TITLE 27

BEHAVIORAL HEALTH

DEPARTMENT OF HUMAN SERVICES

Art. 1. Department of Human Services (Repealed).

Art. 2. General Administrative Provisions (Repealed).

MENTAL HEALTH

General Provisions

Art. 9. Commitment and General Provisions (Repealed).

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Art. 91. Institutions - General Administrative Provisions, 27-91-101 to 27-91-109.

Art. 92. Institutions - Charges for Patients, 27-92-101 to 27-92-109.

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DEPARTMENT OF HUMAN SERVICES

ARTICLE 1

Department of Human Services

27-1-101 to 27-1-306. (Repealed)

Source: L. 2010: Entire article repealed, (SB 10-175), ch. 188, p. 675, § 1, effective April 29.

Editor's note: This article was numbered as article 11 of chapter 3, C.R.S. 1963. For amendments to this article prior to its repeal in 2010, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. The provisions

of this article were relocated to articles 66, 68, and 90 of this title. For the location of specific provisions, see the editor's notes following each section in said articles that were relocated and the comparative tables located in the back of the index.

ARTICLE 2

General Administrative Provisions

27-2-101 to 27-2-110. (Repealed)

Source: L. 2010: Entire article repealed, (SB 10-175), ch. 188, p. 675, § 1, effective April 29.

Editor's note: This article was numbered as article 3 of chapter 130, C.R.S. 1963. For amendments to this article prior to its repeal in 2010, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. The provisions of this article were relocated to article 91 of this title. For the location of specific provisions, see the editor's notes following each section in said article and the comparative tables located in the back of the index.

MENTAL HEALTH

General Provisions

ARTICLE 9

Commitment and General Provisions

27-9-101 to 27-9-133. (Repealed)

Editor's note: (1) This article was numbered as article 1 of chapter 71, C.R.S. 1963. This article was repealed on revision as obsolete, effective July 1, 1975. For pertinent information concerning this article, see (2) of this note.

(2) The article was repealed and reenacted in 1973 with an effective date of July 1, 1974. (See L. 73, p. 819.) Section 3 of chapter 67, Session Laws of Colorado 1974, changed the effective date of the repeal and reenactment from July 1, 1974, to July 1, 1975. (See L. 74, p. 287.) In compiling C.R.S. 1973, which was not available until 1974, two versions were printed. Article 1

of chapter 71, C.R.S. 1963, was reorganized and renumbered as article 9 of title 27 in the compilation of C.R.S. 1973 and contained the original version of article 1 of chapter 71 found in C.R.S. 1963 in effect until July 1, 1975. The repealed and reenacted version of article 1 of chapter 71, C.R.S. 1963, effective July 1, 1975, was renumbered as article 10 in the compilation of C.R.S. 1973 and replaced article 9. (For the version of article 1 of chapter 71 in effect until July 1, 1975, see article 9 of title 27 in the original volume of C.R.S. 1973, pages 381 through 398.) For a detailed comparison of the former article 9 prior to its repeal by revision in 1975, see the comparative tables located in the back of the index.

Cross references: For current provisions concerning care and treatment of persons with mental illness, see article 65 of this title.

ARTICLE 10

Care and Treatment of Persons with Mental Illness

27-10-101 to 27-10-129. (Repealed)

Source: L. 2010: Entire article repealed, (SB 10-175), ch. 188, p. 675, § 1, effective April 29.

Editor's note: This article was numbered as article 1 of chapter 71, C.R.S. 1963. This article replaced article 9 of this title, effective July 1, 1975. For amendments to this article prior to its repeal in 2010, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume and the editor's note following the repeal of article 9 of this title. (For the version of article 1 of chapter 71 in effect July 1, 1975, see article 10 of title 27 in the original volume of C.R.S. 1973, pages 399 through 414.) The provisions of this article were relocated to article 65 of this title. For the location of specific provisions, see the editor's notes following each section in said article and the comparative tables located in the back of the index.

ARTICLE 10.3

Child Mental Health Treatment Act

27-10.3-101 to 27-10.3-108. (Repealed)

Source: L. 2010: Entire article repealed, (SB 10-175), ch. 188, p. 675, § 1, effective April 29.

Editor's note: This article was added in 1999. For amendments to this article prior to its repeal in 2010, consult the Colorado statutory research explanatory note beginning on page vii in the front of this volume. The provisions of this article were relocated to article 67 of this title. For the location of specific provisions, see the editor's notes following each section in said article and the comparative tables located in the back of the index.

ARTICLE 10.5

Care and Treatment of Persons with Intellectual and Developmental Disabilities

PART 1
RIGHTS OF PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

27-10.5-101. Legislative declaration - repeal. (Repealed)

27-10.5-102. Definitions.

27-10.5-103. Duties of the executive director - rules - definitions.

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27-10.5-104. Authorized services and supports - conditions of funding - purchase of services and supports - boards of county commissioners - appropriation.

27-10.5-104.2. Services and supports - waiting list reduction - cash fund - repeal. (Repealed)

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27-10.5-105.5. Revocation of designation - repeal. (Repealed)

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27-10.5-107. Procedure for resolving disputes over eligibility, modification of services or supports, and termination of services or supports.

27-10.5-108. Discharge.

27-10.5-109. Community residential home - licenses - rules - repeal. (Repealed)

27-10.5-109.5. Compliance with local government zoning regulations - notice to local governments - provisional licensure - repeal. (Repealed)

27-10.5-110. Imposition of legal disability - removal of legal right.

27-10.5-110.5. Rights of persons with intellectual and developmental disabilities.

27-10.5-111. Conduct of court proceedings - repeal. (Repealed)

27-10.5-112. Individuals' rights - repeal. (Repealed)

27-10.5-113. Right to individualized plan or individualized family service plan - repeal. (Repealed)

27-10.5-114. Right to medical care and treatment - repeal. (Repealed)

27-10.5-115. Right to humane care and treatment - repeal. (Repealed)

27-10.5-116. Right to religious belief, practice, and worship - repeal. (Repealed)

27-10.5-117. Rights to communications and visits - repeal. (Repealed)

27-10.5-118. Right to fair employment practices - repeal. (Repealed)

27-10.5-119. Right to vote - repeal. (Repealed)

27-10.5-120. Records and confidentiality of information pertaining to eligible persons or their families - repeal. (Repealed)

27-10.5-121. Right to personal property - repeal. (Repealed)

27-10.5-122. Right to influence policy - repeal. (Repealed)

27-10.5-123. Right to notification - repeal. (Repealed)

27-10.5-124. Discrimination - repeal. (Repealed)

27-10.5-125. Transfer of residents. (Repealed)

27-10.5-126. Return of residents. (Repealed)

27-10.5-127. Restoration of rights. (Repealed)

27-10.5-128. Sterilization rights - repeal. (Repealed)

27-10.5-129. Competency to give consent to sterilization - repeal. (Repealed)

27-10.5-130. Court-ordered sterilization - repeal. (Repealed)

27-10.5-131. Confidentiality of sterilization proceedings - repeal. (Repealed)

27-10.5-132. Limitations on sterilization - repeal. (Repealed)

27-10.5-133. Group homes for the developmentally disabled. (Repealed)

27-10.5-134. Civil action and attorney fees - repeal. (Repealed)

27-10.5-135. Terminology - repeal. (Repealed)

27-10.5-136. Adjudication of competency. (Repealed)

27-10.5-137. Federal funds - repeal. (Repealed)

27-10.5-138. Service provision system evaluation. (Repealed)

27-10.5-139. Evaluations to determine whether a defendant is mentally retarded for purposes of class 1 felony trials - repeal. (Repealed)

27-10.5-140. Child find - responsibilities - interagency operating agreements - rules. (Repealed)

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27-10.5-142. Caregiver abuse - duties of the department - working group - issues - report - funding - repeal. (Repealed)

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PART 3
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27-10.5-301. Regional centers for persons with developmental disabilities.

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27-10.5-309. Lease of property at regional center - regional center

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27-10.5-310. Regional centers task force - creation - members - recommendations - utilization study - reporting - repeal. (Repealed)

27-10.5-311. Regional centers - waiver beds - prohibition on closure or sale - repeal. (Repealed)

27-10.5-312. Grand Junction regional center campus - vacating and sale or transfer - legislative declaration - definition - repeal. (Repealed)

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PART 4
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27-10.5-408. (Repealed)

PART 5
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PART 6
STUDY OF SELF-SUFFICIENCY TRUSTS

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PART 7
COORDINATED SYSTEM OF PAYMENT FOR EARLY INTERVENTION SERVICES FOR INFANTS AND TODDLERS

27-10.5-701 to

27-10.5-710. (Repealed)

PART 8
OUTCOME-BASED SUPPORTED EMPLOYMENT SYSTEM FOR INTEGRATED EMPLOYMENT SERVICES FOR PERSONS WITH DISABILITIES, INCLUDING DEVELOPMENTAL DISABILITIES

27-10.5-801. (Repealed)

PART 9
STATE EMPLOYMENT OF PERSONS WITH DEVELOPMENTAL DISABILITIES

27-10.5-901. Legislative declaration.

27-10.5-901.5. Definitions.

27-10.5-902. State employment program for persons with developmental disabilities - creation - rules.

PART 10
GENERAL PROVISIONS

27-10.5-1001. (Repealed)

PART 1

RIGHTS OF PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

27-10.5-101. Legislative declaration - repeal. (Repealed)

Source: L. 75: Entire article added, p. 906, § 1, effective July 1. **L. 85:** Entire section amended, p. 983, § 1, effective July 1. **L. 92:** Entire section amended, p. 1350, § 1, effective July 1. **L. 2013:** (2) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-201 in 2014.

(2) Subsection (2) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-102. Definitions.

As used in this article 10.5, unless the context otherwise requires:

(1) "Authorized representative" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(1.5) "Case management agency" has the same meaning as set forth in section 25.5-6-1702 (2).

(2) "Case management services" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(2.3) "Case manager" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(2.5) (Deleted by amendment, L. 2008, p. 1442, § 1, effective August 5, 2008.)

(3) Repealed.

(4) (Deleted by amendment, L. 2013.)

(5) "Consent" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(6) "Contribution" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(7) "Court" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(7.5) "Defined service area" has the same meaning as set forth in section 25.5-6-1702 (7).

(8) "Department" means the department of human services.

(9) Repealed.

(10) "Developmental disabilities professional" has the same meaning as "intellectual and developmental disabilities professional" as set forth in subsection (21.5) of this section.

(11) (a) "Developmental disability" has the same meaning as "intellectual and developmental disability" as set forth in section 25.5-10-202, C.R.S.

(b) "Person with a developmental disability" has the same meaning as "person with an intellectual and developmental disability" as set forth in section 25.5-10-202, C.R.S.

(c) "Child with a developmental delay" means:

(I) A person less than five years of age with delayed development as defined by the department; or

(II) A person less than five years of age who is at risk of having a developmental disability as defined by the department.

(12) "Early intervention services and supports" means services described in and provided pursuant to part 4 of article 3 of title 26.5, including education, training, and assistance in child development, parent education, therapies, and other activities for infants and toddlers and their families that are designed to meet the developmental needs of infants and toddlers including, but not limited to, cognition, speech, communication, physical, motor, vision, hearing, social-emotional, and self-help skills.

(13) "Eligible for supports and services" refers to any person with an intellectual and developmental disability or delay as determined eligible by the case management agency, pursuant to section 27-10.5-106.

(13.5) (Deleted by amendment, L. 2008, p. 1442, § 1, effective August 5, 2008.)

(13.7) "Enrolled" means that a person with an intellectual and developmental disability who is eligible for supports and services has been authorized, as defined by rules promulgated by the department, to participate in a program funded pursuant to this article.

(14) "Executive director" means the executive director of the department of human services.

(15) "Family" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(15.5) (Deleted by amendment, L. 2013.)

(16) "Gastrostomy tube" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(17) "Human rights committee" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(17.5) Repealed.

(18) "Inclusion" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(19) (Deleted by amendment, L. 2012.)

(19.5) "Individualized family service plan" or "IFSP" means a written plan developed pursuant to 20 U.S.C. sec. 1436 and 34 CFR 303.340 that authorizes the provision of early intervention services to an eligible child and the child's family. An IFSP shall serve as the individualized plan, pursuant to paragraph (c) of subsection (20) of this section, for a child from birth through two years of age.

(20) (a) "Individualized plan" means a written plan designed by an interdisciplinary team for the purpose of identifying:

(I) The needs and preferences of the person or family receiving services;

(II) The specific services and supports appropriate to meet those needs and preferences;

(III) The projected date for initiation of services and supports; and

(IV) The anticipated outcomes to be achieved by receiving the services and supports.

(b) Every individualized plan must include a statement of agreement with the plan, signed by the person receiving services or other such person legally authorized to sign on behalf of the person and a representative of the case management agency.

(c) Any other service or support plan, designated by the department, that meets all of the requirements of an individualized plan will be considered to be an individualized plan pursuant to this article.

(d) (Deleted by amendment, L. 2013.)

(21) "Infants and toddlers" means a child with a developmental delay from birth through two years of age.

(21.5) "Intellectual and developmental disabilities professional" means a person who has professional training and experience in the intellectual and developmental disabilities field, as defined by the department.

(22) "Interdependence" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(23) "Interdisciplinary team" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(24) "Least restrictive environment" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(25) "Person receiving services" means a person with an intellectual and developmental disability who is enrolled in a program funded pursuant to this article.

(25.5) "Program" means a specific group of services or supports as defined by rules promulgated by the department and for which funding is available pursuant to this article to a person with an intellectual and developmental disability who is eligible for supports and services.

(26) Repealed.

(27) "Regional center" means a facility or program operated directly by the department that provides services and supports to persons with intellectual and developmental disabilities.

(28) "Service agency" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(29) "Service and support coordination" means planning, locating, facilitating access to, coordinating, and reviewing all aspects of needed and preferred services, supports, and resources that are provided in cooperation with the person receiving services, the person's family, as appropriate, the family of a child with a developmental delay, and the involved public or private agencies. Planning includes the development or review of an existing individualized plan. "Service and support coordination" also includes the reassessment of the needs and preferences of the person receiving services or the needs and preferences of the family of the person, with maximum participation of the person receiving services and the person's parents, guardian, or authorized representative, as appropriate.

(30) "Services and supports" means one or more of the following: Education, training, therapies, identification of natural supports, and other activities provided to:

(a) Enable persons with intellectual and developmental disabilities to make responsible choices, exert greater control over their lives, experience presence and inclusion in their communities, develop their competencies and talents, maintain relationships, foster a sense of belonging, and experience personal security and self-respect; and

(b) (Deleted by amendment, L. 2022.)

(c) Enable families who choose or desire to maintain a family member with an intellectual and developmental disability at home to obtain support and to enjoy a typical lifestyle.

(31) "Sterilization" has the same meaning as set forth in section 25.5-10-202, C.R.S.

(32) (Deleted by amendment, L. 2013.)

Source: L. 75: Entire article added, p. 906, § 1, effective July 1. **L. 76:** (4)(a) amended, p. 671, § 1, effective May 20. **L. 85:** Entire section R&RE, p. 984, § 2, effective July 1. **L. 88:** (6)(b) amended, p. 1082, § 1, effective April 9. **L. 91:** (13.5) added, p. 1163, § 4, effective March 29. **L. 92:** Entire section R&RE, p. 1351, § 2, effective July 1. **L. 93:** (11)(a) amended, p. 1668, §

81, effective July 1; (8) and (14) amended, p. 1162, § 132, effective July 1, 1994. **L. 2001:** (4) amended, p. 106, § 4, effective March 21. **L. 2002:** (11)(a) amended, p. 1024, § 47, effective June 1. **L. 2004:** (20)(d) added, p. 480, § 1, effective August 4. **L. 2007:** (2.5), (13.5), and (17.5) added, p. 1559, § 5, effective May 31. **L. 2008:** (15.5) added and (24) amended, p. 2179, § 1, effective June 5; entire section amended, p. 1442, § 1, effective August 5; (2.3) and (32) added, p. 2206, § 1, effective August 5. **L. 2009:** (15.5) amended, (SB 09-044), ch. 57, p. 208, § 9, effective March 25. **L. 2010:** (13.7) and (25.5) added and (25) and (32) amended, (HB 10- 1213), ch. 220, p. 960, § 1, effective May 10; (26) repealed, (SB 10-208), ch. 314, p. 1472, § 1, effective May 27. **L. 2013:** Entire section amended, (HB 13-1314), ch. 323, p. 1786, § 2, effective March 1, 2014. **L. 2021:** IP, (13), and (20)(b) amended and (1.5) and (7.5) added, (HB 21-1187), ch. 83, p. 348, § 56, effective July 1, 2024; (3)(b) and (9)(b) added by revision, (HB 21-1187), ch. 83, pp. 348, 354, §§ 56, 70. **L. 2022:** (12) and (30) amended and (17.5) repealed, (HB 22-1295), ch. 123, p. 860, § 109, effective July 1.

Editor's note: (1) Amendments to this section by House Bill 08-1031, Senate Bill 08-002, and House Bill 08-1366 were harmonized.

(2) Subsection (19.5) was originally numbered as (20.5) in House Bill 08-1366 but has been renumbered on revision for ease of location.

(3) Subsection (3)(b) provided for the repeal of subsection (3), effective July 1, 2024. (See L. 2021, pp. 348, 354.)

(4) Subsection (9)(b) provided for the repeal of subsection (9), effective July 1, 2024. (See L. 2021, pp. 348, 354.)

Cross references: For the legislative declaration contained in the 1993 act amending subsections (8) and (14), see section 1 of chapter 230, Session Laws of Colorado 1993.

ANNOTATION

Law reviews. For article, "Group Home Regulations Under State and Federal Law", see 35 Colo. Law. 37 (Feb. 2006).

Adoption of section permitting developmentally disabled persons to live in group homes reflects legislative intent to assist such persons to live in normal residential surroundings. Double D Manor v. Evergreen Meadows, 773 P.2d 1046 (Colo. 1989).

27-10.5-103. Duties of the executive director - rules - definitions.

(1) In order to implement the provisions of this article 10.5, the executive director shall carry out the following duties, subject to available appropriations:

(a) Promote effective coordination with agencies serving persons with intellectual and developmental disabilities in order to improve continuity of services and supports for persons facing life transitions from toddler to preschool, school to adult life, and work to retirement;

(b) Repealed.

(c) Operate regional centers pursuant to part 3 of this article; and

(d) Facilitate employment first policies and practices by:

(I) Providing department input and assistance to the employment first advisory partnership established in part 3 of article 84 of title 8, C.R.S., in carrying out its duties; and

(II) Presenting the reports and recommendations of the employment first advisory partnership to the department's legislative committee of reference pursuant to section 8-84-303 (7), C.R.S.

(2) In accordance with section 24-4-103, and in coordination with the requirements of article 10 of title 25.5, the department shall adopt such rules as are necessary to carry out the provisions and purposes of this article 10.5, including but not limited to the following:

(a) Standards for services and supports, including preparation of individualized plans;

(b) Purchase of services and supports and financial administration;

(c) Procedures for resolving disputes over eligibility determination and the modification, denial, or termination of services;

(d) Procedures for admission to programs contained in this article;

(e) Systems of quality assurance and data collection;

(f) The rights of a person receiving services;

(g) Confidentiality of records of a person receiving services;

(h) Designation of authorized representatives and delineation of their rights and duties pursuant to this article;

(i) (I) The establishment of guidelines and procedures for authorization of persons for administration of nutrition and fluids through gastrostomy tubes.

(II) The department shall require that a service agency providing residential or day program services or supports have a staff member qualified pursuant to subparagraph (III) of this

paragraph (i) on duty at any time the facility administers said nutrition and fluids through gastrostomy tubes, and that the facility maintain a written record of each nutrient or fluid administered to each person receiving services, including the time and the amount of the nutrient or fluid.

(III) A person who is not otherwise authorized by law to administer nutrition and fluids through gastrostomy tubes is allowed to perform the duties only under the supervision of a licensed nurse, a licensed certified midwife, or a licensed physician. A person who administers nutrition and fluids in compliance with this subsection (2)(i) is exempt from the licensing requirements of the "Colorado Medical Practice Act", article 240 of title 12, and the "Nurse and Nurse Aide Practice Act", article 255 of title 12. Nothing in this subsection (2)(i) shall be deemed to authorize the administration of medications through gastrostomy tubes. A person administering medications through gastrostomy tubes is subject to the requirements of part 3 of article 1.5 of title 25.

(IV) As used in this subsection (2)(i):

(A) "Administration" means assisting a person in the ingestion of nutrition or fluids according to the direction and supervision of a licensed nurse, a licensed certified midwife, or a licensed physician.

(B) "Certified midwife" has the same meaning as set forth in section 12-255-104 (3.2).

(j) Repealed.

Source: L. 75: Entire article added, p. 908, § 1, effective July 1. **L. 79:** (4)(b) amended, p. 1640, § 47, effective July 19. **L. 85:** Entire section R&RE, p. 987, § 3, effective July 1. **L. 88:** (2)(j) repealed and (3) amended, pp. 1083, 1082, §§ 9, 2, effective April 9. **L. 91:** (2)(k) added, p. 1164, § 6, effective March 29; (1)(f) amended, p. 1859, § 22, effective April 11. **L. 92:** (2)(k)(V) repealed, p. 2011, § 5, effective June 2; entire section amended, p. 1357, § 3, effective July 1. **L. 93:** (1)(f) amended, p. 1162, § 133, effective July 1, 1994; (1)(f) repealed, p. 1121, § 32, effective July 1, 1994. **L. 94:** (1)(f) RC&RE, p. 2613, § 18, effective July 1. **L. 2003:** IP(2) and (2)(k)(III) amended, p. 714, § 54, effective July 1. **L. 2006:** (1)(f) amended, p. 2021, § 112, effective July 1. **L. 2007:** Entire section amended, p. 1559, § 6, effective May 31. **L. 2008:** (1)(h) and (2)(l) amended, p. 1448, § 2, effective August 5. **L. 2009:** IP(2) amended, (SB 09-044), ch. 57, p. 208, § 10, effective March 25. **L. 2010:** (2)(e) amended, (SB 10-208), ch. 314, p. 1472, § 2, effective May 27. **L. 2013:** Entire section R&RE, (HB 13-1314), ch. 323, p. 1792, § 3, effective March 1, 2014. **L. 2016:** (1)(b) and (1)(c) amended and (1)(d) added, (SB 16-077), ch. 360, p. 1507, § 8, effective July 1. **L. 2019:** IP(2) and (2)(i)(III) amended, (HB 19-1172), ch. 136, p. 1712, § 197, effective October 1. **L. 2020:** (2)(i)(III) amended, (HB 20-1183), ch. 157, p. 704, § 65, effective July 1. **L. 2021:** IP(1) and (1)(b) amended, (SB 21-275), ch. 393, p. 2613, § 6, effective July 1, 2022. **L. 2022:** (1)(b) and (2)(j) repealed, (HB 22-1295), ch. 123, p. 861, § 110, effective July 1.

L. 2023: (2)(i)(III) and (2)(i)(IV) amended, (SB 23-167), ch. 261, p. 1550, § 64, effective May 25.

Editor's note: Amendments to this section by Senate Bill 92-096 and Senate Bill 92-133 were harmonized.

Cross references: For the legislative declaration contained in the 1993 act repealing subsection (1)(f), see section 1 of chapter 230, Session Laws of Colorado 1993. For the legislative declaration contained in the 1994 act recreating and reenacting subsection (1)(f), see section 1 of chapter 345, Session Laws of Colorado 1994. For the legislative declaration in SB 16-077, see section 1 of chapter 360, Session Laws of Colorado 2016.

27-10.5-103.5. Community centered boards and service agencies - local public procurement units - repeal. (Repealed)

Source: L. 92: Entire section added, p. 1077, § 3, effective July 1. **L. 96:** Entire section amended, p. 1476, § 37, effective June 1. **L. 2013:** (2) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-205 in 2014.

(2) Subsection (2) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-104. Authorized services and supports - conditions of funding - purchase of services and supports - boards of county commissioners - appropriation.

(1) Subject to annual appropriations by the general assembly, the department shall provide or purchase, pursuant to subsection (4) of this section, authorized long-term services and supports from case management agencies or service agencies for persons who have been determined to be eligible for such long-term services and supports pursuant to section 27-10.5-106, and as specified in the eligible person's individualized plan. Those long-term services and supports may include, but need not be limited to, the following:

(a) Repealed.

(b) Case management services;

(c) Day services and supports that offer opportunities for persons with intellectual and developmental disabilities to experience and actively participate in valued adult roles in the community. These services and supports will enable persons receiving services to access and participate in community activities, such as work, recreation, higher education, and senior citizen activities. Day services and supports, including early intervention services, may also include the administration of nutrition or fluids through gastrostomy tubes, if administered by a person authorized pursuant to section 27-10.5-103 (2)(i) and supervised by a licensed nurse or physician.

(d) Residential services and supports, including an array of training, learning, experiential, and support activities provided in living alternatives designed to meet the individual needs of persons receiving services and may include the administration of nutrition or fluids through gastrostomy tubes, if administered by a person authorized pursuant to section 27-10.5-103 (2)(i) and supervised by a licensed nurse or physician; and

(e) Ancillary services, including activities that are secondary but integral to the provision of the services and supports specified in this subsection (1).

(2) Service agencies receiving funds pursuant to subsection (1) of this section shall comply with all of the provisions of this article and the rules promulgated thereunder.

(3) Repealed.

(4) (a) The department may purchase services and supports, including service and support coordination, directly from service agencies if:

(I) Required by the federal requirements for the state to qualify for federal funds under Title XIX of the federal "Social Security Act", as amended, including programs authorized pursuant to part 4 of article 6 of title 25.5, C.R.S.; or

(II) Repealed.

(b) The department shall only purchase long-term services and supports directly from those service agencies that meet established standards.

(c) Nothing in this section shall be construed to prohibit the provision of services and supports, including case management services, directly by the department through regional centers, for persons receiving services in regional centers.

(d) Nothing in this section shall be construed to require the provision of services and supports, including case management services, directly by the department.

(5) (a) Each year the general assembly shall appropriate moneys to the department to provide or purchase services and supports for persons with intellectual and developmental disabilities

pursuant to this section. Unless specifically provided otherwise, services and supports shall be purchased on the basis of state funding less any federal or cash funds received for general operating expenses from any other state or federal source, less funds available to a person receiving residential services or supports after such person receives an allowance for personal needs or for meeting other obligations imposed by federal or state law. The yearly appropriation, when combined with all other sources of funds, shall in no case exceed one hundred percent of the approved program costs as determined by the general assembly. Funds received for capital construction shall not be considered in the calculation for the distribution of funds under the provisions of this section.

(b) Repealed.

Source: L. 75: Entire article added, p. 909, § 1, effective July 1. **L. 79:** (6)(b) amended, p. 1640, § 48, effective July 19. **L. 85:** Entire section R&RE, p. 988, § 4, effective July 1. **L. 88:** (2) and (8) amended, p. 1082, § 3, effective April 9; (7)(b) amended, p. 812, § 13, effective May 24. **L. 91:** (1)(d) amended, p. 1163, § 5, effective March 29. **L. 92:** Entire section R&RE, p. 1359, § 4, effective July 1. **L. 93:** (1)(a) amended, p. 1789, § 75, effective June 6; IP(1), IP(4)(a), and (7)(a) amended, p. 1162, § 134, effective July 1, 1994. **L. 94:** (7)(b) amended, p. 823, § 51, effective April 27. **L. 96:** (5) amended, p. 472, § 6, effective July 1. **L. 2008:** Entire section amended, p. 2216, § 1, effective June 5; (4)(a.7) added, p. 2180, § 2, effective June 5; (1) and (3) amended, p. 1448, § 3, effective August 5. **L. 2010:** (7)(b) amended, (HB 10-1013), ch. 399, p. 1916, § 48, effective June 10. **L. 2013:** Entire section R&RE, (HB 13-1314), ch. 323, p. 1794, § 4, effective March 1, 2014. **L. 2021:** IP(1) and (4)(b) amended, (HB 21-1187), ch. 83, p. 348, § 57, effective July 1, 2024; (4)(a)(II)(B) added by revision, (HB 21-1187), ch. 83, pp. 348, 354, §§ 57, 70. **L. 2022:** (1)(a), (3), and (5)(b) repealed, (HB 22-1295), ch. 123, p. 861, § 111, effective July 1.

Editor's note: (1) Amendments to this section by House Bill 08-1366, Senate Bill 08-002, and House Bill 08-1220 were harmonized.

(2) Subsection (4)(a)(II)(B) provided for the repeal of subsection (4)(a)(II), effective July 1, 2024. (See L. 2021, pp. 348, 354.)

Cross references: For the legislative declaration contained in the 1993 act amending the introductory portions to subsections (1) and (4)(a) and subsection (7)(a), see section 1 of chapter 230, Session Laws of Colorado 1993.

ANNOTATION

Annotator's note. Since provisions similar to those in repealed § 27-11-103 were included in this section as amended in 1985, relevant cases construing those provisions in the repealed section have been included in the annotations to this section.

School board lacks standing to challenge the constitutionality of this section because, as a political subdivision of the state whose duty it is to carry out the educational policies of the state, the school district and officers thereof cannot question the constitutionality of a statute fixing their duties. Denver Ass'n for Retarded Children v. Sch. Dist. No. 1, 188 Colo. 310, 535 P.2d 200 (1975).

Kindergarten included in school district's "regular school program". Where the defendant school board conceded that they maintain a free kindergarten for children who are five years of age and, but for the mental retardation or serious handicap of the children being educated through the board, they would attend the district's free kindergarten, such kindergarten is included in the school district's "regular school program" as that phrase is used in this section. Denver Ass'n for Retarded Children v. Sch. Dist. No. 1, 188 Colo. 310, 535 P.2d 200 (1975).

Mandamus proper remedy. Subsection (7)(b) clearly requires that the "school district shall provide to the community incorporated board" a sum of money determined by a stated formula; therefore, the clear right of a school board to demand performance, and the clear legal duty on a school district to act, makes this a proper case for disposition by mandamus. Denver Ass'n for Retarded Children v. Sch. Dist. No. 1, 188 Colo. 310, 535 P.2d 200 (1975).

Superintendent not proper party defendant in mandamus action. Since under § 22-32-107 the official duty of paying over the amounts in question as required by this section was that of the treasurer, as authorized by the board of education, and not that of the superintendent, the superintendent was not a proper party defendant in a mandamus action to require such payment. Denver Ass'n for Retarded Children v. Sch. Dist. No. 1, 188 Colo. 310, 535 P.2d 200 (1975).

Amounts payable under section not subject to prejudgment interest. Since the amounts to be paid under this section arise neither out of contract nor out of a fiduciary relationship, the plaintiffs were not entitled to prejudgment interest. Denver Ass'n for Retarded Children v. Sch. Dist. No. 1, 188 Colo. 310, 535 P.2d 200 (1975).

Applied in Adams County Cmty. Center for Retarded & Seriously Handicapped, Inc. v. State Dept. of Insts., 197 Colo. 448, 594 P.2d 1046 (1979).

27-10.5-104.2. Services and supports - waiting list reduction - cash fund - repeal. (Repealed)

Source: L. 2008: Entire section added, p. 2209, § 2, effective August 5. **L. 2009:** (2) amended, (SB 09-228), ch. 410, p. 2264, § 17, effective July 1. **L. 2013:** (1), (2), and (3)(a) amended and (1.5) added, (HB 13-1314), ch. 323, p. 1796, § 5, effective May 28; (6) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-207 in 2014.

(2) Subsection (6) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-104.5. Case management agencies when acting as a service agency - money - rules.

(1) Repealed.

(2) (Deleted by amendment, L. 92, p. 1363, § 5, effective July 1, 1992.)

(3) The department shall promulgate rules to implement the purchase of long-term services and supports from a case management agency or a service agency. The rules must include, but need not be limited to:

(a) Terms and conditions necessary to promote the effective delivery of services and supports;

(b) Procedures for obtaining an annual audit of case management agencies and service agencies not affiliated with a case management agency to provide financial information deemed necessary by the department to establish costs of long-term services and supports and to ensure proper management of money received pursuant to section 27-10.5-104;

(c) Repealed.

(d) Specification of what long-term services and supports are to be reimbursed by the department and secondarily by the case management agencies, the source of reimbursement, actual long-term service or support costs, incentives, and program service objectives which affect reimbursement;

(e) The methods of coordinating the purchase of services and supports, including, but not limited to, service and support coordination, with other federal, state, and local programs which provide funding for authorized services and supports;

(f) (Deleted by amendment, L. 92, p. 1363, § 5, effective July 1, 1992.)

(g) and (h) (Deleted by amendment, L. 2008, p. 2219, § 2, effective June 5, 2008.)

(i) Criteria for and limitations on any rates that case management agencies charge to service agencies based upon a percentage of the rates that service agencies charge for long-term services and supports.

(3.5) Any incorporated service agency which is registered in Colorado as a foreign corporation shall organize a local advisory board consisting of individuals who reside within the defined service area. The advisory board must be representative of the community at large and persons receiving services and their families.

(4) Upon a determination by the executive director that long-term services or supports have not been provided in accordance with the program or financial administration standards specified in this article 10.5 and the rules and regulations promulgated thereunder, the executive director may reduce, suspend, or withhold payment to a case management agency, service agency under contract with a case management agency, or service agency from which the department of human services purchased long-term services or supports directly. When the executive director decides to reduce, suspend, or withhold payment, the executive director shall specify the reasons therefor and the actions which are necessary to bring the service agency into compliance.

(5) Nothing in this article or in any rules or regulations promulgated pursuant thereto and no actions taken by the executive director pursuant to this article shall be construed to affect the obtaining of funds from local authorities, including those funds obtained from a mill levy assessed by a county or municipality for the purpose of purchasing services or supports for persons with developmental disabilities, or to require that such funds from local authorities be used to supplant state or federal funds available for purchasing services and supports for persons with developmental disabilities.

(6) (Deleted by amendment, L. 92, p. 1363, § 5, effective July 1, 1992.)

Source: L. 85: Entire section added, p. 991, § 5, effective July 1. **L. 88:** (6) amended, p. 1083, § 4, effective April 9. **L. 92:** Entire section amended, p. 1363, § 5, effective July 1. **L. 93:** (3)(d) and (4) amended, p. 1163, § 135, effective July 1, 1994. **L. 2008:** (3) amended, p. 2219, § 2, effective June 5; IP(3) and (3)(a) amended, p. 2180, § 3, effective June 5. **L. 2009:** (1), IP(3), and (3)(b) amended, (SB 09-044), ch. 57, p. 208, § 11, effective March 25. **L. 2013:** (3) amended, (HB 13-1314), ch. 323, p. 1797, § 6, effective March 1, 2014. **L. 2021:** IP(3), (3)(b), (3)(d), (3)(i), (3.5), and (4) amended, (HB 21-1187), ch. 83, p. 349, § 58, effective July 1, 2024; (1)(b) and (3)(c)(II) added by revision, (HB 21-1187), ch. 83, pp. 349, 354, §§ 58, 70.

Editor's note: (1) Amendments to subsection (3) by House Bill 08-1220 and Senate Bill 08-002 were harmonized.

(2) Subsection (1)(b) provided for the repeal of subsection (1), effective July 1, 2024. (See L. 2021, pp. 349, 354.)

(3) Subsection (3)(c)(II) provided for the repeal of subsection (3)(c), effective July 1, 2024. (See L. 2021, pp. 349, 354.)

Cross references: For the legislative declaration contained in the 1993 act amending this section, see section 1 of chapter 230, Session Laws of Colorado 1993.

27-10.5-105. Case management agencies - purchase of services and supports.

(1) Once a case management agency has been designated pursuant to section 25.5-6-1703, it shall, subject to available appropriations:

(a) Determine eligibility and develop an individualized plan for each person who receives long-term services or supports pursuant to section 25.5-6-1704; except that, for a child from birth through two years of age, eligibility determination and development of an individualized family service plan must be made pursuant to part 4 of article 3 of title 26.5;

(b) Provide case management services, including service and support coordination and periodic reviews, for persons receiving services and families with children with intellectual and developmental disabilities;

(c) Obtain or provide early intervention services and supports pursuant to part 4 of article 3 of title 26.5;

(d) Take steps to notify eligible persons, and their families as appropriate, regarding the availability of services and supports;

(e) Pursuant to section 26.5-3-404, collaborate with the department of early childhood as it develops and implements a statewide plan for public education outreach and awareness efforts related to part C child find and the availability of early intervention services.

Source: L. 75: Entire article added, p. 910, § 1, effective July 1. **L. 85:** Entire section R&RE, p. 992, § 6, effective July 1. **L. 88:** (2)(f) repealed and (4) amended, p. 1083, §§ 9, 5, effective April 9. **L. 90:** (2)(a) amended, p. 412, § 42, effective June 7. **L. 92:** Entire section R&RE, p. 1365, § 6, effective July 1. **L. 93:** IP(1) amended, p. 1163, § 136, effective July 1, 1994. **L. 2007:** (2) amended, p. 1562, § 7, effective May 31. **L. 2008:** (2) amended, p. 2220, § 3, effective June

5; entire section amended, p. 1450, § 4, effective August 5. **L. 2010:** (2)(d) amended, (HB 10-1213), ch. 220, p. 961, § 2, effective May 10; (2)(f) repealed, (SB 10-208), ch. 314, p. 1472, § 3, effective May 27. **L. 2013:** Entire section R&RE, (HB 13-1314), ch. 323, p. 1797, § 7, effective March 1, 2014. **L. 2014:** IP(1) and (1)(a) amended, (HB 14-1363), ch. 302, p. 1270, § 33, effective May 31. **L. 2021:** IP(1) and (1)(a) amended, (HB 21-1187), ch. 83, p. 350, § 59, effective July 1, 2024. **L. 2022:** IP(1), (1)(a), (1)(c), and (1)(e) amended, (HB 22-1295), ch. 123, p. 862, §§ 112, 113, effective July 1.

Cross references: For the legislative declaration contained in the 1993 act amending this section, see section 1 of chapter 230, Session Laws of Colorado 1993.

ANNOTATION

Nonprofit corporation offering services to the developmentally disabled pursuant to this section is not a political subdivision for purposes of the federal National Labor Relations Act. The corporation functions not as a state-created department or administrative arm of government, but essentially as a private contractor. Jefferson County Cmty. Ctr. v. N.L.R.B., 732 F.2d 122 (10th Cir. 1984) (decided under former § 27-11-103).

27-10.5-105.5. Revocation of designation - repeal. (Repealed)

Source: L. 85: Entire section added, p. 995, § 7, effective July 1. **L. 88:** (3) amended, p. 1083, § 6, effective April 9. **L. 92:** Entire section amended, p. 1368, § 7, effective July 1. **L. 2013:** (4) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-210 in 2014.

(2) Subsection (4) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-106. Eligibility determination.

Any person may request an evaluation pursuant to section 25.5-6-1704 to determine whether the person has an intellectual and developmental disability and is eligible to receive long-term

services and supports pursuant to this article 10.5. Application for eligibility determination must be made to the case management agency in the defined service area where the person resides.

Source: L. 75: Entire article added, p. 910, § 1, effective July 1. **L. 85:** Entire section R&RE, p. 995, § 8, effective July 1. **L. 88:** (4) amended, p. 1083, § 7, effective April 9. **L. 92:** Entire section amended, p. 1368, § 8, effective July 1. **L. 93:** (1)(b) amended, p. 1163, § 137, effective July 1, 1994. **L. 2007:** (2) and (3) amended, p. 1564, § 8, effective May 31. **L. 2008:** Entire section amended, p. 1453, § 5, effective August 5. **L. 2009:** (1)(b) amended, (SB 09-044), ch. 57, p. 208, § 12, effective March 25. **L. 2010:** (1)(b) and (2) amended and (5) added, (HB 10-1213), ch. 220, p. 961, § 3, effective May 10. **L. 2013:** Entire section R&RE, (HB 13-1314), ch. 323, p. 1798, § 8, effective March 1, 2014. **L. 2014:** Entire section amended, (HB 14-1363), ch. 302, p. 1270, § 34, effective May 31. **L. 2021:** Entire section amended, (HB 21-1187), ch. 83, p. 350, § 60, effective July 1, 2024.

Cross references: For the legislative declaration contained in the 1993 act amending this section, see section 1 of chapter 230, Session Laws of Colorado 1993.

27-10.5-107. Procedure for resolving disputes over eligibility, modification of services or supports, and termination of services or supports.

(1) Every state or local service agency receiving state money pursuant to section 27-10.5-104 or 25.5-10-105 shall adopt a procedure for the resolution of disputes arising between the service agency and any recipient of, or applicant for, services or supports authorized pursuant to section 27-10.5-104 or 25.5-10-105. The procedures must be consistent with rules promulgated by the department pursuant to article 4 of title 24 and must be applicable to the following disputes:

(a) A contested decision that the applicant is not eligible for services or supports;

(b) A contested decision to provide, modify, reduce, or deny services or supports set forth in the individualized plan or individualized family service plan of the person receiving services;

(c) A contested decision to terminate services or supports;

(d) A contested decision that the person receiving services is no longer eligible for services or supports.

(2) (Deleted by amendment, L. 92, p. 1369, § 9, effective July 1, 1992.)

(3) The department shall promulgate rules pursuant to article 4 of title 24, C.R.S., setting forth procedures for the resolution of disputes specified in subsection (1) of this section that shall:

(a) Require that all applicants for services and supports and the parents or guardian of a minor, the guardian, or an authorized representative be informed orally and in writing, in their native language, of the dispute resolution procedures at the time of application, at the time the individualized plan is developed, and any time changes in the plan are contemplated;

(b) Require that a service agency keep a written record of all proceedings specified pursuant to this section;

(c) Require that no person receiving services be terminated from such services or supports during the resolution process;

(d) Require that utilizing the dispute resolution procedure shall not prejudice the future provision of appropriate services or supports to individuals; and

(e) Require that the intended action not occur until after reasonable notice has been provided to the person, the parents or guardian of a minor, the guardian, or an authorized representative, along with an opportunity to utilize the resolution process, except in emergency situations, as determined by the department.

(3.5) The resolution process need not conform to the requirements of section 24-4-105, C.R.S., as long as the rules adopted by the department include provisions specifically setting forth procedures, time frames, notice, an opportunity to be heard and to present evidence, and the opportunity for impartial review of the decision in dispute by the executive director or designee, if the resolution process has failed.

(4) and (5) (Deleted by amendment, L. 92, p. 1369, § 9, effective July 1, 1992.)

Source: L. 75: Entire article added, p. 911, § 1, effective July 1. **L. 85:** Entire section R&RE, p. 996, § 9, effective July 1. **L. 88:** (5) amended, p. 1083, § 8, effective April 9. **L. 92:** Entire section amended, p. 1369, § 9, effective July 1. **L. 2008:** (1) amended, p. 1454, § 6, effective August 5. **L. 2009:** IP(1), IP(3), and (3.5) amended, (SB 09-044), ch. 57, p. 209, § 13, effective March 25. **L. 2013:** IP(1) amended, (HB 13-1314), ch. 323, p. 1798, § 9, effective March 1, 2014. **L. 2022:** IP(1) amended, (HB 22-1295), ch. 123, p. 863, § 114, effective July 1.

27-10.5-108. Discharge.

(1) A person receiving services shall be discharged from services or supports upon a determination, made pursuant to the individualized planning process, that the services or supports are no longer appropriate. At least ten days prior to effectuation of the discharge, notification of discharge shall be given to the person receiving services, the parents or guardian of such a person who is a minor, and such person's legal guardian and authorized representative when applicable.

(2) When a person receiving services notifies a service agency that such person no longer wishes to receive a service or support, the person shall be discharged from such service or support unless the person is subject to a petition to impose a legal disability or to remove a legal right, filed pursuant to section 27-10.5-110 or section 25.5-10-216, C.R.S., or for whom a legal guardian has been appointed, affecting the person's ability to voluntarily terminate services or supports. The parents of the person receiving services who is a minor and such person's guardian shall be notified of the person's wish to terminate services or supports, but no minor will be discharged without the consent of the parent or legal guardian.

Source: L. 75: Entire article added, p. 911, § 1, effective July 1. **L. 85:** Entire section R&RE, p. 997, § 10, effective July 1. **L. 92:** Entire section amended, p. 1371, § 10, effective July 1. **L. 2013:** (2) amended, (HB 13-1314), ch. 323, p. 1799, § 10, effective March 1, 2014.

27-10.5-109. Community residential home - licenses - rules - repeal. (Repealed)

Source: L. 75: Entire article added, p. 911, § 1, effective July 1. **L. 85:** Entire section R&RE, p. 997, § 11, effective January 1, 1986. **L. 92:** Entire section amended, p. 1371, § 11, effective July 1. **L. 94:** Entire section amended, p. 2712, § 287, effective July 1. **L. 2008:** IP(6) amended, p. 1454, § 7, effective August 5. **L. 2009:** (3), (5), and IP(6) amended, (SB 09-044), ch. 57, p. 209, § 14, effective March 25. **L. 2012:** (2) and (3) amended, (HB 12-1294), ch. 252, p. 1260, § 12, effective June 4. **L. 2013:** (6)(d) added, (SB 13-283), ch. 332, p. 1896, § 16, effective May 28; (7) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-214 in 2014.

(2) Subsection (7) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-109.5. Compliance with local government zoning regulations - notice to local governments - provisional licensure - repeal. (Repealed)

Source: L. 2000: Entire section added, p. 1517, § 5, effective June 1. **L. 2013:** (4) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-215 in 2014.

(2) Subsection (4) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-110. Imposition of legal disability - removal of legal right.

(1) Any interested person may petition the court pursuant to section 25.5-10-216, C.R.S., to impose a legal disability on or to remove a legal right from a person with an intellectual and developmental disability as defined in section 25.5-10-202, C.R.S. The petition shall set forth the disability to be imposed or the legal right to be removed and the reasons therefor. The petition may affect the right to contract, the right to determine place of abode or provisions of services and supports, the right to operate a motor vehicle, and other similar rights.

(2) A person shall not be admitted to a regional center without a court order issued pursuant to section 25.5-10-216, except in an emergency, if the person meets the criteria for an enhanced protective placement pursuant to section 16-8.5-118, or for the purpose of temporary respite care.

Source: L. 75: Entire article added, p. 912, § 1, effective July 1. **L. 85:** Entire section R&RE, p. 998, § 12, effective July 1. **L. 92:** Entire section amended, p. 1372, § 12, effective July 1. **L. 2010:** (2)(a)(II) amended, (HB 10-1213), ch. 220, p. 961, § 4, effective May 10. **L. 2013:** Entire section R&RE, (HB 13-1314), ch. 323, p. 1799, § 11, effective March 1, 2014. **L. 2026:** (2) amended, (SB 26-149), ch. 142, p. 787, § 25, effective May 21.

27-10.5-110.5. Rights of persons with intellectual and developmental disabilities.

Each person receiving services pursuant to this article and article 10 of title 25.5, C.R.S., shall have the rights set forth in sections 25.5-10-223 to 25.5-10-230, C.R.S.

Source: L. 2013: Entire section added, (HB 13-1314), ch. 323, p. 1799, § 12, effective March 1, 2014.

27-10.5-111. Conduct of court proceedings - repeal. (Repealed)

Source: L. 75: Entire article added, p. 912, § 1, effective July 1. **L. 85:** Entire section R&RE, p. 1000, § 13, effective July 1. **L. 2013:** (2) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-217 in 2014.

(2) Subsection (2) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-112. Individuals' rights - repeal. (Repealed)

Source: L. 75: Entire article added, p. 912, § 1, effective July 1. **L. 85:** Entire section R&RE, p. 1000, § 14, effective July 1. **L. 92:** Entire section amended, p. 1374, § 13, effective July 1. **L. 2013:** (5) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-218 in 2014.

(2) Subsection (5) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-113. Right to individualized plan or individualized family service plan - repeal. (Repealed)

Source: L. 75: Entire article added, p. 913, § 1, effective July 1. **L. 85:** (1) and (2) amended and (3) repealed, pp. 1001, 1016, §§ 15, 46, effective July 1. **L. 92:** Entire section R&RE, p. 1375, § 14, effective July 1. **L. 2007:** Entire section amended, p. 1565, § 9, effective May 31. **L. 2008:** Entire section amended, p. 1455, § 8, effective August 5. **L. 2010:** (2) amended, (HB 10-1213), ch. 220, p. 962, § 5, effective May 10. **L. 2013:** (3) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-219 in 2014.

(2) Subsection (3) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-114. Right to medical care and treatment - repeal. (Repealed)

Source: L. 75: Entire article added, p. 913, § 1, effective July 1. **L. 85:** (1), (3) to (5), (7), and (8) amended, p. 1001, § 16, effective July 1. **L. 92:** Entire section amended and (6.5) added, pp. 1375, 1157, §§ 15, 13, effective July 1. **L. 97:** (6.5) amended, p. 1024, § 47, effective August 6. **L. 2003:** (3) and (6.5) amended, p. 714, § 55, effective July 1. **L. 2013:** (11) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-220 in 2014.

(2) Subsection (11) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-115. Right to humane care and treatment - repeal. (Repealed)

Source: L. 75: Entire article added, p. 914, § 1, effective July 1. **L. 85:** (2) and (8) amended, p. 1002, § 17, effective July 1. **L. 92:** Entire section R&RE, p. 1377, § 16, effective July 1. **L. 2013:** (12) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-221 in 2014.

(2) Subsection (12) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-116. Right to religious belief, practice, and worship - repeal. (Repealed)

Source: L. 75: Entire article added, p. 915, § 1, effective July 1. **L. 85:** Entire section amended, p. 1004, § 18, effective July 1. **L. 92:** Entire section amended, p. 1379, § 17, effective July 1. **L. 2013:** (2) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-222 in 2014.

(2) Subsection (2) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-117. Rights to communications and visits - repeal. (Repealed)

Source: L. 75: Entire article added, p. 915, § 1, effective July 1. **L. 85:** (1) to (3), (5), and (6) amended and (4) and (7) repealed, pp. 1004, 1016, §§ 19, 46, effective July 1. **L. 92:** Entire section amended, p. 1379, § 18, effective July 1. **L. 2013:** (8) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-223 in 2014.

(2) Subsection (8) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-118. Right to fair employment practices - repeal. (Repealed)

Source: L. 75: Entire article added, p. 916, § 1, effective July 1. **L. 85:** Entire section amended, p. 1004, § 20, effective July 1. **L. 92:** Entire section amended, p. 1379, § 19, effective July 1. **L. 2013:** (7) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-224 in 2014.

(2) Subsection (7) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-119. Right to vote - repeal. (Repealed)

Source: L. 75: Entire article added, p. 916, § 1, effective July 1. **L. 85:** Entire section amended, p. 1005, § 21, effective July 1. **L. 92:** Entire section amended, p. 1380, § 20, effective July 1. **L. 2007:** Entire section amended, p. 1798, § 71, effective June 1. **L. 2013:** Entire section amended, (HB 13-1303), ch. 185, p. 750, § 130, effective May 10; (2) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) Amendments to this section by House Bill 13-1303 and House Bill 13-1314 were harmonized, and this section was relocated to § 25.5-10-225 in 2014.

(2) Subsection (2) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-120. Records and confidentiality of information pertaining to eligible persons or their families - repeal. (Repealed)

Source: L. 75: Entire article added, p. 916, § 1, effective July 1. **L. 85:** Entire section amended, p. 1005, § 22, effective July 1. **L. 92:** Entire section amended, p. 1380, § 21, effective July 1. **L. 2008:** (4) added, p. 1455, § 9, effective August 5. **L. 2013:** (5) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-226 in 2014.

(2) Subsection (5) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-121. Right to personal property - repeal. (Repealed)

Source: L. 75: Entire article added, p. 917, § 1, effective July 1. **L. 85:** Entire section amended, p. 1006, § 23, effective July 1. **L. 92:** Entire section amended, p. 1381, § 22, effective July 1. **L. 2013:** (4) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-227 in 2014.

(2) Subsection (4) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-122. Right to influence policy - repeal. (Repealed)

Source: L. 75: Entire article added, p. 917, § 1, effective July 1. **L. 85:** Entire section amended, p. 1007, § 24, effective July 1. **L. 92:** Entire section amended, p. 1382, § 23, effective July 1. **L. 2013:** (2) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-228 in 2014.

(2) Subsection (2) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-123. Right to notification - repeal. (Repealed)

Source: L. 75: Entire article added, p. 917, § 1, effective July 1. **L. 85:** Entire section amended, p. 1007, § 25, effective July 1. **L. 92:** Entire section amended, p. 1382, § 24, effective July 1. **L. 2013:** (2) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-229 in 2014.

(2) Subsection (2) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-124. Discrimination - repeal. (Repealed)

Source: L. 75: Entire article added, p. 917, § 1, effective July 1. **L. 85:** Entire section amended, p. 1007, § 26, effective July 1. **L. 92:** Entire section amended, p. 1382, § 25, effective July 1. **L. 2013:** (2) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-230 in 2014.

(2) Subsection (2) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-125. Transfer of residents. (Repealed)

Source: L. 75: Entire article added, p. 917, § 1, effective July 1. **L. 85:** Entire section repealed, p. 1016, § 46, effective July 1.

27-10.5-126. Return of residents. (Repealed)

Source: L. 75: Entire article added, p. 917, § 1, effective July 1. **L. 85:** Entire section repealed, p. 1016, § 46, effective July 1.

27-10.5-127. Restoration of rights. (Repealed)

Source: L. 75: Entire article added, p. 917, § 1, effective July 1. **L. 85:** Entire section repealed, p. 1016, § 46, effective July 1.

27-10.5-128. Sterilization rights - repeal. (Repealed)

Source: L. 75: Entire article added, p. 918, § 1, effective July 1. **L. 85:** IP(1), (1)(b), and (2) amended, p. 1007, § 27, effective July 1. **L. 92:** Entire section R&RE, p. 1382, § 26, effective July 1. **L. 2013:** (6) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-231 in 2014.

(2) Subsection (6) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-129. Competency to give consent to sterilization - repeal. (Repealed)

Source: L. 75: Entire article added, p. 918, § 1, effective July 1. **L. 85:** IP(1) and (2) to (4) amended, p. 1008, § 28, effective July 1. **L. 92:** Entire section R&RE, p. 1383, § 27, effective July 1. **L. 2013:** (4) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-232 in 2014.

(2) Subsection (4) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-130. Court-ordered sterilization - repeal. (Repealed)

Source: L. 75: Entire article added, p. 919, § 1, effective July 1. **L. 85:** (1) amended, p. 1009, § 29, effective July 1. **L. 92:** Entire section R&RE, p. 1384, § 28, effective July 1. **L. 2013:** (7) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-233 in 2014.

(2) Subsection (7) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-131. Confidentiality of sterilization proceedings - repeal. (Repealed)

Source: L. 75: Entire article added, p. 919, § 1, effective July 1. **L. 85:** Entire section amended, p. 1009, § 30, effective July 1. **L. 92:** Entire section amended, p. 1386, § 29, effective July 1. **L. 2013:** (2) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-234 in 2014.

(2) Subsection (2) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-132. Limitations on sterilization - repeal. (Repealed)

Source: L. 75: Entire article added, p. 919, § 1, effective July 1. **L. 2013:** (3) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-235 in 2014.

(2) Subsection (3) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-133. Group homes for the developmentally disabled. (Repealed)

Source: L. 75: Entire article added, p. 919, § 1, effective July 1. **L. 76:** (1)(a), (1)(b), and (2) amended and (2.5) added, p. 671, § 2, effective May 20. **L. 85:** Entire section repealed, p. 1016, § 46, effective July 1.

27-10.5-134. Civil action and attorney fees - repeal. (Repealed)

Source: L. 75: Entire article added, p. 920, § 1, effective July 1. **L. 2013:** (2) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-236 in 2014.

(2) Subsection (2) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-135. Terminology - repeal. (Repealed)

Source: L. 75: Entire article added, p. 920, § 1, effective July 1. **L. 85:** Entire section amended, p. 1009, § 31, effective July 1. **L. 92:** Entire section amended, p. 1386, § 30, effective July 1. **L. 2005:** (2) amended, p. 773, § 54, effective June 1. **L. 2006:** (1) amended, p. 1406, § 72, effective August 7. **L. 2013:** (3) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-237 in 2014.

(2) Subsection (3) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-136. Adjudication of competency. (Repealed)

Source: L. 75: Entire article added, p. 920, § 1, effective July 1.

Editor's note: Subsection (2) provided for the repeal of this section, effective July 1, 1976. (See L. 75, p. 920.)

27-10.5-137. Federal funds - repeal. (Repealed)

Source: L. 85: Entire section added, p. 1009, § 32, effective July 1. **L. 2013:** (2) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-238 in 2014.

(2) Subsection (2) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-138. Service provision system evaluation. (Repealed)

Source: L. 85: Entire section added, p. 1009, § 32, effective July 1.

Editor's note: Subsection (2) provided for the repeal of this section, effective July 1, 1988. (See L. 85, p. 1009.)

27-10.5-139. Evaluations to determine whether a defendant is mentally retarded for purposes of class 1 felony trials - repeal. (Repealed)

Source: L. 95: Entire section added, p. 1258, § 24, effective July 1. **L. 2002:** Entire section amended, p. 1541, § 281, effective October 1. **L. 2013:** (2) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: (1) This section was relocated to § 25.5-10-239 in 2014.

(2) Subsection (2) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-140. Child find - responsibilities - interagency operating agreements - rules. (Repealed)

Source: L. 2007: Entire section added, p. 1565, § 10, effective May 31. **L. 2008:** Entire section repealed, p. 1455, § 10, effective August 5.

27-10.5-141. Retaliation prohibited - repeal. (Repealed)

Source: L. 2008: Entire section added, p. 1235, § 5, effective May 27. **L. 2013:** (2) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 13, 56.

Editor's note: Subsection (2) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-142. Caregiver abuse - duties of the department - working group - issues - report - funding - repeal. (Repealed)

Source: L. 2008: Entire section added, p. 2212, § 1, effective June 5. **L. 2013:** (7) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 14, 56.

Editor's note: Subsection (7) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

27-10.5-143. Caregiver abuse - task force - repeal. (Repealed)

Source: L. 2009: Entire section added, (HB 09-1178), ch. 84, p. 308, § 1, effective April 2. **L. 2013:** (3) added by revision, (HB 13-1314), ch. 323, pp. 1799, 1813, §§ 14, 56.

Editor's note: Subsection (3) provided for the repeal of this section, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

PART 2

STATE COUNCIL ON DEVELOPMENTAL DISABILITIES

27-10.5-201. Legislative declaration.

The general assembly finds that state and local agencies provide a variety of services and supports to persons with developmental disabilities including institutional care, residential, social, and income maintenance services, diagnostic and health-related services, and educational and other programs. Because these services and supports are supported by many diverse agencies and organizations and because congress, through the federal "Developmental Disabilities Services and Facilities Construction Act", and amendments thereto, has called for the establishment of state councils to provide coordination and planning in the field of developmental disabilities, the general assembly declares that there is need to establish a state council on developmental disabilities to be responsible for the coordination of services and supports to the persons with developmental disabilities and to serve as an advocate for such persons. The general assembly further finds that there is need to carefully define the duties and responsibilities of a state council on developmental disabilities.

Source: L. 79: Entire part added, p. 1117, § 1, effective July 1. **L. 85:** Entire section amended, p. 1010, § 33, effective July 1. **L. 92:** Entire section amended, p. 1386, § 31, effective July 1. **L. 2002:** Entire section amended, p. 1024, § 48, effective June 1.

27-10.5-202. Definitions.

As used in this part 2, unless the context otherwise requires:

(1) "Developmental disability" means a severe, chronic disability of a person nine years of age or older which:

(a) Is attributable to a mental or physical impairment or combination of mental and physical impairments;

(b) Is manifested before the person attains age twenty-two;

(c) Results in substantial functional limitations in three or more of the following areas of major life activity:

(I) Self-care;

(II) Receptive and expressive language;

(III) Learning;

(IV) Mobility;

(V) Self-direction;

(VI) Capacity for independent living; and

(VII) Economic self-sufficiency; and

(d) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services and supports which are of lifelong or extended duration and are individually planned and coordinated; except that such term when applied to infants and young children means individuals from birth to age nine years, inclusive, who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services or supports are not provided.

(2) "State plan" means the state plan for developmental disabilities established pursuant to the provisions of section 27-10.5-204 and as required by the federal "Developmental Disabilities Services and Facilities Construction Act", and amendments thereto, including the "Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978", Pub.L. 95-602.

(3) "State council" means the Colorado developmental disabilities council established pursuant to section 27-10.5-203.

Source: L. 79: Entire part added, p. 1117, § 1, effective July 1. **L. 92:** Entire section amended, p. 1386, § 32, effective July 1. **L. 2002:** IP(1), (1)(d), and (3) amended, p. 1025, § 49, effective June 1.

Editor's note: Pub.L. 95-602 is contained in 29 U.S.C. sec. 720.

27-10.5-203. Establishment of state council.

(1) There is created in the office of the executive director of the department of human services the Colorado developmental disabilities council. The state council is a **type 1** entity, as defined in section 24-1-105, and exercises its powers and performs its duties and functions under the department. The state council shall operate in accordance with the federal "Developmental Disabilities Assistance and Bill of Rights Act of 2000", 42 U.S.C. sec. 15001 et seq.

(2) The state council consists of twenty-four members appointed by the governor for three-year terms; except that the terms shall be staggered so that no more than eight members' terms expire in the same year. Vacancies shall be filled by appointment for the unexpired term.

(3) (a) The state council must at all times include in its membership representatives of the following:

(I) The principal state agencies, including the state agency that administers funds provided under the federal "Rehabilitation Act of 1973", the state agency that administers funds provided under the federal "Individuals with Disabilities Education Act", the state agency that administers funds provided under the federal "Older Americans Act of 1965", and the state agency that administers funds provided under Titles V and XIX of the federal "Social Security Act" for persons with developmental disabilities;

(II) The University Centers for Excellence in Developmental Disabilities Education, Research, and Service;

(III) Nongovernmental agencies; and

(IV) Private nonprofit groups concerned with services and supports for persons with developmental disabilities.

(b) At least four members of the state council must be persons with developmental disabilities.

(c) At least four members of the state council must be family members or guardians of persons with mentally impairing developmental disabilities, who are not employees of a state agency that receives funds or provides services and supports under this part 2, and who are not employees implementing programs under the federal "Social Security Act" or of any other entity that receives funds or provides services and supports under this part 2. At least one individual of the four appointed in this subsection (3)(c) must be an immediate relative or guardian of an institutionalized or previously institutionalized person with a developmental disability.

(d) At least half of the membership of the state council must be individuals described in subsection (3)(b) or (3)(c) of this section, or parents or guardians of such persons with developmental disabilities.

(4) Members of the state council are entitled to reimbursement for their expenses while attending regular and special meetings of the state council.

(5) The state council shall operate in accordance with bylaws adopted by a quorum of its membership.

(6) For the purposes of holding meetings of the state council, a quorum shall be a simple majority of the state council membership in attendance.

Source: L. 79: Entire part added, p. 1118, § 1, effective July 1. **L. 85:** (2) and (6) amended, p. 1010, § 34, effective July 1. **L. 92:** Entire section R&RE, p. 1387, § 33, effective July 1. **L. 93:** (1) amended, p. 1164, § 138, effective July 1, 1994. **L. 2002:** (1), (2), (3), IP(4), IP(5), (6), and (7) amended, p. 1025, § 50, effective June 1. **L. 2022:** Entire section amended, (SB 22-013), ch. 2, p. 69, § 92, effective February 25; (1) amended, (SB22-162), ch. 469, p. 3379, § 77, effective August 10. **L. 2023:** (4) amended, (SB 23-210), ch. 251, p. 1432, § 14, effective May 24.

Editor's note: Amendments to subsection (1) by SB 22-013 and SB 22-162 were harmonized.

Cross references: (1) For the legislative declaration contained in the 1993 act amending this section, see section 1 of chapter 230, Session Laws of Colorado 1993.

(2) For the "Individuals with Disabilities Education Act", see Pub.L. 91-230, codified at 20 U.S.C. sec. 1400 et seq. For the "Older Americans Act of 1965", see Pub.L. 89-73, codified at 42 U.S.C. sec. 3001 et seq.

(3) For the short title (the "Debbie Haskins 'Administrative Organization Act of 1968' Modernization Act") in SB 22-162, see section 1 of chapter 469, Session Laws of Colorado 2022.

27-10.5-204. Development of the state plan.

The state council shall develop a five-year state plan for developmental disabilities in accordance with the federal "Developmental Disabilities Assistance and Bill of Rights Act of 2000", 42 U.S.C. sec. 15024. The state plan shall include establishment of goals and priorities for meeting the needs of persons with developmental disabilities, including recommendations

concerning state program operations and funding for a comprehensive system of services and supports to persons with developmental disabilities. The state plan shall be prepared in compliance with federal requirements and shall designate the state agency responsible for administration of the state plan. The state council shall submit the state plan to the governor for approval.

Source: L. 79: Entire part added, p. 1118, § 1, effective July 1. **L. 92:** Entire section amended, p. 1389, § 34, effective July 1. **L. 2002:** Entire section amended, p. 1026, § 51, effective June 1.

27-10.5-205. Powers and duties.

(1) The state council shall:

(a) Monitor the plans and programs of state agencies established and administered pursuant to the state plan;

(b) Review budgets and other programs and proposals for funding services and supports to persons with developmental disabilities;

(c) Review programs that provide long-term services and supports to persons with intellectual and developmental disabilities under contracts with state agencies and case management agencies as authorized by the state plan;

(d) Encourage cooperation and coordination of services and supports of public and private agencies including home care services and assist in the elimination of unnecessary and duplicative programs and procedures;

(e) Identify gaps in services and supports to persons with developmental disabilities and monitor programs for deinstitutionalization of such persons;

(f) Serve in an advisory capacity to the governor and the general assembly on matters affecting persons with developmental disabilities;

(g) Meet at least quarterly and as often as necessary to fulfill its duties and responsibilities;

(h) Have all powers necessary to carry out the provisions of this part 2.

Source: L. 79: Entire part added, p. 1118, § 1, effective July 1. **L. 85:** (1)(b), (1)(c), (1)(e), and (1)(f) amended, p. 1011, § 35, effective July 1. **L. 92:** Entire section amended, p. 1389, § 35, effective July 1. **L. 2002:** IP(1) amended, p. 1026, § 52, effective June 1. **L. 2021:** (1)(c) amended, (HB 21-1187), ch. 83, p. 350, § 61, effective July 1, 2024.

27-10.5-206. State council employees.

Subject to available appropriations, the executive director of the department of human services may employ such personnel as are required by the state council, pursuant to the provisions of section 13 of article XII of the state constitution. The executive director of the department of human services will appoint the staff director to the state council, accepting the recommendations of the council.

Source: L. 79: Entire part added, p. 1119, § 1, effective July 1. **L. 93:** Entire section amended, p. 1164, § 139, effective July 1, 1994. **L. 2002:** Entire section amended, p. 1026, § 53, effective June 1.

Cross references: For the legislative declaration contained in the 1993 act amending this section, see section 1 of chapter 230, Session Laws of Colorado 1993.

27-10.5-207. Cooperation of departments.

The departments of human services, public health and environment, and education shall cooperate with the state council in the development of and implementation of the recommendations made within the state plan. Said departments shall provide documents and other assistance requested by the state council or its representatives which are essential for the state council to meet its federal and state statutory requirements.

Source: L. 79: Entire part added, p. 1119, § 1, effective July 1. **L. 92:** Entire section amended, p. 1390, § 36, effective July 1. **L. 93:** Entire section amended, p. 1164, § 140, effective July 1, 1994. **L. 2002:** Entire section amended, p. 1027, § 54, effective June 1.

Cross references: For the legislative declaration contained in the 1993 act amending this section, see section 1 of chapter 230, Session Laws of Colorado 1993.

27-10.5-208. Service provision system evaluation. (Repealed)

Source: L. 85: Entire section added, p. 1011, § 36, effective July 1.

Editor's note: Subsection (2) provided for the repeal of this section, effective July 1, 1988. (See L. 85, p. 1011.)

PART 3

REGIONAL CENTERS

Editor's note: Provisions similar to the provisions of this part 3 were found in article 14 of this title prior to its repeal in 1985.

27-10.5-301. Regional centers for persons with developmental disabilities.

There are hereby established state regional centers in Wheat Ridge, Pueblo, and Grand Junction. The essential object of such regional centers shall be to provide state operated services and supports to persons with developmental disabilities. A regional center may not permit the cultivation, use, or consumption of retail marijuana on its premises.

Source: L. 85: Entire part added, p. 1011, § 37, effective July 1. **L. 92:** Entire section amended, p. 1390, § 37, effective July 1. **L. 2013:** Entire section amended, (SB 13-283), ch. 332, p. 1896, § 17, effective May 28.

ANNOTATION

Law reviews. For article, "Liability of Counties for Support of Inmates in State Institutions", see 29 Dicta 27 (1952).

For the object and purpose of the institution, see People ex rel. Dunbar v. County Court, 128 Colo. 374, 262 P.2d 550 (1953) (decided under former § 27-14-102).

27-10.5-302. Directors.

The executive director shall appoint, pursuant to section 13 of article XII of the state constitution, a director for each regional center. Persons appointed must be skilled and trained administrators with experience related to the needs of persons with developmental disabilities. The director of each regional center shall appoint such other employees in accordance with

section 13 of article XII of the state constitution as are necessary to carry out the functions of the regional center.

Source: L. 85: Entire part added, p. 1012, § 37, effective July 1. **L. 92:** Entire section amended, p. 1390, § 38, effective July 1.

27-10.5-303. Annual reports - publications.

The director of each regional center shall report to the executive director at such times and on such matters as the executive director may require. Publications of each regional center circulated in quantity outside the department shall be subject to the approval and control of the executive director.

Source: L. 85: Entire part 3 added, p. 1012, § 37, effective July 1. **L. 92:** Entire section amended, p. 1391, § 39, effective July 1.

27-10.5-304. Admissions.

(1) There may be admitted to any regional center persons with developmental disabilities who have been ordered placed in a regional center pursuant to section 27-10.5-110, if the applicant or legal guardian is a bona fide resident of Colorado.

(2) (Deleted by amendment, L. 92, p. 1391, § 40, effective July 1, 1992.)

Source: L. 85: Entire part added, p. 1012, § 37, effective July 1. **L. 92:** Entire section amended, p. 1391, § 40, effective July 1.

Cross references: For the interstate compact on mental health, see part 10 of article 60 of title 24.

ANNOTATION

Not all who are committed can be admitted, nor is it desirable that they should be under all circumstances. If it were so, the purpose of the institution might be defeated by over-crowding, resulting in part from the admission of those who are not fit subjects,

and thus making training less effective, if not impossible. People ex rel. Dunbar v. County Court, 128 Colo. 374, 262 P.2d 550 (1953) (decided under former § 27-14-106).

27-10.5-305. Endowment fund.

There is hereby authorized the regional center endowment fund. Any parent, person, corporation, or institution may contribute to said endowment fund. The bylaws to be provided by the department of human services shall prescribe the different endowments; but the investments from said endowment fund shall be in state, county, or city bonds or in first mortgages on improved realty for not more than forty percent of the actual value of such realty.

Source: L. 85: Entire part added, p. 1012, § 37, effective July 1. **L. 92:** Entire section amended, p. 1391, § 41, effective July 1. **L. 94:** Entire section amended, p. 2712, § 288, effective July 1.

Cross references: For the legislative declaration contained in the 1994 act amending this section, see section 1 of chapter 345, Session Laws of Colorado 1994.

27-10.5-306. Gifts - receipt and disposition.

Each regional center is hereby authorized to receive gifts, legacies, devises, and conveyances of property, real or personal, that may be made, given, or granted to or for such regional center. If the gifts are not prescribed, the director, with approval of the executive director, shall exercise such authority and make such disposition of the gift property as may be for the best interest of said regional center.

Source: L. 85: Entire part added, p. 1012, § 37, effective July 1. **L. 92:** Entire section amended, p. 1391, § 42, effective July 1.

27-10.5-307. Expenditures.

No moneys shall be paid by the state treasurer out of any other appropriation for, or moneys belonging to, a regional center, except upon warrants of the controller upon vouchers in favor of the persons to whom the state is indebted on account of said regional center and certified by the director of said regional center.

Source: L. 85: Entire part added, p. 1013, § 37, effective July 1. **L. 92:** Entire section amended, p. 1392, § 43, effective July 1.

27-10.5-308. Buildings - Pueblo. (Repealed)

Source: L. 85: Entire part added, p. 1013, § 37, effective July 1. **L. 91:** Entire section amended, p. 1146, § 17, effective May 18. **L. 92:** Entire section repealed, p. 1392, § 44, effective July 1.

27-10.5-309. Lease of property at regional center - regional center enterprise fund - creation. (Repealed)

Source: L. 85: Entire part added, p. 1013, § 37, effective July 1. **L. 92:** Entire section amended, p. 1392, § 45, effective July 1. **L. 2008:** Entire section repealed, p. 1345, § 3, effective May 27.

27-10.5-310. Regional centers task force - creation - members - recommendations - utilization study - reporting - repeal. (Repealed)

Source: L. 2014: Entire section added, (HB 14-1338), ch. 298, p. 1247, § 1, effective May 31.

Editor's note: Subsection (12) provided for the repeal of this section, effective December 31, 2015. (See L. 2014, p. 1247.)

27-10.5-311. Regional centers - waiver beds - prohibition on closure or sale - repeal. (Repealed)

Source: L. 2015: Entire section added, (SB 15-243), ch. 131, p. 405, § 1, effective August 5. **L. 2016:** Entire section amended, (SB 16-178), ch. 274, p. 1135, § 2, effective June 10.

Editor's note: Subsection (2) provided for the repeal of this section, effective July 1, 2017. (See L. 2016, p. 1135.)

27-10.5-312. Grand Junction regional center campus - vacating and sale or transfer - legislative declaration - definition - repeal. (Repealed)

Source: L. 2016: Entire section added, (SB 16-178), ch. 274, p. 1133, § 1, effective June 10. **L. 2018:** (3)(b) amended, (HB 18-1049), ch. 134, p. 887, § 1, effective April 12. **L. 2019:** (3)(a) and (3)(b)(I) amended, (HB 19-1062), ch. 20, p. 74, § 1, effective August 2.

Editor's note: Subsection (5) provided for the repeal of this section, effective June 30, 2021. (See L. 2016, p. 1133.)

27-10.5-313. Regional center - employees - adult protective services data system check.

On and after January 1, 2019, prior to employment, a regional center shall submit the name of a person who will be providing direct care, as defined in section 26-3.1-101 (3.5), to an at-risk adult, as defined in section 26-3.1-101 (1.5), as well as any other required identifying information, to the department of human services for a check of the Colorado adult protective services data system pursuant to section 26-3.1-111, to determine if the person is substantiated in a case of mistreatment of an at-risk adult.

Source: L. 2017: Entire section added, (HB 17-1284), ch. 272, p. 1505, § 14, effective May 31.

27-10.5-314. Former Teller institute property.

(1) Except as described in subsection (2) of this section, as soon as each person who was receiving services on May 24, 2022, at the former Teller institute federal Indian boarding school property, now owned by the department and operated as a regional center, is transitioned to a residence other than a residence at the regional center, the department shall vacate the property and shall sell all or a portion of the property, or transfer all or a portion of the property, to a state institution of higher education, a local government, a state agency, or a federally recognized tribe in Colorado that is impacted by the operation of the Teller institute.

(2) The department shall not sell or transfer the property, or any portion of the property, until after the identification and mapping of any graves of Native American students buried at the federal Indian boarding school that was located on the property and until after the department, in consultation with tribal governments, develops a plan to acknowledge the abuse and victimization of students and families related to the operation of the federal Indian boarding school located on the property.

Source: L. 2022: Entire section added, (HB 22-1327), ch. 216, p. 1424, § 3, effective May 24.

Cross references: For the short title ("SALT Parity Act") in HB 22-1327, see section 1 of chapter 216, Session Laws of Colorado 2022.

PART 4

FAMILY SUPPORT SERVICES

27-10.5-401 to 27-10.5-408. (Repealed)

Editor's note: (1) This part 4 was added in 1991. For amendments to this part 4 prior to its repeal in 2014, consult the 2013 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume. This part 4 was relocated to part 3 of article 10 of title 25.5, effective March 1, 2014. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated. For a detailed comparison of this part 4, see the comparative tables located in the back of the index.

(2) Section 27-10.5-408 provided for the repeal of this part 4, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

PART 5

COLORADO FAMILY SUPPORT LOAN FUND

27-10.5-501 to 27-10.5-504. (Repealed)

Editor's note: (1) This part 5 was added in 1991. For amendments to this part 5 prior to its repeal in 2014, consult the 2013 Colorado Revised Statutes and the Colorado statutory research

explanatory note beginning on page vii in the front of this volume. This part 5 was relocated to part 4 of article 10 of title 25.5, effective March 1, 2014. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated. For a detailed comparison of this part 5, see the comparative tables located in the back of the index.

(2) Section 27-10.5-504 provided for the repeal of this part 5, effective March 1, 2014. (See L. 2013, pp. 1799, 1813.)

PART 6

STUDY OF SELF-SUFFICIENCY TRUSTS

27-10.5-601. (Repealed)

Source: L. 96: Entire part repealed, p. 563, § 24, effective April 24.

Editor's note: This part 6 was added in 1991. For amendments to this part 6 prior to its repeal in 1996, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

PART 7

COORDINATED SYSTEM OF PAYMENT FOR EARLY INTERVENTION SERVICES FOR INFANTS AND TODDLERS

Editor's note: This part 7 was added in 2007 and was not amended prior to 2008. The substantive provisions of this part 7 were repealed and reenacted in 2008, resulting in the addition, relocation, and elimination of sections as well as subject matter. For the text of this part 7 prior to 2008, consult the 2007 Colorado Revised Statutes. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated.

27-10.5-701 to 27-10.5-710. (Repealed)

Source: L. 2022: Entire part repealed, (HB 22-1295), ch. 123, p. 870, § 135, effective July 1.

Editor's note: (1) This part 7 was added in 2007. For amendments to this part 7 prior to its repeal in 2022, consult the 2021 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume. This part 7 was relocated to part 4 of article 3 of title 26.5. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated. For a detailed comparison of this part 7, see the comparative tables located in the back of the index.

(2) Changes to § 27-10.5-702 (1) by HB 22-1294 were harmonized with HB 22-1295 and relocated to § 26.5-3-402 (1).

PART 8

OUTCOME-BASED SUPPORTED EMPLOYMENT SYSTEM FOR INTEGRATED EMPLOYMENT SERVICES FOR PERSONS WITH DISABILITIES, INCLUDING DEVELOPMENTAL DISABILITIES

27-10.5-801. Pilot program - creation - goals - implementation - reporting - repeal. (Repealed)

Source: L. 2008: Entire part added, p. 378, § 2, effective April 10. **L. 2015:** (4) added by revision, (SB 15-239), ch. 160, pp. 488, 490 §§ 7, 14.

Editor's note: Subsection (4) provided for the repeal of this section, effective July 1, 2016. (See L. 2015, pp. 488, 490.)

PART 9

STATE EMPLOYMENT OF PERSONS WITH DEVELOPMENTAL DISABILITIES

27-10.5-901. Legislative declaration.

(1) The general assembly hereby finds that:

(a) Persons with developmental disabilities represent a population that has long been underutilized and often denied employment opportunities within state government, partially due

to hiring personnel's perceptions and understanding of the operation and requirements of the state personnel system;

(b) Some state agencies are unaware of the avenues that are available within the state personnel system by which state agencies can hire and provide training and support for persons with developmental disabilities; and

(c) Many persons with developmental disabilities, when provided appropriate training and support, can develop sufficient skills and competencies to more than adequately fulfill job expectations in employment positions in state government.

(2) Therefore, it is the intent of the general assembly to create the state employment program for persons with developmental disabilities to encourage and provide incentives for state agencies to give meaningful employment opportunities to persons with developmental disabilities and to improve the state's practices in employing, supervising, and supporting persons with developmental disabilities.

Source: L. 2008: Entire part added, p. 2182, § 1, effective June 5.

27-10.5-901.5. Definitions.

As used in this part 9, unless the context otherwise requires:

(1) "Program" means the state employment program for persons with developmental disabilities created in section 27-10.5-902 (1).

Source: L. 2025: Entire section added, (SB 25-275), ch. 377, p. 2083, § 237, effective August 6.

27-10.5-902. State employment program for persons with developmental disabilities - creation - rules.

(1) There is hereby created within the department the state employment program for persons with developmental disabilities. The department shall design and implement the program to coordinate the hiring of interested persons with developmental disabilities into appropriate and meaningful state employment opportunities. The goal of the program is to identify for persons with developmental disabilities permanent and stable employment opportunities that are integrated within and appropriately meet the service goals of state agencies. The department of human services shall collaborate with the department of personnel in designing the program.

(2) (a) On or before July 1, 2008, the executive directors of the department of human services and the department of personnel shall jointly convene a working group to study and recommend how the state's policies and practices in employing, supervising, and supporting persons with developmental disabilities can be improved in order to effectively and successfully implement the program. The executive directors shall include in the working group persons with expertise in implementing the statutes and rules pertaining to the state personnel system, persons with expertise in interpreting and implementing the federal "Americans with Disabilities Act of 1990", 42 U.S.C. sec. 12101 et seq., and persons with experience in employing and placing for employment persons with developmental disabilities.

(b) The working group shall complete its work and make recommendations to the executive directors of the department of human services and the department of personnel by January 1, 2009. The recommendations of the working group may include, but need not be limited to:

(I) Modifications to rules, statutes, or the state constitution to improve the success of persons with developmental disabilities who are employed through the program; and

(II) Identification or clarification of the roles and responsibilities of persons in the department of human services and the department of personnel in implementing the program efficiently and successfully.

(3) (a) If the working group finds that implementation of the program may require statutory or constitutional changes, the department of human services and the department of personnel shall not implement the program until the general assembly has considered and rejected said changes or until after a bill enacting said statutory changes or a referred measure enacting said constitutional changes has become law.

(b) After the conditions specified in paragraph (a) of this subsection (3) are met, or if the working group finds that neither statutory nor constitutional changes are necessary for implementation of the program, the state board of human services and the state personnel board shall promulgate rules in accordance with the "State Administrative Procedure Act", article 4 of title 24, C.R.S., as follows:

(I) The state board of human services shall promulgate rules as necessary for implementation of the program within the department of human services; and

(II) The state personnel board shall promulgate rules pertaining to the state personnel system as necessary for implementation of the program.

(4) Following promulgation of rules pursuant to subsection (3) of this section and in accordance with said rules and the provisions of this section, the department of human services, in collaboration with the department of personnel, shall implement the program. A state agency that seeks to employ a person with developmental disabilities through the program shall be responsible for hiring and supervision of the person and payment of the person's salary and

benefits. The department, through the program, shall provide guidance to the hiring state agency regarding any additional issues that are pertinent to the person's employment.

(5) Following adoption of the rules specified in subsection (3) of this section, the department shall regularly provide information to state agencies to explain and promote the program. Upon full implementation of the program, each state agency is strongly encouraged to participate in the program by identifying meaningful and appropriate employment positions for persons with developmental disabilities and working with the department to hire persons with developmental disabilities for these positions.

Source: L. 2008: Entire part added, p. 2183, § 1, effective June 5. **L. 2025:** (1) amended, (SB 25-275), ch. 377, p. 2083, § 238, effective August 6.

PART 10

GENERAL PROVISIONS

27-10.5-1001. (Repealed)

Source: L. 2009: Entire part repealed, (SB 09-206), ch. 7, p. 59, § 1, effective March 2.

Editor's note: This part 10 was added in 2008 and was not amended prior to its repeal in 2009. For the text of this part 10 prior to 2009, consult the 2008 Colorado Revised Statutes.

ARTICLE 11

Community Centers - Mentally Retarded and Handicapped

27-11-101 to 27-11-106. (Repealed)

Source: L. 85: Entire article repealed, p. 1016, § 46, effective July 1.

Editor's note: This article was numbered as article 8 of chapter 71 in C.R.S. 1963. For amendments to this article prior to its repeal in 1985, consult the Colorado statutory research

explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

ARTICLE 12

Charges for Patients

27-12-101 to 27-12-109. (Repealed)

Source: L. 2010: Entire article repealed, (SB 10-175), ch. 188, p. 675, § 1, effective April 29.

Editor's note: This article was numbered as article 7 of chapter 71, C.R.S. 1963. For amendments to this article prior to its repeal in 2010, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. The provisions of this article were relocated to article 92 of this title. For the location of specific provisions, see the editor's notes following each section in said article and the comparative tables located in the back of the index.

Institutions

ARTICLE 13

Colorado Mental Health Institute at Pueblo

27-13-101 to 27-13-113. (Repealed)

Source: L. 2010: Entire article repealed, (SB 10-175), ch. 188, p. 675, § 1, effective April 29.

Editor's note: This article was numbered as article 3 of chapter 71, C.R.S. 1963. For amendments to this article prior to its repeal in 2010, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. The provisions of this article were relocated to article 93 of this title. For the location of specific provisions, see the editor's notes following each section in said article and the comparative tables located in the back of the index.

ARTICLE 14

Homes for Mental Defectives

27-14-101 to 27-14-116. (Repealed)

Source: L. 85: Entire article repealed, p. 1016, § 46, effective July 1.

Editor's note: This article was numbered as article 4 of chapter 71 in C.R.S. 1963. For amendments to this article prior to its repeal in 1985, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

Cross references: For current provisions on regional centers, see part 3 of article 10.5 of this title 27.

ARTICLE 15

Colorado Mental Health Institute at Fort Logan

27-15-101 to 27-15-105. (Repealed)

Source: L. 2010: Entire article repealed, (SB 10-175), ch. 188, p. 675, § 1, effective April 29.

Editor's note: This article was numbered as article 5 of chapter 71, C.R.S. 1963. For amendments to this article prior to its repeal in 2010, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. The provisions of this article were relocated to article 94 of this title. For the location of specific provisions, see the editor's notes following each section of said article and the comparative tables located in the back of the index.

ARTICLE 16

Western Regional Mental Health Center

27-16-101 to 27-16-105. (Repealed)

Source: L. 77: Entire article repealed, p. 293, § 7, effective May 26.

Editor's note: This article was numbered as article 9 of chapter 71 in C.R.S. 1963. For amendments to this article prior to its repeal in 1977, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

CORRECTIONS

ARTICLE 20

Penitentiary

27-20-101 to 27-20-203. (Repealed)

Source: L. 77: Entire article repealed, p. 955, § 37, effective August 1.

Editor's note: (1) The provisions of part 1 concerning the state penitentiary and the provisions of part 2, enacted by L. 77, p. 1377, § 1, concerning minimum security facilities, are under the department of corrections. (See articles 20 and 25 of title 17.)

(2) This article was numbered as article 4 of chapter 105 in C.R.S. 1963. For amendments to this article prior to its repeal in 1977, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

ARTICLE 21

Women's Correctional Institution

27-21-101 to 27-21-102. (Repealed)

Source: L. 77: Entire article repealed, p. 955, § 37, effective August 1.

Editor's note: This article was numbered as articles 3 and 4 of chapter 105 in C.R.S. 1963. For amendments to this article prior to its repeal in 1977, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

ARTICLE 22

Reformatory

27-22-101 to 27-22-110. (Repealed)

Source: L. 77: Entire article repealed, p. 955, § 37, effective August 1.

Editor's note: This article was numbered as article 3 of chapter 105 in C.R.S. 1963. For amendments to this article prior to its repeal in 1977, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

ARTICLE 23

Mentally Ill or Retarded Convicts - Transfer

27-23-101 to 27-23-103. (Repealed)

Source: L. 77: Entire article repealed, p. 955, § 37, effective August 1.

Editor's note: (1) The provisions concerning the transfer of inmates with mental health disorders or intellectual and developmental disabilities are under the department of corrections. (See article 23 of title 17.)

(2) This article was numbered as article 2 of chapter 71 in C.R.S. 1963. For amendments to this article prior to its repeal in 1977, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

ARTICLE 24

Convict Labor and Goods

27-24-101 to 27-24-124. (Repealed)

Source: L. 77: Entire article repealed, p. 955, § 37, effective August 1.

Editor's note: This article was numbered as article 5 of chapter 105 in C.R.S. 1963. For amendments to this article prior to its repeal in 1977, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

ARTICLE 25

Correctional Industries

27-25-101 to 27-25-203. (Repealed)

Source: L. 77: Entire article repealed, p. 955, § 37, effective August 1.

Editor's note: (1) The provisions concerning correctional industries are under the department of corrections. (See article 24 of title 17.)

(2) This article was numbered as article 8 of chapter 105 in C.R.S. 1963. For amendments to this article prior to its repeal in 1977, consult the Colorado statutory research explanatory note

and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

ARTICLE 26

Jails

27-26-101 to 27-26-129. (Repealed)

Source: L. 77: Entire article repealed, p. 955, § 37, effective August 1.

Editor's note: (1) The provisions concerning jails are under the department of corrections. (See article 26 of title 17.)

(2) This article was numbered as article 7 of chapter 105 in C.R.S. 1963. For amendments to this article prior to its repeal in 1977, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

ARTICLE 27

Community Correctional Facilities and Programs

27-27-101 to 27-27-112. (Repealed)

Source: L. 77: Entire article repealed, p. 955, § 37, effective August 1.

Editor's note: (1) The provisions concerning community correctional facilities and programs are under the department of corrections. (See article 27 of title 17.)

(2) This article was added in 1974. For amendments to this article prior to its repeal in 1977, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

ARTICLE 28

Restitution to Victims of Crime

27-28-101 to 27-28-102. (Repealed)

Source: L. 77: Entire article repealed, p. 955, § 37, effective August 1.

Editor's note: (1) The provisions concerning restitution to victims of crime are under the department of corrections. (See article 28 of title 17.)

(2) This article was added in 1976 and was not amended prior to its repeal in 1977. For the text of this article prior to 1977, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

OTHER INSTITUTIONS

ARTICLE 35

School for the Deaf and the Blind

27-35-101 to 27-35-116. (Repealed)

Source: L. 77: Entire article repealed, p. 1095, § 5, effective July 1.

Editor's note: (1) The provisions concerning the school for the deaf and the blind have been transferred to article 80 of title 22. (See L. 77, pp. 1090-1095.)

(2) This article was numbered as article 1 of chapter 16 in C.R.S. 1963. For amendments to this article prior to its repeal in 1977, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

COLORADO DIAGNOSTIC PROGRAM

ARTICLE 40

Colorado Diagnostic Program

27-40-101 to 27-40-107. (Repealed)

Source: L. 77: Entire article repealed, p. 955, § 37, effective August 1.

Editor's note: (1) The provisions concerning the Colorado diagnostic program are under the department of corrections. (See article 40 of title 17.)

(2) This article was added in 1974. For amendments to this article prior to its repeal in 1977, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

BEHAVIORAL HEALTH

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PART 1

GENERAL PROVISIONS

27-50-101. Definitions.

As used in this article 50, unless the context otherwise requires:

(1) "Behavioral health" refers to an individual's mental and emotional well-being and actions that affect an individual's overall wellness. Behavioral health issues and disorders include substance use disorders, mental health disorders, serious psychological distress, serious mental disturbance, and suicide and range from unhealthy stress or subclinical conditions to diagnosable and treatable diseases. "Behavioral health" also describes service systems that encompass promotion of emotional health and prevention and treatment services for mental health disorders and substance use disorders.

(2) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-50-102.

(3) "Behavioral health disorder" means an alcohol use disorder, a mental health disorder, or a substance use disorder.

(4) "Behavioral health entity" means a facility or provider organization engaged in providing community-based health services, which may include services for a behavioral health disorder but does not include detention and commitment facilities operated by the division of youth services within the department of human services or services provided by a licensed or certified mental health-care provider under the provider's individual professional practice act on the provider's own premises.

(5) "Behavioral health program" means the specific services and administration of those services by a behavioral health provider.

(6) "Behavioral health provider" means a recovery community organization; a recovery support services organization, as defined in section 27-60-108; or a licensed organization or professional providing diagnostic, therapeutic, or psychological services for behavioral health conditions. Behavioral health providers include a residential child care facility, as defined in section 26-6-903 (29), and a federally qualified health center.

(7) "Behavioral health safety net provider" means comprehensive community behavioral health providers and essential behavioral health safety net providers. A community mental health center pursuant to 42 U.S.C. sec. 300x-2(c) that is licensed as a behavioral health entity may apply to be approved as a comprehensive community behavioral health provider, an essential behavioral health safety net provider, or both.

(8) "Behavioral health safety net services" means the specific behavioral health services for children, youth, and adults that must be provided statewide pursuant to part 3 of this article 50.

(8.5) "Boarding" means when a child or youth under twenty-one years of age has been waiting longer than twelve hours to be placed in an appropriate treatment setting after being clinically assessed and determined to be in need of inpatient psychiatric treatment and received a determination from a licensed provider of medical stability without the need for urgent medical assessment or hospitalization for a physical condition.

(9) "Commissioner" means the commissioner of the behavioral health administration appointed pursuant to section 27-50-103.

(10) "Community-based" means outside of a hospital, psychiatric hospital, detention and commitment facility operated by the division of youth services within the department of human services, or nursing home.

(11) "Comprehensive community behavioral health provider" means a licensed behavioral health entity or behavioral health provider approved by the behavioral health administration to provide care coordination and the following behavioral health safety net services, either directly or through formal agreements with behavioral health providers in the community or region:

(a) Emergency and crisis behavioral health services;

(b) Mental health and substance use outpatient services;

(c) Behavioral health high-intensity outpatient services;

(d) Care management;

(e) Outreach, education, and engagement services;

(f) Mental health and substance use recovery supports;

(g) Repealed.

(h) Outpatient competency restoration; and

(i) Screening, assessment, and diagnosis, including risk assessment, crisis planning, and monitoring to key health indicators.

(11.5) "Covered entity" means an entity subject to HIPAA.

(12) "Department" means the department of human services created pursuant to section 26-1-105.

(13) "Essential behavioral health safety net provider" means a licensed behavioral health entity or behavioral health provider approved by the behavioral health administration to provide care coordination and at least one of the following behavioral health safety net services:

(a) Emergency or crisis behavioral health services;

(b) Behavioral health outpatient services;

(c) Behavioral health high-intensity outpatient services;

(d) Behavioral health residential services;

(e) Withdrawal management services;

(f) Behavioral health inpatient services;

(g) Integrated care services;

(h) Hospital alternatives; or

(i) Additional services that the behavioral health administration determines are necessary in a region or throughout the state.

(13.5) "Extended stay" means when a child or youth under twenty-one years of age has been waiting longer than seventy-two hours to be discharged from an acute level of inpatient psychiatric care to a less intensive or less restrictive clinically appropriate level of psychiatric care, including a discharge home or to a home-like setting with behavioral health supports.

(13.7) "Friends and family input form" means a form created pursuant to section 27-50-110 to allow family and friends to provide health or background information about an individual receiving mental health or substance use services.

(14) "Health information organization network" has the same meaning as defined in section 25-3.5-103 (8.6).

(14.5) "HIPAA" means the federal "Health Insurance Portability and Accountability Act of 1996", 42 U.S.C. secs. 1320d to 1320d-9, as amended.

(15) "Mental health disorder" means one or more substantial disorders of the cognitive, volitional, or emotional processes that grossly impairs judgment or capacity to recognize reality or to control behavior.

(16) "Primary prevention" means activities and strategies used to intervene before health effects occur through measures that prevent the onset of addiction, delay initial use of alcohol, marijuana, and tobacco, deter the use of illegal drugs, and promote health and wellness.

(17) (a) "Priority populations" means people who are:

(I) Uninsured, underinsured, medicaid-eligible, publicly insured, or whose income is below thresholds established by the BHA; and

(II) Presenting with acute or chronic behavioral health needs, including but not limited to individuals who have been determined incompetent to stand trial, adults with serious mental illness, and children and youth with serious emotional disturbance.

(b) The BHA shall further identify underserved populations meeting the criteria of subsection (17)(a) of this section for specific prioritization on a regional or statewide basis based on health equity data, including but not limited to people experiencing or at risk of homelessness; children and youth at risk of out-of-home placement and their parents; people involved with the criminal or juvenile justice system; people of color; American Indians; Alaska natives; veterans; people who are pregnant; people who are lesbian, gay, bisexual, transgender, or queer or questioning; and individuals with disabilities as defined by the federal "Americans with Disabilities Act of 1990", 42 U.S.C. sec. 12101 et seq., as amended. The BHA shall also consider input directly from behavioral health providers that are culturally and linguistically representative of the populations they serve. The BHA shall consider recommendations from the behavioral health administrative services organizations, the advisory council, and regional subcommittees in identifying subpopulations.

(17.3) "Recovery community organization" means an independent nonprofit organization led and governed by representatives of local communities of recovery that organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, or provide peer-run recovery support services.

(17.5) (a) "Recovery residence" means a licensed premises, place, facility, or building that provides housing accommodation for individuals with a primary diagnosis of a behavioral health disorder and that:

(I) Does not permit the possession or use of alcohol or nonprescribed or illicit drugs;

(II) Promotes independent living and life-skill development; and

(III) Provides structured activities and recovery support services that are primarily intended to promote and sustain recovery from behavioral health disorders.

(b) "Recovery residence" does not include:

(I) A private residence in which an individual related to the owner of the residence by blood, adoption, or marriage is required to abstain from substance use or receive behavioral health services for a behavioral health disorder as a condition of residing in the residence;

(II) A behavioral health entity licensed by the BHA to provide residential treatment;

(III) Permanent supportive housing. For the purposes of this subsection (17.5)(b)(III), "permanent supportive housing" means community-based affordable housing where extremely low-income individuals with complex barriers to housing stability and histories of homelessness have a dedicated rental subsidy that is not conditional on participation in supportive services and includes the same rights and responsibilities of tenancy legally guaranteed by a lease agreement and access to intensive coordinated supportive services designed to support tenants to live independently with improved health outcomes and reduced emergency system utilization.

(IV) Shelters, emergency overflow beds, beds in service pursuant to emergency protocols, any other form of transient or exigent housing that has an average stay of less than three days, or housing options that are under the primary oversight of the division of housing in the department of local affairs;

(V) A health facility, as defined in section 24-33.5-1202; or

(VI) A community-based organization or program that has a primary mission of providing supportive services to individuals released from jail or prison, or otherwise involved in the criminal justice system, and that does not require the individual to have a primary behavioral health disorder in order to receive services, including housing.

(18) (a) "State agency" means any state department, state office, or state division in Colorado that administers a behavioral health program.

(b) "State agency" does not include the judicial branch of state government.

(19) "State board" means the state board of human services created pursuant to section 26-1-107.

(20) "Substance use disorder" means a chronic relapsing brain disease, characterized by recurrent use of alcohol, drugs, or both, causing clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

(21) "Substance use disorder program" means a program for the detoxification, withdrawal, maintenance, or treatment of a person with a substance use disorder.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1443, § 1, effective July 1. **L. 2023:** (4), (7), IP(11), and (13) amended and (11)(g) repealed, (HB 23-1236), ch. 206, p. 1056, § 17, effective May 16; (8.5) and (13.5) added, (HB 23-1269), ch. 377, p. 2264, § 4, effective June 5. **L. 2024:** (11.5), (13.7), and (14.5) added, (HB 24-1217), ch. 264, p. 1737, § 1, effective May 28. **L. 2026:** (6) amended and (17.3) added, (HB 26-1378), ch. 245, p. 1391, § 2, effective May 29; (14) amended, (HB 26-1069), ch. 303, p. 1737, § 7, effective June 2; (17.5) added, (SB 26-113), ch. 302, p. 1717, § 1, effective August 12.

27-50-102. Behavioral health administration - creation - coordination - health oversight agency.

(1) There is established in the department of human services the behavioral health administration. Nothing in this subsection (1) precludes any future legislative action taken pursuant to section 27-60-203 (5) regarding the future location of the BHA.

(2) The BHA is charged with creating a coordinated, cohesive, and effective behavioral health system in Colorado. Any state agency that administers a behavioral health program shall collaborate with the BHA to achieve the goals and objectives established by the BHA. In order to ensure regular engagement with other state agencies and to maintain alignment in state programs, resource allocation, priorities, and strategic planning, the commissioner shall chair a regular meeting of the executive directors of state agencies.

(3) For the purpose of overseeing the behavioral health-care system in Colorado and discharging the BHA's duties as described in this article 50, the BHA is a health oversight agency, as defined in 45 CFR 164.501.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1446, § 1, effective July 1. **L. 2023:** (3) added, (HB 23-1236), ch. 206, p. 1057, § 18, effective May 16.

27-50-103. Behavioral health commissioner - appointment - powers, duties, and functions - subdivisions of the BHA.

(1) The governor shall appoint the commissioner, who is the head of the BHA. The commissioner has the full authority, with the governor, to lead and develop the state's vision and strategy for behavioral health for children, youth, and adults.

(2) The commissioner shall:

(a) Be well-versed in behavioral health;

(b) Be registered to vote in Colorado during the commissioner's term of service; and

(c) Have no pecuniary interest, directly or indirectly, in any behavioral health company or agency other than as a behavioral health services recipient.

(3) The commissioner shall ensure that:

(a) Behavioral health programs delivered by state agencies and commercial payers are comprehensive, evidence-based, affordable, high quality, equity-focused, and easily accessible for all Coloradans;

(b) Behavioral health strategies, program priorities, and funding allocations for behavioral health align with the vision set forth by the BHA and the governor; and

(c) There is a streamlined approach to using public money to improve behavioral health across the continuum of care from prevention to recovery.

(4) The commissioner shall engage with the legislative and judicial branches of government to achieve the state's vision for behavioral health.

(5) The commissioner may establish subdivisions, sections, or units necessary for the proper discharge of the powers, duties, and functions of the BHA.

(6) The commissioner shall establish an infrastructure to oversee and be accountable for policy, strategy, and services for children and youth.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1447, § 1, effective July 1.

27-50-104. Powers and duties of the commissioner - rules.

(1) (a) The commissioner may adopt "commissioner rules" for behavioral health programs administered and services provided by the BHA as listed in section 27-50-105 (1). The rules must be promulgated in accordance with section 24-4-103.

(b) Any rules adopted by the executive director of the department of human services prior to July 1, 2022, to implement the behavioral health programs to be administered and services to be provided by the BHA listed in section 27-50-105 (1), and whose content meets the definition of "executive director rules" pursuant to section 26-1-108, are effective until revised, amended, or repealed by the commissioner.

(2) "Commissioner rules" are solely within the province of the commissioner, except those determinations precluded by authority granted to the state board of human services. "Commissioner rules" must include:

(a) Matters of internal administration in the BHA, including organization, staffing, records, reports, systems, and procedures;

(b) Fiscal and personnel administration for the BHA; and

(c) Accounting and fiscal reporting rules for disbursement of federal funds, contingency funds, and proration of available appropriations.

(3) Whenever a statutory grant of rule-making authority in this title 27 refers to the BHA, it means the behavioral health administration acting through either the state board of human services, the commissioner, or both. When exercising rule-making authority pursuant to this title 27, the BHA shall promulgate rules consistent with the powers and the distinction between "board rules" as set forth in section 26-1-107 and "commissioner rules" as set forth in this section.

(4) The rules promulgated by the commissioner pertaining to this title 27 are binding upon the behavioral health providers, vendors, and agents of the BHA. At any public hearing relating to a proposed rule, interested persons have the right to present the person's data, views, or arguments orally. Proposed rules of the commissioner are subject to section 24-4-103.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1447, § 1, effective July 1.

27-50-105. Administration of behavioral health programs - state plan - sole mental health authority - gifts, grants, or donations - repeal.

(1) The BHA shall administer and provide the following behavioral health programs and services:

(a) The regulation of recovery residences pursuant to part 10 of this article 50;

(b) The behavioral health crisis response system created pursuant to section 27-60-103;

(c) The behavioral health capacity tracking system created pursuant to section 27-60-104.5;

(d) The jail-based behavioral health services program created pursuant to section 27-60-106;

(e) Criminal justice diversion programs pursuant to section 27-60-106.5;

(f) Peer support professionals and recovery support services organizations pursuant to section 27-60-108;

(g) The youth mental health services program created pursuant to section 27-60-109;

(h) Behavioral health-care services for rural and agricultural communities pursuant to section 27-60-110;

(i) The county-based behavioral health grant program created pursuant to section 27-60-111;

(j) The behavioral health-care workforce development program created pursuant to section 27-60-112;

(k) The statewide care coordination infrastructure pursuant to section 27-60-204;

(l) High-fidelity wraparound services for children and youth pursuant to article 62 of this title 27;

(m) The behavioral health safety net system pursuant to article 63 of this title 27;

(n) The 988 crisis hotline enterprise created pursuant to section 27-64-103;

(o) The care and treatment of persons with mental health disorders pursuant to article 65 of this title 27;

(p) The community mental health services purchase program pursuant to section 27-66-104;

(q) The standards for approval in the community mental health services purchase program pursuant to section 27-66-105;

(r) Trauma-informed care standards of approval pursuant to section 27-66-110;

(s) The community transition specialist program created pursuant to article 66.5 of this title 27;

(t) The "Children and Youth Mental Health Treatment Act", article 67 of this title 27;

(u) Medication consistency for individuals with behavioral or mental health disorders in the criminal and juvenile justice systems pursuant to article 70 of this title 27;

(v) Grants for public programs pursuant to section 27-80-103;

(w) The purchase of prevention and treatment services pursuant to section 27-80-106;

(x) The designation of managed service organizations pursuant to section 27-80-107;

(y) The "Increasing Access to Effective Substance Use Disorder Services Act" pursuant to section 27-80-107.5;

(z) The coordination of state and federal funds and programs pursuant to section 27-80-109;

(aa) Addiction counselor training requirements pursuant to section 27-80-111;

(bb) The treatment program for high-risk pregnant women created pursuant to section 27-80-112;

(cc) The rural alcohol and substance abuse prevention and treatment program created pursuant to section 27-80-117;

(dd) The care navigation program pursuant to section 27-60-204;

(ee) to (gg) Repealed.

(hh) Temporary financial housing assistance for individuals with substance use disorders pursuant to section 27-80-125;

(ii) Repealed.

(jj) Controlled substances licensing pursuant to part 2 of article 80 of this title 27;

(kk) The comprehensive and coordinated program for the treatment of persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs pursuant to section 27-81-105;

(ll) The standards for public and private treatment facilities that receive public funds pursuant to section 27-81-106;

(mm) Acceptance for substance use disorder treatment pursuant to section 27-81-108;

(nn) Voluntary treatment of persons with substance use disorders pursuant to section 27-81-109;

(oo) Voluntary treatment for persons intoxicated by alcohol, under the influence of drugs, or incapacitated by substances pursuant to section 27-81-110;

(pp) The emergency commitment of persons pursuant to section 27-81-111;

(qq) The involuntary commitment of a person with a substance use disorder pursuant to section 27-81-112;

(rr) Emergency service patrols pursuant to section 27-81-115;

(ss) Payment for treatment pursuant to section 27-81-116;

(tt) The maternal and child health pilot program pursuant to part 2 of article 82 of this title 27;

(uu) Human services referral services pursuant to section 29-11-203;

(vv) DUI treatment programs pursuant to article 2 of title 42;

(ww) Alcohol and drug driving safety education or treatment pursuant to section 42-4-1301.3;

(xx) Gambling addiction account funding pursuant to section 44-30-1301; and

(yy) Sports betting funding pursuant to section 44-30-1509.

(2) (a) The BHA shall formulate a comprehensive state plan for substance use disorder treatment and mental health services programs for the purpose of administering the federal block grant funds described in subsection (2)(c) of this section. The BHA shall submit the state plan to the governor and, upon the governor's approval, submit the state plan to the appropriate United States agency for review and approval.

(b) The BHA is designated as the sole entity for the supervision of the administration of the state plan.

(c) The BHA is designated the official mental health authority and is authorized to receive and administer:

(I) Grants-in-aid from the federal government pursuant to 42 U.S.C. sec. 246; and

(II) Other grants from the federal government for the provision of mental health or integrated behavioral health services.

(3) The BHA may provide consultation and conduct training programs at the state, regional, or local level to support the professional development of licensed or approved behavioral health providers. The BHA may reimburse providers for reasonable and necessary expenses incurred in attending the training programs.

(4) The BHA may seek, accept, and expend gifts, grants, or donations from private or public sources for the purpose of administering any behavioral health program or service described in subsection (1) of this section. The commissioner, with the approval of the governor, may direct the disposition of any gift, grant, or donation for any purpose consistent with the terms and conditions for which the gift, grant, or donation was given.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1448, § 1, effective July 1. **L. 2023:** (1)(dd) amended and (4) added, (HB 23-1236), ch. 206, p. 1057, § 19, effective May 16;

(1)(a) amended, (HB 23-1204), ch. 145, p. 622, § 2, effective August 7. **L. 2024:** (1)(g) amended, (SB 24-001), ch. 367, p. 2470, § 2 effective June 4. **L. 2026:** (1)(ee) and (1)(ii) repealed and (1)(gg) amended, (HB 26-1378), ch. 245, p. 1392, § 3, effective May 29; (1)(a) amended and (1)(ff) repealed, (SB 26-113), ch. 302, p. 1731, § 6, effective August 12.

Editor's note: (1) Subsection (1)(gg)(II) provided for the repeal of subsection (1)(gg), effective July 1, 2026. (See L. 2026, p. 1392.)

(2) Subsection (1)(gg) was amended in HB 26-1378, effective May 29, 2026. For the amendments in effect from May 29, 2026, until July 1, 2026, see chapter 245, Session Laws of Colorado 2026. (L. 2026, p. 1392.)

27-50-106. Transfer of functions.

(1) The powers, duties, and functions previously administered by the department of public health and environment concerning licensing behavioral health entities pursuant to article 27.6 of title 25 shall transfer to the BHA over a period of two years, with all functions fully transferred to the BHA by January 1, 2025, as follows:

(a) The department of public health and environment shall continue issuing and renewing behavioral health entity licenses until September 30, 2023, after which date the department of public health and environment shall not renew or confer any new behavioral health entity licenses. Behavioral health entities that are licensed by the department of public health and environment are subject to the rules and orders of the department of public health and environment until such rules and orders are revised, amended, repealed, or nullified. The department of public health and environment shall continue compliance monitoring and enforcement activities until all licenses the department of public health and environment has conferred are expired, revoked, or surrendered, but not after December 31, 2025.

(b) On July 1, 2023, the department of public health and environment shall transfer any applications pending as of that date to the BHA for disposition.

(c) On July 1, 2023, the BHA shall begin licensing functions for all new or renewal behavioral health entity licenses. Behavioral health entities that are licensed by the BHA are subject to the rules and orders of the state board of human services, including those transferred and not repealed.

(d) Rules concerning behavioral health entities promulgated by the state board of human services pursuant to this section only apply to those behavioral health entities that are licensed by the BHA.

(2) No later than July 1, 2024, all behavioral health entities must be licensed by, and in compliance with the rules and orders of, the state board of human services.

(3) The department of public health and environment and the BHA shall coordinate to ensure that the oversight and licensing of behavioral health entities transfers smoothly between the department of public health and environment and the BHA without any delays in oversight or related duties.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1452, § 1, effective July 1. **L. 2023:** IP(1) and (1)(a) amended, (HB 23-1236), ch. 206, p. 1058, § 20, effective May 16.

27-50-107. State board of human services - rules.

(1) The state board of human services created pursuant to section 26-1-107 is the **type 1** board for promulgating, revising, and repealing BHA rules.

(2) Any rules promulgated by the state board of human services to implement the provisions of this article 50 or any other behavioral health program administered or service provided by the department of human services prior to July 1, 2022, are effective until revised, amended, or repealed by the state board of human services.

(3) The state board of human services may promulgate rules that include, but are not limited to:

(a) Any rules necessary to carry out the purposes of a behavioral health program administered by the BHA as listed in section 27-50-105, including record keeping, data collection, and health information organization network connection;

(b) Conditions that may be imposed on a behavioral health entity for licensure;

(c) Conditions that may be imposed on a behavioral health program for the program to receive public funds as part of the behavioral health safety net system created pursuant to part 3 of this article 50;

(d) Requirements for public and private agencies, organizations, and institutions that the BHA may purchase services from pursuant to section 27-80-106 (1), which requirements must include prohibiting the purchase of services from agencies, organizations, and institutions that deny or prohibit access to medical services or substance use disorder treatment and services to a person who is participating in prescribed medication-assisted treatment, as defined in section 23-21-803, for a substance use disorder; and

(e) (I) Standards that addiction counselors must meet to participate in behavioral health programs or to provide purchased services, and requirements necessary for addiction counselors

to be certified by the state board of addiction counselor examiners, pursuant to part 8 of article 245 of title 12.

(II) The rules promulgated pursuant to subsection (3)(e)(I) of this section must include education requirements for certified addiction technicians, certified addiction specialists, and licensed addiction counselors.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1453, § 1, effective July 1.

27-50-108. Systemwide behavioral health grievance system.

(1) (a) On or before July 1, 2024, the BHA shall create and implement a process for collecting, analyzing, and addressing behavioral health system grievances across payers, behavioral health administrative services organizations, managed care entities, and providers at a systemic level that leverages and does not duplicate existing grievance resolution programs. The BHA shall analyze grievances to identify and address service delivery gaps and to inform statewide behavioral health system policy.

(b) The BHA shall, at a minimum, track grievances by behavioral health provider, topic, region, managed care entity, behavioral health administrative services organizations, payer source, service, or diagnosis and aggregate demographic data. In order to promote transparency, accountability, and system collaboration, the BHA shall publish, at least annually, aggregated and anonymized data on grievances on a public-facing website.

(c) The BHA shall implement a plan to streamline grievance resolution programs, promote transparency, improve consumer experience, and promote clarity and transparency.

(2) On or before July 1, 2024, the BHA shall solicit input from the behavioral health administration advisory council created pursuant to section 27-50-701, the sub-committees created pursuant to section 27-50-703, and demographically diverse stakeholders to develop a process for addressing individual grievances when traditional grievance programs fail.

(3) The BHA may refer individual grievances to the office of the ombudsman for behavioral health access to care, created pursuant to section 27-80-303, when an individual may require further intervention or support to resolve the grievance in accordance with the charge of the ombudsman.

(4) On or before July 1, 2024, the BHA and state agencies shall execute formal data-sharing agreements addressing data sharing consistent with state and federal requirements, cooperation between the BHA and state agencies, and any other provisions necessary to implement this section. At a minimum, the BHA and the following entities shall execute such agreements:

(a) The ombudsman for medicaid managed care, established in section 25.5-5-406.1;

(b) The ombudsman for behavioral health access to care, designated pursuant to section 27-80-303; and

(c) The child protection ombudsman, appointed pursuant to section 19-3.3-102 (3)(a)(I). All data released by the ombudsman shall comply with section 19-3.3-103.5 (1) and (2).

(5) The BHA may promulgate rules as needed to implement this section.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1453, § 1, effective July 1. **L. 2025:** (4)(c) amended, (HB 25-1200), ch. 270, p. 1398, § 12, effective August 6.

27-50-109. Centralized digital consent repository working group - duties - report - repeal. (Repealed)

Source: L. 2024: Entire section added, (HB 24-1217), ch. 264, p. 1737, § 2, effective May 28.

Editor's note: Subsection (7) provided for the repeal of this section, effective September 1, 2026. (See L. 2024, p. 1737.)

27-50-110. Friends and family input form - rules.

(1) (a) On or before July 1, 2025, the BHA shall create a friends and family input form to allow an individual to provide a treating professional or a licensed or designated facility or organization with information related to a patient receiving mental health or substance use services, including:

(I) Information about a patient's:

(A) Diagnosis;

(B) Past hospitalizations;

(C) De-escalation techniques;

(D) Current and past providers and their contact information;

(E) Potential triggers;

(F) Housing status;

(G) Family history, relationships, or social context;

(H) Current medical conditions; and

(I) Current and past medications; and

(II) Any other information as determined by the BHA based on feedback received from stakeholders.

(b) The friends and family input form must include a clear statement that the friends and family input form may become part of the patient's medical record.

(2) On or before October 1, 2024, the BHA shall convene one or more meetings to obtain input and recommendations from stakeholders, including consumer advocates; behavioral health providers, including behavioral health safety net providers; representatives from the department of public health and environment and the department of corrections; individuals with expertise in state and federal privacy law; and individuals who have accessed mental health or substance use services, concerning the best practices for creation and use of the friends and family input form described in subsection (1) of this section.

(3) (a) The friends and family input form may be accepted in writing or electronically by any health-care facility or provider licensed or designated by the BHA, any licensee as defined in section 12-245-202 (8), any registrant as defined in section 12-245-202 (16), the department of public health and environment, the department of corrections, a county or district public health agency, the department of health care policy and financing, or any other treatment facility for individuals with behavioral or mental health disorders.

(b) Covered entities may accept partially completed submissions of the friends and family input form.

(c) A treating professional or a licensed or designated facility or organization shall not distribute the friends and family input form to any other entity if a patient expressly prohibits disclosure, except if a court or other legal authority has ordered the disclosure.

(d) Nothing in this section shall be construed to modify or alter any generally accepted ethics, standards, protocols, or laws governing treating professionals. A covered entity, treating professional, or the professional's designee is not subject to any civil, criminal, or regulatory sanction for acting or failing to act in response to the information contained in the friends and family input form or for declining to accept a friends and family input form.

(e) If a patient explicitly objects to a covered entity receiving information regarding the patient from a specific individual, the covered entity is not required to accept information from the specific individual.

(4) A friend or family member providing information about an individual shall ensure the information is accurate to the best knowledge of the friend or family member providing the information.

(5) (a) An individual with a close, personal interest in the well-being of the patient may provide information pursuant to this subsection (5).

(b) A treating professional or a licensed or designated facility or organization may accept input in writing or through email from another individual.

(c) A treating professional or a licensed or designated facility or organization may accept input verbally, including through voicemail. If a treating professional or a licensed or designated facility or organization accepts input verbally, the treating professional or licensed or designated facility or organization shall establish and document the process for accepting verbal input.

(d) The provider shall acknowledge receipt of the input provided pursuant to this subsection (5) but is not required to disclose additional information.

(6) (a) If the disclosures are permitted by HIPAA, a provider may share a patient's information with family, friends, or any individual with a close, personal interest in the well-being of the patient without the patient's consent if the patient is not present or is incapacitated and the treating professional or the professional's designee determines, based on professional judgment, that it is in the best interest of the patient.

(b) If a provider discloses information about a patient without the patient's consent pursuant to subsection (6)(a) of this section, the provider shall discuss only the information that an individual involved needs to know about a patient's care or payment.

(c) A provider or facility shall not inform a patient's family, friends, or any individual with a close, personal interest in the well-being of the patient about a past medical problem that is unrelated to the patient's current condition.

(d) A provider is not required by HIPAA to share a patient's information when the patient is not present or is incapacitated. The provider may wait until the patient has the opportunity to agree to the disclosure.

(7) The BHA shall create a resource page for both providers and families on its website that includes the friends and family input form and information from federal guidance documents and shall notify interested stakeholders of the availability of the friends and family input form and resource page.

(8) The BHA shall promulgate rules for behavioral health safety net providers related to maintaining and releasing patient information and implementing the friends and family input form.

Source: L. 2024: Entire section added, (HB 24-1217), ch. 264, p. 1737, § 2, effective May 28.

PART 2

BEHAVIORAL HEALTH SYSTEM MONITORING

27-50-201. Behavioral health system monitoring - capacity - safety net performance.

(1) On or before July 1, 2024, the BHA shall establish a performance monitoring system to track capacity and performance of all behavioral health providers, including those that contract with managed care entities or behavioral health administrative services organizations, and inform needed changes to the public and private behavioral health system in the state.

(2) The BHA shall set minimum performance standards for treatment of children, youth, and adults that address key metrics for behavioral health providers and behavioral health administrative services organizations licensed by the BHA pursuant to part 5 of this article 50, including but not limited to:

(a) Accessibility of care, including:

(I) Availability of services;

(II) Timeliness of service delivery; and

(III) Capacity tracking consistent with section 27-60-104.5; and

(b) Quality of care, including appropriate triage and access based on client need and for priority populations.

(3) In setting minimum performance standards, the BHA shall collaborate with state agencies to consider:

(a) Evidence-based and promising practices;

(b) Themes identified through grievances pursuant to section 27-50-108;

(c) Input from the behavioral health administration advisory council created pursuant to section 27-50-701;

(d) Alignment with existing state and federal requirements;

(e) Alignment with the BHA's comprehensive state plan developed pursuant to section 27-50-105 (2); and

(f) Reducing the administrative burden of data collection and reporting for behavioral health providers.

(3.5) (a) In setting minimum performance standards for children and youth under twenty-one years of age, the BHA shall consult with a working group, including members from the department of health care policy and financing, the department of human services, county departments of human or social services, managed care entities, hospitals, and other relevant stakeholders, including stakeholders who represent individuals with intellectual and developmental disabilities, to help develop the performance monitoring system framework that addresses the minimum performance standards for treatment of children and youth pursuant to subsection (2) of this section. The framework must consider measures of accountability for children and youth who are boarding or in extended stay.

(b) The working group may, through gifts, grants, or donations, enter into an agreement with a third-party contractor that has expertise in child welfare and youth mental health research, including outcome measurement and impact analysis, to assist in developing the framework.

(c) No later than April 1, 2024, the working group shall submit the framework to the BHA to inform the performance monitoring system. The BHA shall make the framework publicly available on the BHA's website.

(3.7) (a) (I) Beginning September 1, 2023, and each quarter thereafter until October 1, 2024, each hospital shall report information to the BHA that is consistent with federal privacy laws in a form and manner specified by the BHA on the total number of children and youth patients who were boarding or had extended stays in the previous quarter; if known, how many children and youth who were boarding or had extended stays and were in county custody at the time they were boarding or had extended stays; and, to the extent possible, for patients who were ultimately discharged during the quarter, where the patients were discharged to.

(II) Beginning September 1, 2023, and each quarter thereafter until October 1, 2024, the department of human services, in consultation with county departments of human or social services, shall report information to the BHA in a form and manner specified by the BHA that is consistent with federal privacy laws on the total number of children and youth in the custody of, or who had involvement with, a county department of human or social services who spent time at least overnight in a hotel or a county department of human or social services office as a stopgap setting.

(b) (I) No later than September 1, 2023, and each quarter thereafter until October 1, 2024, the BHA shall report aggregated and de-identified information submitted to the BHA pursuant to subsection (3.7)(a) of this section to the working group. The BHA shall make the de-identified and aggregated data publicly available on the BHA's website.

(II) If the information reported pursuant to this subsection (3.7)(b) is not able to be aggregated and de-identified in compliance with the federal "Health Insurance Portability and Accountability Act of 1996", as amended, 42 U.S.C. secs. 1320d to 1320d-9, the BHA shall not

report the information until the population is large enough to be reported in compliance with the federal law.

(4) The BHA and the department of health care policy and financing shall collaborate to align performance metrics and standards for providers, managed care entities, and behavioral health administrative services organizations to the greatest extent possible.

(5) (a) The BHA shall collaborate with the department of health care policy and financing to establish data collection and reporting requirements that align with the performance standards established in this section and that are of a high value in promoting systemic improvements. In establishing data collection and reporting requirements, the BHA must consider the impact on behavioral health providers and clients and state information technology systems.

(b) Where applicable, the BHA shall coordinate with the health information organization networks to prioritize leveraging the health information organization network infrastructure to meet the requirements of this section and to promote the interoperable exchange of data to improve the quality of patient care. The BHA shall coordinate with the health information organization networks on relevant provisions of the universal contract pursuant to section 27-50-203 (1)(a).

(6) Compliance with the requirements described in this section shall be enforced through:

(a) The universal contracting provisions developed pursuant to section 27-50-203;

(b) Designation of behavioral health administrative services organizations pursuant to section 27-50-402; and

(c) Applicable licensing standards, including licensing behavioral health entities pursuant to part 5 of this article 50.

(7) The BHA shall analyze the data collected pursuant to this section and create public-facing system accountability platforms to report on performance standards for behavioral health providers, behavioral health administrative services organizations, and managed care entities.

(8) The BHA shall document how the BHA's activities conducted pursuant to this section comply with state and federal privacy laws and standards.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1455, § 1, effective July 1. **L. 2023:** (5) amended, (HB 23-1236), ch. 206, p. 1058, § 21, effective May 16; (3.5) and (3.7) added, (HB 23-1269), ch. 377, p. 2264, § 5, effective June 5.

27-50-202. Formal agreements - state agencies and tribal governments.

(1) On or before July 1, 2023, the commissioner shall collaborate with state agencies and tribal governments, while respecting tribal sovereignty, to implement formal agreements between the BHA and state agencies, and the BHA and tribal governments that have initiatives, funding, programs, or services related to behavioral health. The formal agreements must provide the structure for implementing behavioral health standards by formalizing expectations specific to:

(a) Collaborative problem solving for challenges that arise in the behavioral health system;

(b) Consideration of BHA funding and resource allocation priorities across the behavioral health continuum of care, including primary prevention and harm reduction, as well as recommendations for other state agencies' and tribal governments' funding priorities, to ensure a coordinated statewide effort to align behavioral health funding with the BHA's vision, demonstrated gaps in funding or resource allocation, and governor priorities;

(c) Data sharing and health information sharing, including a process for data sharing and analysis that:

(I) Prioritizes protection of patient privacy and, to the extent possible, eliminates any sharing of personally identifiable information and personal health information; and

(II) Must be transparently disclosed to all relevant parties;

(d) Requiring, when applicable, the use of the universal contracting provisions generated in collaboration with state agencies pursuant to section 25-50-203 and the use of behavioral health administrative services organizations pursuant to part 4 of this article 50;

(e) Reporting and data sharing to the BHA, including behavioral-health-related metrics, to ensure state agencies and tribal governments share data;

(f) Managed care entity standards, such as use of nationally recognized practice guidelines for utilization management approved by the BHA and shared parameters for network adequacy;

(g) Parity monitoring and compliance to support the department of health care policy and financing's and the division of insurance's enforcement of parity provisions; and

(h) A method for the state agencies and tribal governments to inform the BHA of problems that need resolution and to collaborate with the BHA to address those problems.

(2) The commissioner, in collaboration with state agencies and tribal governments, shall annually review the formal agreements and update the formal agreements as necessary. Formal agreements may be expanded to other state agencies and branches of government as needed and appropriate.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1456, § 1, effective July 1.

27-50-203. Universal contracting provisions - requirements.

(1) The BHA shall work with the department of health care policy and financing, in collaboration with relevant stakeholders and other state agencies, to develop universal contracting provisions to be used by state agencies when contracting for behavioral health safety net services in the state. The universal contracting provisions must provide clear, standardized requirements addressing at least the following:

(a) Minimum data collection standards and reporting, including electronic data and participation in health information organization networks;

(b) Grievance and occurrence reporting, including to the BHA;

(c) Consequences for not meeting contract requirements; and

(d) Ensuring individuals are connected to the services the individuals require within the behavioral health safety net system.

(2) The universal contracting provisions do not require the expansion of data collection beyond the data already being collected by a state agency, tribal government, or contractor.

(3) Additional terms not included in the universal contract may be negotiated and added by the contracting parties.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1457, § 1, effective July 1. **L. 2025:** (1) and (2) amended, (HB 25-1124), ch. 61, p. 252, § 2, effective August 6.

Cross references: For the legislative declaration in HB 25-1124, see section 1 of chapter 61, Session Laws of Colorado 2025.

27-50-204. Reporting.

(1) Beginning October 1, 2022, and each October 1 thereafter, the BHA shall prepare and submit a report, known as the behavioral health system plan, to the joint budget committee and the public and behavioral health and human services committee of the house of representatives and the health and human services committee of the senate, or any successor committees. At a minimum, the report must include a description of the BHA's vision and strategy for the behavioral health system, updates on performance standards developed pursuant to section 27-

50-201 (2), analysis of the grievances collected pursuant to section 27-50-108, updates on formal agreements and collaborations with state agencies pursuant to this article 50, opportunities to improve reimbursement for integrated physical and mental health services, updates on care coordination pursuant to section 27-50-301 (3), and the report of the advisory council created pursuant to section 27-50-701.

(2) Beginning January 1, 2023, and each January 1 thereafter, the BHA shall present the report prepared pursuant to subsection (1) of this section as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" hearing required by section 2-7-203.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1458, § 1, effective July 1.

PART 3

BEHAVIORAL HEALTH SAFETY NET SYSTEM

27-50-301. Behavioral health safety net system implementation.

(1) No later than July 1, 2024, the BHA, in collaboration with the department of health care policy and financing and the department of public health and environment, shall establish a comprehensive and standardized behavioral health safety net system throughout the state that must include behavioral health safety net services for children, youth, and adults, including adults who have a serious mental illness and children and youth who have a serious emotional disturbance, along a continuum of care.

(2) The BHA shall ensure that all Coloradans have access to the behavioral health safety net system, which must:

(a) Proactively engage priority populations with adequate case management and care coordination throughout the care continuum;

(b) Promote competency in de-escalation techniques;

(c) Develop, maintain, and utilize adequate networks for timely access to treatment, including high-intensity behavioral health treatment and community-based treatment for children, youth, and adults;

(d) Require collaboration with all state and local law enforcement jurisdictions and counties in the service area, including judicial districts and county departments of human or social services;

(e) Triage individuals who need services outside the scope of the behavioral health safety net system;

(f) Incorporate and demonstrate trauma-informed care practices;

(g) Promote patient-centered care and cultural awareness;

(h) Update information as requested by the BHA about available treatment options and outcomes in each region of the state;

(i) Prioritize relevant programs or services eligible for federal grants or reimbursement, including relevant programs or services identified in the federal Title IV-E prevention services clearinghouse;

(j) Utilize evidence-based or evidence-informed programming to promote quality services; and

(k) Meet any other criteria established by the BHA.

(3) In establishing the standardized and comprehensive behavioral health safety net system, the BHA shall:

(a) In collaboration with state agencies and the advisory council created pursuant to section 27-50-701, establish and routinely assess what types of behavioral health services are provided on a community, regional, and statewide basis for children, youth, and adults. The BHA shall ensure that, at a minimum, the following behavioral health safety net services are available for children, youth, and adults statewide:

(I) Emergency or crisis behavioral health services;

(II) Mental health and substance use outpatient services;

(III) Behavioral health high-intensity outpatient services;

(IV) Behavioral health residential services;

(V) Withdrawal management services;

(VI) Behavioral health inpatient services;

(VII) Mental health and substance use recovery supports;

(VIII) Integrated care services;

(IX) Care management;

(X) Outreach, education, and engagement services;

(XI) Outpatient competency restoration;

(XII) Care coordination;

(XIII) Hospital alternatives;

(XIV) Screening, assessment, and diagnosis, including risk assessment, crisis planning, and monitoring to key health indicators; and

(XV) Additional services that the BHA determines are necessary in a region or throughout the state.

(b) When routinely assessing the services available regionally and statewide, as required in subsection (3)(a) of this section, assess adequacy of funding and resources necessary to implement the behavioral health system plan pursuant to section 27-50-204;

(c) Set clinical and practice standards and health, safety, and welfare standards, including standards specific to children and youth, when appropriate, through the licensing of behavioral health entities and the approval of behavioral health safety net providers;

(d) Establish statewide, regional, and local behavioral health network adequacy standards, including standards specific to children and youth, when appropriate; and

(e) Implement a behavioral health administrative services organization structure pursuant to part 4 of this article 50.

(4) Except as provided in section 27-50-303, behavioral health safety net providers shall not refuse to treat an individual based on the individual's:

(a) Insurance coverage, lack of insurance coverage, or ability to pay;

(b) Clinical acuity level related to the individual's behavioral health condition or conditions, including whether the individual has been certified for short-term treatment or long-term care and treatment pursuant to article 65 of this title 27;

(c) Readiness to transition out of the Colorado mental health institute at Pueblo, the Colorado mental health institute at Fort Logan, or any other mental health institute or licensed facility providing inpatient psychiatric services or acute care hospital providing stabilization because the individual no longer requires inpatient care and treatment;

(d) Involvement in the criminal or juvenile justice system;

(e) Current involvement in the child welfare system;

(f) Co-occurring mental health and substance use disorders, physical disability, or intellectual or developmental disability, irrespective of primary diagnosis, co-occurring conditions, or if an individual requires assistance with activities of daily living or instrumental activities of daily living, as defined in section 12-270-104 (6);

(g) Displays of aggressive behavior, or history of aggressive behavior, as a symptom of a diagnosed mental health disorder or substance use disorder;

(h) Clinical presentation or behavioral presentation in any previous interaction with a provider;

(i) Place of residence; or

(j) Disability, age, race, creed, color, sex, sexual orientation, gender identity, gender expression, marital status, national origin, ancestry, or tribal affiliation.

(5) The BHA may promulgate rules or determine other appropriate processes to approve behavioral health providers as behavioral health safety net providers. Behavioral health providers that do not hold a license from the BHA but are otherwise licensed or authorized to provide behavioral health services in the state of Colorado are eligible to be approved as behavioral health safety net providers.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1459, § 1, effective July 1. **L. 2023:** (1) amended, (HB 23-1236), ch. 206, p. 1059, § 22, effective May 16.

27-50-302. Requirement to serve priority populations - screening and triage for individuals in need of behavioral health services - referrals.

(1) Except as provided in this section, comprehensive community behavioral health providers must provide the safety net services listed in section 27-50-101 (11) to priority populations.

(2) Except as provided in section 27-50-303, essential behavioral health safety net providers shall provide the safety net service or services that they contract with the behavioral health administrative services organization or managed care entity to provide to priority populations.

(3) Notwithstanding any other provision of this section to the contrary, emergency and crisis services must be available to any individual who is experiencing a behavioral health crisis, regardless of whether the individual is a priority population.

(4) (a) When a priority population client initiates treatment with a behavioral health safety net provider, prior to the intake the provider shall complete an initial screening and triage process to determine urgency and appropriateness of care with the provider.

(b) The behavioral health safety net provider shall use standard criteria, as determined by the BHA, for determining whether a client's needs exceed the clinical expertise of the provider.

(c) If a priority population client's needs exceed the treatment capacity or clinical expertise of an essential behavioral health safety net provider, the provider shall refer the client to another appropriate provider.

(d) If a priority population client's needs exceed the treatment capacity or clinical expertise of a comprehensive community behavioral health provider, the provider must ensure that the client has access to interim behavioral health services in a timely manner until the client is connected to the most appropriate provider for ongoing care. This may include use of providers within the network of the behavioral health administrative services organization or the regional managed care entity.

(e) The comprehensive community behavioral health provider shall obtain approval from the behavioral health administrative services organization under which the provider is operating, or the regional managed care entity for medicaid clients, prior to referring a priority population client to alternative services; except that an individual experiencing a behavioral health crisis may be referred to emergency or crisis services without prior approval.

(f) A behavioral health safety net provider shall include services that address the language, ability, and cultural barriers, as necessary, to serve communities of color and other underserved populations.

(5) When referring a client to alternative services, a behavioral health safety net provider shall assist the client in identifying and initiating services with an appropriate provider for ongoing care. As appropriate, the behavioral health safety net provider shall use the behavioral health administrative services organization or, for medicaid clients, the regional managed care entity for care coordination.

(6) (a) Behavioral health safety net providers shall track the following information for all individuals who were referred to alternative services pursuant to this section:

(I) Client demographics;

(II) Standardized descriptions of the needs of the client that could not be met and require the client to be referred to another provider;

(III) The outcome and timeliness of the referral; and

(IV) Any other information required by the BHA.

(b) The provider shall provide the report at regular intervals to the BHA and to either the behavioral health administrative services organization under which the provider is operating or, for medicaid clients, to the managed care entity.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1462, § 1, effective July 1. **L. 2023:** (4)(f) added, (HB 23-1236), ch. 206, p. 1059, § 23, effective May 16.

27-50-303. Essential behavioral health safety net providers - approval to serve limited priority populations.

(1) Essential behavioral health safety net providers must serve all priority populations unless the universal contracting provisions with the behavioral health administrative services organization limit the provider's scope and responsibility to a specific underserved population pursuant to subsection (2) of this section.

(2) Behavioral health administrative services organizations may contract with an essential behavioral health safety net provider to provide a safety net service or services, including those determined necessary pursuant to section 27-50-301 (3)(a)(XV), to only one or more specific underserved populations within the priority populations.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1463, § 1, effective July 1.

27-50-304. Behavioral health safety net provider network - incentives - preferred status - rules.

(1) The BHA shall ensure that each region in the state includes a network of behavioral health safety net providers that collectively offer a full continuum of behavioral health services.

(2) The BHA shall provide statewide technical assistance specific to strengthening and expanding the behavioral health safety net system and increasing provider participation within the publicly funded behavioral health safety net provider network.

(3) The BHA and state agencies, through the behavioral health administrative services organizations established pursuant to part 4 of this article 50 and managed care entities as defined in section 25.5-5-403, shall:

(a) Subject to performance and available funds, provide behavioral health safety net providers with opportunities for quality incentives, value-based payment, or other enhanced payments or preferred contract statuses;

(b) Prioritize comprehensive community behavioral health providers in awarding contracts for behavioral health services; and

(c) Consider, upon application, behavioral health safety net providers for state-administered and county-administered grant funds related to the prevention, treatment, recovery, and harm reduction for behavioral health services.

(4) To be eligible for enhanced service payments, behavioral health safety net providers must meet specific BHA licensing or approval standards, pursuant to part 5 of this article 50.

(5) To meet the requirement in subsection (1) of this section, the behavioral health administrative services organizations and managed care entities may contract with potential and existing approved safety net providers to expand service capacity in a specific region of the state.

(6) Nothing in this section limits the ability of state agencies to award contracts or grants for the procurement of behavioral health services directly to any county, city and county, municipality, school district, health service district, or other political subdivision of the state or any county, city and county, district, or juvenile court, or to any nonprofit or for-profit organization in accordance with applicable law.

(7) The BHA may promulgate rules as necessary to implement this section.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1463, § 1, effective July 1.

27-50-305. Resources to support behavioral health safety net providers - independent third-party contract. (Repealed)

Source: L. 2024: Entire section added, (HB 24-1045), ch. 470, p. 3290, § 27, effective August 7. **L. 2026:** Entire section repealed, (HB 26-1378), ch. 245, p. 1391, § 1, effective May 29.

PART 4

BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATIONS

27-50-401. Regional behavioral health administrative services organizations - establishment.

(1) No later than July 1, 2025, the BHA shall select and contract with regionally informed behavioral health organizations to establish, administer, and maintain adequate networks of behavioral health safety net services and care coordination, as described in part 3 of this article 50.

(2) The BHA shall establish a community-informed structure for a behavioral health administrative services organization to operate. In establishing the behavioral health administrative services organization structure, the BHA shall consult with the department of health care policy and financing to ensure consideration of the regional structure that serves the medicaid population.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1464, § 1, effective July 1. **L. 2023:** Entire section amended, (HB 23-1236), ch. 206, p. 1059, § 24, effective May 16.

27-50-402. Behavioral health administrative services organizations - application - designation - denial - revocation.

(1) At least once every five years, the commissioner shall solicit applications through a competitive bid process pursuant to the "Procurement Code", articles 101 to 112 of title 24, for entities to apply to be a behavioral health administrative services organization. Any qualified public or private corporation; for-profit or not-for-profit organization; or public or private agency, organization, or institution may apply in the form and manner determined by the BHA's rules. The BHA is authorized to award contracts to more than one applicant. The BHA shall use competitive bidding procedures to encourage competition and improve the quality of services.

(2) The commissioner shall select a behavioral health administrative services organization based on factors established by BHA rules and the "Procurement Code", articles 101 to 112 of title 24. The BHA shall require an applicant to furnish letters of support from stakeholders in the region the applicant is applying to contract for, including, but not limited to, county commissioners and advocacy or community-based organizations. The letters of support must demonstrate the applicant's ability to serve the community. The factors for selection must include, but are not limited to, the following:

(a) The applicant's experience working with publicly funded clients, including expertise in treating priority populations determined by the BHA;

(b) The applicant's experience working with and engaging relevant stakeholders in the service area, including behavioral health providers; state and local agencies; and the local community, including advocacy organizations and clients of behavioral health services;

(c) The extent to which real or perceived conflicts of interest between the applicant and behavioral health facilities or behavioral health providers are mitigated; and

(d) The extent to which the applicant's board complies with conflict of interest policies, including to the following:

(I) The board shall not have more than fifty percent of contracted providers as board members;

(II) Providers who have ownership or board membership in a behavioral health administrative services organization shall not have control or decision-making authority in the establishment of provider networks; and

(III) An employee of a contracted provider of a behavioral health administrative services organization shall not also be an employee of the behavioral health administrative services organization unless the employee is the clinical officer or utilization management director of the behavioral health administrative services organization. If the individual is also an employee of a provider that has board membership or ownership in the behavioral health administrative services organization, the behavioral health services organization shall develop policies approved by the commissioner to mitigate any conflict of interest the employee may have.

(e) The extent to which the applicant's board membership reflects the diversity and interests of relevant stakeholders, including, but not limited to, representation by individuals with lived behavioral health experience and family of individuals with lived behavioral health experience.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1465, § 1, effective July 1. **L. 2023:** IP(2) amended, (HB 23-1236), ch. 206, p. 1059, § 25, effective May 16.

27-50-403. Behavioral health administrative services organizations - contract requirements - individual access - care coordination.

(1) The BHA shall develop a contract for designated behavioral health administrative services organizations, which must include, but is not limited to, the following:

(a) Requirements to establish and maintain a continuum of care and network adequacy in the service area consistent with part 3 of this article 50, including but not limited to providing all behavioral health safety net services described in section 27-50-301;

(b) Expectations for subcontracting with behavioral health safety net providers and other providers, consistent with part 3 of this article 50, including prioritization of comprehensive community behavioral health providers;

(c) Expectations for adherence to the universal contracting provisions developed pursuant to section 27-50-203 and use of the universal contracting provisions with all relevant subcontractors;

(d) Reporting requirements related to claiming federal funding for eligible services and programs;

(e) Prohibitions on denying or prohibiting access to any medically necessary behavioral health service, including medication-assisted treatment, as defined in section 23-21-803, for a substance use disorder;

(f) Requirements to serve all individuals in need of services and a specific prohibition on denial of services for any of the reasons provided in section 27-50-301 (4);

(g) Agreements on data collection and reporting, including any provisions necessary to implement section 27-50-201;

(h) Procedures related to corrective actions pursuant to section 27-50-402;

(i) Any provisions necessary to ensure the behavioral health administrative services organization fulfills the functions provided in subsection (2) of this section;

(j) Requirements for calculating and reporting the annual administrative costs. The BHA shall establish and enforce the maximum allowable administrative cost ratios for the behavioral health administrative services organizations and report the actual performance of each behavioral health administrative services organization annually.

(k) A requirement that the behavioral health administrative services organization perform appropriate fiscal management and quality oversight of providers in its network within the scope of the provider's contract, including, but not limited to, the behavioral health administrative services organization directly engaging in audits and corrective action plans with providers in its network to ensure compliance with the contract.

(l) Requirements for the behavioral health administrative services organizations to collaborate with diversion programs, statewide criminal justice programs, and the bridges wraparound care program created pursuant to article 8.6 of title 16 when the programs are available in the behavioral health administrative services organization's region.

(2) A behavioral health administrative services organization shall:

(a) Proactively engage hard-to-serve individuals with adequate case management and care coordination throughout the care continuum;

(b) Implement trauma-informed care practices;

(c) Accept and provide behavioral health safety net services to individuals outside of the behavioral health administrative services organization's region;

(d) Promote competency in de-escalation techniques;

(e) Through network adequacy and other methods, ensure timely access to treatment, including high-intensity behavioral health treatment and community-based treatment for all individuals including children, youth, and adults;

(f) Require collaboration with all local law enforcement and county agencies in the service area, including county departments of human or social services and local collaborative management programs within the service area;

(g) Triage individuals who need alternative services outside the scope of the behavioral health safety net system;

(h) Promote patient-centered care, cultural awareness, and coordination of care to appropriate behavioral health safety net providers;

(i) Collaborate with schools and school districts in the service area to identify gaps in services and to promote student access to behavioral health services at school and in the contracting with providers to build the network of behavioral health safety net services, inclusion of relevant programs or services eligible for federal grants or reimbursement, including relevant programs or services identified in the federal Title IV-E prevention services clearinghouse;

(j) Update information as requested by the BHA about available treatment options and outcomes in each region of the state;

(k) Utilize evidence-based or evidence-informed programming to promote quality services;

(l) Consider, when contracting with providers to build the network of behavioral health safety net services, inclusion of relevant programs or services eligible for federal grants or reimbursement, including relevant programs or services identified in the federal Title IV-E prevention services clearinghouse; and

(m) Meet any other criteria established by the BHA.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1466, § 1, effective July 1. **L. 2023:** (1)(i) amended and (1)(k) added, (HB 23-1236), ch. 206, p. 1061, § 30, effective May 16; (2)(f) amended, (HB 23-1249), ch. 287, p. 1730, § 10, effective August 7. **L. 2024:** (1)(l) added, (HB 24-1355), ch. 471, p. 3315, § 16, effective August 7.

Cross references: For the legislative declaration in HB 23-1249, see section 1 of chapter 287, Session Laws of Colorado 2023.

27-50-404. Care coordination - responsibilities of behavioral health administrative services organizations - coordination with managed care entities.

(1) (a) Behavioral health administrative services organizations and managed care entities have the shared responsibility of providing care coordination services in a manner consistent with article 60 of this title 27 for individuals utilizing the behavioral health safety net system.

(b) Managed care entities are responsible for providing care coordination services, as required by section 25.5-5-419, to individuals enrolled in the state medical assistance program.

(c) Behavioral health administrative services organizations are responsible for providing care coordination services, whether directly or through contract with behavioral health safety net providers, to individuals who are not currently enrolled in the state medical assistance program, with access for priority populations as required by part 3 of this article 50.

(d) The BHA shall publish on the BHA's website an easily accessible list of secure transportation providers, as defined in section 27-65-102, that have contracts with behavioral health administrative services organizations. The list must include the contact information for the secure transportation provider, including an active phone number or website.

(2) The BHA shall establish objective and standardized processes for care coordination, including:

(a) Coordination between behavioral health administrative services organizations and other care coordination entities, including managed care entities, case management agencies, counties, and other behavioral health administrative services organizations, to ensure continuity of care across shared populations consistent with subsection (1) of this section;

(b) Referral processes between entities, including a behavioral health administrative services organization's responsibility to provide care coordination to an individual pending commencement of care coordination services by another entity; and

(c) Processes to ensure efficient and person-centered care coordination services for individuals who have acute and complex needs, including individuals involved in the civil involuntary treatment system pursuant to articles 65 and 81 of this title 27; individuals transitioning out of treatment settings or acute care settings; and individuals involved in the child welfare, juvenile justice, or criminal justice systems.

(3) A behavioral health administrative services organization shall ensure care coordination services through its network and include local partners, when appropriate, such as counties, school districts, the office of bridges of Colorado established in article 95 of title 13, and local collaborative management programs.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1468, § 1, effective July 1. **L. 2023:** (3) amended, (HB 23-1249), ch. 287, p. 1730, § 11, effective August 7. **L. 2024:** (3) amended, (HB 24-1355), ch. 471, p. 3315, § 17, effective August 7. **L. 2026:** (1)(d) added, (HB 26-1063), ch. 322, p. 1878, § 2, effective August 12.

Cross references: For the legislative declaration in HB 23-1249, see section 1 of chapter 287, Session Laws of Colorado 2023.

27-50-405. Behavioral health administrative services organizations - stakeholder input - report - rules.

(1) Each behavioral health administrative services organization shall develop a process to solicit and respond to input from stakeholders about behavioral health services and gaps in the service area. A behavioral health administrative services organization shall publicly post an annual report that includes:

(a) A report on the stakeholder input received in the prior year, anonymized and aggregated to protect individual privacy;

(b) Descriptions of how the behavioral health administrative services organization has responded to, or plans to respond to, stakeholder input from the prior year, including descriptions of policy or practice changes or explanations of why no changes were made; and

(c) The plan for stakeholder engagement for the upcoming year.

(2) In soliciting and responding to input from stakeholders pursuant to subsection (1) of this section, the behavioral health administrative services organization shall, at a minimum, engage the following stakeholders within the service area:

(a) Clients of behavioral health services and their families;

(b) Behavioral health safety net providers;

(c) Counties;

(d) Law enforcement;

(e) Hospitals and physical health providers; and

(f) Judicial districts.

(3) The behavioral health administrative services organization may also engage stakeholders in neighboring service areas, as appropriate.

(4) The BHA may promulgate rules as necessary to implement this section.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1469, § 1, effective July 1.

PART 5

BEHAVIORAL HEALTH ENTITIES

27-50-501. Behavioral health entities - license required - criminal and civil penalties.

(1) (a) On and after January 1, 2024, it is unlawful for any person, partnership, association, or corporation to conduct or maintain a behavioral health entity, including a substance use disorder program or alcohol use disorder program, without having obtained a license from the BHA.

(b) On and after January 1, 2024, an entity seeking initial licensure as a behavioral health entity shall apply for a behavioral health entity license from the BHA if the entity would previously have been licensed or subject to any of the following:

(I) Behavioral health entity licensure by the department of public health and environment;

(II) Approval or designation by the office of behavioral health, as it existed before July 1, 2022, or the BHA pursuant to this article 50 or article 66 of this title 27; or

(III) Approval by the office of behavioral health, as it existed before July 1, 2022, or the BHA pursuant to section 27-81-106 as an approved treatment program for substance use disorders.

(c) A facility with a license or approval on or before December 31, 2023, as a behavioral health entity or a substance use disorder program shall apply for a behavioral health entity license prior to the expiration of the facility's current license or approval. Such a facility is subject to the standards under which it is licensed or approved as of January 1, 2024, until such time as the BHA's behavioral health entity license is issued or denied.

(2) Any person who violates the provisions of this section is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not less than fifty dollars but not more than five hundred dollars and may be subject to a civil penalty assessed by the BHA of not less than fifty dollars but not more than one hundred dollars for each day the person is in violation of this section. The assessed penalty accrues from the date the BHA finds that the person is in violation of this section. The BHA shall assess, enforce, and collect the penalty in accordance with article 4 of title 24 and credit the money to the general fund. Enforcement and collection of the penalty occurs following the decision reached in accordance with procedures set forth in section 24-4-105.

(3) (a) Notwithstanding any provision of law to the contrary, the BHA shall only issue or renew a license described in this part 5 if the BHA receives a certificate of compliance for the applicant's building or structure from the division of fire prevention and control in the department of public safety in accordance with part 12 of article 33.5 of title 24; except that:

(I) An applicant that provides only telehealth services is not required to receive a certificate of compliance; and

(II) An applicant that provides only outpatient services may receive a certificate of compliance from the division of fire prevention and control based on inspections conducted by a fire department, as defined in section 24-33.5-1202, that employs an inspector certified pursuant to section 24-33.5-1211 rather than from the division of fire prevention and control.

(b) The BHA shall take action on an application for licensure within thirty days after the date that the BHA receives from the applicant all of the necessary information and documentation required for licensure.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1469, § 1, effective July 1. **L. 2023:** (1)(a), IP(1)(b), and (1)(c) amended, (HB 23-1236), ch. 206, p. 1060, § 26, effective May 16. **L. 2026:** (3) amended, (HB 26-1116), ch. 377, p. 2344, § 2, effective August 12.

27-50-502. Behavioral health entities - minimum standard - rules.

(1) No later than January 1, 2024, the BHA shall promulgate rules pursuant to section 24-4-103 providing minimum standards for the operation of behavioral health entities within the state, including the following:

(a) Requirements to be met by all behavioral health entities to ensure the health, safety, and welfare of all behavioral health entity consumers, including, at a minimum:

(I) Requirements for consumer assessment, treatment, care coordination, patient rights, and consumer notice;

(II) Administrative and operational standards for governance; consumer records and record retention; personnel; admission and discharge criteria; policies and procedures to ensure compliance with regulatory and contract requirements; and quality management;

(III) Data reporting requirements;

(IV) Physical plant standards, including infection control; and

(V) Occurrence reporting requirements pursuant to section 27-50-510;

(b) Service-specific requirements that apply only to behavioral health entities electing to provide that service or set of services, including, at a minimum, standards for the specific types of behavioral health safety net services and other behavioral health services along the continuum of care created by the BHA pursuant to part 3 of this article 50, including but not limited to:

(I) Essential behavioral health safety net provider standards; and

(II) Comprehensive community behavioral health provider standards;

(c) Procedures for mandatory BHA inspections of behavioral health entities;

(d) Procedures for written plans for a behavioral health entity to correct violations found as a result of inspections;

(e) Intermediate enforcement remedies;

(f) Factors for behavioral health entities to consider when determining whether an applicant's conviction of or plea of guilty or nolo contendere to an offense disqualifies the applicant from employment with the behavioral health entity. The state board of human services may determine which offenses require consideration of these factors.

(g) Timelines for compliance with behavioral health entity standards that exceed the standards under which a behavioral health entity was previously licensed or approved.

(2) In approving or rejecting an essential behavioral health safety net provider for eligibility for enhanced service delivery payment, the commissioner shall:

(a) Require training on and provision of culturally competent and trauma-informed services;

(b) Consider the adequacy and quality of the services provided, taking into consideration factors such as geographic location, local community need, and availability of workforce;

(c) Require written policies and procedures on admitting, discharging, triaging, and denying services to clients in alignment with the standards determined by the BHA pursuant to sections 27-50-302 and 27-50-303;

(d) Require that overall responsibility for the administration of an essential behavioral health safety net provider be vested in a director who is a physician or a member of one of the licensed mental health professions, unless the provider is only providing recovery support services. If the director is not a licensed physician or licensed mental health professional, the provider shall employ or contract with at least one licensed physician or licensed mental health professional to advise the director on clinical decisions.

(e) Require that essential behavioral health safety net provider staff include, wherever feasible and appropriate in the discretion of the commissioner, medical staff able to provide medical clearance on site, and other professional staff workers such as psychologists, social workers, educational consultants, peers, community health workers, and nurses, with such

qualifications, responsibilities, and experience that corresponds with the size and capacity of the provider; and

(f) Require that each essential behavioral health safety net provider from which services may be purchased:

(I) Be under the control and direction of a county or local board of health, a board of directors or board of trustees of a corporation, a for-profit or not-for-profit organization, a regional mental health board, or a political subdivision of the state;

(II) Be free of conflicts of interest; and

(III) Enter into a contract developed pursuant to section 27-50-203 and accept publicly funded clients.

(3) In approving or rejecting a comprehensive community behavioral health provider for eligibility for enhanced service delivery payment, the commissioner shall adhere to the standards for essential behavioral health safety net providers established in subsection (2) of this section, and the commissioner shall also:

(a) Require that treatment programs of the comprehensive community behavioral health provider be vested in a director who is a physician or a member of one of the licensed mental health professions. The director is not required to provide oversight or direction for recovery services. If the director is not a physician or licensed mental health professional, the provider shall contract with at least one licensed physician or licensed mental health professional to advise the director on clinical decisions.

(b) Consider whether the comprehensive community behavioral health provider has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations or, in the case of a sole community provider, serves the medically indigent patients within its medical capability;

(c) Require the comprehensive community behavioral health provider to waive charges or charge for services on a sliding scale based on income and require that the provider not restrict access or services because of an individual's financial limitations;

(d) Require the comprehensive community behavioral health provider to serve priority populations;

(e) Encourage the comprehensive community behavioral health provider to emphasize the care and treatment of individuals recently released from incarceration and hospitals or facilities directed toward assisting individuals with behavioral or mental health disorders in the individual's adjustment to and functioning in the community;

(f) Require a process for tracking and reporting denials of care; and

(g) Require that the board in control and direction of the comprehensive community behavioral health provider include voting members that have lived experience with mental health disorders and substance use disorders and parents of children with mental health disorders and substance use disorders.

(4) In approving or rejecting local general or psychiatric hospitals, nontraditional facilities, innovative care models, and other behavioral health facilities or programs for the purchase or designation of services not provided by essential or comprehensive community behavioral health providers, the commissioner shall consider the following factors:

(a) The general quality of care provided to patients by such agencies;

(b) The organization of the medical staff to provide for the integration and coordination of the psychiatric treatment program;

(c) The provisions for the availability of nursing, psychological, and social services and the existence of an organized program of activities under the direction of an occupational therapist or another qualified person;

(d) The licensure of such entity by the department of public health and environment or another state agency where applicable;

(e) The methods by which the agency coordinates its services with those rendered by other agencies to ensure an uninterrupted continuum of care to individuals with behavioral or mental health disorders; and

(f) The availability of such services to the general public.

(5) In approving or rejecting behavioral health safety net providers pursuant to subsections (2) and (3) of this section, or other agencies pursuant to subsection (4) of this section, for the purchase of services, the commissioner shall ensure the behavioral health safety net providers and agencies comply with federal financial participation requirements for department-administered programs.

(6) In addition to these duties, the BHA may promulgate rules related to additional competencies related to serving priority populations. Behavioral health safety net providers approved by the BHA as demonstrating these additional competencies may be eligible for enhanced rates. State agencies shall consider such approved status in determining payment methodologies for services provided.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1471, § 1, effective July 1. **L. 2023:** IP(1) amended, (HB 23-1236), ch. 206, p. 1060, § 27, effective May 16.

27-50-503. Licenses - application - inspection - issuance.

(1) An application for a license to operate a behavioral health entity must be submitted to the BHA annually in the form and manner prescribed by the BHA.

(2) (a) The BHA shall investigate and review each original application and each renewal application for a license to operate a behavioral health entity. The BHA shall determine an applicant's compliance with this article 50 and the rules adopted pursuant to section 27-50-504 before the BHA issues a license.

(b) The BHA shall inspect the applicant's facilities as it deems necessary to ensure that the health, safety, and welfare of the behavioral health entity's consumers are protected. The behavioral health entity shall submit in writing, in a form prescribed by the BHA, a plan detailing the measures that the behavioral health entity will take to correct any violations found by the BHA as a result of inspections undertaken pursuant to this subsection (2).

(3) The BHA shall keep all health-care information or documents obtained during an inspection or investigation of a behavioral health entity pursuant to subsection (2) of this section confidential. Any such records, information, or documents obtained are exempt from disclosure pursuant to sections 24-72-204 and 27-50-510.

(4) (a) With the submission of an application for a license to operate a behavioral health entity, or within ten days after a change in ownership or management of a behavioral health entity, each owner and manager shall submit a complete set of the owner's or manager's fingerprints to the Colorado bureau of investigation for the purpose of conducting a fingerprint-based criminal history record check. The Colorado bureau of investigation shall forward the fingerprints to the federal bureau of investigation for the purpose of conducting fingerprint-based criminal history record checks. Each owner and each manager shall pay the Colorado bureau of investigation the costs associated with the fingerprint-based criminal history record check. Upon completion of the criminal history record check, the Colorado bureau of investigation shall forward the results to the BHA. The BHA may acquire a name-based criminal history record check for an applicant who has twice submitted to a fingerprint-based criminal history record check and whose fingerprints are unclassifiable.

(b) The BHA shall use the information from the criminal history record checks performed pursuant to subsection (4)(a) of this section to determine whether the person applying for licensure has been convicted of a crime that involves conduct that the BHA determines could pose a risk to the health, safety, or welfare of a behavioral health entity's consumers. The BHA shall consider that persons in recovery may have a history of criminal justice involvement and that criminal history does not require a dismissal of an application for a license. The BHA shall keep information obtained in accordance with this subsection (4) confidential.

(5) The BHA shall not issue a license to operate a behavioral health entity if the owner or manager of the behavioral health entity has been convicted of a felony or misdemeanor that

involves conduct that the BHA determines could pose a risk to the health, safety, or welfare of the behavioral health entity's consumers.

(6) Except as otherwise provided in subsection (7) of this section, the BHA shall issue or renew a license to operate a behavioral health entity when it is satisfied that the applicant or licensee is in compliance with the requirements set forth in this article 50 and the rules promulgated pursuant to this article 50. Except for provisional licenses issued in accordance with subsection (7) of this section, a license issued or renewed pursuant to this section expires one year after the date of issuance or renewal.

(7) (a) The BHA may issue a provisional license to operate a behavioral health entity to an applicant for the purpose of operating a behavioral health entity for a period of ninety days if the applicant is temporarily unable to conform to all of the minimum standards required pursuant to this article 50; except that the BHA shall not issue a provisional license to an applicant if the operation of the behavioral health entity will adversely affect the health, safety, or welfare of the behavioral health entity's consumers.

(b) As a condition of obtaining a provisional license, the applicant shall show proof to the BHA that attempts are being made to conform and comply with the applicable standards required pursuant to this article 50.

(c) The BHA shall not grant a provisional license prior to the completion of a criminal history background check in accordance with subsection (4) of this section and a determination in accordance with subsection (5) of this section.

(d) A second provisional license may be issued, for a like term and fee, to effect compliance. No further provisional licenses may be issued for the current year after the second issuance pursuant to this subsection (7)(d).

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1474, § 1, effective July 1.

27-50-504. License fees - rules.

(1) (a) By January 1, 2024, the commissioner shall promulgate rules establishing a schedule of fees sufficient to meet the direct and indirect costs of administration and enforcement of this part 5.

(b) The BHA shall assess and collect, from behavioral health entities subject to licensure pursuant to section 27-50-503, fees in accordance with the fee schedule established pursuant to subsection (1)(a) of this section.

(2) The BHA shall transmit fees collected pursuant to subsection (1) of this section to the state treasurer, who shall credit the money to the behavioral health licensing cash fund created pursuant to section 27-50-506.

(3) Fees collected pursuant to subsection (1) of this section may be used by the BHA to provide technical assistance and education to behavioral health entities related to compliance with Colorado law, in addition to regulatory and administrative functions. The BHA may contract with private entities to assist the BHA in providing technical assistance and education.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1476, § 1, effective July 1. **L. 2023:** (1)(a) amended, (HB 23-1236), ch. 206, p. 1060, § 28, effective May 16.

27-50-505. License - denial - suspension - revocation.

(1) When an application for an initial license to operate a behavioral health entity pursuant to section 27-50-503 has been denied by the BHA, the BHA shall notify the applicant in writing of the denial by mailing a notice to the applicant at the address shown on the application. Any applicant aggrieved by a denial may pursue a review as provided in article 4 of title 24, and the BHA shall follow the provisions and procedures specified in article 4 of title 24.

(2) (a) The BHA may suspend, revoke, or refuse to renew the license of any behavioral health entity that is out of compliance with the requirements of this part 5 or the rules promulgated pursuant to this part 5. Suspension, revocation, or refusal must not occur until after a hearing and in compliance with the provisions and procedures specified in article 4 of title 24; except that the BHA may summarily suspend a behavioral health entity's license before a hearing in accordance with section 24-4-104 (4)(a).

(b) After conducting a hearing in accordance with article 4 of title 24, the BHA may revoke or refuse to renew a behavioral health entity's license if the owner, manager, or administrator of the behavioral health entity has been convicted of a felony or misdemeanor involving conduct that the BHA determines could pose a risk to the health, safety, or welfare of the behavioral health entity's consumers.

(3) The BHA may impose intermediate restrictions or conditions on a behavioral health entity that may include at least one of the following:

(a) Retaining a consultant to address corrective measures;

(b) Monitoring by the BHA for a specific period;

(c) Providing additional training to employees, owners, or operators of the behavioral health entity;

(d) Complying with a directed written plan to correct the violation; or

(e) (I) Paying a civil fine not to exceed two thousand dollars in a calendar year.

(II) The assessment of civil fines shall follow the procedures set forth in section 26.5-5-323.

(4) If the BHA assesses a civil fine pursuant to subsection (3)(e) of this section, the BHA shall transmit the money to the state treasurer, who shall credit the money to the general fund.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1476, § 1, effective July 1. **L. 2023:** (2) amended, (HB 23-1236), ch. 206, p. 1060, § 29, effective May 16.

27-50-506. Behavioral health licensing cash fund - creation.

The behavioral health licensing cash fund, referred to in this section as the "fund", is created in the state treasury. The fund consists of money credited to the fund pursuant to section 27-50-504 (2). The money in the fund is subject to annual appropriation by the general assembly for the direct and indirect costs of the BHA in performing its duties pursuant to this part 5 and part 10 of this article 50. At the end of any state fiscal year, all unexpended and unencumbered money in the fund remains in the fund and must not be credited or transferred to the general fund or any other fund.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1477, § 1, effective July 1. **L. 2026:** Entire section amended, (SB 26-113), ch. 302, p. 1731, § 4, effective August 12.

27-50-507. Employee and contracted service provider - criminal history record check.

A behavioral health entity shall require an applicant seeking employment with, or seeking to contract to provide services for, the behavioral health entity to submit to a criminal history record check before employment or execution of a contract. The behavioral health entity shall pay the costs of the criminal history record check. The criminal history record check must be conducted not more than ninety days before the employment of or contract with the applicant.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1477, § 1, effective July 1.

27-50-508. Enforcement.

The BHA is responsible for the enforcement of this article 50 and the rules adopted pursuant to this article 50.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1477, § 1, effective July 1.

27-50-509. Purchase of services by courts, counties, municipalities, school districts, and other political subdivisions.

Any county, city and county, municipality, school district, health service district, or other political subdivision of the state or any county, city and county, district, or juvenile court may enter into intergovernmental agreements with any county, municipality, school district, health service district, or other political subdivision of the state or may enter into contractual agreements with any provider licensed by the BHA for the purchase of behavioral health services. For the purchase of behavioral health services by counties or cities and counties as authorized by this section, the board of county commissioners of any county or the city council of any city and county may levy a tax not to exceed two mills upon real property within the county or city and county if the board first submits the question of the levy to a vote of the qualified electors at a general election and receives the electors' approval of the levy.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1477, § 1, effective July 1.

27-50-510. Behavioral health entities - consumer information - reporting - release - rules.

(1) Each behavioral health entity licensed, approved, or designated pursuant to this part 5 shall report to the BHA all of the following occurrences:

(a) Any occurrence that results in the death of a patient or resident of the facility and is required to be reported to the coroner pursuant to section 30-10-606, as arising from an unexplained cause or under suspicious circumstances;

(b) Any occurrence that results in any of the following serious injuries to a patient or resident:

(I) Brain or spinal cord injuries;

(II) Life-threatening complications of anesthesia or life-threatening transfusion errors or reactions; or

(III) Second- or third-degree burns involving twenty percent or more of the body surface area of an adult patient or resident or fifteen percent or more of the body surface area of a child patient or resident;

(c) Any occurrence when a patient or resident of the facility cannot be located following a search of the facility, the facility grounds, and the area surrounding the facility, and:

(I) There are circumstances that place the patient's or resident's health, safety, or welfare at risk; or

(II) The patient or resident has been missing for eight hours;

(d) Any occurrence involving physical, sexual, or verbal abuse of a patient or resident, as described in section 18-3-202, 18-3-203, 18-3-204, 18-3-206, 18-3-402, 18-3-404, or 18-3-405, by another patient or resident, an employee of the facility, or a visitor to the facility;

(e) Any occurrence involving caretaker neglect of a patient or resident, as defined in section 26-3.1-101 (2.3);

(f) Any occurrence involving misappropriation of a patient's or resident's property. As used in this subsection (1)(f), "misappropriation of a patient's or resident's property" means a pattern of or deliberately misplacing, exploiting, or wrongfully using, either temporarily or permanently, a patient's or resident's belongings or money without the patient's or resident's consent.

(g) Any occurrence in which drugs intended for use by patients or residents are diverted to use by other persons. If the diverted drugs are injectable, the behavioral health entity shall also report the full name and date of birth of any individual who diverted the injectable drugs, if known.

(h) Any occurrence involving the malfunction or intentional or accidental misuse of patient or resident care equipment that occurs during treatment or diagnosis of a patient or resident and that significantly adversely affects or, if not averted, would have significantly adversely affected a patient or resident of the facility.

(2) The state board of human services shall promulgate rules specifying the manner, time period, and form in which the reports required pursuant to subsection (1) of this section must be made.

(3) Any report submitted pursuant to subsection (1) of this section is strictly confidential; except that information in any such report may be transmitted to an appropriate regulatory agency having jurisdiction for disciplinary or license sanctions. The information in such reports shall not be made public upon subpoena, search warrant, discovery proceedings, or otherwise, except as provided in subsection (5) of this section.

(4) The BHA shall investigate each report submitted pursuant to subsection (1) of this section that the BHA determines was appropriately submitted. For each report investigated, the

BHA shall prepare a summary of its findings, including the BHA's conclusions and whether there was a violation of licensing or approval standards or a deficiency and whether the facility acted appropriately in response to the occurrence. If the investigation is not conducted on site, the BHA shall specify in the summary how the investigation was conducted. Any investigation conducted pursuant to this subsection (4) is in addition to and not in lieu of any inspection required to be conducted pursuant to section 27-50-503 (2) with regard to licensing.

(5) (a) The BHA shall make the following information available to the public:

(I) Any investigation summaries prepared pursuant to subsection (4) of this section;

(II) Any complaints against a behavioral health entity that have been filed with the BHA and that the BHA has investigated, including the conclusions reached by the BHA and whether there was a violation of licensing or approval standards or a deficiency and whether the facility acted appropriately in response to the subject of the complaint; and

(III) A listing of any deficiency citations issued against each behavioral health entity.

(b) The information released pursuant to this subsection (5) shall not identify the patient or resident or the health-care professional involved in the report.

(6) Prior to the completion of an investigation pursuant to this section, the BHA may respond to any inquiry regarding a report received pursuant to subsection (1) of this section by confirming that it has received such report and that an investigation is pending.

(7) In addition to the report to the BHA for an occurrence described in subsection (1)(d) of this section, the occurrence must be reported to a law enforcement agency.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1478, § 1, effective July 1.

PART 6

NETWORK STANDARDS

27-50-601. Department of health care policy and financing - behavioral health network standards.

(1) The statewide managed care system, created pursuant to part 4 of article 5 of title 25.5 and implemented by the department of health care policy and financing, shall use health facilities licensed by the department of public health and environment pursuant to article 1.5 of title 25 or licensed by the BHA pursuant to part 5 of this article 50 and individual behavioral health practitioners licensed by the department of regulatory agencies and federally qualified health

centers, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(4), when creating statewide or regional behavioral health networks.

(2) The department of health care policy and financing shall align all community-based behavioral health programs and networks with the behavioral health continuum of care, behavioral health safety net services, and care coordination provider standards created by the BHA pursuant to part 3 of this article 50.

(3) The department of health care policy and financing shall require that all behavioral health providers enter into a contract developed pursuant to section 27-50-203 when contracting for community-based behavioral health services in the state.

(4) The BHA shall collaborate with the department of health care policy and financing to support the early and periodic screening, diagnostic, and treatment benefit access and provider network.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1480, § 1, effective July 1.

27-50-602. Division of insurance behavioral health network standards.

The commissioner of the division of insurance in the department of regulatory agencies, while assessing and standardizing provider networks in this state pursuant to section 10-1-108, shall ensure community-based behavioral health networks align with the behavioral health continuum of care, behavioral health safety net services, and care coordination provider standards created by the BHA pursuant to part 3 of this article 50.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1481, § 1, effective July 1.

27-50-603. State agency behavioral health network and program standards.

(1) All state agencies administering community-based behavioral health programs shall ensure the community-based behavioral health programs align with the behavioral health continuum of care, behavioral health safety net services, and care coordination provider standards created by the BHA pursuant to part 3 of this article 50.

(2) All state agencies shall use the universal contracting provisions developed pursuant to section 27-50-203 when contracting for community-based behavioral health services in the state.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1481, § 1, effective July 1.

PART 7

BEHAVIORAL HEALTH ADMINISTRATION ADVISORY COUNCIL

27-50-700.3. Definitions.

As used in this part 7, unless the context otherwise requires:

(1) "Advisory council" means the behavioral health administration advisory council created in section 27-50-701 (1).

Source: L. 2025: Entire section added, (SB 25-275), ch. 377, p. 2084, § 239, effective August 6.

27-50-701. Behavioral health administration advisory council - creation - duties - report.

(1) There is created in the behavioral health administration the behavioral health administration advisory council for the purpose of making recommendations to the commissioner and the state board of human services to improve the behavioral health system for children, youth, and adults throughout Colorado.

(2) The advisory council shall receive routine briefings from the commissioner on the progress of the BHA and behavioral health reform efforts, including updates related to performance data collected pursuant to section 27-50-201 and related to formal agreements and collaborations with state agencies pursuant to this article 50, and may provide feedback as a method to ensure accountability and transparency. Other advisory council duties include:

(a) Providing diverse community input on challenges, gaps, and potential solutions to inform the BHA's vision and strategic plan;

(b) Establishing working groups to support the BHA in problem solving and developing solutions;

(c) Ensuring there is public accountability and transparency through reviewing the BHA's public-facing transparency activities, including the performance data collected pursuant to section 27-50-201; and

(d) Preparing an annual report of recommendations and submitting it to the BHA by September 1 of each year. The report shall be included in the BHA's annual behavioral health system plan pursuant to section 27-50-204 (1).

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1481, § 1, effective July 1. **L. 2025:** (1) amended, (SB 25-275), ch. 377, p. 2084, § 240, effective August 6.

27-50-702. Advisory council - membership.

(1) The advisory council membership must be reflective of the demographic and geographic populations of this state to ensure ongoing stakeholder input and involvement.

(2) (a) The advisory council consists of not less than fifteen members and not more than twenty members appointed by the commissioner for three-year terms; except that some of the initial terms may be for two years. In addition to maintaining a majority of members who represent individuals with lived behavioral health experience or families of individuals with lived behavioral health experience, the commissioner shall appoint at least one member that represents:

(I) Rural communities;

(II) Each tribal government within Colorado;

(III) County governments;

(IV) Persons with disabilities, as defined in section 24-34-301, a family member of a person with a disability, or an advocacy organization for persons with disabilities;

(V) The Colorado state judicial branch, in consultation with the state court administrator's office;

(VI) Behavioral health safety net providers;

(VII) Persons with expertise in the behavioral health needs of children and youth; and

(VIII) Persons with expertise in crime victimization, trauma, or adverse childhood experiences as they impact the victim's lifetime.

(b) In making appointments to the advisory council, the commissioner shall consider including members that represent the racial and ethnic diversity of the state; that represent the lesbian, gay, bisexual, transgender, or queer or questioning community; that are involved in the criminal or juvenile justice system; and that represent other populations with health disparities.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1482, § 1, effective July 1. **L. 2023:** (2)(a)(IV) amended, (HB 23-1296), ch. 269, p. 1601, § 12, effective May 25.

27-50-703. Advisory council - regional subcommittees - subcommittees - working groups.

(1) The BHA shall create a regional subcommittee structure as part of the behavioral health administrative service organizations to promote local community input pertaining to behavioral health service needs. In establishing a regional subcommittee structure, the BHA shall, to the best of the BHA's ability, align geographically with judicial districts whenever feasible, taking into consideration community feedback on where and how individuals receive services in their communities. Regional subcommittee members are appointed for three-year terms; except that initial terms may be for two years. The subcommittee consists of nine members. Membership of the regional subcommittees must include:

(a) One individual with expertise in the behavioral health needs of children and youth appointed by a local or regional public health or human service agency within the subcommittee's region;

(b) One individual who represents a behavioral health safety net provider that operates within the region appointed by a local or regional public health or human service agency within the subcommittee's region;

(c) A county commissioner of a county situated within the region appointed by the BHA;

(d) One individual with a connection to a kindergarten through twelfth grade school district within the subcommittee's region appointed by a local or regional public health or human service agency within the subcommittee's region;

(e) One individual with the criminal justice system within the subcommittee's region appointed by a local or regional public health or human service agency within the subcommittee's region;

(f) One individual with lived experience or a community member who is not also a behavioral health provider appointed by a local or regional public health or human service agency within the subcommittee's region;

(g) One individual with lived experience appointed by the BHA; and

(h) Two individuals with lived experience not associated with a behavioral health treatment provider appointed by the behavioral health administrative service organization created pursuant to part 4 of this article 50 who represent the subcommittee's region.

(1.3) The regional subcommittee is created to directly inform the behavioral health administrative service organization in the region in order to improve services, accountability, and transparency in the region. The behavioral health administrative service organization shall staff all subcommittee meetings, which shall meet a minimum of six times a year and allow for public comment during each meeting. The behavioral health administrative service organization shall engage with the regional subcommittee, at a minimum, on the following areas:

(a) When determining what services are needed to establish a full continuum of care in the region;

(b) When addressing barriers to individuals accessing quality and timely care in the region; and

(c) Needed specialty services for priority populations.

(1.5) The behavioral health administration advisory council, created pursuant to section 27-50-701, shall establish a process to receive direct feedback from the regional subcommittee throughout the year to consider including in the behavioral health administration advisory council's annual report required pursuant to section 27-50-701 (2)(d).

(2) The BHA may create committees within the advisory council to meet other state and federal board or advisory council requirements, which may include:

(a) The behavioral health planning and advisory council, authorized pursuant to 42 U.S.C. sec. 300x-3;

(b) The mental health advisory board for service standards and rules created pursuant to section 27-65-130; and

(c) The child and youth mental health services standards advisory board created pursuant to section 27-67-109.

(3) Unless committee membership is established pursuant to state or federal law, the regional subcommittee and committee membership shall maintain a majority of members who represent individuals with lived behavioral health experience or families of individuals with lived behavioral health experience.

(4) The advisory council has the authority to create advisory council workgroups focused on topics of need as determined by the advisory council in collaboration with the BHA.

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1482, § 1, effective July 1. **L. 2023:** (1) and (3) amended and (1.3) and (1.5) added, (HB 23-1236), ch. 206, p. 1061, § 31, effective May 16.

PART 8

MENTAL HEALTH PROGRAMS

27-50-801. Veteran suicide prevention pilot program - rules - report - definitions - repeal. (Repealed)

Source: L. 2022: Entire article added, (HB 22-1278), ch. 222, p. 1483, § 1, effective July 1.

Editor's note: Subsection (7) provided for the repeal of this section, effective June 30, 2025. (See L. 2022, p. 1483.)

27-50-802. Study of health effects of felonizing fentanyl possession - repeal. (Repealed)

Source: L. 2022: Entire section added, (HB 22-1326), ch. 225, p. 1665, § 43, effective July 1.

Editor's note: Subsection (4) provided for the repeal of this section, effective July 1, 2025. (See L. 2022, p. 1665.)

Cross references: For the legislative declaration in HB 22-1326 stating the purpose of, and the provision directing legislative staff agencies to conduct, a post-enactment review pursuant to § 2-2-1201 scheduled in 2025, see sections 1 and 55 of chapter 225, Session Laws of Colorado 2022. To obtain a copy of the review, once completed, go to "Legislative Resources and Requirements" on the Colorado General Assembly's website.

27-50-803. Technical assistance to jails - appropriation.

(1) The behavioral health administration shall provide technical assistance to facilities in meeting their requirements pursuant to section 17-26-104.9 (1.5). Technical assistance includes development and implementation of medication-assisted treatment, development of guidelines for nonmedical evaluations, including timelines for performing a subsequent medical evaluation and administering medical withdrawal management, approval of prescribers by the United States drug enforcement agency, and other appropriate withdrawal management care, and assistance with identifying bulk purchasing opportunities for necessary services.

(2) Repealed.

Source: L. 2022: Entire section added, (HB 22-1326), ch. 225, p. 1669, § 47, effective July 1.

Editor's note: Subsection (2)(b) provided for the repeal of subsection (2), effective July 1, 2024. (See L. 2022, p. 1669).

Cross references: For the legislative declaration in HB 22-1326 stating the purpose of, and the provision directing legislative staff agencies to conduct, a post-enactment review pursuant to § 2-2-1201 scheduled in 2025, see sections 1 and 55 of chapter 225, Session Laws of Colorado 2022. To obtain a copy of the review, once completed, go to "Legislative Resources and Requirements" on the Colorado General Assembly's website.

27-50-804. School-based mental health support program - creation - appropriation - definitions - repeal.

(1) As used in this section, unless the context otherwise requires:

(a) "Cognitive behavioral skill-building" means a theoretical framework underlying a set of skills that may be taught to help an individual improve emotional difficulties ranging from mild worry or disappointment to severe depression, anxiety, or other mental illnesses.

(b) "Evidence-based" means practices, interventions, or programs that are supported by extensive empirical data, including randomized controlled trials, supporting their efficacy for their intended purpose.

(c) "High-quality training" means in-person or virtual training that includes content on theory, rationale, and concrete skills; leverages demonstrations and skills practice with feedback; is grounded in the field of implementation science; and takes into account the clinical and environmental barriers to implementation.

(d) "Implementation and sustainment support" means providing in-person or virtual coaching to assist public schools in planning, executing, reflecting, and building systems to embed program practices in school operations, preferably in partnership with community-based or hospital-based licensed mental health providers.

(e) "Mindfulness" means a framework and set of practices for helping an individual improve awareness of the individual's own thoughts, emotions, physical feelings, and behaviors to increase the individual's resiliency in response to common life events.

(f) "Multi-tiered systems of support" means a framework for enhancing the implementation of evidence-based practices to achieve positive outcomes for every student by organizing the efforts of educators within systems to be more effective.

(g) "Program" means the school-based mental health support program created in subsection (2) of this section.

(2) There is created in the behavioral health administration the school-based mental health support program to provide high-quality training, resources, and implementation and sustainment support for the existing public school educator workforce to provide evidence-based mental health services for students through a contract with an external provider. The program shall emphasize supporting schools in rural areas and schools with students who do not have equitable access to mental health care.

(3) (a) No later than January 1, 2025, the BHA shall contract with an external provider to begin implementing the program no later than the start of the 2025-26 school year.

(b) In contracting with an external provider, the BHA shall:

(I) Establish a timeline that the external provider shall follow in implementing the program;

(II) Establish a plan to evaluate the efficacy of the program across school types and student populations;

(III) Determine, in consultation with the external provider, periodic dates on which to provide funding to the external provider in order for the external provider to make necessary purchases and investments to implement the program; and

(IV) Collaborate with the external provider to determine the cost of implementing the program in at least four hundred public schools by the start of the 2027-28 school year.

(4) (a) An interested external provider must apply for the contract in the manner prescribed by the BHA.

(b) The BHA shall select an external provider that:

(I) Does not have licensing agreements that prohibit the use of curricula or resources that a school district already uses or intends to use in the future; and

(II) Has been subject to external, third-party evaluations that indicate its efficacy among several different school types and with several different student subpopulations.

(c) When selecting an external provider, the BHA shall consider whether an applicant is able to:

(I) Provide high-quality training, resources, and implementation and sustainment support across all three tiers of the multi-tiered systems of support, which include:

(A) Classroom-based mental wellness and resiliency skills for students;

(B) Cognitive behavioral skill-building and mindfulness skill-building for anxiety or depression for youth who demonstrate an additional need for mental health support; and

(C) Resources and training to manage suicide risk and coordinate care among families, schools, and external providers for youth who are at risk of suicide; and

(II) In consideration of local control, flexibly partner with school districts to enable school districts to decide which tiers from among the mental health multi-tiered systems of support to implement; and

(III) Use evidence-based mental health practices that have been subject to external evaluation, randomized controlled trials, and peer review.

(5) In selecting the external provider, the BHA shall prioritize applicants that:

(a) Are not-for-profit entities;

(b) Incur one-time costs and do not require recurring or additional expenses paid for by the BHA beyond the first year of implementation;

(c) Have a demonstrated history of partnerships, and a clear strategy for building future partnerships, with community or hospital-based providers to assist public schools in implementing mental health supports for students; and

(d) Have a demonstrated history of funding internal and external evaluations of the efficacy of the external provider's program in partnership with institutions of higher education or organizations that have similar skills in conducting randomized controlled trials and other quantitative and qualitative evaluation techniques.

(6) (a) For the 2024-25 state fiscal year, the general assembly shall appropriate two million five hundred thousand dollars from the general fund to the department of human services for use by the BHA to administer the program.

(b) The BHA may use up to one hundred thousand dollars of the total appropriation to administer the application and selection process described in subsections (4) and (5) of this section.

(7) This section is repealed, effective July 1, 2028.

Source: L. 2024: Entire section added, (HB 24-1406), ch. 101, p. 318, § 2, effective April 18.

Cross references: For the legislative declaration in HB 24-1406, see section 1 of chapter 101, Session Laws of Colorado 2024.

27-50-805. Contingency management grant program - creation - definitions - repeal.

(1) As used in this section, unless the context otherwise requires:

(a) "Contingency management program" means an evidence-based treatment program that provides motivational incentives to treat individuals with a stimulant use disorder.

(b) "Grant program" means the contingency management grant program created in subsection (2) of this section.

(c) "Stimulant use disorder" means a substance use disorder, as defined in section 27-80-203 (23.3), involving a class of drugs that includes cocaine, methamphetamine, or prescription stimulants.

(d) "Substance use disorder treatment program" has the same meaning as set forth in section 27-80-203 (23.5).

(2) There is created in the behavioral health administration the contingency management grant program to provide grants to substance use disorder treatment programs that implement a contingency management program for individuals with a stimulant use disorder.

(3) (a) Grant recipients may use the money received through the grant program for staffing, training, supplies, administrative costs, the costs of vouchers and prizes up to five hundred ninety-nine dollars per client during the treatment period, and other related expenses as approved by the BHA.

(b) Any money received through the grant program must supplement and not supplant existing substance use disorder treatment and other health-care services. Grant recipients shall not use money received through the grant program for ongoing or existing executive and senior staff salaries or services already covered by medicaid or a client's insurance.

(4) The BHA shall administer the grant program and, subject to available appropriations, shall award grants as provided in this section.

(5) In selecting grant recipients, the BHA shall prioritize applicants that reside in a jurisdiction with demonstrated need to help mitigate overdose incidents and overdose deaths.

(6) The BHA may contract with a grant application and support team to assist the BHA with drafting the grant application, reviewing applications, and administering and processing grant awards.

(7) This section is repealed, effective July 1, 2027.

Source: L. 2024: Entire section added, (HB 24-1045), ch. 470, p. 3290, § 28, effective August 7.

PART 9

SIXTH THROUGH TWELFTH GRADE MENTAL HEALTH SCREENING ACT

27-50-901 to 27-50-903. (Repealed)

Source: L. 2025: Entire part repealed, (SB 25-238), ch. 141, p. 533, § 2, effective April 28.

Editor's note: This part 9 was added in 2023 and was not amended prior to its repeal in 2025. For the text of this part 9 prior to 2025, consult the 2024 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

PART 10

RECOVERY RESIDENCES

27-50-1001. Regulation of recovery residences - license - violations and penalties - rules.

(1) On and after July 1, 2027, it is unlawful for a person to conduct or maintain a recovery residence without having obtained a license from the BHA.

(2) A person that has been found to have violated subsection (1) of this section by a court of competent jurisdiction may be subject to a civil penalty assessed by the BHA of not less than fifty dollars but not more than one hundred dollars for each day the unlicensed recovery residence violated subsection (1) of this section. The assessed penalty accrues from the date the BHA finds that the person is in violation of this section. The BHA shall assess, enforce, and collect the penalty in accordance with article 4 of title 24 and credit the money to the general fund. Enforcement and collection of the penalty occurs following the decision reached in accordance with procedures set forth in section 24-4-105.

(3) The BHA shall take action on an application for licensure within thirty days after the date that the BHA receives the complete application.

(4) (a) Beginning July 1, 2027, a licensed, registered, or certified health-care provider; a behavioral health administrative services organization; a managed care entity, as defined in

section 25.5-5-802 (5); a managed care organization, as defined in section 25.5-5-403 (5); a licensed health-care facility; or a governmental entity shall not refer an individual to a recovery residence or purchase or contract for services from a recovery residence unless the recovery residence has obtained a license from the behavioral health administration.

(b) (I) A recovery residence that is certified pursuant to section 27-80-129 as of June 30, 2027, shall give notice to the BHA prior to July 1, 2027, in the form and manner prescribed by the BHA, that the recovery residence:

(A) Holds a certification as of June 30, 2027;

(B) Is in compliance with all applicable rules for operating a recovery residence adopted pursuant to section 27-50-1002; and

(C) Intends to pursue a recovery residence license from the BHA pursuant to this section.

(II) The certified recovery residence may operate in this state and receive referrals. A certification is in lieu of licensure until the recovery residence is licensed.

(c) (I) A certified recovery residence shall submit an application for licensure to the BHA no less than sixty days prior to one year after the date the recovery residence's certification was last issued pursuant to section 27-80-129. The application must be submitted in the form and manner prescribed by the BHA pursuant to section 27-50-1003.

(II) On and after July 1, 2028, a recovery residence previously certified pursuant to section 27-80-129 shall not operate without applying and being approved for a license pursuant to section 27-50-1003.

(d) Beginning July 1, 2027, a certified recovery residence shall report the occurrences described in section 27-50-1006 to the BHA. The reporting requirements in section 27-50-1006 continue to apply after the certified recovery residence receives a license pursuant to section 27-50-1003.

(e) Beginning July 1, 2027, the BHA may inspect a recovery residence as it deems necessary to ensure the recovery residents' health, safety, and welfare are protected. The recovery residence shall submit in writing, in the form and manner prescribed by the BHA, a plan detailing the measures that the recovery residence will take to correct violations found by the BHA as a result of inspections conducted pursuant to this subsection (4)(e). The BHA may take additional actions in accordance with section 27-50-1005.

(5) (a) A recovery residence owner, employee, or manager, or an individual related to a recovery residence owner, employee, or manager, shall not directly or indirectly:

(I) Solicit, accept, or receive a commission, payment, trade, fee, or anything of monetary or material value for an application to reside in the recovery residence or for any process to determine whether an individual will reside in the recovery residence; or

(II) Solicit, accept, or receive a commission, payment, trade, fee, or anything of monetary or material value from a toxicology laboratory that provides confirmation testing or point-of-care testing for recovery residents.

(b) Subsection (5)(a)(I) of this section does not prevent a recovery residence from receiving payment or fees:

(I) For an individual to reside and receive supports in a recovery residence; or

(II) For supportive services that are required to place the recovery resident.

(6) (a) A recovery residence shall not deny admission to an individual based on the individual's participation in prescribed medication-assisted treatment, as defined in section 23-21-803, for a substance use disorder, including any prescribed or dispensed agonist treatment that is approved by the federal food and drug administration. The recovery residence shall not require an individual to discontinue or taper usage of medication-assisted treatment as a condition of residing in the recovery residence.

(b) A recovery residence shall not categorically prohibit a recovery resident's ability to take prescribed medications, including controlled medications, in accordance with a physician's orders. Admission to, or continued residence in, a recovery residence must not be contingent upon the cessation of taking prescribed medications unless the recovery residence determines, through an individualized assessment, that the recovery resident's use of the medication poses a risk to the safety of the recovery residents, or to the recovery environment, and that the risk cannot be mitigated by reasonable accommodation. In making an individualized determination, the recovery residence shall consider individual factors for the recovery resident who is prescribed the medication that may mitigate or increase risk of misuse or diversion of the prescribed medication. The recovery residence shall establish policies and procedures to implement this subsection (6)(b).

(c) A recovery residence may implement requirements related to the storage and administration of prescribed medications as a means of ensuring safety and preventing diversion of medications.

(7) A recovery residence that is licensed as a behavioral health entity to provide onsite outpatient services to recovery residents must be licensed as a recovery residence. The BHA shall adopt rules to create streamlined regulations for a recovery residence that is licensed as a behavioral health entity, but the rules must not duplicate oversight regulations for a behavioral health entity that is licensed to provide onsite outpatient services. At a minimum, the rules must include, but are not limited to, recovery resident rights, physical environment standards, and incident reporting.

(8) The BHA shall maintain a publicly available list of licensed recovery residences.

(9) (a) Notwithstanding any other provision of this part 10, a recovery residence that is chartered by Oxford House, Inc., or its successor organization, referred to in this subsection (9) as a "chartered recovery residence", may operate in this state and receive referrals and funding pursuant to this part 10 if the chartered recovery residence:

(I) Operates in accordance with this subsection (9);

(II) Operates in accordance with the requirements of homes established pursuant to 42 U.S.C. sec. 300x-25; and

(III) Is democratically run shared housing that has no operator, manager, paid staff, or provision of professional treatment or therapy.

(b) No later than July 1, 2027, Oxford House, Inc. shall provide to the BHA, in the form and manner prescribed by the BHA, a list of all chartered recovery residences in the state as of the date of the notice.

(c) Beginning July 1, 2027, Oxford House, Inc. shall notify the BHA in the form and manner prescribed by the BHA when it issues a new charter to Oxford House, Inc. in the state.

(d) Upon notification that a recovery residence is chartered by Oxford House, Inc. or its successor organization, the BHA shall issue a recovery residence license to the chartered recovery residence.

(e) On and after July 1, 2027, Oxford House, Inc. shall notify the BHA within ten days after closing or revoking a recovery residence's charter.

(f) Beginning July 1, 2027, a chartered recovery residence shall submit occurrence reports to the BHA, in accordance with section 27-50-1006 and in the form, manner, and time frame prescribed by BHA.

(g) A chartered recovery residence is not subject to an initial or annual onsite licensure survey.

(h) Beginning July 1, 2027, the BHA may inspect a chartered recovery residence in response to a complaint or an occurrence report received by the BHA as it deems necessary to ensure that the health, safety, and welfare of recovery residents are protected, and that the chartered recovery residence is operating in accordance with this subsection (9). The BHA may require that Oxford House, Inc. submit in writing, in a form prescribed by the BHA, a plan detailing the measures that Oxford House, Inc. will take to correct violations found by the BHA as a result of inspections undertaken pursuant to this subsection (9). The BHA may take additional actions in accordance with section 27-50-1005.

Source: L. 2026: Entire part added, (SB 26-113), ch. 302, p. 1718, § 2, effective August 12.

27-50-1002. Rules for minimum standards of operation.

(1) No later than May 1, 2027, the BHA shall adopt rules that establish the minimum standards for operating a recovery residence in the state, which rules must include:

(a) Requirements that must be met to ensure the health, safety, and welfare of all recovery residents, including requirements related to:

(I) Recovery resident rights and consumer notice;

(II) Administrative and operational standards for governance, consumer records and record retention, personnel, admission and discharge criteria, policies and procedures to ensure compliance with regulatory and contract requirements, quality management, discharge and transfer policies, individual relapse and safety plans, and program agreements;

(III) Data reporting;

(IV) Physical residence standards, which include obtaining all required building and safety inspections and permits and compliance with applicable building and property maintenance codes that are enforced by a local government applicable to residential dwellings of the same type, size, and occupancy classification in the same jurisdiction;

(V) Occurrence reporting pursuant to section 27-50-1006;

(b) Owner and manager requirements;

(c) Procedures for mandatory BHA inspections of recovery residences;

(d) Procedures for written plans for a recovery residence to correct violations identified as a result of an inspection;

(e) Intermediate enforcement remedies, as described in section 27-50-1005 (3); and

(f) If a recovery residence was certified to operate prior to July 1, 2027, timelines for complying with the recovery residence standards that exceed the standards under which a recovery residence was previously certified.

(2) This section does not exempt a recovery residence or its residents or operators from complying with any state, county, or municipal health, safety, or fire codes. A recovery residence that operates in a single-family or multi-family residential structure is not required to comply with commercial, institutional, or assembly occupancy standards solely by reason of its licensure under this part 10, regardless of the jurisdiction in which the recovery residence operates.

(3) Any rules or regulations adopted pursuant to this section must not prohibit, or be construed to authorize the prohibition of, an individual from residing in a recovery residence

solely on the basis of an individual's prior criminal justice involvement or past criminal convictions.

Source: L. 2026: Entire part added, (SB 26-113), ch. 302, p. 1722, § 2, effective August 12.

27-50-1003. Applications - investigations - inspections - criminal history background checks for owners and managers.

(1) An application for a license to operate a recovery residence must be submitted annually to the BHA in the form and manner prescribed by the BHA.

(2) (a) The BHA shall investigate and review each original application and each renewal application for a license to operate a recovery residence. The BHA shall determine an applicant's compliance with this part 10 and the rules adopted pursuant to section 27-50-1002 before the BHA issues a license.

(b) The BHA shall inspect the applicant's facility as it deems necessary to ensure the health, safety, and welfare of the recovery residents are protected. The recovery residence shall submit in writing, in a form prescribed by the BHA, a plan detailing the measures that the recovery residence will take to correct violations found by the BHA as a result of inspections undertaken pursuant to this subsection (2).

(c) Upon approval of an application for a license, the applicant shall provide notice to the local government that regulates zoning and land use for the jurisdiction where the recovery residence will be located. The notice must include:

(I) A statement of the applicant's intent to operate a recovery residence upon issuance of a recovery residence license by the BHA;

(II) The location of the recovery residence; and

(III) The contact information for the appropriate individual who can be reached to address questions and concerns about the recovery residence.

(3) The BHA shall keep all health-care information or documents obtained during an inspection or investigation of a recovery residence pursuant to subsection (2) of this section confidential. Records, information, or documents obtained are exempt from disclosure pursuant to sections 24-72-204 and 27-50-510.

(4) (a) After submitting an application for a license to operate a recovery residence, or within ten days after a change in ownership or management of a recovery residence, each applicant or owner and manager shall submit to a fingerprint-based criminal history record check. The

applicant or owner and manager must pay the costs associated with the fingerprint-based criminal history record check.

(b) After submitting an application for a license or within ten days after a change in ownership or management, the applicant or owner and manager shall have the applicant's or owner's and manager's fingerprints taken by a local law enforcement agency, or any third party approved by the Colorado bureau of investigation for the purpose of obtaining a fingerprint-based criminal history record check. The applicant or owner and manager shall authorize the entity taking the applicant's or owner's and manager's fingerprints to submit, and the entity shall submit, the complete set of the applicant's or owner's and manager's fingerprints to the Colorado bureau of investigation for the purpose of conducting a fingerprint-based criminal history record check.

(c) If an approved third party takes the applicant's or owner's and manager's fingerprints, the fingerprints may be electronically captured using Colorado bureau of investigation-approved livescan equipment. Third-party vendors shall not keep the applicant's or owner's and manager's information for more than thirty days.

(d) The Colorado bureau of investigation shall use the applicant's or owner's and manager's fingerprints to conduct a criminal history record check using the bureau's records. The Colorado bureau of investigation shall also forward the fingerprints to the federal bureau of investigation for the purpose of conducting a fingerprint-based criminal history record check. The Colorado bureau of investigation, applicant or owner and manager, BHA, and the entity taking fingerprints shall comply with the federal bureau of investigation's requirements to conduct a criminal history record check.

(e) The Colorado bureau of investigation shall return the results of its criminal history record check to the BHA, and the BHA is authorized to receive the results of the federal bureau of investigation's criminal history record check.

(f) The BHA shall evaluate information received from the criminal history record check in accordance with section 24-5-101 and subsection (5) of this section and shall only deny an application based on information obtained from the criminal history record check if the denial is warranted pursuant to section 24-5-101 and subsection (5) of this section.

(g) The BHA shall keep any information obtained pursuant to this subsection (4) confidential.

(5) (a) As used in this subsection (5), "directly related to" means that the criminal offense for which an applicant has been convicted is still relevant at the time of the application for a license and would create an unreasonable risk to public safety because the offense directly relates to the duties and responsibilities of the operation of a recovery residence, as determined by the BHA after consideration of all evidence available to the BHA.

(b) If an applicant has been convicted of a crime, the BHA may only consider the applicant's conviction for a three-year period beginning on the date of conviction or the end of incarceration, whichever date is later, if the applicant has not been convicted of any other criminal offense during the three-year period. After the three-year period, the BHA shall only consider the individual's application for licensure in the same manner as an applicant who does not possess a prior criminal history record; except that the BHA may consider a conviction for a crime that is directly related to the operation of a recovery residence.

(c) If the BHA is considering an applicant's criminal history record during the application process for licensure, the BHA may only deny or refuse to issue or renew the license based on the information in the criminal history record if the BHA determines that the applicant has not been rehabilitated and is unable to perform the duties and responsibilities of the ownership or management of a recovery residence without creating an unreasonable risk to public safety.

(d) An applicant's conviction for a crime does not, in and of itself, disqualify the applicant from being issued a license to operate a recovery residence.

(e) (I) An applicant or potential applicant whose conviction may affect their application for licensure may petition the BHA at any time, including prior to submitting an application, for a decision as to whether the BHA is permitted to consider the applicant's conviction when reviewing the application for licensure.

(II) If the BHA determines that the BHA is permitted to consider an applicant's or potential applicant's conviction, the BHA shall advise the applicant or potential applicant of any actions the applicant or potential applicant may take to remedy the potential effect of the conviction. If a remedial action is advised by the BHA, the applicant may submit a revised petition on or before a date determined by the BHA for completion of the remedial action.

(III) If the BHA makes an initial determination for a potential applicant pursuant to this subsection (5)(e), the BHA may require a new determination at the time an individual formally applies for licensure.

(f) An applicant who petitions the BHA must include in the petition any additional information about the applicant's current circumstances, including the time since the criminal offense was committed and the sentence was completed, the applicant's age at the time the offense was committed, the payment of any court-ordered restitution, evidence of the applicant's rehabilitation, testimonials, and the applicant's employment history and employment aspirations.

(g) (I) In order to deny an application for licensure pursuant to this section based on the information in an applicant's criminal history record, the BHA has the burden to prove by clear and convincing evidence that the denial is directly related to information in the applicant's criminal history record as it pertains to potential performance in, and the potential creation of, an unreasonable risk to public safety through the operation or management of a recovery residence for which the applicant is applying for licensure.

(II) If an individual files a petition for a determination pursuant to this subsection (5), receives notice of an agency adjudicatory hearing, files an answer to the notice pursuant to section 24-4-105 (2)(b), and fails to appear at the scheduled time and place of the hearing, the administrative law judge shall enter a default judgment in favor of the BHA.

(h) This subsection (5) does not:

(I) Negate any provision for licensure in this title 27 that requires an applicant to submit information regarding the applicant's criminal history record to the BHA with an application;

(II) Negate any other reason specified in this title 27 for which the BHA may deny an applicant licensure;

(III) Negate any requirement under federal law that requires an individual to obtain or maintain a license; or

(IV) Negate the list of determining factors that must not be considered regarding an applicant's criminal history record pursuant to section 24-5-101 (2)(b).

(6) Except as otherwise provided in subsection (7) of this section, the BHA shall issue or renew a license to operate a recovery residence when the BHA is satisfied that the applicant or licensee is in compliance with the requirements set forth in this part 10 and the rules adopted pursuant to section 27-50-1002. Except for provisional licenses issued in accordance with subsection (7) of this section, a license issued or renewed pursuant to this section expires one year after the date of issuance or renewal.

(7) (a) The BHA may issue a provisional license to operate a recovery residence to an applicant for the purpose of operating a recovery residence for a period of ninety days if the applicant is temporarily unable to conform to all of the minimum standards required, and the rules adopted, pursuant to this part 10; except that the BHA shall not issue a provisional license to an applicant if the operation of the recovery residence will adversely affect the health, safety, or welfare of the recovery residents.

(b) As a condition of obtaining a provisional license, the applicant shall provide evidence to the BHA that attempts are being made to conform and comply with the applicable standards required, and rules adopted, pursuant to this part 10.

(c) The BHA shall not issue a provisional license prior to the completion of a criminal history record check in accordance with subsection (4) of this section.

(d) The BHA may issue a second provisional license to effect compliance. The BHA shall not issue a third or subsequent provisional license to an applicant in a year.

Source: L. 2026: Entire part added, (SB 26-113), ch. 302, p. 1723, § 2, effective August 12.

27-50-1004. Fees - rules.

(1) (a) No later than May 1, 2027, the BHA shall adopt rules establishing a schedule of license application fees, including renewal application fees, sufficient to meet the direct and indirect costs of administration and enforcement of this part 10.

(b) The BHA shall assess and collect, from recovery residences subject to licensure pursuant to section 27-50-1001, fees in accordance with the fee schedule established pursuant to subsection (1)(a) of this section.

(2) The BHA shall transmit fees collected pursuant to this section to the state treasurer, who shall credit the money to the behavioral health licensing cash fund created pursuant to section 27-50-506.

(3) Behavioral health administration functions related to the licensing of recovery residences pursuant to this part 10 must be entirely funded with the fees collected pursuant to subsection (1) of this section.

Source: L. 2026: Entire part added, (SB 26-113), ch. 302, p. 1727, § 2, effective August 12.

27-50-1005. Denial, suspension, or revocation of license - restrictions - fines.

(1) (a) When the BHA denies an application for an initial license to operate a recovery residence pursuant to section 27-50-1003, the BHA shall notify the applicant in writing by mailing a notice to the address shown on the application. An applicant aggrieved by a denial may pursue a review as provided in article 4 of title 24 and the BHA shall follow the procedures specified in article 4 of title 24.

(b) The BHA may deny an application if the applicant, an affiliate of the applicant, a person employed by the applicant, or a person who resides with the applicant is the subject of, or has previously been the subject of, a negative licensing action or certification withdrawal or termination.

(2) (a) The BHA may suspend, revoke, or refuse to renew the license of a recovery residence that is out of compliance with the requirements of, or rules adopted pursuant to, this part 10. Suspension, revocation, or refusal must not occur until after a hearing and in compliance with the provisions and procedures specified in article 4 of title 24; except that the BHA may summarily suspend a recovery residence's license before a hearing in accordance with section 24-4-104 (4)(a).

(b) After conducting a hearing in accordance with article 4 of title 24, the BHA may revoke or refuse to renew a recovery residence's license if the owner or administrator of the recovery residence has been convicted of a felony or misdemeanor involving conduct that the BHA determines could pose a risk to the health, safety, or welfare of the recovery residents.

(3) The BHA may impose intermediate restrictions or conditions on a recovery residence that may include at least one of the following:

(a) Retaining a consultant to address corrective measures;

(b) Monitoring by the BHA for a specific period;

(c) Providing additional training to employees, owners, or operators of the recovery residence;

(d) Complying with a directed written plan to correct the violation; or

(e) Paying a civil fine in lieu of suspension, revocation, refusal, or any other adverse licensing action, which fine must not exceed two thousand dollars in a calendar year. The BHA shall transmit money received pursuant to this subsection (3)(e) to the state treasurer, who shall credit the money to the general fund.

Source: L. 2026: Entire part added, (SB 26-113), ch. 302, p. 1728, § 2, effective August 12.

27-50-1006. Report of occurrences - investigations - rules - definition.

(1) Each recovery residence shall report to the BHA all of the following occurrences:

(a) Any occurrence that results in the death of a recovery resident of a recovery residence and is required to be reported to the coroner pursuant to section 30-10-606 as arising from an unexplained cause or under suspicious circumstances;

(b) Any occurrence that results in any of the following serious injuries to a recovery resident:

(I) Brain or spinal cord injuries; or

(II) Second- or third-degree burns involving twenty percent or more of the body surface area of an adult recovery resident or fifteen percent or more of the body surface area of a child residing in the recovery residence;

(c) Any occurrence involving physical, sexual, or verbal abuse of a recovery resident by another resident, an employee of the recovery residence, or a visitor, as described in section 18-3-202, 18-3-203, 18-3-204, 18-3-206, 18-3-402, 18-3-404, or 18-3-405;

(d) Any occurrence involving caretaker neglect of a recovery resident, as defined in section 26-3.1-101 (2.3);

(e) Any occurrence involving misappropriation of a recovery resident's property. As used in this subsection (1)(e), "misappropriation of a recovery resident's property" means a pattern of or deliberately misplacing, exploiting, or wrongfully using, either temporarily or permanently, a recovery resident's belongings or money without the recovery resident's consent.

(f) Any occurrence in which drugs intended for use by a recovery resident are diverted for use by another person.

(2) The state board shall adopt rules specifying the manner, time period, and form in which the reports required pursuant to this section must be made.

(3) A report submitted pursuant to subsection (1) of this section is strictly confidential; except that information in a report may be transmitted to an appropriate regulatory agency having jurisdiction for disciplinary or license sanctions. The information in the reports must not be made public upon subpoena, search warrant, discovery proceedings, or otherwise, except as provided in subsection (5) of this section, and is exempt from disclosure pursuant to section 24-72-204.

(4) The BHA shall investigate each report submitted pursuant to subsection (1) of this section that the BHA determines was appropriately submitted. For each report investigated, the BHA shall prepare a summary of its findings, including the BHA's conclusions and whether there was a violation of licensing standards or a deficiency and whether the recovery residence acted appropriately in response to the occurrence. If the investigation is not conducted on site, the BHA shall specify in the summary how the investigation was conducted. An investigation conducted pursuant to this subsection (4) is in addition to and not in lieu of an inspection required to be conducted pursuant to section 27-50-503 (2) with regard to licensing.

(5) (a) The BHA shall make the following information available to the public:

(I) Investigation summaries prepared pursuant to subsection (4) of this section;

(II) Complaints against a recovery residence that have been filed with the BHA and that the BHA has investigated, including the conclusions reached by the BHA and whether there was a violation of licensing or approval standards or a deficiency and whether the recovery residence acted appropriately in response to the subject of the complaint; and

(III) A listing of deficiency citations issued against each recovery residence.

(b) The information released pursuant to this subsection (5) must not identify the recovery resident or the health-care professional involved in the report.

(6) Prior to the completion of an investigation pursuant to this section, the BHA may respond to an inquiry regarding a report received pursuant to subsection (1) of this section by confirming that the BHA has received the report and that an investigation is pending.

(7) In addition to the report to the BHA for an occurrence described in subsection (1)(c) of this section, the occurrence must be reported to a law enforcement agency.

Source: L. 2026: Entire part added, (SB 26-113), ch. 302, p. 1728, § 2, effective August 12.

27-50-1007. Probation placement referrals - judicial updates to identify eligible entities - legislative declaration - repeal.

(1) The general assembly finds that implementing licensing requirements pursuant to this part 10 necessitates that the judicial department update its criteria for entities seeking placement on any approved list used for probation placement referrals.

(2) No later than August 1, 2027, the judicial department shall update any existing request for proposals, approved vendor list, or similar procurement or approval process used to identify entities eligible to receive probation placement referrals to reflect the licensure requirements established by the BHA pursuant to this part 10.

(3) Once the updates required pursuant to subsection (2) of this section are complete, the judicial department shall accept applications from recovery residences licensed by the BHA that provide housing and recovery support services. An eligible recovery residence may apply for inclusion on the approved list.

(4) A recovery residence added to the approved list must remain on the list so long as the recovery residence meets the updated criteria described in subsection (2) of this section.

(5) This section is repealed, effective January 1, 2028.

Source: L. 2026: Entire part added, (SB 26-113), ch. 302, p. 1730, § 2, effective August 12.

27-50-1008. Repeal of part - sunset review.

(1) (a) This part 10 is repealed, effective September 1, 2033.

(b) Before its repeal, the department of regulatory agencies shall review the regulation of recovery residences in accordance with section 24-34-104.

Source: L. 2026: Entire part added, (SB 26-113), ch. 302, p. 1731, § 2, effective August 12.

ARTICLE 60

General Provisions

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GENERAL PROVISIONS

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PART 1

GENERAL PROVISIONS

27-60-100.3. Definitions.

As used in this article 60, unless the context otherwise requires:

(1) "Behavioral health" refers to an individual's mental and emotional well-being and actions that affect an individual's overall wellness. Behavioral health problems and disorders include substance use disorders, serious psychological distress, suicide, and other mental health disorders. Problems ranging from unhealthy stress or subclinical conditions to diagnosable and treatable diseases are included in the term "behavioral health". The term "behavioral health" is also used to describe service systems that encompass prevention and promotion of emotional health, prevention and treatment services for mental health and substance use disorders, and recovery support.

(1.1) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-50-102.

(1.3) "Commissioner" means the commissioner of the behavioral health administration.

(1.5) "Criminal justice diversion program" means a program created pursuant to section 27-60-106.5 or programs operated by cities or counties that connect law enforcement officers with behavioral health providers to assist individuals in need of behavioral health interventions or to divert individuals from the criminal justice system.

(2) "Crisis intervention services" means the array of behavioral health crisis services that are funded by public or private sources and exist to serve individuals who are experiencing a behavioral health crisis.

(3) "Crisis response system" means the behavioral health crisis response system developed and implemented pursuant to this article 60.

(4) "Crisis response system contractor" means an entity that has been awarded a contract to provide one or more crisis intervention services pursuant to section 27-60-103.

(4.7) Repealed.

(5) "State board" means the state board of human services created and authorized pursuant to section 26-1-107.

(6) "State department" means the state department of human services created pursuant to section 26-1-105.

Source: L. 2017: Entire section added, (SB 17-242), ch. 263, p. 1335, § 226, effective May 25. **L. 2018:** (4.7) added, (SB 18-250), ch. 403, p. 2376, § 1, effective June 6. **L. 2020:** (1.5) added, (HB 20-1017), ch. 288, p. 1426, § 11, effective September 14. **L. 2022:** (1.1) and (1.3) added and (4.7) repealed, (HB 22-1278), ch. 222, p. 1519, § 87, effective July 1.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-60-101. Behavioral health crisis response system - legislative declaration.

(1) (a) The general assembly finds and declares that:

(I) There are people in Colorado communities who are experiencing behavioral health crises and need professional behavioral health crisis care or urgent psychiatric care from skilled mental health clinicians and medical professionals who excel at providing compassionate behavioral health crisis intervention and stabilization;

(II) A behavioral health crisis can happen any hour of the day and any day of the week;

(III) Persons in a behavioral health crisis frequently come in contact with community first responders who are often unable to provide necessary behavioral health interventions or who must transport these persons in a behavioral health crisis to emergency rooms for services, or, in cases where a crime is alleged, to jail;

(IV) Colorado ranks fiftieth in the nation in the number of inpatient psychiatric beds;

(V) Fewer than one-half of the persons who are in a behavioral health crisis and are taken to an emergency room are admitted for inpatient hospitalization, meaning that thousands of people each year return to community streets with little, if any, crisis intervention or treatment for behavioral health disorders; and

(VI) Significant time and resources are required of community first responders in addressing persons in a behavioral health crisis and, in many cases, this community response is neither timely nor safe for the person in crisis nor cost-efficient for the state.

(b) The general assembly therefore finds that a coordinated behavioral health crisis response system:

(I) Serves as a comprehensive and preferred response to behavioral health emergencies throughout Colorado by providing for early intervention and effective treatment of individuals who are experiencing a behavioral health crisis;

(I.5) As the appropriate and preferred response to behavioral health crises, eliminates the use of the criminal justice system to hold individuals who are experiencing a mental health crisis and enhances the ability of mental health providers and hospitals to serve individuals who are experiencing a mental health crisis;

(II) Provides an appropriate first line of response to individuals in need of an emergency seventy-two-hour mental health hold and utilizes first responders and information technology systems to integrate available behavioral health crisis responses;

(III) Should be available in all Colorado communities;

(IV) Includes community-based, behavioral health crisis centers where individuals who are experiencing a behavioral health crisis may be stabilized and receive short-term treatment, as clinically appropriate;

(V) Decriminalizes mental health disorders by leading the development of a partnership-supported network of crisis services; and

(VI) Establishes a statewide framework that creates, strengthens, and enhances community partnerships that will facilitate the preferred response to behavioral health crises, including ensuring that peace officers and other first responders are equipped with a variety of options when they encounter a behavioral health crisis.

(c) Therefore, the general assembly declares that it is a matter of statewide concern to incentivize and coordinate existing behavioral health crisis intervention services and to commit resources to expand the crisis response system.

(2) Repealed.

Source: L. 2010: Entire article added, (HB 10-1032), ch. 316, p. 1475, § 1, effective May 27. **L. 2017:** (1) amended, (SB 17-242), ch. 263, p. 1336, § 227, effective May 25; (1)(b) amended, (1)(c) added, and (2) repealed, (SB 17-207), ch. 205, p. 761, § 2, effective August 9.

Editor's note: (1) This section was added by section 1 of ch. 316, Session Laws of Colorado 2010, as § 27-1-210 but was renumbered on revision for ease of location since article 1 of this title was repealed by Senate Bill 10-175.

(2) Amendments to subsection (1)(b) by SB 17-207 and SB 17-242 were harmonized.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017. For the legislative declaration in SB 17-207, see section 1 of chapter 205, Session Laws of Colorado 2017.

27-60-102. Civil commitment statute review task force - legislative declaration - creation - duties - repeal. (Repealed)

Source: L. 2013: Entire section added, (HB 13-1296), ch. 232, p. 1109, § 1, effective May 16.

Editor's note: Subsection (10) provided for the repeal of this section, effective November 1, 2014. (See L. 2013, p. 1109.)

27-60-102.5. Definitions. (Repealed)

Source: L. 2017: Entire section added, (SB 17-207), ch. 205, p. 762, § 3, effective August 9. **L. 2018:** Entire section repealed, (SB 18-094), ch. 30, p. 332, § 2, effective August 8.

Cross references: For the legislative declaration in SB 18-094, see section 1 of chapter 30, Session Laws of Colorado 2018.

27-60-103. Behavioral health crisis response system - services - request for proposals - criteria - reporting - rules - definitions - repeal.

(1) (a) The BHA may issue a statewide request for proposals to entities with the capacity to create a coordinated and seamless behavioral health crisis response system to provide crisis intervention services for communities throughout the state. Separate proposals may be solicited and accepted for each of the five components listed in subsection (1)(b) of this section. The crisis response system created through this request for proposals process must be based on the following principles:

(I) Cultural competence;

(II) Strong community relationships;

(III) The use of peer support;

(IV) The use of evidence-based practices;

(V) Building on existing foundations with an eye toward innovation;

(VI) Utilization of an integrated system of care; and

(VII) Outreach to students through school-based clinics.

(b) The components of the crisis response system must reflect a continuum of care from crisis response through stabilization and safe return to the community, with adequate support for transitions to each stage. Specific components include:

(I) Repealed.

(II) Walk-in crisis services and crisis stabilization units with the capacity for immediate clinical intervention, triage, and stabilization. The walk-in crisis services and crisis stabilization units must employ an integrated health model based on evidence-based practices that consider an individual's physical and emotional health, are a part of a continuum of care, and are linked to mobile crisis services and crisis respite services.

(III) Mobile crisis services and units that are linked to the walk-in crisis services and crisis respite services and that have the ability to initiate a response in a timely fashion to a behavioral health crisis;

(IV) Residential and respite crisis services that are linked to the walk-in crisis services and crisis respite services and that include a range of short-term crisis residential services, including but not limited to community living arrangements; and

(V) Funding for a public information campaign and to ensure that individuals calling or texting the legacy statewide telephone crisis lines are routed to the 988 crisis line.

(1.5) (a) Beginning January 1, 2023, the state department shall create in-home and residential respite care services and facilities for children and families in up to seven regions of the state, as determined by the state department and a committee of interested stakeholders.

(b) (I) For the 2022-23 budget year, the general assembly shall appropriate money from the behavioral and mental health cash fund pursuant to section 24-75-230 to the state department to fund in-home and residential respite care across the state as described in this subsection (1.5).

(II) The use of money appropriated pursuant to this subsection (1.5) and money that originates from the ARPA refinance state money cash fund, created in section 24-75-226.5, appropriated for the same purpose, must conform with the allowable purposes set forth in the federal "American Rescue Plan Act of 2021", Pub.L. 117-2, as the act may be subsequently amended. The state department shall spend or obligate such appropriation in accordance with section 24-75-226 (4)(d).

(III) This subsection (1.5)(b) is repealed, effective September 1, 2027.

(c) (I) Beginning in state fiscal year 2023-24, money appropriated to the state department for the purpose of this subsection (1.5) must continue the statewide access to crisis system services for children and youth until June 30, 2026.

(II) Beginning in the state fiscal year 2022-23, money appropriated to the state department for the purpose of implementing this subsection (1.5) must support residential respite care provided to youth involved in the foster care system.

(III) Respite foster care homes must be in compliance with all other applicable rules regulating foster care homes.

(d) The state department and any person that receives money from the state department shall comply with the compliance, reporting, record-keeping, and program evaluation requirements established by the office of state planning and budgeting and the state controller in accordance with section 24-75-226 (5).

(1.7) Beginning January 1, 2025, the BHA shall use the money transferred to the behavioral and mental health excise tax cash fund pursuant to section 39-37-301 (2)(a)(II) to continue and expand access to behavioral health crisis response system services for children and youth in accordance with this article 60.

(2) The BHA shall collaborate with the committee of interested stakeholders established in subsection (3) of this section to develop the request for proposals, including eligibility and award criteria. Priority may be given to entities that have demonstrated partnerships with Colorado-based resources. Proposals will be evaluated on, at a minimum, an applicant's ability, relative to the specific component involved, to:

(a) Demonstrate innovation based on evidence-based practices that show evidence of collaboration with existing systems of care to build on current strengths and maximize resources;

(b) Coordinate closely with community mental health organizations that provide services regardless of the source of payment, such as behavioral health organizations, community mental health centers, regional care collaborative organizations, substance use treatment providers, and managed service organizations;

(c) Serve individuals regardless of their ability to pay;

(d) Be part of a continuum of care;

(e) Utilize peer supports;

(f) Include key community participants;

(g) Demonstrate a capacity to meet the demand for services;

(h) Understand and provide services that are specialized for the unique needs of child and adolescent patients; and

(i) Reflect an understanding of the different response mechanisms utilized between mental health and substance use disorder crises.

(3) The BHA shall establish a committee of interested stakeholders that will be responsible for reviewing the proposals and awarding contracts pursuant to this section. Representatives from the state department of health care policy and financing must be included in the committee of interested stakeholders. A stakeholder participating in the committee must not have a financial or other conflict of interest that would prevent him or her from impartially reviewing proposals.

(4) (a) If additional money is appropriated, the BHA may issue additional requests for proposals consistent with this section and the state procurement code, articles 101 and 102 of title 24.

(b) If the full appropriation by the general assembly for the implementation of this section is not dispersed as specified in paragraph (a) of this subsection (4), the committee shall accept and review proposals and award contracts as the proposals are received and not require an application be held until a subsequent request for proposals.

(5) If necessary, the state board may promulgate rules to implement the provisions of this article 60 or the services to be supplied pursuant to this article 60.

(6) (a) Beginning in January 2014, and every January thereafter, the BHA shall report progress on the implementation of the crisis response system, as well as information about and updates to the system, as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" hearing required by section 2-7-203.

(b) and (c) Repealed.

(7) Repealed.

(8) (a) On or before January 1, 2023, in order to promote transparency and accountability, the office shall require each administrative service organization that has twenty-five percent or more ownership by providers of behavioral health services to comply with the following conflict of interest policies:

(I) Providers who have ownership or board membership in an administrative service organization shall not have control, influence, or decision-making authority in how funding is distributed to any provider or the establishment of provider networks.

(II) The office shall quarterly review an administrative service organization's funding allocation to ensure that all providers are being equally considered for funding. The office is authorized to review any other pertinent information to ensure the administrative service organization is meeting state and federal rules and regulations and is not inappropriately giving preference to providers with ownership or board membership.

(III) An employee of a contracted provider of an administrative service organization shall not also be an employee of the administrative service organization unless the employee is a medical director for the administrative service organization. If the medical director is also an employee of a provider that has board membership or ownership in the administrative service organization, the administrative service organization shall develop policies, approved by the commissioner of the behavioral health administration, to mitigate any conflict of interest the medical director may have.

(IV) An administrative service organization's board shall not have more than fifty percent of contracted providers as board members, and the administrative service organization is encouraged to have a community member on the administrative service organization's board.

(b) If the office is unable to contract with an administrative service organization that meets the requirements of this subsection (8), the office may designate another existing administrative service organization to temporarily provide the services for that region, for up to one year, pending designation of a new administrative service organization. If the office is unable to designate a new administrative service organization, the temporary administrative service organization may continue to provide the regional behavioral health crisis response system services on a year by year basis.

(c) As used in this subsection (8), unless the context otherwise requires:

(I) "Medical director" means a physician who oversees the medical care and other designated care and services in an administrative services organization. The medical director may be responsible for helping to develop clinical quality management and utilization management.

(II) "Ownership" means an individual who is a legal proprietor of an organization, including a provider or individual who owns assets of an organization, or has a financial stake, interest, or governance role in the administrative services organization.

Source: L. 2013: Entire section added, (SB 13-266), ch. 231, p. 1105, § 1, effective May 16. **L. 2017:** (7) repealed, (SB 17-242), ch. 263, p. 1337, § 228, effective May 25; IP(1)(a), IP(1)(b), (4)(a), (5), and (6) amended and (7) repealed, (SB 17-207), ch. 205, p. 762, § 4, effective August 9. **L. 2018:** IP(1)(a) and (6)(b) amended, (SB 18-161), ch. 123, p. 830, § 4, effective September 1. **L. 2022:** (1.5) added, (HB 22-1283), ch. 185, p. 1243, § 3, effective May 18; (8) added, (SB 22-106), ch. 196, p. 1310, § 2, effective May 20; IP(1)(a), IP(2), (3), (4)(a), and (6)(a) amended and (6)(b) and (6)(c) repealed, (HB 22-1278), ch. 222, p. 1519, § 88, effective July 1. **L. 2024:** (1.5)(b)(II) amended, (HB 24-1466), ch. 429, p. 2944, § 37, effective June 5; (1.7) added, (HB 24-1349), ch. 423, p. 2901, § 5, effective December 17 (see editor's note). **L. 2025:** (1.7) amended, (SB 25-295), ch. 330, p. 1714, § 4, effective May 31; (1)(b)(I) repealed and (1)(b)(V) amended, (SB 25-236), ch. 140, p. 530, § 3, effective July 1.

Editor's note: Section 19(1) of chapter 423 (HB 24-1349), Session Laws of Colorado 2024, provides that changes to this section take effect on the date of the official declaration of the vote thereon by the governor only if, at the November 2024 statewide election, a majority of voters approve the ballot issue referred in accordance with § 39-37-201. The ballot issue, referred to the voters as Proposition KK, was approved on November 5, 2024, and was proclaimed by the

governor on December 17, 2024, see L. 2025, p. 3636. The vote count for the measure was as follows:

FOR: 1,675,123

AGAINST: 1,406,112

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017. For the legislative declaration in SB 17-207, see section 1 of chapter 205, Session Laws of Colorado 2017. For the legislative declaration in HB 22-1283, see section 1 of chapter 185, Session Laws of Colorado 2022. For the legislative declaration in HB 24-1466, see section 1 of chapter 429, Session Laws of Colorado 2024.

27-60-104. Behavioral health crisis response system - crisis service facilities - walk-in centers - mobile response units - report.

(1) All behavioral health entities, crisis walk-in centers, acute treatment units, mobile crisis programs, respite services, and crisis stabilization units within the crisis response system, regardless of program licensure, shall meet standards for approval pursuant to section 27-66-105. Facility-based crisis service providers must be approved or designated to adequately care for an individual brought to the facility through the emergency mental health procedure described in section 27-65-106 and be an approved treatment facility pursuant to section 27-81-106. The arrangements for care must be completed through the crisis response system or prearranged partnerships with other crisis intervention services.

(2) (a) The BHA shall ensure that mobile response units are available to respond to a behavioral health crisis anywhere in the state within no more than two hours, either face-to-face or using telehealth operations, for mobile crisis evaluations.

(b) Mobile crisis services may be delivered by criminal justice diversion programs approved by the BHA or a crisis response system contractor.

(3) (a) All walk-in centers throughout the state's crisis response system must be appropriately designated by the commissioner for an emergency mental health hold, adequately prepared, and properly staffed to accept an individual through the procedure outlined in section 27-65-106 or a voluntary application for mental health services pursuant to section 27-65-103 or 27-65-104. Priority for individuals placed under an emergency mental health hold pursuant to section 27-65-106 is on treating high-acuity individuals in the least restrictive environment without the use of law enforcement.

(a.5) All crisis walk-in centers throughout the state's crisis response system shall be appropriately licensed, adequately prepared, and properly staffed to provide crisis services to an

individual with a substance use disorder, as that term is defined in section 27-81-102, or an individual with a disability, as defined in the federal "Americans with Disabilities Act of 1990", 42 U.S.C. sec. 12101 et seq., as amended, regardless of primary diagnosis, co-occurring conditions, or if the individual requires assistance with activities of daily living, as defined in section 12-270-104. A crisis walk-in center shall prioritize treating high-acuity individuals in the least restrictive environment without the use of law enforcement.

(b) The ability of crisis walk-in centers to accept individuals through an emergency mental health hold outlined in section 27-65-106, a voluntary application for substance use disorder services pursuant to section 27-81-109, or a voluntary application for mental health services pursuant to section 27-65-103 or 27-65-104 may include, but is not limited to, purchasing, installing, and using telehealth operations for mobile crisis evaluations in partnership with hospitals, clinics, law enforcement agencies, and other appropriate service providers.

(3.5) Mobile crisis programs and crisis walk-in centers shall provide crisis response screening services to any individual seeking such services, including youth of any age and an individual with a disability, as defined in the federal "Americans with Disabilities Act of 1990", 42 U.S.C. sec. 12101 et seq., as amended, regardless of primary diagnosis, co-occurring conditions, or if the individual requires assistance with activities of daily living, as defined in section 12-270-104. All additional or corresponding behavioral health services beyond the crisis response screening must be provided in accordance with all applicable state laws, including, but not limited to, sections 12-245-203.5, 13-22-102, 27-65-103, and 27-65-104.

(4) Rural crisis facilities are encouraged to work collaboratively with other facilities in the region that provide care twenty-four hours a day, seven days a week, to form local arrangements.

(5) The BHA shall encourage crisis response system contractors in each region to develop partnerships with the broad array of crisis intervention services through mobile response units and telehealth-capable walk-in centers in rural communities that offer care twenty-four hours a day, seven days a week.

(6) The BHA shall ensure crisis response system contractors are responsible for community engagement, coordination, and system navigation for key partners, including criminal justice agencies, emergency departments, hospitals, primary care facilities, behavioral health entities, walk-in centers, and other crisis service facilities. The goals of community coordination are to:

(a) Formalize relationships with partners in the contractually defined regions;

(b) Pursue collaborative programming for behavioral health services, including, when possible, embedding crisis clinicians and consultants in first response systems;

(c) Build close relationships between first responders and dispatch centers and the crisis response system contractor in the region; and

(d) Coordinate behavioral health crises interventions in the community as early as possible to promote diversion from the criminal justice system and continuity of care.

(6.5) For state fiscal year 2023-24, the BHA shall safeguard partnerships between community-based behavioral health providers and rural hospitals by allocating money to community-based behavioral health providers.

(7) The BHA shall explore solutions for addressing secure transportation, as defined in section 25-3.5-103 (11.4), of individuals placed on a seventy-two-hour treatment and evaluation hold pursuant to article 65 of this title 27, and shall include the following information as part of its 2023 "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" presentation required pursuant to section 2-7-203:

(a) How crisis contractors are facilitating the use of secure transportation or contracting with secure transportation licensees; and

(b) How the BHA has supported and encouraged crisis contractors to include secure transportation in the behavioral health crisis response system.

(8) The BHA shall ensure consistent training for professionals who have regular contact with individuals experiencing a behavioral health crisis.

(9) The BHA shall conduct an assessment of need and capacity of the statewide crisis response system to better understand the state's needs for crisis response and service gaps across the state.

(10) (a) The state department shall annually, in August, notify each public and private school in the state about services provided by the behavioral health crisis response system, including but not limited to how to engage with and what to expect from the services, and the possibility of peer-to-peer counseling as a part of the offered services. The state department shall provide behavioral health crisis response system awareness and educational materials to each public and private school in the state.

(b) The state department shall collaborate with the department of education, created in section 24-1-115, in identifying public and private schools in Colorado, including but not limited to identifying school contact information.

Source: L. 2017: Entire section added, (SB 17-207), ch. 205, p. 764, § 5, effective August 9. **L. 2019:** (1) and IP(6) amended, (HB 19-1237), ch. 413, p. 3640, § 11, effective July 1, 2022. **L. 2020:** (2) amended, (HB 20-1017), ch. 288, p. 1426, § 12, effective September 14. **L. 2021:** (7) amended, (HB 21-1085), ch. 355, p. 2312, § 5, effective June 27. **L. 2022:** (1) and (3)(b) amended and (3)(a.5) and (3.5) added, (HB 22-1214), ch. 142, p. 937, § 1, effective April 27; (10) added, (HB 22-1052), ch. 453, p. 3255, § 2, effective June 8; (2), (3)(a), (5), IP(6), IP(7),

(7)(b), (8), and (9), amended, (HB 22-1278), ch. 222, p. 1520, § 89, effective July 1; (3) amended, (HB 22-1256), ch. 451, p. 3239, § 55, effective August 10; (3)(a) amended, (HB 22-1278), ch. 222, p. 1601, § 251, effective August 10. **L. 2023:** (6.5) added, (HB 23-1236), ch. 206, p. 1064, § 33, effective May 16; (1) and (3.5) amended, (HB 23-1301), ch. 303, p. 1837, § 67, effective August 7.

Editor's note: (1) Amendments to subsection (3)(a) by HB 22-1256 and HB 22-1278 were harmonized.

(2) Amendments to subsection (3)(b) by HB 22-1256 and HB 22-1214 were harmonized.

Cross references: For the legislative declaration in SB 17-207, see section 1 of chapter 205, Session Laws of Colorado 2017.

27-60-104.5. Behavioral health capacity tracking system - rules - legislative declaration - definitions.

(1) (a) The general assembly finds that:

(I) There is a shortage of available beds for psychiatric emergencies, withdrawal management for substance use disorders, and intensive residential inpatient and outpatient behavioral health services in Colorado;

(II) Creating a behavioral health capacity tracking system of available treatment capacity and medication-assisted treatment programs would help families, law enforcement agencies, counties, court personnel, and emergency room personnel locate an appropriate treatment option for individuals experiencing behavioral health crises; and

(III) Further, a tracking system would decrease the time that individuals wait in emergency rooms, ensure that existing resources are maximized, and increase the likelihood that individuals in crisis receive services closer to their community.

(b) Therefore, the general assembly declares that the creation of a behavioral health capacity tracking system is an important tool for addressing behavioral health crises, including connecting individuals to treatment for opioid and other substance use disorders.

(2) As used in this section, unless the context otherwise requires:

(a) "Consistent noncompliance" means when a provider does not complete daily required capacity updates for two or more consecutive days or has five or more days of noncompliance in any given month.

(b) "Tracking system" means the behavioral health capacity tracking system created pursuant to this section.

(3) Pursuant to subsection (8) of this section, the BHA shall implement a behavioral health capacity tracking system, which must include the following:

(a) A twenty-four-hour, web-based platform;

(b) Online access by health-care professionals, law enforcement, and court personnel;

(c) Coordination with the 988 crisis hotline created pursuant to section 27-64-103;

(d) Required capacity updates, at least daily, unless the facility is a residential facility and capacity has not changed, with a penalty for consistent noncompliance, for facilities listed under subsection (3)(e) of this section; except that opioid treatment programs licensed pursuant to section 27-80-204 are only required to update daily whether the program is accepting new clients; and

(e) Capacity reporting for the following facilities and treatment providers statewide:

(I) Facilities that provide evaluation and treatment to individuals held under an emergency commitment pursuant to section 27-81-111, an involuntary commitment pursuant to section 27-81-112, or a civil commitment pursuant to section 27-65-106, including crisis stabilization units, acute treatment units, community mental health centers, and hospitals, including state mental health institutes;

(II) Inpatient treatment facilities;

(III) Residential treatment facilities;

(IV) Withdrawal management facilities; and

(V) Facilities licensed pursuant to section 27-80-204, including opioid treatment programs and medically managed and clinically managed withdrawal management facilities.

(4) In addition to reporting by those facilities listed in subsection (3)(e) of this section, the tracking system may allow any medical provider providing behavioral health treatment as part of the provider's medical practice to participate in the tracking system with prior approval by the BHA.

(5) To the extent possible, the tracking system should be designed to collect the following information:

(a) The name, address, web address, and telephone number of the facility or treatment program and information as to the process for confirming the current availability of a bed or a slot in a treatment program and for reserving a bed or slot in the facility or treatment program;

(b) The license type for the facility or treatment program and the licensed bed capacity of the facility;

(c) The number of beds or slots currently available and staffed for behavioral health services;

(d) Admission and exclusion criteria, including gender, age, acuity level, medical complications, diagnoses, or behaviors excluded, such as intellectual or developmental disabilities, aggression, substance use disorders, traumatic brain injury, or history of violence or aggressive behavior;

(e) The type of substance for which the facility or treatment program provides treatment;

(f) Whether the facility serves involuntary clients;

(g) Payer sources accepted by each facility or treatment program;

(h) The time and date of the last update of information for the facility or treatment program; and

(i) A link to a stable location map.

(6) The tracking system is designed to provide immediate and accurate information regarding the availability of facility beds or slots in treatment programs but does not guarantee availability. The user shall be directed to contact the facility or treatment program directly to confirm capacity and to arrange placement.

(7) Repealed.

(8) Subject to available appropriations, the BHA shall implement a centralized, web-based tracking system as described in this section and shall ensure that appropriate tracking system information is available to the public.

(9) Repealed.

(10) The state board may adopt rules, as necessary, to implement this section.

Source: L. 2019: Entire section added, (HB 19-1287), ch. 175, p. 2012, § 1, effective May 14. **L. 2020:** (8) amended and (9) repealed, (HB 20-1391), ch. 211, p. 1026, § 1, effective June 30; (3)(e)(I) amended, (SB 20-007), ch. 286, p. 1416, § 52, effective July 13. **L. 2022:** IP(3), (4), (8), and (10) amended and (7) repealed, (HB 22-1278), ch. 222, p. 1522, § 90, effective July 1; (3)(e)(I) amended, (HB 22-1256), ch. 451, p. 3235, § 41, effective August 10. **L. 2025:** (3)(c) and (8) amended, (SB 25-236), ch. 140, p. 530, § 4, effective July 1.

27-60-105. Outpatient restoration to competency services - jail-based behavioral health services - responsible entity - duties - report - legislative declaration.

(1) The general assembly finds and declares that:

(a) Colorado's statutory scheme does not designate an entity responsible for competency restoration services, nor does it provide a sufficient framework for the provision of outpatient restoration services to adults or juveniles. As a result, there have been deficits and inconsistencies in the administration of the educational component of outpatient competency restoration services and the coordination and integration of that component with existing services and supports to address the underlying causes of incompetency.

(b) The lack of a designated responsible entity for competency restoration services in Colorado has caused inconsistency in competency restoration services throughout the state and delays in proceedings that impact the due process rights of juveniles and adults involved in the juvenile and criminal justice systems, as well as the interests of victims;

(c) Competency restoration services must be localized and accessible and take into account the public safety, while still allowing for state-level standards and oversight;

(d) Competency restoration services for juveniles must be provided in the least restrictive environment, while taking into account the public safety and the best interests of the juvenile; and

(e) Many services essential to the restoration of competency can be provided through existing programs using existing funding. However, the current system lacks funding and responsibility for the educational component of competency restoration services and case management to access and leverage available services and supports which, combined, will help ensure an integrated approach to competency restoration for juveniles and adults.

(2) The state department serves as a central organizing structure and responsible entity for the provision of competency restoration education services and coordination of competency restoration services ordered by the court pursuant to section 16-8.5-110 (1) or 19-2.5-704 (2), and the behavioral health administration serves as the central organizing structure and responsible entity for jail-based behavioral health services pursuant to section 27-60-106.

(3) The state department shall develop standardized juvenile and adult curricula for the educational component of competency restoration services. The curricula must have a content and delivery mechanism that allows the curricula to be tailored to meet individual needs, including those of persons with intellectual and developmental disabilities.

(4) Beginning July 1, 2019, the state department has the following duties and responsibilities, subject to available appropriations:

(a) To oversee providers of the education component of competency restoration services, including:

(I) Establishing and enforcing qualifications of competency restoration educators, including minimum and ongoing training requirements;

(II) Evaluating models for the delivery of competency restoration education in a manner that maximizes and expands on available resources while minimizing costs to the state; and

(III) Maintaining an adequate pool of competency restoration providers, as defined by:

(A) Qualifications and training;

(B) Geographical accessibility, in light of the goal of ensuring community-based restoration in the least restrictive environment throughout the state; and

(C) Ability to provide culturally competent and developmentally appropriate competency restoration education tailored to an individual's unique needs;

(b) To develop models for providing competency restoration services that integrate competency restoration education with other case management and treatment, ensure continuation of ongoing treatment and services as appropriate, avoid duplication of services, and achieve efficiencies by coordinating with existing community resources and programs;

(c) To preserve the integrity of the competency evaluation process by ensuring that competency restoration educators operate independently from competency evaluators at the case level;

(d) To engage with key stakeholders in the juvenile and adult justice systems to develop best practices in the delivery of competency restoration services; and

(e) To make recommendations for legislation.

(f) Repealed.

(4.5) Beginning July 1, 2023, subject to available appropriations, the behavioral health administration shall oversee functions of the jail-based behavioral health services program created in section 27-60-106.

(5) Notwithstanding section 24-1-136 (11)(a)(I), on or before January 1, 2019, and every January 1 thereafter, the state department shall submit an annual written report to the general assembly summarizing the state department's provision of competency restoration education and its efforts toward the coordination of competency restoration education with other existing services. The report must include:

(a) Data on the number of individuals ordered to competency restoration services, the average time frame for beginning and ending such services, the types of settings in which competency restoration services are provided, and the outcomes of such services;

(b) A description of the state department's engagement with community partners to coordinate competency restoration services in an effective and efficient manner;

(c) Identification of best and promising practices for education and coordination of competency restoration services;

(d) A description of opportunities to maximize and increase available resources and funding; and

(e) A description of gaps in and conflicts with existing funding, services, and programming essential to the effective restoration of competency for juveniles and adults.

(f) Repealed.

(5.5) Notwithstanding section 24-1-136 (11)(a)(I), on or before January 1, 2024, and every January 1 thereafter, the behavioral health administration shall submit an annual written report to the general assembly summarizing the results of the jail-based behavioral health services program created in section 27-60-106. The report must include a description of the services funded through the jail-based behavioral health services program created in section 27-60-106.

(6) In addition to subsection (4) of this section and subject to available appropriations, the state department shall require any county jail to assist in the provision of interim mental health services for individuals who have been court-ordered for inpatient competency restoration and who are waiting admission for an inpatient bed. This section does not toll or otherwise modify the time frames for the state department to offer inpatient admission pursuant to the provisions of section 16-8.5-110.

Source: L. 2017: Entire section added, (SB 17-012), ch. 404, p. 2109, § 3, effective August 9. **L. 2018:** (2), IP(4), (4)(d), (4)(e), IP(5), (5)(d), and (5)(e) amended and (4)(f) and (5)(f) added, (SB 18-250), ch. 403, p. 2376, § 2, effective June 6. **L. 2019:** (2) and IP(4) amended and (6) added, (SB 19-223), ch. 227, pp. 2293, 2290, §§ 20, 12, effective July 1. **L. 2021:** (2) amended, (SB 21-059), ch. 136, p. 749, § 131, effective October 1. **L. 2022:** (2), (3), IP(4), IP(5), (5)(b), and (6) amended, (HB 22-1278), ch. 222, p. 1522, § 91, effective July 1. **L. 2023:** (2), (4)(d), (4)(e), IP(5), (5)(d), and (5)(e) amended, (4)(f) and (5)(f) repealed, and (4.5) and (5.5) added, (HB 23-1236), ch. 206, p. 1062, § 32, effective May 16. **L. 2024:** (2) amended, (HB 24-1034), ch. 372, p. 2521, § 16, effective June 4. **L. 2026:** (2) and (6) amended, (SB 26-149), ch. 142, p. 797, § 51, effective May 21.

Editor's note: Subsection (6) was numbered as (5) in SB 19-223 but has been renumbered on revision for ease of location.

27-60-105.5. Post-dismissal services for persons receiving inpatient restoration services - continuation of services after dismissal - supportive housing - post-dismissal living information collection - definition.

(1) As used in this section, unless the context otherwise requires, "bridges wraparound care program" means the bridges wraparound care program created in section 16-8.6-103.

(2) If the charges against a person who is receiving inpatient restoration services, as described in article 8.5 of title 16, are dismissed following a determination by the court that the person is incompetent to proceed, the state department may continue to provide services to the person for up to ninety days after the charges are dismissed. A person is not required to be in custody to receive services from the state department pursuant to this subsection (2) after charges are dismissed, and a court shall not order a person to remain in custody as a condition of continuing to receive services from the state department.

(3) The state department may enter into an agreement with an organization to provide permanent supportive housing for persons whose charges are dismissed following a determination by the court that the person is incompetent to proceed or pursuant to section 16-8.6-110 following satisfactory completion of a bridges wraparound care program, or for persons who have been referred to the bridges wraparound care program. The state department shall make efforts to collaborate with service providers, including the office of bridges of Colorado established pursuant to section 13-95-103, to ensure continuity of care and service delivery in a manner that avoids duplication and bifurcation of services.

(4) (a) The state department shall collect information concerning where a person lives or intends to live after:

(I) The charges against the person are dismissed following a determination by the court that the person is incompetent to proceed;

(II) The charges against the person are dismissed pursuant to section 16-8.6-110 following satisfactory completion of the bridges wraparound care program; or

(III) The person has been referred to the bridges wraparound care program.

(b) The state department shall work with the office of bridges of Colorado established pursuant to section 13-95-103 to collect the information described in subsection (4)(a) of this section, and the office of bridges of Colorado shall provide the information to the state department.

Source: L. 2025: Entire section added, (SB 25-041), ch. 357, p. 1921, § 1, effective August 6.

27-60-106. Jail-based behavioral health services program - purpose - created - funding - repeal.

(1) There is created in the behavioral health administration the jail-based behavioral health services program, referred to in this section as the "program". The program may receive money from the correctional treatment cash fund pursuant to section 18-19-103 (5)(c)(V).

(2) The purpose of the program is to:

(a) Provide adequate staff to complete behavioral health screenings; prescribe psychiatric medications as necessary; and provide mental health counseling, substance use disorder treatment pursuant to section 18-19-103 (5)(c)(V), and transitional care coordination;

(b) Train jail staff on behavioral health disorders and best practices in working with individuals with mental health, substance use, and co-occurring disorders; and

(c) Fund administrative costs to jails that implement the requirements outlined in subsection (3) of this section.

(3) The BHA shall prioritize jails with minimal behavioral health services, including but not limited to rural and frontier jails.

(4) Subject to available appropriations, the BHA shall require a county jail that receives funding through the program to:

(a) Screen all individuals booked into the jail facility with standardized evidence-based screening tools, as determined by the BHA, for mental health disorders, substance use disorders, and suicide risk;

(b) Assess all individuals when booked into the jail facility and at any time subsequent to booking when clinically indicated for substance use withdrawal symptoms and develop protocols for medical detoxification monitoring procedures, medication-assisted treatment, or other appropriate withdrawal management care, consistent with the requirements pursuant to sections 17-26-104.9 and 17-26-140;

(c) Assess all individuals booked into the jail facility for psychiatric medication needs by requesting and reviewing medical and prescription history;

(d) Have access to all psychiatric medications, as defined by the medication formulary established pursuant to section 27-70-103;

(e) Assist in the provision of coordinated services for individuals in jail custody who may require competency restoration services;

(f) Coordinate services with community behavioral health providers prior to the release of an inmate to ensure continuity of care following his or her release from the jail facility;

(g) Track performance outcomes for measures developed by the BHA, including behavioral health disorder prevalence and service data through information-sharing processes, as defined by the BHA; and

(h) Partner with the BHA to develop feasible health information exchange strategies for medical and behavioral health records.

(5) (a) The BHA shall require a county jail that receives funding through the program to have a policy in place on or before January 1, 2020, that describes how medication-assisted treatment, as defined in section 23-21-803, will be provided, when necessary, to individuals confined in the county jail. The BHA shall require a county jail that receives funding through the program to develop, implement, and publish a policy on or before January 1, 2023, that describes the provision of medication-assisted treatment and other appropriate withdrawal management care upon release from jail.

(b) A sheriff who is the custodian of a county jail or city and county jail may enter into agreements with community agencies, behavioral health organizations, and substance use disorder treatment organizations to assist in the development and administration of medication-assisted treatment in the jail.

(6) Subject to available appropriations, nothing in this section prohibits program funds from being used to meet the requirements outlined in sections 17-26-303 and 17-26-304 for local jails, as defined in section 17-26-302 (2), by providing additional staffing, training, robust behavioral health services and supports, or facility changes. Any facility changes must be approved by the BHA before funds may be expended.

Source: L. 2018: Entire section added, (SB 18-250), ch. 403, p. 2377, § 3, effective June 6. **L. 2019:** (5) added, (SB 19-008), ch. 275, p. 2599, § 7, effective August 2. **L. 2021:** (6) added, (HB 21-1211), ch. 322, p. 1982, § 3, effective June 24. **L. 2022:** (1), (3), IP(4), (4)(a), (4)(g), (4)(h), (5)(a), and (6) amended, (HB 22-1278), ch. 222, p. 1523, § 92, effective July 1; IP(4), (4)(b), and (5)(a) amended, (HB 22-1326), ch. 225, p. 1650, § 27, effective July 1.

Editor's note: Amendments to subsections IP(4) and (5)(a) by HB 22-1278 and HB 22-1326 were harmonized.

Cross references: For the legislative declaration in HB 22-1326 stating the purpose of, and the provision directing legislative staff agencies to conduct, a post-enactment review pursuant to § 2-

2-1201 scheduled in 2025, see sections 1 and 55 of chapter 225, Session Laws of Colorado 2022. To obtain a copy of the review, once completed, go to "Legislative Resources and Requirements" on the Colorado General Assembly's website.

27-60-106.5. Criminal justice diversion programs - report - rules.

(1) (a) The BHA may contract with cities and counties for the creation, maintenance, or expansion of criminal justice diversion programs. The goal of each program created pursuant to this section should be to connect first responders with behavioral health providers to assist individuals in need of behavioral health intervention or to divert individuals from the criminal justice system.

(b) The BHA may require criminal justice diversion programs contracted pursuant to subsection (1)(a) of this section to participate as a mobile crisis service in the behavioral health crisis response system, created pursuant to section 27-60-103.

(2) On or before November 1, 2021, and on or before each November 1 thereafter, the BHA shall include an update regarding the current status of funding and the criminal justice diversion programs implemented pursuant to this section in its report to the judiciary committees of the senate and the house of representatives, the health and human services committee of the senate, the public and behavioral health and human services committee of the house of representatives, or any successor committees, as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" presentation required by section 2-7-203.

(3) The state board of human services, created in section 26-1-107, may promulgate rules to implement the provisions of this section.

Source: L. 2020: Entire section added, (HB 20-1017), ch. 288, p. 1426, § 10, effective September 14. **L. 2022:** (1) and (2) amended, (HB 22-1278), ch. 222, p. 1524, § 93, effective July 1.

27-60-107. Behavioral health entity licenses - assistance - transfer of staff. (Repealed)

Source: L. 2019: Entire section added, (HB 19-1237), ch. 413, p. 3637, § 2, effective August 2. **L. 2022:** Entire section repealed, (HB 22-1278), ch. 222, p. 1524, § 94, effective July 1.

27-60-108. Peer support professionals - cash fund - fees - requirements - rules - legislative declaration - definitions.

(1) (a) The general assembly hereby finds and declares that:

(I) Peer support professionals help people achieve their recovery goals through shared understanding, respect, and empowerment. Peer support offers a form of acceptance, understanding, and validation not often found in other professional relationships.

(II) The federal centers for medicare and medicaid services recognize that peer support professionals can be an important component in a state's delivery of effective mental health and substance use disorder treatment;

(III) Peer support services can cut hospitalizations, increase a person's engagement in self-care and wellness, and help to decrease a person's psychotic symptoms;

(IV) The COVID-19 pandemic has exacerbated Colorado's existing behavioral health workforce shortage, particularly in rural areas and communities of color;

(V) Colorado lacks a behavioral health workforce that reflects the culture, ethnicity, sexual orientation, gender identity, mental health service experiences, and substance use disorder experiences of individuals in the state;

(VI) In the past two years, the number of people who have needed but have not received behavioral health services has nearly doubled. Challenges to the workforce is considered the leading cause for the decreased availability of behavioral health services. Peer support professionals can help fill Colorado's workforce need.

(VII) The substance abuse and mental health services administration has identified peer-run organizations as an evidence-based practice. Peer-run organizations may offer a variety of services, including but not limited to:

(A) Peer-run drop-in centers;

(B) Recovery and wellness centers;

(C) Employment services;

(D) Prevention and early intervention activities;

(E) Peer mentoring for children and adolescents;

(F) Warm lines; or

(G) Advocacy services.

(VIII) Peer-run organizations, including recovery community organizations, are important components in Colorado's behavioral health system. These organizations help individuals define their life goals and find a unique path toward recovery in a holistic manner.

(b) The general assembly finds, therefore, that it is in the best interest of the state to support the peer support professional workforce through the creation of peer-run recovery support services organizations. Peer-run and peer-led organizations will help expand peer support services throughout the state, expand the behavioral health workforce, and save the state money by reducing the need for crisis services.

(2) As used in this section, unless the context otherwise requires:

(a) "Licensed mental health provider" means a:

(I) Mental health professional licensed or certified pursuant to article 245 of title 12, except for unlicensed psychotherapists pursuant to article 245 of title 12;

(II) Advanced practice registered nurse registered pursuant to section 12-255-111 with training in substance use disorders or mental health;

(III) Physician assistant licensed pursuant to section 12-240-113 with specific training in substance use disorders or mental health;

(IV) Psychiatric technician licensed pursuant to article 295 of title 12; and

(V) Medical doctor or doctor of osteopathy licensed pursuant to article 240 of title 12.

(b) "Peer support professional" means a peer support specialist, recovery coach, peer and family recovery support specialist, peer mentor, family advocate, or family systems navigator who meets the qualifications described in subsection (3)(a)(III) of this section.

(c) "Recovery support services organization" means an independent entity led and governed by representatives of local communities of recovery and approved by the commissioner pursuant to subsection (3)(a) of this section.

(3) (a) On or before July 1, 2022, the BHA shall develop a procedure for recovery support services organizations to be approved by the commissioner for reimbursement pursuant to this section. The procedures must ensure that the recovery support services organization:

(I) Provides recovery-focused services and supports;

(II) Employs or contracts with a licensed mental health provider to administer on-going supervision of peer support professionals employed by recovery support services organizations. The licensed mental health provider must be in good standing and must demonstrate having received formal training specific to the provision of peer support services and supervision of peer support professionals;

(III) Employs or contracts with peer support professionals who must:

(A) Self-identify as having experienced the process of recovery from a mental health disorder, substance use disorder, trauma, or one or all of such conditions, either as a consumer of recovery services or as the parent or a family member of the consumer;

(B) Have successfully completed formal training covering all content areas outlined in the core competencies for peer support professionals established by either the BHA or the substance abuse and mental health services administration of the United States department of health and human services; and

(C) Provide nonclinical support services that align with recommendations from the substance abuse and mental health services administration of the United States department of health and human services, including engaging individuals in peer-to-peer relationships that support healing, personal growth, life skills development, self-care, and crisis-strategy development to help achieve recovery, wellness, and life goals;

(IV) Has an established process by which the organization coordinates its services with those rendered by other agencies to ensure an uninterrupted continuum of care to persons with behavioral health disorders; and

(V) Meets any other standards as determined by rule of the executive director.

(b) A peer support professional may provide services for a recovery support services organization in various clinical and nonclinical settings, including but not limited to:

(I) Justice-involved settings;

(II) Physical health settings, such as pediatrician or obstetric and gynecological health-care offices;

(III) Emergency departments;

(IV) Services delivered via telehealth;

(V) Agencies serving homeless communities;

(VI) Peer respite homes;

(VII) School-based health centers; and

(VIII) Home- and community-based settings.

(c) The commissioner, in collaboration with the department of health care policy and financing, may promulgate rules establishing minimum standards that recovery support services organizations must meet.

(4) The BHA may charge a fee for recovery support services organizations seeking approval pursuant to subsection (3)(a) of this section. If the commissioner charges a fee to recovery support services organizations, the commissioner shall promulgate rules to establish the fee in an amount not to substantially exceed the amount charged to other behavioral health providers seeking approval from the BHA. The BHA shall deposit any fees collected into the peer support professional workforce cash fund created in subsection (6) of this section.

(5) The BHA may seek, accept, and expend gifts, grants, or donations from private or public sources for the purposes of this section. The BHA shall transfer each gift, grant, and donation to the state treasurer, who shall credit the same to the peer support professional workforce cash fund created in subsection (6) of this section.

(6) (a) There is created in the state treasury the peer support professional workforce cash fund, referred to in this section as the "fund", which consists of:

(I) Fees collected pursuant to subsection (4) of this section;

(II) Gifts, grants, and donations collected pursuant to subsection (5) of this section; and

(III) Money appropriated to the fund by the general assembly.

(b) The state treasurer shall credit all interest and income derived from the deposit and investment of money in the fund to the fund.

(c) Any unexpended and unencumbered money remaining in the fund at the end of a fiscal year remains in the fund and is not transferred to the general fund or any other fund.

(d) Subject to annual appropriation by the general assembly, the BHA may expend state money from the fund for the purpose of implementing this section.

(7) A peer-run recovery service provider shall not be compelled to seek approval from the BHA to become a recovery support services organization. Expanded service funding available for recovery services through recovery support services organizations is intended to supplement existing state investment in the recovery system infrastructure. The BHA shall fund recovery services, within existing appropriations, including peer-run organizations that do not seek to be recovery support services organizations.

Source: L. 2021: Entire section added, (HB 21-1021), ch. 256, p. 1505, § 1, effective September 7. **L. 2022:** (2)(c), IP(3)(a), (3)(a)(III)(B), (3)(c), (4), (5), (6)(d), and (7) amended, (HB 22-1278), ch. 222, p. 1524, § 95, effective July 1.

27-60-109. Youth mental health services program - established - report - rules - definitions - repeal.

(1) As used in this section, unless the context otherwise requires:

(a) "Portal" means the website or web-based application described in subsection (4) of this section that facilitates the program.

(b) "Program" means the youth mental health services program established in this section.

(c) "Provider" means a licensed psychiatrist regulated pursuant to article 240 of title 12 or any of the following licensees, certified professionals, or candidates regulated pursuant to article 245 of title 12: A licensed psychologist or psychologist candidate; licensed social worker, licensed clinical social worker, or clinical social worker candidate; licensed marriage and family therapist or marriage and family therapist candidate; licensed professional counselor or licensed professional counselor candidate; or licensed addiction counselor, certified addiction specialist, or addiction counselor candidate.

(d) "Telehealth" has the same meaning set forth in section 10-16-123.

(e) "Youth" means:

(I) A person eighteen years of age or younger; and

(II) A person who is twenty-one years of age or younger but older than eighteen years of age who is receiving special education services pursuant to part 1 of article 20 of title 22.

(f) "Youth participant" means a youth who participates in a mental health session that is reimbursed pursuant to the program.

(2) (a) There is established in the behavioral health administration the youth mental health services program to facilitate access to mental health services, including substance use disorder services, for youth to respond to mental health needs identified in an initial mental health screening through the portal. The program reimburses providers for up to three mental health sessions with a youth.

(b) The BHA shall reimburse providers who participate in the program for each mental health session with a youth, either in-person or by telehealth, up to a maximum of three sessions per youth client; except that subject to available money, the BHA may reimburse a provider for additional sessions. To be eligible for reimbursement from the program, a provider must be available to provide three mental health sessions to each youth the provider accepts as a client.

(c) A provider shall maintain client confidentiality pursuant to state or federal law with regard to a youth client who participates in a mental health session with the provider that is reimbursed pursuant to the program.

(3) (a) The BHA shall:

(I) Develop a process consistent with the requirements of this section for providers to apply for, and demonstrate eligibility to receive, reimbursement from the program;

(II) Determine a reasonable rate of reimbursement for each mental health session with a youth client pursuant to the program, which rate must be the same regardless of whether the appointment is a telehealth or in-person appointment; and

(III) Implement a statewide public awareness and outreach campaign about the program. The general assembly encourages the BHA to involve schools, neighborhood youth organizations, health-care providers, faith-based organizations, and any other community-based organizations that interact with youth on the local level in disseminating information about the program.

(b) The state board may promulgate rules necessary for the administration of this section, including rules to protect the privacy of youth who receive services through the program.

(4) (a) The BHA shall enter into an agreement with a vendor to create, or use an existing, website or web-based application as a portal available to youth and providers to facilitate the program. The portal must:

(I) Serve as a platform for initial age-appropriate mental health screenings to determine if a youth may benefit from mental health support;

(II) Allow providers to register and share in-person or telehealth appointment availability;

(III) When possible, connect youth with providers who accept the youth's insurance or payment source that may cover the costs of ongoing mental health treatment, if the youth has insurance or a payment source; and

(IV) Allow a youth, regardless of whether the youth has insurance or any other payment source, to schedule telehealth appointments with a provider. An in-person appointment may be provided if and when available.

(b) Repealed.

(4.5) (a) On or before June 1 of each year, the vendor described in subsection (4) of this section shall deliver to the BHA any of the following, collected during the prior year:

(I) Information about the program collected from surveys of youth participants, parents, and providers; and

(II) Data from evaluations conducted by the vendor about the efficacy of the program, including whether the program is serving the mental health needs of youth participants.

(b) The BHA shall conduct a survey of each provider who participates in the program that solicits feedback about the following:

(I) The met and unmet mental health needs of the youth participants who engaged in treatment with the provider;

(II) Whether the provider made referrals for youth participants for additional services beyond what is provided pursuant to the program; and

(III) Any other elements of the program.

(c) This subsection (4.5) does not authorize the BHA, a provider, a vendor, or any other person to violate applicable federal or state patient privacy laws.

(5) On or before June 30 of each year, the state department shall report to the house of representatives health and human services committee and the senate health and human services committee, or their successor committees, regarding the number of youth who received services under the program, excluding any personally identifiable information in accordance with state and federal law; information in aggregate about the services provided to youth under the program; other relevant information regarding the program; and the information reported to the BHA by the vendor pursuant to subsection (4.5) of this section.

(5.5) Repealed.

(6) This section is repealed, effective June 30, 2034.

Source: L. 2021: Entire section added, (HB 21-1258), ch. 265, p. 1542, § 2, effective June 18. **L. 2022:** (5) and (6) amended and (5.5) added, (HB 22-1243), ch. 189, p. 1263, § 3, effective May 19; (2)(a), (2)(b), IP(3)(a), (3)(a)(III), (3)(b), and IP(4)(a) amended, (HB 22-1278), ch. 222, p. 1525, § 96, effective July 1. **L. 2024:** (1)(b), (2)(a), (5), and (6) amended, (1)(f) and (4.5) added, and (4)(b) repealed, (SB 24-001), ch. 367, p. 2469, § 1, effective June 4. **L. 2026:** (5) amended, (SB 26-169), ch. 311, p. 1812, § 54, effective August 12.

Editor's note: Subsection (5.5)(c) provided for the repeal of subsection (5.5), effective June 30, 2024. (See L. 2022, p. 1263).

Cross references: For the legislative declaration in HB 21-1258, see section 1 of chapter 265, Session Laws of Colorado 2021. For the legislative declaration in HB 22-1243, see section 1 of chapter 189, Session Laws of Colorado 2022.

27-60-110. Behavioral health-care services for rural and agricultural communities - vouchers - contract - appropriation.

(1) No later than one hundred eighty days after June 28, 2021, the BHA, in collaboration with the department of agriculture, shall contract with a nonprofit organization primarily focused on serving agricultural and rural communities in Colorado, as identified by the BHA, to provide vouchers to individuals living in rural and frontier communities in need of behavioral health-care services.

(2) The nonprofit organization awarded the contract pursuant to subsection (1) of this section shall:

(a) Contract with licensed behavioral health-care providers that have completed training on cultural competencies specific to the Colorado agricultural and rural community lifestyle to provide direct behavioral health-care services to farmers, ranchers, farm and ranch workers and their families, and other underserved populations in rural and agricultural communities. At least sixty percent of the money received pursuant to the contract must be used for direct behavioral health-care services described in this subsection (2)(a).

(b) Develop training materials and train behavioral health-care providers on cultural competencies specific to the Colorado agricultural and rural community lifestyle.

(3) For the 2026-27 fiscal year, and each fiscal year thereafter, the general assembly may annually appropriate money for the contract awarded pursuant to subsection (1) of this section.

Source: L. 2021: Entire section added, (SB 21-137), ch. 362, p. 2367, § 14, effective June 28. **L. 2022:** (1) amended, (HB 22-1278), ch. 222, p. 1526, § 97, effective July 1. **L. 2026:** (3) amended, (HB 26-1378), ch. 245, p. 1392, § 4, effective May 29.

Cross references: For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

27-60-111. County-based behavioral health grant program - created - report - rules - repeal. (Repealed)

Source: L. 2021: Entire section added, (SB 21-137), ch. 362, p. 2368, § 15, effective June 28. **L. 2022:** (1), (2)(o), (3), (4), (6), (7), (8), and (9) amended, (HB 22-1278), ch. 222, p. 1526, § 98, effective July 1.

Editor's note: Subsection (10) provided for the repeal of this section, effective July 1, 2023. (See L. 2021, p. 2368.)

27-60-112. Behavioral health-care workforce development program - creation - rules - report.

(1) There is created in the behavioral health administration the behavioral health-care workforce development program, referred to in this section as the "program". The purpose of the program is to increase the behavioral health-care workforce's ability to treat individuals, including youth, with severe behavioral health disorders.

(2) To implement the program, the BHA shall:

(a) Develop an online training system that allows for accessible statewide training opportunities;

(b) (I) Develop an online training curriculum for providers in rural and metro areas to increase competencies in mental health and substance use disorders that will support a high-quality, trained, culturally responsive, and diverse behavioral health-care workforce.

(II) The office shall also:

(A) Develop a process to track, store, and create reports concerning the training and continuing education in the curriculum developed pursuant to subsection (2)(b)(I) of this section and to track providers' completion of in-person and virtual training offered pursuant to this subsection (2)(b); and

(B) Collaborate with credentialing entities to track peer support professionals in the state.

(c) Provide fiscal incentives for lower income individuals to obtain a degree in behavioral health, with funding specifically targeted for rural areas of the state;

(d) Provide training to the existing behavioral health-care workforce to be certified in federally reimbursed services; and

(e) Provide capacity-building grants to diversify the safety net provider workforce and meet the requirements of part 3 of article 50 of this title 27.

(3) The state board may promulgate rules as necessary for the implementation of this section.

(4) For the state fiscal year 2021-22 and each state fiscal year thereafter for which the program receives funding, the BHA shall report a summary of the expenditures from the program, the impact of the expenditures in increasing the behavioral health-care workforce, and any recommendations to strengthen and improve the behavioral health-care workforce as part of

its annual presentation to the general assembly required under the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", part 2 of article 7 of title 2.

Source: L. 2021: Entire section added, (SB 21-137), ch. 362, p. 2370, § 16, effective June 28. **L. 2022:** (1), IP(2), (2)(e), (3), and (4) amended, (HB 22-1278), ch. 222, p. 1528, § 99, effective July 1; (2)(b) amended, (SB 22-181), ch. 452, p. 3252, § 5, effective July 1.

Editor's note: Section 38 of chapter 362 (SB 21-137), Session Laws of Colorado 2021, provides that section 16 of the act adding this section takes effect only if SB 21-288 becomes law and takes effect either upon the effective date of SB 21-137 or one day after the passage of SB 21-288, whichever is later. SB 21-288 became law and took effect June 11, 2021, and SB 21-137 took effect June 28, 2021.

Cross references: (1) For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

(2) For the legislative declaration in SB 22-181, see section 1 of chapter 452, Session Laws of Colorado 2022.

27-60-113. Out-of-home placement for children and youth with mental or behavioral needs - rules - report - legislative declaration - repeal. (Repealed)

Source: L. 2021: Entire section added, (SB 21-137), ch. 362, p. 2371, § 17, effective June 28. **L. 2022:** Entire section repealed, (HB 22-1283), ch. 185, p. 1244, § 4, effective May 18; (2) amended, (HB 22-1295), ch. 123, p. 863, § 115, effective July 1.

Editor's note: (1) Subsection (2) was amended in HB 22-1295. Those amendments were superseded by the repeal of this section in HB 22-1283.

(2) This section was relocated to § 26-5-117.

Cross references: (1) For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

(2) For the legislative declaration in HB 22-1283, see section 1 of chapter 185, Session Laws of Colorado 2022.

27-60-114. Colorado land-based tribe behavioral health services grant - creation - funding - definitions - repeal.

(1) As used in this section, unless the context otherwise requires:

(a) "Colorado land-based tribe" means the southern Ute Indian tribe and the Ute mountain Ute tribe.

(b) "Grant applicant" means the southern Ute Indian tribe, the Ute mountain Ute tribe, or any authorized department, division, or affiliate thereof that applies for the grant pursuant to this section.

(c) "Grant program" means the Colorado land-based tribe behavioral health services grant program created in subsection (2) of this section.

(d) "Grant recipient" means the southern Ute Indian tribe, the Ute mountain Ute tribe, or any authorized department, division, or affiliate thereof that is awarded the grant pursuant to this section.

(2) There is created in the state department the Colorado land-based tribe behavioral health services grant program to provide funding to one or more Colorado land-based tribes to support capital expenditure for the renovation or building of a behavioral health facility to provide behavioral and mental health services as the grant recipient may deem appropriate, which services may include inpatient services and transitional housing to principally or fully serve American Indian and Alaska native individuals, including those who may be eligible for Indian health service benefits.

(3) The grant recipient may use the money received through the grant program for capital expenditure costs associated with renovating an existing behavioral health facility or building a new behavioral health facility to provide behavioral health services as the grant recipient may deem appropriate, which may include inpatient behavioral health services and transitional housing, to principally serve the American Indian and Alaska native patients including those who may be eligible for Indian health service benefits. Subject to available appropriations, the state department shall implement and administer the grant program and shall award the grant to the grant recipient in an amount not greater than five million dollars.

(4) An eligible Colorado land-based tribe may apply to the state department in accordance with the procedures, time frames, and requirements set by the state department to receive money through the grant program.

(5) The state department shall review applications received from grant applicants pursuant to this section.

(6) To receive a grant, a grant applicant must submit an application to the state department in the form prescribed by the state department.

(7) The state department may select a grant recipient to receive the grant under this grant program in an amount not greater than five million dollars.

(8) To be eligible to receive a grant, a grant applicant that requests grant money that originates from the money the state received from the coronavirus state fiscal recovery fund must submit to the state department a written justification as set forth in 31 CFR 35.6 (b)(4) for the capital expenditure; except that this requirement does not apply if the state department determines that the written justification is not required based on how the expenditures authorized pursuant to this section will be reported to the United States department of the treasury. For money that did not originate from the money the state received from the coronavirus state fiscal recovery fund, a written justification is not required, except as the state department determines necessary to comply with federal written justification requirements.

(9) The state department and the grant recipient shall comply with the compliance, reporting, record-keeping, and program evaluation requirements established by the office of state planning and budgeting and the state controller in accordance with section 24-75-226 (5).

(10) For state fiscal year 2022-23, the general assembly shall appropriate five million dollars from the behavioral and mental health cash fund created in section 24-75-230 to the state department to be used for the purposes of this section.

(11) The state department shall distribute the grant money to the grant recipient within thirty days after the grant recipient submits a written justification specified in subsection (8) of this section but not later than December 31, 2024. The grant recipient shall spend or obligate all grant money awarded to the grant recipient in accordance with section 24-75-226 (4)(d).

(12) This section is repealed, effective July 1, 2027.

Source: L. 2022: Entire section added, (SB 22-148), ch. 217, p. 1428, § 2, effective May 24. **L. 2024:** (8) and (11) amended, (HB 24-1466), ch. 429, p. 2944, § 38, effective June 5.

Cross references: For the legislative declaration in SB 22-148, see section 1 of chapter 217, Session Laws of Colorado 2022. For the legislative declaration in HB 24-1466, see section 1 of chapter 429, Session Laws of Colorado 2024.

27-60-115. Behavioral health feasibility study - authority to contract - report - definitions - appropriation. (Repealed)

Source: L. 2023: Entire section added, (HB 23-1153), ch. 283, p. 1672, § 1, effective May 30. **L. 2026:** Entire section repealed, (HB 26-1295), ch. 121, p. 528, § 31, effective August 12.

27-60-116. Withdrawal management facilities - data collection - approval of admission criteria - definition.

(1) (a) No later than July 1, 2025, the behavioral health administration shall collect data from each withdrawal management facility on the total number of individuals who were denied admittance or treatment for withdrawal management during the previous calendar year and the reason for the denial.

(b) The BHA shall share the data received from withdrawal management facilities pursuant to subsection (1)(a) of this section with behavioral health administrative services organizations.

(2) Beginning January 1, 2025, the BHA shall review and approve any admission criteria established by a withdrawal management facility, as defined in section 27-66.5-102.

(3) As used in this section, "withdrawal management facility" has the same meaning as set forth in section 27-66.5-102.

Source: L. 2024: Entire section added, (HB 24-1045), ch. 470, p. 3288, § 22, effective August 7 (see editor's note).

Editor's note: Section 32 of chapter 470, (HB 24-1045), Session Laws of Colorado 2024, provides that subsection (1)(b) takes effect July 1, 2025, and the remainder of the section takes effect August 7, 2024.

27-60-117. Crisis response continuum of care - reimbursement shortages and gaps - report - repeal.

(1) On or before January 1, 2027, the behavioral health administration, in collaboration with the department of health care policy and financing, shall provide information to the house of representatives health and human services committee and the senate health and human services committee, or their successor committees, and any impacted state agency, regarding the reimbursement shortages and gaps within the continuum of care for behavioral health crisis response, and reimbursement and funding options at the state and federal level that are available to address shortages and gaps, including funding for treatment in place.

(2) This section is repealed, effective June 30, 2027.

Source: L. 2025: Entire section added, (SB 25-042), ch. 28, p. 158, § 2, effective August 6.

PART 2

BEHAVIORAL HEALTH ADMINISTRATION

27-60-201. Legislative declaration.

(1) The general assembly finds and declares that:

(a) On April 8, 2019, the Colorado behavioral health task force was created, bringing together individuals representing diverse and balanced perspectives with respect to issues such as adults, children, and families who are dealing with mental health or substance use issues, key executive agencies representing state, local, and tribal governments, criminal justice experts, advocacy groups, behavioral health experts, and consumers;

(b) The mission of the behavioral health task force was to evaluate and create a plan to improve the current behavioral health system in Colorado;

(c) The behavioral health task force focused on creating a behavioral health system that includes equitable access to whole-person care;

(d) In September 2020, the behavioral health task force released its blueprint, subcommittee, and COVID-19 special committee reports that outline its vision for behavioral health reform; and

(e) The findings and recommendations of the task force indicate that it is imperative that an improved behavioral health system in Colorado:

(I) Provide equitable and meaningful access to services and care for Coloradans, regardless of ability to pay, co-occurring conditions, disability, linguistics, geographic location, racial or

ethnic identity, religion, socioeconomic status, sexual orientation, age, gender identity, housing status, history of criminal justice involvement, payer source, culture, or any other factor;

(II) Provide access to care that:

(A) Integrates physical and behavioral health;

(B) Is culturally and linguistically responsive, trauma-informed, and tailored to the individual and specific family needs; and

(C) Prioritizes all aspects of health, including wellness, and early interventions and supports that help people stay successfully and meaningfully connected to the community where they live, work, and play;

(III) Provides a continuum of services for children, youth, and adults, including meeting the unique needs of children and youth. Young people have different needs than adults and should be offered developmentally appropriate and culturally competent services.

(IV) Provides access to quality and affordable services in a variety of methods, including in-person and virtual services;

(V) Provides access to behavioral health services in regions and communities without necessitating engagement with the criminal or juvenile justice systems;

(VI) Provides Coloradans with access to affordable care that keeps them healthy, and administrative efficiencies across the behavioral health-care industry align with payment models and incentives that drive quality and improved outcomes;

(VII) Includes a high-quality, trained, culturally responsive, trauma-informed, and diverse professional behavioral health workforce that delivers outcomes and equitable access to care; and

(VIII) Provides Coloradans with an opportunity to achieve and maintain mental wellness by addressing social determinants of health, such as housing, transportation, and employment, in addition to the integration of physical and behavioral health care.

(2) The general assembly further finds that in implementing the findings and recommendations of the Colorado behavioral health task force it is imperative to rely on all stakeholders working together to hold the behavioral health system accountable to ensure all Coloradans are receiving the care needed to fulfill the task force's aim of ensuring a quality behavioral health system.

(3) Therefore, the general assembly declares that, to ensure a standard of high-quality, integrated, and consumer-centric access to behavioral health-care services, it is imperative that the recommendations and findings included in the blueprint created by the Colorado behavioral health task force be followed and that a single state agency, known as the behavioral health administration, be established to lead and promote the state's behavioral health priorities. It is

imperative that the behavioral health administration transform the state's current behavioral health system by:

(a) Coordinating and integrating the delivery of behavioral health services in Colorado;

(b) Setting standards for the behavioral health system to improve the quality and equity of care;

(c) Ensuring that behavioral health services respond to the changing needs of communities, monitor state and local outcomes, support tribal needs, and evaluate state efforts;

(d) Improving equitable access to, quality of, and affordability of behavioral health services for Coloradans;

(e) Preserving and building upon the integration of behavioral and physical health care that treats the whole person;

(f) Leading and promoting Colorado's priority of addressing the increasing need for behavioral health services;

(g) Eliminating unnecessary fragmentation of services and streamlining access;

(h) Addressing social determinants of health as a core component of behavioral health outcomes;

(i) Promoting transparency and accountability of behavioral health reform outcomes and spending of taxpayer dollars; and

(j) Reducing administrative burden on behavioral health-care providers so they are able to focus on client care.

Source: L. 2021: Entire part added, (HB 21-1097), ch. 48, p. 198, § 1, effective April 22.

27-60-202. Definitions.

As used in this part 2, unless the context otherwise requires:

(1) "Behavioral health" has the same meaning as set forth in section 27-60-100.3.

(2) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-50-102.

(2.5) "Care coordination" means services that support individuals and families and initiate care and navigating crisis supports, mental health and substance use disorder assistance, and services that address the social determinants of health, and preventive care services.

(3) Repealed.

(4) "State department" means the state department of human services created pursuant to section 26-1-105.

Source: L. 2021: Entire part added, (HB 21-1097), ch. 48, p. 201, § 1, effective April 22; (2.5) added, (SB 21-137), ch. 362, p. 2374, § 18, effective June 28. **L. 2022:** (2) amended and (3) repealed, (HB 22-1278), ch. 222, p. 1531, § 101, effective July 1.

Cross references: For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

27-60-203. Behavioral health administration - timeline.

(1) to (4) Repealed.

(5) (a) On or before July 1, 2022, the behavioral health administration is established in the state department. During the time it takes for the BHA to become fully operational, it remains a part of the state department until a determination is made by the general assembly concerning the department it will be permanently located in.

(b) On or before November 1, 2024, the state department shall provide a report to the joint budget committee, the public and behavioral health and human services committee of the house of representatives, and the health and human services committee of the senate, or any successor committees, concerning recommendations on whether the BHA should remain in the state department or be transferred to a different department within the state.

(c) If the general assembly takes no additional legislative action on or before June 30, 2025, the BHA will remain in the state department.

Source: L. 2021: Entire part added, (HB 21-1097), ch. 48, p. 201, § 1, effective April 22. **L. 2022:** (1), (2), (3), and (4) repealed, (HB 22-1278), ch. 222, p. 1531, § 102, effective July 1.

27-60-204. Care coordination infrastructure - implementation - care navigation program - creation - report - rules - definition.

(1) **Care coordination infrastructure.**

(a) No later than July 1, 2024, the BHA, in collaboration with the department of health care policy and financing, shall develop a statewide care coordination infrastructure to drive accountability and more effective behavioral health navigation to care that builds upon and collaborates with existing care coordination services. The infrastructure must include:

(I) A website and mobile application that serves as a centralized gateway for information for patients, providers, and care coordination and that facilities access and navigation of behavioral health-care services and support; and

(II) A cloud-based platform to allow providers that do not utilize an electronic health record to actively participate in the care coordination infrastructure.

(b) The BHA shall convene a working group of geographically and demographically diverse partners and stakeholders, including those with lived and professional experience, to provide feedback and recommendations that inform and guide the development of the statewide care coordination infrastructure developed pursuant to subsection (1)(a) of this section.

(c) The department of health care policy and financing, the division of insurance in the department of regulatory agencies, and the working group created pursuant to subsection (1)(b) of this section shall determine how medicaid and private insurance existing care coordination services are aligned with the statewide care coordination infrastructure described in subsection (1)(a) of this section.

(d) The BHA shall implement, directly or through a contractor, a comprehensive and robust marketing and outreach plan to make Coloradans aware of the website, mobile application, cloud-based platform, and associated care coordination services developed pursuant to subsection (1)(a) of this section.

(2) The BHA shall ensure navigators are available through the website and mobile application developed pursuant to subsection (1)(a) of this section, as well as in specific regional locations. The statewide care coordination infrastructure is responsible for providing regional access to care coordination services.

(3) The BHA shall utilize behavioral health administrative services organizations established pursuant to part 4 of article 50 of this title 27 to help individuals and families initiate care and ensure timely access to person-centered, trauma-informed, and culturally responsive quality crisis supports; mental health and substance use disorder services; and preventive care services, including services that address the social determinants of health. When possible, the care coordination infrastructure must integrate with other health-care system resources to serve individuals with complex needs.

(4) In implementing the care coordination infrastructure developed pursuant to subsection (1) of this section, the BHA shall:

(a) Train new and existing navigators on the behavioral health safety net system services for children, youth, and adults, behavioral health service delivery procedures, and social determinants of health resources. At a minimum, the BHA shall train existing managed care entity providers, employees of the 988 crisis hotline enterprise created in section 27-64-103, 911 dispatchers, BHA care coordinators and navigators, and other providers participating in other safety net provider settings;

(b) Ensure that the care coordination infrastructure can direct individuals where to seek in-person or virtual navigation support;

(c) Ensure that the administrative burden associated with provider enrollment and credentialing for navigators and care coordination providers is minimal;

(d) As part of the annual report submitted pursuant to section 27-50-204, include a summary of outcomes for individuals who access the statewide care coordination infrastructure; and

(e) Ensure the 988 crisis hotline established pursuant to article 64 of this title 27:

(I) Responds to anyone experiencing a mental health or substance use crisis;

(II) Documents referrals and transfers of care of persons with one or more community-based service providers, such as care coordination and care navigation services; and

(III) Includes connections to:

(A) The forthcoming Colorado behavioral health resource navigation system, which more quickly links individuals in crisis with available services;

(B) The statewide and regional care coordination system;

(C) Peer support services; and

(D) The behavioral health crisis response system created pursuant to section 27-60-103.

(5) Each behavioral health administrative services organization established pursuant to part 4 of article 50 of this title 27 shall:

(a) Utilize navigators trained in the use of the care coordination infrastructure pursuant to subsection (4)(a) of this section to identify community-based and social determinants of health services and capacity, including on-the-ground local support to encourage participation and engagement in services;

(b) Utilize navigators and coordinators to support individuals in connecting to the safety net system created pursuant to part 3 of article 50 of this title 27, including services not covered by an individual's insurance;

(c) Monitor and report quarterly on the safety net system and safety net providers to support accountability in connecting individuals to services and the delivery of those services to individuals with the highest needs;

(d) Support continued connection with the safety net system after an individual is discharged from hospitalization, the criminal justice system, an emergency department, or other behavioral health facilities, including withdrawal management facilities and jails, by building multi-sector, multi-system referral and outcome tracking into the care coordination system;

(e) Require contracted providers to use the statewide care coordination system, report on outcomes, including how and when individuals accessed care, and work collaboratively with the care coordination entity to ensure individuals receive needed services in a timely manner; and

(f) Any other duties required by law or the BHA.

(6) Beginning January 2025, and each January thereafter, the department of health care policy and financing shall assess the care coordination services provided by managed care entities and provide a report as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" hearing required by section 2-7-203. At a minimum, the report must include:

(a) The number of individuals served by each managed care entity through care coordination;

(b) Data on care coordination services provided by each managed care entity, including follow-up contacts to ensure clients were connected to services;

(c) Data on efforts made to reconnect with individuals who did not initially follow through on care coordination services;

(d) Data on referrals to community-based services and follow-up services by each managed care entity for individuals served through care coordination services; and

(e) Data on the utilization of care navigation services pursuant to subsection (9) of this section in accordance with state and federal health-care privacy laws.

(7) The BHA and any person that receives money from the state department shall comply with the compliance, reporting, record-keeping, and program evaluation requirements established by the office of state planning and budgeting and the state controller in accordance with section 24-75-226 (5).

(8) Repealed.

(9) **Care navigation program.**

(a) As used in this section, "engaged client" means an individual who is interested in and willing to engage in substance use disorder treatment and recovery services or other treatment services either for the individual or an affected family member or friend.

(b) Subject to available appropriations, the BHA shall implement a care navigation program to assist engaged clients in obtaining access to treatment for substance use disorders. At a minimum, services available statewide must include independent screening of the treatment needs of the engaged client using nationally recognized screening criteria to determine the correct level of care; the identification of licensed or accredited substance use disorder treatment options, including social and medical detoxification services, medication-assisted treatment, and inpatient and outpatient treatment programs; and the availability of various treatment options for the engaged client.

(c) To implement the care navigation program, the BHA shall, directly or through contract, provide care navigation services and align the care navigation services with the care coordination infrastructure established pursuant to this section.

(d) The state board may promulgate any rules necessary to implement the care navigation program.

Source: L. 2021: Entire section added, (SB 21-137), ch. 362, p. 2374, § 19, effective June 28. **L. 2022:** Entire section amended, (SB 22-177), ch. 223, p. 1607, § 2, effective July 1; (1)(a), (1)(b), (1)(d), and (2) amended, (HB 22-1278), ch. 222, p. 1533, § 103, effective July 1. **L. 2023:** IP(1)(a), (6)(c), and (6)(d) amended, (6)(e) added, and (9) added with relocations, (HB 23-1236), ch. 206, p. 1064, § 34, effective May 16.

Editor's note: (1) Subsection (8)(b) provided for the repeal of subsection (8), effective July 1, 2023. (See L. 2022, p. 1607.)

(2) Subsections (9)(a), (9)(b), (9)(c), and (9)(d) are similar to former § 27-80-119 (2), (3), (4), and (7), respectively, as they existed prior to 2023.

Cross references: (1) For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

(2) For the legislative declaration in SB 22-177, see section 1 of chapter 223, Session Laws of Colorado 2022.

27-60-205. (Reserved)

27-60-206. Substance use workforce stability grant program - repeal.

(1) There is established in the BHA the substance use workforce stability grant program, referred to in this section as the "grant program". The BHA shall administer the grant program and shall develop policies and procedures for the grant program, which must include a grant application process, criteria for awarding grants and determining the amount of a grant award, and the timeline for awarding grants and distributing grant money.

(2) A substance use disorder treatment provider or a recovery provider, including providers that serve children, and a local government, as defined in section 27-60-501, is eligible for a grant. In order to receive a grant, a provider must submit an application to the BHA and must prioritize providing services to voluntary and civil clients.

(3) The BHA shall accept and review grant applications and award grants. The BHA shall prioritize awarding grants to providers that offer same-day or next-day appointments, serve low-income and marginalized populations, or intend to expand the number of individuals they serve.

(4) A grant recipient shall use a grant award to support direct care staff who spend fifty percent or more of their time working with clients. Supporting direct care staff may include temporary salary increases, recruitment and retention bonuses, and other tactics that support staff.

(5) (a) The general assembly shall appropriate to the state department money from the behavioral and mental health cash fund created in section 24-75-230 for the grant program.

(b) The state department, BHA, and any person who receives money from the BHA, including each grant recipient, shall comply with the compliance, reporting, record-keeping, and program evaluation requirements established by the office of state planning and budgeting and the state controller in accordance with section 24-75-226 (5).

(6) This section is repealed, effective June 30, 2027.

Source: L. 2022: Entire section added, (HB 22-1281), ch. 182, p. 1218, § 3, effective May 18. **L. 2025:** (5)(a) amended, (SB 25-312), ch. 301, p. 1538, § 16, effective May 30.

Cross references: For the legislative declaration in HB 22-1281, see section 1 of chapter 182, Session Laws of Colorado 2022.

27-60-207. Ibogaine research pilot program - creation - federal approval - fund - rules - reporting - definitions - repeal.

(1) As used in this section, unless the context otherwise requires:

(a) "Benefit-sharing plan" means an arrangement with Indigenous communities traditionally connected to the use of ibogaine or iboga that is intended to share in the benefits that arise from the research, therapeutic use, or commercialization of ibogaine or iboga. Benefits may include:

(I) Financial benefit sharing;

(II) Collaborative research or data sharing;

(III) Conservation support for plant species and habitats;

(IV) Community-identified development priorities;

(V) Cultural or educational exchanges; and

(VI) Utilizing a source for ibogaine that engages in benefit-sharing and ethical and sustainable cultivation practices.

(b) "Fund" means the ibogaine research pilot program cash fund created in subsection (10) of this section.

(c) "Ibogaine pilot site" means a facilitation site selected and authorized by the BHA to administer the pilot program.

(d) "Pilot program" means the ibogaine research pilot program established in subsection (2) of this section.

(2) There is established in the BHA the ibogaine research pilot program for the purpose of supporting research on the safety and effectiveness of using ibogaine to treat mental health conditions and substance use disorders.

(3) The BHA shall operate the pilot program. In operating the pilot program, the BHA:

(a) May approve up to five ibogaine pilot sites;

(b) May require a memorandum of understanding with each pilot site to ensure proper administration of the pilot program;

(c) In partnership with the ibogaine pilot sites, and in coordination with other appropriate state agencies, may seek federal authorization pursuant to 21 U.S.C. sec. 872(e) or other applicable federal law for purposes of expanding or advancing ibogaine research efforts;

(d) Shall assist the ibogaine pilot sites to complete and submit an investigational new drug application or revise and expand upon an existing investigational new drug application with the United States food and drug administration in accordance with 21 CFR part 312;

(e) Shall consider whether to obtain federal research program status under 21 U.S.C. sec. 872 or other applicable federal law for the purposes of expanding or advancing research efforts of the pilot sites;

(f) May negotiate a memorandum of understanding with the United States drug enforcement administration, United States department of health and human services, United States food and drug administration, United States attorney general, or any other appropriate federal agency, as necessary to ensure federal compliance and proper administration of the pilot program;

(g) May contract with individuals with expertise in behavioral health, nursing, researching a schedule I controlled substance, drug development, institutional review board and United States food and drug administration regulatory compliance, and physician consultation services to assist in the administration of the pilot program;

(h) May assist ibogaine pilot sites with funding opportunities, including identifying and applying for state, federal, or private grants;

(i) May award grants to selected ibogaine pilot sites to assist with operational costs; and

(j) May collaborate and enter into agreements with other states, state agencies, federally recognized tribes, and public or private entities to participate in multi-state consortia or similar efforts, including the sharing of data, funding, research, clinical protocols, and regulatory best practices related to ibogaine and ibogaine-related therapies.

(4) (a) The BHA shall establish a process to solicit and select ibogaine pilot sites.

(b) The BHA shall establish a pilot proposal review committee to review applications received from the solicitation process required by subsection (4)(a) of this section and make a recommendation to the BHA on the selection or denial of each application. The BHA shall notify each applicant of the selection decision within ninety days after the application deadline set by the BHA.

(5) To be eligible as an ibogaine pilot site, an applicant must:

(a) Demonstrate an intent to pursue the federal approval to operate an ibogaine pilot site to study safety and treatment effectiveness of the use of ibogaine to treat mental health conditions and substance use disorders; and

(b) Establish a benefit-sharing plan, which may be developed in consultation with Indigenous communities or their recognized governing institutions traditionally connected to ibogaine or iboga, that directly benefits those communities and shares in the benefits arising from research, therapeutic use, or commercialization of ibogaine or iboga. The benefit-sharing plan must include documentation of the sourcing of ibogaine or iboga.

(c) In developing a benefit-sharing plan pursuant to this subsection (5), applicants may consider internationally recognized principles related to equitable benefit sharing that may arise from the use of resources and traditional knowledge.

(6) (a) The commissioner shall adopt rules that are necessary to establish and administer the ibogaine pilot program. At a minimum, the commissioner shall adopt rules on the following:

(I) The application process for prospective ibogaine pilot site applicants;

(II) Criteria for awarding grants to ibogaine pilot sites to assist the ibogaine pilot site with funding;

(III) Data and research collection by the ibogaine pilot sites on the use and effectiveness of ibogaine in treating mental health conditions and substance use disorders;

(IV) Information sharing between the ibogaine pilot sites and the BHA;

(V) Adverse event reporting; and

(VI) Other rules that are necessary for the safe and effective operation of the ibogaine pilot sites and administration of the ibogaine research pilot program established by this section.

(b) With the exception of the requirements of subsection (6)(a) of this section, the commissioner shall not adopt rules that are duplicative of federal law.

(7) On or before a date set by the BHA and annually thereafter that the pilot program is operational, each ibogaine pilot site must submit the data and research as required pursuant to subsection (6)(a)(III) of this section for the proceeding year to the BHA.

(8) At least annually, but not more than quarterly, beginning one month after the date set by the BHA described in subsection (7) of this section while the pilot program is operational, the BHA must review the data and research submitted by the ibogaine pilot sites, as required by subsection (7) of this section, and post a report detailing the ibogaine pilot site findings on the BHA's website.

(9) The BHA may seek, accept, and expend gifts, grants, or donations received from private or public sources for the purposes of this section. The BHA shall transmit all money received through gifts, grants, or donations to the state treasurer, who shall credit the money to the ibogaine research pilot program cash fund created in subsection (10) of this section. The BHA may accept donations of in-kind services for purposes of this section.

(10) The ibogaine research pilot program cash fund is created in the state treasury. The fund consists of gifts, grants, and donations credited to the fund pursuant to subsection (9) of this section and any other money that the general assembly may appropriate or transfer to the fund. The state treasurer shall credit all interest and income derived from the deposit and investment of money in the fund to the fund. Money in the fund is continuously appropriated to the BHA for

the purpose of administering the ibogaine research pilot program and awarding grants to selected ibogaine pilot sites.

(11) The operation of an ibogaine pilot site in accordance with this section is contingent on federal approval.

(12) This section does not preclude a person from administering ibogaine outside of the pilot program in compliance with federal law or as permitted pursuant to the "Natural Medicine Health Act of 2022", article 170 of title 12, and the "Colorado Natural Medicine Code", article 50 of title 44.

(13) An individual or entity participating in the pilot program must not be prosecuted or otherwise disciplined for actions or conduct permitted pursuant to this section.

(14) (a) A physician or health-care professional administering ibogaine to participants as part of the pilot program, or an ibogaine pilot site, is not liable for money damages in a civil malpractice action, a physical or psychological injury that a participant may experience as a result of being administered ibogaine as a participant in the pilot program, unless the injury was the direct result of the physician's or health-care professional's intentional misconduct, gross negligence, or a deviation from the generally accepted standards of practice.

(b) This subsection (14) does not apply to administrative proceedings.

(15) The BHA shall work to secure federal research and development funding available through the advanced research projects agency for health within the federal department of health and human services, or other available federal funding, in order to advance research efforts on the use of ibogaine as a treatment for serious mental illnesses.

(16) Subsections (1), (2), (3), (4), (5), (6), (7), (8), (11), (12), (13), (14), and (15) of this section take effect if the BHA receives one hundred fifty thousand dollars in gifts, grants, or donations, or if the BHA receives in-kind donations for which the value is equal to one hundred fifty thousand dollars, before January 1, 2028, for the purpose of implementing this section. The commissioner of the BHA shall notify the revisor of statutes in writing of the date on which the condition specified in this subsection (16) has occurred by emailing the notice to revisorofstatutes.ga@coleg.gov. Subsections (1), (2), (3), (4), (5), (6), (7), (8), (11), (12), (13), (14), and (15) of this section take effect on the date identified in the notice to the revisor of statutes that the BHA has received one hundred fifty thousand dollars in gifts, grants, or donations, or an in-kind donation for which the value is equal to one hundred fifty thousand dollars, for the purpose of this section, or, if the notice to the revisor of statutes does not specify that date, on the date of the notice to the revisor of statutes.

(17) (a) The BHA must receive additional gifts, grants, or donations in the amount necessary to cover the total remaining cost of operating the pilot program for the duration of the pilot program, or in-kind donations for which the value is equal to the amount necessary to cover the

total remaining cost of operating the pilot program for the duration of the pilot program, within three hundred sixty-five days following the date on which subsections (1), (2), (3), (4), (5), (6), (7), (8), (11), (12), (13), (14), and (15) of this section take effect.

(b) This section is repealed if the BHA does not receive additional gifts, grants, or donations in the amount necessary to cover the total remaining cost of operating the pilot program for the duration of the pilot program, or in-kind donations for which the value is equal to the amount necessary to cover the total remaining cost of operating the pilot program for the duration of the pilot program, within three hundred sixty-five days following the date on which the revisor of statutes receives notice pursuant to subsection (16) of this section. The commissioner of the BHA shall notify the revisor of statutes of the date on which the condition specified in this subsection (17)(b) has occurred by emailing the notice to revisorofstatutes.ga@coleg.gov.

(18) (a) If, on or before January 1, 2028, the money in the fund has never reached or exceeded one hundred fifty thousand dollars, or additional gifts, grants, or donations in the amount necessary to cover the total remaining cost of the pilot program are not received within three hundred sixty-five days following the date on which the revisor of statutes receives notice pursuant to subsection (16) of this section, the state treasurer shall return from the fund to the grantor or donor the amount of the grantor's or donor's gifts, grants, or donations and, notwithstanding subsection (17) of this section, the BHA shall not accept additional gifts, grants, or donations for the purposes of this section.

(b) If any money remains in the fund after the state treasurer returns money to donors or grantors pursuant to subsection (18)(a) of this section, as applicable, the state treasurer shall, prior to the repeal of the fund, transfer all unexpended and unencumbered money in the fund to the regulated natural medicine cash fund created in section 44-50-601.

Source: L. 2026: Entire section added, (HB 26-1325), ch. 372, p. 2250, § 2, effective August 12.

Cross references: For the legislative declaration in HB 26-1325, see section 1 of chapter 372, Session Laws of Colorado 2026.

PART 3

BEHAVIORAL HEALTH-CARE PROVIDER WORKFORCE

Cross references: For the legislative declaration in SB 22-181, see section 1 of chapter 452, Session Laws of Colorado 2022.

27-60-301. Definitions.

As used in this part 3, unless the context otherwise requires:

(1) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-60-203.

(2) "Behavioral health aide" or "aide" means an individual who:

(a) Addresses mental health conditions and substance use disorders to promote healthy individuals, families, and communities;

(b) Dependent on the level of certification of the individual, may act as a community educator and provide expanded services for more complex behavioral health needs; and

(c) Is familiar with state and local resources and can provide referrals and other additional services.

(3) "Behavioral health provider" means a recovery community organization, as defined in section 27-50-101, a recovery support services organization, as defined in section 27-60-108, or a licensed organization or professional that provides diagnostic, therapeutic, or psychological services for behavioral health conditions. Behavioral health providers include a residential child care facility, as defined in section 26-6-903 (29), and a federally qualified health center, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(4).

(4) "Community college" means a community college described in section 23-60-205 that is governed by the state board for community colleges and occupational education.

(5) "Fund" means the behavioral and mental health cash fund created in section 24-75-230 (2)(a).

(6) "Institution of higher education" means a local district college operating pursuant to article 71 of title 23 or an institution of higher education.

(7) "Learning management system" means an online training curriculum developed for health-care providers in rural and metro areas pursuant to section 27-60-112 (2)(b) to increase competencies in mental health and substance use disorders that will support a high-quality, trained, culturally responsive, and diverse behavioral health-care provider workforce.

(8) "Peer support professional" has the same meaning as set forth in section 27-60-108 (2)(b).

(9) "Plan" means the behavioral health-care provider workforce plan created by the BHA pursuant to section 27-60-302.

(10) "Priority populations" means:

(a) People experiencing homelessness;

(b) People involved with the criminal justice system;

(c) People of color;

(d) American Indians and Alaska natives;

(e) Veterans;

(f) People who are lesbian, gay, bisexual, transgender, or queer or questioning;

(g) Older adults;

(h) Children and families; and

(i) People with disabilities, including people who are deaf and hard of hearing, people who are blind or deafblind, people with brain injuries, people with intellectual and developmental disabilities, and people with other co-occurring disabilities.

(11) "Substance use disorder" means a chronic relapsing brain disease, characterized by recurrent use of alcohol, drugs, or both, causing clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Source: L. 2022: Entire part added, (SB 22-181), ch. 452, p. 3244, § 2, effective July 1. **L. 2023:** (3) amended, (HB 23-1301), ch. 303, p. 1838, § 68, effective August 7. **L. 2026:** (3) amended, (HB 26-1378), ch. 245, p. 1392, § 5, effective May 29.

27-60-302. Behavioral health-care provider workforce plan - expansion - current workforce.

(1) On or before September 1, 2022, the behavioral health administration shall create and begin to implement a behavioral health-care provider workforce plan to expand and strengthen Colorado's behavioral health-care provider workforce to serve children, youth, and adults. In creating the plan, the BHA shall consider the stakeholder recommendations that address the behavioral health workforce shortage published by the department in December 2021.

(2) (a) The plan shall include:

(I) The development and implementation of recruitment methods to increase and diversify the behavioral health-care provider workforce through identifying the cultural barriers to entering the behavioral health-care field and incorporating the appropriate strategies to overcome those barriers;

(II) Strategies to aid publicly funded behavioral health providers in retaining well-trained, clinical behavioral health-care providers at all levels; and

(III) Regulatory changes to reduce barriers.

(b) As part of the plan, the BHA shall use money appropriated to the BHA to partner with organizations such as local, state, and national organizations representing priority populations.

(3) (a) The plan shall require the BHA to partner with the department of higher education to better prepare the future behavioral health-care provider workforce for public sector service, to develop paid job shadowing and internship opportunities, and to develop partnerships with organizations that can offer such opportunities.

(b) The BHA and the department of higher education shall provide incentives to institutions of higher education for the purpose of marketing and promoting behavioral health-care educational programs to students and increasing the number of students who graduate with a degree in a behavioral health-care field of study.

(4) (a) The plan must include strategies for the BHA to work with community colleges and other institutions of higher education to recruit and develop the skills of residents of rural communities and residents of state-designated health professional shortage areas, as defined in section 25-1.5-402 (11), with the goal of educating these residents in behavioral health-care fields to provide services for children, youth, and adults so that the residents return and practice in the rural areas and other shortage areas.

(b) The strategies implemented by the BHA in subsection (4)(a) of this section shall include student loan repayment programs and scholarships to individuals who are committed to providing behavioral health-care services in rural communities and state-designated health professional shortage areas, as defined in section 25-1.5-402 (11), for at least three years. The BHA shall coordinate and work in conjunction with the Colorado health service corps to expand and increase the loan repayments made pursuant to section 25-1.5-503.

(5) The BHA, in collaboration with the community college system, the department of higher education, and the state work force development council created in section 24-46.3-101, and institutions of higher education shall create a new behavioral health-care educational program that provides tiered advancement opportunities for behavioral health-care providers at all levels, from advancement for individuals in entry-level positions to individuals who hold a bachelor's degree.

(6) The BHA shall use the money appropriated by the general assembly to increase the number of peer support professionals across the state to ensure that a person struggling with a mental health disorder or a substance use disorder who is in need of assistance can connect with a peer support specialist who has had similar experiences living with a mental health disorder or a substance use disorder. The purpose of the peer support professional is to help people achieve

their recovery goals through shared understanding, respect, and empowerment. Peer support professionals provide nonclinical support services that align with recommendations from the substance abuse and mental health services administration of the United States department of health and human services, including engaging individuals in peer-to-peer relationships that support healing, personal growth, life skills development, self-care, and crisis strategy development, to help achieve recovery, wellness, and life goals.

(7) The BHA shall include in the plan the recommendations of the director of the division of professions and occupations pursuant to section 12-20-103 (8).

(8) (a) The plan must include proposals to work with local law enforcement agencies, the P.O.S.T. board created in section 24-31-302, a peace officer organization, as defined in section 24-32-3501, a statewide organization representing professional firefighters, and a statewide association representing emergency medical service providers to:

(I) Cross-train current and former first responders in behavioral health;

(II) Help increase cultural competencies in first responders and law enforcement; and

(III) Reduce the stigma of receiving mental health services.

(b) The proposals implemented by the BHA pursuant to subsection (8)(a) of this section must include student loan repayment programs and scholarships for current and former first responders who have at least five years of first responder experience and mental health professionals who are committed to providing behavioral health services in local communities to first responders for at least five years.

(c) The BHA may coordinate and work in conjunction with the Colorado health service corps, as defined in section 25-1.5-502, to expand and increase the student loan repayments made pursuant to section 25-1.5-503.

(9) The plan shall include strategies to utilize Colorado-based behavioral health-care providers to expand telehealth capacity and infrastructure in order to prioritize timely access to behavioral health-care services and address service gaps.

(10) Through an interagency agreement, the BHA shall create a plan for collaboration between the BHA, the department of regulatory agencies, the department of public health and environment, the department of health care policy and financing, the department of education, the department of early childhood, and the department of labor and employment to raise awareness among health-care providers and behavioral health-care providers concerning the availability of opportunities to invest in and strengthen their professional behavioral health-care staff.

Source: L. 2022: Entire part added, (SB 22-181), ch. 452, p. 3245, § 2, effective July 1. **L. 2024:** (5) amended, (HB 24-1450), ch. 490, p. 3423, § 69, effective August 7.

27-60-303. Behavioral health administration - additional duties - collaboration with state agencies - agricultural and rural community behavioral health program - training curriculum for criminal justice treatment provider endorsement - strategies to strengthen behavioral health-care provider workforce.

(1) The BHA shall:

(a) In collaboration with the department of regulatory agencies, establish workforce standards that strengthen the behavioral health-care provider workforce, including telehealth providers, and increase opportunities for peer support professionals and behavioral health aides. If practicable, the standards must be aligned with national standards and address health equity; rural, frontier, and urban needs; pediatric care; specialty care; and care for individuals with complex needs.

(b) Provide and fund opportunities for training and certification with state, national, and international credentialing entities;

(c) Work with other state agencies to reduce the administrative burden across agencies to ensure behavioral health-care providers have additional time to focus on patient care;

(d) Collaborate with the department of public health and environment to:

(I) Further develop current assessments that exist in rules promulgated by the state board of health pursuant to section 25-1.5-404 (1)(a) that measure community-level shortages of behavioral health-care providers who provide services for children, youth, and adults; and

(II) Expand the Colorado health service corps created in section 25-1.5-503 to improve access to behavioral health-care services in communities where workforce shortages exist by providing loans to behavioral health providers to practice in these communities and to work with priority populations; and

(e) Collaborate with the department of higher education, the state board for community colleges and occupational education created in section 23-60-104, the department of education, the state work force development council created in section 24-46.3-101, the department of labor and employment, and the department of health care policy and financing, as applicable, to:

(I) Update career pathways to align with postsecondary degree programs, work-based learning programs, and apprenticeship programs to ensure that behavioral health education and training are responsive to the needs of the labor market in order to provide behavioral health-care services across the care continuum for children, youth, and adults;

(II) Prepare students and current workers in the behavioral health-care field with the skills and credentials they need for jobs and careers, including through the use of the department of labor and employment's work-based learning programs, to assist with identifying industry-relevant skills, certifications, and credentials in the behavioral health-care field;

(III) Secure federal funding that supports training, education, and apprenticeships in behavioral health-care-related occupations;

(IV) Enhance and expand the direct-care workforce to provide behavioral health-care services for children, youth, and adults enrolled in programs administered by the department of health care policy and financing;

(V) Address licensing and credentialing portability issues that affect the ability of children, youth, and adults to access behavioral health-care services;

(VI) Explore the requirements that must be met for certified addiction specialist and certified addiction technician classes to be taught remotely; and

(VII) Explore the feasibility of remote supervisory observation for each behavioral health-care field.

(1.5) (a) The BHA shall create the agricultural and rural community behavioral health program and identify a specific BHA staff person to serve as a liaison between the BHA, the department of agriculture, behavioral health-care providers, rural community leaders, agricultural communities, and nonprofit organizations that serve agricultural communities. The agricultural and rural community behavioral health program shall:

(I) Engage in statewide community outreach to educate communities on the behavioral health issues farmers, ranchers, other agricultural industry workers, their families, and rural communities experience;

(II) Establish interdepartmental relationships; and

(III) Develop an understanding of and address the root causes of behavioral health issues in the agricultural industry and in rural communities.

(b) The agricultural and rural community behavioral health program shall coordinate training for behavioral health providers to serve farmers, ranchers, other agricultural industry workers, and their families experiencing behavioral health issues.

(c) The agricultural and rural community behavioral health program staff liaison shall serve on the agricultural behavioral health community of practice work group, created in section 35-1-121, and provide support to the work group as needed.

(d) The BHA and the department of agriculture shall enter into an interagency agreement to share data collected in the course of understanding and addressing the behavioral health-care

issues in the agricultural industry and in rural communities. The interagency agreement must state that the data shared will be aggregated and anonymized, and data sharing must be in compliance with state and federal data privacy laws.

(2) (a) The BHA shall use the learning management system to implement a comprehensive, collaborative, and cross-system training certification and training curriculum of evidence-based treatment and evidence-based criminal justice approaches for behavioral health-care providers working in programs to obtain a criminal justice treatment provider endorsement. The curriculum shall include:

(I) Training to ensure cross-system alignment around a proactive, coordinated, and prerelease care plan for individuals who are incarcerated in jail, prison, and community corrections facilities;

(II) Specialized training and skills-building in cultural competencies and otherwise culturally responsive approaches to supervision and treatment of individuals who are or were in the criminal justice system; and

(III) Specific strategies to address the rights and needs of crime victims and the behavioral health-care provider's role in preventing harm or increasing risk to identified crime victims.

(b) For the purposes of subsection (2)(a) of this section, the BHA shall add relevant content to the curriculum developed in the learning management system and shall ensure that the learning management system is accessible and promoted to all criminal justice agencies in the state.

(3) The BHA shall develop strategies to strengthen Colorado's current behavioral health-care provider workforce. The strategies shall include:

(a) Using the learning management system to increase the capacity of providers to support a culturally competent behavioral health-care provider workforce to provide services for children, youth, and adults. This includes building from the standards and statewide core competencies developed pursuant to the learning management system and offering ongoing professional development opportunities to train behavioral health-care providers to treat complex needs across the continuum of care. If practicable, the standards shall align with national standards and shall address health equity; rural, frontier, and urban needs; pediatric care; specialty care; and care for persons with complex needs. The BHA shall use the learning management system to create course work to increase and improve competencies in behavioral health care.

(b) Developing methods supported by the BHA, the department of regulatory agencies, the department of public health and environment, the department of health care policy and financing, and the department of labor and employment for behavioral health providers to address burnout; training; supervision, including the exploration of opportunities for behavioral health providers

to be reimbursed for providing clinical supervision; and career pathways for professional behavioral health-care providers.

Source: L. 2022: Entire part added, (SB 22-181), ch. 452, p. 3248, § 2, effective July 1. **L. 2024:** (1.5) added, (SB 24-055), ch. 469, p. 3270, § 1, effective August 7. **L. 2025:** (1.5)(d) amended, (SB 25-300), ch. 428, p. 2453, § 46, effective August 6.

27-60-304. Reports.

(1) In 2023, 2024, 2025, 2026, and 2027 the state department of human services shall include an overview of the BHA's progress toward addressing the behavioral health-care provider workforce shortage during the hearings held prior to the regular session of the general assembly under the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", part 2 of article 7 of title 2.

(2) On or before January 1, 2023, and on or before each January 1 thereafter, the community college system shall submit a report to the BHA. At a minimum, the report must include a summary of the behavioral health career pathway and its implementation, including an accounting of how money was used to expand or support training, education, and certifications in the behavioral health career pathway to increase employment in the behavioral health sector.

(3) The state department, the BHA, and any person who receives money from the BHA shall comply with the compliance, reporting, record-keeping, and program evaluation requirements established by the office of state planning and budgeting and the state controller in accordance with section 24-75-226 (5).

Source: L. 2022: Entire part added, (SB 22-181), ch. 452, p. 3250, § 2, effective July 1. **L. 2024:** (1) and (2) amended, (HB 24-1465), ch. 257, p. 1685, § 11, effective May 24.

27-60-305. Repeal of part.

This part 3 is repealed, effective July 1, 2027.

Source: L. 2022: Entire part added, (SB 22-181), ch. 452, p. 3251, § 2, effective July 1. **L. 2024:** Entire section amended, (HB 24-1465), ch. 257, p. 1686, § 12, effective May 24.

PART 4

EARLY INTERVENTION, DEFLECTION, AND REDIRECTION FROM THE CRIMINAL JUSTICE SYSTEM GRANT PROGRAM

Cross references: For the legislative declaration in SB 22-196, see section 1 of chapter 193, Session Laws of Colorado 2022.

27-60-401. Definitions.

As used in this part 4, unless the context otherwise requires:

(1) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-60-203.

(2) "Community-based organization" means a nonprofit organization that is representative of the community served, or significant segments of the community served, and engaged in meeting that community's needs in the areas of social, human, or health services.

(3) "Eligible entity" means:

(a) A community-based organization;

(b) A nonprofit hospital that provides behavioral health treatment;

(c) A local government;

(d) A federally recognized Indian tribe;

(e) An office that provides or coordinates court-appointed counsel to represent indigent clients charged with a criminal offense in municipal or state court;

(f) A federally qualified health center, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(4), that partners and submits a joint application with a community-based organization, nonprofit hospital that provides behavioral health treatment, local government, or federally recognized Indian tribe;

(g) A rural health clinic, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(2), that partners and submits a joint application with a community-based organization, nonprofit hospital that provides behavioral health treatment, local government, or federally recognized Indian tribe; and

(h) A local law enforcement agency, but only for the purpose of developing or expanding a co-responder community response program, as defined in section 24-32-3501 (8).

(4) "Grant program" means the early intervention, deflection, and redirection from the criminal justice system grant program established in section 27-60-402.

(5) "Local government" means a county, municipality, or city and county.

(6) "Local law enforcement agency" means a county sheriff's office or a municipal police department.

(7) "Review committee" means the early intervention, deflection, and redirection from the criminal justice system grant review committee created in section 27-60-403.

Source: L. 2022: Entire part added, (SB 22-196), ch. 193, p. 1282, § 2, effective May 19.

27-60-402. Early intervention, deflection, and redirection from the criminal justice system grant program - established - permissible uses.

(1) There is established in the behavioral health administration the early intervention, deflection, and redirection from the criminal justice system grant program to provide grants to eligible entities to fund programs and other strategies that:

(a) Provide behavioral health treatment or resources to prevent individuals from becoming involved in the criminal justice system or further penetrating into the system;

(b) Facilitate a direct community response to effectively respond to a person in a behavioral health crisis with the goal of preventing people with behavioral health needs from being arrested; or

(c) After an arrest, redirect individuals with behavioral health needs, including individuals engaged in competency evaluation or restoration provided in a community setting and not in a jail-based setting, from the criminal justice system to appropriate community-based treatment and support services.

(2) An early intervention, deflection, and redirection from the criminal justice system grant may be used for any of the following:

(a) To support, create, or expand pre-arrest early intervention programs, including community-based alternative response programs described in section 24-32-3501 (8);

(b) To support, create, or expand co-responder community response, as defined in section 24-32-3501 (8);

(c) To fund enhanced staffing, facility improvements, or security measures for existing crisis walk-in centers, crisis stabilization units, mobile crisis services, or crisis respite services, as described in section 27-60-103 (1)(b), and withdrawal management programs at facilities

approved pursuant to article 81 of this title 27. A crisis walk-in center must use a grant award to enable the crisis walk-in center to accept all behavioral health related first responder drop-offs and provide crisis receiving and stabilization services. Grants awarded for crisis stabilization units, mobile crisis services, crisis respite services, and withdrawal management programs must be used to provide crisis receiving and stabilization services.

(d) Collaboration between community-based organizations and court-appointed counsel who represent indigent clients to facilitate behavioral health screening and assessment and to help clients access behavioral health and other supportive services, particularly during early stages in a criminal proceeding;

(e) Comprehensive service delivery, including models where multiple partners co-locate or create new resource centers, to ensure swift connection to and receipt of social support services including, but not limited to, counseling, job placement services, housing navigation assistance and support, benefits enrollment, family counseling, substance use treatment, case management services, peer support, and other supportive services. To receive a grant for comprehensive service delivery, the applicant must demonstrate collaboration with local partners that will provide social support services as part of the comprehensive service delivery.

(f) Comprehensive pre-release planning for individuals in a jail or prison with behavioral health needs, to prevent reincarceration;

(g) To support, create, or expand programs to help people who have a pending municipal criminal case attend their court dates and avoid jail for non-appearance, such as through court reminders, ride assistance, or other supportive interventions. A program that operates with grant money must serve a substantial number of people with behavioral health needs.

(h) To establish and operate, or fund an existing, mobile medication-assisted treatment unit;

(i) Other innovations or programs aimed at deflecting, redirecting, or otherwise preventing people with behavioral health needs from further penetrating into the criminal justice system;

(j) Technical assistance and capacity-building, as identified by the applicant as a component of the program, to support delivery of evidence-based or evidence-informed services along the behavioral health continuum of care; and

(k) Capital expenditures related to providing the treatment and services described in this subsection (2).

(3) The BHA shall provide grant recipients with information about the 988 crisis hotline, defined in section 27-64-102, to ensure that the grant recipients are aware of the services available by using the 988 crisis hotline.

(4) (a) The behavioral health administration shall administer the grant program in collaboration with the department of public safety. The BHA shall create a grant application

process and shall make the process publicly available on its website prior to accepting applications. The BHA shall begin accepting grant applications no later than December 31, 2022.

(b) The BHA and department of public safety shall engage in statewide community outreach to make eligible entities aware of the grant program, application process, and deadlines.

(c) No later than sixty days before the grant application deadline, the BHA and department of public safety shall jointly hold a public meeting to present information about the grant program and to give eligible entities the opportunity to ask questions regarding the grant program. The BHA may allow electronic attendance and participation at the meeting.

(d) The BHA shall provide grant application and program development support upon request to an eligible entity that has an annual budget of less than one million dollars. Available support may include assistance with grant-writing, program design, identifying sustainable funding opportunities, program implementation, and data-gathering and evaluation.

Source: L. 2022: Entire part added, (SB 22-196), ch. 193, p. 1283, § 2, effective May 19.

27-60-403. Grant program application - criteria - award - rules.

(1) In order to receive a grant, an eligible entity must offer a monetary contribution or in-kind contributions, as described in subsection (4) of this section, that directly support the services provided with a grant award and must submit an application to the BHA. Two or more eligible entities may collaborate on a program and submit a joint application. At a minimum, an application must include:

(a) The requested amount of the grant award and a description of the program that will be operated with the grant award, including a description of how the proposed program meets the purposes of the grant program described in section 27-60-402 (1);

(b) The source of the contributing funds or in-kind contributing resources provided by the applicant, as described in subsection (4) of this section;

(c) Whether the program plans to use the 988 crisis hotline defined in section 27-64-102 as a part of the program;

(d) Information about the applicant's ability and intent to sustain the services provided with a grant award beyond the duration of the grant, if applicable;

(e) A description of any agreements or partnerships necessary to carry out the grant activities and how grant money will be allocated among partners, if needed to perform activities in the application;

(f) Data documenting the need for the project, including the projected demographic information of clients to be served, including age, race, ethnicity, gender, and any other relevant demographic information;

(g) Projected outcomes, specific performance measures, and data collection methods necessary for the grantee and the BHA to assess the impact of the proposed program;

(h) A description of the applicant's experience in providing culturally competent and gender responsive services, and whether the applicant is representative of the individuals the applicant seeks to serve with a grant;

(i) A description of how the program would add value to existing local efforts in the program area, if any, that align with the purposes of this grant program described in section 27-60-402 (1);

(j) A commitment that all services will be provided on a voluntary basis and that the applicant will not require warrant checks or fingerprinting to receive services;

(k) If the applicant is a local government or federally recognized Indian tribe applying for a grant for a capital expenditure, the applicant must demonstrate collaboration with community-based organizations or nonprofit hospitals that are providing treatment and services described in subsection (3) of this section in association with the capital expenditure;

(l) If the applicant is a law enforcement agency, the applicant must demonstrate compliance with the reporting requirements described in section 24-31-903 (2); and

(m) Any other information required by the BHA.

(2) (a) There is created in the BHA an early intervention, deflection, and redirection from the criminal justice system grant review committee to review grant applications and make recommendations to the BHA and department of public safety. The commissioner of the BHA shall ensure that the composition of the review committee is racially, ethnically, and geographically diverse and representative of communities most impacted by the criminal justice system. The review committee consists of the following members:

(I) The commissioner of the BHA or the commissioner's designee;

(II) The director of the division of criminal justice or the director's designee;

(III) The following individuals appointed by the commissioner of the BHA, in consultation with the director of the division of criminal justice within the department of public safety:

(A) Two clinicians with experience providing behavioral health treatment services to individuals who have been involved in the criminal justice system, one of whom must specialize in substance abuse disorder treatment, who also have experience providing culturally responsive treatment in communities of color and other underserved populations;

(B) Two representatives of organizations with experience awarding grants in behavioral health fields;

(C) A researcher from an institution of higher education with a background in effective interventions that prevent or redirect people with a behavioral health disorder from being involved with the criminal justice system;

(D) A person who was impacted by the criminal justice system, either personally or through a family member, and the person or the family member had behavioral health needs while involved in the criminal justice system;

(E) A victim's advocate with experience in providing culturally responsive services in communities of color, or a representative from a community-based victim services organization that specializes in serving victims of color;

(F) A representative of a federally recognized Indian tribe with jurisdiction in Colorado;

(G) A member of law enforcement that has participated in co-responder community response, as defined in section 24-32-3501 (8);

(H) A public defender or private criminal defense attorney with experience representing people with a behavioral health disorder; and

(I) A prosecutor with experience operating a diversion program specifically for individuals with a behavioral health disorder.

(b) Members of the review committee serve without compensation and without reimbursement for expenses. Members of the review committee shall disclose any conflicts of interest, including whether the member represents an organization that may seek a grant from the grant program.

(c) The review committee shall review applications for grants submitted pursuant to this section and make recommendations to the BHA and department of public safety about which applicants should receive grants and the amount of each grant.

(3) After receiving and reviewing recommendations from the review committee and after consultation with the department of public safety, the BHA shall award grants. In addition to considering the recommendations of the review committee and after considering the information included in the grant application, when awarding grants, the BHA shall ensure that:

(a) The proposed program fills an existing gap in behavioral health response, as identified in the application, in the program service area and would meet the needs of the identified target population served by the program; and

(b) Any direct services provided through the program will use evidence-based or evidence-informed interventions that align with trauma-informed and harm reduction principles.

(4) The BHA shall only award grants to applicants that offer a monetary contribution or in-kind contributions that directly support the services provided with a grant award. In determining the amount of contributing resources required for an applicant, the BHA shall consider the size of the applicant organization, including available staff and annual operating budget. The BHA may waive the contributing resources requirement for an applicant that is requesting a grant award of less than fifty thousand dollars.

(5) (a) A grant recipient must spend or obligate any grant money in accordance with section 24-75-226 (4)(d).

(b) A grant recipient may use no more than ten percent of a grant award for administrative costs associated with receipt of the grant award.

Source: L. 2022: Entire part added, (SB 22-196), ch. 193, p. 1285, § 2, effective May 19; (5)(a) amended, (HB 22-1411), ch. 271, p. 1961, § 20, effective May 27. **L. 2023:** IP(2)(a), (2)(b), and (2)(c) amended, (HB 23-1301), ch. 303, p. 1838 § 69, effective August 7.

27-60-404. Grant program reporting requirements.

(1) Each grant recipient shall submit a report to the BHA following the expiration of the grant term. The report must include:

(a) Information about the use of the grant award, including the program operated with the grant award and the number of individuals the program diverted or redirected from the criminal justice system;

(b) The number of individuals served through the program who may have come into contact with the criminal justice system;

(c) The number of individuals referred by the program to treatment; and

(d) Whether the recipient is continuing the program and any other information requested by the state department.

(2) (a) On or before January 31 of each year, the house of representatives judiciary committee, the house of representatives health and human services committee, the senate health and human services committee, and the senate judiciary committee, or their successor committees, shall hold a joint hearing on the grant program. At the hearing, the state department shall report to the committees about the grant program, which must include an overview of the grant program, information on the type of services funded with a grant award, and where services were provided.

(b) Notwithstanding section 24-1-136 (11)(a)(I), the reporting requirement in this subsection (2) continues indefinitely.

Source: L. 2022: Entire part added, (SB 22-196), ch. 193, p. 1288, § 2, effective May 19. **L. 2026:** (2)(a) amended, (SB 26-169), ch. 311, p. 1812, § 55, effective August 12.

27-60-405. Grant program funding - requirements - reports - appropriation.

(1) The general assembly shall appropriate to the state department money from the behavioral and mental health cash fund created in section 24-75-230 to implement the grant program.

(2) (a) The state department, BHA, and any person who receives money from the BHA, including each grant recipient, shall comply with the compliance, reporting, record-keeping, and program evaluation requirements established by the office of state planning and budgeting and the state controller in accordance with section 24-75-226 (5).

(b) For each grant awarded for a capital expenditure, the BHA is responsible for preparing the written justification required pursuant to 31 CFR 35.6 (b)(4). A grant applicant that requests grant money that originates from the money the state received from the coronavirus state fiscal recovery fund for a capital expenditure must submit to the BHA information requested by the BHA for inclusion in the written justification; except that this requirement does not apply if the BHA determines that the written justification is not required based on how the expenditures authorized pursuant to this part 4 will be reported to the United States department of the treasury. For grant money that did not originate from the money the state received from the coronavirus state fiscal recovery fund, a written justification is not required, except as the BHA determines necessary to comply with federal written justification requirements.

Source: L. 2022: Entire part added, (SB 22-196), ch. 193, p. 1289, § 2, effective May 19. **L. 2024:** (2)(b) amended, (HB 24-1466), ch. 429, p. 2945, § 39, effective June 5. **L. 2025:** (1) amended, (SB 25-312), ch. 301, p. 1538, § 17, effective May 30.

Cross references: For the legislative declaration in HB 24-1466, see section 1 of chapter 429, Session Laws of Colorado 2024.

27-60-406. Repeal of part.

This part 4 is repealed, effective January 31, 2027.

Source: L. 2022: Entire part added, (SB 22-196), ch. 193, p. 1289, § 2, effective May 19.

PART 5

COMMUNITY BEHAVIORAL HEALTH-CARE CONTINUUM GAP GRANT PROGRAM

Cross references: For the legislative declaration in HB 22-1281, see section 1 of chapter 182, Session Laws of Colorado 2022.

27-60-501. Definitions.

As used in this part 5, unless the context otherwise requires:

(1) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-60-203.

(2) "Behavioral health administrative services region" means a behavioral health administrative services region designated by the BHA commissioner after consultation with the department of health care policy and financing and consideration of the regional structure that serves the medicaid population.

(3) "Behavioral health-care services assessment tool" means the assessment tool described in section 27-60-502 (1)(c) developed by the BHA to identify regional gaps in behavioral health-care services.

(4) "Care access point" means a location at which a person seeking behavioral health care can receive care coordination.

(5) "Community-based organization" means a nonprofit or for-profit organization that provides behavioral health-care services.

(6) "Grant program" means the community behavioral health-care continuum gap grant program established in section 27-60-502.

(7) "Local education provider" means a school district, a charter school authorized pursuant to part 1 of article 30.5 of title 22, an institute charter school authorized pursuant to part 5 of article 30.5 of title 22, or a board of cooperative services as defined in section 22-5-103.

(8) "Local government" means a county, municipality, city and county, or local education provider.

(9) "Medication-assisted treatment" or "MAT" has the same meaning as set forth in section 23-21-803.

(10) "Nonprofit organization" means an organization that is exempt from taxation under section 501 (c)(3) of the federal "Internal Revenue Code of 1986", as amended.

Source: L. 2022: Entire part added, (HB 22-1281), ch. 182, p. 1212, § 2, effective May 18.

27-60-502. Behavioral health-care continuum gap grant program - established - rules.

(1) (a) There is established in the behavioral health administration the behavioral health-care continuum gap grant program to provide grants to local governments, community-based organizations, and nonprofit organizations for programs and services along the behavioral health-care continuum in areas of highest need, including children-oriented, youth-oriented, and family-oriented behavioral health-care services.

(b) (I) The behavioral health administration shall administer the grant program. The BHA shall create a grant application process and make the process publicly available on its website prior to accepting applications. The BHA shall begin accepting grant applications no later than December 31, 2022.

(II) The BHA shall provide grant application support to an applicant, upon request, from a grant application writing professional who is independent from the grant program.

(III) In connection with the review of grant applications and awards, the BHA shall solicit input from a diverse stakeholder group that reflects the geographic and demographic diversity of the entire state, including members from rural and urban areas, and members of diverse racial, disability, and cultural groups and of diverse sexual orientations and genders.

(c) The BHA shall develop a behavioral health-care services assessment tool to identify regional gaps in behavioral health and substance use disorder services, underserved populations, and unmet behavioral health needs on the behavioral health-care service continuum. The BHA shall make the assessment tool publicly available on its website prior to accepting applications for a grant pursuant to this part 5. The BHA shall make technical assistance available to eligible entities that need assistance using the assessment tool.

(d) In administering the grant program, the BHA may award the following types of grants:

(I) Community investment grants, as described in subsection (2) of this section, to address identified local behavioral health-care needs along the continuum of behavioral health care, including services for adults or families with acute, complex, or severe conditions and needs; and

(II) Children, youth, and family services grants, as described in subsection (3) of this section, to expand children-oriented, youth-oriented, and family-oriented behavioral health-care services to address identified local behavioral health-care needs along the continuum of behavioral health care, including services for children, youth, and families with acute, complex, or severe conditions and needs.

(2) **Community investment grants.**

(a) As part of the grant program, the BHA shall award grants to invest in and address identified behavioral health-care needs in the grant applicant's community.

(b) A community-based organization, local government, federally recognized Indian tribe, or nonprofit organization is eligible for a community investment grant.

(c) (I) A community investment grant award must be used:

(A) For evidence-based or evidence-informed services along the behavioral health-care continuum, including prevention, treatment, crisis services, recovery, harm reduction, care navigation and coordination, trauma recovery, trauma-informed training, training on providing services in a culturally responsive manner, transitional housing, supportive housing, and recovery homes;

(B) For capital expenditures related to providing evidence-based or evidence-informed services, which may include the creation or redesign of mental health inpatient beds, emergency room beds for mental health crisis patients, outpatient mental health beds, and step-down facilities connected with a hospital;

(C) To expand capacity for existing treatment, programs, or services within the grant recipient's jurisdiction or service area; and

(D) For a new capital construction project that has progressed through the design review process, has obtained approval for applicable development and building permits, provides access to multiple critical services in one central location within the community served, is easily accessible by first responders and community members, and demonstrates strong community support.

(II) A grant recipient that is a primary care provider, withdrawal management provider, outpatient substance use treatment provider, or hospital may use a grant award to create a program commonly known as "treatment on demand" to prepare providers to offer same-day access to initiate medication-assisted treatment, substance use counseling, peer support, and navigation services. As part of a treatment-on-demand program, a grant award may be used for:

(A) Technical assistance to redesign access and improve efficiencies that would make treatment accessible on a same-day basis, including education of providers on determination of levels of care as described by the American Society of Addiction Medicine;

(B) Developing protocols and credentialing providers to initiate psychopharmacological treatments; or

(C) Recruiting and training peer support professionals to act as navigators and advocates for individuals and developing partnerships across levels of care to facilitate transfers of care from hospital and withdrawal management programs to ongoing treatment.

(3) **Children, youth, and family services grants.**

(a) As part of the grant program, the BHA shall award children, youth, and family services grants to expand children-oriented, youth-oriented, and family-oriented behavioral health-care services with the goal of establishing a care access point in each behavioral health administrative services region.

(b) A community-based organization; local government; federally recognized Indian tribe; local collaborative management programs, as described in section 24-1.9-102; local juvenile services planning committee created pursuant to section 19-2.5-302; or nonprofit organization is eligible for a children, youth, and family services grant.

(c) A children, youth, and family services grant award may be used for:

(I) Establishing and operating a children-oriented, youth-oriented, and family-oriented care access point that is physically connected to a family resource center, as defined in section 26-18-102, or a facility that provides behavioral health-care treatment;

(II) Children-oriented, youth-oriented, and family-oriented behavioral health-care navigation and coordination services;

(III) Expanding evidence-based or evidence-informed behavioral health-care treatment, including substance use disorder treatment, for children, youth, and families;

(IV) Intensive outpatient services, including high-fidelity wraparound youth mobile response and expanded caregiver interventions; and

(V) Capital expenditures related to providing the treatment and services described in this subsection (3)(c).

Source: L. 2022: Entire part added, (HB 22-1281), ch. 182, p. 1213, § 2, effective May 18. **L. 2024:** (2)(c)(I) amended, (HB 24-1176), ch. 251, p. 1660, § 1, effective May 24.

27-60-503. Grant program application - criteria - contributing resources - award - rules.

(1) In order to receive a grant, an entity must use the behavioral health-care services assessment tool or a county, regional, or community assessment tool to identify gaps in behavioral health-care services in the behavioral health administrative services region served by the grant award and submit an application to the BHA. At a minimum, the application must include:

(a) Whether the grant is a community investment grant, as described in section 27-60-502 (2), or a children, youth, and family services grant, as described in section 27-60-502 (3);

(b) The requested amount of the grant award and a description of the service that will be provided with the grant award;

(c) A demonstration of the need for the service that will be provided, including whether the service addresses a gap in services identified by the applicant;

(d) A demonstration that the applicant has collaborated or communicated with relevant community-based organizations and with a local government in which services will be offered;

(e) The source of contributing funds or in-kind contributing resources, as described in subsection (3) of this section, or whether the applicant is requesting a waiver from the contributing funds or in-kind contributing resources requirement;

(f) Whether the intended use of the grant award aligns with a regional opioid settlement plan, if applicable, or a local public health needs assessment for the area in which the services will be provided;

(g) A plan to sustain the services provided with a grant award beyond the duration of the grant, if applicable;

(h) A description of the applicant's experience in providing culturally competent and gender responsive services, and whether the applicant is representative of the individuals the applicant seeks to serve with the grant; and

(i) Any other information required by the state department.

(2) The BHA shall accept and review grant applications and award grants. In awarding grants, the BHA shall consider the criteria described in subsection (1) of this section and shall give preference to applicants providing a service that addresses a gap in behavioral health or substance use disorder services identified by the applicant with the behavioral health-care services assessment tool.

(3) (a) The BHA shall only award grants to applicants that offer a monetary contribution or in-kind contributions that directly support the services provided with a grant award. In

determining the amount of contributing resources required for an applicant, the BHA shall consider the size of the applicant organization, including available staff and annual operating budget. The BHA may waive the contributing resources requirement for an applicant that is requesting a grant award of less than fifty thousand dollars.

(b) In determining whether an applicant has identified a gap in services on the behavioral health-care service continuum, the BHA shall accept the results of an assessment conducted by the applicant with the behavioral health-care services assessment tool developed by the BHA or a county, regional, or community assessment tool that demonstrates gaps in services.

(c) A program funded by a grant award must comply with the federal "Americans with Disabilities Act of 1990", 42 U.S.C. sec. 12101 et seq., as amended, and serve individuals with a disability, as defined in the federal act, regardless of primary diagnosis, co-occurring conditions, or if the individual requires assistance with activities of daily living, as defined in section 12-270-104.

(4) (a) A grant recipient must spend or obligate any grant money in accordance with section 24-75-226 (4)(d).

(b) A grant recipient may use no more than ten percent of a grant award for administrative costs associated with receipt of the grant award.

Source: L. 2022: Entire part added, (HB 22-1281), ch. 182, p. 1215, § 2, effective May 18; (4)(a) amended, (HB 22-1411), ch. 271, p. 1960, § 19, effective May 27.

27-60-504. Grant program reporting requirements.

(1) Each grant recipient shall submit a report to the BHA following the expiration of the grant term. The report must include:

(a) Information about the use of the grant award, including the services provided with a grant award and where those services were provided;

(b) The amount of contributing funds or in-kind contributing resources that supported the services;

(c) Aggregated demographic information of the individuals who receive services funded with a grant award;

(d) Whether the recipient is continuing to provide the services, and any other information requested by the state department.

(2) (a) In its annual report to the committees of reference pursuant to the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" required by section 2-7-203, the state department shall provide information about the grant program, including information on the type of services funded with a grant award and where those services were provided.

(b) Notwithstanding section 24-1-136 (11)(a)(I), the reporting requirement in this subsection (2) continues indefinitely.

Source: L. 2022: Entire part added, (HB 22-1281), ch. 182, p. 1217, § 2, effective May 18.

27-60-505. Grant program funding - requirements - reports.

(1) The general assembly shall appropriate to the state department seventy-five million dollars from the behavioral and mental health cash fund created in section 24-75-230 to implement the grant program.

(2) Of the money appropriated to the state department, regardless of the source, the BHA shall award grants in the following manner:

(a) At least thirty-four million dollars for community investment grants, as described in section 27-60-502 (2); and

(b) At least thirty-nine million dollars for children, youth, and family services grants, as described in section 27-60-502 (3).

(3) (a) The state department, BHA, and any person who receives money from the BHA, including each grant recipient, shall comply with the compliance, reporting, record-keeping, and program evaluation requirements established by the office of state planning and budgeting and the state controller in accordance with section 24-75-226 (5).

(b) To be eligible to receive grant money for a capital expenditure, the grant applicant that requests grant money that originates from the money the state received from the coronavirus state fiscal recovery fund must submit to the BHA a written justification as set forth in 31 CFR 35.6 (b)(4) for the capital expenditure; except that this requirement does not apply if the BHA determines that the written justification is not required based on how the expenditures authorized pursuant to this part 5 will be reported to the United States department of the treasury. For grant money that did not originate from the money the state received from the coronavirus state fiscal recovery fund, a written justification is not required, except as the BHA determines necessary to comply with federal written justification requirements.

Source: L. 2022: Entire part added, (HB 22-1281), ch. 182, p. 1217, § 2, effective May 18. **L. 2024:** IP(2) and (3)(b) amended, (HB 24-1466), ch. 429, p. 2945, § 40, effective June 5. **L. 2025:** (2) amended, (SB 25-312), ch. 301, p. 1538, § 18, effective May 30.

Cross references: For the legislative declaration in HB 24-1466, see section 1 of chapter 429, Session Laws of Colorado 2024.

27-60-506. Repeal of part.

This part 5 is repealed, effective January 31, 2027.

Source: L. 2022: Entire part added, (HB 22-1281), ch. 182, p. 1218, § 2, effective May 18.

ARTICLE 61

Behavioral Health Transformation Council

27-61-101 and 27-61-102. (Repealed)

Source: L. 2018: Entire article repealed, (SB 18-161), ch. 123, p. 830, § 1, effective September 1.

Editor's note: This article was added in 2010. For amendments to this article prior to its repeal in 2018, consult the 2017 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

ARTICLE 62

High-fidelity Wraparound Services for Children and Youth

27-62-101. Definitions.

27-62-102. High-fidelity wraparound services for children and youth - interagency coordination - reporting.

27-62-103. Standardized assessment tool - standardized screening

tools - interagency coordination - single referral and entry point.

27-62-101. Definitions.

As used in this article 62, unless the context otherwise requires:

(1) "At risk of out-of-home placement" means a child or youth who is eligible for medical assistance pursuant to articles 4, 5, and 6 of title 25.5 and the child or youth:

(a) Has been diagnosed as having a mental health disorder, as defined in section 27-65-102, or a behavioral health disorder; and

(b) May require a level of care that is provided in a residential child care facility, inpatient psychiatric hospital, or other intensive care setting outside of the child's or youth's home. "At risk of out-of-home placement" includes a child or youth who:

(I) Is entering the division of youth services; or

(II) Is at risk of child welfare involvement.

(1.5) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-50-102.

(2) "Behavioral health disorder" means a substance use disorder, mental health disorder, or one or more substantial disorders of the cognitive, volitional, or emotional processes that grossly impair judgment or capacity to recognize reality or to control behavior, including serious emotional disturbances. "Behavioral health disorder" also includes those mental health disorders listed in the most recent versions of the diagnostic statistical manual of mental health disorders, the diagnostic classification of mental health and developmental disorders of infancy and early childhood, and the international statistical classification of diseases and related health problems.

(3) "Child and youth" means a person who is twenty-six years of age or younger.

(3.5) "Commissioner" means the commissioner of the behavioral health administration.

(4) "Managed care entity" means an entity that enters into a contract to provide services in the statewide managed care system pursuant to articles 4, 5, and 6 of title 25.5.

(5) "Mental health professional" means an individual licensed as a mental health professional pursuant to article 245 of title 12 or a professional person, as defined in section 27-65-102 (27).

(6) "Out-of-home placement" means a child or youth who is eligible for medical assistance pursuant to articles 4, 5, and 6 of title 25.5 and the child or youth:

(a) Has been diagnosed as having a mental health disorder, as defined in section 27-65-102, or a behavioral health disorder; and

(b) May require a level of care that is provided in a residential child care facility, inpatient psychiatric hospital, or other intensive care setting outside of the child's or youth's home. "Out-of-home placement" includes a child or youth who:

(I) Has entered the division of youth services; or

(II) Is at risk of child welfare involvement.

(7) "Standardized assessment tool" means a multipurpose instrument that facilitates the link between assessment and level of care and individualized service planning, facilitates quality improvement activities, and allows for monitoring of outcomes of services.

(8) Repealed.

(9) "Wraparound" means a high-fidelity, individualized, family-centered, strengths-based, and intensive care planning and management process used in the delivery of behavioral health services for a child or youth with a behavioral health disorder, commonly utilized as part of the system of care framework.

Source: L. 2019: Entire article added, (SB 19-195), ch. 190, p. 2101, § 4, effective August 2. **L. 2022:** (1.5) and (3.5) added and (8) repealed, (HB 22-1278), ch. 222, p. 1534, § 104, effective July 1; (1)(a), (5), and (6)(a) amended, (HB 22-1256), ch. 451, p. 3235, § 42, effective August 10.

27-62-102. High-fidelity wraparound services for children and youth - interagency coordination - reporting.

(1) Pursuant to section 25.5-5-803 (4), the BHA shall work collaboratively with the department of health care policy and financing, counties, and other relevant departments, as appropriate, to develop and oversee wraparound services for children and youth at risk of out-of-home placement or in an out-of-home placement. As part of routine collaboration, the BHA shall assist the department of health care policy and financing in developing a model of sustainable funding for wraparound services. The BHA and the department of health care policy and financing shall monitor and report the annual cost savings associated with eligible children and youth receiving wraparound services to the public through the annual hearing, pursuant to the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", part 2 of article 7 of title 2.

(2) Subject to available appropriations, two full-time staff persons shall be appointed by the commissioner to support and facilitate interagency coordination pursuant to this article 62, part 8 of article 5 of title 25.5, and any other related interagency behavioral health efforts as determined by the commissioner.

Source: L. 2019: Entire article added, (SB 19-195), ch. 190, p. 2103, § 4, effective August 2. **L. 2020:** (2) amended, (HB 20-1384), ch. 172, p. 790, § 4, effective June 29. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1534, § 105, effective July 1.

27-62-103. Standardized assessment tool - standardized screening tools - interagency coordination - single referral and entry point.

(1) **Standardized assessment tool.** Subject to available appropriations, the BHA shall select a single standardized assessment tool to facilitate identification of behavioral health issues and other related needs in children and youth and to develop a plan to implement the tool for programmatic utilization. The BHA shall consult with the department of health care policy and financing, managed care entities, counties, stakeholders, and other relevant departments, as appropriate, prior to selecting the tool.

(2) **Standardized screening tools.** Subject to available appropriations, the BHA shall select developmentally appropriate and culturally competent statewide behavioral health standardized screening tools for primary care providers serving children, youth, and caregivers in the perinatal period, including postpartum women. The BHA and the department of human services may make the tools available electronically for health-care professionals and the public. Prior to the adoption of the standardized assessment tool described in subsection (1) of this section, and the standardized screening tools described in this subsection (2), the BHA shall lead a public consultation process involving relevant stakeholders, including health-care professionals and managed care entities, with input from the department of health care policy and financing, the department of public health and environment, and the division of insurance.

(3) **Single statewide referral and entry point.** Subject to available appropriations, the BHA, in conjunction with the department of health care policy and financing, the department of public health and environment, and other relevant departments and counties, as necessary, shall develop a plan for establishing a single statewide referral and entry point for children and youth who have a positive behavioral health screening or whose needs are identified through a standardized assessment. In developing the single statewide referral and entry point plan, the BHA shall seek input from relevant stakeholders, including counties, managed care entities participating in the statewide managed care system, families of children and youth with behavioral health disorders, communities that have previously implemented wraparound services, mental health professionals, and other relevant departments.

Source: L. 2019: Entire article added, (SB 19-195), ch. 190, p. 2103, § 4, effective August 2. **L. 2020:** Entire section amended, (HB 20-1384), ch. 172, p. 791, § 5, effective June 29. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1534, § 106, effective July 1.

ARTICLE 63

Community Behavioral Health Safety Net System

27-63-101. Definitions.

27-63-102. High-intensity behavioral health treatment programs - identification - departments' duties. (Repealed)

27-63-103. Implementation plan - departments' duties - report. (Repealed)

27-63-104. Community behavioral health safety net system advisory body - creation - membership - repeal. (Repealed)

27-63-105. Safety net system implementation - safety net system criteria.

27-63-106. Safety net system - effectiveness - report.

27-63-101. Definitions.

As used in the article 63, unless the context otherwise requires:

(1) "Behavioral health" refers to an individual's mental and emotional well-being development and actions that affect an individual's overall wellness. Behavioral health problems and disorders include substance use disorders, serious psychological distress, suicidal ideation, and other mental health disorders. Problems ranging from unhealthy stress or subclinical conditions to diagnosable and treatable diseases are included in the term "behavioral health". An intellectual or developmental disability is insufficient to either justify or exclude a finding of a behavioral health disorder.

(2) Repealed.

(3) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-50-102.

Source: L. 2019: Entire article added, (SB 19-222), ch. 226, p. 2266, § 6, effective May 20. **L. 2022:** (2) repealed and (3) added, (HB 22-1278), ch. 222, p. 1535, § 107, effective July 1.

27-63-102. High-intensity behavioral health treatment programs - identification - departments' duties. (Repealed)

Source: L. 2019: Entire article added, (SB 19-222), ch. 226, p. 2267, § 6, effective May 20. **L. 2022:** Entire section repealed, (HB 22-1278), ch. 222, p. 1535, § 108, effective July 1.

27-63-103. Implementation plan - departments' duties - report. (Repealed)

Source: L. 2019: Entire article added, (SB 19-222), ch. 226, p. 2267, § 6, effective May 20. **L. 2022:** Entire section repealed, (HB 22-1278), ch. 222, p. 1535, § 108, effective July 1.

27-63-104. Community behavioral health safety net system advisory body - creation - membership - repeal. (Repealed)

Source: L. 2019: Entire article added, (SB 19-222), ch. 226, p. 2268, § 6, effective May 20. **L. 2020:** (2)(b) amended, (SB 20-136), ch. 70, p. 300, § 57, effective September 14. **L. 2022:** Entire section repealed, (HB 22-1278), ch. 222, p. 1535, § 108, effective July 1.

27-63-105. Safety net system implementation - safety net system criteria.

(1) No later than January 1, 2024, the department shall implement the comprehensive proposal and the funding model developed pursuant to section 27-63-104 (2), which shall meet the following criteria:

(a) The safety net system must not refuse to treat an individual, including youth, based on the following:

(I) The individual's insurance coverage, lack of insurance coverage, or ability or inability to pay for behavioral health services;

(II) The individual's clinical acuity level related to the individual's behavioral health disorder, including whether the individual has been certified pursuant to article 65 of this title 27;

(III) The individual's readiness to transition out of the Colorado mental health institute at Pueblo, the Colorado mental health institute at Fort Logan, or any other mental health institute because the individual no longer requires inpatient care and treatment;

(IV) The individual's involvement in the criminal or juvenile justice system;

(V) The individual's current involvement in the child welfare system;

(VI) The individual's co-occurring mental health and substance use disorders, physical disability, or intellectual or developmental disability; or

(VII) The individual's displays of aggressive behavior, or history of aggressive behavior, as a result of a symptom of a diagnosed mental health disorder or substance intoxication;

(b) The safety net system must:

(I) Proactively engage hard-to-serve individuals with adequate case management and care coordination throughout the care continuum;

(II) Promote competency in de-escalation techniques;

(III) Utilize adequate networks for timely access to treatment, including high-intensity behavioral health treatment and community treatment for children, youth, adults, and other individuals;

(IV) Require collaboration with all local law enforcement jurisdictions and counties in the service area, including county departments of human or social services;

(V) Triage individuals who need alternative services outside the scope of the safety net system;

(VI) Promote patient-centered care and cultural awareness;

(VII) Update information as requested by the department about available treatment options and outcomes in each region of the state;

(VIII) Utilize evidence-based or evidence-informed programming to promote quality services; and

(IX) Meet any other criteria established by the department.

(2) The safety net system must have a network of behavioral health-care providers that collectively offer a full continuum of services to ensure individuals with severe behavioral health disorders are triaged in a timely manner to the appropriate care setting if an individual behavioral health-care provider is unable to provide ongoing care and treatment for the individual. The departent shall consider behavioral health safety net providers, behavioral health administrative services organizations, contractors for the statewide behavioral health crisis response system, and other behavioral health community providers as key elements in the behavioral health safety net system.

Source: L. 2019: Entire article added, (SB 19-222), ch. 226, p. 2269, § 6, effective May 20. **L. 2022:** (2) amended, (HB 22-1278), ch. 222, p. 1597, § 243, effective August 10.

27-63-106. Safety net system - effectiveness - report.

(1) From January 1, 2022, until July 1, 2024, the BHA shall provide an annual report on the progress made by the BHA on the behavioral health safety net system to the public through the annual hearing, pursuant to the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", part 2 of article 7 of title 2.

(2) Notwithstanding section 24-1-136 (11)(a)(I), no later than January 1, 2025, the BHA shall provide an annual report to the joint budget committee of the general assembly related to the expenditures, outcomes, and effectiveness of the safety net system by service area region, including any recommendations to improve the system and the transparency of the system.

Source: L. 2019: Entire article added, (SB 19-222), ch. 226, p. 2271, § 6, effective May 20. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1536, § 110, effective July 1.

ARTICLE 64

988 Crisis Hotline Enterprise

27-64-101. Legislative declaration.
27-64-102. Definitions.
27-64-103. 988 crisis hotline enterprise - creation - powers and duties.
27-64-104. 988 crisis hotline cash fund - creation.
27-64-105. Reports.

27-64-101. Legislative declaration.

(1) The general assembly finds and declares that:

(a) On July 16, 2020, the federal communications commission adopted rules, and on October 17, 2020, congress passed the "National Suicide Hotline Designation Act of 2020", designating 988 as the three-digit number for the national suicide prevention lifeline to aid rapid access to suicide prevention and mental health support services;

(b) It is imperative for Colorado to implement 988 as the three-digit number for crisis response services in Colorado in order to comply with federal regulations; improve quality and access to behavioral health crisis services, especially for underserved populations and in rural areas of the state; and reduce stigma surrounding suicide, mental health, and substance use conditions;

(c) The 988 crisis hotline enterprise provides valuable benefits and services to telephone service users when the enterprise funds the 988 crisis hotline and provides crisis outreach, stabilization, and acute care to individuals calling the 988 crisis hotline from any jurisdiction in Colorado twenty-four hours a day, seven days a week;

(d) By providing the benefits and services specified in subsection (1)(c) of this section, the 988 crisis hotline enterprise engages in an activity conducted in the pursuit of a benefit, gain, or livelihood, and therefore operates as a business;

(e) Consistent with the determination of the Colorado supreme court in Nicholl v. E-470 Public Highway Authority, 896 P.2d 859 (Colo. 1995), that the power to impose taxes is inconsistent with enterprise status under section 20 of article X of the state constitution, it is the conclusion of the general assembly that the charges imposed by the enterprise is a fee, not a tax, because the charges are imposed for the specific purpose of allowing the enterprise to defray the costs of providing the benefits and services specified in subsection (1)(c) of this section to telephone service users and the charges are imposed at rates that are reasonably calculated based on the cost of the services received by telephone service users;

(f) So long as the 988 crisis hotline enterprise qualifies as an enterprise for purposes of section 20 of article X of the state constitution, the revenue from the charges imposed by the enterprise are not state fiscal year spending, as defined in section 24-77-102 (17), or state revenues, as defined in section 24-77-103.6 (6)(c), and do not count against either the state fiscal year spending limit imposed by section 20 article X of the state constitution or the excess state revenues cap, as defined in section 24-77-103.6 (6)(b)(I); and

(g) No other enterprise created simultaneously or within the preceding five years serves primarily the same purpose as the 988 crisis hotline enterprise and the 988 crisis hotline enterprise will generate revenue from charges of less than one hundred million dollars total in its first five fiscal years. Accordingly, the creation of the 988 crisis hotline enterprise does not require voter approval pursuant to section 24-77-108.

Source: L. 2021: Entire article added, (SB 21-154), ch. 360, p. 2343, § 1, effective September 7.

27-64-102. Definitions.

As used in this article 64, unless the context otherwise requires:

(1) "988 crisis hotline" means a state-identified hotline participating in the national suicide prevention lifeline network to respond to statewide or regional behavioral health crisis calls.

(1.5) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-50-102.

(2) "Charge" means the 988 surcharge imposed by the enterprise pursuant to section 27-64-103 (4)(a) and the prepaid wireless 988 charge imposed by the enterprise pursuant to section 27-64-103 (4)(b).

(3) "Enterprise" means the 988 crisis hotline enterprise created in section 27-64-103.

(4) "National suicide prevention lifeline" means a national network of local crisis centers maintained by the federal substance abuse and mental health services administration that provides free and confidential emotional support to people in suicidal crisis or emotional distress twenty-four hours a day, seven days a week.

(5) "Veterans crisis line" means the veterans crisis line maintained by the United States department of veterans affairs.

Source: L. 2021: Entire article added, (SB 21-154), ch. 360, p. 2344, § 1, effective September 7. **L. 2022:** (1.5) added, (HB 22-1278), ch. 222, p. 1536, § 111, effective July 1.

27-64-103. 988 crisis hotline enterprise - creation - powers and duties.

(1) There is created in the behavioral health administration the 988 crisis hotline enterprise. The enterprise is and operates as a government-owned business within the BHA for the business purpose of imposing charges pursuant to subsections (4)(a) and (4)(b) of this section, and utilizing the charges' revenue to fund the 988 crisis hotline and provide crisis outreach, stabilization, and acute care to individuals calling the 988 crisis hotline. The enterprise is a **type 1** entity, as defined in section 24-1-105, and exercises its power and performs its duties and functions under the BHA.

(2) The enterprise constitutes an enterprise for purposes of section 20 of article X of the state constitution so long as it retains the authority to issue revenue bonds and receives less than ten percent of its total revenues in grants from all Colorado state and local governments combined. So long as it constitutes an enterprise pursuant to this subsection (2), the enterprise is not subject to section 20 of article X of the state constitution.

(3) The enterprise is governed by a board of directors appointed by the governor.

(4) The enterprise's primary powers and duties are to:

(a) Effective January 1, 2022, impose a 988 surcharge on service users, as defined in section 40-17.5-101 (13), in an amount to be established annually by the enterprise, in collaboration with the public utilities commission, but not to exceed thirty cents per month per 988 access connection, as defined in section 40-17.5-101 (2). On or before October 1, 2021, and on or before October 1 of each year thereafter, the enterprise, in collaboration with the public utilities commission, shall establish the amount of the surcharge for the next calendar year. The amount of the surcharge must be reasonably calculated based on the cost of the services received by telephone service users. The amount of the surcharge imposed per 988 access connection must be uniform, regardless of the technology used to provide the 988 access connection.

(b) Effective January 1, 2022, impose a prepaid wireless 988 charge on each retail transaction, as defined in section 40-17.5-101 (10), in an amount to be established annually by the enterprise, in collaboration with the public utilities commission, but not to exceed thirty cents per each retail transaction in which prepaid wireless service is purchased in Colorado. On or before October 1, 2021, and on or before October 1 of each year thereafter, the enterprise, in collaboration with the public utilities commission, shall establish the amount of the charge for the next calendar year. The amount of the charge must be reasonably calculated to meet the needs of the enterprise.

(c) As required by subsection (5) of this section, fund the 988 crisis hotline to provide intervention services and crisis care coordination to individuals calling the 988 crisis hotline;

(d) (I) Engage the services of third parties serving as crisis vendors to provide crisis outreach; stabilization, including, but not limited to, recovery support and mobile response units; acute care; and marketing for the 988 crisis hotline;

(II) Enter into any other contracts necessary for professional and technical assistance and advice and to supply other services related to the conduct of the affairs of the enterprise, without regard to the "Procurement Code", articles 101 to 112 of title 24.

(III) The BHA shall provide office space and administrative staff to the enterprise pursuant to a contract entered into pursuant to subsection (4)(d)(II) of this section.

(e) By resolution, authorize and issue revenue bonds that are payable only from the money in the 988 crisis hotline cash fund created in section 27-64-104; and

(f) Adopt, amend, or repeal policies for the regulation of its affairs and the conduct of its business consistent with this section.

(5) (a) On or before July 1, 2022, the enterprise shall fund a nonprofit organization to operate the 988 crisis hotline and provide intervention services and crisis care coordination to individuals

calling the 988 crisis hotline from any jurisdiction within Colorado twenty-four hours a day, seven days a week.

(b) The nonprofit organization shall:

(I) Have an active agreement with the administrator of the national suicide prevention lifeline for participation within the network;

(II) Meet the national suicide prevention lifeline requirements and best practice guidelines for operational and clinical standards;

(III) Meet the national suicide prevention lifeline requirements for serving high-risk and specialized populations;

(IV) Deploy mobile response units and co-responder programs that are part of the behavioral health crisis response system, created pursuant to section 27-60-103, and coordinate access to crisis walk-in centers, as appropriate; and

(V) Provide follow-up services to individuals accessing the 988 crisis hotline.

(6) The enterprise shall collaborate with the national suicide prevention lifeline and the veterans crisis line for the purpose of ensuring consistent public messaging about the 988 crisis hotline center and available services.

(7) The enterprise shall consider funding to ensure that individuals calling or texting the legacy statewide telephone crisis lines are routed to the 988 crisis hotline.

(8) The enterprise is subject to the open meetings provisions of the "Colorado Sunshine Act of 1972", contained in part 4 of article 6 of title 24, and the "Colorado Open Records Act", part 2 of article 72 of title 24.

(9) For purposes of the "Colorado Open Records Act", part 2 of article 72 of title 24, and except as may otherwise be provided by federal law or regulation or state law, the records of the enterprise are public records, as defined in section 24-72-202 (6), regardless of whether the enterprise receives less than ten percent of its total annual revenue in grants, as defined in section 24-77-102 (7), from all Colorado state and local governments combined.

(10) The enterprise is a public entity for purposes of part 2 of article 57 of title 11.

Source: L. 2021: Entire article added, (SB 21-154), ch. 360, p. 2345, § 1, effective September 7. **L. 2022:** (1) and (4)(d)(III) amended, (HB 22-1278), ch. 222, p. 1536, § 112, effective July 1. **L. 2023:** (1) amended, (HB 23-1301), ch. 303, p. 1838, § 70, effective August 7. **L. 2025:** (4)(d)(I) and (7) amended, (SB 25-236), ch. 140, p. 530, § 5, effective July 1. **L. 2026:** (4)(b) amended, (HB 26-1115), ch. 17, p. 80, § 1, effective March 26.

27-64-104. 988 crisis hotline cash fund - creation.

(1) The 988 crisis hotline cash fund, referred to in this section as the "fund", is created in the state treasury. The fund consists of money credited to the fund in accordance with article 17.5 of title 40.

(2) The state treasurer shall credit all interest and income derived from the deposit and investment of money in the fund to the fund.

(3) Money in the fund is continuously appropriated. The enterprise may expend money from the fund for the purposes outlined in section 27-64-103 (4)(c) and (4)(d).

(4) The board may seek, accept, and expend gifts, grants, or donations from private or public sources for the purposes of this section, so long as the combination of grants from state and local governments is less than ten percent of the enterprise's total annual revenue.

Source: L. 2021: Entire article added, (SB 21-154), ch. 360, p. 2347, § 1, effective September 7. **L. 2023:** (3) amended, (HB 23-1236), ch. 206, p. 1065, § 35, effective May 16.

27-64-105. Reports.

(1) Beginning January 1, 2023, and each January 1 thereafter, the BHA shall:

(a) Submit information about the usage of the 988 crisis hotline and services provided to the federal substance abuse and mental health services administration and information about the expenditures of the 988 crisis hotline cash fund to the federal communications commission; and

(b) Report progress on the implementation of the 988 crisis hotline, including the usage of the 988 crisis hotline, the services provided, and the deposits and expenditures from the 988 crisis hotline cash fund as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" hearing required by section 2-7-203.

Source: L. 2021: Entire article added, (SB 21-154), ch. 360, p. 2347, § 1, effective September 7. **L. 2022:** IP(1) amended, (HB 22-1278), ch. 222, p. 1537, § 113, effective July 1.

ARTICLE 64.5

System of Care for Children and Youth with Complex Behavioral Health Needs

27-64.5-101. Definitions.

27-64.5-102. System of care for children and youth - report - rules.

27-64.5-101. Definitions.

As used in this article 64.5, unless the context otherwise requires:

(1) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-50-102.

(2) "Child or youth" means an individual who is less than twenty-one years of age.

(3) "State department" means the state department of human services created pursuant to section 26-1-105.

Source: L. 2024: Entire article added, (HB 24-1038), ch. 459, p. 3181, § 4, effective June 6.

27-64.5-102. System of care for children and youth - report - rules.

(1) No later than July 1, 2024, the behavioral health administration, in collaboration with the state department and the department of health care policy and financing pursuant to part 20 of article 6 of title 25.5, shall begin developing a system of care for children and youth who have complex behavioral health needs. At a minimum, the system of care must include:

(a) Implementation of a standardized assessment tool that:

(I) Expands upon and modifies the assessment tool described in section 19-1-115 (4)(e)(I);

(II) Makes recommendations regarding the appropriate level of care necessary to meet the child's or youth's treatment needs;

(III) Informs the child's or youth's treatment planning, including behavioral health programming and medical needs; and

(IV) Is administered to children and youth who are enrolled in the state medical assistance program or any child or youth who meets the referral requirements established by the behavioral health administration, the state department, and the department of health care policy and

financing, which requirements must not exclude a child or youth based on the child's or youth's disability or diagnosis;

(b) Intensive-care coordination for children and youth enrolled in the state medical assistance program pursuant to articles 4, 5, and 6 of title 25.5;

(c) Expanded supportive services for children and youth pursuant to subsection (2) of this section; and

(d) Expanded access to treatment foster care, as defined in section 26-6-903.

(2) No later than October 1, 2024, the BHA shall promulgate rules in collaboration with the state department and the department of health care policy and financing for the administration and implementation of the system of care for children and youth. At a minimum, the rules must address:

(a) The populations eligible for the system of care components;

(b) Mechanisms for determining eligibility for participating in the system of care; and

(c) Requirements for residential treatment providers to obtain cultural competency related to the provision of services under a system of care.

(3) Notwithstanding section 24-1-136 (11)(a)(I), beginning January 2025, and each January thereafter, the state department shall report progress on the development and implementation of the system of care developed pursuant to this section to the house of representatives health and human services committee and the senate health and human services committee, or their successor committees, during the hearings held pursuant to the "SMART Act", part 2 of article 7 of title 2.

Source: L. 2024: Entire article added, (HB 24-1038), ch. 459, p. 3181, § 4, effective June 6.

MENTAL HEALTH AND MENTAL HEALTH DISORDERS

ARTICLE 65

Care and Treatment of Persons with Mental Health Disorders

PART 1
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PART 2
CIVIL COMMITMENT OF INCOMPETENT AND UNRESTORABLE PERSON

27-65-201. Court supervision of incompetent and unrestorable person ordered into civil commitment - repeal.

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PART 1

EMERGENCY MENTAL HEALTH HOLDS AND CERTIFICATION FOR TREATMENT

27-65-101. Legislative declaration.

(1) The general assembly declares that the purposes of this article 65 are:

(a) To secure for each person with a mental health disorder such care and treatment suited to the person's needs and to ensure that the care and treatment are skillfully and humanely administered with full respect for the person's dignity and personal integrity;

(b) To deprive a person of the person's liberty for purposes of care or treatment only when less restrictive alternatives are unavailable and only when the person's safety or the safety of others is endangered;

(c) To provide the fullest possible measure of privacy, dignity, and other rights to persons undergoing care and treatment for a mental health disorder;

(d) To encourage the use of voluntary, rather than coercive, measures to provide care and treatment for mental health disorders and to provide the care and treatment in the least restrictive setting;

(e) To provide appropriate information to family members concerning the location and fact of admission of a person with a mental health disorder to inpatient or residential care and treatment;

(f) To encourage the appropriate participation of family members in the care and treatment of a person with a mental health disorder and, when appropriate, to provide information to family members in order to facilitate that participation; and

(g) To facilitate the recovery and resiliency of each person who receives care and treatment pursuant to this article 65.

(2) To carry out these purposes, the provisions of this article 65 must be liberally construed.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3170, § 1, effective August 10.

Editor's note: This section is similar to former § 27-65-101 as it existed prior to 2022.

ANNOTATION

Law reviews. For article, "Patients' Rights vs. Patients' Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado", see 58 Den. L.J. 567 (1981).

Annotator's note. Since § 27-65-101 is similar to § 27-10-101 as it existed prior to the 2010 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

The intent of this article is to provide services to all mentally ill persons, as defined, not just to those persons who are so mentally ill as to be gravely disabled or an imminent danger to themselves or others. Goebel v. Colo. Dept. of Institutions, 830 P.2d 1036 (Colo. 1992).

The statutory scheme for the care and treatment of mentally ill persons is calculated (1) to provide care and treatment adequately suited to the needs of patients in a dignified and least restrictive manner and (2) to ensure against premature release of patients when that release would pose a likely risk of serious bodily harm to the patient or others as a result of the patient's mental condition. Perreira v. State, 768 P.2d 1198 (Colo. 1989); People in Interest of Reynes, 870 P.2d 518 (Colo. App. 1993).

Difference from criminal commitment not violative of equal protection. The differences in the commitment procedures and standards of release for criminal and civil commitments do not violate equal protection of the laws. People v. Chavez, 629 P.2d 1040 (Colo. 1981).

Entire tenor of this article is to recognize and protect the dignity and legal rights of patients treated pursuant to its provisions. Goedecke v. State Dept. of Insts., 198 Colo. 407, 603 P.2d 123 (1979).

Concern of general assembly was to devise system which protects rights of the individual while, at the same time, creating a method to discover the truth of the patient's mental illness and whether this illness causes the individual to be a danger to others or to himself or to be gravely disabled. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

This article applies to both voluntary and involuntary patients. Goebel v. Colo. Dept. of Institutions, 764 P.2d 785 (Colo. 1988); Goebel v. Colo. Dept. of Institutions, 830 P.2d 1036 (Colo. 1992).

Primary purpose of civil commitment is to secure such treatment as is suited to the needs of the person under conditions which are as least restrictive of liberty as practicable. People v. Chavez, 629 P.2d 1040 (Colo. 1981).

This act applies to those who are mentally ill and seek treatment before they become so mentally ill as to be dangerous or gravely disabled. Goebel v. Colo. Dept. of Institutions, 830 P.2d 1036 (Colo. 1992).

Article is to be strictly construed to see that no limit is placed on a person's right to seek voluntary treatment. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

The provisions of this article must be strictly construed because of their curtailment of personal liberty. People in Interest of Bucholz, 778 P.2d 300 (Colo. App. 1989).

Powers to confine carefully restrained. The state's power to confine persons on the basis of mental illness must be carefully restrained by procedural safeguards, and can be invoked only by conditions great enough to justify such a massive curtailment of liberty. People v. Lane, 196 Colo. 42, 581 P.2d 719 (1978).

Disability sufficient to justify involuntary commitment must arise as result of mental illness; and in keeping with the statutory purpose, it must be so grave that the person's safety is threatened by his inability to take care of his basic personal needs. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Mere disability alone is insufficient to warrant involuntary commitment. Mere disability alone, even if found in conjunction with mental illness, is not enough to warrant involuntary commitment. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Duty of a therapist to protect third persons from harm must be measured by the foreseeability of the risk and whether the danger created is sufficiently large to embrace the specific harm. Brady v. Hopper, 570 F. Supp. 1333 (D. Colo. 1983) (decided prior to enactment of § 13-21-117).

The therapist-patient relationship is one which under certain circumstances will give rise to a duty on the part of the therapist to protect third persons from harm. Brady v. Hopper, 570 F. Supp. 1333 (D. Colo. 1983) (decided prior to enactment of § 13-21-117).

For due process considerations in civil commitment proceedings, see People v. Chavez, 629 P.2d 1040 (Colo. 1981).

Less restrictive alternatives need not be considered as a condition precedent to certification. Civil commitment constitutes a severe infringement of liberty requiring due process protection. However, the statutory scheme set forth in this article contains a number of procedural safeguards that greatly reduce the inherent risk of erroneous deprivation. Therefore, due process does not require a mandatory hearing at the time of certification since the statute provides for a hearing on request. People v. Stevens, 761 P.2d 768 (Colo. 1988).

Psychologist-client privilege. In keeping with the statutory goal of securing care and treatment on an individual basis, former § 27-10-120 is intended as an authorization for a psychologist to testify to observations concerning an involuntarily detained person when the issue before the court is whether the statutory conditions for certification for short-term treatment have been satisfied. People v. District Court, 797 P.2d 1259 (Colo. 1990).

Applied in People in Interest of Paiz, 43 Colo. App. 352, 603 P.2d 976 (1979); Sisneros v. District Court, 199 Colo. 179, 606 P.2d 55 (1980); People in Interest of Freeman, 636 P.2d 1334 (Colo. App. 1981); People v. White, 656 P.2d 690 (Colo. 1983).

27-65-101.5. Nonapplicability of article if individual has intellectual and developmental disability or neurocognitive disorder.

The provisions of part 5 of article 10 of title 25.5 apply and this article 65 does not apply if a person has an intellectual and developmental disability or a neurocognitive disorder, as those terms are defined in section 25.5-10-501, without any other mental health disorder that is not an intellectual and developmental disability or neurocognitive disorder and that substantially contributes to whether the respondent is a danger to the respondent's self or a danger to others, or is gravely disabled.

Source: L. 2026: Entire section added, (SB 26-149), ch. 142, p. 727, § 2, effective May 21.

27-65-102. Definitions.

As used in this article 65, unless the context otherwise requires:

(1) "Acute treatment unit" means a facility or a distinct part of a facility for short-term psychiatric care, which may include treatment for substance use disorders, that provides a total, twenty-four-hour, therapeutically planned and professionally staffed environment for persons who do not require inpatient hospitalization but need more intense and individual services than are available on an outpatient basis, such as crisis management and stabilization services.

(2) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-60-203.

(3) "Behavioral health crisis" means a significant disruption in a person's mental or emotional stability or functioning resulting in an urgent need for immediate assessment and treatment to prevent a serious deterioration in the person's mental or physical health.

(4) "Behavioral health crisis response team" means a mobile team that responds to people in the community who are in a behavioral health crisis and includes at least one licensed or bachelor-degree-level behavioral health worker. A "behavioral health crisis response team" includes, but is not limited to, a co-responder model, mobile crisis response unit, or a community response team.

(5) "Behavioral health entity" has the same meaning as set forth in section 27-50-101.

(6) "Certified peace officer" means any certified peace officer as described in section 16-2.5-102.

(7) "Commissioner" means the commissioner of the behavioral health administration established in section 27-60-203.

(8) "Court" means any district court of the state of Colorado and the probate court in the city and county of Denver.

(9) "Court-ordered evaluation" means an evaluation ordered by a court pursuant to section 27-65-106.

(10) "Danger to others" means a person poses a substantial risk of physical harm to another person or persons, as manifested by evidence of recent homicidal or other violent behavior by the person in question, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt, or threat to do serious physical harm by the person in question.

(10.2) "Danger to the person's self", or similar terminology, means a person poses a substantial risk of physical harm to the person's self as manifested by evidence of recent threats or attempts at suicide or serious bodily harm to the person's self.

(11) "Department" or "CDHS" means the department of human services.

(12) "Emergency medical services facility" means a general hospital with an emergency department or a freestanding emergency department, as defined in section 25-1.5-114 (5). An emergency medical services facility is not required to be, but may elect to become, a facility designated or approved by the commissioner.

(13) "Emergency medical services provider" has the same meaning as set forth in section 25-3.5-103 (8).

(14) Repealed.

(15) "Facility" means a public hospital or a licensed private hospital, behavioral health entity, institution, or residential child care facility that provides treatment for persons with mental health disorders.

(16) "Family member" means a spouse, partner in a civil union, as defined in section 14-15-103 (5), parent, adult child, or adult sibling of a person with a mental health disorder.

(17) "Gravely disabled" means a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about or providing for the person's essential needs without significant supervision and assistance from other people. As a result of being incapable of making these informed decisions, a person who is gravely disabled is at risk of substantial bodily harm, dangerous worsening of any concomitant serious physical illness, significant psychiatric deterioration, or mismanagement of the person's essential needs that could result in substantial bodily harm. A person of any age may be "gravely disabled", but the term does not include a person whose decision-making capabilities are limited solely by the person's developmental disability.

(18) "Hospitalization" means twenty-four-hour out-of-home placement for treatment in a facility for a person with a mental health disorder.

(19) "Independent professional person" means a professional person who evaluates a minor's condition as an independent decision-maker and whose recommendations are based on the standard of what is in the best interest of the minor. The professional person may be associated with the admitting facility if the professional person is free to independently evaluate the minor's condition and need for treatment and has the authority to refuse admission to any minor who does not satisfy the statutory standards specified in section 27-65-104 (2).

(20) "Intervening professional" means a person who is one of the following:

(a) A professional person;

(b) A physician assistant licensed pursuant to section 12-240-113;

(c) An advanced practice registered nurse, as defined in section 12-255-104 (1);

(d) A registered professional nurse, as defined in section 12-255-104 (11), who has specific mental health training as identified by the BHA;

(e) A clinical social worker licensed pursuant to part 4 of article 245 of title 12;

(f) A marriage and family therapist licensed pursuant to part 5 of article 245 of title 12;

(g) A professional counselor licensed pursuant to part 6 of article 245 of title 12; or

(h) An addiction counselor licensed pursuant to part 8 of article 245 of title 12.

(21) "Lay person" means a person identified by another person who is detained on an involuntary emergency mental health hold pursuant to section 27-65-106, certified for short-term treatment pursuant to section 27-65-108.5, 27-65-109, or 27-65-109.5, or certified for long-term care and treatment pursuant to section 27-65-110 who is authorized to participate in activities related to the person's involuntary emergency mental health hold, short-term treatment, or long-term treatment, including court appearances, discharge planning, and grievances. The person may rescind the lay person's authorization at any time.

(22) "Mental health disorder" means one or more substantial disorders of the cognitive, volitional, or emotional processes that grossly impairs judgment or capacity to recognize reality or to control behavior and includes a mental disability or developmental disability, as those terms are defined in section 16-8.5-101, which has led a court to find the person with the disability incompetent to proceed pursuant to article 8.5 of title 16.

(23) "Minor" means a person under eighteen years of age; except that the term does not include a person who is fifteen years of age or older who is living separately and apart from the person's parent or legal guardian and is managing the person's own financial affairs, regardless of the person's source of income, or who is married and living separately and apart from the person's parent or legal guardian.

(24) "Patient representative" means a person designated by a mental health facility to process patient complaints or grievances or to represent patients who are minors pursuant to section 27-65-104 (4).

(24.5) "Persistent mental health disorder" means:

(a) A mental health disorder that has resulted in the person having three or more of the following within the preceding three years:

(I) An emergency mental health hold pursuant to section 27-65-106;

(II) A certification for short-term treatment pursuant to section 27-65-109 or 27-65-109.5;

(III) A finding of incompetency to proceed pursuant to article 8 or 8.5 of title 16; or

(IV) An inpatient psychiatric hospitalization; and

(b) A professional person with an established treatment relationship with the person, as described in section 27-65-109.5 (1)(a), has evaluated the person within the preceding ninety days or a professional person conducting an evaluation or treatment pursuant to this article 65 has given consideration to the person's history of psychiatric deterioration and cycling through interventions and determined that:

(I) The person currently has a mental health disorder that substantially impairs the person's ability to make informed decisions about treatment;

(II) Voluntary treatment is unlikely to be sufficient to prevent further psychiatric deterioration or crisis episodes based on the person's treatment history and current presentation;

(III) Involuntary treatment is clinically indicated and appropriate given the person's current condition, level of functioning, and treatment history, including any failures to maintain voluntary treatment despite any prior assurances the person would; and

(IV) The person has not had a continuous period of twelve or more months of immediately preceding stability, unless the professional person documents specific clinical findings that current psychiatric deterioration is occurring notwithstanding the period of stability.

(25) "Petitioner" means any person who files any petition in any proceeding in the interest of any person who allegedly has a mental health disorder or is allegedly gravely disabled.

(26) "Physician" means a person licensed to practice medicine in this state.

(27) "Professional person" means a person licensed to practice medicine in this state, a psychologist licensed to practice in this state, or a person licensed and in good standing to practice medicine in another state or a psychologist licensed to practice and in good standing in another state who is providing medical or clinical services at a treatment facility in this state that is operated by the armed forces of the United States, the United States public health service, or the United States department of veterans affairs.

(27.5) "Psychiatric deterioration" means a measurable decline in overall functioning due to the person's mental health disorder. Psychiatric deterioration may be evidenced by, but not limited to, a person's increased severity or frequency of symptoms; diminished ability to perform activities of daily living resulting in mental, emotional, or physical harm; or inability to recognize the need for intervention, which has a substantial probability of resulting in harm or further decompensation to the person.

(28) "Residential child care facility" has the same meaning as set forth in section 26-6-903 (29). A residential child care facility may be eligible for designation by the commissioner pursuant to this article 65.

(29) "Respondent" means either a person alleged in a petition filed pursuant to this article 65 to have a mental health disorder or be gravely disabled or a person certified pursuant to the provisions of this article 65.

(30) "Screening" means a review of all petitions, to consist of an interview with the petitioner and, whenever possible, the respondent; an assessment of the problem; an explanation of the petition to the respondent; and a determination of whether the respondent needs and, if so, will accept on a voluntary basis, a comprehensive evaluation, treatment, referral, and other appropriate services, either on an inpatient or an outpatient basis.

(31) "Secure transportation provider" means a provider licensed pursuant to section 25-3.5-310 to provide public or private secure transportation services.

(32) "Substantial risk of serious harm to others" means an appreciable and considerable risk that the person will commit a criminal act against a person now or in the reasonably foreseeable future that causes serious bodily injury, as defined in section 18-1-901, to another person, or is likely to cause serious emotional distress to a reasonable person.

Source: L. 2022: (1.5)(a) and (28) amended, (HB 22-1295), ch. 123, p. 863, § 116, effective July 1; (2) and (7) added, (12) and (28) amended, and (14) repealed, (HB 22-1278), ch. 222, p. 1537, § 114, effective July 1; entire article amended with relocations, (HB 22-1256), ch. 451, p. 3171, § 1, effective August 10; (14) repealed, (HB 22-1256), ch. 451, p. 3240, § 56, effective August 10; (5) and (15) amended, (HB 22-1278), ch. 222, p. 1594, § 235, effective July 1, 2024. **L. 2026:** (10), (11), (21), and (22) amended and (10.2), (24.5), (27.5), and (32) added, (SB 26-149), ch. 142, p. 727, § 3, effective May 21.

Editor's note: (1) This section is similar to former § 27-65-102 as it existed prior to 2022.

(2) Subsection (2) was numbered as § 27-65-102 (1.3) in HB 22-1278 (see L. 2022, p. 1537). That provision was harmonized with subsection (2) of this section as it appears in HB 22-1256.

(3) Subsection (5) was numbered as § 27-65-102 (1.5) in HB 22-1278 (see L. 2022, p. 1594). That provision was harmonized with subsection (5) of this section as it appears in HB 22-1256, effective July 1, 2024.

(4) Subsection (1.5)(a) was amended in HB 22-1295. Those amendments were superseded by the amendments to this section in HB 22-1256, effective August 10, 2022, and HB 22-1278, effective July 1, 2024. For the amendments to section 27-65-102 (1.5)(a) in HB 22-1295 in effect from July 1, 2022, to August 10, 2022, see chapter 123, Session Laws of Colorado 2022 (L. 2022, p. 863).

(5) Subsection (7) was numbered as § 27-65-102 (2.5) in HB 22-1278 (see L. 2022, p. 1537). That provision was harmonized with subsection (7) of this section as it appears in HB 22-1256.

(6) Subsection (12) was numbered as § 27-65-102 (5.5) in HB 22-1278 (see L. 2022, p. 1537). That provision was harmonized with subsection (12) of this section as it appears in HB 22-1256.

(7) Subsection (14) was numbered as § 27-65-102 (6) in HB 22-1278 (see L. 2022, p. 1537). That provision was harmonized with subsection (14) of this section as it appears in HB 22-1256.

(8) Subsection (15) was numbered as § 27-65-102 (7) in HB 22-1278 (see L. 2022, p. 1594). That provision was harmonized with subsection (15) of this section as it appears in HB 22-1256, effective July 1, 2024.

(9) Subsection (28) was numbered as § 27-65-102 (18) in HB 22-1278 (see L. 2022, p. 1537). That provision was harmonized with HB 22-1295 and subsection (28) of this section as it appears in HB 22-1256.

(10) Subsection (14) was repealed in § 56 of HB 22-1256, effective August 10, 2022. However, those repeals were superseded by the amendment of this entire article by § 1 of HB 22-1256, effective August 10, 2022.

ANNOTATION

Law reviews. For article on commitment of mental patients, see 13 Rocky Mt. L. Rev. 99 (1941). For article, "Liability of Counties for Support of Inmates in State Institutions", see 29 Dicta 27 (1952). For article, "Commitment Procedures in Colorado", see 29 Dicta 273 (1952). For article, "Legal Capacity of Adjudged Incompetents", see 29 Dicta 292 (1952). For article, "Civil Commitment of the Mentally Ill in the Denver Probate Court", see 46 Den. L.J. 496 (1969). For article, "Due Process in Involuntary Civil Commitment and Incompetency Adjudication Proceedings: Where Does Colorado Stand?", see 46 Den. L.J. 516 (1969). For article, "The Supreme Court Sidesteps the Right to Treatment Question; O'Conner v. Donaldson", see 47 U. Colo. L. Rev. 299 (1976). For article, "Patients' Rights vs. Patients' Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado", see 58 Den. L.J. 567 (1981). For article, "The Homeless and the Law", see 14 Colo. Law. 405 (1985). For article, "Group Home Regulations Under State and Federal Law", see 35 Colo. Law. 37 (Feb. 2006). For article, "How to Reconcile Advance Care Directives With Attempted Suicide", see 42 Colo. Law. 97 (July 2013).

Annotator's note. Since § 27-65-102 is similar to § 27-10-102 as it existed prior to the 2010 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

Definitions in former subsections (5) and (7) are sufficiently clear and definite.

The definitions of mental illness and of the condition of being gravely disabled in former subsections (5) and (7) are sufficiently clear and definite to apprise both lay and professional persons of the type of conduct necessary for certification for short-term treatment. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Definition of "gravely disabled" in former subsection (5) refers to an existing rather than a prospective inability to provide for one's "basic personal needs". The determination at a certification hearing as to whether a person is "gravely disabled" must focus on the individual's existing condition, and not on the possibility of future relapse. People in Interest of Bucholz, 778 P.2d 300 (Colo. App. 1989).

Definition of "gravely disabled" takes precedence over a respondent's own testimony regarding the respondent's mental state. People in Interest of Ramsey, 2023 COA 95, 541 P.3d 1198.

Phrase "basic personal needs" means those fundamental necessities of human existence, such as food, shelter, clothing, and medical care, which an individual must obtain and maintain in order to live safely. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Statutory definition of mental illness, on its own terms, cannot be read to intend that every idiosyncratic or eccentric person requires involuntary medical intervention. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

A court's determination regarding whether a respondent has a "mental health disorder" takes precedence over a respondent's own testimony regarding the respondent's mental state. People in Interest of Ramsey, 2023 COA 95, 541 P.3d 1198.

It is necessary prerequisite to ordering short-term involuntary psychiatric treatment that the professional treatment and evaluation staff find, after analysis, that the person for whom certification is sought is mentally ill and, as a result of mental illness, is a danger to others or to himself or is gravely disabled. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

For previous definition of "insane person", see Arridy v. People, 103 Colo. 29, 82 P.2d 757 (1938); Browne v. Smith, 119 Colo. 469, 205 P.2d 239 (1949).

Applied in People in Interest of Paiz, 43 Colo. App. 352, 603 P.2d 976 (1979).

27-65-103. Voluntary applications for mental health services.

(1) Nothing in this article 65 in any way limits the right of any person to make a voluntary application at any time to any public or private agency or professional person for mental health services, either by direct application in person or by referral from any other public or private agency or professional person. Subject to section 15-14-316 (4), a ward, as defined in section 15-14-102 (15), may be admitted to a hospital or institutional care and treatment for a mental health

disorder with the guardian's consent for as long as the ward agrees to such care and treatment. The guardian shall immediately notify in writing the court that appointed the guardian of the admission.

(2) For the purpose of this article 65, the treatment by prayer in the practice of the religion of any church that teaches reliance on spiritual means alone for healing is considered a form of treatment.

(3) The medical and legal status of all voluntary patients receiving treatment for mental health disorders in inpatient or custodial facilities must be reviewed at least once every six months.

(4) Voluntary patients are afforded all the rights and privileges customarily granted by hospitals to their patients.

(5) (a) If at any time during an emergency mental health hold of a person who is confined involuntarily the facility staff requests the person to sign in voluntarily and the person elects to do so, the following advisement shall be given orally and in writing and an appropriate notation shall be made in the person's medical record by the professional person or the professional person's designated agent:

NOTICE

The decision to sign in voluntarily should be made by you alone and should be free from any force or pressure implied or otherwise. If you do not feel that you are able to make a truly voluntary decision, you may continue to be held at the hospital involuntarily. As an involuntary patient, you will have the right to protest your confinement and request a hearing before a judge.

(b) This subsection (5) does not apply to a person on an emergency mental health hold in an emergency medical services facility.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3175, § 1, effective August 10.

Editor's note: This section is similar to former § 27-65-103 as it existed prior to 2022.

ANNOTATION

Law reviews. For article, "Commitment Procedures in Colorado", see 29 Dicta 273 (1952). For article, "Legal But Not Fair: Legal Implications of a Mental Illness Medical Model", see 11 Colo. Law. 1234 (1982). For article, "Legislative Update", see 12 Colo. Law. 1251 (1983). For article, "Legislative Update", see 13 Colo. Law. 1419 (1984). For article, "Nailing Jello to the Wall: Colorado Regulates Psychotherapists", see 19 Colo. Law. 71 (1990).

No limit on right to seek voluntary treatment. This article is to be strictly construed to see that no limit is placed on a person's right to seek voluntary treatment. People v. Taylor, 618 P.2d 1127 (Colo. 1980) (decided prior to 2010 amendments to this article).

27-65-104. Voluntary applications for mental health services - treatment of minors - definition.

(1) Notwithstanding any other provision of law, a minor who is fifteen years of age or older, whether with or without the consent of a parent or legal guardian, may consent to receive mental health services to be rendered by a facility, a professional person, or mental health professional licensed pursuant to part 3, 4, 5, 6, or 8 of article 245 of title 12 in any practice setting. Such consent is not subject to disaffirmance because of minority. The professional person or licensed mental health professional rendering mental health services to a minor may, with or without the consent of the minor, advise the minor's parent or legal guardian of the services given or needed.

(2) A minor who is fifteen years of age or older or a minor's parent or legal guardian, on the minor's behalf, may make a voluntary application for hospitalization. An application for hospitalization on behalf of a minor who is under fifteen years of age and who is a ward of the department must not be made unless a guardian ad litem has been appointed for the minor or a petition for the same has been filed with the court by the agency having custody of the minor; except that such an application for hospitalization may be made under emergency circumstances requiring immediate hospitalization, in which case the agency shall file a petition for appointment of a guardian ad litem within seventy-two hours after application for admission is made, and the court shall immediately appoint a guardian ad litem. Procedures for hospitalization of a minor may proceed pursuant to this section once a petition for appointment of a guardian ad litem has been filed, if necessary. Whenever an application for hospitalization is made, an independent professional person shall interview the minor and conduct a careful investigation into the minor's background, using all available sources, including, but not limited to, the minor's parents or legal guardian, the minor's school, and any other social service agencies. Prior to admitting a minor for hospitalization, the independent professional person shall make the following findings:

(a) That the minor has a mental health disorder and is in need of hospitalization;

(b) That a less restrictive treatment alternative is inappropriate or unavailable; and

(c) That hospitalization is likely to be beneficial.

(3) An interview and investigation by an independent professional person is not required for a minor who is fifteen years of age or older and who, upon the recommendation of the minor's treating professional person, seeks voluntary hospitalization with the consent of the minor's parent or legal guardian. In order to assure that the minor's consent to such hospitalization is voluntary, the minor shall be advised, at or before the time of admission, of the minor's right to refuse to sign the admission consent form and the minor's right to revoke the minor's consent at a later date. If a minor admitted pursuant to this subsection (3) subsequently revokes the minor's consent after admission, a review of the minor's need for hospitalization pursuant to subsection (4) of this section must be initiated immediately.

(4) (a) The need for continuing hospitalization of all voluntary minor patients must be formally reviewed at least every two months. Review pursuant to this subsection (4) must fulfill the requirement specified in section 19-1-115 (8) when the minor is fifteen years of age or older and consenting to hospitalization.

(b) The review must be conducted by an independent professional person who is not a member of the minor's treating team; or, if the minor, the minor's physician, and the minor's parent or legal guardian do not object to the need for continued hospitalization, the review required pursuant to this subsection (4) may be conducted internally by the hospital staff.

(c) The independent professional person shall determine whether the minor continues to meet the criteria specified in subsection (2) of this section and whether continued hospitalization is appropriate and shall, at a minimum, conduct an investigation pursuant to subsection (2) of this section.

(d) Ten days prior to the review, the patient representative at the mental health facility shall notify the minor of the date of the review and shall assist the minor in articulating to the independent professional person the minor's wishes concerning continued hospitalization.

(e) Nothing in this section limits a minor's right to seek release from the facility pursuant to any other provision of law.

(5) Every six months the review required pursuant to subsection (4) of this section shall be conducted by an independent professional person who is not a member of the minor's treating team and who has not previously reviewed the minor pursuant to subsection (4) of this section.

(6) (a) When a minor does not consent to or objects to continued hospitalization, the need for such continued hospitalization must, within ten days, be reviewed pursuant to subsection (4) of this section by an independent professional person who is not a member of the minor's treating

team and who has not previously reviewed the minor pursuant to this subsection (6). The minor shall be informed of the results of the review within three days after the review's completion. If the conclusion reached by the professional person is that the minor no longer meets the standards for hospitalization specified in subsection (2) of this section, the minor must be discharged.

(b) If, twenty-four hours after being informed of the results of the review specified in subsection (6)(a) of this section, a minor continues to affirm the objection to hospitalization, the director of the facility or the director's duly appointed representative shall advise the minor that the minor has the right to retain and consult with an attorney at any time and that the director or the director's duly appointed representative shall file, within three days after the request of the minor, a statement requesting an attorney for the minor or, if the minor is under fifteen years of age, a guardian ad litem. The minor; the minor's attorney, if any; and the minor's parent, legal guardian, or guardian ad litem, if any, shall be given written notice that a hearing upon the recommendation for continued hospitalization may be had before the court or a jury upon written request directed to the court pursuant to subsection (6)(d) of this section.

(c) Whenever the statement requesting an attorney is filed with the court, the court shall ascertain whether the minor has retained counsel, and, if the minor has not, the court shall, within three days, appoint an attorney to represent the minor, or if the minor is under fifteen years of age, a guardian ad litem. Upon receipt of a petition filed by the guardian ad litem, the court shall appoint an attorney to represent the minor under fifteen years of age.

(d) (I) The minor or the minor's attorney or guardian ad litem may, at any time after the minor has continued to affirm the minor's objection to hospitalization pursuant to subsection (6)(b) of this section, file a written request that the recommendation for continued hospitalization be reviewed by the court or that the treatment be on an outpatient basis. If review is requested, the court shall hear the matter within ten days after the request, and the court shall give notice of the time and place of the hearing to the minor; the minor's attorney, if any; the minor's parents or legal guardian; the minor's guardian ad litem, if any; the independent professional person; and the minor's treating team. The hearing must be held in accordance with section 27-65-113.1; except that the court or jury shall determine that the minor is in need of care and treatment if the court or jury makes the following findings:

(A) That the minor has a mental health disorder and is in need of hospitalization;

(B) That a less restrictive treatment alternative is inappropriate or unavailable; and

(C) That hospitalization is likely to be beneficial.

(II) At the conclusion of the hearing, the court may enter an order confirming the recommendation for continued hospitalization, discharge the minor, or enter any other appropriate order.

(e) For purposes of this subsection (6), "objects to hospitalization" means that a minor, with the necessary assistance of hospital staff, has written the minor's objections to continued hospitalization and has been given an opportunity to affirm or disaffirm such objections forty-eight hours after the objections are first written.

(f) A minor may not again object to hospitalization pursuant to this subsection (6) until ninety days after conclusion of proceedings pursuant to this subsection (6).

(g) In addition to the rights specified in section 27-65-119 for persons receiving evaluation, care, or treatment, a written notice specifying the rights of minor children under this section must be given to each minor upon admission to hospitalization.

(7) A minor who no longer meets the standards for hospitalization specified in subsection (2) of this section must be discharged.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3176, § 1, effective August 10. **L. 2026:** IP(6)(d)(I) amended, (SB 26-149), ch. 142, p. 729, § 4, effective May 21.

Editor's note: The provisions of this section are similar to several former provisions of § 27-65-103 as they existed prior to 2022. For a detailed comparison, see the comparative tables located in the back of the index.

ANNOTATION

Law reviews. For article, "Consent to Treatment and Access to Minors' Medical Records", see 17 Colo. Law. 1323 (1988).

27-65-105. Rights of respondents.

Unless specifically stated in an order by the court, a respondent does not forfeit any legal right or suffer legal disability by reason of the provisions of this article 65.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3179, § 1, effective August 10; (6) repealed, (HB 22-1256), ch. 451, p. 3240, § 56, effective August 10.

Editor's note: (1) The provisions of this section are similar to § 27-65-104 as it existed prior to 2022.

(2) Subsection (6) was repealed in § 56 of HB 22-1256, effective August 10, 2022. However, those repeals were superseded by the amendment of this entire article by § 1 of HB 22-1256, effective August 10, 2022.

ANNOTATION

Law reviews. For article, "Legal Capacity of Adjudged Incompetents", see 29 Dicta 292 (1952). For article, "Legal But Not Fair: Legal Implications of a Mental Illness Medical Model", see 11 Colo. Law. 1234 (1982).

Annotator's note. Since § 27-65-105 is similar to § 27-65-104 as it existed prior to the 2022 amendments to this article and to laws antecedent to that section, relevant cases construing those provisions have been included in the annotations to this section.

Patient's common-law right to decline medical treatment is among those protected by this section and is preserved intact in the absence of some finding that the patient's illness has so impaired his judgment that he is incapable of participating in decisions affecting his health. Goedecke v. State Dept. of Insts., 198 Colo. 407, 603 P.2d 123 (1979).

Right of incompetent to decline treatment. The right to decline medical treatment is not lost to a patient who is mentally incapable of deciding that question for himself. People in Interest of Medina, 662 P.2d 184 (Colo. App. 1982), aff'd, 705 P.2d 961 (Colo. 1985).

When nonconsensual treatment may be ordered. Treatment with antipsychotic medication should not be ordered unless: (1) The patient is incompetent to effectively participate in the treatment decision; (2) such treatment is necessary to prevent long-term deterioration in the patient's mental condition; (3) a less intrusive treatment is not available; and (4) the patient's need for such treatment overrides any legitimate interest of the patient in refusing treatment. In any event, and the order for involuntary medication cannot exceed six months without further extension. People v. Medina, 705 P.2d 961 (Colo. 1985).

A court may authorize the administration of a backup medication only when the petitioner presents clear and convincing evidence, and the court finds a specific articulable concern, that the involuntary administration of the primary medication will be ineffective if the patient experiences a recurrence of a condition or symptoms that previously required administration of the backup medication. People in Interest of D.N.W., 2024 COA 129, 564 P.3d 1126.

Medina test for forcibly administering medication applies equally to a forcible increase in medication dosage. The second

Medina element requires a patient to be deteriorating, which does not mean the same thing as "not improving". A patient who is simply not improving will not satisfy the Medina test for forcible administration of medication. People v. Marquardt, 2016 CO 4, 364 P.3d 499.

The fourth factor dictated in Medina was met when the court reduced dosage of antipsychotic medication to minimize side effects suffered by plaintiff. Clear and convincing evidence existed that the need for the drug, as ordered to be administered by the trial court, outweighed all legitimate interests the petitioner had in refusing such treatment. Donaldson v. District Court for the City and County of Denver, 847 P.2d 632 (Colo. 1993).

For capacity of incompetent to contract and to execute deeds, see Rohrer v. Darrow, 66 Colo. 463, 182 P. 13 (1919); Davis v. Colo. Kenworth Corp., 156 Colo. 98, 396 P.2d 958 (1964).

Applied in People in Interest of Freeman, 636 P.2d 1334 (Colo. App. 1981).

27-65-106. Emergency mental health hold - screening - court-ordered evaluation - discharge instructions - respondent's rights.

(1) An emergency mental health hold may be initiated under one of the following conditions:

(a) (I) When a certified peace officer has probable cause to believe a person has a mental health disorder and, as a result of the mental health disorder, is an imminent danger to the person's self, an imminent danger to others, or gravely disabled, the certified peace officer may take the person into protective custody and transport the person to a facility designated by the commissioner for an emergency mental health hold. If a facility is not available, the certified peace officer may transport the person to an emergency medical services facility. The certified peace officer may request assistance from a behavioral health crisis response team for assistance in detaining and transporting the person or an emergency medical services provider in transporting the person; or

(II) When an intervening professional reasonably believes that a person appears to have a mental health disorder and, as a result of the mental health disorder, appears to be an imminent danger to the person's self, an imminent danger to others, or gravely disabled, the intervening professional may cause the person to be taken into protective custody and transported to a facility designated by the commissioner for an emergency mental health hold. If a facility is not available, the certified peace officer may transport the person to an emergency medical services facility. The intervening professional may request assistance from a certified peace officer, a secure transportation provider, or a behavioral health crisis response team for assistance in detaining and transporting the person, or assistance from an emergency medical services provider in transporting the person.

(b) (I) When a person petitions the court in the county in which the respondent resides or is physically present requesting an evaluation of the respondent's condition and alleging that the respondent appears to have a mental health disorder and, as a result of the mental health disorder, appears to be a danger to the respondent's self, a danger to others, or gravely disabled.

(II) Any person who files a malicious or false petition for an evaluation of a respondent pursuant to this section is subject to criminal prosecution.

(2) (a) When a person is taken into custody pursuant to subsection (1) of this section, the person must not be detained in a jail, lockup, or other place used for the confinement of persons charged with or convicted of penal offenses. Unless otherwise required by law, a certified peace officer may transport the person to an emergency medical services facility or facility designated by the commissioner for an emergency mental health hold even if a warrant has been issued for the person's arrest if the certified peace officer believes it is in the best interest of the person. The person must not be held on an emergency mental health hold for longer than seventy-two hours after the hold is placed or ordered. Nothing in this section prohibits an emergency medical services facility from involuntarily holding the person in order to stabilize the person as required pursuant to the federal "Emergency Medical Treatment and Labor Act", 42 U.S.C. sec. 1395dd, or if the treating professional determines that the person's physical or mental health disorder impairs the person's ability to make an informed decision to refuse care and the provider determines that further care is indicated.

(b) This section does not preclude:

(I) A court from ordering an evaluation at the jail when the person is lawfully confined in jail because the person is charged with or convicted of a penal offense; or

(II) A person or entity that has care and custody of a detained person from transporting the detained person to an emergency medical services facility or facility designated by the commissioner for an emergency mental health hold.

(3) When a person is placed on an emergency mental health hold pursuant to subsection (1) of this section and is presented to an emergency medical services facility or a facility designated by the commissioner for an emergency mental health hold, the facility shall require a BHA-approved application in writing, stating the circumstances under which the person's condition was called to the attention of the intervening professional or certified peace officer and further stating sufficient facts, obtained from the intervening professional's or certified peace officer's personal observations or obtained from others whom the intervening professional or certified peace officer reasonably believes to be reliable, to establish that the person has a mental health disorder and, as a result of the mental health disorder, is an imminent danger to the person's self, a danger to others, or gravely disabled. The application must indicate when the person was taken into custody and who brought the person's condition to the attention of the intervening

professional or certified peace officer. A copy of the application must be furnished to the person being evaluated, and the application must be retained in accordance with section 27-65-123 (4).

(4) (a) The petition for a court-ordered evaluation filed pursuant to subsection (1)(b) of this section must contain the following:

(I) The name and address of the petitioner and the petitioner's interest in the case;

(II) The name of the respondent for whom evaluation is sought, and, if known to the petitioner, the address, age, gender, marital status, occupation, and any animals or dependent children in the respondent's care;

(III) Allegations of fact indicating that the respondent may have a mental health disorder and, as a result of the mental health disorder, may be a danger to the respondent's self, a danger to others, or gravely disabled and showing reasonable grounds to warrant an evaluation;

(IV) The name and address of every person known or believed by the petitioner to be legally responsible for the care, support, and maintenance of the respondent, if available; and

(V) The name, address, and telephone number of the attorney, if any, who has most recently represented the respondent.

(a.5) The petition for a court-ordered evaluation filed pursuant to subsection (1)(b) of this section may contain the respondent's history of emergency mental health holds invoked pursuant to this section, certifications for short-term treatment or long-term care and treatment, findings of incompetency to proceed pursuant to article 8 or 8.5 of title 16, and inpatient psychiatric hospitalizations, and a statement whether the petitioner believes the respondent has a persistent mental health disorder. In determining whether probable cause exists to order an evaluation, the court shall consider any history of emergency mental health holds invoked pursuant to this section, certifications for short-term treatment or long-term care and treatment, findings of incompetency to proceed pursuant to article 8 or 8.5 of title 16, and inpatient psychiatric hospitalizations, and whether the respondent may qualify as having a persistent mental health disorder.

(b) Upon receipt of a petition satisfying the requirements of subsection (4)(a) of this section, if the court is not satisfied that probable cause exists to issue an order for an evaluation, the court shall identify a facility designated by the commissioner, an intervening professional, or a certified peace officer to provide screening of the respondent to determine whether probable cause exists to believe the allegations.

(c) Following the screening described in subsection (4)(b) of this section, the facility, intervening professional, or certified peace officer designated by the court shall file a report with the court and may initiate an emergency mental health hold at the time of screening. The report must include a recommendation as to whether probable cause exists to believe that the respondent has a mental health disorder and, as a result of the mental health disorder, is a danger

to the respondent's self, a danger to others, or gravely disabled, and whether the respondent will voluntarily receive evaluation or treatment. The screening report submitted to the court pursuant to this subsection (4)(c) is confidential in accordance with section 27-65-123 and must be furnished to the respondent or the respondent's attorney or personal representative.

(d) Whenever it appears, by petition and screening pursuant to this section, to the satisfaction of the court that probable cause exists to believe that the respondent has a mental health disorder and, as a result of the mental health disorder, is a danger to the respondent's self, a danger to others, or gravely disabled, and that efforts have been made to secure the cooperation of the respondent but the respondent has refused or failed to accept an evaluation voluntarily, the court shall issue an order for an evaluation authorizing a certified peace officer or secure transportation provider to take the respondent into custody and transport the respondent to a facility designated by the commissioner for an emergency mental health hold. At the time the respondent is taken into custody, a copy of the petition and the order for an evaluation must be given to the respondent and promptly thereafter to the one lay person designated by the respondent and to the person in charge of the facility named in the order or the respondent's designee. If the respondent refuses to accept a copy of the petition and the order for an evaluation, the refusal must be documented in the petition and the order for the evaluation.

(5) When a person is transported to an emergency medical services facility or a facility designated by the commissioner, the facility may detain the person under an emergency mental health hold for evaluation for a period not to exceed seventy-two hours from the time the emergency mental health hold was placed or ordered. Nothing in this section prohibits an emergency medical services facility from involuntarily holding the person in order to stabilize the person as required pursuant to the federal "Emergency Medical Treatment and Labor Act", 42 U.S.C. sec. 1395dd, or if the treating professional determines that the individual's physical or mental health disorder impairs the person's ability to make an informed decision to refuse care and the provider determines that further care is indicated. If, in the opinion of the person in charge of the evaluation, the person can be properly cared for without being detained, the person shall be provided services on a voluntary basis. If the person in charge of the evaluation determines the person should be released, the person in charge of the evaluation may terminate the emergency mental health hold.

(6) (a) Each person detained for an emergency mental health hold pursuant to this section shall receive an evaluation as soon as possible after the person presents to the facility, or as soon as possible where the person is confined for a criminal charge if the person is already lawfully confined in jail, and shall receive such treatment and care as the person's condition requires for the full period that the person is held. The evaluation must include an assessment to determine if the person continues to meet the criteria for an emergency mental health hold and requires further mental health care in a facility designated by the commissioner. The evaluation must state whether the person should be released, referred for further care and treatment on a voluntary basis, or certified for short-term treatment pursuant to section 27-65-109.

(b) Each evaluation must be completed using a standardized form approved by the commissioner and may be completed by a professional person; a licensed advanced practice registered nurse with training in psychiatric nursing; or a licensed physician assistant, a licensed clinical social worker, a licensed professional counselor, or a licensed marriage and family therapist who has two years of experience in behavioral health safety and risk assessment working in a health-care setting.

(c) If the person conducting an evaluation pursuant to subsection (6)(a) of this section is not a professional person and the evaluating person recommends the detained person be certified for short-term treatment pursuant to section 27-65-109, the evaluating person shall notify the facility of the recommendation. A certification may only be initiated by a professional person.

(7) (a) If a person is evaluated at an emergency medical services facility and the evaluating professional determines that the person continues to meet the criteria for an emergency mental health hold pursuant to subsection (1) of this section, the emergency medical services facility shall immediately notify the BHA if the facility cannot locate appropriate placement. Once notified, the BHA shall support the emergency medical services facility in locating an appropriate placement option on an inpatient or outpatient basis, whichever is clinically appropriate.

(a.5) A person who is lawfully confined for a criminal charge in jail may be placed only in a secure placement or may be cared for in the person's place of confinement while the person is lawfully detained. If a person placed under an emergency mental health hold is released from confinement, the person or entity responsible for the person's confinement shall coordinate with the BHA to transfer the person to an emergency medical services facility or a facility designated by the commissioner for an emergency mental health hold.

(b) If an appropriate placement option cannot be located pursuant to subsection (7)(a) of this section and the person continues to meet the criteria for an emergency mental health hold pursuant to subsection (1) of this section and the person has been medically stabilized, the emergency medical services facility may place the person under a subsequent emergency mental health hold. If the facility places the person under a subsequent emergency mental health hold, the facility shall immediately notify the BHA, the person's lay person, and the court, and the court shall immediately appoint an attorney to represent the person. The facility may notify the court where the person resides by mail. Once the court is notified, the emergency medical services facility is not required to take any further action to provide the person with an attorney unless specified in subsection (10) of this section. The emergency medical services facility shall notify the BHA after each emergency mental health hold is placed. The BHA is responsible for actively assisting the facility in locating appropriate placement for the person. If the person has been recently transferred from an emergency medical services facility to a facility designated by the commissioner and the designated facility is able to demonstrate that the facility is unable to complete the evaluation before the initial emergency mental health hold is set to expire, the

designated facility may place the person under a subsequent emergency mental health hold and shall immediately notify the BHA and lay person.

(c) The BHA shall maintain data on the characteristics of each person placed on a subsequent emergency mental health hold pursuant to subsection (7)(b) of this section. The BHA may contract with entities coordinating care or with providers serving within the safety net system developed pursuant to section 27-63-105 to meet the requirements of this subsection (7).

(d) A hospital that is subject to the federal "Emergency Medical Treatment and Labor Act", 42 U.S.C. sec. 1395dd, shall only discharge a person placed on an emergency mental health hold if the person no longer meets the criteria for an emergency mental health hold; except that a hospital may transfer the person to another hospital if the hospital is unable to provide the appropriate medical or behavioral health care to the person and the receiving hospital agrees to the transfer.

(8) (a) The facility shall provide each person detained for an emergency mental health hold discharge instructions. The discharge instructions must be completed for every person, regardless of the person's discharge status, before the person is released. If the detained person refuses to accept the discharge instructions, the refusal must be documented in the person's medical record. At a minimum, the discharge instructions must include:

(I) A summary of why the person was detained or evaluated for an emergency mental health hold; detailed information as to why the evaluating professional determined the person no longer meets the criteria for an emergency mental health hold or certification pursuant to section 27-65-109; and whether the person may receive services on a voluntary basis pursuant to subsection (6) of this section;

(II) If the person's medications were changed or the person was newly prescribed medications during the emergency mental health hold, a clinically appropriate supply of medications, as determined by the judgment of a licensed health-care provider, for the person until the person can access another provider or follow-up appointment;

(III) A safety plan for the person and, if applicable, the person's lay person where indicated by the person's mental health disorder or mental or emotional state;

(IV) Notification to the person's primary care provider, if applicable;

(V) A referral to appropriate services, if such services exist in the community, if the person is discharged without food, housing, or economic security. Any referrals and linkages must be documented in the person's medical record.

(VI) Information on the 988 crisis hotline operated pursuant to section 27-64-103 and information on the availability of peer support services;

(VII) Information on how to establish a psychiatric advance directive if one is not presented;

(VIII) Medications that were changed during the emergency mental health hold, including any medications that the person was taking or that were previously prescribed upon admission, and which medications, if any, were changed or discontinued at the time of discharge;

(IX) A list of any screening or diagnostic tests conducted during the emergency mental health hold, if requested;

(X) A summary of therapeutic treatments provided during the emergency mental health hold, if requested;

(XI) Any laboratory work, including blood samples or imaging that was completed or attempted, if requested;

(XII) The person's vital signs upon discharge from the emergency mental health hold, if requested;

(XIII) A copy of any psychiatric advance directive presented to the facility, if applicable; and

(XIV) How to contact the discharging facility if needed.

(b) The facility shall document in the person's medical record whether the person accepted the discharge instructions. The facility shall provide the discharge instructions to the person's parent or legal guardian if the person is under eighteen years of age, and to the person's lay person, when possible.

(c) Upon discharge, the facility shall discuss with the person, the person's parent or legal guardian, or the person's lay person the statewide care coordination infrastructure established in section 27-60-204 to facilitate a follow-up appointment for the person within seven calendar days after the discharge. Facilities shall comply with this subsection (8)(c) when the statewide care coordination infrastructure created in section 27-60-204 is fully operational, as determined by the BHA. The BHA shall immediately notify facilities when the statewide care coordination infrastructure is available to assist persons with discharge.

(d) (I) The facility shall, at a minimum, attempt to follow up with the person, the person's parent or legal guardian, or the person's lay person within seventy-two hours after discharge, excluding weekends and holidays. The facility is encouraged to utilize peer support professionals, as defined in section 27-60-108 (2)(b), when performing follow-up care with individuals and in developing a continuing care plan pursuant to subsection (8)(a)(I) of this section. The facility may facilitate follow-up care through contracts with community-based behavioral health providers or the 988 crisis hotline operated pursuant to section 27-64-103. If the facility facilitates follow-up care through a third-party contract, the facility shall obtain authorization from the person to provide follow-up care.

(II) If the person is enrolled in medicaid, the facility is not required to meet the requirements of this subsection (8)(d) and instead, the facility shall notify the person's relevant managed care

entity, as defined in section 25.5-5-403, of the person's discharge and need for ongoing follow-up care prior to the person's discharge.

(III) If the facility contracts with a safety net provider, as defined in section 27-50-101, to provide behavioral health services to a person on or following an emergency mental health hold, the facility shall work with the safety net provider in order to meet the requirements of this subsection (8)(d).

(e) The facility shall encourage the person to designate a family member, friend, or other person as a lay person to participate in the person's discharge planning and shall notify the person that the person is able to rescind the authorization of a lay person at any time. If the person designates a lay person and has provided necessary authorization, the facility shall attempt to involve the lay person in the person's discharge planning. The facility shall notify the lay person that the person is being discharged or transferred.

(9) (a) On or before July 1, 2024, and each July 1 thereafter, each emergency medical services facility that has evaluated a person pursuant to this section shall provide an annual report to the BHA that includes only disaggregated and nonidentifying information concerning persons who were treated at an emergency medical services facility pursuant to this section. The report must comply with section 24-1-136 (9) and is exempt from section 24-1-136 (11)(a)(I). The report must contain the following:

(I) The names and counties of the facilities;

(II) The total number of persons treated pursuant to this section, including a summary of demographic information;

(III) A summary regarding the different reasons for which persons were treated pursuant to this section; and

(IV) A summary of the disposition of persons transferred to a designated facility.

(b) (I) Any information disaggregated and provided to the BHA pursuant to this subsection (9) is privileged and confidential. Such information must not be made available to the public except in an aggregate format that cannot be used to identify an individual facility. The information is not subject to civil subpoena and is not discoverable or admissible in any civil, criminal, or administrative proceeding against an emergency medical services facility or health-care professional. The information must be used only to assess statewide behavioral health services needs and to plan for sufficient levels of statewide behavioral health services. In collecting the data pursuant to the requirements of this subsection (9), the BHA shall protect the confidentiality of patient records, in accordance with state and federal laws, and shall not disclose any public identifying or proprietary information of any hospital, hospital administrator, health-care professional, or employee of a health-care facility.

(II) Subsection (9)(b)(I) of this section does not apply to information that is otherwise available from a source outside of the data collection activities required pursuant to subsection (9)(a) of this section.

(10) (a) A person detained for an emergency mental health hold pursuant to this section has the following rights:

(I) To be told the reason for the person's detainment and the limitations of the person's detainment, including a description of the person's right to refuse medication, unless the person requires emergency medications, and that the detainment does not mean all treatment during detainment is mandatory;

(II) To request a change to voluntary status;

(III) To be treated fairly, with respect and recognition of the person's dignity and individuality, by all employees of the facility with whom the person comes in contact;

(IV) To not be discriminated against on the basis of age, race, ethnicity, religion, culture, spoken language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity, or gender expression;

(V) To retain and consult with an attorney at any time; except that, unless specified in subsection (7)(b) of this section, the facility is not required to retain an attorney on behalf of the person but must allow the person to contact an attorney;

(VI) To continue the practice of religion;

(VII) Within twenty-four hours after the person's request, to see and receive the services of a patient representative who has no direct or indirect clinical, administrative, or financial responsibility for the person;

(VIII) To have reasonable access to telephones or other communication devices and to make and to receive calls or communications in private. Facility staff shall not open, delay, intercept, read, or censor mail or other communications or use mail or other communications as a method to enforce compliance with facility staff.

(IX) To wear the person's own clothes, keep and use the person's own personal possessions, and keep and be allowed to spend a reasonable sum of the person's own money. A facility may temporarily restrict a person's access to personal clothing or personal possessions, until a safety assessment is completed. If the facility restricts a person's access to personal clothing or personal possessions, the facility shall have a discussion with the person about why the person's personal clothing or personal possessions are being restricted. A licensed medical professional or a licensed behavioral health professional shall conduct a safety assessment as soon as possible. The licensed professional shall document in the person's medical record the specific reasons why it is not safe for the person to possess the person's personal clothing or personal possessions. The

facility shall periodically conduct additional safety assessments to determine whether the person may possess the person's personal clothing or personal possessions, with the goal of restoring the person's rights established pursuant to this section.

(X) To keep and use the person's cell phone, unless access to the cell phone causes the person to destabilize or creates a danger to the person's self or others, as determined by a provider, facility staff member, or security personnel involved in the person's care;

(XI) To have the person's information and records disclosed to family members and a lay person pursuant to section 27-65-123;

(XII) To have the person's treatment records remain confidential, except as required by law;

(XIII) To not be fingerprinted, unless required by law;

(XIV) To not be photographed, except upon admission for identification and administrative purposes. Any photographs must be confidential and must not be released by the facility except pursuant to a court order. Nonmedical photographs must not be taken or used without appropriate consent or authorization.

(XV) To have appropriate access to adequate water, hygiene products, and food and to have the person's nutritional needs met in a manner that is consistent with recognized dietary practices;

(XVI) To have personal privacy to the extent possible during the course of treatment; and

(XVII) To have the ability to meet with visitors in accordance with the facility's current visitor guidelines.

(b) A person's rights pursuant to this subsection (10) may only be denied if access to the item, program, or service causes the person to destabilize or creates a danger to the person's self or a danger to others, as determined by a licensed provider involved in the person's care. Denial of any right must be entered into the person's treatment record and must be made available, upon request, to the person, the person's legal guardian, or the person's attorney.

(c) A facility shall not intentionally retaliate or discriminate against a detained person or employee for contacting or providing information to any official or to an employee of any state protection and advocacy agency or for initiating, participating in, or testifying in a grievance procedure or in an action for any remedy authorized pursuant to this section. Any facility that violates this subsection (10) commits an unclassified misdemeanor and shall be fined not more than one thousand dollars.

(d) Any person whose rights are denied or violated pursuant to this section has the right to file a complaint against the facility with the behavioral health administration and the department of public health and environment.

(e) Notwithstanding subsection (10)(b) of this section, a person's rights pursuant to this subsection (10) may be restricted in any manner allowed by law if the person is lawfully confined for a criminal charge in jail.

Source: L. 2022: (4)(b) and (4)(d) amended, (HB 22-1278), ch. 222, p. 1539, § 116, effective July 1; (1)(a), (1)(b), (3), IP(9)(a), and (9)(b) amended, (HB 22-1278), ch. 222, p. 1537, § 115, effective July 1; Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3179, § 1, effective August 10; (1), (7), (8), (9), and (10) repealed, (HB 22-1256), ch. 451, p. 3240, § 56, effective August 10; Entire section amended, (HB 22-1256), ch. 451, p. 3207, § 2, effective July 1, 2023. **L. 2023:** IP(9)(a) amended, (HB 23-1236), ch. 206, p. 1065, § 36, effective May 16. **L. 2025:** (8)(a)(VI) and (8)(d)(I) amended, (SB 25-236), ch. 140, p. 531, § 6, effective July 1; (6)(a) amended and (7)(d) added, (SB 25-042), ch. 28, p. 159, § 4, effective August 6. **L. 2026:** IP(1), (1)(a), (1)(b)(I), (2), (3), (4)(a)(III), (4)(c), (4)(d), (6)(a), (8)(d)(I), and (10)(b) amended and (4)(a.5), (7)(a.5), and (10)(e) added, (SB 26-149), ch. 142, p. 729, § 5, effective May 21; (8)(d)(I) amended, (HB 26-1116), ch. 377, p. 2344, § 1, effective August 12.

Editor's note: (1) The provisions of this section are similar to several former provisions of §§ 27-65-105 and 27-65-106 as they existed prior to 2022. For a detailed comparison, see the comparative tables located in the back of the index.

(2) Subsection (1)(a) was numbered as § 27-65-105 (1)(a)(I) in HB 22-1278 (see L. 2022, p. 1537). That provision was harmonized with subsection (1)(a) of this section as it appears in HB 22-1256.

(3) Subsection (1)(a)(I.5) was amended in HB 22-1278. Those amendments were superseded by the repeal of subsection (1)(a)(I.5) in HB 22-1256.

(4) Subsection (1)(b) was numbered as § 27-65-105 (1)(b) in HB 22-1278 (see L. 2022, p. 1538). That provision was harmonized with subsection (1)(b) of this section as it appears in HB 22-1256.

(5) Subsection (1)(c) was amended in HB 22-1278. Those amendments were superseded by the repeal of subsection (1)(c) in HB 22-1256.

(6) Subsection (3) was numbered as § 27-65-105 (3) in HB 22-1278 (see L. 2022, p. 1538). That provision was harmonized with subsection (3) of this section as it appears in HB 22-1256.

(7) Subsection (4)(b) was numbered as § 27-65-106 (4) in HB 22-1278 (see L. 2022, p. 1539). That provision was harmonized with subsection (4)(b) of this section as it appears in HB 22-1256.

(8) Subsection (4)(d) was numbered as § 27-65-106 (6) in HB 22-1278 (see L. 2022, p. 1539). That provision was harmonized with subsection (4)(d) of this section as it appears in HB 22-1256.

(9) Subsection IP(9)(a) was numbered as § 27-65-105 IP(7)(a) in HB 22-1278 (see L. 2022, p. 1539). That provision was harmonized with subsection IP(9)(a) of this section as it appears in HB 22-1256.

(10) Subsection (9)(b) was numbered as § 27-65-105 (7)(b)(I) in HB 22-1278 (see L. 2022, p. 1539). That provision was harmonized with subsection (9)(b) of this section as it appears in HB 22-1256.

(11) Subsections (1), (7), (8), (9), and (10) were repealed in § 56 of HB 22-1256, effective August 10, 2022. However, those repeals were superseded by the amendment of this entire article by § 1 of HB 22-1256, effective August 10, 2022.

(12) Amendments to subsection (8)(d)(I) by SB 26-149 and HB 26-1116 were harmonized.

Cross references: For rights of persons under arrest, see part 4 of article 3 of title 16.

ANNOTATION

Law reviews. For article, "Commitment Procedures in Colorado", see 29 Dicta 273 (1952). For article, "One Year Review of Civil Procedure and Appeals", see 38 Dicta 133 (1961). For article, "One Year Review of Torts", see 38 Dicta 93 (1961). For article, "Patients' Rights vs. Patients' Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado", see 58 Den. L.J. 567 (1981). For article, "New Legislation Concerning the Mentally Disabled", see 11 Colo. Law. 2131 (1982). For article, "The Clinton Mental Health Case — A Civil Procedure Lesson", see 19 Colo. Law. 1809 (1990). For article, "Clinton Redux: A Mental Health and Technical Defense Follow-up", see 22 Colo. Law. 2389 (1993). For article, "How to Reconcile Advance Care Directives With Attempted Suicide", see 42 Colo. Law. 97 (July 2013).

Annotator's note. Since § 27-65-106 is similar to § 27-65-105 and § 27-65-106 as they existed prior to the 2022 amendments to this article and to laws antecedent to those sections, relevant cases construing those provisions have been included in the annotations to this section.

For constitutional considerations, see Barber v. People, 127 Colo. 90, 254 P.2d 431 (1953).

Due process considerations do not require an in-person evaluation by an intervening professional prior to placement on an involuntary hold. Tracz

v. Centennial Peaks, 9 P.3d 1168 (Colo. App. 2000).

Purpose of section. This section was designed to protect the mentally ill person from himself. Kendall v. People, 126 Colo. 573, 252 P.2d 91 (1952).

Article necessitates strict compliance. In situations involving involuntary confinement, strict compliance with this article is a necessity. People in Interest of Henderson, 44 Colo. App. 102, 610 P.2d 1350 (1980).

For requirement of strict compliance with statutory procedure, see Hultquist v. People, 77 Colo. 310, 236 P. 995 (1925); Okerberg v. People, 119 Colo. 529, 205 P.2d 224 (1949); Kendall v. People, 126 Colo. 573, 252 P.2d 91 (1952); Barber v. People, 127 Colo. 90, 254 P.2d 431 (1953); Rickey v. People, 129 Colo. 174, 267 P.2d 1021 (1954).

For specificity of required report, see Kendall v. People, 126 Colo. 573, 252 P.2d 91 (1952).

A proceeding under this article is not a criminal action. Kendall v. People, 126 Colo. 573, 252 P.2d 91 (1952).

Proceeding has nonadversarial nature. An inquiry into the mental capacity of a person is a statutory proceeding of a nonadversary nature. Young v. Colo. Nat'l Bank, 148 Colo. 104, 365 P.2d 701 (1961).

Findings of screening facility or professional person are not binding upon the court. In re People in Interest of Hill, 118 Colo. 571, 198 P.2d 450 (1948).

An adverse finding in mental illness may bear grave consequences in that the person may be denied his liberty and incapacitated to contract, and while it does not necessarily bring his name or reputation into disrepute, it is, nevertheless, a blot on his life and those he might have brought into being. Kendall v. People, 126 Colo. 573, 252 P.2d 91 (1952).

Procedure provisions of the Colorado rules of civil procedure are not applicable to mental illness proceedings. Hultquist v. People, 77 Colo. 310, 236 P. 995 (1925).

Use of this emergency procedure is not limited to patients who decline voluntary treatment. People in Interest of Paiz, 43 Colo. App. 352, 603 P.2d 976 (1979).

"Probable cause" should not be measured by yardstick of legal technicality, but by the factual and practical considerations upon which a reasonable physician acts. People in Interest of Paiz, 43 Colo. App. 352, 603 P.2d 976 (1979).

Reversible error occurred under subsection (1)(a) where jury instruction included neither the element of "probable cause" nor a definition of "gravely disabled" even though prosecution relied upon that provision as the basis for taking defendant into custody. People v. Marquez-Lopez, 952 P.2d 788 (Colo. App. 1997).

Emergency medical personnel has no duty to make an independent determination as to whether the intervening professional had probable cause to institute the hold-and-treat procedure. Tracz v. Centennial Peaks, 9 P.3d 1168 (Colo. App. 2000).

Subsection (1)(b) does not require prior judicial testing before one who has been a voluntarily committed outpatient can be taken into custody. People in Interest of Henderson, 610 P.2d 1350 (Colo. App. 1980).

Contrary to patient's claim, no court hearing or 24-hour notice is required to take mentally ill person into custody under this section. Nor does this section specify that the patient must designate or approve of the treatment facility to which he is committed. Ketchum v. Cruz, 775 F. Supp. 1399 (D. Colo. 1991).

Voluntary treatment program not terminated when patient taken into custody and then returned to hospital. Where voluntarily committed outpatient was off the hospital premises and was taken into custody by the police and then returned to the hospital, this did not, as a matter of law, terminate his voluntary treatment program. People in Interest of Henderson, 610 P.2d 1350 (Colo. App. 1980).

When a county court judge initiates a 72-hour hold, the result is a defect of process depriving the court of subject matter jurisdiction. People In Interest of Lloyd-Pellman, 844 P.2d 1309 (Colo. App. 1992).

A subsequent certification during the 72-hour hold period does not cure the defect. People In Interest of Lloyd-Pellman, 844 P.2d 1309 (Colo. App. 1992).

Violation of this section, while relevant to claim for malpractice, cannot, by definition, create a claim based on negligence per se. Bauer v. Sw. Denver Mental Health Ctr., 701 P.2d 114 (Colo. App. 1985).

Private hospital and privately employed doctor and nurse were not "state actors" who could be held liable for a constitutional violation under 42 U.S.C. § 1983. Wittner v. Banner Health, 720 F.3d 770 (10th Cir. 2013).

This section's grant of authority for a short-term involuntary hold in a private hospital does not pass the nexus/compulsion test for turning the private action of the hospital or the certifying doctor into state action. Wittner v. Banner Health, 720 F.3d 770 (10th Cir. 2013).

Involuntary commitment of the mentally ill is not a public function, that is, a traditional and exclusive function of the state, and thus state action. Wittner v. Banner Health, 720 F.3d 770 (10th Cir. 2013).

Private actor not transformed into a state actor under a joint action test. Allowing a hospital to hold a patient does not make the state responsible for a doctor's decision to medicate the patient, depriving the patient of constitutional rights. Wittner v. Banner Health, 720 F.3d 770 (10th Cir. 2013).

State's relationship with a private actor is no more than the mere private purchase of contract services. Public-private relationship did not transcend that of mere client and contractor because the private and public actors did not commingle their responsibilities. The state lacked the authority to unilaterally place patients at the hospital; it merely authorized the hospital to accept patients if it so chose. Wittner v.

Banner Health, 720 F.3d 770 (10th Cir. 2013).

Applied in People v. Lane, 196 Colo. 42, 581 P.2d 719 (1978); People in Interest of Paiz, 43 Colo. App. 352, 603 P.2d 976 (1979); People v. Chavez, 629 P.2d 1040 (Colo. 1981); Brown v. Jensen, 572 F. Supp. 193 (D. Colo. 1983); People in Interest of Schmidt, 720 P.2d 629 (Colo. App. 1986); Asten v. City of Boulder, 652 F. Supp. 2d 1188 (D. Colo. 2009).

27-65-107. Emergency transportation - application - screening - respondent's rights.

(1) (a) If a certified peace officer or emergency medical services provider has probable cause to believe a person is experiencing a behavioral health crisis and, without professional intervention, may be a danger to the person's self, a danger to others, or gravely disabled, the certified peace officer or emergency medical services provider may take the person into protective custody and transport the person to an outpatient mental health facility or a facility designated by the commissioner for an emergency mental health hold or other clinically appropriate facility designated by the commissioner. If a facility is not available, the person may be taken to an emergency medical services facility.

(b) A person may not be transported pursuant to this subsection (1) if an intervening professional has assessed the person during the same emergency event and determined the person does not meet the criteria for an emergency mental health hold pursuant to section 27-65-106.

(c) If a behavioral health crisis response team is known to be available in a timely manner, the certified peace officer or emergency medical services provider shall access the behavioral health crisis response team prior to involuntarily transporting a person pursuant to this subsection (1).

(2) When a person is transported against the person's will pursuant to subsection (1) of this section, the facility shall require an application, in writing, stating the circumstances under which the person's condition was called to the attention of the certified peace officer or emergency medical services provider and further stating sufficient facts, obtained from personal observations or obtained from others whom the certified peace officer or emergency medical services provider reasonably believes to be reliable, to establish that the person is experiencing a behavioral health crisis or is gravely disabled and, as a result, it is believed that without professional intervention the person may be a danger to the person's self or a danger to others. The application must indicate the name of the person and the time the person was transported. A copy of the application must be furnished to the person being transported.

(3) (a) Once the person is presented to an outpatient mental health facility or facility designated by the commissioner, an intervening professional shall screen the person immediately. If an intervening professional is not immediately available, the person must be screened within eight hours after the person's arrival at the facility to determine if the person meets criteria for an

emergency mental health hold pursuant to section 27-65-106. Once the screening is complete and if the person meets the criteria, the intervening professional shall first pursue voluntary treatment and evaluation. If the person refuses or the intervening professional has reasonable grounds to believe the person will not remain voluntarily, the intervening professional may place the person under an emergency mental health hold pursuant to section 27-65-106.

(b) If a person detained pursuant to this section is transported to an emergency medical services facility, the involuntary transportation hold expires upon the facility receiving the person for screening by an intervening professional.

(4) (a) A person detained pursuant to this section has the following rights while being detained, which must be explained to the person before being transported to a receiving facility:

(I) To not be detained under an emergency transportation hold pursuant to this section for longer than fourteen hours, to not be transported for longer than six hours, and to receive a screening within eight hours after being presented to the receiving facility. This subsection (4)(a)(I) does not prohibit a facility from holding the person as authorized by state and federal law, including the federal "Emergency Medical Treatment and Labor Act", 42 U.S.C. sec. 1395dd, or if the treating professional determines that the individual's physical or mental health disorder impairs the person's ability to make an informed decision to refuse care and the provider determines that further care is indicated.

(II) To request a phone call to an interested party prior to being transported. If the certified peace officer or emergency medical services provider believes access to a phone poses a physical danger to the person or someone else, the receiving facility shall make the call on the person's behalf immediately upon arrival at the receiving facility.

(III) To wear the person's own clothes and keep and use personal possessions that the person had in the person's possession at the time of detainment. A facility may temporarily restrict a person's access to personal clothing or personal possessions until a safety assessment is completed. If the facility restricts a person's access to personal clothing or personal possessions, the facility shall have a discussion with the person about why the person's personal clothing or personal possessions are being restricted. A licensed medical professional or a licensed behavioral health professional shall conduct a safety assessment as soon as possible. The licensed professional shall document in the person's medical record the specific reasons why it is not safe for the person to possess the person's personal clothing or personal possessions.

(IV) To keep and use the person's cell phone, unless access to the cell phone causes the person to destabilize or creates a danger to the person's self or a danger to others, as determined by a provider, facility staff member, or security personnel involved in the person's care;

(V) To have appropriate access to adequate water and food, and to have the person's nutritional needs met in a manner that is consistent with recognized dietary practices, to the extent reasonably possible at the receiving facility;

(VI) To be treated fairly, with respect and recognition of the person's dignity and individuality; and

(VII) To file a grievance with the BHA, the department of public health and environment, or the office of the ombudsman for behavioral health access to care established pursuant to part 3 of article 80 of this title 27.

(b) A person's rights pursuant to subsection (4)(a) of this section may only be denied if access to the item, program, or service causes the person to destabilize or creates a danger to the person's self or a danger to others, as determined by a licensed provider involved in the person's care or transportation. Denial of any right must be entered into the person's treatment record or BHA-approved form. Information pertaining to a denial of rights contained in the person's treatment record must be made available, upon request, to the person, the person's attorney, or the person's lay person.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3183, § 1, effective August 10. **L. 2023:** (3), IP(4)(a), and (4)(a)(V) amended, (HB 23-1236), ch. 206, p. 1065, § 37, effective May 16. **L. 2026:** (1), (2), (4)(a)(IV), and (4)(b) amended, (SB 26-149), ch. 142, p. 733, § 6, effective May 21.

27-65-108. Care coordination for persons certified or in need of ongoing treatment.

(1) A facility designated by the commissioner shall notify and engage the BHA prior to terminating or transferring a person certified pursuant to section 27-65-108.5, 27-65-109, 27-65-109.5, 27-65-110, or 27-65-111. The BHA shall provide care coordination services to support a person whose certification is terminated but who is in need of ongoing treatment and services.

(2) The BHA shall, directly or through a contract, provide care coordination services to a person certified pursuant to section 27-65-108.5, 27-65-109, 27-65-109.5, 27-65-110, or 27-65-111 and determined by the designated facility and the BHA to need care coordination services.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3185, § 1, effective July 1, 2024. **L. 2023:** Entire section amended, (HB 23-1138), ch. 423, p. 2490, § 13, effective July 1, 2024. **L. 2026:** Entire section amended, (SB 26-149), ch. 142, p. 734, § 7, effective May 21.

27-65-108.3. Criteria and standards for certification for short-term treatment and certification for long-term care and treatment.

(1) A respondent may be certified for short-term treatment pursuant to section 27-65-108.5, 27-65-109, or 27-65-109.5, or certified for long-term care and treatment pursuant to section 27-65-110, if:

(a) The respondent has been advised of the availability of, but has not accepted, voluntary treatment or, with consideration of all reasonably available information, including the relevant history of the respondent, there are reasonable grounds to believe that the respondent will not remain in a voluntary treatment program; and

(b) The respondent, by clear and convincing evidence, has a mental health disorder and, as a result of the mental health disorder, the respondent is a danger to the respondent's self, a danger to others, or gravely disabled.

(2) When evaluating a person to determine whether the person meets the criteria pursuant to subsection (1) of this section, the court, evaluator, or intervening professional shall take into consideration:

(a) The person's statements and insights into the person's own mental health disorder;

(b) Clinical diagnosis and clinical perspective on the person's current mental state and prognosis;

(c) The person's willingness to voluntarily seek and comply with a treatment plan in the reasonably foreseeable future;

(d) Recent overt acts by the person to threaten, cause, or attempt to cause harm to the person's self or others;

(e) Previous patterns of deterioration that resulted in the person's hospitalization, arrest, or certification for short-term treatment;

(f) Whether the person was found in a condition where the person was not able to care for the person's own basic needs in order to avoid the risk of serious physical harm; and

(g) The frequency, recency, and severity of the considerations described in subsections (2)(b) to (2)(f) of this section and the likelihood that the conditions and events will reoccur without involuntary treatment.

(3) When evaluating whether a person is a danger to the person's self or a danger to others, is gravely disabled, or poses a substantial risk of serious harm to others, the court, evaluator, professional person, or intervening professional shall, whenever possible, use all reasonable efforts to learn about prior relevant behaviors and prior diagnoses through available and reliable sources, including the person's prior medical and mental health records, police reports, and

information from reliable individuals who have a relationship or regular substantial interactions with the person.

(4) The court, evaluator, professional person, or intervening professional shall consider whether the person has a history of emergency mental health holds invoked pursuant to section 27-65-106, certifications for short-term treatment or long-term care and treatment, findings of incompetency to proceed pursuant to article 8 or 8.5 of title 16, and inpatient psychiatric hospitalizations, and whether the person may qualify as having a persistent mental health disorder.

(5) The court or professional person shall assess a person who is incarcerated or in inpatient treatment as if the person were in the community when evaluating whether the person meets the criteria pursuant to subsection (1) of this section.

Source: L. 2026: Entire section added, (SB 26-149), ch. 142, p. 734, § 8, effective May 21.

27-65-108.5. Court-ordered certification for short-term treatment for incompetent defendants in a criminal matter - contents of petition - procedure to contest petition - commitment to behavioral health administration - definition.

(1) Upon petition of a county attorney, an appointed legal guardian, the district attorney, an intervening professional acting within the scope of their authority, a professional person, a representative of the BHA, or a representative of CDHS, a court shall certify a person for short-term treatment for not more than three months under the following conditions:

(a) The person is a respondent in a criminal matter in which the person has been found incompetent to proceed;

(b) The court hearing the criminal matter referred the matter for filing of a petition pursuant to section 16-8.5-117;

(c) The person has been advised of the availability of, but has not accepted, voluntary treatment, or, if reasonable grounds exist to believe that the person will not remain in a voluntary treatment program, the person's acceptance of voluntary treatment does not preclude certification;

(d) The person meets the criteria for certification for short-term treatment pursuant to section 27-65-108.3 (1); and

(e) The person, the person's legal guardian, and the person's lay person, if applicable, have been advised of the person's right to an attorney and to contest the certification for short-term treatment.

(2) The petition filed pursuant to subsection (1) of this section must:

(a) State sufficient facts to establish reasonable grounds that the respondent meets the criteria for certification for short-term treatment pursuant to section 27-65-108.3 (1);

(b) Be accompanied by a report of the competency evaluator or professional person who has evaluated the respondent within ninety-one days before submitting the petition, unless the respondent whose certification is sought has refused to submit to an evaluation or the respondent cannot be evaluated due to the respondent's condition;

(c) Be filed within fourteen days after the initiating party received the court order from the criminal court initiating the process; and

(d) Provide recommendations if any certification should occur on an inpatient or outpatient basis.

(2.1) The petition filed pursuant to subsection (1) of this section may contain the respondent's history of emergency mental health holds invoked pursuant to section 27-65-106, certifications for short-term treatment or long-term care and treatment, findings of incompetency to proceed pursuant to article 8 or 8.5 of title 16, and inpatient psychiatric hospitalizations, and a statement as to whether the petitioner believes the respondent has a persistent mental health disorder.

(2.5) (a) An emergency mental health hold ordered pursuant to section 27-65-106 is not a prerequisite to initiate a certification for short-term treatment pursuant to this section.

(b) A respondent is not required to be under the care of an appropriate provider who is willing to hold a certification for short-term treatment in order to initiate a certification pursuant to this section.

(3) Within twenty-four hours after certification, copies of the certification must be personally delivered to the respondent, the BHA or CDHS, and any known provider or facility that has custody of the respondent. The department shall retain a copy as part of the respondent's record. If the criminal case is pending, or not yet dismissed, the petitioning party shall give notice of the filing of the petition to the criminal court, and the court shall provide the notice to the prosecuting and defense attorneys in the criminal case and any attorney appointed pursuant to section 27-65-113.5. The court shall ask the respondent to designate one other person whom the respondent wants to be informed regarding the petition. If the respondent is incapable of making such a designation at the time the petition is delivered, the court may ask the respondent to designate such person as soon as the respondent is capable.

(4) Whenever a petition is filed pursuant to this section, the court shall immediately appoint an attorney to represent the respondent. The court shall provide the respondent with a written notice that the respondent has a right to a hearing on the petition and may make a written request for a jury trial. The respondent has the right to an attorney for all proceedings conducted pursuant

to this section, including any appeals. The attorney representing the respondent must be provided with a copy of the petition and any supporting materials immediately upon the attorney's appointment. The respondent may only waive counsel when the respondent makes a knowing and voluntary waiver in front of the court.

(5) Upon the filing of the petition pursuant to this section and affording the respondent a chance to contest the petition, the court may grant or deny certification based on the facts established in the petition, subject to the court's further review or a jury trial.

(6) Within fourteen days after receipt of the petition filed pursuant to this section, the respondent, or the respondent's attorney, may request a jury trial by filing a written motion with the court.

(7) The respondent may knowingly and voluntarily consent in writing to the petition.

(7.1) (a) If the respondent is certified for short-term treatment, unless an appropriate provider has already been identified and is willing to hold the certification, the court shall order CDHS to provide care coordination and make diligent efforts to find a provider for the respondent.

(b) The department may receive and possess all information relevant to the proceedings pursuant to this section, including competency evaluations, any medical and mental health records for which a waiver or privilege has been found in proceedings pursuant to this section or pursuant to article 8.5 of title 16, and relevant criminal justice records, including any criminal history of the respondent.

(c) The court may order:

(I) The petitioner and any district attorney responsible for prosecuting a criminal case that led to proceedings pursuant to this section or section 16-8.5-117 to send relevant records to CDHS within seven days after the court's order; and

(II) Any current or former attorney who represented the respondent in any proceeding to send materials to CDHS, with the respondent's consent, to assist in care coordination.

(d) CDHS may, as necessary, share information with potentially appropriate care providers and the parties, and shall keep the court apprised in writing of efforts to find an appropriate provider for the respondent.

(7.5) If the court certifies the respondent for short-term treatment and the court finds that inpatient treatment is necessary pursuant to section 27-65-118 (1)(a) but an inpatient care provider has not been located that will accept the respondent after all reasonable efforts have been exhausted, the court shall notify CDHS and certify the respondent for outpatient treatment pursuant to section 27-65-109.5.

(8) The respondent or the respondent's attorney may, at any time, file a written request for the court to review short-term certification or request that inpatient certification be changed to

outpatient treatment. If the review is requested, the court shall hear the matter within fourteen days after the request, and the court shall give notice to the respondent, the respondent's attorney, the department, and the community or facility provider who is or will provide treatment. The hearing must be held in accordance with section 27-65-113.1. At the conclusion of the hearing, the court may enter or confirm the certification for short-term treatment, discharge the respondent, or enter any other appropriate order.

(9) In determining whether to certify the respondent or ruling upon any objection to the certification, the court shall consider the respondent's history of emergency mental health holds invoked pursuant to section 27-65-106, certifications for short-term treatment or long-term care and treatment, findings of incompetency to proceed pursuant to article 8 or 8.5 of title 16, and inpatient psychiatric hospitalizations, and whether the respondent qualifies as having a persistent mental health disorder.

(10) and (11) Repealed.

(12) For the purposes of this section only, "respondent" means the defendant in the referring criminal matter.

Source: L. 2023: Entire section added, (HB 23-1138), ch. 423, p. 2485, § 5, effective July 1, 2024. **L. 2024:** (1)(b) amended, (HB 24-1034), ch. 372, p. 2521, § 17, effective June 4. **L. 2026:** IP(1), (1)(b), (1)(d), (2), (3), (8), and (9) amended, (2.1), (2.5), (7.1), and (7.5) added, and (10) and (11) repealed, (SB 26-149), ch. 142, p. 736, § 9, effective May 21.

27-65-109. Certification for short-term treatment - procedure.

(1) A person may be certified for not more than three months for short-term treatment under the following conditions:

(a) The professional staff of the facility detaining the person on an emergency mental health hold has evaluated the person and has found the person meets the criteria for certification for short-term treatment pursuant to section 27-65-108.3 (1);

(b) The facility or community provider that will provide short-term treatment has been designated by the commissioner to provide such treatment; and

(c) The person, the person's legal guardian, and the person's lay person, if applicable, have been advised of the person's right to an attorney and to contest the certification for short-term treatment.

(2) The notice of certification must be signed by a professional person who participated in the evaluation conducted pursuant to subsection (1)(a) of this section. The notice of certification must:

(a) State facts sufficient to establish reasonable grounds to believe that the respondent meets the criteria for certification for short-term treatment pursuant to section 27-65-108.3 (1);

(b) Be filed with the court within forty-eight hours, excluding Saturdays, Sundays, and court holidays, after the date of certification;

(c) Be filed with the court in the county in which the respondent resided or was physically present immediately prior to being taken into custody; and

(d) Provide recommendations if the certification should take place on an inpatient or outpatient basis.

(2.5) (a) If the professional staff of the facility detaining the person on an emergency mental health hold has determined the person has a persistent mental health disorder, the notice of certification must state that the person has a persistent mental health disorder and include a summary of the person's history of emergency mental health holds invoked pursuant to section 27-65-106, certifications for short-term treatment or long-term care and treatment, findings of incompetency to proceed pursuant to article 8 or 8.5 of title 16, and inpatient psychiatric hospitalizations.

(b) In ruling upon any objection to the certification, the court shall consider the person's history of emergency mental health holds invoked pursuant to section 27-65-106, certifications for short-term treatment or long-term care and treatment, findings of incompetency to proceed pursuant to article 8 or 8.5 of title 16, and inpatient psychiatric hospitalizations, and whether the person qualifies as having a persistent mental health disorder.

(3) Within twenty-four hours after certification, copies of the certification must be personally delivered to the respondent, the BHA, and a copy must be kept by the evaluating facility as part of the respondent's record, if applicable. The facility or court shall ask the respondent to designate a lay person whom the respondent wishes to be informed regarding certification. If the respondent is incapable of making such a designation at the time the certification is delivered, the respondent must be asked to designate a lay person as soon as the respondent is capable. In addition to the copy of the certification, the respondent must be given a written notice that a hearing upon the respondent's certification for short-term treatment may be had before the court or a jury upon written request directed to the court pursuant to subsection (6) of this section.

(4) Upon certification of the respondent, the facility designated for short-term treatment has custody of the respondent.

(5) Whenever a certification is filed with the court by a professional person, the court shall immediately appoint an attorney to represent the respondent. The respondent has the right to an

attorney for all proceedings conducted pursuant to this section, including any appeals. The attorney representing the respondent must be provided with a copy of the certification immediately upon the attorney's appointment. The respondent may only waive counsel when the respondent makes a knowing and intelligent waiver in front of the court.

(6) The respondent or the respondent's attorney may at any time file a written request that the certification for short-term treatment or the treatment be reviewed by the court or that the treatment be on an outpatient basis. If review is requested, the court shall hear the matter within ten days after the request, and the court shall give notice to the respondent and the respondent's attorney and the certifying and treating professional person of the time and place of the hearing. The hearing must be held in accordance with section 27-65-113. At the conclusion of the hearing, the court may enter or confirm the certification for short-term treatment, discharge the respondent, or enter any other appropriate order.

(7) Repealed.

(8) Whenever it appears to the court, by reason of a report by the treating professional person or the BHA or any other report satisfactory to the court, that a respondent detained for evaluation and treatment or certified for short-term treatment should be transferred to another facility for treatment and the safety of the respondent or the public requires that the respondent be transported by a secure transportation provider or a law enforcement agency, the court may issue an order directing the law enforcement agency where the respondent resides or secure transportation provider to deliver the respondent to the designated facility.

(9) In accordance with the procedures described in section 27-65-112, a respondent certified for short-term treatment may be discharged upon the signature of the treating medical professional and the medical director of the facility. A respondent certified for short-term treatment on an outpatient basis may be discharged upon the signature of the approved professional person overseeing the respondent's treatment, and the professional person shall notify the BHA prior to the discharge. A facility or program shall make the respondent's discharge instructions available to the respondent, the respondent's attorney, and the respondent's legal guardian, if applicable, within seven days after discharge, if requested. A facility or program that is transferring a respondent to a different treatment facility or to an outpatient provider shall provide all treatment records to the facility or provider accepting the respondent at least twenty-four hours prior to the transfer.

(10) If the professional person in charge of the evaluation and treatment believes that a period longer than three months is necessary to treat the respondent, the professional person shall file with the court an extended certification at least thirty days prior to the expiration date of the original certification. An extended certification for treatment must not be for a period of more than three months. The respondent is entitled to a hearing on the extended certification under the same conditions as an original certification. The attorney initially representing the respondent shall continue to represent the respondent, unless the court appoints another attorney.

(11) The department and the BHA may receive and possess all information relevant to the proceedings held pursuant to this section, including competency and mental health evaluations; any medical and mental health records for which a waiver or privilege has been found in proceedings held pursuant to this section or pursuant to article 8 or 8.5 of title 16; and relevant criminal justice records, including any criminal history of the respondent. The department may share and discuss the relevant information with the parties to the proceedings.

Source: L. 2022: (1)(c) amended, (HB 22-1278), ch. 222, p. 1540, § 117, effective July 1; entire article amended with relocations, (HB 22-1256), ch. 451, p. 3186, § 1, effective August 10; (1), (2), (3), (6), (7), (8), and (10) amended, (HB 22-1256), ch. 451, p. 3217, § 3, effective July 1, 2024. **L. 2026:** (1), IP(2), (2)(a), and (9) amended, (2.5) and (11) added, and (7) repealed, (SB 26-149), ch. 142, p. 739, § 10, effective May 21.

Editor's note: (1) This section is similar to former §§ 27-65-107 and 27-65-108 as they existed prior to 2022. For a detailed comparison, see the comparative tables located in the back of the index.

(2) Subsection (1)(c) was numbered as § 27-65-107 (1)(c) in HB 22-1278 (see L. 2022, p. 1540). That provision was harmonized with subsection (1)(c) of this section as it appears in HB 22-1256.

ANNOTATION

I. General Consideration.

II. Procedural Requirements.

III. Findings Necessary.

I. GENERAL CONSIDERATION.

Law reviews. For article, "Procedures for Involuntary Commitment on the Basis of Alleged Mental Illness", see 42 U. Colo. L. Rev. 231 (1970). For article, "Patients' Rights vs. Patients' Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado", see 58 Den. L.J. 567 (1981). For article, "New Legislation Concerning the Mentally Disabled", see 11 Colo. Law. 2131 (1982). For article, "Pre-trial Technical Defenses to Mental Health Certification", see 17 Colo. Law. 1327 (1988). For article, "Perreira v. Colorado — A Psychiatrist's Duty to Protect Others", see 18 Colo. Law. 2323 (1989). For article, "The Clinton Mental Health Case — A Civil Procedure Lesson", see 19 Colo. Law. 1809 (1990). For article, "Clinton Redux: A Mental Health and Technical Defense Follow-up", see 22 Colo. Law. 2389 (1993).

Annotator's note. Since § 27-65-109 is similar to § 27-65-107 and § 27-65-108 as they existed prior to the 2022 amendments to this article and to laws antecedent to those

sections, relevant cases construing those provisions have been included in the annotations to this section.

Constitutionality. Failure of this section to require a mandatory state-initiated hearing before the involuntary commitment of an individual for up to 90 days does not render the statute unconstitutional. Brown v. Jensen, 572 F. Supp. 193 (D. Colo. 1983); Curnow v. Yarbrough, 676 P.2d 1177 (Colo. 1984).

The term "danger" in subsection (1)(a) does not offend due process as long as the state proves by clear and convincing evidence that there is a reasonable basis to believe that the individual's mental illness results in a present danger to herself or others or renders her gravely disabled. People v. Stevens, 761 P.2d 768 (Colo. 1988).

Less restrictive alternatives need not be considered as a condition precedent to certification. Civil commitment constitutes a severe infringement of liberty requiring due process protection. However, the statutory scheme set forth in this article contains a number of procedural safeguards that greatly reduce the inherent risk of erroneous deprivation. Therefore, due process does not require a mandatory hearing at the time of certification since the statute provides for a hearing on request. People v. Stevens, 761 P.2d 768 (Colo. 1988).

Subsequent certification proceedings are not rendered invalid as a result of the certification for short-term treatment being set aside. People in Interest of Dveirin, 755 P.2d 1207 (Colo. 1988).

State's interest in certifying individual for short-term treatment is to provide care to one whose mental condition poses a threat to society or to the person himself. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Civil commitment statute must be liberally construed to promote the legislative purpose of encouraging the "use of voluntary rather than coercive measures to secure treatment and care for mental illness". Sisneros v. District Court, 199 Colo. 179, 606 P.2d 55 (1980).

This article is to be strictly construed to see that no limit is placed on a person's right to seek voluntary treatment. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Statutory definition of mental illness, on its own terms, cannot be read to intend that every idiosyncratic or eccentric person requires involuntary medical intervention. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Voluntary treatment program not terminated. Where voluntarily committed outpatient was off the hospital premises and was taken into custody by the police and then returned to the hospital, this did not, as a matter of law, terminate his voluntary treatment program. People in Interest of Henderson, 44 Colo. App. 102, 610 P.2d 1350 (1980).

Standard for liability of medical professionals. In determining whether to release an involuntarily committed mental patient, the psychiatrist has a legal duty to

exercise due care, consistent with the knowledge and skill ordinarily possessed by psychiatric practitioners under similar circumstances, to determine whether the patient has a propensity for violence and would present an unreasonable risk of serious bodily harm to others. Perreira v. State, 768 P.2d 1198 (Colo. 1989).

In discharging his duty, a psychiatrist may be required to take reasonable precautions to protect the public from the danger created by the release giving due consideration to extending the term of the patient's commitment or placing appropriate conditions and restrictions on such release. Perreira v. State, 768 P.2d 1198 (Colo. 1989).

Standard for liability of medical professionals. No duty exists to prevent a third person from harming another unless a special relation exists between the actor and the wrongdoer or between the actor and the victim. Perreira v. State, 738 P.2d 4 (Colo. App. 1986).

Medical professionals involved in the care and treatment of a mentally ill patient have a legal duty under the "special relation" rule to prevent the patient from harming himself or others only if the patient in their care constitutes a danger to himself or to the safety of others. Perreira v. State, 738 P.2d 4 (Colo. App. 1986).

This danger may be shown by evidence of injurious acts, attempts, or threats by the patient. Perreira v. State, 738 P.2d 4 (Colo. App. 1986).

A psychotherapist treating a mental patient as an outpatient may fall under the special relation rule. Perreira v. State, 738 P.2d 4 (Colo. App. 1986).

Certification for involuntary short-term mental health treatment entered by a professional person under this section is not a court order under § 13-5-142 (1)(c) or § 13-9-123 (1)(c) and a person's information should not be sent to the Colorado bureau of investigation for forwarding on to the national instant criminal background check system (NICS), which would subject the person to federal firearms prohibitions. Ray v. People, 2019 COA 24, 456 P.3d 54.

Subsection (6) does not allow an individual to challenge the entry of the certification order or inclusion of their name in the NICS under § 13-9-123 (1)(c) after their case has been closed. People in Interest of R.Z., 2025 COA 58, 574 P.3d 747.

Applied in People v. Lane, 196 Colo. 42, 581 P.2d 719 (1978); Gatwick v. State Dept. of Insts., 198 Colo. 407, 603 P.2d 123 (1979); People in Interest of Paiz, 43 Colo. App. 352, 603 P.2d 976 (1979); People v. Chavez, 629 P.2d 1040 (Colo. 1981); In re P.F. v. Walsh, 648 P.2d 1067 (Colo. 1982); Brown v. Jensen, 572 F. Supp. 193 (D. Colo. 1983); People v. Medina, 705 P.2d 961 (Colo. 1985).

II. PROCEDURAL REQUIREMENTS.

Involuntary commitment to mental hospital is deprivation of liberty which the state cannot accomplish without procedural safeguards. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

This section sets out certain procedures which the general assembly and our courts have determined are adequate to protect a respondent's due process rights. These procedures include: (1) a professional decision to initiate the 72-hour evaluation; (2) professional medical evaluation at the time of involuntary short-term commitment; (3) notice concerning certification within 24 hours to the person committed; (4) notice concerning certification to one other person the respondent designates; (5) prompt appointment of an attorney; (6) a hearing within 10 days if requested (7) the burden of proof by clear and convincing evidence upon the petitioner; and (8) optional court appointment of an independent professional person to examine the respondent. Curnow v. Yarbrough, 676 P.2d 1177 (Colo. 1984); People in Interest of Reynes, 870 P.2d 518 (Colo. App. 1993).

Strict adherence to procedural requirements of this section is required because of the curtailment of personal liberty which results from certification for treatment of mental illness. Sisneros v. District Court, 199 Colo. 179, 606 P.2d 55 (1980).

In situations involving involuntary confinement, strict compliance with this article is a necessity. People in Interest of Henderson, 44 Colo. App. 102, 610 P.2d 1350 (1980).

Procedural prerequisites to obtaining certification must be met for court to have subject matter jurisdiction, so review of such issues is by court not jury. People in Interest of Bailey, 745 P.2d 280 (Colo. App. 1987).

Right to a mental health certification review hearing within 10 days of the filing of a petition for certification is for protection of certified person and may be waived by such person without vitiating jurisdiction of court. People in Interest of Lynch, 783 P.2d 848 (Colo. 1989).

When the procedural provisions of former § 27-10-105 are not followed, even a credible certification cannot cure the jurisdictional defect. People in Interest of Lloyd-Pellman, 844 P.2d 1309 (Colo. App. 1992).

The statutorily defined procedures for civil commitment proceedings have been applied to hearings involving the issue of nonconsensual treatment with antipsychotic medication. People ex rel. Ofengand, 183 P.3d 688 (Colo. App. 2008).

Because a committed patient's right to counsel during civil commitment proceedings is derived from the civil commitment statutes, any defect in respondent's waiver of counsel is analyzed under the standard applicable to statutory defects in civil commitment proceedings. People ex rel. Ofengand, 183 P.3d 688 (Colo. App. 2008).

Where respondent seeks reversal of civil commitment order based on the failure to comply strictly with statutory requirements, and where the defect, if any, does not implicate the jurisdiction of the trial court to grant the order, the appeals court's inquiry is whether the defect concerns a failure to comply with essential statutory provisions grave enough to undermine confidence in the fairness and outcome of the certification

proceedings. People ex rel. Ofengand, 183 P.3d 688 (Colo. App. 2008).

This inquiry includes: (1) the evaluation of the gravity of the deviation from statutory provisions, including a consideration of due process concerns; and (2) a determination of any prejudice to respondent caused by the deviation. People ex rel. Ofengand, 183 P.3d 688 (Colo. App. 2008).

Patient to be advised of available, voluntary treatments. A trial court exceeds its jurisdiction in affirming a petitioner's short-term certification, in light of the uncontroverted jury finding that the petitioner had not been properly advised of the availability of voluntary treatment for mental illness, as required by this section. Sisneros v. District Court, 199 Colo. 179, 606 P.2d 55 (1980).

Privilege against self-incrimination is inapplicable to civil commitment proceedings. Due process does not require that the fifth amendment privilege against self-incrimination be extended to this state's civil commitment proceedings. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Nor does privilege against self-incrimination apply to hearings on the forcible administration of medication, which occur during the civil commitment process. People ex rel. Strodtman, 293 P.3d 123 (Colo. App. 2011).

Former §§ 27-10-111 (1) and 27-10-107 (3), read together, clearly and unambiguously grant a right to a jury hearing to a person being certified for short-term treatment. People in Interest of Hoylman, 865 P.2d 918 (Colo. App. 1993).

Failure to abide by statutory requirement of forthwith appointment of counsel in mental health certification proceeding did not constitute personal jurisdiction defect, as requirement for appointment of counsel did not affect the nature of notice to be given to mentally ill person or statutory requirements for acquisition of jurisdiction over person. People in Interest of Clinton, 762 P.2d 1381 (Colo. 1988).

For the purposes of subsection (7), neither the Eclipse system, the user interface of the judicial branch's computerized case management system, nor its underlying database, ICON, functions as an "index of cases". Therefore, the court clerk is not required to remove an individual's name from either upon discharge. People in Interest of T.T., 2019 CO 54, 442 P.3d 851.

Reversible error where trial court failed to comply with essential statutory provision requiring respondent's waiver of counsel to be made knowingly, intelligently, and in writing in a hearing involving a petition for involuntary administration of medication. People ex rel. Ofengand, 183 P.3d 688 (Colo. App. 2008).

A court does not need to conduct an evidentiary hearing under subsection (6) before it is authorized to enter an order causing an individual's name to be added to the NICS under § 13-9-123 (1)(c). People in Interest of R.Z., 2025 COA 58, 574 P.3d 747.

III. FINDINGS NECESSARY.

If it is shown that person is mentally ill, short-term involuntary commitment

cannot be justified unless it is shown that, as a result of such illness, the person is: (1) a danger to others; (2) a danger to himself; (3)"gravely disabled" because of an inability to take care of basic personal needs; or (4) "gravely disabled" because the person is "making irrational or grossly irresponsible decisions concerning his person and lacks the capacity to understand this is so". People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Section requires that causal nexus be established between a person's mental illness and the condition of being a danger to others or to himself or gravely disabled. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Disability sufficient to justify involuntary commitment must arise as result of mental illness; and in keeping with the statutory purpose, it must be so grave that the person's safety is threatened by his inability to take care of his basic personal needs. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Mere disability alone is insufficient to warrant involuntary commitment. Mere disability alone, even if found in conjunction with mental illness, is not enough to warrant involuntary commitment. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Dangerousness to others may be shown by evidence of injurious acts, attempts, or threats. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Dangerousness to oneself may be shown by similar evidence, where the individual's injurious behavior is directed toward himself. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Passive injury to oneself, because of an inability to take care of one's most basic personal needs, may be as dangerous or damaging to the individual as the active threat posed by suicide. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Standard of proof necessary to commit for short-term involuntary psychiatric treatment, "clear and convincing evidence", adopted by the general assembly for treatment, strikes a fair balance between the interest of the individual and the interest of the state. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Standard of proof met. Where three medical experts testified at appellant's certification hearing that she was dangerous or potentially dangerous to herself or to others there was clear and convincing evidence that there was a reasonable basis to believe that appellant's mental illness resulted in a present danger to herself or others, thereby satisfying the prerequisite conditions for short-term certification. People v. Stevens, 761 P.2d 768 (Colo. 1988).

Applied in People v. Lane, 196 Colo. 42, 581 P.2d 719 (1978); People in Interest of Paiz, 43 Colo. App. 352, 603 P.2d 976 (1979); In re P.F. v. Walsh, 648 P.2d 1067 (Colo. 1982); Brown v. Jensen, 572 F. Supp. 193 (D. Colo. 1983); People v. Medina, 705 P.2d 961 (Colo. 1985); People in Interest of Ramsey, 2023 COA 95, 541 P.3d 1198.

27-65-109.5. Certification for short-term outpatient treatment.

(1) A person may be certified for not more than three months for short-term outpatient treatment if a professional person or intervening professional acting within the scope of their authority and licensure:

(a) Has an established treatment relationship with the person, including having provided care to the person in the past three months, which care forms the basis for requesting the outpatient certification;

(b) Has evaluated the person within the past three months and opined that the person meets the criteria for certification for short-term treatment pursuant to section 27-65-108.3 (1); and

(c) Files with the court a signed outpatient certification.

(2) (a) The professional person or intervening professional acting within the scope of their authority and licensure is the petitioner.

(b) Prior to filing the petition, the petitioner shall:

(I) Ask the respondent to designate a lay person whom the respondent wishes to be informed regarding the outpatient certification;

(II) Provide the respondent with a copy of the outpatient certification; and

(III) Provide the respondent with the contact information for the court in which the outpatient certification will be filed and for any designated provider that is willing to hold the outpatient certification and that has been identified by the commissioner to provide treatment.

(3) The signed outpatient certification must:

(a) State sufficient facts to establish reasonable grounds that the respondent meets the criteria set forth in section 27-65-108.3;

(b) Be filed with the court within fourteen days, excluding Saturdays, Sundays, and court holidays, after the initiating party received the court order from the criminal court initiating the outpatient certification, and a copy must be provided to CDHS and the BHA within twenty-four hours after filing the outpatient certification;

(c) Provide all contact information that the petitioner has for the respondent;

(d) Provide the name and contact information for the lay person designated by the respondent, or for any family or friends of the respondent if the respondent was unwilling or incapable of designating a lay person; and

(e) Identify any designated provider that is willing to hold the outpatient certification and that has been identified by the commissioner to provide treatment or include a statement that a designated provider needs to be identified.

(4) (a) If the petitioner has determined the respondent has a persistent mental health disorder, the notice of outpatient certification must state that the respondent has a persistent mental health disorder and include a summary of the respondent's history of emergency mental health holds invoked pursuant to section 27-65-106, certifications for short-term treatment or long-term care and treatment, findings of incompetency to proceed pursuant to article 8 or 8.5 of title 16, and inpatient psychiatric hospitalizations.

(b) In ruling upon any objection to the certification, the court shall consider the respondent's history of emergency mental health holds invoked pursuant to section 27-65-106, certifications for short-term treatment or long-term care and treatment, findings of incompetency to proceed pursuant to article 8 or 8.5 of title 16, and inpatient psychiatric hospitalizations, and whether the respondent qualifies as having a persistent mental health disorder.

(5) (a) Once the BHA receives the notice of outpatient certification, if no designated provider has been identified, the BHA shall provide care coordination pursuant to section 27-65-108, which includes making diligent efforts to identify a designated provider to hold the outpatient certification and provide care to the respondent. The BHA shall keep the court, petitioner, and county attorney informed in writing regarding any designated provider that will hold the outpatient certification and provide care to the respondent.

(b) Once a provider is designated to hold the outpatient certification, the provider shall notify the BHA if the provider has not made contact with the respondent within seven days after accepting the outpatient certification. The BHA shall notify the court in writing that the provider has not made contact with the respondent within seven days after accepting the outpatient certification.

(6) If the respondent has not designated a lay person whom the respondent wishes to be informed regarding the outpatient certification, the respondent must be asked and allowed to designate a lay person as soon as the respondent is capable and willing to do so.

(7) Whenever an outpatient certification is filed with the court by a professional person or intervening professional, the court shall immediately appoint an attorney to represent the respondent. The respondent has the right to an attorney for all proceedings conducted pursuant to this section, including any appeals. The attorney representing the respondent must be provided with a copy of the outpatient certification and all supporting documentation immediately upon the attorney's appointment. The respondent may only waive counsel when the respondent makes a knowing and intelligent waiver in front of the court.

(8) The respondent or the respondent's attorney may at any time file a written request that the certification for short-term treatment or the treatment be reviewed by the court. If a review is requested, the court shall hear the matter within ten days after the request, and the court shall give notice to the respondent and the respondent's attorney and the certifying and treating professional person or intervening professional of the time and place of the hearing. The hearing

must be held in accordance with section 27-65-113.1. At the conclusion of the hearing, the court may enter or confirm the outpatient certification for short-term treatment, discharge the respondent, or enter any other appropriate order.

(9) This section does not require a court appearance if the respondent does not contest the outpatient certification and a designated provider is identified to hold the outpatient certification and the designated provider makes contact with the respondent within seven days after the designated provider begins holding the outpatient certification.

(10) The court shall set a hearing within thirty days if:

(a) The respondent requests to contest, modify, or terminate the outpatient certification;

(b) The outpatient certification was filed and a designated provider was not identified within seven days after the filing of the outpatient certification; or

(c) The designated provider did not make contact with the respondent within seven days after the designated provider began holding the outpatient certification.

(11) The court may set a court review or hearing for good cause shown at any time upon the request of a party, the county attorney responsible for proceedings, or the court's own motion.

(12) The BHA may receive and possess all information relevant to the proceedings pursuant to this section, including competency and mental health evaluations; any medical and mental health records for which a waiver or privilege has been found in proceedings pursuant to this section or pursuant to article 8 or 8.5 of title 16; and relevant criminal justice records, including any criminal history of the respondent. The BHA may share and discuss the relevant information with the parties to the proceedings.

(13) In accordance with the procedures described in section 27-65-112, a respondent certified for short-term treatment on an outpatient basis may be discharged upon the signature of the approved professional person overseeing the respondent's treatment, and the professional person shall notify the BHA prior to the discharge. A facility or program shall make the respondent's discharge instructions available to the respondent, the respondent's attorney, and the respondent's legal guardian, if applicable, within seven days after discharge, if requested. A facility or program that is transferring a respondent to a different treatment facility or to an outpatient provider shall provide all treatment records to the facility or provider accepting the respondent at least twenty-four hours prior to the transfer.

(14) If the professional person in charge of the evaluation and treatment believes that a period longer than three months is necessary to treat the respondent, the professional person shall file with the court an extended certification at least thirty days prior to the expiration date of the original certification. An extended certification for treatment must not be for a period of more than three months. The respondent is entitled to a hearing on the extended certification under the

same conditions as an original certification. The attorney initially representing the respondent shall continue to represent the respondent, unless the court appoints another attorney.

(15) This section does not preclude any proceedings or actions pursuant to section 27-65-106, 27-65-108.5, or 27-65-109.

Source: L. 2026: Entire section added, (SB 26-149), ch. 142, p. 740, § 11, effective May 21.

27-65-110. Certification for long-term care and treatment - procedure.

(1) Whenever a respondent has received an extended certification for treatment pursuant to section 27-65-109 (10), including as it is applied to court-ordered certification pursuant to section 27-65-108.5, the professional person in charge of the certification for short-term treatment or the BHA may file a petition with the court at least thirty days prior to the expiration date of the extended certification for long-term care and treatment of the respondent under the following conditions:

(a) The professional staff of the agency or facility providing short-term treatment has analyzed the respondent's condition and has found that the respondent continues to meet the criteria and standards for certification for short-term treatment pursuant to section 27-65-108.3 (1); and

(b) The facility that will provide long-term care and treatment has been designated by the commissioner to provide the care and treatment.

(2) Every petition for long-term care and treatment must include a request for a hearing before the court prior to the expiration of six months after the date of original certification and provide a recommendation as to whether the certification for long-term care and treatment should take place on an inpatient or outpatient basis. A copy of the petition must be delivered personally to the respondent for whom long-term care and treatment is sought and electronically delivered to the respondent's attorney of record simultaneously with the filing.

(3) Within ten days after receipt of the petition, the respondent or the respondent's attorney may request a hearing before the court or a jury trial by filing a written request with the court.

(4) The court or jury shall determine whether the conditions of subsection (1) of this section are met and whether the respondent continues to meet the criteria and standards for certification for short-term treatment pursuant to section 27-65-108.3 (1). The court shall issue an order of long-term care and treatment for a term not to exceed six months, discharge the respondent for whom long-term care and treatment was sought, or enter any other appropriate order. An order for long-term care and treatment must grant custody of the respondent to the BHA for placement with an agency or facility designated by the commissioner to provide long-term care and

treatment. The BHA may delegate the physical custody of the respondent to a facility designated by the commissioner and the requirement for the provision of services and care coordination. When a petition contains a request that a specific legal disability be imposed or that a specific legal right be deprived, the court may order the disability imposed or the right deprived if the court or a jury has determined that the respondent has a mental health disorder or is gravely disabled and that, as a result, the respondent is unable to competently exercise the specific legal right or perform the function for which the disability is sought to be imposed. Any interested person may ask leave of the court to intervene as a copetitioner for the purpose of seeking the imposition of a legal disability or the deprivation of a legal right.

(5) An original order of long-term care and treatment or any extension of such order expires on the date specified, unless further extended as provided in this subsection (5). If an extension is being sought, the professional person in charge of the evaluation and treatment shall certify to the court at least thirty days prior to the expiration date of the order in force that an extension of the order is necessary for the care and treatment of the respondent subject to the order in force, and a copy of the certification must be simultaneously delivered to the respondent and electronically delivered to the respondent's attorney of record. At least twenty days before the expiration of the order, the court shall give written notice to the respondent and the respondent's attorney of record that a hearing upon the extension may be had before the court or a jury upon written request to the court within ten days after receipt of the notice. If a hearing is not requested by the respondent within such time, the court may proceed ex parte. If a hearing is timely requested, the hearing must be held before the expiration date of the order in force. If the court or jury finds that the conditions of subsection (1) of this section continue to be met and that the respondent has a mental health disorder and, as a result of the mental health disorder, is a danger to the respondent's self, a danger to others, or gravely disabled, the court shall issue an extension of the order. Any extension must not exceed six months, but there may be as many extensions as the court orders pursuant to this section.

(6) A respondent certified for long-term care and treatment may be discharged from the facility upon the signature of the treating professional person and medical director of the facility, and the facility shall notify the BHA prior to the respondent's discharge. The facility shall make the respondent's discharge instructions available to the respondent, the respondent's attorney, the respondent's lay person, and the respondent's legal guardian, if applicable, within one week after discharge, if requested. A facility that is transferring a respondent to a different facility or to an outpatient program shall provide all treatment records to the facility or provider accepting the respondent at least twenty-four hours prior to the transfer.

Source: L. 2022: (1)(c) and (4) amended, (HB 22-1278), ch. 222, p. 1540, § 118, effective July 1; entire article amended with relocations, (HB 22-1256), ch. 451, p. 3188, § 1, effective

August 10. **L. 2025:** IP(1) amended, (SB 25-041), ch. 357, p. 1929, § 12, effective August 6. **L. 2026:** (1), (4), and (5) amended, (SB 26-149), ch. 142, p. 744, § 12, effective May 21.

Editor's note: (1) The provisions of this section are similar to several former provisions of § 27-65-109 as they existed prior to 2022. For a detailed comparison, see the comparative tables located in the back of the index.

(2) Subsection (1)(c) was numbered as § 27-65-109 (1)(c) in HB 22-1278 (see L. 2022, p. 1540). That provision was harmonized with subsection (1)(c) of this section as it appears in HB 22-1256.

(3) Subsection (4) was numbered as § 27-65-109 (4) in HB 22-1278 (see L. 2022, p. 1540). That provision was harmonized with subsection (4) of this section as it appears in HB 22-1256.

ANNOTATION

Law reviews. For article, "Patients' Rights vs. Patients' Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado", see 58 Den. L.J. 567 (1981). For article, "Legal But Not Fair: Legal Implications of a Mental Illness Medical Model", see 11 Colo. Law. 1234 (1982). For article, "Pre-trial Technical Defenses to Mental Health Certification", see 17 Colo. Law. 1327 (1988).

Annotator's note. Since § 27-65-110 is similar to § 27-65-109 as it existed prior to the 2022 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

The term "danger" in subsection (1)(a) does not offend due process as long as the state proves by clear and convincing evidence that there is a reasonable basis to believe that the individual's mental illness results in a present danger to herself or others or renders her gravely disabled. People v. Stevens, 761 P. 2d 768 (Colo. 1988).

Less restrictive alternatives need not be considered as a condition precedent to certification. Civil commitment constitutes a severe infringement of liberty requiring due process protection. However, the statutory scheme set forth in this article contains a number of procedural safeguards that greatly reduce the inherent risk of erroneous deprivation. Therefore, due process does not require a mandatory hearing at the time of certification since the statute provides for a hearing on request. People v. Stevens, 761 P.2d 768 (Colo. 1988).

These statutory requirements are mandatory and must be strictly carried out. Watkins v. People, 140 Colo. 228, 344 P.2d 682 (1959).

Thus, the failure to deliver personally to a respondent in a mental health

proceeding a copy of the petition for long-term care and treatment, as required by subsection (2), deprives the court of personal jurisdiction over the respondent to proceed on the petition and does not toll the relevant time limits for a hearing on the petition. Gilford v. People, 2 P.3d 120 (Colo. 2000).

But only statutory deviations that are considered serious enough to undermine the confidence in the fairness and outcome of judicial proceedings will justify a dismissal of an order that was not made in strict compliance with procedural aspects of the civil commitment statutes. Hearing for extension of long-term care and treatment and for administration of involuntary medications that took place six days after expiration of respondent's certification was held not to undermine the confidence in the fairness and outcome of the certification proceedings when respondent received a full hearing and had previously declined to have the hearing before the expiration date of the certification. People in Interest of Gilford, 983 P.2d 156 (Colo. App. 1999)

Key inquiry in determining whether a failure to follow the civil commitment statute was a violation of an individual's due process rights is whether the failure violates an "essential condition" of the statute. Such determination is made by evaluating the gravity of the deviation from the statutory procedures and requires consideration of any due process concerns and any prejudice to the respondent. People in Interest of Gilford, 983 P.2d 156 (Colo. App. 1999).

Special statutory proceeding. An action in the district court to inquire into the mental health of a party can best be described as a special statutory proceeding; it is neither a criminal case nor a civil action. Sabon v. People, 142 Colo. 323, 350 P.2d 576 (1960).

Request for jury trial must be honored. Where the respondent or his attorney requests a jury trial, the court is required to honor the request. Young v. Brofman, 139 Colo. 296, 338 P.2d 286 (1959).

Defendant held to have been wrongfully deprived of opportunity to demand a jury trial. Hultquist v. People, 77 Colo. 310, 236 P. 995 (1925).

Court may enter judgment notwithstanding the verdict on jury's factual finding under this section as a matter of law when the evidence is undisputed. People in Interest of Lees, 745 P.2d 281 (Colo. App. 1987).

The determination at a certification hearing as to whether a person is "gravely disabled" must focus on the individual's existing condition and not on the possibility of future relapse. People in Interest of Bucholz, 778 P.2d 300 (Colo. App. 1989).

Underlying propensity for dangerousness, even though related to future conduct, is sufficient to meet the test of presenting a danger to one's self and others. People in Interest of King, 795 P.2d 273 (Colo. App. 1990).

Review of commitment order based on erroneous diagnosis. Where an order of commitment is based on an erroneous

diagnosis, that order can be reviewed on appeal. Zimmerman v. Angele, 137 Colo. 129, 321 P.2d 1105 (1958).

Subsection (5) extension runs from expiration of previous order. The period of extension allowed by subsection (5) is to run from the date the previous order expires, and not from the date the extension order is entered. People in Interest of Archuleta, 653 P.2d 93 (Colo. App. 1982).

Person confined only to extent necessary to protect society. A person who is found to be mentally ill is treated and confined only to the extent necessary for the protection of society. Parks v. Denver District Court, 180 Colo. 202, 503 P.2d 1029 (1972).

Medication not to be given over incompetent's objection absent court order. Absent an emergency situation calling for immediate action (in which event the least intrusive means should be used by the physician to meet the emergency), antipsychotic medication shall not be administered to a mentally incompetent institutionalized patient who has not given his consent to this medication unless ordered by a court following a proper hearing. People in Interest of Medina, 662 P.2d 184 (Colo. App. 1982), aff'd, 705 P.2d 961 (Colo. 1985).

Order for involuntary medication must not extend beyond expiration date of the order of long-term care and treatment. Hopkins v. People, 772 P.2d 624 (Colo. App. 1988).

Applied in People v. Lane, 196 Colo. 42, 581 P.2d 719 (1978); People in Interest of Paiz, 43 Colo. App. 352, 603 P.2d 976 (1979); People v. Chavez, 629 P.2d 1040 (Colo. 1981); Brown v. Jensen, 572 F. Supp. 193 (D. Colo. 1983); People in Interest of Kleinfieldt, 680 P.2d 864 (Colo. App. 1984).

27-65-111. Certification on an outpatient basis - civil commitment - short-term and long-term treatment.

(1) Any respondent certified pursuant to section 27-65-108.5, 27-65-109, or 27-65-110 may be provided treatment on an outpatient basis. The outpatient treatment provider shall develop a treatment plan for the respondent receiving treatment on an outpatient basis with the goal of the respondent finding and sustaining recovery. The treatment plan must include measures to keep the respondent or others safe, as informed by the respondent's need for certification. The treatment plan may include, but is not limited to:

(a) Intensive case management;

(b) Assertive community treatment;

(c) Peer recovery services;

(d) Individual or group therapy;

(e) Day or partial-day programming activities;

(f) Intensive outpatient programs;

(g) Educational and vocational training or activities; and

(h) Housing and transportation assistance.

(2) The respondent, the respondent's legal guardian, the respondent's patient representative or the respondent's lay person, or any party at any court hearing may contest a respondent's treatment regimen, including court-ordered medications, at any court hearing related to the respondent's certification for treatment.

(3) The facility responsible for providing services to a respondent on a certification on an outpatient basis shall proactively reach out to the respondent to engage the respondent in treatment. If the respondent refuses treatment or court-ordered medication and is decompensating psychiatrically, the court may order a certified peace officer or secure transportation provider to transport the respondent to an appropriate, least-restrictive designated facility in collaboration with the BHA and the provider holding the certification. The respondent does not need to be an imminent danger to the respondent's self or an imminent danger to others for the provider to request, and the court to order, transportation to a facility for the respondent to receive treatment and court-ordered medications. The facility responsible for providing services to a respondent on a certification on an outpatient basis shall provide the court information on the facility's proactive outreach to the respondent and the professional person's and psychiatric advanced practice registered nurse's basis for medical opinion.

(4) If a respondent is placed in a more restrictive setting, the respondent has the right to judicial review within ten days after filing a written request.

(5) (a) In addition to any other limitation on liability, a person providing care to a respondent placed on short-term or long-term certification on an outpatient basis is only liable for harm subsequently caused by or to a respondent who:

(I) Has been terminated from certification despite meeting statutory criteria for certification pursuant to section 27-65-108.5, 27-65-109, or 27-65-110; or

(II) Provided services to the respondent not within the scope of the person's professional license, or was reckless or grossly negligent in providing services.

(b) A provider is not liable if a respondent's certification is terminated, despite meeting criteria for certification, if the provider is unable to locate the respondent despite proactive and reasonable outreach.

(6) A respondent subject to a certification for short-term treatment, certification for long-term care and treatment, or civil commitment pursuant to section 27-65-201 on an outpatient basis has the following rights, in addition to those enumerated in section 27-65-119:

(a) To request a change to voluntary status. A change to voluntary status may be denied by the supervising professional person or advanced practice registered nurse with training in psychiatric nursing responsible for the respondent's treatment if the professional person or advanced practice registered nurse with training in psychiatric nursing determines reasonable grounds exist to believe that the respondent will not remain in a voluntary treatment program. This subsection (6)(a) does not apply to a respondent who is civilly committed pursuant to section 27-65-201.

(b) To be treated fairly, with respect and recognition of the respondent's dignity and individuality, by all employees of the treatment facility with whom the respondent comes in contact;

(c) To appropriate treatment, which must be administered skillfully, safely, and humanely. A respondent shall receive treatment suited to the respondent's needs that must be determined in collaboration with the respondent.

(d) To not be discriminated against on the basis of age, race, ethnicity, religion, culture, spoken language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity, or gender expression;

(e) To retain and consult with an attorney at any time;

(f) Within forty-eight hours after the respondent's request, to see and receive the services of a patient representative, including a peer specialist, who has no direct or indirect clinical, administrative, or financial responsibility for the respondent;

(g) To have the respondent's behavioral health orders for scope of treatment or psychiatric advance directive reviewed and considered by the court as the preferred treatment option for involuntary administration of medications unless, by clear and convincing evidence, the respondent's directive does not qualify as effective participation in behavioral health decision-making;

(h) To have the respondent's information and records disclosed to adult family members and a lay person pursuant to section 27-65-123;

(i) To have access to a representative within the facility who provides assistance to file a grievance; and

(j) To have the right to file a motion with the court at any time to contest the certification. This subsection (6)(j) does not apply to a respondent who is civilly committed pursuant to section 27-65-201.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3190, § 1, effective July 1, 2024. **L. 2023:** IP(1) and (5)(a)(I) amended, (HB 23-1138), ch. 423, p. 2490, §

14, effective July 1, 2024. **L. 2026:** (3), IP(6), (6)(a), and (6)(j) amended, (SB 26-149), ch. 142, p. 745, § 13, effective May 21.

27-65-112. Termination of certification for short-term and long-term treatment.

(1) (a) An original or extended certification for short-term treatment issued pursuant to section 27-65-108.5, 27-65-109, or 27-65-109.5, or an order or extension for certification for long-term care and treatment pursuant to section 27-65-110, terminates when the professional person in charge of treatment of the respondent and the BHA, after a reasonable observation and treatment period, determine the respondent no longer meets the criteria for certification for short-term treatment pursuant to section 27-65-108.3 (1).

(b) Prior to terminating a certification for short-term treatment, the facility or community provider that is certified to provide treatment to the respondent shall review and consider the reasonably available history of the respondent, including any history of emergency mental health holds invoked pursuant to section 27-65-106, certifications for short-term treatment or long-term care and treatment, findings of incompetency to proceed pursuant to article 8 or 8.5 of title 16, and inpatient psychiatric hospitalizations.

(c) A certification for short-term treatment must not be terminated less than thirty days after the date of the initial certification unless the termination complies with subsection (1)(d) of this section. A certification for short-term treatment of a respondent who has a persistent mental health disorder must not be terminated unless the termination complies with subsection (1)(e) of this section unless the certification is being terminated by:

(I) A community provider holding an outpatient certification that employs two or more professional persons; or

(II) A facility holding an inpatient certification that has two or more professional persons working in the twelve hours preceding the time prior to the termination.

(d) (I) The professional person in charge of the respondent's care shall not approve the termination of the respondent's certification within thirty days after the date of the initial certification for short-term treatment unless two professional persons have individually consulted and reviewed the respondent's case and agree that the respondent no longer meets the criteria for certification for short-term treatment.

(II) At least one of the professional persons must be the professional person most responsible for interacting with and providing direct care and treatment to the respondent. The professional person in charge of the respondent's care may serve as one of the two professional persons if the professional person in charge of the respondent's care is the professional person most responsible for interacting with and providing direct care and treatment to the respondent. The other professional person is not required to interact with the respondent. This subsection (1)(d) does

not prevent either professional person from interacting with or examining the respondent if it is medically appropriate.

(III) When consulting and reviewing the respondent's case, both professional persons shall consider the requirements of section 27-65-108.3 (2), (3), and (4).

(e) The professional person in charge of the care of a respondent who has a persistent mental health disorder shall not approve the termination of the respondent's certification from an inpatient setting within thirty days after the date of the initial certification for short-term treatment unless two professional persons independently evaluate the respondent, independently agree that the respondent no longer meets the criteria for certification for short-term treatment, and independently sign a statement in accordance with subsection (1)(f) of this section. Both professional persons shall consider the requirements of section 27-65-108.3 (2), (3), and (4).

(f) (I) If the respondent has a persistent mental health disorder and the professional person is discharging the certification for short-term treatment from an inpatient setting, the professional person shall sign a written statement that states:

(A) Terminating the certification for short-term treatment, rather than transferring the certification to an outpatient provider or outpatient setting, is medically appropriate; and

(B) The professional person reasonably believes that the respondent will seek the recommended psychiatric care without a continued certification within the next sixty days despite considerations of any past: Psychiatric deterioration; statements of the respondent asserting a willingness to seek voluntary care that the respondent did not subsequently pursue; history of repetitive emergency mental health holds pursuant to section 27-65-106 or certifications for short-term treatment or long-term care and treatment; and criminal charges for which the respondent was found incompetent to proceed pursuant to article 8.5 of title 16.

(II) This subsection (1)(f) does not create a cause of action. A professional person or entity that provides care to a respondent under a certification is not liable for compliance or noncompliance with this subsection (1)(f).

(g) Subsections (1)(d), (1)(e), and (1)(f) of this section do not apply if a certification for short-term treatment is transferred to another inpatient or outpatient provider or if a respondent is discharged from an inpatient setting when the professional person signs an outpatient certification pursuant to section 27-65-109.5 (3)(e) that includes a statement that a provider needs to be identified.

(h) When a certification for short-term treatment or an extended certification is terminated pursuant to this section, the professional person in charge of providing treatment to the respondent shall notify the court in writing within five days after the termination. If the respondent has a persistent mental health disorder and was terminated from an inpatient setting within thirty days after the date of the initial short-term certification, the notice must include a

copy of the statement described in subsection (1)(f) of this section and be placed in the respondent's medical record.

(2) Before termination, a respondent who leaves a facility may be returned to the facility by order of the court without a hearing or by the superintendent or director of the facility without a court order. After termination, a respondent may be returned to the facility only in accordance with this article 65.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3192, § 1, effective August 10; entire section amended, (HB 22-1256), ch. 451, p. 3219, § 4, effective July 1, 2024. **L. 2023:** (1) amended, (HB 23-1138), ch. 423, p. 2490, § 15, effective July 1, 2024. **L. 2026:** (1) amended, (SB 26-149), ch. 142, p. 746, § 14, effective May 21.

Editor's note: The provisions of this section are similar to former § 27-65-110 as it existed prior to 2022. For a detailed comparison, see the comparative tables located in the back of the index.

ANNOTATION

Law reviews. For article, "Patients' Rights vs. Patients' Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado", see 58 Den. L.J. 567 (1981). For article, "Perreira v. Colorado — A Psychiatrist's Duty to Protect Others", see 18 Colo. Law. 2323 (1989).

Annotator's note. Since § 27-65-112 is similar to § 27-65-110 as it existed prior to the 2022 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

Superintendent may release inmate only upon restoration to reason. The only ground upon which the superintendent of the Colorado state hospital can legally release an inmate therefrom is restoration to reason. People ex rel. Best v. County Court, 110 Colo. 249, 132 P.2d 799 (1942).

When person is no longer insane he is restored to reason, and, consequently, when the court found respondent not mentally ill as charged in the complaint, the court had a duty to order her discharged, and in failing to do so, it committed error. In re People in Interest of Hill, 118 Colo. 571, 198 P.2d 450 (1948).

Standard of care for determining release. In determining whether to release an involuntarily committed mental patient, the psychiatrist has a legal duty to exercise due care, consistent with the knowledge and skill ordinarily possessed by psychiatric practitioners under similar circumstances to determine whether the patient has a

propensity for violence and would present an unreasonable risk of serious bodily harm to others. Perreira v. State, 768 P.2d 1198 (Colo. 1989).

In discharging his duty, a psychiatrist may be required to take reasonable precautions to protect the public from the danger created by the release giving due consideration to extending the term of the patient's commitment or placing appropriate conditions and restrictions on such release. Perreira v. State, 768 P.2d 1198 (Colo. 1989).

Order remanding inmate to asylum without new trial by jury held proper. Where it appeared to the district court that an inmate of the state insane asylum, having received a probationary discharge, was not restored to reason, an order remanding him to the asylum without a new trial by jury was held proper. Metaxos v. People, 76 Colo. 264, 230 P. 608 (1924).

Distinction permitted from escape by person committed by criminal insanity adjudication. Given the state's obvious interest in protecting the public from those who previously have engaged in overt criminal conduct but have been relieved of criminal responsibility by reason of legal insanity, there is no difficulty in finding a rational basis for legislation that proscribes as criminal a knowing escape by a person committed to an institution as a result of an insanity adjudication in a criminal case, but does not impose a similar sanction upon a person who escapes from a facility to which he has been civilly committed. People v. Giles, 662 P.2d 1073 (Colo. 1983).

For continuing jurisdiction of district court, see Zimmerman v. Angele, 137 Colo. 129, 321 P.2d 1105 (1958).

Applied in People v. Chavez, 629 P.2d 1040 (Colo. 1981).

27-65-113. Jurisdiction - transfer.

(1) (a) The court in which a petition or certification is filed pursuant to this article 65, or a court authorized to conduct proceedings pursuant to this article 65 that receives a court order transferring jurisdiction of a civil commitment pursuant to section 16-8.5-118, is the court of original jurisdiction and of continuing jurisdiction for any further proceedings pursuant to this article 65.

(b) When the convenience of the parties and the ends of justice would be promoted by a change in the court having jurisdiction, the court may order a transfer of the proceeding to another county. Until further order of the transferee court, if any, it is the court of continuing jurisdiction. If multiple criminal courts refer a matter for proceeding pursuant to section 27-65-201 or 27-65-108.5, any court with jurisdiction may transfer the proceeding to another county and allow for consolidation of proceedings into one proceeding, which may occur in any county that promotes the convenience of the parties and the ends of justice.

(2) (a) Except as otherwise provided in this subsection (2), any petition, certification, transfer of jurisdiction of a civil commitment, or request for a proceeding may be filed where the respondent resides or is physically present for treatment.

(b) A request for appointment of an attorney or for proceedings pursuant to section 27-65-104 regarding voluntary treatment of a minor to which the minor objects may be filed in the jurisdiction where the minor is hospitalized.

(c) A petition or request for a proceeding regarding an emergency mental health hold ordered pursuant to section 27-65-106 or certification for short-term treatment ordered pursuant to section 27-65-109 may be filed in the jurisdiction where the respondent resides, was physically present and transported for an emergency mental health hold, or is currently in an inpatient setting receiving treatment.

(d) A petition or request for a proceeding regarding certification for short-term treatment for incompetent defendants in a criminal matter pursuant to section 27-65-108.5 or a civil commitment pursuant to section 27-65-201 may be filed in the jurisdiction where the respondent resides, was physically present immediately prior to the filing of the petition, or is receiving inpatient treatment or where the criminal court that referred the matter is located.

(3) (a) In the event that a respondent or a person who is ordered committed pursuant to section 16-8.5-118, or is being supervised in a commitment pursuant to section 27-65-201, or is found not guilty by reason of impaired mental condition pursuant to section 16-8-103.5 (5), or by reason of insanity pursuant to section 16-8-105 (4) or 16-8-105.5, refuses to accept medication, the court having jurisdiction of the action pursuant to subsection (1) of this section; the court committing the person or defendant to the custody of the department pursuant to section 16-8-103.5 (5), 16-8-105 (4), or 16-8-105.5; or the court of the jurisdiction in which the designated facility treating the respondent or person is located has jurisdiction and venue to accept a petition by a treating physician and to enter an order requiring that the respondent or person accept the treatment or, in the alternative, that the medication be forcibly administered to the respondent or person. The court of the jurisdiction in which the designated facility is located shall not exercise its jurisdiction without the permission of the court that committed the person to the custody of the department. Upon the filing of the petition, the court shall appoint an attorney, if one has not been appointed, to represent the respondent or person and hear the matter within ten days.

(b) In any case brought pursuant to subsection (3)(a) of this section in a court for the county in which the treating facility is located, the county where the proceeding was initiated pursuant to subsection (1) of this section or the court committing the person to the custody of the department pursuant to section 16-8-103.5 (5), 16-8-105 (4), or 16-8-105.5 shall either reimburse the county in which the proceeding pursuant to this subsection (3) was filed and in which the proceeding was held for the reasonable costs incurred in conducting the proceeding or conduct the proceeding itself using its own personnel and resources, including its own district or county attorney, as the case may be.

(c) In the case of a defendant who is found incompetent to proceed pursuant to section 16-8.5-103 and who refuses to accept medication, the jurisdiction for the petition for involuntary treatment procedures is as set forth in section 16-8.5-106.

(4) In any case in which there has been a change of venue to a county other than the county of residence of the respondent or the county in which the certification proceeding was commenced, the county from which the proceeding was transferred shall either reimburse the county to which the proceeding was transferred and in which the proceeding was held for the reasonable costs incurred in conducting the proceeding or conduct the proceeding itself using its own personnel and resources, including its own district or county attorney, as the case may be.

(5) If a civil proceeding was initiated pursuant to this article 65 or transferred pursuant to section 16-8.5-118 but the proceeding is no longer proper because the court determined that the respondent has an intellectual and developmental disability or a neurocognitive disorder, as those terms are defined in section 25.5-10-501, without any other mental health disorder, the court may maintain jurisdiction by ordering the case to proceed pursuant to article 10 of title 25.5.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3193, § 1, effective August 10. **L. 2023:** (5)(a) and (5)(b) amended, (HB 23-1236), ch. 206, p. 1066, § 38, effective May 16; (1), (5)(a), and (5)(b) amended, (HB 23-1138), ch. 423, p. 2491, § 16, effective July 1, 2024. **L. 2026:** Entire section amended, (SB 26-149), ch. 142, p. 748, § 15, effective May 21.

Editor's note: The provisions of this section are similar to former § 27-65-111 as it existed prior to 2022. For a detailed comparison, see the comparative tables located in the back of the index.

ANNOTATION

Law reviews. For article, "Commitment Procedures in Colorado", see 29 Dicta 273 (1952). For article, "New Legislation Concerning the Mentally Disabled", see 11 Colo. Law. 2131 (1982). For article, "Respect for the Values and Preferences of Mental Patients: The Medina Trilogy", see 11 Colo. Law. 3014 (1982). For article, "The Clinton Mental Health Case — A Civil Procedure Lesson", see 19 Colo. Law. 1809 (1990).

Annotator's note. Since § 27-65-113 is similar to former § 27-65-113, to § 27-65-111 as it existed prior to the 2022 amendments to this article, and to laws antecedent to that section, relevant cases construing those provisions have been included in the annotations to this section.

Involuntary commitment to mental hospital is deprivation of liberty which the state cannot accomplish without procedural safeguards. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Privilege against self-incrimination inapplicable to civil commitment proceedings. Due process does not require that the fifth amendment privilege against self-incrimination be extended to Colorado's civil commitment proceedings. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Former §§ 27-10-111 (1) and 27-10-107 (3), read together, clearly and unambiguously grant a right to a jury hearing to a person being certified for short-term treatment. People in Interest of Hoylman, 865 P.2d 918 (Colo. App. 1993).

The right to effective assistance of counsel applies to proceedings conducted under § 16-8.5-112 and subsection (5)(c) of this section. People in Interest of Uwayezuk, 2023 COA 69, 537 P.3d 377.

The term "danger" in subsection (1) does not offend due process as long as the state proves by clear and convincing evidence that there is a reasonable basis to believe that the individual's mental illness results in a present danger to herself or others or renders her gravely disabled. People v. Stevens, 761 P. 2d 768 (Colo. 1988).

Standard of proof meets minimum standards of procedural due process. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Less restrictive alternatives need not be considered as a condition precedent to certification. Civil commitment constitutes a severe infringement of liberty requiring due process protection. However, the statutory scheme set forth in this article contains a number of procedural safeguards that greatly reduce the inherent risk of erroneous deprivation. Therefore, due process does not require a mandatory hearing at the time of certification since the statute provides for a hearing on request. People v. Stevens, 761 P.2d 768 (Colo. 1988).

"Clear and convincing evidence", required by subsection (1), is evidence which is stronger than a preponderance of the evidence, and which is unmistakable and free from serious or substantial doubt. People v. Lane, 196 Colo. 42, 581 P.2d 719 (1978).

Where three medical experts testified at the certification hearing that appellant was potentially dangerous to herself or to others, there was clear and convincing evidence that there was a reasonable basis to believe that appellant's mental illness resulted in a present danger to herself or others, thereby satisfying the prerequisite conditions for short-term certification pursuant to former § 27-10-107. People v. Stevens, 761 P.2d 768 (Colo. 1988).

The need for electroconvulsive therapy for a person involuntarily committed must be established by clear and convincing evidence. People in Interest of M.K.M., 765 P.2d 1075 (Colo. App. 1988).

If it is shown that person is mentally ill, short-term involuntary commitment cannot be justified unless it is shown that, as a result of such illness, the person is: (1) a danger to others; (2) a danger to himself; (3) "gravely disabled" because of an inability to take care of basic personal needs; or (4) "gravely disabled" because the person is "making irrational or grossly irresponsible decisions concerning his person and lacks the capacity to understand this is so". People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Mere disability alone is insufficient to warrant involuntary commitment. Mere disability alone, even if found in conjunction with mental illness, is not enough to warrant involuntary commitment. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Dangerousness to others may be shown by evidence of injurious acts, attempts, or threats. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Dangerousness to oneself may be shown by similar evidence, where the individual's injurious behavior is directed toward himself. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Passive injury to oneself, because of an inability to take care of one's most basic personal needs, may be as dangerous or damaging to the individual as the active threat posed by suicide. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Former § 27-10-107 requires that a causal nexus be established between a person's mental illness and the condition of being a danger to others or to himself or gravely disabled. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

Uncorroborated psychiatric opinion sufficient. In some cases, a psychiatric opinion, not corroborated by evidence of recent dangerous conduct, may constitute "clear and convincing evidence" of dangerousness, and therefore may be sufficient to sustain a commitment based on dangerousness. People v. Lane, 196 Colo. 42, 581 P.2d 719 (1978).

Right of indigent appellant to transcript at state expense. An indigent appellant in a mental health proceeding for involuntary confinement and treatment has a right under the due process guarantees of the United States and Colorado constitutions to a transcript at state expense. Goedecke v. State Dept. of Insts., 198 Colo. 407, 603 P.2d 123 (1979).

Stringent release standards reasonably related to public safety. The more stringent standards of release applicable to the criminally committed defendant reflect the increased risk to the public associated with the release decision, and, as in the case of automatic commitment, they are reasonably related to the state's interest in public safety. People v. Chavez, 629 P.2d 1040 (Colo. 1981).

Court order required for administering medication to incompetent absent his consent. Absent an emergency situation calling for immediate action (in which event the least intrusive means should be used by the physician to meet the emergency), antipsychotic medication shall not be administered to a mentally incompetent

institutionalized patient who has not given his consent to this medication unless ordered by a court following a proper hearing. People in Interest of Medina, 662 P.2d 184 (Colo. App. 1982), aff'd, 705 P.2d 961 (Colo. 1985); People v. Pflugbeil, 834 P.2d 843 (Colo. App. 1992).

Test in People v. Medina, 705 P.2d 961 (Colo. 1985), for forcibly administering medication applies equally to a forcible increase in medication dosage. The second Medina element requires a patient to be deteriorating, which does not mean the same thing as "not improving". A patient who is simply not improving will not satisfy the Medina test for forcible administration of medication. People v. Marquardt, 2016 CO 4, 364 P.3d 499.

The statutory authorization to forcibly administer medication related to mental illnesses does not grant the state unlimited authority to administer any medical treatment or medication, even if the four Medina factors are satisfied. The involuntary chemical castration of a person committed by the state to the care of the state hospital by virtue of his mental illness may only be authorized by the general assembly through statute, which it is not. People in Interest of C.J.R., 2016 COA 133, 409 P.3d 536.

The possibility that a certain medication may no longer be an effective treatment, or may not be taken voluntarily, at some unspecified time in the future is insufficient to justify the entry of an order authorizing the immediate administration of multiple other medications. As such, the people failed to meet the burden set forth under People in Interest of Medina. People in Interest of R.C., 2019 COA 99M, 451 P.3d 1229.

"Ten days" in subsection (5) means ten total days, not ten business days, for the purpose of determining a hearing date to certify short-term treatment and involuntary medication administration. People in Interest of Ramsey, 2023 COA 95, 541 P.3d 1198.

For presence of respondent at hearing, see Isham v. People, 82 Colo. 550, 262 P. 89 (1927).

For reopening of proceedings under earlier provisions, see Wood v. Throckmorton, 26 Colo. 248, 57 P. 699 (1899); Ex parte Rainbolt, 64 Colo. 581, 172 P. 1068 (1918); People ex rel. Best v. County Court, 110 Colo. 249, 132 P.2d 799 (1942); In re People in Interest of Hill, 118 Colo. 571, 198 P.2d 450 (1948).

Assistant county attorney is absolutely immune from suit concerning her actions and omissions related to the fulfillment of her statutory obligation pursuant to former subsection (5) to conduct commitment proceedings once the petition for a 72-hour evaluation has been submitted. Scott v. Hern, 216 F.3d 897 (10th Cir. 2000).

Applied in Sisneros v. District Court, 199 Colo. 179, 606 P.2d 55 (1980); In re A.W., 637 P.2d 366 (Colo. 1981); In re P.F. v. Walsh, 648 P.2d 1067 (Colo. 1982).

27-65-113.1. Hearing procedures.

(1) A hearing held pursuant to section 27-65-108.5, 27-65-109, 27-65-109.5, 27-65-110, 27-65-201, or 27-65-202 must be conducted in the same manner as other civil proceedings before the court.

(2) The court, after consultation with the respondent's counsel to obtain the counsel's recommendations, may appoint a professional person to examine the respondent for whom a certification for short-term treatment or long-term care and treatment is sought and testify at the hearing as to the results of the professional person's examination. The court-appointed professional person shall act solely in an advisory capacity, and no presumption is attached to the professional person's findings.

(3) Upon request of a legal guardian appointed pursuant to article 14 of title 15, the legal guardian may intervene in any proceeding brought pursuant to this article 65 concerning the legal guardian's ward and, through counsel, may present evidence and represent to the court the views of the legal guardian concerning the appropriate disposition of the case.

(4) A lay person may submit an affidavit to the court concerning the lay person's relationship to the respondent, how long the lay person has known the respondent, the lay person's physical address, and the lay person's views concerning the appropriate disposition of the respondent's case.

Source: L. 2026: Entire section added, (SB 26-149), ch. 142, p. 751, § 16, effective May 21.

27-65-113.5. County attorney and district attorney responsibilities.

(1) The county attorney or district attorney in a county or city and county that has a population equal to or less than fifty thousand people, or a qualified attorney acting as the county or district attorney's designee who is appointed by the district court, has the following powers and responsibilities:

(a) To file and appear on behalf of the county or state in all proceedings brought pursuant to this article 65 or transferred from the criminal court pursuant to section 16-8.5-118, unless expressly relieved or modified by statute;

(b) To assist a nonprofessional individual who is attempting to initiate a request to the court for an evaluation, pursuant to section 27-65-106 (1)(b), of a person whom the nonprofessional individual believes meets the criteria for a certification by providing information and assisting in making filings to the court;

(c) To exercise due diligence in gathering information from available sources for use in proceedings brought pursuant to this article 65; and

(d) To share and provide information about proceedings brought pursuant to this article 65 to interested parties as allowable by law.

Source: L. 2026: Entire section added, (SB 26-149), ch. 142, p. 751, § 16, effective May 21.

27-65-114. Appeals.

(1) Appellate review of any order for certification for short-term treatment or long-term care and treatment or for civil commitment may be had as provided in the Colorado appellate rules. An appeal must be advanced upon the calendar of the appellate court and must be decided at the earliest practicable time. Pending disposition by the appellate court, the court may make such order as the court may consider proper in the premises relating to the care and custody of the respondent.

(2) The court shall advise a respondent subject to an order for certification for short-term treatment or long-term care and treatment or for civil commitment of the respondent's right to appeal the order at the conclusion of any hearing.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3195, § 1, effective August 10. **L. 2026:** Entire section amended, (SB 26-149), ch. 142, p. 752, § 17, effective May 21.

Editor's note: This section is similar to former § 27-65-112 as it existed prior to 2022. For a detailed comparison, see the comparative tables located in the back of the index.

ANNOTATION

Applied in Goedecke v. State Dept. of Insts., 198 Colo. 407, 603 P.2d 123 (1979) (decided prior to 2010 amendments to this article).

27-65-115. Habeas corpus.

Any person detained pursuant to this article 65 is entitled to an order in the nature of habeas corpus upon proper petition to any court generally empowered to issue orders in the nature of habeas corpus.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3195, § 1, effective August 10.

Editor's note: This section is similar to former § 27-65-113 as it existed prior to 2022.

ANNOTATION

Applied in Goedecke v. State Dept. of Insts., 198 Colo. 407, 603 P.2d 123 (1979) (decided prior to 2010 amendments to this article).

27-65-116. Restoration of rights.

Any person who, by reason of a judicial decree entered by a court of this state prior to July 1, 1975, is adjudicated as a person with a mental illness is deemed to have been restored to legal capacity and competency.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3195, § 1, effective August 10.

Editor's note: This section is similar to former § 27-65-114 as it existed prior to 2022.

ANNOTATION

Annotator's note. Since § 27-65-116 is similar to § 27-65-114 as it existed prior to the 2022 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

For the unconstitutionality of this section as it existed prior to the 1977 amendment, see Estate of Phillips v. People, 192 Colo. 273, 558 P.2d 438 (1976).

Applied in People v. Lane, 196 Colo. 42, 581 P.2d 719 (1978).

27-65-117. Discrimination - definition.

No person who has received an evaluation or treatment pursuant to this article 65 may be discriminated against for receiving an evaluation or treatment. For purposes of this section, "discrimination" means giving any undue weight to the fact of hospitalization or outpatient care and treatment unrelated to a person's present capacity to meet standards applicable to all persons. Any person who suffers injury by reason of a violation of this section has a civil cause of action.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3195, § 1, effective August 10; (1)(b) and (1)(c) repealed, (HB 22-1256), ch. 451, p. 3240, § 56, effective August 10.

Editor's note: (1) This section is similar to former § 27-65-115 as it existed prior to 2022.

(2) Subsections (1)(b) and (1)(c) were repealed in § 56 of HB 22-1256, effective August 10, 2022. However, those repeals were superseded by the amendment of this entire article by § 1 of HB 22-1256, effective August 10, 2022.

Cross references: For rights of persons in custody upon criminal charges, see part 4 of article 3 of title 16.

ANNOTATION

Applied in Goedecke v. State Dept. of Insts., 198 Colo. 407, 603 P.2d 123 (1979) (decided prior to 2010 amendments to this article).

27-65-118. Right to treatment - rules.

(1) (a) Any person receiving an evaluation or treatment pursuant to this article 65 is entitled to medical and psychiatric care and treatment, with regard to services listed in section 27-50-301 and services listed in rules authorized by section 27-66-102, suited to meet the person's individual needs, delivered in such a way as to keep the person in the least-restrictive environment, and delivered in such a way as to include the opportunity for participation of family members in the person's program of care and treatment, when appropriate. A person receiving an evaluation or treatment pursuant to this article 65 must not be denied care or discharged due to an inability to pay. This subsection (1)(a) does not create any right with respect

to any person other than the person receiving an evaluation, care, or treatment. The professional person and the agency or facility providing an evaluation, care, or treatment shall keep records detailing all care and treatment received by the person, and the records must be made available, upon the person's written authorization, to the person's attorney or the person's personal physician. The records are permanent records and must be retained in accordance with section 27-65-123 (4).

(b) Any person receiving an evaluation or treatment pursuant to this article 65 may petition the court pursuant to section 13-45-102, for release to a less restrictive setting within or without a treating facility or release from a treating facility when adequate medical and psychiatric care and treatment are not administered.

(2) The BHA shall promulgate rules to assure that each agency or facility providing an evaluation, care, or treatment requires the following:

(a) Consent for specific therapies and major medical treatment in the nature of surgery. The nature of the consent, by whom it is given, and under what conditions, is determined by rules of the BHA.

(b) The order of a physician for any treatment or specific therapy based on appropriate medical examinations;

(c) Notation in the patient's treatment record of periodic examinations, evaluations, orders for treatment, and specific therapies, signed by personnel involved;

(d) Conduct according to the guidelines contained in the regulations of the federal government and the rules of the BHA with regard to clinical investigations, research, experimentation, and testing of any kind; and

(e) Documentation of the findings, conclusions, and decisions in any administrative review of a decision to release or withhold the information requested by a family member or lay person pursuant to section 27-65-123 (1)(g) or (1)(h) and documentation of any information given to a family member or lay person.

Source: L. 2022: IP(2), (2)(a), and (2)(d) amended, (HB 22-1278), ch. 222, p. 1540, § 119, effective July 1; entire article amended with relocations, (HB 22-1256), ch. 451, p. 3195, § 1, effective August 10. **L. 2025:** (1)(a) amended, (HB 25-1326), ch. 309, p. 1612, § 7, effective August 6. **L. 2026:** (1)(a) amended, (SB 26-149), ch. 142, p. 752, § 18, effective May 21.

Editor's note: (1) This section is similar to former § 27-65-116 as it existed prior to 2022.

(2) Subsection IP(2) was numbered as § 27-65-116 IP(2) in HB 22-1278 (see L. 2022, p. 1540). That provision was harmonized with subsection IP(2) of this section as it appears in HB 22-1256.

(3) Subsection (2)(a) was numbered as § 27-65-116 (2)(a) in HB 22-1278 (see L. 2022, p. 1541). That provision was harmonized with subsection (2)(a) of this section as it appears in HB 22-1256.

(4) Subsection (2)(d) was numbered as § 27-65-116 (2)(d) in HB 22-1278 (see L. 2022, p. 1541). That provision was harmonized with subsection (2)(d) of this section as it appears in HB 22-1256.

ANNOTATION

Law reviews. For article, "Patients' Rights vs. Patients' Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado", see 58 Den. L.J. 567 (1981). For article, "Legal But Not Fair: Legal Implications of a Mental Illness Medical Model", see 11 Colo. Law. 1234 (1982). For article, "Status Report: The 'Confidentiality Law'", see 19 Colo. Law. 441 (1990).

Annotator's note. Since § 27-65-118 is similar to § 27-65-116 as it existed prior to the 2022 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

Availability of records. Section 25-1-801 can be read consistently with subsection (1)(a) as a specific exception to a general policy of broad disclosure. Brown v. Jensen, 572 F. Supp. 193 (D. Colo. 1983).

Whether respondent is entitled to treatment in least restrictive possible environment is a matter for court, not jury, to decide under habeas corpus proceeding. People in Interest of Bailey, 745 P.2d 280 (Colo. App. 1987); People in Interest of Lees, 745 P.2d 281 (Colo. App. 1987).

Voluntary patients as well as involuntary patients are entitled to the rights granted by this section. Goebel v. State Dept. of Insts., 764 P.2d 785 (Colo. 1988); Goebel v. Colo. Dept. of Institutions, 830 P.2d 1036 (Colo. 1992).

This section applies to those who voluntarily receive mental health services and could not be voluntarily committed. Goebel v. Colo. Dept. of Institutions, 830 P.2d 1036 (Colo. 1992).

Person need not be so mentally ill as to be gravely disabled or a danger to himself or others for purposes of this section. Goebel v. Colo. Dept. of Institutions, 830 P.2d 1036 (Colo. 1992).

Person need not have been previously hospitalized to be entitled to mental health services. A person who has received either evaluation or treatment services under the Act is entitled to mental health services specified in this section. Goebel v. Colo.

Dept. of Institutions, 830 P.2d 1036 (Colo. 1992).

Under the language of this section, chronically mentally ill persons who have received treatment, but who are not gravely disabled or a danger to themselves or others, have a right to treatment if they received evaluation or treatment under any provisions of this article. Goebel v. Colo. Dept. of Institutions, 830 P.2d 1036 (Colo. 1992).

A person need not have had prior hospitalization before such person is entitled to treatment under this section. Such person need only have received either evaluation or treatment services under this act to be eligible for treatment under this section. Goebel v. Colo. Dept. of Institutions, 830 P.2d 1036 (Colo. 1992).

Applied in Romero v. Schauer, 386 F. Supp. 851 (D. Colo. 1974); Goedecke v. State Dept. of Insts., 198 Colo. 407, 603 P.2d 123 (1979).

27-65-119. Rights of respondents certified for short-term treatment or long-term care and treatment.

(1) Each respondent certified for short-term treatment or long-term care and treatment on an inpatient basis pursuant to sections 27-65-108.5, 27-65-109, and 27-65-110 has the following rights and shall be advised of such rights by the facility:

(a) To be treated fairly, with respect and recognition of the respondent's dignity and individuality, by all employees of the facility with whom the respondent comes in contact;

(b) To not be discriminated against on the basis of age, race, ethnicity, religion, culture, spoken language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity, or gender expression;

(c) To retain and consult with an attorney at any time;

(d) To meet with or call a personal clinician, spiritual advisor, counselor, the 988 crisis hotline, family member, workplace, child care provider, or school at all reasonable times;

(e) To continue the practice of religion;

(f) Within twenty-four hours after the respondent's request, to see and receive the services of a patient representative who has no direct or indirect clinical, administrative, or financial responsibility for the person;

(g) To receive and send sealed correspondence, as well as to be given the assistance of facility staff if the respondent is unable to write, prepare, or mail correspondence. Facility staff shall not open, delay, intercept, read, or censor mail or other communications or use mail or other communications as a method to enforce compliance with facility staff.

(h) To have the respondent's behavioral health orders for scope of treatment or psychiatric advance directive reviewed and considered by the court as the preferred treatment option for involuntary administration of medications unless, by clear and convincing evidence, the respondent's directive does not qualify as effective participation in behavioral health decision-making;

(i) To have reasonable access to telephones or other communication devices and to make and receive calls or communications in private;

(j) To have frequent and convenient opportunities to meet with visitors;

(k) To see the respondent's attorney, clergyperson, or physician at any time;

(l) To wear the respondent's own clothes, keep and use the respondent's own personal possessions, including the person's cell phone, and keep and be allowed to spend a reasonable sum of the respondent's own money;

(m) To have the respondent's information and records disclosed to family members and a lay person pursuant to section 27-65-123;

(n) To have the respondent's treatment records remain confidential, except as required by law;

(o) To have appropriate access to adequate water, hygiene products, and food and to have the respondent's nutritional needs met in a manner that is consistent with recognized dietary practices;

(p) To have personal privacy to the extent possible during the course of treatment; and

(q) To have access to a representative within the facility who provides assistance to file a grievance.

(2) A respondent's rights under subsection (1) of this section may be denied if access to the item, program, or service would endanger the safety of the respondent or another person in close proximity and may only be denied by a person involved in the respondent's care. Denial of any right must be entered into the respondent's treatment record. Information pertaining to a denial of rights contained in the respondent's treatment record must be made available, upon request, to the respondent, the respondent's legal guardian, or the respondent's attorney.

(3) A respondent admitted to or in a facility must not be fingerprinted unless required by other provisions of law.

(4) A respondent may be photographed upon admission for identification and the administrative purposes of the facility. The photographs are confidential and must not be released by the facility except pursuant to court order. Nonmedical photographs shall not be taken or used without appropriate consent or authorization.

(5) Any respondent receiving evaluation or treatment under any of the provisions of this article 65 is entitled to a written copy and verbal description in a language or modality accessible to the person of all the rights enumerated in this section, and a minor child must receive written notice of the minor's rights as provided in section 27-65-104 (6)(g). A list of the rights must be prominently posted in all evaluation and treatment facilities in the predominant languages of the community and explained in a language or modality accessible to the respondent. The facility shall assist the respondent in exercising the rights enumerated in this section.

(6) A facility shall not intentionally retaliate or discriminate against a person or employee for contacting or providing information to any official or to an employee of any state protection and advocacy agency, or for initiating, participating in, or testifying in a grievance procedure or in an action for any remedy authorized pursuant to this section. Any facility that violates this subsection (6) commits an unclassified misdemeanor and shall be fined not more than one thousand dollars.

(7) Any respondent whose rights are denied or violated pursuant to this section has the right to file a compliant against the facility with the behavioral health administration and the department of public health and environment.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3196, § 1, effective August 10; entire section amended, (HB 22-1256), ch. 451, p. 3220, § 5, effective July 1, 2023. **L. 2023:** IP(1) amended, (HB 23-1138), ch. 423, p. 2491, § 17, effective July 1, 2024. **L. 2025:** (1)(d) amended, (SB 25-236), ch. 140, p. 531, § 7, effective July 1.

Editor's note: This section is similar to former § 27-65-117 as it existed prior to 2022.

Cross references: For rights of persons in custody upon criminal charges, see part 4 of article 3 of title 16.

ANNOTATION

Law reviews. For article, "Patients' Rights vs. Patients' Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado", see 58 Den. L.J. 567 (1981). For article, "Legislative Update", see 13 Colo. Law. 1419 (1984). For article, "In re Romero: Sterilization and Competency", see 68 Den. U. L. Rev. 105 (1991).

Annotator's note. Since § 27-65-119 is similar to § 27-65-117 as it existed prior to the 2022 amendments to this article, relevant

cases construing that provision have been included in the annotations to this section.

Treatment to be as minimally restrictive as practicable. The primary purpose of a civil commitment is to secure such treatment as is suited to the needs of the person under conditions which are as least restrictive of liberty as practicable. People v. Chavez, 629 P.2d 1040 (Colo. 1981).

Applied in Goedecke v. State Dept. of Insts., 198 Colo. 407, 603 P.2d 123 (1979).

27-65-120. Administration or monitoring of medications to persons receiving treatment.

The commissioner has the power to direct the administration or monitoring of medications in conformity with part 3 of article 1.5 of title 25 to persons receiving treatment in facilities designated pursuant to this article 65.

Source: L. 2022: Entire section amended, (HB 22-1278), ch. 222, p. 1541, § 120, effective July 1; entire article amended with relocations, (HB 22-1256), ch. 451, p. 3197, § 1, effective August 10.

Editor's note: (1) This section is similar to former § 27-65-118 as it existed prior to 2022.

(2) This section was numbered as § 27-65-118 in HB 22-1278 (see L. 2022, p. 1541). That provision was harmonized with this section as it appears in HB 22-1256.

27-65-121. Employment of persons in a facility - rules.

The BHA shall adopt rules governing the employment and compensation for the administration of care or treatment to persons receiving care or treatment pursuant to this article 65. The BHA shall establish standards for reasonable compensation for such employment.

Source: L. 2022: Entire section amended, (HB 22-1278), ch. 222, p. 1541, § 121, effective July 1; entire article amended with relocations, (HB 22-1256), ch. 451, p. 3197, § 1, effective August 10.

Editor's note: (1) This section is similar to former § 27-65-119 as it existed prior to 2022.

(2) This section was numbered as § 27-65-119 in HB 22-1278 (see L. 2022, p. 1541). That provision was harmonized with this section as it appears in HB 22-1256.

27-65-122. Voting in public elections.

Any person receiving evaluation, care, or treatment pursuant to this article 65 must be given the opportunity to exercise the person's right to register and to vote in primary and general elections. The agency or facility providing evaluation, care, or treatment shall assist the person, upon the person's request, to obtain voter registration forms and mail ballots and to comply with any other prerequisite for voting.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3197, § 1, effective August 10.

Editor's note: This section is similar to former § 27-65-120 as it existed prior to 2022.

ANNOTATION

Law reviews. For article, "Patients' Rights vs. Patients' Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado", see 58 Den. L.J. 567 (1981).

Applied in Goedecke v. State Dept. of Insts., 198 Colo. 407, 603 P.2d 123 (1979) (decided prior to 2010 amendments to this article).

27-65-123. Records.

(1) Except as provided in subsection (2) of this section, all information obtained and records prepared in the course of providing any services to any person pursuant to any provision of this article 65 are confidential and privileged matter. The information and records may be disclosed only:

(a) In communications between qualified professionals, facility personnel, or state agencies in the provision of services or appropriate referrals;

(b) When the recipient of services designates persons to whom information or records may be released; but, if a recipient of services is a ward or conservatee and the ward's or conservatee's guardian or conservator designates, in writing, persons to whom records or information may be disclosed, the designation is valid in lieu of the designation by the recipient; except that nothing in this section compels a physician, psychologist, social worker, nurse, attorney, or other professional personnel to reveal information that has been given to the person in confidence by members of a patient's family or other informants;

(c) To the extent necessary to make claims on behalf of a recipient of aid, insurance, or medical assistance to which the recipient may be entitled;

(d) If the BHA has promulgated rules for the conduct of research. Such rules must include, but are not limited to, the requirement that all researchers must sign an oath of confidentiality. All identifying information concerning individual patients, including names, addresses, telephone numbers, and social security numbers, must not be disclosed for research purposes.

(e) To the courts, as necessary for the administration of this article 65;

(f) To persons authorized by an order of court after notice and opportunity for hearing to the person to whom the record or information pertains and the custodian of the record or information pursuant to the Colorado rules of civil procedure;

(g) To family members upon admission of a person with a mental health disorder for inpatient or residential care and treatment. The only information that may be released pursuant to this subsection (1)(g) is the location and fact of admission of the person with a mental health disorder who is receiving care and treatment. The disclosure of location is governed by the procedures in section 27-65-124 and is subject to review pursuant to section 27-65-124.

(h) To family members or a lay person actively participating in the care and treatment of a person with a mental health disorder, regardless of the length of the participation. The information released pursuant to this subsection (1)(h) is limited to one or more of the following: The diagnosis, the prognosis, the need for hospitalization and anticipated length of stay, the discharge plan, the medication administered and side effects of the medication, and the short-term and long-term treatment goals. The disclosure is governed by the procedures in section 27-65-124 (2) and is subject to review pursuant to section 27-65-124.

(i) In accordance with state and federal law to the agency designated pursuant to the federal "Protection and Advocacy for Individuals with Mental Illness Act", 42 U.S.C. sec. 10801 et seq., as the governor's protection and advocacy system for Colorado.

(2) Nothing in subsection (1)(g) or (1)(h) of this section precludes the release of information to a parent concerning the parent's minor child.

(3) (a) Nothing in this article 65 renders privileged or confidential any information, except written medical records and information that is privileged pursuant to section 13-90-107, concerning observed behavior that constitutes a criminal offense committed upon the premises of any facility providing services pursuant to this article 65 or any criminal offense committed against any person while performing or receiving services pursuant to this article 65.

(b) Subsection (1) of this section does not apply to physicians or psychologists eligible to testify concerning a criminal defendant's mental condition pursuant to section 16-8-103.6.

(4) (a) All facilities shall maintain and retain permanent records, including all applications as required pursuant to section 27-65-106 (3).

(b) Outpatient or ambulatory care facilities shall retain all records for a minimum of seven years after discharge from the facility for persons who were eighteen years of age or older when admitted to the facility, or until twenty-five years of age for persons who were under eighteen years of age when admitted to the facility.

(c) Inpatient or hospital care facilities shall retain all records for a minimum of ten years after discharge from the facility for persons who were eighteen years of age or older when admitted to the facility, or until twenty-eight years of age for persons who were under eighteen years of age when admitted to the facility.

(5) Nothing in this section prohibits or limits the sharing of information by a state institution of higher education police department to authorized university administrators pursuant to section 23-5-141.

(6) Nothing in this section prohibits the limited disclosure of necessary information to the prosecuting attorney and criminal defense counsel if a criminal case is still pending against the person.

(7) (a) Court records in proceedings brought pursuant to this article 65 must be maintained separately by the clerks of the several courts and the case number and proceedings must not be made public or released, except as provided in this section.

(b) Upon the termination of a certification pursuant to section 27-65-112 or the termination of civil commitment pursuant to section 27-65-202, the clerk of the court shall immediately seal the record in the case and omit the respondent's name from the index of cases in the court until and unless the respondent becomes subject to an order of certification for long-term care and treatment pursuant to section 27-65-110 and unless the court orders the records opened for good cause shown. In the event a petition is filed pursuant to section 27-65-110 or 27-65-201, the certification record may be opened and become part of the record in the certification for long-term care and treatment case and the name of the respondent indexed.

(c) Notwithstanding subsection (7)(b) of this section, while a matter is pending or after it is sealed, the court may disclose the existence of the proceeding, the case number, and court records to the respondent or any attorney representing the respondent in any proceeding or matter with a release signed by the respondent or pursuant to a court order. When a court order specifically authorizing disclosure or a valid release for a record is presented to the clerk of the court, the clerk shall acknowledge the existence of the case and provide the case number and records to the respondent or authorized requestor possessing a court order or a release.

(8) When a certified peace officer initiates or participates in the initiation of an emergency mental health hold as described in section 27-65-106, the court, county attorney, or district

attorney conducting any subsequent proceedings pursuant to this article 65, and the provider who conducts an evaluation or provides care, may, without court authorization, provide the certified peace officer's agency with the following limited information, if available:

(a) Whether or not a professional person found the respondent met the criteria for certification for short-term treatment pursuant to section 27-65-108.3 (1);

(b) Whether the respondent was released or remains in inpatient care and whether further care is being provided to the respondent; and

(c) Whether or not further proceedings were initiated for a certification for short-term treatment.

(9) Sealing records by the court does not prevent a party to related criminal cases, a party to a proceeding brought pursuant to this article 65, the department, a professional person, or an intervening professional with lawful possession of records from maintaining and using the records, unless prohibited by law.

(10) A party to related criminal cases, a party to a proceeding brought pursuant to this article 65, the department, a professional person, or an intervening professional may seek to unseal case records for good cause, which includes the need to use the records in other criminal proceedings involving competency pursuant to article 8.5 of title 16 or proceedings brought pursuant to this article 65.

(11) The district attorney may provide information to a victim when necessary to comply with the "Victim Rights Act", part 3 of article 4.1 of title 24.

(12) (a) This article 65 does not require a covered entity, as defined in the federal "Health Insurance Portability and Accountability Act of 1996", 42 U.S.C. secs. 1320d to 1320d-9, to use or disclose protected health information or other personally identifiable information in a manner that is inconsistent with, or exceeds the requirements of, the federal law and its implementing regulations, including 45 CFR 160 and 45 CFR 164.

(b) Consistent with the federal "Health Insurance Portability and Accountability Act of 1996", 42 U.S.C. secs. 1320d to 1320d-9, and its implementing regulations, a covered entity may use or disclose protected health information for treatment, payment, and health-care operations, including disclosures necessary to support care coordination and the management of an individual's care, as authorized pursuant to 45 CFR 164.506.

(c) Any use or disclosure of protected health information pursuant to this article 65 must comply with the minimum necessary standards set forth in 45 CFR 164.502 (b) and 45 CFR 164.514 (d), as applicable.

Source: L. 2022: (1)(d) amended, (HB 22-1278), ch. 222, p. 1541, § 122, effective July 1; entire article amended with relocations, (HB 22-1256), ch. 451, p. 3198, § 1, effective August 10. **L. 2023:** (1)(a) amended, (HB 23-1236), ch. 206, p. 1067, § 39, effective May 16; (6) added, (HB 23-1138), ch. 423, p. 2492, § 20, effective July 1, 2024. **L. 2026:** (7), (8), (9), (10), (11), and (12) added, (SB 26-149), ch. 142, p. 753, § 19, effective May 21.

Editor's note: (1) This section is similar to former § 27-65-121 as it existed prior to 2022.

(2) Subsection (1)(d) was numbered as § 27-65-121 (1)(d) in HB 22-1278 (see L. 2022, p. 1541). That provision was harmonized with this section as it appears in HB 22-1256.

Cross references: For privilege of communication of physicians generally, see §§ 13-90-107 (1)(d) and 13-90-108.

ANNOTATION

Law reviews. For article, "Patients' Rights vs. Patients' Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado", see 58 Den. L.J. 567 (1981). For article, "Status Report: The 'Confidentiality Law'", see 19 Colo. Law. 441 (1990).

Annotator's note. Since § 27-65-123 is similar to § 27-65-121 as it existed prior to the 2022 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

Use of information in criminal proceeding limited. No information produced at a hearing on involuntary short-term certification for psychiatric treatment can be used to incriminate the person sought to be committed in future criminal proceedings, unless it is available to the prosecution from other sources. People v. Taylor, 618 P.2d 1127 (Colo. 1980).

In a federal criminal prosecution and investigation, federal privilege law preempts this more protective Colorado privilege statute. In Re Grand Jury No. 91-1, 795 F. Supp. 1057 (D. Colo. 1992).

Because of the curtailment of personal liberty that results from certification of mental illness, strict adherence to the procedural requirements in civil commitment statutes is required. People in Interest of Dveirin, 755 P.2d 1207 (Colo. 1988); People in Interest of Reynes, 870 P.2d 518 (Colo. App. 1993).

Psychologist-client privilege. In keeping with the statutory goal of securing care and treatment on an individual basis, this section is intended as an authorization for a psychologist to testify to observations concerning an involuntarily detained person when the issue before the court is whether the statutory conditions for certification for

short-term treatment have been satisfied. People v. District Court, 797 P.2d 1259 (Colo. 1990); People v. Hynes, 917 P.2d 328 (Colo. App. 1996).

Applied in Brady v. Hopper, 570 F. Supp. 1333 (D. Colo. 1983).

27-65-124. Request for release of information - procedures - review of a decision concerning release of information.

(1) When a family member requests the location and fact of admission of a person with a mental health disorder pursuant to section 27-65-123 (1)(g), the treating professional person or the professional person's designee, who must be a professional person, shall decide whether to release or withhold such information. The location must be released unless the treating professional person or the professional person's designee determines, after an interview with the person with a mental health disorder, that release of the information to a particular family member would not be in the best interests of the person with a mental health disorder. Any decision to withhold information requested pursuant to section 27-65-123 (1)(g) is subject to administrative review pursuant to this section upon request of a family member or the person with a mental health disorder. The treating facility shall make a record of the information given to a family member pursuant to this subsection (1). For the purposes of this subsection (1), an adult person having a similar relationship to a person with a mental health disorder as a spouse, lay person, parent, child, or sibling of a person with a mental health disorder may also request the location and fact of admission concerning a person with a mental health disorder.

(2) (a) When a family member requests information pursuant to section 27-65-123 (1)(h) concerning a person with a mental health disorder, the treating professional person or the professional person's designee shall determine whether the person with a mental health disorder is capable of making a rational decision in weighing the person's confidentiality interests and the care and treatment interests implicated by the release of information. The treating professional person or the professional person's designee shall then determine whether the person with a mental health disorder consents or objects to the release of information. Information must be released or withheld in the following circumstances:

(I) If the treating professional person or the professional person's designee makes a finding that the person with a mental health disorder is capable of making a rational decision concerning the person's interests and the person with a mental health disorder consents to the release of information, the treating professional person or the professional person's designee shall order the release of the information unless the professional person or the professional person's designee determines that the release would not be in the best interests of the person with a mental health disorder.

(II) If the treating professional person or the professional person's designee makes a finding that the person with a mental health disorder is capable of making a rational decision concerning the person's interests and the person with a mental health disorder objects to the release of information, the treating professional person or the professional person's designee shall not order the release of the information.

(III) If the treating professional person or the professional person's designee makes a finding that the person with a mental health disorder is not capable of making a rational decision concerning the person's interests, the treating professional person or the professional person's designee may order the release of the information if the professional person or the professional person's designee determines that the release would be in the best interests of the person with a mental health disorder.

(IV) Any determination as to capacity pursuant to this subsection (2)(a) must be used only for the limited purpose of this subsection (2)(a).

(b) A decision by a treating professional person or the professional person's designee concerning the capability of a person with a mental health disorder pursuant to subsection (2)(a)(III) of this section is subject to administrative review upon the request of the person with a mental health disorder. A decision by a treating professional person or the professional person's designee to order the release or withholding of information pursuant to subsection (2)(a)(III) of this section is subject to administrative review upon the request of either a family member or the person with a mental health disorder.

(c) The director of the treating facility shall make a record of any information given to a family member pursuant to subsection (2)(a) of this section and section 27-65-123 (1)(h).

(3) When administrative review is requested pursuant to subsection (1) or (2)(b) of this section, the director of the facility providing care and treatment to the person with a mental health disorder shall cause an objective and impartial review of the decision to withhold or release information. The director of the facility shall conduct the review, if the director is a professional person. If the director is not available or if the director cannot provide an objective and impartial review, the review must be conducted by a professional person designated by the director of the facility. The review must include, but need not be limited to, an interview with the person with a mental health disorder. The facility providing care and treatment shall document the review of the decision.

(4) If a person with a mental health disorder objects to the release or withholding of information, the person with a mental health disorder and the person's attorney, if any, must be provided with information concerning the procedures for administrative review of a decision to release or withhold information. The person with a mental health disorder must be informed of any information proposed to be withheld or released and to whom and be given a reasonable

opportunity to initiate the administrative review process before information concerning the person's care and treatment is released.

(5) A family member whose request for information is denied must be provided with information concerning the procedures for administrative review of a decision to release or withhold information.

(6) A person with a mental health disorder may file a written request for review by the court of a decision made upon administrative review to release information to a family member requested pursuant to section 27-65-123 (1)(h) and proposed to be released pursuant to subsection (2) of this section. If judicial review is requested, the court shall hear the matter within ten days after the request, and the court shall give notice to the person with a mental health disorder and the person's attorney, the treating professional person, and the person who made the decision upon administrative review of the time and place of the hearing. The hearing must be conducted in the same manner as other civil proceedings before the court.

(7) In order to allow a person with a mental health disorder an opportunity to seek judicial review, the treating facility or the treating professional person or the professional person's designee shall not release information requested pursuant to section 27-65-123 (1)(h) until five days after the determination upon administrative review of the director or the director's designee is received by the person with a mental health disorder, and, once judicial review is requested, the treating facility or the treating professional person or the professional person's designee shall not release information except by court order. However, if the person with a mental health disorder indicates an intention not to appeal a determination upon administrative review that is adverse to the person concerning the release of information, the information may be released less than five days after the determination upon review is received by the person with a mental health disorder.

(8) This section provides for the release of information only and is not deemed to authorize the release of the written medical record without authorization by the patient or as otherwise provided by law.

(9) For purposes of this section, the treating professional person's designee shall be a professional person.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3199, § 1, effective August 10.

Editor's note: This section is similar to former § 27-65-122 as it existed prior to 2022.

ANNOTATION

Law reviews. For article, "Status Report: The 'Confidentiality Law'", see 19 Colo. Law. 441 (1990).

27-65-125. Treatment in federal facilities.

(1) If a person is certified pursuant to this article 65 and is eligible for hospital care or treatment by an agency of the United States, and if a certificate of notification from the agency showing that facilities are available and that the person is eligible for care or treatment is received, the court may order the person to be placed in the custody of the agency for hospitalization. When any person is admitted pursuant to an order of court to any hospital or institution operated by any agency of the United States within or outside this state, the person is subject to the rules and regulations of the agency. The chief officer of any hospital or institution operated by an agency in which the person is so hospitalized shall, with respect to the person, be vested with the same powers as the chief officer of the Colorado mental health institute at Pueblo with respect to detention, custody, transfer, conditional release, or discharge of patients. Jurisdiction is retained in the appropriate courts of this state to inquire into the mental condition of a person so hospitalized and to determine the necessity for continuance of the person's hospitalization.

(2) An order of a court of competent jurisdiction of another state, territory, or the District of Columbia authorizing hospitalization of a person to any agency of the United States has the same effect as to the person while in this state as in the jurisdiction in which the court entering the order is situated; the courts of the state or district issuing the order retain jurisdiction of the person so hospitalized for the purpose of inquiring into the person's mental condition and for determining the necessity for continuance of the person's hospitalization. Consent is given to the application of the law of the state or district in which the court issuing the order for hospitalization is located, with respect to the authority of the chief officer of any hospital or institution operated in this state by any agency of the United States to retain custody, transfer, conditionally release, or discharge the person hospitalized.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3202, § 1, effective August 10; Entire section repealed, (HB 22-1256), ch. 451, p. 3240, § 56, effective August 10.

Editor's note: (1) This section was similar to former § 27-65-123 as it existed prior to 2022.

(2) This section was repealed in § 56 of HB 22-1256, effective August 10, 2022. However, that repeal was superseded by the amendment of this entire article by § 1 of HB 22-1256, effective August 10, 2022.

27-65-126. Transfer of persons into and out of Colorado - reciprocal agreements.

The transfer of a person hospitalized voluntarily pursuant to this article 65 out of Colorado or under the laws of another jurisdiction into Colorado are governed by the provisions of the interstate compact on mental health.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3202, § 1, effective August 10; Entire section repealed, (HB 22-1256), ch. 451, p. 3240, § 56, effective August 10.

Editor's note: (1) This section is similar to former § 27-65-124 as it existed prior to 2022.

(2) This section was repealed in § 56 of HB 22-1256, effective August 10, 2022. However, that repeal was superseded by the amendment of this entire article by § 1 of HB 22-1256, effective August 10, 2022.

Cross references: For the interstate compact on mental health, see part 10 of article 60 of title 24.

27-65-127. Imposition of legal disability - deprivation of legal right - restoration.

(1) (a) When an interested person wishes to obtain a determination as to the imposition of a legal disability or the deprivation of a legal right for a person who has a mental health disorder and who is a danger to the person's self or others, is gravely disabled, or is insane, as defined in sections 16-8-101 and 16-8-101.5, and who is not then subject to proceedings pursuant to this article 65 or part 3 or part 4 of article 14 of title 15, the interested person may petition the court for a specific finding as to the legal disability or deprivation of a legal right. Actions commenced pursuant to this subsection (1) may include but are not limited to actions to determine contractual rights and rights with regard to the operation of motor vehicles.

(b) The petition must set forth the disability to be imposed or the legal right to be deprived and the reasons.

(2) The court may impose a legal disability or may deprive a respondent of a legal right only upon finding both of the following:

(a) That the respondent is a person with a mental health disorder and is a danger to the respondent's self or others, is gravely disabled, or insane, as defined in section 16-8-101; and

(b) That the requested disability or deprivation is both necessary and desirable.

(3) Repealed.

(4) To have a legal disability removed or a legal right restored, any interested person may file a petition with the court that made the original finding. No legal disability may be imposed nor a legal right be deprived for a period of more than six months without a review hearing by the court at the end of six months, at which time the findings specified in subsection (2) of this section must be reaffirmed to justify continuance of the disability or deprivation. A copy of the petition must be served on the person who filed the original petition, on the person whose rights are affected if the person is not the petitioner, and upon the facility where the person whose rights are affected resides, if any.

(5) Whenever any proceedings are instituted or conducted pursuant to this section, the following procedures apply:

(a) Upon the filing of a petition, the court shall appoint an attorney to represent the respondent. The respondent may replace the attorney with an attorney of the respondent's own choosing at any time. Attorney fees for an indigent respondent are paid by the court.

(b) The court, upon request of an indigent respondent or the respondent's attorney, shall appoint, at the court's expense, one or more professional persons of the respondent's choosing to assist the respondent in the preparation of the respondent's case.

(c) Upon demand made at least five days prior to the date of hearing, the respondent has the right to a trial of all issues by a jury of six.

(d) At all times the burden is upon the person seeking imposition of a disability or deprivation of a legal right or opposing removal of a disability or deprivation to prove all essential elements by clear and convincing evidence.

(e) Pending a hearing, the court may issue an order temporarily imposing a disability or depriving the respondent of a legal right for a period of not more than ten days in conformity with the standards for issuance of ex parte temporary restraining orders in civil cases, but no individual habilitation or rehabilitation plan is required prior to the issuance of the order.

(f) Except as otherwise provided in this subsection (5), all proceedings must be held in conformance with the Colorado rules of civil procedure, but no costs may be assessed against the respondent.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3203, § 1, effective August 10. **L. 2025:** (1)(a) amended, (HB 25-1058), ch. 15, p. 59, § 27, effective August 6.

Editor's note: (1) This section is similar to former § 27-65-127 as it existed prior to 2022.

(2) Subsection (3)(b) provided for the repeal of subsection (3), effective July 1, 2025. (See L. 2022, p. 3203.)

ANNOTATION

Annotator's note. Since § 27-65-127 is similar to § 27-10-125 as it existed prior to the 2010 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

Equal protection not violated. There is a rational basis for distinguishing between this section and former § 27-10-107; the sections address parties who are not similarly situated. Curnow v. Yarbrough, 676 P.2d 1177 (Colo. 1984).

Court may issue order depriving involuntarily committed person of the legal right to possess weapons pursuant to this section. People v. Pflugbeil, 834 P.2d 843 (Colo. App. 1992).

Subsection (1)(a)'s plain meaning provides that an interested person may initiate a court proceeding when (1) the subject is insane, as defined in § 16-8-101, and (2) the person is not then subject to proceedings under this article. The statute presupposes that a not guilty by reason of insanity adjudicated patient could be subject to provisions under this article. The statute also presupposes that not every not guilty by reason of insanity patient is subject to this article. Neiberger v. Hawkins, 239 F. Supp. 2d 1140 (D. Colo. 2002).

Applied in Brown v. Jensen, 572 F. Supp. 193 (D. Colo. 1983).

27-65-128. Administration - rules.

The BHA shall promulgate any rules and develop and distribute any applications or forms necessary to consistently enforce the provisions of this article 65, including rules concerning involuntary feeding tubes for individuals with an eating disorder. The BHA shall proactively train providers, facilities, counties, judges, magistrates, intervening professionals, and certified peace officers on the procedures under this article 65, which training must include an understanding of the criteria for invoking an emergency mental health hold pursuant to section

27-65-106, the definition of "gravely disabled" and how a person who is gravely disabled may present physically and psychiatrically, and suggested templates and resources to be used by facilities to meet the requirements of section 27-65-106 (8)(a)(III) and (8)(a)(VII).

Source: L. 2022: Entire section amended, (HB 22-1278), ch. 222, p. 1541, § 123, effective July 1; Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3204, § 1, effective August 10. **L. 2024:** Entire section amended, (SB 24-117), ch. 443, p. 3093, § 2, effective June 6.

Editor's note: (1) This section is similar to former § 27-65-128 as it existed prior to 2022.

(2) Amendments to this section by HB 22-1256 and HB 22-1278 were harmonized.

27-65-129. Payment for counsel.

In order to provide legal representation to persons eligible for an attorney pursuant to this article 65, the judicial department shall pay, out of money appropriated by the general assembly, sums directly to the appointed attorney on a case-by-case basis or, on behalf of the state, shall pay lump-sum grants to and contract with individual attorneys, legal partnerships, legal professional corporations, public interest law firms, or nonprofit legal services corporations.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3204, § 1, effective August 10.

Editor's note: This section is similar to former § 27-65-129 as it existed prior to 2022.

27-65-130. Advisory board - created - service standards and rules.

(1) (a) An advisory board, referred to in this section as the "board", is established for the purpose of assisting and advising the commissioner in accordance with subsection (2) of this section in the development of service standards and rules. The board consists of no fewer than eleven but not more than fifteen members appointed by the governor, as follows:

(I) One representative from the department of human services;

(II) One representative from the BHA;

(III) One representative from the department of public health and environment;

(IV) One representative from the university of Colorado health sciences center;

(V) One representative from a leading professional association of psychiatrists in this state;

(VI) One member representing proprietary skilled health-care facilities;

(VII) One member representing nonprofit health-care facilities;

(VIII) One member representing the Colorado bar association;

(IX) One member representing consumers of services for persons with mental health disorders;

(X) One member representing families of persons with mental health disorders;

(XI) One member representing children's health-care facilities; and

(XII) Other persons from both the private and the public sectors who are recognized or known to be interested and informed in the area of the board's purpose and function.

(b) In making appointments to the board, the governor is encouraged to include representation by at least one member who is a person with a disability, as defined in section 24-34-301, a family member of a person with a disability, or a member of an advocacy group for persons with disabilities, provided that the other requirements of this section are met.

(2) The advisory board is responsible for recommending standards and rules relevant to the provisions of this article 65 for the programs of mental health services to those patients in any health-care facility that has either separate facilities for the care, treatment, and rehabilitation of persons with mental health disorders or those health-care facilities that have as the health-care facility's only purpose the care and treatment of such persons.

Source: L. 2022: Entire section amended, (SB 22-013), ch. 2, p. 70, § 93, effective February 25; IP(1)(a) and (1)(a)(II) amended, (HB 22-1278), ch. 222, p. 1541, § 124, effective July 1; Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3205, § 1, effective August 10. **L. 2023:** (1)(b) amended, (HB 23-1296), ch. 269, p. 1601, § 13, effective May 25.

Editor's note: (1) This section is similar to former §§ 27-65-130 and 27-65-131 as they existed prior to 2022.

(2) This section was numbered as § 27-65-131 in SB 22-013 (see L. 2022, p. 70). That provision was harmonized with this section as it appears in HB 22-1256.

(3) Subsection IP(1)(a) was numbered as § 27-65-131 (1)(a) in HB 22-1278 (see L. 2022, p. 1541). That provision was harmonized with subsection IP(1)(a) of this section as it appears in HB 22-1256.

(4) Subsection (1)(a)(II) was numbered as § 27-65-131 (1)(c)(I) in HB 22-1278 (see L. 2022, p. 1542). That provision was harmonized with subsection (1)(a)(II) of this section as it appears in HB 22-1256.

ANNOTATION

Law reviews. For article, "Patients' Rights vs. Patients' Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado", see 58 Den. L.J. 567 (1981).

27-65-131. Data report.

(1) On or before January 1 of each year, the BHA shall submit a report to the general assembly on the outcomes and effectiveness of the involuntary commitment system described in this article 65, disaggregated by region, including any recommendations to improve the system and outcomes for persons involuntarily committed or certified pursuant to this article 65. The report must include aggregated and disaggregated nonidentifying individual-level data. At a minimum, the report must include:

(a) The number of seventy-two-hour emergency mental health holds that occurred in the state and the number of people placed on a seventy-two-hour emergency mental health hold, including:

(I) A summary of the reason each person was placed on an emergency mental health hold;

(II) Demographic information of each person placed on an emergency mental health hold;

(III) Disposition of each person placed on an emergency mental health hold;

(IV) How often a facility was required to ask for assistance from the BHA to find placement for the person pursuant to section 27-65-106 and if placement was found, the average length of time a person had to wait for the placement and the challenges encountered in finding a placement;

(V) How many subsequent emergency mental health holds were placed pursuant to section 27-65-106 due to a lack of appropriate placement options; and

(VI) How each emergency mental health hold originated, whether by a certified peace officer; intervening professional, including specific professional type; or a court order;

(b) The number and characteristics of each certification for short-term treatment, including an extension of short-term treatment, and long-term care and treatment that occurred in the state, including:

(I) The number of inpatient versus outpatient certifications;

(II) The reason for initiating each certification;

(III) The number of certifications initiated by a court order, professional person, or certified peace officer;

(IV) The average length of each certification;

(V) The demographics of each individual on a certification for short-term treatment;

(VI) The services provided;

(VII) The services needed that were not available; and

(VIII) Any identified barriers preventing the provision of needed services;

(c) The outcome of each certification for short-term treatment and certification for long-term care and treatment;

(d) The reason each certification was discontinued, disaggregated by those successfully discharged; voluntarily discharged; transferred; not located; with treatment compliance concerns; unable to transfer to another facility or provider, for lack of payment to treatment providers; and for any other reasons;

(e) The person's housing and employment status when certification was discontinued;

(f) What services were provided versus what services were most frequently needed by people certified on an outpatient basis;

(g) Barriers and opportunities with local providers, the judicial branch, and law enforcement;

(h) How many individuals were placed in the custody of the BHA on a certification for short-term treatment who were concurrently involved in the criminal justice system, including the outcomes of each person and any barriers and opportunities that may exist to better serve the population;

(i) Information regarding certifications for short-term outpatient treatment filed pursuant to section 27-65-109.5, including:

(I) The number of signed outpatient certifications:

(A) That identified a designated provider to hold the outpatient certification;

(B) That did not identify a designated provider initially but identified a designated provider within seven days after the signed outpatient certification was filed;

(C) That did not identify a designated provider initially but identified a provider more than seven days after the signed outpatient certification was filed;

(D) That did not identify a designated provider and a provider was never designated;

(II) The average amount of time it took to identify a designated provider to hold the outpatient certification if a designated provider was not initially identified but was later identified; and

(III) Any available information on the frequency and reasons for denials and barriers to identifying a designated provider to hold outpatient certifications; and

(j) Information regarding the frequency of denials and barriers to placements identified by CDHS when providing care coordination pursuant to section 27-65-108.5. CDHS shall provide this information to the BHA at least annually.

Source: L. 2022: Entire article amended with relocations, (HB 22-1256), ch. 451, p. 3206, § 1, effective August 10. **L. 2026:** IP(1) and (1)(g) amended and (1)(i) and (1)(j) added, (SB 26-149), ch. 142, p. 754, § 20, effective May 21.

27-65-132. Recognition of Tribal court commitment orders - applicability - process - definitions.

(1) As used in this section, unless the context otherwise requires:

(a) "Behavioral health commitment order" or "commitment order" includes:

(I) Emergency mental health holds as described in section 27-65-106 or as described in Tribal codes;

(II) Certification for short-term treatment as described in section 27-65-109 or as described in Tribal codes;

(III) Long-term care and treatment of persons with mental health disorders as described in section 27-65-110 or as described in Tribal codes;

(IV) An emergency commitment as described in section 27-81-111 or as described in Tribal codes;

(V) An involuntary commitment of a person with a substance use disorder as described in section 27-81-112 or as described in Tribal codes; or

(VI) A commitment order permitted by federal, state, or Tribal law.

(b) "State" means the state of Colorado.

(c) "Tribal court" means any court or other federally or tribally established tribunal of a federally recognized Tribe duly established pursuant to federal law or Tribal law, including the Courts of Indian Offenses, Ute Mountain Ute agency, organized pursuant to 25 CFR part 11.

(d) "Tribe" means the Southern Ute Indian Tribe, the Ute Mountain Ute Tribe, or a federally recognized Tribe acknowledged by the "Federally Recognized Indian Tribe List Act of 1994", Pub.L. 103-454, 108 Stat. 4791.

(2) The state, county, or municipal law enforcement agencies; state courts; hospitals; behavioral health facilities; health-care providers; and others within the state responsible for providing services to the person subject to a behavioral health commitment order shall recognize a commitment order entered by the Tribal court of a federally recognized Tribe and that concerns a person under the Tribal court's jurisdiction to the same extent as a commitment order entered by a state court.

(3) A health-care provider may communicate with the officers of a Tribal court regarding a patient under the health-care provider's care pursuant to a Tribal court commitment order described in subsection (2) of this section, to the same extent that the health-care provider can communicate with officers of a court pursuant to a state court commitment order. Communications may include the nature of the treatment needed and provided, a patient's medical and mental health status, the extent to which the patient poses a danger to the patient's self or the community, and, if necessary, the need for additional treatment.

(4) If a Tribal court issues an order rescinding the Tribal court's original behavioral commitment order, the state, county, or municipal law enforcement agencies; state courts; hospitals; behavioral health facilities; health-care providers; and others within the state responsible for providing services to the person subject to a behavioral health commitment order shall recognize the order rescinding the Tribal court's original behavioral health commitment order and release the person subject to the behavioral health commitment order.

(5) This section applies to people subject to Tribal court behavioral health commitment orders.

Source: L. 2025: Entire section added, (SB 25-009), ch. 165, p. 670, § 2, effective May 5.

PART 2

CIVIL COMMITMENT OF INCOMPETENT AND UNRESTORABLE PERSON

27-65-201. Court supervision of incompetent and unrestorable person ordered into civil commitment - repeal.

(1) Once a criminal court has transferred jurisdiction of a civil commitment pursuant to section 16-8.5-118 to a civil court with jurisdiction pursuant to section 27-65-113, the civil court has exclusive jurisdiction over the civil commitment.

(2) Upon receiving jurisdiction of a civil commitment, the civil court shall:

(a) Notify the county attorney;

(b) Appoint an attorney to represent the respondent and provide copies of any documents sent from the criminal court to the respondent's attorney; and

(c) Set a review hearing and order the respondent brought before the court.

(3) At the review hearing, the court shall:

(a) Ensure the respondent is represented by counsel; and

(b) Advise the respondent of the following rights:

(I) The right to appear in person at any proceeding, unless waived by the respondent;

(II) The right to be represented by privately retained counsel, or court-appointed counsel if the respondent does not have privately retained counsel, during any proceeding held pursuant to this article 65, including any appeals;

(III) The right to request modification of the terms of the civil commitment; and

(IV) The right to periodic review of the civil commitment and the right to contest, including by trial, whether the respondent qualifies for termination of civil commitment.

(4) At any time during the civil commitment, the court may:

(a) Modify any court order or any term of the civil commitment upon request of the parties after giving the parties an opportunity to object and be heard;

(b) Issue a warrant for the respondent's arrest and order the respondent be brought before the court if the court determines the respondent has failed to comply with any of the court's orders, including the respondent's unauthorized departure from the physical custody of a provider;

(c) Order CDHS to provide to the court:

(I) An updated opinion on whether the respondent meets the criteria for termination of civil commitment pursuant to section 27-65-202; and

(II) An opinion on whether the respondent has an intellectual and developmental disability or neurocognitive disorder, as those terms are defined in section 25.5-10-501, without having any other mental health disorder that is not an intellectual and developmental disability or neurocognitive disorder and that substantially contributes to whether the respondent is a danger to the respondent's self or a danger to others, or is gravely disabled.

(d) Upon the request of any party, the request of the individual or entity with physical care and custody of the respondent, or the court's own motion, conduct a review of the respondent's placement and enter any orders necessary for sharing or receiving information necessary to review and modify the placement, unless the respondent is placed into inpatient care at the discretion of CDHS;

(e) Order, as necessary, appropriate entities, including the sheriff, to bring the respondent before the court or take the respondent to the placement where physical custody of the respondent has been ordered;

(f) Appoint a legal guardian pursuant to article 14 of title 15; or

(g) Issue orders as necessary to effectuate and enforce the court's powers and responsibilities pursuant to this section, including authorization for the reasonable use of force, warrants for the arrest of the respondent, or contempt proceedings against a noncompliant individual or entity.

(5) (a) The court shall ensure the respondent is placed in the least-restrictive placement adequate to protect the victim and the community and provide, to the greatest extent possible, the appropriate level of care, treatment, and supervision of the respondent.

(b) If the respondent is not placed into inpatient care at the discretion of CDHS or if CDHS proposes to move the respondent into or out of inpatient care, the court shall, prior to modifying the civil commitment to change the respondent's provider or placement, review the appropriateness of the proposed provider or placement, including whether the provider fits the respondent's diagnosis and treatment needs and whether the placement sufficiently protects the community from the substantial risk of serious harm to others posed by the respondent.

(c) Upon request, the court shall permit CDHS, the parties, or the appointed legal guardian the opportunity to object and be heard prior to the court's decision. The court may permit testimony if the court believes it would be helpful to the court's decision.

(d) When deciding whether to approve the new provider or placement, the court shall give due deference to CDHS and the opinion of any medical professional on the appropriateness of the provider and placement for the respondent, victims, and community, but deference must not be given to CDHS or a medical professional as to whether the placement sufficiently protects any victims and the community from the substantial risk of serious harm to others posed by the

respondent. When considering the appropriateness of the placement for the respondent, victims, and community, the court shall consider the totality of the circumstances, including:

(I) The respondent's statements and insights into the respondent's mental health disorder;

(II) The clinical diagnosis and clinical perspective on the respondent's current mental state and prognosis;

(III) The respondent's willingness and demonstrated ability to voluntarily seek and comply with a treatment plan in the reasonably foreseeable future;

(IV) Recent overt acts by the respondent to threaten, cause, or attempt to cause harm to the respondent's self or others;

(V) Previous patterns of deterioration that resulted in the respondent's hospitalization, arrest, or certification for short-term treatment;

(VI) Whether the respondent was found in a condition where the respondent was not able to care for the respondent's own basic needs in order to avoid the risk of serious physical harm;

(VII) The frequency, recency, and severity of the considerations described in subsections (5)(d)(II) to (5)(d)(VI) of this section and the likelihood that the conditions and events will reoccur without inpatient treatment;

(VIII) Whether the respondent opposes the placement;

(IX) Whether community-based placement can be reasonably accommodated;

(X) The limited resources of the state and the needs of others; and

(XI) The placement recommendations of any treating professionals.

(e) The court shall not permit or order a respondent to be placed into a community-based setting outside of inpatient care for the first time since being civilly committed unless:

(I) Any victims have been notified of a critical stage, as defined in section 24-4.1-302 (2)(q.3), and given the opportunity to be heard; and

(II) The district attorney in the case that sought civil commitment or enhanced protective placement has been notified and given an opportunity to object and be heard.

(f) If the court modifies the respondent's provider or placement, the court shall issue any orders necessary to mitigate the respondent's risk to any victims or the community, including ordering the provider to take reasonable and practicable protective measures to prevent the respondent from contacting any victims; except that the court shall not order the respondent to comply with any conditions that are not necessary to mitigate the respondent's risk or with which the respondent cannot comply.

(6) (a) If the court orders the respondent to be placed into inpatient care at the discretion of CDHS, the executive director of CDHS shall designate the state facility at which the respondent is held for care and treatment and may transfer the respondent from one facility to another if, in the opinion of the executive director, it is appropriate to do so in the interest of the proper care, custody, and treatment of the respondent or for the protection of the public or personnel at the facilities in question.

(b) Notwithstanding subsection (6)(a) of this section, CDHS shall:

(I) Ensure the respondent is placed in the least-restrictive placement adequate to protect the victim and the community and provide, to the greatest extent possible, the appropriate level of care, treatment, and supervision of the respondent; and

(II) Not place the respondent in a community-based setting outside of inpatient care for the first time since the respondent was civilly committed without prior approval of the court pursuant to subsection (5) of this section.

(7) Termination of the civil commitment is governed by section 27-65-202.

(8) The provider charged with the physical care and custody of the respondent shall submit a report to the court and the parties annually by the date the respondent was civilly committed unless a substantially similar examination was ordered by the court within the previous twelve months. The report must include:

(a) The provider's opinion about whether the respondent is appropriately placed and meets the criteria for termination of the civil commitment pursuant to section 27-65-202;

(b) A summary of the materials reviewed, assessments conducted, and other bases of opinions rendered;

(c) The respondent's diagnosis and whether the respondent's symptoms are in remission;

(d) A summary of the services or treatment provided to the respondent since the last report and the respondent's progress;

(e) A summary of the respondent's compliance with treatment or services, including information about medications currently prescribed to the respondent and whether the respondent is compliant with taking the prescribed medications;

(f) An assessment of the respondent's risk of harm to others;

(g) A summary of the respondent's treatment or service needs by utilizing evidence-based standards of individualized treatment and management of individuals civilly committed;

(h) A summary of the specific treatment or service options available to the respondent in the community and the specific treatment or service options available to the respondent at a facility designated by the executive director of CDHS;

(i) A summary of whether and how ongoing risks could be mitigated if the respondent were placed in the community; and

(j) Specific facts and evidence supporting each opinion made pursuant to subsection (8)(a) of this section.

(9) The court may order any treatment or service provider who has agreed or who has been ordered to provide services or treatment to the respondent to issue regular progress reports containing information required pursuant to subsection (8) of this section or other information deemed necessary for the court's supervision of the civil commitment, but the court shall not require a provider to submit progress reports more frequently than every ninety days.

(10) (a) The court may, upon a showing of good cause, order CDHS to facilitate an examination by a professional person regarding the respondent's progress with treatment and whether the respondent meets the criteria for conversion of the civil commitment to an enhanced protective placement, certification for short-term treatment, or short-term protective placement, or meets the criteria for termination of the civil commitment pursuant to section 27-65-202, unless CDHS has facilitated a similar examination of the respondent in the past one hundred twenty days. The respondent shall cooperate with any examinations ordered pursuant to this subsection (10)(a).

(b) Statements made by the respondent during an examination conducted pursuant to this subsection (10) must not be used in any criminal prosecution.

(c) Good cause includes a respondent's timely request for an evaluation that allows a competency evaluator to provide a second opinion in response to the report provided pursuant to subsection (8) of this section that opines that the respondent does not meet the criteria for termination.

(11) This section is repealed, effective July 1, 2031.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 755, § 21, effective May 21.

27-65-202. Termination of civil commitment - repeal.

(1) The court shall terminate a respondent's civil commitment ordered pursuant to section 27-65-201 if the respondent:

(a) No longer poses a substantial risk of serious harm to others; or

(b) Does not have a mental health disorder that is likely to cause the respondent to be a danger to the respondent's self or a danger to others and the respondent has demonstrated

sufficient capacity and willingness to conform the respondent's conduct to the requirements of the law.

(2) (a) If a treatment provider charged with the physical care and custody of the respondent determines that the respondent meets the standard for termination from civil commitment pursuant to subsection (1) of this section, the provider or the provider's designee shall report the determination to the court that placed the respondent into the provider's care and custody, the county attorney, and the district attorney who originally sought civil commitment or an enhanced protective placement pursuant to section 16-8.5-118. The court shall furnish a copy of any reports received to the respondent and the respondent's counsel.

(b) The determination reported pursuant to subsection (2)(a) of this section must include:

(I) The treatment provider's opinion that the respondent meets the criteria for termination of the civil commitment pursuant to subsection (1) of this section;

(II) An assessment of the respondent's risk of harm to others; and

(III) Specific facts and evidence supporting each opinion in the report, including a summary of the materials reviewed, assessments conducted, and other bases of opinions rendered.

(3) (a) The respondent may request termination of the civil commitment in writing at any time the respondent would not be prohibited from having a subsequent termination trial pursuant to subsection (7) of this section.

(b) The court shall deny the request unless the request for termination includes an opinion from a professional person that the respondent currently meets the criteria for termination of the civil commitment pursuant to subsection (1) of this section.

(4) (a) If the court does not deny the request for termination without a hearing, the court shall permit the county attorney and the district attorney who originally sought civil commitment or enhanced protective placement pursuant to section 16-8.5-118 fourteen days to object to termination or request an opportunity to conduct an independent evaluation by an expert of the county attorney's or district attorney's own choosing and expense.

(b) If neither the county attorney nor the district attorney objects or requests an opportunity to request an independent evaluation, the court shall terminate the respondent's civil commitment.

(c) If either the county attorney or the district attorney requests an opportunity to conduct an independent evaluation, the court shall grant that request, order the respondent to comply with the evaluation, and permit the county attorney or district attorney a reasonable period of time to identify an expert, conduct the evaluation, and issue a report. If both the county attorney and district attorney request an independent evaluation, the court shall treat the request as a joint

request for a single independent evaluation. The cost of the independent evaluation must be paid for by the requesting party.

(d) If the respondent does not cooperate with the evaluation, the court may grant additional time or deny the respondent's request for termination.

(e) Upon receipt of the independent evaluation report, the county attorney or district attorney must provide a copy to the respondent's counsel and the court within fourteen days.

(f) If neither the county attorney nor district attorney objects within the time permitted by the court, the court shall terminate the respondent's civil commitment.

(5) (a) If either the county attorney or district attorney timely objects, the court shall, as soon as practicable, bring the respondent before the court, ensure the respondent and the respondent's counsel received a copy of the report, and advise the respondent of the right to demand a trial by the court or the right to demand, in writing, a jury trial of not more than six individuals to determine whether the respondent meets the criteria for termination pursuant to subsection (1) of this section.

(b) If the respondent demands a trial before the court, the court shall schedule the trial to begin within thirty-five days after the demand. If the respondent demands a jury trial, the court shall schedule the trial to begin within seventy-two days after the demand. A delay attributable to the respondent is excluded from the time limitations in this subsection (5)(b). If the court does not begin the trial within the time permitted pursuant to this subsection (5)(b), the court shall terminate the civil commitment and release the respondent from the provider's care and custody.

(c) If the county attorney does not object to termination but the district attorney does, the district attorney has standing to serve as the county attorney for the limited purpose of trial and any appeals related to the trial. The county attorney shall timely provide the district attorney all information and records relevant to the trial in the county attorney's possession or control without subpoena or court order. The district attorney's limited standing does not extend to any other matters related to the civil commitment and terminates upon resolution of the trial and any related appeals.

(6) (a) At the trial, if any evidence is introduced that shows the respondent does not meet the criteria for termination of the civil commitment pursuant to subsection (1) of this section, the respondent has the burden to show by a preponderance of the evidence that the respondent meets the criteria for termination pursuant to subsection (1) of this section.

(b) If the trier of fact finds, by a preponderance of the evidence, that the respondent meets the criteria for termination pursuant to subsection (1) of this section, the court shall order the respondent released from the provider's care and custody and terminate the respondent's civil commitment. If the trier of fact finds, by a preponderance of the evidence, that the respondent does not meet the criteria for termination pursuant to subsection (1) of this section, the court

shall continue the civil commitment and may enter or modify any orders to assist in progressing the treatment of the respondent or that are necessary to protect the public.

(7) If the trier of fact finds the respondent does not meet the criteria for termination pursuant to subsection (1) of this section, the respondent is not entitled to another termination trial within one year after the conclusion of the previous trial for termination.

(8) If the respondent does not meet the criteria for termination pursuant to subsection (1) of this section and has a mental health disorder that is an intellectual and developmental disability or a neurocognitive disorder, as those terms are defined in section 25.5-10-501, without having any other mental health disorder that is not an intellectual and developmental disability or neurocognitive disorder and that substantially contributes to whether the respondent is a danger to the respondent's self or a danger to others, or is gravely disabled, the court shall convert the civil commitment to an enhanced protective placement and may modify the terms of the enhanced protective placement in accordance with section 25.5-10-507.

(9) If the defendant does not meet the criteria for termination pursuant to subsection (1) of this section and has co-occurring mental health disorders that include an intellectual and developmental disability or a neurocognitive disorder, as those terms are defined in section 25.5-10-501, the court may, upon the recommendation of CDHS, convert a civil commitment to an enhanced protective placement and modify the terms of the enhanced protective placement in accordance with section 25.5-10-507.

(10) This section is repealed, effective July 1, 2031.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 761, § 21, effective May 21.

ARTICLE 65.5

Eating Disorder Treatment and Recovery Facilities

27-65.5-101. Eating disorder treatment and recovery facilities - rules.

27-65.5-101. Eating disorder treatment and recovery facilities - rules.

(1) No later than January 1, 2026, the behavioral health administration, established in section 27-50-102, shall require all eating disorder treatment and recovery facilities to hold an appropriate designation based on the level of care the facility provides, including facilities that offer intensive outpatient treatment, partial hospitalization, residential programs, and inpatient

programs. Licensed clinicians who are not facility-based and offer behavioral health therapy to individuals with an eating disorder on an outpatient basis are not required to hold a designation.

(2) The state board of human services shall promulgate rules for eating disorder treatment and recovery facilities that must:

(a) Allow a patient to request and have access to any medical examination, including a weigh-in, without other patients present in the same room;

(b) Prohibit a treatment facility from requiring that a patient remove all clothing during a weigh-in without providing clothing that sufficiently provides privacy and covers the patient's body;

(c) Prohibit a treatment facility from requiring that a patient perform physical exercises during a weigh-in, unless the treatment provider has sufficient cause to believe that the patient would be at risk of harm, at which point the treatment provider shall document the need for further investigation in the patient's medical record and ask the patient to perform any physical exercise in a location with sufficient privacy and in a way that preserves the patient's dignity to the greatest extent possible;

(d) Require a treatment facility to provide gender nonconforming and transgender patients with the same restroom policies provided for cisgender patients;

(e) Prohibit a treatment facility from requiring that patients share a single stall with a staff member or another patient while in the act of using the restroom;

(f) Require a treatment facility's policies to respect and accommodate a patient's sexual orientation, gender identity, religion, and, unless clinically contraindicated, personal dietary ethics;

(g) Require the presence of appropriate and qualified staff to treat a patient at all times, including during weigh-ins, restroom time, vital sign checks, and behavioral health treatment and group therapy. If a staff member performs multiple functions at a treatment facility, the rules must ensure providers preserve and prioritize the therapeutic relationship between the staff member and patient.

(h) Address the use of restraints and restriction of a patient's allowed bodily movement. The rules must ensure that restriction of movement is never used as a form of punishment and that patients are permitted a minimum amount of physical activity per day as clinically appropriate.

(i) Address the use of bed-based or room-based care, ensuring these practices are used as a last resort and that staff meaningfully engage patients to avoid these restrictive measures; except that this subsection (2)(i) does not apply to an eating disorder program in a general hospital setting;

(j) Require a treatment facility to implement a trauma-informed treatment framework;

(k) Establish the minimum rights each patient is entitled to at a treatment facility and require that patient rights be publicly posted and provided to each patient electronically and in writing. In addition, the formal grievance process for a patient to file a complaint against the treatment facility through the behavioral health administration for an alleged violation of the patient's rights must be publicly posted and provided to each patient electronically and in writing.

(l) Prior to involuntarily placing a feeding tube for a minor patient, require the eating disorder treatment and recovery facility to obtain informed written consent from both the patient and the patient's parent or legal guardian if the patient is fifteen years of age or older or from only the patient's parent or legal guardian if the patient is fourteen years of age or younger. If a patient is fifteen years of age or older and does not consent to or objects to the continued use of an involuntary feeding tube, the patient may seek review pursuant to section 27-65-104 (6).

Source: L. 2024: Entire article added, (SB 24-117), ch. 443, p. 3091, § 1, effective June 6.

ARTICLE 66

Community Mental Health Services - Purchase

27-66-101. Definitions.

27-66-102. Administration - rules.

27-66-103. Community mental health services - purchase program.

27-66-104. Types of services purchased - limitation on payments.

27-66-105. Standards for approval - repeal. (Repealed)

27-66-106. Federal grants-in-aid and other grants for mental health and integrated behavioral health services - administration. (Repealed)

27-66-107. Purchase of services by courts, counties, municipalities, school districts, and other political subdivisions. (Repealed)

27-66-108. Institutes and training programs. (Repealed)

27-66-109. Family mental health services grant program - rural areas - creation - administration - report - repeal. (Repealed)

27-66-110. Trauma-informed care standards of approval.

27-66-101. Definitions.

As used in this article 66, unless the context otherwise requires:

(1) Repealed.

(1.3) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-50-102.

(1.5) "Behavioral health entity" has the same meaning as defined in section 27-50-101.

(1.7) "Commissioner" means the commissioner of the behavioral health administration.

(2) to (6) Repealed.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 701, § 2, effective April 29. **L. 2017:** IP, (1), IP(2), (3), and (6) amended, (SB 17-242), ch. 263, p. 1349, § 245, effective May 25. **L. 2019:** (1.5) added, (HB 19-1237), ch. 413, p. 3642, § 14, effective July 1, 2022. **L. 2022:** (1), (2), and (3) repealed and (1.5) amended, (HB 22-1278), ch. 222, p. 1583, § 213, effective July 1; (1.3) and (1.7) added and (4), (5), and (6) repealed, (HB 22-1278), ch. 222, p. 1542, § 125, effective July 1; (1.5)(a) amended, (HB 22-1295), ch. 123, p. 864, § 117, effective July 1.

Editor's note: (1) This section is similar to former § 27-1-201 as it existed prior to 2010.

(2) Subsection (1.5)(a) was amended in HB 22-1295. Those amendments were superseded by the amendment of subsection (1.5) in HB 22-1278.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-66-102. Administration - rules.

(1) The commissioner has the power and duty to administer and enforce the provisions of this article 66.

(2) The state board of human services may adopt reasonable and proper rules to implement this article 66 in accordance with the provisions of section 24-4-103 and consistent with sections 27-90-102 and 27-90-103.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 702, § 2, effective April 29. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1542, § 126, effective July 1.

Editor's note: This section is similar to former § 27-1-202 as it existed prior to 2010.

27-66-103. Community mental health services - purchase program.

In order to encourage the development of preventive, treatment, and rehabilitative services through new community mental health programs, the improvement and expansion of existing community mental health services, and the integration of community with state mental health services, there is established a program to purchase community mental health services by the BHA.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 702, § 2, effective April 29. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1542, § 127, effective July 1.

Editor's note: This section is similar to former § 27-1-203 as it existed prior to 2010.

Cross references: For provisions on community-centered boards that provide services for persons with developmental disabilities, see part 1 of article 10.5 of this title 27.

ANNOTATION

This program does not provide substantive rights to community treatment for chronically ill persons. Goebel v. State Dept. of Insts., 764 P.2d 785 (Colo. 1988) (decided prior to 2010 amendments to this article).

27-66-104. Types of services purchased - limitation on payments.

Community mental health services may be purchased from behavioral health safety-net providers that have been approved by the commissioner.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 702, § 2, effective April 29. **L. 2011:** (4)(a) amended, (SB 11-225), ch. 189, p. 731, § 5, effective May 19. **L. 2012:** (4)(a) amended, (HB 12-1247), ch. 53, p. 197, § 8, effective March 22. **L. 2013:** (4)(a) amended, (HB 13-1181), ch. 74, p. 241, § 9, effective March 22. **L. 2016:** (4)(a) amended, (HB 16-1408), ch. 153, p. 471, § 23, effective May 4; (4)(b) repealed, (HB 16-1408), ch. 153, p. 472, § 26, effective July 1. **L. 2017:** (4) amended, (SB 17-264), ch. 353, p. 1839, § 2, effective June 5. **L. 2019:** (1), IP(2)(a), (2)(a)(II), (2)(a)(III), (2)(b), (3), and (6) amended and (2)(a)(IV) added, (HB 19-1237), ch. 413, p. 3642, § 15, effective July 1, 2022. **L. 2022:** (1), (2)(b), (3), and (5) amended, (HB 22-1278), ch. 222, p. 1542, § 128, effective July 1; Entire section amended, (HB 22-1278), ch. 222, p. 1587, § 215, effective July 1, 2024.

Editor's note: (1) This section is similar to former § 27-1-204 as it existed prior to 2010.

(2) Subsection (4)(c) provided for the repeal of subsection (4), effective September 1, 2017. (See L. 2017, p. 1839.)

27-66-105. Standards for approval - repeal. (Repealed)

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 704, § 2, effective April 29. **L. 2017:** IP(1), (1)(f), and (2)(e) amended, (SB 17-242), ch. 263, p. 1350, § 246, effective May 25. **L. 2018:** (1)(e) amended, (SB 18-096), ch. 44, p. 475, § 19, effective August 8. **L. 2019:** (1)(a), IP(2), and (3) amended and (1)(g) and (4) added, (HB 19-1237), ch. 413, p. 3643, § 16, effective July 1, 2022. **L. 2022:** IP(1), (1)(d), IP(2), (3), and (4) amended, (1)(g) repealed, and (5) added, (HB 22-1278), ch. 222, p. 1543, § 129, effective July 1.

Editor's note: (1) This section is similar to former § 27-1-205 as it existed prior to 2010.

(2) Subsection (5) provided for the repeal of this section, effective July 1, 2024. (See L. 2022, p. 1543.)

27-66-106. Federal grants-in-aid and other grants for mental health and integrated behavioral health services - administration. (Repealed)

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 705, § 2, effective April 29. **L. 2018:** Entire section amended, (SB 18-096), ch. 44, p. 475, § 20, effective

August 8. **L. 2019:** Entire section amended, (HB 19-1237), ch. 413, p. 3638, § 4, effective August 2; entire section amended, (HB 19-1237), ch. 413, p. 3643, § 17, effective July 1, 2022. **L. 2022:** Entire section repealed, (HB 22-1278), ch. 222, p. 1544, § 130, effective July 1.

27-66-107. Purchase of services by courts, counties, municipalities, school districts, and other political subdivisions. (Repealed)

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 705, § 2, effective April 29. **L. 2019:** Entire section amended, (HB 19-1287), ch. 175, p. 2015, § 2, effective May 14; entire section amended, (HB 19-1237), ch. 413, p. 3644, § 18, effective July 1, 2022. **L. 2022:** Entire section repealed, (HB 22-1278), ch. 222, p. 1544, § 130, effective July 1.

27-66-108. Institutes and training programs. (Repealed)

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 705, § 2, effective April 29. **L. 2022:** Entire section repealed, (HB 22-1278), ch. 222, p. 1544, § 130, effective July 1.

27-66-109. Family mental health services grant program - rural areas - creation - administration - report - repeal. (Repealed)

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 705, § 2, effective April 29.

Editor's note: (1) Subsection (5) provided for the repeal of this section, effective July 1, 2010. (See L. 2010, p. 705.)

(2) This section was similar to former § 27-1-209 as it existed prior to 2010.

27-66-110. Trauma-informed care standards of approval.

The BHA shall establish care standards and an approval process that a qualified residential treatment program, as defined in section 26-6-903 (26), must meet to ensure that qualified

residential treatment programs have a trauma-informed treatment model that addresses the needs of children and youth with serious emotional or behavioral health disorders or disturbances.

Source: L. 2019: Entire section added, (HB 19-1308), ch. 256, p. 2462, § 12, effective August 2. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1544, § 131, effective July 1; Entire section amended, (HB 22-1295), ch. 123, p. 864, § 118, effective July 1.

Editor's note: Amendments to this section by HB 22-1278 and HB 22-1295 were harmonized.

ARTICLE 66.5

Community Transition Specialist Program

27-66.5-101. Short title.

27-66.5-102. Definitions.

27-66.5-103. Community transition specialist program - program requirements - acceptance of referrals - contract for services - rules.

27-66.5-104. Data collection and recommendations.

27-66.5-105. Reporting requirements - "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" report.

27-66.5-101. Short title.

The short title of this article 66.5 is the "Community Transition Specialist Program Act".

Source: L. 2018: Entire article added, (SB 18-270), ch. 223, p. 1421, § 1, effective May 21.

27-66.5-102. Definitions.

As used in this article 66.5, unless the context otherwise requires:

(1) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-50-102.

(2) "Commissioner" means the commissioner of the behavioral health administration.

(3) "High-risk individual" means a person who:

(a) Has a significant mental health or substance use disorder, as evidenced by:

(I) An emergency mental health hold pursuant to section 27-65-106;

(II) A certification for short-term treatment or extended short-term treatment pursuant to section 27-65-108.5 or 27-65-109;

(III) Long-term care and treatment pursuant to section 27-65-110;

(IV) An emergency commitment pursuant to section 27-81-111;

(V) An involuntary commitment pursuant to section 27-81-112; or

(VI) Receiving voluntary behavioral health services pursuant to section 27-65-103, 27-65-104, 27-81-109, or 27-81-110; and

(b) Repealed.

(c) Is not currently engaged or actively enrolled in consistent community-based behavioral health treatment.

(4) Repealed.

(4.5) "Transition services" include, but are not limited to, one or more of the following services:

(a) Access to housing or residential program placement;

(b) Access to behavioral health treatment or benefits;

(c) Advocacy to insurance companies and providers for the appropriate type and intensity of mental health or substance use disorder services;

(d) Planning for follow-up services and coordination within the behavioral health system after hospitalization or discharge from a withdrawal management facility, acute treatment service facility, crisis stabilization service facility, or a hospital or an emergency department following a visit for behavioral health reasons;

(e) Assistance with preparing advance directives;

(f) Obtaining a representative payee or guardian;

(g) Family supportive services; or

(h) Compliance with court appearances or probation.

(5) "Transition specialist" means a person who assists high-risk individuals with transition services.

(6) "Withdrawal management facility" means a facility that provides twenty-four-hour supervised withdrawal from alcohol or drugs in a residential setting.

Source: L. 2018: Entire article added, (SB 18-270), ch. 223, p. 1421, § 1, effective May 21. **L. 2020:** (3)(a)(IV) and (3)(a)(V) amended, (SB 20-007), ch. 286, p. 1416, § 53, effective July 13. **L. 2021:** IP(3)(a), (3)(a)(IV), (3)(a)(V), (3)(c), and (5) amended, (3)(a)(VI) and (4.5) added, and (3)(b) repealed, (HB 21-1130), ch. 45, p. 190, § 1, effective April 20. **L. 2022:** (1) and (2) amended and (4) repealed, (HB 22-1278), ch. 222, p. 1544, § 132, effective July 1; (3)(a)(I), (3)(a)(II), (3)(a)(III), and (3)(a)(VI) amended, (HB 22-1256), ch. 451, p. 3236, § 43, effective August 10. **L. 2023:** (3)(a)(II) amended, (HB 23-1138), ch. 423, p. 2492, § 18, effective July 1, 2024.

27-66.5-103. Community transition specialist program - program requirements - acceptance of referrals - contract for services - rules.

(1) The community transition specialist program is established in the behavioral health administration. The program coordinates referrals of high-risk individuals from withdrawal management facilities, facilities providing acute treatment services, facilities providing crisis stabilization services, and hospitals or emergency departments to appropriate transition specialists.

(2) On or before January 1, 2019, the program must be available statewide, subject to available appropriations. The program must have a process to accept referrals for high-risk individuals and coordinate contact between referred high-risk individuals and appropriate transition specialists. To the extent possible, the coordinated contact must take place prior to the release or discharge of the high-risk individual from a facility.

(3) The program must encourage, but cannot require, withdrawal management facilities, facilities providing acute treatment services, facilities providing crisis stabilization services, and hospitals or emergency departments to contact the program before releasing or discharging a high-risk individual.

(4) The program may encourage, but cannot require, a high-risk individual to accept services from a transition specialist. Participation by a high-risk individual is voluntary and the individual has the right to decline community transition specialist services.

(5) The BHA may contract with a vendor to provide the referral and coordination services required by this article 66.5.

(6) The state board of human services may promulgate rules necessary for the implementation of this article 66.5.

Source: L. 2018: Entire article added, (SB 18-270), ch. 223, p. 1423, § 1, effective May 21. **L. 2021:** (1), (2), (3), and (6) amended, (HB 21-1130), ch. 45, p. 191, § 2, effective April 20. **L. 2022:** (1), (5), and (6) amended, (HB 22-1278), ch. 222, p. 1544, § 133, effective July 1.

27-66.5-104. Data collection and recommendations.

(1) The BHA shall collect information on the following:

(a) Current practices, criteria, and procedures regarding follow-up care for high-risk individuals released or discharged from emergency or involuntary holds, certifications, or commitments; and

(b) Existing capacity to serve high-risk individuals after release or discharge.

(2) On or before January 1, 2020, and on or before January 1 each year thereafter, the BHA shall analyze the data collected in accordance with subsection (1) of this section and prepare recommendations to increase access to, and coordination of, transition specialist services for high-risk individuals. The recommendations must be reported to the commissioner and included in the reporting requirements in section 27-66.5-105.

Source: L. 2018: Entire article added, (SB 18-270), ch. 223, p. 1423, § 1, effective May 21. **L. 2022:** IP(1) and (2) amended, (HB 22-1278), ch. 222, p. 1545, § 134, effective July 1.

27-66.5-105. Reporting requirements - "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" report.

The BHA shall report information on the community transition specialist program in the BHA's annual presentation to the general assembly required under the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", part 2 of article 7 of title 2.

Source: L. 2018: Entire article added, (SB 18-270), ch. 223, p. 1423, § 1, effective May 21. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1545, § 135, effective July 1.

ARTICLE 67

Children and Youth Mental Health Treatment Act

27-67-101. Short title.
27-67-102. Legislative declaration.
27-67-103. Definitions.
27-67-104. Provision of mental health treatment services for children and youth.
27-67-105. Monitoring - reports.
27-67-106. Funding - rules.
27-67-107. Dispute resolution - rules.
27-67-108. Repeal of article. (Repealed)
27-67-109. Child and youth mental health services standards - advisory board.

27-67-101. Short title.

The short title of this article 67 is the "Children and Youth Mental Health Treatment Act".

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 708, § 2, effective April 29. **L. 2018:** Entire section amended, (HB 18-1094), ch. 343, p. 2037, § 1, effective June 30.

Editor's note: This section is similar to former § 27-10.3-101 as it existed prior to 2010.

27-67-102. Legislative declaration.

(1) The general assembly finds that many parents in Colorado experience challenging circumstances because their children have significant mental health needs. Many times, the parents are loving, caring parents who have become increasingly frustrated in their attempts to navigate the various governmental systems, including child welfare, mental health, law enforcement, juvenile justice, education, and youth services, in an attempt to find help for their children. Frequently in these situations, an action in dependency or neglect under article 3 of title 19 is neither appropriate nor warranted.

(2) The general assembly finds that it is desirable to assist children and youth with mental health needs and their families. The general assembly further finds that it is desirable to make mental health services more available to families who want treatment for their children. The general assembly finds that it is in the best interest of the state to provide a full range of mental

health treatment services, including residential care, to children and youth who are not eligible for medicaid. The general assembly further finds that, although the mental health agencies are responsible for providing or coordinating the full range of mental health treatment services, including residential care, for those children and youth who have been found to be categorically eligible for medicaid, there remains a population of children and youth in need of mental health services who are not categorically eligible for medicaid. Accordingly, the general assembly determines that it is appropriate to adopt a program pursuant to which a continuum of services would be provided to these children and youth.

(3) The general assembly therefore finds that children and youth who are categorically eligible for medicaid and who may be eligible for mental health treatment services, including residential care, may need support in identifying clear appeals processes.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 708, § 2, effective April 29. **L. 2017:** (1) amended, (HB 17-1329), ch. 381, p. 1984, § 64, effective June 6. **L. 2018:** Entire section amended, (HB 18-1094), ch. 343, p. 2037, § 2, effective June 30.

Editor's note: This section is similar to former § 27-10.3-102 as it existed prior to 2010.

27-67-103. Definitions.

As used in this article 67, unless the context otherwise requires:

(1) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-50-102.

(1.3) "Behavioral health safety net provider" has the same meaning as defined in section 27-50-101.

(1.5) "Care management" includes, but is not limited to, consideration of the continuity of care and array of services necessary for appropriately treating a child or youth and the decision-making authority regarding the child's or youth's placement in and discharge from behavioral health services.

(2) "Child or youth at risk of out-of-home placement" means a child or youth who, although not otherwise categorically eligible for medicaid, meets the following criteria:

(a) The child or youth has been diagnosed as having a mental health disorder, as defined in section 27-65-102;

(b) The child or youth requires a level of care that is provided in a residential child care facility pursuant to section 25.5-6-903, or that is provided through community-based programs, and who, without such care, is at risk of unwarranted child welfare involvement or other system involvement, as described in section 27-67-102, in order to receive funding for treatment;

(c) If the child or youth is determined to be in need of placement in a residential child care facility, he or she shall apply for supplemental security income, but any determination for supplemental security income must not be a criterion for a child or youth to receive services pursuant to this article 67;

(d) The child or youth is a person for whom there is no pending or current action in dependency or neglect pursuant to article 3 of title 19; and

(e) The child or youth is younger than eighteen years of age, but he or she may continue to remain eligible for services until his or her twenty-first birthday.

(2.5) "Commissioner" means the commissioner of the behavioral health administration.

(3) "Community-based care" means any intervention that is designed to be an alternative to residential or hospital level of care in which the child or youth resides within a noninstitutional setting.

(4) Repealed.

(5) "County department" means the county or district department of human or social services.

(6) "Family advocate" has the same meaning as provided in section 27-69-102 (5).

(7) "Family systems navigator" has the same meaning as provided in section 27-69-102 (5.5).

(8) "First-level appeal" means the initial process a medicaid member is required to enact to contest a benefit, service, or eligibility decision made by medicaid or a medicaid managed care entity.

(9) "Medicaid child or youth who is at risk of out-of-home placement" means a child or youth who is categorically eligible for medicaid but who otherwise meets the definition of a child or youth who is at risk of out-of-home placement as defined in subsection (2) of this section.

(10) "Mental health agency" means a behavioral health services contractor through the behavioral health administration serving children and youth statewide or in a particular geographic area and with the ability to meet all expectations of this article 67.

(11) "Professional person" means a person licensed to practice medicine in this state, a psychologist certified to practice in this state, or a person licensed and in good standing to

practice medicine in another state or a psychologist certified to practice and in good standing in another state who is providing medical or clinical services at a treatment facility in this state that is operated by the armed forces of the United States, the United States public health service, or the United States department of veterans affairs.

(12) Repealed.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 708, § 2, effective April 29. **L. 2017:** IP, (2)(a), and IP(3) amended, (SB 17-242), ch. 263, p. 1350, § 247, effective May 25. **L. 2018:** Entire section R&RE, (HB 18-1094), ch. 343, p. 2038, § 3, effective June 30; (5) amended, (SB 18-092), ch. 38, p. 453, § 139, effective August 8; (2)(b) amended, (HB 18-1328), ch. 184, p. 1244, § 7, effective June 7, 2019. **L. 2022:** (1) and (10) amended, (1.5) and (2.5) added, and (12) repealed, (HB 22-1278), ch. 222, p. 1545, § 136, effective July 1; (2)(a) amended, (HB 22-1256), ch. 451, p. 3236, § 44, effective August 10; (1.3) added and (10) amended, (HB 22-1278), ch. 222, p. 1594, § 236, effective July 1, 2024; (4)(b) added by revision, (HB 22-1278), ch. 222, pp. 1594, 1605, §§ 236, 263.

Editor's note: (1) This section is similar to former § 27-10.3-103 as it existed prior to 2010.

(2) Section 10 of chapter 184 (HB 18-1328), Session Laws of Colorado 2018, provides that section 7 of the act changing subsection (2)(b) takes effect upon notice to the revisor of statutes pursuant to section 25.5-5-306 (6) as enacted in section 2 of the act. For more information, see HB 18-1328. (L. 2018, p. 1247.) On August 14, 2019, the revisor of statutes received the notice referred to in § 25.5-5-306 (6) that the federal department of health and human services approved the waiver on June 7, 2019.

(3) (a) Subsection (5) was numbered as subsection (4) in SB 18-092. That provision was harmonized with and relocated to subsection (5) as it appears in HB 18-1094.

(b) Amendments to subsection (2)(b) by HB 18-1094 and HB 18-1328 were harmonized, effective June 7, 2019.

(4) Amendments to subsection (10) by sections 136 and 236 of HB 22-1278 were harmonized, effective July 1, 2024.

(5) Subsection (4)(b) provided for the repeal of subsection (4), effective July 1, 2024. (See L. 2022, pp. 1594, 1605.)

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017. For the legislative declaration in SB 18-092, see section 1 of

chapter 38, Session Laws of Colorado 2018. For the legislative declaration in HB 18-1328, see section 1 of chapter 184, Session Laws of Colorado 2018.

27-67-104. Provision of mental health treatment services for children and youth.

(1) (a) A parent or guardian may apply to a mental health agency on behalf of a child or youth for mental health treatment services for the child or youth pursuant to this section, if the parent or guardian believes the child or youth is at risk of out-of-home placement. The parent's or guardian's request for services described in this section may be done with assistance from a family advocate, family systems navigator, nonprofit advocacy organization, or county department; however, the BHA is not obligated to pay for any services provided by entities with which they do not contract. In such circumstances, the mental health agency is responsible for evaluating the child or youth and clinically assessing the child's or youth's need for mental health services and, when warranted, to provide treatment services as necessary and in the best interests of the child or youth and the child's or youth's family. When evaluating a child or youth for eligibility, the mental health agency shall use a standardized risk stratification tool, in a manner determined by rule of the state board of human services. Following the evaluation of the child or youth, the mental health agency shall provide a written notification to the child's or youth's parent or guardian that includes a comprehensive list of potential treatment providers, with a disclosure that the child's or youth's family may choose to seek services from the provider of their choice, including but not limited to the mental health agency. The written notification must also inform the child's or youth's family that they may request assistance from a family advocate, family systems navigator, nonprofit advocacy organization, or county department; however, the BHA is not obligated to pay for any services provided by entities with which they do not contract. The BHA shall maintain a list of available providers on a public website and shall update the website quarterly. The mental health agency is responsible for the provision of the treatment services and care management, including any residential treatment, community-based care, or any post-residential follow-up services that may be appropriate for the child's or youth's needs or the child's or youth's family's needs. A dependency or neglect action pursuant to article 3 of title 19 is not required in order to allow a family access to residential mental health treatment services for a child or youth.

(b) At the time of the assessment by the mental health agency, if requested services are denied, or at the time when the mental health agency has recommended that the child or youth be discharged from services, the mental health agency shall advise the family, both orally and in writing, of the appeal process available to them. The mental health agency shall have two working days within which to complete any internal appeal process. Within five working days after the mental health agency's final denial or recommendation for discharge, a parent or guardian may request an objective third party at the BHA who is a professional person to review the action of the mental health agency. A family advocate, family systems navigator, nonprofit

advocacy organization, or county department may assist a family in filing an appeal; however, the BHA is not obligated to pay for any services provided by entities with which they do not contract. The review must occur within three working days of the parent's or guardian's request. The professional person shall determine if the requested services are appropriate.

(1.5) (a) The parent or guardian of a medicaid child or youth who is at risk of out-of-home placement may request, within five days after all first-level medicaid appeals processes are exhausted, an objective third party at the BHA who is a professional person to review the service request made to medicaid. A family advocate, family system navigator, or county department may assist a family in filing an appeal. The review must occur within three working days of the parent's or guardian's request.

(b) The administrative law judge considering the medicaid appeal for the medicaid child or youth who is at risk of out-of-home placement shall take into consideration the objective third-party review by the BHA as part of the administrative law judge's reconsideration and decision of the medicaid service request.

(2) If at any time the mental health agency determines pursuant to section 19-3-304 that there is reasonable cause to know or suspect that a child or youth has been subjected to abuse or neglect, then the mental health agency shall immediately make a referral to the statewide child abuse hotline established in section 26-5-111 or the appropriate county department. Within ten working days after the referral, if assigned for an assessment by the county department, a representative of the mental health agency shall meet with the county department and the family. Upon referral to the county department, if assigned for an assessment, the county department shall proceed with the assessment to determine whether there is a sufficient basis to believe that physical or sexual abuse or neglect or some other form of abuse or neglect of a child's or youth's physical well-being has occurred.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 709, § 2, effective April 29. **L. 2018:** Entire section amended, (HB 18-1094), ch. 343, p. 2039, § 4, effective June 30; (1)(a) amended, (HB 18-1431), ch. 313, p. 1892, § 11, effective August 8. **L. 2022:** (1) and (1.5) amended, (HB 22-1278), ch. 222 , p. 1546, § 137, effective July 1.

Editor's note: (1) This section is similar to former § 27-10.3-104 as it existed prior to 2010.

(2) Amendments to subsection (1)(a) by HB 18-1094 and HB 18-1431 were harmonized.

27-67-105. Monitoring - reports.

(1) On or before September 1, 2018, and by September 1 of each year thereafter, each mental health agency shall report to the BHA the following information:

(a) The number of children and youth who are at risk of out-of-home placement and whose parent or legal guardian requested residential or community-based care pursuant to section 27-67-104 to whom the following services were provided:

(I) An assessment pursuant to section 27-67-104 (1)(a);

(II) Community-based care;

(III) Residential treatment; or

(IV) Post-residential follow-up services;

(b) The number of children and youth who are at risk of out-of-home placement and for whom a child abuse and neglect referral was made to the county department;

(c) The number of children and youth for whom either:

(I) An assessment was requested but not performed, and the reasons that the assessment was not performed; or

(II) An assessment was performed but the mental health agency did not provide services pursuant to this article 67, and the reasons that services were not provided, including whether the family refused the services offered;

(d) The costs associated with the provision of the mental health treatment services described in subsection (1)(a) of this section;

(e) The demographic information of the children, youth, and families served, as outlined by the BHA;

(f) The outcomes of treatment for the children and youth served, as determined by the BHA in consultation with mental health agencies, service providers, and families;

(g) The length of stay and funding totals for residential services and community-based care; and

(h) The aggregate number of third-party reviews completed by the BHA for children served pursuant to this article 67, delineated by children who are and are not categorically eligible for medicaid.

(2) On or after January 1, 2019, the BHA shall make the information obtained pursuant to subsection (1) of this section available to the public by posting it to the BHA's website. Any information so posted must not include any personal health information.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 710, § 2, effective April 29. **L. 2018:** Entire section R&RE, (HB 18-1094), ch. 343, p. 2041, § 5, effective June 30; IP(1)(a) and (1)(b) amended, (HB 18-1431), ch. 313, p. 1893, § 12, effective August 8. **L. 2022:** IP(1), (1)(e), (1)(f), (1)(h), and (2) amended, (HB 22-1278), ch. 222, p. 1547, § 138, effective July 1.

Editor's note: (1) This section is similar to former § 27-10.3-105 as it existed prior to 2010.

(2) Subsections IP(1)(a) and (1)(b) were amended in HB 18-1431, effective August 8, 2018. However, those amendments were superseded by the repeal and reenactment of this section in HB 18-1094, effective June 30, 2018.

27-67-106. Funding - rules.

(1) In order to make mental health treatment available, it is the intent of the general assembly that mental health treatment provided pursuant to this article to each child described in section 27-67-103 (2) be provided by mental health agencies.

(2) (a) If neither the family's private insurance nor federal medicaid funding cover all of the costs associated with the services provided to a child at risk of out-of-home placement pursuant to this article, then the family is responsible for paying that portion that is not covered by private insurance or federal medicaid funding on a sliding scale basis as set forth in subsection (3) of this section. Any remaining portion of the services not covered by private insurance, federal medicaid funding, or the family's share, shall be paid for from any moneys appropriated by the general assembly for that purpose.

(b) Repealed.

(3) The state board of human services shall promulgate rules implementing a sliding scale for the payment of services, including mental health treatment and room and board, that are not covered by private insurance or federal medicaid funding. It is the intent of the general assembly that subsidies provided by the state through general fund money must be used to assist the lowest income families to ensure the maximum use of appropriate least restrictive treatment services and to provide access to the greatest number of children and youth.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 712, § 2, effective April 29. **L. 2016:** (2)(a) amended and (2)(b) repealed, (HB 16-1408), ch. 153, p. 472,

§§ 24, 26, effective July 1. **L. 2018:** (3) amended, (HB 18-1094), ch. 343, p. 2042, § 6, effective June 30.

Editor's note: This section is similar to former § 27-10.3-106 as it existed prior to 2010.

27-67-107. Dispute resolution - rules.

(1) The BHA shall utilize, when appropriate, established grievance and dispute resolution processes in order to assure that parents have access to mental health services on behalf of their children.

(2) The state board of human services shall promulgate rules to assure that a grievance process is available to parents concerning the provision of mental health services and to assure that a dispute resolution process is available for disputes between the county departments and mental health agencies.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 712, § 2, effective April 29. **L. 2022:** (1) amended, (HB 22-1278), ch. 222, p. 1547, § 139, effective July 1.

Editor's note: This section is similar to former § 27-10.3-107 as it existed prior to 2010.

27-67-108. Repeal of article. (Repealed)

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 712, § 2, effective April 29. **L. 2018:** Entire section repealed, (HB 18-1094), ch. 343, p. 2043, § 7, effective June 30.

Editor's note: This section was similar to former § 27-10.3-108 as it existed prior to 2010.

27-67-109. Child and youth mental health services standards - advisory board.

(1) The advisory board established in subsection (2) of this section is responsible for recommending standards and rules relevant to the provision of mental health services to children and youth covered by this article 67.

(2) An advisory board to the BHA is established for the purpose of assisting and advising the commissioner in accordance with this section in the development of service standards and rules. The advisory board consists of not less than eleven nor more than fifteen members appointed by the BHA as follows:

(a) One representative each from the BHA; the office of children, youth, and families; the department of health care policy and financing; and a leading professional association of psychiatrists in this state;

(b) One member representing nonprofit health-care facilities;

(c) One member representing children or youth consumers of services for persons with mental health disorders;

(d) One member representing families of persons with mental health disorders;

(e) One member representing children's health-care facilities;

(f) One member representing a behavioral health safety net provider that performs evaluations pursuant to this article 67;

(g) One member representing a county human or social services agency;

(h) One member representing individuals with intellectual and developmental disabilities; and

(i) Other persons from both the private and the public sectors who are recognized or known to be interested and informed in the area of the advisory board's purpose and function.

(3) In making appointments to the advisory board, the BHA must include representation by at least one member who is a person with a disability, a family member of a person with a disability, or a member of an advocacy group for persons with disabilities, provided that the other requirements of subsection (2) of this section are met.

Source: L. 2018: Entire section added, (HB 18-1094), ch. 343, p. 2043, § 8, effective June 30. **L. 2019:** (3) amended, (SB 19-241), ch. 390, p. 3474, § 42, effective August 2. **L. 2020:** (3) amended, (HB 20-1392), ch. 132, p. 575, § 4, effective June 26. **L. 2022:** IP(2), (2)(a), and (3) amended, (HB 22-1278), ch. 222, p. 1548, § 140, effective July 1; (2)(f) amended, (HB 22-1278), ch. 222, p. 1595, § 237, effective July 1, 2024.

ARTICLE 68

Mental Health Services Pilot Program for Families of Discharged Veterans of Operation Enduring Freedom and Operation Iraqi Freedom

27-68-101 to 27-68-106. (Repealed)

Editor's note: (1) This article was added with relocations in 2010 containing provisions of part 3 of article 1 of this title and was subsequently repealed in 2010. This article was not amended prior to its repeal in 2010. For a detailed comparison of this article, see the comparative tables located in the back of the index.

(2) Section 27-68-106 provided for the repeal of this article, effective July 1, 2010. (See L. 2010, p. 715.)

ARTICLE 69

Family Advocacy Mental Health Juvenile Justice Programs

27-69-101 to 27-69-106. (Repealed)

Editor's note: (1) This article 69 was added in 2010. For amendments to this article 69 prior to its repeal in 2021, consult the 2020 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

(2) Section 27-69-106 provided for the repeal of this article 69, effective July 1, 2021. (See L. 2011, p. 198.)

(3) Section 27-69-104 (3)(a) was amended in HB 21-1187, effective July 1, 2024. Those amendments were superseded by the repeal of this article 69, effective July 1, 2021.

ARTICLE 70

Medication Consistency for Individuals with Behavioral or Mental Health Disorders in the Criminal and Juvenile Justice Systems

27-70-101. Legislative declaration. 27-70-102. Definitions.

27-70-103. Medication consistency for individuals with behavioral or mental health disorders in the criminal and juvenile justice systems - medication formulary - cooperative purchasing - reporting - rules.

27-70-101. Legislative declaration.

(1) The general assembly finds and declares that:

(a) The lack of medication consistency for individuals with behavioral or mental health disorders who are involved in the criminal and juvenile justice systems creates additional, often serious, problems for these individuals;

(b) It is critical that the state increase the likelihood that a broad spectrum of effective medications, including psychotropic medications, are available to these individuals, regardless of setting or service provider;

(c) By working cooperatively with the criminal and juvenile justice systems and mental health service providers, the state can help ensure medication consistency and also decrease overall state costs through the use of a common and agreed upon medication formulary and cooperative purchasing;

(d) Prior to its repeal in 2018, the medication consistency work group of the behavioral health transformation council identified mental health medications that are essential and preferred for a basic medication formulary that could be used across all public systems to increase medication continuity for individuals with behavioral or mental health disorders in the criminal and juvenile justice systems; and

(e) Increasing information sharing across systems and service providers about the importance of medication consistency and the use of a common and agreed upon medication formulary and cooperative purchasing will result in long-term benefits for the state and for individuals with behavioral or mental health disorders who are involved in the criminal and juvenile justice systems.

Source: L. 2017: Entire article added, (SB 17-019), ch. 405, p. 2113, § 1, effective August 9. **L. 2018:** (1)(d) amended, (SB 18-161), ch. 123, p. 831, § 5, effective September 1.

27-70-102. Definitions.

As used in this article 70, unless the context otherwise requires:

(1) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-50-102.

(2) "Facility" means a federally qualified health-care center, clinic, behavioral health entity, institution, acute treatment unit, jail, facility operated by the department of corrections, or a facility operated by the division of youth services.

(3) "Medication formulary" means the medication formulary established pursuant to section 27-70-103 for use by providers.

(4) Repealed.

(5) "Provider" means any person, facility, or government entity responsible for providing mental health services related to the care and treatment of an individual with behavioral or mental health disorders who is or was involved with the criminal or juvenile justice system.

Source: L. 2017: Entire article added, (SB 17-019), ch. 405, p. 2114, § 1, effective August 9. **L. 2019:** (2) amended, (HB 19-1237), ch. 413, p. 3644, § 19, effective July 1, 2022. **L. 2022:** (1) amended and (4) repealed, (HB 22-1278), ch. 222, p. 1548, § 141, effective July 1; (2) amended, (HB 22-1278), ch. 222, p. 1595, § 238, effective July 1, 2024.

27-70-103. Medication consistency for individuals with behavioral or mental health disorders in the criminal and juvenile justice systems - medication formulary - cooperative purchasing - reporting - rules.

(1) (a) Beginning December 1, 2017, the state board of human services, in consultation with the department of corrections, shall promulgate rules that require providers under the department's and the BHA's authority to use a medication formulary that has been developed collaboratively by departments, agencies, and providers. Public hospitals and licensed private hospitals may also, at their discretion, participate in the medication formulary. Using consulting services as necessary, the department and the BHA shall also develop processes for education and marketing related to information regarding the medication formulary and cooperative purchasing opportunities for facilities and providers.

(b) For the sole purpose of ensuring medication consistency for persons with mental health disorders in the criminal and juvenile justice systems, the department of corrections, counties, the division of youth services, community mental health centers, and other providers shall share patient-specific mental health and treatment information. All such information sharing must comply with confidentiality requirements, including any necessary memorandums of understanding between providers, set forth in the federal "Health Insurance Portability and Accountability Act of 1996", 45 CFR parts 2, 160, 162, and 164.

(2) Beginning July 1, 2018, the BHA shall have the following duties and responsibilities, subject to available appropriations:

(a) On or before September 1, 2018, and every September 1 of every even-numbered year thereafter, the BHA shall conduct a review of the medication formulary to address any urgent concerns related to the formulary and to propose updates to the formulary. During this review, the BHA shall also create the appropriate notification process for updates to the formulary.

(b) On or before July 1, 2019, and every two years thereafter as necessary, the BHA shall conduct a review of the medication formulary to update the medication formulary and ensure compliance with the medicaid formulary used by the department of health care policy and financing.

(c) The BHA, in collaboration with the office of information technology, the office of e-health innovation, the department of health care policy and financing, the department of public safety, the department of corrections, and other agencies as appropriate, shall develop a plan by which the patient-specific information required by subsection (1)(b) of this section can be shared electronically, while still in compliance with confidentiality requirements, including any necessary memorandums of understanding between providers, set forth in the federal "Health Insurance Portability and Accountability Act of 1996", 45 CFR 2, 160, 162, and 164.

(d) (I) The BHA shall encourage providers that have been granted purchasing authority by the department of personnel pursuant to section 24-102-204 to utilize cooperative purchasing for the medication formulary, as authorized pursuant to section 24-110-201, unless the provider can obtain the medication elsewhere at a lower cost. The use of cooperative purchasing may, and is encouraged to, include external procurement activity, as defined in section 24-110-101 (2), if the external procurement activity aggregates purchasing volume to negotiate discounts with manufacturers, distributors, and other vendors.

(II) Any external procurement activity, as defined in section 24-110-101 (2), used by providers for purposes of this article 70 is encouraged to include an ongoing drug utilization review process. The purpose of the review process is to help ensure a structured, ongoing review of health-care provider prescribing, pharmacist dispensing, and patient use of medication. The review must include a comprehensive analysis of patients' prescription and medication data to help ensure appropriate medication decision-making and positive patient outcomes by providing educational feedback to providers on appropriate medication utilization.

(e) The BHA shall investigate and develop options for collaboration with local county jails to coordinate medication purchasing.

(3) (a) Beginning in January 2019, and every January thereafter, the BHA and the department of corrections shall report progress on the implementation and use of the medication formulary and cooperative purchasing as part of the BHA's and department's "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" hearing required by

section 2-7-203. The department and the BHA shall make such reports to the joint health and human services committee and the joint judiciary committee, or any successor committees.

(b) This section is exempt from the provisions of section 24-1-136 (11), and the periodic reporting requirement of that section shall remain in effect until changed by the general assembly acting by bill.

Source: L. 2017: Entire article added, (SB 17-019), ch. 405, p. 2114, § 1, effective August 9. **L. 2018:** (2)(e) amended, (SB 18-161), ch. 123, p. 831, § 6, effective September 1. **L. 2022:** (1)(a), IP(2), (2)(a), (2)(b), (2)(c), (2)(d)(I), (2)(e), and (3)(a) amended, (HB 22-1278), ch. 222, p. 1548, § 142, effective July 1.

ARTICLE 71

Mental Health Residential Facility

27-71-101. Legislative declaration.

27-71-102. Definitions.

27-71-103. Mental health residential facilities - additional beds.

27-71-104. Mental health residential facilities - initial license requirements - repeal. (Repealed)

27-71-105. Mental health residential facilities - licensing requirements - rules.

27-71-101. Legislative declaration.

The general assembly finds and declares that there is an urgent need for community-based mental health residential beds throughout the state to serve individuals who need the support of a residential setting.

Source: L. 2022: Entire article added, (HB 22-1303), ch. 183, p. 1221, § 3, effective May 18.

27-71-102. Definitions.

As used in this article 71, unless the context otherwise requires:

(1) "Assisted living residence" has the same meaning as defined in section 25-27-102 (1.3).

(2) "Behavioral health administration" or "BHA" means the behavioral health administration established pursuant to section 27-60-203.

(3) "Behavioral health disorder" has the same meaning as defined in section 25-27.6-102 (5).

(4) "Behavioral health entity" has the same meaning as defined in section 25-27.6-102 (6).

(5) "Department" means the department of human services.

(6) "Level of care" means the intensity of effort required to diagnose, preserve, or maintain an individual's physical or emotional status, with consideration toward creating a minimally restrictive and homelike environment, when feasible and safe.

(7) "Long term facility" means a residential facility operated by a behavioral health entity or assisted living residence with the intent to support, stabilize, and promote long-lasting recovery by providing the appropriate level of care to patients with mental health disorders.

(8) "Mental health residential facility" or "mental health facility" means a residential mental health facility operated by a behavioral health entity or an assisted living residence to serve individuals with a mental health disorder who need the support of a long-term residential setting including persons coming from a:

(a) Colorado mental health institute;

(b) Hospital designated as a placement facility for seventy-two hour evaluation and treatment, and short-term and long-term support;

(c) Community behavioral health safety net provider;

(d) Walk-in crisis center, crisis stabilization unit, or acute treatment unit operating as part of the behavioral health crisis response system; or

(e) Hospital emergency room.

Source: L. 2022: Entire article added, (HB 22-1303), ch. 183, p. 1221, § 3, effective May 18.

27-71-103. Mental health residential facilities - additional beds.

(1) (a) On or before July 1, 2024, the department and the department of health care policy and financing shall jointly create, develop, or contract, which may include the cost of renovation at private facilities, for at least an additional one hundred and twenty-five beds at mental health residential facilities throughout the state based on the greatest areas of need. The beds in the mental health facilities are available for adult individuals in need of ongoing supportive services, but individuals with a severe mental illness or a dual diagnosis of mental illness and alcohol or

substance use disorder must be prioritized. When available, the department shall use existing department properties for the mental health facilities.

(b) At a minimum, the department shall ensure that the mental health residential facilities offer the following services:

(I) Assistance with medication;

(II) Direct support personnel including assistance with activities of daily living;

(III) Intensive case management services;

(IV) Life skills training; and

(V) Non-medical transportation.

(c) The department and the department of health care policy and financing shall work collaboratively to ensure the beds in the mental health facilities are eligible for federal funding through the medical assistance program.

(2) (a) The beds at the mental health facilities created pursuant to this section are intended primarily for adult individuals with serious mental illness or a co-occurring mental health and substance use disorder in need of services. A mental health facility may also provide services to an individual in need of competency restoration pursuant to article 8.5 of title 16 who does not require imprisonment in a jail.

(b) The department, in collaboration with the behavioral health administration and the department of health care policy and financing, shall prioritize placement for individuals in the civil system who are leaving the mental health institutes at Pueblo and Fort Logan, civil individuals being discharged from inpatient settings, individuals receiving involuntary mental health treatment pursuant to article 65 of this title 27, and civil individuals in need of residential services who are in a mental health crisis facility, acute care hospital, or in the community.

(c) The state department, in collaboration with the behavioral health administration and the department of health care policy and financing, shall establish criteria for admissions and discharge planning, quality assurance monitoring, appropriate length of stay, and compliance with applicable federal law. For the mental health residential facilities created pursuant to this section, admission criteria for facilities must include:

(I) Prioritization of people with serious mental illness who have complex or co-occurring conditions as defined by the state department; and

(II) For treatment beds that do not serve individuals covered under a home- and community-based waiver, offering priority placement to individuals under a certification for short-term or extended short-term treatment pursuant to section 27-65-108.5, 27-65-109, or 27-65-109.5, and long-term care and treatment pursuant to section 27-65-110 on an outpatient basis.

(d) The state department shall collaborate with relevant stakeholders when establishing the criteria described in subsection (2)(c) of this section.

(3) The department shall distribute the money for the creation of additional beds pursuant to this section no later than December 30, 2024. Any person receiving money pursuant to this section shall spend or obligate all money received in accordance with section 24-75-226 (4)(d).

Source: L. 2022: Entire article added, (HB 22-1303), ch. 183, p. 1222, § 3, effective May 18. **L. 2024:** (3) amended, (HB 24-1466), ch. 429, p. 2945, § 41, effective June 5. **L. 2026:** (2)(c)(II) amended, (SB 26-149), ch. 142, p. 798, § 52, effective May 21.

Cross references: For the legislative declaration in HB 24-1466, see section 1 of chapter 429, Session Laws of Colorado 2024.

27-71-104. Mental health residential facilities - initial license requirements - repeal. (Repealed)

Source: L. 2022: Entire article added, (HB 22-1303), ch. 183, p. 1224, § 3, effective May 18. **L. 2023:** (3) amended, (HB 23-1236), ch. 206, p. 1067, § 40, effective May 16.

Editor's note: Subsection (4) provided for the repeal of this section, effective September 1, 2024. (See L. 2022, p. 1224.)

27-71-105. Mental health residential facilities - licensing requirements - rules.

(1) On and after July 1, 2023, unless licensed as an assisted living facility, any person, partnership, association, or corporation operating a mental health residential facility shall obtain a license from the behavioral health administration. By July 1, 2023, the BHA shall promulgate rules establishing minimum standards for the operation and licensing of mental health facilities. The rules must address, at a minimum, health, safety, welfare, and programmatic and treatment consideration.

(2) Notwithstanding the requirement of subsection (1) of this section, a mental health facility need not be licensed as a mental health facility if the facility is:

(a) Licensed pursuant to article 27 of title 25; and

(b) Providing services to individuals under a home- and community-based services for persons with major mental health disorders waiver pursuant to part 6 of article 6 of title 25.5.

Source: L. 2022: Entire article added, (HB 22-1303), ch. 183, p. 1225, § 3, effective May 18.

ALCOHOL AND SUBSTANCE USE - ALCOHOL AND SUBSTANCE USE DISORDERS

ARTICLE 80

Alcohol and Substance Use - Alcohol and Substance Use Disorders

PART 1
PROGRAMS AND SERVICES

27-80-101. Definitions.

27-80-102. Duties of the behavioral health administration.

27-80-103. Grants for public programs.

27-80-104. Cancellation of grants.

27-80-105. Annual distribution of funds.

27-80-106. Purchase of prevention and treatment services.

27-80-107. Designation of managed service organizations - purchase of services - revocation of designation.

27-80-107.5. Increasing access to effective substance use disorder services act - managed service organizations - substance use disorder services - assessment - community action plan - allocations - reporting requirements - evaluation.

27-80-107.7. Increase synthetic opiate treatment - report. (Repealed)

27-80-107.8. Withdrawal management and crisis service expansion - appropriation.

27-80-108. Rules.

27-80-109. Coordination of state and federal funds and programs.

27-80-110. Reports. (Repealed)

27-80-111. Counselor training - fund created - rules.

27-80-112. Legislative declaration - treatment program for high-risk pregnant women - creation.

27-80-113. Substance use and addiction counseling and treatment - necessary components.

27-80-114. Treatment program for high-risk pregnant and parenting women -

cooperation with organizations.

27-80-115. Treatment program for high-risk pregnant and parenting women - data collection.

27-80-116. Fetal alcohol spectrum disorders - legislative declaration - health warning signs - federal funding.

27-80-117. Rural alcohol and substance abuse prevention and treatment program - creation - administration - cash fund - definitions - repeal.

27-80-118. Center for research into substance use disorder prevention, treatment, and recovery support strategies - established - appropriation - legislative declaration.

27-80-119. Care navigation program - creation - reporting - rules - legislative declaration - definition. (Repealed)

27-80-120. Building substance use disorder treatment capacity in underserved communities - grant program. (Repealed)

27-80-121. Perinatal substance use data linkage project - center for research into substance use disorder prevention, treatment, and recovery support strategies - report.

27-80-122. Recovery residence certifying body - competitive selection process - appropriation - repeal.

27-80-123. High-risk families cash fund - creation - services provided - report - definition - repeal. (Repealed)

27-80-124. Colorado substance use disorders prevention collaborative - created - mission - administration - report - repeal. (Repealed)

27-80-125. Housing assistance for individuals with a substance use disorder - report - rules - appropriation.

27-80-126. Recovery support services grant program - creation - eligibility - reporting requirements - appropriation - rules - definitions. (Repealed)

27-80-127. Children and youth in need of residential mental health and substance use treatment - repeal.

27-80-128. Fentanyl education and treatment program.

27-80-129. Regulation of recovery residences - rules - definitions - repeal.

PART 2
CONTROLLED SUBSTANCES

27-80-201. Short title.

27-80-202. Legislative declaration.

27-80-203. Definitions.

27-80-204. License required - controlled substances - repeal.

27-80-205. Issuance of license - fees.

27-80-206. Controlled substances program fund - disposition of fees.

27-80-207. Qualifications for license.

27-80-208. Denial, revocation, or suspension of license - other disciplinary actions - notice.

27-80-209. Exemptions.

27-80-210. Records to be kept - order forms.

27-80-211. Enforcement and cooperation.

27-80-212. Records confidential.

27-80-213. Rules - policies.

27-80-214. Defenses.

27-80-215. Central registry - registration required - notice - repeal.

27-80-216. Policy verifying identity.

PART 3
BEHAVIORAL HEALTH ACCESS TO CARE OMBUDSMAN

27-80-301. Short title.

27-80-302. Definitions.

27-80-303. Office of ombudsman for behavioral health access to care - creation - appointment of ombudsman - duties.

27-80-304. Liaisons - department - commissioner of insurance.

27-80-305. Qualified immunity.

27-80-306. Annual report.

PART 1

PROGRAMS AND SERVICES

Editor's note: This part 1 was added with relocations in 2010 containing provisions of part 2 of article 1 of title 25. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated. For a detailed comparison of this part 1, see the comparative tables located in the back of the index.

27-80-101. Definitions.

As used in this article 80, unless the context otherwise requires:

(1) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-50-102.

(2) "Commissioner" means the commissioner of the behavioral health administration.

(2.3) "Department" means the department of human services created in section 26-1-105.

(2.6) "Designated service area" means the geographical substate planning area specified by the commissioner to be served by a behavioral health administrative services organization, as described in section 27-80-107.

(3) Repealed.

(4) "Fetal alcohol spectrum disorder" or "FASD" means a continuum of permanent birth defects caused by maternal consumption of alcohol during pregnancy. "FASD" includes, but is not limited to, fetal alcohol syndrome.

(4.7) Repealed.

(5) "Public program" means a program concerning the problems of alcohol or drug abuse sponsored by a county, district, or municipal public health agency, county department of human or social services, court, probation department, law enforcement agency, school, school system, board of cooperative services, Indian tribal reservation, or state agency. "Public program" includes any alcohol or drug abuse treatment program required as a condition of probation under part 2 of article 11 of title 16, any alcohol or drug abuse program administered by the division of adult parole under article 2 of title 17, any community correctional facility or program administered under article 27 of title 17, and any alcohol or drug abuse treatment program administered by the division of youth services under title 19.

(6) and (7) Repealed.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 721, § 2, effective April 29; (5) amended, (HB 10-1422), ch. 419, p. 2091, § 85, effective August 11. **L. 2011:** (7) repealed, (HB 11-1144), ch. 65, p. 173, § 3, effective August 10. **L. 2017:** IP and (2) amended, (4.7) added, and (6) repealed, (SB 17-242), ch. 263, p. 1353, § 253, effective May 25; IP and (5) amended, (HB 17-1329), ch. 381, p. 1985, § 66, effective June 6. **L. 2018:** (5) amended, (SB 18-092), ch. 38, p. 453, § 140, effective August 8. **L. 2022:** (1) and (2) amended, (2.3) and (2.6) added, and (3) and (4.7) repealed, (HB 22-1278), ch. 222, p. 1549, § 143, effective July 1; (2.6) amended, (HB 22-1278), ch. 222, p. 1597, § 244, effective August 10.

Editor's note: (1) This section is similar to former § 25-1-201 as it existed prior to 2010.

(2) Subsection (5) was numbered as § 25-1-201 (4) in House Bill 10-1422 (see L. 2010, p. 2091) but was relocated due to its harmonization with this section as it was added by Senate Bill 10-175.

Cross references: For the legislative declaration in the 2011 act repealing subsection (7), see section 1 of chapter 65, Session Laws of Colorado 2011. For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017. For the legislative declaration in SB 18-092, see section 1 of chapter 38, Session Laws of Colorado 2018.

27-80-102. Duties of the behavioral health administration.

(1) The behavioral health administration is a **type 2** entity, as defined in section 24-1-105, and is responsible for the powers, duties, and functions relating to the alcohol and drug driving safety program specified in section 42-4-1301.3. The behavioral health administration shall formulate a comprehensive state plan for substance use disorder treatment programs. The behavioral health administration shall submit the state plan to the governor and, upon the governor's approval, submit it to the appropriate United States agency for review and approval. The state plan must include, but not be limited to:

(a) A survey of the need for the prevention and treatment of alcohol and drug abuse, including a survey of the health facilities needed to provide services and a plan for the development and distribution of facilities and programs throughout the state;

(b) A plan for programs to educate the public in the problems of alcohol and drug abuse;

(c) A survey of the need for trained teachers, health professionals, and others involved in the prevention and treatment of alcohol and drug abuse and the rehabilitation of abusers, and a plan to provide the necessary training for such persons;

(d) Provisions for the periodic review and updating of the state plan, which shall take place at least annually.

(2) The department, acting by and through the behavioral health administration, is designated as the sole state agency for the supervision of the administration of the state plan.

(3) Repealed.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 722, § 2, effective April 29. **L. 2017:** IP(1) and (2) amended, (SB 17-242), ch. 263, p. 1353, § 254,

effective May 25. **L. 2021:** (3) added, (SB 21-239), ch. 266, p. 1548, § 4, effective June 18. **L. 2022:** IP(1) amended, (SB 22-162), ch. 469, p. 3379, § 78, effective August 10. **L. 2023:** IP(1) and (2) amended, (HB 23-1236), ch. 206, p. 1067, § 41, effective May 16.

Editor's note: This section is similar to former § 25-1-202 as it existed prior to 2010.

Cross references: (1) For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

(2) For the short title (the "Debbie Haskins 'Administrative Organization Act of 1968' Modernization Act") in SB 21-162, see section 1 of chapter 469, Session Laws of Colorado 2022.

27-80-103. Grants for public programs.

(1) The BHA may make grants, from money appropriated by the general assembly for purposes of this section or available from any other governmental or private source, to approved public programs.

(2) A public program may provide, but need not be limited to, any of the following:

(a) Acute medical services, including emergency services and detoxification;

(b) Case finding, diagnosis, treatment, counseling, individual or group psychotherapy, after-care treatment, and other rehabilitation services;

(c) Education and counseling regarding the use and abuse of alcohol and drugs;

(d) Programs for prevention of alcohol and drug abuse administered by the department of public health and environment;

(e) Training of teachers, health professionals, and others in the field of alcohol and drug abuse and addiction counseling;

(f) Coordination of existing services and the development of other needed services through demonstration and evaluation projects; or

(g) Services to pregnant women who are alcohol and drug dependent through demonstration and evaluation projects.

(3) In approving any public program, the BHA shall take into consideration the following:

(a) The community need for the public program;

(b) The range of services to be provided;

(c) The integration of the public program with, and the participation of, other public and nongovernmental agencies, organizations, institutions, and individuals, and their services and facilities, if any, that are available to assist the public program;

(d) The adequacy of the public program to accomplish its purposes; and

(e) Any other information the BHA deems necessary.

(4) Applications for grants made pursuant to subsection (1) of this section are made to the BHA, on forms furnished by the BHA, and must contain any information the BHA requires. Wherever possible, the BHA shall give priority to public programs that are community-based and include services to children and juveniles as well as adults, that provide a comprehensive range of services, and that evidence a high degree of community support, either financial or in the furnishing of services and facilities, or both.

(5) Whenever the BHA or any department or agency of the state has money available from any source for public programs, the BHA, department, or agency is authorized to distribute the money in accordance with the state plan and to make reasonable rules for the administration of the public programs.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 722, § 2, effective April 29. **L. 2017:** (1), IP(3), (3)(e), (4), and (5) amended, (SB 17-242), ch. 263, p. 1354, § 255, effective May 25. **L. 2022:** (1), (2)(d), IP(3), (3)(e), (4), and (5) amended, (HB 22-1278), ch. 222, p. 1550, § 145, effective July 1.

Editor's note: This section is similar to former § 25-1-203 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-80-104. Cancellation of grants.

(1) The BHA may cancel a grant for any public program for any of the following reasons:

(a) There is no longer a need for the public program.

(b) Funds for the public program are not available.

(c) The public program does not meet the standards or requirements adopted by the BHA or does not conform to the comprehensive state plan for substance use disorder treatment programs.

(2) Before canceling a grant for the reasons set forth in subsection (1)(c) of this section, the BHA shall notify the person or agency in charge of the public program of the deficiency in the program, and the person or agency must be given a reasonable amount of time to correct the deficiency.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 723, § 2, effective April 29. **L. 2017:** IP(1), (1)(c), and (2) amended, (SB 17-242), ch. 263, p. 1354, § 256, effective May 25. **L. 2022:** IP(1), (1)(c), and (2) amended, (HB 22-1278), ch. 222, p. 1551, § 146, effective July 1.

Editor's note: This section is similar to former § 25-1-204 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-80-105. Annual distribution of funds.

Funds for public programs shall be distributed annually, if available.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 724, § 2, effective April 29.

Editor's note: This section is similar to former § 25-1-205 as it existed prior to 2010.

27-80-106. Purchase of prevention and treatment services.

(1) Using money appropriated for purposes of this section or available from any other governmental or private source, the BHA may purchase services for prevention or for the treatment of alcohol and drug abuse or substance use disorders or both types of services on a contract basis from any tribal nation or any public or private agency, organization, or institution approved by the BHA. The services purchased may be any of those provided through a public program, as set forth in section 27-80-103 (2). In contracting for services, the BHA shall attempt

to obtain services that are in addition to, and not a duplication of, existing available services or services that are of a pilot or demonstration nature. An agency operating a public program may also purchase services on a contract basis.

(2) (a) In addition to the services purchased pursuant to subsection (1) of this section, using money appropriated for purposes of this section or available from any other governmental or private source, the BHA may purchase services for the treatment of alcohol and drug abuse or substance use disorders on a contract basis from a behavioral health administrative services organization for a designated service area as set forth in section 27-80-107. A public or private agency, organization, or institution approved by the BHA through the process set forth in section 27-80-107 may be designated as a behavioral health administrative services organization.

(b) Behavioral health administrative services organizations receiving money pursuant to this subsection (2) shall comply with all relevant provisions of and rules promulgated pursuant to this article 80.

(3) Repealed.

(4) As of July 1, 2022, the department of public health and environment is the state department responsible for the administration of prevention services pursuant to this section.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 724, § 2, effective April 29. **L. 2017:** Entire section amended, (SB 17-242), ch. 263, p. 1355, § 257, effective May 25. **L. 2019:** (3) added, (SB 19-228), ch. 276, p. 2605, § 9, effective May 23. **L. 2022:** (1) and (2)(a) amended and (4) added, (HB 22-1278), ch. 222, p. 1551, § 147, effective July 1; (2)(a) and (2)(b) amended, (HB 22-1278), ch. 222, p. 1597, § 245, effective August 10.

Editor's note: (1) This section is similar to former § 25-1-206 as it existed prior to 2010.

(2) Subsection (3)(c) provided for the repeal of subsection (3), effective September 1, 2020. (See L. 2019, p. 2605.)

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-80-107. Designation of managed service organizations - purchase of services - revocation of designation.

(1) The behavioral health administration shall establish designated service areas to provide substance use disorder treatment and recovery services in a particular geographical region of the state.

(2) To be selected as a designated managed service organization to provide services in a particular designated service area, a private corporation, for profit or not for profit, or a public agency, organization, or institution shall apply to the behavioral health administration for a designation in the form and manner specified by the commissioner or the commissioner's designee. The designation process is in lieu of a competitive bid process pursuant to the "Procurement Code", articles 101 to 112 of title 24. The commissioner or the commissioner's designee shall make the designation based on factors established by the commissioner or the commissioner's designee. The factors for designation established by the executive director or the executive director's designee include the following:

(a) Whether the managed service organization has experience working with public treatment agencies and collaborating with other public agencies;

(b) Whether the managed service organization has experience working with publicly funded clients, including expertise in treating priority populations designated by the behavioral health administration;

(c) Whether the managed service organization has offices in and provides services in the substate planning area or is willing to relocate to the substate planning area;

(d) Whether the managed service organization has experience using the cost-share principles used by the behavioral health administration in its contracts with providers and is willing to cost-share;

(e) Whether the managed service organization has developed an effective, integrated information and fiscal reporting system and has experience working with and is able to comply with state and federal reporting requirements;

(f) Whether the managed service organization has experience engaging in a clinical quality improvement process; and

(g) Whether the managed service organization has experience with public funding requirements and state contracting requirements.

(2.5) (a) On or before January 1, 2023, in order to promote transparency and accountability, the behavioral health administration shall require each managed service organization that has twenty-five percent or more ownership by providers of behavioral health services to comply with the following conflict of interest policies:

(I) Providers who have ownership or board membership in a managed service organization shall not have control, influence, or decision-making authority in how funding is distributed to any provider or the establishment of provider networks.

(II) The behavioral health administration shall quarterly review a managed service organization's funding allocation to ensure that all providers are being equally considered for funding. The behavioral health administration is authorized to review any other pertinent information to ensure the managed service organization is meeting state and federal rules and regulations and is not inappropriately giving preference to providers with ownership or board membership.

(III) An employee of a contracted provider of a managed service organization shall not also be an employee of the managed service organization unless the employee is a medical director for the managed service organization. If the medical director is also an employee of a provider that has board membership or ownership in the managed service organization, the managed service organization shall develop policies, approved by the commissioner of the behavioral health administration, to mitigate any conflict of interest the medical director may have.

(IV) A managed service organization's board shall not have more than fifty percent of contracted providers as board members, and the managed service organization is encouraged to have a community member on the managed service organization's board.

(b) If the office is unable to contract with a managed service organization that meets the requirements of this subsection (2.5), the office may designate another existing managed service organization to temporarily provide the services for that region, for up to one year, pending designation of a new managed service organization. If the office is unable to designate a new managed service organization, the temporary managed service organization may continue to provide the regional substance use disorder services on a year by year basis.

(c) As used in this subsection (2.5), unless the context otherwise requires:

(I) "Medical director" means a physician who oversees the medical care and other designated care and services in a managed service organization. The medical director may be responsible for helping to develop clinical quality management and utilization management.

(II) "Ownership" means an individual who is a legal proprietor of an organization, including a provider or individual who owns assets of an organization, or has a financial stake, interest, or governance role in the managed service organization.

(3) The designation of a managed service organization by the commissioner, as described in subsection (2) of this section, is an initial decision of the department that may be reviewed by the executive director in accordance with the provisions of section 24-4-105. Review by the executive director in accordance with section 24-4-105 constitutes final agency action for purposes of judicial review.

(4) (a) The terms and conditions for providing substance use disorder treatment and recovery services must be specified in the contract entered into between the behavioral health administration and the designated managed service organization. Contracts entered into between the behavioral health administration and the designated managed service organization must include terms and conditions prohibiting a designated managed service organization contracted treatment provider from denying or prohibiting access to medication-assisted treatment, as defined in section 23-21-803, for a substance use disorder.

(b) Contracts entered into between the behavioral health administration and the designated managed service organization must include terms and conditions that outline the expectations for the designated managed service organization to invest in the state's recovery services infrastructure, which include peer-run recovery support services and specialized services for underserved populations. Investments are based on available appropriations.

(5) The contract may include a provisional designation for ninety days. At the conclusion of the ninety-day provisional period, the commissioner may choose to revoke the contract or, subject to meeting the terms and conditions specified in the contract, may choose to extend the contract for a stated time period.

(6) A managed service organization that is designated to serve a designated service area may subcontract with a network of service providers to provide treatment and recovery services for alcohol and drug abuse and substance use disorders within the particular designated service area.

(7) (a) The commissioner may revoke the designation of a designated managed service organization upon finding that the managed service organization is in violation of the performance of the provisions of or rules promulgated pursuant to this article 80. The revocation must conform to the provisions and procedures specified in article 4 of title 24, and occur only after notice and an opportunity for a hearing is provided as specified in article 4 of title 24. A hearing to revoke a designation as a designated managed service organization constitutes final agency action for purposes of judicial review.

(b) Once a designation has been revoked pursuant to subsection (7)(a) of this section, the commissioner may designate one or more service providers to provide the treatment services pending designation of a new designated managed service organization or may enter into contracts with subcontractors to provide the treatment services.

(c) From time to time, the commissioner may solicit applications from applicants for managed service organization designation to provide substance use disorder treatment and recovery services for a specified planning area or areas.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 724, § 2, effective April 29. **L. 2017:** (1), IP(2), (2)(b), (2)(d), (3), (4), (5), (6), and (7) amended, (SB 17-

242), ch. 263, p. 1355, § 258, effective May 25. **L. 2020:** (4) amended, (SB 20-007), ch. 286, p. 1390, § 2, effective July 13. **L. 2021:** (1), (4), (6), and (7)(c) amended, (HB 21-1021), ch. 256, p. 1510, § 3, effective September 7. **L. 2022:** (2.5) added, (SB 22-106), ch. 196, p. 1312, § 3, effective May 20. **L. 2023:** (1), IP(2), (2)(b), (2)(d), IP(2.5)(a), (2.5)(a)(II), (3), (4), (5), and (7) amended, (HB 23-1236), ch. 206, p. 1067, § 42, effective May 16.

Editor's note: This section is similar to former § 25-1-206.5 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-80-107.5. Increasing access to effective substance use disorder services act - managed service organizations - substance use disorder services - assessment - community action plan - allocations - reporting requirements - evaluation.

(1) The short title of this section is the "Increasing Access to Effective Substance Use Disorder Services Act".

(2) On or before February 1, 2017, each behavioral health administrative services organization designated pursuant to section 27-80-107 shall assess the sufficiency of substance use disorder services within its geographic region for adolescents ages seventeen and younger, young adults ages eighteen through twenty-five, pregnant women, women who are postpartum and parenting, and other adults who are in need of such services. During the community assessment process, each behavioral health administrative services organization shall seek input and information from appropriate behavioral health entities, county departments of human or social services, local public health agencies, substance use disorder treatment providers, law enforcement agencies, probation departments, organizations that serve veterans or homeless individuals, and other relevant stakeholders. The community assessment must include an analysis of existing funding and resources within the community to provide a continuum of substance use disorder services, including prevention, intervention, treatment, and recovery support services, for adolescents ages seventeen and younger, young adults ages eighteen through twenty-five, pregnant women, women who are postpartum and parenting, and other adults who are in need of such services.

(3) (a) On or before March 1, 2017, each behavioral health administrative services organization that has completed a community assessment pursuant to subsection (2) of this section shall prepare and submit in electronic format to the BHA and the department of health care policy and financing a community action plan to increase access to effective substance use disorder services, referred to in this section as the "community action plan". The community

action plan must summarize the results of the community assessment and include a description of how the behavioral health administrative services organization will utilize its allocation of funding from the marijuana tax cash fund created in section 39-28.8-501 to address the most critical service gaps in its geographic region and a timeline for implementation of the community action plan.

(b) A behavioral health administrative services organization may periodically update its community action plan to reflect changes in community needs and priorities. Any such updated plan must be submitted in electronic format to the BHA and the department of health care policy and financing.

(c) On or before May 1, 2017, the BHA shall post the community action plans from the behavioral health administrative services organizations developed pursuant to subsection (3)(a) of this section on its website. On or before May 1, 2017, the BHA shall submit a report summarizing all of the community action plans received from the behavioral health administrative services organizations to the joint budget committee, the health and human services committee of the senate, and the public and behavioral health and human services committee of the house of representatives, or any successor committees. The BHA shall post on its website any updated community action plans received pursuant to subsection (3)(b) of this section.

(4) (a) Repealed.

(b) On July 1, 2017, and on every July 1 thereafter, the BHA shall disburse to each behavioral health administrative services organization that has submitted a community action plan one hundred percent of the behavioral health administrative services organization's allocation from the money appropriated from the marijuana tax cash fund.

(c) It is the intent of the general assembly that each behavioral health administrative services organization use money allocated to it from the marijuana tax cash fund to cover expenditures for substance use disorder services that are not otherwise covered by public or private insurance. Each behavioral health administrative services organization may use its allocation from the marijuana tax cash fund to implement its community action plan, including expenditures for substance use disorder services and for any start-up costs or other expenses necessary to increase capacity to provide such services. A behavioral health administrative services organization must spend its allocation in the state fiscal year in which it is received or in the next state fiscal year thereafter. If there is any money from the allocation remaining after the second state fiscal year, then the behavioral health administrative services organization shall return the money to the BHA. If an enhanced residential and inpatient substance use disorder treatment and medical detoxification services benefit becomes available under the Colorado medical assistance program, behavioral health administrative services organizations shall determine to what extent money allocated from the marijuana tax cash fund may be used to assist in providing substance use disorder treatment, including residential and inpatient substance use disorder treatment and

medical detoxification services, if those services are not otherwise covered by public or private insurance.

(d) Repealed.

(5) (a) On or before September 1, 2017, and on or before each September 1 thereafter, each behavioral health administrative services organization shall submit an annual report to the BHA, the joint budget committee, the health and human services committee of the senate, and the public and behavioral health and human services committee of the house of representatives, or their successor committees, concerning the amount and purpose of actual expenditures made using money from the marijuana tax cash fund in the previous state fiscal year. The report must contain a description of the impact of the expenditures on addressing the needs that were identified in the initial and any subsequent community assessments and action plans developed pursuant to subsection (3) of this section, as well as any other requirements established for the contents of the report by the BHA.

(b) A behavioral health administrative services organization shall provide the BHA with information about actual expenditures as required by the BHA.

(c) Repealed.

(6) Repealed.

(7) Notwithstanding section 24-1-136 (11)(a)(I), the BHA shall report on outcomes related to the implementation of this section as part of its annual "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" hearing required by section 2-7-203, beginning with the hearing that precedes the 2019 legislative session.

Source: L. 2016: Entire section added, (SB 16-202), ch. 209, p. 748, § 1, effective June 1. **L. 2017:** IP(5)(c) amended, (SB 17-234), ch. 154, p. 524, § 17, effective August 9. **L. 2018:** (4)(c), (4)(d)(I), (5)(a), (5)(b), IP(5)(c), and (5)(c)(II) amended and (7) added, (HB 18-1172), ch. 110, p. 801, § 1, effective April 9; (4)(c) amended, (HB 18-1136), ch. 373, p. 2271, § 3, effective June 5. **L. 2022:** (3), (4)(b), (4)(c), (5)(a), (5)(b), and (7) amended, and (4)(a), (4)(d), (5)(c), and (6) repealed, (HB 22-1278), ch. 222, p. 1553, § 149, effective July 1; (2), (3), (4)(b), (4)(c), (5)(a), and (5)(b) amended, (HB 22-1278), ch. 222, p. 1598, § 246, effective August 10.

Editor's note: Amendments to subsection (4)(c) by HB 18-1172 and HB 18-1136 were harmonized.

27-80-107.7. Increase synthetic opiate treatment - report. (Repealed)

Source: L. 2022: Entire section added, (HB 22-1326), ch. 225, p. 1650, § 28, effective July 1. **L. 2023:** (1)(d) amended, (HB 23-1204), ch. 145, p. 622, § 3, effective August 7. **L. 2026:** Entire section repealed, (SB 26-113), ch. 302, p. 1733, § 12, effective August 12.

27-80-107.8. Withdrawal management and crisis service expansion - appropriation.

(1) On or before January 1, 2023, each managed service organization shall:

(a) Contract to provide short-term residential placement for withdrawal management, crisis stabilization, or medication-assisted treatment for persons in immediate need of detoxification and stabilization services, with a provider that is licensed by the state of Colorado to provide those services. The managed service organization is encouraged to contract with crisis service providers that have existing contracts with administrative services organizations for the purpose of providing crisis stabilization services for individuals who need substance use services.

(b) Develop a payment schedule that includes admission and service rates from the managed service organization to the provider and organizational funding for training and coordination with first responders or referring entities; and

(c) Provide training to, and ongoing coordination with, first responders or referring entities concerning the available services to be utilized in lieu of arrest and transport to jail, to the greatest extent possible.

(2) For the 2022-23 state fiscal year, the general assembly shall appropriate ten million dollars to the behavioral health administration to be distributed to managed service organizations for the purpose of implementing this section. Any unexpended money remaining at the end of the 2022-23 state fiscal year from this appropriation:

(a) Does not revert to the general fund or any other fund;

(b) May be used by the behavioral health administration in the 2023-24 or 2024-25 state fiscal years without further appropriation; and

(c) Must not be used for any other purpose other than the purposes set forth in this section.

Source: L. 2022: Entire section added, (HB 22-1326), ch. 225, p. 1658, § 37, effective July 1.

Cross references: For the legislative declaration in HB 22-1326 stating the purpose of, and the provision directing legislative staff agencies to conduct, a post-enactment review pursuant to § 2-2-1201 scheduled in 2025, see sections 1 and 55 of chapter 225, Session Laws of Colorado 2022. To obtain a copy of the review, once completed, go to "Legislative Resources and Requirements" on the Colorado General Assembly's website.

27-80-108. Rules.

(1) The state board of human services, created in section 26-1-107, has the power to promulgate rules governing the provisions of this article 80. The rules may include, but are not limited to:

(a) Requirements for the operation of a public program, including record keeping and data compilation;

(b) Conditions that may be imposed on a public program for the program to maintain grant eligibility;

(c) Requirements for public and private agencies, organizations, and institutions from which the behavioral health administration may purchase services pursuant to section 27-80-106 (1), which requirements must include prohibiting the purchase of services from entities that deny or prohibit access to medical services or substance use disorder treatment and services to persons who are participating in prescribed medication-assisted treatment, as defined in section 23-21-803, for a substance use disorder;

(d) Requirements for managed service organizations that are designated by the commissioner to provide services in a designated service area pursuant to section 27-80-106 (2);

(e) Standards that addiction counselors must meet to participate in public programs or to provide purchased services and certification requirements necessary to be certified by the director of the division of professions and occupations, pursuant to part 8 of article 245 of title 12;

(e.5) On or before March 1, 2022, standards that addiction counselors must meet to participate in public programs or to provide purchased services and education requirements necessary to be licensed by the director of the division of professions and occupations, pursuant to part 8 of article 245 of title 12;

(f) Any rules that are necessary to carry out the purposes of the treatment program for high-risk pregnant women created in section 27-80-112.

(2) In the rules promulgated pursuant to subsection (1)(e) of this section, the state board of human services shall include education requirements for certified addiction technicians, certified addiction specialists, and licensed addiction counselors.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 726, § 2, effective April 29. **L. 2017:** Entire section amended, (SB 17-242), ch. 263, p. 1357, § 259, effective May 25. **L. 2019:** (1)(e) amended, (HB 19-1172), ch. 136, p. 1714, § 200, effective October 1. **L. 2020:** (1)(c) amended, (SB 20-007), ch. 286, p. 1390, § 3, effective July 13; (2) added, (HB 20-1206), ch. 304, p. 1543, § 41, effective July 14. **L. 2021:** (1)(e.5) added and (2) amended, (HB 21-1305), ch. 399, p. 2649, § 6, effective July 1. **L. 2023:** (1)(c) and (1)(d) amended, (HB 23-1236), ch. 206, p. 1069, § 43, effective May 16.

Editor's note: This section is similar to former § 25-1-207 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-80-109. Coordination of state and federal funds and programs.

(1) Requests for state appropriations for substance use disorder treatment programs must be submitted to the BHA and the office of state planning and budgeting on dates specified by the BHA, consistent with requirements and procedures of the office of state planning and budgeting. After studying each request, the BHA shall make a report with its comments and recommendations, including priorities for appropriations and a statement as to whether the requested appropriation would be consistent with the comprehensive state plan for substance use disorder treatment programs. The BHA shall submit its reports to the governor, the office of state planning and budgeting, and the joint budget committee, together with all pertinent material on which the report's recommendations are based.

(2) The BHA shall also review applications for federal grants for substance use disorder treatment programs submitted by any department or agency of state government; political subdivision of the state; Indian tribal reservation; or other public or private agency, organization, or institution. The BHA shall transmit to the division of planning and to the appropriate United States agency its comments and recommendations, together with a statement as to whether the grant would be consistent with the comprehensive state plan for substance use disorder treatment programs.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 727, § 2, effective April 29. **L. 2017:** Entire section amended, (SB 17-242), ch. 263, p. 1357, § 260,

effective May 25. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1557, § 151, effective July 1.

Editor's note: This section is similar to former § 25-1-209 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-80-110. Reports. (Repealed)

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 727, § 2, effective April 29. **L. 2017:** Entire section amended, (SB 17-242), ch. 263, p. 1358, § 261, effective May 25; entire section repealed, (SB 17-234), ch. 154, p. 524, § 18, effective August 9.

Editor's note: (1) This section was similar to former § 25-1-210 as it existed prior to 2010.

(2) This section was amended in SB 17-242. Those amendments were superseded by the repeal of this section in SB 17-234, effective August 9, 2017.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-80-111. Counselor training - fund created - rules.

(1) The commissioner shall establish by rule fees to be charged for addiction counselor training. The amount assessed must be sufficient to cover a portion of the costs of administering the training, and the money collected must be deposited in the addiction counselor training fund. Additional funding may be obtained from general, cash, or federal funds otherwise appropriated to the BHA.

(2) There is created in the office of the state treasurer the addiction counselor training fund, referred to in this section as the "fund". Money collected pursuant to subsection (1) of this section shall be deposited in the fund. The money in the fund is subject to annual appropriation by the general assembly to the BHA for the administration of addiction counselor training requirements established by rules of the state board of human services pursuant to section 27-80-

108 (1)(e). Money in the fund at the end of the fiscal year must remain in the fund and not revert to the general fund.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 727, § 2, effective April 29. **L. 2017:** Entire section amended, (SB 17-242), ch. 263, p. 1358, § 262, effective May 25. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1557, § 152, effective July 1.

Editor's note: This section is similar to former § 25-1-211 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-80-112. Legislative declaration - treatment program for high-risk pregnant women - creation.

(1) The general assembly hereby finds and declares that the health and well-being of the women of Colorado is at risk; that such women are at risk of poor birth outcomes or physical and other disabilities due to substance abuse, which is the abuse of alcohol and drugs, during the prenatal period; that early identification of such high-risk pregnant women and substance abuse treatment greatly reduce the occurrence of poor birth outcomes; and that the citizens of Colorado will greatly benefit from a program to reduce poor birth outcomes and subsequent problems resulting from such poor birth outcomes in cases involving high-risk pregnant women through the cost savings envisioned by the prevention and early treatment of such problems.

(2) In recognition of such problems, there is hereby created a treatment program for high-risk pregnant women in the behavioral health administration.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 728, § 2, effective April 29. **L. 2022:** (2) amended, (HB 22-1278), ch. 222, p. 1557, § 153, effective July 1.

Editor's note: This section is similar to former § 25-1-212 as it existed prior to 2010.

27-80-113. Substance use and addiction counseling and treatment - necessary components.

Any entity that qualifies to provide services pursuant to section 25.5-5-202 (1)(r) in regard to the treatment program for high-risk pregnant women, shall make available, in addition to substance use and addiction counseling and treatment: Risk assessment services; care coordination; nutrition assessment; psychosocial counseling; intensive health education, including parenting education and education on risk factors and appropriate health behaviors; home visits; transportation services; and other services deemed necessary by the BHA and the department of health care policy and financing.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 728, § 2, effective April 29. **L. 2017:** Entire section amended, (SB 17-242), ch. 263, p. 1358, § 263, effective May 25. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1558, § 154, effective July 1.

Editor's note: This section is similar to former § 25-1-213 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-80-114. Treatment program for high-risk pregnant and parenting women - cooperation with organizations.

The department of health care policy and financing shall cooperate with any organizations that desire to assist the department of health care policy and financing in the provision of services connected with the treatment program for high-risk pregnant and parenting women. Organizations may provide services that are not provided to persons pursuant to the treatment program for high-risk pregnant and parenting women, article 2 of title 26, and articles 4, 5, and 6 of title 25.5, which may include, but shall not be limited to, needs assessment services, preventive services, rehabilitative services, care coordination, nutrition assessment, psychosocial counseling, intensive health education, home visits, transportation, development of provider training, child care, and other necessary components of residential or outpatient treatment or care.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 728, § 2, effective April 29. **L. 2019:** Entire section amended, (HB 19-1193), ch. 272, p. 2570, § 6, effective May 23.

Editor's note: This section is similar to former § 25-1-214 as it existed prior to 2010.

Cross references: For the legislative declaration in HB 19-1193, see section 1 of chapter 272, Session Laws of Colorado 2019.

27-80-115. Treatment program for high-risk pregnant and parenting women - data collection.

The department of health care policy and financing shall create a data collection mechanism regarding persons receiving services pursuant to the treatment program for high-risk pregnant and parenting women that must include the collection of data on cost-effectiveness, success of the program, and other data the department of health care policy and financing deems appropriate.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 728, § 2, effective April 29. **L. 2019:** Entire section amended, (HB 19-1193), ch. 272, p. 2570, § 7, effective May 23.

Editor's note: This section is similar to former § 25-1-215 as it existed prior to 2010.

Cross references: For the legislative declaration in HB 19-1193, see section 1 of chapter 272, Session Laws of Colorado 2019.

27-80-116. Fetal alcohol spectrum disorders - legislative declaration - health warning signs - federal funding.

(1) The general assembly finds and declares that:

(a) Fetal alcohol exposure is the leading known cause of preventable intellectual and developmental disabilities and birth defects in the children of this state;

(b) Individuals with undiagnosed fetal alcohol spectrum disorders suffer substantially from secondary issues such as child abuse and neglect, separation from families, multiple foster placements, depression, aggression, school failure, juvenile detention, and job instability;

(b.5) Compared to individuals diagnosed before age twelve, individuals with undiagnosed FASD are two to four times more likely to suffer from inappropriate sexual behavior; disrupted school experiences; trouble with the law; alcohol and substance problems or disorders; or confinement in a jail, a hospital or treatment facility for persons with behavioral or mental health disorders, or a substance use disorder treatment facility;

(c) These secondary disabilities come at a high cost to individuals, their families, and society;

(d) A survey performed in 2006 by the Colorado pregnancy risk assessment system estimated that eleven and two-tenths percent of women in Colorado said that they drank alcohol during the last three months of their pregnancy; and

(e) The commission should evaluate the current use and distribution of written and electronic informational materials designed to increase awareness of the consequences of drinking alcohol while pregnant and should investigate additional means by which such written and electronic materials might best be used.

(2) The general assembly therefore declares that fetal alcohol exposure and its related problems can be reduced substantially by a greater awareness of the consequences of drinking alcohol while pregnant and by early diagnosis and receipt of appropriate and effective intervention.

(3) Each person licensed pursuant to section 44-3-401 (1)(h) to (1)(t) or 44-3-401 (1)(v) to sell malt, vinous, and spirituous liquors or licensed pursuant to section 44-4-104 (1)(c) to sell fermented malt beverages is hereby encouraged to post a health warning sign informing patrons that the consumption of alcohol during pregnancy may cause birth defects, including fetal alcohol spectrum disorders.

(4) Repealed.

(5) The behavioral health administration is authorized to apply for federal funding for fetal alcohol spectrum disorder programs and to receive and disburse the federal funds to public and private nonprofit organizations.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 728, § 2, effective April 29. **L. 2011:** Entire section amended, (HB 11-1144), ch. 65, p. 170, § 2, effective August 10. **L. 2015:** (3) and (4)(c) amended, (HB 15-1204), ch. 121, p. 374, § 23, effective April 24. **L. 2016:** (3) amended, (SB 16-189), ch. 210, p. 783, § 80, effective June 6. **L. 2017:** IP(1)

and (1)(b.5) amended, (SB 17-242), ch. 263, p. 1359, § 264, effective May 25. **L. 2018:** (3) amended, (HB 18-1025), ch. 152, p. 1080, § 16, effective October 1. **L. 2024:** (5) added, (HB 24-1045), ch. 470, p. 3291, § 29, effective August 7.

Editor's note: (1) This section is similar to former § 25-1-216 as it existed prior to 2010.

(2) Subsection (4)(e) provided for the repeal of subsection (4), effective June 30, 2015. (See L. 2011, p. 170.)

Cross references: For the legislative declaration in the 2011 act amending this section, see section 1 of chapter 65, Session Laws of Colorado 2011. For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-80-117. Rural alcohol and substance abuse prevention and treatment program - creation - administration - cash fund - definitions - repeal.

(1) As used in this section, unless the context otherwise requires:

(a) "Program" means the rural alcohol and substance abuse prevention and treatment program created pursuant to subsection (2) of this section that shall consist of the rural youth alcohol and substance abuse prevention and treatment project and the rural detoxification project.

(b) "Rural area" means a county with a population of less than thirty thousand people, according to the most recently available population statistics of the United States bureau of the census.

(c) "Youth" means an individual who is at least eight years of age but who is less than eighteen years of age.

(2) (a) (I) There is created the rural alcohol and substance abuse prevention and treatment program in the BHA to provide:

(A) Prevention and treatment services to youth in rural areas. The services may include providing alternative activities for youth through the rural youth alcohol and substance abuse prevention and treatment project; and

(B) Treatment services through the rural detoxification project for persons with substance use disorders.

(II) The BHA shall administer the program pursuant to rules adopted by the state board of human services as of January 1, 2010, or as amended by the state board.

(b) The BHA shall incorporate provisions to implement the program into its regular contracting mechanism for the purchase of prevention and treatment services pursuant to section 27-80-106, including detoxification programs. The BHA shall develop a method to equitably distribute and provide additional money through contracts to provide for prevention services for and treatment of persons in rural areas.

(c) Notwithstanding any provision of this section to the contrary, the BHA shall implement the program on or after January 1, 2011, subject to the availability of sufficient money to operate an effective program, as determined by the BHA.

(3) (a) There is created in the state treasury the rural alcohol and substance abuse cash fund, referred to in this section as the "fund", that consists of the rural youth alcohol and substance abuse prevention and treatment account, referred to in this section as the "youth account", and the rural detoxification account, referred to in this section as the "detoxification account". The fund is comprised of money collected from surcharges assessed pursuant to sections 18-19-103.5, 42-4-1307 (10)(d)(I), and 42-4-1701 (4)(f). The money collected from the surcharges must be divided equally between the youth account and the detoxification account. The fund also includes any money credited to the fund pursuant to subsection (3)(b) of this section. Money in the fund credited pursuant to subsection (3)(b) of this section must be divided equally between the youth account and the detoxification account unless the grantee or donor specifies to which account the grant, gift, or donation is to be credited. The money in the fund is subject to annual appropriation by the general assembly to the BHA for the purpose of implementing the program. All interest derived from the deposit and investment of money in the fund remains in the fund. Any unexpended or unencumbered money remaining in the fund at the end of a fiscal year remains in the fund and shall not be transferred or credited to the general fund or another fund; except that any unexpended and unencumbered money remaining in the fund as of August 30, 2030, is credited to the general fund.

(b) The BHA is authorized to accept grants, gifts, or donations from any private or public source on behalf of the state for the purpose of the program. The BHA shall transmit all private and public money received through grants, gifts, or donations to the state treasurer, who shall credit the same to the fund.

(3.5) As of July 1, 2022, the department of public health and environment is the state department responsible for the administration of prevention services pursuant to this section.

(4) (a) This section is repealed, effective September 1, 2030.

(b) Prior to such repeal, the program shall be reviewed as provided in section 24-34-104, C.R.S.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 730, § 2, effective April 29; (3)(a) amended, (HB 10-1347), ch. 258, p. 1159, § 6, effective July 1. **L. 2016:** (3)(a) and (4)(a) amended, (HB 16-1168), ch. 93, p. 261, § 1, effective April 14. **L. 2017:** (2) and (3) amended, (SB 17-242), ch. 263, p. 1359, § 265, effective May 25. **L. 2022:** IP(2)(a)(I), (2)(a)(II), (2)(b), (2)(c), and (3), amended and (3.5) added, (HB 22-1278), ch. 222, p. 1558, § 155, effective July 1. **L. 2025:** (3)(a) and (4)(a) amended, (SB 25-195), ch. 243, p. 1229, § 2, effective August 6.

Editor's note: (1) This section is similar to former § 25-1-217 as it existed prior to 2010.

(2) Subsection (3)(a) was numbered as § 25-1-217 (3)(a) in House Bill 10-1347 (see L. 2010, p. 1159) but was relocated due to its harmonization with this section as it was added by Senate Bill 10-175.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-80-118. Center for research into substance use disorder prevention, treatment, and recovery support strategies - established - appropriation - legislative declaration.

(1) The general assembly finds that:

(a) Opioid addiction has emerged as a significant public health concern in Colorado, with more than ten thousand deaths attributed to drug overdoses since 2000, and the annual rate of death from drug overdose doubling from seven-point-eight deaths per one hundred thousand people in 2000 to fifteen-point-seven deaths per one hundred thousand people in 2015. This rate is significantly higher than the national rate.

(b) The abuse of prescription drugs is the fastest growing substance abuse problem in the United States, particularly among adolescents;

(c) Each year, there are approximately seventeen thousand overdose deaths from opioid painkillers nationally and approximately three hundred such deaths in Colorado;

(d) According to the centers for disease control, Colorado's drug overdose mortality rate has increased by five hundred percent since 2014;

(e) Colorado and other states in the region have the highest death rates attributable to alcohol in the country, and approximately eighteen percent, or one out of every five, of all Colorado adults engaged in heavy or binge drinking monthly;

(f) In addition to opioids, prescription drugs, and alcohol, surveys show use rates for methamphetamine, cocaine, and other illicit drugs are higher in Colorado than in other states; and

(g) There is a lack of sufficient research on the most effective strategies for addressing substance use disorders across the full continuum of recommended services that include prevention, early intervention, treatment, and recovery support services.

(2) The general assembly therefore finds that for Colorado to respond to these issues and to foster the health, welfare, and safety of the state's residents, it is hereby declared that it is the state's policy to facilitate research into substance use disorder prevention, treatment, and recovery support strategies.

(3) A center for research into substance use disorder prevention, treatment, and recovery support strategies, referred to in this section as the "center", is established in the university of Colorado health sciences center. Subject to available appropriations, the center's mission is to:

(a) Establish or expand programs for research concerning prevention, treatment, and recovery support strategies for substance use disorders, including but not limited to opioid addiction;

(b) Establish or expand innovative treatments for substance use disorders, including but not limited to opioid addiction;

(c) Expand partnerships and collaboration with substance use disorder professionals, other programs at the university of Colorado, and other organizations with similar missions throughout the state and nation; and

(d) Seek federal and private resources to further the center's research activities.

(4) (a) The center shall develop and implement a series of continuing education activities designed to help a prescriber of pain medication to safely and effectively manage patients with pain and, when appropriate, prescribe opioids or medication-assisted treatment. The educational activities must also include best practices for prescribing benzodiazepines and the potential harm of inappropriately limiting prescriptions to chronic pain patients. The educational activities must apply to physicians, physician assistants, nurses, and dentists, with an emphasis on physicians, physician assistants, nurses, and dentists serving underserved populations and communities.

(b) The center shall also develop education and training for law enforcement officers and first responders concerning the use of opioid antagonists for opioid overdose and community-based training for persons at risk of opioid overdose.

(c) The center shall engage in community engagement activities to address substance use prevention, harm reduction, criminal justice system response, treatment, and recovery.

(d) For the 2021-22 state fiscal year, and each fiscal year thereafter, the general assembly shall appropriate seven hundred fifty thousand dollars to the center from the marijuana tax cash fund created in section 39-28.8-501 for the purposes of this subsection (4).

(5) (a) The center shall develop and implement a program to increase public awareness concerning the safe use, storage, and disposal of opioids and the availability of naloxone and other drugs used to block the effects of an opioid overdose.

(b) For the 2021-22 state fiscal year, and each state fiscal year thereafter, the general assembly shall appropriate two hundred fifty thousand dollars to the center from the marijuana tax cash fund created in section 39-28.8-501 (1) for the purposes of this subsection (5).

(6) (a) The center may employ up to three additional employees to work as grant writers in order to aid local communities in need of assistance in applying for grants to access state and federal money to address opioid and other substance use disorders in their communities. The center shall determine the communities in which to provide the grant writing assistance.

(b) For the fiscal year 2019-20, the general assembly shall appropriate money from the marijuana tax cash fund created in section 39-28.8-501 (1) to the department for allocation to the center for the purposes of this subsection (6). The center may use the money to hire new employees and for the direct and indirect costs associated with this subsection (6).

Source: L. 2017: Entire section added, (SB 17-193), ch. 202, p. 747, § 1, effective May 18. **L. 2018:** (4) added, (HB 18-1003), ch. 224, p. 1429, § 5, effective May 21. **L. 2019:** (5) and (6) added, (SB 19-228), ch. 276, p. 2605, § 10, effective May 23. **L. 2020:** (5)(b)(I) amended, (HB 20-1364), ch. 205, p. 1009, § 1, effective June 30. **L. 2021:** (4)(c) RC&RE, (4)(d) added, and (5)(b) amended, (SB 21-137), ch. 362, p. 2375, § 20, effective June 28; (4)(a) amended, (HB 21-1276), ch. 364, p. 2402, § 17, effective July 1.

Editor's note: Subsection (4)(c)(II) provided for the repeal of subsection (4)(c), effective September 1, 2019. (See L. 2018, p. 1429.)

Cross references: (1) For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

(2) For the legislative declaration in HB 21-1276, see section 1 of chapter 364, Session Laws of Colorado 2021.

27-80-119. Care navigation program - creation - reporting - rules - legislative declaration - definition. (Repealed)

Source: L. 2019: Entire section added, (HB 19-1287), ch. 175, p. 2015, § 3, effective May 14. **L. 2020:** (3) and (8) amended, (HB 20-1391), ch. 211, p. 1026, § 2, effective June 30. **L. 2021:** (2) amended, (HB 21-1021), ch. 256, p. 1512, § 9, effective September 7. **L. 2022:** (3), (4), IP(6), (6)(f), (7), and (8) amended, (HB 22-1278), ch. 222, p. 1559, § 156, effective July 1. **L. 2023:** Entire section repealed, (HB 23-1236), ch. 206, p. 1070, § 47, effective May 16.

27-80-120. Building substance use disorder treatment capacity in underserved communities - grant program. (Repealed)

Source: L. 2019: Entire section added, (HB 19-1287), ch. 175, p. 2018, § 4, effective May 14. **L. 2021:** (7) repealed, (SB 21-137), ch. 362, p. 2375, § 21, effective June 28; (4) amended, (HB 21-1021), ch. 256, p. 1512, § 10, effective September 7. **L. 2022:** (1), (2), (3), and (6) amended, (HB 22-1278), ch. 222, p. 1560, § 157, effective July 1. **L. 2026:** Entire section repealed, (HB 26-1378), ch. 245, p. 1391, § 1, effective May 29.

27-80-121. Perinatal substance use data linkage project - center for research into substance use disorder prevention, treatment, and recovery support strategies - report.

(1) The center for research into substance use disorder prevention, treatment, and recovery support strategies established in section 27-80-118, referred to in this section as the "center", in partnership with an institution of higher education and the state substance abuse trend and response task force established in section 18-18.5-103, shall conduct a statewide perinatal substance use data linkage project that uses ongoing collection, analysis, interpretation, and dissemination of data for the planning, implementation, and evaluation of public health actions to improve outcomes for families impacted by substance use during pregnancy. The data linkage project shall utilize data from the medical assistance program established in articles 4 to 6 of title 25.5; the electronic prescription drug monitoring program created in part 4 of article 280 of title 12; the Colorado TRAILS system, as defined in section 16-20.5-102 (10); the Colorado immunization information system created pursuant to part 24 of article 4 of title 25; the Colorado child care assistance program created in part 1 of article 4 of title 26.5; the BHA; the early intervention program for infants and toddlers under part C of the federal "Individuals with Disabilities Education Act", 20 U.S.C. sec. 1400 et seq.; the Colorado department of education; other data sources related to maternal health, as collected by the Colorado department of public health and environment; the Colorado all-payer health claims database described in section 25.5-

1-204; family experiences and provider perspectives, when necessary; and birth and death records to examine the following:

(a) Health-care utilization by pregnant and postpartum women with substance use disorders and their infants compared to the general population;

(b) Human service, education, public health program utilization, and substance use treatment by pregnant and postpartum women with substance use disorders and their infants compared to the general population;

(c) Health-care, human service, education, and public health program outcomes, including morbidity and mortality outcomes, among pregnant and postpartum women with substance use disorders and their infants compared to the general population; and

(d) Costs associated with health-care, human service, education, and public health program provisions for pregnant and postpartum women with substance use disorders and their infants compared to the general population.

(2) The data linkage project shall use vital records to establish maternal and infant dyads beginning at the birth hospitalization and retrospectively link the prenatal period and prospectively link the first year postpartum.

(3) The data linkage project may conduct ongoing research related to the incidence of perinatal substance exposure or related infant and family health, education, and human service outcomes based on the standards specified in sections 19-1-103 (1)(a)(VII) and 19-3-102 (1)(g) for determining child abuse or neglect or whether a child is neglected or dependent.

(4) The data linkage project may connect additional state and non-state data sources for the purpose of improving population-level estimates of perinatal substance exposure and examining system utilization and outcomes.

(5) The governor's office of information technology shall obtain data and perform secure linkage and anonymization on behalf of the state.

(6) Notwithstanding section 24-1-136 (11)(a)(I), on or before January 1, 2021, and annually thereafter throughout the duration of the data linkage project, the center shall report progress on the data linkage project and the results, if available, to the health and insurance committee and the public health care and human services committee of the house of representatives and the health and human services committee of the senate or their successor committees.

Source: L. 2019: Entire section added, (SB 19-228), ch. 276, p. 2606, § 12, effective May 23. **L. 2020:** (2.5) added, (SB 20-028), ch. 186, p. 854, § 7, effective June 30. **L. 2021:** Entire section amended, (SB 21-137), ch. 362, p. 2375, § 22, effective June 28. **L. 2022:** IP(1) amended, (HB 22-1295), ch. 123, p. 864, § 119, effective July 1; IP(1) amended, (HB 22-1278),

ch. 222, p. 1561, § 158, effective July 1. **L. 2024:** (1) and (3) amended, (SB 24-047), ch. 440, p. 3082, § 10, effective June 6.

Editor's note: Amendments to this subsection IP(1) by HB 22-1278 and HB 22-1295 were harmonized.

Cross references: For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

27-80-122. Recovery residence certifying body - competitive selection process - appropriation - repeal.

(1) No later than January 1, 2022, the BHA shall use a competitive selection process pursuant to the "Procurement Code", articles 101 to 112 of title 24, to select a recovery residence certifying body to:

(a) Certify recovery residences pursuant to section 27-80-129; and

(b) Educate and train recovery residence owners and recovery residence staff on industry best practices, including best practices for providing culturally responsive and trauma-informed care.

(2) Repealed.

(3) This section is repealed, effective June 30, 2027.

Source: L. 2019: Entire section added, (HB 19-1009), ch. 274, p. 2591, § 4, effective May 23. **L. 2021:** Entire section R&RE, (SB 21-137), ch. 362, p. 2376, § 23, effective June 28. **L. 2022:** IP(1) and (2) amended, (HB 22-1278), ch. 222, p. 1561, § 159, effective July 1. **L. 2023:** (1)(a) amended, (HB 23-1204), ch. 145, p. 622, § 4, effective August 7. **L. 2025:** (2) repealed, (SB 25-266), ch. 108, p. 460, § 3, effective July 1. **L. 2026:** (3) added, (SB 26-113), ch. 302, p. 1732, § 7, effective August 12.

Cross references: For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

27-80-123. High-risk families cash fund - creation - services provided - report - definition - repeal. (Repealed)

Source: L. 2019: Entire section added, (HB 19-1193), ch. 272, p. 2571, § 8, effective May 23. **L. 2020:** (3) repealed, (HB 20-1388), ch. 124, p. 523, § 4, effective June 24. **L. 2021:** (4) and (5)(b) amended, (SB 21-137), ch. 362, p. 2386, § 34, effective June 28. **L. 2022:** (2), IP(4), (5), (6), IP(7), and (7)(a) amended, (HB 22-1278), ch. 222, p. 1561, § 160, effective July 1. **L. 2026:** (8) and (9) added, (HB 26-1378), ch. 245, p. 1392, § 6, effective May 29.

Editor's note: (1) This section was numbered as § 27-80-119 in HB 19-1193 but was renumbered on revision for ease of location.

(2) Subsections (8) and (9) were added in HB 26-1378, effective May 29, 2026. For the amendments in effect from May 29, 2026, to July 1, 2026, see chapter 245, Session Laws of Colorado 2026. (L. 2026, p. 1392.)

(3) Subsection (9) provided for the repeal of this section, effective July 1, 2026. (See L. 2026, p. 1392.)

27-80-124. Colorado substance use disorders prevention collaborative - created - mission - administration - report - repeal. (Repealed)

Source: L. 2021: Entire section added, (HB 21-1276), ch. 364, p. 2402, § 18, effective July 1. **L. 2022:** Entire section repealed, (HB 22-1278), ch. 222, p. 1562, § 161, effective July 1.

Editor's note: This section was relocated to § 25-20.5-1802 in 2022.

27-80-125. Housing assistance for individuals with a substance use disorder - report - rules - appropriation.

(1) The BHA shall establish a program to provide temporary financial housing assistance to individuals with a substance use disorder who have no supportive housing options when the individual is:

(a) Transitioning out of a residential treatment setting and into recovery; or

(b) Receiving treatment for the individual's substance use disorder.

(2) The BHA may promulgate rules establishing the maximum amount of temporary financial assistance that an individual can receive and the maximum amount of time for which an individual may receive assistance. Rules promulgated pursuant to this subsection (2) related to the time for which an individual may receive assistance must be clinically based, culturally responsive, and trauma-informed.

(3) In awarding temporary financial housing assistance in accordance with this section, the BHA shall consider funding for individuals entering into a recovery residence, as defined in section 27-50-101.

(4) Notwithstanding section 24-1-136 (11)(a)(I), by February 1, 2022, and by February 1 each year thereafter, the BHA shall submit a report detailing the amount of housing assistance provided in the prior year, the number of individuals and the entities that received the housing assistance, and the duration of housing assistance each individual or entity received to the health and human services committee of the senate, the health and insurance and the public and behavioral health and human services committees of the house of representatives, and the opioid and other substance use disorders study committee created in section 10-22.3-101, or any successor committees.

(5) Repealed.

Source: L. 2021: Entire section added, (SB 21-137), ch. 362, p. 2377, § 24, effective June 28. **L. 2022:** IP(1), (2), (3), (4), and (5) amended, (HB 22-1278), ch. 222, p. 1562, § 162, effective July 1. **L. 2023:** (3) amended, (HB 23-1204), ch. 145, p. 623, § 5, effective August 7. **L. 2025:** (5) repealed, (SB 25-266), ch. 108, p. 461, § 4, effective July 1. **L. 2026:** (3) amended, (SB 26-113), ch. 302, p. 1732, § 8, effective August 12.

Cross references: For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

27-80-126. Recovery support services grant program - creation - eligibility - reporting requirements - appropriation - rules - definitions. (Repealed)

Source: L. 2021: Entire section added, (SB 21-137), ch. 362, p. 2377, § 24, effective June 28. **L. 2022:** (2), (4), (5), (6)(a), IP(7)(a), (7)(a)(IV), (7)(b), and (8) amended, (HB 22-1278), ch.

222, p. 1563, § 163, effective July 1. **L. 2024:** (3)(b) amended, (SB 24-048), ch. 405, p. 2785, § 5, effective August 7. **L. 2025:** (4) amended and (8) repealed, (SB 25-266), ch. 108, p. 461, § 5, effective July 1. **L. 2026:** Entire section repealed, (HB 26-1378), ch. 245, p. 1391, § 1, effective May 29.

27-80-127. Children and youth in need of residential mental health and substance use treatment - repeal.

(1) On or before July 1, 2023, the behavioral health administration, created pursuant to part 2 of article 60 of this title 27, shall create, develop, or contract to add additional residential substance use treatment beds for youth. To the greatest extent possible, the department shall ensure that both mental health and substance use treatment services are available in one residential location. The department shall work collaboratively with the behavioral health administration for licensing and determining the greatest areas of need.

(2) (a) (I) For the 2022-23 budget year, the general assembly shall appropriate five million dollars from the behavioral and mental health cash fund, created pursuant to section 24-75-230, to the department to expand substance use residential treatment beds for adolescents, as described in subsection (1) of this section.

(II) The use of money appropriated pursuant to this subsection (2) and money that originates from the ARPA refinance state money cash fund, created in section 24-75-226.5, appropriated for the same purpose, must conform with the allowable purposes set forth in the federal "American Rescue Plan Act of 2021", Pub.L. 117-2, as amended. The department shall spend or obligate such appropriation in accordance with section 24-75-226 (4)(d).

(b) This subsection (2) is repealed, effective September 1, 2027.

(3) The department of human services and any person that receives money from the department of human services shall comply with the compliance, reporting, record-keeping, and program evaluation requirements established by the office of state planning and budgeting and the state controller in accordance with section 24-75-226 (5).

(4) This section is known as the "Andy Campos-Padilla Act".

Source: L. 2022: Entire section added, (HB 22-1283), ch. 185, p. 1244, § 5, effective May 18. **L. 2024:** (2)(a)(II) amended, (HB 24-1466), ch. 429, p. 2946, § 42, effective June 5.

Cross references: For the legislative declaration in HB 22-1283, see section 1 of chapter 185, Session Laws of Colorado 2022. For the legislative declaration in HB 24-1466, see section 1 of chapter 429, Session Laws of Colorado 2024.

27-80-128. Fentanyl education and treatment program.

The behavioral health administration shall develop a fentanyl education program for the purpose of sections 18-1.3-410 and 18-1.3-510. The fentanyl education program must include information regarding the nature and addictive elements of synthetic opiates, their dangers to a person's life and health, access to and administration of opioid antagonists and non-laboratory synthetic opiate detection tests, and laws regarding synthetic opiates, including criminal penalties and immunity for reporting an overdose event pursuant to section 18-1-711. The BHA may update the fentanyl education program curriculum as necessary.

Source: L. 2022: Entire section added, (HB 22-1326), ch. 225, p. 1651, § 30, effective July 1. **L. 2024:** Entire section amended, (HB 24-1037), ch. 458, p. 3173, § 24, effective June 6.

Cross references: For the legislative declaration in HB 22-1326 stating the purpose of, and the provision directing legislative staff agencies to conduct, a post-enactment review pursuant to § 2-2-1201 scheduled in 2025, see sections 1 and 55 of chapter 225, Session Laws of Colorado 2022. To obtain a copy of the review, once completed, go to "Legislative Resources and Requirements" on the Colorado General Assembly's website.

27-80-129. Regulation of recovery residences - rules - definitions - repeal.

(1) As used in this section:

(a) "Certifying body" means the body that certifies a recovery residence approved by the behavioral health administration in the department of human services pursuant to section 27-80-122.

(b) (I) "Recovery residence" means any premises, place, facility, or building that provides housing accommodation for individuals with a primary diagnosis of a substance use disorder that:

(A) Is free from alcohol and nonprescribed or illicit drugs;

(B) Promotes independent living and life skill development; and

(C) Provides structured activities and recovery support services that are primarily intended to promote recovery from substance use disorders.

(II) "Recovery residence" does not include:

(A) A private residence in which an individual related to the owner of the residence by blood, adoption, or marriage is required to abstain from substance use or receive behavioral health services for a substance use disorder as a condition of residing in the residence;

(B) The supportive residential community for individuals who are homeless operated under section 24-32-724 at the Fort Lyon property for the purpose of providing substance abuse supportive services, medical care, job training, and skill development for the residents;

(C) A facility approved for residential treatment by the behavioral health administration in the department of human services; or

(D) Permanent supportive housing units incorporated into affordable housing developments.

(2) A recovery residence may admit individuals who are receiving medication-assisted treatment, including agonist treatment, for substance use disorders; except that a recovery residence receiving state money or providing services that are paid for through state programs shall not deny admission to persons who are participating in prescribed medication-assisted treatment, as defined in section 23-21-803, for a substance use disorder.

(3) (a) A person shall not operate a recovery residence or a substantially similar facility, and a licensed, registered, or certified health-care provider; a managed care entity, as defined in section 25.5-5-802 (5); a managed care organization, as defined in section 25.5-5-403 (5); or a licensed health facility shall not refer an individual to a recovery residence, unless the residence:

(I) Is certified by a certifying body as specified in subsection (4) of this section;

(II) Is chartered by Oxford House or its successor organization; or

(III) Has been operating as a recovery residence in Colorado for thirty or more years as of May 23, 2019.

(b) If a person is operating a recovery residence or a substantially similar facility in violation of subsection (3)(a) of this section, the behavioral health administration shall send the facility a cease-and-desist letter.

(4) The behavioral health administration shall, by rule, determine the requirements for a certifying body seeking approval for purposes of subsection (3)(a)(I) of this section, which rules must include a requirement that a certifying body include a representative from the behavioral health administration on its board.

(5) A recovery residence owner, employee, or administrator, or an individual related to a recovery residence owner, employee, or administrator, shall not directly or indirectly:

(a) Solicit, accept, or receive a commission, payment, trade, fee, or anything of monetary or material value, excluding the supportive services required to place the resident:

(I) For admission of a resident, except for state or federal contracts that specifically reimburse for resident fees;

(II) From a treatment facility that is licensed or certified by the department of public health and environment for the treatment of substance use disorders; or

(III) From a facility approved for residential treatment by the behavioral health administration in the department of human services;

(b) Solicit, accept, or receive a commission, payment, trade, fee, or anything of monetary or material value from a toxicology laboratory that provides confirmation testing or point-of-care testing for residents.

(6) A recovery residence shall have the following in place for each client at the time an individual becomes a client of the recovery residence:

(a) A signed program agreement between the recovery residence and the client that outlines the requirements the client must follow to reside at the recovery residence; the drug screening policy; and the recovery residence's code of conduct that prohibits the use of alcohol, nonprescribed drugs, and illicit drugs; and notice of immediate discharge for possession of alcohol, nonprescription drugs, or illicit drugs in the recovery residence; and

(b) A relapse plan that must be implemented if the client returns to the use of alcohol, nonprescribed drugs, or illicit drugs. The relapse plan must outline steps that must be taken to evaluate and address the client's return to use and to allow the client to remain in the recovery residence after a relapse has occurred, if possible. The recovery residence must provide notification to the client if the client's relapse plan has failed.

(7) (a) Recovery residence staff shall develop a client discharge and transfer policy and submit it for approval to its certifying body. Recovery residence staff shall implement a client discharge and transfer policy that is approved by the certifying body. After the certifying body approves the recovery residence's client discharge and transfer policy, the recovery residence staff may discharge or transfer a client with twenty-four hours' notice if the relapse plan has failed, according to the policy, in any of the following circumstances:

(I) The discharge or transfer is necessary for the safety of the client because the recovery residence is unable to meet the needs of the client; or

(II) If the client returns to the use of alcohol, nonprescription drugs, or illicit drugs.

(b) Recovery residence staff may immediately discharge or transfer a client, according to the policy, if the client is in possession of alcohol, nonprescription drugs, or illicit drugs in the recovery residence.

(c) If a client is unable or no longer wishes to reside in a recovery residence, or is discharged or transferred from a recovery residence, prior to the client vacating the recovery residence, the recovery residence staff shall:

(I) Document in the client's record detailed information regarding the basis for the discharge or transfer;

(II) Provide the client with a referral to treatment services or other recovery support services;

(III) Provide the client with a referral to appropriate services if the client is discharged without food, housing, or economic security, if such services exist in the community; and

(IV) Provide the client with the phone number to contact the 988 crisis hotline operated pursuant to section 27-64-103, information on the availability of peer support services, and information about the behavioral health services directory provided by the behavioral health administration.

(d) Recovery residence staff shall document in the client's record any referrals provided to the client pursuant to subsection (7)(c) of this section. If the client refuses to accept the discharge or transfer, the recovery residence staff shall document the refusal in the client's record.

(e) The recovery residence shall, at a minimum, attempt to follow up with the client's designated emergency contact at the time of discharge. The recovery residence is encouraged to utilize peer support professionals, as defined in section 27-60-108, when performing follow-up care with clients. A recovery residence may facilitate follow-up care through contacts with community-based providers or the 988 crisis hotline operated pursuant to section 27-64-103.

(8) The certifying body shall establish a fair and accessible grievance and appeal process for clients to appeal a discharge or transfer decision made by a recovery residence. The grievance and appeal process must, at a minimum:

(a) Require written documentation of the grievance within one week of receiving the grievance if the grievance is received verbally; and

(b) Provide the client with a decision not later than seventy-two hours after the date the client submits a grievance or appeal.

(9) The recovery residence shall provide a client who is discharged or transferred with a written notice indicating the reason for discharge, treatment referrals, and referrals for other services the client is receiving. The written notice must outline the client's right to appeal the discharge or transfer, the timeline required for an appeal, and how to submit an appeal.

(10) Any certified recovery residence or client adversely affected or aggrieved by a decision made by the certifying body pursuant to this section has the right to appeal to the Colorado department of personnel and administration, office of administrative courts and may subsequently seek judicial review of the certifying body's action.

(11) A recovery residence shall make the recovery residence's code of conduct, drug screening policy, and discharge and transfer policy accessible in all common areas of the recovery residence.

(12) The recovery residence shall not consider age, gender, disability, race, color, ancestry, citizenship, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law when determining whether to discharge or transfer a client.

(13) This section is repealed, effective July 1, 2027.

Source: L. 2023: Entire section added with relocations, (HB 23-1204), ch. 145, p. 618, § 1, effective August 7. **L. 2024:** IP(1)(b)(I), (3), and (4) amended, (SB 24-048), ch. 405, p. 2785, § 6, effective August 7. **L. 2025:** (7)(c)(IV) and (7)(e) amended, (SB 25-236), ch. 140, p. 532, § 8, effective July 1. **L. 2026:** (13) added, (SB 26-113), ch. 302, p. 1731, § 5, effective August 12.

Editor's note: This section is similar to former § 25-1.5-108.5 as it existed prior to 2023.

PART 2

CONTROLLED SUBSTANCES

Editor's note: This part 2 was added with relocations in 2012. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated. For a detailed comparison of this part 2, see the comparative tables located in the back of the index.

27-80-201. Short title.

This part 2 shall be known and may be cited as the "Colorado Licensing of Controlled Substances Act".

Source: L. 2012: Entire part added with relocations, (SB 12-1311), ch. 281, p. 1595, § 5, effective July 1.

Editor's note: This section is similar to former § 12-22-301 as it existed prior to 2012.

27-80-202. Legislative declaration.

The general assembly finds, determines, and declares that strict control of controlled substances within this state is necessary for the immediate and future preservation of the public peace, health, and safety and that the licensing, record-keeping, penalty, and other provisions contained in this part 2 are necessary for the achievement of such control.

Source: L. 2012: Entire part added with relocations, (SB 12-1311), ch. 281, p. 1595, § 5, effective July 1.

Editor's note: This section is similar to former § 12-22-302 as it existed prior to 2012.

27-80-203. Definitions.

As used in this part 2, unless the context otherwise requires:

(1) and (2) Repealed.

(3) "Administer" means to apply a controlled substance, whether by injection, inhalation, ingestion, or any other means, directly to the body of a patient.

(4) "Agent" means an authorized person who acts on behalf of or at the direction of a person licensed or otherwise authorized under this part 2. "Agent" does not include a common or contract carrier, a public warehouseman, or an employee of a carrier or warehouseman.

(5) "Bureau" means the drug enforcement administration, or its successor agency, of the United States department of justice.

(6) (a) "Compound" means to prepare, mix, assemble, package, or label a drug or device:

(I) As the result of a practitioner's prescription drug order, chart order, or initiative, based on the relationship between the practitioner, patient, and pharmacist in the course of professional practice; or

(II) For the purpose of, or as an incident to, teaching or chemical analysis and not for sale or dispensing.

(b) "Compound" also includes the preparation of drugs or devices in anticipation of prescription drug orders based on routine, regularly observed prescribing patterns.

(7) "Controlled substance" shall have the same meaning as in section 18-18-102 (5), C.R.S.

(8) "Deliver" or "delivery" means actual, constructive, or attempted transfer of a controlled substance whether or not there is an agency relationship.

(9) Repealed.

(10) "Device" means an instrument, apparatus, implement, machine, contrivance, implant, or similar or related article that is required under federal law to bear the label, "**Caution: federal law requires dispensing by or on the order of a physician.**" "Device" also includes any component part of, or accessory or attachment to, any such article, whether or not the component part, accessory, or attachment is separately so labeled.

(11) "Dispense" means to interpret, evaluate, and implement a prescription drug or controlled substances order or chart order, including the preparation of a drug or device for a patient or patient's agent in a suitable container appropriately labeled for subsequent administration to or use by a patient.

(12) "Distribute" means to deliver a controlled substance other than by administering or dispensing.

(13) (a) "Drug" means any of the substances:

(I) Recognized as drugs in the official United States pharmacopoeia, national formulary, or the official homeopathic pharmacopoeia of the United States, or a supplement thereof;

(II) Intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in individuals or animals;

(III) Other than food, intended to affect the structure or any function of the body of individuals or animals; or

(IV) Intended for use as a component of any substance specified in subparagraph (I), (II), or (III) of this paragraph (a).

(b) "Drug" does not include devices or their components, parts, or accessories.

(14) to (16) Repealed.

(16.3) "Medically managed treatment" means a program of care designed to promote the medical and psychiatric stability of an individual with a substance use disorder by addressing acute physiological signs and symptoms of substance withdrawal or the ongoing management of addiction-related symptoms and may include the administration or dispensing of any formulation of a controlled substance medication approved under federal law or regulation as part of treatment for a substance use disorder, which may range from short-term intoxication or treatment focusing on stabilizing and reducing immediate physiological symptoms to long-term medication management intended to decrease illicit substance use and support sustained recovery. Services provided as part of medically managed treatment are intended to be integrated

with behavioral health interventions that address the underlying factors contributing to the substance use disorder.

(16.5) "Opioid treatment program" means a treatment program licensed pursuant to this part 2 and certified as an opioid treatment program by the federal substance abuse and mental health services administration pursuant to the rules of the federal department of health and human services and the federal drug enforcement administration, to provide medication-assisted treatment for people diagnosed with an opioid-use disorder.

(17) "Peace officer" shall have the same meaning as set forth in section 16-2.5-101, C.R.S.

(18) "Person" means any individual, government, governmental subdivision, agency, business trust, estate, trust, partnership, corporation, association, institution, or other legal entity.

(19) "Peyote" means all parts of the plant presently classified botanically as lophophora williamsii lemaire, whether growing or not, the seeds thereof, any extraction from any part of such plant, and every compound, manufacture, salt, derivative, mixture, or preparation of such plant or its seeds or extracts.

(20) "Practitioner" means a person authorized by law to prescribe any drug or device, acting within the scope of such authority.

(21) "Prescription drug" means a drug that, prior to being dispensed or delivered, is required to be labeled with the following statement: "Caution: Federal law prohibits dispensing without a prescription.", "Rx only", or "Caution: Federal law restricts this drug to use by or on the order of a licensed veterinarian."

(22) and (23) Repealed.

(23.3) "Substance use disorder" means a chronic relapsing brain disease that is diagnosed by a licensed practitioner qualified to diagnose substance use disorders. "Substance use disorder" is characterized by recurrent use of alcohol, drugs, or both, causing clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

(23.5) "Substance use disorder treatment program" means a program licensed pursuant to this part 2 for the medically managed treatment of a person with a substance use disorder. "Substance use disorder treatment program" includes an opioid treatment program.

(24) and (25) Repealed.

Source: L. 2012: Entire part added with relocations, (SB 12-1311), ch. 281, p. 1596, § 5, effective July 1. **L. 2017:** (1) and (2) repealed, (9), (14), and (25) amended, and (23.3) and (23.5) added, (SB 17-242), ch. 266, p. 1360, § 263, effective May 25. **L. 2019:** (3), (6)(a)(II), and (23.5)

amended, (16.5) added, and (23) repealed, (SB 19-219), ch. 277, p. 2613, § 2, effective August 2; (23.3) amended, (HB 19-1172), ch. 136, p. 1714, § 201, effective October 1. **L. 2026:** (9), (14), (15), (16), (22), (24), and (25) repealed, (16.3) added, and (23.3) and (23.5) amended, (HB 26-1214), ch. 231, p. 1339, § 2, effective August 12.

Editor's note: This section is similar to former § 12-22-303 and § 12-22-102 as they existed prior to 2012.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

ANNOTATION

Annotator's note. The following annotations include cases decided under former provisions similar to this section.

The distinction between marihuana and marihuana concentrate as set forth in subsections (17) and (18) complies with both the equal protection and due process requirements of the Colorado and United States Constitutions. People v. Rickstrew, 712 P.2d 1008 (Colo. 1986).

Marijuana and hashish are separate drugs. The general assembly has utilized language which sufficiently distinguishes "marijuana" and "hashish" as being separate dangerous drugs. People v. Magoon, 645 P.2d 286 (Colo. App. 1982).

The statutory definition of marijuana includes all variants of the species cannabis including cannabis indicia. People v. Wimer, 799 P.2d 436 (Colo. App. 1990).

Any amount of marihuana sufficient to ingest will support a conviction for possession of contraband in a detention facility, where statute fails to specify an amount. People v. Greenwell, 830 P.2d 1116 (Colo. App. 1992).

27-80-204. License required - controlled substances - repeal.

(1) (a) In accordance with part 3 of article 18 of title 18, a substance use disorder treatment program that compounds, administers, or dispenses a controlled substance shall annually obtain a license issued by the BHA for each place of business or professional practice located in this state.

(b) (I) This subsection (1) is repealed, effective September 1, 2041.

(II) Prior to the repeal, the department of regulatory agencies shall review the licensing functions of the BHA as provided in section 24-34-104. In conducting the review, the department

of regulatory agencies shall consider whether the licensing pursuant to this subsection (1) should be combined with the licensing of any other substance use disorder treatment programs by the department.

(2) Persons licensed as required under this part 2, or otherwise licensed as required by federal law, may possess, distribute, dispense, or administer controlled substances only to the extent authorized by their licenses and in conformity with the provisions of this part 2 and with article 18 of title 18.

(3) An employee of a facility, as defined in section 25-1.5-301, who is administering and monitoring medications to persons under the care or jurisdiction of the facility pursuant to part 3 of article 1.5 of title 25 need not be licensed by the BHA to lawfully possess controlled substances under this part 2.

(4) A person who is required to be but is not yet licensed may apply for a license at any time. A person who is required to be licensed under this part 2 shall not engage in any activity for which a license is required until the BHA grants the person's application and issues a license to the person.

(5) Repealed.

Source: L. 2012: Entire part added with relocations, (SB 12-1311), ch. 281, p. 1601, § 5, effective July 1. **L. 2014:** (1)(b)(I) amended, (HB 14-1173), ch. 291, p. 1191, § 2, effective May 31. **L. 2017:** (1)(a) and (1)(b)(II) amended, (SB 17-242), ch. 263, p. 1361, § 267, effective May 25. **L. 2019:** (1)(b)(I) and (2) amended and (5) repealed, (SB 19-219), ch. 277, p. 2614, § 3, effective August 2. **L. 2022:** (1)(a), (1)(b)(II), (3) and (4) amended, (HB 22-1278), ch. 222, p. 1564, § 164, effective July 1. **L. 2026:** (1)(b)(I) amended, (HB 26-1214), ch. 231, p. 1340, § 3, effective August 12.

Editor's note: This section is similar to former § 12-22-304 as it existed prior to 2012.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-80-205. Issuance of license - fees.

(1) The BHA, as provided in section 27-80-204 (1), shall issue the appropriate license to each substance use disorder treatment program meeting all the requirements of this part 2 unless

it determines that the issuance of the license would be inconsistent with the public interest. In determining the public interest, the BHA shall consider the following factors:

(a) Maintenance of effective controls against diversion of controlled substances into illegitimate medical, scientific, or industrial channels;

(b) Compliance with applicable state and local laws;

(c) Any conviction of the applicant under any federal or state law relating to a controlled substance;

(d) Past experience in the manufacture or distribution of controlled substances and the existence in the applicant's establishment of effective controls against diversion;

(e) Any false or fraudulent information in an application filed under this part 2;

(f) Suspension or revocation of the applicant's federal registration to manufacture, distribute, or dispense a controlled substance as authorized by federal law; and

(g) Any other factors relevant to and consistent with the public peace, health, and safety.

(2) Issuance of a license under subsection (1) of this section does not entitle a licensee to distribute or professionally use controlled substances beyond the scope of the licensee's federal registration.

(3) (a) Repealed.

(a.5) The BHA may administratively set initial and annual license fees for substance use disorder treatment programs to approximate the direct and indirect costs of the program.

(b) The BHA shall transmit the fees collected pursuant to this section to the state treasurer for deposit in the controlled substances program fund created in section 27-80-206.

(4) Any person who is licensed may apply for license renewal not more than sixty days before the expiration date of the license.

(5) The United States, the state of Colorado, or any political subdivision of the state is not required to pay any license fee required by this part 2.

Source: L. 2012: Entire part added with relocations, (SB 12-1311), ch. 281, p. 1602, § 5, effective July 1. **L. 2014:** (3)(a)(I) repealed and (3)(a.5) added, (HB 14-1173), ch. 291, p. 1192, § 5, effective May 31. **L. 2017:** IP(1) and (3)(a.5) amended, (SB 17-242), ch. 263, p. 1361, § 268, effective May 25. **L. 2019:** IP(1) amended and (3)(a) repealed, (SB 19-219), ch. 277, p. 2614, § 4, effective August 2. **L. 2022:** IP(1), (3)(a.5), and (3)(b) amended, (HB 22-1278), ch. 222, p. 1564, § 165, effective July 1.

Editor's note: This section is similar to former § 12-22-305 as it existed prior to 2012.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-80-206. Controlled substances program fund - disposition of fees.

There is created in the state treasury the controlled substances program fund. The BHA shall transmit all money it collects pursuant to this part 2 to the state treasurer, who shall credit the money to the controlled substances program fund. The general assembly shall annually appropriate money from the controlled substances program fund to the BHA for the purposes authorized by this part 2. All money credited to the controlled substances program fund and any interest earned on the fund remains in the fund and does not revert to the general fund or any other fund at the end of any fiscal year.

Source: L. 2012: Entire part added with relocations, (SB 12-1311), ch. 281, p. 1604, § 5, effective July 1. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1564, § 166, effective July 1.

Editor's note: This section is similar to former § 12-22-306 as it existed prior to 2012.

27-80-207. Qualifications for license.

(1) An applicant for a license under this part 2 shall have adequate and proper facilities for the handling and storage of controlled substances and shall maintain proper control over the controlled substances to ensure the controlled substances are not illegally dispensed or distributed.

(2) Repealed.

(3) The BHA shall not grant a license to a person who has been convicted within the last two years of a willful violation of this part 2 or any other state or federal law regulating controlled substances.

(4) Except for fees, compliance by a registrant with the provisions of the federal law respecting registration entitles the registrant to be licensed under this part 2.

Source: L. 2012: Entire part added with relocations, (SB 12-1311), ch. 281, p. 1604, § 5, effective July 1. **L. 2019:** (2) repealed, (SB 19-219), ch. 277, p. 2615, § 5, effective August 2. **L. 2022:** (3) amended, (HB 22-1278), ch. 222, p. 1565, § 167, effective July 1.

Editor's note: This section is similar to former § 12-22-307 as it existed prior to 2012.

27-80-208. Denial, revocation, or suspension of license - other disciplinary actions - notice.

(1) The BHA may deny, suspend, or revoke a license issued under this part 2 pursuant to article 4 of title 24, or take other disciplinary action as set forth in subsection (2.5) of this section, at the BHA's discretion, upon a finding that the licensee:

(a) Has furnished false or fraudulent information in an application filed under this part 2;

(b) Has been convicted of, or has had accepted by a court a plea of guilty or nolo contendere to, a felony under any state or federal law relating to a controlled substance;

(c) Has had his or her federal registration to manufacture, distribute, or dispense a controlled substance suspended or revoked; or

(d) Has violated any provision of this part 2 or the rules of the BHA or of the state board of human services created in section 26-1-107.

(2) The BHA may limit revocation or suspension of a license to the particular controlled substance that was the basis for revocation or suspension.

(2.5) If the BHA determines that a licensee has committed an act that would authorize the BHA to deny, revoke, or suspend a license, the BHA may, at its discretion, impose other disciplinary actions that may include, but need not be limited to, a fine not to exceed five hundred dollars, probation, or stipulation.

(3) If the BHA suspends or revokes a license, the BHA may place all controlled substances owned or possessed by the licensee at the time of the suspension or on the effective date of the revocation order under seal. The BHA may not dispose of substances under seal until the time for making an appeal has elapsed or until all appeals have been concluded, unless a court orders otherwise or orders the sale of any perishable controlled substances and the deposit of the proceeds with the court. When a revocation order becomes final, all controlled substances may be forfeited to the state.

(4) The BHA shall promptly notify the bureau and the appropriate professional licensing agency, if any, of all charges and the final disposition of the charges, and of all forfeitures of a controlled substance.

(5) (a) On or before July 1, 2020, the BHA shall develop and implement a formal, simple, accurate, and objective system to track and categorize complaints made against a licensee and disciplinary action taken pursuant to this part 2.

(b) Repealed.

Source: L. 2012: Entire part added with relocations, (SB 12-1311), ch. 281, p. 1604, § 5, effective July 1. **L. 2014:** IP(1) amended and (2.5) added, (HB 14-1173), ch. 291, p. 1192, § 3, effective May 31. **L. 2019:** IP(1) and (1)(c) amended and (5) added, (SB 19-219), ch. 277, p. 2615, § 6, effective August 2. **L. 2022:** IP(1), (1)(d), (2), (2.5), (3), (4), and (5)(a) amended, (HB 22-1278), ch. 222, p. 1565, § 168, effective July 1.

Editor's note: (1) This section is similar to former § 12-22-308 as it existed prior to 2012.

(2) Subsection (5)(b)(II) provided for the repeal of subsection (5)(b), effective July 1, 2021. (See L. 2019, p. 2615.)

27-80-209. Exemptions.

(1) The provisions of section 18-18-414, C.R.S., do not apply to:

(a) Agents of persons licensed under this part 2 or under part 3 of article 18 of title 18, C.R.S., acting within the provisions of their licenses; or

(b) Officers or employees of appropriate agencies of federal, state, or local governments acting pursuant to their official duties.

(2) All combination drugs that are exempted by regulation of the attorney general of the United States department of justice, pursuant to section 1006 (b) of Public Law 91-513 (84 Stat. 1236), known as the "Comprehensive Drug Abuse Prevention and Control Act of 1970", on or after July 1, 1981, are exempt from this part 2 and part 3 of article 18 of title 18, C.R.S.

(3) This part 2 does not apply to peyote if it is used in religious ceremonies of any bona fide religious organization.

(4) Section 27-80-210 does not apply to a practitioner authorized to prescribe any controlled substance that is listed in schedules III, IV, or V of part 2 of article 18 of title 18, C.R.S., and that

is manufactured, received, or dispensed by the practitioner in the course of his or her professional practice, unless:

(a) The practitioner dispenses, other than by direct administration, a schedule III, IV, or V controlled substance to his or her patients, and the practitioner charges the patients either separately or together with charges for other professional services; or

(b) The practitioner regularly engages in dispensing a schedule III, IV, or V controlled substance to his or her patients.

(5) The exemptions set forth in this section are available as a defense to any person accused of violating section 18-18-414, C.R.S.

(6) The state is not required to negate any exemption or exception in this part 2 or in part 3 or 4 of article 18 of title 18, C.R.S., in any complaint, information, indictment, or other pleading or in any trial, hearing, or other proceeding under this part 2 or under part 4 of article 18 of title 18, C.R.S. The burden of proving an exemption or exception is upon the person claiming the exemption or exception.

Source: L. 2012: Entire part added with relocations, (SB 12-1311), ch. 281, p. 1605, § 5, effective July 1.

Editor's note: This section is similar to former § 12-22-317 as it existed prior to 2012.

27-80-210. Records to be kept - order forms.

(1) Each person licensed or otherwise authorized under this part 2 or other laws of this state to manufacture, purchase, distribute, dispense, administer, store, or otherwise handle controlled substances shall keep and maintain separate detailed and accurate records and inventories relating to controlled substances and retain the records and inventories for a period of two years after the respective dates of the transactions as shown on the records and inventories.

(2) The record of any controlled substance distributed, administered, dispensed, or otherwise used must show the date the controlled substance was distributed, administered, dispensed, used, or otherwise disposed of, the name and address of the person to whom or for whose use the controlled substance was distributed, administered, dispensed, used, or otherwise disposed of, and the kind and quantity of the controlled substance.

(3) A person who maintains a record required by federal law that contains substantially the same information as set forth in subsections (1) and (2) of this section is deemed to comply with the record-keeping requirements of this part 2.

(4) A person required to maintain records pursuant to this section shall keep a record of any controlled substance lost, destroyed, or stolen, the kind and quantity of the controlled substance, and the date of the loss, destruction, or theft.

(5) A person licensed or otherwise authorized under this part 2 or other laws of this state shall distribute, administer, dispense, use, or otherwise dispose of controlled substances listed in schedule I or II of part 2 of article 18 of title 18, C.R.S., only pursuant to an order form. Compliance with the provisions of federal law respecting order forms is deemed compliance with this section.

Source: L. 2012: Entire part added with relocations, (SB 12-1311), ch. 281, p. 1606, § 5, effective July 1.

Editor's note: This section is similar to former § 12-22-318 as it existed prior to 2012.

27-80-211. Enforcement and cooperation.

(1) Each peace officer and district attorney in this state shall enforce this part 2 and shall cooperate with all agencies charged with the enforcement of the laws of this state, all other states, and the United States relating to controlled substances.

(2) The BHA shall cooperate with all agencies charged with the enforcement of the laws of this state, all other states, and the United States relating to controlled substances. To this end, the BHA shall:

(a) Arrange for the exchange of information among governmental officials concerning the use and abuse of controlled substances;

(b) Cooperate with the bureau and with local, state, and other federal agencies by maintaining a centralized unit to accept, catalogue, file, and collect statistics, including records of dependent and other controlled substance law offenders within the state, and make the information available for federal, state, and local law enforcement or regulatory purposes. The BHA shall not furnish the name or identity of a patient whose identity could not be obtained under section 27-80-212.

(c) Respond to referrals, complaints, or other information received regarding possible violations and, upon notification of the appropriate licensing authority, if applicable, and upon a written finding by the commissioner that probable cause exists to believe that there is illegal distribution or dispensing of controlled substances, to make any inspections, investigations, and

reports that may be necessary to determine compliance with this part 2 by all licensed or otherwise authorized individuals who handle controlled substances;

(d) Cooperate with and make information available to appropriate state licensing and registration boards regarding any violations of this part 2 by persons licensed or registered by the boards;

(e) Enter into contracts and encourage and conduct educational and research activities designed to prevent and determine misuse and abuse of controlled substances.

Source: L. 2012: Entire part added with relocations, (SB 12-1311), ch. 281, p. 1607, § 5, effective July 1. **L. 2019:** (2)(b) amended, (SB 19-219), ch. 277, p. 2615, § 7, effective August 2. **L. 2022:** IP(2), (2)(b), and (2)(c) amended, (HB 22-1278), ch. 222, p. 1566, § 169, effective July 1.

Editor's note: This section is similar to former § 12-22-319 as it existed prior to 2012.

27-80-212. Records confidential.

Prescriptions, orders, and records required by this part 2 and stocks of controlled substances are open for inspection only to federal, state, county, and municipal officers whose duty it is to enforce the laws of this state or of the United States relating to controlled substances or the regulation of practitioners. No officer having knowledge, by virtue of his or her office, of a prescription, order, or record shall divulge his or her knowledge, except in connection with a prosecution or proceeding in court or before a licensing or registration board or officer to which prosecution or proceeding the person to whom the prescriptions, orders, or records relate is a party.

Source: L. 2012: Entire part added with relocations, (SB 12-1311), ch. 281, p. 1607, § 5, effective July 1.

Editor's note: This section is similar to former § 12-22-320 as it existed prior to 2012.

27-80-213. Rules - policies.

(1) The BHA shall update rules and promulgate new rules, as necessary and pursuant to article 4 of title 24, to implement this part 2. The BHA shall make the rules available to the public on its website.

(2) The BHA shall adopt rules, in accordance with article 4 of title 24, for the conduct of medically managed treatment.

(3) The BHA shall develop a policy that separates the administration of this part 2 from the administration of article 81 of this title 27. The policy must ensure that the BHA's performance of its duties pursuant to this part 2 does not interfere with the performance of its duties as required by article 81 of this title 27.

Source: L. 2012: Entire part added with relocations, (SB 12-1311), ch. 281, p. 1608, § 5, effective July 1. **L. 2017:** (2) amended, (SB 17-242), ch. 263, p. 1362, § 269, effective May 25. **L. 2019:** (2) amended and (3) added, (SB 19-219), ch. 277, p. 2616, § 8, effective August 2. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1566, § 170, effective July 1. **L. 2026:** (2) amended, (HB 26-1214), ch. 231, p. 1341, § 4, effective August 12.

Editor's note: This section is similar to former § 12-22-321 and § 12-22-322 as they existed prior to 2012.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-80-214. Defenses.

The common law defense known as the "procuring agent defense" is not a defense to any crime in this part 2 or in title 18, C.R.S.

Source: L. 2012: Entire part added with relocations, (SB 12-1311), ch. 281, p. 1608, § 5, effective July 1.

Editor's note: This section is similar to former § 12-22-324 as it existed prior to 2012.

27-80-215. Central registry - registration required - notice - repeal.

(1) (a) On or before July 1, 2020, the BHA shall develop or procure a secure online central registry, referred to in this section as the "registry", to register patients treated in a opioid treatment program.

(b) The BHA shall operate and maintain the registry or enter into an agreement with a third party to operate and maintain the registry on its behalf.

(c) Each opioid treatment program shall register and maintain an account with the registry.

(d) Repealed.

(2) (a) (I) In order to prevent simultaneous enrollment of a patient in more than one opioid treatment program, each opioid treatment program shall fully participate in the registry, including submitting a query to the registry for each patient and entering in patient information as required by this part 2 and BHA rule.

(II) For each patient, the entry into the registry must include the patient's name, the opioid treatment program providing treatment to the patient, and any information the BHA deems necessary to further the goals of this part 2.

(III) Any person seeking treatment from an opioid treatment program must provide the program with any information required by this section and authorize the program to query the registry. A program may not query or enter any information into the registry without authorization from the patient.

(b) The BHA shall establish the method for opioid treatment programs to enter information into the registry and query the registry for information concerning prospective patients.

(3) (a) This section is repealed, effective September 1, 2041.

(b) Prior to the repeal, the department of regulatory agencies shall review the registration functions of the BHA as provided in section 24-34-104.

Source: L. 2019: Entire section added, (SB 19-219), ch. 277, p. 2616, § 9, effective August 2. **L. 2022:** (1)(a), (1)(b), (2)(a)(I), (2)(a)(II), (2)(b), and (3)(b) amended, (HB 22-1278), ch. 222, p. 1566, § 171, effective July 1. **L. 2026:** (1)(a) and (3)(a) amended, (HB 26-1214), ch. 231, p. 1341, § 5, effective August 12.

Editor's note: Subsection (1)(d)(II) provided for the repeal of subsection (1)(d), effective July 1, 2021. (See L. 2019, p. 2616.)

27-80-216. Policy verifying identity.

The BHA shall establish a policy on how an opioid treatment program must verify the identity of individuals initiating into medically managed treatment for a substance use disorder. The BHA policy must include verification requirements for individuals without identification and individuals experiencing homelessness.

Source: L. 2019: Entire section added, (SB 19-227), ch. 273, p. 2583, § 13, effective May 23. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1567, § 172, effective July 1. **L. 2026:** Entire section amended, (HB 26-1214), ch. 231, p. 1341, § 6, effective August 12.

PART 3

BEHAVIORAL HEALTH ACCESS TO CARE OMBUDSMAN

27-80-301. Short title.

The short title of this part 3 is the "Behavioral Health Access to Care Ombudsman Act".

Source: L. 2018: Entire part added, (HB 18-1357), ch. 252, p. 1548, § 1, effective August 8.

27-80-302. Definitions.

As used in this part 3, unless the context otherwise requires:

(1) "Health-care provider" or "provider" means:

(a) A professional person, as defined in section 27-65-102 (27);

(b) A mental health professional licensed or certified under article 245 of title 12;

(c) Any other health-care provider regulated by the state when engaged in assisting consumers with behavioral health-care access and coverage issues; or

(d) A health-care facility licensed pursuant to section 25-1.5-103, when the facility is engaged in assisting consumers with behavioral health-care access and coverage issues.

(2) "Office" means the office of the ombudsman for behavioral health access to care created in section 27-80-303.

(3) "Ombudsman" means the individual designated pursuant to section 27-80-303 as the ombudsman for behavioral health access to care.

Source: L. 2018: Entire part added, (HB 18-1357), ch. 252, p. 1548, § 1, effective August 8. **L. 2019:** (1)(b) amended, (HB 19-1172), ch. 136, p. 1714, § 202, effective October 1. **L. 2022:** (1)(a) amended, (HB 22-1256), ch. 451, p. 3237, § 45, effective August 10.

27-80-303. Office of ombudsman for behavioral health access to care - creation - appointment of ombudsman - duties.

(1) (a) There is created in the office of the executive director of the department the office of the ombudsman for behavioral health access to care for the purpose of assisting Coloradans in accessing behavioral health care. The office of the ombudsman for behavioral health access to care is a **type 1** entity, as defined in section 24-1-105.

(b) The department and the BHA shall offer the office limited support with respect to:

(I) Personnel matters;

(II) Recruitment;

(III) Payroll;

(IV) Benefits;

(V) Budget submission, as needed;

(VI) Accounting;

(VII) Office space, facilities, and technical support; and

(VIII) Administrative support that will help maintain the independence of the office.

(c) The office operates with full independence and has complete autonomy, control, and authority over operations, budget, and personnel decisions related to the office and the ombudsman, subject to state personnel and fiscal rules. The office may seek, accept, and expend gifts, grants, or donations for the purpose of operating the office. The department may, but is not required to, provide funding to the office.

(2) By November 1, 2018, the governor shall designate an ombudsman for behavioral health access to care, who shall serve as director of the office. The ombudsman shall serve as a neutral party to help consumers, including consumers who are uninsured or have public or private health benefit coverage, including coverage that is not subject to state regulation, and health-care providers, acting on their own behalf, on behalf of a consumer with the consumer's written permission, or on behalf of a group of health-care providers, navigate and resolve issues and ensure compliance regarding consumer access to behavioral health care, including care for mental health conditions and substance use disorders.

(3) The ombudsman shall:

(a) Interact with consumers and health-care providers with concerns or complaints to help the consumers and providers resolve behavioral health-care access and coverage issues;

(b) Identify, track, and report to the appropriate regulatory or oversight agency concerns, complaints, and potential violations of state or federal rules, regulations, or statutes concerning the availability of, and terms and conditions of, benefits for mental health conditions or substance use disorders, including potential violations related to quantitative and nonquantitative treatment limitations;

(c) Receive and assist consumers and providers in reporting concerns and filing complaints with appropriate regulatory or oversight agencies relating to inappropriate care, a procedure for an emergency mental health hold pursuant to section 27-65-106, a certification for short-term treatment pursuant to section 27-65-108.5 or 27-65-109, or a certification for long-term care and treatment pursuant to section 27-65-110;

(d) Provide appropriate information to help consumers obtain behavioral health care;

(e) Develop appropriate points of contact for referrals to other state and federal agencies;

(f) Provide appropriate information to help consumers or health-care providers file appeals or complaints with the appropriate entities, including insurers and other state and federal agencies; and

(g) Be the appointing authority for any employees the office may choose to hire. Any such employees are state employees subject to the state personnel system.

(4) The ombudsman, employees of the office, and any persons acting on behalf of the office shall comply with all state and federal confidentiality laws that govern the department and the BHA with respect to the treatment of confidential information or records and the disclosure of such information and records.

(5) In the performance of the ombudsman's duties, the ombudsman shall act independently of the department and the BHA. Any recommendations made or positions taken by the ombudsman do not reflect those of the department or the BHA.

Source: L. 2018: Entire part added, (HB 18-1357), ch. 252, p. 1549, § 1, effective August 8. **L. 2021:** (1)(b), (1)(c), (2), (3)(e), and (3)(f) amended and (3)(g) added, (SB 21-137), ch. 362, p. 2380, § 25, effective June 28. **L. 2022:** (1)(a), IP(1)(b), (4), and (5) amended, (HB 22-1278), ch. 222, p. 1567, § 173 effective July 1; (1)(a) amended, (SB 22-162), ch. 469, p. 3379, § 79, effective August 10; (3)(c) amended, (HB 22-1256), ch. 451, p. 3237, § 46, effective August 10. **L. 2023:** IP(1)(b) and (5) amended, (HB 23-1236), ch. 206, p. 1070, § 44, effective May 16; (3)(c) amended, (HB 23-1138), ch. 423, p. 2492, § 19, effective July 1, 2024.

Editor's note: Amendments to subsection (1)(a) by SB 22-162 and HB 22-1278 were harmonized.

Cross references: For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021. For the short title (the "Debbie Haskins 'Administrative Organization Act of 1968' Modernization Act") in SB 22-162, see section 1 of chapter 469, Session Laws of Colorado 2022.

27-80-304. Liaisons - department - commissioner of insurance.

The commissioner of insurance and the executive director of the department shall each appoint a liaison to the ombudsman to receive reports of concerns, complaints, and potential violations described in section 27-80-303 (3)(b) from the ombudsman, consumers, or health-care providers.

Source: L. 2018: Entire part added, (HB 18-1357), ch. 252, p. 1551, § 1, effective August 8. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1568, § 174, effective July 1.

27-80-305. Qualified immunity.

The ombudsman and employees or persons acting on behalf of the office are immune from suit and liability, either personally or in their official capacities, for any claim for damage to or loss of property, or for personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred within the scope of employment, duties, or responsibilities pertaining to the office, including issuing reports or recommendations; except that nothing in this section protects those persons from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of the person.

Source: L. 2018: Entire part added, (HB 18-1357), ch. 252, p. 1551, § 1, effective August 8.

27-80-306. Annual report.

(1) On or before September 1, 2020, and on or before September 1 of each year thereafter, the ombudsman shall prepare and submit, in accordance with subsection (2) of this section, a

written report that includes information from the preceding fiscal year concerning actions taken by the ombudsman relating to the duties of the office set forth in section 27-80-303.

(2) The ombudsman shall submit the report required by this section to the governor, the executive director of the department and the commissioner of the BHA, the commissioner of insurance, the senate committee on health and human services or any successor committee, and the house of representatives committees on health and insurance and public and behavioral health and human services or any successor committees. Notwithstanding section 24-1-136 (11)(a)(I), the reporting requirement set forth in this section continues indefinitely.

(3) The ombudsman shall post the annual report on the BHA's website.

(4) The ombudsman shall not include in the report required by this section any personally identifying information about an individual consumer or health-care provider or identifying information about a health-care facility licensed pursuant to section 25-1.5-103 or an emergency medical services facility, as defined in section 27-65-102.

Source: L. 2018: Entire part added, (HB 18-1357), ch. 252, p. 1551, § 1, effective August 8. **L. 2022:** (2) and (3) amended, (HB 22-1278), ch. 222, p. 1568, § 175, effective July 1; (4) amended, (HB 22-1256), ch. 451, p. 3237, § 47, effective August 10.

ARTICLE 81

Substance Use Disorders Education, Prevention, and Treatment

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27-81-111. Emergency commitment.

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27-81-113. Records of persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of substances.

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27-81-115. Emergency service patrol - establishment - rules.

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27-81-101. Legislative declaration.

(1) The general assembly recognizes the character and pervasiveness of substance use disorders and that substance use disorders are serious problems. The general assembly further finds and declares that these problems have been very seriously neglected and that the social and economic costs and the waste of human resources caused by substance use disorders are massive, tragic, and no longer acceptable. The general assembly believes that the best interests of this state demand an across-the-board, locally oriented attack on the massive problems of drug abuse and substance use disorders. The attack includes prevention, education, and treatment, and this article 81 provides a base from which to launch the attack and reduce the tragic human loss.

(2) It is the policy of this state that persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs should be afforded treatment so they may lead normal lives as productive members of society. The general assembly finds and declares that substance use disorders are matters of statewide concern.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 732, § 2, effective April 29. **L. 2017:** Entire section amended, (SB 17-242), ch. 263, p. 1362, § 270, effective May 25. **L. 2020:** Entire section R&RE, (SB 20-007), ch. 286, p. 1392, § 11, effective July 13.

Editor's note: This section is similar to former § 27-82-101 as it existed prior to 2020.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

ANNOTATION

Annotator's note. Since § 27-81-101 is similar to § 25-1-301 as it existed prior to the 2010 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

Compelling state interest. The state has a compelling interest in protecting an intoxicated individual and the general public from the catastrophic consequences of alcohol abuse. Carberry v. Adams County Task Force on Alcoholism, 672 P.2d 206 (Colo. 1983).

Applied in Ramos v. Lamm, 485 F. Supp. 122 (D. Colo. 1979).

27-81-102. Definitions.

As used in this article 81, unless the context otherwise requires:

(1) "Administrator" means the administrator of an approved treatment facility or an individual authorized in writing to act as the administrator's designee.

(1.2) "Alcohol use disorder" means a chronic relapsing brain disease characterized by recurrent use of alcohol causing clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, and home.

(2) "Approved private treatment facility" means a private agency meeting the standards prescribed in section 27-81-106 (1) and approved under section 27-81-106.

(3) "Approved public treatment facility" means a treatment agency operating under the direction and control of or approved by the BHA or providing treatment pursuant to this article 81 through a contract with the BHA pursuant to section 27-81-105 (7) and meeting the standards prescribed in section 27-81-106 (1) and approved pursuant to section 27-81-106.

(3.3) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-50-102.

(3.5) "Behavioral health entity" has the same meaning as defined in section 27-50-101.

(3.7) "Commissioner" means the commissioner of the behavioral health administration.

(4) "Court" means the district court in the county in which the person named in a petition filed pursuant to this article resides or is physically present. In the city and county of Denver, "court" means the probate court.

(5) "Department" means the department of human services created in section 26-1-105, C.R.S.

(6) Repealed.

(6.5) "Drug" means a controlled substance, as defined in section 18-18-102 (5), and toxic vapors.

(6.8) "Emergency medical services facility" has the same meaning as set forth in section 27-65-102.

(7) "Emergency service patrol" means a patrol established under section 27-81-115.

(8) Repealed.

(9) "Incapacitated by alcohol" means that a person, as a result of the use of alcohol, is unconscious, has his or her judgment otherwise so impaired that he or she is incapable of realizing and making a rational decision with respect to his or her need for treatment, is unable to take care of his or her basic personal needs or safety, or lacks sufficient understanding or capacity to make or communicate rational decisions about himself or herself.

(9.2) "Incapacitated by drugs" means that a person, as a result of the use of drugs, is unconscious or has judgment otherwise so impaired that the person is incapable of realizing and making a rational decision with respect to the person's need for treatment, is unable to take care of basic personal needs or safety, or lacks sufficient understanding or capacity to make or communicate rational decisions concerning himself or herself.

(9.4) "Incapacitated by substances" means that a person is incapacitated by alcohol or is incapacitated by drugs.

(10) Repealed.

(11) "Intoxicated person" or "person intoxicated by alcohol" means a person whose mental or physical functioning is temporarily but substantially impaired as a result of the presence of alcohol in his or her body.

(12) "Licensed physician" means either a physician licensed by the state of Colorado or a hospital-licensed physician employed by the admitting facility.

(13) "Minor" means a person under the age of eighteen years.

(13.5) Repealed.

(13.6) "Person under the influence of drugs" means any person whose mental or physical functioning is temporarily but substantially impaired as a result of the presence of drugs in the person's body.

(13.7) "Public funds" means money appropriated to the behavioral health administration by the general assembly or any other governmental or private sources for withdrawal management in approved facilities pursuant to this article 81.

(13.8) "Substance use disorder" means a chronic relapsing brain disease, characterized by recurrent use of alcohol, drugs, or both, causing clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

(13.9) "Toxic vapors" means a substance or product containing such substances as defined in section 18-18-412 (3).

(14) "Treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation, and career counseling that may be extended to a person with a substance use disorder, a person incapacitated by substances, a person under the influence of drugs, and a person intoxicated by alcohol.

(15) Repealed.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 732, § 2, effective April 29. **L. 2011:** (10) repealed, (HB 11-1303), ch. 264, p. 1172, § 81, effective August 10. **L. 2017:** IP, (1), (3), (6), and (14) amended, (13.5) added, and (15) repealed, (SB 17-242), ch. 263, p. 1362, § 271, effective May 25. **L. 2019:** (1) amended and (3.5) and (13.7) added, (HB 19-1237), ch. 413, p. 3644, § 20, effective July 1, 2022. **L. 2020:** (1) and (14) amended and (1.2), (6.5), (9.2), (9.4), (13.6), (13.8), and (13.9) added, (SB 20-007), ch. 286, p. 1392, § 12, effective July 13. **L. 2021:** (13.8) amended, (SB 21-266), ch. 423, p. 2803, § 26, effective July 2. **L. 2022:** (3) and (13.7) amended, (3.3) and (3.7) added, and (6), (8) and (13.5) repealed, (HB 22-1278), ch. 222, p. 1568, § 176, effective July 1; (3.5)(a) amended, (HB 22-1295), ch. 123, p. 864, § 120, effective July 1; (3.5) amended, (HB 22-1278), ch. 222, p. 1595, § 239, effective July 1, 2024. **L. 2024:** (6.8) added, (HB 24-1079), ch. 199, p. 1218, § 1, effective May 17.

Editor's note: (1) This section is similar to former § 25-1-302 as it existed prior to 2010.

(2) The provisions of this section are similar to several former provisions of § 27-82-102 as they existed prior to 2020. For a detailed comparison of this section, see SB 20-007, L. 2020, p. 1392.

(3) (a) Subsection (13.8) is similar to former § 27-82-102 (13.5) as it would have become effective July 1, 2022.

(b) Subsection (13.8) was added in 2020 by SB 20-007, effective July 1, 2022. It was subsequently amended in SB 21-266 to give it effect July 2, 2021.

(4) Subsection (3.5)(a) was amended in HB 22-1295. Those amendments were superseded by the amendment of subsection (3.5) in HB 22-1278, effective July 1, 2024.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-81-103. Powers of the behavioral health administration.

(1) To carry out the purposes of this article 81, the BHA may:

(a) Plan, establish, and maintain substance use disorder treatment programs as necessary or desirable;

(b) Make contracts necessary or incidental to the performance of its duties and the execution of its powers, including contracts with public and private agencies, organizations, and individuals to pay them for services rendered or furnished to persons with substance use disorders, persons intoxicated by alcohol, or persons under the influence of drugs;

(c) Solicit and accept for use any gift of money or property made by will or otherwise and any grant of money, services, or property from the federal government, the state, or any political subdivision thereof or any private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for any grant;

(d) Administer or supervise the administration of the provisions relating to persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs of any state plan submitted for federal funding pursuant to federal health, welfare, or treatment legislation;

(e) Coordinate its activities and cooperate with substance use disorder treatment programs in this state and other states and make contracts and other joint or cooperative arrangements with state, local, or private agencies in this state and other states for the treatment of persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs and for the common advancement of substance use disorder treatment programs;

(f) Keep records and engage in research and the gathering of relevant statistics;

(g) Do other acts and things necessary or convenient to execute the authority expressly granted to it; and

(h) Acquire, hold, or dispose of real property, or any interest therein, and construct, lease, or otherwise provide substance use disorder treatment facilities for persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 733, § 2, effective April 29. **L. 2017:** IP(1), (1)(a), (1)(b), (1)(d), (1)(e), and (1)(h) amended, (SB 17-242), ch. 263, p. 1363, § 272, effective May 25. **L. 2020:** (1)(a), (1)(b), (1)(d), (1)(e), and (1)(h) amended, (SB 20-007), ch. 286, p. 1394, § 13, effective July 13. **L. 2022:** IP(1) amended, (HB 22-1278), ch. 222, p. 1569, § 177, effective July 1.

Editor's note: This section is similar to former § 25-1-303 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-81-104. Duties of the behavioral health administration - review.

(1) The BHA shall:

(a) Develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of substance use disorders and treatment of persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs, in cooperation with public and private agencies, organizations, and individuals, and provide technical assistance and consultation services for these purposes;

(b) Coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of substance use disorders and treatment of persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs;

(c) Utilize behavioral health entities, community mental health centers and clinics, or other approved treatment facilities, whenever feasible;

(d) Cooperate with the department of corrections in establishing and conducting programs for the prevention of substance use disorders and treatment of persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs in appropriate

agencies and institutions and for persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs in or on parole from correctional institutions and in carrying out duties specified in subsections (1)(i) and (1)(k) of this section;

(e) Cooperate with the department of education, schools, police departments, courts, and other public and private agencies, organizations, and individuals in establishing programs for the prevention of substance use disorders and treatment of persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs and preparing curriculum materials for use at all levels of school education;

(f) Prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol and drugs;

(g) Develop and implement, as an integral part of substance use disorder treatment programs, an educational program for use in the treatment of persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs. The program must include the dissemination of information concerning the nature and effects of alcohol and drugs.

(h) Organize and foster training programs for all persons engaged in treatment of persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs;

(i) Sponsor and encourage research into the causes and nature of substance use disorders and treatment of persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs, and serve as a clearinghouse for information relating to substance use disorders;

(j) Specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(k) Advise the governor in the preparation of a comprehensive plan for treatment of persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs for inclusion in the state's comprehensive health plan;

(l) Review all state health, welfare, and treatment plans to be submitted for federal funding under federal legislation and advise the governor on provisions to be included relating to substance use disorders, persons with substance use disorders, and persons under the influence of drugs;

(m) Assist in the development of, and cooperate with, substance use education and treatment programs for employees of state and local governments and businesses and industries in this state;

(n) Utilize the support and assistance of interested persons in the community, particularly persons with substance use disorders that are in remission, to encourage persons with substance use disorders to voluntarily undergo treatment;

(o) Cooperate with the department of transportation in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while under the influence of, or impaired by, alcohol or drugs;

(p) Encourage general hospitals and other appropriate health facilities to admit without discrimination persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs and to provide them with adequate and appropriate treatment;

(q) Encourage all health and disability insurance programs to include substance use disorders as a covered illness;

(r) Submit to the governor an annual report covering the activities of the BHA; and

(s) Train emergency departments and certified peace officers in the procedures required pursuant to sections 27-81-111 and 27-81-112.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 734, § 2, effective April 29. **L. 2017:** Entire section amended, (SB 17-242), ch. 263, p. 1364, § 273, effective May 25. **L. 2019:** (1)(c) amended, (HB 19-1237), ch. 413, p. 3645, § 21, effective July 1, 2022. **L. 2020:** Entire section amended, (SB 20-007), ch. 286, p. 1394, § 14, effective July 13. **L. 2022:** IP(1) and (1)(r) amended, (HB 22-1278), ch. 222, p. 1569, § 178, effective July 1; IP(1), (1)(q), and (1)(r) amended and (1)(s) added, (HB 22-1326), ch. 225, p. 1671, § 52 effective July 1.

Editor's note: (1) This section is similar to former § 25-1-304 as it existed prior to 2010.

(2) Amendments to subsection (1)(r) by HB 22-1278 and HB 22-1326 were harmonized.

Cross references: (1) For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

(2) For the legislative declaration in HB 22-1326 stating the purpose of, and the provision directing legislative staff agencies to conduct, a post-enactment review pursuant to § 2-2-1201 scheduled in 2025, see sections 1 and 55 of chapter 225, Session Laws of Colorado 2022. To obtain a copy of the review, once completed, go to "Legislative Resources and Requirements" on the Colorado General Assembly's website.

ANNOTATION

Applied in Ramos v. Lamm, 485 F. Supp. 122 (D. Colo. 1979) (decided prior to 2010 amendments to this article).

27-81-105. Comprehensive program for treatment - regional facilities.

(1) The BHA shall establish a comprehensive and coordinated program for the treatment of persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs.

(2) Insofar as money available to the BHA permits, the program established in subsection (1) of this section must include all of the following:

(a) Emergency treatment;

(b) Inpatient treatment;

(c) Intermediate treatment; and

(d) Outpatient and follow-up treatment.

(3) The BHA shall provide adequate and appropriate treatment for persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs admitted pursuant to sections 27-81-109 to 27-81-112. Except as otherwise provided in section 27-81-111, treatment must not be provided at a correctional institution, except for inmates.

(4) The BHA shall maintain, supervise, and control all facilities it operates subject to policies of the department. The administrator of each facility shall make an annual report of the facility's activities to the commissioner in the form and manner specified by the commissioner.

(5) All appropriate public and private resources shall be coordinated with and utilized in the program if possible.

(6) The commissioner shall prepare, publish, and distribute annually a list of all approved public and private treatment facilities.

(7) The BHA may contract for the use of any facility as an approved public treatment facility if the commissioner, subject to the policies of the department, considers it to be an effective and economical course to follow.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 736, § 2, effective April 29. **L. 2017:** (1), IP(2), (3), (4), and (7) amended, (SB 17-242), ch. 263, p. 1366, § 274, effective May 25. **L. 2020:** (1) and (3) amended, (SB 20-007), ch. 286, p. 1396, § 15, effective July 13. **L. 2022:** (1), IP(2), (3), (4), (6), and (7) amended, (HB 22-1278), ch. 222, p. 1569, § 179, effective July 1.

Editor's note: This section is similar to former § 25-1-305 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-81-106. Standards for public and private treatment facilities - fees - enforcement procedures - penalties.

(1) In accordance with the provisions of this article 81, the BHA shall establish standards for approved treatment facilities that receive public funds. A treatment facility shall meet the established standards to be approved as a public or private treatment facility. The BHA shall fix the fees to be charged for the required inspections. The fees charged to approved treatment facilities that provide level I and level II programs, as provided in section 42-4-1301.3 (3)(c), must be transmitted to the state treasurer, who shall credit the fees to the alcohol and drug driving safety program fund created in section 42-4-1301.3 (4)(a). The standards may concern only health standards to be met and standards of treatment to be afforded patients and must reflect the success criteria established by the general assembly.

(2) The BHA shall periodically inspect approved public and private treatment facilities at reasonable times and in a reasonable manner.

(3) The BHA shall maintain a list of approved public and private treatment facilities.

(4) Each approved public and private treatment facility shall file with the BHA, on request, data, statistics, schedules, and any other information the BHA reasonably requires. The commissioner shall remove from the list of approved treatment facilities an approved public or private treatment facility that fails, without good cause, to furnish any data, statistics, schedules, or other information, as requested, or files fraudulent returns.

(5) The BHA, after a hearing, may suspend, revoke, limit, restrict, or refuse to grant an approval for failure to meet its standards.

(6) A person shall not operate a private or public treatment facility in this state without approval from the BHA; except that this article 81 does not apply to a private treatment facility

that accepts only private money and does not dispense controlled substances. The district court may restrain any violation of, review any denial, restriction, or revocation of approval under, and grant other relief required to enforce the provisions of this section.

(7) Upon petition of the BHA and after a hearing held upon reasonable notice to the facility, the district court may issue a warrant to an officer or employee of the BHA authorizing the officer or employee to enter and inspect at reasonable times, and examine the books and accounts of, any approved public or private treatment facility that refuses to consent to inspection or examination by the BHA or which the BHA has reasonable cause to believe is operating in violation of this article 81.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 736, § 2, effective April 29. **L. 2017:** Entire section amended, (SB 17-242), ch. 263, p. 1366, § 275, effective May 25. **L. 2020:** (6) R&RE, (SB 20-007), ch. 286, p. 1397, § 16, effective July 13. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1570, § 180, effective July 1.

Editor's note: (1) This section is similar to former § 25-1-306 as it existed prior to 2010.

(2) Subsection (6) is similar to former § 27-82-103 (6) as it existed prior to 2020.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-81-107. Compliance with local government zoning regulations - notice to local governments - provisional approval - repeal. (Repealed)

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 737, § 2, effective April 29. **L. 2017:** (1), IP(2), and (3) amended, (SB 17-242), ch. 263, p. 1367, § 276, effective May 25. **L. 2019:** (1) amended and (4) added, (HB 19-1237), ch. 413, p. 3645, § 22, effective July 1, 2022. **L. 2022:** (1), IP(2), and (3) amended, (HB 22-1278), ch. 222, p. 1570, § 181, effective July 1.

Editor's note: (1) Prior to its repeal, this section was similar to former § 25-1-306.5 as it existed prior to 2010.

(2) Subsection (4) provided for the repeal of this section, effective July 1, 2024. (See L. 2019, p. 3645.)

27-81-107.5. Licensure. (Repealed)

Source: L. 2019: Entire section added, (HB 19-1237), ch. 413, p. 3645, § 23, effective July 1, 2022. **L. 2022:** Entire section repealed, (HB 22-1278), ch. 222, p. 1571, § 182, effective July 1.

27-81-108. Acceptance for treatment - rules.

(1) The commissioner shall adopt and may amend and repeal rules for acceptance of persons into the substance use disorder treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of drugs. In establishing the rules, the following standards guide the commissioner:

(a) If possible a patient shall be treated on a voluntary rather than an involuntary basis.

(b) Qualified staff shall assess the proper level of care for the person pursuant to rules adopted by the commissioner and make a referral for placement.

(c) A person must not be denied treatment solely because the person has withdrawn from treatment against medical advice on a prior occasion or because the person has relapsed after earlier treatment.

(d) An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

(e) Provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will have available and utilize other appropriate treatment.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 738, § 2, effective April 29. **L. 2017:** IP(1) amended, (SB 17-242), ch. 263, p. 1367, § 277, effective May 25. **L. 2020:** IP(1), (1)(b), and (1)(c) amended, (SB 20-007), ch. 286, p. 1397, § 17, effective July 13. **L. 2022:** IP(1) and (1)(b) amended, (HB 22-1278), ch. 222, p. 1571, § 183, effective July 1.

Editor's note: This section is similar to former § 25-1-307 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-81-109. Voluntary treatment of persons with substance use disorders.

(1) A person with a substance use disorder, including a minor, may apply for voluntary treatment directly to an approved treatment facility.

(2) Subject to rules adopted by the commissioner, the administrator in charge of an approved treatment facility shall determine who is admitted for treatment. If a person is refused admission to an approved treatment facility, the administrator may refer the person to another approved and appropriate treatment facility for treatment if it is deemed likely to be beneficial. A person must not be referred for further treatment if it is determined that further treatment is not likely to bring about significant improvement in the person's condition, or treatment is no longer appropriate, or further treatment is unlikely to be beneficial.

(3) If a patient receiving residential care leaves an approved treatment facility, the person is encouraged to consent to outpatient treatment or supportive services, if appropriate.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 738, § 2, effective April 29. **L. 2017:** (1) and (3) amended, (SB 17-242), ch. 263, p. 1368, § 278, effective May 25. **L. 2020:** Entire section R&RE, (SB 20-007), ch. 286, p. 1397, § 18, effective July 13. **L. 2022:** (2) amended, (HB 22-1278), ch. 222, p. 1571, § 184, effective July 1.

Editor's note: (1) This section is similar to former § 25-1-308 as it existed prior to 2010.

(2) This section is similar to former § 27-82-105 as it existed prior to 2020.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

ANNOTATION

Law reviews. For article, "Consent to Treatment and Access to Minors' Medical Records", see 17 Colo. Law. 1323 (1988).

27-81-110. Voluntary treatment for persons intoxicated by alcohol, under the influence of drugs, or incapacitated by substances.

(1) A person intoxicated by alcohol, under the influence of drugs, or incapacitated by substances, including a minor if provided by rules of the BHA, may voluntarily admit the person's self to an approved treatment facility for an emergency evaluation to determine need for treatment.

(2) The administrator shall immediately evaluate or examine a person who voluntarily enters an approved treatment facility. If the person is found to be in need of treatment, the administrator shall admit the person or refer the person to another appropriate facility. If a person is found not to be in need of treatment, the administrator shall release the person and may refer the person to another appropriate facility.

(3) Except as provided in subsection (7) of this section, a treatment facility shall immediately release a voluntarily admitted person upon the person's request.

(4) A person who is not admitted to an approved treatment facility or referred to another health facility, and who has no money, may be taken to the person's home, if any. If the person has no home, the approved treatment facility may assist the person in obtaining shelter.

(5) If a person is admitted to an approved treatment facility, the person's family or next of kin must be notified as promptly as possible in accordance with federal confidentiality regulations for substance use disorder patient records, which regulations are found at 42 CFR part 2, as amended. If an adult person requests that there be no notification, the adult person's request must be respected.

(6) If the administrator determines that it is for the person's benefit, the person must be encouraged to agree to further diagnosis and appropriate voluntary treatment.

(7) Nothing in this section precludes the administrator from seeking emergency commitment of a person as provided in section 27-81-111 or involuntary commitment of a person as provided in section 27-81-112, regardless of whether the person has been voluntarily admitted under this section. In such case, the administrator's further conduct is governed by section 27-81-111 or 27-81-112, as applicable.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 738, § 2, effective April 29. **L. 2020:** Entire section R&RE, (SB 20-007), ch. 286, p. 1398, § 19, effective July 13. **L. 2022:** (1) amended, (HB 22-1278), ch. 222, p. 1572, § 185, effective July 1.

Editor's note: (1) This section is similar to former § 25-1-309 as it existed prior to 2010.

(2) This section is similar to former § 27-82-106 as it existed prior to 2020.

ANNOTATION

Law reviews. For article, "Consent to Treatment and Access to Minors' Medical Records", see 17 Colo. Law. 1323 (1988).

27-81-111. Emergency commitment.

(1) (a) When a person is under the influence of or incapacitated by substances and is clearly dangerous to the health and safety of the person's self or others, law enforcement authorities or an emergency service patrol, acting with probable cause, shall take the person into protective custody in an approved treatment facility. If no such facilities are available, the person may be detained in an emergency medical services facility, or jail, but only for as long as may be necessary to prevent injury to the person's self or others or to prevent a breach of the peace. A law enforcement officer or emergency service patrol officer, in detaining the person, is taking the person into protective custody. In so doing, the detaining officer may protect the officer's self by reasonable methods but shall make every reasonable effort to protect the detainee's health and safety. Taking a person into protective custody pursuant to this section is not an arrest, and an entry or other record shall not be made to indicate that the person has been arrested or charged with a crime. Law enforcement or emergency service personnel who act in compliance with this section are acting in the course of their official duties and are not criminally or civilly liable. Nothing in this subsection (1) precludes a person intoxicated by alcohol, under the influence of drugs, or incapacitated by substances who is not dangerous to the health and safety of the person's self or others from being assisted to the person's home or like location by the law enforcement officer or emergency service patrol officer.

(b) (Deleted by amendment, L. 2024.)

(c) A law enforcement officer or emergency service patrol officer who takes a juvenile into protective custody pursuant to subsection (1)(a) of this section shall not detain the juvenile in jail.

(2) A law enforcement officer, emergency service patrol officer, physician, spouse, guardian, or relative of the person to be committed or any other responsible person may make a written application for emergency commitment under this section, directed to the administrator of the approved treatment facility. The application must state the circumstances requiring emergency

commitment, including the applicant's personal observations and the specific statements of others, if any, upon which the applicant relies in making the application. A copy of the application must be furnished to the person to be committed.

(3) If the administrator approves the application, the administrator shall commit, evaluate, and treat the person for a period not to exceed five days. A peace officer, the emergency service patrol, or any interested person shall bring the person to the facility. If necessary, the court may be contacted to issue an order to the police, the peace officer's department, or the sheriff's department to transport the person to the facility.

(4) If the administrator determines that the application fails to sustain the grounds for emergency commitment as set forth in subsection (1) of this section, the administrator shall refuse the commitment, immediately release the detained person, and encourage the person to seek voluntary treatment, if appropriate.

(5) When the administrator determines that the grounds for commitment no longer exist, the administrator shall discharge the person committed under this section. A person committed under this section must not be detained in any treatment facility for more than five days; except that a person may be detained for longer than five days at the approved treatment facility if, in that period of time, a petition for involuntary commitment has been filed pursuant to section 27-81-112. A person must not be detained longer than ten days, excluding weekends and holidays, after the date of filing of the petition for involuntary commitment unless a valid medical reason exists for detaining a person longer.

(6) Whenever a person is involuntarily detained pursuant to this section, the administrator shall, within twenty-four hours after detainment, advise the person who is involuntarily detained, both orally and in writing, of the person's right to challenge the detention by application to the courts for a writ of habeas corpus, to be represented by counsel at every stage of any proceedings relating to commitment and recommitment, and to have counsel appointed by the court or provided by the court if the person wants the assistance of counsel and is unable to obtain counsel.

(7) Any law enforcement officer, emergency service personnel, physician, spouse, guardian, or relative of any person to be committed; any treatment facility administrator or the administrator's designee; or any other employee or person acting on behalf of an approved treatment facility, participating in or carrying out the emergency commitment or treatment as described in this section, whether acting individually or in his or her official capacity, is not criminally or civilly liable therefor.

(8) (a) On or before July 1, 2024, and each July 1 thereafter, each local law enforcement agency that has taken a person into protective custody pursuant to this section shall provide an annual report to the BHA that includes only disaggregated and nonidentifying information concerning persons who were taken into protective custody in an approved treatment facility or

detained in an emergency medical services facility or jail. The report must comply with section 24-1-136 (9) and is exempt from section 24-1-136 (11)(a)(I). The report must contain the following:

(I) The names and counties of the facilities and jails;

(II) The total number of persons taken into protective custody pursuant to this section, including a summary of demographic information;

(III) A summary regarding the different reasons for which persons were taken into protective custody pursuant to this section; and

(IV) The length of time each person was held under protective custody.

(b) Each emergency medical services facility that detains a person under protective custody or detains or holds a person on an emergency commitment shall provide a quarterly report to the BHA with the following information:

(I) The total number of persons detained under protective custody and the total number of persons held in the emergency medical services facility on an emergency commitment;

(II) The total number of days each person was detained or held;

(III) Whether each person was transferred to another facility, released, or placed on an involuntary commitment; and

(IV) Whether the emergency medical services facility transferred each person to the local jail to be detained under protective custody or for an emergency commitment and the reason for the transfer.

(c) Any information disaggregated and provided to the BHA pursuant to this subsection (8) is privileged and confidential. The BHA shall not make the information available to the public except in an aggregate format that cannot be used to identify an individual facility. The information is not subject to civil subpoena and is not discoverable or admissible in any civil, criminal, or administrative proceeding against an approved treatment facility, emergency medical services facility, jail, law enforcement officer, or emergency service patrol officer. The BHA shall only use the information to assess statewide behavioral health services needs and withdrawal management needs and to plan for sufficient levels of statewide behavioral health and withdrawal management services. In collecting the data pursuant to the requirements of this subsection (8), the BHA shall protect the confidentiality of patient records, in accordance with state and federal laws, and shall not disclose any public identifying or proprietary information of any approved treatment facility or emergency medical services facility. This subsection (8)(c) does not apply to information that is otherwise available from a source outside of the data collection activities required pursuant to subsection (8)(a) of this section.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 739, § 2, effective April 29. **L. 2020:** Entire section amended, (SB 20-007), ch. 286, p. 1399, § 20, effective July 13. **L. 2021:** (1)(a) amended, (SB 21-059), ch. 136, p. 749, § 132, effective October 1. **L. 2024:** (1) amended and (8) added, (HB 24-1079), ch. 199, p. 1218, § 2, effective May 17.

Editor's note: This section is similar to former § 25-1-310 as it existed prior to 2010.

ANNOTATION

Law reviews. For comment, "Leake v. Cain: Abrogation of the Public Duty Doctrine in Colorado?", see 59 U. Colo. L. Rev. 383 (1988).

Annotator's note. Since § 27-81-111 is similar to § 25-1-310 as it existed prior to the 2010 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

Due process considerations. A judicial hearing as a prerequisite to commitment of a clearly dangerous intoxicated person would hinder the government's efforts in controlling alcohol abuse without providing additional procedural safeguards. Due process demands only that a neutral fact finder independently determine that the statutory requirements for commitment and release are satisfied. Due process does not dictate that the neutral and detached fact finder be law-trained or a judicial or administrative officer. Carberry v. Adams County Task Force on Alcoholism, 672 P.2d 206 (Colo. 1983).

Intent of subsection (1). In enacting subsection (1), the general assembly did not intend the police to take into protective custody every intoxicated person they meet. Rather, the general assembly designated a specific class of intoxicated persons who are subject to emergency commitment and left the determination of whether a particular individual is clearly dangerous to the police. Therefore, the decision to take a person into protective custody is discretionary and protected by official immunity. Leake v. Cain, 720 P.2d 152 (Colo. 1986).

Class of persons section was designated to protect. Respondents-decedents are not included within the class of persons that subsection (1) was designated to protect, since the statutory intent was not to protect members of the public against intoxicated persons. Therefore, police officers had no duty to take defendant into "protective custody" or to escort him to his home. Leake v. Cain, 720 P.2d 152 (Colo. 1986).

The language of this section indisputably articulates a clear legislative determination that the act of taking a person into civil protective custody is not an arrest. Colo. v. Dandrea, 736 P.2d 1211 (Colo. 1987); Anaya v. Crossroads Care Sys., 973 F. Supp. 1228 (D. Colo. 1997).

This section cannot be used to justify the equivalent of a criminal custodial arrest not supported by probable cause. People v. Dandrea, 736 P.2d 1211 (Colo. 1987).

This section clearly contemplates encounters between police officers and those whom they perceive are intoxicated, without any requirement that the officers also suspect involvement in criminal activity. People v. Herrera, 1 P.3d 234 (Colo. App. 1999).

In order to take an individual into protective custody under this section, an officer must have probable cause to believe that the person is sufficiently intoxicated as to be a danger to himself, herself, or others, given the totality of the circumstances. United States v. Gilmore, 945 F. Supp. 2d 1211 (D. Colo. 2013).

A pat-down search under this section is justified by a reasonable concern for police officer safety as balanced against a limited intrusion into an individual's expectation of privacy. People v. Dandrea, 736 P.2d 1211 (Colo. 1987); United States v. Gilmore, 945 F. Supp. 2d 1211 (D. Colo. 2013).

When a search is conducted pursuant to protective custody the scope of the officer's inventory search is limited by the privacy interest of the detainee. People v. Chaves, 855 P.2d 852 (Colo. 1993).

Officers exceeded their authority under this section by conducting an inventory search at the point of detention, rather than just a pat-down search. People v. Herrera, 1 P.3d 234 (Colo. App. 1999).

The inventory search of a civil detainee does not permit officers to search closed containers without a warrant. The purpose of such a search is to ensure that all of the detainee's possessions are held safely and to remove those which may be dangerous. People v. Chaves, 855 P.2d 852 (Colo. 1993).

Limited pat-down search of person being taken into protective custody did not violate the fourth amendment of the U.S. constitution, and the pistol discovered during that search need not be suppressed, because the police officer had probable cause to initiate the process of taking the person into protective custody. United States v. Gilmore, 945 F. Supp. 2d 1211 (D. Colo. 2013).

27-81-112. Involuntary commitment of a person with a substance use disorder.

(1) The court may commit a person to the custody of the BHA upon the petition of the person's spouse or guardian, a relative, a physician, an advanced practice registered nurse, the administrator in charge of an approved treatment facility, a certified peace officer, or any other responsible person. The petition must allege that the person has a substance use disorder and that the person has threatened or attempted to inflict or inflicted physical harm on the person's self or on another and that unless committed, the person is likely to inflict physical harm on the person's self or on another or that the person is incapacitated by substances. A refusal to undergo

treatment does not constitute evidence of lack of judgment as to the need for treatment. The petition must be accompanied by a certificate of a licensed physician who has examined the person within ten days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal must be alleged in the petition, or an examination cannot be made of the person due to the person's condition. The certificate must set forth the physician's findings in support of the petition's allegations.

(2) A court shall not accept a petition submitted pursuant to subsection (1) of this section unless there is documentation of the refusal by the person to be committed to accessible and affordable voluntary treatment. The documentation may include, but is not limited to, notations in the person's medical or law enforcement records or statements by a physician, advanced practice registered nurse, or witness.

(3) (a) Upon filing the petition, the person whose commitment is sought must be notified of the person's right to:

(I) Enter into a stipulated order of the court for committed treatment in order to expedite placement in an approved treatment facility by the BHA; or

(II) Contest the commitment proceeding.

(b) If a stipulated order is entered, the BHA shall place the person in an approved treatment program that reflects the level of need of the person.

(c) If the person whose commitment is sought exercises the right to contest the petition, the court shall fix a date for a hearing no later than ten days, excluding weekends and holidays, after the date the petition was filed. A copy of the petition and the notice of the hearing, including the date fixed by the court, must be personally served on the petitioner, the person whose commitment is sought, and one of the person's parents or the person's legal guardian if the person is a minor. A copy of the petition and notice of hearing must be provided to the BHA, to counsel for the person whose commitment is sought, to the administrator in charge of the approved treatment facility to which the person may have been committed for emergency treatment, and to any other person the court believes advisable.

(4) At the hearing, the court shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person must be present unless the court believes that the person's presence is likely to be injurious to the person; in this event, the court shall appoint a guardian ad litem to represent the person throughout the proceeding. If the person has refused to be examined by a licensed physician, the person must be given an opportunity to be examined by a court-appointed licensed physician. If the person refuses and there is sufficient evidence to believe that the allegations of the petition are true or if the court believes that more medical evidence is necessary, the court may commit the person to a licensed hospital for a period of not more than five days for a

diagnostic examination. In such event, the court shall schedule a further hearing for final determination of commitment, in no event later than five days after the first hearing.

(5) If after hearing all relevant evidence, including the results of any diagnostic examination by the licensed hospital, the court finds that grounds for involuntary commitment have been established by clear and convincing proof, the court shall make an order of commitment to the BHA. The BHA has the right to delegate physical custody of the person to an appropriate approved treatment facility. The court may not order commitment of a person unless the court determines that the BHA is able to provide adequate and appropriate treatment for the person, and the treatment is likely to be beneficial.

(6) Upon the court's commitment of a person to the BHA, the court may issue an order to the sheriff to transport the person to the facility designated by the BHA.

(7) A person committed as provided for in this section remains in the custody of the BHA for treatment for a period of up to ninety days. At the end of the ninety-day period, the treatment facility shall automatically discharge the person unless the BHA, before expiration of the ninety-day period, obtains a court order for the person's recommitment on the grounds set forth in subsection (1) of this section for a further period of ninety days unless discharged sooner. If a person has been committed because the person is a person with a substance use disorder who is likely to inflict physical harm on another, the BHA shall apply for recommitment if, after examination, it is determined that the likelihood to inflict physical harm on another still exists.

(8) A person who is recommitted as provided for in subsection (7) of this section and who has not been discharged by the BHA before the end of the ninety-day period is discharged at the expiration of that ninety-day period unless the BHA, before expiration of the ninety-day period, obtains a court order on the grounds set forth in subsection (1) of this section for recommitment for a further period, not to exceed ninety days. If a person has been committed because the person is a person with a substance use disorder who is likely to inflict physical harm on another, the BHA shall apply for recommitment if, after examination, it is determined that the likelihood to inflict physical harm on another still exists. Only two recommitment orders pursuant to subsection (7) of this section and this subsection (8) are permitted.

(9) Upon the filing of a petition for recommitment under subsections (7) and (8) of this section, the court shall fix a date for hearing not later than ten days, excluding weekends and holidays, after the date the petition was filed unless a valid medical reason exists for delaying the hearing. A copy of the petition and of the notice of hearing shall be served and provided as required in subsection (3) of this section. At the hearing, the court shall proceed as provided in subsection (4) of this section.

(10) The BHA shall provide adequate and appropriate treatment of a person committed to its custody. The BHA may transfer any person committed to its custody from one approved treatment facility to another, if transfer is advisable.

(11) The BHA shall discharge a person committed to its custody for treatment at any time before the end of the period for which the person has been committed if either of the following conditions is met:

(a) In the case of a person with a substance use disorder committed on the grounds that the person is likely to inflict physical harm upon another, that the person no longer has a substance use disorder that requires treatment or the likelihood to inflict physical harm upon another no longer exists; or

(b) In the case of a person with a substance use disorder committed on the grounds of the need of treatment and incapacity, that the incapacity no longer exists, or in the case of a person with a substance use disorder committed on any grounds pursuant to this section, that further treatment is not likely to bring about significant improvement in the person's condition, or treatment is no longer appropriate, or that further treatment is unlikely to be beneficial.

(12) The court shall inform the person whose commitment or recommitment is sought of the person's right to contest the application, to be represented by counsel at every stage of any proceedings relating to the person's commitment and recommitment, and to have counsel appointed by the court or provided by the court if the person wants the assistance of counsel and is unable to obtain counsel. If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel for the person regardless of the person's wishes. The person whose commitment or recommitment is sought shall be informed of the person's right to be examined by a licensed physician of the person's choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician.

(13) If a private treatment facility agrees with the request of a competent patient or the patient's parent, sibling, adult child, or guardian to accept the patient for treatment, the administrator of the public treatment facility shall transfer the patient to the private treatment facility.

(14) A person committed under this article 81 may at any time seek to be discharged from commitment by an order in the nature of habeas corpus.

(15) The venue for proceedings under this section is the county in which the person to be committed resides or is present.

(16) All proceedings conducted pursuant to this article 81 are conducted by the district attorney of the county where the proceeding is held or by an attorney acting for the district attorney appointed by the court for that purpose; except that, in any county or in any city and county having a population exceeding one hundred thousand persons, the proceedings shall be conducted by the county attorney or by an attorney acting for the county attorney appointed by the court.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 741, § 2, effective April 29. **L. 2017:** (1), (3), (5), (6), (7), (8), (10), and (11) amended, (SB 17-242), ch. 263, p. 1368, § 279, effective May 25. **L. 2020:** Entire section amended, (SB 20-007), ch. 286, p. 1401, § 21, effective July 13. **L. 2022:** (1) amended, (HB 22-1326), ch. 225, p. 1672, § 54, effective July 1; (1), (3)(a)(I), (3)(b), (3)(c), (5), (6), (7), (8), (10), and IP(11) amended, (HB 22-1278), ch. 222, p. 1572, § 186, effective July 1.

Editor's note: (1) This section is similar to former § 25-1-311 as it existed prior to 2010.

(2) Amendments to subsection (1) by HB 22-1278 and HB 22-1326 were harmonized.

Cross references: (1) For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

(2) For the legislative declaration in HB 22-1326 stating the purpose of, and the provision directing legislative staff agencies to conduct, a post-enactment review pursuant to § 2-2-1201 scheduled in 2025, see sections 1 and 55 of chapter 225, Session Laws of Colorado 2022. To obtain a copy of the review, once completed, go to "Legislative Resources and Requirements" on the Colorado General Assembly's website.

ANNOTATION

Applied in People in Interest of N.G., 2025 COA 92, 582 P.3d 1042.

27-81-113. Records of persons with substance use disorders, persons intoxicated by alcohol, and persons under the influence of substances.

(1) The registration and other records of treatment facilities are confidential and fully protected as outlined in federal confidentiality regulations for substance use disorder records found at 42 CFR part 2, as amended, and are privileged to the patient.

(2) Notwithstanding subsection (1) of this section, the commissioner may make available information from patients' records for purposes of research into the causes and treatment of substance use disorders. Information made available pursuant to this subsection (2) must not be published in a way that discloses patients' names or other identifying information.

(3) Nothing in this section prohibits or limits the sharing of information by a state institution of higher education police department to authorized university administrators pursuant to section 23-5-141.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 743, § 2, effective April 29. **L. 2011:** (3) added, (HB 11-1169), ch. 119, p. 374, § 4, effective April 20. **L. 2017:** (2) amended, (SB 17-242), ch. 263, p. 1370, § 280, effective May 25. **L. 2020:** Entire section amended, (SB 20-007), ch. 286, p. 1404, § 22, effective July 13. **L. 2022:** (2) amended, (HB 22-1278), ch. 222, p. 1573, § 187, effective July 1.

Editor's note: This section is similar to former § 25-1-312 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-81-114. Rights of persons receiving evaluation, care, or treatment.

(1) A facility shall immediately advise each person receiving evaluation, care, or treatment under any provision of this article 81, orally and in writing, that the person has and is afforded the following rights:

(a) To be evaluated to determine the person's behavioral health treatment needs relating to the use of substances, including alcohol or drugs;

(b) If under an emergency commitment pursuant to section 27-81-111, to refuse to be examined by a licensed physician for certification. A person's refusal to be examined for certification may be alleged in a petition for involuntary commitment. A person may request to be examined by the person's physician, or a court may order a person to be evaluated by a licensed physician for certification.

(c) To receive timely medical and behavioral health care and treatment, as specified in law, that is determined based on the person's needs and that is delivered in the least restrictive treatment setting possible, as set forth in BHA rules;

(d) To be treated fairly and to receive the same consideration and access to appropriate services as others, regardless of race, color, national origin, age, gender identity, gender expression, sexual orientation, political affiliation, religious beliefs, financial status, or disability;

(e) To contest a commitment proceeding or to enter into a stipulated order of the court for committed treatment;

(f) To retain and consult with an attorney at any time and to have an attorney appointed by or provided by the court in a timely manner in any proceedings relating to commitment or recommitment if the person wants the assistance of an attorney and is unable to obtain an attorney;

(g) To at any time seek to be discharged from commitment by an order in the nature of habeas corpus;

(h) Once no longer under the influence of drugs or intoxicated by alcohol, to sign in and seek voluntary substance use disorder treatment, unless the administrator determines in writing that reasonable grounds exist to believe that the person will not remain in voluntary treatment or that the person is clearly dangerous to the health and safety of himself or herself or others;

(i) If in committed treatment, to receive twenty-four-hour notice prior to being transferred to another facility;

(j) To have reasonable opportunities for continuing visitation and communication with the person's family and friends, consistent with an effective treatment program and as determined in BHA rules. Each person may meet with the person's attorney, clergyperson, or health-care provider at any time.

(k) To have reasonable access to mail and writing materials, including postage, as well as the assistance of facility staff if the person is unable to write, prepare, or mail correspondence;

(l) Subject to BHA rules relating to the use of telephones and other communication devices, to have reasonable access to telephones or other communication devices, and to make and to receive calls or communications in privacy. Facility staff shall not open, delay, intercept, read, or censor mail or other communications or use mail or other communications as a method to enforce compliance with facility staff.

(m) To wear his or her own clothes, keep and use personal possessions, and keep and be allowed to spend a reasonable sum of the person's own money;

(n) To have access to medical records;

(o) To have treatment records remain confidential, except as required by law;

(p) To not be fingerprinted, unless required by law;

(q) To refuse to be photographed, except for treatment facility identification purposes;

(r) To have the opportunity to register and vote by absentee ballot with the assistance of facility staff;

(s) To have appropriate access to adequate food, water, and hygiene products;

(t) To have physical privacy in showering, changing, and using the restroom; and

(u) To be free of restraints and solitary confinement.

(2) Only qualified staff providing evaluation, treatment, or care for a person may deny or restrict the person's rights under subsection (1) of this section if the person's health or safety would be clearly endangered if the rights were not denied or restricted. If a person's rights are denied or restricted, the reason for the denial or restriction must be explained to the person and entered into the person's treatment record. The facility shall provide the person and the person's attorney the information pertaining to a denial or restriction of rights contained in the person's treatment record. The person's rights must be immediately restored as soon as the person's health and safety are no longer clearly endangered.

(3) A person receiving evaluation, care, or treatment under any provision of this article 81 may submit a grievance or complaint against the facility or facility staff pursuant to a grievance or complaint process, which is explained to the person in detail and included with the oral and written explanation of rights.

(4) As part of the immediate oral and written advisement of the rights enumerated in this section, a facility shall also include the telephone number and email address for the office of the ombudsman for behavioral health access to care, created in section 27-80-303. The written advisements must be translated if the person cannot read or understand English. The administrator shall cause the rights enumerated in this section to be posted in a prominent location where clients in the facility reside, which posting must also include the number and email address for the office of the ombudsman for behavioral health access to care, created in section 27-80-303.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 743, § 2, effective April 29. **L. 2020:** Entire section R&RE, (SB 20-007), ch. 286, p. 1404, § 23, effective July 13. **L. 2021:** (1)(d) amended, (HB 21-1108), ch. 156, p. 897, § 43, effective September 7. **L. 2022:** (1)(c), (1)(j), and (1)(l) amended, (HB 22-1278), ch. 222, p. 1574, § 188, effective July 1.

Editor's note: This section is similar to former § 25-1-313 as it existed prior to 2010.

Cross references: For the legislative declaration in HB 21-1108, see section 1 of chapter 156, Session Laws of Colorado 2021.

27-81-115. Emergency service patrol - establishment - rules.

(1) The BHA and cities, counties, city and counties, and regional service authorities may establish emergency service patrols. A patrol consists of persons trained to give assistance in the streets and in other public places to persons who are intoxicated by alcohol, under the influence of drugs, or incapacitated by substances. Members of an emergency service patrol must be capable of providing first aid in emergency situations and are authorized to transport a person intoxicated by alcohol, under the influence of drugs, or incapacitated by substances to the person's home and to and from treatment facilities.

(2) The commissioner shall adopt rules for the establishment, training, and conduct of emergency service patrols.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 744, § 2, effective April 29. **L. 2017:** (1) amended, (SB 17-242), ch. 263, p. 1370, § 281, effective May 25. **L. 2020:** (1) amended, (SB 20-007), ch. 286, p. 1407, § 24, effective July 13. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1574, § 189, effective July 1.

Editor's note: This section is similar to former § 25-1-314 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-81-116. Payment for treatment - financial ability of patients.

(1) If treatment is provided by an approved public treatment facility and the patient, including a committed person, has not paid the charge therefor, the approved treatment facility is entitled to any payment received by the patient or to which the patient may be entitled because of the services rendered and from any public or private source available to the approved treatment facility because of the treatment provided to the patient. The approved treatment facility may seek and obtain a judgment in an appropriate court for any fees or charges that have not been paid.

(2) A patient in an approved treatment facility, or the estate of the patient, or a person obligated to provide for the cost of treatment and having sufficient financial ability is liable to the approved treatment facility for the cost of maintenance and treatment of the patient therein in accordance with rates established. The approved treatment facility may seek and obtain a judgment in an appropriate court for any fees or charges that have not been paid.

(3) The commissioner shall adopt rules that establish a standardized ability-to-pay schedule, under which those with sufficient financial ability are required to pay the full cost of services provided and those who are totally without sufficient financial ability are provided appropriate treatment at no charge. The schedule shall take into consideration the income, including government assistance programs, savings, and other personal and real property, of the person required to pay and any support the person required to pay furnishes to another person as required by law.

(4) Nothing in this section shall prohibit an approved treatment facility from charging a minimal fee for therapeutic purposes.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 744, § 2, effective April 29. **L. 2022:** (3) amended, (HB 22-1278), ch. 222, p. 1574, § 190, effective July 1.

Editor's note: This section is similar to former § 25-1-315 as it existed prior to 2010.

27-81-117. Criminal laws - limitations.

(1) A county, municipality, or other political subdivision may not adopt or enforce a local law, ordinance, resolution, or rule having the force of law that includes drinking, being a person with an alcohol use disorder, or being found in an intoxicated condition as one of the elements of the offense giving rise to a criminal or civil penalty or sanction.

(2) A county, municipality, or other political subdivision shall not interpret or apply any law of general application to circumvent the provisions of subsection (1) of this section.

(3) Nothing in this article 81 affects any law, ordinance, resolution, or rule against drunken driving, driving under the influence of alcohol or drugs, or other similar offense involving the operation of a vehicle, an aircraft, or a boat or machinery or other equipment or regarding the sale, purchase, dispensing, possessing, or use of drugs or alcoholic beverages at stated times and places or by a particular class of persons.

(4) The fact that a person is intoxicated by alcohol, under the influence of drugs, or incapacitated by substances does not prevent the person's arrest or prosecution for the commission of any criminal act or conduct not enumerated in subsection (1) of this section.

(5) Nothing in this article 81 limits the right of a police officer to make an otherwise legal arrest, notwithstanding the fact that the arrested person may be intoxicated by alcohol, under the influence of drugs, or incapacitated by substances.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 744, § 2, effective April 29. **L. 2017:** (1) amended, (SB 17-242), ch. 263, p. 1370, § 282, effective May 25. **L. 2020:** Entire section amended, (SB 20-007), ch. 286, p. 1407, § 25, effective July 13.

Editor's note: This section is similar to former § 25-1-316 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-81-118. Opioid crisis recovery funds advisory committee - creation - membership - purpose.

(1) There is created the opioid crisis recovery funds advisory committee, referred to in this section as the "committee", which is created to advise and collaborate with the department of law on uses of any custodial funds received by the state as the result of opioid-addiction-related litigation and for which the use of the funds is not predetermined or committed by court order or other action by a state or federal court of law.

(2) (a) The committee consists of members appointed as follows:

(I) Thirteen members appointed by the governor, including:

(A) One member licensed to practice medicine pursuant to article 240 of title 12;

(B) One member licensed to practice pharmacy pursuant to article 280 of title 12;

(C) One member licensed to practice as a nurse or as a certified midwife pursuant to part 1 of article 255 of title 12;

(D) One member licensed as a dentist pursuant to article 220 of title 12;

(E) One member licensed as a veterinarian pursuant to article 315 of title 12;

(F) One member licensed as a physical therapist pursuant to article 285 of title 12;

(G) One member representing a local public health agency;

(H) One member who has been affected by the opioid crisis;

(I) One family member of a person who has been affected by the opioid crisis;

(J) One member representing an advocacy organization for people with substance use disorders;

(K) Two members appointed from nominees submitted by statewide organizations representing counties, with one member representing the western slope and one member representing the eastern part of the state; and

(L) One member from an association that represents behavioral health providers;

(II) Two members appointed by the commissioner, one of whom must represent an association of substance use providers;

(III) Two members appointed by the executive director of the department of public health and environment, one of whom is a pain management patient;

(IV) One member appointed by the executive director of the department of regulatory agencies;

(V) One member appointed by the executive director of the department of health care policy and financing;

(VI) One member from the state substance abuse trend and response task force, created in section 18-18.5-103, appointed by the attorney general;

(VII) One member from the center for research into substance use disorder prevention, treatment, and recovery support strategies, created in section 27-80-118 (3), appointed by the director of the center;

(VIII) One member from each safety net hospital that provides addiction services, appointed by the hospital;

(IX) One member from the Colorado district attorneys' council, or any successor organization, appointed by its executive director;

(X) Two members representing law enforcement agencies, one of whom is appointed by the Colorado association of chiefs of police, or any successor organization, and one of whom is appointed by the county sheriffs of Colorado, or any successor organization; and

(XI) One member representing the Colorado municipal league, or any successor organization, appointed by the president of the executive board of the Colorado municipal league or the president's designee.

(b) The attorney general shall notify the appointing authorities if the state receives a settlement or damage award for which the use of the custodial funds is not predetermined or committed by court order or other action by a state or federal court of law. The appointing authorities shall make their initial appointments to the committee no later than ninety days after receiving the notice.

(3) Each member of the committee who is appointed pursuant to subsection (2) of this section serves at the pleasure of the appointing authority that appointed the member. The appointing authority shall fill a vacancy in the same manner as the initial appointment.

(4) If the state receives custodial funds from a settlement or damage award from opioid-addiction-related litigation and the use of the funds is not predetermined or committed by court order or other action by a state or federal court of law, the attorney general shall convene and call a meeting of the committee, and any subsequent meetings as necessary, to seek input and recommendations from the committee on the proper expenditure of the funds received.

(5) (a) Each member of the committee shall maintain confidentiality throughout the process of determining the proper expenditure of custodial funds. Members shall not disclose the contents of any requests for funding with anyone outside of the committee.

(b) Each committee member shall affirm that the member does not have a personal or financial interest regarding any organization that may request funding. Members shall disclose all potential conflict of interest situations to the attorney general before reviewing funding requests.

Source: L. 2020: (2)(a)(I)(C) amended, (HB 20-1183), ch. 157, p. 705, § 67, effective July 1; entire section added, (SB 20-007), ch. 286, p. 1407, § 26, effective July 13. **L. 2022:** (2)(a)(II) amended, (HB 22-1278), ch. 222, p. 1575, § 191, effective July 1. **L. 2023:** (2)(a)(I)(C) amended, (SB 23-167), ch. 261, p. 1551, § 65, effective May 25.

Editor's note: (1) This section was added with amended provisions relocated from § 27-82-114.

(2) Subsection (2)(a)(I)(C) was numbered as § 27-82-114 (2)(a)(I)(C) in HB 20-1183. That provision was harmonized with and relocated to this section as this section appears in SB 20-007.

ARTICLE 82

Maternal and Child Health Pilot Program

PART 1
GENERAL PROVISIONS

27-82-101 to

27-82-114. (Repealed)

PART 2
MATERNAL AND CHILD HEALTH PILOT PROGRAM

27-82-201. Legislative declaration.

27-82-202. Definitions.

27-82-203. Maternal and child health pilot program - created - eligibility of grant recipients - rules - report.
27-82-204. Funding for pilot program.
27-82-205. Repeal of part. (Repealed)

PART 1

GENERAL PROVISIONS

27-82-101 to 27-82-114. (Repealed)

Source: L. 2020: Entire part repealed, (SB 20-007), ch. 286, p. 1410, § 27, effective July 13.

Editor's note: (1) This part 1 was added with relocations in 2010, except for §§ 27-82-103.5 and 27-82-114, which were added in 2019. For amendments to this part 1 prior to its repeal in 2020, consult the 2019 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

(2) This part 1 was repealed and relocated to various sections within article 81 of title 27 in 2020.

PART 2

MATERNAL AND CHILD HEALTH PILOT PROGRAM

27-82-201. Legislative declaration.

The general assembly finds and declares that facilities that provide treatment to individuals with a substance use disorder, including medication-assisted treatment, and clinics that provide obstetric and gynecological health-care services would better serve pregnant and postpartum women if the services could be coordinated and provided to women at the same location. It is the intent of the general assembly to fund a pilot program to integrate these health-care services at specified facilities and clinics and require the BHA to evaluate the pilot program and report the results of the pilot program to the general assembly.

Source: L. 2019: Entire part added, (SB 19-228), ch. 276, p. 2607, § 13, effective May 23. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1575, § 192, effective July 1.

27-82-202. Definitions.

As used in this part 2, unless the context otherwise requires:

(1) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-50-102.

(1.5) "Clinic" means a site that provides obstetric and gynecological health care.

(2) "Licensed health-care provider" means a physician or physician assistant licensed pursuant to article 240 of title 12 or a nurse or certified midwife licensed pursuant to part 1 of article 255 of title 12.

(3) "Pilot program" means the maternal and child health pilot program created in section 27-82-203.

(4) "Treatment facility" means a health-care facility that provides substance use disorder or medication-assisted treatment and that is approved by the behavioral health administration pursuant to section 27-81-106.

Source: L. 2019: Entire part added, (SB 19-228), ch. 276, p. 2607, § 13, effective May 23. **L. 2020:** (2) amended, (HB 20-1183), ch. 157, p. 705, § 68, effective July 1; (4) amended, (SB 20-007), ch. 286, p. 1417, § 54, effective July 13. **L. 2022:** (1) and (4) amended and (1.5) added, (HB 22-1278), ch. 222, p. 1575, § 193, effective July 1. **L. 2023:** (2) amended, (SB 23-167), ch. 261, p. 1551, § 66, effective May 25.

27-82-203. Maternal and child health pilot program - created - eligibility of grant recipients - rules - report.

(1) There is created in the behavioral health administration the maternal and child health pilot program. The BHA shall administer the pilot program. The purpose of the pilot program is to:

(a) Provide grants to two treatment facilities to facilitate the integration of obstetric and gynecological health care; and

(b) Provide grants to four clinics to facilitate the integration of behavioral health, including substance use disorder treatment or medication-assisted treatment, into obstetric and gynecological health care at the clinics.

(2) The BHA shall determine the criteria for treatment facilities and clinics to be eligible to receive the grants.

(3) (a) (I) A treatment facility that is awarded a grant shall integrate prenatal, postpartum, and other health-care services delivered by licensed health-care providers into the services currently provided at the treatment facility.

(II) A treatment facility that is awarded a grant may use the grant to hire clinical staff and to provide clinical updates, including training staff and upgrading and changing technology platforms to support integrated care, in order to perform obstetric and gynecological health care within the treatment facility. A treatment facility with low patient volume may partner with other treatment facilities and clinics to provide integrated care.

(b) (I) A clinic that is awarded a grant shall integrate behavioral health-care services provided by social workers and other behavioral health-care professionals licensed pursuant to article 245 of title 12, including mental health services, substance use disorder treatment, or medication-assisted treatment, into the health-care services currently provided at the clinic.

(II) A clinic may use the grant for services including training clinical staff, upgrading and changing technology platforms to support integrated care, employing behavioral health-care providers, and coordinating and referring patients to behavioral health-care providers outside the clinic.

(4) The state board of human services within the department of human services, in consultation with the BHA, may promulgate rules to implement the pilot program. The rules must include:

(a) The procedures and timelines by which a treatment facility or clinic may apply for a grant;

(b) Grant application contents; and

(c) Criteria for determining eligibility for and the amount of each grant awarded to a treatment facility or clinic.

(5) The commissioner of the BHA shall determine a process to evaluate the grant recipients and the integration of health care resulting from the pilot program. The BHA shall report the results of the pilot program to the public and behavioral health and human services and the health and insurance committees of the house of representatives and the health and human services committee of the senate, or their successor committees.

Source: L. 2019: Entire part added, (SB 19-228), ch. 276, p. 2607, § 13, effective May 23. **L. 2022:** IP(1), (2), IP(4), and (5) amended, (HB 22-1278), ch. 222, p. 1575, § 194, effective July 1.

27-82-204. Funding for pilot program.

(1) (a) For the 2021-22 fiscal year, and each fiscal year thereafter, the general assembly shall appropriate money from the marijuana tax cash fund created in section 39-28.8-501 (1) to the BHA to implement the pilot program. The BHA may use a portion of the money annually appropriated for the pilot program to pay the direct and indirect costs incurred to administer the pilot program.

(b) If any unexpended or uncommitted money appropriated for a fiscal year remains at the end of that fiscal year, the BHA may expend the money in accordance with this section in the succeeding fiscal year without further appropriation.

(2) The BHA may solicit, accept, and expend any gifts, grants, or donations from private or public sources to implement or administer the pilot program.

Source: L. 2019: Entire part added, (SB 19-228), ch. 276, p. 2609, § 13, effective May 23. **L. 2021:** (1) amended, (SB 21-137), ch. 362, p. 2381, § 26, effective June 28. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1576, § 195, effective July 1.

Cross references: For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

27-82-205. Repeal of part. (Repealed)

Source: L. 2019: Entire part added, (SB 19-228), ch. 276, p. 2609, § 13, effective May 23. **L. 2021:** Entire section repealed, (SB 21-137), ch. 362, p. 2387, § 36, effective June 28.

Cross references: For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

INSTITUTIONS

ARTICLE 90

Institutions - Department of Human Services

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27-90-100.3. Definitions.

As used in this article, unless the context otherwise requires:

(1) "Department" means the department of human services created in section 26-1-105, C.R.S.

(2) "Executive director" means the executive director of the department of human services.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 755, § 2, effective April 29.

27-90-101. Executive director - division heads - interagency council - advisory boards.

(1) (a) Medical personnel employed at any of the institutions subject to the control of the executive director, the medical director of which is licensed to practice medicine in this state, shall be exempt from the provisions of the "Colorado Medical Practice Act", article 240 of title 12, with respect to service rendered to bona fide patients or inmates at those institutions, if such personnel: Are licensed to practice medicine in any other state of the United States or any province of Canada; have satisfactorily completed an internship of not less than one year in the United States, Canada, or Puerto Rico in a hospital approved for that purpose by the American medical association; have satisfactorily completed three years of postgraduate residency training, or its equivalent, in their particular specialty in a hospital approved for that purpose by the American Medical Association; and can read, write, speak, and understand the English language. Proof that the requirements have been met shall be submitted to and approved or disapproved by the executive director.

(b) All personnel who cannot satisfy all of the requirements set forth in subsection (1)(a) of this section shall be exempt from the "Colorado Medical Practice Act", article 240 of title 12, with respect to services rendered to bona fide patients or inmates at said institutions, if the personnel are of good moral character, are graduates of an approved medical college as defined in section 12-240-104 (3), have completed an approved internship of at least one year as defined in section 12-240-104 (2) within nine months after first being employed, pass the examinations approved by the Colorado medical board under the "Colorado Medical Practice Act" and the National Board of Medical Examiners, the National Board of Examiners for Osteopathic Physicians and Surgeons, or the Federation of State Medical Boards, or their successor organizations, on subjects relating to the basic sciences, are able to read, write, speak, and understand the English language, and, in the case of personnel who are not citizens of the United States, become citizens within the minimum period of time within which the particular individual can become a citizen according to the laws of the United States and the regulations of the immigration and naturalization service of the United States, department of justice, or any successor agency, or within such additional time as may be granted by said boards.

(c) Medical personnel granted exemption under paragraphs (a) and (b) of this subsection (1) may not practice medicine except as described in this subsection (1) without first complying with all of the provisions of the "Colorado Medical Practice Act".

(2) The governor may appoint an interagency council to serve at his or her pleasure, to be composed of such representatives as he or she may select from the departments of public health and environment, labor and employment, health care policy and financing, human services, personnel, and such other state officers and officials as he or she may deem appropriate.

(3) The governor may appoint advisory boards to consult with the executive director and the chief officer of any institution within the jurisdiction of the department. Any such advisory board shall consist of not less than five nor more than fifteen persons recognized or known to be

interested and informed in the area of the institution's purpose and function. Members of the advisory boards shall serve without compensation but may be reimbursed for actual and necessary expenses incurred in attending regular meetings. Advisory boards established pursuant to this subsection (3) shall meet quarterly and during any interim on call of the executive director.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 755, § 2, effective April 29; (1)(b) amended, (HB 10-1260), ch. 403, p. 1990, § 87, effective July 1. **L. 2011:** (1)(b) amended, (HB 11-1303), ch. 264, p. 1172, § 82, effective August 10. **L. 2019:** (1)(a) and (1)(b) amended, (HB 19-1172), ch. 136, p. 1714, § 203, effective October 1.

Editor's note: (1) This section is similar to former § 27-1-102 as it existed prior to 2010.

(2) Subsection (1)(b) was numbered as § 27-1-102 (2)(c) in House Bill 10-1260 (see L. 2010, p. 1990) but was relocated due to its harmonization with this section as it was added by Senate Bill 10-175.

27-90-102. Duties of executive director - governor acquire water rights - rules.

(1) The duties of the executive director are:

(a) To manage, supervise, and control the charitable, behavioral or mental health, custodial, and special educational public institutions operated and supported by the state; to manage and supervise the special agencies, departments, boards, and commissions transferred to or established within the department by law; to improve, develop, and carry forward programs of therapy, counseling, and aftercare to the end that a person dependent upon tax-supported programs may be afforded opportunity and encouragement to overcome the disability causing his or her partial or total dependence upon the state;

(b) To supervise the business, fiscal, budget, personnel, and financial operations of the department and the institutions and activities under his or her control;

(c) In consultation with the several superintendents, the chief officer of the Colorado mental health institute at Pueblo, the head of the administrative division for the Colorado mental health institute at Fort Logan, and the director of the division of planning, to develop a systematic building program providing for the projected, long-range needs of the institutions under his or her control;

(d) To classify the lands connected with the state institutions under his or her control and determine which are of such character as to be most profitably used for agricultural purposes,

taking into consideration the needs of all state institutions for the food products that can be grown or produced thereon and the relative value of such agricultural use in the treatment or rehabilitation of the persons confined in those institutions;

(e) To the extent practical, to utilize the staff and services of other state agencies and departments, within their respective statutory functions, including administrative law judges appointed pursuant to part 10 of article 30 of title 24, C.R.S., to carry out the purposes of this article;

(f) To examine and evaluate each child committed to the department and to place each child committed pursuant to section 19-2.5-1525;

(g) To transfer between appropriate state institutions children committed to the department pursuant to section 19-2.5-1532;

(h) To require of the head of each institution and agency assigned to the department an annual report containing information, and submitted at a time, as the executive director decides;

(i) To exercise control over publications of the department and subdivisions thereof and cause publications that are approved for circulation in quantity outside the executive branch to be issued in accordance with the provisions of section 24-1-136, C.R.S.;

(j) To implement the procedures regarding children who are in detention or who have or may have a behavioral or mental health disorder or an intellectual and developmental disability specified in the provisions of the "Colorado Children's Code" contained in articles 1, 2.5, and 3 of title 19;

(k) To carry out the duties prescribed in article 11.7 of title 16, C.R.S.; and

(l) To provide information to the director of research of the legislative council concerning population projections, research data, and the projected long-range needs of the institutions under the control of the executive director and any other related data requested by the director.

(2) The executive director shall have such other powers, duties, and functions as are prescribed for heads of principal departments in the "Administrative Organization Act of 1968", article 1 of title 24, C.R.S.

(3) On behalf of the state of Colorado, the governor is authorized to acquire water and water rights for the operation of the Colorado mental health institute at Fort Logan. Title to that property may be acquired in fee simple absolute by purchase, donation, or the exercise of the power of eminent domain through condemnation proceedings in accordance with law from funds made available by the general assembly.

(4) (a) (I) The executive director shall appoint a board of medical consultants.

(II) The executive director shall determine the membership of the board based on the medical and surgical needs of the department.

(III) The executive director shall determine the qualifications for appointment to the board of medical consultants; except that all members of the board shall be licensed by the Colorado medical board pursuant to article 240 of title 12.

(b) A person serving on the board of medical consultants shall provide not more than one thousand hours of consultation per year in his or her capacity as a board member.

(c) Members of the board of medical consultants shall be compensated at a rate that shall be approved by the executive director. Compensation shall be paid from available funds of the department.

(d) The board members shall act as medical consultants to the department with respect to persons receiving services from the institutions listed in section 27-90-104 and from any institution operated pursuant to part 10 of article 2.5 of title 19.

(e) A member of the board of medical consultants, for all activities performed within the course and scope of his or her responsibilities to the department, is a "public employee" as defined in section 24-10-103 (4), C.R.S.

(5) (a) The executive director shall have authority to adopt "executive director rules", as described in section 26-1-108, C.R.S., for programs administered and services provided by the department as set forth in this title. The rules shall be promulgated in accordance with the provisions of section 24-4-103, C.R.S.

(b) Whenever a statutory grant of rule-making authority in this title refers to the department, state department, or the department of human services, it shall mean the department of human services acting through either the state board of human services or the executive director or both. When exercising rule-making authority under this title, the department, either acting through the state board or the executive director, shall establish rules consistent with the powers and the distinction between "board rules" as set forth in section 27-90-103 and "executive director rules" as set forth in this section.

(c) Any rules adopted by the state board of human services to implement the provisions of this title prior to March 25, 2009, whose content meets the definition of "executive director rules" shall continue to be effective until revised, amended, or repealed by the executive director.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 756, § 2, effective April 29; (4)(a)(III) amended, (HB 10-1260), ch. 403, p. 1991, § 88, effective July 1. **L. 2017:** IP(1), (1)(a), and (1)(j) amended, (SB 17-242), ch. 263, p. 1375, § 292, effective May 25. **L. 2019:** (4)(a)(III) amended, (HB 19-1172), ch. 136, p. 1715, § 204, effective October 1. **L.**

2021: (1)(f), (1)(g), and (4)(d) amended, (SB 21-059), ch. 136, p. 750, § 133, effective October 1. **L. 2022:** (1)(j) amended, (SB 22-212), ch. 421, p. 2981, § 68, effective August 10.

Editor's note: (1) This section is similar to former § 27-1-103 as it existed prior to 2010.

(2) Subsection (4)(a)(III) was numbered as § 27-1-103 (3)(a)(III) in House Bill 10-1260 (see L. 2010, p. 1991), but was relocated due to its harmonization with this section as it was added by Senate Bill 10-175.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-90-103. State board of human services - rules.

(1) The state board of human services, created in section 26-1-107, C.R.S., is authorized to adopt "board rules" as necessary to implement the programs administered and the services provided by the department as provided in this title. The rules shall be promulgated in accordance with the provisions of section 24-4-103, C.R.S.

(2) "Board rules" are rules promulgated by the state board of human services governing:

(a) Program scope and content;

(b) Requirements, obligations, and rights of clients and recipients;

(c) Nonexecutive director rules concerning vendors, providers, and other persons affected by acts of the department.

(3) (a) Any rules adopted by the executive director to implement the provisions of this title prior to March 25, 2009, whose content meets the definition of "board rules" shall continue to be effective until revised, amended, or repealed by the state board of human services.

(b) Any rules adopted by the state board to implement the provisions of this title prior to March 25, 2009, whose content meets the definition of "executive director rules" shall continue to be effective until revised, amended, or repealed by the executive director.

(4) Whenever a statutory grant of rule-making authority in this title refers to the department, the state department, or the department of human services, it shall mean the department of human services acting through either the state board of human services or the executive director. When exercising rule-making authority under this title, the state department, either acting through the state board or the executive director, shall establish rules consistent with the powers

and the distinction between "board rules" as set forth in this section and "executive director rules" as set forth in section 27-90-102.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 758, § 2, effective April 29.

Editor's note: This section is similar to former § 27-1-103.5 as it existed prior to 2010.

27-90-104. Institutions managed, supervised, and controlled.

(1) The department shall manage, supervise, and control the following state institutions:

(a) Colorado mental health institute at Pueblo;

(b) Wheat Ridge regional center;

(c) Grand Junction regional center;

(d) Lookout Mountain school, at Golden;

(e) Mount View school, at Morrison;

(f) Colorado mental health institute at Fort Logan, in Denver;

(g) Golden Gate youth camp, in Gilpin county;

(h) Lathrop Park youth camp, in Huerfano county; and

(i) Pueblo regional center.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 759, § 2, effective April 29.

Editor's note: This section is similar to former § 27-1-104 as it existed prior to 2010.

27-90-105. Future juvenile detention facility needs.

(1) (a) The general assembly hereby finds and declares that currently there are no juvenile detention facilities with commitment beds or locked detention beds in the southwest portion of Colorado and that the nearest such facility in the Grand Junction or Glenwood Springs area is as

much as four hours away from some southwestern communities. As a result of this distance, authorities in the southwest region of the state often avoid detention even though such avoidance presents a public safety problem, and those juveniles who are taken to distant facilities lose the critical access to family members and local community agencies that would otherwise render their transitional return to the community less difficult.

(b) The general assembly further finds and declares that the juvenile population in detention is expected to increase by seventy and nine hundredths percent by the year 2002. In addition, the general assembly finds and declares that the juvenile commitment population is expected to increase by forty-nine and nine-tenths percent by the year 2002. The general assembly finds and declares that the growth patterns on the western slope of the state have led to a growth in population of at-risk youth and increased crime and that the office of youth services accordingly has experienced a shortfall of both detention and commitment beds in the western part of the state.

(c) The general assembly therefore determines that it would be appropriate to consider the need for the construction of a juvenile detention facility in southwest Colorado.

(2) (a) The department is directed to assess the need for, and to determine the community commitment to, a new multipurpose juvenile detention facility to be constructed in La Plata county that would serve the following detention and treatment needs of juveniles in the southwest portion of the state:

(I) Secure facility housing of juveniles who are detained on juvenile-related charges; and

(II) Secure facility and medium secure facility housing of juveniles who are committed to the division of youth services.

(b) In assessing the need for such a facility and the services to be rendered at such a facility, the department shall evaluate privatization options.

(3) The department shall present its findings, conclusions, and recommendations to the capital development committee of the general assembly on or before November 1, 1996.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 760, § 2, effective April 29. **L. 2017:** (2)(a)(II) amended, (HB 17-1329), ch. 381, p. 1985, § 67, effective June 6.

Editor's note: This section is similar to former § 27-1-104.4 as it existed prior to 2010.

27-90-106. Legislative review of facilities program plans for juvenile facilities. (Repealed)

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 761, § 2, effective April 29. **L. 2015:** Entire section repealed, (SB 15-270), ch. 296, p. 1220, § 21, effective June 5.

Editor's note: This section was similar to former § 27-1-104.5 as it existed prior to 2010.

27-90-107. Transfer of functions.

(1) The department has the authority to execute, administer, perform, and enforce the rights, powers, duties, functions, and obligations vested in the board of control of the state children's home, the board of control of the Mount View girls' school, and the division of administration of the division of parole prior to July 1, 1959.

(2) Except where the context plainly requires otherwise, "board" or "boards of control", with reference to the institutions and the division listed in subsection (1) of this section, means and refers to the department of human services.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 761, § 2, effective April 29.

Editor's note: This section is similar to former § 27-1-106 as it existed prior to 2010.

27-90-108. Transfer of employees, records, and property - retirement benefits protected - decision of governor.

(1) All employees of the division of administration of the division of parole and all employees of the boards of control enumerated in section 27-90-107 who were engaged in the performance of duties prescribed and supervised by the division of administration of the division of parole and the boards, respectively, and who were transferred to the department of institutions on July 1, 1959, shall retain all rights to retirement benefits under the laws of the state, and their services shall be deemed to have been continuous. All funds, accounts, books, records, documents, and equipment of the boards and the division of administration of the division of parole became the property of the department of institutions on July 1, 1959.

(2) All questions pertaining to the proper disposition of funds, accounts, books, records, documents, or equipment arising under this article and section 17-1-101, C.R.S., and caused by the transfer of powers, duties, rights, functions, and obligations from any board of control to the department of institutions shall be determined by the governor.

(3) Whenever in this article a department, agency, division, or unit thereof is transferred to the department of institutions, the provisions of subsections (1) and (2) of this section shall be declared applicable in effecting such transfer.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 761, § 2, effective April 29.

Editor's note: This section is similar to former § 27-1-107 as it existed prior to 2010.

27-90-109. Department may accept gifts, donations, and grants.

The department or any institution managed, supervised, and controlled by the department may accept or refuse to accept, on behalf of and in the name of the state, gifts, donations, and grants, including grants of federal funds, for any purpose connected with the work or programs of the department or of any such institution. The executive director, with the approval of the governor, has the power to direct the disposition of any such gift, donation, and grant so accepted for any purpose consistent with the terms and conditions under which given.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 762, § 2, effective April 29.

Editor's note: This section is similar to former § 27-1-108 as it existed prior to 2010.

27-90-110. Rules for this article 90 and certain provisions in title 19.

Pursuant to section 24-4-103, the department shall promulgate such rules as are necessary to implement the provisions of this article 90 and the procedures specified in sections 19-2.5-305, 19-2.5-1102, 19-2.5-1525, 19-2.5-1532, 19-3-403, 19-3-506, 19-3-507, and 19-3-508 regarding children who are in detention or who have or may have a behavioral or mental health disorder or an intellectual and developmental disability.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 762, § 2, effective April 29. **L. 2017:** Entire section amended, (SB 17-242), ch. 263, p. 1376, § 293, effective May 25. **L. 2021:** Entire section amended, (SB 21-059), ch. 136, p. 750, § 134, effective October 1.

Editor's note: This section is similar to former § 27-1-109 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-90-111. Employment of personnel - screening of applicants - disqualifications from employment - contracts - rules - definitions.

(1) The general assembly recognizes that many of the individuals receiving services from department employees pursuant to title 26 or this title 27 are unable to defend themselves and are therefore vulnerable to abuse or assault. It is the intent of the general assembly to minimize the potential for hiring and employing persons with a propensity toward abuse, assault, or similar offenses against others for positions that would provide them with unsupervised access to vulnerable persons. The general assembly declares that, in accordance with section 13 of article XII of the state constitution, for purposes of terminating employees in the state personnel system who are finally convicted of criminal conduct, offenses involving moral turpitude include, but are not limited to, the disqualifying offenses specified in subsection (9) of this section.

(2) For purposes of this section, unless the context otherwise requires:

(a) "Contracting agency" means an agency, corporation, nonprofit entity, or any other outside entity that contracts with the department to provide services pursuant to title 26 or this title 27 and that provides services that involve direct contact with vulnerable persons.

(b) "Conviction" means a verdict of guilty by a judge or jury or a plea of guilty or nolo contendere that is accepted by the court or adjudication for an offense that would constitute a criminal offense if committed by an adult. "Conviction" also includes having received a deferred judgment and sentence or deferred adjudication; except that a person shall not be deemed to have been convicted if the person has successfully completed a deferred sentence or deferred adjudication.

(b.5) "Department employee" means an employee of the department who is employed through the state personnel system of the state of Colorado.

(c) "Direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to vulnerable persons, regardless of the level of supervision of the department employee. "Direct contact" may include positions in which persons have access to or unsupervised time with clients or patients, including but not limited to maintenance personnel, housekeeping staff, kitchen staff, and security personnel.

(d) Repealed.

(d.5) "Independent contractor" means an individual who contracts directly with the department and who is designated, by the executive director or the executive director's designee, as serving in a contract position involving direct contact with vulnerable persons.

(e) "Vulnerable person" means any individual served by the department who is susceptible to abuse or mistreatment because of the individual's circumstances, including but not limited to the individual's age, disability, frailty, behavioral or mental health, intellectual and developmental disability, or ill health.

(3) The employment screening and disqualification requirements in this section apply to the following facilities or programs operated by the department:

(a) Any facility operated by the department for the care and treatment of persons with a mental health disorder pursuant to article 65 of this title 27;

(b) Any facility operated by the department for the care and treatment of persons with intellectual and developmental disabilities pursuant to article 10.5 of this title 27;

(c) Repealed.

(d) Any direct services identified and provided by the department in which department employees, independent contractors, or contracting agencies have direct contact with vulnerable persons in a state-operated facility or in a vulnerable person's home or residence;

(e) Veterans community living centers operated pursuant to article 12 of title 26, C.R.S.;

(f) Any facility directly operated by the department in which juveniles who are in the custody of the department reside, including detention or commitment centers; and

(g) Any secure facility contracted for by the department pursuant to section 19-2.5-1502 in which juveniles who are in the custody of the department reside.

(4) Prior to the department's permanent employment of a person in a position that would require that person to have direct contact with a vulnerable person, the executive director or any division head of the department shall make an inquiry to the director of the Colorado bureau of investigation to ascertain whether the person has a criminal history. The person's employment is conditional upon a satisfactory state and national fingerprint-based criminal history record check. A record check conducted pursuant to this subsection (4) must include but need not be limited to

arrests, conviction records, and the disposition of any criminal charges. The department shall require the person to have the person's fingerprints taken by a local law enforcement agency or any third party approved by the Colorado bureau of investigation. If an approved third party takes the person's fingerprints, the fingerprints may be electronically captured using Colorado bureau of investigation-approved livescan equipment. Third-party vendors shall not keep the applicant information for more than thirty days unless requested to do so by the applicant. The department shall forward those fingerprints to the Colorado bureau of investigation for the purpose of fingerprint processing utilizing the files and records of the Colorado bureau of investigation and the federal bureau of investigation. When the results of a fingerprint-based criminal history record check of a person performed pursuant to this section reveal a record of arrest without a disposition, the department shall require that person to submit to a name-based judicial record check, as defined in section 22-2-119.3 (6)(d). The department shall pay for the costs of record checks conducted pursuant to this section out of existing appropriations.

(5) The executive director or any division head shall contact previous employers of any person who is one of the top three finalists for a position that would require that person to have direct contact with any vulnerable person, for the purpose of obtaining information and recommendations that may be relevant to the person's fitness for employment. Any previous employer of an applicant for employment who provides information to the executive director or a division head or who makes a recommendation concerning the person shall be immune from civil liability unless the information is false and the previous employer knows such information is false or acts with reckless disregard concerning the veracity of the information.

(6) Any local agency or provider of services pursuant to this title or title 26, C.R.S., may investigate applicants for employment.

(7) The executive director, any division head, or any local agency or provider who relies on information obtained pursuant to this section in making an employment decision or who concludes that the nature of any information disqualifies the person from employment as either a department employee or an independent contractor is immune from civil liability for that decision or conclusion unless the information relied upon is false and the executive director, division head, or local agency or provider knows the information is false or acts with reckless disregard concerning the veracity of the information.

(8) The executive director may promulgate such rules as are necessary to implement the provisions of this section.

(9) (a) If the criminal history record check conducted pursuant to subsection (4) or (11) of this section indicates that a prospective department employee or prospective independent contractor was convicted of any of the disqualifying offenses set forth in subsection (9)(b) or (9)(c) of this section, the person is disqualified from employment either as a department employee or as an independent contractor in a position involving direct contact with vulnerable persons. The department shall not hire or retain a person who is disqualified as a result of this

section for a position involving direct contact with vulnerable persons nor is the person eligible to contract for or continue in a contract position designated by the executive director or the executive director's designee as involving direct contact with vulnerable persons.

(b) Except as otherwise provided in subsection (9)(d) of this section, a person is disqualified from employment either as a department employee or as an independent contractor, regardless of the length of time that may have passed since the discharge of the sentence imposed for any of the following criminal offenses:

(I) A crime of violence, as defined in section 18-1.3-406, C.R.S.;

(II) Any felony offense involving unlawful sexual behavior, as defined in section 16-22-102 (9), C.R.S.;

(III) Any felony, the underlying factual basis of which has been found by the court on the record to include an act of domestic violence, as defined in section 18-6-800.3, C.R.S.;

(IV) Any felony offense of child abuse, as defined in section 18-6-401, C.R.S.; or

(V) Any felony offense in any other state, the elements of which are substantially similar to the elements of any of the offenses described in subparagraph (I), (II), (III), or (IV) of this paragraph (b).

(c) Except as otherwise provided in subsection (9)(d) of this section, a person is disqualified from employment either as a department employee or as an independent contractor if less than ten years have passed since the person was discharged from a sentence imposed for conviction of any of the following criminal offenses:

(I) Third degree assault, as described in section 18-3-204, C.R.S.;

(II) Any misdemeanor, the underlying factual basis of which has been found by the court on the record to include an act of domestic violence, as defined in section 18-6-800.3, C.R.S.;

(III) Violation of a protection order, as described in section 18-6-803.5, C.R.S.;

(IV) Any misdemeanor offense of child abuse, as defined in section 18-6-401, C.R.S.;

(V) Any misdemeanor offense of sexual assault on a client by a psychotherapist, as defined in section 18-3-405.5, C.R.S.; or

(VI) Any misdemeanor offense in any other state, the elements of which are substantially similar to the elements of any of the offenses described in subparagraph (I), (II), (III), (IV), or (V) of this paragraph (c).

(d) If a person was adjudicated a juvenile delinquent for the commission of any disqualifying offense set forth in either paragraph (b) or (c) of this subsection (9) and more than seven years have elapsed since the commission of the offense, the person may submit a written request to the

executive director as provided in subsection (13) of this section for reconsideration of the disqualification.

(10) (a) Any department employee who is employed in a position involving direct contact with vulnerable persons and who is arrested, charged with, or issued a summons and complaint for any of the disqualifying offenses set forth in subsection (9)(b) or (9)(c) of this section shall inform his or her supervisor of the arrest, charges, or issuance of a summons and complaint before returning to work. Any department employee who fails to make such a report or disclosure may be terminated from employment. The department or any facility operated by the department shall advise its employees and independent contractors in writing of the requirement for self-reporting of the disqualifying offenses set forth in subsection (9)(b) or (9)(c) of this section.

(b) Any department employee who is charged with any of the disqualifying offenses set forth in subsection (9)(b) of this section must be suspended until resolution of the criminal charges or completion of administrative action by the department. A department employee who is charged with any of the disqualifying offenses set forth in subsection (9)(c) of this section may be suspended at the discretion of the department until resolution of the criminal charges or completion of administrative action by the department. The department employee shall inform his or her supervisor of the disposition of the criminal charges. Any department employee who fails to report such information may be terminated from employment. Upon notification to the department that the department employee has received a conviction for any of the disqualifying offenses described in subsection (9)(b) or (9)(c) of this section, the department employee must be terminated from employment. Nothing in this subsection (10)(b) prohibits the department from taking administrative action if the department employee's conduct would justify disciplinary action under section 13 of article XII of the state constitution for failure to comply with standards of efficient service or competence or for willful misconduct, willful failure, or inability to perform his or her duties.

(11) The general assembly recognizes that the department contracts with persons to serve in positions that involve direct contact with vulnerable persons in state-operated facilities or to provide state-funded services that involve direct contact with vulnerable persons in the homes and residences of such vulnerable persons. In order to protect vulnerable persons who come into contact with these independent contractors, the executive director or his or her designee shall designate those contract positions that involve direct contact with vulnerable persons that are subject to the provisions of this subsection (11). In any contract initially entered into or renewed on or after July 1, 1999, concerning a contract position that has been designated as involving direct contact with vulnerable persons, the department shall include the following terms and conditions:

(a) That the independent contractor shall submit to a state and national fingerprint-based criminal history record check as described in subsection (4) of this section for state employees; except that the independent contractor shall bear the cost of such criminal history record checks;

(b) That the independent contractor shall report any arrests, charges, or summonses for any of the disqualifying offenses specified in subsection (9)(b) or (9)(c) of this section to the independent contractor's supervisor at the department before returning to work;

(c) That the independent contractor may be suspended or terminated, at the discretion of the department, prior to the resolution of the criminal charges for any of the disqualifying offenses specified in subsection (9)(b) or (9)(c) of this section;

(d) That, upon notification to the department that the independent contractor has been convicted for any of the disqualifying offenses described in subsection (9)(b) or (9)(c) of this section, the independent contractor's position with the department must be terminated.

(11.5) (a) The general assembly also recognizes that the department contracts with outside contracting agencies for services where the contracting agency's employees will have direct contact with vulnerable persons who receive services pursuant to title 26 and this title 27. To protect vulnerable persons who come into contact with employees of a contracting agency, the executive director, or his or her designee, shall designate those contracts that will involve direct contact with vulnerable persons and that are therefore subject to the provisions of this subsection (11.5). Any contract with a contracting agency that is initially entered into or is renewed on or after July 1, 2018, and that has been designated as a contract that involves direct contact with vulnerable persons, must include the following terms and conditions:

(I) The contracting agency shall submit its employees who will have direct contact with vulnerable persons as a result of the contract to a state and national fingerprint-based criminal history record check. The contracting agency shall provide the information required by subsection (4) of this section to the executive director or any division head of the department who works directly with the contracting agency.

(II) That the contracting agency shall require its employees who will have direct contact with vulnerable persons as a result of the contract to report any arrests, charges, or summonses for any of the disqualifying offenses specified in subsection (9)(b) or (9)(c) of this section to the contracting agency's supervisor before returning to work. The contracting agency's supervisor shall immediately notify the executive director or the respective division head of the department who works directly with the contracting agency upon notification of any such report made by an employee.

(III) That the contracting agency may be required to remove an employee from having direct contact with vulnerable persons, at the discretion of the department, prior to the resolution of the criminal charges for any of the disqualifying offenses specified in subsection (9)(b) or (9)(c) of this section;

(IV) That, upon notification to the department that the contracting agency's employee who has direct contact with vulnerable persons as a result of the contract has been convicted of any of the disqualifying offenses specified in subsection (9)(b) or (9)(c) of this section, such employee is no longer permitted to work in any capacity with the department where he or she would have direct contact with vulnerable persons as a result of the contract; and

(V) That, if the contracting agency fails to comply with subsections (11.5)(a)(I) to (11.5)(a)(IV) of this section, the contract may be immediately terminated.

(b) If the contracting agency is also licensed pursuant to section 26-6-905 and has conducted a criminal history record check pursuant to section 26-6-905 (8)(a)(III) for its employees who will have direct contact with vulnerable persons as a result of the contract, the department may accept such criminal history record check to satisfy the requirements of this subsection (11.5).

(12) A department employee, independent contractor, or employee of a contracting agency who is disqualified due to conviction of any of the disqualifying offenses set forth in subsection (9)(b) or (9)(c) of this section may submit a written request to the executive director for reconsideration of the disqualification. Reconsideration pursuant to this subsection (12) may only be based on a mistake of fact such as an error in the identity of the person for whom the criminal history record check was performed pursuant to subsection (11) of this section. If the executive director determines that there was a mistake of fact involving the identity of the person, the executive director shall issue a finding that the disqualifying factor is not a bar to the person's employment either as a department employee or as an independent contractor or employee of a contracting agency.

(13) (a) A department employee, an independent contractor, or an employee of a contracting agency who is disqualified for conviction of an offense specified in subsection (9)(c) of this section may submit a written request to the executive director for reconsideration of the disqualification and a review of whether the person poses a risk of harm to vulnerable persons. In reviewing a disqualification, the executive director shall give predominant weight to the safety of vulnerable persons over the interests of the disqualified person. The final determination must be based upon a review of:

(I) The seriousness of the disqualifying offense;

(II) Whether the person has a conviction for more than one disqualifying offense;

(III) The vulnerability of the victim at the time the disqualifying offense was committed;

(IV) The time elapsed without a repeat of the same or similar disqualifying offense;

(V) Documentation of successful completion of training or rehabilitation pertinent to the disqualifying offense; and

(VI) Any other relevant information submitted by the disqualified person.

(b) The decision of the executive director shall constitute final agency action.

(14) Nothing in this section shall be construed to preclude the department or the director of any facility operated by the department from adopting a policy regarding self-reporting of arrests, charges, or summonses or a policy regarding disqualification from employment that includes other offenses not set forth in paragraph (b) or (c) of subsection (9) of this section.

(15) (a) In considering any disciplinary action under section 24-50-125 (1) against an employee who is certified to any class or position in the state personnel system for engaging in mistreatment, abuse, neglect, or exploitation against a vulnerable person, the appointing authority shall give weight to the safety of vulnerable persons over the interests of any other person. For purposes of this subsection (15), "mistreatment", "abuse", "neglect", or "exploitation" shall have the same definitions as contained in article 22 of title 16, articles 3 and 6.5 of title 18, articles 1 and 3 of title 19, article 3.1 of title 26, and this article 90 and titles 38 and 42 of the code of federal regulations, as amended.

(b) If the appointing authority finds that the employee has engaged in mistreatment, abuse, neglect, or exploitation against a vulnerable person, the appointing authority may take such disciplinary action as the appointing authority deems appropriate, up to and including termination, taking into consideration the harm or risk of harm to vulnerable persons created by the employee's actions. Nothing in this subsection (15)(b) affects the constitutional or statutory due process rights afforded to an employee who is certified to any class or position in the state personnel system.

(c) This subsection (15) applies regardless of whether the employee has been charged with or convicted of a disqualifying offense under subsection (9)(b) or (9)(c) of this section.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 762, § 2, effective April 29. **L. 2013:** (3)(e) amended, (HB 13-1300), ch. 316, p. 1692, § 87, effective August 7. **L. 2014:** (3)(e) amended, (SB 14-096), ch. 59, p. 274, § 30, effective August 6. **L. 2015:** (3)(c)(II) added by revision, (SB 15-239), ch. 160, pp. 488, 490 §§ 8, 14. **L. 2017:** (2)(e), (3)(a), and (3)(b) amended, (SB 17-242), ch. 263, p. 1376, § 294, effective May 25; (4) amended, (SB 17-189), ch. 149, p. 504, § 14, effective August 9. **L. 2018:** (1), (2)(a), (2)(c), (3)(d), (4), (7), (9)(a), IP(9)(b), IP(9)(c), (10), (11), (12), and IP(13)(a) amended, (2)(b.5), (2)(d.5), and (11.5) added, and (2)(d) repealed, (HB 18-1411), ch. 238, p. 1484, § 2, effective May 24; (15) added, (HB 18-1065), ch. 142, p. 919, § 1, effective August 8. **L. 2019:** (4) amended, (HB 19-1166), ch. 125, p. 558, § 49, effective April 18. **L. 2021:** (3)(g) amended, (SB 21-059), ch. 136, p. 750, § 135, effective October 1. **L. 2022:** (4) amended, (HB 22-1270), ch. 114, p. 532, § 52, effective April 21; (11.5)(b) amended, (HB 22-1295), ch. 123, p. 865, § 121, effective July 1.

Editor's note: (1) This section is similar to former § 27-1-110 as it existed prior to 2010.

(2) Subsection (3)(c)(II) provided for the repeal of subsection (3)(c), effective July 1, 2016. (See L. 2015, pp. 488, 490.)

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-90-112. Youth neuro-psych facility - funding - repeal.

(1) Beginning July 1, 2022, the department of human services shall begin the process to create, develop, or contract for a neuro-psych facility. The neuro-psych facility must have a capacity of at least sixteen residential beds for Colorado youth who are less than twenty-one years of age. The department shall develop and implement admission criteria that ensures that Colorado children and youth, prior to being admitted, have been evaluated for the least restrictive level of care and that geographic location, current health-care provider, and payer type are not the primary determining factors in whether a youth has access to a bed at the neuro-psych facility.

(2) (a) (I) For the 2022-23 budget year, the general assembly shall appropriate money from the behavioral and mental health cash fund pursuant to section 24-75-230 to the department of human services to fund operational support for psychiatric residential treatment facilities for youth and qualified residential treatment programs for youth across the state as described in this subsection (2).

(II) Money spent pursuant to this subsection (2) must conform with the allowable purposes set forth in the federal "American Rescue Plan Act of 2021", Pub.L. 117-2, as amended. The department of human services shall spend or obligate such appropriation in accordance with section 24-75-226 (4)(d).

(b) This subsection (2) is repealed, effective September 1, 2027.

(3) The department of human services and any person that receives money from the department of human services shall comply with the compliance, reporting, record-keeping, and program evaluation requirements established by the office of state planning and budgeting and the state controller in accordance with section 24-75-226 (5).

Source: L. 2022: Entire section added, (HB 22-1283), ch. 185, p. 1244, § 6, effective May 18. **L. 2024:** (2)(a)(II) amended, (HB 24-1466), ch. 429, p. 2946, § 43, effective June 5.

Cross references: For the legislative declaration in HB 22-1283, see section 1 of chapter 185, Session Laws of Colorado 2022. For the legislative declaration in HB 24-1466, see section 1 of chapter 429, Session Laws of Colorado 2024.

ARTICLE 91

Institutions - General Administrative Provisions

27-91-101. Legislative declaration.
27-91-102. Boards of control entitled only to actual expenses.
27-91-103. Debts in excess of appropriation - emergencies.
27-91-104. The term "officer" includes members of boards.
27-91-105. Indebtedness limited to appropriation.
27-91-106. Violation - penalty.
27-91-107. Purchase of supplies by and from institutions.
27-91-108. Display of flags.
27-91-109. Personal display of flags.

27-91-101. Legislative declaration.

The purpose of this section and section 27-91-102 is to provide for the payment of actual expenses only, in lieu of stated salaries and mileage, to all members of boards of control of state institutions.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 768, § 2, effective April 29.

Editor's note: This section is similar to former § 27-2-101 as it existed prior to 2010.

27-91-102. Boards of control entitled only to actual expenses.

A member of a board of control, trustees, or commissioners of all institutions supported by or under the patronage and control of the state shall receive as compensation for his or her services only actual expenses incurred in attendance upon and in going to and returning from each regular and special meeting of the board of control, trustees, or commissioners or for performing any services whatever for the institution of which he or she is a member of the board of control,

trustees, or commissioners, payment to be made out of the funds appropriated for the support and maintenance of the respective institutions. In all cases of cash paid out by the member of a board of control, trustees, or commissioners, an itemized account, accompanied by the proper vouchers therefor, signed by the party to whom such money has been paid, shall accompany the vouchers upon which all warrants for such expenditures shall issue.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 768, § 2, effective April 29.

Editor's note: This section is similar to former § 27-2-102 as it existed prior to 2010.

27-91-103. Debts in excess of appropriation - emergencies.

The various officers designated by law to control and direct the fiscal affairs of the several state institutions shall not contract within any year any indebtedness in excess of the amount named in any appropriation made for the support of any state institution during that time; but, in cases of emergency, the governor may authorize the contraction of such indebtedness that in his or her judgment is absolutely necessary for the maintenance and support of the institution, until such time as the general assembly meets. The officers of any state institution, supported by the levy of any special tax, shall contract no indebtedness in any year in excess of eighty percent of the gross amount of the levy made for that year from which to support that institution.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 768, § 2, effective April 29.

Editor's note: This section is similar to former § 27-2-103 as it existed prior to 2010.

ANNOTATION

Applied in Hoyt v. Trustees of State Normal Sch., 96 Colo. 442, 44 P.2d 513 (1935) (decided prior to 2010 amendments to this article).

27-91-104. The term "officer" includes members of boards.

The term "officer" as used in section 27-91-105 includes any member of the various boards created by law to govern or supervise the respective state institutions.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 768, § 2, effective April 29.

Editor's note: This section is similar to former § 27-2-104 as it existed prior to 2010.

27-91-105. Indebtedness limited to appropriation.

It is unlawful for any officer of any state institution of this state to incur or contract any indebtedness for, on behalf of, or in the name of the state institution or in the name of the state in excess of the sum appropriated by the general assembly for the use or support of the institution for the fiscal year. An officer of any state institution shall not draw any money from the state treasury unless the same is absolutely needed and required by the institution at the time, and then only upon the warrant of the controller.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 768, § 2, effective April 29.

Editor's note: This section is similar to former § 27-2-105 as it existed prior to 2010.

27-91-106. Violation - penalty.

Any person who violates any of the provisions of section 27-91-105 is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than three hundred dollars.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 769, § 2, effective April 29.

Editor's note: This section is similar to former § 27-2-106 as it existed prior to 2010.

27-91-107. Purchase of supplies by and from institutions.

(1) The following designated state institutions are within the purview of this section: All facilities of the departments of corrections and human services, the Colorado mental health institute at Pueblo, the Wheat Ridge regional center, the Grand Junction regional center, the Pueblo regional center, the Lookout Mountain school at Golden, the Mount View school at Morrison, the Colorado industries for the blind, and the Colorado psychiatric hospital.

(2) When any of the institutions enumerated in subsection (1) of this section are in need of supplies that are grown, produced, or manufactured by any other of the institutions, it shall purchase the same from the other institution if it has a surplus thereof of suitable quality available for sale at a price not in excess of the current market price for such supplies, and it is the duty of the managing boards of such respective institutions to require observance of the provisions of this section.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 769, § 2, effective April 29.

Editor's note: This section is similar to former § 27-2-107 as it existed prior to 2010.

27-91-108. Display of flags.

(1) The chief administrative officer of any state institution supported in whole or in part by the state and under the control of the state shall have erected and maintained, at the entrance of the institution or on the principal administrative building or grounds thereof, a suitable flagstaff with the attachments necessary for the display of flags and shall cause to be displayed thereon the flags of the United States and of the state of Colorado. The flag of the state of Colorado shall be the same size as the flag of the United States with which it is displayed. If both flags are displayed on one flagstaff, the flag of the state of Colorado shall be placed below the flag of the United States.

(2) (a) The chief administrative officer of any court facility supported in whole or in part by the state and under the control of the state shall cause to be permanently and prominently displayed the flag of the United States, as described in chapter 1 of title 4, U.S.C., in each courtroom when a court proceeding is in session. A flag displayed in a courtroom must measure three by five feet. No alleged failure to cause the flag of the United States to be permanently and

prominently displayed in a courtroom supported in whole or in part by the state and under the control of the state shall be the basis of any challenge to such court's authority or jurisdiction or for any appeal of any decision, order, or judgment of such court.

(b) The flags of the United States and of the state of Colorado shall be permanently and prominently displayed in all committee rooms under the control of the general assembly of the state of Colorado.

(c) On and after September 1, 1996, the chief administrative officer of any school supported in whole or in part by the state and under the control of the state shall cause to be displayed permanently and prominently the flag of the United States, as described in chapter 1 of title 4, U.S.C., in each academic classroom when an academic class is in session. A flag displayed in an academic classroom shall measure no less than either twelve by eighteen inches if it is displayed in a frame or two by three feet if it is displayed on a flagstaff.

(3) The chief administrative officer of any school or court facility supported in whole or in part by the state and under the control of the state is hereby authorized to accept donations of flags to be displayed in classrooms or courtrooms pursuant to the provisions of subsection (2) of this section.

(4) (a) The chief administrative officer of any state institution, school, or court facility described in this section shall not permit the display of any depiction or representation of a flag of the United States that is intended for public view and permanently affixed or attached to any part of the building or grounds of said state institution, school, or court facility, and which display does not conform with 4 U.S.C. sec. 7.

(b) Nothing in this subsection (4) shall be construed to preclude the temporary display of any instructional or historical materials or student work product included as part of a lesson not permanently affixed or attached to any part of said building or grounds.

(5) Any flag of the United States displayed pursuant to this section shall be displayed as described in 4 U.S.C. sec. 7.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 769, § 2, effective April 29.

Editor's note: This section is similar to former § 27-2-108 as it existed prior to 2010.

27-91-109. Personal display of flags.

(1) The right to display reasonably the flag of the United States shall not be infringed with respect to the display:

(a) On an individual's person;

(b) Anywhere on an individual's personal or real property; and

(c) In the buildings or on the grounds of any tax-supported property in the state; except that the state or political subdivision that has jurisdiction over the building or grounds may adopt reasonable rules and regulations regarding the size, number, placement, manner of display, and lighting of the flag, and the location, size, and height of flagpoles.

(2) (a) Notwithstanding any provision of subsection (1) of this section to the contrary, the right with respect to an individual's real property shall be subject to reasonable restrictive covenants or equitable servitudes; except that no such covenant or servitude, nor any owners' association shall prohibit the outdoor display of the flag of the United States by a property owner on that owner's property if the flag is displayed in a manner consistent with chapter 1 of title 4 of the United States Code, as amended.

(b) Notwithstanding any provision of paragraph (a) of this subsection (2) to the contrary, an owners' association, the state, or a political subdivision may adopt reasonable rules and regulations regarding the size, number, placement, manner of display, and lighting of the flag, and the location, size, and height of flagpoles.

(3) For purposes of this section, "display reasonably" shall be presumed to include a display of the flag of the United States that is consistent with chapter 1 of title 4 of the United States Code, as amended.

(4) A right described in subsection (1) of this section is a civil right of free speech and a protected form of expression under the first amendment to the United States constitution and section 10 of article II of the state constitution.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 770, § 2, effective April 29.

Editor's note: This section is similar to former § 27-2-108.5 as it existed prior to 2010.

ARTICLE 92

Institutions - Charges for Patients

27-92-101. Liability.
27-92-102. Cost determination.
27-92-103. Extent of liability.
27-92-104. Determination of ability to pay.
27-92-105. Effect of determination.
27-92-106. Appeal.
27-92-107. Service.
27-92-108. Certificate - prima facie evidence.
27-92-109. Further actions.

27-92-101. Liability.

(1) When a person is admitted, committed, or transferred to a public institution of this state supervised by the department of human services for the care, support, maintenance, education, or treatment of persons with mental health disorders, the person, his or her spouse, and his or her parents are liable for the costs of his or her care, support, maintenance, and treatment to the extent and in the manner provided in this article 92. No other relatives of the person are liable to any extent for such costs.

(2) This article 92 also applies to those persons received pursuant to article 8 of title 16 and sections 16-13-216, 19-2.5-1525, and 19-2.5-1532, but not by way of exclusion.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 771, § 2, effective April 29. **L. 2017:** (1) amended, (SB 17-242), ch. 263, p. 1376, § 295, effective May 25. **L. 2021:** (2) amended, (SB 21-059), ch. 136, p. 751, § 136, effective October 1.

Editor's note: This section is similar to former § 27-12-101 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

ANNOTATION

Law reviews. For article, "Liability of Counties for Support of Inmates in State Institutions", see 29 Dicta 27 (1952). For article, "Commitment Procedures in Colorado", see 29 Dicta 273 (1952). For comment on State v. Estate of Burnell, 165 Colo. 205, 439 P.2d 38 (1969), appearing below, see 45 Den. L.J. 788 (1968). For article, "Protecting the Mentally Incompetent Child's Trust Interest from State Reimbursement Claims", see 58 Den. L.J. 557 (1981).

Annotator's note. Since § 27-92-101 is similar to § 27-12-101 as it existed prior to the 2010 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

Statutory scheme in this article is clear and unambiguous. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

For constitutionality of section, see Wigington v. State Home & Training Sch., 175 Colo. 159, 486 P.2d 417 (1971).

There is no constitutional inequality in requiring those receiving more expensive care to be liable for additional costs through assets which they may have accumulated. State v. Estate of Burnell, 165 Colo. 205, 439 P.2d 38 (1968).

A mental patient who voluntarily works in a state hospital and is not paid for such services is not unconstitutionally denied equal protection of the laws or subjected to slavery or involuntary servitude. In re Estate of Buzzelle v. Colo. State Hosp., 176 Colo. 554, 491 P.2d 1369 (1971).

This section provides the remedy for collection for maintenance of a mentally ill or deficient pauper from his relatives while an inmate at the state hospital. People ex rel. Zimmerman v. Herder, 122 Colo. 456, 223 P.2d 197 (1950).

This section clearly imposes liability on the estate of a criminally insane person who is committed or transferred to a public institution operated by the state of Colorado for care and maintenance. State v. Estate of Burnell, 165 Colo. 205, 439 P.2d 38 (1968).

Imposition of liability in derogation of common law. The imposition of liability upon relatives for the costs of care and maintenance of mental incompetents confined in mental institutions is in derogation of the common law. At common law it was the rule that in the absence of express contract or fraud, public authorities could not recover either from the person confined, from his estate, or from those under a common-law duty to support him, the expenses incurred on account of the committed patient. In re Estate of Randall v. Colo. State Hosp., 166 Colo. 1, 441 P.2d 153 (1968).

A statute imposing liability where none previously existed must be strictly construed in favor of the person against whom its provisions are intended to be applied. In re Estate of Randall v. Colo. State Hosp., 166 Colo. 1, 441 P.2d 153 (1968).

Exemptions from claim. The general assembly intended that an incompetent's estate be given the benefit of the same exemptions afforded to a normal judgment

debtor. State v. Estate of Butler, 30 Colo. App. 246, 491 P.2d 102 (1971).

The exemption provisions of § 13-54-102 are applicable to the assets in the estate of a mental incompetent, and insurance proceeds in such an estate are exempt from an approved claim of the Colorado state hospital. State v. Estate of Butler, 30 Colo. App. 246, 491 P.2d 102 (1971).

There is no statutory compulsion requiring work, labor, or services by medically adjudicated incompetents whose confinement is not for punishment but rather for treatment. In re Estate of Buzzelle v. Colo. State Hosp., 176 Colo. 554, 491 P.2d 1369 (1971).

This section contains no express language requiring compensation for occupational therapy, nor any language from which an inference necessarily should be drawn that the state should pay a patient for his voluntary services. In re Estate of Buzzelle v. Colo. State Hosp., 176 Colo. 554, 491 P.2d 1369 (1971).

27-92-102. Cost determination.

(1) The department of human services shall periodically determine the individual cost for the care, support, maintenance, treatment, and education of the patients of each of the public institutions supervised by the department of human services. In making the determination, it is proper for the department to use averaging methods to the extent that it is not practicable, in the judgment of the executive director of the department of human services, to compute the actual cost for each patient.

(2) With respect to a resident patient who is under the age of twenty-one years, the department of human services shall deduct from the determined cost an amount equal to the average per capita cost for the education of children with disabilities pursuant to article 20 of title 22, C.R.S.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 771, § 2, effective April 29.

Editor's note: This section is similar to former § 27-12-102 as it existed prior to 2010.

ANNOTATION

Law reviews. For article, "Protecting the Mentally Incompetent Child's Trust Interest from State Reimbursement Claims", see 58 Den. L.J. 557 (1981).

Charges not based on insurance. The charges, i.e., the actual cost of the care, are the same whether the patient has insurance or not. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977) (decided prior to 2010 amendments to this article).

27-92-103. Extent of liability.

(1) The department of human services shall assess against the patient, spouse, or parents made liable by section 27-92-101, or any of them, all or such part of the cost as they are respectively able to pay, but the department of human services shall not assess against the liable persons in the aggregate more than the whole of such cost.

(2) The liability of each parent shall cease when such parent has completed the payments as assessed in this article or upon the patient's eighteenth birthday, whichever event first occurs.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 771, § 2, effective April 29. **L. 2011:** (2) amended, (HB 11-1303), ch. 264, p. 1172, § 83, effective August 10.

Editor's note: This section is similar to former § 27-12-103 as it existed prior to 2010.

ANNOTATION

Law reviews. For article, "Protecting the Mentally Incompetent Child's Trust Interest from State Reimbursement Claims", see 58 Den. L.J. 557 (1981).

Annotator's note. Since § 27-92-103 is similar to § 27-12-103 as it existed prior to the 2010 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

Voluntary work not unconstitutional. A mental patient who voluntarily works in a state hospital and is not paid for such services is not unconstitutionally denied equal protection of the laws or subjected to slavery or involuntary servitude. In re Estate of Buzzelle v. Colo. State Hosp., 176 Colo. 554, 491 P.2d 1369 (1971).

Determination and assessment conditions precedent to collection. Under this statutory scheme, the determination of ability to pay made pursuant to former § 27-12-104 and the assessment made thereon pursuant to this section are conditions precedent to collection. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

For the estate of the deceased to be liable for the care of her daughter, a claim

would have to be one that could have been asserted against the deceased in her lifetime. In re Estate of Randall v. Colo. State Hosp., 166 Colo. 1, 441 P.2d 153 (1968).

This section contains no express language requiring compensation for occupational therapy, nor any language from which an inference necessarily should be drawn that the state should pay a patient for his voluntary services. In re Estate of Buzzelle v. Colo. State Hosp., 176 Colo. 554, 491 P.2d 1369 (1971).

27-92-104. Determination of ability to pay.

(1) All insurance and other benefits payable for the care, support, maintenance, and treatment of a patient shall be considered available for payment of the cost determined under section 27-92-102.

(2) The department of human services shall determine the ability of a patient and his or her spouse to pay the balance of the cost by consideration of the following factors: Income reportable under Colorado law; the age of the patient and spouse; the number of dependents, their ages, and their mental and physical condition; provision for retirement years; the length of the patient's care or treatment; liabilities; and assets. The determination shall be made according to schedules contained in published rules, adopted in accordance with the provisions of article 4 of title 24, C.R.S.

(3) If it is determined that the patient and his or her spouse are unable to pay the entire cost determined under section 27-92-102 and the length of the patient's care and treatment at a state institution is reasonably anticipated to be less than six months, the department of human services shall determine the parent's ability to pay by consideration of the same factors referred to in subsection (2) of this section, applying each such factor to the parent.

(4) If it is determined that the patient and his or her spouse are unable to pay the entire cost determined under section 27-92-102 and the length of the patient's care and treatment at a state institution is reasonably anticipated to exceed six months, the department of human services shall determine the parent's ability to pay by reference to the parent's net taxable income reportable under Colorado law and to the patient's length of care or treatment. At the request of the parent, the department shall also consider other factors relevant to the interest of avoiding undue hardship to the family unit. Other factors may include the parent's age, provision for retirement years, assets, liabilities, and the number of dependents, their mental and physical condition, and their educational requirements. The determination shall be made according to schedules contained in published rules adopted in accordance with the provisions of article 4 of title 24, C.R.S.

(5) Should any parent not file a Colorado income tax return, the parent's net Colorado taxable income equivalent shall be determined by reference to his or her United States income

tax return as though all the income disclosed by that return had been derived from sources within Colorado, and the table of rates shall be applied to the net taxable income equivalent.

(6) Upon the willful failure of any patient, spouse, or parent to furnish to the department of human services, upon request, copies of his or her income tax returns, he or she shall be deemed to have the ability to pay the entire cost determined under this article.

(7) Every agency and department of the state is required to render all reasonable assistance to the executive director of the department of human services in obtaining all information necessary for proper implementation of the purposes of this article. Nothing in this subsection (7) shall be construed to require the department of revenue to produce a copy of any person's income tax return solely upon the request of the department of human services, but the department of revenue shall deliver a copy of any such return upon the request of the taxpayer or his or her duly authorized representative, pursuant to section 39-21-113 (4), C.R.S.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 772, § 2, effective April 29.

Editor's note: This section is similar to former § 27-12-104 as it existed prior to 2010.

ANNOTATION

I. General Consideration.

II. Insurance.

III. Determination.

IV. Amount of Liability.

I. GENERAL CONSIDERATION.

Law reviews. For article, "Protecting the Mentally Incompetent Child's Trust Interest from State Reimbursement Claims", see 58 Den. L.J. 557 (1981).

Annotator's note. Since § 27-92-104 is similar to § 27-12-104 as it existed prior to the 2010 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

Ambiguous term construed in favor of insured. Even if an insurance company intended charges to mean other than actual cost, its intent is ambiguously stated, and therefore the term must be construed in favor of the insured. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

Benefits received by individuals at state mental health hospital from veterans administration and the Colorado old age pension program fall under the term "other benefits payable" in subsection (1). As such, they may be applied to cover costs of care at the hospital. In re Estate of Nau, 183 P.3d 626 (Colo. App. 2007).

II. INSURANCE.

Insurance coverage to be used to reimburse costs. The plain and obvious purpose of subsection (1) is to provide that where insurance coverage exists it shall be used to reimburse the state for the actual cost of the care, support, maintenance, and treatment of the patient. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

Subsection (1) makes the consideration of insurance mandatory by the use of the word "shall". State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

Insurance is to be considered available for payment of the entire cost before any allowance or remission based on the patient's ability to pay is permitted. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

Subsection (1) refers only to the role which insurance proceeds should play in the department of institutions' decision relative to its determination of the ability of the patient or relative to pay. State ex rel. Fort Logan Mental Health Center v. Harwood, 34 Colo. App. 213, 524 P.2d 614 (1974).

III. DETERMINATION.

Liability attaches when determination made. The liability which attaches for accrued costs of maintenance and care in a public institution under former § 27-12-101 becomes a debt upon determination by the department of institutions that the relative is able to pay. If no determination of ability to pay has been made, the amount expended by the state in caring for the incompetent does not accrue and cannot be claimed as a debt against the estate of the deceased relative. People ex rel. Schauer v. Bozaich, 29 Colo. App. 468, 487 P.2d 597 (1971).

Collection of insurance proceeds is not condition precedent to determination of ability to pay. State ex rel. Fort Logan Mental Health Center v. Harwood, 34 Colo. App. 213, 524 P.2d 614 (1974).

Determination and assessment conditions precedent to collection. Under this statutory scheme, the determination of ability to pay made pursuant to this section and the assessment made thereon pursuant to former § 27-12-103 are conditions precedent to collection. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

Failure to comply with and to exhaust statutory remedies under this article precludes later argument on the issues in a collection action. In re estate of Carlson, 749 P.2d 993 (Colo. App. 1987).

Failure to make determination bars collection. In the absence of a determination of ability to pay or an actual assessment, this section does not permit the collection of hospital expenses up to the amount of the insurance benefits payable for such expenses nor may the state maintain an action to recover for the costs of hospital care. State ex rel. Fort Logan Mental Health Center v. Harwood, 34 Colo. App. 213, 524 P.2d 614 (1974).

When the state does not determine the patient's ability to pay the balance, the doctrine of res judicata will bar collection of any balance. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

But does not obviate liability. The fact that liability cannot be asserted until a determination of ability to pay has been made in no way obviates the liability itself. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

Trustee bank is not liable for payments to hospital for care given by hospital to beneficiary where bank did not willfully fail to supply tax returns to hospital for its determination of beneficiary's ability to pay. State v. First Interstate Bank of Denver, 743 P.2d 449 (Colo. App. 1987).

IV. AMOUNT OF LIABILITY.

Liability for actual cost of care. The initial liability is for the actual cost of the care provided, and is incurred as the day-to-day expenditures are made. Schleiger v. State, 193 Colo. 531, 568 P.2d 441 (1977).

Regardless of insurance. The actual cost of the care are the same whether the patient has insurance or not. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

"Charges" are "made" and "incurred" within the meaning of an insurance policy as each day passes while the patient is hospitalized, not when the bill is sent or the assessment made. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

When remission from full cost allowed. Only if insurance is not available to pay the full cost and only if the patient personally is unable to pay the full cost does he get a remission or allowance from the full cost. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

State may collect only what patient is able to pay. The initial liability is for the actual cost of the care provided, but the state may collect, when there is no insurance, only that amount which the patient is able to pay. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

Or spouse or parents. In those instances where there is no insurance, the state may collect only that portion of the person's liability for the actual cost as the patient, spouse, or parents are able to pay. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

The parent is liable for the actual cost of care upon admission. State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

27-92-105. Effect of determination.

A determination of the ability of a patient, spouse, or parent to pay shall remain in effect until a redetermination is made.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 773, § 2, effective April 29.

Editor's note: This section is similar to former § 27-12-105 as it existed prior to 2010.

ANNOTATION

Applied in People ex rel. Schauer v. Bozaich, 29 Colo. App. 468, 487 P.2d 597 (1971) (decided prior to 2010 amendments to this article).

27-92-106. Appeal.

Appeals from the determination of the ability of a patient or relative to pay, as provided in this article, may be taken to any court of record in Colorado having jurisdiction of the patient or his or her spouse or parents liable for payment; but no appeal may be taken until the executive director of the department of human services has ruled upon a written request for a review of the determination. The request shall be made within sixty days after receipt of notification of the determination, and the applicant shall be notified of the decision of the executive director within forty-five days after the receipt of the applicant's request for review.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 773, § 2, effective April 29.

Editor's note: This section is similar to former § 27-12-106 as it existed prior to 2010.

27-92-107. Service.

Service of any notification, information, or request for information, review, or redetermination, accomplished by certified mail, return receipt requested, or in any manner provided by the Colorado rules of civil procedure, shall be sufficient for all purposes of this article.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 773, § 2, effective April 29.

Editor's note: This section is similar to former § 27-12-107 as it existed prior to 2010.

27-92-108. Certificate - prima facie evidence.

In any action or proceeding to enforce the claims of the state provided for in this article, a certificate by the chief administrative officer of the institution involved or the executive director of the department of human services as to any fact or matter necessary to the establishment of the claim which is a matter of record in the institution or in the department of human services shall constitute prima facie evidence.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 773, § 2, effective April 29.

Editor's note: This section is similar to former § 27-12-108 as it existed prior to 2010.

27-92-109. Further actions.

(1) A patient, spouse, or parent liable by this article who fails to pay the amounts assessed pursuant to this article shall be proceeded against in any manner authorized by law for the collection of sums due and owing to the state of Colorado.

(2) All property of persons liable pursuant to this article shall be subject to application to claims irrespective of its origin, composition, or source subject to the exemptions set forth in section 13-54-102, C.R.S.

(3) Claims against responsible relatives in other states may be enforced as claims for support under the provisions of the "Uniform Interstate Family Support Act", article 5 of title 14, C.R.S.

(4) In the absence of fraud, the patient, spouse, and parents shall be liable only to the extent of assessments actually made against them respectively in accordance with this article.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 773, § 2, effective April 29.

Editor's note: This section is similar to former § 27-12-109 as it existed prior to 2010.

ANNOTATION

Law reviews. For article, "Protecting the Mentally Incompetent Child's Trust Interest from State Reimbursement Claims", see 58 Den. L.J. 557 (1981).

Annotator's note. Since § 27-92-109 is similar to § 27-12-109 as it existed prior to the 2010 amendments to this article, relevant cases construing that provision have been included in the annotations to this section.

Legislative intent relating to exemptions. The general assembly intended that an incompetent's estate be given the benefit of the same exemptions afforded to a normal judgment debtor. State v. Estate of Butler, 30 Colo. App. 246, 491 P.2d 102 (1971).

Benefits received by individuals at state mental health hospital from veterans administration and the Colorado old age pension program may be applied to cover costs of care at the hospital under former § 27-12-104 and therefore are not exempt under this section. In re Estate of Nau, 183 P.3d 626 (Colo. App. 2007).

In the absence of a determination of ability to pay and of an actual assessment, the state may not maintain an action to recover for the costs of hospital care. State ex rel. Fort Logan Mental Health Center v. Harwood, 34 Colo. App. 213, 524 P.2d 614 (1974).

Applied in State v. Schleiger, 37 Colo. App. 195, 547 P.2d 1295 (1975), aff'd, 193 Colo. 531, 568 P.2d 441 (1977).

ARTICLE 93

Colorado Mental Health Institute at Pueblo

27-93-101. Institute established.

27-93-102. Capacity to take property.

27-93-103. Employees - adult protective services data system check - publications.

27-93-104. Authorized utilization of medical facilities at institute - equipment replacement fund.

27-93-105. Alternative uses for institute facilities.

27-93-106. Access to inpatient civil beds at institute.

27-93-101. Institute established.

(1) There is established the Colorado mental health institute at Pueblo for the treatment and care of persons who may have a behavioral or mental health disorder from any cause and for other persons in state institutions on an inpatient and outpatient basis and in state programs relating to the treatment of substance use disorders who may require medical care and treatment within the capabilities of the staff and facilities of the institute.

(2) All materials without limitation that contain the former names of the Colorado mental health institute at Fort Logan and the Colorado mental health institute at Pueblo shall be utilized to the maximum extent possible in the ordinary course of business before being replaced.

(3) The Colorado mental health institute at Pueblo is authorized to contract, pursuant to the federal government procurement process, with federal agencies to provide psychiatric, medical, and surgical services at the institute to persons under the care of or in the custody or control of an agency of the federal government, so long as the provision of such services does not exceed the capabilities of the staff and facilities of the institute and does not preempt services to state patients.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 774, § 2, effective April 29. **L. 2017:** (1) amended, (SB 17-242), ch. 263, p. 1377, § 296, effective May 25.

Editor's note: This section is similar to former § 27-13-101 as it existed prior to 2010.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

27-93-102. Capacity to take property.

The Colorado mental health institute at Pueblo is authorized to receive gifts, legacies, devises, and conveyances of property, real or personal, that may be made, given, or granted to or for the Colorado mental health institute at Pueblo. The chief officer of the institute, with the approval of the governor, shall make disposition of such gifts or property as may be for the best interest of said Colorado mental health institute at Pueblo.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 774, § 2, effective April 29.

Editor's note: This section is similar to former § 27-13-102 as it existed prior to 2010.

27-93-103. Employees - adult protective services data system check - publications.

(1) The head of the administrative division overseeing the Colorado mental health institute at Pueblo shall appoint or employ, pursuant to section 13 of article XII of the state constitution, such administrators, physicians, nurses, attendants, and additional employees as may be necessary for the proper conduct of said institute. The head of the administrative division may contract with the board of regents of the university of Colorado health sciences center or any other governing board of a state-supported institution of higher education for the provision of services by physicians and other health-care practitioners when deemed necessary for the proper conduct of the institute. During the performance of any duties by the physicians and other health-care practitioners for the department of human services, the physicians and other health-care practitioners are "public employees" as defined in section 24-10-103 (4), C.R.S., and the limitation of section 24-30-1517 (2), C.R.S., shall not apply.

(1.5) On and after January 1, 2019, the head of the administrative division overseeing the Colorado mental health institute at Pueblo shall, prior to employment, submit the name of a person who will be providing direct care, as defined in section 26-3.1-101 (3.5), to an at-risk adult, as defined in section 26-3.1-101 (1.5), as well as any other required identifying information, to the department of human services for a check of the Colorado adult protective services data system pursuant to section 26-3.1-111 to determine if the person is substantiated in a case of mistreatment of an at-risk adult.

(2) Publications of the institute circulated in quantity outside the institute shall be subject to the approval and control of the executive director of the department of human services.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 774, § 2, effective April 29. **L. 2017:** (1.5) added, (HB 17-1284), ch. 272, p. 1506, § 15, effective May 31.

Editor's note: This section is similar to former § 27-13-103 as it existed prior to 2010.

27-93-104. Authorized utilization of medical facilities at institute - equipment replacement fund.

(1) A person committed to the custody of or cared for in the department of human services or the department of corrections who requires medical care and treatment that can be advantageously treated by psychiatric, medical, or surgical care available at the Colorado mental health institute at Pueblo may be treated at the institute. Charges for patient care and treatment shall be made in the manner provided in article 92 of this title. A specific appropriation shall be made annually for the general medical division of the Colorado mental health institute at Pueblo, based upon projections of the total patient load and associated costs from all institutions, and the department of human services shall determine at least annually the per diem expenses and the actual utilization of the general medical division by each institution, including other divisions of the Colorado mental health institute at Pueblo.

(2) A person under the care of or in the custody or control of an agency of the federal government whose psychiatric, medical, or surgical needs could be advantageously treated at the Colorado mental health institute at Pueblo may be treated at the institute pursuant to a contract between the institute and the agency of the federal government.

(3) A contract entered into pursuant to subsection (2) of this section shall cover the full direct and indirect costs of services as determined by generally accepted accounting principles and shall include a fee to cover the need for replacement of existing equipment which would occur because of this additional use. All fees collected pursuant to this subsection (3) shall be collected by the Colorado mental health institute at Pueblo and shall be transmitted to the state treasurer, who shall credit the same to the equipment replacement fund, which fund is hereby created. Moneys in the equipment replacement fund shall be appropriated by the general assembly on an annual basis to the department of human services for replacement of existing equipment made necessary pursuant to this section.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 774, § 2, effective April 29.

Editor's note: This section is similar to former § 27-13-109 as it existed prior to 2010.

27-93-105. Alternative uses for institute facilities.

The department of human services shall determine the existence of resources at the Colorado mental health institute at Pueblo that are in excess of the needs of the primary purpose of the institute and may make available to the regents of the university of Colorado, on mutually

agreeable terms, a maximum of ten beds at the institute for the purpose of teaching students in the family practice medical training program conducted by and under the control of the regents. The resources shall be a supplement to any existing health-care resources and academic facilities in the region.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 775, § 2, effective April 29.

Editor's note: This section is similar to former § 27-13-110 as it existed prior to 2010.

27-93-106. Access to inpatient civil beds at institute.

The department shall develop and implement admission criteria that ensures individuals, prior to being admitted, have been evaluated for the least restrictive level of care and that geographic location, current health-care provider, and payer type are not the primary determining factor in whether an individual has access to a civil inpatient bed.

Source: L. 2019: Entire section added, (SB 19-222), ch. 226, p. 2266, § 4, effective May 20.

Cross references: For the legislative declaration in SB 19-222, see section 1 of chapter 226, Session Laws of Colorado 2019.

ARTICLE 94

Colorado Mental Health Institute at Fort Logan

27-94-101. Legislative declaration.
27-94-101.5. Definitions.
27-94-102. Establishment of mental health center.
27-94-103. Employees - adult protective services data system check - publications.
27-94-104. Capacity to take property.
27-94-105. Admissions to center - transfers - releases.
27-94-106. Access to inpatient civil beds at center.
27-94-107. Renovation for additional beds.

27-94-108. Construction and operation of an outpatient treatment facility.

27-94-101. Legislative declaration.

In order to provide a program to promote mental health in the state of Colorado, a mental health center is established as provided in this article.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 775, § 2, effective April 29.

Editor's note: This section is similar to former § 27-15-101 as it existed prior to 2010.

27-94-101.5. Definitions.

As used in this article 94, unless the context otherwise requires:

(1) "Center" means the Colorado mental health institute at Fort Logan established pursuant to section 27-94-102 (1).

(2) "Department" means the department of human services.

Source: L. 2025: Entire section added, (SB 25-275), ch. 377, p. 2084, § 241, effective August 6. **L. 2026:** (2) added, (SB 26-149), ch. 142, p. 787, § 26, effective May 21.

27-94-102. Establishment of mental health center.

(1) There is hereby established at the site of Fort Logan, Denver county, Colorado, a mental health center to be known as the Colorado mental health institute at Fort Logan. The center shall be under the general supervision and control of the department of human services.

(2) All materials without limitation that contain the former names of the Colorado mental health institute at Fort Logan and the Colorado mental health institute at Pueblo shall be utilized to the maximum extent possible in the ordinary course of business before being replaced.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 775, § 2, effective April 29. **L. 2025:** (1) amended, (SB 25-275), ch. 377, p. 2084, § 242, effective August 6.

Editor's note: This section is similar to former § 27-15-102 as it existed prior to 2010.

27-94-103. Employees - adult protective services data system check - publications.

(1) The head of the administrative division overseeing the center shall appoint or employ, pursuant to section 13 of article XII of the state constitution, administrators, physicians, nurses, attendants, and additional employees as necessary for the proper conduct of the center. The head of the administrative division may contract with the board of regents of the university of Colorado health sciences center for the provision of services by physicians when deemed necessary for the proper conduct of the center, and during the performance of any duties by the physicians for the department of human services, the physicians are "public employees" as defined in section 24-10-103 (4), C.R.S., and the limitation of section 24-30-1517 (2), C.R.S., shall not apply.

(1.5) On and after January 1, 2019, the head of the administrative division overseeing the center shall, prior to employment, submit the name of a person who will be providing direct care, as defined in section 26-3.1-101 (3.5), to an at-risk adult, as defined in section 26-3.1-101 (1.5), as well as any other required identifying information, to the department of human services for a check of the Colorado adult protective services data system pursuant to section 26-3.1-111 to determine if the person is substantiated in a case of mistreatment of an at-risk adult.

(2) Publications of the center circulated in quantity outside the center shall be subject to the approval and control of the executive director of the department of human services.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 776, § 2, effective April 29. **L. 2017:** (1.5) added, (HB 17-1284), ch. 272, p. 1506, § 16, effective May 31.

Editor's note: This section is similar to former § 27-15-103 as it existed prior to 2010.

27-94-104. Capacity to take property.

The center is authorized to receive gifts, legacies, devises, and conveyances of property, real and personal, that may be granted or given to the center. The executive director of the department

of human services, with the approval of the governor, shall make disposition of such property as may be for the best interest of said center.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 776, § 2, effective April 29.

Editor's note: This section is similar to former § 27-15-104 as it existed prior to 2010.

27-94-105. Admissions to center - transfers - releases.

(1) A person who by law is committed to the department of human services for placement in a state hospital may be committed to or placed in the center upon order of a court of competent jurisdiction, except those persons committed to the Colorado mental health institute at Pueblo pursuant to a judicial determination of not guilty by reason of insanity and those persons committed under section 16-8-106 (1), C.R.S., relating to commitments for observation and examination.

(2) A person placed at the center may be transferred to the Colorado mental health institute at Pueblo, the Wheat Ridge regional center, the Grand Junction regional center, the Pueblo regional center, the Mount View school, or the Lookout Mountain school in accordance with law.

(3) A person placed at the center may be released under such terms and conditions as would entitle him or her to his or her release from the Colorado mental health institute at Pueblo.

Source: L. 2010: Entire article added with relocations, (SB 10-175), ch. 188, p. 776, § 2, effective April 29.

Editor's note: This section is similar to former § 27-15-105 as it existed prior to 2010.

27-94-106. Access to inpatient civil beds at center.

The department shall develop and implement admission criteria that ensures individuals, prior to being admitted, have been evaluated for the least restrictive level of care and that geographic location, current health care provider, and payer type are not the primary determining factor in whether an individual has access to a civil inpatient bed.

Source: L. 2019: Entire section added, (SB 19-222), ch. 226, p. 2266, § 5, effective May 20.

Cross references: For the legislative declaration in SB 19-222, see section 1 of chapter 226, Session Laws of Colorado 2019.

27-94-107. Renovation for additional beds.

(1) The department of human services shall renovate a building at the center to add at least sixteen inpatient beds. The department shall spend or obligate all money appropriated for the renovation in accordance with section 24-75-226 (4)(d).

(2) Initially, the beds may be used for persons needing competency services. When the wait list for inpatient competency restoration services for defendants not admitted within the time limits set forth in section 16-8.5-110 (3)(a)(II) or (3)(a)(III) is eliminated or trending so that it can be reasonably expected to be eliminated within one year, the department of human services shall implement a plan to transition the beds created in subsection (1) of this section to serve civil patients and immediately notify the joint budget committee of the general assembly. Within one year after the notification to the joint budget committee, all beds created pursuant to subsection (1) of this section must serve civil patients.

Source: L. 2022: Entire section added, (HB 22-1303), ch. 183, p. 1221, § 2, effective May 18. **L. 2024:** (1) amended, (HB 24-1466), ch. 429, p. 2946, § 44, effective June 5. **L. 2026:** (2) amended, (SB 26-149), ch. 142, p. 798, § 53, effective May 21.

Cross references: For the legislative declaration in HB 22-1303, see section 1 of chapter 183, Session Laws of Colorado 2022. For the legislative declaration in HB 24-1466, see section 1 of chapter 429, Session Laws of Colorado 2024.

27-94-108. Construction and operation of an outpatient treatment facility.

(1) No later than October 1, 2027, the department shall construct and operate an outpatient treatment facility for adults with behavioral health needs, including adults who are found incompetent to proceed and unlikely to be restored to competency pursuant to article 8.5 of title 16.

(2) A person may be referred to the outpatient treatment facility by a court conducting a competency proceeding pursuant to article 8.5 of title 16, by the bridges wraparound care

program established in article 8.6 of title 16, or by any other program or facility within the department, including programs operated through contracts with the department. A person shall not be referred to the outpatient treatment facility from any source outside of competency-related proceedings, the bridges wraparound care program, or the department.

(3) At a minimum, the department shall ensure that the outpatient treatment facility offers mental health therapy, medication management services, and case management services. The department may offer outpatient treatment services as community-based services, as telehealth services, or in-person at the outpatient treatment facility.

(4) The department may open and operate additional outpatient treatment facilities or contract with other entities at the department's discretion, subject to additional appropriations. The department may hold all civil certifications at a single location, and contractors and other department treatment facilities may provide services to support the civil certifications.

Source: L. 2026: Entire section added, (SB 26-149), ch. 142, p. 787, § 27, effective May 21.