressing maternal mortality rates.

***How can Colorado move this forward*?** Long-term funding stability would be necessary to expand programs such as PROSPER to reduce barriers to maternal mental health care. Given TABOR limitations and as described in Chapter 5, any effort to access public funds to scale up programs like PROSPER will likely require a policy-informed funding approach.

Rec. 2	**Colorado decision-makers should develop a CoCM implementation initiative focused on obstetric practices.**

Why take this on? Women enrolled in CoCM through women's health providers experience greater improvements in depressive symptoms, better overall functioning, and higher satisfaction with their care.[107] They are also more likely to adhere to prescribed antidepressant medications, which can be crucial for managing mental health during and after pregnancy. When CoCM programs are designed to be culturally relevant, mothers benefit even more, showing significant improvements in the quality of care they receive, as well as in the severity and remission of their depression.[108] Building on the foundation of PROSPER, we recommend

expanding CoCM in obstetric practices as the model has been shown to significantly improve mental health outcomes for women, particularly in managing perinatal depression.

How can Colorado move this forward? A successful perinatal CoCM program would need to use a hub-and-spoke approach, connecting resources from a core center of excellence with primary care and obstetric practices statewide. Philanthropy could help support needed startup costs and technical assistance.

Rec. 3	**To increase access to maternal mental health services for women with high-risk pregnancies and parents of medically complex infants hospitalized in NICUs across Colorado, CU School of Medicine should expand access to the programs that address parental mental health, such as the CoWBHW Connections Program.**

Why take this on? Supporting maternal mental health is directly linked to positive outcomes in children's mental health.[109] Parents who have a baby in the NICU have a significantly higher incidence of PTSD, anxiety, and depression, so mental health support is especially critical in helping these parents cope and enhance parent-child interactions. The existing Connections Program addresses this by offering a spectrum of care that includes both virtual and in-person perinatal mental health support, developmental monitoring, and testing, ensuring that both mothers and infants receive comprehensive care. Additional funding can help close critical gaps in service delivery, particularly during the vulnerable post-discharge period.

How can Colorado move this forward? Several strategic actions can be implemented to expand the reach of the CoWBHW Connections Program and similar programs to care for parents of premature or critically ill infants, but they will require philanthropic support to launch. CHCO, UC Health, and University of Colorado School of Medicine operate a long-standing partnership to coordinate obstetrical, fetal, neonatal and pediatric care. There is an opportunity to use this ecosystem to increase connection to NICUs across the state and to ensure that families of premature or critically ill infants receive the necessary mental health support through expansion and alignment with the Connections Program, which already provides services across these three systems. As part of these efforts, it will be important to scale remote engagement services to improve access to perinatal mental health support, particularly in rural and underserved areas. By expanding both virtual and in-person care options offered by the Connections Program through partnerships with NICUs across the state, parents can receive comprehensive mental health support and infants can receive developmental monitoring, regardless of their location.

Grief and Trauma Care for Children and Youth

Approximately two-thirds of U.S. children will experience at least one traumatic event before age 16.[110] Exposure to traumatic events, especially those that occur during childhood, are

strong drivers of future psychological and behavioral health problems including depression, PTSD, maladaptive grief reactions, substance abuse, violent behavior, suicide, and the intergenerational transmission of trauma, with lasting effects on a child's stress response system and overall development, leading to poorer health outcomes in adulthood if not addressed early.[111] Bereavement is the most frequently reported type of trauma among clinic-referred youth but is often the most distressing[112] and the strongest predictor of school problems (e.g., lower grades, increased drop-out, etc.).[113] Bereaved youth are susceptible to a wide range of additional psychological and behavioral health problems over the long-term, including post-traumatic stress, depression, substance abuse, and suicide risk.[114,115]

Recommendations for Grief and Trauma Services

Rec. 1	**Improve provider capacity in trauma and grief best practice care delivery statewide.**

Why take this on? Trauma- and grief-focused services are critically needed and effective;[116] yet there is a lack of specialized trauma-focused therapies, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Trauma and Grief Component Therapy (TGCT), and Dialectical Behavior Therapy (DBT) across Colorado. Access to these services is further hindered by high out-of-pocket costs, making them inaccessible to many families, and there is no access to evidence-based care for bereavement and grief (e.g., Multidimensional Grief Therapy).

How can Colorado move this forward? Philanthropy could support training and dissemination initiatives and facilitate partnerships with state and national leaders in evidence-based trauma and grief therapies to provide training to the state's key clinical programs.

Chapter 3: School Mental Health

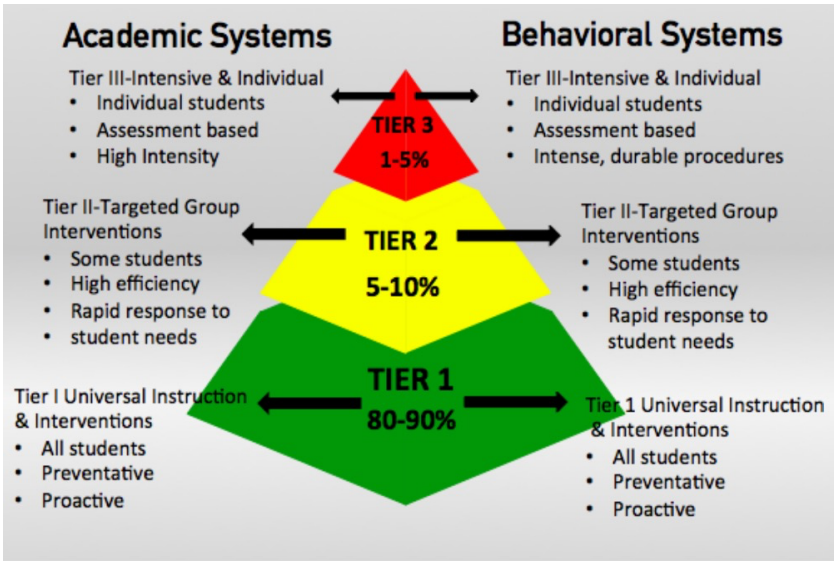
Since children and youth spend most of their time in school, schools play a key role in the overall landscape of youth mental health. Though not medical services providers, schools are key settings for prevention, early detection of mental health needs (ranging from routine to urgent to crisis), and connecting students and caregivers to evidence-based support. School-based mental health services, which are often provided by local behavioral health professionals who partner with schools, facilitate students' "fast, effective, equitable and destigmatized mental health support in school, where they are every day."[117] In recognition of their central role, the Colorado General Assembly recently passed legislation to further support school mental health initiatives, including HB 23-1003 (June 2023) to fund optional universal screenings, SB 24-007 for behavioral health first aid training (June 2024), and HB 22-1295 (August 2022) for early childhood mental health. See Appendix V for more details.

Colorado's Framework for School Mental Health

The framework recognized nationally and embraced by the Colorado Department of Education (CDE) to guide school districts is the Multi-Tiered System of Supports (MTSS). MTSS emphasizes evidence-based and informed practices and promotes early identification and intervention strategies to improve student academic and behavioral outcomes. The model outlines three tiers of support (see Figure 6) designed to assist all students while addressing individual needs.

In this chapter, we highlight mental health service delivery in schools, rather than the broader range of prevention and emotional wellness promotion. Tier 3 is the section of the MTSS framework where clinical mental health interventions primarily fall. It is important, though, to be mindful that the other two tiers are important for early identification and prevention. Colorado foundations and the state of Colorado have made substantial investments in holistic youth mental health supports in schools. This includes investments by foundations and the State in the curriculum and supporting school districts to create environments where students feel supported, safe and engaged, including the Youth Connections program and the Jule Settlement fund grants.[118,119,120] While some of these programs are inclusive of the entire spectrum of MTSS supports, the emphasis tends to be on Tier 1 and Tier 2 supports.

Figure 6. Multi-Tiered System of Support



The availability and diversity of Tier 3 MTSS services varies across districts, depending on funding, staffing, community partnerships, and the priorities of both the school and the community.[121] At a practical level, larger school districts tend to have more resources and staffing, but there is still variation, with some districts offering a comprehensive range of services across all tiers, while others focus primarily on specific tiers. Many less resourced districts often can only provide basic services.

While all districts employ school-based counselors, it is important to differentiate between counselors who provide only academic supports and those who provide mental health supports. Additionally, even for those who are qualified and employed to provide mental health supports, resource challenges can limit their ability to do so. However, even in the most

resourced districts, given the range of mental health needs experienced by students, there will always be gaps that need to be filled through partnerships with clinical services providers.

School Mental Health Partnerships

School mental health services can be provided by school behavioral health professionals employed by schools (e.g., school psychologists and school social workers) and by community-based professionals who provide services on or off campus.[122] Services can also be provided in person or through telehealth, and the evidence for the efficacy of telehealth is sound.[123,124,125] These community partnerships with local behavioral health professionals are critical for ensuring more intensive needs are met.

School-Based Health Centers (SBHC)

School-Based Health Centers (SBHCs) are medical clinics located on school grounds that provide healthcare services to students. Often operated by Federally Qualified Health Center (FQHC) partners, SBHCs can play an important role in expanding access to high-quality, comprehensive primary care, especially for underserved and at-risk populations.[126] Colorado has 72 SBHCs across 31 generally larger school districts offering universal screening, SUD services, and brief therapy services. While psychiatry services are uncommon, many providers can prescribe medications with support from CoPPCAP (discussed in Chapter 2).

Program Spotlight

Therapeutic Response and Urgent Stabilization Team (TRUST)

Caring for Denver, Denver Public Schools, and Denver Health- which runs 19 SBHCs in the Denver area, are piloting a crisis response resource known as TRUST.[127] TRUST operates a special team of three therapists and one full-time care coordinator who can provide brief interventions (6-12 sessions) to assess students and ensure they are stable. TRUST strives to connect students to a therapeutic appointment within 48 hours, and care coordinators ensure a warm hand-off between services should students and families need longer-term care. Coordinators also help families secure other resources as needed.

Local Community Partnerships

A wide variety of additional community partnerships can help support mental health services in schools. Partners may go to schools to deliver group and/or individual therapy, and schools may also have referral-based relationships for treatment in the community. Schools commonly have some level of relationship with one of Colorado's 18 CMHC systems for support in addressing student and staff mental health needs, though this varies greatly across the state. Non-profit mental health programs also deliver mental health services in schools statewide. In addition, the CHCO Pediatric Mental Health Institute and the CU Department of Psychiatry offer Tier 3 programming to many districts. Services range from routine to more intensive, but stakeholders

report that services more intensive than routine counseling are generally lacking, especially in rural and mountain communities that face broader workforce and access issues.

Virtual and Other Care Partnerships

Many Colorado schools partner with or provide referrals to private and publicly funded virtual care providers to meet student and staff mental health needs. Notable examples include the following:

- **I Matter** is available directly to students and is not a school-based service. Schools can refer students and caregivers to the I Matter program for up to six free sessions of in-person or virtual therapy sessions.
- **Hazel Health** provides tele-mental health services to K-12 students and is directly funded by the district. Families incur no out-of-pocket costs for services, regardless of insurance status, and Hazel coordinates closely with school and district personnel. Hazel Health currently serves many Colorado students within the biggest districts in the Denver Metro region.
- **Second Wind** serves children and youth (ages 19 and younger) at risk for suicide with licensed community therapists and teletherapy, providing up to 12 free counseling sessions (eight additional by request from mental health staff).
- **Care Solace** supports school districts in connecting students to care and providing care coordination in Denver Public Schools, the largest school district in Colorado.

School District Challenges in Supporting Mental Health

All school districts are challenged to some degree by limited funding, workforce shortages, teacher burnout, and increased mental health needs for both students and their families that intensified post-COVID. Some school districts address financial gaps via mechanisms such as voter-approved mill levy overrides (MLOs) and various federal, state, and philanthropic grant opportunities. However, less-resourced school districts—especially in low-income and rural areas—have fewer resources needed to secure such funding. (See Appendix W for details on various funding mechanisms.) Teachers are also challenged with many stresses, including the need to address student learning loss post-pandemic,[128] burnout, and their own mental health concerns as well as behavioral and mental health concerns of their students. These issues create challenges with retention and hiring, adding substantial financial and administrative costs for school districts and further challenging their capacity[129,130]

Program Spotlight

Compassion and Dignity for Educators Program

This program from the Crown Institute at CU Boulder provides an online certificate and resources to support educators' well-being. It integrates evidence-based compassion training in educational and organizational contexts,[131,132] and clinical research demonstrates that the program has effectively reduced teacher burnout and improved teacher retention. The curriculum equips educators with self-care strategies and compassionate leadership, benefiting both educators and their school communities.[133,134] See Appendix X.

Rural and Mountain School Districts Challenges

Approximately 83% of Colorado's 178 school districts are in rural and mountain communities, serving one in six students.[135] While mental health issues are prevalent in rural areas, these communities often lack the resources to support youth, with only one mental health provider for every 1,282 residents, compared to one for every 755 in urban areas.[136] These communities tend to face broader workforce challenges, ranging from the very high costs of living in mountain communities to transportation to limited health and community options for care. While these schools can provide solid supports through their staff, most are dependent on CMHCs and community non-profits to supplement these efforts, often staffed by providers that themselves face the same workforce and resource challenges. While many have embraced teletherapy as a supplemental strategy, stakeholders uniformly noted a strong preference for in-person care provided by people living in and culturally representative of their communities, which has limited uptake of telehealth options.[137] Despite these challenges and uniform challenges in providing services more intensive than routine counseling, stakeholders reported that most rural districts have strongly embraced the importance of providing mental health supports.

Program Spotlight

CHCO's Rural Schools Consultation Team

CHCO's Rural Schools Consultation team provides via telehealth multidisciplinary diagnostic and behavioral evaluations to Durango School District 9-R students (ages 6-18) struggling within the school setting. The team-based approach focuses on understanding the drivers of behavioral difficulties and working with students, caregivers, and schools to implement specific recommendations to maximize students' classroom success. CHCO also provides education and training to teachers, mental health providers, and special education staff focused on students at-risk of reaching the highest levels of need.

Recommendations for School Mental Health

Rec. 1	**Colorado philanthropy should lead development of a long-term strategy for resourcing and scaling school mental health access programs across a continuum throughout the state, building upon existing successful programs.**

Why take this on? Schools across Colorado are all working to meet the needs of their students and, in some cases, their families, working closely with a wide array of school partners, such as SBHCs, CMHCs, non-profit service delivery partners, and private in-person and telehealth vendors. While the quality and availability of these services vary widely, and access to care more intensive than routine counseling is in short supply statewide (and particularly lacking in Colorado's 148 rural and mountain districts), the myriad of state-level and locally-driven efforts to address these needs—which have accelerated post-pandemic—are lacking the overarching strategy necessary to both address systemic barriers and accelerate progress.

How can Colorado move this forward? Philanthropy is uniquely positioned to engage local communities and key leaders to develop a statewide strategy to fill key gaps and build local capacity over the longer term. Given the compounding financing, workforce, and other systemic issues involved, the effort will also require partnerships with organizations able to support overall and local planning, capacity building, policy and financing supports, and technical assistance for care options prioritized for development. The effort should also address the full MTSS array, from Tier 1 supports to build resiliency and promote well-being for all students, to the most intensive Tier 3 supports for youth and families in crisis that go beyond short-term stabilization to provide effective pathways to recovery and thriving. All the organizations highlighted in this report have a potential role to play, but it will be critical to balance the advantages of centralized, highly expert resources with the cultures, values, strengths, and gaps of each of Colorado's 183 diverse districts.

Rec. 2	**Expand access to programs, such as Colorado's Compassion and Dignity for Educators program, to decrease teacher burnout and increase retention, recognizing the diversity of needs and preferences across Colorado's 183 districts.**

Why take this on? The mental and physical well-being of teachers is intrinsically important, as well as in its impact on students. Colorado teachers are experiencing historically high levels of stress, with 66% reporting a significant decline in their mental health and 47% contemplating leaving the profession in the near future.[138,139] Burnout can lead to lower productivity, poor performance, low self-confidence, and increased irritability,[140] as well as a loss of connection with students and families, making it more difficult to support students in need.[141] Scaling programs such as the Compassion and Dignity for Educators program could substantially reduce teacher burnout and enhance retention across Colorado, as long as they were developed in partnership with local communities.

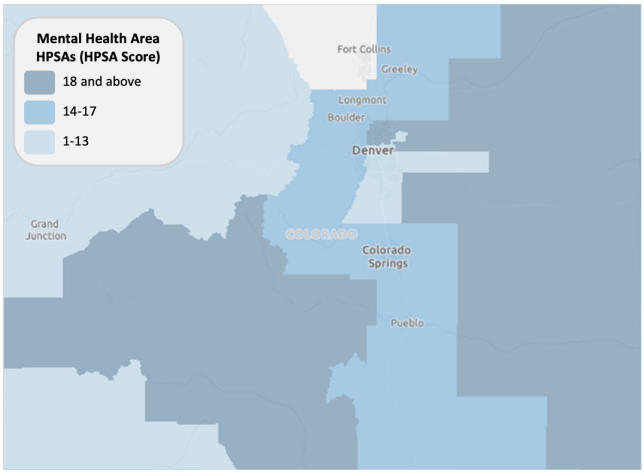
How can Colorado move this forward? Philanthropy could help scale components of the program through various pathways, including integrating the program into CU Boulder's teacher leadership master's program or refining the certificate program to be offered as mini courses through the broader university and community college systems to respond to the

broader array of school settings and professional needs across the state's 183 districts. Such programming could also be shared through Colorado's established learning collaborative networks. Such support could take the form of bolstering the program's sustainability, such as funding the necessary staff for expansion, refining digital resources, and creating ongoing educator communities. To go beyond the focus of programs such as Compassion and Dignity for Educators that are primarily preventative and focused on improving wellbeing and retention, the effort could also partner with efforts such as CU Anschutz's Colorado Educator Support Program, which provides direct clinical services for teachers.

Chapter 4: Behavioral Health Workforce and Innovation

Compared to the U.S. overall, Colorado fairs well in terms of its licensed behavioral health workforce, which includes psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, and licensed addiction counselors/specialists**.** Licensed professionals provide diagnostic and treatment services overseen by the Colorado Division of Professions and Occupations. Colorado has one mental health provider[H] for every 220 people, compared to one provider for every 340 individuals nationally.[142] Similarly, Colorado ranks ninth out of the 50 states for its ratio of mental health providers per 100,000 population.[143,I] For the ratio by mental health provider type, see Appendix Y. Yet, like the rest of the nation, Colorado faces a shortage of mental health professionals for many populations (e.g., Medicaid beneficiaries and rural populations).[144,145,146]

Figure 7. Colorado Mental Health Professional Shortage Area Map



The Health Resources and Services Administration (HRSA) categorizes mental health shortage areas by zip code, using metrics such as the ratio of mental health providers to population, the percentage of people living in poverty, and travel times required to access mental health care. Higher numbers

[H] County Health Rankings and Roadmaps defines "mental health providers" as "psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care."
[I] America's Health Rankings includes the following in its definition of "metal health providers": psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care.

denote more severe shortages. As shown in Figure 7,[J] counties in the eastern and southern mountain areas of Colorado are the most severe, followed by Front Range areas outside of Denver and, finally, by the far northwest and southwest reaches of the state.[147]

Licensed professionals make up only a part of Colorado's behavioral health workforce. Non-licensed professionals, including peer and family support specialists, behavioral health care coordinators in primary care, case managers and qualified mental health professionals (QMHPs) in community mental health settings, psychiatric technicians in hospital settings, recovery coaches in substance use treatment settings, and others, play a critical role in augmenting, extending, and providing additional supports to that core of licensed professionals. Across all licensed and non-licensed behavioral health workers, the Colorado Department of Labor and Employment (CDLE) reported a 152% increase in the number of behavioral health job openings between 2019 and 2022 – the most significant increase of any industry in the state – with projected growth in behavioral health jobs of 30% or higher by 2030.[148]

Innovating to Address Workforce Challenges

Addressing Colorado's labor challenges requires solutions designed to optimize, sustain, and extend the state's existing mental health workforce. (Appendix AA details the Meadows Institute's framework for addressing mental health workforce challenges.)

Extending the Workforce with Non-licensed Professionals

Colorado is currently undertaking a multi-year, $50 million effort to address its behavioral health workforce challenges.[149] In 2022, the Colorado General Assembly passed SB 22-181, which empowers the Colorado Community College System (CCCS), in collaboration with the Colorado Behavioral Health Administration and the Department of Higher Education, to play a crucial role in addressing workforce shortages. Specifically, it allowed CCCS to develop a behavioral health education pathways initiative, which incorporates a variety of workforce efforts, such as employee retention programs based on salary increases and other incentives. Of particular importance, the initiative emphasizes growing Colorado's non-licensed provider workforce. It targets non-licensed professionals (e.g., bachelor's and associate-level staff) and peer counselors who play an important role in expanding the workforce and allowing licensed clinicians to operate at the top of their license. Key initiatives include:

- **Development of new educational pathways.** The new pathways for behavioral health center on five new "micro-credential" behavioral health pathways that are short term and stackable, allowing students to enter the workforce immediately while furthering academic pursuits.[150,151]

[J] The Mental Health Area HPSA Score was developed by the National Health Service Corps (NHSC) in determining priorities for assignment of clinicians. The scores range from 0 to 26: The higher the score, the greater the priority.

- **Creation of the Qualified Behavioral Health Assistant (QBHA) credential.** Among the multiple micro-credentials created, the QBHA is a paraprofessional role that works under clinical supervision to carry out a wide array of activities reimbursable by Medicaid (and potentially other payers over time).
- **Expanding and strengthening peer professionals.** While still in development, BHA is working toward peer support certification and standardization and providing grants to increase the number and quality of peer support specialists.[152]

Additionally, Colorado has several loan repayment programs that target licensed behavioral health professionals in HPSAs and rural areas. Examples include the Colorado Health Service Corps Provider Loan Repayment Program[153] and the Colorado Rural Essential Access Provider Loan Repayment Program.[154] The National Health Service Corps offers loan repayment for healthcare professionals working in designated HPSAs for at least two years.[155]

Digital Mental Health Technologies (DMHT)

DMHT can offset mental health workforce challenges by:

- Increasing access to care via telehealth care delivery,
- More effectively and efficiently matching patient needs and providers' expertise,
- Supporting early identification through screening,
- Improving care by enabling outcomes monitoring during and between visits, and
- Increasing engagement with evidence-based practices between episodes of care.

While more research and validation are needed for many digital solutions, technologies that have the most near-term opportunities to bolster the workforce are those:

- Used in conjunction with clinician care to ensure their safety and efficacy.
- Digital translations of established practices.[156]

For an in-depth discussion of DMHT's advantages, see Appendix BB. A sampling of DMHT companies serving Colorado's youth is listed in Appendix CC.

Spotlight	**Digital Mental Health Technology (DMHT) and Youth Preferences**
	Many young people prefer digital-based tools, telehealth services, and youth-centered integrated mental health centers over traditional care.[157] A recent survey of 14- to 22-year-olds found that most young people (54%) have used technology to support their well-being, and many prefer to use technology and/or web-based mental health services over services delivered in person.[158] The rates are even higher among Latino (64%) and Black (58%) young people, mainly due to apps' relative affordability, accessibility, and challenges in finding a therapist with a racial/ethnic background that matches that of the young person seeking support. These findings are not surprising given that 88% of 13- to 18-year-olds have their own smartphone,[159] and 94% of teens have *access* to a smartphone in the home.

While telehealth and other DMHT is often desired by youth, many youth and families prefer in-person care. Additionally, DMHT cannot address the need for on-the-ground staff in clinics, mobile treatment teams, and hospitals. To address both youth preferences and provider concerns, DMHT is best seen as (1) a choice that many youth and families prefer, either overall or in specific situations (e.g., transportation barriers) and (2) an option when there are no available in person providers, even when in person may be preferred (as long as it is adequate). It is also important to note that many providers may need education to understand how to work with youth and DMHT (e.g., finding private spaces in a small home).

Investing in Telehealth and DMHT

Many investors and entrepreneurial stakeholders we interviewed see Colorado as an attractive market, as the state invests in and prioritizes youth mental health, especially with the establishment of initiatives like the BHA and I Matter. Colorado has attracted several youth-serving companies, such as Hazel, Equip and Little Otter, and is home to others like SonderMind, demonstrating Colorado's innovative ecosystem. Colorado's Office of eHealth Innovation provides governance for the state's Health IT strategy, with the goal of advancing health equity and reducing health disparities through coordinated health information technology, policies, and funding.[160] Of particular interest, its Telehealth and Digital Inclusion initiative convenes a myriad of organizations to better understand and address barriers to telehealth access, such as understanding ways to increase adoption among non-users in rural regions and conducting an analysis of payment parity between telehealth and non-telehealth visits.[161]

Colorado has also facilitated telehealth company entry and expansion within the Colorado marketplace by participating in all major professional licensure compacts for clinical mental health professions: Interstate Medical Licensure Compact for physicians including psychiatrists (40 participating states as well as Washington, D.C., and Guam); the Psychology Interjurisdictional Compact for psychologists (42 member states); [162] the Counseling Compact for professional counselors (37 member states)[163]; and the Social Work Licensure Compact[164] (22 member states). See Appendix Z for additional details.

Recommendations for Colorado's Behavioral Health Workforce

With increasing demand for mental health services, it is critical that Colorado explore new approaches that expand and strengthen the workforce. This section offers strategies for how the state can mitigate workforce challenges and build on existing efforts.

Rec. 1	**To maximize the impact of the state's behavioral health workforce initiatives, the BHA should increase awareness among eligible behavioral health clinicians on loan repayment opportunities available in Colorado, expand the micro-credentialing program to more college systems, and include micro-credentialing pathways focused on priority youth-serving models, including integrated healthcare.**

Why take this on? Colorado has taken important steps to expand the workforce (e.g., SB 22-181 and micro-credentialing). Even so, many providers are not aware of loan repayment options and colleges outside of the community college system have not been included in the micro-credentialing program. By expanding the behavioral health pathway initiative with additional colleges and higher education systems (e.g., Colorado Mountain College, Technical College of the Rockies, etc.), this important program can reach more areas of Colorado. While the approach should include all priority youth-serving models, we recommend that integrated care models have a particular focus given their ability to maximize the impact of physician time eight times over[165] and support early identification and intervention (as described in Chapter 2). Creating a statewide pipeline of non-licensed behavioral health care managers (BHCMs), a cornerstone of the integrated care model CoCM, could help support the integration efforts, particularly in rural and mountain communities.

How can Colorado move this forward? As the behavioral health pathway initiative evolves, BHA and its educational partners can focus on specific micro-credentials strategically able to further key reforms, such as integrating behavioral health into primary care settings. To advance this, the state could create a BHCM micro-credential to support CoCM as described in Chapter 2.

Philanthropy can play a crucial role in advancing new behavioral health education pathways by partnering with institutions of higher education to develop new or enhanced credentialing programs. Philanthropy can support the development of specialized curricula tailored to support paraprofessional roles essential in behavioral health integration. Philanthropy can provide funding to establish micro-credentialing programs at new campuses and college systems.

Rec. 2	**To address rural mental health workforce needs in schools, the Colorado Department of Higher Education (CDHE) should support "grow your own" behavioral health professional programs targeting residents of rural communities. CDHE should also provide scholarships and/or loan forgiveness programs.**

Why take this on? Rural communities face school mental health professional shortages, and nearby community mental health partners are often overstretched. The Colorado Rural Health Equity (CRHE) initiative investigated various strategies for retaining school mental health professionals in rural areas, including resort communities where year-round populations are

stretched, and costs of living are high. While stakeholders noted that higher salaries and loan forgiveness programs are important, they also highlighted the need for "grow your own" programs focused on residents already established and committed to living in these communities. These initiatives enable rural residents to pursue paraprofessional degrees or complete licensure programs while staying in their communities, fostering a more stable, committed workforce.

How can Colorado move this forward? Establishing partnerships between the CDHE and local educational institutions can facilitate the creation of accessible behavioral health degree programs that blend online coursework with local internships. One example is the University of Denver's Morgridge College of Education,[166] which offers a Rural Hybrid School Psychology program designed for rural settings. This program combines online learning with in-person components, making it more accessible to people in remote areas. Furthermore, targeted scholarship initiatives (e.g., the Colorado Health Service Corps Provider Loan Repayment Program)[167] offer loan repayment assistance to graduates serving areas of high need. Free or reduced tuition should also be available for school employees pursuing graduate degrees in mental health, potentially through community partnerships or state-legislated efforts.

Philanthropy can play a crucial role in expanding these initiatives by investing in scholarships, program development, and community engagement efforts. Philanthropic organizations can help establish mentorship programs that connect students with experienced professionals in the field, offering guidance and fostering a commitment to rural mental health.

Rec. 3	**To sustain telehealth flexibilities established during the COVID-19 pandemic that increased access to care but currently remain in flux, national advocates across public and private sectors should support federal advocacy efforts to make these flexibilities permanent.**

Why take this on? During the COVID-19 PHE the federal government introduced regulation flexibilities that enabled telehealth to be a significant strategy in addressing the national mental health crisis.[168,169] Telemedicine has proven effective in bridging the gap between patients and providers for those who desire it, reducing barriers to care, and supporting those most in need. At its pandemic peak, telehealth represented 40% of mental health and substance use outpatient visits and remains strong, representing 36% of outpatient visits currently.[170] As noted in CMS' 2022 informational bulletin on youth behavioral health, telehealth played a crucial role in providing youth access to behavioral health services during the pandemic, particularly for youth living in rural areas.[171]

There are concerns that telehealth's successful growth may fall victim to federal inertia. While many telehealth flexibilities have been made permanent, broader telehealth flexibilities are set

to expire at the end of March 2025 unless extended or made permanent by Congress. Additionally, the Drug Enforcement Administration (DEA) released the proposed Special Registrations for Telemedicine and Limited State Telemedicine Registrations, which would dramatically limit virtual prescribing and add additional regulatory requirements that behavioral health organizations have warned would be overly burdensome. Uncertainty regarding the end of telehealth flexibilities, increased regulatory burdens, and the potential for in-person treatment requirements threaten the viability of telehealth companies working at all behavioral healthcare system levels. Providing a permanent solution to allow telehealth flexibility is imperative to companies' survival and ability to extend care to millions of people.[172]

How can Colorado move this forward?

Philanthropy can invest in national advocacy organizations focused on advancing access to behavioral healthcare for all Americans, supporting telehealth prioritization, and maintaining the flexibilities first established during the COVID-19 pandemic. Additionally, policy efforts should engage public and private health plans to help them fully include telehealth providers in their network adequacy standards to reach more Coloradoans and address parity concerns.

Rec. 4	**National advocates should work with federal and state legislative and regulatory agencies to reduce antiquated regulatory barriers and advance clearer pathways for DMHT reimbursement inclusive of but not limited to telehealth.**

Why take this on? DMHT companies face challenges in achieving financial sustainability. For non-telehealth-based DMHTs, the central problem is the lack of reimbursement mechanisms, as many fall outside of the scope of what is directly reimbursable.[173]

- Many tele-mental health companies blend provider-facing care with digital mental health technologies. These companies may use DMHT as a digital supplement to therapy, such as providing asynchronous psychoeducation to a patient or interactive practice planning after each therapy session. While this may help optimize therapists' time and support quality treatment, these activities are not reimbursable.
- Non-telehealth DMHTs (e.g., coaching via chat) do not fit into existing health insurance reimbursement codes and often lack the necessary evidence base to meet the CMS threshold for reimbursement. While CMS is developing mechanisms to reimburse proven digital mental health products, implementation of these efforts will take years and will likely apply to a relatively few FDA-approved digital mental health applications.

How can Colorado move this forward?

To advance DMHT reimbursement, philanthropy and investor organizations should support state and national-level advocacy efforts calling for new reimbursement mechanisms for evidenced-based DMHT. Philanthropy and investors should also support the development of a multistakeholder group charged with developing evidence standards that are both flexible and

protect patients. This balance of safety and flexibility will ensure that vendors and investors have the predictability needed to make continued investments in DMHT.[174] An essential step in delineating clear evidence standards will be to better define and categorize various types of DMHT.[175,176]

Chapter 5: Systemic Cross-Cutting Recommendations

Colorado has multiple entities currently involved in promoting policy change related to child and youth mental health. These organizations have employed a variety of strategies to promote mental health policy improvements, ranging from ballot initiatives to class action lawsuits, to enact their organizational priorities. And while all of these organizations have overall helped to advance incremental reforms and improvements over the last two decades, the structural issues at the heart of the youth mental health crisis that grew over the last decade remain unchanged: the lack of proactive detection and timely access to care that drives the current 10 year average wait for help which has led to a crisis-driven system with perennial workforce challenges.

The Meadows Institute has identified two essential elements for sustained, systemic policy change that have been central to successes that have led to more focused systemic changes at the federal level and in states.

- The first is the ability to **integrate in-depth programmatic research with targeted, responsive legislative advocacy**. The majority of the groups currently doing legislative advocacy in Colorado are reliant on third parties to inform the programmatic elements of their advocacy strategies. Accordingly, their success depends on (1) the **quality of the programmatic inputs they use** (e.g., national research versus Colorado-specific data, deep implementation experience regarding programs or higher-level reviews) and (2) the **strength of their relationship with the source** (e.g., are they just incorporating research from third parties or do they have a close working relationship with the source of their programmatic inputs).
- The second is the superior efficacy of **high-level grasstops advocacy**. Figure 8 shows the classic distinction between grassroots advocacy (which is most mental health advocacy groups operate in Colorado and nationally) and grasstops advocacy. The key difference between the two is that grasstops advocacy is based on long-term relationships and education rather than public pressure. The Massachusetts Association for Mental Health (in Massachusetts) offers an example of successfully advancing policies over time within a state.

Figure 8. Grassroots and Grasstops Advocacy

Systemic Cross-Cutting Recommendations

Rec. 1	**To realize the full potential of these recommendations, a statewide multi-year, multi-sector policy and practice improvement effort focused on children and youth should be funded and modeled on successful initiatives in other states.**

Why take this on? Only an organization with the capacity to leverage long-term relationships with senior leaders in the executive and legislative branches has been shown historically in Colorado to produce rapid, transformative change. Furthermore, without a nonpartisan, independent, sustained policy-level initiative, reforms in any state tend to be incremental, and, absent a focus on partnering relationships with top leaders, systemic change is not possible. Additionally, given the complex policy landscape of any state, only a dedicated, multi-year, research-based initiative will have the ability to successfully navigate issues such as Colorado's TABOR law, challenges posed by recent lawsuits, the unfolding redesign of state agencies, and current budget and Medicaid funding challenges.

Based on our review, no single Colorado entity has the capacity and ability on its own to carry out the necessary policy research and sustained, data-driven advocacy necessary to advance a multi-year children and youth mental health policy and practice improvement effort. But while no single organization has the capacity to take this on, a partnership between current entities with long-term trusting relationships with key leaders and a proven track record of enacting sustained, multi-year reforms could ground an independent, nonpartisan effort.

How can Colorado move this forward? The recommendations in this assessment could inform either more focused philanthropic efforts with a policy focus or a broader scale initiative. To advance the policy components of all recommendations in this report and maximize both their

transformative power and their ability to leverage public funding, we recommend that a few lead funders catalyze a broader philanthropic effort to enact a practice-driven child and youth mental health policy improvement initiative in Colorado. Given current momentum, we recommend that the initiative be designed and launched in 2025, targeting initial legislative wins in the 2026 and 2027 legislative sessions.

Rec. 2	**To ensure sustainable public funding for these recommendations, a targeted financial and feasibility assessment should be carried out to develop actionable public financings strategies based on lessons learned from other successful efforts to leverage public funding given TABOR requirements.**

Why take this on? Colorado is uniquely positioned to leverage public-private partnerships in support of transforming youth mental health, but TABOR limitations make it unlikely that the state will be able to rely primarily on general funds to address the numerous behavioral healthcare needs that children and youth face across the state absent a set of targeted financing strategies informed by other successful policy initiatives in Colorado. Appendix J provides more background on such strategies, which include:

- **Bringing a new tax to voters via ballot.** While there are several past examples of successes and some viable strategies for moving forward, this would be challenging as the process is designed to be rigorous to limit the establishment of new taxes absent widespread public consensus. While the immediate budget environment argues against pursuing a ballot initiative in the short-term, mental health enjoys broad bipartisan public interest and has been successfully leveraged to enact new taxes recently.
- **Pursuing new revenue through a fee or special purpose authority.** Unlike a new tax, this avenue may not require the same level of direct voter approval. Options include (a) adding fees, provided that they directly benefit those that pay for it, and (b) adding fees on internet transactions. Given the strong level of public support for mental health initiatives, these are potentially feasible approaches as the state's economic environment rebounds.
- **Repurposing existing revenues.** Colorado policymakers have the authority to repeal existing sources of revenue and direct those resources to specific uses. While the amount of funding is typically less robust and predictable than a fee or dedicated tax, a much wider array of revenues can be repurposed, even those revenues unconnected to the service being provided.
- **Leveraging public-private partnerships or other cost sharing mechanisms.** The establishment of Colorado's Elevate Quantum tech hub in 2023 is a prime example of how public-private collaboration can both overcome the funding restrictions inherent in TABOR and leverage the expertise and investment of private investors.

Despite the challenges of TABOR limitations, Colorado has a strong track record bringing together respected organizations to build new programs in partnership with the Colorado General Assembly. See Appendix J for examples.

How can Colorado move this forward? This assessment identifies multiple opportunities to improve care for Colorado children and youth, but philanthropy alone can neither scale nor sustain these efforts. Accordingly, targeted, in-depth financial and feasibility analysis and planning will be essential to both the expansion of needed services and their maintenance over time. Colorado philanthropists are well positioned to move this forward by collaborating with an array of partners.

Appendices

Appendix A: Summary of Domain-Specific and Systemic Recommendations

Table A1 below lists the recommendations that are discussed in detail throughout Chapters Two through Four. They are summarized here for convenience.

Table A-1. Summarized Domain-Specific Recommendations

Summarized Domain Specific Recommendations	
Recommendations for Mild to Moderate Mental Health Needs	
1	To increase mental health treatment for mild to moderate conditions, Colorado's Medicaid program should cover and reimburse primary care providers for CoCM.
2	To increase mental health treatment for mild to moderate conditions, philanthropy should invest in technical assistance and implementation support to defray CoCM "start-up" costs in pediatric practices, catalyzing uptake across the state.
3	To support pediatric practices as CoCM capacity ramps up, the Colorado General Assembly should establish permanent funding for CoPPCAP.
4	To improve I Matter's program quality and outcomes, increase the use of evidence-informed practices by funding measurement-informed care initiatives, improving clinical training, and addressing gaps in diagnostic assessments and data collection.
Recommendations for Complex and Intensive Mental Health Needs	
1	Navigation programs, such as CHCO's Care Transitions Team, should be invested in as a best practice model that can be replicated in other health systems across the state**.**
2	The BHA, with funding prioritized by the Colorado General Assembly, should expand access to Multisystemic Therapy (MST) to serve children and youth outside of the justice system, including those most at risk of violence.
3	The BHA, with funding prioritized by the Colorado General Assembly, should include Coordinated Specialty Care (CSC) as part of the Intensive Behavioral Health Services framework to better serve all youth with First Episode Psychosis.
Recommendations for Crisis Care Needs	
1	CHCO should accelerate its timeline for creating two crisis stabilization units, providing Colorado with a more appropriate, evidence-based setting for youth experiencing a mental health crisis.
2	The BHA should partner with local health systems to build regional behavioral health campuses with crisis stabilization services that connect to specialty resources in urban areas.
3	The BHA should create and deploy Youth Crisis Outreach Teams (YCOT) across Colorado, in partnership with best practice partners such as CHCO, Aspen Hope Center, and Your Hope Center.
Recommendations for Maternal Mental Health Needs	
1	To identify and address the mental health needs of Colorado mothers before, during, and after pregnancy, CU School of Medicine should identify sustainable funding to continue and expand programs such as PROSPER.

Summarized Domain Specific Recommendations	
2	Colorado decision-makers should develop a CoCM implementation initiative focused on obstetric practices.
3	To increase access to maternal mental health services for women with high-risk pregnancies and parents of medically complex infants hospitalized in NICUs across Colorado, CU School of Medicine should expand access to the programs that address parental mental health, such as the CoWBHW Connections Program.
Recommendations for Grief and Trauma	
1	Improve provider capacity in trauma and grief best practice care delivery statewide.
Recommendations for School Mental Health	
1	Colorado philanthropy should lead development of a long-term strategy for resourcing and scaling school mental health access programs across a continuum throughout the state, building upon existing successful programs.
2	Expand access to programs, such as Colorado's Compassion and Dignity for Educators program, to decrease teacher burnout and increase retention, recognizing the diversity of need and preferences across Colorado's 183 districts.
Recommendations for Workforce and Innovation	
1	To maximize the impact of the state's behavioral health workforce initiatives, the BHA should increase awareness among eligible behavioral health clinicians on loan repayment opportunities available in Colorado, expand the micro-credentialing program to more college systems and include micro-credentialing pathways focused on priority youth-serving models, including integrated healthcare.
2	To address rural mental health workforce needs in schools, the Colorado Department of Higher Education (CDHE) should support "grow your own" behavioral health professional programs targeting residents of rural communities. CDHE should also provide scholarships and/or loan forgiveness programs.
3	To sustain telehealth flexibilities established during the COVID-19 pandemic that increased access to care but currently remain in flux, national advocates across public and private sectors should support federal advocacy efforts to make these flexibilities permanent.
4	National advocates should work with federal and state legislative and regulatory agencies to reduce antiquated regulatory barriers and advance clearer pathways for DMHT reimbursement inclusive of but not limited to telehealth.

Table A-2. Summarized Systemic Recommendations

Summarized Systemic Recommendations	
1	To realize the full potential of these recommendations, a statewide multi-year, multi-sector policy and practice improvement effort focused on children and youth should be funded and modeled on successful initiatives in other states.
2	To ensure sustainable public funding for these recommendations, a targeted financial and feasibility assessment should be carried out to develop actionable public financings strategies based on lessons learned from other successful efforts to leverage public funding given TABOR requirements.

Appendix B: Acronym List

Acronym	Acronym List
Abbreviation	**Phrase**
ADHD	Attention Deficit Hyperactivity Disorder
ARPA	American Rescue Plan Act
ASO	Administrative Service Organization
BHA	Colorado Behavioral Health Administration
BHASO	Behavioral Health Administrative Services Organizations
BHCM	Behavioral Health Care Manager
BHI	Behavioral Health Integration
CBT	Cognitive Behavioral Therapy
CCBHCs	Certified Community Behavioral Health Clinics
CCCS	Colorado Community College System
CDE	Colorado Department of Education
CDHS	Colorado Department of Human Services
CDLE	Colorado Department of Labor and Employment
CDPHE	Colorado Department of Public Health & Environment
CHCO	Children's Hospital Colorado
CHF	Colorado Health Foundation
CMC	Colorado Mountain College
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CoCM	Collaborative Care Model
CoPPCAP	Colorado Pediatric Psychiatry Consultation and Access Program
CoWBHW	Colorado Center for Women's Behavioral Health and Wellness
CPAP	Child Psychiatry Access Program
CRHE	Colorado Rural Health Equity
CSC	Coordinated Specialty Care
CSU	Crisis Stabilization Unit
CU	University of Colorado
DBT	Dialectical Behavior Therapy
DEA	Drug Enforcement Administration
DMHT	Digital Mental Health Technology
DOL	Department of Labor

Acronym	Acronym List
EBP	Evidence-Based Practice
ESSER	Elementary and Secondary School Emergency Relief
FEP	First Episode Psychosis
FFPSA	Family First Prevention Services Act
FHPC	Farley Health Policy Center
FQHC	Federally Qualified Health Center
GAD-7	Generalized Anxiety Disorder-7
HB	House Bill
HCPF	Department of Health Care Policy and Financing
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IBH	Integrated Behavioral Health
IBHS	Intensive Behavioral Health Services
IEP	Individualized Education Plan
IFSP	Individual Family Service Plan
IOP	Intensive Outpatient Program
MCPAP	Massachusetts Child Psychiatry Access Project
MHA	Mental Health America
MIC	Measurement Informed Care
MLO	Mill Levy Override
MSO	Managed Service Organization
MST	Multisystemic Therapy
MTSS	Multi-Tiered System of Supports
NHSC	National Health Service Corps
NICU	Neonatal Intensive Care Unit
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
PCN	Pediatric Care Network
PCP	Primary Care Provider
PHE	Public Health Emergency
PHMI	Pediatric Mental Health Institute
PHP	Partial Hospitalization Program

Acronym	Acronym List
PHQ-A	Patient Health Questionnaire-9 Modified for Adolescents
PPS	Prospective Payment System
Project AWARE	Project Advancing Wellness and Resiliency in Education
PROSPER	Perinatal Resource Supporting Obstetric Screening, Psychiatric Education, Equity, and Referral
PSYPACT	Psychology Interjurisdictional Compact
RAE	Regional Accountable Entity
RAISE	Recovery After an Initial Schizophrenia Episode
REAP	Colorado Rural Essential Access Provider Loan Repayment Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SBHC	School-Based Health Center
SHS	School Health Services
STEP	Substance Abuse Treatment, Education and Prevention
SUD	Substance use disorder: SUD
SWLC	Social Work Licensure Compact
TABOR	Taxpayer Bill of Rights
TRUST	Therapeutic Response and Urgent Stabilization Team
USDE	U.S. Department of Education
YCOT	Youth Crisis Outreach Teams
Youth ACT	Youth Assertive Community Treatment

Appendix C: Glossary

Acceptance and Commitment Therapy (ACT): Considered a "third wave" cognitive behavioral therapy (CBT) protocol. This approach differs from traditional CBT in that the aim is not better control of thoughts, feelings, sensations, and/or memories, but rather mindfulness to and acceptance of these private experiences. ACT demonstrates greater changes in psychological flexibility, mindfulness, and valued living as compared to CBT. ACT has been studied in youth with social anxiety, obsessive-compulsive spectrum disorders, and depression. There are a variety of protocols for ACT depending on the setting or target population.

Assertive Community Treatment (ACT): An evidence-based, multidisciplinary team approach designed to provide treatment, rehabilitation, and support services to people who are diagnosed with severe mental illness and most at risk for homelessness, psychiatric crisis and hospitalization, and involvement in the criminal justice system. The ACT team, comprised of members from the fields of psychiatry, nursing, psychology, social work, substance use, and vocational rehabilitation, provides direct services that are tailored to meet an individual's specific needs. Team members collaborate to deliver integrated services, assist in making progress toward goals, and adjust services over time to meet recipients' changing needs and goals.

Behavioral Health Administration Service Organizations (BHASOs): BHASOs split Colorado into four regions that are aligned with Colorado's Medicaid program regions. BHASOs are intended to "establish, administer, and maintain" regional networks of behavioral health care providers.

Behavioral Health Care: Assessment and treatment of mental health conditions and substance use disorders.

Behavioral Health: A term used to be inclusive of both mental health and substance use disorders, programs, and systems.

Bereavement: Bereavement, the experience or deprivation of loss by death, is a particularly potent form of trauma, especially for youth of color due to their higher rates of exposure to deaths from COVID-19 and community violence.

Case Management: A coordinated approach to ensure that individuals receive comprehensive care and services. Case managers work with clients to develop and implement care plans, connect them with necessary resources, monitor progress, and adjust plans as needed to achieve optimal outcomes.

Certified Community Behavioral Health Clinic (CCBHC): A specially designated clinic that provides a comprehensive range of mental health and substance use services. CCBHCs are designed to ensure access to coordinated, comprehensive behavioral health care to anyone in the community regardless of ability to pay, place of residence, age, etc. In addition to state requirements, CCBHCs must meet certain uniform national standards set forth by the federal government.

Cognitive Behavioral Therapy (CBT): CBT has demonstrated significant and enduring treatment outcomes, and effects lasting for a minimum of one year after treatment. Furthermore, researched CBT interventions showed the greatest amount of diversity among study participants, treatment format, treatment setting, and therapist background. CBT is most frequently provided in individual or group therapy, parent training, or teacher consultation. These protocols involve a cognitive component — sessions dedicated to psychoeducation, recognizing the physical signs of anxiety, direct work on cognitive distortions, and instructions on coping skills. These protocols also involve a behavioral component, which is referred to as exposure and response prevention.

Collaborative Care Model (CoCM): An established evidence-based, financially sustainable, team approach to integrated care that routinely measures both clinical outcomes and patient goals over time to increase the effectiveness and scale of mental health and substance use disorder treatment in primary care settings. Under the model, a primary care provider, a psychiatric consultant, and a behavioral health care manager work together to promptly detect and provide early intervention for common behavioral health problems, measure patient progress toward treatment targets, coordinate needed referrals to specialists, and adjust care when appropriate.

Community Mental Health Centers (CMHCs): CMHCs are designated behavioral health facilities mandated to provide inpatient, outpatient, partial hospitalization, emergency, and consultative and educational services to children, older adults, and patients with serious mental illnesses through a variety of programs tailored to specific community needs.

Coordinated Specialty Care (CSC): The most effective treatment for first-episode psychosis, CSC is a multi-disciplinary treatment team approach that provides more robust support to patients than typical office visits and medication management. The intervention involves an average of two years of intensive outpatient treatment that includes effective medication, education, and skill-building for the patient and their family and encourages them to maintain school enrollment and continue (or regain) a healthy developmental track.

Dialectical Behavior Therapy (DBT): DBT is an evidence-based form of cognitive behavioral therapy for people who experience significant trouble managing their emotions, thoughts, and behaviors

Family Education and Support Services: Assistance and resources provided to families of individuals with mental health conditions. These can include educational programs, support groups, counseling, and other resources to help families cope and support their loved ones effectively.

First Episode Psychosis: The first time an individual experiences psychotic symptoms or a psychotic episode.

Integrated Care: The systematic coordination of physical and behavioral health care whereby behavioral health specialty and general medical care providers work together to address both the physical and behavioral health needs of their patients.

Intensive Outpatient Program (IOP): IOPs are an important part of the continuum of care and can serve as alternatives to inpatient hospitalization for children and youth with the most serious mental health needs. An IOP allows the child to remain in the community while attending treatment three to four days per week for several hours each day. This treatment modality utilizes group therapy and can have a specific focus on family support and therapy.

Managed Care Organization (MCO): An organization that delivers and manages health services under a risk-based arrangement. The MCO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of service costs for the typical patient.

Measurement Informed Care (MIC): Systematically tracking symptoms, progress, and outcomes using standardized tools throughout treatment; ensures that treatment is continuously adjusted based on data-driven feedback, leading to better patient outcomes.

Mental Health: This term includes emotional, psychological and social well-being. Mental health is inclusive of thoughts, emotions, and behaviors.

Mental Illness: Discrete and treatable health conditions involving functional impairment related to thinking, emotion, or behavior. Examples of mental illnesses include anxiety, depression, post-traumatic stress disorder, schizophrenia, and other psychotic disorders.

Multi-Tiered System of Supports (MTSS): An approach based on a problem-solving model that documents students' performances after changes to classroom instruction have been made to show that additional interventions are needed.

Multisystemic Therapy (MST): A proven family- and community-based treatment for at-risk youth with intensive needs and their families. It is most effective for treating youth who have committed violent offenses, have serious mental health or substance use concerns, are at risk of out-of-home placement, and/or have experienced abuse and neglect.

Primary Care: Basic or general health care, traditionally provided by family practice, pediatric, and internal medicine providers.

Respite Care: Temporary relief for caregivers by providing short-term care for individuals with mental health conditions. This service allows caregivers to take a break while ensuring that their loved ones receive proper care and supervision in a safe environment.

Taxpayer Bill of Rights (TABOR): Adopted in 1992, TABOR restricts government spending by placing revenue retention limits on all levels of government (state, county, and municipal) using a set formula based on inflation and population. If revenues collected by state and local governments exceed the prior year's revenues by more than inflation plus population growth, the excess must be refunded, regardless of any separate financial or programmatic needs otherwise identified by policymakers.

Trauma: Trauma is the experience of a real or perceived threat to life or bodily integrity of oneself or a loved one, which also causes an overwhelming sense of terror, hopelessness, and/or fear.

Youth Crisis Outreach Teams (YCOT): YCOTs serve children and youth between the ages of 3-17 and feature robust relationships with community partners to meet urgent needs with an urgent response.

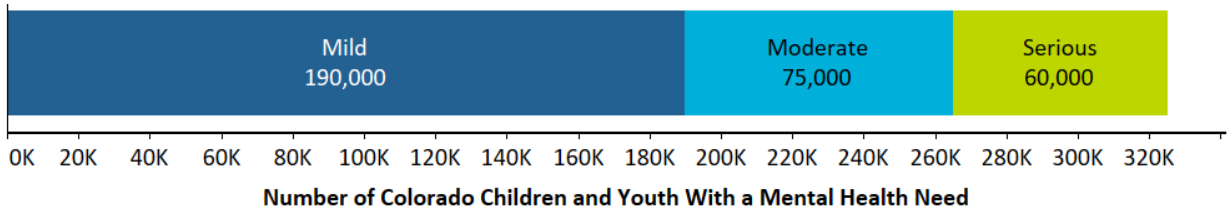
Appendix D: Data Book

The Behavioral Health Needs of Coloradan Children and Youth

The behavioral health capacity needed in a particular system depends on the number of people with mental health needs in that system, which is a function of the current and future size and demographic breakdown of the local population in that system. For example, the link between poverty and poor mental health outcomes is well established, with exposures to multiple stressors resulting in people with low incomes having an increased risk for mental illness.[177,178] Other demographic characteristics, such as age, gender, race, and ethnicity, are also known to be associated with mental health presentation, treatment, and outcomes. For example, most mental illnesses develop between the ages of 12 and 25.[179] Research also indicates that women have higher rates of anxiety and mood disorders than men, while men have higher rates of externalizing and SUD.[180] Further, disparities in access to mental health care exist across racial and ethnic identifications, with non-White individuals less likely to have access to or to seek mental health care.[181]

Colorado's children and youth behavioral health needs are vast: **Nearly 40% of Colorado school-aged children and youth (ages 6–17) have a mental health need,**[182,183,184,185] but most of these children and youth exhibit mild to moderate symptoms (80% or 265,000 children and youth) that can be successfully addressed through early intervention. See Figure D-1.

Figure D-1. Number of Children and Youth with Mental Health Needs in Colorado



Demographics of Children and Youth in Colorado

In Table D-1, we present 2022 population estimates for young children (under 6), children (6-11), youth (12-17), and young adults (18-25) living in Colorado by race and ethnicity. Over one-third of the estimated 1.85 million children, youth, and young adults living in Colorado were young adults (ages 18-25). Most of the population was non-Hispanic White (57%) or Hispanic/Latino (31%). Racial and ethnic distributions remained consistent across age groups.

Table D-1. Race & Ethnicity of Colorado Children, Youth, and Young Adults by Age (2022)[186,187]

Race/Ethnicity	Age Group				Total	% of Total
	Under 6	6 to 11	12 to 17	18 to 25		
African American	11,000	11,000	14,000	23,000	60,000	3%
Asian/Pacific Islander	15,000	18,000	18,000	27,000	80,000	4%

Race/Ethnicity	Age Group				Total	% of Total
	Under 6	6 to 11	12 to 17	18 to 25		
Hispanic/Latino	130,000	130,000	140,000	180,000	570,000	31%
Multiple Races	27,000	27,000	27,000	28,000	110,000	6%
Native American	1,200	2,200	1,700	3,100	8,500	<1%
Non-Hispanic White	200,000	220,000	240,000	370,000	1,050,000	57%
Other Races	1,600	2,100	2,300	2,300	8,500	<1%
Total	**380,000**	**420,000**	**440,000**	**630,000**	**1,850,000**	**100%**

In Table D-2, we provide estimates on health insurance coverage by age and poverty level. In 2022, an estimated 41% of young adults (18-25) and 30% of children and youth under 18 lived in poverty. Health insurance coverage was slightly lower among those in poverty compared to the general population (90% of those living in poverty had any health insurance compared to 95% of those in the general population). Public insurance, through Medicaid, was the most common form of coverage for those in poverty, covering 51% of the population in poverty. In contrast, 70% of the general population had private insurance. Coverage rates were relatively consistent among those under 18 (95%-97% of the general population), but they dropped to 88% for young adults in the general population.

Table D-2. Health Insurance Coverage of Colorado Children, Youth, and Young Adults by Age (2022)[188,189]

Insurance Coverage	Age Group				Total	% of Total
	Under 6	6 to 11	12 to 17	18 to 25		
Total Population	**380,000**	**420,000**	**440,000**	**630,000**	**1,850,000**	**100%**
Any Health Insurance	370,000	400,000	420,000	560,000	1,750,000	95%
Private Health Insurance	240,000	270,000	300,000	460,000	1,300,000	70%
Public Health Insurance	140,000	140,000	140,000	120,000	540,000	29%
Medicaid	*140,000*	*140,000*	*140,000*	*110,000*	*530,000*	*98%*
Population in Poverty[K]	**120,000**	**130,000**	**120,000**	**260,000**	**630,000**	**100%**
Any Health Insurance	110,000	120,000	110,000	230,000	570,000	90%
Private Health Insurance	33,000	39,000	37,000	170,000	280,000	44%
Public Health Insurance	85,000	90,000	80,000	65,000	320,000	51%
Medicaid	*85,000*	*90,000*	*80,000*	*65,000*	*320,000*	*100%*

Table D-3 outlines the educational attainment status of Colorado young adults and adults ages 26 and older. Among adults 26 and older, 44% had a bachelor's degree or higher, while 7% had less than a high school education. Young adults more frequently attained a high school diploma

[K] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. Poverty data obtained from the U.S. Census Bureau. (2023, December).

(32%) or some college/associate degree (40%). These trends may be explained by the substantial proportion of young adults currently enrolled in higher education.

Table D-3. Education Attainment by Colorado Adults by Age (2022)[190,191]

Education Attainment	18 to 25 Years Old		26+ Years Old	
	Population	%	Population	%
Less Than High School	70,000	11%	290,000	7%
High School or Equivalent	200,000	32%	790,000	20%
Some College or Associates	250,000	40%	1,100,000	28%
Bachelor's or Higher	110,000	17%	1,700,000	44%
Total	**630,000**	**100%**	**3,900,000**	**100%**

Colorado Youth Mental Health Prevalence

In Table D-4, we estimated the prevalence of mental health conditions present among Colorado youth (12-17) in 2022. Approximately one-fourth of youth were estimated to have anxiety (110,000; 25%) or depression (100,000; 23%), and 15% were estimated to have Attention-deficit/hyperactivity disorder. More severe conditions that may require intensive mental health services, such as a serious emotional disturbance (SED) or Bipolar 1, affected approximately 47,000 (11%) and 900 (<1%) youths, respectively.

Table D-4. Mental Health Prevalence Among Colorado Youth (2022)[192,193]

Mental Health Condition	Population	%
Severe emotional disturbance (SED)[194]	47,000	11%
Anxiety[195]	110,000	25%
Depression[196]	100,000	23%
Attention-deficit/hyperactivity disorder[197]	65,000	15%
Post-traumatic stress disorder[198]	16,000	4%
Bipolar I[199]	900	<1%

Please also note that these disorders are not evenly distributed across age; ADHD tends to emerge soonest, followed by anxiety disorders, depression, and the more severe disorders. Table D-5 below provides an overview.

Table D-5. Onset of Disorders and Conditions by Age

Condition[200]	Onset by Age 14[L]	Onset by Age 25[M]	Median Age of Onset
Any mental health condition	50%[201]	75%	14 Years[202]
Attention-deficit/hyperactivity disorder	57%	92%	12 Years

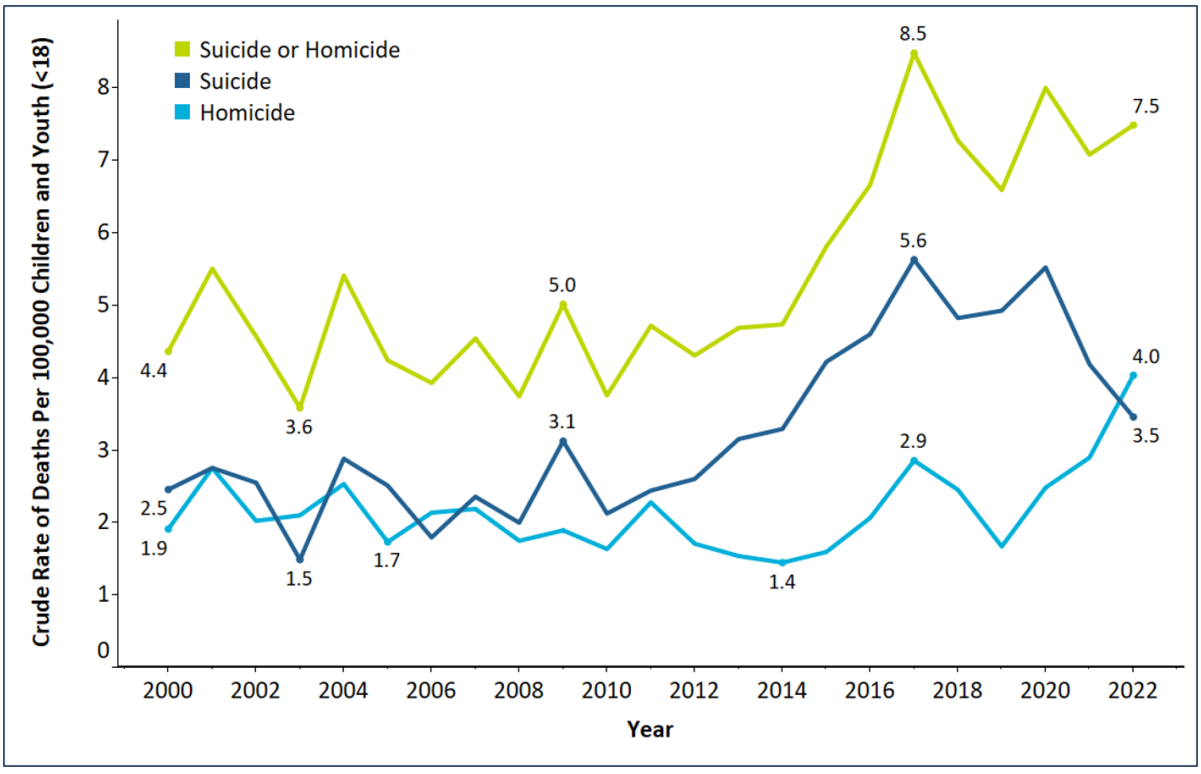
[L] Age of onset rates are rounded to reflect error inherent in the underlying meta-analytic estimates.
[M] Age of onset rates are rounded to reflect error inherent in the underlying meta-analytic estimates.

Anxiety-Disorders[N]	38%	73%	17 Years
Post-traumatic stress disorder	17%	43%	30 Years
Bipolar disorder	5%	32%	33 Years
Depression	3%	37%	30 Years
Schizophrenia-spectrum/primary psychotic disorders	2%	47%	25 Years

Suicide and Homicide Mortality

Figure D-2 illustrates the trends in suicide and homicide mortality rates among Colorado children and youth under 18 between 1999 and 2022. The suicide and homicide mortality rates were roughly comparable between 1999 and 2012. In 2012, the suicide rate increased substantially while the homicide rate declined. This trend persisted until 2020, when the homicide rate doubled between 2020 and 2022, and the suicide rate declined by 38%. In 2022, the suicide rate declined to the lowest rate observed since 2014. In 2022 (the most recent year with finalized data available), there were 91 violent deaths among Colorado children and youth: 49 died from homicide, and 42 died from suicide. See Table D-6.

Figure D-2. Trends in Suicide and Homicide Mortality Among Colorado Children and Youth (<18) (2000-2022)[203]



[N] Excluding PTSD.

Table D-6. Deaths from Suicide, Homicide, Drug Overdose, and Alcohol Among Colorado Children and Youth

Deaths From Suicide[O]		Deaths From Homicide[P]		Deaths From Drug Overdose[Q]		Alcohol-Related Deaths[R]	
Deaths	Rate Per 100,000 Children and Youth	Deaths	Rate Per 100,000 Children and Youth	Deaths	Rate Per 100,000 Children and Youth	Deaths	Rate Per 100,000 Children and Youth
42	3.5	49	4.0	32	2.6	<10	-

The links between violence and mental illness are complex. Overall, mental illnesses do not cause violence, but some specific mental illnesses can contribute to violence against oneself or others if left untreated.[204] However, there are evidence-based treatments that can be effective in reducing violence. The Meadows Institute estimates that there are approximately 1,600 high-need youth in Colorado today who could benefit from care that may reduce their risk of violence as well as better use of available resources; they are currently using a disproportionate amount of hospital capacity and other intensive resources in the state.[205] Approximately 1,300 of these youth are at risk largely due to serious behavioral disorders, often related to delinquency, for which there are well-established treatments available to reduce risks of violence by up to 75%.[206]

Colorado High School Student Substance Use

Table D-7 presents findings from Colorado's Healthy Kids Survey on past 30-day substance use among high school students. One-quarter of students reported using alcohol (24%), and 13% reported using cannabis in the past 30 days. The rates of alcohol, cannabis, cocaine, and ecstasy use increased incrementally with age. Use of cocaine, ecstasy, methamphetamine, or heroin was infrequent, with 2% or fewer students reporting lifetime use.

Table D-7. Substance Use Among Colorado High School Students (2021)[207]

High School Student Substance Use	Age				Total
	15 and Younger	16 Years Old	17 Years Old	18 and Older	
% Used alcohol in the past 30 days	17%	26%	32%	35%	24%
% Used cannabis in the past 30 days	10%	14%	19%	19%	13%
% Ever used inhalants	2%	2%	2%	2%	2%

[O] Deaths from suicide are classified using underlying cause-of-death ICD-10 codes U03, X60–X84, and Y87.0.
[P] Deaths from homicide are classified using underlying cause-of-death ICD-10 codes U01-U02, X85-Y09, and Y87.1.
[Q] Deaths from drug overdose are classified using underlying cause-of-death ICD-10 codes of X40–X44, X60–X64, X85, and Y10–Y14.
[R] Alcohol-related deaths are classified using an underlying or multiple cause-of-death category of "alcohol-induced causes."

High School Student Substance Use	Age				Total
	15 and Younger	16 Years Old	17 Years Old	18 and Older	
% Ever used cocaine	1%	2%	3%	5%	2%
% Ever used ecstasy	2%	2%	3%	4%	2%
% Ever used heroin	1%	1%	1%	1%	1%
% Ever used methamphetamine	1%	1%	1%	1%	1%

Table D-8 includes our estimates on the number of youth (12-17) with a substance use disorder (SUD) in Colorado. In 2022, approximately 11% of all youth (50,000) had an SUD, which is slightly higher than the national rate of 9%. In Colorado, drug use disorders were more common, affecting 8% (37,000 youth) compared to 7% nationally. Of these youth with SUDs, drug use disorders were more common (74% of SUD cases, or 37,000 youth) than alcohol use disorders (42%, or 21,000 youth).[S] Alcohol-related SUDs were present in 5% of Colorado youth, higher than the 3% national average and opioid use disorder rates were consistent with national figures, with 1% affected in both Colorado and the U.S.

Table D-8. Substance Use Disorder Prevalence Among Colorado Youth (2022)[208,209,210]

Substance Use Disorder	Population	%
Any Substance Use Disorder (SUD)	**50,000**	**11%**
Alcohol-Related SUD	21,000	5%
Drug-Related SUD	37,000	8%
Opioid Use Disorder	4,500	1%

[S] A subset of youth experience both alcohol and drug use disorders. Therefore, the sum of youth with alcohol use disorders and drug use disorders exceeds the total number with "any substance use disorder".

Appendix E: Colorado Children and Youth Behavioral Health Implementation and Meadows Institute Recommendations Alignment

The Colorado Children and Youth Behavioral Health Implementation Plan demonstrates the responsibility of state agencies to capture feedback from a broad spectrum of stakeholders across the state. This inclusive approach resulted in 95 actionable recommendations, reflecting the diverse needs and perspectives of communities. These recommendations span six pillars of the comprehensive plan, with the six priority items accounting for 39 of the action items to be addressed in the first two years. These six priorities emphasize high intensity needs to address the state's identified overreliance on hospitalization for conditions that could be effectively treated in the community. While the remaining 56 action items are not inconsistent with our findings, they represent a broader scope that extends beyond the focus of this report. At this time, no plans or next steps have been communicated for the remaining action items. For more information on the six priority items, see Table E-1 below.

Table E-1: Children's Behavioral Health Implementation Plan Priorities

Children's Behavioral Health Implementation Plan Priorities	
Priority	**Action**
Priority 1: Create Behavioral Health Administration Advisory Council	Establish a governance structure that includes various committees, councils and work groups to address child and youth behavioral health
	Consolidating Children, Youth, and Family Behavioral Health efforts into a single state system governance plan
	Create advisory councils for juvenile justice and school-based behavioral health, including a unified approach for state resources to support school district mental health needs
Priority 2: Develop a set of services to address high acuity behavioral health needs	Deliver services in a system of care structure that: • Builds upon the current Crisis Resolution Teams pilot • Expands standardized assessments • Intensive care coordination • Expands support services to include children and youth with serious emotional disturbances
	Increase residential provider clinical quality and oversight
	Support increase of residential workforce capacity
	Incentivize residential providers to take youth with the highest acuity

Children's Behavioral Health Implementation Plan Priorities	
Priority 3: Create policy that increases investment in promotion and prevention efforts	Create sustainable funds and advisory councils for prevention efforts
	Develop a state-level prevention framework
Priority 4: Create implementation plan to deliver intensive in-home and community-based services	Identifying list of intensive in-home and community-based behavioral health interventions
	Include support services for those with complex behavioral health needs including habilitative residential services
Priority 5: Create policies that support the formation of the Affordable Care Collaborative; Including complete service continuum, support services and fiscal policies.	Establish a Children's Behavioral Health Benefit
	Defining services and interventions for ACC Phase III
	Assessing the need for Substance Use Disorder treatment services
	Include standardized assessment tool
	Alternative payment model for safety net providers
Priority 6: Behavioral Health Administrative Service Organizations (BHASOs)	Completing RFI and RFP processes for BHASO
	Integrating BHA services into BHASO contracts
	Operationalizing BHASO by July 2025

Implementing this comprehensive plan and achieving the envisioned transformation will take time, as the new system requires careful development and operational refinement to function as designed. To that end, priorities one, five, and six do not align with our recommendations. Nevertheless, our recommendations are not inconsistent with these priorities, ensuring alignment within the broader strategic framework. While this long-term work is underway, our recommendations focus on pragmatic steps that can be taken within the next 12 months to three years to deliver more immediate, impactful changes to Colorado's children and youth behavioral health landscape. Building on these six priorities, our recommendations take a fundamentally different approach by focusing on transforming the system itself. Traditional methods of treating mental health separately from physical health have resulted in fragmented, inadequate, and often inappropriate care. This has led to an overreliance on jails, emergency departments, and hospital beds—models that fail to deliver better outcomes for individuals. In contrast, the principles guiding our ideal system of care emphasize integration as the standard, aligning care for mental illnesses with the best practices for physical health. By prioritizing early detection and timely access to evidence-based care, we aim to mirror the excellence seen in top-tier health systems for other conditions. The recommendations in this report serve as a roadmap for building a behavioral health system that replaces reactive and siloed approaches with proactive, coordinated care that truly meets people's needs.

In Table E-2 below, we demonstrate where our recommendations align with the six priority items identified in the implementation plan. While these distinctions are not inconsistent with the state's broader vision, our recommendations emphasis the need for a more immediate focus on actionable, short-term solutions that address critical gaps in care, streamline implementation processes, and achieve visible progress within a shorter timeframe.

Table E-2: Meadows Institute Recommendation and Implementation Plan Matrix

Meadows Institute Recommendations and Implementation Plan Matrix	
Meadows Institute Recommendations	**Children and Youth Behavioral Health Implementation Plan Priorities**
Recommendations for Mild to Moderate Mental Health Needs	
To increase mental health treatment for mild to moderate conditions, Colorado's Medicaid program should cover and reimburse primary care providers for CoCM.	**Priority 3:** Create policy that increases investment in promotion and prevention efforts
	Not inconsistent with **Priority 5**
To increase mental health treatment for mild to moderate conditions, philanthropy should invest in technical assistance and implementation support to defray CoCM "start-up" costs in pediatric practices, catalyzing uptake across the state.	**Priority 3:** Create policy that increases investment in promotion and prevention efforts
To support pediatric practices as CoCM capacity ramps up, the Colorado General Assembly should establish permanent funding for CoPPCAP.	**Priority 3:** Create policy that increases investment in promotion and prevention efforts
	Not inconsistent with **Priority 5**
To improve I Matter's program quality and outcomes, increase the use of evidence-informed practices by funding measurement-informed care initiatives, improving clinical training, and addressing gaps in diagnostic assessments and data collection.	**Priority 3:** Create policy that increases investment in promotion and prevention efforts
Recommendations for Complex and Intensive Mental Health Needs	
Navigation programs, such as CHCO's Care Transitions Team, should be invested in as a best practice model that can be replicated in other health systems across the state**.**	**Priority 2:** Develop a set of services to address high acuity behavioral health needs
The BHA, with funding prioritized by the Colorado General Assembly, should expand access to Multisystemic Therapy (MST) to serve children and youth outside of the justice system, including those most at risk of violence.	**Priority 2:** Develop a set of services to address high acuity behavioral health needs
	Priority 4: Create implementation plan to deliver intensive in-home and community-based services

Meadows Institute Recommendations and Implementation Plan Matrix	
BHA, with funding prioritized by the Colorado General Assembly, should include Coordinated Specialty Care (CSC) as part of the Intensive Behavioral Health Services framework to better serve all youth with First Episode Psychosis.	**Priority 2:** Develop a set of services to address high acuity behavioral health needs
	Priority 4: Create implementation plan to deliver intensive in-home and community-based services
Recommendations for Crisis Care Needs	
CHCO should accelerate its timeline for creating two crisis stabilization units, providing Colorado with a more appropriate, evidence-based setting for youth experiencing a mental health crisis.	**Priority 2:** Develop a set of services to address high acuity behavioral health needs
	Priority 4: Create implementation plan to deliver intensive in-home and community-based services
The BHA should partner with local health systems to build regional behavioral health campuses with crisis stabilization services that connect to specialty resources in urban areas.	**Priority 2:** Develop a set of services to address high acuity behavioral health needs
	Priority 4: Create implementation plan to deliver intensive in-home and community-based services
The BHA should create and deploy Youth Crisis Outreach Teams (YCOT) across Colorado, in partnership with best practice partners such as CHCO, Aspen Hope Center, and Your Hope Center.	**Priority 2:** Develop a set of services to address high acuity behavioral health needs
	Priority 4: Create implementation plan to deliver intensive in-home and community-based services
Recommendations for Maternal Mental Health Needs	
To identify and address the mental health needs of Colorado mothers before, during, and after pregnancy, CU School of Medicine should identify sustainable funding to continue and expand programs such as PROSPER.	**Priority 4:** Create implementation plan to deliver intensive in-home and community-based services
Colorado decision-makers should develop a CoCM implementation initiative focused on obstetric practices.	Not addressed in the Colorado Children and Youth Behavioral Health Implementation Plan.
To increase access to maternal mental health services for women with high-risk pregnancies and parents of medically complex infants hospitalized in NICUs across Colorado, CU Medicine should expand access to the programs that address parental mental health, such as the CoWBHW Connections Program.	**Priority 4:** Create implementation plan to deliver intensive in-home and community-based services

Meadows Institute Recommendations and Implementation Plan Matrix	
Recommendations for Grief and Trauma	
Improve provider capacity in trauma and grief best practice care delivery statewide.	**Priority 2:** Develop a set of services to address high acuity behavioral health needs
Recommendations for School Mental Health	
Colorado philanthropy should lead development of a long-term strategy for resourcing and scaling school mental health access programs across a continuum throughout the state, building upon existing successful programs.	**Priority 1:** Create Behavioral Health Administration Advisory Council **Priority 3:** Create policy that increases investment in promotion and prevention efforts **Priority 4:** Create implementation plan to deliver intensive in-home and community-based services
Expand access to programs, such as Colorado's Compassion and Dignity for Educators program, to decrease teacher burnout and increase retention, recognizing the diversity of need and preferences across Colorado's 183 districts.	**Priority 3:** Create policy that increases investment in promotion and prevention efforts
Recommendations for Workforce	
To maximize the impact of the state's behavioral health workforce initiatives, the BHA should increase awareness among eligible behavioral health clinicians on loan repayment opportunities available in Colorado, expand the micro-credentialing program to more college systems and include micro-credentialing pathways focused on priority youth-serving models, including integrated healthcare.	**Priority 2:** Develop a set of services to address high acuity behavioral health needs
To address rural mental health workforce needs in schools, the Colorado Department of Higher Education (CDHE) should support "grow your own" behavioral health professional programs targeting residents of rural communities. CDHE should also provide scholarships and/or loan forgiveness programs.	**Priority 2:** Develop a set of services to address high acuity behavioral health needs
To sustain telehealth flexibilities established during the COVID-19 pandemic that increased access to care but currently remain in flux, national advocates across public and private sectors should support federal advocacy efforts to make these flexibilities permanent.	**Priority 2:** Develop a set of services to address high acuity behavioral health needs

Meadows Institute Recommendations and Implementation Plan Matrix	
National advocates should work with federal legislative and regulatory agencies to reduce antiquated regulatory barriers and advance clearer pathways for DMHT reimbursement inclusive of but not limited to telehealth.	**Priority 2:** Develop a set of services to address high acuity behavioral health needs
Systemic Recommendations	
To realize the full potential of these recommendations, a statewide multi-year, multi-sector policy and practice improvement effort focused on children and youth should be funded and modeled on successful initiatives in other states.	**Priority 3:** Create policy that increases investment in promotion and prevention efforts
To ensure sustainable public funding for these recommendations, a targeted financial and feasibility assessment should be carried out to develop actionable public financings strategies based on lessons learned from other successful efforts to leverage public funding given TABOR requirements.	**Priority 3:** Create policy that increases investment in promotion and prevention efforts

Appendix F: Colorado Health Institute Recommendation Comparison

- In February 2023, the Colorado Health Institute (CHI) released *Solutions to Strengthen Colorado's Youth Mental Health Ecosystem: Recommendations from the Field*. CHI's report served as a foundational document for the Meadows Institute analysis, and Table F-1 compares recommendations from CHI to those from this report. High-level observations include:
- CHI presents its recommendations along five pillars, which are underlined in the CHI column below. The Meadows Institute presents recommendations by specified domains as indicated in the left-most column. CHI pillars and Meadows Institute domains are particularly aligned in the areas of crisis care needs, trauma, school mental health, and workforce. Meadows Institute recommendations explore solutions by level of acuity, with more focus on specific programmatic interventions.
- CHI recommendations dive more deeply into the context of school mental health, with more focus on wellness-centered and stigma-reduction approaches. They also center on schools as a primary focus for mental health screening and referral to services, whereas the Meadows Institute focuses on screening and connections through primary care. The approaches highlighted in each report could be seen as complementary, though the CHI report cites only examples of other schools employing screening and no evidence of its efficacy.
- CHI also focuses more on principles and strategies to promote culturally responsive care, which is consistent and additive to the more specific Meadows Institute programmatic recommendations.
- In terms of mental health services, the CHI recommendations are generally higher-level, and the Meadows Institute recommendations more specific. The CHI recommendations tend to focus on principles and supportive strategies that are critical to incorporate into the development of any new service. Conversely, the Meadows Institute focused on identifying specific services with the most potential impact to both address gaps and promote systemic change. The recommendations therefore are best seen as complementary, but largely non-overlapping.
- The Meadows Institute also considers recommendations related to maternal mental health and system-level strategies, which the CHI report does not.

Table F-1: Comparison of Meadows Institute and Colorado Health Institute Recommendations

Domain (Meadows Institute)	Meadows Institute Recommendations	CHI Recommendations
Mild to Moderate Mental Health Needs	1. To increase mental health treatment for mild to moderate conditions, Colorado's Medicaid program should cover and reimburse primary care providers for CoCM.	While the CHI report does focus on early intervention, it does not put forward any recommendations related to primary care. Instead, its Prevention & Early Intervention recommendations focus on schools. Whereas the Meadows Institute recommendations focused on screening in primary care, the CHI recommendations focus on universal school-based mental health screenings for all K-12 students.
	2. To increase mental health treatment for mild to moderate conditions, philanthropy should invest in technical assistance and implementation support to defray CoCM "start-up" costs in pediatric practices, catalyzing uptake across the state.	
	3. To support pediatric practices as CoCM capacity ramps up, the Colorado General Assembly should establish permanent funding for CoPPCAP.	
	4. To improve I Matter's program quality and outcomes, increase the use of evidence-informed practices by funding measurement-informed care initiatives, improving clinical training, and addressing gaps in diagnostic assessments and data collection.	
Complex & Intensive Mental Health Needs	1. Navigation programs, such as CHCO's Care Transitions Team, should be invested in as a best practice model that can be replicated in other health systems across the state.	CHI does not recommend specific evidence-based models or approaches in its report. However, in its recommendations on Culturally Responsive Approaches, it talks about the importance of trauma-informed, family centered programs. All the programs highlighted by the Meadows Institute are consistent with the CHI recommendations. But the Meadows Institute focuses more on describing the most effective of the potential programs to implement, whereas CHI focuses
	2. The BHA, with funding prioritized by the Colorado General Assembly, should expand access to Multisystemic Therapy (MST) to serve children and youth outside of the justice system, including those most at-risk of violence.	

Domain (Meadows Institute)	Meadows Institute Recommendations	CHI Recommendations
	3. The BHA, with funding prioritized by the Colorado General Assembly, should include Coordinated Specialty Care (CSC) as part of the Intensive Behavioral Health Services framework to better serve all youth with First Episode Psychosis.	more on principles that need to be incorporated in the use of any model across a diverse state. The broader need to tailor programs to the needs of communities of color, address generational trauma, build resilience, and promote mental health wellness within families are critical factors to keep in mind as one advances any specific type of care, including those recommended by the Meadows Institute.
Crisis Care Needs	1. CHCO should accelerate its timeline for creating two crisis stabilization units, providing Colorado with a more appropriate, evidence-based setting for youth experiencing a mental health crisis.	While CHI does not put forward specific recommendations about the service array necessary for an effective crisis system for youth in Colorado, it does include recommendations for school-based crisis supports as part of its broader recommendations on Recovery-Oriented Mental Health Crisis Response. These recommendations focus on integrating supports for students both during and after a behavioral health crisis into schools. This includes establishing partnerships with community organizations to provide ongoing follow-up and support for students recovering from mental health crises. We see these recommendations as complementary to the more specific recommendations in this report.
	2. The BHA should partner with local health systems to build regional behavioral health campuses with crisis stabilization services that connect to specialty resources in urban areas.	
	3. The BHA in partnership with CHCO should create and deploy Youth Crisis Outreach Teams (YCOT) across Colorado, in partnership with best practice partners such as CHCO, Aspen Hope Center, and Your Hope Center.	
Maternal Mental Health Needs	1. To identify and address the mental health needs of Colorado mothers before, during, and after pregnancy, CU School of Medicine should identify sustainable funding to continue and expand programs such as PROSPER.	CHI does not address maternal health in its report, so there are no parallel recommendations.
	2. Colorado decision-makers should develop a CoCM implementation initiative focused on obstetric practices.	

Domain (Meadows Institute)	Meadows Institute Recommendations	CHI Recommendations
	3. To increase access to maternal mental health services for women with high-risk pregnancies and parents of medically complex infants hospitalized in NICUs across Colorado, CU School of Medicine should expand access to the programs that address parental mental health, such as the CoWBHW Connections Program.	
Grief and Trauma	1. Improve provider capacity in trauma and grief best practice care delivery statewide.	As noted above, the CHI does not recommend any specific programs. However, a core component of its principles regarding Culturally Responsive Approaches is a focus on trauma-informed programs, including programs to address generational trauma. The recommendations are complementary to those of the Meadows Institute.
School Mental Health	1. Colorado philanthropy should lead development of a long-term strategy for resourcing and scaling school mental health access programs across a continuum throughout the state, building upon existing successful programs.	As noted above, the Meadows Institute report focused more on Tier 3, whereas the CHI report focused more on Tier 1 wellness and population-focused strategies. Its Prevention & Early Intervention pillar focuses on promoting mental health messaging in schools, education on mental health concepts to reduce stigma and normalize discussions, and messaging in middle and high schools featuring real students discussing mental health and its impacts. CHI also focuses on universal screening for mental health needs in schools and Tier 2 and 3 supports to refer youth to needed care.

Domain (Meadows Institute)	Meadows Institute Recommendations	CHI Recommendations
	2. Expand access to programs, such as Colorado's Compassion and Dignity for Educators program, to decrease teacher burnout and increase retention, recognizing the diversity of need and preferences across Colorado's 183 districts.	As part of its Workforce recommendations, CHI focuses on enhancing the capacity of school staff and mental health professionals to recognize and respond to mental health disorders and trauma with a youth-focused lens. This includes providing adequate training and support, so could be seen as complementary to the Meadows Institute recommendation. However, the Meadows Institute recommendations prioritize supports to help teachers and school staff, rather than expansion of their capacity to help students.
Workforce	1. To maximize the impact of the state's behavioral health workforce initiatives, BHA should increase awareness among eligible behavioral health clinicians on loan repayment opportunities available in Colorado, expand the micro-credentialing program to more college systems and include micro-credentialing pathways focused on priority youth-serving models, including integrated healthcare.	*CHI does not put forward a parallel recommendation.*
	2. To address rural mental health workforce needs in schools, the Colorado Department of Higher Education (CDHE) should support "grow your own" behavioral health professional programs targeting residents of rural communities. CDHE should also provide scholarships and/or loan forgiveness programs.	*CHI does not put forward a parallel recommendation.*

Domain (Meadows Institute)	Meadows Institute Recommendations	CHI Recommendations
	3. To sustain telehealth flexibilities established during the COVID-19 pandemic that increased access to care but currently remain in flux, national advocates across public and private sectors should support federal advocacy efforts to make these flexibilities permanent. 4. National advocates should work with federal legislative and regulatory agencies to reduce antiquated regulatory barriers and advance clearer pathways for DMHT reimbursement inclusive of but not limited to telehealth.	In its Workforce recommendations, CHI focuses on community-centered recruitment, which is a broader frame aligned with the core rational for the related Meadows Institute recommendations. The CHI recommendations are broader, with a focus on multiple ways that philanthropic and state leaders could support community-based organizations and providers to recruit and retain a culturally and linguistically competent behavioral health workforce, including early career exploration programs, internships, scholarships, and stipends. Both reports advocate for alternative mental health workers, such as community health workers and peer support specialists, and CHI calls on them to be reimbursable by Medicaid. Conversely, the Meadows Institute focuses on two high leverage sets of recommendations that are consistent with the CHI approach.
Systemic	1. To realize the full potential of these recommendations, a statewide multi-year, multi-sector policy and practice improvement effort focused on children and youth should be funded and modeled on successful initiatives in other states. 2. To ensure sustainable public funding for these recommendations, a targeted financial and feasibility assessment should be carried out to develop actionable public financings strategies based on lessons learned from other successful efforts to leverage public funding given TABOR requirements.	Similar to the Meadows Institute report, the CHI includes multiple specific policy recommendations. Its primary overall system recommendations center on data sharing across agencies and reducing barriers related to parental consent, as opposed to the Meadows Institute focus on accelerating systemic reforms more broadly, addressing TABOR limitations, and national partnerships. Within its Infrastructure and Coordination pillar, CHI calls for the creation of data sharing pathways, including integrated systems of data across social services, education, and health systems.

Domain (Meadows Institute)	Meadows Institute Recommendations	CHI Recommendations
		It also calls for protecting student data privacy by holding student educational records separately from medical records to ensure compliance with FERPA and elimination of consent-related barriers to care for students.
Recommendations Beyond the Meadows Institute Domain Framework	The Meadows Institute does not put forward a parallel recommendation.	Within its Prevention & Early Intervention pillar, CHI calls for the creation of culturally responsive safe spaces in schools and communities to destigmatize mental health issues and promote early intervention.
	The Meadows Institute does not put forward a parallel recommendation.	Within its Culturally Responsive Approaches pillar, CHI calls for investments in research and scaling opportunities for evidence-based mental health interventions designed for and by communities of color, including traditional healing methods.
	The Meadows Institute does not put forward a parallel recommendation.	Within its Infrastructure and Coordination pillar, CHI calls for the creation of a workforce of youth-focused liaisons to facilitate communication between clinical environments and schools, address barriers to care, and ensure seamless integration of students back into school.

Appendix G: Colorado State Ranking

National rankings of states' mental health service spending and quality are designed and intended to offer comparisons between states to help inform future policy efforts. The Mental Health America (MHA) rankings of the 51 U.S. states and the District of Columbia focus on 15 measures related to the prevalence of mental health conditions and access to care among adults and youth.[211] Underlying data for these measures are generated primarily from three large, national studies,[212] the U.S. Department of Education,[T,213,214] and County Health Rankings and Roadmaps.[215]

These ratings are not designed to provide an accurate picture of a state's overall commitment to mental health. The report cautions that the 15 measures "are not a complete picture of the mental health system" and should instead be used as a "foundation for understanding" mental health needs overall, insurance availability, and access to care.

Table G-1 provides an overview of the summary scores for Colorado from MHA's 2024 report, and Table G-2 breaks down the underlying metrics that comprise the adult, youth, prevalence, and access to care scales.[216] The "prevalence" and "access to care" summary scores were generated by pooling the seven variables in Table G-2 within each state and standardizing the scores (using *z*-scores) for comparison.[217]

Overall, MHA ranks Colorado 46th out of 51 states and the District of Columbia. This score is to a large degree by Colorado's high prevalence of mental illness (ranking 50th of out 51; Table G-1). Note that Colorado ranked in the lowest ten states across every resident-reported measure of prevalence in Table G-2. Conversely, the rankings painted a more positive picture of access to care in Colorado (ranking 17th out of 51 on the primarily resident-reported measures of access to care; Table G-1), including a relatively high available workforce (ranking 10th out of 51; Table G-2). In summary, these rankings suggest that Colorado provides better access to care for mental health and substance use disorder when it is needed, but the prevalence of mental illness and substance use disorder among Colorado residents is highly elevated compared to other states.

[T] Percent of Students Identified with Emotional Disturbance for an Individualized Education Program was calculated as the percent of children identified as having an emotional disturbance among all enrolled students of "school age," which includes kindergarten, grades 1-12, and "ungraded."

Table G-1. Colorado Rankings in MHA's "Ranking the States" (2024; Range: 1-51)[U]

Metric	Colorado Ranking
Overall[V]	**46**
Adult[W]	40
Youth[X]	44
Prevalence[Y]	50
Access to care[Z]	17

Table G-2. Breakdown of Underlying Rankings for MHA's "Ranking the States" Domains (2024; Range: 1-51)[AA]

Metric	Indicators	Colorado Ranking
Individual Metrics by Domain: Prevalence		
Adults	Any mental illness	41
	With SUD in the Past Year	48
	Serious Thoughts of Suicide	47
Youth	One or more Major Depressive Episodes in the Past Year	47

[U] Higher scores indicate higher prevalence and lower access to care.

[V] The overall ranking leverages the following 15 indicators: Adults with any mental illness, adults and youth with substance use disorder in the past year, adults and youth with serious thoughts of suicide, youth who experienced one or more major depressive episodes in the past year, adults with substance use disorder who needed but did not seek treatment, youth who experienced one or more major depressive episodes but did not seek treatment, adults with mental illness that are uninsured, adults with a cognitive disability that could not see a doctor due to costs, adults and youth with mental illness who have private insurance that did not cover mental or emotional problems, students with emotional disturbances for an individualized education program, youth flourishing, and mental health workforce availability.

[W] The adult ranking uses the following 7 indicators: Adults with any mental illness, adults with substance use disorder in the past year, adults with substance use disorder who needed but did not seek treatment, adults with serious thoughts of suicide, adults with mental illness that are uninsured, adults with a cognitive disability that could not see a doctor due to costs, and adults with mental illness who have private insurance that did not cover mental or emotional problems.

[X] The youth ranking uses the following 7 indicators: Youth who experienced one or more major depressive episodes in the past year, youth with substance use disorder in the past year, youth with serious thoughts of suicide, youth who experienced one or more major depressive episodes but did not seek treatment, youth with mental illness who have private insurance that did not cover mental or emotional problems, students with emotional disturbances for an individualized education program and youth flourishing.

[Y] The prevalence ranking uses the following 7 indicators: Adults with any mental illness, youth who experienced one or more major depressive episodes in the past year, adults and youth with substance use disorder in the past year, adults and youth with serious thoughts of suicide and youth flourishing.

[Z] The access to care ranking uses the following 8 indicators: adults with substance use disorder who needed but did not seek treatment, youth who experienced one or more major depressive episodes but did not seek treatment, adults with mental illness that are uninsured, adults with a cognitive disability that could not see a doctor due to costs, adults and youth with mental illness who have private insurance that did not cover mental or emotional problems, students with emotional disturbances for an individualized education program and mental health workforce availability.

[AA] Higher scores indicate higher prevalence and lower access to care.

Metric	Indicators	Colorado Ranking
	With SUD in the Past Year	45
	Serious Thoughts of Suicide	43
	Flourishing[BB]	44
Individual Metrics by Domain: Access to Care		
Adults	Adults with SUD Who Needed but Did Not Receive Treatment	35
	Adults with a Mental Illness Who Are Uninsured	22
	14+ Mentally Unhealthy Days a Month Who Could Not See a Doctor Due to Costs	25
	Adults with a Mental Illness with Private Insurance That Did Not Cover Mental/Emotional Problems	16
Youth	Youth with Major Depressive Episode Who Did Not Receive Mental Health Services	18
	Youth with Private Insurance That Did Not Cover Mental or Emotional Problems	17
	Students with Emotional Disturbance that qualify for an Individualized Education Program	30
Overall	Mental Health Workforce Availability	10

It should be noted that the 2024 report used different metrics compared to prior years,[CC,DD] meaning that the rankings for this year cannot be reliably compared to previous annual reports. The MHA rankings thus represent one way of examining a state's mental health system and "provide a snapshot of mental health status among youth and adults for policy and program planning, analysis, and evaluation." Finally, MHA's rankings rely primarily on self-reported metrics and do not incorporate policy changes and mental health expenditures into their analysis.

[BB] The newly added "flourishing" metric was derived from three questions in the National Children's Health Survey. Health Resources and Services Administration, Maternal and Child Health Bureau. (2021-2022). Previously Cited. For children ages 6-17 years, three questions were asked that aimed to capture curiosity and discovery about learning, resilience, and self-regulation, including "How often does this child: (1) show interest and curiosity in learning new things, (2) work to finish tasks he or she starts, and (3) stay calm and in control when faced with a challenge." The "Always" or "Usually" responses indicate the child meets the flourishing item criteria. These three measures were developed based on a review of positive health indicators by a Technical Expert Panel of experts in survey methodology, children's health, community organizations, and family leaders and public comment. MHA coded youth as "flourishing" if the youth scored optimally on all three flourishing items. Although not explicitly stated in the methodology, this item was likely reverse coded prior to pooling with the other prevalence metrics, as lower levels of youth flourishing could indicate higher prevalence of mental illness.

[CC] The following four indicators were included in the 2023 rankings but removed in 2024: adults with AMI who did not receive treatment, adults with AMI reporting unmet needs, youth with severe MDE, and youth with severe MDE who received some consistent treatment.

[DD] The following four indicators were added in 2024: youth with serious thoughts of suicide, adults with substance use disorder who needed but did not seek treatment, adults with mental illness who have private insurance that did not cover mental or emotional problems, and youth flourishing.

Appendix H: Revenue Options to Overcome TABOR Restrictions

Colorado's TABOR restrictions introduce a level of complexity to revenue generation that is not present in other states. The Meadows Institute worked with the Colorado Fiscal Institute to identify potential examples of the first three approaches below. Note that the final proposal—"Leveraging Public-Private Partnerships or Other Cost Sharing Mechanisms"—is solely that of the Meadows Institute.

Bringing a New Tax to Voters via Ballot

Any new or increased tax resulting in net new revenue must meet TABOR's complicated enactment requirements, including a direct vote on the ballot by Colorado citizens. The process is designed to be onerous to limit the establishment of new taxes; however, a direct tax for mental health has the greatest potential for raising revenue and is typically more predictable as a long-term revenue stream compared to other options.

The success of 2024's Proposition KK (Prop. KK) points to the willingness of Colorado voters to take on new taxes to address mental health. Prop. KK added a 6.5% tax on gun makers and dealers on the retail sales of firearms, certain gun parts, and ammunition. While the bulk of Prop. KK's revenue is directed towards crime victim services, a small portion of the funding is dedicated to crisis and veterans' mental health services. The marketing campaign in support of Prop. KK leaned heavily on the mental health aspects.

A new Colorado mental health tax faces two potential headwinds:

- **The economic picture of Colorado is vastly different than when Prop KK. was conceived.** As a result, voters may be less interested in passing taxes for new services, given the state's deficit and the potential for cuts to existing services. Media reports signal that the state may need to attempt to implement new taxes to address existing services, making proposals to add new taxes a non-starter.
- **Voters may balk at a mental health tax given the passage of Prop. KK in 2024.** Though most Prop. KK funding is not directed to mental health, voters may feel that they voted for a mental health tax and be reluctant to pursue additional spending on an issue they feel they've already addressed.

Examples

- Adding an additional 1 Percent Income Tax for Filers Earning Above $500,000. This action could generate $550 million in new revenue while impacting only 2% of Colorado tax filers. A similar 2022 tax increase for filers earning more than $300,000 passed to fund the Healthy School Meals campaign, providing free school meals for all Colorado kids.
- Doubling the wine and alcohol sales tax could generate $50 million annually. These sorts of "sin" taxes have historically been some of the more successful initiatives in Colorado and have slightly less burdensome ballot requirements because they do not require a change to constitutional language. Colorado currently has some of the lowest alcohol tax rates in the country, and a tax on alcohol to fund mental health could be seen as closely related.

Pursuing New Revenue Through a Fee or Special Purpose Authority

There are two main ways Colorado can raise revenues without requiring voter approval:

- **Raising fees.** Colorado officials can levy or increase fees without meeting the TABOR requirements imposed on new taxes; however, the fee funds must directly benefit those who pay for it (e.g., Colorado's gas fee pays for road maintenance). *Note: Fee revenues, unless falling under an explicit TABOR exemption or explicitly exempted by voters, must be included in the calculation of fiscal year spending and within the TABOR allowable revenue limits. Fees must also have a close enough nexus to the service being provided, or they run the risk of being considered a tax.*

  Example: Establishing a fee on digital advertising dedicated to mental health could generate $82.5 million annually. In Colorado, it would be possible to structure this revenue source as a fee, although there is a risk of it being challenged as a backdoor attempt to establish a new tax. The key would be making the case for the strong nexus between online activity and youth mental health. Such an argument would benefit from the fact Colorado policymakers have already highlighted the impact of social media and other online activities on youth mental health.

- **Colorado policymakers could levy a fee on internet transactions and use those fees to fund a behavioral health enterprise.** "Enterprises" are statutory workarounds that Colorado policymakers have frequently used to overcome TABOR restrictions. Revenue generated by enterprises is not subject to TABOR restrictions and does not require voter approval unless the enterprise is expected to generate more than $100 million in fee revenue in the first five years of operation.

  An enterprise serves as a government-owned business authorized to issue its own revenue bonds and raise its own fee revenue that provides services. Examples of existing Colorado enterprises include all institutions of higher education, the unemployment insurance fund, and the paid family and medical leave program. *Note: Enterprise fee revenue must cover the cost of services the enterprise provides;*

enterprises lack the ability to supplement revenue with general tax dollars or transfers from state or local governments.

Repurposing Existing Revenues

Colorado policymakers have the authority to repeal existing tax credits and direct those resources to specific uses. In contrast to the process for establishing a fee, those uses need not have a direct nexus to the service being provided.

Examples

- Reducing the ad valorem tax credit (estimated to generate as much as $308 million);
- Repealing the stripper well exemption (generating $61 million); or
- Reducing the net operating loss deduction available to C-corporations (generating as much as $300 million).

Although repurposing existing revenues could provide significant funding, there are several potential drawbacks. Many of the revenue sources are volatile, reducing the ability to predict revenues year by year. Depending on the scope and focus, repurposing can trigger TABOR voter approval requirements. Repurposing revenues also necessarily depends on raising costs for other industries, potentially pitting behavioral health against the interests of other sectors. The Meadows Institute would be happy to provide more details in this area upon request.

Leveraging Public-Private Partnerships or Other Cost Sharing Mechanisms

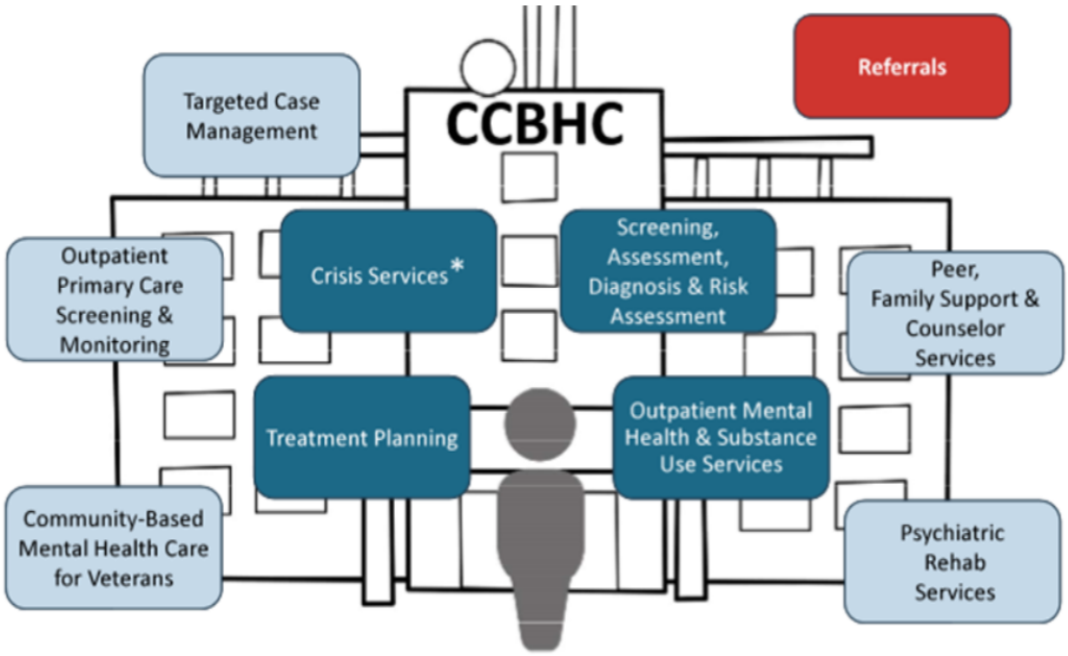
Public-private partnerships are a particularly attractive component of Colorado's funding ecosystem and may offer opportunities to scale data-driven solutions without running afoul of TABOR. The establishment of Colorado's Elevate Quantum tech hub in 2023 is a prime example of how public-private collaboration can both overcome the funding restrictions inherent in TABOR and leverage the expertise and investment of private investors such as the tech industry. As a technology and innovation hub focused on quantum computing, the costs inherent in establishing the necessary technology infrastructure for Elevate Quantum were beyond what Colorado could invest through its general fund. However, by partnering with investors, tech companies, research institutions, and other states, Colorado was able to develop a quantum ecosystem that has attracted over $1 billion in venture capital[218] while remaining within TABOR's funding restrictions. Through this partnership, private companies benefit from access to Colorado's public resources, including land, tax incentives, and regulatory support. In turn, the state has been able to seed an important new industry and access federal funding and resources[219] that would otherwise be out of reach.

Appendix I: Certified Community Behavioral Health Clinics

What is a Certified Community Behavioral Health Clinic?

A Certified Community Behavioral Health Clinic (CCCBHC) is a specially designated clinic that provides a comprehensive range of mental health and SUD services. They are required to serve anyone seeking care for mental health or SUD, regardless of ability to pay, insurance coverage, place of residence, or age. They must deliver a comprehensive continuum of care encompassing nine core services, which range from screening and early detection to treatment and 24-hour crisis services, care coordination, and integration with medical services (Figure I-1).

Figure I-1. CCBHC Core Services



What is the difference between a CMHC and CCBHC?

Community mental health centers (CMHCs) often function as safety net mental health providers; however, there is great variability around the scope of services they provide and the populations they serve. This has resulted in disparities in access and quality of care. The goal of the CCBHC model is to ensure access to coordinated, comprehensive behavioral health care for anyone in the community regardless of ability to pay, place of residence, age, etc.[220] CCBHCs receive an enhanced federal reimbursement rate through the Prospective Payment System (PPS) relieving them from some of the budgetary constraints that many CMHCs face.

How are CCBHC funded?

CCBHCs are funded through the Medicaid demonstration program or through SAMHSA grants. These funding mechanisms allow more flexible funding that is needed for essential services that form the backbone of public behavioral health systems, particularly for people with the most

severe and complex needs. CCBHCs serve as a preferred vehicle for ongoing federal behavioral health funding. Since 2016, state governments nationwide have utilized CCBHCs as a key strategy for expanding community behavioral health services. To date, the federal government has invested more than $1.7 billion in grant funding to expand CCBHCs. Funding for CCBHCs was a key component of the 2022 Bipartisan Safer Communities Act, which directed an unprecedented $9 billion to support CCBHC expansion and implementation in states. In March 2024, the federal government established a permanent definition of CCBHC services within the Medicaid program, ensuring the continued growth of this model nationally.

What is the impact of the CCBHC model?

Analysis of initial national CCBHC implementation shows that integrating services using the CCBHC model has reduced spending while helping to achieve better patient outcomes. According to the National Council for Mental Wellbeing, the CCBHCs model has enabled clinics to increase the number of people they can serve by up to 33%, provide access to mental health and substance use care much faster than other clinics (from an average of 48 days to less than a week wait time), and are more often able to provide medication-assisted treatment (80% compared to 64% of time).[221]

Colorado and CCBHCs

In 2016, Colorado was one of 24 states selected to participate in SAMHSA's initial CCBHC planning grant program. Following a year-long planning and building period, Colorado was not one of the eight states selected to receive the first demonstration model funds. Due to budget concerns, the state decided not to further pursue funding. In 2023, Colorado applied again for a CCBHC planning grant but was not selected. In 2024, the Colorado General Assembly passed HB 24-1384, requiring the Colorado Department of Health Care Policy & Financing (HCPF) and the Behavioral Health Administration (BHA) to apply again for a CCBHC planning grant.

In September 2024, HCPF, in partnership with the BHA, submitted an application for a 2024 CCBHC planning grant. In January 2025, SAMHSA awarded Colorado, among other states, a $1 million, one-year CCBHC Medicaid Demonstration Program planning grant. The intention of this planning grant is to assist states in preparing an application for the four-year demonstration program, developing their CCBHC certification process, and establishing prospective payment systems for Medicaid-reimbursable services. As explained in Colorado’s application, the state anticipates that it will be able to serve 310,000 unique individuals within four years if awarded a federal CCBHC demonstration grant in 2026.

Why does it matter?

The CCBHC model provides a standardized framework to enhance federal funding for essential services that form the backbone of behavioral health systems, particularly for people with the

most severe and complex needs. CCBHCs are required to provide both screening and crisis services as part of their core services and can maximize federal funding to provide such services. Consequently, many states are utilizing CCBHCs as a component of their safety net structure. If Colorado is awarded entry into the CCBHC demonstration grant program, we expect the state to pursue a similar course of action.

By securing higher, predictable cost-based reimbursement rates and expanding the universe of reimbursable services, the CCBHC model can reduce financial strain on CMHCs and the mental health system as a whole. While shifts in the federal landscape have introduced some uncertainty, policymakers on both sides of the aisle have invested significant federal dollars in making CCBHCs the preferred funding vehicle for community mental health resources.

Appendix J: Criteria for New Safety Net Provider Types

As part of the behavioral health system transformation happening across the state, the BHA created two new safety provider licensure types: comprehensive providers and essential providers. These providers subcontract with BHASOs.[222] Overall, comprehensive providers offer a full spectrum of care, while essential providers provide care coordination (i.e., helping people access the treatment and services they need that are provided by other agencies) and at least one other key behavioral health service. To qualify as a comprehensive or essential provider, provider, entities must meet the specific requirements below and cannot deny services based on certain characteristics of an individual as outlined in Table J-1 below.[223]

Table J-1. Requirements for Comprehensive and Essential Providers

Comprehensive Provider	Essential Provider
Provide all the following services directly or through contracted agreement: • Emergency and crisis behavioral health services • Behavioral health outpatient services • Behavioral health high-intensity outpatient services • Care management • Outreach, education, and engagement services • Behavioral health recovery supports • Outpatient competency restoration • Screening, assessment, and diagnosis, including risk assessment • Crisis planning and monitoring of key health indicators	Provide care coordination (i.e., helping people access the treatment and services they need that are provided by other agencies) and deliver at least one of the following services: • Emergency or crisis behavioral health services • Behavioral health outpatient services • Behavioral health high-intensity outpatient services • Behavioral health residential services • Withdrawal management services • Behavioral health inpatient services • Integrated care services • Hospital alternatives • Additional services that the BHA determines are necessary in a region or throughout the state

Appendix K: Mental Health Best Practices for Children, Youth, and Families

Overarching Framework: Quality Improvement and Health Care

In 2001, the Institutes of Medicine (IOM) fundamentally changed the national dialogue regarding the design of health care systems through the landmark publication of its "Crossing the Quality Chasm"[224] report, which became the first in a series of IOM publications that have underscored the need to fundamentally shift operational priorities and the commitment from health care delivery organizations to ongoing quality improvement. In many ways, the premise of the report is quite simple: the health care industry must move from a traditional "command and control" model to a continuous quality improvement model. These are lessons that the U.S. manufacturing sector had to learn and apply in the 1980s and 1990s, building on the work of pioneers such as Edward Deming and leading to a variety of standards and frameworks now widely used across industry (e.g., ISO 9001:2008[225]).

The "Quality Chasm" report and subsequent IOM reports built upon prior reports from the late 1990s to demonstrate the serious quality gaps in the U.S. health care system. Many of these quality gaps have been associated with the shift in treatment to greater numbers of chronic illnesses (versus acute illnesses), an important subset of which includes addictions, serious mental illnesses for adults, and serious emotional disturbances for children and youth. The series of IOM reports focuses on applying the broader framework of performance and quality improvement to the delivery of health care services. The "Quality Chasm" report argues convincingly that these quality gaps cost the U.S. upwards of $750 billion in 2009 in poor, inefficient, wasteful, and ineffective care. The need for systematic change was clear and stark.

In 2006, the IOM focused its attention on mental health and substance use disorders,[226] documenting severe system-level quality gaps and describing a framework for improving them. The resulting report was explicit in its findings, both in demonstrating the existence of effective treatment and the woeful inadequacy of most mental health/substance use disorder delivery systems in effectively promoting it:

> *Effective treatments exist and continually improve. However, as with general health care, deficiencies in care delivery prevent many from receiving appropriate treatments. That situation has serious consequences – for people who have the conditions; for their loved ones; for the workplace; for the education, welfare, and justice systems; and for the nation as a whole.*[227]

The report notes that the challenges facing mental health/substance use disorder systems are, in many ways, more severe than those facing the broader health system because of "a number of distinctive characteristics, such as the greater use of coercion into treatment, separate care delivery systems, a less developed quality measurement infrastructure, and a differently

structured marketplace."[228] Nonetheless, the IOM recommended clearly that the advised shift from command and control models of quality assurance to customer-oriented quality improvement was both necessary and possible within behavioral health systems; these systems have capacity similar to that of health care systems to produce better outcomes with lower costs.

The implications of the IOM's recommended shift from command-and-control models to continuous quality improvement is not just about improving the quality-of-care delivery; it is also essential to controlling costs, as documented in one of the latest reports in the Quality Chasm report and related report series.[229] The report states the matter in its characteristically direct manner, as quoted below:

Consider the impact on American services if other industries routinely operated in the same manner as many aspects of health care:

- If banking were like health care, automated teller machine (ATM) transactions would take not seconds but perhaps days or longer as a result of unavailable or misplaced records.
- If home building were like health care, carpenters, electricians, and plumbers each would work with different blueprints, with very little coordination.
- If shopping were like health care, product prices would not be posted, and the price charged would vary widely within the same store, depending on the source of payment.
- If automobile manufacturing were like health care, warranties for cars that require manufacturers to pay for defects would not exist. As a result, few factories would seek to monitor and improve production line performance and product quality.
- If airline travel were like health care, each pilot would be free to design his or her own preflight safety check, or not to perform one at all.

The point is not that health care can or should function in precisely the same way as all other sectors of people's lives; each is very different from the others, and every industry has room for improvement. Yet if some of the transferable best practices from banking, construction, retailing, automobile manufacturing, flight safety, public utilities, and personal services were adopted as standard best practices in health care, the nation could see patient care in which:

- Records were immediately updated and available for use by patients.
- Treatments were proven reliable at the core and tailored at the margins.
- Patient and family needs and preferences were a central part of the decision process.
- All team members were fully informed in real time about each other's activities.
- Prices and total costs were fully transparent to all participants.
- Payment incentives were structured to reward outcomes and value, not volume.
- Errors were promptly identified and corrected.

- Results were routinely captured and used for continuous improvement.[230]

Defining Best Practices

There are hundreds of evidence-based practices (EBPs) available for mental health and substance use disorder treatment, and the most definitive listing of these practices was provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Registry for Evidence-Based Programs and Practices (NREPP).[231] While much of the NREPP website was discontinued as of 2018, it has been replaced by the Evidence-Based Practices Resource Center, which now provides information and tools to incorporate evidence-based practices into community or clinical settings rather than a comprehensive listing of EBPs. Other definitive listings of EBPs are provided by the Society of Clinical Child and Adolescent Psychology,[232] Evidence-Based Behavioral Practice,[233] Blueprints for Health Youth Development,[234] and, for child welfare populations, the California Evidence-Based Clearinghouse for Child Welfare.[235] Additionally, with the passage of the Family First Prevention Services Act (FFPSA), the federal Administration of Children and Families (ACF) is also developing and populating a clearinghouse on evidence-based and promising practices.[236]

The terms "evidence-based practice," "evidence-based treatment," or "empirically supported treatment" are meant to refer to psychological treatments that have undergone scientific evaluation. There are five levels used to evaluate the evidence base for psychosocial treatments for children and adolescents.[237, 238] On the first level are "well-established" treatments that have undergone at least two randomized clinical trials (RCTs) and have been studied by independent teams working at different research settings. The second level includes "probably efficacious" treatments that have strong research support, but treatment may not have been tested by independent teams; or only one study shows the treatment is much more effective than a well-established treatment; or, if at least two studies show it is better than no treatment. Interventions in the third level are treatments considered "possibly efficacious" in that there may be one study showing that the treatment is better than no treatment, or there may be several smaller clinical studies without highly rigorous methodological and procedural controls (e.g., randomization). The fourth level contains treatments considered "experimental" in that they have not been studied carefully, and the fifth level are treatments that have been tested and do not work.

Successful promotion of best practices also requires understanding of the real-world limitations of each specific best practice, so that the understandable stakeholder concerns that emerge can be anticipated and incorporated into the best practice promotion effort. This process is sometimes called "using practice-based evidence" to inform implementation and is a core feature of continuous quality improvement. The reasons for stakeholder concerns at the "front line" implementation level are well documented and significant.[239] One major issue is that the

literature prioritizes RCTs that address efficacy in controlled research settings, whereas practitioners require research evidence on effectiveness in typical practice settings. This "efficacy-effectiveness gap" was clearly defined in the 1999 U.S. Surgeon General's report on mental health services in America[240] and centers on the much more complex realities that practitioners face in the field. Research that addresses the complexities of typical practice settings (e.g., staffing variability due to vacancies, turnover, inconsistent quality of providers' training, and inconsistent fidelity to existing models) is lacking, and the emphasis on RCTs is not amenable to exploration of clinically relevant constructs like engagement and therapeutic relationships. Related uncertainties about implementing best practices include a lack of clarity about the interactions of development and ecological context with the interventions. While it is generally accepted that development involves continuous and dynamic interactions between individuals and their environments over time, and is inextricably linked to natural contexts, the efficacy research literature is largely silent on these relationships.[241] Because of this, practitioners must in many cases extrapolate from the existing research evidence.

One of the biggest concerns about best practices — and one that is certainly highly relevant for a state as diverse as Texas — involves application of practices to individuals and families from diverse cultural and linguistic backgrounds. There are inherent limitations in the research base regarding diversity that often lead providers, people receiving services, and other stakeholders to question the extent to which the research evidence supporting best practices is applicable to their communities and the situations they encounter daily. Further, there is wide consensus in the literature that too little research has been carried out to document the differential efficacy of best practices across cultures.[242] Given that few best practices have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense to implement best practices within the context of ongoing evaluation and quality improvement efforts to determine whether they are effective – or more accurately, how they might need to be adapted to be maximally effective – for the local populations being served. The California Institute for Mental Health has compiled an analysis regarding the cross-cultural applications of major best practices.[243] There is also increasing recognition of best practices for refugee and immigrant communities.[244]

It is critical to ground best practice promotion in specific standards for culturally and linguistically appropriate care. The most well-known national standards related to health disparities focus on services for members of underrepresented groups. The National Standards for Cultural and Linguistically Appropriate Services in Health Care (CLAS Standards)[245] were adopted in 2001 by the U.S. Department of Health and Human Service's Office of Minority Health with the goals of "equitable and effective treatment in a culturally and linguistically appropriate manner" and "as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all

patients/consumers" in order "to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans." Updated in 2013, the CLAS Standards now include 15 standards addressing the broad themes of culturally competent care, language access, and organizational supports for cultural competence;[246] the CLAS standards are most widely recognized in the broader health field. In mental health, a set of SAMHSA standards for African American, Asian American/Pacific Islander, Hispanic/Latino, and American Indian groups is also available.[247] Guidance for multicultural applications is available as well.[248]

Major Evidence-Based Practices for Children, Youth, and Families

Integrated Primary Care

Integrated behavioral health (IBH) programs provide the opportunities to improve outcomes and promote a broader culture of medical care that includes physical, emotional, and behavioral health in treatment approaches. Annual well-child visits with primary care providers provide an excellent opportunity for children and youth to access both physical and behavioral health care, especially within comprehensive integrated primary care settings. Collaborative care programs, where primary care providers, care managers, and behavioral health specialists work as a team to provide patient care, can have a positive impact. A 2015 meta-analysis in the Journal of the American Medical Association (JAMA) Pediatrics indicated that "the probability was 66% that a randomly selected youth would have a better outcome after receiving integrated medical-behavioral treatment than a randomly selected youth after receiving usual care."[249]

A Meadows Mental Health Policy Institute 2016 report[250] proposed that IBH programs should include the following seven core components:

- Integrated organizational culture,
- Population health management,
- Structured use of a team approach,
- IBH staff competencies,
- Universal screening for the most prevalent primary health and behavioral health conditions,
- Integrated person-centered treatment planning, and
- Systematic use of evidence-based clinical models.

Effective IBH programs utilize evidence-based treatment interventions to achieve better outcomes and more cost-effective care. They track primary health and behavioral health outcomes and use health information technology to manage population outcomes in order to use interventions that ensure quality care.

Behavioral health integration in primary care settings increases access to behavioral health services for children and youth with mild-to-moderate mental health conditions. About 75% of children and youth with psychiatric disorders can be seen in the pediatrician's office.[251] Importantly, however, there are often significant limitations. Pediatricians typically do not deliver mental health services because of limited time during each patient visit, minimal training and knowledge of behavioral health disorders, concern about prescribing psychotropic medications, gaps in knowledge of local resources, and lack of knowledge about or limited access to behavioral health specialists.[252] However, a fully-scaled implementation example suggests that two thirds of behavioral health care could be provided in pediatric settings with the right integration supports.[253]

Behavioral health integration in primary care settings also aligns with the concept of the "medical home." According to the American Academy of Pediatrics, the pediatric health home — sometimes called the "pediatric medical home" — refers to "delivery of advanced primary care with the goal of addressing and integrating high quality health promotion, acute care, and chronic condition management in a planned, coordinated, and family-centered manner."[254]

Providing additional perspective, the American Academy of Child and Adolescent Psychiatry (AACAP) has developed "Best Principles for Integration of Child Psychiatry into the Pediatric Health Home." AACAP identifies key components of the behavioral health integration framework within the pediatric medical home.[255] These include the following strategies:[256]

- Screening and early detection of behavioral health problems.
- Triage/referral to appropriate behavioral health treatments.
- Timely access to child and adolescent psychiatry consultations that include indirect/curbside consultation as well as face-to-face consultation with the patient and family by the child and adolescent psychiatrist.
- Access to child psychiatry specialty treatment services for those who have moderate-to-severe psychiatric disorders.
- Care coordination that assists in delivery of mental health services and strengthens collaboration with the health care team, parents, family, and other child-serving agencies.
- Monitoring outcomes at both an individual and delivery-system level.

Examples of Integrated Primary Care Models

Pediatric Collaborative Care Model (CoCM) brings together physical and mental health care treatment within a pediatrician's office. In this integrated care approach, a pediatrician, a psychiatric consultant and behavioral health care manager work together to detect and provide established treatments for common mental health problems, measure patients' progress toward treatment targets, and adjust care when appropriate. CoCM is a data-driven, patient-

centered approach that multiplies the expertise of scarce mental health clinicians through task sharing, technology, structured teamwork, and telehealth. The Collaborative Care team is led by a pediatrician and includes behavioral health care managers, psychiatric consultants and other mental health professionals all empowered to work together. The team implements a measurement-focused care plan based on evidence-based practice guidelines and focuses particular attention on patients struggling to meet clinical goals.

Massachusetts Child Psychiatry Access Project (MCPAP) offers one promising approach to supporting pediatric primary care physicians to care for the mental health needs of children and adolescents within the primary medical home. e. Established in 2004, MCPAP is a national leader and model that has inspired many other states to create similar programs. It supports over 95% of the pediatric primary care providers in Massachusetts. MCPAP has six regional behavioral health consultation hubs, each with a child psychiatrist, a licensed therapist, and a care coordinator. Each hub also operates a dedicated hotline that can include the following services: timely over-the-phone clinical consultation, expedited face-to-face psychiatric consultation, care coordination for referrals to community behavioral health providers, and ongoing professional education designed for primary care providers. In 2014, following a MCPAP consultation, primary care providers reported managing 67% of the types of problems that they typically would have referred to a child psychiatrist before they enrolled in the program. The MCPAP model was so instrumental in providing accessible behavioral health care for children and youth that it expanded to develop MCPAP for Moms. Created in 2014, MCPAP for Moms is a collaborative model that involves obstetricians, internists, family physicians, and psychiatrists. Its mission is to promote maternal and child health for pregnant and postpartum women for up to one year after delivery to prevent, identify, and manage mental health and substance use disorders.[257]

Seattle Children's Partnership Access Line (PAL) is another leading model of integrating behavioral health care into primary care for children and youth. PAL is a telephone-based mental health consultation system that provides services to Washington and Wyoming. It is available to primary care physicians, nurse practitioners, and physician assistants. Users of this model receive a child mental health care guide and advice from a child psychiatrist that includes a summary of the consult conversation. In addition, the PAL program includes a social worker who can provide a list of local resources tailored to an individual patient and their insurance. If a child needs to be evaluated in person, PAL helps link families to providers in their respective communities. PAL can assist with identifying locations that have telemedicine appointment available. The PAL team also provides educational presentations to primary care providers on aspects of managing behavioral health issues in the primary care setting. Primary care providers reported that in 87% of their consultation calls, they usually received new psychosocial treatment advice. They also reported that children with a history of foster care placements

experienced a 132% increase in outpatient mental health visits after the consultation call. Feedback from primary care provider surveys also reported "uniformly positive satisfaction" with PAL.[258] In 2017, following the implementation of PAL, antipsychotic prescriptions for children enrolled in Washington State's Medicaid program decreased by nearly half.[259]

The **Integrated Behavioral Health Care Management** program at Children's Health in Dallas, formerly Children's Medical Center, provides a promising approach to behavioral health care for children and youth. In 2013, Children's Health began an IBH program within its pediatric outpatient clinics. In July 2015, it was fully implemented with care managers covering all 18 Children's Health Pediatric Group clinics. As of January 2017, the team included 10 licensed master's-level behavioral health clinicians (LPCs, LCSWs, and LMFTs) and two clinical psychologists. The behavioral health team provides consultation and direct treatment to patients who receive primary care in the outpatient clinics. Behavioral health screening tools for monitoring depression are administered and tracked with every well-child visit, starting at age 11. Implementation of these tools has contributed to studies that have shown excellent results, such as more than a 50% reduction in symptoms of depression. One strength of the program is a shared electronic medical record system that offers both primary care and specialty behavioral health providers access to a patient's records, enabling better care coordination. In addition, members of the behavioral health team are co-located with their primary care colleagues in the pediatric clinic setting, increasing accessibility to behavioral health care. The behavioral health team conducts educational presentations for primary care providers on topics such as depression, attention-deficit hyperactivity disorder, and parenting skills. Moreover, the behavioral health team meets internally every two weeks for formal case discussions and treatment planning. Finally, the program uses telemedicine to deliver primary care services to children and youth in local schools to increase access.

The Rees-Jones Center for Foster Care Excellence, located at Children's Health in Dallas, is another Texas-based best practice program. The Rees-Jones Center for Foster Care Excellence uses a specialized integrated health care model that addresses the needs of children and youth in foster care as they often need additional supports. One of its promising practices is the structured use of a team approach with a care team of primary care and behavioral health providers as well as a nurse coordinator and a child protective services (CPS) liaison. All members of the care team are co-located and fully collaborative, and they provide evidence-based, trauma-informed primary care and therapeutic services. Center staff described the nurse coordinator and CPS liaison positions, specifically, as central and critical to the model. Other core IBH components of The Rees-Jones Center for Foster Care Excellence include the use of a shared electronic medical records system, which allows all team members to access a child or youth's record and document clinical observations and recommendations in one place;

implementation of daily and weekly formal case discussions and treatment planning; and regular staff trainings.

School-Based Mental Health Services

Prevention efforts shift as children (ages six to 12) enter school to focus on increasing positive social interactions, decreasing aggression and bullying, and increasing academic motivation. The education and mental health systems in the United States have a long history of providing mental health services to children. With the passage of the Education of All Handicapped Children Act in 1975 (reauthorized in 1990 as the Individuals with Disabilities Act, or IDEA), education systems were given greater responsibility to meet the needs of students with mental and behavioral health concerns.[260] Schools provide a natural setting for mental health services, including prevention.[261, 262] In fact, studies show that for many children and youth, schools seem to be their primary mental health system (one finding showed that for children who receive any type of mental health service, over 70% receive the service from their school).[263] Schoolwide prevention and services that promote behavioral health reduce violence and create a positive school climate that benefits all students.[264]

School-based behavioral health and prevention are best implemented through a public health approach.[265] The public health model could provide a framework that spans the broad range of age groups and challenges seen in public school systems and could support the following recommendations for enhancing school-based mental health services models:

- Implement schoolwide prevention programs and acknowledge that this will require new roles for community workers and school staff.
- Improve the educational outcomes of students by using evidence-based and empirically supported selective and indicated prevention programs, with particular attention to the academic needs of students with emotional disturbances served in special education.

Other sources point out emerging trends and practices in school mental health that highlight successful collaboration between schools, communities, and families.[266] As such, several EBPs build on prevention efforts and provide diverse community-based approaches for addressing mental health needs within a school environment. These approaches are summarized below.

Community-Partnered School Behavioral Health (CP-SBH) is a term used for supporting student behavioral health along the full prevention-intervention continuum by bringing together community behavioral health providers with schools and families. These community providers augment existing school resources to provide a more comprehensive array of services (e.g., trauma-informed care, medication management, substance use prevention) within the school building.[267] These partnerships allow schools to expand their behavioral health capacity through enhanced staffing, resources, skills, and knowledge. Comprehensive service provision

through CP-SBH can include screening prevention for students identified as at risk for behavioral health problems, and specialized intervention services such as clinical assessment and treatment. CP-SBH programs share several best practice policies and procedures, including establishing and maintaining effective partnerships, integrating community-partnered school behavioral health into multi-tiered systems of support (universal prevention, targeted prevention, individualized intervention and supports, specialized support for substance use and abuse problems), and utilizing empirically supported treatments. In addition, CP-SBH programs also focus on facilitating family-school-community teaming; collecting, analyzing, and utilizing data; and obtaining, sustaining, and leveraging diverse funding streams.[268] Some of the advantages of this approach include improving access to behavioral health services, reducing the stigma of seeking services, being able to generalize treatment to the child's school environment, and having an impact on attendance and educational outcomes.

Social Emotional Learning (SEL) is the process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, feel, and show empathy for others, establish, and maintain supportive relationships, and make responsible and caring decisions. It encourages school-family-community partnerships to create educational experiences that foster trusting and collaborative relationships.[269] The framework consists of five core competencies:

1. Self-Awareness,
2. Self-Management
3. Social Awareness,
4. Relationship Skills, and
5. Responsible Decision-Making.[270]

As of 2023-24 school year, 83% of principals reported that their schools used an SEL curriculum.[271] Further evidence indicates that a well-implemented SEL program improves academic, emotional, and behavioral outcomes for children.[272] To be effective, a program should incorporate four areas:

1. Sequenced activities that are led in a coordinated and connected way to model and emphasis skills.
2. Active forms of learning to enforce skills
3. Focused on developing one or more social skills.
4. Explicit about targeting specific skills.[273]

For more information about SEL, see: https://casel.org/.

Multi-Tiered System of Supports (MTSS) is an approach based on a problem-solving model that documents students' performances after changes to classroom instruction have been made to show that additional interventions are needed. It ensures that instruction and interventions are matched to student needs. PBIS is consistent with the principles of MTSS, which include research-based instruction in general education, universal screening to identify additional needs, a team approach to the development and evaluation of alternative interventions, a multi-tiered application of evidence-based instruction determined by identified need, continuous monitoring of the intervention, and parent involvement throughout the process.[274]

- In Colorado, MTSS was defined in 2016 as a prevention-based framework of team-driven data-based problem solving for improving the outcomes of every student through family, school, and community partnering and a layered continuum of evidence-based practices applied at the classroom, school, district, region, and state level and has five components:
    1. Team-Driven Shared Leadership,
    2. Data-Based Problem Solving and Decision-Making,
    3. Family, School, and Community Partnering,
    4. Layered Continuum of Supports, and
    - Evidence-Based Practices.[275]

Positive Behavioral Interventions and Supports (PBIS) is an Implementation framework for maximizing the selection and use of evidence-based prevention and intervention practices along a multi-tiered continuum that supports the academic, social, emotional, and behavioral competence of all students.[276] The model includes Tier 1 (everyone), Tier 2(small groups), and Tier 3 (individual/intensive) systems of support that improve functioning and outcomes (personal, health, social, family, work, and recreation) for all children and youth by making problem behavior less effective, efficient, and relevant – while making desired behavior more functional. PBIS has three primary features: (1) functional (behavioral) assessment; (2) comprehensive intervention, and (3) lifestyle enhancement.[277, 278, 279, 280] The value of schoolwide PBIS integrated with mental health services and supports, according to the Bazelon Center, lies in its three-tiered approach. Eighty percent (80-90%) of students fall into Tier 1. For them, schoolwide PBIS creates "a social environment that reinforces positive behavior and discourages unacceptable behaviors."[281] Tier 2 students benefit from some additional services, often provided in coordination with the mental health system. This, the report notes, makes it "easier to identify students who require early intervention to keep problem behaviors from becoming habitual"[282] and to provide that intervention. Finally, tier-three students, who have the most severe behavioral-support needs, can receive intensive services through partnerships between the school, the mental health system, other child-serving agencies, and family. The Center for Positive Interventions and Supports (PBIS) has more information about this approach and its specific interventions.[283]

The Interconnected Systems Framework (ISF)[284] enhances the MTSS framework by helping schools extend the array of mental health supports provided to students and families through collaboration with community providers. ISF provides a structure and process for education and community providers to interact in an efficient and effective way to improve education and life outcomes for students. For example, by partnering with your mental health authority or local community-based mental health providers, schools can more effectively respond to the increased mental and behavioral health needs of students.

Restorative Justice in Education (RJE) stems from the broader practice of Restorative Practices (RP), which are an approach rooted in the philosophy and principles that positive interpersonal relationships are the foundation for individuals being productive members of a community. RP places emphasis on maintaining and strengthening those relationships as the primary way of improving the environment and overall climate of a given community.[285] In a school setting, a restorative, relational approach to improving student behavior and building school community focuses on processes that foster belonging over exclusion, social engagement over control, and meaningful accountability over punishment.[286] Fully evolving to a restorative approach involves a change in how staff, teachers, and administration views the roles of students, teachers, and leadership. There is a shift in how relationships within the school function. Relationships are considered the foundation of RJE.[287]

The Denver Public Schools Restorative Justice Project also serves as a model example.[288] In the 2007–2008 school year, over 1,000 referrals were made for restorative justice services (unduplicated count of 812 students), with almost 180 of these cases being provided in lieu of suspension or for reduced out-of-school suspension as a result of the referral. Over half (52%) of the cases resulted in a "restorative agreement." Students, parents, and teachers all gave strong endorsement for the restorative justice process, noting its fairness and helpfulness with resolving conflicts as well as its influence on students' improvements in listening skills, empathy, anger control, respect, and appropriate reparative action planning. All participating schools showed reductions in out-of-school suspensions and expulsions compared to the prior year's total.[289]

Interpersonal Psychotherapy for Adolescents Skills Training (IPT-AST) is a manualized program delivered by mental health clinicians at schools. The program aims to decrease depressive symptoms by helping youth improve their relationships and interpersonal interactions. The psychotherapy group teaches youth communication strategies and interpersonal problem-solving skills that they can apply to their relationships. In order to implement IPT-AST to fidelity, training must be received through the treatment developers. For more information about IPT-AST, see: https://policylab.chop.edu/people/jami-young.

The **Cognitive Behavioral Intervention for Trauma in Schools** (CBITS) program focuses primarily on reducing symptoms of posttraumatic stress disorder, depression, and behavioral problems for children and youth in grades three through eight. CBITS, which was first used in the 2000–2001 school year in the Los Angeles Unified School District, adopts a school-based group and intervention focus. Although primarily directed toward younger children, CBITS has been expanded to include high school students who have experienced notable trauma. Structurally, the program uses a mix of session formats, featuring group sessions, individual student sessions, parent psychoeducational sessions, and a teacher educational session. The program is administered by mental health clinicians and claims effectiveness with multicultural populations.[290] In order to implement CBITS to fidelity, training and certification must be received through the treatment developers. For more information about CBITS, see: https://cbitsprogram.org/.

Teacher-Child Interaction Therapy (TCIT) is a professional development, train-the-trainer-model designed to strengthen teacher-child relationship skills for children with disruptive behavior or those at risk of developing disruptive behavior. It is a prevention and intervention program. TCIT is implemented in elementary schools or early childcare settings. To implement TCIT to fidelity, training and certification must be received through the treatment developers. For more information about TCIT, see: http://www.tcit.org or https://pcit-training.com/teacher-child-interaction-training-training-calendar/.

Promoting Alternative Thinking Strategies (PATHS) is a program designed to reduce aggressive behavior and increase social competencies in children aged four to 12 years. The curriculum is designed to be used by educators to help children with poor classroom behavior and performance. Although primarily focused on the school setting (small groups and classroom), information and activities are also included for use with parents. In order to implement PATHS to fidelity, training and certification must be received through the treatment developers. For more information about PATHS, see: http://www.pathstraining.com/main/.

Think:Kids is a program that uses a collaborative problem solving approach with students in a school environment. The program teaches skills related to problem solving, flexibility, and frustration tolerance. Unlike traditional models of discipline, this approach avoids the use of power, control, and motivational procedures; instead, it focuses on building helping relationships and teaching children and youth the skills they need to succeed. Documented outcomes included reductions in time out of the classroom, detentions, suspensions, injuries, teacher stress, and alternative school placement. In order to implement Think:Kids to fidelity, training and certification must be received through the model developers. For more information about Think:Kids, see: http://www.thinkkids.org/train/certification/.

Clinic and Home-Based Interventions

There is growing evidence that in most situations, children and youth can be effectively served in their homes and communities and that community-based treatment programs are often superior to institution-based programs. Studies show that except for children and youth with highly complex needs or dangerous behaviors (e.g., fire setting or repeated sexual offenses), programs in community settings are more effective than those in institutional settings; intensive, community-based, and family-centered interventions are the most promising.[291] Even children and youth with serious emotional disturbances and longstanding difficulties can make and sustain larger gains in functioning when treatment is provided in a family-focused and youth-centered manner within their communities.

The development and dissemination of evidence-based psychosocial interventions for children and youth has rapidly expanded in recent years. The ideal system would have well-established treatment protocols offered in clinics, schools, or homes with the objectives of (1) decreasing problematic symptoms and behaviors, (2) increasing youth and parent skills and coping, and (3) preventing out-of-home placement. This section describes EBPs for specific referral problems. This list is not meant to be exhaustive; rather, it provides examples that can be used as resources. Many of the EBPs discussed below fall under the umbrella categories of behavioral therapy or cognitive behavioral therapy in that the focus of intervention is on the cognitions, emotions, or behaviors of the child, youth, caregiver, or teacher, and on the variables that predict these outcomes.

Disruptive Behaviors

The Incredible Years[292] focuses on reducing disruptive behavior and preventing conduct problems, targeting infants to school-age children. This is accomplished through an interaction of three programs aimed at improving the skills of the child (in the areas of academic and social achievement), parent (to increase communication and nurturing approaches), and teacher (promoting effective classroom management and instruction of social skills). This curriculum particularly targets risk factors for conduct disorder and promotes a positive environment for the child both in the home and at school. To implement the Incredible Years program to fidelity, training and certification must be received through the treatment developers. For more information about the Incredible Years, see: http://www.incredibleyears.com/.

Positive Parenting Program (Triple P)[293] is aimed at teaching parents strategies to prevent emotional, behavioral, and developmental problems in their children. Triple P includes five levels of varying intensity (from the dissemination of printed materials to eight- to 10-session parenting programs and more enhanced interventions for families experiencing higher levels of relational stress). Using social learning, cognitive behavioral, and developmental theories in

combination with studies of risk and protective factors for these problems, Triple P aims to increase the knowledge and confidence of parents in dealing with their children's behavioral issues. To implement Triple P to fidelity, training and certification must be received through the treatment developers. For more information about Triple P, see: www.triplep.net.

Parent Management Training – The Oregon Model (PMTO) promotes social skills and prevents, reduces, and reverses the development of moderate-to-severe conduct problems in children and youth. PMTO focuses on parent training, classroom behavior management, and peer interventions. To implement PMTO to fidelity, training and certification must be received through the treatment developers. For more information about PMTO, see: https://www.generationpmto.org/.

Coping Power Program reduces disruptive behavior in school and home settings. Originally it was developed as a school-based program and has since been adapted to be delivered in outpatient mental health settings. The program is offered to late elementary and middle school students. Its curriculum components focus on skills to enhance emotional awareness, organizational skills, problem solving, goal setting, and social skills. These skills are taught in cognitive behavioral group sessions provided in schools, individual sessions at clinics, and behavioral training groups for parents and guardians. To implement the Coping Power Program to fidelity, training and certification must be received through the treatment developers. For more information about the Coping Power Program, see: https://www.copingpower.com.

Problem Solving Skills Training (PSST) reduces oppositional, aggressive, and antisocial behavior in children aged seven to 14 years. The program uses a cognitive behavioral method to teach parents and children more skillful behavior. Children are typically given homework to help them practice implementing these skills. Most sessions are individual, but parents may be brought in to observe and to learn how to assist in reinforcing new skills. To implement PSST to fidelity training must be received through the treatment developers. For more information about PSST, see: https://yaleparentingcenter.yale.edu/.

Parent-Child Interaction Therapy (PCIT) has strong support as an intervention for use with children ages three to six who are experiencing oppositional disorders.[294, 295, 296] PCIT works by improving parent-child attachment by coaching parents on how to manage their child's behavior. It uses structural play and specific communication skills to help parents implement constructive discipline and limit setting. PCIT teaches parents how to assess their child's immediate behavior and give feedback while an interaction is occurring. In addition, parents learn how to give their children direction toward positive behavior. A therapist guides parents through education and skill-building sessions and oversees practice sessions with the child. PCIT has been adapted for use with Hispanic/Latino and American Indian families. To implement

PCIT to fidelity, training and certification must be received through the treatment developers at PCIT International. For more information about PCIT, see: http://www.pcit.org/.

Multisystemic Therapy (MST) is a proven community-based treatment for youth ages 12-17 with intensive needs and their families. Research has shown that MST is effective for treating youth with complex needs, including those who have committed violent offenses, have serious mental health or substance abuse concerns, are at risk for out-of-home placement, or who have experienced abuse or neglect.[297, 298] MST is an intensive, home-based service model provided to families in their natural environment at times convenient to the family. It offers low caseloads and varies in frequency, duration, and intensity levels, with the average length of treatment being between three and five months. The primary goals of MST are to reduce youth criminal activity, reduce other types of antisocial behavior such as substance abuse, and achieve these outcomes while decreasing rates of incarceration and out-of-home placement. At its core, MST assumes that problems are multi-determined, and to be effective, treatment must have an impact and focus on multiple systems, such as a youth's peer group, family, schools, and neighborhood. Accordingly, MST is designed to increase family functioning by helping parents improve how they monitor their children, as well as reducing familial conflict and improving communication, among other factors. For more information about MST, see: http://www.mstservices.com/.

Multidimensional Family Therapy (MDFT) is a family-based program designed to treat a range of problem behaviors in youth, such as "substance abuse, delinquency, antisocial and aggressive behaviors, school and family problems, and emotional difficulties."[299] MDFT has good support for White, African American, and Hispanic/Latino youth between the ages of 11 and 18 across urban, suburban, and rural settings.[300, 301, 302] Treatment usually lasts four to six months and can be used alone or with other interventions. MDFT is a multi-component and multilevel intervention system that assesses and intervenes at three levels: (1) with the youth and parents individually, (2) with the family as an interacting system, and (3) with individuals in the family relative to their interactions with influential social systems (e.g., school, juvenile justice) that affect the youth's development. MDFT interventions are solution-focused and emphasize immediate and practical outcomes in important functional domains of the youth's everyday life. MDFT can operate as a standalone outpatient intervention in any community-based clinical or prevention facility. It also has been successfully incorporated into existing community-based drug treatment programs, including hospital-based day treatment programs. To implement MDFT to fidelity, training and certification must be received through the treatment developers. For more information about MDFT, see: http://www.mdft.org/.

Treatment Foster Care Oregon (TFCO) is a program that provides youth with (1) a consistent reinforcing environment where they are mentored, (2) daily structure, (3)

close supervision of their whereabouts, and (4) help to avoid deviant peer associations while providing them with the support and assistance needed to establish prosocial peer relationships. TFCO also has program versions for children and youth ages three to 18 years. In order to implement TFCO to fidelity, training and certification must be received through the treatment developers. For more information about TFCO, see: https://www.tfcoregon.com.

Autism Spectrum Disorders

Applied Behavior Analysis (ABA) has good support for the treatment of autism, particularly in young children.[303, 304, 305, 306, 307, 308] ABA can be used in a school or clinic setting and is typically delivered between two and five days per week for anywhere from two weeks to 11 months. ABA is one of the most widely used approaches for children and youth with autism. The ABA approach teaches social, motor, and verbal behaviors as well as reasoning skills. ABA teaches skills using behavioral observation and positive reinforcement or prompting to teach each step of a behavior. Generally, ABA involves intensive training for therapists, extensive time spent in ABA therapy (20 to 40 hours per week), and weekly supervision by experienced clinical supervisors known as certified behavior analysts. It is preferred that a parent or other caregiver be involved in helping generate these skills outside of school. In the ABA approach, developing and maintaining a structured working relationship between parents and professionals is essential to ensure consistency of training and maximum benefit. In order to implement ABA to fidelity, ABA therapists must obtain certification as a Board-Certified Behavior Analyst® (BCBA® or BCBA-D). For more information about ABA, see: https://www.bacb.com.

Anxiety

Cognitive Behavioral Therapy (CBT) has demonstrated significant and enduring treatment outcomes, and effects lasting for a minimum of one year after treatment.[309] Furthermore, researched CBT interventions showed the greatest amount of diversity among study participants, treatment format, treatment setting, and therapist background. CBT is most frequently provided in individual or group therapy, parent training, or teacher consultation. These protocols involve a *cognitive* component — sessions dedicated to psychoeducation, recognizing the physical signs of anxiety, direct work on cognitive distortions, and instructions on coping skills. These protocols also involve a *behavioral* component, which is referred to as exposure and response prevention. Generally, the younger the child, the more parent training is involved in these protocols. There is typically more emphasis on exposure and response prevention than on cognitions, which can be difficult to assess in young children.

CBT protocols are effective for many different kinds of anxiety disorders (e.g., separation anxiety, phobias, obsessive-compulsive disorder). For these different diagnoses, the focus of the treatment differs, but all the protocols will gradually and systematically help children

approach their fears and decrease their avoidance (e.g., avoiding separation from caregivers in the case of separation anxiety, or avoiding social situations in the case of social anxiety).

- Social Effectiveness Therapy for Children and Adolescents (SET-C) [310] is an exposure and response prevention protocol for children and youth ages seven to 17 years that targets social phobia. This protocol includes group social skills training, peer generalization sessions, and individual exposure therapy sessions.
- FRIENDS[311] is a family-based, group cognitive-behavioral treatment for children and youth ages seven to 16 years who meet criteria for depression or generalized anxiety disorder, social phobia, or separation anxiety disorder. Although primarily developed for implementation in a group format by trained mental health providers, it can also be delivered in individual session format and implemented by teachers, counselors, and youth workers who have undergone accredited training.
- Coping Cat Parents[312] is a 16-session, cognitive behavioral protocol for children ages seven to 13 years who meet criteria for generalized anxiety disorder, social phobia, or separation anxiety disorder. The protocol involves individual sessions with the child or youth, and parent training sessions. There is an adolescent version of this protocol (C.A.T. Project) for youth ages 14 to 17 years.
- Acceptance and Commitment Therapy (ACT)[313] is considered a "third wave" CBT protocol. This approach differs from traditional CBT in that the aim is not better control of thoughts, feelings, sensations, memories, but rather mindfulness to and acceptance of these private experiences. ACT demonstrates greater changes in psychological flexibility, mindfulness, and valued living as compared to CBT. ACT has been studied in youth with social anxiety, obsessive-compulsive spectrum disorders, and depression. There are a variety of protocols for ACT depending on the setting or target population.

These protocols are most frequently taught in doctoral programs for clinical child psychologists. Continuing education in CBT for already licensed professionals can be obtained through the following organizations:

- The Beck Institute for Cognitive Behavioral Therapy,
- The Academy of Cognitive Therapy, and
- The National Association of Cognitive-Behavioral Therapists.

Mood Disorders

CBT[314, 315, 316] has been the most widely researched treatment for adolescent depression. There are many individual protocols for CBT for youth. These protocols are most frequently taught in doctoral programs for clinical child psychologists. As noted above, continuing education in CBT for already licensed professionals can be obtained via the following organizations:

- The Beck Institute for Cognitive Behavioral Therapy,
- The Academy of Cognitive Therapy, and

- The National Association of Cognitive-Behavioral Therapists.

Family Focused Treatment for Adolescents (FFT-A) is a psychosocial treatment for youth with bipolar disorder that consists of 21 sessions (12 weekly, six biweekly, and three monthly) for nine months. Sessions involve the youth with bipolar disorder, their parents, and available siblings. The focus of the first seven to 10 sessions is psychoeducation. Later, the focus is on communication enhancement training and problem-solving skills training. To implement FFT to fidelity, training must be received through the treatment developer at **David Miklowitz, PhD, who can be contacted at** dmiklowitz@mednet.ucla.edu.

Multi-Family Psychoeducational Psychotherapy (MF-PEP) is an eight-session (90 minutes per session) group treatment for children ages eight to 12 years old with mood disorders. Sessions begin and end with children and parents together; the bulk of each session is run separately for parents and children. To implement MF-PEP to fidelity, training must be received through the treatment developer **Mary A. Fristad, PhD, ABPP, whose background and contact information can be found at this link:** https://wexnermedical.osu.edu/neurological-institute/researchers/mary-fristad-phd-abpp.

Interpersonal Psychotherapy for Adolescents (IPT-A) is a treatment for adolescent depression that focuses on how interpersonal issues are related to the onset or maintenance of depressive symptoms. The treatment addresses emotion regulation, communication, and problem-solving skills. In order to implement IPT-A to fidelity, training must be received through the treatment developer Laura Mufson, PhD, whose background and contact information can be found at this link: https://www.columbiapsychiatry.org/profile/laura-mufson-phd.

Trauma-Related Disorders

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has strong support for efficacy with children and youth ages three to 18 years and their parents.[317, 318, 319, 320] It can be provided in individual, family, and group sessions in outpatient settings. TF-CBT addresses anxiety, self-esteem, and other symptoms related to traumatic experiences. This treatment intervention is designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. It integrates cognitive and behavioral interventions with traditional child abuse therapies to enhance children and youth's interpersonal trust and re-empowerment. TF-CBT has been applied to an array of anxiety symptoms as well as intrusive thoughts of the traumatic event, avoidance of reminders of the trauma, emotional numbing, excessive physical arousal/activity, irritability, and trouble sleeping or concentrating. It also addresses issues commonly experienced by traumatized children and youth, such as poor self-esteem, difficulty trusting

others, mood instability, and self-injurious behavior, including substance use. TF-CBT has been adapted for Hispanic/Latino children and youth and some of its assessment instruments are available in Spanish.[321] In order to implement TF-CBT to fidelity, training and certification must be received through the treatment developers at the TF-CBT National Therapist Certification Program: https://tfcbt.org/.

Prolonged Exposure Therapy for Adolescents (PE-A) is a treatment that facilitates adolescents' processing of trauma through in vivo and imaginal exposure techniques. PE-A emphasizes psychoeducation and behavioral relaxation training. In order to implement PE-A to fidelity, training and certification must be received through the treatment developers at: https://www.med.upenn.edu/ctsa/pe_certification.html.

Cognitive Processing Therapy is a treatment for trauma that uses cognitive modification, exposure, and behavioral activation techniques. To implement cognitive processing therapy to fidelity, training and certification must be received through the treatment developers at: https://cptforptsd.com/achieving-provider-status/.

Trauma and Grief Component Therapy for Adolescents (TGCTA) is an evidence-based, assessment-driven treatment for adolescents ages 11-21 who have been exposed to trauma, bereavement, traumatic bereavement, or other life adversities, placing them at high risk for severe and persistent distress, functional impairment, and developmental disruption. Originally designed for small group settings, TGCTA can also be used effectively in individual treatment. TGCTA is guided by a developmental psychopathology model of childhood traumatic stress, multidimensional grief theory, and a strengths-based, wellness-oriented conceptual framework. TCTA has shown effectiveness in reducing posttraumatic stress reactions, maladaptive grief, depression, school problems, disruptive behavior, and violent behavior.

Child-Parent Psychotherapy (CPP) is an intervention model for children aged 0-5 who have experienced traumatic events and/or are experiencing mental health, attachment, and/or behavioral problems. The treatment is based in attachment theory and integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. Therapeutic sessions include the child and parent or primary caregiver. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g. cultural norms and socioeconomic and immigration-related stressors). Targets of intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. For children exposed to trauma, caregiver and child are guided

to create a joint narrative of the traumatic event and to identify and address traumatic triggers that generate dysregulated behaviors and affect.

Suicidal and Self-Injurious Behaviors

Dialectical Behavior Therapy (DBT) is an evidence-based form of cognitive behavioral therapy for people who experience significant trouble managing their emotions, thoughts, and behaviors. DBT is well supported for adults and adolescents (DBT-A),[322, 323, 324] and has moderate support for children (DBT-C) with severe emotion dysregulation. DBT-A includes parents or other caregivers in the skills training group. This inclusion allows parents and caregivers to coach their adolescents in developing skills and improve their own skills for interacting with their adolescent. Therapy sessions usually occur twice a week. DBT strategies include both acceptance-oriented (validation) and more change-oriented (problem-solving) approaches. DBT proposes that comprehensive treatment needs to help children and youth develop new skills, address motivational obstacles to implementing these skills, and generalize what they learn in their daily lives. It also needs to keep therapists motivated and skilled. In standard outpatient DBT, these four functions are addressed through four different modes that support treatment delivery: group skills training, individual psychotherapy, telephone coaching between sessions, and a therapist consultation team meeting. Skills are taught in four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. To implement DBT to fidelity, training and certification must be received through the treatment developers at Behavioral Tech: https://behavioraltech.org/.

Eating Disorders

Dialectical Behavior Therapy: Specific adaptations of the original DBT model have been developed for eating disorders. To implement DBT to fidelity, training and certification must be received through the treatment developers at Behavioral Tech: https://behavioraltech.org/.

Family-Based Therapy (FBT or "Maudsley Approach") is an intensive outpatient treatment where parents play an active role in helping their youth restore their weight to normal levels. To implement FBT to fidelity, training and certification must be received through the treatment developers at: http://train2treat4ed.com/fbt-for-anorexia-nervosa.

Substance Abuse

Multidimensional Family Therapy: See our summary in the Disruptive Behaviors subsection and, for more details, see: http://www.mdft.org/.

Multisystemic Therapy: See our summary in the Disruptive Behaviors subsection and, for more details, see: http://www.mstservices.com/.

Dialectical Behavior Therapy: See our summary in the Suicidal and Self-Injurious Behaviors subsection for more details. Specific adaptations of DBT have been developed for substance abuse. In order to implement DBT to fidelity, training and certification must be received through the treatment developers at Behavioral Tech: https://behavioraltech.org/.

Brief Strategic Family Therapy is a problem-focused, family-based approach to eliminating substance abuse risk factors. It targets problem behaviors in children and youth ages six to 17 years and strengthens family functioning. Brief Strategic Family Therapy provides families with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill-building strategies to strengthen family relationships. It targets conduct problems, associations with anti-social peers, early substance use, and problematic family relations; it also has support for use with Hispanic families.[325, 326] In order to implement Brief Strategic Family Therapy to fidelity, training and certification must be received through the treatment developers at: http://www.bsft.org/.

Functional Family Therapy (FFT) is a short-term (approximately 30 hours) family therapy intervention and juvenile diversion program for children and youth ages of 11 and 18 who are at risk of substance abuse, and their families, targeting a range of behavior problems, including violence, drug use/abuse, and conduct disorder as well as family conflict. FFT targets intervention toward multiple areas of family functioning and ecology and features well-developed protocols for training, implementation (i.e., service delivery, supervision, and organizational support), and quality assurance and improvement.[327] FFT focuses on family alliance and involvement in treatment. The initial focus is to motivate the family and prevent dropout from services. Intervention incorporates community resources for maintaining, generalizing, and supporting family change.[328] To implement FFT fidelity, training and certification must be received through the treatment developers at: https://www.fftllc.com/.

Motivational Interviewing (MI) is an evidence-based approach to help people address their ambivalence to change. There are four core principles: express empathy, roll with resistance, develop discrepancy, and support self-efficacy.[329] Multiple disciplines use MI and much of the literature focuses on reducing the use of substances and addressing co-occurring (mental health and substance use) disorders.[330]

Grief and Bereavement

Multidimensional Grief Therapy (MGT) is an intervention designed to reduce unhelpful grief reactions (grief that keeps kids "stuck"), promote adaptive grief reactions (grief that helps kids to cope better after a death), and help bereaved children and adolescents lead healthy, happy, productive lives. *MGT* includes specific treatment sessions that target each dimension of grief as described by multidimensional grief theory based on each child's individual assessment. *MGT*

sessions also include a number of caregiver-child exercises that help to build communication and *caregiver grief facilitation* (caregiver behaviors or activities that help youth to grieve in adaptive ways).

Trauma and Grief and Component Therapy for Adolescents (TGCTA): See our summary in the Trauma-Related Disorders subsection and, for more details, see this fact sheet.

Risk of Out-of-Home Placement

Parents play a major role in these empirically supported treatment protocols. Without a stable caregiver, many of the protocols described above would be difficult to implement effectively. Therefore, for children and youth who are at risk for out-of-home placement, the following programs should be considered in addition to the EBPs discussed above.

Wraparound Service Coordination (based on the standards of the National Wraparound Initiative) is an integrated care coordination approach delivered by professionals, alongside youth and family partners, for children and youth involved with multiple systems who are at the highest risk for out-of-home placement.[331, 332, 333] Wraparound is not a treatment per se. Instead, wraparound facilitation is a care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they address the needs of the child or youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of children and youth and their family members. Finally, there is an emphasis on integrating children and youth into the community and building the family's social support network. The wraparound process also centers on intensive care coordination by a child and family team (CFT) coordinated by a wraparound facilitator. The family, the youth, and the family support network comprise the core of the CFT members, who are joined by parent and youth support staff, providers involved in the care of the family, representatives of agencies with which the family is involved, and natural supports chosen by the family. The CFT is the primary point of responsibility for coordinating the many services and supports that are involved with the family, with the family and child/youth ultimately driving the process. The wraparound process involves multiple phases, with responsibility for care coordination increasingly shifting from the wraparound facilitator and the CFT to the family.[334]

Coordinated Specialty Care (CSC) for first-episode psychosis (FEP) is delivered by a multi-disciplinary team of mental health professionals, including psychiatrists, therapists and substance use disorder counselors, employment specialists, and peer specialists. Early detection of psychosis is important since people with psychoses typically do not receive care and treatment until five years after the onset of symptoms.[335] The CSC team provides community education activities and develops strategic partnerships with key entities in the community, which are critical elements of the program. The team also plays a role in detecting emerging psychosis and creating channels through which youth and young adults can be referred for treatment. CSC is individually tailored to the person experiencing early psychosis and it actively engages the family in supporting recovery. CSC provides effective treatments for psychosis, including medication management, individual therapy, and illnesses management as well as other less common evidence-based approaches such as Supported Education and Supported Employment that are known to help people with serious mental illnesses retain or recover a meaningful life in the community. The ultimate goal of CSC is to provide effective treatment and support as early in the illness process as possible so that people can remain on a healthy developmental path. A 2016 study by Kane and colleagues on the multi-site Recovery After an Initial Schizophrenia Episode (RAISE) study (conducted across 34 clinics in 21 states) showed that study participants had a better quality of life and were more involved in work and school, especially when they received CSC within the first 17 months of the onset of psychosis.[336] CSC was better than care as usual at helping people remain on a normal developmental path. Researchers have also compared the costs of CSC to care as usual and found that CSC was less expensive per unit of improvement in quality of life.[337] According to the CSC model on which the two RAISE programs are based,[338] teams should, at a minimum, consist of the following:[339]

- A team leader or coordinator (PhD or master's degree) who is responsible for the client's overall treatment plan and programming as well as the team's coordination and functioning.
- A psychiatrist[340] trained in treatment of early psychosis, who provides medication management, actively monitors and helps ameliorate medication side effects, and coordinates treatment with primary care and other specialty medical providers.
- A primary clinician (PhD or master's degree), who provides in-depth individual and family support, suicide prevention planning, and crisis management, and, along with the team leader and other clinicians, assists with access to community resources and supports as well as other clinical, rehabilitation, and case management-related services.
- A Supported Employment specialist (occupational therapist or master's level clinician) to help consumers re-enter school or work.
- Recent developments in FEP care have increasingly led to the expectation that a peer specialist should also be included on the team.[341] This position should be filled by a

person who has experienced serious mental illness and has been able to recover from it or develop a productive and satisfying life while continuing to receive treatment.

Assertive Community Treatment (ACT) for Transition-Age Youth uses a recovery/resilience orientation that offers community-based, intensive case management and skills building in various life domains. It also includes medication management and substance abuse services for youth ages 18 to 21 with severe and persistent mental illness. More broadly, ACT is an integrated, self-contained service approach in which a range of treatment, rehabilitation, and support services are directly provided by a multidisciplinary team composed of psychiatrists, nurses, vocational specialists, substance abuse specialists, peer specialists, mental health professionals, and other clinical staff in the fields of psychology, social work, rehabilitation, counseling, and occupational therapy. Given the breadth of expertise represented on the multidisciplinary team, ACT provides a range of services to meet individual consumer needs, including (but not limited to) service coordination, crisis intervention, symptom and medication management, psychotherapy, co-occurring disorders treatment, employment services, skills training, peer support, and wellness recovery services. Most ACT services are delivered to the consumer within their home and community rather than provided in hospital or outpatient clinic settings, and services are available around the clock. Each team member is familiar with each consumer served by the team and is available when needed for consultation or assistance. The most recent conceptualizations of ACT include peer specialists as integral team members. ACT is intended to serve individuals with severe and persistent mental illness, significant functional impairments (such as difficulty with maintaining housing or employment), and continuous high service needs (such as long-term or multiple acute inpatient admissions or frequent use of crisis services).[342, 343, 344]

The **Intensive In-Home and Child and Adolescent Psychiatric Services** (IICAPS) model was developed by Yale University to provide a home-based alternative to inpatient treatment for children and youth returning from out-of-home care or who are at risk of requiring out-of-home care because of psychiatric, emotional, or behavioral difficulties. Services are provided by a clinical team that includes a master's-level clinician and a bachelor's-level mental health counselor. The clinical team is supported by a clinical supervisor and a child and adolescent psychiatrist. IICAPS services are typically delivered for an average of six months. IICAPS staff also provide emergency crisis response 24 hours a day, seven days a week.

HOMEBUILDERS is an intensive family preservation program designed for children and youth from birth to 17 years who are at imminent risk of out-of-home placement or scheduled to reunify with their families within a week.[345] The program uses intensive, on-site intervention aimed at teaching families problem-solving skills that might prevent future crises. HOMEBUILDERS is structured around a quality enhancement system, QUEST, which supports a

three-part methodology (delineation of standards, measurement and fidelity of service implementation, and development of quality enhancement plans), offers training for state agencies, and claims a significant success rate (86%) of children and youth who have avoided placement in state-funded foster care and other out-of-home care.[346] HOMEBUILDERS generally intervenes when families are in crisis and provides an average of 40 to 50 hours of direct service on a flexible schedule.[347]

Partners with Families & Children: Spokane (**Partners**)[348] is a service that relies on referrals from child welfare, law enforcement, or public health agencies. As such, Partners' main goal is to assist children, youth, and their families in situations of persistent child neglect or those in which briefer interventions are unlikely to be effective.[349] The program is a community-based family treatment program based on wraparound principles and focused on enhancing parent-child relationships through case management, substance abuse and mental health services, and parenting resources provided by an individualized family care team. These components aim to better assist the whole family in the cessation or prevention of neglect and maltreatment, working toward recovery through the combined efforts of an assigned family team coordinator, a core team (which involves partnerships with community organizations such as schools and Head Start programs), and family team meetings.[350] Partners' approach is designed to place parents at the center of a teamwork-driven model that creates therapeutic change to address immediate and anticipated problems that might otherwise lead to neglect, abuse, and removal.[351]

Out-of-Home Treatment

Residential treatment is no longer considered the most beneficial way to treat children and youth with significant difficulties. The 1999 Surgeon Generals' Report on Mental Health states, "Residential treatment centers (RTCs) are the second most restrictive form of care (next to inpatient hospitalization) for children and youth with severe mental disorders. In the past, admission to an RTC was justified on the basis of community protection, child protection, and benefits of residential treatment. However, none of these justifications have stood up to research scrutiny. In particular, youth who display seriously violent and aggressive behavior do not appear to improve in such settings, according to limited evidence."[352]

Residential treatment represents a necessary component of the continuum of care for children and youth whose behaviors cannot be managed effectively in a less restrictive setting. However, as residential treatment is among the most restrictive mental health services provided to children and youth, this level of intervention should be reserved for situations when less restrictive placements are ruled out. For example, specialized residential treatment services are supported for youth with highly complex needs or dangerous behaviors (e.g., fire setting) that may not respond to intensive, nonresidential service approaches.[353] Yet, on a

national basis, children and youth are too often placed in residential treatment because more appropriate community-based services are not available.

The Substance Abuse and Mental Health Services Administration (SAMHSA) created the National Building Bridges Initiative (BBI) to identify and promote best practices and policies.[354] BBI is now an independent 501(c)3 organization devoted to developing strong and closely coordinated partnerships and collaborations between families, youth, community- and residential-based treatment and service providers, advocates, and policymakers.[355] Resources, tip-sheets and tools to ensure best practices can be found at: www.buildingbridges4youth.org.[356]

Although it is typically preferable to treat children and youth in their homes and communities, they sometimes need to be placed outside of their homes for their own safety or the safety of others. Safety should be the primary determinant in selecting out-of-home treatment as an option, as the evidence-based community interventions described above allow for even the most intensive treatment services to be delivered in community settings. Whether the child or youth is facing a temporary situation or a crisis or requires longer-term care, the ideal residential intervention should be based on the core values and principles outlined in the BBI Joint Resolution, which focus on the following:

- Family-driven and youth-guided care and engagement,
- Cultural and linguistic competence,
- Clinical excellence and quality standards,
- Accessibility and community involvement,
- Transition planning,
- Workforce development, and
- Evaluation and continuous quality improvement.[357]

When residential treatment is provided, there should be extensive family involvement. Residential (and community-based) services and supports need to be thoroughly integrated and coordinated, and residential treatment and support interventions need to work to maintain, restore, repair, or establish relationships between the child/youth and their family and community. Family involvement is essential throughout the course of residential treatment, especially at admission, in the development of the treatment plan, when milestones are reached, and in discharge planning.

Treatment foster care is another promising area, particularly Treatment Foster Care Oregon (TFCO). TFCO, formerly Multidimensional Treatment Foster Care, is the most well-known and well-researched intensive foster care model. TFCO has demonstrated effectiveness as a cost-effective alternative to group or residential treatment, incarceration, and hospitalization for

youth who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. TFCO is a well-established EBP that has demonstrated outcomes and cost savings when implemented with fidelity and with research support for its efficacy with Caucasian, African American, and American Indian youth and families.[358,359,360,361] There is an emphasis on teaching interpersonal skills and on participation in positive social activities including sports, hobbies, and other forms of recreation. Placement in foster parent homes typically lasts about six months. Aftercare services remain in place for as long as the parents choose, but typically last about one year. To implement TFCO to fidelity, training and certification must be received through the program developers at: https://www.tfcoregon.com/index.php/implementation/.

Keeping Foster and Kin Parents Supported and Trained (KEEP®) was developed by the developers of the TFCO model. KEEP® is a skills development program for foster parents and kinship parents of children ages zero to five years and youth (KEEP SAFE™). The 16-week program is taught in 90-minute group sessions to seven to 10 foster or kinship parents. Facilitators draw from an established protocol manual and tailor each session to address the needs of parents and children.[362] The goal of the program is to teach parents effective parenting skills, including appropriate praise, positive reinforcement, and discipline techniques.[363] Childcare and snacks are provided as part of the sessions. A small study of the program funded by the U.S. Department of Health and Human Services Children's Bureau showed fewer placement breakdowns, fewer behavioral and emotional problems, and fewer foster parents dropping out from providing care.[364] A larger randomized study in San Diego showed that biological or adoptive parents who participated in the KEEP® program were reunified with their children more frequently. The study also showed fewer disruptions from foster placements. KEEP® has been implemented in Oregon, Washington, California, Maryland, New York City, and four regions in Tennessee, as well as in Sweden and Great Britain. To implement KEEP® to fidelity, training and certification must be received through the program developers at: https://www.keepfostering.org/.

The Crisis Continuum

Developing a full continuum of crisis response has been shown to keep children and youth safely in their homes, schools, and communities and helps avoid unnecessary placements in hospitals and residential settings.[365] Examples of crisis response includes warm lines; 24 hours a day, seven days a week hotlines; mobile crisis supports; short- to intermediate term- in-home supports; and local out-of-home options such as respite care, 23-hour stabilization/observation beds, and short-term residential interventions.

Often, the first strategy to address a behavioral health crisis is the use of phone support or telehealth support. In these situations, it is important that the service provider can screen, assess, and triage as well as the capacity to provide ongoing consultation, time-limited follow-

up care, and linkages to transportation resources. These activities should be supported by protocols and electronic systems that communicate results to professionals and systems to determine the appropriate level of services.

In some circumstances, it may be necessary to provide a mobile response. A mobile crisis service includes home-, school-, and community-based crisis response care for the purpose of de-escalation, assessment, and safety and treatment planning. A number of states offer child and youth-specific mobile crisis response systems, with Texas recently joining the ranks (in addition to New Jersey, Kansas, Nevada, Oklahoma, Louisiana, and Ohio). The most evidence-based and well-established of such models is Connecticut's Mobile Response and Stabilization Services (MRSS). In Texas, Youth Crisis Outreach Teams (YCOTs) serve children and youth between the ages of 3-17 and feature robust relationships with community partners to meet urgent needs with an urgent response. MRSS/YCOT programming always entails rapid response to crises and strengths-based, trauma-responsive care with an aim of reducing more restrictive, out-of-home placements or placement disruption. In addition to initial crisis response, MRSS/YCOT provides extensive follow-up services, which can serve anyone in the family who needs support as there is an established link between the stability of children and their caregivers/family members. Follow-up services providing ongoing stabilization, skills training, and connection to longer-term care options within the community.

Summary Statement

The focus of this appendix is on the use of evidence-based practices (EBPs) in children's mental health. Its purpose is to help clinicians, agencies, and decision-makers identify what works when treating various mental health conditions and disorders. As demonstrated in this appendix, there are many programs, practices, and techniques that have evidence of effectiveness, and using these EBPs have been shown to improve outcomes. The list of EBPs is always changing as new research is conducted and new data are obtained. Currently, there are a host of clinical trials underway that will continue to add information to this growing field. The good news is that we are getting better at knowing what works. Unfortunately, knowing what works and doing what works are two separate issues. The goal is for practitioners and policymakers to have the best available scientific evidence to make informed decisions about what to do and when.

Appendix L: Collaborative Care Model

The Collaborative Care Model (CoCM) is an extensively evidenced-based model for behavioral health integration in primary care and pediatric settings. CoCM has been shown to be effective for various behavioral health problems across diverse populations and treatment settings. Furthermore, CoCM is the integrated behavioral health model with the strongest evidence-base to effectively address the needs of our mental health care system, especially for children and youth.[366,367,368,369]

CoCM is a systematic and evidence-based approach[370] to delivering mental health services effectively and efficiently in primary care and pediatric settings at a population level. In CoCM, a team of professionals, including a primary care provider or pediatrician, consulting psychiatrist and a behavioral health care manager (BHCM), work together to coordinate care and ensure access to the best treatment available for a patient's needs. CoCM is particularly adept at detecting common behavioral health problems like depression because it incorporates another proven approach: universal screening and measurement-informed care (MIC). After implementation of CoCM, every medical visit includes screening for common behavioral health disorders (e.g., depression or anxiety), like routine measurement of common physical health markers like blood sugar and cholesterol. When a need is detected, the CoCM team implements a measurement-guided care plan based on evidence-based practice guidelines and follows each patient to defined treatment targets.[371]

Evidence-Based Principles

CoCM has five primary evidence-based principles or pillars.

Figure L-1. CoCM Principles

Patient-centered Team Care
CoCM is patient-centered, meaning that all care delivered through the model is done, to the greatest extent possible, with the patient's interests, preferences, and schedule in mind. All three core members of the CoCM team work together to achieve this goal.
Population-based Care
CoCM leverages a care team to screen an entire patient population and influence the care of far more patients than they would be able to see working on their own, allowing a whole population of patients to be carefully managed and enter treatment more quickly and preventing patients from falling through the cracks.
Measurement-based Treatment to Target
When outcomes are tracked in the CoCM treatment registry, the CoCM treatment team is responsible for ensuring that patients' outcome scores improve according to evidence-based metrics, such as response or remission.
Evidence-based Care
CoCM is itself evidence-based, and additionally, the model incorporates other evidence-based treatments, including medication prescribing guidelines (that may include the use of treatment algorithms) and brief interventions such as cognitive behavioral therapy, problem solving therapy, or motivational interviewing.
Accountable Care
In CoCM, the clinical team is incentivized to provide high-value care, as opposed to high-volume care. The team may regularly be presented with data on their patients' treatment progress, providing the opportunity for clinicians to continuously improve their treatment strategies.

Collaborative Care Model Clinical Workflow

CoCM presents an innovative approach to integrating behavioral health services within pediatric care settings, aiming to improve early identification of behavioral health needs and access to youth mental health care. A broad-based overview of a pediatric CoCM program clinical workflow is as follows.

After adopting universal behavioral health screening, a pediatric practice must define the target population and diagnostic scope for its CoCM program. For example, a practice may define its target population as pediatric patients between the ages of four and 21, and its diagnostic scope as depression, anxiety, and ADHD. Patients in the target population who screen positive for conditions within the diagnostic scope or display concerning signs/symptoms are considered for referral to the CoCM program.

Typically, the pediatrician will inform the patient and their guardian of the program and offer them enrollment. For billing purposes, the pediatrician informs the patient and guardian that, depending on their health insurance, they may receive a monthly bill for CoCM services (i.e., cost sharing). This discussion between the pediatrician, patient (as developmentally appropriate), and guardian is considered the "consent process." Verbal consent must be documented in the medical record. Uninsured patients and their guardian(s) should also be informed that they may receive a bill for CoCM services (though they may not be required to pay the bill due to sliding scale payment arrangements). If the patient is ultimately enrolled in CoCM, the pediatrician will connect them with the program's BHCM.

The BHCM connects with the patient and guardian via warm handoff in person, by telephone, or through secure messaging to schedule an intake visit. During this visit, the BHCM conducts a full behavioral health evaluation that explores current symptoms in addition to a comprehensive history of diagnoses, treatments (including medication and psychotherapy), higher acuity care, and comorbid medical problems. In this evaluation, the BHCM also administers evidence-based assessments, such as the Patient Health Questionnaire-9 Modified for Adolescents (PHQ-A) and the Generalized Anxiety Disorder-7 (GAD-7). The BHCM may, with guardian permission, speak with a school representative to obtain BH assessment teacher reports (e.g., Vanderbilt Assessment Scale) or other relevant collateral information. The BHCM writes a draft report of the findings from the intake evaluation and enters demographic data, visit data, and assessment results into the patient registry.

During weekly case reviews with the psychiatric consultant, the BHCM reviews the treatment registry broadly, with each patient considered for detailed discussion. The BHCM and psychiatric consultant typically discuss new patients and those with acute events; patients who are not responding to treatment or following up as scheduled with the BHCM are also prioritized. The BHCM, with help from the psychiatric consultant, develops a personalized treatment plan, which may include parent training, interaction with school-based care, medication recommendations, brief psychotherapy, and/or psychosocial interventions for new patients. This plan is then described in the BHCM's report, which is preliminarily discussed with the patient and guardian and sent to the pediatrician. The pediatrician then reviews the patient's treatment plan with recommendations from the rest of the CoCM team.

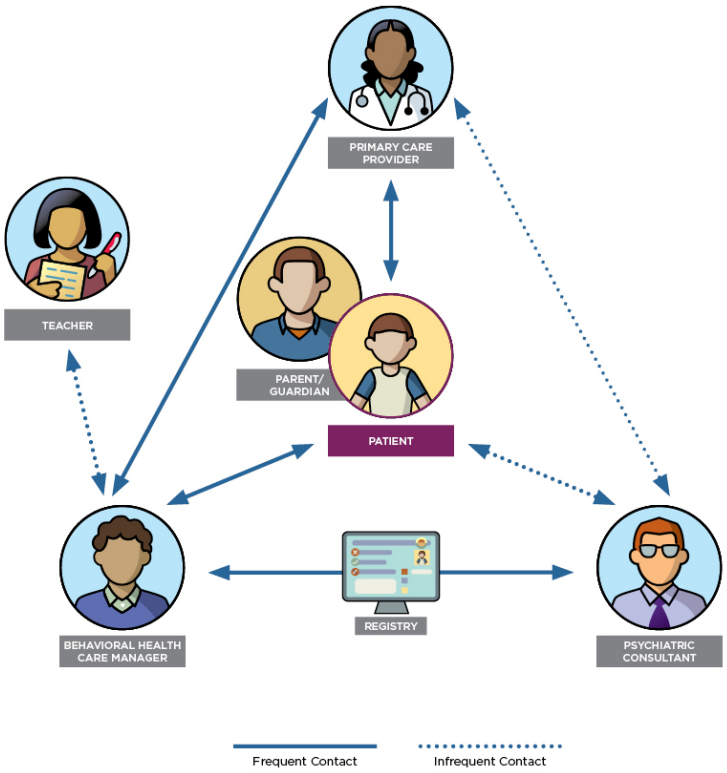
If the psychiatric consultant recommends medications and the pediatrician agrees, the pediatrician will write prescriptions and schedule a visit with the patient and guardian to discuss the recommended medications further. The pediatrician is always welcome to ask follow-up questions of the CoCM team. Due to this bidirectional collaboration, CoCM provides valuable real-time education opportunities for pediatricians, rendering them more knowledgeable about relevant psychopharmacology during future patient encounters. When

the CoCM team recommends specific psychotherapy, these services are typically delivered by the BHCM directly. The BHCM most commonly provides brief behavioral health interventions, such as motivational interviewing or behavioral activation, though other modalities or psychosocial interventions may be used as indicated. In some cases, patients can be referred to community providers (while still being followed in CoCM) if they require more extensive therapy, long-term therapy, or additional interventions for which the BHCM is not adequately trained.

After the CoCM intake visit and initial recommendations, patients are followed closely by the BHCM. Typically, patients interact with the BHCM and potentially their guardians, a minimum of two times per month while in active treatment. During each interaction between the patient, guardian, and BHCM, the BHCM administers evidence-based assessments, and adds follow-up results to the treatment registry. The goal for each target symptom is remission, which is defined differently for each instrument. With the PHQ-A, for example, remission is defined as a score of less than five. Patient treatment response is also tracked, which is typically defined as a reduction from the baseline score of 50% or more with the PHQ-A. Of note, the choice of instruments is discretionary for each CoCM program. The BHCM and psychiatric consultant update treatment plans for existing CoCM patients during case review sessions based on clinical progress. All treatment plan updates, including updated medication recommendations, are sent to the pediatrician. Each patient is considered for review weekly in case review sessions with the psychiatric consultant (and is reviewed at least monthly). The BHCM also remains in close contact with the patient's guardian to discuss treatment recommendations and proposed changes. Additionally, the BHCM may remain in ongoing communication with school representatives or teachers, if indicated and permissible. On average, patients remain in the active treatment phase of the program for three to six months.

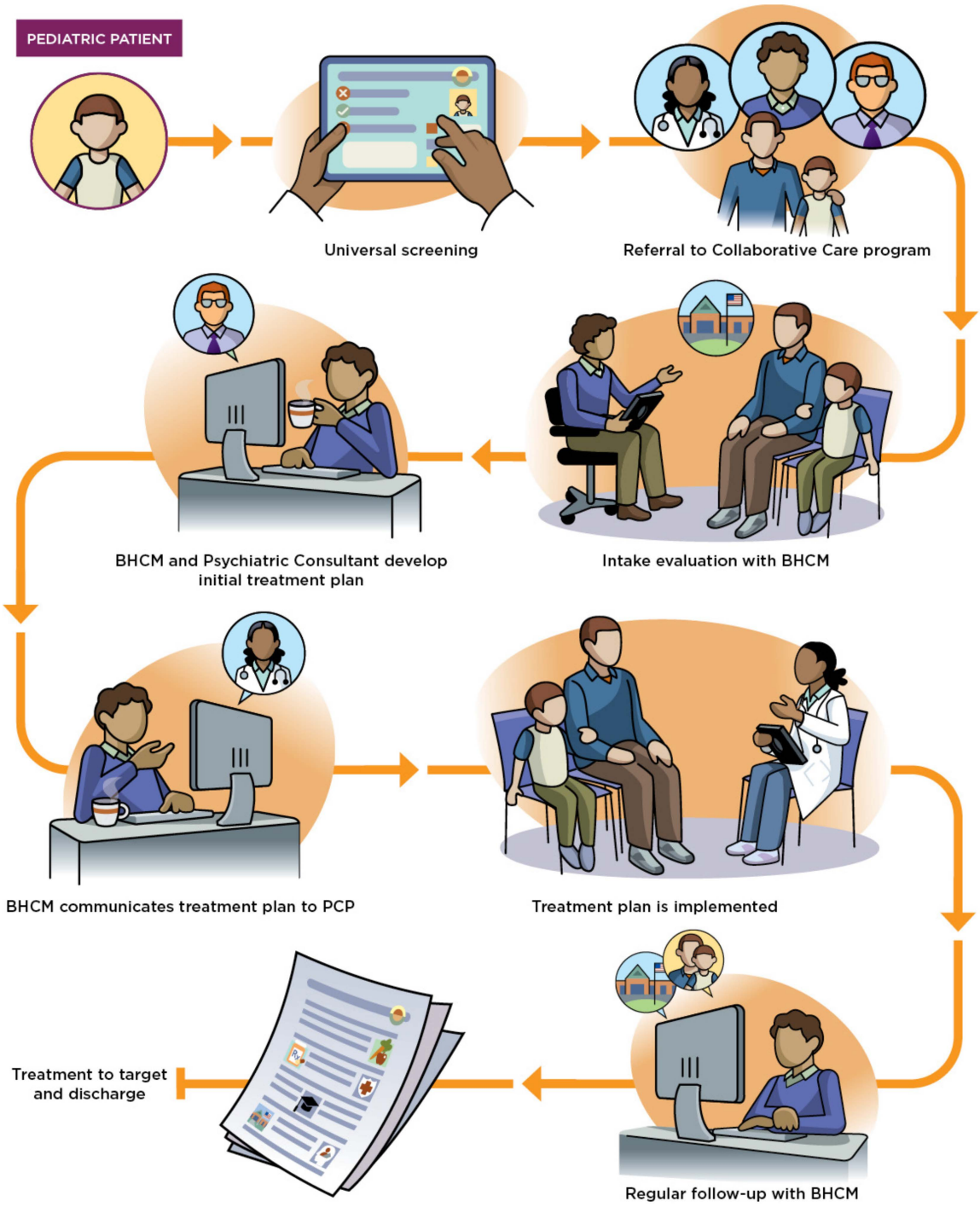
A patient moves from active treatment into the relapse prevention phase of the CoCM program when they achieve symptom response or remission. At this point, the patient's frequency of interaction with the BHCM typically decreases to approximately once per month, and the clinical focus shifts to creating a plan to mitigate future worsening of symptoms. This relapse prevention plan integrates the patient’s goals, medication recommendations (if applicable), and guidance on the use of key therapy skills interventions. After successful maintenance in relapse prevention for two to three months, patients are typically discharged from CoCM and back to the care by their pediatrician entirely. Patients can re-enroll in CoCM if clinically necessary.

Figure L-2. CoCM



Primary care providers participating in the CCMP can access free CoCM technical assistance and implementation support at no cost, including billing support, one-on-one coaching, and workflow development. The New York State OMH tailors its technical assistance to each provider by administering an informal needs assessment and addressing their unique needs to support CoCM implementation. And yet, despite the efficacy demonstrated through CoCM, and the many accolades the state has received for piloting and implementing CoCM in New York, the model remains underutilized in the state and region. Funded through a managed care carve-out arrangement, state level policy and program decisions have created administrative hurdles further complicating the implementation of CoCM and making the process challenging for many providers.

Figure L-3. Pediatric Collaborative Care Model Clinical Workflow



Appendix M: Colorado Pediatric Psychiatry Consultation and Access Program (CoPPCAP)[372]

What is The Colorado Pediatric Psychiatry Consultation and Access Program?

The Colorado Pediatric Psychiatry Consultation and Access Program (CoPPCAP) provides a range of services to support the integration of behavioral health into pediatric primary care. CoPPCAP's key services include:

- **Psychiatric Consultation**: Real-time, peer-to-peer psychiatric consultations for pediatric primary care providers. This allows clinicians to receive guidance on the assessment, management, and treatment of children and adolescents with mental health concerns.
- **Care Coordination**: The program helps connect patients and families with appropriate community-based mental health resources and services, ensuring coordinated and comprehensive care.
- **Provider Education**: Delivers training and educational opportunities for pediatric primary care teams to build their knowledge and skills in identifying, addressing, and referring patients with behavioral health needs.
- **Telehealth Support**: The program leverages telehealth technology to provide access to psychiatric consultations, particularly for providers and families in rural or underserved areas.
- **Resource Navigation**: Maintains a directory of local and statewide mental health resources, which it shares with primary care practices to facilitate patient referrals and linkages to care.

Figure M-1. CoPPCAP

CoPPCAP
Colorado Pediatric Psychiatry Consultation & Access Program

Colorado Pediatric Psychiatry Consultation and Access Program

Question: How do I assess and treat mental health concerns in primary care?

Answer: CoPPCAP! CoPPCAP aims to increase the ability and comfort of primary care clinicians to provide basic mental health assessment and treatment for their child and adolescent patients.

Core Components:

1) Telephone consultation (within 45 minutes of a request) with a child psychiatrist or e-consult answered within 24 hrs. **Toll-Free Number: 1-888-910-0153 (Monday - Friday 9:00 AM - 4:30 PM)**
2) Access to information about community resources through a clinical care coordinator/navigator.
3) Free education opportunities through different formats (see below)
4) A toolkit of screening tools and educational materials provided through website.
5) Direct face-to-face or telehealth consultation for patients with difficult diagnostic or treatment issues.
6) Payor blind, may seek consultation for any patient in practice up to age 25.
7) Community of Practice: monthly virtual gathering to discuss cases.

Sample of Free Educational Sessions			
ECHO Core Essentials (8 sessions, 3-4 times/year)	**ECHO Beyond Core Essentials (8 sessions, 3-4 times/year)**	**Learning Collaborative (September)**	**Lunch & Learn (as requested)**
Screening and Assessment	Treatment of Anxiety and Depression: Beyond 2 SSRIs	Motivational Interview	Screening Tools
What is Therapy?	Disruptive Behaviors in Preschoolers	Working with Parents of Preschoolers with Difficult Behaviors	Anxiety
ADHD	Disruptive Behaviors in School Age Children	Applying Acceptance and Commitment Therapy (ACT) in Primary Care	Suicide
Crisis and Chaos in the Primary Care Setting	Substance Use Disorder	Working with Interviewing Teens Around Mood (Depression) and Risk	Depression

What CoPPCAP participants have said:

- *Maura Capaul, FNP, Lafayette Pediatrics and Internal Medicine:* "I am so happy with your program. I take one piece of information from a consult and it's like a big cascade to apply with so many other patients!"
- *Michele Wallendal, MD, Pediatrics 5280:* "I want you to know that the last family you helped me find local resources for is extremely happy."
- *And always*: "Thanks so much; that was so very helpful."

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Toll-Free Number: 1-888-910-0153; **Fax** Number: 720-777-7309; www.CoPPCAP.org
NOTE: Pediatric provider line; not intended for use by parents

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HRSA
Health Resources & Services Administration

Appendix N: I Matter Program

I Matter offers therapy services by telehealth or in-person, depending on the patient preference and provider availability. All youth 18 years of age or younger qualify, as do youth ages 19-21 receiving special education services. Youth eleven or younger must have a parent to sign up. Youth and/or their parents and caregivers can sign up directly on the I Matter website after taking a short survey to help match the youth with a therapist.

Ninety-six agencies and 233 clinicians, including 34 Spanish speaking clinicians, provide services through I Matter. I Matter clinicians do not diagnose participating children and youth, but they do address common issues like anxiety, depression, coping skills, and family conflict. To determine a child's therapy needs, I Matter clinicians utilize the Pediatric Symptom Checklist, a screening tool that identifies changes in emotional and behavioral health and symptoms for children and the CRAFFT, a substance use screening tool validated for adolescents ages 12-21.

As of October 2023, there have been:

- 10,166 unduplicated youth participated in the program
- 82% show rate for scheduled appointments (October 2021 - October 2023)
- 58% of sessions have been telehealth, and 42% of sessions have been in person
- 1,016 sessions were provided in Spanish
- 1,215 youth served indicated they receive special education services[373]

At the time of the report, there were only nine on the waitlist, all of whom a care navigator had already contacted.

Figure N-1. I Matter

I Matter.

About The Program

In May 2024, Colorado **Senate Bill 24-001** officially established I Matter as a permanent behavioral health services program to provide free access to mental health services for youth.

The program is open to youth 18 years of age or younger or 21 years of age or younger if receiving special education services. Youth 12 and older can sign up without parent or guardian permission.

The program is funded by the Colorado Behavioral Health Administration, and provides up to six free behavioral health sessions for youth in Colorado and reimburses participating licensed therapists from agencies and independent contractors.

Youth and their parents/guardians can sign up for the program in less than 10 minutes at **IMatterColorado.org**, or **YoImportoColorado.org** for Spanish-language services. No insurance or other documentation is needed.

The I Matter program also has a statewide public awareness and outreach campaign. Both the awareness campaign and the IMatterColorado.org website were informed by youth feedback.

For general inquiries about the program, view the **FAQs**. To inquire about being a provider within the program, contact **providers@imattercolorado.org**.

To receive help with the website or support in scheduling a session, email **support@imattercolorado.org**.

To learn more about the progress of the program, view the I Matter reports **here**.

COLORADO
Behavioral Health Administration

Appendix O: Key Services Provided in the Continuum of Intensive Services

Continuum of Intensive Services in an Ideal System	
Program or Service	**Description and Services Provided**
Youth Assertive Community Treatment	Addresses the significant needs of children ages 10-21 who are at risk of entering high intensity services or returning home from high intensity services, such as inpatient settings or residential services, through the use of a multi-disciplinary team.
Multisystemic Therapy (MST)	MST is an intensive, home-based service model provided to families in their natural environment, at times convenient to the family, to help them function well and safely over the long term. The primary goals of MST are to reduce youth criminal activity, reduce other types of antisocial behavior such as drug abuse, and achieve these outcomes at a cost savings by decreasing rates of incarceration and out-of-home placement.
Coordinated Specialty Care Intensive Community Based Services (CSC)	A team-based approach to providing care for individuals experiencing early episodes of psychosis. This includes personalized treatment plans that integrate psychotherapy, medication management, supported employment and education, family education and support, and case management.
Intensive Outpatient Programs (IOP)	IOPs are an important part of the continuum of care and can serve as alternatives to inpatient hospitalization for children and youth with the most serious mental health needs. An IOP allows the child to remain in the community while attending treatment three to four days per week for several hours each day. This treatment modality utilizes group therapy and can have a specific focus on family support and therapy.
Partial Hospitalization Programs (PHP)	PHPs serve as an alternative to inpatient hospitalization or a step-down from inpatient hospitalization for children and youth with serious mental health needs. In a PHP, the child continues to reside at home but commutes to a treatment center five days a week, usually for a full day of treatment with time incorporated for educational support. This treatment makes use of group therapy and can be targeted toward family support and therapy.
Respite Care	Temporary relief for caregivers by providing short-term care for individuals with mental health conditions. This service allows caregivers to take a break while ensuring that their loved ones receive proper care and supervision in a safe environment.
Family Education and Support Services	Assistance and resources provided to families of individuals with mental health conditions. This can include educational programs, support groups, counseling, and other resources to help families cope and support their loved ones effectively.
Case Management	A coordinated approach to ensure that individuals receive comprehensive care and services. Case managers work with clients to develop and implement care plans, connect them with necessary resources, monitor progress, and adjust plans as needed to achieve optimal outcomes.

Appendix P: Multisystemic Therapy in Colorado

Implementation and Fidelity Monitoring in Colorado

MST Network Partners are the intermediary that supports MST providers develop, implement, and evaluate their MST programs by working with agencies, communities, tribes, and governmental entities.

Colorado providers partner with the below Network Partners:

- Mid-Plains Center for Behavioral Health
- MST Associates
- Rocky Mountain MST
- MST Services

MST Adaptations Available in Colorado

There are a number of MST adaptations being offered in Colorado by different providers. Some of the adaptations being offered are:

Adaptation	Description
MST	MST is a family and home-based treatment that strives to change how youth function in their natural settings- home, school and neighborhood- in ways that promote positive social behavior while decreasing antisocial behavior including substance use. The primary goals of MST are to: (a) reduce youth criminal activity; (b) reduce antisocial behavior including substance abuse; and (c) achieve these outcomes at a cost savings by decreasing rates of incarceration and out-of- home placement.
MST-Problem Sexual Behavioral (PSB)	This adaptation of MST is for youth, ages 10-17, with externalizing, delinquent behaviors, including aggressive (e.g., sexual assault, rape) and non-aggressive (e.g., molestation of younger children) sexual offenses.
MST-Substance Abuse (SA)	The MST-SA program name is reserved for use by MST programs specialized in serving a very high percentage of substance-abusing youth. Like MST, MST-SA is an evidence-based treatment for substance abuse that includes drug and alcohol testing.

MST Providers in Colorado

In Colorado there are seven distinct providers with most teams located in Denver.

Provider	Team Name	MST Adaptation	City	Zip Code	Network Partner
Savio House	Colorado Springs 1	MST	Colorado Springs	80903	Mid-Plains Center for Behavioral Health
	Savio Monday 1	MST	Denver	80219	Mid-Plains Center for Behavioral Health
	Savio PSB	MST-PSB	Denver	80219	Mid-Plains Center for Behavioral Health

Provider	Team Name	MST Adaptation	City	Zip Code	Network Partner
	Savio Tuesday 1	MST	Denver	80219	Mid-Plains Center for Behavioral Health
	Rocky Mountains Central	MST	Denver	80219	Mid-Plains Center for Behavioral Health
	Savio Wednesday 2	MST	Denver	80219	MST Associates
	Western Slope Team	MST	Denver	80219	MST Associates
	Savio Wednesday 1	MST	Denver	80219	Rocky Mountain MST
	Larimer Team	MST	Longmont	80504	Rocky Mountain MST
Synergy Outpatient Services	Synergy3	MST-SA	Denver	80236	MST Services
Four Feathers Counseling	FFC SOCO	MST	Colorado Springs	80905	Rocky Mountain MST
Health Solutions	Team Cactillama	MST	Pueblo		Rocky Mountain MST
	Team Molly Bo	MST	Pueblo	81001	Rocky Mountain MST
Mind Springs Health	Mind Springs Health MST	MST	Grand Junction	81501	Rocky Mountain MST
North Range Behavioral Health	North Range 2	MST	Greely	80631	Rocky Mountain MST
	NRBH Team 1	MST	Greely	80631	Rocky Mountain MST
Southern Colorado Community Action Agency	SoCoCAA West	MST	Ignacio	81137	Rocky Mountain MST
	Southern Colorado MST	MST	Ignacio	81137	Rocky Mountain MST

MST Funding in Colorado

In Colorado MST is funded through a combination of sources and has been offered in Colorado at least since 2018 and by a variety of providers across most of the regions of the state. Providers are providing basic MST and adaptations to youth populations such as foster care youth, juvenile justice and youth with substance use disorders.

Medicaid

The Colorado State Plan covers MST services (H2033). Provider requirements, MST Therapists are full-time Masters-level staff, or Bachelors-level staff with a minimum of five years appropriate clinical experience, in mental health or child welfare services. MST Clinical Supervisors are highly experienced Masters or Ph.D. level mental health or child welfare professionals.

Family First Prevention Services Act (FFPSA)

MST is written into The Colorado Department of Human Services' FFPSA Five-Year Plan.

State and Federal Funds

In 2018, Colorado Office of State Planning and Budget (OSPB) selected MST Expansion Program to receive implementation funds through a hybrid Pay For Success (PFS) approach. In a PFS approach the implementation and initial risk is shared between state and investors.

Appendix Q: Continuum of Crisis Service in an Ideal System

Values and Guidelines

Substance Abuse and Mental Health Services Administration (SAMHSA) practice guidelines provide an overview of the ideal continuum of crisis services and outline essential values for crisis services.[374] These values and guidelines emphasize:

- Rapid response
- Safety
- Crisis triage
- Active engagement of the person in crisis
- Reliance on natural supports

Table Q-1. Continuum of Crisis Services in an Ideal System

Continuum of Crisis Services in an Ideal System[375]	
Program or Service	**Description and Services Provided**
24/7 Crisis Hotline	These hotlines provide direct services delivered through a free telephone line that is answered 24 hours a day, 7 days a week (24/7) by licensed and trained staff. A 24/7 crisis hotline provides immediate support, appropriate referrals, and links to a mobile crisis team or emergency medical services (EMS) response, if appropriate.
9-8-8 Colorado Mental Health Line	The state version of the national emergency hotline allows anyone with emotional, mental health or substance use concerns to be immediately connected with a trained specialist. It offers free, immediate, confidential human support 24/7.[376]
Mental Health Integration with 9-1-1 Response	When someone calls 9-1-1 and reports a mental health emergency, the call center plays a role in dispatching law enforcement as the first response includes a mental health clinician who can manage calls with clinical expertise and effectively assess the presence of an emergency related to mental health needs.
Youth and Family Mobile Outreach Team	Community-based service for children, youth, and families who feel the child or youth is in crisis. Team members specialized in working with youth and caregivers deescalate crises, provide limited in-home supports, and link the young person and family to appropriate ongoing services. Such teams in multiple states have been shown to reduce emergency department use, psychiatric hospitalization, and out-of-home placement.
Crisis Transportation	A crisis system should include transportation services that are provided in a safe and timely manner when crisis services are needed. Ideally, this service is provided by mobile crisis teams, but may be also provided by EMS, or local law enforcement.

Continuum of Crisis Services in an Ideal System[375]	
Program or Service	**Description and Services Provided**
Children and Adolescent Walk-in Crisis Center	These centers are physical walk-in locations where crisis assessments and triage are conducted by licensed mental health clinicians with the support of a physician or advanced practice practitioner. Crisis urgent care centers, which may or may not be based in a hospital, provide immediate walk-in crisis services (including assessment), medication evaluation and administration, and support services.
Crisis Telehealth Services	Crisis telehealth services provide access to emergency psychiatry services at crisis facilities and other settings, allowing highly trained staff to provide interventions over the phone or video without the cost of the person in crisis needing to be on site continuously, or when services would otherwise be unavailable. These services include assessment, crisis de-escalation, and prescribing services.
Children's Crisis Stabilization	A team approach to stabilizing children at risk for behavioral health crises through short-term mental health consultation and treatment, intensive crisis respite support, and family peer advocacy. These services are provided to children and their families at home or other community-based locations by a team of professionals. Crisis Stabilization services are available to children whose symptoms and behaviors put them at risk for admission to a psychiatric hospital or ER, but for whom safety can be assured for at least 72 hours.
Children and Adolescent Psychiatric Emergency Centers	Also referred to as psychiatric emergency services, the essential functions of these centers include immediate access to assessment and triage, treatment, and stabilization for people with the most serious and emergent psychiatric symptoms. Services include assessment, treatment, and stabilization services.
Child and Adolescent Inpatient Psychiatric Treatment Centers	Inpatient psychiatric hospitalization is the highest level of care for individuals with acute safety concerns or serious impairment in functioning, such that they are not able to be cared for safely in the home or community setting. Inpatient psychiatric care is provided by a multidisciplinary team that may consist of psychiatrists, psychologists, social workers, nurses, and behavioral health technicians. The goal of an inpatient psychiatric hospitalization is to provide crisis stabilization and intensive treatment in a safe and therapeutic setting.
Children's Crisis Residence	A short-term, intensive, and supportive living environment for children and adolescents who are experiencing an acute psychiatric crisis. The goal of a Children's Crisis Residence is to provide immediate stabilization, assessment, and intervention in a safe and therapeutic setting, thereby avoiding the need for hospitalization or other more intensive levels of care.

Appendix R: Colorado Crisis Care Services Providers Reviewed

Program / Service and Colorado Providers	
24/7 Crisis Hotline	
• Colorado Crisis Services and national 988 response center	
Mental Health Integration with 9-1-1 Response	
• Colorado Crisis Services	
Mobile Outreach Teams	
• Aspen HOPE Center • Axis Health System • Centennial Mental Health Center • Denver Health and Hospital Authority • Diversus Health • Gunnison Valley Health • Health Solutions • Jefferson Center for Mental Health	• Mind Springs Health • North Range Behavioral Health • San Luis Valley Behavioral Health • Solvista • Specialized Alternatives for Families and Youth • SummitStone Health Partners • Valley-Wide Health Systems • Your Hope Center
Crisis Transportation	
Not available in Colorado	
Walk-In Crisis Center	
• AllHealth Network • Aurora Mental Health Center • Axis Health System • Diversus Health • Health Solutions	• Jefferson Center for Mental Health • Mental Health Partners • North Range Behavioral Health • WellPower
Crisis Telehealth Services	
• Colorado Crisis Services	
Children's Crisis Residences	
• Jefferson Center for Mental Health	
Children's Crisis Stabilization	
• Jefferson Center for Mental Health	
Psychiatric Emergency Centers	
• Centennial Peaks Hospital • Children's Hospital Colorado • Denver Health • Parkview Medical Center	• St. Mary's Medical Center • UCHealth • West Springs Hospital
Hospital Emergency Departments	
• Arkansas Valley Regional Medical Center • Aspen Valley Hospital • Banner Health • Centennial Peaks Hospital • Children's Hospital Colorado • Community Hospital • Delta County Memorial Hospital • Denver Health	• Parkview Medical Center • Penrose-St. Francis Health Services • Porter Adventist Hospital • Presbyterian/St. Luke's Medical Center • Saint Joseph Hospital • San Luis Valley Health • Sky Ridge Medical Center • Southeast Colorado Hospital

Program / Service and Colorado Providers	
• Estes Park Health • Family Health West Hospital • Grand River Hospital • Health One • Littleton Adventist Hospital • Lutheran Medical Center • Melissa Memorial Hospital • Montrose Regional Health • North Colorado Medical Center	• Southwest Memorial Hospital • St. Mary's Medical Center • St. Vincent Hospital • Swedish Medical Center • UCHealth • Vail Health Hospital • West Springs Hospital • Yuma District Hospital
Child and Adolescent Inpatient Services	
• Cedar Springs Hospital • Children's Hospital Colorado • Denver Health	• Denver Springs • Peak View Behavioral Health

Appendix S: Youth Crisis Outreach Teams

Youth Crisis Outreach Teams (YCOT) is a home and community-based crisis intervention model that works across family systems to provide rapid crisis response and stabilization services in settings, such as schools, with the goal of helping a person stabilize and connect with ongoing services to prevent reoccurrence.

The YCOT model aims to prevent emergency room use and the disruptive, out-of-home placement and care for children and youth, it also aims to treat emerging concerns rapidly before a situation escalates further or becomes unsafe. Creating a response model that is based on what the child, youth, or family consider urgent must be the basis of any YCOT model. Extending this family-centered approach to include peers and siblings empowers YCOTs to help anyone in the family who needs connections to appropriate supports and ongoing services. This strategy strengthens the whole family unit and helps to equip the family with the skills they need to avoid future crises. The approach requires creative problem solving, caregiver skill building, and strong referral pathways to community services.

Relationships with child-serving community partners are also critical to the model's success. YCOTs must invest heavily in building relationships with schools, which are often where children and youth experience crises. Moreover, how schools handle these crises has a substantial influence on outcomes. In Connecticut, almost half (45% in 2023) of child and youth mobile team deployments are in schools.[377] This is critical because schools are often hesitant to trust outside parties in crisis situations and thus choose to respond on their own or bring students to the hospital where they often wait for hours to be seen and are sent home with little in the way of services. For schools to feel comfortable using YCOTs, they must provide rapid response by being able to anticipate what to expect when a team is deployed and receive follow-up support from the team after a crisis event. Building school relationships is time consuming and requires deliberate effort but will greatly increase the success of the model.

Crisis mobile teams are considered by SAMHSA, among other experts, an essential component of the crisis continuum of mental health care. These teams provide rapid crisis response and stabilization services at home or in community settings, with the goal of helping a person stabilize and connect with ongoing services to prevent recurrence. Mobile crisis teams are interdisciplinary in nature, making them uniquely equipped to deal not only with clinical presentations, but external factors as well. Mobile outreach services for all ages include crisis de-escalation and stabilization, screening and assessment, safety planning, and care management focused on connections to long-term mental health services.

Efficacy of Youth Crisis Outreach Teams

While difficult to track, the holistic, whole-family approach used by YCOTs helps strengthen families, which benefits all children and youth in a home. The use of YCOTs is increasing nationally, with important lessons learned from other states[31] and localities based on their experiences that are worth mentioning:

- YCOT response should be face-to-face in most instances. For example, Connecticut has a face-to-face response rate of 85%.[32] Teams often respond to a crisis reported for one reason, but when they meet the family, they realize there are other, often more significant, concerns than what led to the initial call.
- Successful teams provide acute phase stabilization as well as ongoing stabilization; remaining connected to families for at least eight weeks and making warm connections for ongoing, community-based services; helping families more effectively tap into positive relationships and support systems.

Table S-1. Youth Crisis Outreach Team Benefits

YCOT Benefits At-A-Glance
Hospital diversion[378]
Decreased juvenile justice involvement[379]
Decreased entry to foster care and disruptions to placement[380]
Decreased truancy and missed school[381]

[31] Examples include Connecticut, Nevada, New Jersey, Ohio, Oklahoma, and Washington.

[32] Response rate was obtained from our conversations with administrators who oversee the Connecticut program.

Appendix T: Projected Costs for Youth Crisis Outreach Team (YCOT) Staffing Options

Table T-1. Projected Costs Per Youth Mobile Crisis Team[382]

Projected Costs Per Youth Mobile Crisis Team			
Salaries	**Salary/Rate**	**# FTEs**	**Cost**
Licensed Clinician	$92,470	3.0	$277,410
Family Support Peer Partner	$52,260	3.0	$156,780
Program Director	$102,420	1.0	$102,420
Psychiatrist	$225,650	0.2	$45,130
Sub-Total Salary		*7.2*	*$581,740*
Benefits	24%		$139,618
Total Personnel Costs		7.2	$799,800
Direct Costs	25%		$145,435
Total Direct Expenses			*$1,084,853*
Indirect	12%		$69,808
Total Program Costs			**$1,154,661**
Average Costs Per Child	**180 per year (15 per month)**		**$6,415**

Colorado could consider a tiered YCOT staffing model that can match availability to the needs of the community, given that some communities (like Denver) will need multiple teams and 24/7 access, and smaller communities may only need a team operating during day-time hours. The table below gives an overview of how costs and treatment approaches could vary across three levels of availability.

Table T-2. Youth Crisis Outreach Team (YCOT) Staffing Options Youth Crisis Outreach Team (YCOT) Staffing Options

Overview of 24/7 YCOT Coverage Staffing Options				
Tier	**Annual Cost Per Team**	**Full Coverage**	**Weekday Coverage**	**Weekend Coverage**
1	**$1.9M**	YCOT available 24/7 1 LPHA, 1 Family Partner or QMHP, and a supervisor available for clinical consult.	YCOT staff available for a total of 16 hours each weekday for crisis response, stabilization, follow-up care, and community outreach/engagement activities. YCOT Core Team available 8 hours. Reduced YCOT Team available 8 hours.	Reduced YCOT Team available for a total of 8 hours each weekend day for crisis response, stabilization, follow-up care, and community outreach/engagement activities.

Overview of 24/7 YCOT Coverage Staffing Options				
Tier	**Annual Cost Per Team**	**Full Coverage**	**Weekday Coverage**	**Weekend Coverage**
			On-call coverage provided by Reduced YCOT Team, available 24/7 for crisis response only.	On-call coverage provided by Reduced YCOT Team, available 24/7 for crisis response only.
2	**$1.7M**	YCOT available 24/7 1 LPHA, 1 Family Partner or QMHP, and a supervisor available for clinical consult.	YCOT staff available for a total of 12 hours each weekday for crisis response, stabilization, follow-up care, and community outreach/engagement activities. YCOT Core Team available 8 hours. Reduced YCOT Team available 4 hours. On-call coverage provided by Reduced YCOT Team, available 24/7 for crisis response only.	On-call coverage provided by Reduced YCOT Team, available 24/7 for crisis response only.
3	**$1.1M**	YCOT available 8 hours per weekday with potential for flexing time to expand coverage minimally.	YCOT staff available for a total of 8 hours each weekday for crisis response, stabilization, follow-up care, and community outreach/engagement activities (YCOT Core Team). No YCOT specific mobile response after hours or on weekends, expectation of alternative/pre-YCOT coverage.	No YCOT specific mobile response after hours or on weekends, expectation of alternative/pre-YCOT coverage.

Appendix U: Colorado Perinatal Resource Supporting Obstetric Screening, Psychiatric Education, Equity, and Referral (PROSPER)[383]

What is The Colorado Perinatal Resource Supporting Obstetric Screening, Psychiatric Education, Equity, and Referral initiative?

The Colorado Perinatal Resource Supporting Obstetric Screening, Psychiatric Education, Equity, and Referral (PROSPER) program, administered by the University of Colorado School of Medicine, is an initiative focused on integrating behavioral health services into maternal care. By leveraging the expertise within the Department of Psychiatry, PROSPER offers services to support obstetric providers and their patients throughout the perinatal period.

- **Obstetric Provider Support**
  - Provides training and education for obstetric providers on maternal mental health screening, assessment, and referral.
  - Offers guidance on implementing universal screening for perinatal mood and anxiety disorders within obstetric practices.

- **Psychiatric Consultation**
  - Connects obstetric providers with perinatal psychiatrists for real-time, expert consultation on the management of mental health conditions during pregnancy and postpartum.

- **Care Coordination**
  - Assists in linking pregnant and postpartum patients to appropriate community-based mental health services and resources.
  - Helps facilitate warm handoffs and follow-up to ensure continuity of care.

- **Provider Networking and Collaboration**
  - Facilitates networking and knowledge-sharing opportunities for obstetric providers, mental health clinicians, and other stakeholders.
  - Fosters interprofessional collaboration and the development of integrated care pathways.

- **Health Equity Initiatives**
  - Places a strong emphasis on addressing disparities in access to maternal mental health services, particularly for underserved and marginalized populations.
  - Works to identify and address barriers to care through targeted outreach and community engagement.

Figure U-1. PROSPER Flyer

Appendix V: Statewide School-Based Efforts Overview

School-Based Efforts Overview	
Project Advancing Wellness and Resiliency in Education (AWARE)	Project AWARE is a SAMHSA-funded initiative to establish sustainable school-based mental health infrastructure in Colorado. The program provides training and resources for implementing MTSS across school districts and fosters collaboration among CDE, state agencies, school districts, tribal education agencies, mental health providers, and families.
Landscape of Wellness & Belonging	Developed by Project AWARE, the Landscape of Wellness & Belonging is a virtual resource hub for educators, school leaders, and district staff.[384] It offers tools to support well-being and belonging in school communities, organized around five core components: school environment, relationships, health and well-being, social-emotional and behavioral skills, and engaging learning practices. Project AWARE designed the Landscape for use within the MTSS framework.
School Crisis Toolkit	The BHA, Office of School Safety, and the CDE are developing a School Crisis Toolkit[385] to help Colorado schools respond effectively to mental health crises. This toolkit will provide timely crisis assessment, intervention, and postvention strategies tailored to the needs of students and school communities. The Office of School Safety is the primary agency supporting safety planning for Colorado schools.
Behavioral Health First Aid Training Program	In June 2024, the General Assembly approved the Behavioral Health First Aid Training Program with CDPHE's Office of Suicide Prevention, funded with an annual appropriation of $250,000. This program trains educators, school staff, and youth organization employees to recognize warning signs of mental illness and substance use. Additionally, in April 2024, legislation was passed to establish a program within the BHA to support mental health training for school professionals in districts with limited access to care.[386]
Universal Screening for 6th - 12th Grade	In June 2023, the General Assembly approved the School Mental Health Assessment (HB23-1003), appropriating $475,000 per year. In participating schools, the BHA offers mental health screenings to identify students in need, contact parents, and connect them to services. Colorado schools use the Behavior Intervention Monitoring Assessment System (BIMAS-2) and the Devereux Student Strengths Assessment (DESSA) to evaluate behavioral health needs. Parents are notified in writing to allow for opting out of the program.[387]
Early Childhood Efforts	The Colorado Department of Early Childhood oversees Universal Preschool Colorado and develops curriculum to train early care professionals in addressing young children's mental health needs (HB22-1295). Additionally, Right Start Colorado is an initiative aimed at expanding infant and early childhood mental health services by enhancing workforce capacity for professionals serving children from birth to five years old.

Appendix W: School Mental Health Funding Sources

School districts in Colorado must braid and stack[388] a variety of funding sources to meet student needs. Most district funding is derived from the state's school funding formula established by Colorado's School Finance Act. Another significant source of revenue is categorical funds, which are state and federal dollars allocated to specific student populations or service areas (e.g., special education). Colorado Department of Education (CDE) and school districts face challenges in addressing gaps in mental health funding, as state and federal categorical funds typically do not cover these shortfalls.[389] School districts often seek additional funding sources to bridge financial gaps, such as voter-approved mill levy overrides (MLOs), marijuana tax revenue, opioid settlement funds, and various federal, state, and philanthropic grant opportunities, including Medicaid.

State Funding

The foundation of school-based mental health support in Colorado is built upon three key state grant programs:

- **The Behavioral Health Care Professionals Grant Program:** This program aims to increase the number of mental health professionals in schools, helping to address the growing demand for student mental health services.
- **The Comprehensive Health Education Grant:** This includes Student Wellness Grants, which support schools in implementing health education programs that promote overall wellness, mental health awareness, and resilience among students.
- **The K-5 Social and Emotional Health Act Pilot Grant:** This pilot grant focuses on developing and testing social and emotional learning initiatives for younger students, fostering a supportive environment that enhances emotional well-being.[390]

Additionally, in 2014, the Colorado General Assembly established the Marijuana Tax Cash Fund, which allocates sales tax revenue generated from the sale of retail and medical marijuana. The CDE receives a portion of this tax revenue to support the above grant programs, providing essential funding for mental health initiatives in schools.[391]

School Funding Finance Formula Overhaul

The School Funding Finance Formula Overhaul, enacted by the 74th General Assembly (2024) through HB 24-1448, was a landmark reform aimed at increasing educational funding by $500 million over six years.[392] It would have marked the first time since 2008 that Colorado met its constitutional requirements for funding school needs. However, despite bipartisan support for the overhaul, a projected budget shortfall of nearly $1 billion is raising concerns about the implementation timeline and potential reductions in funding. In November 2024, Governor Jared Polis' released a 2025-26 budget proposal that would shift some aspects of the financing overhaul to account for the budget shortfall. School district funding would be shifted from a

four-year enrollment average to a current-year enrollment estimate, a change that would reduce funding for districts with declining enrollment. Additionally, the governor's proposal would phase in the new school funding formula over the course of seven years instead of six. The powerful six-member Joint Budget Committee, which writes the budget and has the most say on spending, will soon begin crafting its proposal that it will release in March or April 2025.

Federal Funding

Colorado receives funding from various federal sources, with the Elementary and Secondary School Emergency Relief (ESSER) funds serving as a significant support mechanism since March 2020. Over $67 million of ESSER funds have been allocated specifically for mental health services and supports in schools.[393,GG] However, it is important to highlight that these funds expired in September 2024. And, even more worrisome, some Local Education Agencies (LEAs) have not fully utilized all their ESSER funding and are at risk of losing the funding. The CDE created a process for these LEAs to submit liquidation extensions through October 15, 2024, allowing the state to submit a request to the U.S. Department of Education (USDE) to permit some obligated ESSER funding to be spent through the end of December 2024 or through March 2026 if an extension is granted.[394]

In addition to these measures, the CDE is working to integrate existing ESSER-funded programs into ongoing school operations to ensure the sustainability of vital initiatives, particularly those related to mental health services.[395] To support this transition, HB 24-1406 was passed, establishing a new School-Based Mental Health Support Program. The BHA will administer the program, providing evidence-based mental health training, resources, and implementation support to public school educators. A key focus will be on assisting schools in rural areas and those with limited access to mental health care. Importantly, this new program is required to be implemented by the start of the 2025-2026 school year, ensuring continued support for students' mental health needs in Colorado.[396] Fortunately, in November 2024, the CDE received a $1.6 million five-year annual grant award (2025-29) to hire school-based mental health professionals and strengthen support for youth experiencing mental health challenges.[397]

School-Based Health Center Funding

Colorado has 72 SBHCs located within 31 school districts, and the Colorado Department of Public Health and Environment (CDPHE) provides core funding to 59 of them. More broadly, Colorado SBHCs rely on a variety of funding sources, including grants and reimbursement, and while most are publicly funded, some operate as commercial entities. Many SBHCs, such as Denver Health or Pueblo Community Health Center, are FQHCs and eligible for federal funding.

[GG] States can also use these funds to improve basic programs, summer learning and after-school programs, other support programs, evidence-based activities to meet comprehensive needs of students, supports for students with disabilities, student attendance and engagement, and supports for students experiencing homelessness.

Youth Healthcare Alliance provides a map of all Colorado School-Based Clinic locations. Additionally, 22 SBHCs collaborate with the BHA to implement adolescent substance use and mental health screening and intervention services. In SBHCs in Denver Public Schools, Denver Health offers similar services.[398]

District Mill Levy Override (MLO)

MLOs are locally authorized funding sources available exclusively for students within the district and are typically earmarked for specific programs or purposes outlined in the ballot language.[399] Placing an MLO on the ballot is a time and resource-intensive process, which poses significant challenges for lower-income districts. These districts often lack the financial and administrative capacity to navigate the complexities of the ballot process, leading to disparities in funding opportunities and contributing to inequities across school districts. A recent Colorado Health Foundation report highlighted a significant increase in successful MLOs that specifically allocate funding for youth behavioral health services in CO school districts. From 2015 to 2019, the number of successful MLOs with a youth behavioral health component rose dramatically from four to 16, indicating a strong trend toward prioritizing mental health in education funding.[400]

Medicaid School Health Services Program

The Medicaid School Health Services (SHS) Program allows Colorado school districts to claim reimbursement for Medicaid-covered services provided in schools.[401] Districts can use these funds to enhance, expand, or support health services available to their students. Unlike many states, where Medicaid reimbursement is limited to services specified in Individualized Education Plans (IEPs) or Individual Family Service Plans (IFSPs), Colorado expanded its SHS Program in 2020 to include any Medicaid-eligible student upon establishing medical necessity.[402] This expansion broadened the scope of reimbursement across school districts.

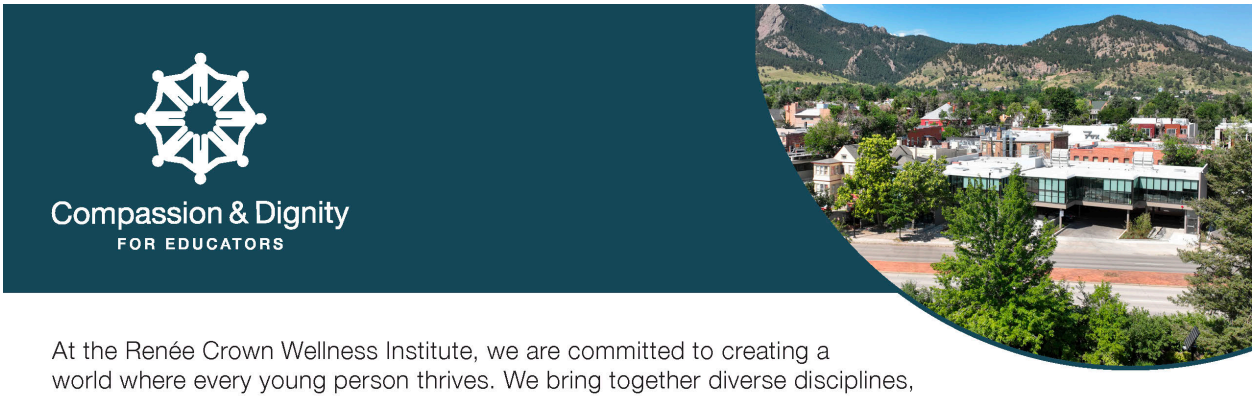
As of 2021, Medicaid reimbursement funds supported a total of 925 staff across school districts, including school psychologists and various special service providers, and allocated $16.7 million specifically for mental, social, and emotional health initiatives.[403] For districts with a high proportion of Medicaid beneficiaries, these reimbursements serve as a crucial revenue source, providing a sustainable funding stream for essential mental health services.

Opioid and Juul Lab Settlement Funds

In 2020, Colorado's attorney general reached a settlement with the e-cigarette manufacture Juul Labs, allocating funds to address youth vaping and opioid misuse. A total of $17.4 million from this settlement will be awarded to 42 schools and organizations. These grants will support educational programs, prevention initiatives, and treatment services, including $6 million

allocated for non-profits and government entities and $11.4 million for local education providers.[404]

Appendix X: Compassion and Dignity for Educators



At the Renée Crown Wellness Institute, we are committed to creating a world where every young person thrives. We bring together diverse disciplines, perspectives, and people to promote the wellness of young people and the systems and adults who support them through interdisciplinary research-practice partnerships. We seek to promote the wellness of young people and the systems and adults who support them through interdisciplinary research-practice partnerships. That is the shared work of the Renée Crown Wellness Institute.

The Compassion & Dignity for Educators Project brings together researchers, practitioners, PK-12 educators, and contemplative experts. From these many sources of expertise, we design, offer, and study programs and practices to support educators in cultivating compassion and dignity in schools.

GOALS

Educators are essential in tending to the hearts and minds of young people. Young people carry both tremendous stress and capacity for agency and action, and they are in need of caring adults who will support them and hold their dignity at the center of their work. And yet, educators also carry enormous stress and receive limited support to realize the dreams that led them to the teaching profession. Too often educators experience stress, overwhelm, and burnout, as well as moral distress from witnessing the pain of their students. (Diliberti et al., 2021; Gray et al., 2017; Marshall et al., 2022; Skaalvik & Skaalvik, 2011)

How can we address the increasing pressure on educators and schools today in ways that recognize the dignity of youth, their families and communities, and educators? One promising approach is through introducing educators to the practices of compassion within the context of teaching, learning, and leading in schools.

> *I didn't imagine that this course would affect me so much. It has greatly altered how I see the world, how I see myself, how I treat my spouse and kids, and what I expect from others. I feel empowered to know that I have inherent worth and am allowed to make mistakes like everyone else. I have given myself a lot more grace because of what I learned through this course. This course filled a need that I wasn't aware of lacking.*
>
> **– Middle School Teacher**

Our programs focus on the wellness of educators and schools, encouraging educators to develop greater capacities for compassion for self and others, to bring such knowledge and skill into their schools, and to work towards safe and caring schools that promote justice.

crown institute
The Renée Crown Wellness Institute
University of Colorado **Boulder**

Compassion and Dignity for Educators
OFFERINGS

The Compassion & Dignity for Educators programs integrate research in neuroscience, psychology, and education with the expertise of educators and contemplative wisdom. Educators engage in core activities including: compassion meditation practices, reflection and inquiry, community-building, and planning and organizing for compassion in action in their school communities.

Cultivating Compassion & Dignity in Ourselves and Our Schools Certificate

We collaboratively designed a digital certificate, Cultivating Compassion & Dignity in Ourselves and Our Schools, offered through the Teacher Leadership Program at the University of Colorado Boulder.

The certificate is a four-course sequence designed to prepare educators to lead efforts that promote compassion and dignity in educational settings and to provide supports and resources for caring for themselves and others and for cultivating and sustaining compassion in their school communities. The certificate was collaboratively designed by the Crown Institute and the Compassion Institute, working in collaboration with teachers, counselors, and administrators.

Nearly 100 educators have enrolled in the digital certificate program. Educators who completed the certificate report that they significantly increased their compassion for others and for themselves, and report that they experienced significantly lower burnout and stress over the four-course sequence. Educators also report responding more skillfully to suffering in their schools.

ASYNCHRONOUS COURSEWORK — **SYNCHRONOUS COURSEWORK**

COURSE 1: Awareness & Intention		COURSE 2: Self-Compassion & Dignity	COURSE 3: Compassion in its Fullness		COURSE 4: Capstone: Compassion in Action
Settling the Mind	Loving Kindness & Compassion for a Loved One	Compassion & Kindness for Self	Common Humanity	Broadening Compassion	Active Compassion

Compassion Cultivation Training© (CCT™) for Educators

CCT™ is an 8-week series for educators offered in partnership with the Compassion Institute and taught by certified CCT™ instructors at the Crown Institute. CCT™ is designed to develop the qualities of compassion, empathy, and kindness for self and others. Approximately 90 educators—including principals, district leaders, state curriculum leaders, teachers, and school-based mental health providers—have completed CCT™ for Educators.

> *"I felt like the course definitely helped me grow as a leader. It helped me realize that leading is not just the principal or vice principal or those big roles, but you can lead through your actions. You can lead through showing compassion. You can lead through standing up for something that you see by identifying that suffering."*
>
> **– Elementary School Teacher**

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University of Colorado Boulder

For more information, feel free to explore our website *www.colorado.edu/crowninstitute.*

Please contact *compassion-dignity@colorado.edu* with program-specific questions.

Appendix Y: Estimates of Colorado's Licensed Behavioral Health Workforce

Table EE-1 provides estimates of Colorado's behavioral health workforce. In 2021, Colorado had 11.7 active psychiatrists per 100,000 residents, slightly less than the national rate of 12.4 active psychiatrists per 100,000 residents. However, the state had a higher rate of child and adolescent psychiatrists, with 16.8 per 100,000 residents under 18, compared to the national rate of 15.4. In August 2024, there were 53.7 active psychologists per 100,000 residents. The most common behavioral health providers in August 2024 were licensed professional counselors, with 176.2 providers per 100,000 residents, and licensed social workers, with 161.7 providers per 100,000 residents.

Table Y-1. Colorado Behavioral Health Workforce[405,406]

Provider Type (data year)	Colorado		United States[407]
	Number of Providers	Providers Per 100,000 Population	Providers Per 100,000 Population
Psychiatrist[408, 409] (2021)	676	11.7	12.4
Child and Adolescent Psychiatrist[410] (2024)	208	16.8	15.4
Licensed Psychologist	3,099	53.7	-
Licensed Social Worker[411]	9,329	161.7	-
Licensed Marriage and Family Therapist	1,398	24.2	-
Licensed Professional Counselor	10,168	176.2	-
Licensed Addiction Counselor/Specialist	4,103	71.1	-

Appendix Z: Colorado's Professional Licensure Compacts

While entry or expansion in any state marketplace takes time, Colorado has an advantage over many other states regarding provider licensing because it participates in all major professional licensure compacts in the mental health space. Colorado is an Interstate Medical Licensure Compact (IMLC) state, meaning that qualified physicians from other member states—there are currently 40 member states, as well as the District of Columbia and the territory of Guam—have an expedited pathway to Colorado medical licensure.[412] Similarly, Colorado is a member of:

- The Psychology Interjurisdictional Compact (PSYPACT), which facilitates licensing for psychologists in participating states. Forty-two (42) states are PSYPACT members, and two other states have introduced PSYPACT legislation.[413]
- The Counseling Compact, which allows qualified licensed professional counselors living in one member state to practice in another member state more easily. Thirty-seven (37) states are currently Counseling Compact members.[414]
- The Social Work Licensure Compact (SWLC) is the newest of the professional compacts. The compact's language was finalized in January 2023, and multistate licenses will not be issued for another 12 to 24 months. Colorado is one of only 22 states to have enacted SWLC legislation.[415]

Appendix AA: Meadows Institute Framework for Addressing Mental Health Workforce Challenges

Table AA-1. Meadows Institute: Addressing Mental Health Workforce Challenges

Term	Definition(s)	Example(s)
Optimize	Making the most of provider skills, enabling providers to operate at the top of their training	Application of the Collaborative Care Model (CoCM) to fidelity
		AI-assisted charting technology
		Development of behavioral health care manager (BHCM) certification training programs
		The University/Children's Hospital offers a number of training opportunities to optimize the BH workforce
		Anshutz' program training child and adolescent psychiatric advance practice providers (APPs), to be competent, compassionate, and culturally sensitive
		Violet provides cultural competency analytics and training to better match patients to culturally competent care
	Connecting patients to the most appropriate care for their needs as efficiently as possible, reducing unnecessary load on the care system	Measurement-informed Care (MIC)
Sustain	Supporting the existing workforce, so its members will (a) remain in the workforce and (b) continue effectively serving people with mental health needs	Programs addressing provider burnout; CU Boulder Crown Institute has developed programs that address compassion fatigue in educators and co-designed an online certificate to support educators in cultivating compassion for self and others
Extend	Increasing the reach and impact of the existing mental health workforce	Training and inclusion of paraprofessionals in mental health care
		Contracting with digital mental health tech companies
		CoCM, which utilizes BHCMs in primary care settings, allowing psychiatrists to serve up to eight times the number of patients through CoCM vs. care as usual
		AI-assisted documentation tools

Appendix BB: Digital Solutions to Bolster the Mental Health Workforce and Youth Access to Care

Digital mental health technology (DMHT), such as telehealth and mental health apps, can impact the challenges of mental health workforce in the following ways:

1. **More effectively and efficiently match patient needs and providers' expertise:** To optimize the existing workforce for their highest and best potential, DMHT, powered by data science, helps match provider specialties with patient diagnoses and acuity levels, cultural fit, and insurance. It can also help overcome geographic barriers.

2. **Support universal screening for early identification:** Early identification and treatment are vital for expanding access to care and treating conditions when they are more manageable and require less intervention by credentialed clinicians. DMHT can be transformational in achieving earlier and increased universal screening in both educational and health settings at a large scale. DMHT helps by removing labor-intensive paperwork, automatically notifying appropriate staff of serious and immediate mental health and behavioral concerns and easing problematic workflows and staffing bottlenecks.

3. **Improve clinician care by enabling outcomes monitoring:** DMHT can be deployed to facilitate measurement-informed care, using validated assessments completed by patients and reviewed by clinicians to assess the effectiveness of treatment and adjust treatment as needed to improve outcomes.[416] It can also be used to implement components of other evidence-based models, such as maintaining a registry and tracking symptoms for the Collaborative Care Model in integrated care settings.

4. **Increase engagement with evidence-based practices:** Rather than replacing traditional therapy, integrating DMHT into clinical care as "digital supplements" increases patients' access to proven evidence-based practices (EBPs). DMHT can be used to increase engagement with homework between sessions (an integral component of many EBPs) and engagement with accepted therapy and interventions generally.[417] DMHT can easily be layered on top of sessions to extend the therapeutic process or, in some cases, used to reduce the amount of time or frequency of sessions.[418]

Prioritizing DMHTs With the Most Evidence for Integration into Clinical Care

Many digital mental health tools support youth mental health, both directly and in support of clinician and school services. DMHTs exist across multiple mediums and can expand access to well-established evidence-based therapy models through new means—essentially acting as "digital translations of psychosocial interventions,"[419] such as cognitive behavioral therapy or acceptance and commitment therapy.[420] DMHTs can also be based on entirely new and emerging technologies, including some that use artificial intelligence. They can be integrated with clinician care or completely self-guided.

Table BB-1. Categories of Digital Mental Health Tools

Category		Description	Examples in Colorado
Telehealth+	Telehealth+	Teleconference or videoconference tools that use data science to assist in matching patients to the best-fit provider, simplify the insurance process, and/or integrate digital measurement-informed care to assist in providing the most appropriate and effective provider care.	Equip Hazel Health Little Otter Manatee Meru Health SonderMind Talkiatry
Screening & Monitoring	Patient Reported	Universal screening tools employed in health, educational, or other settings; digital tools to support measurement-informed care (i.e., repeated and validated assessments to track symptoms and outcomes that can be provided digitally in a provider's office or remotely).	Babyscripts Panorama
	Passive Monitoring	Wearables that track certain behaviors to identify mental health conditions (e.g., sleep, movement); technology that detects changes in speech patterns that could indicate a mental health issue; passive monitoring of smartphone data.	Health Rhythms
Treatment	Clinician-Supported DMHT	Patient-facing digital clinical interventions that are integrated into clinician's treatment. The clinician may incorporate the tool fully into care (i.e., for use during a session) or recommend it to a patient as homework (e.g., to reinforce care between sessions).	Aviva (Oui Therapeutics) Meru Health
	Self-Guided DMHT	Self-guided digital clinical interventions that an individual uses independently – no clinician oversight is involved. This may include chatbots.	myStrength Nod (by Grit)

Category		Description	Examples in Colorado
Prevention	Psychoeducation	Systemic, structured, and didactic content regarding various mental health challenges, their causes, and treatments. These can be provided via videos, games, or other engaging formats. This content can be offered in schools or in conjunction with clinical care.	Babyscripts Panorama YOU (by Grit)

While more rigorous research and validation in real-world settings is needed for many digital mental health tools, technologies that have the **most near-term opportunities** to bolster the workforce in support of youth mental healthcare are:

1. Used in conjunction with **clinician care** so that clinicians can ensure their safety and efficacy.
2. Primarily comprised of **digital translations of established practices** that are not dependent on new and emerging technologies.

The "telehealth+" category, described in HH-1, includes care provided by a clinician or overseen by a clinician (such as peer support). The second category of DMHT, screening and monitoring tools, can (1) help identify youth who may need clinician care or (2) can be used to enhance clinician care by providing new approaches to measurement and monitoring. Digital screening tools are instrumental in making universal screening feasible in schools. While some technologies can be used primarily for an individual's self-awareness and tracking, monitoring tools have the most clinical value when used in conjunction with a clinician.

Finally, digital treatments, often referred to as digital therapeutics, may be used as part of treatment or therapy. Digital treatments should not replace clinician services but may be used as a stopgap before a patient can receive psychotherapy care services, as an adjunct to care, or as part of care maintenance.[421] They can be offered as "digital supplements," adjunctive to therapy, such as providing psychoeducation and skills practices between provider sessions, or they can be delivered as primarily standalone treatments with infrequent provider check-ins.[422]

Digital treatment technologies built on the foundation of existing evidence-based strategies, such as cognitive behavioral therapy or acceptance and commitment therapy, have the most immediate potential to bolster the pediatric mental health workforce. While the pace of technological development poses difficulties in ensuring rigorous testing of every new technology, a "minimum evidence standard" could be used where the primary purpose would be to demonstrate adherence to core elements of the treatment model.[423,424] It is also ideal for these studies to assess acceptability (e.g. user satisfaction) and engagement (e.g., attrition) measures.[425]

Appendix CC: Sampling of Relevant Digital Mental Health Companies Active in Colorado

Table CC-1. Relevant Digital Mental Health Companies Active in Colorado

Company	Description	Population	Diagnoses/Issues Addressed	Service Delivery Setting
Babyscripts	Virtual maternity care that integrates physical and mental health	Pregnant people	N/A. BabyScripts assesses mental health risk	Assessments and resources are delivered at the individual level
Equip	Evidence-based virtual eating disorder treatment	Children, teens, adults	Eating Disorders (Range)	Individual
Grit Digital (Nod)	Grit Digital creates digital solutions for behavioral health and wellbeing. One solution, Nod, addresses loneliness on college campuses by helping students build meaningful social connections.	College students; Nod is also being piloted in Colorado high schools	Loneliness	Individual
Hazel Health	Hazel Health partners with schools and families to provide physical and mental health care (via telehealth) that helps students feel better and get back to learning.	K-12 students	A range, including but not limited to anxiety, depression, family issues, and grief and loss	School
Headway	Headway helps patients find therapists covered by insurance.	All ages		Individual
Little Otter	Virtual mental health care – including psychiatry – for children and their families	Ages 0-14 and their families	Anxiety, depression, trauma, eating disorders, ADHD, behavioral challenges, OCD, grief/loss.	Individual/Family
Manatee	Virtual mental health care for children and families	Ages 4-19 and families	Anxiety, depression, trauma	Individual/Family
Meru Health	12-week continuous care model in which individuals can connect	State of Colorado employees and their eligible dependent	Anxiety, depression, burnout	Individual

Company	Description	Population	Diagnoses/Issues Addressed	Service Delivery Setting
	with a therapist via video and chat. Meru also offers an 8-week coaching program for stress and mild anxiety and depression.			
myStrength	A digital mental health solution that helps patients with mental health challenges recover mentally and physically.	Ages 13+	Anxiety, depression, stress and other related issues	Individual
NeuroFlow	NeuroFlow enables measurement-informed and integrated care across health systems	All Ages	N/A. NeuroFlow does not provide treatment; however, its technology supports measurement-informed care.	Healthcare Settings
Sol Mental Health	Virtual as well as in-person therapy and psychiatric care.	Adolescents	Anxiety-related disorders, depression-related disorders, bipolar-spectrum disorders, trauma-related disorders	Individual
SonderMind	SonderMind offers virtual therapy and psychiatric services.	All ages	Anxiety, depression, ADHD, grief and loss and other conditions	Individual
Talkiatry	Online mental healthcare from psychiatrists who take insurance.	All ages	Anxiety, ADHD, bipolar disorder, depression, OCD, PTSD	Individual
Vita Health Care	Mental healthcare services platform designed to deliver teletherapy to adolescents.[426]	12+	Anxiety, ADHD, depression, OCD, trauma, suicide intervention	Individual

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