LARIMER COUNTY COMMUNITY MASTER PLAN FOR BEHAVIORAL HEALTH

Changing the Paradigm

Larimer County, Colorado

August 2018

http://LarimerCountyMentalHealth.info

Letter from Steve Johnson

Steve Johnson - *Larimer County Commissioner*

On behalf of the Board of Larimer County Commissioners, I thank you for reviewing the *2018 Community Master Plan for Behavioral Health*; a report that provides a strategic blueprint for Larimer County to address its growing behavioral health challenges.

It's time for Larimer County to meet the behavioral health challenges we have in our community, and facilitate a plan to improve the lives and health of all our citizens. Mental health matters!

- It matters to the estimated 66,000 people in our county who need treatment, but can't get it because of long wait lists and the shortage of facilities;
- It matters to small businesses dealing with the loss of productivity of employees with untreated chronic depression.
- It matters to the 158 families in Larimer County who lost a loved one to suicide in 2016 and 2017;
- It matters to our seniors, many of whom feel isolated and alone and where (nationally) suicide is the leading cause of death in those over 85 years of age;
- It matters to our kids in school, 40% of whom feel hopelessness more than once in the past two weeks.
- It matters to taxpayers who repeatedly pay to incarcerate individuals who are suffering from an untreated or undertreated behavioral health condition or conditions;
- It matters to the 1 in 5 residents dealing with the effects of untreated behavioral health issues every single day.

It's time for Larimer County to meet the behavioral health challenges we have in our community, and facilitate a plan to improve the lives and health of all our citizens. Mental health matters!

Larimer County has listened and learned from our past efforts. We've worked with our cities and towns, our providers, our non-profits, and citizens from every part of the county for over two years to develop this plan. We've carefully studied the needs in our community, what's available now, where the gaps in services and coverage are, and what is needed to fill those gaps.

The *2018 Community Master Plan for Behavioral Health* focuses on getting needed services into communities via existing successful programs and proven methods. It focuses on addressing unmet needs including, crisis services and coordinated care, through a regional behavioral health facility managed by the County but staffed by service providers with proven records of success. It focuses on youth, prevention, early identification and intervention. It focuses on a continuum of quality, coordinated behavioral health treatment and services.

Come join us in making this plan happen and making mental health care a reality for all of our citizens.

Steve Johnson

Steve Johnson
Larimer County Commissioner

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With Sincere Gratitude...

This report, the *Larimer County Community Master Plan for Behavioral Health: Changing the Paradigm*, is the culmination of nearly 20 years of hard work, commitment, collaboration, successes, failures, and dedication. The comprehensive evaluation of behavioral health service needs within our community, and the resulting *Community Master Plan* would not have been possible without the many individuals and organizations throughout the County who worked together to understand this complex set of issues and create appropriate community-based solutions.

The Board of County Commissioners of Larimer County would like to thank the Mental Health and Substance Use Alliance of Larimer County for their years of dedication and for commissioning the report *What Will it Take?: Solutions to Mental Health Service Gaps in Larimer County*, as well as the Health District of Northern Larimer County staff for authoring the April 2018 and original (February 2016) versions of that document. That report provides the research and expert insight that is needed to help Larimer County facilitate the enhancement and development of critically needed behavioral health services within the County.

We sincerely appreciate the assistance of the Mental Health Guidance Team (a diverse working group from the Mental Health and Substance Use Alliance of Larimer County membership), which included individuals from four organizations: SummitStone Health Partners, Larimer County Criminal Justice Services, the Health District of Northern Larimer County, and UCHealth. This group's tireless hours of meeting, analyzing, and offering comments and feedback provided significant value to this project.

We are especially grateful to the behavioral health professionals working in our communities and throughout the County, who diligently provide services to individuals and families struggling with behavioral health issues. These professionals provided invaluable input and perspectives to help formulate this plan.

We are deeply indebted to the citizens of our community. Individuals and entire families actively demonstrated interest in solving our community's behavioral health problems by providing comments and feedback during public hearings and listening sessions, and by reaching out to staff via email and phone calls to share their stories and insights. Their input informed the *Community Master Plan* and specifically highlighted the need for prevention, early identification, and intervention services for youth.

Together, listening to community feedback and expert insights, Larimer County is dedicated to convening community-based partnerships and facilitating solutions to enhance and strengthen the current services provided and to address the most critical gaps we have in behavioral health treatment and support services throughout the community.

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Executive Summary

Larimer County is taking a bold stand to ensure that our community members have access to critically needed behavioral health resources and services. The County's objective: to facilitate quality behavioral health care to meet the needs of residents, at the right level of care, at the right time, and at the right cost.

Over the last several years, local and national behavioral health experts, Larimer County citizens, and other key stakeholders took a close look at the behavioral health resources and services available in our community, and came to a key finding that should concern everyone:

> **While many quality services currently exist in our community, Larimer County does *not* have a continuum of behavioral health treatment and support services that is sufficient to meet the needs of our residents.**[1]

Drilling down into the numbers, that means in 2016, *more than 26,000 Larimer County residents did not get the behavioral health treatment they needed.* These residents—our family members, friends, schoolmates, neighbors, and co-workers—had no choice but to continue to suffer from untreated depression, anxiety, bi-polar disorder, post-traumatic stress disorder, alcohol and substance use disorders, and other issues. The cost of untreated behavioral health issues to residents, their families, and every citizen of Larimer County is sobering: poor adolescent development, poor school and work performance, impaired relationships, exacerbated physical health issues, incarceration, increased jail and court costs, and a suicide rate that is among the highest in the U.S.

This report, the *Larimer County Community Master Plan for Behavioral Health: Changing the Paradigm,* lays out a strategic plan to positively impact our community's behavioral health with a 20-year investment in our community. This effort is *not* about growing County government. Instead, through a thoughtful and participatory process, Larimer County will facilitate the implementation of a strategic blueprint to invest in our citizen's health and the health of our County.

The Need for Services is Real

Behavioral health includes promoting well-being by preventing or intervening in mental illnesses as well as substance use disorders (commonly known as addiction). All of these can have a profound influence on well-being and are not rare conditions. Indeed, behavioral health disorders are quite common nationwide and in Larimer County.

In 2016, more than 26,600 Larimer County residents needed, but did not receive, behavioral health care services.

- Nationally, 1 in 5 individuals have a mental illness[2]
- Depression is the leading cause of disability worldwide[3]
- In Larimer Country, an estimated 41,000 residents have a mental illness and 30,000 have a substance use disorder (and many suffer from both conditions)[4]
- 14% of Larimer County residents report experiencing eight or more days of poor mental health in the previous 30 days[5]

Behavioral health disorders can take a particular toll on youth:

- Depression has a significant impact on adolescent development and well-being: it can adversely affect school and work performance, impair peer and family relationships, and exacerbate other health conditions, including asthma and obesity[6 7 8]
- Depressive episodes often persist, recur, or continue into adulthood[9]
- Youths who have had a major depressive episode in the past year are at greater risk for suicide and are more likely than other youths to initiate alcohol and other drug use, experience concurrent substance use disorders, and smoke daily[10 11 12]

However, despite all of this, we know that treatment works: 70-90% of individuals with mental illness see an improvement in their symptoms and quality of life after participating in treatment.[13]

Significant Gaps Exist Within Our Community

Behavioral health issues are complex diseases that require individualized treatment approaches tailored to the person's severity of disease and specific health care needs, just like any other chronic health condition. This requires a system of care that has a range of levels and types of care available to appropriately meet the needs of patients accessing the system. When appropriate levels of care are not available, individuals often go untreated or receive limited or fragmented treatment, resulting in the utilization of more costly services in hospitals, emergency departments, crisis care, and the County jail.

Mental illness and addiction treatment services are tragically underfunded and not available to many residents:

- In 2016, more than 26,600 Larimer County residents needed, but did not receive, behavioral health care services[14]
- In Larimer County, many types and levels of care simply do not exist, payment options are limited including high out of pocket costs or insurance coverage is not available, and long wait times for services are ever present
- Of Colorado youths that had a major depressive episode in the past year,[15] 58.7% did not receive treatment[16]

Although Larimer County has many quality services, it does not currently have the range of services needed, nor does it have a centralized facility or "hub" where crisis and coordinated care can be effectively and efficiently managed for all the residents of Larimer County. A broader care continuum that is both distributed throughout Larimer County, and the communities that compose the County, and available through a centralized facility needs to be available to meet the needs of thousands of residents who need mental health and addiction services.

Changing the Paradigm

We've known about the growing behavioral health issues and service needs in our County (and the country) for a long time. If the solutions were simple, we would have already fixed these problems. A long-term, multi-pronged solution will require more resources and effort than one organization or municipality can provide. Accordingly, the plan presented in this report represents the work of many individuals and organizations that, over the last several years, studied the issues and worked together to develop solutions.

In 2013, as part of Larimer County's most recent 5-year strategic planning process, more than 300 citizens came together to identify the most pressing needs in our community; they identified "public safety and community health" as a core mission and mandate of Larimer County

The Board of County Commissioners resolved to address the complex community challenge of improving mental health and addiction services through the *Larimer County Strategic Plan* covering 2013 to 2018

Perhaps most influential in the design of this plan has been the work of the Community Mental Health and Substance Use Alliance (MHSU Alliance), a partnership of local organizations. Studying the issue with help from a national consulting firm, the NIATx Foundation, the MHSU Alliance produced a comprehensive report, *What Will It Take?: Solutions for Mental Health Service Gaps in Larimer County.* It was their work that produced the key finding that Larimer County does not have an adequate continuum of services

The MHSU Alliance's report recommended the development and expansion of treatment capacity to provide services for more than 5,000 residents each year, with funds earmarked for a distributed service model through community-based services (including early identification and intervention services, suicide prevention programs, expansion of outpatient services and supportive-housing, and ongoing assistance for those with more intensive needs), and the development of a 24/7 Behavioral Health Services Center, which would become the hub for crisis and withdrawal management (detox) services, as well as coordinated care.[17]

Following the Alliance's seminal report, key stakeholders in Larimer County collaborated to orchestrate this plan, the *Larimer County Community Master Plan for Behavioral Health: Changing the Paradigm*. Those involved included national and local experts, licensed community providers (mental, behavioral and primary care health fields), representatives from municipalities and educational communities, consumers, family members, and other community members.

The collaborators assessed and incorporated nationally recognized best-practice models and continuums of care, such as those from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Society of Addiction Medicine. SAMHSA's Law Enforcement Sequential Intercept model, which offers a framework for interface and diversion, as well as current Larimer County programs, also informed the process.

County staff also held or attended more than 300 meetings with key stakeholders and provided more than 250 community presentations. In addition, more than 600 surveys were completed by community members and behavioral health providers. Among other items, these shareholders repeatedly highlighted meeting the needs of youth, prevention and early identification and intervention services.

The *Larimer County Community Master Plan for Behavioral Health*

The *Larimer County Community Master Plan for Behavioral Health* establishes a strategic outline for continuous progress and advancement toward improving the community's connectedness, resilience and overall health, lessening inequity in access to care, and ensuring the efficiency of behavioral health services. The plan follows a three-pronged approach:

> Among other items, shareholders repeatedly highlighted meeting the needs of youth, prevention and early identification and intervention services.

1. Expand and enrich local behavioral health services across the County (Distributive Services)
2. Facilitate connections between community-based services with services/providers in a centralized facility providing a stronger care coordination system and building transition bridges across providers and services in and outside of the facility (Distributive and In-Facility Services)
3. Build a regional behavioral health facility to provide coordinated care and crisis services (Facility Services)

Within these three approaches, a variety of programs, services, and activities could be funded that will further our goals in the areas of Promotion, Prevention, Treatment, Recovery, Health and Wellness Maintenance, and Support Services.

In addition to outlining the steps above, a significant foundation has been laid for other aspects of the plan:

- The Larimer County Board of County Commissioners earmarked land at the intersection of South Taft Hill Road and Trilby Road for a new behavioral health facility
- A five-year estimated budget has been compiled by the Larimer County Offices of Finance and Budget utilizing significant data gathered through and by Larimer County, the Mental Health and Substance Use Alliance, and the NIATx Foundation
- A resolution describing a proposal for the imposition of a 0.25% County-wide sales and use tax for the purpose of providing mental health care services for residents of Larimer County was referred to the November 2018 ballot by the Larimer County Board of Commissioners in July 2018.

Moving forward with these plans hinges on voter's approval of this new, long-term (20 year) dedicated behavioral health funding stream.

One way or another, we all pay for a lack of comprehensive behavioral health services in our community. With the support of residents, municipalities, and key shareholders, Larimer County intends to change the behavioral health paradigm and facilitate meeting the behavioral health needs of Northern Colorado citizens.

How We Got Here

We've known about the growing behavioral health (mental health and/or substance use) issues and service needs in our County (and the country) for a long time. Having a mental illness isn't generally talked about and suffering often goes untreated. Sporadic treatment or no treatment at all is common. The brain is a fundamental part of the human body, yet it is generally separated from primary medical care. Mental health insurance coverage is supposed to have parity with primary care coverage, but services, access, and truly addressing mental health and substance use needs fall far behind primary care medical coverage.

If the solutions were simple, we would have already fixed these issues. Mental illness and substance use disorders are complex individual, family, and societal problems. A long-term, multi-pronged solution will require more resources and effort than one organization or municipality can provide.

In 1999, 20 behavioral health providers and organizations formed a membership group now known as the Mental Health and Substance Use Alliance (MHSU Alliance). Their mission: to address the lack of coordinated behavioral health care and services within Larimer County. Fast forward to today, nineteen years later, the MHSU Alliance continues its collaborative effort to improve the lives of those impacted by behavioral health issues and community-based efforts to address these growing problems have continued to develop.

The *Larimer County Community Master Plan for Behavioral Health: Changing the Paradigm* (the *Community Master Plan*) has been nearly 20 years in the making. It has been collaboratively orchestrated with engagement from key stakeholders, including national experts, licensed community providers (mental, behavioral, and primary care health fields), representatives from municipalities, higher education and public education, and consumers, families, and other community members. The *Community Master Plan* offers a behavioral health continuum of care focused on promoting coordinated care for improving wellness and health outcomes. It establishes a strategic outline for continuous progress and advancement toward improving the community's resilience, connectedness, and overall health, lessening inequity in access to care, and ensuring the efficiency of behavioral health services.

This effort is *not* about growing County government. Instead, through a thoughtful and participatory process, Larimer County has designed and will facilitate the implementation of the *Community Master Plan* to positively impact our community's behavioral health using short-term steps, and a long-term, three-pronged approach.

Where We Are Going

In July 2018, the Larimer County Board of Commissioners, referred a resolution to the November 2018 ballot describing a proposal for the imposition of a 0.25% County-wide sales and use tax for the purpose of providing mental health care services for residents of Larimer County.

This long-term (20 year) dedicated funding stream, would allow the County to facilitate a three-pronged approach to change our County's paradigm regarding a lack of appropriate continuum of care services and treatments for mental health and substance use disorders.

If approved by voters, the County will implement the *Larimer County Community Master Plan for Behavioral Health,* which establishes a strategic outline for continuous progress and advancement toward improving the community's connectedness, resilience and overall health, lessening inequity in access to care, and ensuring the efficiency of behavioral health services.

For additional details, please see Appendix A, a Resolution Describing a Proposal for the Imposition of a 0.25% County-wide Sales and Use Tax for the Purpose of Providing Mental Health Care Services for Residents of Larimer County.

What Are Behavioral Health Services?

"Behavioral health is the scientific study of the emotions, behaviors and biology relating to a person's mental well-being, their ability to function in everyday life and their concept of self. 'Behavioral health' is the preferred term to 'mental health.' A person struggling with his or her behavioral health may face stress, depression, anxiety, relationship problems, grief, addiction, ADHD or learning disabilities, mood disorders, or other psychological concerns. Counselors, therapists, life coaches, psychologists, nurse practitioners or physicians can help manage behavioral health concerns with treatments such as therapy, counseling, or medication."[18]

The Differences Between Behavioral Health and Mental Health

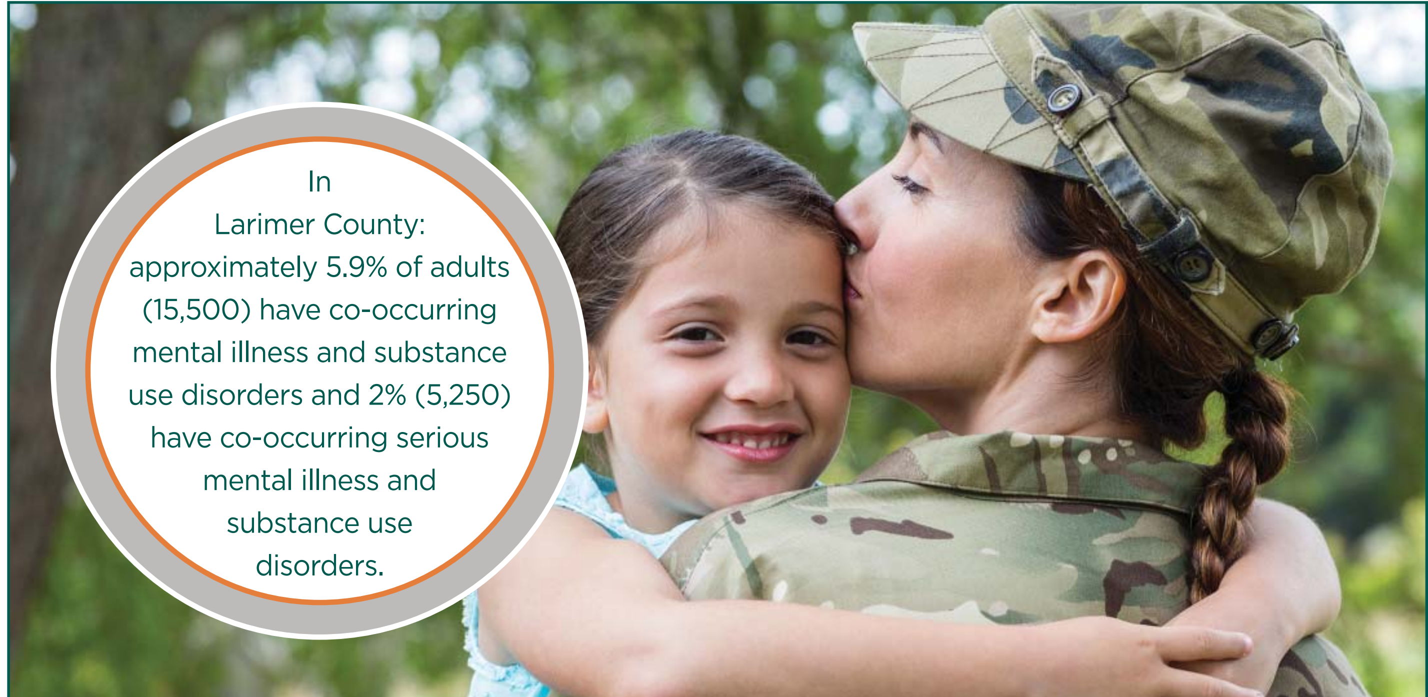
Many people are more familiar with the term mental health. Mental health covers many of the same issues as behavioral health, but this term only encompasses the biological component of this aspect of wellness. **The term "behavioral health" encompasses all contributions to mental wellness including substances and their abuse, behavior, habits, and other external forces.**[19]

Co-Occurring Disorders

An individual is said to have a co-occurring disorder when they have both a mental illness and a substance-use disorder, or a combination of other disorders, such as a mental disorder and an intellectual disability. According to the National Alliance on Mental Illness (NAMI), about a third of all people experiencing mental illness, and about half of the population living with severe mental illness, also experience a substance use disorder. Similarly, about a third of all alcohol abusers and more than half of all drug abusers report experiencing mental illness.[20] **The MHSU Alliance extrapolated this data to Larimer County: approximately 5.9% of adults (15,500) have co-occurring mental illness and substance use disorders and 2% (5,250) have co-occurring *serious* mental illness and substance use disorders.**[21]

Psychologytoday.com offers this information regarding co-occurring disorders:

> Clients with co-occurring disorders (COD) typically have one or more disorders relating to the use of alcohol and/or other drugs as well as one or more mental disorders. A client can be described as having co-occurring disorders when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from another disorder.



Common examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and poly-drug addiction with schizophrenia, and borderline personality disorder with episodic poly-drug abuse. Thus, there is no single combination of co-occurring disorders; in fact, there is great variability among them.

The combination of a substance-use disorder and a psychiatric disorder varies along important dimensions, such as severity, chronicity, disability, and degree of impairment in functioning. For example, the two disorders may each be severe or mild, or one may be more severe than the other. Additionally, the severity of both disorders may change over time. Levels of disability and impairment in functioning may also vary.

People with co-occurring disorders often experience more severe and chronic medical, social, and emotional problems than people experiencing a mental health condition or substance-use disorder alone. Because they have two disorders, they are vulnerable to both relapse and a worsening of the psychiatric disorder. Further, addiction relapse often leads to psychiatric distress, and worsening of psychiatric problems often leads to addiction relapse. Thus, relapse prevention must be specifically designed for the unique needs of people with co-occurring disorders. Compared to patients who have a single disorder, patients with co-existing conditions often require longer treatment, have more crises, and progress more gradually in treatment. Approximately 7.9 million adults in the United States had co-occurring disorders in 2014.[22]

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 68% of individuals with mental health conditions also have one or more medical conditions.[23] Persons with serious mental illness tend to be in poorer physical health than persons without mental illness, especially in regard to obesity, cardiovascular and gastrointestinal disorders, diabetes, HIV, and both chronic and acute pulmonary disease. The high incidence of substance use disorders contributes to this overall poorer health.[24]

The levels and types of care needed to assist individuals experiencing complex medical, mental and/or substance use issues is not a one-size-fits-all solution. Instead, differing levels of care, types of treatment and coordination of care and services are needed to meet the needs of these vulnerable individuals.

The Need for Services is Real

Today, right now, someone you know is struggling with their mental health. According to the U.S. Surgeon General, "Mental illness is more common than cancer, diabetes or heart disease." National and local statistics show that **one in five of us has a mental health issue.**

Larimer County holds the dubious distinction of having one of the highest suicide rates in the country. Between 2016 and 2017, 158 people in Larimer County died by suicide and over a ten-year period, that number surpassed 660 citizens[25].

Adult Behavioral Health Needs

Mental illnesses are common, treatable medical conditions that disrupt a person's thinking, feeling, and daily functioning. They are not imaginary, something to "get over," or character flaws. They can be caused by trauma, chemical imbalance, environment, and genetics. Mental illness impacts all of us, either directly or through those we love, work with, or encounter in our daily lives.

The statistics regarding behavioral health issues are astounding:

- It is estimated that 41,000 Larimer County residents have a mental illness and 30,000 have a substance use disorder (with many individuals suffering from both conditions).[26]
- 14% of Larimer County residents report experiencing eight or more days of poor mental health in the previous 30 days.[27]
- Depression is the leading cause of disability worldwide.[28]
- 20% of youths ages 13–18 live with a mental health condition.[29]
- Individuals with minimal social support networks who display chronic behavioral health issues often have no options. An ambulance ride to the emergency room is frequently the result. These services are costly, generally producing no long-term stability or recovery, and with much of the expense being incurred by taxpayers.
- TREATMENT WORKS: **70-90% of individuals with mental illness see an improvement in their symptoms and quality of life after participating in treatment.**[30]

TREATMENT WORKS:
70-90% of individuals with mental illness see an improvement in their symptoms and quality of life after participating in treatment.

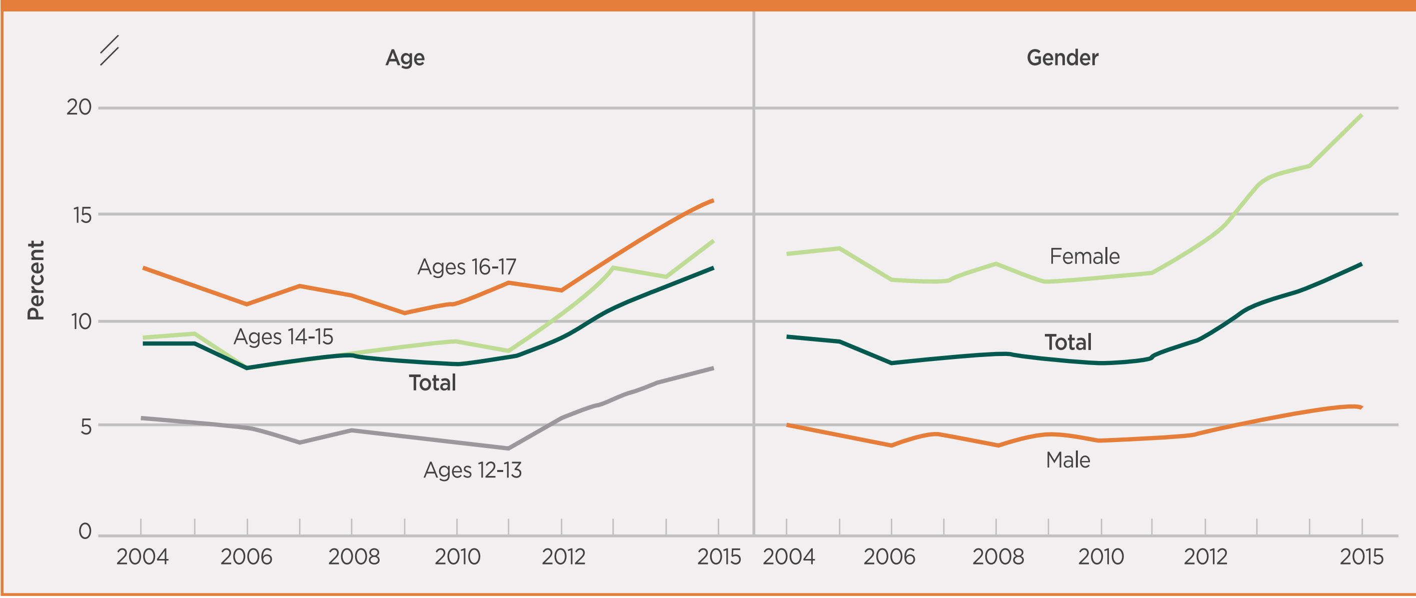
Stigma, shame, and lack of insurance are commonly cited as the reasons people don't seek or get help. In Larimer County, we can add to that list: even for those who do want treatment (an estimated 4,700 individuals in 2018)[31], many of those services simply do not exist, payment options are limited including high out of pocket costs or insurance coverage is not available, and long wait times for services are ever present.

Youth Behavioral Health Needs

Mental health and substance use issues often run in families and youth face additional challenges, including short- and long-term behavioral and physical health consequences. **It is estimated that 20% of youth ages 13-18 live a with mental health condition.**[32] According to the Federal Interagency Forum on Child and Family Statistics (www.ChildStats.gov):

- Depression has a significant impact on adolescent development and well-being[33].
- Adolescent depression can adversely affect school and work performance, impair peer and family relationships, and exacerbate the severity of other health conditions, such as asthma and obesity.[34 35 36]
- Depressive episodes often persist, recur, or continue into adulthood.[37]
- Youth who have had a major depressive episode (MDE) (Figures 1 and 2) in the past year are at greater risk for suicide and are more likely than other youth to initiate alcohol and other drug use, experience concurrent substance use disorders, and smoke daily.[381 39 40]

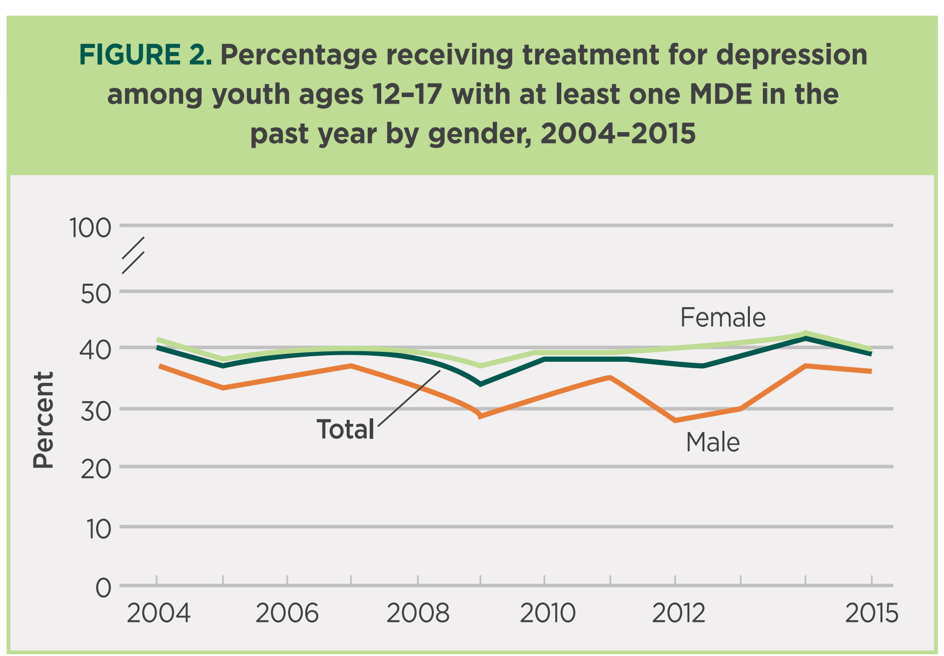
FIGURE 1. Percentage of youth ages 12–17 who experienced a major depressive episode (MDE) in the past year by age and gender, 2004–2015



SOURCE: Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health*, from the Federal Interagency Forum on Child and Family Statistics website, ChildStats.gov.

NOTE: MDE is defined as a period of at least two weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities plus at least four additional symptoms of depression (such as problems with sleep, eating, energy, concentration, and feelings of self-worth), as described in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*.

FIGURE 2. Percentage receiving treatment for depression among youth ages 12–17 with at least one MDE in the past year by gender, 2004–2015



SOURCE: Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health*, from the Federal Interagency Forum on Child and Family Statistics website, ChildStats.gov.

NOTE: Treatment is defined as seeing or talking to a medical doctor or other professional and/or using prescription medication in the past year for depression. Respondents with unknown treatment data were excluded.

According to the SAMHSA *Behavioral Health Barometer, Colorado* report, in 2014-2015, **13.7% of youth age 12-17 had a major depressive episode in the past year**[41]. Further, this same report shows that of those youth having a major depressive episode, **58.7% did not receive treatment at this critical juncture in their life**.[42] (For additional Colorado behavioral health youth and adult statistics, please see Appendix B, Substance Abuse and Mental Health Services Administration: *Behavioral Health Barometer, Colorado, Volume 4.*)

Schools are a common place where youth and families often turn to when seeking help. School districts, individual schools, and school staff have become critical facilitators and providers of suicide awareness and prevention training. In addition, schools provide educational and social-emotional counseling and wellness services (as funding allows), and work diligently to help connect families and students to outside resources.

Schools have a core mission to educate children and youth. While many support services are available through our educational systems, schools were never intended to be the primary mechanism for identification of issues or the provision of behavioral health services. Even if it is known that a student may have a mental health or substance use issue, districts and schools struggle to find resources. The ratio of school counselors to students is very low, and as diligently as these individuals work to provide educational and social-emotional counseling, they are *not* usually licensed or trained in clinical diagnosis and treatment methodologies.

The Opioid Epidemic

In addition to the issues facing youth and adults in particular, we've all heard about the growing opioid epidemic, a crisis that is costing an estimated $504 billion annually on a national level. In Colorado, 70% of heroin users say they started their drug use with prescription medications. We know that treatment to safely withdraw from opioids works and recovery is possible when the appropriate level of care is available. However, Larimer County currently has extremely limited local substance use withdrawal services and lacks many levels of care entirely.

So how do we effectively impact the growing behavioral health crisis for both adults and the youth in our communities? We need to understand the facts and our history. We need to utilize our own community's insights, identified priorities, and needs, along with research and assessment from local and national experts, to craft a plan of action and make the changes we need to impact our future.

Significant Gaps Exist....

Significant Gaps Exist Within Our Community

Mental Illness and addiction are unfortunately all too common, and yet tragically underfunded. **Mental illness and addiction are complex diseases that require individualized treatment approaches tailored to the person's severity of disease and their specific health care needs, just like any other chronic health condition.** This requires a system of care that has a range of levels of care available to appropriately meet the needs of patients. **When appropriate levels of care are not available, individuals often go untreated or are undertreated, which results in the utilization of more costly care in our hospitals, emergency departments, and crisis services.**

Although Larimer County has many quality services, it does *not* currently have the range of services needed (a continuum of care to meet differing severity and scope of needs) *nor* does it have a centralized, regional facility where crisis and coordinated care can be effectively and efficiently managed for all the residents of Larimer County. A broader care continuum that is both distributed throughout Larimer County and available through a centralized "hub" facility needs to be available to meet the needs of thousands of residents who need mental health and addiction services.

Mental illness and addiction are complex diseases that require individualized treatment approaches tailored to the person's severity of disease and their specific health care needs, just like any other chronic health condition.

Investing in Our Future

Larimer County encompasses 2,640 square miles and has a population of more than 330,000 residents living in diverse geographic locales, including rural, suburban, and unincorporated areas. Mental illness and addiction spans across all ages, races, socioeconomic statuses, and backgrounds, with **one in five County residents—more than 66,000 people** from diverse backgrounds—**struggling with behavioral health issues**.

Larimer County's Five-Year Strategic Plan

As part of Larimer County's most recent five-year strategic planning process, over 300 citizens came together to identify the most pressing needs in our community. **The group identified "public safety and community health" as a core mission and mandate of Larimer County. The Board of County Commissioners resolved to address the complex community challenge of improving mental health and addiction services through the *Larimer County Strategic Plan 2013–2018*** (Appendix C).

In 2016, voters were asked to approve a ballot measure that would have funded behavioral health initiatives, but the measure failed. The County subsequently performed focus groups on the issue and learned that approximately 40% of those who had not supported the initiative would have supported it with clearer messaging. Further, the County learned that more collaboration and coalition building was needed to truly create a community-wide set of solutions. To that end, over the last two years the County has invested in this effort; the County has asked for input and feedback and engaged with diverse stakeholders, including municipalities, health care providers, community agencies, law enforcement staff, and residents, to help determine solutions to address these costly and complex community problems.

Larimer County is uniquely positioned to facilitate scaled partnerships to create solutions for diverse populations and geographic locales; our area extends from Estes Park to Berthoud, from Wellington to Loveland, and from Fort Collins to Red Feather.

The County Commissioners have heard the citizens loud and clear. The County's goal is to facilitate quality behavioral health care to meet the needs of our residents, at the right level of care, at the right time, and at the right cost. The resolution will require short-term, first steps, as well as long-term investments.

First Steps

Larimer County has already started to address our community's behavioral health needs with two important programs in the Larimer Criminal Justice Services department.

Alternatives to Incarceration for Individuals with Mental Health Needs

A 2015 study of 155 Larimer County Jail frequent utilizers (those booked four or more times in a year) found that nine out of ten of these individuals had substance use problems and nearly half had a mental illness. To more effectively address this situation, the County developed the Alternatives to Incarceration for Individuals with Mental Health Needs (AIIM) program. On-site services for AIIM program participants include: 1) comprehensive client assessments; 2) integrated mental health and co-occurring substance abuse treatment, including on-site psychiatric care; 3) case-management services to identify needs and connect participants with community resources, such as housing, food, health care, and employment assistance; 4) storage and administration of psychotropic medications; 5) monitoring of court-ordered requirements (e.g., substance use, payments of fines, costs and restitution, and completion of community service); and 6) crisis care.

Prior to AIIM, 27 clients used 1,620 jail bed days. In one year of the AIIM program, providing these individuals with substance withdrawal services and mental health treatment, the County was able to produce a 60% reduction in bed days (652 versus 1,620). The County and the criminal justice system essentially avoided the cost of nearly 970 bed days, and the individuals were more effectively served for their behavioral health issues.

The Co-Responder Program

In March 2018, the County received a grant from the Colorado Office of Behavioral Health to help fund a new co-responder program to more efficiently and effectively address non-criminal-based behavioral health issues. Based on an emerging, national best practice model, the Co-Responder Program of the Larimer County Criminal Justice Services teams law enforcement officers with behavioral health specialists from SummitStone Health Partners to de-escalate situations when law enforcement is called, but people may not actually be engaged in criminal activity. When these individuals are found to be in need of behavioral health care, the Co-Responder Program staff can help divert them away from costly facilities like hospital emergency rooms and the county jail. The program emphasizes treatment over incarceration and provides early diversion whenever possible. Coordinated care with ongoing case management helps to ensure individuals receive the follow-up services they need to reduce any further over-use of the wrong, costly systems.

While the Larimer County Co-Responder program is just launching, similar programs around the Country have demonstrated savings by increased efficiency and outcomes of law enforcement calls for service that involve those with mental illness.

While the Larimer County Co-Responder program is just launching, similar programs around the country have demonstrated savings by increased efficiency and better outcomes of law enforcement calls for service that involve those with behavioral health issues, including mental illness, substance use disorders and co-occurring conditions. Early intervention can decrease the number of repeat calls for service, which also saves money for the law enforcement agency. Outcomes observed in established programs include: saving lives, reductions in the amount of time spent on mental health related calls, reductions in repetitive calls for emergency services, and increases in the use of treatment services instead of criminal justice services.

Changing the Paradigm

Our Vision, Mission, and Goals

The *Larimer County Community Master Plan for Behavioral Health: Changing the Paradigm* recognizes that the great majority of people in the County who need mental health and/or substance use disorder services simply continue to suffer without help, putting great physical, emotional, and financial strain on themselves, their families, and our community.

Utilizing the emergency room or the county jail to address behavioral health needs is *not* a long-term, cost-effective solution. According to the National Institutes of Health, research shows that the economic cost of mental health disorders is $300 billion annually, or $1,000 per person in the U.S. Further, the economic cost of substance use is about $600 billion annually, or nearly $2,000 per person. **However, every $1 spent on substance use treatment yields $4 to $7 in economic benefits such as reduced criminal justice costs.**[43]

Larimer County has established a Vision, Mission, and Goals for changing the behavioral health paradigm in Larimer County.

VISION	MISSION	GOALS
A collaborative effort of diverse community stakeholders who have identified gaps in service and developed an efficient and effective continuum of affordable, accessible behavioral health care to enable our community the opportunity for improved well-being.	*To ensure accessible behavioral health care is available when it is needed, providing the right level of care at the right time, every time.*	**1.** *Enhance community-based services to shift from an acute-care model to a recovery-based model of care.* **2.** *Improve access to behavioral health services in both rural and urban areas.* **3.** *Promote emotional health and well-being.* **4.** *Reduce substance abuse.* **5.** *Reduce attempted and completed suicides.* **6.** *Reduce recidivism for individuals with unmet behavioral health issues.*

Listening to Our Community

Listening to community members *and* behavioral health experts is integral to achieving this vision. In developing the *Community Master Plan*, the County dedicated resources to engage with the community, key stakeholders, and local and national experts, to ensure that the plan starts producing both short-impact and long-term solutions for our community.

Since the launch of the County's most recent five-year strategic plan, Larimer County has invested resources (including dedicated staff) to understanding our community's behavioral health issues, needs, and gaps, and performed an extensive engagement process.

The County held Commissioner-citizen meetings, conducted surveys, and held meetings with key stakeholder groups (such as behavioral and mental health providers, municipalities, school districts, higher education, and community stakeholder groups) to ascertain what community members believe are the most critical needs and how the County should address these needs.

Larimer County Citizen, Municipality, and Organizational Outreach

In January and June 2018, County commissioners held eleven Commission-citizen meetings focused on behavioral health needs in Larimer County. More than 135 community members attended; they actively engaged in the conversation about our community's behavioral health needs as well as asked questions about what the County's next steps would be to address the growing needs. Although each meeting and participants had some unique concerns and different talking points, five key themes emerged.

1. Resources need to be available "upstream" of crisis care. We need to address prevention, early identification and intervention, and health and wellness maintenance. Since schools serve as a hub for youth, services available within/through the schools should be explored.
2. Rural towns and unincorporated areas face additional challenges accessing behavioral health care. Telecounseling and telepsychiatry services may offer real solutions to remote locations, as well as to people who experience barriers due to transportation and mobility issues.
3. The need for more behavioral health providers and diversity of services offered in our county is real. Often, even if an individual has insurance, he or she cannot access care because we do not have enough providers offering differing modalities of care and accepting different kinds of insurance, including Medicaid.
4. Workforce development programs need to be explored with higher education systems, to develop a strong local network of services and providers as well as attract providers to our community.
5. The *Community Master Plan* needs to address mental health throughout the lifespan (from early childhood through geriatric populations) and offer a continuum of care for individuals, so each person can get the right level of care, at the right time, and at the right cost.

Another key part of the County's listening efforts has been community meetings with many different stakeholders. Larimer County staff have provided more than 250 community presentations since 2016 and have hosted or attended more than 300 meetings with key stakeholder entities including, but not limited to: municipalities (City of Fort Collins, City of Loveland, Town of Estes Park, Town of Berthoud, and rural areas including LaPorte, Wellington, and Red Feather), non-profits (The Center for Family Outreach, Alliance for Suicide Prevention of Larimer County, Imagine Zero, SummitStone Health Partners, Child Advocacy Center, etc.), and health care and first responder organizations (UCHealth, Thompson Valley and Poudre Valley emergency medical services, Kaiser Permanente, Banner Health, Salud Family Health Centers, and Sunrise Community Health, etc.), and the three school districts (Estes Park, Thompson, and Poudre).

At these meetings the need for a continuum of care and access to affordable services at the right time emerged also as key messages. Additional items

included medically monitored detoxification services and a centralized location or "hub" to manage crisis and coordinate care.

Lastly, over 600 surveys were completed by community members and behavioral health providers, either in person or submitted to the Larimer County Mental Health Matters website (www.LarimerCountyMentalHealth.info). Among the survey results:

- **More than 80%** of community members and providers believe **we have an inadequate number of providers** in Larimer County
- When community members were asked to rank **barriers to care that make it difficult to access treatment in Larimer County**, the highest ranked items were:
  - Cost of treatment: 81%
  - Lack of insurance: 63%
  - Wait time too long to get services: 62%
  - Lack of services and/or providers for children/adolescents/youth: 59%
  - Service needed is not available: 54%
  - Lack of available services/space for inpatient care based on insurance: 53%
- **51% of community members were not able to find the initial help they needed in Larimer County,** and a significant number of individuals shared personal experiences similar to these:
  - "Nothing." "Nothing." "Nothing."
  - "Still looking for effective treatment." "Still struggling." "Still waiting to be seen."
  - "The repetitive cycle...build up to overload, because the mental health services are not available or too expensive. Start to act out, which leads to break down, then to emergency room, get evaluated, then off to Children's Hospital (if there is a bed). Wait a few months and repeat cycle."

When asked to rank community priorities/needs for behavioral health, community members and providers identified their top five items:

Community Members	Providers
1. Youth and adolescent well-being	1. Strengthen early identification/intervention services
2. Suicide prevention	2. Develop stronger integrated health systems
3. Homelessness	3. Advocacy for insurance coverage of mental health
4. Crisis stabilization	4. Increase training/tools for youth and families
5. Early identification and intervention for children/youth	5. Crisis care for youth

These issues are too large for one municipality or organization to resolve; instead, the solution will require a long-term dedicated funding stream, and a multi-pronged approach.

Larimer County Department of Health and Environment: Community Health Improvement Plan

In 2008, Colorado passed the Public Health Reauthorization Act, which requires local public health agencies to create a health improvement plan based on a community health assessment process and community input. Larimer County's plan, the *Community Health Improvement Plan* (CHIP), is a community-driven, five-year plan that allows for the community to identify priority areas and work collaboratively, utilizing community capacity, to achieve success in the identified priority areas. Larimer County's plan is developed every five years; the first was in 2013, and the second in 2018.

For the 2018 plan, the Larimer County Department of Health and Environment facilitated a community health summit with more than 200 community partners representing diverse organizations. Data was presented to the community members; they then engaged in a prioritization process to identify the CHIP priority areas for the 2018-2023 *Community Health Improvement Plan*. One of the identified priorities is:

> *In an equitable and culturally responsive manner, promote mental and emotional wellbeing across the lifespan, specifically focusing on addressing gaps in the required continuum of care, substance use disorder and treatment, and primary prevention efforts.*

As a preliminary step for this priority, the CHIP team compiled a detailed work plan itemizing the community-based strategies that are currently being implemented in Larimer County through various organizations, coalitions, and partnerships. These strategies range from identifying and intervening in the environmental risk factors for mental health and substance use, to strategies looking to enhance clinical services for individuals in need of these services. This work plan not only shows the community the great work that is already being done around mental health and emotional well-being in our County, but it also provides a foundation for organizations to identify gaps in community work, partner around complimentary work, and collaborate on funding opportunities.

The Community Health Improvement Plan serves as a complimentary work plan to the *Community Master Plan for Behavioral Health.*

The *Community Health Improvement Plan* serves as a complementary work plan to the *Community Master Plan*. The CHIP provides an abundance of information around ongoing community focuses, programs, and areas of need. For the next five years, it will serve as a guiding plan for organization in community-led efforts around mental health and emotional well-being. It will support existing efforts and promote genuine and sustainable collaboration between organizations working on similar strategies. And it will serve as an important starting point for developing partnerships to expand community-driven mental health prevention and treatment initiatives to fill gaps across the continuum of care. (For further information on the draft CHIP, please see Appendix D, Larimer County Department of Health and Environment: *Community Health Improvement Plan*.)

Listening to the Experts

All communities want individual citizens and their communities to thrive and to be resilient, especially when faced with challenges and critical junctures in their lives. Researching and understanding continuum of care models and emerging national best-practice models, as well as listening to our community's local experts (the MHSU Alliance and law enforcement staff) were critical to informing the *Community Master Plan.*

Continuums of Care and Why They Matter

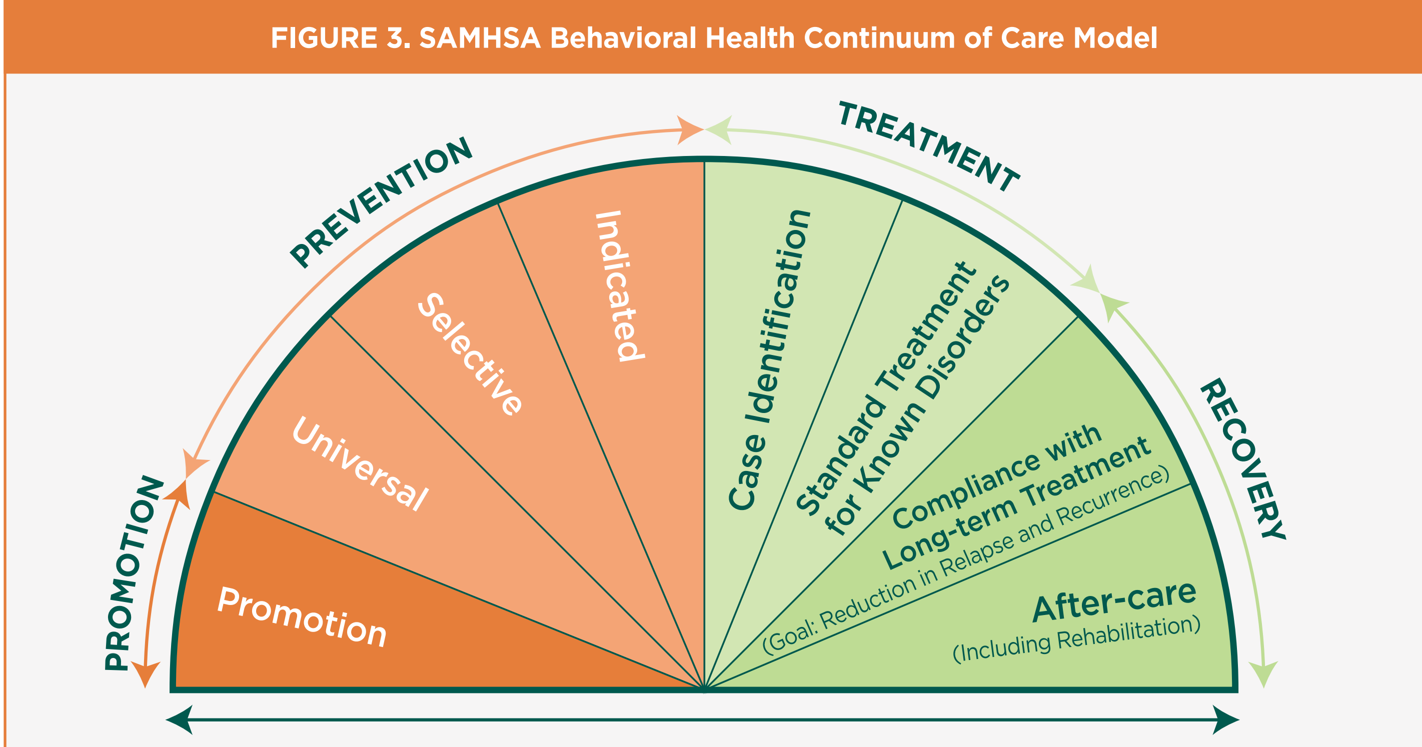
Experts in the fields of mental health and substance use utilize continuums of care (levels of care) to help provide a framework for behavioral health needs and services. Different entities use different continuums, based on their audiences and areas of focus. Larimer County evaluated multiple continuums but focused on two specific models to inform the *Community Master Plan:* the SAMHSA Behavioral Health Continuum of Care Model (a holistic model encompassing both mental health and substance use realms), and the American Society of Addiction Medicine (ASAM) model for addictions and care based on intensity of needs and the services to be delivered.

Substance Abuse and Mental Health Services Administration Continuum of Care Model

The SAMHSA Behavioral Health Continuum of Care Model (Figure 3) offers a comprehensive health model with emphasis on the following overarching components:

- **Promotion:** Strategies designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services.
- **Prevention:** Delivered prior to the onset of a disorder. Interventions intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use.
- **Treatment:** Services for people diagnosed with a substance use or other behavioral health disorder.
- **Recovery:** Services support individuals' abilities to live productive lives in the community and can often help with abstinence.

FIGURE 3. SAMHSA Behavioral Health Continuum of Care Model



SOURCE: Substance Abuse and Mental Health Services Administration, 2014. Retrieved image from http://SAMHSA.gov/prevention.

In the SAMHSA model, risk and protective factors are critical, especially when looking at youth mental health and factors regarding substance use. The National Institute on Drug Abuse describes the influence of risk and protective factors:

> Research over the past two decades has tried to determine how drug abuse begins and how it progresses. Many factors can add to a person's risk for drug abuse. **Risk factors can increase a person's chances for drug abuse, while protective factors can reduce the risk.** Please note, however, that most individuals at risk for drug abuse do not start using drugs or become addicted. **A risk factor for one person may not be for another.**
>
> **Risk and protective factors can affect children at different stages of their lives. At each stage, risks occur that can be changed through prevention intervention**. Early childhood risks, such as aggressive behavior, can be changed or prevented with family, school, and community interventions that focus on helping children develop appropriate, positive behaviors. If not addressed, negative behaviors can lead to more risks, such as academic failure and social difficulties, which put children at further risk for later drug abuse.
>
> **Research-based prevention programs focus on intervening early in a child's development to strengthen protective factors before problem behaviors develop**.
>
> Figure 4 *(next page)* describes how risk and protective factors affect people in five domains, or settings, where interventions can take place.

Risk and protective factors can affect children at different stages of their lives. At each stage, risks occur that can be changed through prevention intervention.

FIGURE 4. Risk factors and protective factors that can affect a person's risk for drug abuse, and the domains where intervention can take place.

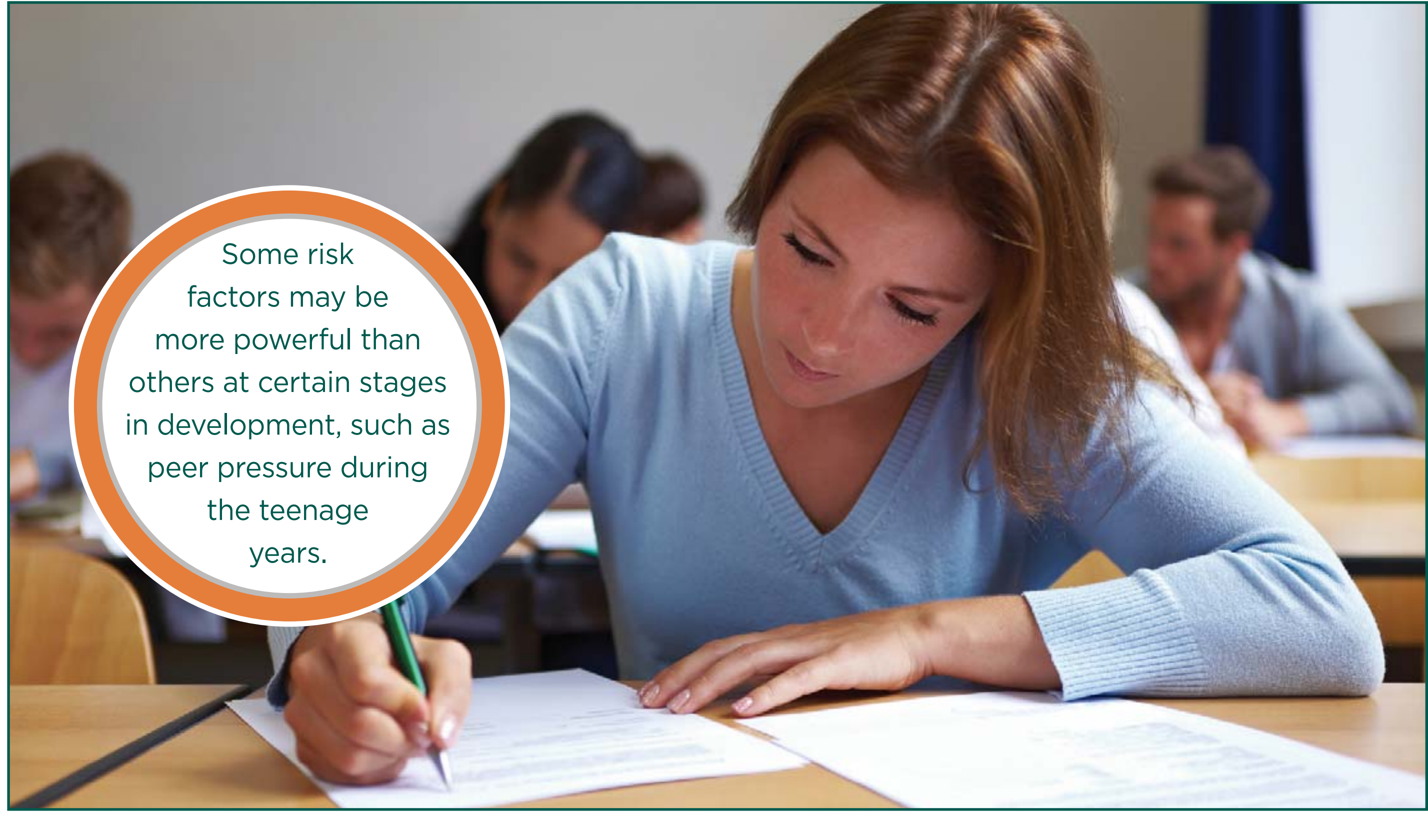
Risk Factors	Domain	Protective Factors
Early Aggressive Behavior	Individual	Self-Control
Lack of Parental Supervision	Family	Parental Monitoring
Substance Abuse	Peer	Academic Competence
Drug Availability	School	Anti-drug Use Policies
Poverty	Community	Strong Neighborhood Attachment

> Risk factors can influence drug abuse in several ways. The more risks a child is exposed to, the more likely the child will abuse drugs. Some risk factors may be more powerful than others at certain stages in development, such as peer pressure during the teenage years; just as some protective factors, such as a strong parent-child bond, can have a greater impact on reducing risks during the early years. **An important goal of prevention is to change the balance between risk and protective factors so that protective factors outweigh risk factors.**[44]

In addition, as SAMHSA notes:

> People have biological and psychological characteristics that can make them vulnerable or resilient to potential behavioral health problems. Individual-level protective factors might include a positive self-image, self-control, or social competence. In addition, people do not live in isolation, they are part of families, communities, and society. A variety of risk and protective factors exist within each of these environmental contexts.[45]

To get upstream of the growing mental illness and substance use problem, Larimer County residents need to have a more comprehensive system and set of resources for resiliency building, prevention, early identification and intervention, community connectedness, mental health and substance use disorder treatments, recovery, and health and wellness maintenance options.

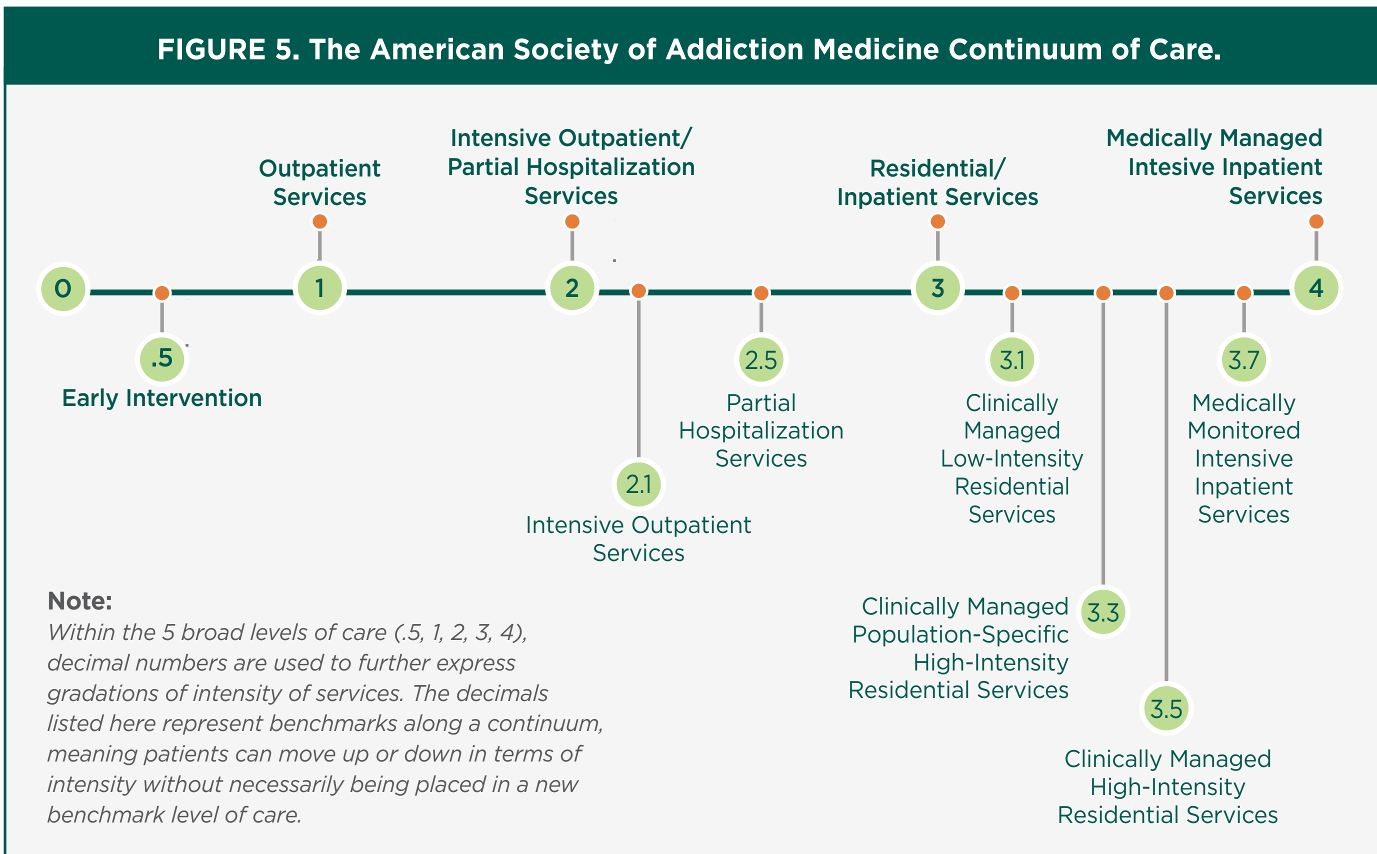


American Society of Addiction Medicine Continuum of Care

The second continuum of care evaluated is from the American Society of Addiction Medicine (ASAM). As described by ASAM:

> The *ASAM Criteria* describes treatment as a continuum marked by four broad levels of service and an early intervention level. Within the five broad levels of care, decimal numbers are used to further express gradations of intensity of services. These levels of care provide a standard nomenclature for describing the continuum of recovery-oriented addiction services. Clinicians are able to conduct a multidimensional assessment that explores individual risks and needs, as well as strengths, skills and resources. The Criteria then provides clinicians with a recommended ASAM Level of Care that matches intensity of treatment services to identified patient needs."[46] The Criteria have become the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions."[47]

FIGURE 5. The American Society of Addiction Medicine Continuum of Care.



The ASAM Criteria ranges from the least intensive to the left (Early Intervention, Outpatient and Intensive Outpatient) to the most intensive interventions on the right (Partial Hospitalization, Residential, and Inpatient Services)."[48] The model is useful for both adult and youth populations, although it should be noted that youth services, along with special populations, may need to be addressed as separate spaces.

Using a combination of the SAMHSA and ASAM continuums, the *Community Master Plan for Behavioral Health* will work to move the barometer and drive our citizen's and community's behavioral health upstream toward prevention and health maintenance. This is a significant part of the cultural shift that will come along with improving the breadth and depth and continuum of behavioral health care in our community. Treating the whole person, mind and body, has proven repeatedly to provide the best health outcomes for individuals, families, and entire communities.

Law Enforcement Sequential Intercept Model: A Framework for Interface and Diversion

The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems, as they address concerns about criminalization of people with mental illness.

The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points are law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support.

The intercept model provides an organizing tool for a discussion of diversion and linkage alternatives and for systematically addressing criminalization. Using this model, a community can develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment.

The report's key finding: While many quality services currently exist in our community, Larimer County does not have a continuum of mental health treatment and support services that is sufficient to meet the needs of our residents.

(For more detailed information this model, please see Appendix E, Substance Abuse and Mental Health Services Administration: SAMHSA's Efforts on Criminal and Juvenile Justice Issues; Larimer County Sequential Intercept Map.)

The Mental Health and Substance Use Alliance: What Will It Take? Solutions to Mental Health Service Gaps in Larimer County Report (Data-Driven Assessment)

The Mental Health and Substance Use Alliance of Larimer County, a partnership of local organizations, with the assistance of several community partners such as the Health District of Northern Larimer County, SummitStone Health Partners, Larimer County Criminal Justice Services, UCHealth, North Range Behavioral Health, and a national consulting firm, NIATx Foundation, studied the County's behavioral health service issues with an emphasis on substance use disorders in adults.

The group focused its efforts on mapping out existing resources and service utilization, identifying the current gaps in services, and making recommendations to fill these gaps and create a more comprehensive continuum of care for substance use and the adult population. Their efforts resulted in a comprehensive community report, *What Will It Take?: Solutions to Mental Health Service Gaps in Larimer County*, which was released in April 2018.

The report's key finding: While many quality services currently exist in our community, Larimer County does not have a continuum of mental health treatment and support services that is sufficient to meet the needs of our residents.

The ASAM model was the cornerstone tool used in the comprehensive community assessment and report. As stated in *What Will It Take?*, "A full Continuum of Care (based on the ASAM model) recommends that the Substance Use Disorder (SUD) treatment services include Outpatient Services, Intensive Outpatient, Residential/ Inpatient Services and Medically Managed Intensive Services."

Our community lacks, among other things, entire levels of care; we have very limited self-pay options and no withdrawal management (drug/alcohol detoxification) for residents with public or commercial insurance, no short-term intensive residential treatment unit, and no centralized facility where care can be more effectively implemented and coordinated.[49]

The MHSU Alliance recommends the development and expansion of treatment capacity to provide services for over 5,000 residents in Larimer County each year.

- **First, the MHSU Alliance recommends that funds be earmarked for a distributed service model throughout the County.** Gaps in community-based services are identified in early identification and early intervention services for youth and families as well as for effective and efficient suicide prevention programs. Other gaps in community-based services would require an expansion of outpatient services and supportive-housing as well as ongoing assistance for those with more intensive needs.

- **Second, the MHSU Alliance recommends the development of a 24/7 Behavioral Health Services Center, which would become the hub for crisis and withdrawal management (detox) services, as well as coordinated care.**

(For a review of the very comprehensive Mental Health and Substance Use Alliance report, *What Will It Take?: Solutions to Mental Health Service Gaps in Larimer County*, please see Appendix F.**)**

National Emerging Best-Practice Models

According to Mental Health America's ranking of states that indicate prevalence of mental illness and access to care, Colorado ranks 48th overall. Our community has often been cited as one of the healthiest or happiest communities, as well as noted as one of best places to live and to raise a family, yet **we have a suicide rate that is nearly double the national average.** Larimer County recently reached its highest suicide rate in ten years, at 25 per 100,000, which is much higher than the state rate of 19.5 per 100,000.

For decades, behavioral health has been an afterthought in most communities. **Nationally, it is estimated that over 44 million adults live with a mental illness, yet over 60% do not receive treatment.** As a County, it is a smart investment in resources and people to address behavioral health issues and to work to improve the overall health of our residents, including children, youth and families. We know that 58% of the population has at least one chronic condition, and that number is expected to rise even higher, yet efforts to stem or even reverse the rising numbers of Americans who develop chronic illnesses have fallen remarkably short. Years of research focused on promoting healthier behaviors have missed the mark by failing to tackle the single greatest contributor to the chronic, physical illness epidemic: mental illness. Patients who have both mental and chronic physical health conditions have increased health care costs at a rate of $560 per month, compared to those with only a physical disease such as diabetes, asthma, or hypertension.

Looking outside our state lines to find solutions and emerging best practices has been an important piece of the research and development of the *Community Master Plan*. Several models around the country have been used to inform our decisions. Only programs that have proven records of success, reductions in the costly over-utilization of jails and emergency rooms, reductions in criminal activity, and improved health outcomes were considered during this process.

Our primary goal in seeking out models around the country was to find programs that focused on a coordinated system of care through prevention, intervention, recovery, resilience, and wellness. We also wanted to learn from programs that gathered reliable data on outcomes to show that what they were implementing was having a positive impact on their community. Although every program is unique to its own community's needs, gathering information on various behavioral

health components of different programs helped Larimer County in creating an efficient and effective framework to meet the behavioral health needs of our own community.

Two of the nation's most successful behavioral health programs are located in San Antonio, Texas. The Restoration Center opened in 2008 and was designed to treat people with mental illness instead of arresting them. Since that time, close to 50,000 people have been treated and diverted from the criminal justice system. This model has saved law enforcement more than 100,000 staff hours and saved taxpayers more than $50 million in medical and criminal justice system costs. Providing psychiatric care, substance abuse services, and outpatient transitional services under one roof required close collaboration with city and community leaders, private and non-profit businesses, and schools. Partnerships were built with law enforcement, first responders, and emergency rooms as well, which has translated to a 50% reduction in emergency room use by people with mental illness.

Across the street from The Restoration Center is Haven for Hope, a 22-acre behavioral health campus that was created after 18 months of research and visits to more than 200 homeless shelters around the country. Haven for Hope's mission is to offer a place of hope and new beginnings for individuals struggling with mental illness and addiction, by providing a coordinated and efficient system of care. Haven for Hope has over 187 community partners, 69 of which have services on the campus. Having a campus for community wellness and recovery support increases accessibility and efficiency of resources for those in need.

Another community, King County in Washington state, in 1989 began to phase in mental health reform designed to increase access to care, client satisfaction, and administrative efficiency, and provide greater accountability for outcomes and service quality. The King County Regional Support Network has developed a coordinated system of service delivery, across the lifespan, with outstanding outcomes and systematic program evaluation. The Regional Support Network helps ensure that clients have access to a continuum of services and that barriers are eliminated where possible. The Network partners with other systems, institutions, organizations, and providers, and provides services that are informed by research and evidence-based practices. This model has led to King County being at the top of nationally recognized standards of care for mental illness and substance abuse treatment.

In Colorado, we are seeing mental health reform efforts emerging as well. There are varying scopes and sizes of projects happening around the state that have helped inform our process. One such example is supported by the Douglas County Board of County Commissioners. The Douglas County Mental Health Initiative has worked to unite community partners to address unmet mental health needs, connect people to mental health services, and prevent those in need from falling through the cracks of the mental health system. Douglas County has pursued a Co-Responder model program, called the Community Response Team (CRT). As a result of that effort, Douglas County has seen a reduction of criminal filings and an increase in treatment referrals over the past three years. Another aspect of the Douglas County initiative is a stigma reduction campaign, designed so that individuals who need treatment are more likely to seek it. The campaign is intended to help people start the conversation about mental health by offering tips to help normalize those conversations and integrate them into our everyday health discussions.

In Colorado, we are seeing mental health reform efforts emerging as well. There are varying scopes and sizes of projects happening around the state that have helped inform our process.

Most recently on our radar to watch as a community in reform is Summit County, Colorado. After successfully passing a sales tax on tobacco products in 2017, the County plans to expand access to youth mental health services, increase access to behavioral health care in rural areas, and provide incentives for medical professionals to work in underserved areas. Summit County leadership has noted that jails are the most expensive and least therapeutic places to treat mental health crises, but also recognizes that when there is no place else to go, that is where people end up.

The Larimer County *Community Master Plan* is a culmination of national, state, and local research, gathered by experts in the field of behavioral health. We recognize our unique community needs and the many similarities we have to other communities that are also struggling with mental health and addiction issues. Years of thoughtful and inclusive research has been conducted to inform this community plan.

The Larimer County Community Master Plan For Behavioral Health

So, what can County residents expect to receive if a long-term, dedicated funding stream is available? By listening to both community-identified needs and priorities as well as expert advice and analysis, Larimer County has determined it will facilitate a three-pronged approach with a 20-year dedicated investment in our community**:**

1. Expand and enrich local behavioral health services across the County (Distributive Services)
2. Facilitate connections between community-based services with services/providers in a centralized facility providing a stronger care coordination system and building transition bridges across providers and services in and outside of the facility, (Distributive and In-Facility Services)
3. Build a regional behavioral health facility or "hub" to provide crisis services and coordinated care (Facility Services)

Within these three approaches, a variety of programs, services, and activities could be funded that will further our goals in the areas of Promotion, Prevention, Treatment, Recovery, Health and Wellness Maintenance, and Support Services.

Distributive Services Throughout Larimer County: Strengthening and Enhancing Current Service and Care Provision

Distributive services will enhance and strengthen current and new service provision throughout the County, specifically prioritizing activities and services within the Promotion, Prevention and Recovery spectrums of the SAMHSA continuum of care.

Services may be coordinated with and enhanced through collaborative efforts with: school districts/schools, non-profit organizations, municipalities, and medical and behavioral health providers serving youth, adults, vulnerable and at-risk populations needing behavioral health services and/or support services to prevent the need for behavioral health treatment/services.

Community-based services offered through the distributive model is a combination of recommendations from the MHSU Alliance recommended services (see Appendix E) as well as new, additional examples of upstream concepts that will fortify prevention and promotion activities/services (reinforcing the entire continuum of behavioral health services), as well as recovery, health and wellness maintenance and some treatment-related activities and services.

Examples of programs, services and activities that could be funded in the areas of **Promotion, Prevention, Health and Wellness Maintenance, and Recovery:**

- **Education and outreach campaigns**
- **Health and wellness promotional campaigns**
- **School health, wellness, and connections programs**
- **Expansion of early identification and early intervention services**

As Mental Health America states, "Whenever warning signs are observed, resources should be available to parents or guardians to access comprehensive mental health and substance use evaluations and services needed to promote recovery. Access to adequate care can reduce barriers to learning and improve educational, behavioral and health outcomes for our youth. The best services promote collaboration among all the people available to help, including families, educators, child welfare case workers, health insurers, and community mental health and substance use treatment providers. Barriers should be reduced and incentives created to ensure increase collaboration across systems and funding sources."[50]

In our area, this could include:

- Expanding mental health and substance use identification services through local non-profit organizations and resources/connections with behavioral and mental health providers through early education centers and the medical community
- Utilizing school-based health centers as a primary means to identifying and addressing behavioral health issues, particularly in elementary and middle school populations
- Expanding and attracting early intervention specialists to our community

- **Working with school districts to develop and expand the nationally recognized school-based health center model,** which offers integrated and comprehensive medical and behavioral health services for students, and prioritizing services in high-needs schools[51]
- **Trainings for parents, youth, adults, service providers, and others**
  - Suicide prevention (such as, Question Persuade Refer,[52] and Signs of Suicide[53]), working with school districts to identify their needs and provide additional support services based on needs
  - Youth and adult Mental Health First Aid[54]
  - Parent education on healthy brain development
  - Trauma-informed care
  - Adverse childhood experiences[55]
- **Funding for school districts/schools for behavioral health support**
  - Clinically licensed mental and behavioral health providers, including but not limited to licensed professional counselors, licensed clinical social workers (LCSW), psychologists, psychiatrists, etc.
  - Support for programs like CAYAC (Child, Adolescent, and Young Adult Connections)[56]
  - Support for district and school behavioral/mental health teams
  - Telehealth programing: telemedicine (integrated with behavioral health services), telecounseling, telepsychiatry programming[57]
- **Coordinating efforts with municipalities for assessment/reassessment services, transportation, etc.**
- **Working with higher education to develop professional development tracks and innovative modeling** to grow our network of behavioral health care providers, strengthen the diversity and breadth of therapeutic models offered, offer more services to reduce wait times, and address the gaps in care currently experienced
- **Recovery and health and wellness maintenance**
  - Recovery 12-step/support programs[58]
  - Complementary therapies such as, but not limited to art, music, nutrition, meditation, yoga, and breathing therapies[59], especially those tied with medical health programming
  - Supportive services for those in permanent supportive housing that help tenants to achieve and maintain stability in housing, such as case management, care coordination, and referrals to treatment for behavioral health disorders[60]

Additional Distributive Services in **Treatment** could include:

- **Moderately Intensive to Intensive Care Coordination** providing higher level care coordination for those with the most complex needs or more significant behavioral health disorders (expands existing community model)[61], and for those who have a new or acute need where additional support would help to re-set the baseline and maintain good behavioral health
- **Creating, enhancing, expanding local telecounseling/telepsychiatry services** to reach the County's rural and non-incorporated areas, breaking down the barriers to care and providing access for these non-centralized county residents
- Expansion of **assessment/reassessment[62] services and certified addiction counselors**[63] within the community and within schools (as desired)

Distributive and In-Facility Services: The Right Care, At the Right Time, At the Right Cost

For some individuals, especially those with higher needs such as co-occurring disorders or chronic mental or substance use disorders, resourcing will require services be within both the distributive model (community-based) and a centralized behavioral health care facility.

Coordination between systems and community service providers will be critical to the overall success of any community behavioral health reform effort. Additionally, by building transition bridges/care coordination across existing providers and networks inside and outside of the facility, it is projected that service expansion will be specifically for Intensive Outpatient and Outpatient services, especially for substance use disorders.

Critical gaps in behavioral health services have been identified, including detoxification services, residential treatment services, and crisis stabilization services, all of which require an efficiently and effectively run treatment facility to fill the gaps and centralize care coordination.

Within the **Treatment** spectrum of the SAMHSA continuum of care model, examples of these services would be:

- **Care coordination** between the behavioral health facility and community services
- Further development of **resource networks** to share information regarding provider capacity, insurance accepted, modalities of care offered, etc.
- **Assistance funds** (while insurance is anticipated to pay for most of the services) to provide **limited help** with service expense(s) and flexible funding to assist with medications, transportation, deductibles/co-pays, etc., in the facility and within the following levels of care[64]:
    - Intensive Outpatient (IOP) services with average length of stay 30 visits[65]
    - Outpatient (OP) services with average length of stay 10 visits[66]
    - Medication Assisted Treatment (MAT)[67]
    - Other assistance as needed to ensure care

Facility Services: Crisis and Coordinated Care

Experts including NIATx and the MHSU Alliance have determined that a centralized and comprehensive community-based behavioral health facility is a more appropriate setting to care for individuals with mental health issues than a jail or hospital emergency room. By providing an early intervention alternative to detention or a hospital visit, officials anticipate law enforcement resources, as well as jail and emergency room costs, will be avoided.

A centralized Behavioral Health Services Center or Hub would bring missing critical levels of care to our community, allowing residents to get the care they need, when they need it, which is vital to getting people engaged in other levels of treatment and on the path to recovery.

Through years of research conducted on the unique needs of our community, **critical gaps in behavioral health services have been identified, including detoxification services, residential treatment services, and crisis stabilization services, all of which require an efficiently and effectively run treatment facility to fill the gaps and centralize care coordination.**[68]

Larimer County intends to build and manage the facility and contract with different entities for the services within the facility. This is *not* about Larimer County becoming a behavioral health provider, or growing government; it is about facilitating a care continuum with the right experts providing services. This type of "No Wrong Door" service center is what is being recommended across the country, due to its efficiency and effectiveness at assessing the needs of individuals and getting them placed into the correct level of care, in front of properly trained staff who have the expertise to match the person's need immediately.

Services Provided

As described in *What Will it Take?: Solutions to Mental Health Service Gaps in Larimer County,* **Treatment and Support Services** provided within the facility will include:

- **Medical clearance and triage, assessment, and reassessment** (as necessary). Medical clearance includes the 24/7 services to perform a medical screening/clearance to ensure that what the client is displaying is not due to a physical condition and his/her appropriateness for care at the facility.

- **Assessment/Reassessment** includes therapeutic assessment and diagnosis of mental illnesses and substance use disorders provided by licensed behavioral health staff including psychiatrists, licensed clinicians with differential diagnosis expertise. Assessment results will be used to make connections to an appropriate level of care.
- **Relocation of the SummitStone Health Partners' existing Riverside Avenue Crisis Stabilization Unit (CSU)** to the new centralized facility. Offering crisis call operations, walk-in crisis assessments, and expansion crisis stabilization care beds to 26.
- **Withdrawal Management Services** (also known as "detox"), including the following levels:
  - **Social Model Withdrawal Management,** with an average length of stay of 2.8 days
  - **Medically Monitored Withdrawal Management**, with an average length of stay of 5 days. Withdrawal management services includes adequate staff to enable good triage and assessment, flow between levels of care, engagement of clients in treatment to the greatest level possible, administering of personal meds and meds for initial withdrawal, start of medication-assisted treatment for opioid withdrawal, and support of ambulatory detox.
- **Short Term Intensive Residential (STIR)**, with an average length of stay of 12 days providing short-term intensive treatment for substance use disorders.

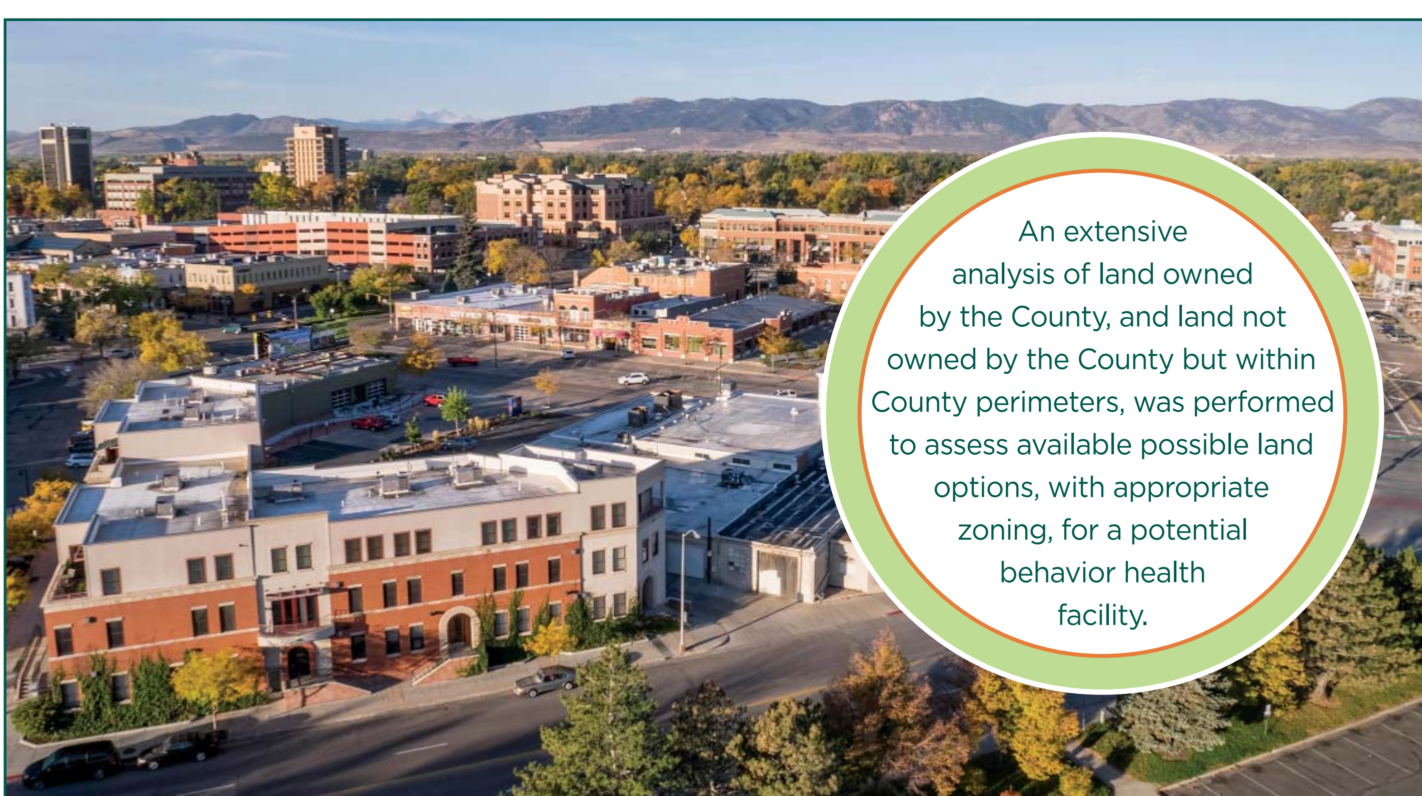
For specific details on capacities, please see *What Will It Take?: Solutions to Mental Health Service Gaps in Larimer County* report, Appendix A, List of Recommended Services and Capacity (February 2018 Update).

Land Planning

Designing a comprehensive, regional behavioral health facility requires proactive planning, expertise, and a thorough assessment of requirements including zoning, site design, and land planning.

An extensive analysis of land owned by the County, and land not owned by the County but within County perimeters, was performed to assess available possible land options, with appropriate zoning, for a potential behavior health facility. In 2017, ten possible sites were identified with five in Fort Collins, two in Loveland, two in Timnath and one in Johnstown, ranging in size from 30–40 acres and in price from $1,050,000 to $4,000,000.

The only site of the ten evaluated that is owned by Larimer County was also determined to be the most centrally located in the County. This 40-acre tract of land is epi-center to the County's population bases and is located at the intersection of South Taft Hill Road and Trilby Road, adjacent to the present Larimer County landfill, which is projected to close in 2025.[69]



This land is available, is owned by the County, and is equidistant or "mid-county" from Fort Collins to Loveland, equidistant from the nearest medical providers, and near the population centers of Larimer County. Additionally, this site is open and provides potential for not only a new behavioral health facility, but also outdoor activities and future growth. Utilities are near the site and fiber optics are adjacent to the site (on Taft Hill Road), providing for convenient infrastructure development.

This new behavioral health facility or hub would help to ensure seamless care coordination and fill in critical gaps in the continuum of care for those experiencing crisis and substance use disorder issues.

A significant commitment was made by the Larimer County Board of County Commissioners at the January 2018 Admin Matters meeting, as they earmarked the land at the intersection of South Taft Hill Road and Trilby Road for a new behavioral health facility, should the voters approve a new long-term (25 year), dedicated behavioral health funding stream.

Site Design

In March 2017, Larimer County retained the services of HDR, a global firm with nearly 10,000 employees and more than 225 offices, including in Denver and Fort Collins, that specializes in engineering, architecture, and environmental and construction services, to provide professional services for Larimer County's Phase 2 Regional Wasteshed Planning Study. Simultaneously, as part of this process, in August 2017 a three-day land planning and site design charette was held to explore the possibility of co-locating a new behavioral health facility on land adjacent to the current landfill. A minimum of 28 acres would be needed to accomplish the master plan development, preliminary facility layout, associated infrastructure, and desired future services of a behavioral health facility.[70] On the earmarked land, the new behavioral health facility would co-exist (with appropriate screening and buffers) with a potential future solid waste infrastructure within existing county-owned land.

At the design charette, key Larimer County departments and services participated, along with representatives from behavioral health shareholder organizations, including UCHealth, SummitStone Health Partners, and the Health District of Northern Larimer County. According to Janice Mierzwa, Regional Senior Director of Emergency Services for UCHealth, "The land use and design charrette created a forum to envision what is both possible and reasonable for integrated mental health services in Larimer County." HDR helped the group to develop a common vision and preliminary site design for a behavioral health facility. A significant part of this three-day process was defining the behavioral health space needs, including:

- Short and long-term goals
- Capacity needs
- Population growth
- Creative and innovative visioning of programming for now and into the future

This new behavioral health facility or hub would help to ensure seamless care coordination and fill in critical gaps in the continuum of care for those experiencing crisis and substance use disorder issues. According to Gary Darling, Director of the Co-Responder program for Larimer County and one of the participants in the charette, "Only a continuation of ongoing treatment at the right level will have the desired long-term result. We must have the appropriate facilities available when needed and resources in the community when appropriate to deliver the proper doses of treatment for individuals in need."

(See Appendix G for the full HDR Land Use Planning Report.)

Return on Investment

A return on investment analysis assesses the efficiency of an investment against the costs of that investment.[71] While it is generally a business metric, it can be applied to investments in social realms, including behavioral health.

To understand the soundness of Larimer County's investment in a three-pronged behavioral health approach (working to move the dial upstream toward prevention and health maintenance), it is important to understand the efficiency and effectiveness of treatment and costs, versus the significant and inappropriate utilization of downstream community resources (emergency room and jail) to "manage" individuals in our community suffering with behavioral health issues.

Treatment Effectiveness

The U.S. Department of Health and Human Services and other sources provide clear evidence regarding the effectiveness of treatment:

- **Improvement rates for mental health treatment are comparable to improvement rates for other health conditions.** For example, the rate of improvement following treatment for individuals with bipolar disorder is about 80%; for major depression, panic disorder, and obsessive-compulsive disorder, improvement rates are about 70%. The success rate for those with schizophrenia is 60%. **These rates are quite comparable to rates of improvement for individuals who suffer from physical disorders,** including asthma and diabetes at 70-80%, cardiovascular disease, 60-70%, and heart disease, 41-52%.[72]
- Patients with chronic health conditions—especially diabetes and hypertension—who also have a substance use disorder and receive substance use disorder treatment are more likely to better manage their diabetes or hypertension. They require fewer medical services and cost less than patients who do not receive SUD treatment.[73]
- **Like other chronic diseases, addiction can be managed successfully.** Treatment enables people to counteract addiction's powerful disruptive effects on the brain and behavior and regain control of their lives. The chronic nature of the disease means that relapsing to drug abuse is not only possible but likely, with symptom recurrence rates like those for other well-characterized chronic medical illnesses—such as diabetes, hypertension, and asthma, which also have both physiological and behavioral components.[74]
- **Successful treatment for addiction typically requires continual evaluation and modification as appropriate, like the approach taken for other chronic diseases.** For example, when a patient is receiving active treatment for hypertension and symptoms decrease, treatment is deemed successful, even though symptoms may recur when treatment is discontinued. For the addicted individual, lapses to drug abuse do not indicate failure—rather, they signify that treatment needs to be reinstated or adjusted, or that alternate treatment is needed.[75]
- **Major savings to the individual and to society related to substance use disorder treatment stem from fewer interpersonal conflicts, greater workplace productivity, and fewer drug-related accidents, including overdoses and deaths.**[76]

Treatment, with timely access, provided on a continuum of care, which offers varying levels/types of treatment, is efficient and effective and a significantly more cost-effective investment than the limited or non-existent treatment services received in an emergency room or in jail.

Cost Comparisons

The use of downstream community resources to address individuals with behavioral health issues is expensive and offers limited effectiveness and no long-term efficiencies.
The costs associated with such resources include:

- Ambulance: more than $1,200 per transport[77]
- Emergency room visit: $2,500 (average)[78] and upwards of $10,000 for a level 5 visit[79]
- Larimer County Jail: $113 a day[80]

According to the MHSU Alliance report *What Will it Take?,* an estimated 53,800 Larimer County residents have a mental illness, and 26,000 have a substance use disorder (with many individuals suffering from both conditions).[81]

Lack of availability and engagement in treatment burdens our community in several ways:

- According to data collected on the Emergency Department (ED) at UCHealth Poudre Valley Hospital in Fort Collins, arrivals at the ED with mental health clinical classifications are on the rise, consequently resulting in a steadily increasing demand for emergency response services and associated costs. From 2014 to 2016, the total annual mental health arrivals at the ED rose from approximately 6,912 to 8,170, an 18% increase in two years, and the trend continues upward.[82]
- According to Larimer County Jail reports, in 2016 approximately 29% of inmates reported mental health issues and approximately 51% reported substance use issues; approximately 25% of inmates have co-occurring mental health and substance use issues. In 2016, the population of inmates in the Larimer County Jail reporting either a mental health issue, a substance use issue, or both, utilized approximately 106,077 jail bed days (291 beds per day on average) and had approximately 3,284 new arrests (9 arrests per day on average). **At current jail bed costs ($113 per day in 2017), this population represents an approximate $12,000,000 annual cost to Larimer County, which is roughly half of the jail's total 2016 operating budget.**[83]

SAMHSA states the following regarding mental illness intervention and prevention savings:

> **Data have shown that early intervention following the first episode of a serious mental illness can make an impact. Coordinated, specialized services offered during or shortly after the first episode of psychosis are effective for improving clinical and functional outcomes. In addition, the Institute of Medicine and National Research Council's *Preventing Mental, Emotional and Behavioral Disorders Among Young People* report in 2009**

notes that cost-benefit ratios for early treatment and prevention programs for addictions and mental illness programs range from 1:2 to 1:10. This means a $1 investment yields $2 to $10 savings in health costs, criminal and juvenile justice costs, educational costs, and lost productivity.[84]

According to the National Institute on Drug Abuse, "Every dollar invested in addiction treatment programs yields a return of between $4-$7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to health care are included, total savings can exceed costs by a ratio of 12:1.[85]

Investing in behavioral health services, access to care, and levels and types of treatment is a smart and cost-efficient investment in individual citizens' quality of life and family soundness, and our community's health and financial well-being.

Benefits

As has already been demonstrated in the previous section, the benefits to individuals, families, and entire communities are plentiful when appropriate behavioral health services are available and provided at the right time. Benefits can be categorized in a variety of ways, including cost avoidance, risk mitigation, and realization of potential, etc.

Investing in our County's individual residents and in our community's collective behavioral health is expected to produce benefits including (but not limited to):

- Healthier children, due to early identification and early intervention.
- More individuals identified and provided early intervention services when signs of mental health and substance use issues are present, as a result of mental health training(s), crisis intervention, and other community-based strategies.

According to the National Institute on Drug Abuse, "Every dollar invested in addiction treatment programs yields a return of between $4-$7 in reduced drug-related crime, criminal justice costs, and theft."

- Reduced health system costs by lowering the incidence of repeat admissions and misuse of higher-than-needed levels of care.
- Reduced criminal justice system costs by diverting people toward treatment whenever possible.
- Individual lives saved by increasing suicide prevention awareness and skills, and collective community lives saved by better utilization of first responders' time and efforts, leading to increased access to 24-hour crisis response.
- Neighborhoods kept safer by providing appropriate re-entry and re-integration support and services to offenders with mental health and substance use issues.
- Improved access to the right level of coordinated care for those experiencing homelessness in our community.
- Strong local economies built by linking people in need with coordinated care, housing, job training, and employment services.
- Help for people with addiction who are ready for treatment, by providing the right level of affordable and accessible substance use treatment and recovery programs.
- Help for youth and special populations, such as veterans and their families, get the behavioral health care they need at the earliest intervention point possible.

(For further information on treatment benefits, please see Appendix H, Treatment is Cost Effective, and Benefits are Spread Between Many Different Pockets.)

Performance Measures and Accountability

By building relationships and actively participating in initiatives, such as the MHSU Alliance, Larimer County plans to facilitate the partnerships that will help expert community provider's more effectively address our community's growing behavioral health issues.

Figure 6 below shows examples of the types of relationships and service models Larimer County will explore to effectively partner with the key stakeholders who are currently serving our community's behavioral health needs and who have diligently worked to lay the groundwork for expanded service offerings.

FIGURE 6. Examples of relationships and service models Larimer County will explore to partner with the key stakeholders.

Relationship Building

Why Collaborate?

- Strengthen or expand programs, quality of services.
- Gain back-office or administrative efficiencies.
- Achieve greater economies of program scale.
- Reach new geographies, impact varied populations.
- Strengthen and enhance existing or generate new services.
- Expand program and client reach.

Endorsement	Associations & Coordination	Collaboration & Collective Impact Models	Shared Services	Joint Programming	Affiliates & Merger
Public support & shared branding in support of a shared mission; Recognizing and supporting a shared & common agenda.	A group of organizations that voluntarily join forces to accomplish a shared purpose; Mutually reinforcing activities;	Shared mission, goals, decision-making and resources; Informal but systematic interaction toward activities or services areas;	Jointly hiring a 3rd party to share an existing resources to provide defined services—accounting, marketing, It, office space.	Contractual programming; Shared accountability & measurement; Reduces duplication, expands the range and quality of services.	Fully integrated programming, management, planning and funding; Combining two organizations through legal affiliates, or formal governance structure.

Level of Integration

Less ········· More

SOURCE: The Bridgespan Group article: Partnerships and Collaborations, Spectrum of Collaboration, January 1, 2015. Adapted for use by Mental Health Matters, 2018.

The County itself will *not* be providing behavioral health services, but it will need to ensure that service providers, funded through a dedicated funding stream, have performance measures, data sharing agreements, and accountability structures in place to ensure the desired collective impact and highest and best use of public funds.

Performance measurement is the regular collection and reporting of data to track work produced and results achieved.[86] We measure performance indicators so we can perform programmatic adjustments to ensure that we are meeting goals. Indicators will be created in collaboration with and for all parties that are participating in the three-pronged approach of distributive services, distributive/facility, and facility.

Performance measurement is the regular collection and reporting of data to track work produced and results achieved. We measure performance indicators so we can perform programmatic adjustments to ensure that we are meeting goals.

Population health, which can be defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group," and "an approach to health that aims to improve the health of an entire human population,"[87] will be the pinnacle measurement; most important will be the prevalence and/or reduction of untreated behavioral health issues, including suicide rates, and substance use disorders within our community, and the overall prevalence of behavioral health issues within our community.

Performance measurements will also be designed for organizational performance, including service providers and/or funded partners. At the appropriate time, baseline data will be established, and measurements will be developed through collaborative discussions with each entity working with Larimer County. Measurements will be designed to include, but not be limited to: specific number of service units, quality, efficacy, and impact (at both the individual and community levels).

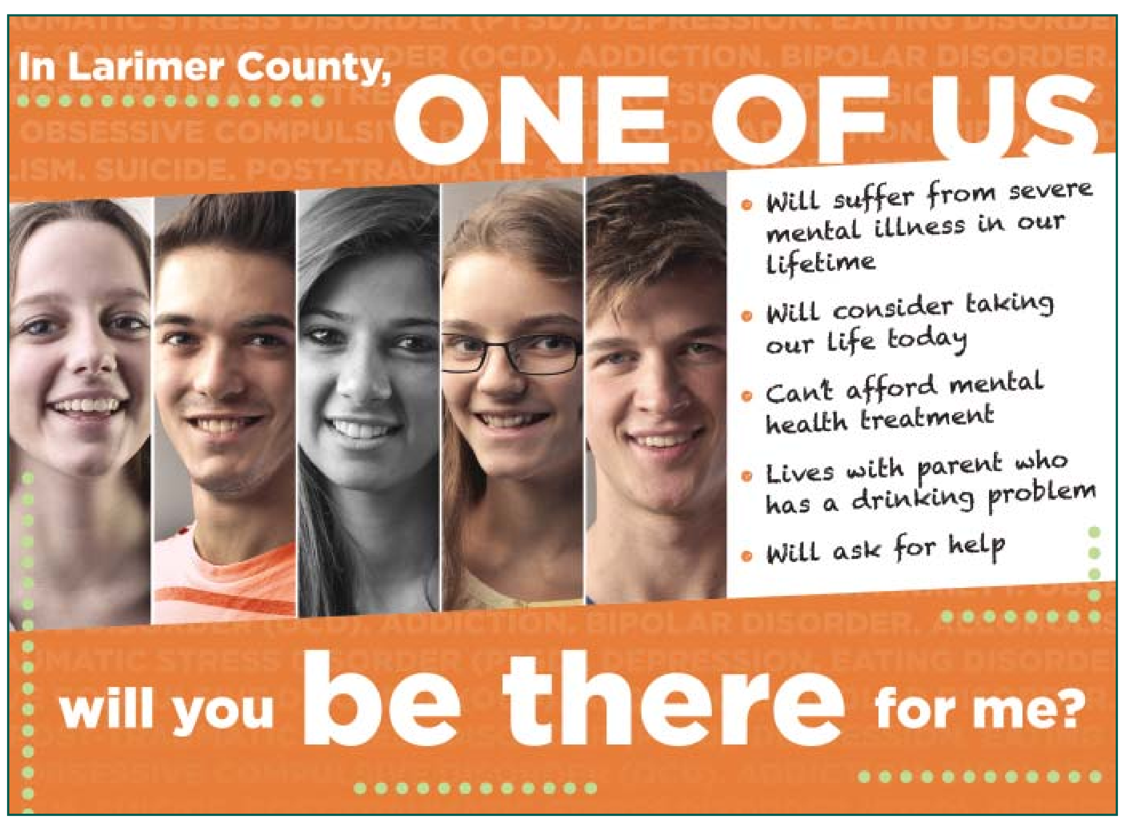
As is customary for Larimer County, transparency is our ever-present commitment as will be the sharing of data gathered from established performance measures and outcomes being produced around the county from this funding.

Behavioral Heath Policy Council

A behavioral health Policy Council will be formed with a purpose to foster regional coordination and cooperation in matters relating to the provision of a continuum of behavioral health services in Larimer County by:

1. providing an organizational framework to ensure effective communication and coordination of behavioral health-related issues and services among Larimer County local governments and between provider agencies involved in the delivery of such services in Larimer County;
2. serving as a vehicle for the collection and exchange of behavioral health-related information and expertise and representation of the interests of all Larimer County residents;
3. providing a forum to identify, discuss, study and collectively approve solutions to regional behavioral health problems for consideration by the Board of County Commissioners;
4. developing and endorsing policy regarding behavioral health issues for ratification by the Larimer County Board of County Commissioners;
5. reviewing budget proposals presented to the Council by the Larimer County Behavioral Health Director prior to submittal to the Board of County Commissioners;
6. promoting behavioral health awareness, planning, cooperation and coordination for the benefit of all Larimer County residents;
7. reviewing services, needs and resources, reaching consensus and presenting issues concerning the program to the Board of County Commissioners;
8. reviewing and approving an annual report to be presented to the Board of County Commissioners for review and publication.

The Policy Council shall have the authority to review, recommend, approve and adopt matters related to the Behavioral Health Program. Decisions made by the Council must be ratified by the Board of County Commissioners.



Estimated Five-Year Budget

The estimated 5-year budget (Appendix I) and was created by the Larimer County Finance and Budget offices.

In terms of revenue, the budget shows estimated sales tax and interest revenue in the first year (2019) as $15,700,000. This calculation was estimated using a typical, conservative revenue estimate for a .25% sales tax, (a quarter on $100.00), so as to not overstate potential resources. The mental health ballot initiative will state a *maximum* amount that shall not be exceeded, of $19,000,000 in sales tax in the first year, as required by the Tax Payor Bill of Rights (TABOR) amendment.

While the budget highlights expenses associated with the long-term capital investment of building, operating and maintaining a comprehensive, regional behavioral health facility, it also includes projected revenues and expenses associated with the first and second prongs (distributive community services and distributive/in-facility client assistance and care coordination services) of the three-pronged approach. This combination of immediate investment in our communities through distributive and distributive/in-facility funding highlights the County's commitment to ensuring collective impact throughout our county, while securing funding for the behavioral health facility.

Assumptions embedded in the budget include:

1. Projected numbers are based on estimated future costs, which may fluctuate significantly.
2. Facility construction costs are estimated on a 55,000 square foot facility. The size of the facility could increase/decrease based on final design specifications.
3. The collection rate on public and private insurance billing for Behavioral Health services can range from 3% to 90%. We have used a 50% collection rate on estimated insurance billing based on utilization rates provided in Appendix 1: Revenue Profiles in the Mental Health and Substance Use Alliance report.

Please note that this budget estimate is subject to change and is provided as a reference example only. It will be updated to present-day projections if voters approve the November 2018 behavioral health initiative. Larimer County will of course share this information with the public, as part of its normal practice of transparency.

In terms of revenue, the budget shows estimated sales tax and interest revenue in the first year (2019) as $15,700,000. This calculation was estimated using a typical, conservative revenue estimate for a .25% sales tax, (a quarter on $100.00), so as to not overstate potential resources.

Glossary of Terms

Accountability – performance indicators established to measure and evaluate the effectiveness of the services provided and to improve their quality.

Addiction or Substance Use Disorder – a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by an inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.[88]

Admission (Medical) – the formal acceptance by a hospital or other inpatient health care facility of a patient who is to be provided with room, board, and continuous nursing service in an area of the hospital or facility where patients generally reside at least overnight.[89]

American Society of Addiction Medicine (ASAM) – a professional medical society representing over 5,000 physicians, clinicians, and associated professionals in the field of addiction medicine. Founded in 1954, ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.[90]

Behavioral Health – includes not only ways of promoting well-being by preventing or intervening in mental illness such as depression or anxiety, but also has as an aim preventing or intervening in alcohol/substance abuse or other addictions. [91]

Behavioral Health Assessment/Reassessment – an in-depth and detailed assessment of an individual's emotional, social, behavioral, and developmental functioning utilizing observation and validated screening tools, which often help to demonstrate severity of the issue(s), such as: Patient Health Questionnaire (PHQ-2, PHQ-9, PHQ-13) for depression, or the Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs, etc. An assessment is usually the first stage of a treatment process and is administered by a licensed behavioral health provider.

Child, Adolescent, and Young Adult Connections (CAYAC) – a service of the Health District of Northern Larimer County's Connections program. It is a partnership of the Health District of Northern Larimer County, SummitStone Health Partners, Poudre School District, and other community resources. The program's goal is the early identification and treatment of mental health and substance use disorders that affect health, happiness, family, and school.[92]

Certified Addictions Counselor (CAC) – Colorado has four main levels of certification: three at the certification level and one licensed level. The four levels are: Certified Addiction Counselor I (CAC-I), Certified Addiction Counselor II (CAC-II), Certified Addiction Counselor III (CAC-III) and Licensed Addiction Counselor (LAC). The first three levels require the completion of education as well as a practicum and supervised experience. The LAC level requires a master's level degree in a behavioral science, if from another state, or a combination of a degree as well as supervised experience.[93]

Client Assistance Funds – flexible funding to provide limited help for items such as medications, transportation, co-pays/deductibles, and personal emergency funds, for individuals who have limited means (uninsured or Medicaid beneficiaries), as well as those who, without such assistance funds would experience barriers to care.[94]

Co-Occurring Disorder (Dual Diagnosis or Co-existing) – refers to an individual who has a co-existing mental illness and a substance-use disorder, or another combination of disorders (such as mental disorders and intellectual disability). Clients with co-occurring disorders (COD) typically have one or more disorders

relating to the use of alcohol and/or other drugs as well as one or more mental disorders. A client can be described as having co-occurring disorders when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from another disorder.[95]

Continuum of Care (Levels) – a system that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensity of care.[96]

Coordinated Care – the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care, to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.[97]

Co-Responder Program, Larimer County Criminal Justice Services – consists of two-person teams comprised of a law enforcement officer and a behavioral health specialist to intervene on mental and/or substance use police calls to de-escalate situations that may have historically resulted in arrest and to assess whether the person should be referred for an immediate behavioral health assessment.[98]

Crisis Stabilization – centers and/or services generally offered 24/7 to provide time limited (average length of stay is 3-5 days) crisis support, information, and referrals to anyone in need.

Crisis Stabilization Unit (CSU) – within a behavioral health facility, a level of care and services provided for individuals to receive crisis stabilization services in a safe, structured setting. It provides continuous 24-hour observation and supervision for individuals who do not require intensive clinical treatment in an inpatient setting and would benefit from a short-term structured stabilization setting. The primary objective of a CSU is to promptly conduct a comprehensive assessment of the patient and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the patient to a level of functioning that requires a less-restrictive level of care. Generally, CSU stays are expected to be 72 hours or less in duration, with efficient and coordinated transfer of the individual to a less-restrictive level of care following stabilization.[99]

Distributive Services – the provision of services and activities throughout the community versus in a central location and/or through a single entity.

Early Identification/Early Intervention (EI/EI) – a term used in many disciplines, including mental health, substance use disorders, and primary medical care. Early identification is a systems approach for screening and assessment to identify behavioral health issues and provide appropriate, evidence-based strategies and interventions at the earliest possible intervention point to ensure that health issues are addressed.

Intensive Outpatient Program (IOP) – a type of specialized outpatient addiction recovery program that provides more structure and a more intensive level of care than a standard outpatient program, while still accommodating the person's home and work life. It can be used as a follow-up to successful detox, as a primary form of care, or as part of an aftercare plan for someone who has completed an inpatient program.[100] IOP may be recommended for those who do not need medically supervised detox. IOP can also enable people in recovery therapies following successful detox, on a part-time yet intensive schedule, designed to accommodate work and family life.[101]

Larimer County – a specific region of the state of Colorado, located in north central area. The county is vast and has diverse geographic features and population densities. It encompasses over 2,640 square miles, extends to the Continental Divide, and includes Rocky Mountain National Park and eight incorporated cities within its boundaries as well as several mountain communities. Larimer County is the sixth largest county in Colorado based on population. It has a local government that serves as a separate administrative area of a state, with ten elected officials, including three elected County Commissioners, who serve as the main policy-making body in the County and work to represent the interest of the citizens of Larimer County at local, state, and national levels. Commissioners are elected at large from one of three geographic districts for four-year staggered terms. Commissioners are limited to serving three four-year terms.[102]

Licensed Addiction Counselor (LAC) – Colorado has four main levels of certification: three at the certification level and one licensed level. A Licensed Addiction Counselor must have a master's level degree in a behavioral science, if from another state, or a combination of a degree as well as supervised experience.[103]

Major Depressive Episode (MDE) – a period of at least two weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities, plus at least four additional symptoms of depression (such as problems with sleep, eating, energy, concentration, and feelings of self-worth), as described in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).[104]

Mental Health Colorado – the state's leading advocate for the prevention, diagnosis, and treatment of mental health and substance use disorders. It is a non-profit, nonpartisan organization and an affiliate of Mental Health America.[105]

Mental Health America (MHA) – the nation's leading community-based non-profit dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all Americans.[106]

Medical Clearance – a determination by a provider based on current practice guidelines, examination, history, and any appropriate testing, that no obvious reasons for exclusion have been identified.[107]

Medically Monitored Withdrawal – according to the American Society of Addiction Medicine's criteria levels of care, "there are five types of detoxification strategy that may be administered to patients with alcohol or substance abuse disorders. Two of these strategies involve medically monitored detoxification for the more intense cases of withdrawal: Level III.7-D and Level IV-D. Level III.7-D is medically monitored inpatient detoxification and is used to treat severe cases of withdrawal. Patients assigned to this level of treatment require 24-hour nursing care and physician supervision, evaluation, withdrawal management and visitation when necessary. It usually takes place within a licensed health care facility, rehabilitation facility or a freestanding detoxification center."[108]

Medication Assisted Treatment (MAT) – the use of medication in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery.[109]

Mental Health – includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.[110]

Outpatient Program (OP) – outpatient mental health and/or substance use disorder programs allow an individual to receive treatment from a provider, but the individual continues to live at home and not in-residence to access treatment. On a care continuum, this level of treatment is the first level of treatment and is not as highly structured and/or intense as an Intensive Outpatient Program or residential program.

National Alliance on Mental Illness (NAMI) – the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness through education, advocacy, listening, and leading.[111]

Non-profit – an organization formed to serve a public or mutual benefit rather than the pursuit or accumulation of owner or investor profit.[112]

Performance Measures – establishing the quantitative and qualitative milestones that make it possible to measure progress toward the intended impact.[113]

Peer Support – occurs when people provide knowledge, experience, emotional, social or practical help to each other, and where colleagues, members of self-help organizations and others meet, in person or online, as equals to give each other support on a reciprocal basis.[114] In the context of behavioral health, peer support is delivered by individuals who have common life experiences with the people they are serving. People with mental and/or substance use disorders have a unique capacity to help each other based on a shared affiliation and a deep understanding of this experience. In self-help and mutual support, people offer this support, strength, and hope to their peers, which allows for personal growth, wellness promotion, and recovery. Research has shown that peer support facilitates recovery and reduces health care costs. Peer support also helps promote a sense of belonging within the community. The ability to contribute to and enjoy one's community is key to recovery and well-being. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives.[115]

Permanent Supportive Housing (PSH) – an innovative program that combines affordable housing with supportive services to help people lead more stable lives. PSH targets people who are homeless, have one or more disabilities, experience multiple barriers to

housing, and need supportive services. When people know they have a safe place to live and sleep, their mental health, physical health, and other needs can finally be addressed. The PSH model has been shown to save communities money by reducing costs to various public service systems, including health care and emergency services.[116]

Prevention – engaging in proactive strategies to address factors related to wellness, stability, and reducing the need for crisis services.[117]

Recovery – a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.[118]

Return on Investment (ROI) – assesses the efficiency of an investment against the costs of that investment.[119]

Risk and Protective Factors – risk factors are those circumstances that put an individual, especially children and youth, at risk for coping in a healthy way and can contribute to psychological disorders like major depression or post-traumatic stress disorder. Protective factors are the opposite. These are circumstances that can help protect an individual, especially children and youth, by helping them with their symptoms and/or finding meaning in their experiences.[120]

Short-Term Intensive Residential (STIR) – intensive, but short-term (average length of stay is 12 days) treatment for substance use disorders.[121]

Social Model Withdrawal Management/Social Detoxification – a detoxification program delivered in an organized, residential, non-medical setting. Services are administered by appropriately trained personnel who provide 24-hour monitoring, observation, and support in a supervised environment for a client to achieve initial recovery from the effects of alcohol or another drug. Social detoxification is characterized by its emphasis on peer and social support, and it provides care for clients whose intoxication or withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support, but the full resources of a medically monitored inpatient detoxification are not necessary.[122]

Stigma – a strong lack of respect for a person or a group of people, or a bad opinion of them, because they have done something society does not approve of.[123]

Substance Abuse and Mental Health Services Administration (SAMHSA) – the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.[124]

Substance Use Disorder or Addiction – a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by an inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.[125]

Supportive Services (for those in Permanent Supportive Housing) – services that help tenants in Permanent Supportive Housing to achieve and maintain stability in housing, not treatment of their mental disease.[126] Services may include: case management, care coordination, and referral to treatment for behavioral health disorders.

Systems of Care – coordinated, integrated, and effective services meeting the unique needs of individuals operating in conjunction with an interagency network of other necessary services. Clients must have available an identifiable and qualified person or team responsible for their support and treatment that should provide treatment and rehabilitation in the most appropriate and least restrictive environment in the community of the client's choosing.

Telemedicine – the remote delivery of health care services including assessment, diagnosis, and treatment using telecommunications technology. This includes a wide array of clinical services using Internet, wireless, satellite, and teleconferencing.[127] It allows health care professionals to evaluate, diagnose, and treat patients in remote locations using telecommunications technology, and allows patients in remote locations to access health services expertise quickly, efficiently, and without travel.

Telepsychiatry – the application of telemedicine to the specialty field of psychiatry. The term typically describes the delivery of psychiatric assessment and

care through telecommunications technology, usually videoconferencing.[128] Telepsychiatry, a subset of telemedicine, can involve providing a range of services including psychiatric evaluations, therapy (individual therapy, group therapy, family therapy), patient education, and medication management. Telepsychiatry can involve direct interaction between a psychiatrist and the patient. It also encompasses psychiatrists supporting primary care providers with mental health care consultation and expertise. Mental health care can be delivered in a live, interactive communication. It can also involve recording medical information (images, videos, etc.) and sending this to a distant site for later review.[129] Telecounseling utilizes the same technology as telepsychiatry, except services are performed by a licensed professional counselor or higher credentialed individual, not a psychiatrist.

Triage – the process of determining the priority of patients' treatments based on the severity of their conditions.[130]

Wellness – the quality or state of being healthy in body and mind, especially as the result of deliberate effort.[131]

Withdrawal Management Services (a.k.a. Detoxification) – refers to the social, medical and psychological treatment of individuals who are experiencing a withdrawal syndrome due to either reducing their use of a drug or totally ceasing their use.[132] Withdrawal management is a critical part of substance use disorder treatment and one step in a continuum of care for individuals experiencing a substance use disorder.

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Appendix A

07242018 R013

RESOLUTION NO. _____

A RESOLUTION DESCRIBING A PROPOSAL FOR THE IMPOSITION OF A 0.25% COUNTY-WIDE SALES AND USE TAX FOR THE PURPOSE OF PROVIDING MENTAL HEALTH CARE SERVICES FOR RESIDENTS OF LARIMER COUNTY, REFERRING A BALLOT ISSUE TO THE 2018 GENERAL ELECTION BALLOT FOR THE APPROVAL OF SUCH PROPOSAL, AND CALLING AN ELECTION.

WHEREAS, the 2013-2018 Larimer County Strategic Plan identified seven community goals, one of which was titled *Safety and Wellbeing* and had the overarching purpose of enhancing the safety and wellbeing of Larimer County residents by promoting a continuum of support and services to proactively address the causative issues of mental health and substance abuse in our community; and

WHEREAS, the term 'mental health' refers to cognitive, behavioral, and emotional wellbeing that can affect daily life, relationships, psychological resilience and even physical health; and

WHEREAS, mental illness and substance use disorders are serious health issues for children, teens, adults and seniors in Larimer County and, although great strides have been made, many of our citizens experience the negative effects of mental health issues themselves or through family members, neighbors or friends; and

WHEREAS, comprehensive, community-based services that respond to those with mental health needs are cost-effective and access to necessary medication and appropriate treatment helps prevent individuals from ending up in emergency rooms and the criminal justice system; and

WHEREAS, the provision of a continuum of mental health services in our community is critical to individuals, families, schools, businesses, law enforcement and healthcare providers and there is a strong and growing body of evidence that supports the cost effectiveness and benefits to communities that have successfully implemented continuums of mental health and related care; and

WHEREAS, it is in the best interests and welfare of Larimer County Citizens that they have the option of voting on a sales tax to fund mental health care services for residents of Larimer County including Berthoud, Estes Park, Fort Collins, Johnstown, Loveland, Timnath, Wellington, Windsor and other rural communities within Larimer County; and

WHEREAS, the County recognizes the importance of broad community input from municipal partners and healthcare providers in establishing and operating these services; and

WHEREAS, Article 2 of Title 29, Colorado Revised Statutes, as amended, authorizes referral of a county-wide sales and use tax to the registered electors of a county either by resolution adopted by the Board of County Commissioners of such county or by petition initiated and signed by five percent of the registered electors of such county; and

WHEREAS, pursuant to §29-2-104(3), Colorado Revised Statutes, as amended, the Board of County Commissioners of Larimer County ("County") in the State of Colorado ("State") desires to refer to the registered electors of the County a proposal for a county-wide sales and use tax at the next general election on November 6, 2018, a day which is within the next succeeding 120 days after the adoption of this Resolution; and

WHEREAS, §29-2-105, Colorado Revised Statutes, as amended, requires that a proposal for a county-wide sales and use tax contain certain provisions concerning the amount, levying and scope of such tax; and

WHEREAS, Article X, Section 20 of the State Constitution requires voter approval of the proposed county-wide sales and use tax; and

WHEREAS, §29-2-103.9 Colorado Revised Statutes authorizes Larimer County to levy a sales tax of up to one-quarter of one percent for the purpose of providing, directly or indirectly, mental health care services to residents of the Larimer County who are in need of mental health care services and to family members of such residents.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF LARIMER COUNTY that there shall be referred to the registered electors of the County at the general election to be held on November 6, 2018, the following proposal:

Section 1. THAT a county-wide one-quarter of one percent (0.25%) sales tax beginning January 1, 2019 in accordance with the provisions of Article 2, Title 29, Colorado Revised Statutes, as amended, and ending December 31, 2038, shall be imposed on the sale of tangible personal property at retail and the furnishing of services in the County, as provided in §29-2-105(d)(1), Colorado Revised Statutes, as amended, and as is more fully hereinafter set forth.

(a) For the purposes of this sales tax proposal, all retail sales are consummated at the place of business of the retailer unless the tangible personal property sold is delivered by the retailer or his agent to a destination outside the limits of the County or to a common carrier for delivery to a destination outside the limits of the County. The gross receipts from such sales shall include delivery charges when such charges are subject to the state sales and use tax imposed by Article 26 of Title 39, Colorado Revised Statutes, as amended, regardless of the place to which delivery is made. If a retailer has no permanent place of business in the County or has more than one place of business, the place or places at which the retail sales are consummated for the purpose of a sales tax imposed by this

proposal shall be determined by the provisions of Article 26 of Title 39, Colorado Revised Statutes, as amended, and by rules and regulations promulgated by the State Department of Revenue.

(b) The amount subject to tax shall not include the amount of any sales or use tax imposed by Article 26 of Title 39, Colorado Revised Statues, as amended.

(c) The tangible personal property and services taxable pursuant to this proposal shall be the same as the tangible personal property and services taxable pursuant to §39-26-104, Colorado Revised Statutes, as amended, and subject to the same exemptions as those specified in Part 7, Article 26, Title 39, Colorado Revised Statutes, as amended, and further subject to the exemptions for:

(1) The exemption for sales of machinery or machine tools specified in §39-26-709 (1), C.R.S.;

(2) The exemption for sales of electricity, coal, wood, gas, fuel oil, or coke specified in §39-26-715 (1)(a)(II), C.R.S.;

(3) The exemption for sales of food for home consumption specified in §39-26-707 (1)(e), C.R.S.;

(4) The exemption for vending machine sales of food specified in §39-26-714 (2), C.R.S.;

(5) The exemption for occasional sales by a charitable organization specified in §39-26-718 (1)(b), C.R.S.;

(6) The exemption for sales of farm equipment and farm equipment under lease or contract specified in §39-26-716 (2) (b) and (2)(c), C.R.S.;

(7) The exemption for sales of low-emitting motor vehicles, power sources, or parts used for converting such power sources as specified in §39-26-719(1), C.R.S.;

(8) The exemption for sales of components for production of energy from renewable energy sources specified in §39-26-724, C.R.S.

(d) All sales of personal property on which a specific ownership tax has been paid or is payable shall be exempt from the sales tax imposed by the County when such sales meet both of the following conditions:

(1) The purchaser is a non-resident of or has his principal place of business outside of the County; and

(2) Such personal property is registered or required to be registered outside the limits of the County under the laws of the State.

(e) The county-wide sales tax shall not apply to the sale of construction and building materials, as the term is used in §29-2-109, Colorado Revised Statutes, as amended, if such materials are picked up by the purchaser and if the purchaser of such materials presents to the retailer a building permit or other documentation acceptable to the County evidencing that a local use tax has been paid or is required to be paid.

(f) The county-wide sales tax will not apply to the sale of tangible personal property at retail or the funishing of services if the transaction was previously subjected to a sales or use tax already imposed on the purchaser or user by another statutory or home rule county equal to or in excess of that sought to be imposed by the County. A credit shall be granted against the sales tax imposed by the County with respect to such transaction equal in amount to the lawfully imposed local sales or use tax previously paid by the purchaser or user to the previous statutory or home rule county. The amount of the credit shall not exceed the sales tax imposed by the County.

(g) The county-wide sales tax will not apply to the sale of food purchased with food stamps. For purposes of this paragraph, "food" shall have the meaning as provided in 7 U.S.C. § 2012(g) as such section existed on October 1, 1987 or as such section is thereafter amended.

(h) The county-wide sales tax will not apply to the sale of food purchased with funds provided by the special supplemental food program for women, infants and children, 42 U.S.C. §1786. For purposes of this paragraph, "food" shall have the same meaning as provided in 42 U.S.C. §1786 as such section existed on October 1, 1987 or as such section is thereafter amended.

(i) Any person engaging in the business of selling tangible personal property at retail, or the furnishing of certain services as herein specified, is required to obtain a license therefore, which license shall be granted at no cost and issued by a designated official of the County Financial Administration Division. Such license shall be granted upon application stating the name and address of the person desiring such license, the name of such business and location, and such other facts as the said official may reasonably require. In case business is transacted at two (2) or more separate places by one person, a separate license for each place of business shall be required. Each license shall be posted in a conspicuous place in the place of business for which it is issued. No license shall be transferable. Any license may be revoked for cause as provided in §39-26-103, Colorado Revised Statutes, as amended, and any amendment thereto enacted before the effective date of this proposal, which provision is incorporated herein by this reference. No

license shall be required for any person engaged exclusively in the business of selling commodities which are exempt from taxation under this proposal.

(j) The vendor (retailer) shall not be entitled as collecting agent to withhold a collection fee unless such a fee, and the amount thereof is established by the Board of County Commissioners. If such fee is established, it will be administered as specified in Section 39-26-105, C.R.S. No vendor shall be entitled to the collection fee for any month that the vendor is or remains delinquent.

(k) The sales tax imposed shall be collected, administered and enforced by the Executive Director of the Department of Revenue in the same manner as the collection, administration and enforcement of the State sales tax, as provided by Article 26 of Title 39, Colorado Revised Statutes, as amended.

Section 2. THAT a county-wide one-quarter of one percent (0.25%) use tax beginning January 1, 2019 in accordance with the provisions of Article 2, Title 29, Colorado Revised Statutes, as amended, and ending December 31, 2038, shall be imposed for the privilege of using or consuming in the County any construction and building materials purchased at retail and for the privilege of storing, using, or consuming in the County any motor and other vehicles, purchased at retail on which registration is required. The use tax shall not apply:

(a) to the storage, use, or consumption of any tangible personal property the sale of which is subject to a retail sales tax imposed by the County;

(b) to the storage, use or consumption of any tangible personal property purchased for resale in the County either in its original form or as an ingredient of a manufactured or compounded product, in the regular course of a business;

(c) to the storage, use or consumption of tangible personal property brought into the County by a non-resident thereof for his own storage, use, or consumption while temporarily within the County; however, this exemption does not apply to the storage, use, or consumption of tangible personal property brought into this state by a non-resident to be used in the conduct of a business in this state;

(d) to the storage, use, or consumption of tangible personal property by the United States government, or the State, or its institutions, or its political subdivisions in their governmental capacities only or by religious or charitable corporations in the conduct of their regular religious or charitable functions;

(e) to the storage, use, or consumption of tangible personal property by a person engaged in the business of manufacturing or compounding for sale, profit, or use any article, substance, or commodity, which tangible personal property enters into the processing of or becomes an ingredient or component part of the product or

service which is manufactured, compounded, or furnished and the container, label, or the furnished shipping case thereof;

(f) to the storage, use, or consumption of any article of tangible personal property the sale or use of which has already been subjected to a legally imposed sales or use tax of another statutory or home rule county equal to or in excess of that imposed by the County. A credit shall be granted against the use tax imposed by the County with respect to a person's storage, use, or consumption in the County of tangible personal property purchased in another statutory or home rule county. The amount of the credit shall be equal to the tax paid by the person by reason of the imposition of a sales or use tax of the other statutory or home rule county on the purchase or use of the property. The amount of the credit shall not exceed the tax imposed by this proposal;

(g) to the storage, use, or consumption of tangible personal property and household effects acquired outside of the County and brought into it by a nonresident acquiring residency;

(h) to the storage or use of a motor vehicle if the owner is or was, at the time of purchase, a non-resident of the County and he purchased the vehicle outside of the County for use outside of the County and actually so used it for a substantial and primary purpose for which it was acquired and he registered, titled, and licensed said motor vehicle outside of the County;

(i) to the storage, use or consumption of any construction and building materials and motor and other vehicles on which registration is required if a written contract for the purchase thereof was entered into prior to the effective date of this use tax;

(j) to the storage, use, or consumption of any construction and building materials required or made necessary in the performance of any construction contract bid, let, or entered into, any time prior to the effective date of this use tax; or

(k) to the storage of construction and building materials.

Section 3. THAT the use tax provided-for herein shall be applicable to every motor vehicle for which registration is required by the laws of the State of Colorado, and no registration shall be made of any motor or other vehicle for which registration is required, and no certificate of title shall be issued for such vehicle by the Department of Revenue or its authorized agents until any tax due upon the use, storage, or consumption thereof pursuant hereto has been paid. The use tax imposed hereby shall be collected by the authorized agent of the Department of Revenue in this county. The proceeds of said use tax shall be paid to the County periodically in accordance with an agreement entered into by and between the County and the Department of Revenue.

Section 4. THAT distribution of all sales and use tax collected by the Director of Revenue, pursuant to this proposal, shall be to the County, which shall expend such moneys as described herein.

Section 5. THAT except as provided by §39-26-208 Colorado Revised Statutes, as amended, any use tax imposed shall be collected, enforced and administered by the County:

(a) Any person required to obtain a building permit within Larimer County and the owner of the real property shall be jointly and severally responsible for paying the Larimer County Sales and Use Tax. Prior to the issuance of a building permit, an amount of tax to be held on deposit shall be estimated by determining the building value for permit purposes and multiplying that value by a percentage prescribed by the Planning and Building Services Director. The County through the owner or contractor shall collect this amount. Upon payment of such sales or use tax deposit, the County shall issue a sales or use tax receipt identifying the address for which the purchase is being made and the county building permit number. It shall be the duty of the owner and/or contractor and subcontractors who are hired to do the stated work or any portion thereof to submit a project cost report to the Financial Officer, on forms authorized by the Financial Officer, stating the actual amounts of any purchases of fixtures or any other construction materials and supplies or tangible personal property for such work and to remit any tax due in excess of the sales or use tax deposit. In any case, the general contractor and/or owner will be held liable for the payment of all taxes for such materials.

(b) The owner and/or contractor shall keep and preserve all invoices, receipts and statements showing such purchases of construction materials and supplies and tangible personal property for a period of three (3) years after completion of construction. The County may, within that three-year period, conduct an audit of such records of the owner and/or contractor and any other relevant information to verify the actual cost of the construction materials and supplies and tangible personal property used therein to determine the actual tax due. If the actual tax due is more than that paid by the taxpayer, the Financial Officer shall serve a notice of determination, assessment and demand for payment on the taxpayer notifying him or her of the deficiency which may include penalty and interest.

Section 6. THAT if the majority of the qualified electors voting thereon vote for approval of the county-wide sales and use tax, such county-wide sales and use tax shall be effective throughout the incorporated and unincorporated portions of the County beginning January 1, 2019, and ending December 31, 2038.

Section 7. THAT revenues received by the County from the sales and use tax authorized hereby, net of expenses of the County in collecting, administering and enforcing such sales and use tax (the "net sales and use tax revenues"), and earnings from the investment of the net sales and use tax revenues shall be deposited to a fund known as

the county Mental Health Care services fund. The fund shall be used only for the purpose of providing detox and behavioral/mental health care facilities and services in accordance with this resolution and in accordance with §29-2-103.9 Colorado Revised Statutes.

Section 8. THAT for purposes of State Constitution Article X, Section 20, the receipt and expenditure of the sales and use tax revenues and earnings from the investment of sales and use tax revenues shall be accounted for, budgeted and appropriated separately from other revenues and expenditures of the County and outside of the fiscal year spending of the County as calculated under Article X, Section 20, and nothing in Article X, Section 20 shall limit the receipt and expenditure in each fiscal year of the full amount of such revenues, nor shall receipt and expenditure of such revenues affect or limit the receipt or expenditure of any and all other revenues of the County for any fiscal year.

Section 9. THAT the ballot title and ballot question on the county-wide sales and use tax proposal that shall be referred to the registered electors of the County at the general election to be held on Tuesday, November 6, 2018, shall be as follows:

SHALL LARIMER COUNTY TAXES BE INCREASED $19,000,000 DOLLARS ANNUALLY (ESTIMATED FIRST FISCAL YEAR DOLLAR INCREASE IN 2019), AND BY WHATEVER ADDITIONAL AMOUNT AS MAY BE RAISED ANNUALLY THEREAFTER, FOR A PERIOD OF 20 YEARS BY THE IMPOSITION OF A .25% (25 CENTS ON 100 DOLLARS) SALES AND USE TAX, WITH ALL REVENUE FROM SUCH TAX TO BE USED IN ACCORDANCE WITH THE BOARD OF COUNTY COMMISSIONERS RESOLUTION NO. 07242018R013 FOR THE FOLLOWING MENTAL/BEHAVIORAL HEALTH CARE PURPOSES:

-PROVIDE PREVENTATIVE, EARLY IDENTIFICATION, INTERVENTION, SUPPORT, AND TREATMENT SERVICES FOR YOUTH, ADULTS, FAMILIES, AND SENIOR CITIZENS, EITHER DIRECTLY OR INDIRECTLY, WHO ARE RESIDENTS OF LARIMER COUNTY INCLUDING BERTHOUD, ESTES PARK, FORT COLLINS, JOHNSTOWN, LOVELAND, TIMNATH, WELLINGTON, WINDSOR AND RURAL COMMUNITIES OF LARIMER COUNTY, THROUGH IN-PERSON AND OTHER DELIVERY METHODS, WHICH MAY INCLUDE TELE-SERVICES, COMMUNITY BASED SERVICES AND OTHER SERVICE OPTIONS; AND

-ACQUIRE, CONSTRUCT, IMPROVE, MAINTAIN, LEASE, REMODEL, STAFF, EQUIP, AND OPERATE NEW AND/OR EXISTING MENTAL/BEHAVIORAL HEALTH FACILITIES;

AND SHALL THE COUNTY BE AUTHORIZED TO COLLECT, RETAIN AND SPEND ALL PROCEEDS OF SUCH TAX WITHOUT LIMITATION BY ARTICLE X, SECTION 20 OF THE COLORADO CONSTITUTION, AND FURTHER PROVIDED THAT AN ANNUAL REPORT SHALL BE PUBLISHED AND PROVIDED TO THE

BOARD OF COUNTY COMMISSIONERS ON THE DESIGNATION OR USE OF THE REVENUES FROM THE TAX INCREASE IN THE PRECEDING CALENDAR YEAR CONSISTENT WITH ITS APPROVED PURPOSES?

_______________YES

_______________NO

Section 10. THAT the approval of this resolution shall be considered Final Action for setting the ballot title and ballot question and final action for all other purposes under §1-11-203.5 Colorado Revised Statutes.

Section 11. THAT the conduct of the election shall conform, so far as practicable, to the general election laws of the State. The County hereby adopts the provisions of §1-11-203.5, Colorado Revised Statutes, as amended, as the exclusive procedure for protesting or contesting the content of the ballot title set forth above.

Section 12. THAT the cost of the election shall be paid from the general fund of the County.

Section 13. THAT the County Clerk and Recorder is hereby designated as the County's "designated election official," as defined in §1-1-104(8), Colorado Revised Statutes, as amended, as the person responsible for running the election, and is directed and authorized to take such action as may be necessary to call, hold and canvass the election in accordance with law.

Section 14. THAT pursuant to §29-2-104(5), Colorado Revised Statutes, as amended, the County Clerk and Recorder shall cause to be published the text of the proposal for a county-wide sales and use tax four separate times, a week apart, in the official newspaper of the County and each city and incorporated town within the County.

Section 15. THAT the County Clerk and Recorder shall cause to be published, at least ten days before the election and in the form and containing the information required by law, the notice required by §1-5-205, Colorado Revised Statutes, as amended. Such notice shall also be posted as required by §1-5-205(1.3), Colorado Revised Statutes, as amended.

Section 16. THAT the County Clerk and Recorder shall cause a notice to all registered electors of the County to be mailed in accordance with Article X, Section 20(3)(b) of the State Constitution and other applicable laws. Such notice shall be in the form and contain the information required by law.

Section 17. THAT a notice of the adoption of this county-wide sales and use tax proposal by a majority of the registered electors voting thereon shall be submitted by the County Clerk and Recorder to the Executive Director of the Department of Revenue

at least 45 days prior to the effective date of such tax, together with a certified copy of this Resolution.

Section 18. THAT the County is authorized to adopt such uniform rules and regulations as may be necessary for the administration and enforcement of the sales and use tax; and the Board of County Commissioners or their authorized representatives are hereby empowered to enter into and execute on behalf of the county any agreements necessary for the administration and enforcement of the sales and use tax. The Board of County Commissioners may change the procedures of collection of the sales and use tax, vendor fees, and the administration or enforcement of the sales and use tax, but may not add or eliminate exeptions withour further voter approval, except the Board of County Commissioners may add, eliminate or change exemptions without further voter approval to reflect changes in the exemptions as set forth in state law.

Section 19. THAT the officers and employees of Larimer County and the Larimer County Clerk and Reocrder are authorized to take all action necessary to carry out this resolution pursuant to Colorado law.

Section 20. THAT if any provision of this proposal or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect the provisions or applications of this proposal regarding the sales and use tax which can be given affect without the invalid provision or application and to this end, the provisions of this proposal are declared to be severable.

ADOPTED this 24th day of July, 2018.

BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF LARIMER

Steve Johnson
Chair

ATTEST:

By: Elizabeth Kimball
Deputy Clerk of the Board

LARIMER COUNTY CLERK
SEAL
COLORADO

APPROVED AS TO FORM:

By: [signature] 7-19-18
Deputy County Attomey Date

Appendix B

Behavioral Health Barometer

Colorado, Volume 4

Indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System

Acknowledgments

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by RTI International under contract No. 283–12–0605 with SAMHSA, U.S. Department of Health and Human Services (HHS).

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Originating Office

Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857.

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FOREWORD

The Substance Abuse and Mental Health Services Administration (SAMHSA), an operating division within the U.S. Department of Health and Human Services (HHS), is charged with reducing the impact of substance abuse and mental illness on America's communities. SAMHSA is pursuing this mission at a time of significant change.

Behavioral Health Barometer: Colorado, Volume 4: Indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System is one of a series of national and state reports that provide a snapshot of behavioral health in the United States. The report presents a set of substance use and mental health indicators as measured through the National Survey on Drug Use and Health (NSDUH), the National Survey of Substance Abuse Treatment Services (N-SSATS), and the Uniform Reporting System (URS), sponsored by SAMHSA. This array of indicators provides a unique overview of the nation's behavioral health at a point in time as well as a mechanism for tracking change and trends over time. Because of the partial redesign of the 2015 NSDUH (the source of much of the data included in this report), certain measures included in previous Barometer reports are not included in this report. These measures include any illicit drug use, misuse of prescription drugs, perceived risk from substance use, binge and heavy alcohol use, and substance use treatment among those with a substance use disorder (for more information, please see https://www.samhsa.gov/data/sites/default/files/NSDUH-TrendBreak-2015.pdf). The 2015 report includes single-day counts of the number of individuals in substance use treatment from N-SSATS. The Behavioral Health Barometers provide critical information in support of SAMHSA's mission of reducing the impact of substance abuse and mental illness on America's communities.

Behavioral Health Barometers for the nation and for all 50 states and the District of Columbia* are published as part of SAMHSA's larger behavioral health quality improvement approach.

Kana Enomoto, MA, Acting Deputy Assistant Secretary
Substance Abuse and Mental Health Services Administration

* N-SSATS collects data throughout the 50 states, the District of Columbia, Puerto Rico, and other U.S. jurisdictions, which include the territory of Guam, the Federated States of Micronesia, the Republic of Palau, Puerto Rico, and the Virgin Islands of the United States.

INTRODUCTION

Purpose of this Report. *Behavioral Health Barometer: Colorado, Volume 4* provides an annual update on a series of topics that focus on substance use and mental health (collectively referred to as *behavioral health*) in Colorado and the United States. SAMHSA selected specific topics and indicators in this report to represent a cross-section of the key behavioral health indicators that are assessed in SAMHSA data collections, including NSDUH, N-SSATS, and URS. This report is intended to provide a concise, reader-friendly summary of key behavioral health measures for lay and professional audiences.

Organization of this Report. This report is divided into sections based on content areas and age groups. It begins with sections on substance use, mental health, and mental health treatment among youths aged 12 to 17, followed by a section on mental health and mental health service use among adults aged 18 or older. Next are sections on substance use, use disorders, and treatment among youths and adults.

Figure titles are included above all graphics, including callouts for figure notes that are presented on pages 15 and 16. These figure notes include additional information about the measures, populations, and analyses presented in the graphics and text. Definitions of key measures and terms included in the report are presented on page 17.

Methodological Information. The NSDUH data included on pages 1, 2, 3, 5, 7, 8, 11, and 12 are state estimates based on a small area estimation (SAE) procedure, a statistical model in which state-level NSDUH data from 2 consecutive survey years are combined with local-area county and census block group/tract-level data from the state. This model-based methodology provides more precise estimates at the state level than those based solely on the sample, particularly for states with smaller sample sizes. The measures on pages 4, 6, and 9 are annual averages based on 5 combined years of NSDUH data because the corresponding small area estimates are unavailable. Statistical tests have been conducted for all statements appearing in the text of the report based on NSDUH data, including (1) statistical tests between the state and the nation as a whole using the SAE procedure to account for the correlation between the state and national estimates, (2) statistical tests between different years of data in the state using the SAE procedure to take into account the correlation across time in the local area predictors used in the models (please see Figure Note 1 on page 15 for more information), and (3) statistical tests between the state and the nation using t-tests on pages with direct estimates based on combined years of NSDUH data. Unless explicitly stated that a difference is not statistically significant, all statements based on NSDUH data that describe differences are significant at the .05 level. Page 10 presents URS data, which are derived from counts of mental health consumers in the public mental health system, and pages 13 and 14 present N-SSATS data, which are derived from counts of people enrolled at substance use treatment facilities. Because these two data sources are derived from counts from all facilities rather than from a sample of facilities, conducting significance tests is not necessary.

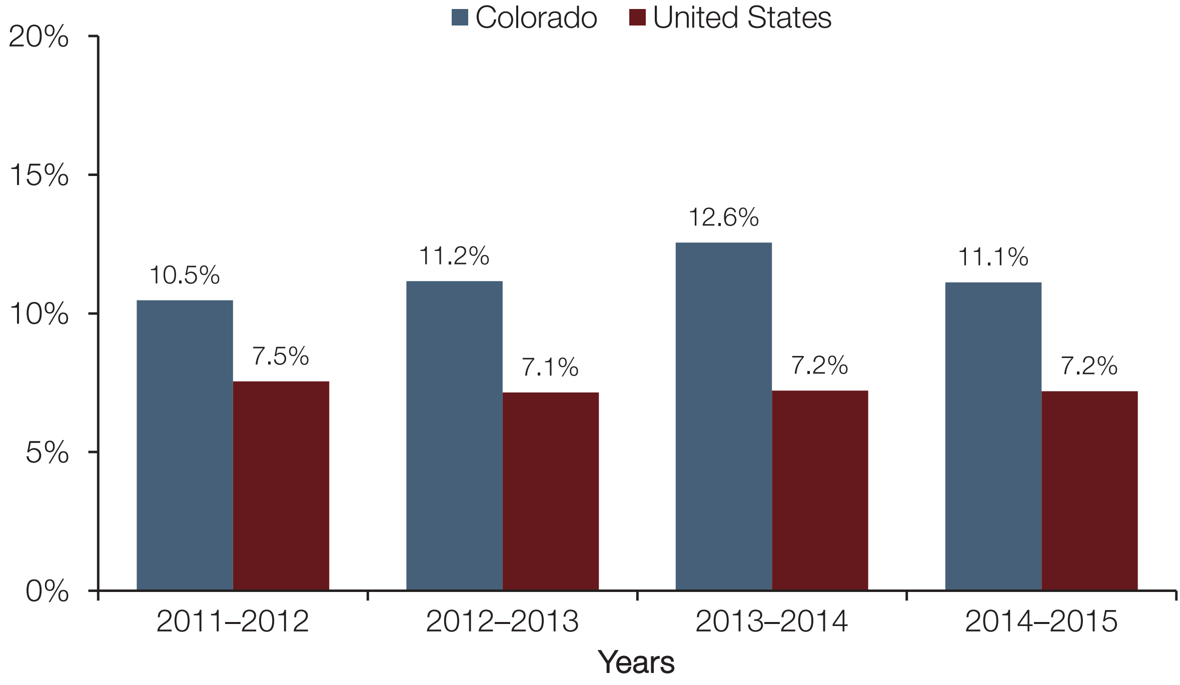
Tables that display all data points included in this report, including tests of statistical significance and standard errors, are available on request. To request these tables or to ask any questions regarding how to use or interpret the data included in this report, please contact CBHSQRequest@samhsa.hhs.gov.

YOUTH SUBSTANCE USE

MARIJUANA USE

Past Month Marijuana Use Among Adolescents Aged 12–17 in Colorado and the United States (Annual Averages, 2011–2012 to 2014–2015)[1]

In 2014–2015, Colorado's annual average percentage of marijuana use among adolescents aged 12–17 was higher than the corresponding national annual average percentage.

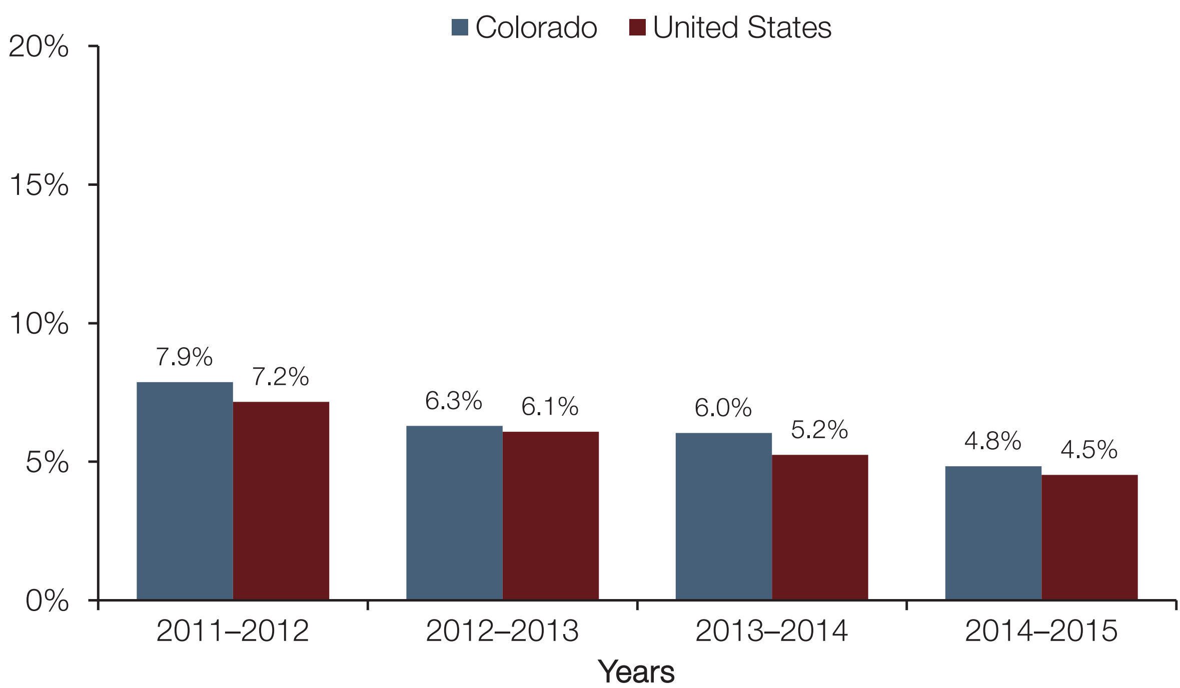


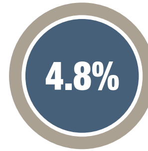
In Colorado, an annual average of about 46,000 adolescents aged 12–17 (11.1% of all adolescents) in 2014–2015 used marijuana in the past month. The annual average percentage in 2014–2015 was not significantly different from the annual average percentage in 2011–2012.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2012 to 2014–2015.

Past Month Cigarette Use Among Adolescents Aged 12–17 in Colorado and the United States (Annual Averages, 2011–2012 to 2014–2015)[1]

In 2014–2015, Colorado's annual average percentage of cigarette use among adolescents aged 12–17 was similar to the corresponding national annual average percentage.



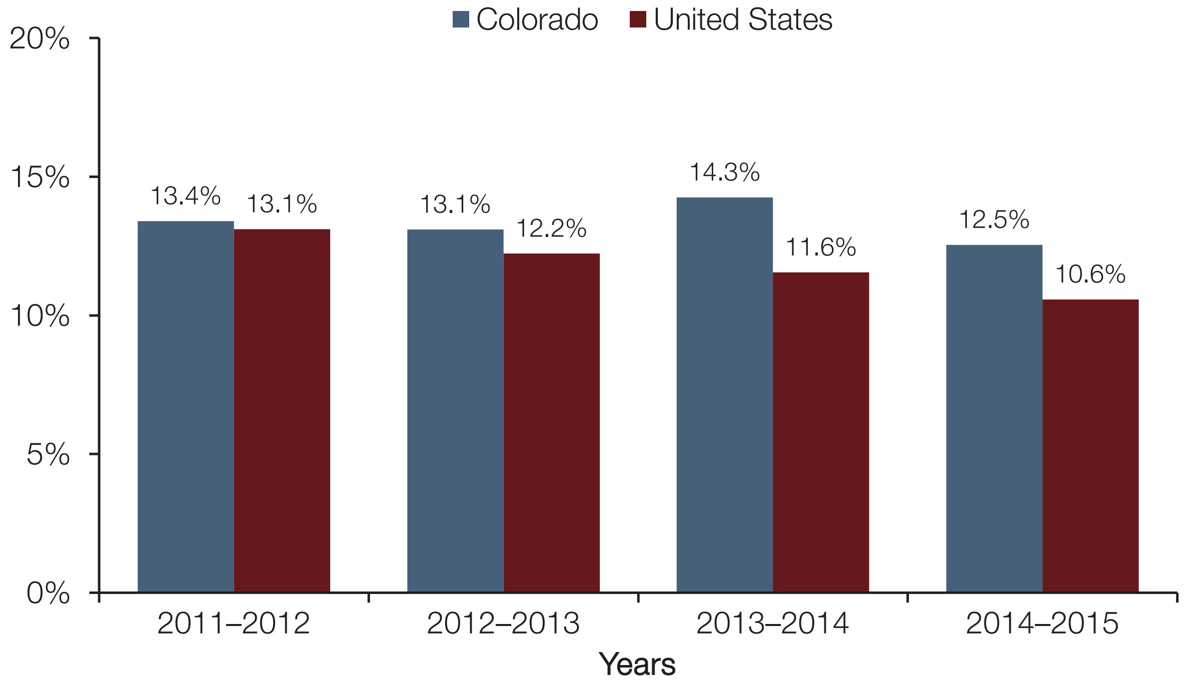


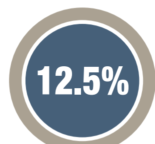
In Colorado, an annual average of about 20,000 adolescents aged 12–17 (4.8% of all adolescents) in 2014–2015 used cigarettes in the past month. The annual average percentage in 2014–2015 was lower than the annual average percentage in 2011–2012.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2012 to 2014–2015.

Past Month Alcohol Use Among Adolescents Aged 12–17 in Colorado and the United States (Annual Averages, 2011–2012 to 2014–2015)[1]

In 2014–2015, Colorado's annual average percentage of alcohol use among adolescents aged 12–17 was similar to the corresponding national annual average percentage.



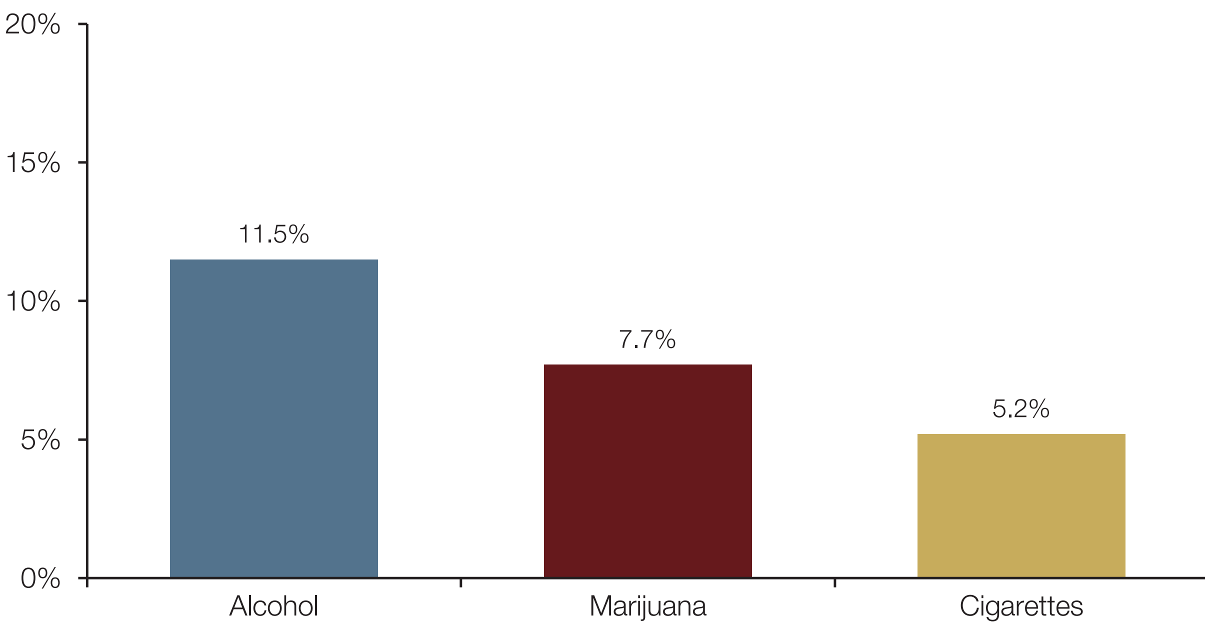


In Colorado, an annual average of about 52,000 adolescents aged 12–17 (12.5% of all adolescents) in 2014–2015 used alcohol in the past month. The annual average percentage in 2014–2015 was not significantly different from the annual average percentage in 2011–2012.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2012 to 2014–2015.

Past Year Initiation (First Use) of Selected Substances Among Adolescents Aged 12–17 in Colorado (Annual Averages, 2011–2015)[2]

Among adolescents aged 12–17 in Colorado from 2011 to 2015, an annual average of 11.5% initiated alcohol use (i.e., used it for the first time) in the past year, an annual average of 7.7% initiated marijuana use in the past year, and an annual average of 5.2% initiated cigarette use in the past year.



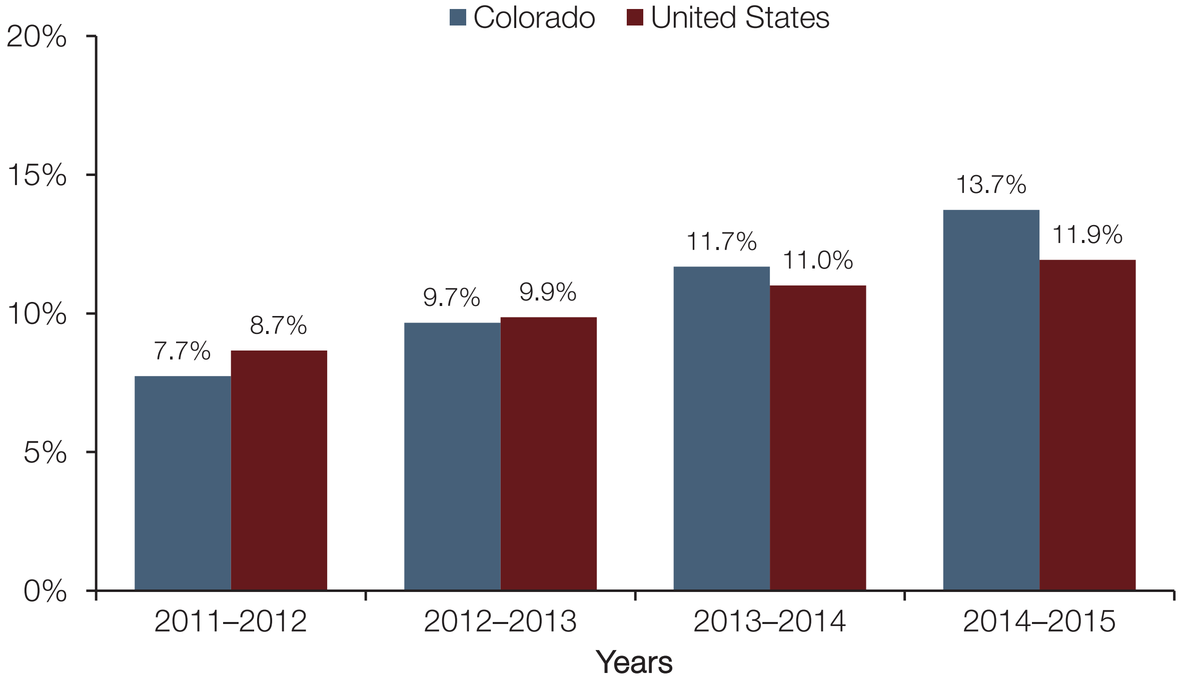
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2015.

YOUTH MENTAL HEALTH AND SERVICE USE

DEPRESSION

Past Year Major Depressive Episode (MDE) Among Adolescents Aged 12–17 in Colorado and the United States (Annual Averages, 2011–2012 to 2014–2015)[1,3]

In 2014–2015, Colorado's annual average percentage of major depressive episode (MDE) among adolescents aged 12–17 was similar to the corresponding national annual average percentage.



In Colorado, an annual average of about 57,000 adolescents aged 12–17 (13.7% of all adolescents) in 2014–2015 had experienced an MDE in the past year. The annual average percentage in 2014–2015 was higher than the annual average percentage in 2011–2012.

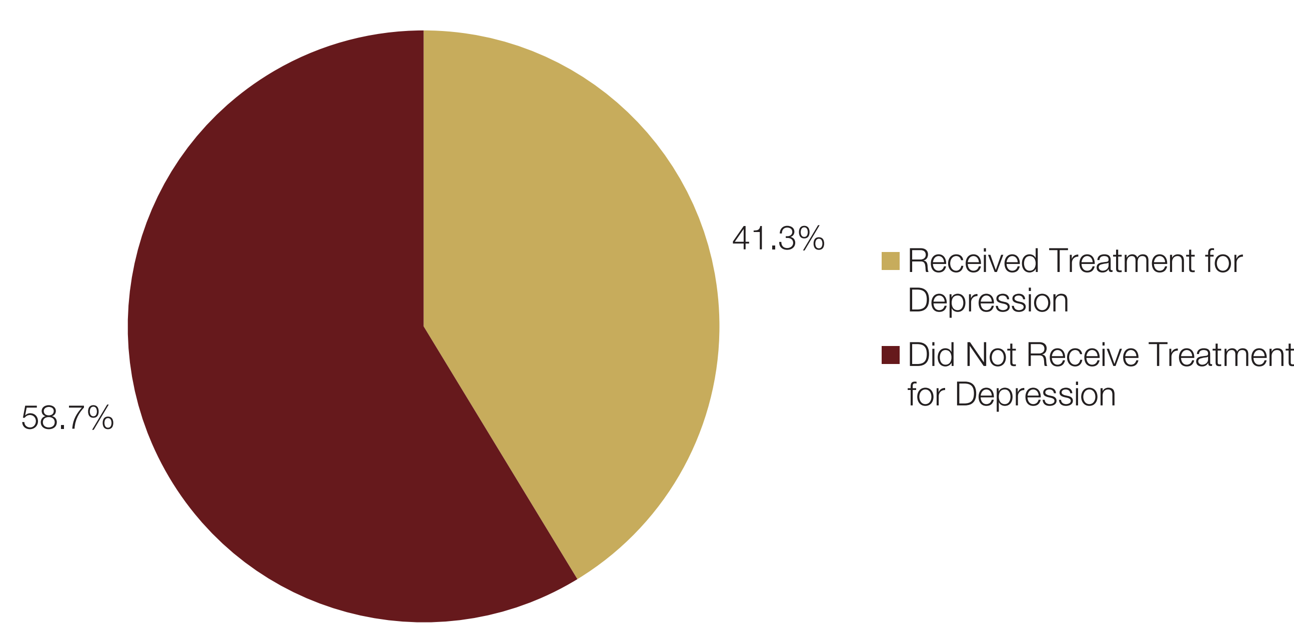
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2012 to 2014–2015.

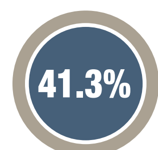
YOUTH MENTAL HEALTH AND SERVICE USE

TREATMENT FOR DEPRESSION

Past Year Treatment for Depression Among Adolescents Aged 12–17 with Major Depressive Episode (MDE) in Colorado (Annual Average, 2011–2015)[2,4]

From 2011 to 2015, Colorado's annual average percentage of past year treatment for depression among adolescents aged 12–17 with past year MDE was similar to the corresponding national annual average percentage (38.9%).





In Colorado, an annual average of about 19,000 adolescents aged 12–17 with past year MDE (41.3% of all adolescents with past year MDE) from 2011 to 2015 received treatment for their depression in the past year.

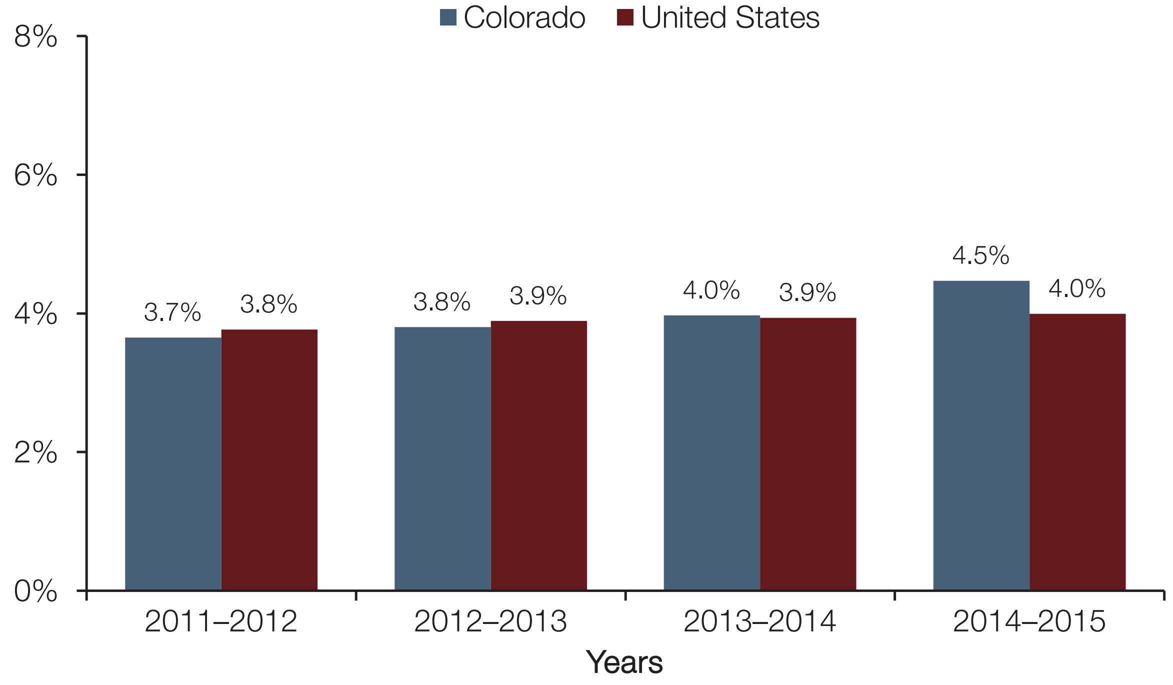
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2015.

MENTAL HEALTH AND SERVICE USE

SERIOUS THOUGHTS OF SUICIDE

Past Year Serious Thoughts of Suicide Among Adults Aged 18 or Older in Colorado and the United States (Annual Averages, 2011–2012 to 2014–2015)[1,5]

In 2014–2015, Colorado's annual average percentage of adults aged 18 or older with past year serious thoughts of suicide was similar to the corresponding national annual average percentage.

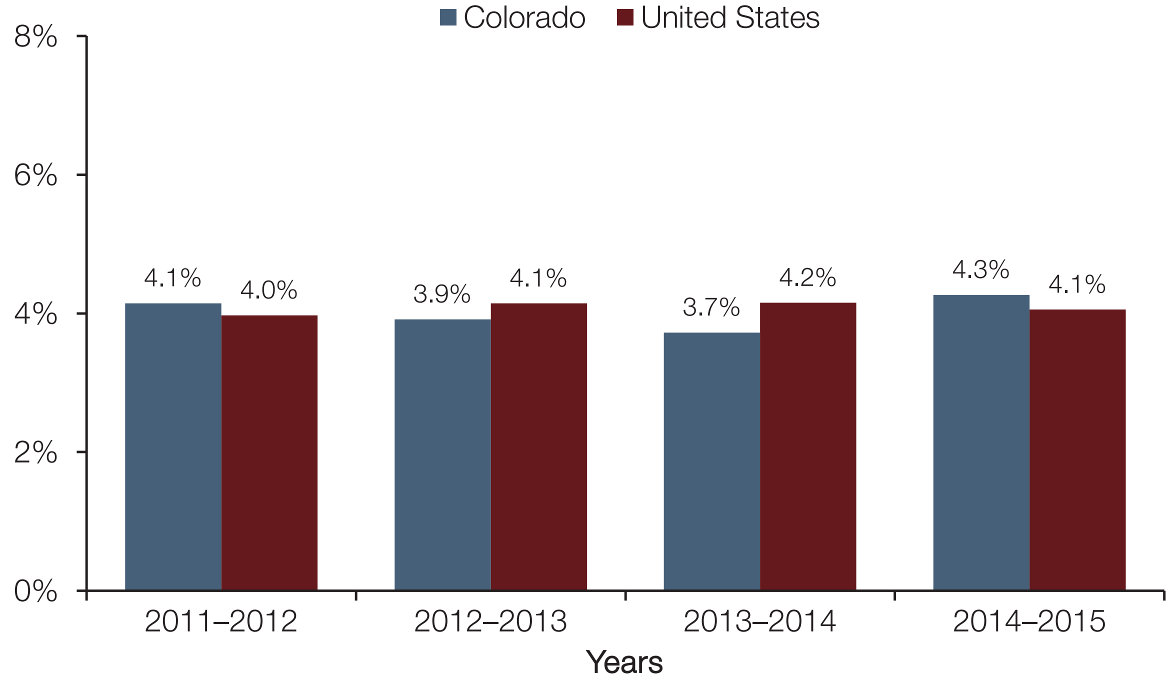


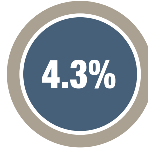
In Colorado, an annual average of about 182,000 adults aged 18 or older (4.5% of all adults) in 2014–2015 had serious thoughts of suicide in the past year. The annual average percentage in 2014–2015 was not significantly different from the annual average percentage in 2011–2012.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2012 to 2014–2015.

Past Year Serious Mental Illness (SMI) Among Adults Aged 18 or Older in Colorado and the United States (Annual Averages, 2011–2012 to 2014–2015)[1,6]

In 2014–2015, Colorado's annual average percentage of past year serious mental illness (SMI) among adults aged 18 or older was similar to the corresponding national annual average percentage.





In Colorado, an annual average of about 173,000 adults aged 18 or older (4.3% of all adults) in 2014–2015 had SMI in the past year. The annual average percentage in 2014–2015 was not significantly different from the annual average percentage in 2011–2012.

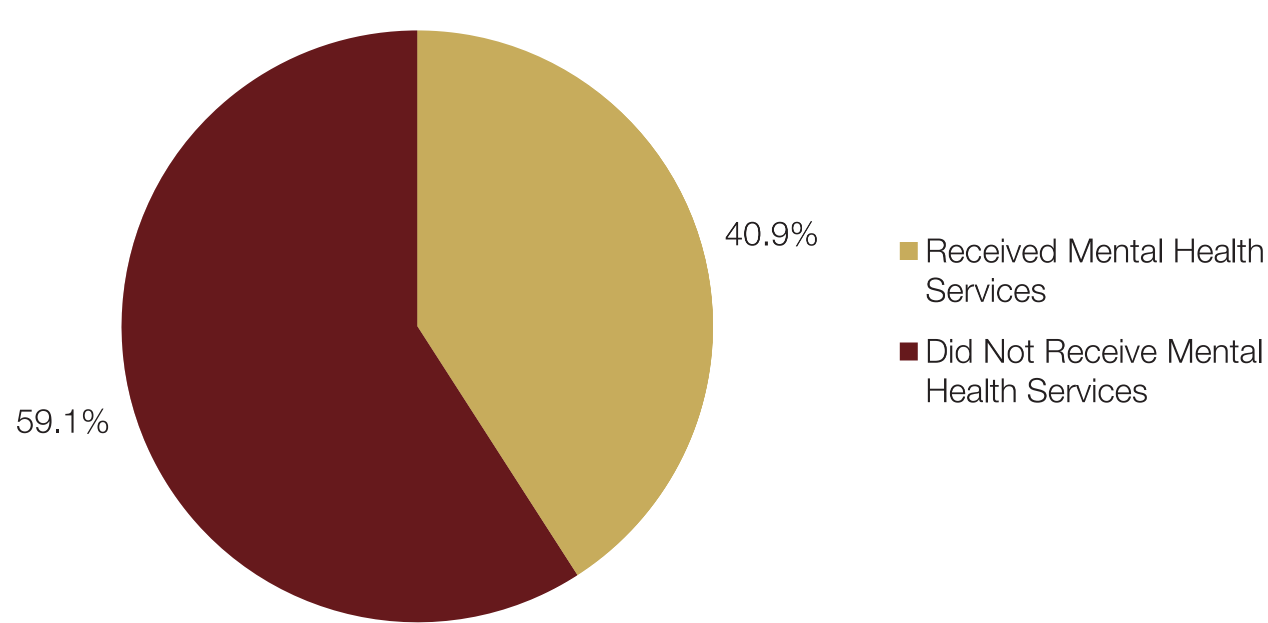
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2012 to 2014–2015.

MENTAL HEALTH AND SERVICE USE

MENTAL HEALTH SERVICE USE AMONG ADULTS WITH ANY MENTAL ILLNESS

Past Year Mental Health Service Use Among Adults Aged 18 or Older with Any Mental Illness (AMI) in Colorado (Annual Average, 2011–2015)[2,7]

From 2011 to 2015, Colorado's annual average of past year mental health service use among adults aged 18 or older with any mental illness (AMI) was similar to the corresponding national annual average percentage (42.9%).

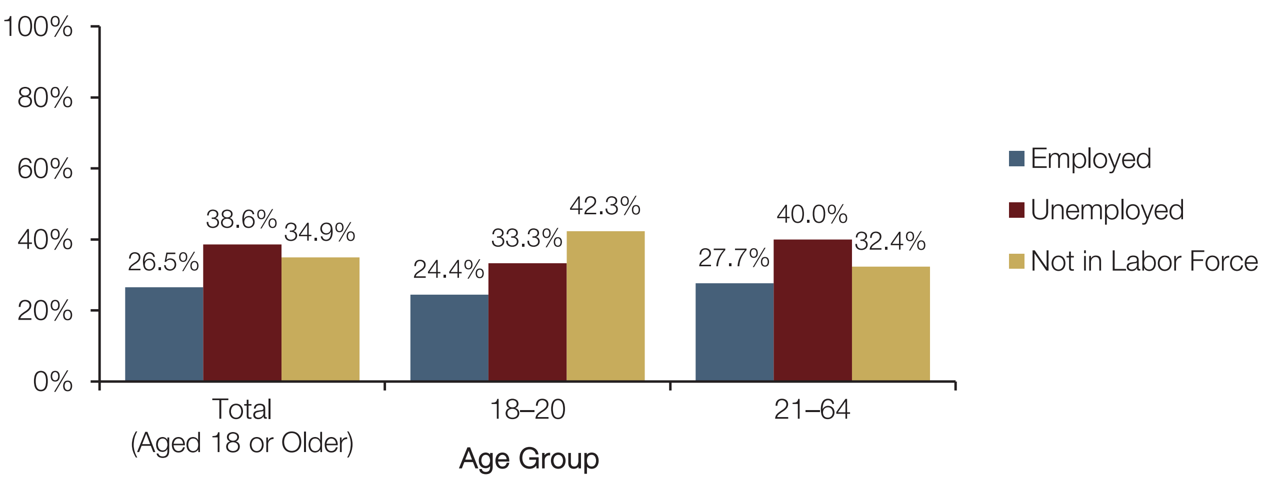


In Colorado, an annual average of about 297,000 adults aged 18 or older with AMI (40.9% of all adults with AMI) from 2011 to 2015 received mental health services in the past year.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2015.

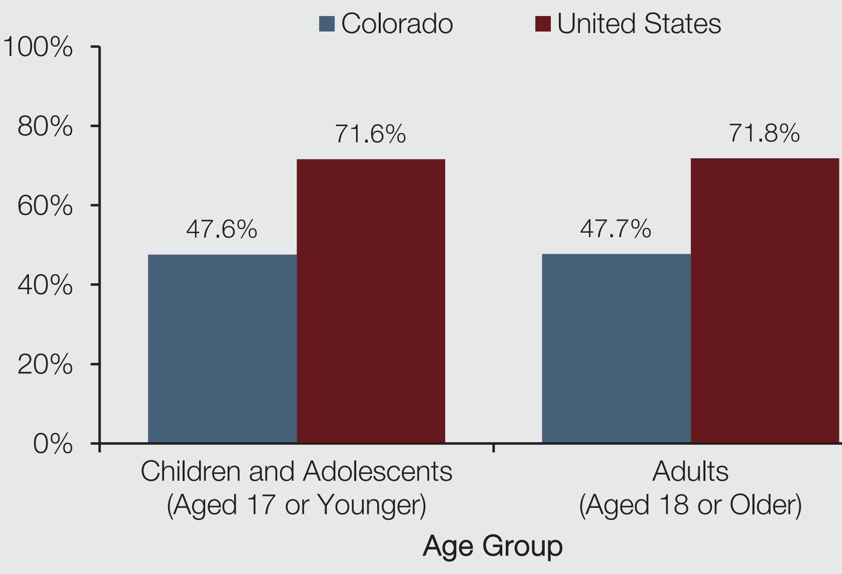
Adult Mental Health Consumers Served in the Public Mental Health System in Colorado, by Age Group and Employment Status (2015)[8]

Among adults served in Colorado's public mental health system in 2015, 42.3% of those aged 18–20, 32.4% of those aged 21–64, and 76.4% of those aged 65 or older were not in the labor force.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, Uniform Reporting System, 2015.

Mental Health Consumers in Colorado and the United States Reporting Improved Functioning from Treatment Received in the Public Mental Health System (2015)



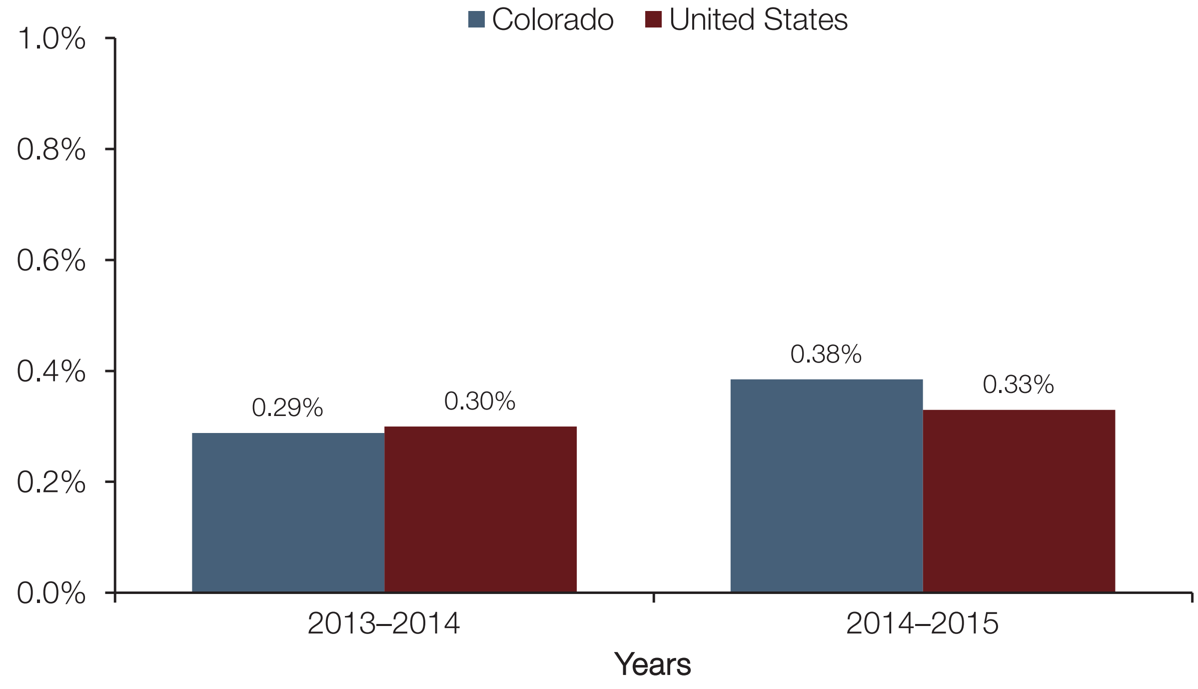
In 2015, 39,177 children and adolescents (aged 17 or younger) were served in Colorado's public mental health system.

The annual average percentage of children and adolescents (aged 17 or younger) reporting improved functioning from treatment received in the public mental health system was lower in Colorado than in the nation as a whole. The annual average percentage for adults (aged 18 or older) was lower in Colorado than in the nation as a whole.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, Uniform Reporting System, 2015.

Past Year Heroin Use Among Individuals Aged 12 or Older in Colorado and the United States (Annual Averages, 2013–2014, 2014–2015)[1,9]

In 2014–2015, Colorado's annual average percentage of past year heroin use among individuals aged 12 or older was similar to the corresponding national annual average percentage.

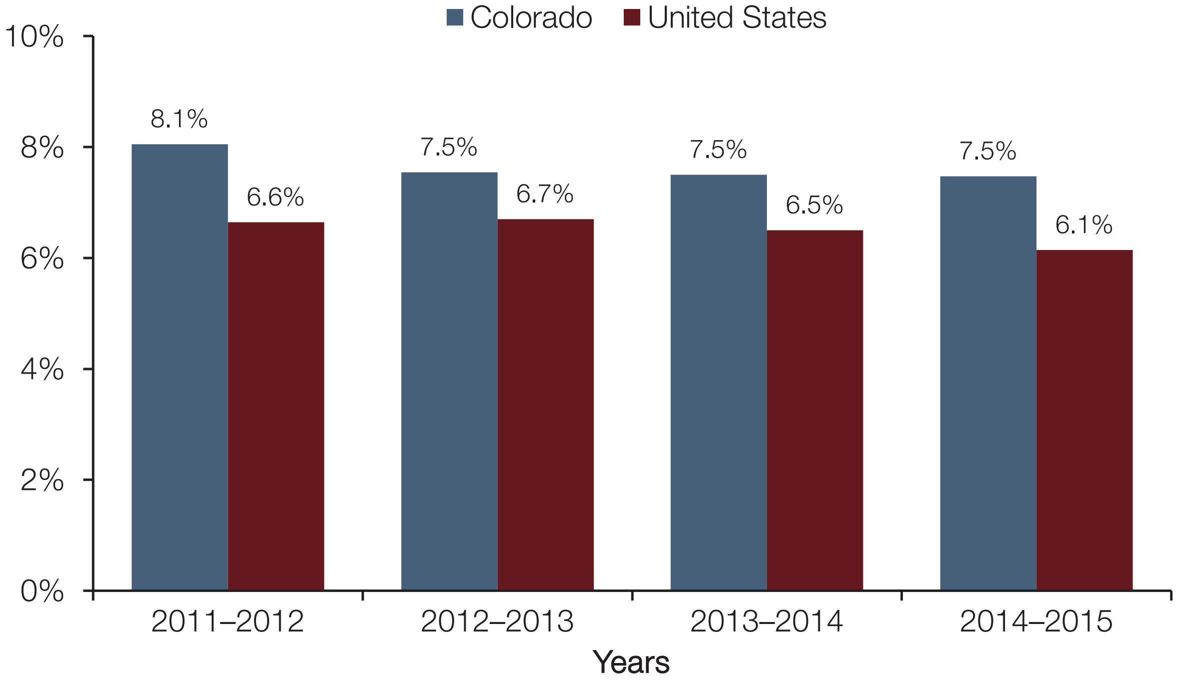


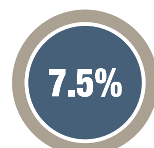
In Colorado, an annual average of about 17,000 individuals aged 12 or older (0.38% of all individuals in this age group) in 2014–2015 had used heroin in the past year. The annual average percentage in 2014–2015 was higher than the annual average percentage in 2013–2014.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2013–2014 and 2014–2015.

Past Year Alcohol Use Disorder Among Individuals Aged 12 or Older in Colorado and the United States (Annual Averages, 2011–2012 to 2014–2015)[1]

In 2014–2015, Colorado's annual average percentage of past year alcohol use disorder among individuals aged 12 or older was higher than the corresponding national annual average percentage.





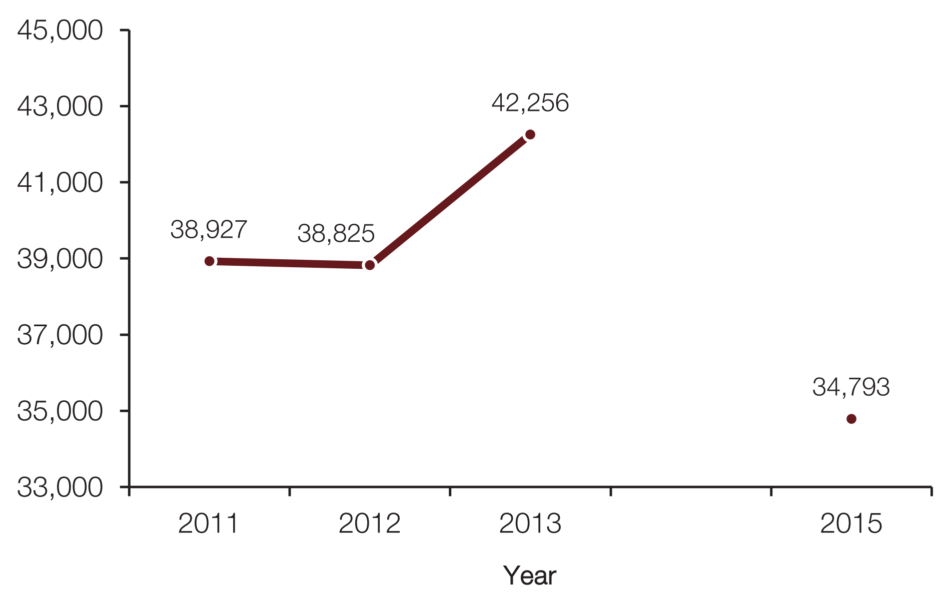
In Colorado, an annual average of about 335,000 individuals aged 12 or older (7.5% of all individuals in this age group) in 2014–2015 had an alcohol use disorder in the past year. The annual average percentage in 2014–2015 was not significantly different from the annual average percentage in 2011–2012.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2012 to 2014–2015.

SUBSTANCE USE TREATMENT

ENROLLMENT AND TREATMENT FOCUS

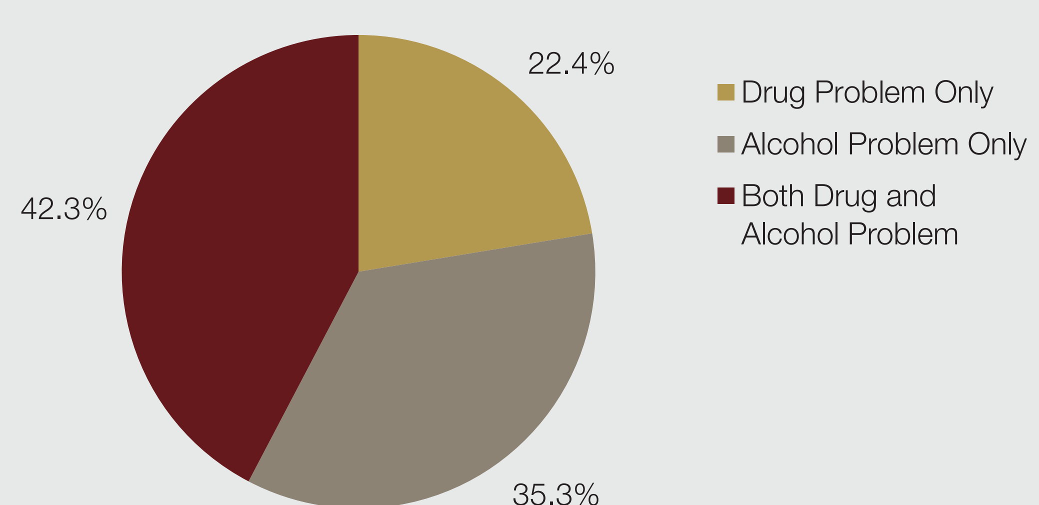
Number of Individuals Enrolled in Substance Use Treatment in Colorado: Single-Day Counts (2011–2013, 2015)[10]



In a single-day count in 2015, 34,793 individuals in Colorado were enrolled in substance use treatment—a decrease from 38,927 individuals in 2011.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys of Substance Abuse Treatment Services, 2011–2013, 2015.

Substance Use Problems Among Individuals Enrolled in Substance Use Treatment in Colorado: Single-Day Count (2015)[11]



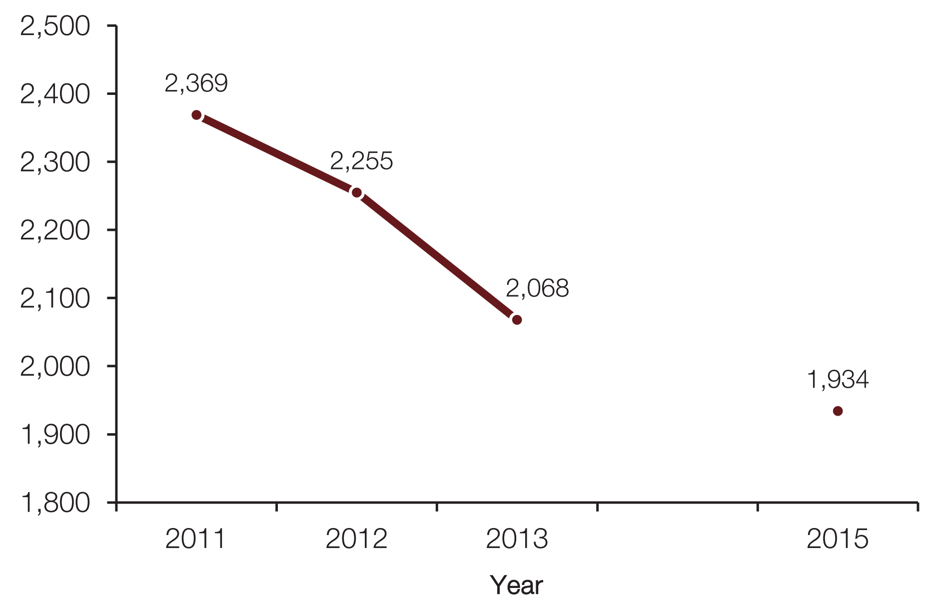
Among individuals in Colorado enrolled in substance use treatment in a single-day count in 2015, 22.4% were in treatment for a drug problem only, 35.3% were in treatment for an alcohol problem only, and 42.3% were in treatment for both drug and alcohol problems.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey of Substance Abuse Treatment Services, 2015.

SUBSTANCE USE TREATMENT

OPIOIDS (MEDICATION-ASSISTED THERAPY)

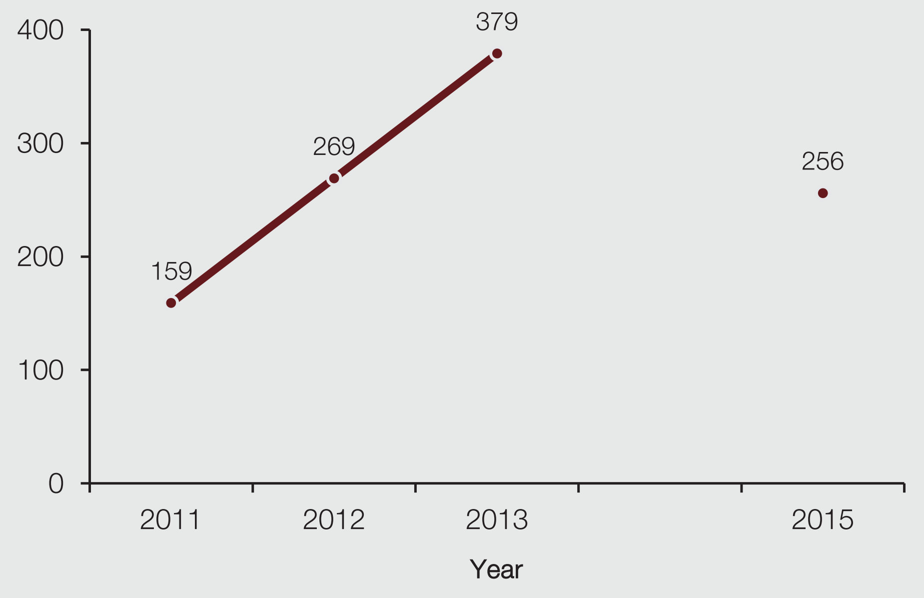
Number of Individuals Enrolled in Opioid Treatment Programs in Colorado Receiving Methadone: Single-Day Counts (2011–2013, 2015)[12]



In a single-day count in 2015, 1,934 individuals in Colorado were receiving methadone in opioid treatment programs as part of their substance use treatment—a decrease from 2,369 individuals in 2011.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys of Substance Abuse Treatment Services, 2011–2013, 2015.

Number of Individuals Enrolled in Treatment at Substance Use Treatment Facilities in Colorado Receiving Buprenorphine: Single-Day Counts (2011–2013, 2015)[12,13]



In a single-day count in 2015, 256 individuals in Colorado were receiving buprenorphine as part of their substance use treatment—an increase from 159 individuals in 2011, but a decrease from 269 individuals in 2012 and 379 individuals in 2013.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys of Substance Abuse Treatment Services, 2011–2013, 2015.

FIGURE NOTES

[1] State estimates on this page are based on a small area estimation procedure in which state-level National Survey on Drug Use and Health (NSDUH) data from 2 consecutive survey years are combined with local-area county and census block group/tract-level data from the state. This model-based methodology provides more precise estimates at the state level than those based solely on the sample, particularly for states with smaller sample sizes.

- Statistical tests between the state and the nation as a whole using small area estimates account for the correlation between the state and national estimates. For additional information on how these tests are conducted, please see https://www.samhsa.gov/data/sites/default/files/NSDUHsaePvalue2015A/NSDUHsaePvalueDocs2015.htm.

- Statistical tests between different years of data in the state using small area estimates take into account the correlation across time in the local area predictors used in the models, and these tests are conducted differently if the years being compared include overlapping years (e.g., 2013–2014 vs. 2014–2015) or years that do not overlap (e.g., 2010–2011 vs. 2014–2015).

  – For more information on how these tests are conducted when comparing overlapping years, please see https://www.samhsa.gov/data/sites/default/files/NSDUHsaeShortTermCHG2015/NSDUHsaeShortTermCHG2015.htm.

  – For more information on how these tests are conducted when comparing years that do not overlap, please see https://www.samhsa.gov/data/sites/default/files/NSDUHsaeLongTermCHG2015/NSDUHsaeLongTermCHG2015.htm.

[2] Estimates are annual averages based on combined 2011–2015 NSDUH data or combined 2009–2015 NSDUH data where indicated. These estimates are based solely on the sample, unlike estimates based on the small area estimation procedure as stated above.

[3] Respondents with unknown past year major depressive episode (MDE) data were excluded.

[4] Respondents with unknown past year MDE or unknown treatment data were excluded.

[5] Estimates were based only on responses to suicide items in the NSDUH Mental Health module. Respondents with unknown suicide information were excluded.

[6] Estimates of serious mental illness (SMI) and any mental illness (AMI) presented in this publication may differ from estimates in other publications as a result of revisions made to the NSDUH mental illness estimation models in 2012. Other NSDUH mental health measures presented were not affected. The 2013, 2014, and 2015 Barometer reports include the revised SMI and AMI estimates. For further information, see *Revised Estimates of Mental Illness from the National Survey on Drug Use and Health*, which is available on the SAMHSA Web site at https://www.samhsa.gov/data/sites/default/files/NSDUH148/NSDUH148/sr148-mental-illness-estimates.pdf.

[7] Respondents were not to include treatment for drug or alcohol use. Respondents with unknown service use information were excluded. Estimates were based only on responses to items in the NSDUH Adult Mental Health Service Utilization module.

[8] Not in labor force is defined as those who did not have a job and who were not looking for a job. Examples could include those who were students, retired, disabled, or not working due to family responsibilities. Note that mental health consumers aged 65 or older are not included because they are of retirement age.

[9] State estimates of past year heroin use based on a small area estimation procedure are not available prior to 2013–2014.

[10] Single-day counts reflect the number of individuals who were enrolled in substance use treatment on March 31, 2011; March 30, 2012; March 29, 2013; and March 31, 2015. Single-day counts of the number of individuals enrolled in substance use treatment were not included in the 2014 National Survey of Substance Abuse Treatment Services (N-SSATS).

[11] Enrollees whose substances were unknown were excluded.

[12] These counts reflect only individuals who were receiving these specific medication-assisted therapies as part of their opioid treatment in specialty substance abuse treatment programs; they do not include counts of individuals who were receiving other types of treatment (including those who received MAT from private physicians) for their opioid addiction on the reference dates.

[13] Physicians who obtain specialized training per the Drug Addiction Treatment Act of 2000 (DATA 2000) may prescribe buprenorphine to treat opioid addiction. Some physicians are in private, office-based practices; others are affiliated with substance abuse treatment facilities or programs and may prescribe buprenorphine to clients at those facilities. Additionally, opioid treatment programs (OTPs) may also prescribe and/or dispense buprenorphine. The buprenorphine single-day counts include only those clients who received/were prescribed buprenorphine by physicians affiliated with substance abuse treatment facilities; they do not include clients from private practice physicians.

Alcohol use disorder is defined using diagnostic criteria specified within the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), which include such symptoms as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past year. For details, see American Psychiatric Association (1994).

Any mental illness (AMI) among adults aged 18 or older is defined as currently or at any time in the past year having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet DSM-IV criteria. Adults who had a diagnosable mental, behavioral, or emotional disorder in the past year, regardless of their level of functional impairment, were defined as having AMI.

Major depressive episode (MDE) is defined as in the DSM-IV, which specifies a period of at least 2 weeks in the past year when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms.

Mental health service use is defined in NSDUH for adults aged 18 or older as receiving treatment or counseling for any problem with emotions, nerves, or mental health in the 12 months before the interview in any inpatient or outpatient setting, or the use of prescription medication for treatment of any mental or emotional condition that was not caused by the use of alcohol or drugs.

Number of individuals enrolled in substance use treatment refers to the number of clients in treatment at alcohol and drug abuse facilities (public and private) throughout the 50 states, the District of Columbia, and other U.S. jurisdictions.

Serious mental illness (SMI) is defined in NSDUH as adults aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified in the DSM-IV and has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities. SMI estimates are based on a predictive model applied to NSDUH data and are not direct measures of diagnostic status. The estimation of SMI covers any mental disorders that result in serious impairment in functioning such as major depression, schizophrenia, and bipolar disorders. However, NSDUH data cannot be used to estimate the prevalence of specific mental disorders in adults. For details on the methodology, see Section B.4.4 in Appendix B of the *2014 National Survey on Drug Use and Health: Methodological Summary and Definitions* (https://www.samhsa.gov/data/sites/default/files/NSDUH-MethodSummDefs2014/NSDUH-MethodSummDefs2014.htm). It should be noted that SAMHSA has recently updated the definition of SMI for use in mental health block grants to include mental disorders as specified in the DSM-5.

Treatment for depression is defined as seeing or talking to a medical doctor or other professional or using prescription medication for depression in the past year.

REFERENCES AND SOURCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (DSM-IV) (4th ed.). Washington, DC: Author.

The National Survey on Drug Use and Health (NSDUH) is an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). NSDUH is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the U.S. civilian, noninstitutionalized population aged 12 years or older and includes mental health issues and mental health service utilization for adolescents aged 12–17 and adults aged 18 or older. Conducted by the federal government since 1971, NSDUH collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence. The data used in this report are based on information obtained from approximately 67,500 individuals aged 12 or older per year in the United States. Additional information about NSDUH is available at https://www.samhsa.gov/data/population-data-nsduh.

The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual census designed to collect information from all public and private treatment facilities in the United States that provide substance abuse treatment. The objectives of N-SSATS are to collect multipurpose data that can be used to assist SAMHSA and state and local governments in assessing the nature and extent of services provided and in forecasting treatment resource requirements, to update SAMHSA's Inventory of Behavioral Health Services, to analyze general treatment services trends, and to generate the Behavioral Health Treatment Services Locator (https://findtreatment.samhsa.gov/). Additional information about N-SSATS is available at https://www.samhsa.gov/data/substance-abuse-facilities-data-nssats.

The Uniform Reporting System (URS) is a SAMHSA data reporting system that collects aggregate data that describe the characteristics of individuals served by the State Mental Health Agency, which is primarily responsible for the provision and facilitation of publicly funded mental health and support services to children and adults with mental illnesses. The data are for a given 12-month period and include treatment setting and service types, performance and outcome measures, and indicators that support the use of the state's Community Mental Health Services Block Grant. This reporting system utilizes a standardized reporting of state mental health data.

HHS Publication No. SMA–17–Baro–16–States–CO
2017

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Behavioral Health Statistics and Quality
www.samhsa.gov

Appendix C

LARIMER COUNTY STRATEGIC PLAN

2013-2018

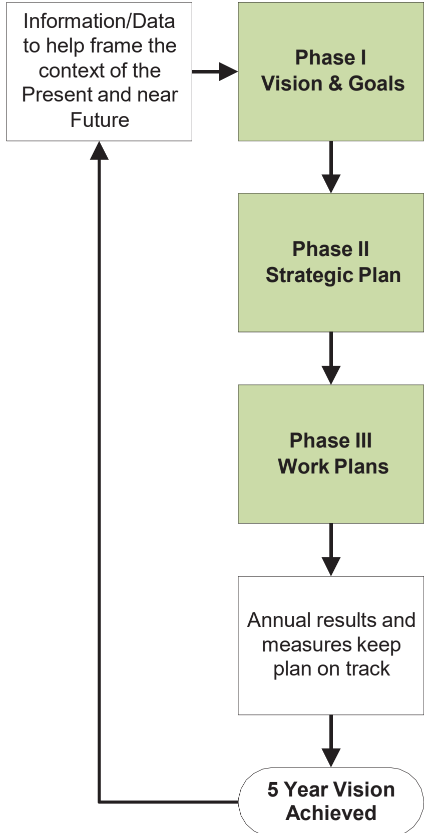
Vision, Mission, Goals and Objectives

The Strategic Plan shows how Larimer County adds value to the lives of its citizens. It is a vision for the next 5 years and is used to drive work plans that achieve our goals.

Larimer County Strategic Plan

INTRODUCTION

This plan was developed as a part of Larimer County's "Planning our Future" process involving citizens, community leaders, the Board of County Commissioners, Elected Officials and employees. The result is a community vision for Larimer County, a set of high-level goals that County government aspires to, and a series of objectives to drive action in the next 5 years. Here is a summary of our overall process.



The strategic plan (this document) was developed by reviewing data about the county: indicators of how well our departments are achieving their current goals, any issues occurring in our community that affect our ability to deliver services, Elected Office and citizen input. A vision and high-level goals were developed by the Board of County Commissioners to describe "what" Larimer County (as a community and as an organization) looks like in 5 years. The vision and goals are the basis for creating a strategic plan: "how" Larimer County organization will achieve these goals. The objectives in the Strategic Plan are the foundation for creating tactical work plans to manage what needs to happen in order for the objectives to be fulfilled.

THE VISIONING PROCESS

To develop a vision for Larimer County, we followed a process that included input from a variety of sources. The 2013 Larimer County Citizen Survey generated input from a random sampling of citizens, including a supplemental question to identify what Larimer County should focus on in the next 5 years. We gathered data from a variety of sources, both external to county government and internal (external data such as building trends, economic trends, major events affecting the county; and internal data such as employee survey, critical performance areas by division, and so forth).

In February, a leadership summit was held with various representatives in the county: city, non-profit, business. In a day-long session, teams of these leaders looked at Larimer County as a community and developed feedback and ideas of what the county might look like in the future. These ideas provided more insight into areas of concern and areas of opportunity in the county.

Data/input from these sources were compiled and summarized so that the Elected Officials could have ample input to develop vision statements, not only for their own area of expertise, but also for how it fit into the county as a whole. The Board of County Commissioners, in addition to providing their own perspective, took all of this input and formulated our vision statement for the next 5 years.

Once a vision had been created, the work began. Strategic planning was conducted via several sessions with county government leaders who were challenged to answer the question “how can we make the vision a reality?” The Strategic Plan is the basis for how offices, divisions and departments develop work plans, actual measurable tactics that when completed, build the vision.

MISSION/VISION/GUIDING PRINCIPLES

LARIMER COUNTY MISSION

The people of Larimer County Government, consistent with our shared vision, are dedicated to delivering the services mandated by law, and services determined by the Elected Officials to be necessary to protect the health, safety and welfare of the citizens of Larimer County. In doing so, we hold to the following:

- To work for the benefit of all the citizens of Larimer County and consistently take the customers' interest and their changing needs into consideration when making decisions;
- To hold the citizens' funds in trust, and seek to make the most efficient use of those dollars by employing them prudently, honestly, and without favor;
- To maintain and enhance our skills, knowledge and professionalism in order to serve the residents of Larimer County in a competent and effective manner;
- To respect and uphold the rights of all individuals, regardless of ethnicity, race, gender, political beliefs or socioeconomic status;
- To seek constant improvement in the provision of services through innovation, integrity and competence;
- To incorporate positive character values in our daily activities.

COMMUNITY VISION

Larimer County is a thriving, friendly place where people of all ages, cultures, and economic backgrounds live, work, play, and most of all, call home. Whether you are a first-time visitor or long-time resident, you enjoy spending time here.

- ✧ Our strength lies in the diversity, talents and character of our people. We encourage and foster an environment of respect, supporting both physical and mental health.
- ✧ Our county is beautiful and clean. We protect our air and water, open spaces and natural resources. We are prepared for wildfires, floods and water supply. There are plenty of things to do both in nature and within our local communities.
- ✧ We have safe and clean neighborhoods, schools, businesses, roads, structures and parks throughout our county.
- ✧ A prosperous economy is powered by innovation, education, a business-friendly atmosphere, well-paying jobs, affordable housing, and convenient transportation networks that keep pace with growth.
- ✧ We place a priority on our youth and their healthy development so that quality of life extends to future generations.
- ✧ We “tell our story” so our residents understand, engage and are fully vested in our shared Community Vision.
- ✧ We promote collaboration with citizens, local governments, businesses, non-profits and community organizations by working together to create the County’s future.

This vision is stewarded by a continuously improving government that acts with common sense as it conducts County business. County services are accessible and convenient, supported by a solid funding plan with predictable and diverse revenue.

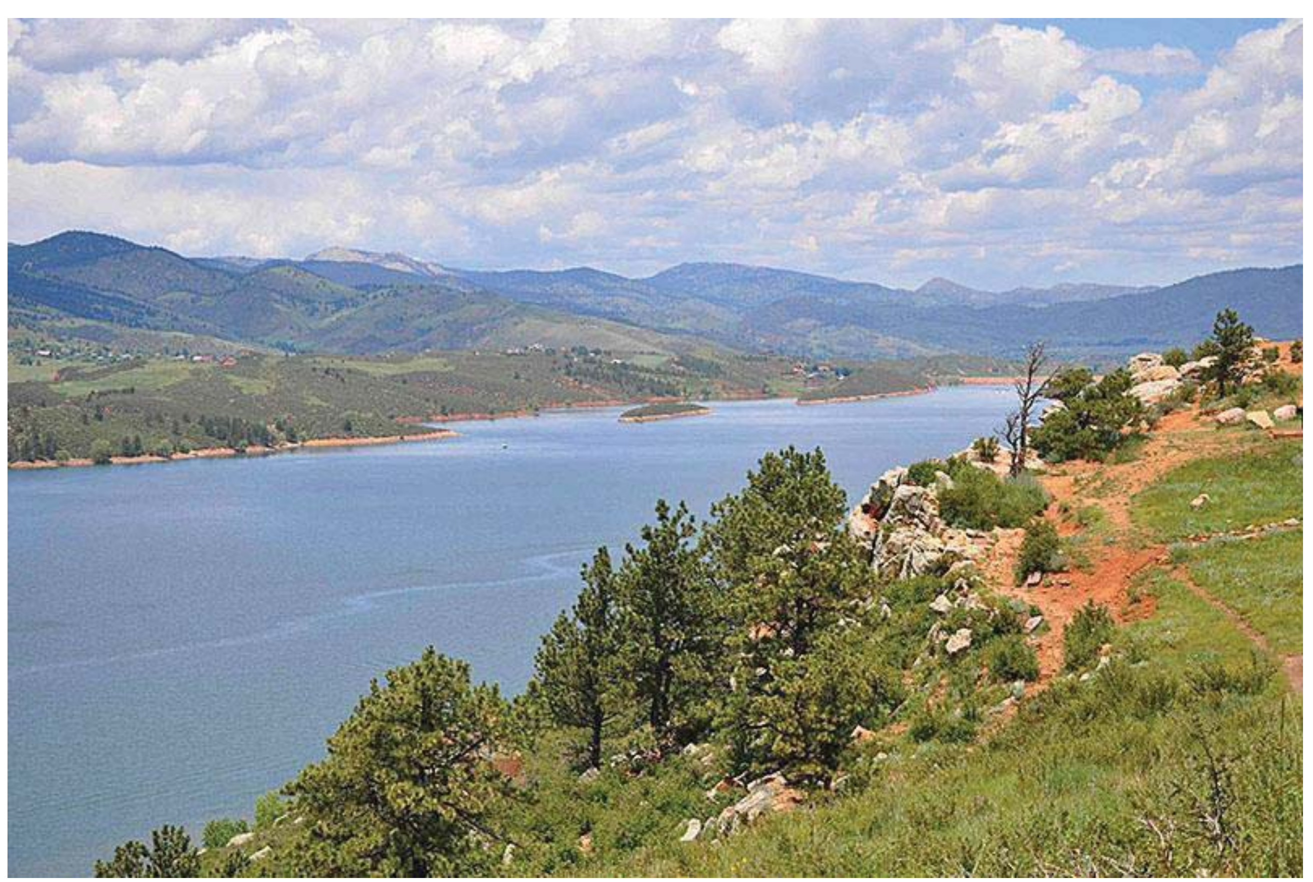
GUIDING PRINCIPLES

Larimer County will add value to the lives of its citizens today and in the future by:

- Being good stewards of public resources
- Promoting innovation and continuous improvement
- Providing quality customer service
- Empowering people to take responsibility
- Cultivating partnerships
- Being a fulfilling and enjoyable place to work

SLOGAN and LOGO

LARIMER COUNTY - COMMITTED TO EXCELLENCE



2013-2018 LARIMER COUNTY STRATEGIC PLAN

The Strategic Plan is organized by Goal and detailed into Objectives.

- Objectives are "SMART" (Specific, Measurable, Attainable, Realistic, and Timely)
- Work Plans are not discussed in the Strategic Plan, but they will be developed into tactical, implementable plans.

GOAL 1 SAFETY AND WELLBEING

Enhance the safety and wellbeing of our community by promoting a continuum of support and services to proactively address causal issues like Mental Health and Substance Abuse, integrated into the Criminal Justice system.

1. By the end of 2017, to better protect public safety and streamline informed decision making, appropriate criminal justice entities can securely and remotely access shared criminal record data and status information for individuals.

2. By the end of 2018, treatment providers and criminal justice agencies in Larimer County have developed a 24/7/365 multi-services center (detox, acute treatment unit, out-patient services, residential treatment, etc.) with linkages to a full continuum of treatment options to serve the public and criminal offenders.

3. By the end of 2018, the number of children and youth in Larimer County who are receiving appropriate mental health or substance abuse intervention and treatment services has increased by 15 percentage points compared to a 2014 baseline.

4. By the end of 2018, at least 100 "high need" individuals, as identified by assessment, are participating in an appropriate treatment program with an emphasis on programs with judicial oversight. Of those individuals, at least 60% will complete their assigned program. "High need" individuals include either 1) citizens who access the emergency response system three or more times per month or 2) citizens who are convicted of a crime and have been diagnosed with a substantial mental health condition.

GOAL 2 ECONOMIC DEVELOPMENT

Larimer County is a recognized center for supporting business by turning innovation into reality. We plan for improvement by encouraging smart business growth, more and better jobs.

1. By the end of 2015, working with economic development partners, Larimer County will identify and prioritize infrastructure and amenity components within the County's control that inhibit or enhance economic development success. By 2016 plans will be in place to address the highest priority needs.

2. By the end of 2015 Larimer County will develop a comprehensive economic development framework that defines the County's role, strategic partners, and targeted activities to 1) support innovation and entrepreneurship in Larimer County and 2) influence the retention and creation of opportunities that increase the wealth and/or wellbeing of the community and its residents.

3. By January of 2017 Larimer County will align the necessary resources to update the Comprehensive Master Plan. Preparations will include involving citizens to identify needs and current conditions, evaluating current land use regulations and development processes, and establishing a cash reserve fund.

GOAL 3 ALL-HAZARDS EMERGENCY MANAGEMENT

We proactively deal with threats from natural and human-caused hazards within and around Larimer County.

1. By June 2014, designate a County staff member to coordinate the initial recovery activities and work with the Long-Term Recovery Group on long-term recovery goals. Assist in the establishment of a VOAD (Voluntary Organizations Active in Disaster), and act as the County's representative to the Long-Term Recovery Group and VOAD.

2. By the end of 2015, develop and implement a training and education program for citizens at risk of all hazards to protect their lives and property.

3. By the end of 2014, ensure that the Emergency Operations Plan is updated to optimize coordinated emergency response efforts.

4. By end of 2015, review and revise as appropriate the County's Building, Fire, and Land Use Codes to require and enforce suitable mitigation for new construction in hazardous areas.

5. By June 2016, perform an Unmet Needs and Community Fragility Study for Larimer County and outline how the information can be used to reduce unmet needs and decrease community fragility from emergencies and disasters long-term.

GOAL 4 TRANSPORTATION

We have an efficient transportation system and road network with safe and well-maintained roads and alternative modes of transportation.

1. By the end of 2020, 100% of the publicly owned and maintained bridges, on mainline collector or arterial roads, in unincorporated in Larimer County will be structurally sufficient.

2. By the end of 2016, an evaluation of the transportation needs and challenges for seniors living in unincorporated Larimer County will be completed. Existing and new options for addressing those needs and challenges will be identified, prioritized, and implemented.

3. By mid 2016, a prioritized list of transportation needs in unincorporated Larimer County will be completed, and the gap between existing funding and the cost of those prioritized needs will be identified. By the end of 2016, options to close the gap in transportation funding will be identified.

4. By the end of 2016 a Coalition in Larimer County will be established to promote the use of compressed natural gas (CNG). The Coalition, led by Larimer County, will create a countywide plan that will identify the CNG fueling sites and fleet conversions.

   By the end of 2018, two (2) publicly accessible fueling sites will be operational in Larimer County and 100 public agency fleet vehicles will be converted to CNG.

GOAL 5 COLLABORATE

We have a culture of collaboration among towns, cities, businesses, non-profit organizations and citizens as the first choice strategy to accomplish the Vision and Goals.

1. By April 2014, a team will be in place. Their role is to develop strategies to reduce costs, magnify positive outcomes, streamline government operations, and emphasize collaboration between Larimer County and other organizations as a foundation of our culture.
2. By the end of 2014, identify, assess and recognize existing collaboration successes and develop a strategy to replicate them.

GOAL 6 OPERATIONS

Larimer County government operates with a collaborative culture, a well-managed budget and continuously improving processes. We have evaluated our practices and services for the way we fund and operate, and have a plan for improvement.

1. By April 2014, identify common objectives that benefit the County and, by the end of 2018, implemented at least 3 collaborative projects across departments and elected offices to maximize the efficient, effective and shared use of resources.
2. By the end of 2016, structure department or service budgets using a common set of components to ensure core services are funded at a basic level and discretionary funds are allocated based on priority and value back to the County.
3. By the end of 2016, analyze processes and infrastructure to determine appropriate balance of cost, natural resource impacts and community benefit, and identify strategies for improvement.

GOAL 7 CUSTOMER SERVICE

Government services are customer-centric, accessible and transparent. We leverage technology for better/faster customer service, allowing many services to be done online.

1. By July 2015, create a comprehensive citizen communication strategy that:
   a. reports outcomes from County services,
   b. enhances recognition of the linkages among County services,
   c. seeks feedback to spark improvement in County services.
2. By July 2015, implement a uniform, countywide system for monitoring and improving the customer service experience of citizens.
3. By the end of 2017, take a regional leadership role by establishing an information and access hub to connect citizens to the government services they need.

For further information please contact:
Linda Hoffmann, County Manager
lhoffmann@larimer.org | 970.498.7004

LARIMER COUNTY | HEALTH & ENVIRONMENT
1525 Blue Spruce Drive, Colorado 80524, 970.498.67100, Larimer.org/health

Draft CHIP Promoting Mental Health and Emotional Wellbeing Across the Lifespan work plan.

On April 30th, community partners representing coalitions, groups, and organizations focused on promoting mental health and emotional wellbeing across the lifespan came together to identify work that is already being done between coalitions and through various organizational partnerships in Larimer County and where gaps exist around mental and emotional wellbeing. This information was then compiled and developed into a DRAFT work plan with 6 goals across the mental health continuum, from primary prevention to after care.

This work plan focuses on collaborative work around prevention, screenings, connections to services, enhancing services, and aftercare. If you would like more information on the gaps in clinical mental health services and the existing mental health services in Larimer County, please review the Health District's Assessment "What Will It Take". CHIP is interested in organizations working to enhance and support the expansion of clinical services, but this work plan will not be detailing out all clinical services since this assessment was done so recently.

Within each of these areas there are a few **DRAFT** objectives with accompanying strategies that are already existent and suggestions for additional work that can be done. Also listed are the coalitions, or organizations focused on partnerships, who are leading the effort right now.

Please take the time to review and **ADD COMMENTS** (or email comments to Kelsey Lyon) for this work plan to confirm any of:

1. **Your coalition/organization's strategies**
2. **Your evaluation measures that are already developed**
3. **Confirming where you are in the process**
    a. **Assessment - Gathering data around a particular issue**
    b. **Planning - Creating a work plan, evaluation framework, or detailed strategy**
    c. **Implementation - Implementing the strategy/work plan**
    d. **Evaluating - If you are collecting data around impact (this can be done after or during implementation)**
    e. **Complete - You have implemented the strategy and after evaluating the impact have determined this will be an ongoing strategy towards meeting a goal. - Please add verbiage around sustainability/continuity**
    f. **Other - Please describe**
4. **Your suggestions for potential additional efforts**
5. **Your suggestions of wording changes to goal, objectives, or strategies**

Provide opioid awareness messaging to the public.	LCDHE	Planning		
Reduce stigma and increase awareness around pregnancy related depression for women and families, through posters, brochures, and outreach (Spanish and English).	Pregnancy Related Depression	Implementation		

Kelsey Conlon
8:20 AM Today
Resolve
Strategy: Provide standard opioid education to interested community groups.
Step in Process: Implementation
Evaluation: # of education sessions

This is a community plan and we welcome all feedback. Please forward this to any other additional contacts that may be interested in being part of this work. We welcome any and all feedback. Please provide this information by June 22nd.

Thanks, The CHIP Team

Goal #1: Increase environmental protective factors and decrease environmental risk factors for mental health and substance use and increase resiliency among residents of Larimer County.

Strategy	Ownership	Where in the process	Possible partners	Measures of Success/Impact
Older Adults: Assess the gaps around environmental factors for older adults and identify the community capacity and interest of the community for this work.				
Suggestion: Look into unique need, capacity and interest in new ideas to reduce social isolation i.e. college kids living with elderly, chickens in nursing homes, etc., and improving access to care, including transportation.	CHIP	Suggestion PAFC has conducted a mental health survey around supporting the mental health of older adults with the aim of finding a project to address	Office on Aging, Partnership for Age Friendly Communities (PAFC), policy makers, Columbine, City of Fort Collins Natural Areas Department (programming), UC Heath Aspen Club	
Suggestion: Provide respite care to families and individuals who need it.		Suggestion	Northern Colorado Respite Coalition	
Adults: Engage in policy change around environmental factors that contribute to mental health and substance use, both as a protective and risk factor.				
Engage in tobacco policy change processes to reduce prevalence and initiation of tobacco use and exposure to secondhand smoke.	CTC/Tobac co Coalition	Implementation	Local municipalities, county government,	

			Schools and colleges, employers, CBOs	
Target residents within mobile home communities that are within growth management areas to enhance policy and built environment to promote civic engagement.	LCDHE Built Environment	Implementation	City of Fort Collins Natural Areas Department (programming, civic engagement around nature), The Family Center/La Familia,Colorado Trust	
Persistent Drunk Drivers Prevention Project (new as of Fall 2017)	Team Wellness & Prevention	Assessment	Law Enforcement (Sheriff, CSUPD, Loveland PD, committed to date) CSU,	
Families: Provide family support, aimed at adult caregivers to promote self-sufficiency and decrease other risk factors.				
Building Community Prevention: The Building Community program offers preventative services for the community. At our Community Life Centers we focus on helping families and individuals avoid or overcome barriers to self-sufficiency by offering services in the areas of: – Family Support	Matthews House	Implementation		

– Adult Education – Child Education & Activities – Career Development – Recreation				
Provide respite care to families and individuals who need it.				
Youth: Identify and impact environmental elements that promote substance use, including social norms and policy				
Increase parent engagement and positive conversations around substance use with children through the Speak Now! Parent engagement series.	Southern Larimer Prevention Partnership (SLPP)	Implementation	CTC and Tobacco Program,Team Wellness	
Increase perception that most youth are not using marijuana, alcohol, pills through a Youth Social Norms campaign.	SLPP	Implementation	Youth Action for Health	
Increase positive peer support and commitment with in school through Sources of Strength.	SLPP/PSD/TSD	Implementation	Youth Action for Health	
Increase public knowledge/awareness around issues as suicide and youth substance use.	SLPP	Implementation	SummitStone, Health District, Youth Action for Health	
Reduce youth problem behaviors (substance use, violence, delinquency, etc.) through reducing risk factors and increasing protective factors in Fort Collins and Estes Park.	CTC	Planning		
Provide respite care to families and individuals who need it.			Respite Coalition,	

			Colorado Respite Coalition	
Advocate for policies/practices that support youth health and wellness	Partnership for Healthy Youth	Planning/Implementation	Youth Action for Health	
SUGGESTION: Need curriculum of increasing protective factors and increasing resiliency at elementary school level (before stigma sets in)		Suggestion		
Early Childhood: Expand the early childhood workforce and community capacity to meet the social development and emotional wellbeing needs of families and young children.				
Create a system that supports and sustains a culturally responsive family and child-serving workforce.	Leap Coalition	Implementation		Provide and expand participation in cultural awareness leadership trainings (yes/no) Construct a resource bank of helpful tips, strategies, and best practices to serve as a guiding reference and tool when implementing Leap work plans and future work (yes/no) Establish an agreed upon common understanding for cultural terms (e.g., culture, diversity and inclusion, culturally responsive, cultural) and share with wider community (yes/no)
Increase the number of professionals working in the classroom.	Leap- Early Childhood Mental Health (ECMH) Workgroup/ Early Childhood Council Larimer County (ECCLC)	Implementation		Create a pool of qualified ECE paraprofessionals to provide temporary additional support for classrooms with high-needs children (yes/no) Increase workforce retention by creating a substitute workforce to allow teachers more time outside of the classroom (yes/no) Increase support for ECE professionals by creating mentorship programs (yes/no) Support the community Workforce Initiative (WFI) to recruit additional ECE professionals by promoting this career path in partnership with high schools and higher education, with specific emphasis on recruiting from culturally-

	Workforce Initiative			diverse communities (yes/no)
Address policy barriers to increase early childhood workforce.	Leap-ECMH Workgroup/ ECCLC /Child Care Waiver Task Force	Implementation		Explore child-care regulation waiver possibilities to allow ECE professionals to work with young children while receiving required training/certification (yes/No) Advocate for expanding the types of degrees awarded with additional points by Professional Development Information System for ECE professionals to include mental health fields with early childhood knowledge (yes/no)
Ensure that family and child-serving professionals have the skill sets to understand the social and emotional development to effectively support families.	Leap-Integrated Care, Home Visiting, and ECMH workgroups	Implementation	KIDS Physician Outreach Committee, Child, Adolescent and Young Adult Connections(CAYAC)	Provide and/or support training around early childhood/infant mental health for existing mental health clinicians (yes/no) Support opportunities for other relevant trainings around social emotional development Expand access to training and community resources through an annual large forum and follow-up Community Conversations Number of social emotional training hours Number of social emotional trainings
Leverage existing family networks and champions to increase support for families, including support for all types of caregiver networks.	Leap/Family Strengthening workgroup/ Be Ready	Planning phase	Grandparents Alliance,Mothers of Preschoolers groups,Churches?Foster Care, Adoptive Parent groups,The Family Center/La Familia, Foothills Family	Engage family leaders in planning, expanding, and identifying both formal and informal social events to support and raise awareness about early childhood Support and expand family networks that include professional support, such as the “Parent Café” model

			Support Advisory Board, Parent to Parent of Colorado, Larimer County Child Family Leadership Training Institute,The Hub?,Children ,Youth & Family Services, Matthews House	
Provide respite care to families and individuals who need it.			Colorado Respite Coalition, Respite Care Inc,Easter Seals, Churches	

Goal #2: Increase awareness and decrease stigma around mental health and substance use for all ages in Larimer County in a culturally responsive way, focusing on targeting early childhood, youth, specific adult populations, providers, and the Larimer County population overall.

Strategy	Ownership	Where in the process	Possible partners	Measures of Success/Impact
Older Adults: Provide education to older adults, families of older adults, providers and the community about mental health needs of the aging population, including depression, isolation, and dementia.				
Research viewpoint of providers around mental health for older adults	Partnership for Age Friendly Communities	Assessment	PAFC,Health District, SummitStone, Office of Aging, Veterans programs,,Private Mental Health Providers	
Promote programs like Dementia Friendly Communities, QPR trainings		Suggestion	Aspen Club, Health District, SummitStone	
Adults: Provide Education and awareness to the community and providers around mental health and emotional wellbeing, including substance use in the adult population.				
Provide Hope for Today trainings, a free community education program available to any group seeking to understand more about suicide, as well as ways to intervene and save a life. Participants are provided with knowledge of how to respond to a person in crisis and how to recognize suicide warning signs and mental health disorders such as depression and bipolar disorder. This program is presented to college students, faith	Alliance for Suicide Prevention	Implementation	Health District, SummitStone,	

communities, businesses, and law enforcement each year.				
Opioid provider education: Through the NCHA, a group of Weld and Larimer County Representatives have received grant funding to provide medical provider education around opioids. The regions are: Estes Park - Fort Collins - Loveland – South Loveland Area - Greeley	NCHA, LCDHE, The Health District	Planning	Regional Health Connector	
Provide Mental Health First Aid, a free course available to anyone who would like to take it. SummitStone is planning on training two Spanish speaking trainers to reach the Spanish speaking population. It is focused on how to talk to adults, particularly loved ones when you suspect a mental health need.	SummitStone, Health District, NCHA	Implementation, panning for Spanish speakers	The Family Center/La Familia	
Raise awareness, improving knowledge/practices of treating people with substance use disorders. Targeted at SummitStone, probation and alternative sentencing organizations and their staff.	MHSUA	Planning		
Increase awareness and decrease stigma about substance use disorders and people with SUDS. Public awareness campaign. Targeted to adult/young adult Larimer County residents.	MHSUA	Planning	Health Department PIO, Mental Health Matters, CSU, Front Range Community College,	

Provide QPR trainings to reduce suicidal behaviors by providing innovative, practical and proven suicide prevention training. We believe that quality education empowers all people, regardless of their background, to make a positive difference in the life of someone they know.	Connections/CAY AC	Implementation		
Provide opioid awareness messaging to the public.	LCDHE	Planning		
Reduce stigma and increase awareness around pregnancy related depression for women and families, through posters, brochures, and outreach (Spanish and English).	Pregnancy Related Depression	Implementation	The Family Center/ La Familia,	
Increase awareness and decrease stigma around mental health in Larimer County through presentations to the community.	Mental Health Matters			
Design and implement marking materials to decrease stigma around seeking mental health services.	SummitStone Latinx Advisory Group		Youth Action for Health	
Develop and implement campaign around mental health facility ballot initiative.	Gil and Natalie, Citizens group	Planning		
Youth: Provide education and awareness around youth mental health and emotional wellbeing in Larimer County				
Provide the R.A.P.P. Program for middle and high school, education and opportunity for referral around suicide.	Alliance for Suicide Prevention	Implementation		

Support an integrated approach across schools and departments to align efforts around mental, social, and emotional wellbeing in support of the Whole School Whole Child model.	Poudre School District	Implementation	Thompson and Estes Park School districts?	
Through education of our families, hope to prevent stigma and address risk factors with youth being raised in kinship care.	Grand Families Coalition	Implementation	Children Youth and Family Services,	
Provide Youth Mental Health First Aid.	Connections/CAYAC	Implementation	CTC	
Provide a family/parent education speaker series on many different mental health needs.	Connections/CAYAC	Implementation	CTC	
Early Childhood: Increase knowledge of child development and early childhood needs in order to create and maintain community environments that are supportive of social development and emotional wellbeing for all families and young children.				
Promote social norms and policies that improve environments for social and emotional wellbeing.	Leap workgroups-Screening and Referral/KIDS and Family Strengthening/Be Ready	Implementation		Work in collaboration with Be Ready Campaign to ensure that social emotional messages and resources are part of Be Ready and are accessible to parents, caregivers and community members. Promote the importance of monitoring and screening young children for social and emotional development as part of healthy child development. Include messaging that it is okay to ask for help if you are concerned
Create universal access to parenting information around social and	Leap workgroup-Family	Planning		Promote access to parenting information prior to parenthood Support variety of parenting

emotional development, with an emphasis on channels and locations already used by parents.	Strengthening/Be Ready			programs and explore alternative delivery modes, based on gaps analysis Explore feasibility of universal postpartum visits including a model that provides primary prevention support following birth and is integrated with the health care system.
Expand access to training and community resources through an annual large forum and follow-up Community Conversations	Leap - Community Conversations	Implementation		# of trainings # of total training hours attended # of unique participants

Goal #3: Increase culturally responsive preventative support efforts and referrals to non-clinical supports for at risk individuals across the lifespan.

Strategy	Ownership	Where in the process	Possible partners	Measures of Success/Impact
Older Adults: Assess the need and capacity, develop partnerships, create and promote programs that support the mental health needs of older adults and their families, and promote and refer to existing groups.				
Develop a work plan around decreasing social isolation, possibly through a friendly visitor program		Planning	Office on Aging, Volunteers of america, CSU Department of Healthy Aging,Veterans groups, Meals on Wheels?Faith Based orgainzations,Home Healthcare Agencies	
Identify and promote existing	CSU Extension	Pilot Phase	Office on Aging,	

programs that enhance/enrich quality of life, such as “A Little Help,” which connects older adults with community members who can complete small chores and “Home Share,” where connects two unrelated people to live together, and the Grand Families Coalition Support group (bilingual)	and others? PFAFC		Volunteers of America, CSU Department of Healthy Aging	
Adults: Assess the need for, create, and promote support groups for adult populations who are not already being served, especially focused on the under-resourced communities, and promote and refer to existing groups.				
SUGGESTION: Assess interest and existing capacity for services for adults to rehabilitate so they can reunify with their children in foster care.		Suggestion		
Parent education and parent support groups for adoptive parents of traumatized children/youth (TAPT-IN)	CSU	Assessment	Leap?	
SUGGESTION: Promote existing support groups provided by partnership organizations, such as La Familia’s Sexual Advocacy Spanish Speaking Women’s group and Family Strengthening group, Matthew’s House Strengthening Families group and others.		Suggestion		
Provide referral to support resources for women in Larimer County communities through outreach and school fairs and posters,brochures.	PRD	Implementation		

Youth: Assess the need for, create, and promote support groups for youth populations who are not already being served, and promote and refer to existing groups.				
SUGGESTION: Promote existing support groups such as Matthews House's Empowering Youth program, Grand Families Coalition and Splash.		Suggestion		
In Estes Park School district, implement wellness plans that could include counselors and more and suicide prevention strategies	Estes Park School District	Planing - Pilot program of Mental Health Colorado School Toolkit		
SUGGESTION: Develop and promote curriculum to increase school based mental health providers, and funding.		Suggestion	PSD,TSD, Park	
Early Childhood: Build and Strengthen community relationships to encourage social development and emotional wellbeing for families and young children.				
Leverage existing family networks and champions to increase support for families, including support for all types of caregiver networks (e.g., grand families, foster families, fathers).	Leap work group - Family Strengthening/Be Ready	Planning phase		Engage family leaders in planning, expanding, and identifying both formal and informal social events to support and raise awareness about early childhood Support and expand family networks that include professional support, such as the "Parent Café" model
Promote relationships among community professionals to build "no wrong door" approach in order to increase family's access to services and referrals.	Leap	Implementation		Increase caregiver and professional knowledge of parenting education/training and other current resources by working with United Way 2-1-1 to analyze gaps & challenges of database, advocate for changes,

				and promote provider participation in maintaining accurate and current information Percent of people reporting to have increased professional network at Leap sponsored events Number of unique participants attending networking opportunities from diverse Organizations Number of professional networking opportunities

Goal #4: Increase the amount of early clinical detection and screening for mental health needs across the lifespan.

Strategy	Ownership	Where in the process	Possible partners	Measures of Success/Impact
Older Adults: Increase early clinical detection and screening for mental health needs for older adults.				
Increase screening of older adults before entering living facilities.	Health Sector Partnership	Implementation		
SUGGESTION: Provider education around the importance of screening for older adults (depression, isolation, dementia etc.), including suggested tool.		Suggestion	Aspen Club, Health District,SummitStone,Private Mental Health Providers, Home Healthcare Providers	
Promote Zero suicide and CAMS training in health systems and with providers	Imagine Zero	Implementation		
Adults: Increase early clinical detection and screening for mental health needs for adults.				

Increase the screening for mental health upon police intervention.	Larimer County Co-Responder Program	Planning		
Promote Zero Suicide and CAMS training in health systems and with providers.	Imagine Zero	Implementation		
Regional Health Connector (RHC): Expanding SBIRT model in Larimer County. Targeted at primary care practices and practitioners. Referral to Treatment Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.	Regional Health Connector	Implementation		
Promote screening and tools for screening to providers and families.	PRD/AMD	Implementation	LCDHE,	
Youth: Increase screening and referral for youth.				
Promote early clinical detection in youth in kinship care, mental health, suicide awareness, drug abuse.	Grand Families Coalition	Implementation		
Promote Zero suicide and CAMS training in health systems and with providers	Imagine Zero	Implementation		

Promote identifying friends or self who could be at risk for suicide through the R.A.P.P program	Alliance for Suicide Prevention	Implementation	Youth Action for Health,School Disticts, Faith based organizations	
In Estes Park Schools, implement screenings.	Estes Park School District	Planing - Pilot program of Mental Health Colorado School Toolkit		
SUGGESTION: Develop and promote curriculum to increase school based mental health providers, and funding for early screening;include substance abuse (including tobacco/nicotine)		Suggestion	PSD, TSD, Park	
Early Childhood: **Develop and utilize resources to support early identification of social and emotional concerns for families**				
Support a coordinated system for developmental monitoring and screening for children for social and emotional concerns.	Leap workgroup- Screening & Referral/KIDS, Integrated Care,	Implementation		Facilitate bi-directional communication between primary care providers and behavioral health clinicians by identifying and addressing barriers Create and promote referral protocols and common forms for coordinating referrals across systems For ECE Providers: Provide on-going support and and technical assistance. For medical Providers: Provide on-going support and and technical assistance.

Goal #5: Streamline referral processes and resource repositories for easier and more appropriate referral and de-duplication of efforts.

Strategy	Ownership	Where in the process	Possible partners	Measures of Success/Impact
Older adults: Identify best process for connecting older adults with appropriate resources and educate providers and community partners.				
SUGGESTION: Identify best referral process for older adults with mental health needs, both clinical and non-clinical interventions.		Suggestion	Connections, 2-1-1, Office on Aging, healthinfosource.com, Health Sector Partnership, and all other resource lists	
SUGGESTION: Provider education around best referrals (depression, isolation, dementia etc.)		Suggestion		
Adults: Identify best process for connecting adults with appropriate resources and educate providers and community partners.				
SUGGESTION: Identify best process for adults with mental health needs, both clinical and non-clinical.		Suggestion	Connections, 2-1-1, healthinfosource.com, Health Sector Partnership, and all other resource lists	
SUGGESTION: Provider education around best referrals		Suggestion		
Refer those those in need to resources needed versus continuing CJ cycle.	Larimer County Co Responder Program	Planning		

Promote provider toolkit, which outlines best referral to tx from provider to patients (or moms of patients) to ensure tx is received and condition is treated for pregnancy related depression.	Pregnancy Related Depression Coalition.	Implementation		
Regional Health Connector (RHC): Expanding SBIRT model in Larimer County.	Regional Health Connector	Implementation		
Increase referrals to appropriate tobacco treatment services	CTC/Tobacco Coalition/Health District	Implementation		
Connect primary care providers to behavioral health resources to close the communication gap between primary care providers and behavioral health providers.	Regional Health Connector	Implementation		
Youth: Identify best process for connecting youth with appropriate resources and educate providers and community partners.				
SUGGESTION: Identify best process for youth with mental health needs, both clinical and non-clinical.		Suggestion	Connections, 2-1-1, health info source, Health Sector Partnership, Imagine Zero, and all other resource lists	
SUGGESTION: Provider education around best referrals		Suggestion		
Work with school liaisons to better coordinate with families, schools and	CAYAC	Implementation		

TX providers				
Develop sustainable process for referrals from R.A.P.P	Alliance for Suicide Prevention, PSD	Implementation		
Implement Trauma assessment and treatment recommendations for kids.	Human Services & SAMSHA:	Implementation		
Early Childhood: Develop and utilize resources to support appropriate referrals and intervention of social and emotional concerns for families and young children in Larimer County.				
Support a coordinated system for developmental referral and evaluation for children for social and emotional concerns.	Leap/KIDS	Implementation		Facilitate bi-directional communication between primary care providers and behavioral health clinicians by identifying and addressing barriers Create and promote referral protocols and common forms for coordinating referrals across systems For ECE Providers: Provide on-going support and and technical assistance. For medical Providers: Provide on-going support and and technical assistance.

Goal #6: Enhance and expand access to mental health resources and providers that are culturally and linguistically appropriate for our populations.

Strategy	Ownership	Where in the process	Possible partners	Measures of Success/Impact
Older Adults: Assess need for mental health providers skilled in working with older adults across the continuum of care and who accept medicare, and identify ways to fill those gaps.				
Assess the gap in behavioral health providers who accept Medicare.	Health District	Assessment Completed		

SUGGESTION: Work with behavioral health providers to identify barriers to accepting medicare.		Suggestion		
Adults: Assess need for mental health providers across the continuum of care, and identify ways to fill those gaps.				
Assess the gap in behavioral health providers for adults across the continuum of care.	Health District, MHSUA	Assessment Completed		
SUGGESTION: Identify additional ways to fill gaps across the continuum of care		Suggestion		
Promote wellness Court for offenders with identified mental health issues	Larimer County Justice	Implemented		
Provide Medicaid resources for non-convicted but incarcerated	State legislation	Complete		
Increase access to Medication Assisted Treatment (MAT) in Larimer County.	Opioid Prevention Workgroup	Implementation		
Enhance/improve approach to “frequent utilizers” of high cost, crisis and acute services. (May be a Pay for Success project)	MHSUA	Planning		
Coordinate RX services in criminal justice system	Larimer County	Implementation		
Youth:Assess need for mental health providers across the continuum of care, and identify ways to fill those gaps.				
Assess the gap in behavioral health providers for adults across the continuum of care.	Health District.	Assessment Completed		
SUGGESTION: Identify additional		Suggestion		

ways to fill gaps across the continuum of care				
Early Childhood: Mobilize and coordinate system of support for early intervention and intensive and therapeutic interventions for families and young children in Larimer County				
Identify and mobilize supports for caregivers of high needs children.	Leap workgroup-ECMH and KIDS	Implementation		For professionals working with high needs children/ ECE providers: Build community capacity to provide reflective supervision/consultation Provide paraprofessional support for ECE teachers working with high-needs children Develop support protocol for early childhood education providers working with children with behavioral concerns
SUGGESTION: Increase Providers with early childhood knowledge of mental health disorders		Suggestion		
Utilize a family centered and culturally-responsive approach to support families and children in need of intensive intervention.	Leap workgroup - ECMH	Planning phase implementing		Increase understanding of HIPPA, FERPA, and 42 CFR for sharing information Promote a multidisciplinary approach to intervention across multiple systems which interact with the child and family, including case Develop MOUs among key organizations

Goal #7: Identify gaps and enhance best practice aftercare in Larimer County.

Strategy	Ownership	Where in the process	Possible partners	Measures of Success/Impact
Older Adults: Identify gaps and enhance best practice aftercare in Larimer County.				
SUGGESTION: Assess the gap in behavioral health in aftercare		Suggestion		
SUGGESTION: Identify ways to enhance aftercare, and access capacity		Suggestion		
Adults: Identify gaps and enhance best practice aftercare in Larimer County.				
SUGGESTION Assess the gap in behavioral health in aftercare		Suggestion		
SUGGESTION: Identify ways to enhance aftercare, and access capacity		Suggestion		
SUGGESTION: Expanding access to low-intensity residential housing programs (halfway houses).		Suggestion		
Youth: Identify gaps and enhance best practice aftercare in Larimer County.				
SUGGESTION: Assess the gap in behavioral health in aftercare		Suggestion		
SUGGESTION: Identify ways to enhance aftercare, and access capacity		Suggestion		
Early Childhood: Identify gaps and enhance best practice aftercare in Larimer County.				
SUGGESTION: Assess the gap in		Suggestion		

behavioral health in aftercare				
SUGGESTION: Identify ways to enhance aftercare, and access capacity		Suggestion		

SAMHSA's Efforts on Criminal and Juvenile Justice Issues

SAMHSA supports treatment and recovery efforts for people in criminal and juvenile justice systems with mental and/or substance use disorders.

Given the high prevalence of people with mental and substance use disorders involved with the justice system, SAMHSA has prioritized this population. Recognizing that behavioral health treatment and recovery support services are critical but also need to be balanced with the community priority of public safety, SAMHSA has created an array of programs, technical assistance centers, resources, and policy initiatives that take these issues into consideration.

SAMHSA's criminal justice work is organized around a framework for intervention referred to as the Sequential Intercept Model. This model identifies five key points for "intercepting" individuals with behavioral health issues, linking them to services and preventing further penetration into the criminal justice system. This model builds on collaboration between the criminal justice and behavioral health systems; highlights where to intercept individuals as they move through the criminal justice system; identifies critical decision-makers who can authorize movement away from the justice system and into treatment; and delineates essential partnerships among mental health, substance abuse, law enforcement, pre-trial services, courts, judges, jails, community corrections, social services, and others. Through its criminal justice initiatives, SAMHSA aims to:

- Bring about strategic linkages with community-based behavioral health providers, the criminal justice system and community correctional health
- Promote effective diversion and reentry programs
- Foster policy development at the intersection of behavioral health and justice issues

Examples of SAMHSA Initiatives at Each Intercept

Intercept 1: Community and Law Enforcement

The Early Diversion Program aims to divert people with mental health, substance use, or co-occurring disorders from the criminal justice system and into community services without the leverage of the court. The program focuses on the role of law enforcement officials working collaboratively with community behavioral health providers to prevent arrest and adjudication. Through this partnership law enforcement and behavioral health agencies design, implement, and oversee comprehensive strategies for diversion and engagement practices. Developed with input from a partnership with the International Association of Chiefs of Police, this program aims to divert individuals at the earliest opportunity into community-based service alternatives, for crisis intervention, screening, assessment, and referral to treatment before an arrest is made, while simultaneously maintaining public safety.
The Teen Court Program focuses on preventing juvenile crime by diverting youth with substance use treatment needs from deeper immersion in the traditional juvenile justice system to teen courts. SAMHSA's Teen Court program provides substance use treatment services and related recovery support services to youth with substance use or co-occurring treatment needs. Teen courts are peer-run courts where youth sentence their peers for minor delinquent and status offenses and other problem behaviors, providing positive alternative sanctions for first-time offenders. Expected outcomes from this program include reduced substance use and criminal activity, improved health and better quality of life, and increased productivity.

Intercept 2: Arrest and Initial Detention/Court Hearings

The Adult Behavioral Health Treatment Court Collaborative aims to allow local courts more flexibility to collaborate with multiple criminal justice system components and local community treatment and recovery providers to address the behavioral health needs of adults who are involved with the criminal justice system and provide the opportunity to divert them from the criminal justice system. The collaborative will allow eligible individuals to receive treatment and recovery support services regardless of what court they enter. This program will focus on connecting with individuals early in their involvement with the criminal justice system and prioritizing the participation of municipal and misdemeanor courts in the collaborative. Municipal courts have been prioritized in this program as they are often the court of first appearance and have the potential for earliest diversion from the justice system. Most arrested people appear before a municipal court (or its equivalent). Given the high volume of cases, the high prevalence of individuals presenting with behavioral health disorders, and the likelihood of less-serious charges, municipal courts are an opportune vehicle for diverting people with behavioral health needs into treatment. Diversion through municipal mental health courts has been effective in improving public safety; reducing incarceration rates for people with mental and/or substance use disorders; connecting participants to services and increased treatment success; and improving access to housing and other community supports−all towards enhancing participants' quality of life.

Intercept 3: Jails/Specialty Courts

At this intercept, most of SAMHSA's efforts involve working with specialty or problem-solving courts. These courts may include drug courts, mental health courts, tribal wellness courts, veterans' courts, and domestic violence courts. The focus of these courts is to address the underlying mental health and substance use issues and related needs of offenders by using the sanctioning power of the court to connect with treatment and other alternatives to incarceration. For example, research has demonstrated that drug courts help reduce recidivism and substance use among offenders and increase their likelihood of successful habilitation through early, continuous, and intense judicially supervised treatment; mandatory periodic drug testing; and the use of appropriate judicial sanctions and linkage with other services and supports.

In FY 2013, SAMHSA awarded new grants under its Jail Diversion program. This three-year grant program emphasizes early diversion of people with behavioral health conditions at risk of being arrested. This program has prioritized veterans.

Adult Treatment Drug Courts expand and/or enhance substance abuse treatment services (screening, assessment, case management, recovery support services) in existing adult and family "problem solving" courts, which use the treatment drug court model with defendants/offenders. Adult drug court models include drug courts serving adults, tribal healing-to-wellness courts, driving-while-intoxicated/driving-under-the-influence courts, co-occurring drug and mental health courts, veterans' courts, and municipal courts that use the problem-solving model. The program provides a coordinated, multi-system approach designed to combine the sanctioning power of treatment drug courts with effective treatment services to break the cycle of criminal behavior, alcohol and/or drug use, and incarceration or other penalties.

The Joint Adult Drug Court Solicitation to Enhance Services, Coordination, and Treatment (DOJ/BJA) aims to expand and/or enhance the drug court capacity of states, localities, and tribes to reduce crime and substance abuse among high risk/high need offenders. This evidence-based approach includes the key elements of judicially supervised treatment, drug testing, community supervision, appropriate sanctions, and recovery support services. This grant program serves high risk/high need populations diagnosed with substance dependence or addiction to alcohol/other drugs and identified as needing immediate treatment. The program also provides services for co-morbid conditions, such as mental health problems.

Adult Tribal Healing to Wellness Courts Program provides resources for tribal courts to divert American Indians and Alaska Natives with substance use and co-occurring mental health disorders away from the criminal justice system and into behavioral health treatment.

The Juvenile Treatment Drug Court Program diverts young people from juvenile detention to community-based behavioral health treatment, with the goal of treatment and recovery and prevention of deeper involvement with juvenile and criminal justice systems.
Reclaiming Futures(link is external) is a jointly funded program among SAMHSA, the Department of Justice's (DOJ) Office of Juvenile Justice and Delinquency Prevention, and the Robert Wood Johnson Foundation. This is an intensive youth diversion and community integration program. SAMHSA's role within this initiative is the provision of behavioral health services for the youth in treatment drug courts.
A Juvenile Mental Health Treatment Courts Database, maintained by the SAMHSA GAINS Center, provides resources for case management and support for youth with behavioral health needs in the juvenile justice system. Juvenile courts focus on treatment and rehabilitation and help divert youth from juvenile detention facilities to community-based services in their local systems of care.
The Adult Mental Health Treatment Courts Database, also maintained by the SAMHSA GAINS Center, provides a roster of mental health courts in the United States. It includes:

- The location of each mental health court
- The year established
- Target participants
- Approximate annual enrollments or total enrollments
- Contact information

Intercept 4: Reentry from Jails and Prisons to the Community

Individuals with mental and/or substance use disorders involved with the criminal justice system can face many obstacles accessing quality behavioral health services. Too often, many return to drug use, criminal behavior, or homelessness upon reentry into society.
SAMHSA uses a two-pronged approach to help meet the needs of individuals returning to the community, and the needs of the community, through:

1. Supporting grant programs such as the SAMHSA Offender Reentry Program (ORP) that expands and enhances substance use treatment services for individuals reintegrating into communities after being released from correctional facilities
2. Actively partnering with other federal agencies to address myriad issues related to offender reentry through the implementation of policy changes, making recommendations to U.S. states and local governments, and eliminating myths surrounding offender reentry

SAMHSA's Offender Reentry Program expands and enhances substance use treatment and related recovery and reentry services for adult offenders who are returning to their families and community after incarceration in state and local facilities including prisons, jails, or detention centers. The program encourages stakeholders to work together to give adult offenders with co-occurring substance use and mental health disorders the opportunity to improve their lives through recovery. The program also helps people develop the capacity and skills to become productive members of the community and reduce the probability of re-offending and re-incarceration.

Other Resources and Programs

Some Offender Reentry grantees are using SAMHSA's Opioid Overdose Prevention Toolkit, which equips communities and local governments with materials to develop policies and practices that help prevent opioid-related overdoses and deaths. It also addresses issues for first responders, treatment providers, and those recovering from opioid overdose.

SAMHSA's Treatment Locator is an online source of information for people seeking treatment facilities in the United States or U.S. territories for mental and/or substance use disorders. The Locator can be searched by state, city, or address.
Visit the SAMHSA GAINS Center and the SAMHSA store for additional reentry publications and information.
The SAMHSA-funded STAR (Support, Technical Assistance, and Resources) Center(link is external) has developed a three-part series(link is external) to support the justice-involved community. These products focus on supporting people with psychiatric disabilities in the criminal justice system, and provide a self-advocacy and empowerment toolkit and a promising practices guide.
The Affordable Care Act presents opportunities to expand coverage to individuals who generally have not had health insurance in the past and are reentering the community from jails and prisons. SAMHSA's Enrollment Coalitions Initiative targets these uninsured individuals in the new Health Insurance Marketplace through its Criminal Justice Organizations coalition. The Health Insurance Marketplace website also has outreach and education information for people in courts and corrections systems. Or visit Healthcare.gov's section on incarcerated people to learn more.
SAMHSA is involved in the Federal Interagency Reentry Council(link is external), established by the Attorney General in 2011, which works to improve the criminal justice system and connections with the community in order to minimize the challenges for people reentering the community from incarceration. The council consists of cabinet level representatives from 20 federal agencies who work to make communities safer by reducing recidivism and victimization, assisting those who return from prison and jail to become productive citizens, and saving taxpayer dollars by lowering the direct and collateral costs of incarceration.
The Council represents a significant executive branch commitment to coordinating reentry efforts and advancing effective reentry policies. It is premised on the recognition that multiple federal agencies play a role in offender reentry. The reentry population comes into contact with a wide range of systems beyond the criminal justice system: health care systems, employment and workforce systems, housing and homeless shelters and supports, child support offices, etc.
A primary focus of the Council is to remove federal barriers to successful reentry, so that motivated individuals who have served their time and paid their debts are able to compete for a job, attain stable housing, support their children and their families, and contribute to their communities. Participating council agencies are taking concrete steps towards these ends, to not only reduce recidivism and high correctional costs but also to improve public health, child welfare, employment, education, housing, and other key reintegration outcomes.
The Federal Interagency Reentry Council has information and resources related to health care for prisoners, including Snapshot: Health Care and Behavioral Health(link is external).
SAMHSA's Criminal Justice programs and policy staff are key participants in multiple Federal Interagency Reentry Council workgroups, including:

- The DOJ-led Reentry Council Support Workgroup
- The DOJ-led Reentry Research Workgroup
- The Department of Health and Human Services' (HHS) Reentry Health Care Access Workgroup
- The HHS-led Women and Reentry Workgroup
- The HHS-led Reentry and Child Support Workgroup
- The HHS-led Benefits Access Plan Workgroup
- The DOJ and HHS' Reentry Program Management Subcommittee

DOJ's National Reentry Resource Center (NRRC)(link is external) provides education, training, and technical assistance to states, tribes, territories, local governments, service providers, non-profit organizations, and corrections institutions working on prisoner reentry. The NRRC's mission is to advance the reentry field through knowledge transfer and dissemination and to promote evidence-based best practices. Specifically, the NRRC provides a one-stop, interactive source of current, evidence-based, and user-friendly reentry

information; individualized, targeted technical assistance for Second Chance Act grantees; and training, distance learning, and knowledge development to support grantees and advance the reentry field. Established in 2008 by the Second Chance Act (Public Law 110-199) (PDF | 221 KB), the NRRC is administered by DOJ's Bureau of Justice Assistance and is a project of the Council of State Governments Justice Center, along with key project partners including the Urban Institute, the Association of State Correctional Administrators, and the American Probation and Parole Association.
SAMHSA, along with other federal agencies, serves on the Federal Interagency Reentry Council Subcommittee for Children of Incarcerated Parents. As this subcommittee report – 2014 (PDF | 264 KB)(link is external) notes, the arrest of a parent can have a significant impact on a child's social and emotional well-being. The sudden loss of a parent to incarceration and the trauma associated can have lasting consequences for a child. These children may face increased risk of homelessness, household disruption, problems at school, and behavioral and emotional difficulties, including depression, fear for their incarcerated parent, confusion, and anger towards authorities.

Intercept 5: Community Corrections.

SAMHSA has no major programs addressing the Community Corrections at this time. Access DOJ's National Institute of Justice for more information on community corrections.

SOURCE: June 20, 2018 retrieved from the Substance Abuse and Mental Health Services Administration, (SAMSHA), https://www.samhsa.gov/criminal-juvenile-justice/samhsas-efforts

Appendix F

What Will it Take?: Solutions to Mental Health Service Gaps in Larimer County

Mental Health and Substance Use Alliance of Larimer County
An Unincorporated Non-Profit Association and Health Alliance

April 2018
Update of previous version (Recommendations for the Development of Critical Behavioral Health Services in Larimer County), published February 23, 2016 with limited revision on April 12, 2016

"Mental illness is a leading cause of suffering, economic loss and social problems. It accounts for over 15% of the disease burden in developed countries, which is more than the disease burden caused by all cancers."

No Health Without Mental Health (2007)

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Abstract

Behavioral health disorders, including mental illness and substance use disorders, are serious, chronic, and potentially life-threatening health issues. In Larimer County, Colorado, tens of thousands of residents suffer from these conditions. Left untreated, behavioral health disorders can lead to poor quality of life, unstable employment, poverty, chronic health conditions, early death, and suicide. The cost to the community is high as well, with frequent use of high-cost resources such as emergency rooms and criminal justice services.

These disorders *can* be treated effectively, allowing people to function better and regain control of their lives. As is true with many chronic conditions, treatment often entails a broad continuum of services, including crisis stabilization, detox, and inpatient, outpatient, short-term intensive residential treatment, and long-term residential treatment (halfway houses and sober living homes).

Unfortunately, the majority of people with these disorders never get the treatment they need. In Larimer County, most of the people who need these services simply continue to suffer, putting great physical, emotional, and financial strain on themselves, their families, and their communities.

The Mental Health and Substance Use Alliance of Larimer County, a partnership of local organizations, with the assistance of a national consulting firm, NIATx, has studied existing resources, identified gaps in services, and has made recommendations to fill these gaps to create a more comprehensive set of services in the report *What Will It Take? Solutions for Mental Health Services Gaps in Larimer County*.

The Alliance's key finding: *while many quality services exist here, Larimer County does not have a continuum of mental health treatment and support services that is sufficient to meet the needs of local residents.*

The Alliance recommends the development and expansion of treatment capacity to provide services for over 5,000 residents in Larimer County each year. First, the Alliance recommends the development of a 24/7 Behavioral Health Services Center, which would provide state-of-the-art care and serve as a central hub for many services. The Center would:

- Provide onsite medical clearance/triage as well as patient-centered assessment services to get people into the right level of care
- Provide stabilization services for people experiencing mental health crises (through relocation of existing Crisis Stabilization Unit to the new facility)
- Provide a safe place for people to withdraw from alcohol and/or drugs, and begin medication-assisted treatment when appropriate
- Facilitate entry into treatment after stabilization of mental health crises and/or after detoxification from substances
- Provide intensive residential treatment for substance use disorders

- Facilitate entry into other community-based services, assist with overcoming barriers such as transportation, and assist uninsured and underinsured individuals with affording care

Second, the Alliance also recommends that funds be earmarked for community services to expand access to step-down housing; provide ongoing assistance for those with significant disorders in permanent supportive housing and in the community; support suicide prevention efforts; and support early identification and intervention services for youth and families.

The Alliance estimates the annual cost to provide all recommended services in the center and in the community is $15.2 million (taking into account $6.5 million in revenues). The one-time cost of construction of a new 60,000-square-foot Behavioral Health Services Center, including projected land costs, is estimated at $33.4 million if built in 2020.

Finally, outside of the recommended budget, the Alliance also recommends that existing organizations and service providers will need to continue to expand outpatient treatment for substance use disorders including medication-assisted treatment and intensive outpatient treatment, in order to meet the treatment needs of additional individuals being engaged in treatment through new and improved Larimer County services.

There is ample evidence to demonstrate significant value and benefits of the treatment of behavioral health disorders. Patients and families benefit from increased health, well-being and ability to function in their family, work, community and society (similar benefits as those seen for managing symptoms of diabetes or hypertension). Communities realize reductions in related costs. The National Institute of Health estimates that every dollar spent on addiction treatment yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs and theft. When healthcare related cost avoidance related to reduced use of emergency departments, ambulance and inpatient treatment are included, the total cost reductions can exceed costs by a ratio of 12 to 1.

Executive Summary

Introduction

Behavioral health disorders, including mental illness and substance use disorders, are serious, chronic, and potentially life-threatening health issues. In Larimer County, Colorado, tens of thousands of residents have a mental illness, a substance use disorder, or both. Effective treatment and support services for these disorders do exist, but due to insufficient local resources and critical service gaps, only a small percentage of those who need help get it. The great majority of people who need these services in Larimer County simply continue to suffer, putting great physical, emotional, and financial strain on themselves, their families, and their communities.

In recent years, several organizations have recognized the severe gaps in local behavioral health services and called for an improved behavioral healthcare system. In 2015, the Mental Health and Substance Use Alliance of Larimer County, a partnership of local organizations, consumer and family advocates, and treatment and service providers, declared that its highest priority was to determine the extent of the need and to create a plan to expand critical behavioral health services. *What Will It Take? Solutions for Mental Health Services Gaps in Larimer County* is the result of the Alliance's investigation.

This document is intended to:

- Delineate what is needed for a more complete continuum of care capable of providing adequate levels of affordable care for those with behavioral health needs (focusing on the best evidence, high quality, and access to care); understand what actually exists in our community; and determine the gaps
- Determine a cost estimate for filling the gaps, potential revenue sources, and the remaining need for funding

The Alliance's aim is to help citizens and service providers understand the existing challenges, garner commitment to making improvements, and stimulate significant development and expansion of critical behavioral health services in Larimer County. Ultimately, our goal is to ensure that Larimer County has the resources needed to meet the growing behavioral health needs of its citizens.

The Alliance engaged the services of the NIATx group to aid in data collection, analysis, and development of the recommendations in this document. NIATx, a multidisciplinary team of consultants with expertise in public policy, agency management, and systems engineering, has worked with more than 1,000 treatment providers and more than 50 state and county governments.

The Need for Behavioral Health Services in Larimer County

Behavioral health disorders, including mental illness and substance use disorders, are common. In Larimer County, approximately 53,800 adults (ages 18 and older) have a mental illness, and

just over 12,300 of those individuals have a serious mental illness. Approximately 26,000 have a substance use disorder (many suffer from both mental health and substance use disorders). Like other common chronic health conditions, such as diabetes and heart disease, these conditions can affect people of all ages and all socioeconomic backgrounds.

Left untreated, behavioral health disorders can lead to greater suffering from symptoms, poor quality of life, a reduced ability to function, and the use of more intensive and higher-cost treatment. People with behavioral health disorders are also at risk for unstable employment, poverty, chronic health conditions, early death, and suicide. In fact, adults living with serious mental illness die on average 25 years earlier than others. The cost to the community is high as well. Many people who don't get adequate treatment repeatedly use high-cost community services, such as emergency departments and criminal justice services.

Behavioral health disorders *can* be treated effectively, allowing people to function better and regain control of their lives. As is true with many chronic conditions, ongoing treatment and support, involving a broad continuum of services designed to meet evolving needs, is often necessary. This continuum of services includes assessment, crisis stabilization, detox/withdrawal management services, inpatient treatment, outpatient and intensive outpatient treatment including Medication-Assisted Treatment (MAT), residential treatment, and step-down and supportive housing options such as halfway houses, sober living homes and permanent supportive housing.

Effective treatment for these disorders imparts significant benefits. Patients (and their families) benefit from improved health and well-being, as well as the ability to function in the family, at work, and in the community. Communities gain active and functioning residents and see reduced law enforcement and corrections-related expenses. Indeed, every dollar spent on addiction treatment yields a return of $4 to $7 in reduced drug-related crime and criminal justice costs, according to the National Institute on Drug Abuse, part of the National Institutes of Health. When savings related to healthcare, such as a lower use of emergency departments, ambulance services, and inpatient treatment, are included, savings can exceed costs by a ratio of 12 to 1.

Unfortunately, the majority of people with these disorders never get the treatment they need. In Larimer County and many other communities, patients and family members often experience great difficulty in accessing treatment and related services, due in large part to a severe shortage of local resources. A lack of treatment resources is particularly true in the area of substance use disorders.

In Larimer County, an estimated 26,000 people have a substance use disorder and currently need treatment, yet only about 2,300 actually receive care each year. This means that, each year, tens of thousands of residents in the county need, but do not get, treatment. Although many of these people are not yet seeking treatment, about 1,200 do want or would seek help, but are unable to get it due to the absence of many critical levels of care in the County. Due to the lack of local detoxification services, many of the people not yet seeking treatment but needing to safely detox from alcohol and/or drugs, currently end up in local jails and emergency departments where they are typically released without any follow up care. This is often an ongoing strain on those resources (law enforcement, EMS, emergency departments) due to the revolving door these residents continue to go through, and is extremely costly.

In order to meet the treatment needs of our citizens in Larimer County, this investigation found that it will be necessary to make treatment and related services available for over 5,000 people each year (about 2,300 who currently get some form of treatment, plus about 1,200 who are seeking but not getting treatment due to a lack of services, plus approximately 1,200 more who might be persuaded to seek treatment given better engagement and outreach through a local detox, as well as accounting for local population growth of an additional 500).

Providing a full and improved continuum of care each year for these people is critical to their recovery. However, current local treatment and support services are insufficient to meet that demand. As a result, far too many Larimer County residents with mental illness and/or a substance use disorder simply are not getting the behavioral healthcare they need.

Key Finding

While many quality services exist here, Larimer County does not have a continuum of mental health treatment and support services that is sufficient to meet the needs of the many County residents with mental illnesses and/or substance use disorders.

Key Recommendations

The Mental Health and Substance Use Alliance of Larimer County recommends the expansion of existing community-based treatment and support services, along with the development of a 24/7 Behavioral Health Services Center. These recommendations would provide a new state-of-the-art model of care for people with mental illness and/or substance use disorders.

The Behavioral Health Services Center and related services would:

- Bring missing levels of care to our community, so people can get the affordable care they need (Detox, residential treatment, etc.)
- Expand local services that are currently available only to limited residents (such as Medication-assisted treatment, etc.)
- Enable a more thorough, formal, patient-centered assessment process that will help people enter the right level of care at the right time
- Ensure that transitions between levels of care are seamless and efficient
- Reduce the number of people who go through withdrawal in jail, an emergency room, or on the street, by providing a place to safely detox (where they can also get connected to treatment and begin a path to recovery)
- Facilitate entry into treatment from crisis and detoxification levels of care

Recommended services to be provided at the Center include:

- Triage, medical clearance examination, and various levels of assessment and re-assessment
- A Crisis Stabilization Unit (CSU); an existing CSU would be moved to the Center

- A range of withdrawal management (drug/alcohol detoxification) services
- Residential treatment for substance use disorders
- Care coordination to ensure connection to and coordination with community-based treatment
- Transportation services to reduce the burden on local law enforcement and EMS and assist with access to services in rural areas of Larimer County

Funds should also be earmarked to expand existing services in the community, including:

- Early-identification and early-intervention services and resources for youth and families at risk for or experiencing mental illness or substance use issues or disorders
- Suicide prevention efforts
- Staffing for long-term residential treatment (halfway houses) to help people transition from inpatient treatment to community living
- Support services to enable treatment and care coordination for people living in Permanent Supportive Housing
- Moderately intensive to intensive care coordination for people with particularly intensive and complex needs

Funds should also be earmarked to help people who can't afford to pay the full cost of care, including those who need:

- Outpatient treatment (OP)
- Intensive outpatient treatment (IOP)
- Medication-assisted treatment (MAT)

Additional community services may need to be expanded or developed in order to meet the needs of additional people being engaged in treatment, including:

- Outpatient treatment (OP)
- Intensive outpatient treatment (IOP)
- Medication-assisted treatment (MAT)
- Voluntary sober-living options such as Oxford houses (more capacity is needed)

Because there are other funding sources for these services, they have not been included in the budget for recommended service expansion.

Specific Recommendations

Specific recommendations to create and support services include:

1. **Expand treatment capacity** to provide services to over 5,000 adults. The total annual utilization of all services included in the recommended model is estimated at over 10,000 admissions (defined broadly).

2. **Provide most services in one facility,** to create efficiencies and a better continuum of care.

3. **Create the ability to perform medical clearance screenings and triage on-site,** to reduce the need for emergency-room levels of care and transport to other levels of care.

   Provide in-depth assessment and re-assessment (differential diagnosis) on site, in order to place patients in appropriate levels of care.

4. **Move the existing Crisis Stabilization Unit to the Behavioral Health Services Center,** to provide walk-in crisis assessment and short-term crisis stabilization for people whose symptoms and treatment can be managed in non-hospital settings. *Build: 16 beds with the capacity to provide up to 1,700 admissions. Begin operation with: Approximately 10 beds for up to 700 admissions.*

5. **Create a Withdrawal Management Center (drug/alcohol detoxification) in the Behavioral Health Services Center** to support detox from alcohol or drugs and transition individuals into treatment. Provide social (clinically managed) (American Society of Addiction Medicine (ASAM level 3.2) and medically-monitored (ASAM level 3.7) levels of detox services; start patients on Medication-assisted treatment for alcohol and opioid use disorders; and support more ambulatory detox (ASAM level 2.0) managed on an outpatient basis in the community. Those with higher-level medical needs will continue to access the intensive inpatient detoxification services (ASAM level 4.0) provided in local hospital settings. *Build: 32 beds with the capacity for approximately 4,300 annual admissions. Begin operations with: 26 beds with the capacity for approximately 3,500 admissions per year.*

6. **Create or support several levels of residential care to support up to 795 short-term and long-term supported residential admissions,** as follows:

   - **Create a short-term, intensive residential treatment unit** in the facility, which would provide a safe therapeutic environment where clinical services and medications are available to patients who are medically stable and withdrawn from substances. *Build: 16 beds with the capacity for up to 400 annual admissions. Begin operations with: 13 beds with the capacity for up to 320 admissions per year.*
   - **Support low-intensity residential services** designed to build and reinforce a stable routine in a safe and supportive context for residents who lack a stable living environment. Provide 24/7 certified addiction counselors. *Encourage development of facilities (55 beds) by community providers.*
   - **Encourage the expansion/development of independent, voluntary sober housing** in the community, such as Oxford Houses, to provide safe and supportive living environments for those who choose and can pay for this type of residence. No external financing is recommended for this type of housing.

7. **Provide funding to support behavioral health support services,** including:

    - Early-identification and early-intervention services and resources for youth and families at risk for or experiencing mental illness or substance use issues or disorders
    - Suicide prevention efforts
    - Moderately intensive to intensive care coordination for up to 250 clients
    - A client assistance fund to help cover needs such as transportation, co-pays (including for IOP and OP), medication, and personal emergencies, for up to 1,400 clients
    - Support services in Permanent Supportive Housing for up to 100 clients with chronic health conditions who lack family/social supports and are disconnected from employment and other community functions (housing to be provided by other sources)

8. **Encourage the development of community capacity for intensive outpatient services** for individuals who require a more structured substance use disorder outpatient treatment experience than traditional outpatient treatment. *Capacity needed: 1,400 IOP admissions, an average of 30 visits per admission, and an average daily census of 63*. (Note: Since health insurance is likely to cover these services, this document's budget recommendation is for financial assistance for up to 175 uninsured or underinsured individuals.)

9. **Encourage the development of community capacity for outpatient substance use disorder treatment, including medication-assisted treatment** to provide up to 4,700 admissions. (Note: Since health insurance is likely to cover these services, this document's budget recommendation is assistance for up to 525 uninsured or underinsured people.)

Financial and Facility Needs

Financial Resources Needed

The estimated annual cost to provide these services is $15.2 million (taking into account an anticipated $6.5 million in client and payer revenues).

Projected Overall Operating Budget	
Personnel	$11.7 million
Operational (operational costs, maintenance, equipment, contracted services, etc.)	7.2 million
Client Assistance	2.3 million
Family and Youth Resources and Suicide Prevention Resources	0.5 million
TOTAL	**$21.7 million**
Less Client and Payer Revenues	6.5 million
Needed Annual Funding	**$15.2 million**

Facility Needs and Associated Costs

Estimates for facility space and costs are based on providing many services in one facility. Based on current estimates, a 60,000-square-foot facility is needed. Total facility and estimated land costs are estimated at $33.4 million (if built in 2020). Facility costs have not been included for low-intensity residential services. Land costs will depend on the site selected.

Similar to other dedicated, state-of-the-art health facilities in the area, such as the $20M Cancer Center built by UCHealth in 2014, this facility will house key treatment services in one place. This "No Wrong Door" type of system is considered best practice in the health care sector. One key difference is that the services provided by other healthcare facilities, such as the Cancer Center, are paid for by health insurance; while only about 30% of costs of the recommended behavioral health treatment services would receive insurance reimbursement. This results in the funding gap of about $15 million a year.

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History of the Alliance and Introduction to the Need

This report is the result of efforts of the Mental Health and Substance Use Alliance of Larimer County (Alliance), (formerly the Community Mental Health and Substance Abuse Partnership of Larimer County before mid-2016), and a sub-group of Alliance Members coming together as a "Guidance Team."

The Alliance, established in 1999, is a collaborative effort between over twenty organizations, consumers, consumer and family advocates, and treatment and service providers. (See Appendix G for Alliance membership list and Appendix H for Guidance Team membership list).

The overarching goal of the Alliance is to restructure our system of mental health and substance abuse services, significantly improving responsiveness to the needs of people affected by substance use disorders and mental illness in our community. The Alliance's vision is for a well-coordinated, well-funded continuum of substance abuse and mental health services, which will achieve our maximum potential for meeting community needs and promote a healthier community through healthier individuals and families.

The Alliance operates under an Unincorporated Nonprofit Association agreement, has a joint budget funded in part by its members, and is convened and staffed by the Health District of Northern Larimer County. Decision-making is by a Steering Committee and is based on recommendations made by workgroups and staff.

Since its inception, the members of the Alliance have worked on innovative, collaborative improvements. After an initial assessment in February 2001, the Alliance published its report, "Mental Illness and Substance Abuse in Larimer County: The Challenges We Face Today." That report, along with a follow-up report in 2008, "Mental Illness and Substance Abuse in Larimer County: Foundation of Progress, Future of Hope," fueled ongoing planning to address the top priorities for change. The Alliance has a long history of successful systems level changes and new programs. A few key examples of these include:

- Transforming previously separate mental health and substance use disorder treatment services into "co-occurring capable" services, including the integration of services at the nonprofit organization now called SummitStone Health Partners.
- Training professionals and community members in how to best respond to the needs of those with mental illnesses and substance use disorders.
- Development of the Connections Mental Health & Substance Abuse Resources program in partnership with the Health District and SummitStone Health Partners. Connections helps community members access behavioral health treatment and support services through information, referral, care coordination, connection to low-cost services, and other supports.
- Working with the Poudre Valley Health System to develop the Crisis Assessment Center (CAC) at the Poudre Valley Hospital Emergency Room, creating a unified approach to those experiencing mental health and substance use related crises.

- Development of a “Crisis Consistency Matrix” decision-support tool to help first contacts and responders know how to assess a behavioral health crisis situation and determine the best place to take the person in crisis for care; ongoing updates and training on use of the matrix.
- Development of Community Dual Disorders Treatment team (CDDT) based on the evidence-based practice Integrated Dual Disorder Treatment (IDDT), for those with the most severe co-occurring mental illness and substance use disorders.
- Development of transportation options from Larimer County to the NRBH Detox facility located in Weld County.
- Placement of Integrated Care Teams, including psychiatric care, at the Fort Collins Salud Family Health Center and the Family Medicine Center, expanding the ability of primary care clinics to address behavioral health issues.

The community has also developed critically important new services over the past few years. For example:

- In 2014, an evidence-based Assertive Community Treatment (ACT) team was developed by SummitStone Health Partners and now has also incorporated the local Integrated Dual Disorders Treatment (IDDT) team within its services to provide people with severe mental illness and/or substance use disorders with intensive, evidence-based treatment and support services.
- In 2015, the Crisis Stabilization Unit began operation in Fort Collins, providing ten beds for 24/7 crisis stabilization and one 23-hour observation bed.
- From 2015-2017, due to changes in payment structures, some Intensive Outpatient Programs (IOPs) have been developed in Larimer County.
- In 2016, the Connections Program expanded its services to assist youth and families through the Child, Adolescent and Young Adult Connections (CAYAC) Team, which help youth and families with potential, emerging and existing behavioral health challenges navigate the process of assessment, treatment and ongoing recovery.
- Since the 2016 report, the number of Medication-Assisted Treatment (MAT) providers has significantly increased. There are now at least fifteen clinics in Larimer County that provide some level of MAT services to their clients. A table of current MAT providers is included in the list of SUD treatment services provided in Appendix J.
    - SummitStone has added weekly Medication-Assisted Treatment (MAT) induction clinics for Suboxone and Vivitrol in Loveland. Induction for Vivitrol is also available in Fort Collins, and SummitStone is hoping to offer Suboxone induction in the near future. For now, Fort Collins clients can go to Loveland for induction. Many of SummitStone’s MAT clients also choose to participate in SummitStone’s Acudetox services which uses acupuncture to reduce the symptoms associated with addiction recovery including withdrawal symptoms, cravings and anxiety.
    - Behavioral Health Group has added Suboxone services in addition to their methadone services and is able to serve up to 200 clients between the two treatment programs
    - Front Range Clinic has opened locations in Fort Collins and Loveland where clients can receive MAT (Suboxone or Vivitrol) in an outpatient setting, supported by in-house outpatient behavioral health treatment and case management. The clinic

accepts all insurance including Medicaid and clients are able to access services at any one of the clinic's locations in order to receive more timely access to treatment.
    - The Colorado Clinic has expanded the number of providers who are licensed to prescribe Suboxone.
- SummitStone expanded its adolescent SUD team in the past year and a half. More prevention, education, and treatment is now happening in in the community and outpatient locations.
- Harmony Foundation (in Estes Park) has expanded its medically-monitored withdrawal management program from seven beds to 23, for those with private insurance or the ability to pay out of pocket.
- Larimer County law enforcement agencies received a grant to help fund their behavioral health co-responder program. The model is one where police officers team up with behavioral health specialists to respond to incidents where a person may need crisis intervention for mental health or substance abuse issues. The grant award comes from the Colorado Department of Human Services Office of Behavioral Health, and the funding will allow the Larimer County Sheriff's Office, Fort Collins Police Services and the Loveland Police Department to pair trained behavioral health specialists with police. Behavioral health specialists from SummitStone Health Partners, as well as the police officers themselves, will be trained to work together to help individuals get access to the resources they need. In turn, officials hope it will help avoid costly alternatives for taxpayers such as sending people struggling with mental or substance abuse issues to emergency rooms or the jail creating earlier diversion alternatives for individuals.
- Mountain Crest Behavioral Health Center has added eight additional hospital-level inpatient beds, and one additional Intensive Outpatient Program (IOP) for chemical dependency.

Purpose and Approach of this Document

While this community has succeeded in expanding and improving its behavioral health services, community members remain acutely aware that there are still a number of significant needs that remain unmet. Many of the current needs, such as the need for local withdrawal management (detox) services, and the lack of local residential treatment, were identified early in the Alliance's history and have grown in their intensity and impact over time; to the point that several major community organizations have mentioned the need for an improved behavioral healthcare system in their strategic plans, including Larimer County, the City of Fort Collins, and the Health District of Northern Larimer County. Others are emerging as contemporary issues as the population grows and as leaders and service providers learn more about the specific needs of people with behavioral health disorders and available best practices to address those needs.

The recommendations included in this document focus primarily on adult services, however some funding is being recommended for youth and family-oriented services. The recommendations are the result of community leaders, service providers, consumers and community members recognizing that this community must identify the extent of, and fill, these critical gaps in the system of behavioral health care in order to give people suffering from these health disorders the same chance for recovery and health that is expected from other health care.

The first three steps to improving the behavioral health care system by providing state-of-the-art services include:

1. Delineate what is needed for a more complete continuum of care capable of providing adequate levels of care for those with behavioral health needs (focusing on the best evidence, high quality, and access to care), understand what actually exists in our community, and determine the gaps.
2. Determine a cost estimate for filling the gaps, and determine potential revenue sources and the remaining need for funding.
3. Determine community interest in developing resources to fill the service gaps.

The recommendations contained in this document address the first two steps. The purpose of these recommendations is to help citizens and service providers understand existing challenges, garner commitment to making changes and improvement, and stimulate significant development and expansion of critical behavioral health services in Larimer County in order to guarantee Larimer County's capacity to meet the growing behavioral health needs of its citizens.

The Importance of Adequate Services for Those with Behavioral Health Disorders

Behavioral health disorders, including mental illness and substance use disorders, include a wide range of serious health issues – in this case, health conditions impacting the brain - that are chronic and potentially life-threatening, similar to other chronic health disorders such as diabetes, heart disease and cancer. These disorders of the brain are common and can affect anyone at any age or socio-economic status. They are also treatable and recovery is possible. Increasingly, research is helping treatment providers hone in on the most successful treatment approaches, and treatment effectiveness is improving. Like other health disorders, early identification and access to effective treatment is critical to reducing disability and saving lives.

Though these conditions are diagnosable health disorders, consumers and families regularly report great difficulty in getting access to the recommended range of services – a situation that is quite different than access to care for other chronic illnesses, such as cancer or diabetes.

The growing body of evidence for treatment success has resulted in the development of guidelines that outline the continuum of behavioral health treatment services necessary in order for a community to adequately address behavioral health disorders and minimize their impact on community members and the community itself.

When our community's services were compared to this continuum of services, our analysis (outlined in depth later in this document) indicated that many excellent treatment services for behavioral health disorders exist in Larimer County. In some areas, our community is close to the amount and level of care needed, or is likely to be able to reach those levels with recently expanded payer sources, if attention is paid to developing the appropriate levels for the needs – for example, in the areas of outpatient treatment, information and referral services, and the new crisis stabilization services.

However, it was also determined that many of the more intensive levels of treatment are missing or incomplete in our community, and the necessary range of support services are also not provided at adequate levels at the current time. **The key finding of this investigation is that Larimer County does not have a continuum of mental health treatment and support services that is sufficient to meet the needs of people who have mental illnesses and/or substance use disorders.** As a result, these people often simply cannot get the level of care that they need in order to address their illness and are often not connected to the appropriate level of care as their condition changes. This creates prolonged suffering for these individuals and their families, as well as puts an unnecessary strain on local law enforcement, EMS and the emergency departments, that are often much costlier levels of care.

While many quality services are being provided, the effectiveness of these existing services is compromised by the lack of other needed services. In order to provide those who suffer from mental health disorders with the treatment most likely to effectively impact their disorder, the development of additional levels of care and state-of-the-art treatment is critical.

Summarized, this process identified a number of key levels of care to be added or expanded in a Behavioral Health Services Center in order to provide adequate standards of care in Larimer County.

- Initial assessment, triage and medical clearance examination
- Thorough patient-centered assessment processes to accurately guide placement and transitions into and between community levels of care]
- Just-under Hospitalization level of care (Currently available through existing Crisis Stabilization Unit (CSU), but recommended to be met through moving existing CSU to facility)
- Withdrawal Management (Drug/Alcohol Detoxification) services
  - Clinically Managed Detox (social model)
  - Medically-Monitored Detox
- Residential Treatment for substance use disorders

Services that need to be developed or expanded in the community include:

- Long-term step-down residential options including “halfway houses” and “Oxford houses”
- Outpatient treatment for substance use disorders (including Medication Assisted Treatment)
- Intensive Outpatient Treatment services (IOP);
- Support Services (moderately intensive to intensive care coordination, support services for those with chronic conditions who live in Permanent Supportive Housing, and client assistance funds).

In careful consideration of how best to provide these services, it is recommended that many of the services be grouped together in a 24-7 Services Center providing a new state-of-the-art model of care, and enabling more seamless transitions between levels of care through a true “No Wrong Door” system. This approach is an emerging best practice because of its ability to better

coordinate services and supports while reducing the burden on individuals and families who must navigate a complicated system of care during a crisis episode.

However, other services are best provided largely in the community, such as support services for those in Permanent Supportive Housing, low-acuity longer term residential treatment for substance use disorders, care coordination, and outpatient and intensive outpatient treatment.

Some services would require additional funding; other services could be expanded by existing service providers utilizing already existing revenue sources.

Each level of care is described in more detail later in this document.

The Scope and Impact of the Problem: Why a More Complete Continuum of Behavioral Health Treatment Services is Important

Mental illness and substance use disorders have significant impacts on individuals, families and our community. A few key statistics are included here to illustrate the scope and impact of the problem. Additional statistics are reported in a companion document entitled "Supplementary Behavioral Health Research Findings and Statistics."

Prevalence of Mental Illness and Substance Use Disorders

Mental illnesses and substance use disorders are common and can impact people at any age, ethnicity, and income level.

Mental Illness

Applying Colorado data from the 2015 and 2016 SAMHSA National Survey on Drug Use and Health (NSDUH) to Larimer County, there are approximately 53,800 adults (18 and older) in this county (20.1%) who have any mental illness. Of those 53,800 people, just over 12,300 (4.6%) have a serious mental illness.[1]

Substance Use Disorders

Again extrapolating state-level 2015 and 2016 NSDUH data to Larimer County, we estimate that 8.5% of individuals aged 12 and older (25,000 people) have a substance use disorder.[1] (An additional 1,000 individuals have been added to this number to account for populations not included in the NSDUH for a total of 26,000 people). Thousands of these individuals have more than one substance use disorder diagnosis (alcohol, heroin, marijuana etc.) and require different types and levels of treatment to address their specific disorder(s). Alcohol is the leading

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[1] Center for Behavioral Health Statistics and Quality. (2017). *2016 National Survey on Drug Use and Health: Detailed Tables.* Substance Abuse and Mental Health Services Administration, Rockville, MD.

substance of abuse and addiction; 6.4% (18,500 people) of the population aged 12 and older is reported to have an alcohol use disorder.[2]

Co-Occurring Mental Illness and Substance Use Disorders

Mental illness and substance use disorders often occur together and are referred to as co-occurring disorders.

- About a third of all people experiencing mental illness and about half of the people living with severe mental illness also experience substance abuse.[3] Similarly, about a third of all alcohol abusers and more than half of all drug abusers report experiencing a mental illness.[4]
- Extrapolating national data to Larimer County, approximately 5.9% of adults (15,500) had co-occurring mental illness and substance use disorder, and 2.0% (5,250) had co-occurring serious mental illness and substance use disorder.

Impact on Health and Longevity

Burden of Disease/Disability Adjusted Life Years (DALY's)

Mental illnesses and substance use disorders are major health problems worldwide. In "No Health Without Mental Health," the authors state that "Mental illness is a leading cause of suffering, economic loss and social problems. It accounts for over 15% of the disease burden in developed countries, which is more than the disease burden caused by all cancers".[5] According to the Global Burden of Diseases, Injuries and Risk Factors 2010 report, mental and behavioral health disorders are the leading cause of disability in the U.S.[6]

Premature Death

Mental illness and substance use disorders can significantly reduce longevity.

- Overall, a 2015 analysis of over 200 international studies over a decade found that people with mental health conditions were more than twice as likely to die over roughly 10 years, versus people without the disorders. Their risk of death from "unnatural causes" -- including suicide and accidents -- was seven times higher. But their odds of dying from physical health conditions were also elevated, by an average of 80 percent.[7]

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[2] Ibid.
[3] Dual Diagnosis. (n.d.). Retrieved February 05, 2016, from https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Dual-Diagnosis
[4] Ibid.
[5] Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A. (2007). No health without mental health. *The Lancet, 370* (9590), 859–877.
[6] Institute for Health Metrics and Evaluation. (2013). *The State of US Health: Innovations, Insights, and Recommendations from the Global Burden of Disease Study*. Seattle, WA: Author.
[7] Rubin, Rita. (2015). Mental Disorders Linked With Chronic Disease. *The Journal of the American Medical Association,* Volume 313 (2), 125.

- Adults living with serious mental illness may die on average twenty-five years earlier than other Americans[8]; and about 60% of that additional mortality may be due to physical illness.[9]
- Also contributing is the impact of substance use, misuse and abuse. Colorado ranks second worst among all states for prescription drug misuse among people between the ages of 12 and 25. More than 255,000 Coloradans misuse prescription drugs, and deaths involving the use of opioids nearly quadrupled between 2000 and 2011.[10]

Suicide

Suicide is death caused by intentional, self-inflicted injuries. While not always associated with behavioral health issues, it is most often related to depression and substance use. Of adults committing suicide, it is estimated that 90% have a mental health disorder[11] and this number is consistent among youth who commit suicide.[12]

- Larimer County and Colorado both have a suicide rate much higher than the national average (US: 13.9 (per 100,000)[13]; Colorado: 20.5[14]; Larimer County: 20.9[15]).
- In 2015, there were eighty-three (83) deaths by suicide in Larimer County, the highest number of suicides ever recorded by the coroner's office. In comparison to the 83 deaths by suicide, only 52 people died as a result of car accidents in Larimer County in 2015. Alcohol or drugs were present in 66% of the suicides, and 35% of fatalities due to motor vehicle crashes involved drivers who tested positive for alcohol and/or drugs.[16] Only 40% were actively in treatment for a behavioral health issue. [17]

Lack of Treatment for Behavioral Health Disorders

Despite the enormous health burden of behavioral health disorders, many people with mental illness or substance use disorders do not get treatment for their condition. A key 2011 study

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[8] http://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

[9] De Hert, M., et al. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*, *10*(1), 52–77.

[10] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2013). The National Survey on Drug Use and Health Report: State Estimates of Nonmedical Use of Prescription Pain Relievers. Rockville, MD: Substance Abuse and Mental Health Services Administration

[11] American Foundation for Suicide Prevention. (n.d.). Key Research Findings. Retrieved from https://www.afsp.org/understanding-suicide/key-research-findings.

[12] Shaffer, D., Craft, L. (1999). Methods of Adolescent Suicide Prevention. *Journal of Clinical Psychiatry*, *6 (Suppl 2),* 70-74.

[13] Drapeau, C. W., & McIntosh, J. L. (for the American Association of Suicidology). (2017). U.S.A. suicide 2016: Official final data. Washington, DC: American Association of Suicidology. Retrieved from http://www.suicidology.org.

[14] Colorado Center for Health and Environmental Data. (2017). Suicides in Colorado: Crude suicide rates per 100,000 population. Retrieved from https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/CoVDRS_12_1_17/Story1?:embed=y&:showAppBanner=false&:showShareOptions=true&:display_count=no&:showVizHome=no#8

[15] Ibid.

[16] Wilkerson, J.A. (2016). 2015 Annual Report: Office of the Larimer County Coroner Medical Examiner. Loveland, CO. Retrieved from https://www.larimer.org/sites/default/files/uploads/2017/2015-annual-report.pdf

[17] D. Fairman (personal communication, September 25, 2017)

stated, “A substantial proportion of adults with common mental disorders fail to receive any treatment even when these conditions are quite severe and disabling.”[18]

- According to the World Health Organization, “In developed countries with well-organized health care systems, between 44% and 70% of patients with mental disorders do not receive treatment.”[19] Indeed, SAMHSA indicates that on average, 44.7% of American adults who experienced mental illness in the past year received some type of mental health care.[20]
- Even fewer people with substance use disorders receive the treatment they need. Just ten percent of adults with substance use disorders receive treatment in a given year, with twenty-nine percent of those who do get treatment receiving care considered to be minimally adequate.[21]

Using prevalence data from N-SSATS and NSDUH, it is estimated that approximately 25,000 people in Larimer County meet the criteria for needing treatment for substance use disorders. It is also estimated that only about 2,300 people receive care for their substance use disorder(s) each year, leaving nearly 24,000 people needing but not receiving treatment. Of those 24,000, it was estimated that approximately 1,200 are ready for treatment and seek it, but do not receive that treatment. (See pages 43-51 for information on how prevalence estimates were updated since the original 2016 publication of this report.)

A number of factors may be involved in the gap between need for treatment for behavioral health disorders and accessing that treatment. One study of barriers to mental health treatment stated, “Several factors are thought to impede appropriate mental health care seeking including lack of perceived need for treatment, stigma, pessimism regarding the effectiveness of treatments, lack of access due to financial barriers, and other structural barriers such as inconvenience or inability to obtain an appointment.”[22] Additional factors may also be at play, including the lack of availability of needed treatment services in the community where people live.

The Effectiveness of Treatment of Behavioral Health Disorders as Chronic Diseases

Mental and substance use disorders affect people from all walks of life and all age groups. These illnesses are common, chronic, and often serious. However, they can be managed through ongoing treatment and support. According to the National Institute for Health (NIH), Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition):

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[18] Mojtabai, R., Olfson, M., Sampson, N. A., Jin, R., Druss, B., Wang, P. S., R.C., Kessler, R. C. (2011). Barriers to mental health treatment: results from the National Comorbidity Survey Replication. Psychological Medicine, 41(08), 1751–1761. http://doi.org/10.1017/S0033291710002291

[19] World Health Organization, & Noncommunicable Disease and Mental Health Cluster. (2003) *Investing in mental health.* Geneva: World Health Organization. Retrieved from http://www.myilibrary.com?id=9723

[20] SAMHSA. National Survey on Drug Use and Health. Center for Behavioral Health Statistics and Quality; 2014.

[21] SAMHSA. 2014.

[22] Andrade, L. H., Alonso, J., Mneimneh, Z., Wells, J. E., Al-Hamzawi, A., Borges, G., … Kessler, R. C. (2014). Barriers to mental health treatment: results from the WHO World Mental Health surveys. Psychological Medicine, 44(06), 1303–1317. http://doi.org/10.1017/S0033291713001943

> Like other chronic diseases, addiction can be managed successfully. Treatment enables people to counteract addiction's powerful disruptive effects on the brain and behavior and to regain control of their lives. The chronic nature of the disease means that relapsing to drug abuse is not only possible but also likely, with symptom recurrence rates similar to those for other well-characterized chronic medical illnesses -- such as diabetes, hypertension, and asthma that also have both physiological and behavioral components.[23]

Unfortunately, particularly in the past, when relapse occurred, some considered treatment a failure. However, NIDA states,

> Successful treatment for addiction typically requires continual evaluation and modification as appropriate, similar to the approach taken for other chronic diseases. For example, when a patient is receiving active treatment for hypertension and symptoms decrease, treatment is deemed successful, even though symptoms may recur when treatment is discontinued. For the addicted individual, lapses to drug abuse do not indicate failure -- rather, they signify that treatment needs to be reinstated or adjusted, or that alternate treatment is needed."[24]

The figures on the following page shows that the treatment for all chronic illnesses, including substance use disorders, is effective when administered but symptoms usually return after discontinuing treatment. Addiction treatment, like treatment for all chronic diseases, requires ongoing care in order to be effective.

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[23] National Institute for Health. (2012). Principles of Drug Addiction and Treatment: A research-based guide. NIH Publication No. 12-4180. Retrieved from https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/drug-addiction-treatment-worth-its-cost

[24] National Institute for Health (2012)

Figure 1: Why is Addiction Treatment Evaluated Differently? Both Require Ongoing Care[25]

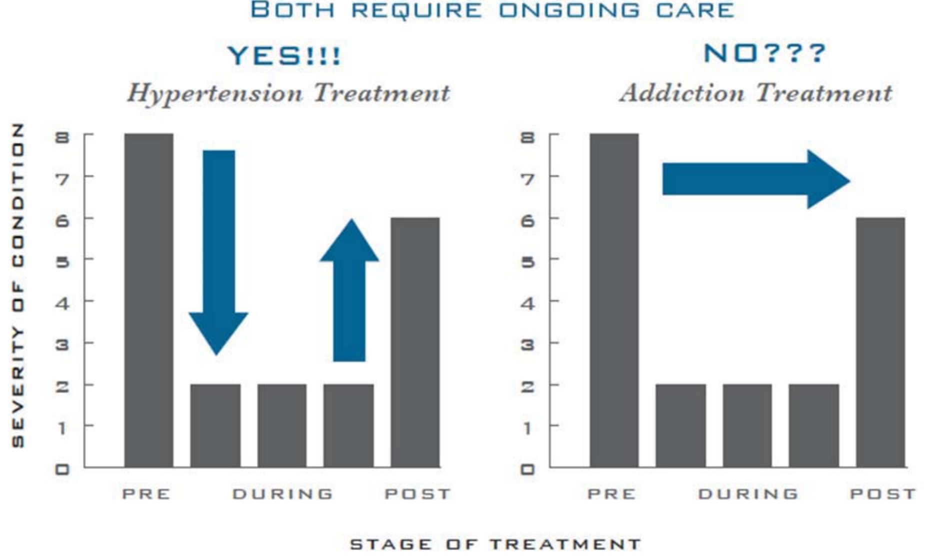
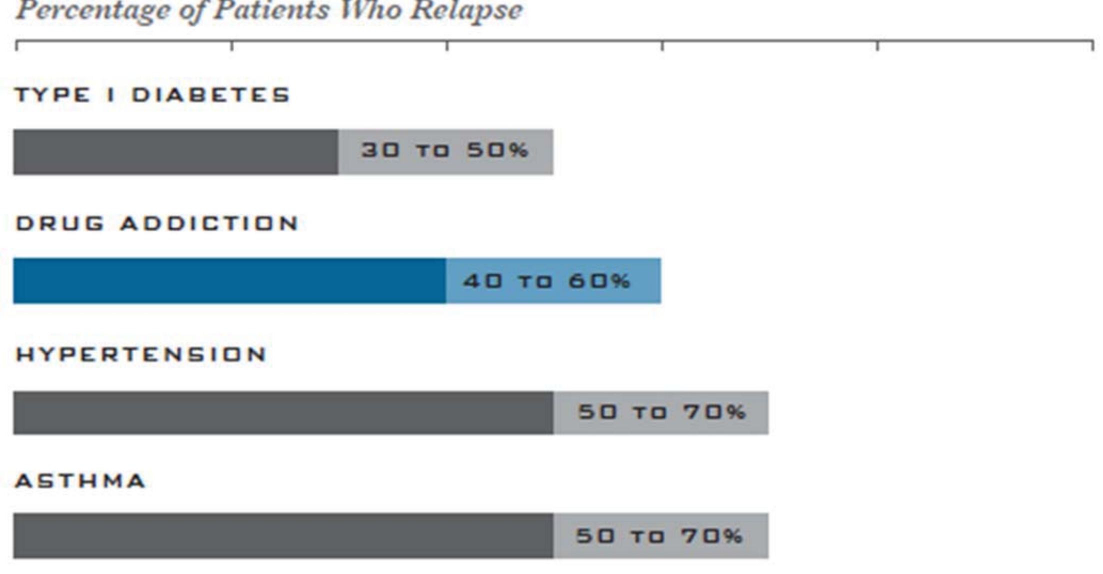


Figure 2: Percentage of Patients Who Relapse[26]



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[25] National Institute for Health (2012)
[26] National Institute for Health (2012)

Additionally, the effectiveness of treatments for chronic illnesses vary depending on the specific circumstances affecting each individual situation, resulting in varying levels of treatment success and different definitions of treatment success for each individual in treatment. The National Institute on Drug Abuse states that, "In addition to stopping drug abuse, the goal of treatment is to return people to productive functioning in the family, workplace, and community." According to research that tracks individuals in treatment over extended periods, most people who get into and remain in treatment stop using drugs, decrease their criminal activity, and improve their occupational, social, and psychological functioning. For example, methadone treatment has been shown to increase participation in behavioral therapy and decrease both drug use and criminal behavior. However, individual treatment outcomes depend on the extent and nature of the patient's problems, the appropriateness of treatment and related services used to address those problems, and the quality of interaction between the patient and his or her treatment providers.[27]

When people with behavioral health disorders do not receive appropriate, timely, or adequate treatment, the result is often greater suffering from symptoms; impacts on overall health and longevity; reduced ability to function in their families, school, work or social activities; utilization of additional, more intensive and higher cost levels of treatment; and utilization of high cost services such as emergency departments and involvement in the criminal justice system. SAMHSA reports that those with undiagnosed, untreated, or undertreated co-occurring mental illness and substance use disorders may suffer from a higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, and early death.[28]

Impact on Self-Sufficiency and Cost to Society

Health Problems and High Health Costs

Behavioral health conditions can be associated with poorer physical health as well as higher health costs overall:

- Medical costs for treating those patients with chronic medical and comorbid mental health/substance use disorder (MH/SUD) conditions can be 2-3 times as high as for those who don't have the comorbid MH/SUD conditions. The *additional* healthcare costs incurred by people with behavioral comorbidities were estimated to be $293 billion in 2012 across commercially-insured, Medicaid, and Medicare beneficiaries in the United States.[29]
- According to a 2015 study of 155 high utilizers of the Larimer County Jail, the high utilizers were also frequent utilizers of acute, high cost services. They had 136% higher Medicaid costs than other Larimer County Medicaid patients. Roughly 9 of every 10 of those studied were identified as having substance use problems, nearly half had a mental illness, and almost all of those with mental illnesses also had a co-occurring substance use disorder. Sixty-five percent of visits to the Emergency Department at Poudre Valley

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[27] National Institute for Health (2012)
[28] Substance Use Disorders. (n.d.). Retrieved February 05, 2016, from http://www.samhsa.gov/disorders/substance-use
[29] Melek, S., Norris, D., & Paulus, J..(2014). Economic Impact of Integrated Medical-Behavioral Healthcare. Denver, CO: Milliman, Inc. for American Psychiatric Association.

Hospital by these individuals were identified as related to substance use (primarily alcohol).[30]

Unemployment, Underemployment, and Poverty

Mental illness and substance use disorders are often associated with problems with employment as well as being at risk for poverty and homelessness.

- People with disabilities have high unemployment rates and people with serious mental illnesses have the highest unemployment rate of any group with disabilities.[31]
- According to a NAMI 2014 report, over 80% of those with serious mental illness are unemployed.[32]

Financial Impacts

It is difficult, if not impossible, to put a cost on human suffering. However, it is possible to at least begin to understand the staggering financial impact of behavioral health disorders, remembering that they are quite often untreated or not adequately treated.

- The Substance Abuse and Mental Health Administration estimated that the U.S. national expenditure for mental health care alone was $147 billion in 2009.[33]
- Combining these figures with updated projections of lost earnings and public disability insurance payments associated with mental illness, an estimate for the financial cost of mental disorders was at least $467 billion in the U.S. in 2012.[34]
- Illicit drug use, often related to substance use disorders and mental illness, costs Americans $193 billion in overall costs (including health care, loss of work productivity, and costs related to crime).[35]

Lost Productivity

Behavioral health disorders impair functioning, resulting in impacts on work and home life.

- One study showed that approximately 80% of persons with depression reported some level of functional impairment because of their depression, and 27% reported serious difficulties in work and home life.[36] Impacts on work functioning include reduced

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[30] TriWest Group. 2015. *Larimer County High Utilizer Study*. (2015). Larimer County, Colorado: Health District of Northern Larimer County and the Community Mental Health and Substance Abuse Partnership of Larimer County.

[31] National Governors Association. (2007). Promoting Independence and Recovery through Work: Employment for People with Psychiatric Disabilities. Washington, D.C.: National Governors Association.

[32] Dlehl, S., Douglas, D., & Honberg, R.. (2014). *Road to Recovery: Employment and Mental Illness*. Arlington, VA: National Alliance on Mental Illness. Retrieved from https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/RoadtoRecovery.pdf

[33] Substance Abuse and Mental Health Services Administration. (2013). National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2009. HHS Publication No. SMA-13-4740. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[34] Insel, T.R. (2011). Director's Blog: The Global Cost of Mental Illness. Retrieved from http://www.nimh.nih.gov/about/director/2011/the-global-cost-of-mental-illness.shtml

[35] National Institute on Drug Abuse. (2015). Trends and Statistics. Retrieved from http://www.drugabuse.gov/related-topics/trends-statistics

[36] Pratt, L. & Brody, D.. (2008). Depression in the United States household population, 2005-2006. National Center for Health Statistics Data Brief, 7. Retrieved from from:http://www.cdc.gov/nchs/data/databriefs/db07.htm#ref08

productivity due to both absenteeism as well as presenteeism, whereby workers show up to work but produce reduced results.
- According to a 2002 study, "mental illness is the number one cause of disability for American business and industry today and is second only to cardiovascular disease in total disability costs."[37]

Service Utilization and Related Costs

Many people who don't get the right service or treatment enter a cycle of repeated use of the highest cost services in our community, such as emergency departments, or may become involved with the costly criminal justice system.

- For example, according to the 2015 Frequent Utilizer Study done in Larimer County, 72% of visits to the Poudre Valley Hospital Emergency Department by 155 high utilizers of the Larimer County Jail were related to mental health and/or substance use.[38]
- This same group of 155 high utilizers of acute and crisis services are costing our community over $2.2 million dollars in potentially avoidable costs each year. Despite these costs, high utilizers are not experiencing improvements in their underlying mental illnesses and substance use disorders or their service utilization over time.[39]

Criminal Justice and Community Safety

Adults with serious mental illness are at increased risk for criminal justice involvement.[40] According to a 2015 Urban Institute study, they tend to stay in jail longer than those without mental illnesses, return to jail more often and cost local jurisdictions more money while incarcerated. More frequently than not, they are jailed for minor offenses, such as trespassing, disorderly conduct, disturbing the peace or illicit drug use.[41]

- 30% of inmates at the Larimer County Jail at a point in time in 2016 had a mental illness; 52% had substance use related issues; and 27% had co-occurring mental illness and substance use.[42]
- 26% of the general population (without mental illnesses or substance use disorder) at the Larimer County Jail recidivated (returned to jail) in 2016. Comparatively, during the same year, 66% of those with mental illnesses, 65% with substance use disorders, and 69%] of those with co-occurring disorders recidivated.[43] These percentages are fairly consistent with what the jail has seen in previous years (in 2013 the percentages varied by up to two percentage points).

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[37] Marlowe, J.F. (2002). Depression's surprising toll on worker productivity. *Employee Benefits Journal*, *27*(1): 16-21.
[38] TriWest Group. 2015.
[39] TriWest Group. 2015.
[40] Munetz, M.R., Grande, T.P., Chambers, M.R. (2001). The incarceration of individuals with severe mental disorders. *Community Mental Health Journal Aug; 37(4)*: 361-372.
[41] Kim, K., Becker-Cohen, M., & Serakos, M. (2015). The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System. Retrieved from http://www.urban.org/UploadedPDF/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf
[42] D. Stalls (personal communication, August 18, 2017)
[43] D. Stalls (2017)

- More than one-tenth of costs of behavioral health treatment were spent in jails in 2011, equaling more than $93 million.[44]

Timely and adequate treatment for behavioral health disorders has the potential to significantly reduce these impacts and thereby provide remarkable value to individuals impacted by mental illness and/or substance use disorders, their families and friends, workplaces, and the community itself.

Process for the Development of this Report

A report was originally released in February of 2016 as "Recommendations for the Development of Critical Behavioral Health Services in Larimer County" and was updated slightly in April of 2016. This report, is the result of an update of the original 2016 report to reflect current community needs and opportunities. The initial NIATx report from 2016 is included as Appendix K of this report. The application and modification of NIATx' report by local experts in 2016 is included in Appendix L. For this update, NIATx provided a written response to the updates that were made to the original report and the current recommendations of the Guidance Team, which is included in Appendix M. Application and modification of NIATx 2018 input is included on pages 43-51 of this report.

As work on the development of these recommendations began, the Guidance Team adopted the following objective, vision, and process:

Objective

Create recommendations to inform a future plan that would make significant headway in filling critical gaps in behavioral health care services for those experiencing the health conditions of mental illness and substance use disorders in Larimer County.

Vision

Larimer County residents with mental illnesses and/or substance use disorders will:

- Achieve their optimal recovery and health
- Have an equivalent level of support and effective treatment available as community members with other chronic and potentially life-threatening illnesses such as cancer, diabetes and heart disease
- Receive the most effective diagnostic, treatment and supportive services in a timely manner in the community in which they live.

Our community will:

[44] TriWest Group. (2011)

- Be a thriving, productive and safe place to live that supports mental and emotional well-being and a high quality of life for its citizens
- Maintain and add to its world-class status through providing the standard of care for behavioral health care treatment as an integrated and critical part of its state-of-the-art healthcare system
- Make the most of limited resources and reduce the avoidable use of inappropriate and high cost acute, crisis and intensive services such as emergency departments, hospitals, criminal justice, detention centers, etc.

Process

1. **Identify the behavioral health services most needed in the community.** Clearly identify and list the most critical gaps in services, including background to indicate why changes are needed. In evaluating and describing the needed services, utilize nationally recognized or adopted levels and standards of care and state-of-the-art treatment approaches.

2. **Determine the level of need for each identified service.** Analyze the projected need and utilization of the identified services, now and into the future.

3. **Perform financial analysis.** For the identified services and level of projected use, estimate the projected cost as well as revenues and resources potentially available for operation of the services (now and into the future); determine level of gap in funding, if any. If gaps exist, determine potential approaches for funding the gaps. Develop an estimated pro forma balancing projected funding with prioritized services.

4. **Create recommendations to inform the creation of a plan for the development and implementation of critical services.** Create basic combined recommendations listing the services (levels of care and standards of care) to be provided, the estimated amounts of care, the proposed organization of care for effectiveness and efficiency, and an estimated balanced funding approach.

5. **Analyze potential benefits to individuals and the community.** Determine how impact will be measured, and create informed estimates of anticipated benefits.

Methods and Limitations

The development of these recommendations consisted of two phases:

Phase I: Mapping and Analysis of Existing Substance Use Disorder Services by American Society of Addiction Medicine (ASAM) Levels of Care

1. Alliance staff completed a project to map existing substance use disorder services in Larimer County by ASAM level, and to collect detailed information about services and gaps in those ASAM levels identified as potentially not having sufficient service capacity. Data collection from direct service providers included: capacity information, service utilization, referral systems, and programmatic detail.

2. The Mental Health and Substance Use Alliance of Larimer County and the Guidance Team identified the key mental health services listed in this document as those most needed in the community to fill current gaps in mental health services. Although a tool similar to the ASAM tool for substance use disorder services was not discovered, the need for these services was mentioned consistently in a series of discussions of need in 2014 and 2015.

Phase II: Analysis of Gaps in Services and Recommendation of Services Needed

1. To aid in data collection, analysis and development of recommendations, the Alliance engaged the consulting services of the NIATx Group in the development of these recommendations. NIATx group is a multidisciplinary team of consultants with a unique blend of expertise in public policy, agency management, and systems engineering. NIATx has the benefit of having worked with 1000+ treatment providers and 50+ state and county governments. NIATx is also affiliated with the Addiction Treatment Technology Center (ATTC) Network. The ATTC Network is responsible for cataloging and providing training on evidence-based practices throughout the United States and its territories. The specific consultants who worked on this project are:
   - Todd Molfenter, Ph.D., Principal, NIATx
   - Victor Cappoccia, Ph.D., Senior Scientist, NIATx
   - Colette Croze, Principal, M.S.W., Croze Consulting

2. Alliance staff and NIATx consultants collaborated in data collection, and NIATx performed data analysis on data from a variety of sources, including collection of utilization data from the following organizations:

   - Colorado Access Behavioral Care: the Behavioral Health Organization (BHO) for Northeast Colorado; which manages services for people with Medicaid behavioral health coverage
   - Rocky Mountain Health Plans: the Regional Care Coordination Organization (RCCO) for Larimer County; which manages services for people with Medicaid medical coverage
   - Signal Behavioral Health Network: the Managed Services Organization (MSO) for Larimer County; which manages and coordinates substance use treatment contracts and manages data related to SUD treatment utilization
   - Northeast Behavioral Health: the former BHO for the region and current manager of crisis stabilization services for Larimer and Weld Counties
   - Data collection from direct service providers as needed

Throughout the process, additional background information was gathered from members of the MHSU Alliance, and interviews with providers, consumers and other community members, including case examples illustrating service gaps. Additionally, the Guidance Team for this project, a Subcommittee of the MHSU Alliance, discussed findings and recommendations and provided guidance throughout the development of this document in both 2015/16 and 2017/18.

Phase I: Mapping and Analysis of Existing Substance Use Disorder Services by American Society of Addiction Medicine (ASAM) Levels of Care

Introduction to Mapping Project

The Mental Health and Substance Use Alliance identified the goal of providing the most effective services for those with substance use disorders as their top priority in 2013, and reaffirmed this in early 2017. Staff embarked on an effort to map local service availability compared to service needs to address these illnesses at all levels of severity. As a result of the study of effective approaches, it became clear that Larimer County has specific gaps in services for individuals with substance use disorders.

To determine the levels of care that a community needs to effectively treat substance use disorders, the Alliance used the levels developed by the American Society of Addiction Medicine (ASAM). Criteria were developed by ASAM through a collaborative process "to define one national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction". They have become the "most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions."[45]

Importance of a Quality Assessment-Based System in Placing a Person in the Right Level of Care

To determine the right level of care for an individual at any stage of needing assistance, the critical first step is a comprehensive assessment, performed by a well-trained professional. This assessment determines the appropriate level of care for that individual at that time, based on the following six (6) dimensions:[46]

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potentials
6. Recovery/living environment

The following chart describes the Placement Criteria recommended by ASAM to be used before recommending an appropriate level of care for a particular individual in need of treatment for substance use disorder.

[45] American Society of Addiction Medicine. (2013). The Six Dimensions of Multidimensional Assessment. The ASAM Criteria. Retrieved from http://asamcontinuum.org/knowledgebase/what-are-the-six-dimensions-of-the-asam-criteria/
[46] American Society of Addiction Medicine. (2013).

Figure 3: ASAM Patient Placement Criteria[47]

Screening → Diagnosis → Severity → Readiness & Relapse Potential

Patient Placement Criteria

DIMENSIONS

1 Intoxication Withdrawal

2 Biomedical

3 Emotional Behavioral

4 Treatment Acceptance/ Resistance

5 Relapse Potential

6 Recovery Environment

Decision Rules

LEVEL OF CARE

1. Outpatient

2. Intensive Outpatient

3. Medically Monitored Intensive Inpatient

4. Medically Managed Intensive Inpatient

#RxSummit
NATIONAL RX DRUG ABUSE SUMMIT

An assessment-based system ensures that each person's needs are assessed through an objective set of evidence-based criteria. Ideally, the individual will be assessed for all behavioral health disorders, including mental illness, and not just for their level of substance use disorder. This requires that the community have well-trained and highly skilled clinicians with state-of-the-art knowledge who can make accurate diagnostic decisions and treatment recommendations.

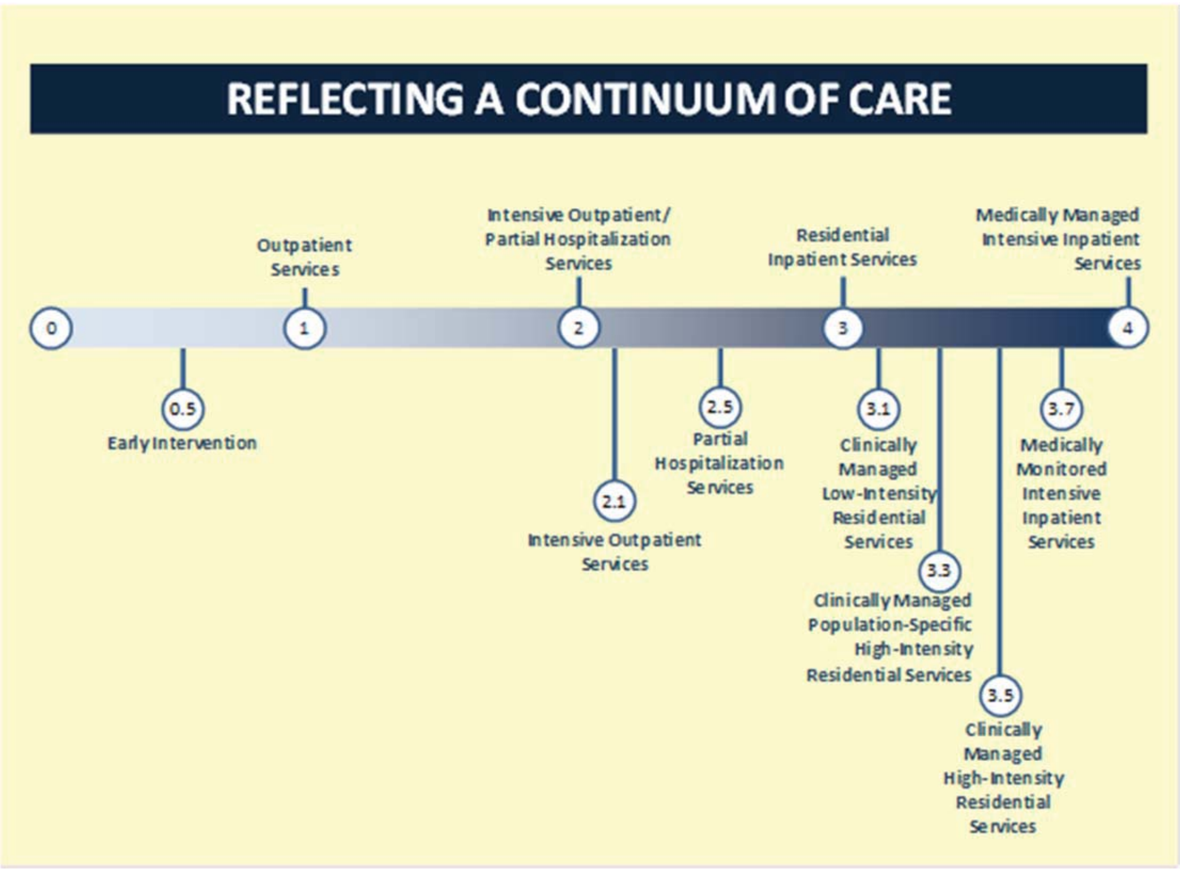
The ASAM Levels of Care for Treatment of Substance Use Disorders

The chart below illustrates ASAM's listing of the continuum of levels of care necessary in order to be able to refer a person to the level of care appropriate for their particular need. Services in the continuum range from the least intensive interventions on the left (Early Intervention, Outpatient, and Intensive Outpatient Services), to the most intensive interventions on the right (Partial hospitalization, Residential, and Inpatient Services). When critically important service

[47] American Society of Addiction Medicine. (2013).

levels are missing, a community lacks the tools needed to give a person experiencing substance use disorder the best evidence-based chance of recovery.

Figure 4: The ASAM Continuum of Care[48]



It is important to note that, <u>in addition to</u> the levels of treatment, a full continuum of care <u>also</u> needs appropriate Withdrawal Management (detoxification) levels of service. Prior to placing a person in a treatment program, an individual may need a safe process and/or place that can help them through the detoxification process, help them understand their level of disorder and their options for treatment, and help them connect to the appropriate level of treatment. A medically-monitored or medically-managed level of withdrawal management has the added considerable benefit of being able to provide observed induction of Medication-Assisted Treatment (MAT).

It is also important to note that, substance use disorder (SUD), is considered a chronic disorder, and that over time, many individuals will need to be re-evaluated and placed in a different level of care.   Like other chronic illnesses (asthma, diabetes, hypertension, etc.), ongoing evaluation

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[48] American Society of Addiction Medicine. (2013).

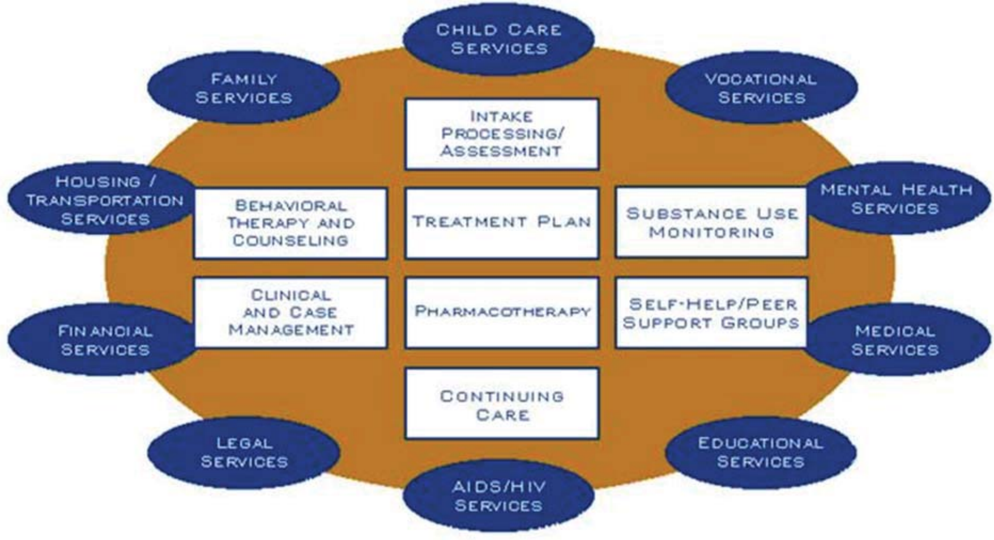
and periodic modification of treatment services for substance use disorders based on individual need produces the best results.[49]

Components of Substance Use Disorder Treatment

The following chart illustrates the essential elements of effective treatment (listed in the center of the chart). The exact configuration of treatment, as with any disorder, will depend on the individual's particular circumstances. Different configurations of treatment are also considered to have varying levels of effectiveness. For example, for an individual with an opioid use disorder, there is evidence that indicates that the most effective treatment will include both Medication Assisted Treatment and counseling; the next most effective treatment includes Medication Assisted Treatment without counseling; and the third most effective treatment includes counseling without Medication Assisted Treatment. For other disorders, treatment may vary according to the substance(s) used and the individual's unique situation.

Depending on an individual's particular need, they may also need assistance linking to some of the support services surrounding the essential treatment services. The recommendations contained in this document do not seek to address the adequacy of *all* aspects of the treatment system, but instead focus on several critical areas that have been deemed the most important to address at this time; however, all elements described in the chart below need to be present in order for the system of care to be the *most* effective.

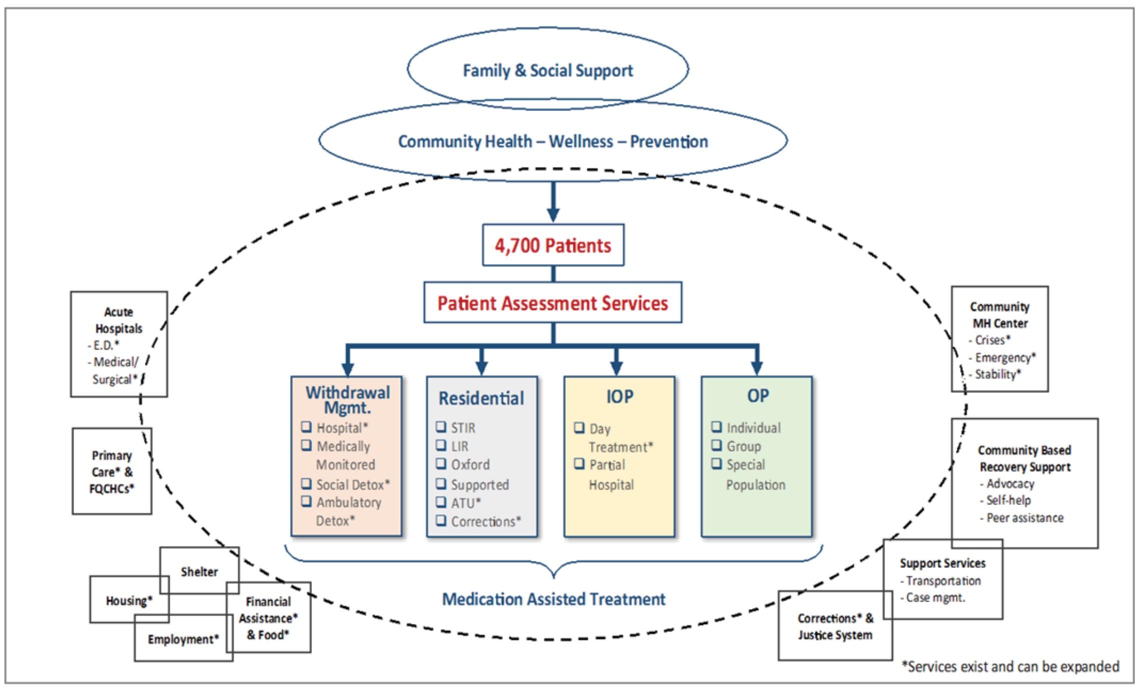
Figure 5: Components of Comprehensive Drug Abuse Treatment[50]



[49] National Institute on Drug Abuse. (2007). Components of Comprehensive Drug Treatment. Retrieved from http://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iii/4-components-comprehensive-drug-addiction-treatm

[50] National Institute on Drug Abuse. (2007).

Similarly, according to NIATx 2016 report, the following chart represents an Optimal Larimer County SUD Treatment System



Mapping Project: Process

The MHSU Alliance mapping project began with Alliance staff outlining existing local services as they relate to the ASAM levels of care framework. Utilizing the ASAM continuum of care framework [Figure 4], Alliance staff reviewed those treatment programs licensed by the Colorado Department of Human Services' (CDHS) Office of Behavioral Health (OBH) that are located in Larimer County or outside of the county, but frequently used by residents of Larimer County. Each licensed treatment provider was aligned with the level of care they provide. Staff then prioritized those organizations for interviews that serve the largest number of Larimer County residents, are most often referred by clinicians in the field, and represent all levels of care. A list of organizations interviewed is included in Appendix I.

In person or phone interviews were then conducted in order to determine:

1. What services are available?
2. Are the services generally open to new clients or often full?
3. How much do services cost?
4. Do the services meet the basic standards for that level of care?

Upon completion of the interview process, staff compiled a matrix of existing community services compared to each of the ASAM levels of care previously determined to be necessary for a complete community substance use treatment system. The Guidance team then used this matrix to designate local services as adequate, near adequate, or in need of increased services. For those

levels with a need for more services, the Guidance Team then identified Key Elements of each level of care in an ***ideal*** system, using literature from the field to help inform their work.

The Guidance Team then combined the results of this 2015 service mapping with previous work of the Alliance, ongoing feedback from the Interagency Group (a local group of service providers that meets regularly to reduce barriers to care for those with complex needs), and client interviews. This led to the Guidance Team reaching consensus on which services are critically needed in the community in order to achieve a more comprehensive system of care for people with substance use disorders.

In 2017, the data collected from the 2015 service mapping was updated by Alliance staff to reflect changes in community services since 2015, and the resulting information was used to update this report and the recommendations.

Analysis of Existing Levels of Care for Substance Use Disorders Available to Residents of Larimer County, Compared to ASAM Level of Care Continuum

Withdrawal Management (a.k.a. Alcohol and Drug Detoxification)

When an individual discontinues his/her use of alcohol or drugs, withdrawal management helps the person withdraw/detox as either an inpatient or outpatient by providing an environment that is safe, supportive and, when needed due to severity, medically supervised.

The levels of Withdrawal Management (WM) outlined by ASAM include:[51]

- Level 1-WM: **Ambulatory** Withdrawal Management without Extended On-Site Monitoring (e.g., physician's office, home health care agency). This level of care is an organized outpatient service monitored at predetermined intervals.
- Level 3.2-WM: **Clinically-Managed Residential** Withdrawal Management (e.g., nonmedical or social detoxification setting). This level emphasizes peer and social support and is intended for patients whose intoxication and/or withdrawal acuity is sufficient to warrant 24-hour support.
- Level 3.7-WM: **Medically-Monitored Inpatient** Withdrawal Management. Unlike Level III.2.D, this level provides 24-hour medically supervised detoxification services, which allows for monitoring and intervening in the unpredictable and potentially dangerous process of withdrawal from alcohol and other substances through evaluation and monitoring of existing medical conditions, monitoring and support for vital signs, and administration of medications to assist in the withdrawal process.
- Level 4-WM: **Medically-Managed Intensive Inpatient** Withdrawal Management. This level provides 24-hour care in an acute care inpatient setting, such as an inpatient behavioral health hospital or a hospital, and is used when the existence of concomitant

[51] American Society of Addiction Medicine. (2014). *The ASAM Standards of Care for the Addiction Specialist Physician*. Chevy Chase, MD: Author

medical conditions require ongoing monitoring and intervention throughout the detoxification in order to ensure the safety of the patient.

Effectiveness of withdrawal management (WM) has the best chance when the individual receives timely care, at the right level of WM care for their situation, and when the withdrawal management service has the capacity to provide comprehensive assessment and referral/connection which results in successfully connecting the patient to the next appropriate level of treatment. Treatment close to the patient's home and support system, when possible, is important in order to encourage both support and continuation in treatment.

Local Situation

The majority of Larimer County individuals who go through supervised withdrawal management currently get their care from what is widely known as the "Detox Center" in Greeley, the closest regional "social" withdrawal management program to those living in Larimer County, located at North Range Behavioral Health (NRBH) in Weld County. The program is a Level 3.2, clinically managed residential withdrawal management program, also called "social detox". NRBH has 23 beds to serve the 12 counties in the Northeast region.

According to UCHealth's emergency departments (Poudre Valley Hospital, Medical Center of the Rockies and the Harmony free-standing location), 591 individuals were transferred to the Weld County NRBH detox facility in 2016. Data was not available from McKee Medical Center in Loveland, the other emergency department in Larimer County. The average length of stay for individuals being served by the NRBH detox during this period was 2.8 days. The number of Larimer County residents being transferred to NRBH for detox services has declined significantly over the years due to transportation barriers and NRBH often operating at capacity of beds, leaving many residents to complete their detox in the local emergency departments.

If the individual is experiencing the need for inpatient hospitalization, they can be admitted to Mountain Crest Behavioral Health Center, the inpatient behavioral health hospital in Fort Collins run by UCHealth, for *medically managed intensive inpatient withdrawal management*. Mountain Crest recently expanded their beds by eight, from 26 to 34, now including seven adult inpatient beds, 14 nursing intensive psychiatric beds, five acute inpatient psychiatric beds, and eight adolescent beds. These beds can be used flexibly to meet overflow needs, and all 34 beds can be used for medically-managed withdrawal management as needed.

Clear View Behavioral Health opened a psychiatric hospital in Johnstown in 2016, which offers medically-managed withdrawal management and SUD treatment. Clear View has a contract with the VA to provide these services for local veterans. Clear View also accepts Medicaid.

Harmony Foundation, in Estes Park, also provides medically-monitored withdrawal management, particularly for those entering their treatment program, and for those with a payer source other than Medicaid (generally either insurance or private funds). Harmony Foundation recently expanded their beds from seven to 23.

North Range Behavioral Health Detox in Greeley, Mountain Crest Behavioral Health, and Clearview Behavioral Health accept Medicaid for detoxification services. NRBH reports that Medicaid covers only about 50% of the cost for an individual in social detox.[52] One reason for this is that Medicaid does not cover medically-monitored inpatient detox or detox that occurs in a residential treatment facility; it only covers social model detox or detox that occurs in a hospital on a medical or psychiatric unit.

When the withdrawal management services are full locally, people sometimes must travel to the next nearest facilities, located in Denver, Boulder, and Louisville. Centennial Peaks Hospital in Louisville provides an inpatient medically managed withdrawal management option with 16 dedicated beds in the chemical dependency unit. Medicaid does not cover the services provided by Centennial Peaks, and Medicaid patients must be referred to the facility through a community health center or emergency department. Mental Health Partners in Boulder has a social detox with 20 beds and does accept Medicaid and offer a sliding scale for self-pay clients.

Challenges to Receiving Appropriate, Local Withdrawal Management Services

This review of services revealed that there are multiple, serious challenges for individuals who reside in Larimer County that need withdrawal management, as well as for the providers and services that attempt to refer them into withdrawal management. Although there is adequate capacity for medically-managed withdrawal management at the inpatient hospital level of care (which costs over 10 times the amount of social detox), **there are no licensed facilities offering either social or medically-monitored withdrawal management services that are open to all residents regardless of ability to pay, in Fort Collins or Loveland.**

When an individual is in need of a safe environment to detox, it can take significant time to get to a facility that provides withdrawal management. Challenges are regularly experienced, particularly when facilities are full, or transportation is not available. Often, the individual receives services in a location outside of their community, making it difficult to make a seamless connection to the next level of treatment.

Because of the difficulty of getting people into an appropriate withdrawal management program in a timely manner, it appears that increasingly, many people are simply held at the emergency department or in jail long enough to become functional again (not necessarily fully sober), and are then released. These are high cost, inefficient, and usually inappropriate settings for detox to occur. They do not have the staffing or training to specialize in effective withdrawal management, and they have limited resources, if any, for effectively connecting individuals into appropriate treatment. See page 56 for a visual representation of potential diversion opportunities from these community services into new proposed services related to this report. The process and challenges are discussed in more detail below.

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[52] K. Collins (personal communication, March 13, 2015)

Impact on Hospitals

In Larimer County, when an individual is intoxicated or experiencing withdrawal, typically they will first be brought to an emergency department. Based on national rates of emergency department visits with a first-listed alcohol-related diagnosis, Larimer County emergency departments are seeing approximately 2,000 of these types of visits annually[53], which is slightly lower but similar, to what local UCHealth emergency department data (approx. 2,500) is reporting for these types of visits annually. It is also important to note that these rates of emergency department visits do not include visits with a first-listed drug-related diagnosis and only account for alcohol-related diagnoses, so the rate of both alcohol and drug-related visits is likely higher. The Nationwide Emergency Department Sample (NEDS) data also tracks the rates of visits with a first-listed mental health or substance abuse related diagnosis and reported a 76% increase in Alcohol-related disorders from 2006 to 2014, and a 74% increase of Substance-related disorders during the same time period.[54] Compared to emergency department diagnosis categories (Injury, medical, mental health/substance abuse, and maternal/neonatal) between 2006 and 2014, mental health/substance abuse was the only category that had no diagnoses decrease during that time period.

Individuals treated in UCHealth emergency rooms at the Poudre Valley Hospital, Medical Center of the Rockies, or the UCHealth Emergency Room on Harmony Road in Fort Collins are assessed by a team member from the Crisis Assessment Center (CAC). The CAC is operated by UCHealth's Behavioral Health Services team supervised by the Mountain Crest Behavioral Health Center.

The CAC staff members perform mental health and substance use assessments and work to streamline transitions to appropriate treatment for people in mental health and substance use crises. Once it is determined that the individual requires withdrawal management services, CAC staff obtain medical clearance and begin the process of locating a bed, which is most often found at either North Range Behavioral Health in Greeley or, if the need is for inpatient hospitalization, Mountain Crest Behavioral Health Center. This process could take from about two hours to up to five hours or more to complete.

Currently, because facilities are often at capacity or because transportation to the North Range Behavioral Health Detox in Greeley is difficult, patients are often retained in the Emergency Department until their intoxication level lowers to a level judged acceptable by staff. Individuals are then released back into the community, typically without connection to comprehensive withdrawal management or treatment services.

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[53] National Institutes of Health. National Institute on Alcohol Abuse and Alcoholism. (2013). Alcohol-related emergency department visits and hospitalizations and their co-occurring drug-related, mental health, and injury conditions in the united states: findings form the 2006-2010 nationwide emergency department sample (NEDS) and nationwide inpatient sample (NIS). Retrieved from https://pubs.niaaa.nih.gov/publications/NEDS&NIS-DRM9/NEDS&NIS-DRM9.pdf

[54] Moore, B., Stocks, C., & Owens, P. (2017). Trends in Emergency Department Visits, 2006-2014. Agency for Healthcare Research and Quality. Retrieved from https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf

From the beginning of 2015 through October 2015, the Crisis Assessment Center at Poudre Valley Hospital reported that NRBH refused admission to detox services nearly 500 times. Reasons for refusals vary, but most often include the following: the center is full, there are insufficient staff members to cover all the beds, there are not any beds for the gender of the individual needing services, or there is no timely transportation available. (NRBH is contracted to provide transportation for patients from the PVH CAC but sometimes has staffing shortages).

In Southern Larimer County, individuals who are not taken to the Medical Center of the Rockies are taken to the emergency room at McKee Medical Center. Staff at McKee Medical Center work directly with NRBH to appropriately place individuals in need of their services. Data is currently not available on how many individuals are currently admitted to these emergency rooms for detoxification services.

Impact on Criminal Justice

Larimer County Jail data from 2016 shows that approximately 60 were brought to the jail for detox without any pending criminal charges, because the emergency departments and Weld County's detox was full.[55] This places a significant burden on law enforcement and jail staff, as they lack the resources, training, and time to appropriately and safely manage these individuals.

In addition to a need for those individuals that are detoxing in the jail, there were other criminal justice populations identified throughout this process that would also benefit from the addition of social or medically-monitored withdrawal management services within Larimer County. The County's Community Corrections and Work Release Departments often have individuals within their programs who could benefit from these services. Currently, if an individual reports to Work Release intoxicated they are either turned away and told to obtain a new admission date, or they are admitted into the program and go through detox in the facility, but without proper medical care or staffing to supervise the detox process. Work Release staff reported that many of these individuals acknowledge that they will not be able to successfully detox on their own in the community before reporting to the program, which results in them reporting back to the program intoxicated multiple times until they are eventually revoked back to the jail for non-compliance. Community Corrections also has individuals that report to their treatment or residential programs intoxicated that could benefit from dedicated withdrawal management services in the community. This would be a great benefit for both the staff and the clients as it would allow individuals to receive proper withdrawal management care, rather than individuals having to detox in a criminal justice setting without appropriately trained staff.

The Challenge of Medical Needs

In Larimer County, the sheer numbers of individuals currently detoxifying on the street, in shelters, jail and/or the Emergency Department (ED), indicates a need to expand the original focus on medically-monitored detox in 2016 to include the flexibility to provide a

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[55] S. Prevost (personal communication, November 20, 2017)

range of detoxification services that meet the needs of a wide variety of community members. Providing both clinically managed (social) and medically-monitored detox options will create the ability to determine the level of a person's detoxification process based on their individual and often changing needs over time.

As the NRBH facility is licensed as a social detox, its funding mechanism does not cover staff who are licensed and trained at the level that would be needed for medical monitoring or management. Individuals who present directly to the detox or who are dropped off by law enforcement don't always receive medical clearance, but when individuals are transferred to the detox after first presenting to an emergency department (as is usually the case for Larimer County residents), NRBH typically asks that they are cleared for social detox before completing the transfer.

Because the NRBH Detox facility does not currently have medical personnel, individuals may be transferred to the emergency room at Northern Colorado Medical Center in Greeley if they (1) become non-responsive and need medical attention; (2) become too aggressive for detox staff to handle; or (3) have withdrawal symptoms so severe that they require medication. In the case of this third scenario, the individual will be transferred to the emergency room for medication management and then be returned to the NRBH detox facility. To avoid many of these transfers, NRBH staff reported in 2015 that they were investigating options to provide some of this medical care on-site, and in 2017, NRBH is actively working to develop medically-monitored service capability, and the quote below from a NRBH report echoes the recommendations being made in this report for Larimer County:

> "Our hope and dream continues to be to determine a funding mechanism to fund 24/7 nursing coverage for our Detox facility. In addition, we need medical oversight and physician rounding at least several hours per day. While a fairly costly enterprise, we believe that it would have significant impacts on ER utilization (in both counties) as well as increase our ability to manage medically or psychiatrically complex clients."[56]

There is a significant difference between a detox center that can utilize medical intervention and a social detox center. According to the Treatment Improvement Protocol (TIP) 45, *Detoxification and Substance Abuse Treatment*, "Social detoxification is preferable to detoxification in unsupervised settings such as the street, shelters or jails." However, social detoxification is not the recommended standalone standard of care:

> "The management of an individual in alcohol withdrawal without medication is a difficult matter because the indications for this have not been established firmly through scientific studies or any evidence-based methods. Furthermore, the course of alcohol withdrawal is unpredictable and currently available techniques of

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[56] *North Range Behavioral Health, Health and Human Services Community Partnership Program report for January 1-June 30, 2015* (Rep.). (n.d.).

> screening and assessment do not allow us to predict with confidence who will or will not experience life-threatening complications."[57]

Importantly, many individuals, particularly those who with dependence on opioids, will benefit most from starting appropriate medical treatment at just the right point during their detoxification, and that treatment cannot begin in a social detox facility. However, that treatment can begin in a facility providing medically-monitored detoxification beds.

Some, like those currently spending approximately five hours in the Emergency Department at a hospital to detox enough to be released, may utilize social detox initially; however, the specific focus of staff and programming on detoxification, and also in relationship and trust building, may result in longer stays with greater levels of detoxification, as well as better engagement in treatment over time. The ability to provide more intensive detoxification, and the ability to begin induction on Medication Assisted Treatment (MAT) in medically-monitored detox beds, provides a key opportunity to address the current revolving door of individuals using high cost services such as EDs and the jail for detox.

The Challenge of Receiving Care Far From Home

Currently most Larimer County community members receiving withdrawal management must be transported to Weld County for detoxification services. This results in the need for expensive transportation and reduced efficiencies in getting people to timely detox services. It also creates burdens on Emergency Departments while patients are waiting for transportation. Additionally, this also creates limitations on appropriate aftercare, follow-up, and involvement of family members in treatment processes.

Summary of Withdrawal Management Service Gaps

- The only withdrawal management beds available in Larimer County are hospital based medically managed beds, which, though needed for some, are far more expensive than needed for most individuals needing detoxification.
- The majority of Larimer County individuals receiving detoxification must be sent to Weld County (North Range Behavioral Health).
- Services available at NRBH are limited to social model detox. Medically-monitored withdrawal management is now considered the best practice for a large proportion of those in need of withdrawal management care.
- Both social and medically-monitored beds are needed to be able to meet the full spectrum of withdrawal management needs in Larimer County.
- Currently, without local withdrawal management beds, and with both geographic and capacity issues impacting the ability to utilize NRBH detoxification services, many Larimer County individuals are being "detoxed" in emergency rooms and in the jails, or remain on the street to detox.
- Transportation to Weld County for detox is inefficient and expensive.

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[57] *KAP keys for clinicians based on TIP 45, detoxification and substance abuse treatment*. (2006). Rockville, MD?: U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

- Utilization of non-local detoxification services limited appropriate aftercare, follow-up and involvement of family members.

Residential Treatment for Substance Use Disorders

One of the levels of care on the ASAM Continuum that is largely missing from Larimer County is Clinically Managed Residential Services. Residential treatment is indicated for individuals deemed to specifically need care outside their normal living arrangement in order to bring a serious disorder under control and teach the individual how to manage it in the future. Treatment is provided in a highly structured setting within specialty substance use disorder treatment facilities or facilities with a broader behavioral health focus, and can range from short term stays of 14 days to longer-term stays up to 6-12 months, though the longer stays are unusual. Good outcomes are generally contingent on adequate treatment length. Research by the Center for Substance Abuse Treatment (CSAT) has shown that length of stay is positively related to treatment outcomes and that increasing lengths of stay improve treatment outcomes. For residential or outpatient treatment, participation for less than 90 days has been found to be of limited or no effectiveness, and treatments lasting significantly longer are often indicated.[58] Currently, substance abuse providers generally appear to interpret the data to mean that a combination of treatment methodologies for at least 90 days (which could, for example, include residential, intensive outpatient and outpatient services) would meet that 90-day minimum.

Residential treatment is distinguishable from inpatient treatment services, which take place within specialized units in hospitals, and are more geared toward stabilization. Residential treatment services are currently considered to have the best chance of success when the client is able to receive services in the community in which s/he will live upon completion of treatment. Sending individuals across the state can alienate the family and support system from the treatment process, rather than including them, and can create more struggles when transitioning back into the community.

One of the greatest barriers to receiving residential services is the cost of care. Medicaid, which provides at least partial funding for many levels of care, does not pay for residential treatment in any setting, although single case agreements have been approved on an infrequent basis.[59] Private pay residential treatment services charge $20,000 or more for a 28-day program. This can be very cost prohibitive for individuals and families; however, individuals who have the means to pay can typically get into treatment the same day they seek services.

Most often, Larimer County residents must leave their community to gain access to affordable residential treatment. For those individuals who do not have the means to pay, there are some programs in Colorado that have other funding mechanisms that help make this level of care more affordable but those are very limited, impact few people, and have waiting lists that are weeks to months long. For example, residents of Larimer County who do not have significant monetary resources and need residential care most often go to the Transitional Residential Treatment program (TRT) run by NRBH in Greeley, which has 20 beds. This program has other funding

[58] Substance Abuse Program Administrators Association. (n.d.). Treatment. Retrieved from http://www.sapaa.com/page/wp_sa_treatment
[59] K.Collins (personal communication, 2017)

that reduces the average daily charge to $230/day, far less than the $600 to $800 or more daily charges of other treatment options, as well as a sliding fee scale based on income that can further reduce the daily rate to around $40.

From January 1, 2016 – December 31, 2016, only 45 Larimer County residents were able to access this service. North Range often has a waiting list of two to six weeks for admission to residential treatment unless the client fits into one of the block grant priority populations (pregnant women, IV drug users or women with dependent children). As part of the program, clients are encouraged and supported in seeking employment. Once employed, they are encouraged but not required to pay a certain percentage of their income to help support the cost of their treatment.

For residential treatment outside of the region, a small number of Larimer County residents have accessed the Intensive Residential Program (IRT) at Arapahoe House in the Denver area, Colorado's largest provider of addiction treatment. However; Arapahoe House ceased operations in January of 2018. Efforts are underway to fill the resulting gap in treatment through other organizations and options; therefore, it is unknown how access will be impacted for Larimer County residents.

The largest provider of residential SUD services in Larimer County is Larimer County Community Corrections (LCCC). However, the ability to access these services is limited to those involved in the criminal justice system. In 2016, at least 430 individuals received residential SUD treatment through LCCC, and another 25 individuals completed intakes but left prior to initiating treatment.[60]

For those who have significant monetary resources, there are other options, both inside and outside of Larimer County, for licensed residential SUD care. Within Larimer County, Harmony Foundation in Estes Park is a licensed provider, as is Narconon in Fort Collins. Inner Balance, Harvest Farm, and AspenRidge Recovery provide sober living environments and partial hospitalization and intensive outpatient programs for residents, but are not licensed to provide residential treatment.

Other licensed providers outside the community include the Veterans Hospital in Cheyenne whose catchment area includes Larimer County, Centennial Peaks Psychiatric Hospital in Louisville, Mental Health Partners in Boulder and the Stout Street Foundation in the Denver metro area, but they serve few Larimer County residents. Stout Street does not charge clients for the services; their program is a work-based program where individuals are connected with employment during their stay in the program. A portion of their earnings go toward their treatment costs, while another portion of their earnings go toward individual savings plans to develop a financial foundation upon completion of this level of care.

[60] M. Ruttenberg (personal communication, August 2, 2017)

Other levels of Residential care include Low Intensity Residential (LIR) (aka halfway house) services (ASAM 3.1), which are designed to build and reinforce a stable routine for residents in a safe and supportive context. Program components include education, group counseling/support by certified personnel, orientation to employment and employment in preparation to community reintegration. LIR houses are appropriate for residents who lack a stable living environment, and other social supports. No LIR houses currently exist in Larimer County.

Independent, voluntary sober housing, like "Oxford Houses" represent safe and supportive living environments for those who choose and can pay for this type of residence. There are currently three Oxford Houses in Larimer County with a total capacity of 22 beds.

Finally, for those with chronic behavioral or somatic health conditions, who lack family/social supports, and are disconnected from employment and other community functions, supported housing is an effective and cost efficient resource to house people with chronic and severe mental health, substance use disorders, or dual diagnoses, long term disabilities, and other traditionally high users of health and social support services. A permanent supportive housing facility with 60 units exists in Larimer County and another facility is being planned; however, it is estimated by Housing Catalyst that three facilities are needed in order to meet the needs in our community. Additionally, while funding for facility construction is available, lack of funding for the supportive services indicated by the model is often the limiting factor that reduces the feasibility of creating additional permanent supportive housing projects.

The chart on the following page illustrates the residential care options that appear to be most often used by Larimer County residents, and gives a sense of length of stay and cost.

Figure 6: Licensed SUD Residential Providers Most Used by Larimer County Residents

Organization	Length of Stay	Payment (Medicaid does not cover residential treatment)			Waiting List
	90-Day Standard	Insurance	Dept. of Corrections	Self-pay cost	How long?
North Range Behavioral Health (Greeley) Level of care: TRT	35 day average	X		$230/day with sliding fee option (down to $40/day)	2-6 weeks; Always have a wait list
Larimer Co Community Corrections (Fort Collins) Level of care: IRT (Men's & Women's)	Up to 90 days		X	$0	45-90 days
Larimer Co Community Corrections (Fort Collins) Level of care: STIRRT	3 weeks residential with 9 months weekly outpatient		X	$0	Intakes every third Tuesday
Harmony Foundation, Inc. (Estes Park) Level of care: IRT	28 Days	X		$26,000	Same Day
Narconon Colorado (Fort Collins) Level of care: TRT	Avg. 4 mos.	X		$30,000	Same Day

The development of affordable local residential SUD care is considered a critically needed behavioral health service. It is vitally important that once a person is willing to participate fully in their treatment, the treatment be quickly available and that cost not be a barrier to care. Time is of the essence when an individual reaches out for treatment services: "Longer waits for treatment increase the opportunities that other events will arise, thereby further interfering with

treatment entry."[61] Further, the best care will involve the family or support system, and that is best done when the treatment is provided locally. Some of the pinnacles of substance use disorder treatment include starting as early in the disorder as possible, and engaging the family and other natural supports in the treatment process.[62] When an individual has to leave his/her community to access services, family participation can be hindered.

Summary of Residential Treatment Service Gaps

- Larimer County does not have local Short-Term Residential Treatment beds even though this is a key level of the ASAM continuum of care for substance use disorders.
- Those needing Residential Treatment must go outside of the community to receive care and very few individuals actually do this.
- Even when care is available outside of the community, access to this care is limited by wait lists and affordability.
- Family involvement, and continuity of care in the local community is limited when non-local residential treatment services are utilized.
- Low Intensity Residential (LIR) (aka halfway house) services are not currently available in Larimer County.
- Independent, voluntary sober housing, like "Oxford Houses" are not currently available in Larimer County.
- Funding for the "supportive services" which include treatment for mental illness and substance use disorders among other services is often a limiting factor that reduces the feasibility of creating additional permanent supportive housing projects.

Intensive Outpatient Treatment Programs (IOP)

Intensive Outpatient Treatment Programs (IOP) programs are another vital pillar of the continuum, as IOP serves a level of care appropriate for individuals requiring more than standard outpatient treatment. IOP is defined as nine or more hours (fewer than 20 hours) of structured counseling and educational services per week. In these programs, individuals attend very intensive and regular treatment sessions multiple times a week early in their treatment for an initial period.

Individuals in IOP can secure and/or maintain employment, as well as address other aspects of their life in need of attention while remaining engaged in treatment. IOP services can be used for a variety of purposes: As an entry point into treatment for individuals assessed for that level of care; as a step-up option from regular outpatient treatment for clients in the event their condition worsens; or as a step-down from an inpatient or residential program. After completing intensive outpatient treatment, individuals often step down into regular outpatient treatment, which meets less frequently and for fewer hours per week, to help sustain their recovery.

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[61] Redko, C., Rapp, R. C., & Carlson, R. G. (2006). Waiting Time as a Barrier to Treatment Entry: Perceptions of Substance Users. *Journal of Drug Issues*, *36*(4), 831–852.

[62] Werner, D., Young, N.K., Dennis, K, & Amatetti, S.. (2007). *Family-Centered Treatment for Women with Substance Use Disorders – History, Key Elements and Challenges*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Until 2015, Larimer County was entirely missing this critically important level of care. Due to a decision by Colorado Medicaid to cover IOP, Larimer County now has several organizations offering IOP services, shown in the chart below.

Figure 7: Chemical Dependency Intensive Outpatient Programs (IOP) in Larimer County

Organization	Length of Stay	Number of Groups/Slots	Payment			Cost
	90-Day Standard 12-13 weeks		Medicaid	Insurance	Self-pay cost	
SummitStone Health Partners (FC)	90 Days	3, 3-hour groups per week plus an individual appointment/12 slots per group	X	X	Self-pay is based on a sliding scale	
Mountain Crest/PVHS (FC)	7 weeks	2 groups/12 slots per group	X	X	$350/ visit	$6,452 for whole program
Harmony Foundation (Estes Park)	28 days	One group/ up to 12 slots reserved for people in their transition of care program		X		
Inner Balance (Loveland)	28 days	Unknown		X		$10,000
Clear View Behavioral Health (Johnstown)	No limitation	5 groups, up to 10 per group	X	X		
AspenRidge Recovery (Fort Collins)	13 weeks	One group/12 slots per group		X		
		Total of 135 slots currently available.				

It is not known whether existing services are capable of meeting the current needs for IOP.

Projections related to this update report show that 1,000 IOP admissions will be necessary to meet the needs of those individuals being served through a facility offering many of the services being recommended and this would not be able to be met with current capacity. It is obvious that the current total of 135 IOP treatment slots at any one time will not be sufficient to meet that need. However, due to insurance reimbursement for this level of care, it is hoped that additional capacity for IOP can be developed in the community to support the growing need.

One of the biggest remaining challenges to individuals needing Intensive Outpatient services can be for those who do not have insurance, do not have insurance that covers this care, or who have insurance but who must still meet deductibles and copays. For instance, Medicare does not cover IOP treatment and so in order to receive care, clients must either be placed in partial hospitalization treatment or attend multiple outpatient treatment groups. Another key challenge is that since there are still few IOP services offered, there are not many options for when a person can attend, which can be difficult for people to balance with work obligations. Finally, best practices indicate that population-specific IOP groups, for example, groups based on gender, can be more effective than open groups; but the services have not grown in this community to the extent to be able to offer those yet.

Veterans can also access IOP at the Cheyenne facility, which has no waiting list, although the distance is a barrier. Program length and cost vary according to the individual's situation. Staff report that the local veterans services are attempting to establish services in Fort Collins.

Summary of Gaps in Intensive Outpatient Treatment

- While current IOP options are growing in Larimer County, it is unknown whether existing options are meeting the current need for this level of care.
- The existing IOP slots available would not be sufficient to meet the projected need for 1,000 IOP admissions related to increased engagement in treatment of those individuals who might be engaged through local detoxification and other proposed services. However, the fact that reimbursement is now available for IOP services indicates the potential for expanding these services to meet this need.
- Client needing IOP services often cannot afford them due to not having insurance, insurance plans not covering IOP or having high deductibles and copays.
- Currently, while IOP options are growing in the community, there is a still a need for a wider range of options for IOP services at different times and locations to accommodate client life obligations and work schedules.
- Best practice approaches such as gender or population specific IOP groups are recommended to be developed.
- There are still some uninsured individuals and underinsured individuals who have insurance plans with high deductibles and copays that limit their ability to afford intensive outpatient treatment.

Medication-Assisted Treatment Services

"Medication-Assisted Treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders, and can help some people to sustain recovery."[63]

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[63] SAMHSA: https://www.integration.samhsa.gov/clinical-practice/mat/mat-overview

Medications used to treat opioid use disorder include naltrexone (brand name Vivitrol), buprenorphine (common brand names Suboxone and Probuphine), and methadone. These can be delivered in an outpatient setting, although different restrictions apply for each medication. Methadone has been used for decades but must be administered in a highly structured clinic that is certified as an opioid treatment program (OTP) by SAMHSA. Naltrexone is most often used as an extended-release injectable administered monthly, and can be prescribed and administered by any healthcare provider who is licensed to prescribe medications.

Local Availability of Medication-Assisted Treatment

Local availability of MAT has greatly expanded in the past few years, and continues to become increasingly accessible to patients as more locations open, providers expand their caseloads, and options for sliding scale and Medicaid payments are accepted. There are several clinics that now offer Medication-Assisted Treatment in Larimer County.

Suboxone is available through programs at SummitStone Health Partners, Sunrise Community Health, the Colorado Clinic, Front Range Clinic, and certain other providers in primary care. Family Medicine Center and the Salud Clinic offer Suboxone programs to patients of their primary care clinics, and Colorado State University offers all forms of Medication Assisted Treatment to enrolled students who are in need of those services. Behavioral Health Group is a certified opioid treatment program and offers both methadone and suboxone.

Vivitrol is now available locally to patients at the following clinics, all of which take Medicaid except for Aspen Ridge North:

- Front Range clinics
- Aspen Ridge North
- Clear View Behavioral Health (for detox patients)
- SummitStone (and Sunrise Clinic via SummitStone)
- Harmony Foundation
- North Range Behavioral Health (took on many 1st Alliance clients so some of our Larimer people likely ended up with them)
- Cheyenne VA hospital
- Colorado State University (students only)

A number of private physicians offer Medication-Assisted Treatment in one form or another, and that number is increasing over time. For a list of providers offering MAT, see Appendix J.

Summary of Gaps in Medication Assisted Treatment

- While access to Medication-Assisted Treatment is improving in Larimer County, there are still challenges and barriers. Even with increased capacity for MAT, as the number of people with opioid use disorders grows, capacity will need to expand to meet the need.
- Limits on the number of individuals who can be served by each practitioner currently impact capacity, as does provider understanding of MAT and willingness to be involved with this type of treatment.

- Patients on MAT often have a variety of complex needs that require moderate to intensive care coordination that is limited in the community. For instance, even on MAT, a patient's acuity of needs can vary widely over time, requiring the need to navigate to different levels of care, some of which don't exist and others that may not allow continuation on MAT.
- For those on MAT, attitudes towards medications that reduce cravings for opioids and alcohol often impact policies and procedures that either do not allow for prescription of MAT in certain settings (such as residential treatment or criminal justice), or require cessation of MAT while in that setting.
- Some forms of MAT with proven effectiveness may not be prescribed due to higher associated costs, and may not be affordable to those who are uninsured, underinsured or have insurance plans that don't cover specific forms of MAT.
- There are still some uninsured individuals and underinsured individuals who have insurance plans with high deductibles and copays that limit their ability to afford MAT.

Outpatient Treatment Services

Since outpatient services are a key part of the continuum of treatment services in any behavioral health treatment system, outpatient services were also examined in order to assess what currently exists in Larimer County.

The vast majority of substance use disorder (SUD) treatment services available to Larimer County residents fall within the outpatient category on the continuum. There are several organizations in the county providing SUD outpatient services. For instance, SummitStone Health Partners has 28 FTE dedicated to outpatient services. Other organizations offering outpatient SUD services include Mountain Crest Behavioral Health, HalfMoon Resources, Heart-Centered Counseling, and A New Perspective.

In addition to general SUD outpatient services for the general population, there are outpatient treatment services available both individually and in groups for those with co-occurring mental illness and substance use disorders (through SummitStone, the HUB for those with an open Child Protection case, and the Assertive Community Treatment/Community Dual Disorder Treatment Team). There is also one SUD clinician in Fort Collins providing outpatient treatment for veterans; and there is a program offering SUD services for court-ordered domestic violence clients. Additionally, substance use disorder treatment is available for some people involved in the criminal justice system through Alternatives to Incarceration for Individuals with Mental Health Needs (AIMM), the Wellness Court, and the Residential Dual Disorder Treatment (RDDT) program.

Over seventy private mental health providers list having a Certified Addiction Counselor (CAC) or Licensed Addictions Counselor (LAC) qualification or list substance use counseling as one of their specialties on the Larimer County referral website www.HealthInfoSource.com. However, these are independent practitioners for whom payer sources, actual availability, and connection to other parts of the treatment system is unknown, thus it is difficult to determine the capacity of these providers for filling the need for outpatient substance use disorder treatment.

There is anecdotal evidence that organizations are having some difficulty in hiring licensed behavioral health clinicians, and this may also include those who are certified or licensed to specialize in the treatment of substance use disorders.

Finally, there are about 15 organizations providing Driving Under the Influence (DUI) services, but these services are psychoeducational in nature and are not considered outpatient treatment.

A recent change that has made a difference for those who have low incomes and are in need of outpatient treatment for substance use disorders was the 2014 expansion of Medicaid to adults with low incomes. Since Medicaid provides medically-necessary outpatient services for its clients, there is a payer source that was not previously available, which has resulted in the expansion of outpatient services and provides likelihood that outpatient services can expand even more to better meet local need.

There are still some uninsured individuals and underinsured individuals who have insurance plans with high deductibles and copays that limit their ability to afford outpatient treatment.

Summary of Gaps in Outpatient Treatment

- It is unknown whether existing options for outpatient treatment are meeting the current need for this level of care.
- It is likely that existing capacity for outpatient treatment would need to increase in order to meet the projected need for about 6,000 outpatient admissions related to increased engagement in treatment of those individuals who might be engaged through local detoxification and other proposed services. However, the fact that there are payor sources for outpatient treatment indicates the potential for expanding these services to meet this need.
- Local workforce capacity, especially for licensed providers, may hamper the expansion of outpatient services
- There are still some uninsured individuals and underinsured individuals who have insurance plans with high deductibles and copays that limit their ability to afford outpatient treatment.
- Care coordination for individuals with complex needs who are receiving outpatient treatment and who need to access other services in the community is available for some, but many need this type of assistance and cannot access it.

Existing Capacity of Critical Treatment Services for Mental Illness in Larimer County

While a wide range of services focused specifically on the treatment of mental illness are important in a behavioral health treatment system, recommendations in the 2016 report focused primarily on one key level of treatment known to be needed in Larimer County – the Acute Treatment Unit (ATU) level of care. In 2018, with the development of a Crisis Stabilization Unit (CSU) in Larimer County in 2015, it is believed that the care provided by an ATU is now available through the CSU. However, the continuum of care would work best if the Crisis Stabilization Unit were located on site with Withdrawal Management services and Residential Treatment Options for SUDs, for reasons described below.

A summary of both ATU and CSU levels of care is provided below.

Acute Treatment Unit (ATU)

As defined by the Colorado Department of Public Health and Environment (CDPHE), an Acute Treatment Unit (ATU) is a facility or a distinct part of a facility for short-term psychiatric care, which may include substance use disorder treatment, and which provides a total, 24-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.

Acute Treatment Units serve an important purpose in a community continuum of care. Short-term sub-acute psychiatric care assists an individual who may be harmful to themselves or others and requires stabilization and evaluation. They are significantly less costly than inpatient hospitalization. ATUs also serve as a bridge to longer term care and treatment services.

There are currently no ATUs in Larimer County. The closest ATU is a 16-bed facility in Greeley, run by NRBH. The average length of stay in 2016 was 5.15 days. The annual occupancy rate is 73%. While the ATU in Weld County is not always accessible, there are other options for acute treatment in Louisville and Arapahoe County. Within the NRBH system, individuals who are intoxicated and also demonstrate a need for mental health crisis services are first admitted to the detox. Once detox is progressing, they are evaluated for mental health concerns and admitted to the ATU when appropriate. However, when individuals have to leave their community for services, there is not often seamless connection to ongoing care, which helps to prevent future crises.

Having a local ATU would give a more appropriate and lower-cost option for patients who need stabilization but don't require hospitalization. Other benefits include providing easier access for family support, and easier transition to the next level of care due to its existence in our local community. When significant care is needed, but not at the level of inpatient hospitalization, an ATU also offers a significantly less costly alternative to hospitalization. Providers have consistently stated that some admissions to Mountain Crest Behavioral Health Center have been made because of the need for quick 24/7 services with psychiatric care, but that for some patients, the care does not have to be at the inpatient hospitalization level.

Crisis Stabilization Unit (CSU)

The state of Colorado began providing partial funding to add Crisis Stabilization Units (CSU) in 2015 in various locations in the state. In Larimer County, SummitStone Health Partners opened the Community Crisis Clinic in Fort Collins in 2015, which provides 24/7 walk-in and mobile services to people with a self-identified behavioral health crisis. This facility addresses the immediate crisis needs of individuals and families in all of Larimer County. Currently, this facility takes approximately 1,700 crisis calls in a year, with over 2,000 walk-in services, and 660 admissions to crisis stabilization beds; however, the facility is operating at approximately 55% of capacity so there is room for growth. When a person is admitted, the Crisis Stabilization Unit can provide up to five days of intensive services for adults in need of stabilization,

including those on a 72-hour mental health hold. In Greeley, NRBH's ATU also provides CSU services for residents of Weld County.

Change in Recommendations Regarding Crisis Stabilization Unit (CSU) vs. Acute Treatment Unit (ATU)

The differences between an Acute Treatment Unit (ATU) level of care and a Crisis Stabilization Unit (CSU) level of care are minimal. While creating a local Acute Treatment Unit (ATU) was one of the original recommendations in the 2016 "Recommendations" report, and was deemed a critical need, current recommendations have changed, as a result of the local Crisis Stabilization Unit (CSU) that now exists in Larimer County.

The Larimer County CSU, if located at the new facility being proposed, could meet all of the needs that an ATU could, providing a close, more quickly accessible facility with ready psychiatric care for those experiencing the need for 24/7 services, and a more robust entry point into the continuum of services being developed within the facility and in the community. There would be a very significant benefit of locating the CSU in the same facility with withdrawal management services, since CSUs don't provide withdrawal management. This means that currently, patients with drugs or alcohol in their system are often diverted to the Emergency Room, NRBH in Greeley, or inpatient hospitalization. A more efficient and higher standard of care for a person who is experiencing both a mental health disorder and a substance use disorder would be to be able to serve them in one facility, making it easy to flexibly and quickly place them in the level of care appropriate for their stage of need, and move them as needs change.

Summary of Gaps in ATU/CSU Level of Care

- While Larimer County does not currently have an ATU, it does have a CSU which has capacity to expand services to meet increasing needs over time and which provides the same level of care as an ATU.
- Current limitations on the existing CSU include the inability to effectively serve individuals in need of detoxification from substances, which results in individuals needing to be transported from the CSU to a detoxification facility (or often ending up in the Emergency Department at local hospitals) if they are in crisis but have alcohol or drugs in their system. Best practice indicates that the siting of CSU services at the same location as withdrawal management services is an effective practice.

Other Significant Community Needs Identified

In speaking with citizens, care providers and others throughout the process of creating these recommendations, two other themes emerged in terms of community interests and needs related to behavioral health care and support: 1) An interest in early identification and intervention with youth and families; and 2) An interest in suicide prevention.

Early Identification and Intervention with Youth and Families

It is widely shown that the earlier identification of mental illness and substance use issues happens, the better the outcomes due to the ability to initiate intervention and support earlier. While the majority of services included in this report focus on adults, the Guidance Team creating these recommendations is aware of community interest in early identification and intervention and recognizes the need to support identification, treatment and support services that will benefit families and youth. While specific recommendations would require further study to develop, potential areas of focus include supporting youth substance use prevention programming; expanding existing programming improving the connection between schools, early identification, and treatment services for youth and families; and increasing access to child and adolescent psychological and psychiatric services.

Suicide Prevention

Although Larimer County's suicide rate is higher than the national average; little funding is currently available to support dedicated suicide prevention programming, although models with evidence of effectiveness exist. Again, while specific recommendations have not yet been made, potential areas of support include supporting the sustainability of current, local and grassroots suicide prevention efforts in order to facilitate the expansion of the evidence-based ZeroSuicide model across the community, and support the expansion of suicide prevention training for community members that will increase identification of individuals at risk for suicide, and connection of these individuals to support and treatment.

Summary of Gaps in Behavioral Health Services in Larimer County

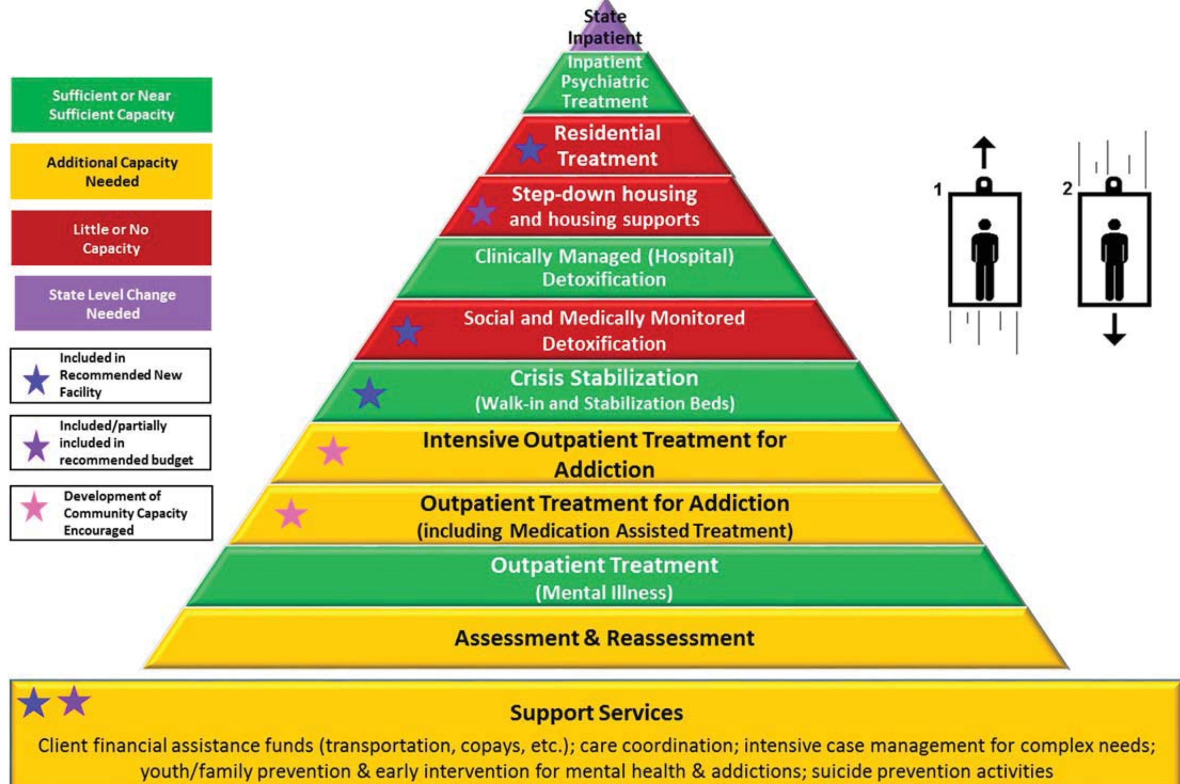
Key service gaps identified for Larimer County include:

- Local Withdrawal Management (Drug/Alcohol Detoxification) services, including access to both social model beds and medically-monitored beds
- Residential Treatment and Residential step-down options for substance use disorders including
  - Short-Term Residential Treatment beds
  - Long-Term Residential Treatment ("Halfway Houses") to help people transition from residential treatment to supported-living in the community
  - Voluntary "sober living" houses such as Oxford Houses
  - Support services to enable treatment and care coordination for people living in Permanent Supportive Housing
- Moderately intensive to intensive care coordination for people with particularly intensive and complex needs
- Client financial assistance to assist people with affording care
- Funding for early identification and early intervention services and resources for youth and families at risk for or experiencing mental illness and/or substance use issues or disorders
- Funding for suicide prevention efforts

The graphic below (Figure 8) illustrates the key levels of care needed in a system of care, and shows those that are currently provided at adequate levels in our community in green. Those needing increased capacity are shown in yellow. Those in red do not currently exist at all in Larimer County.

Expanding both the services in yellow as well as developing local services currently depicted in red is the focus of the recommendations in this document.

Figure 8: Current Behavioral Health Service Capacity in Larimer County



Calculation of Need and Number of Individuals to be Served

In the original 2016 report, NIATx provided a rationale for the calculation of need and resulting number of individuals to be served by the recommended development and expansion of services. This was based on Colorado prevalence data from the 2014 National Survey of Drug Use and Health, a calculation of the number of individuals currently estimated to be receiving treatment, and the number of individuals who therefore can be calculated that need, but do not receive treatment. Additionally, data estimates were applied to identify a smaller number of individuals who need and seek treatment, but still do not get treatment. These data points were used to project a working hypothesis of serving about 4,700 patients. However, Alliance project staff have taken a more in-depth look at our local community need and service utilization, utilized updated national data, and assessed other existing withdrawal management services in Colorado, in order to determine that now over 5,000 individuals would need to be served.

Figure 9: Original Projected Substance Use Disorder Need Diagram (From NIATx 2016 Report using 2014 data)

31,000
Residents
Meet Criteria

2,800
Receive
Treatment

28,200
Need But Do
Not Receive

4,200
Projected
Utilization

1,400
Need, Seek,
and Do Not

500
Population
and Utilization

4,700
Patients
Working

The following is a description of the key differences between the NIATx estimates of people with substance use disorders and the Alliance staff estimates.

NIATx's original SUD prevalence estimate (31,000) combined 2014 NSDUH data categories of individuals with alcohol dependence (8.4%), with the number of individuals with drug dependence (2.8%), giving them a total of 31,000 or roughly 11% of Larimer County's population aged 12 and older in 2016. However, the NIATx estimates did not account for the thousands of individuals who have both alcohol dependence and drug dependence, which can artificially inflate the totals if they are simply added together. This would, then, result in a total number of substance use disorders in the County, but not the number of people with a substance use disorder.

In order to eliminate duplication, Alliance staff utilized the most current 2016 NSDUH data, which does now account for individuals with more than one substance use disorder diagnosis, thus giving an updated estimate of approximately 25,000 (8.5%) residents in Larimer County with a substance use disorder.

Additionally, because the NSDUH prevalence data does not include individuals that are homeless or transient that are not sheltered, or individuals who are incarcerated in correctional facilities, it is missing critical populations. These two populations of people account for a large percentage of emergency, law enforcement, and behavioral health services utilization across the County, and prevalence of mental illness and substance use disorders in these populations are often higher than the general population. Thus, it was critical for Alliance staff to include these populations in the updated recommendations, as these sub-groups are frequently utilizing local resources and emergency services and would benefit the most from a full continuum of care services.

As an illustration, Table 1 below illustrates the 2017 Average Daily Criminal Justice Population Totals for Larimer County that would not have been included in the NIATx 2016 SUD prevalence estimates. Jail data reported that approximately 50% of this total daily population of 1,054 have substance use-related issues (or over 500 individuals).[64]

Table 1: Larimer County Average Daily Criminal Justice Population Totals

Avg. Daily Population (2017)	Jail	Community Corrections	Work Release
	584	297	173
Total	**1,054** (approximately 500 with substance use related issues)		

Alliance staff also included estimates for the local homeless population, as this population was also not accounted for in the 2016 SUD prevalence estimates. Larimer County currently has a monthly population of individuals experiencing non-chronic homelessness between 200-400 and approximately 325 individuals experiencing chronic homelessness[65]. National data indicates that about two-thirds of those experiencing chronic homelessness have SUD-related issues and approximately 37% of the nation's general homeless population has either a serious mental illness and/or SUD-related issues[66]. Applying these national statistics to the local population would indicate that Larimer County has between 300-350 individuals experiencing homelessness with some SUD treatment needs.

In order to account for the additional incarcerated individuals (500) and the homeless population with treatment needs (325), staff added an additional 1,000 individuals to the total SUD prevalence in the county (26,000).

The Guidance Team also asked staff to dig deeper into local realities regarding utilization data of emergency departments, law enforcement, jail, behavioral health providers and service payers. As a result of this work, changes were made to the NIATx working hypothesis of 4,700 people

[64] D. Stalls (personal communication, August 18, 2017)

[65] H. LeMasurier (personal communication, March 21, 2018)

[66] SAHMSA. (2018). Homelessness and Housing. Accessed from https://www.samhsa.gov/homelessness-housing

being served that was used in the 2016 report. A new working hypothesis of over 5,000 people was developed as a result of the updated prevalence data (26,000 individuals with SUDs in Larimer County), additional utilization information gathered by MHSU Alliance staff, and the addition of two new populations of individuals to the working hypothesis.

The first new population the Guidance Team identified includes those individuals who don't meet the criteria for treatment but who may occasionally need to use detoxification services. This is likely a small number of admissions who have had heavy binge drinking episodes (sporting events, music festivals etc.). Larimer County has much higher reported binge drinking rates compared to the state[67], as well as a high prevalence for music/beer festivals and has a local university student population. Therefore, it seemed critical to include this population in the new estimates and need for services.

The second new population that was included by staff, were those individuals who do meet the clinical criteria for treatment, but are not generally seeking it. NIATx focused on those individuals currently receiving treatment and those who needed treatment and were seeking it, but do not currently get treatment. However, staff identified a large number of individuals who needed treatment services but weren't actively seeking it, yet these were the individuals that were taking up a large portion of the local law enforcement and emergency service resources on a consistent basis. It is these reasons that this population of individuals needs to be accounted for when considering how to improve current services, because these are the individuals that have the best opportunities to be diverted away from the jail and ED systems (see Figure 16). UCHealth documented approximately 2,300 admissions to their local emergency departments (EDs) in 2016 for alcohol detox only[68]. Mountain Crest also identified several hundred individuals currently utilizing their hospital-level of care for detox that could be served more appropriately at a local lower level detoxification facility. There were an additional 60 individuals in 2016 brought to the jail to detox, either because the emergency departments were busy or the Greeley detox was full[69]. We have estimated that these approximately 2,400 total ED visits and jail admits represent approximately 1,000 individuals accounting for about 2.5 ED visits per person/per year.

Finally, MHSU Alliance staff also accounted for people who are currently detoxing in some of our other correctional facilities (Work Release, Community Corrections etc.). Staff gathered this admissions data from the various sources mentioned above, to calculate an estimated total of projected admissions to a local detoxification facility. See Table 2 below for these projections.

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[67] 2016 Community Health Survey. Health District of Northern Larimer County. Retrieved from https://www.healthdistrict.org/2016-community-health-assessment

[68] C. Lowe, UCHealth (personal communication, 2017)

[69] S. Prevost, LCSO (personal communication, 2017)

Table 2: Withdrawal Management (Detox) Admission Projections

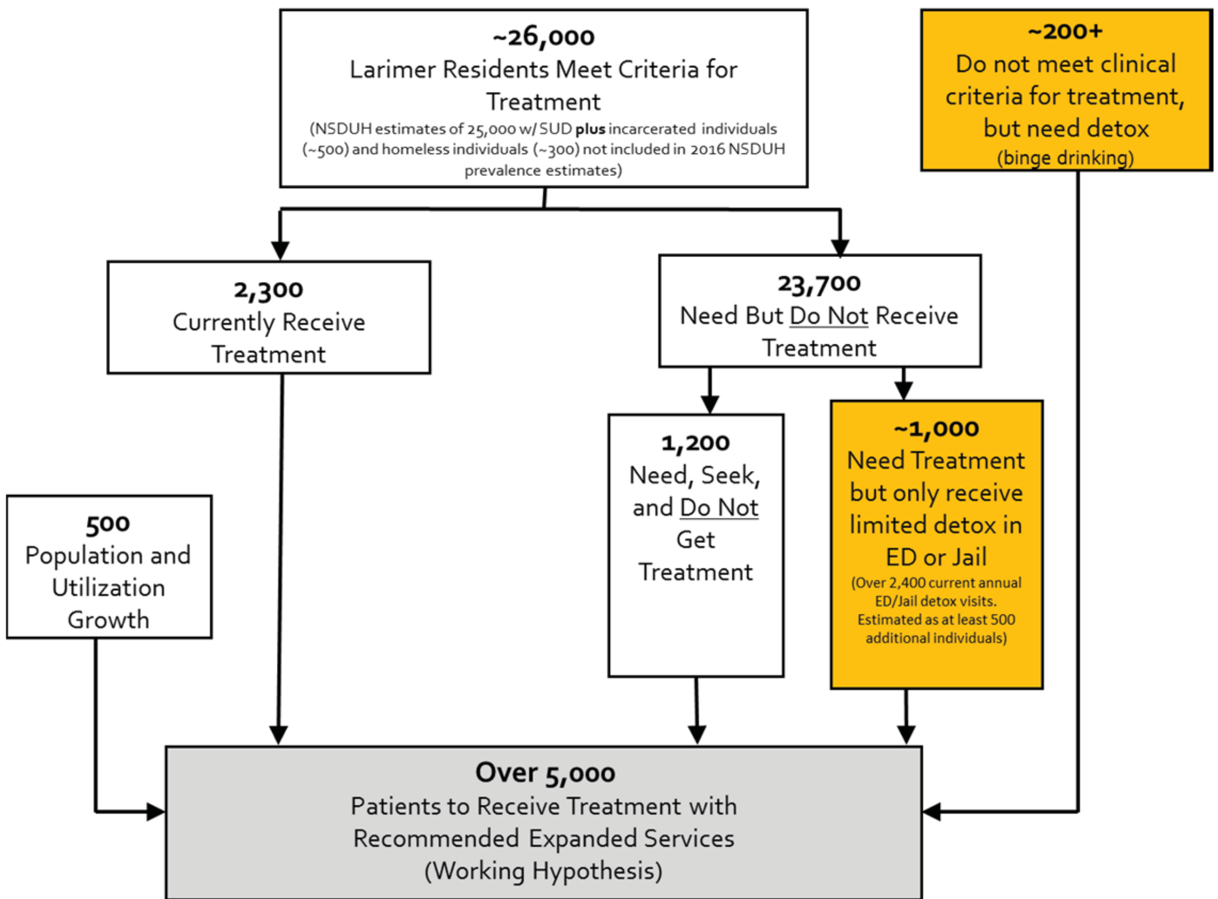
Admissions Source	WM/Detox Admissions	Comments
UCHealth Transfers to Greeley NRBH Detox – 2016	591	Number of individuals transferred from UCHealth care to NRBH Greeley Detox in 2016
UCHealth Emergency Departments -2016	2,000	ED visits with first-listed alcohol-related diagnosis (number is higher if drug-related diagnoses were included)
UCHealth Mtn. Crest	500	Projected individuals who could have been served by Greeley detox but no beds or transportation was available
LC Jail – 2016	60	Individuals brought to jail for detox only, without any pending charges
Work Release/Community Corrections –Estimate	75	Projected individuals detoxing in other correctional settings because no local detox facility exists
Community Walk-ins	350	Local dedicated detox facility would encourage walk-ins
Projected Admissions Totals	***3,500 admissions** (not patients)	

*Staff was able to project a total admissions/visit count based on local utilization data. This does not represent a total number of patients that would be served. More information is needed in order to accurately project the total number of patients served within the projected 3,500 admissions, as it is very likely that many of these patients would account for multiple admits.

These individuals could instead be brought to a local detoxification facility, if available, reducing the burden on the local jail, correctional facilities, and the EDs. This addition of a local detoxification facility would also allow individuals to be properly assessed and possibly retained into other levels of treatment, rather than just being released back into the community without a referral. It would also ensure that individuals would have the proper medical care and access to medications that is needed for individuals to safely and more comfortably detox.

Based on the additional individuals being served and previously unidentified populations in NSDUH's prevalence estimates (ex. homeless/transient & institutionalized in correctional facilities), as well as the additional individuals identified in need of detoxification services, we have increased the overall patient working hypothesis from the NIATx 4,700 people to over 5,000.

Figure 10: Substance Use Disorder Need Diagram (Updated by Staff, 2018)



Note that NIATx states in Appendix M: "Despite the unique withdrawal management environment in Colorado, NIATx group continues to think the Larimer Group's "capture rate" could be overstated.

Projection of Admissions to Specific Levels of Care

In their 2016 report, NIATx projected the number of direct admissions into specific services as well as the step-down admissions into various levels of service for approximately 4,700 patients. The figure on the following page describes areas where changes were made to NIATx projections during the 2018 update.

Figure 11: NIATx 2016 Patient Flow: Direct and Step-Down Admissions for 4,700 patients

DIRECT ADMISSIONS		STEP-DOWN ADMISSIONS			
		Withdrawal Management	Residential	IOP	OP
Withdrawal Management	1,175 25%		294 25%	295 25%	589 50%
Residential	470 10%			94 20%	330 70%
IOP	700 15%				630 90%
OP	2,350 50%				
MAT	25% of all direct				
Care Coordination	30% of all direct				
Sub-Total Direct Admissions	4,700 100%	1175	470	700	2350
Subtotal Step-Down Admissions			294	389	1,550
Total Admissions By Service		1,175	764	1,089	3,900

Local utilization data (ED, MtnCrest, Corrections etc.) indicated a much greater need for detox services in the community than NIATx estimated in 2016. This number has been increased by staff to **3,500 admissions**, to be served at both the medically-monitored and the "social" level of withdrawal management.

The "social" detox level has much shorter lengths of stay and typically serves those populations who are not actively seeking treatment and are likely less motivated. This equates to much higher admission rates than other levels of care and many individuals being re-admitted multiple times into this level of care. Step-down into other levels of ongoing treatment are likely to be lower for social detox than for other levels of detox. Because of this, staff broke the detox population into two distinct groups (Seeking TX v. Not Seeking TX). The "social" detox group would likely utilize detox services multiple times before being motivated enough to access other levels of care (Residential, IOP, OP etc.)

NIATx assumed a 25% step-down rate from Withdrawal Mgmt. into Residential, 25% into IOP, and 50% into OP services.

Colorado historically has much lower step-down rates from Withdrawal Mgmt. into Residential care (3-5%). Because of this staff reduced NIATx's 25% rate down to 10%, which still assumes a better retention rate than state rates due to thorough patient assessments and care coordination efforts recommended by staff.

Staff also applied much lower step-down percentages into these other levels of care for the population accessing "social" detox due to them not actively seeking treatment and likely decreased personal motivation for treatment services.

Figure 12 below provides updated projected admissions totals from MHSU Alliance staff work in 2018.

Figure 12: Updated 2018 Direct and Step-Down Admissions (Alliance)

DIRECT ADMISSIONS		STEP-DOWN ADMISSIONS			
		Withdrawal Management	Residential	IOP	OP
Withdrawal Management	3,500		325 5-10%	600 10-25%	1,425 25-50%
Residential	470			94 20%	330 70%
IOP	700				630 90%
OP	2,350				
MAT	25% of all direct				
Care Coordination	30% of all direct				
Sub-Total Direct Admissions	7,020	3,500	470	700	2350
Subtotal Step-Down Admissions			325	694	2384
Total Admissions By Service		3,500	795	1,394	4,734
Total Admissions Across Services					10,423

The new estimates of over 5,000 patients represents over 10,000 total admissions. These updated totals were used to estimate the number of beds, facility space, staffing, and other resources that would be needed to accommodate the community need.

Figure 13: Updated 2018 Patient Distribution and Capacity Estimates (Alliance)

Residential (595 total admissions)			
Loc.	**No. of Admits**	**Calculation**	**Est. Cap.**
STIR 12 days	318 53%	318@12 ALOS=3816/328days	12 beds
STIR 21(C) days	318 53%	318@21 ALOS=6678 per request	20 beds
LIR	198 33%	398@90 ALOS= 35,820/328/2 =	55 beds
SH	40 7%	Permanent housing. Service budget impact only	
SbH	40 7%		

The area circled in red is different from original NIATx calculations. Alliance staff calculated the total number of LIR beds needed, but then reduced the number by half due to budget considerations and the feasibility of going from no capacity to 155 beds. This meant also reducing the total Residential admissions by 200 and re-calculating the distribution percentages across the various residential levels of care.

LIR 398/2 = 198 & 110 beds/2 = 55 beds

Total Admissions 795 – 200 = 595

Intensive Outpatient (IOP) (1,394 total admissions)
No. of Admissions: 1394 patients
Calculation: 1,394 @ 12days ALOS = 16,728 treatment days/263 average days
Result: 63 patient census per day = 6 groups of 10

Outpatient (OP) (4,734 total admissions)
No. of Admissions: 4734 patients
Calculation: 4,734 @ 10 session average = 43,740 treatment hours/26 hrs per week per clinician / 50 weeks
Result: Staff capacity = 34 FTE clinicians

Recommendations to Fill Gaps in Behavioral Health Services in Larimer County

The previous information has been used to develop specific recommendations to create and support adequate services in each of the areas where gaps have been identified. It is recommended that many of the proposed services be provided in one facility in order to create efficiencies and a better continuum of care; however, many services will also be supported throughout the community. The following is a summary of these recommendations:

1. **Expand treatment capacity** to provide services to over 5,000 adults. The total annual utilization of all services included in the recommended model is estimated at over 10,000 admissions (defined broadly).

2. **Create the ability to perform medical clearance screenings and triage on-site,** to reduce the need for emergency-room levels of care and transport to other levels of care.

   Provide in-depth assessment and re-assessment (differential diagnosis) on site, in order to place patients in appropriate levels of care.

3. **Move the existing Crisis Stabilization Unit to the Behavioral Health Services Center,** to provide walk-in crisis assessment and short-term crisis stabilization for people whose symptoms and treatment can be managed in non-hospital settings. *Build: 16 beds with the capacity to provide up to 1,700 admissions. Begin operation with: Approximately 10 beds and 700 admissions.*

4. **Create a Withdrawal Management Center (drug/alcohol detoxification) in the Behavioral Health Services Center** to support detox from alcohol or drugs and transition individuals into treatment. Provide clinically-managed (social) (American Society of Addiction Medicine (ASAM) level 3.2) and medically-monitored (ASAM level 3.7) levels of detox services; start patients on Medication-assisted treatment for alcohol and opioid use disorders; and support more ambulatory detox (ASAM level 2.0) managed on an outpatient basis in the community. Those with higher-level medical needs will continue to access the intensive inpatient detoxification services (ASAM level 4.0) provided in local hospital settings. *Build: 32 beds with the capacity for approximately 4,300 annual admissions. Begin operations with: 26 beds with the capacity for approximately 3,500 admissions per year.*

5. **Create or support several levels of residential care to support up to 795 short-term and long-term supported residential admissions,** as follows:

   - **Create a short-term, intensive residential treatment unit** in the facility, which would provide a safe therapeutic environment where clinical services and medications are available to patients who are medically stable and withdrawn from substances. *Build: 16 beds with the capacity for up to 400 annual admissions. Begin operations with: 13 beds with the capacity for up to 320 admissions per year.*
   - **Support low-intensity residential services** designed to build and reinforce a stable routine in a safe and supportive context for residents who lack a stable living

environment. Provide 24/7 certified addiction counselors. Encourage development of facilities (55 beds) by community providers.
- **Encourage the expansion/development of independent, voluntary sober housing** in the community, such as Oxford Houses, to provide safe and supportive living environments for those who choose and can pay for this type of residence. No external financing is recommended for this type of housing.

6. **Provide funding to support behavioral health support services,** including:

    - Early-identification and early-intervention services and resources for youth and families at risk for or experiencing mental illness or substance use issues or disorders
    - Suicide prevention efforts
    - Moderately intensive to intensive care coordination for up to 250 clients
    - A client assistance fund to help cover needs such as transportation, co-pays (including for IOP and OP), medication, and personal emergencies, for up to 1,380 clients
    - Support services in Permanent Supportive Housing for up to 100 clients with chronic health conditions who lack family/social supports and are disconnected from employment and other community functions (housing to be provided by other sources)

7. **Encourage the development of community capacity for intensive outpatient services** for individuals who require a more structured substance use disorder outpatient treatment experience than traditional outpatient treatment. Capacity needed: 1,400 IOP admissions, an average of 30 visits per admission, and an average daily census of 63. (Note: Since health insurance is likely to cover these services, this document's budget recommendation is for financial assistance for up to 175 uninsured or underinsured individuals.)

8. **Encourage the development of community capacity for outpatient substance use disorder treatment, including medication-assisted treatment** to provide up to 4,700 admissions. (Note: Since health insurance is likely to cover these services, this document's budget recommendation is assistance for up to 525 uninsured or underinsured people.)

Impact of Implementation of Recommendations on Service Levels in the Community

Implementation of the recommendations contained in this document would result in a greatly expanded and more complete continuum of care for mental illnesses and addictions in Larimer County.

Figure 14 on the following page shows how the implementation of the recommendations contained in this document would impact the local availability of services compared to Figure 15, which shows current services and local capacity.

Figure 14: Projected Behavioral Health Service Capacity in Larimer County after Implementation of Recommendations

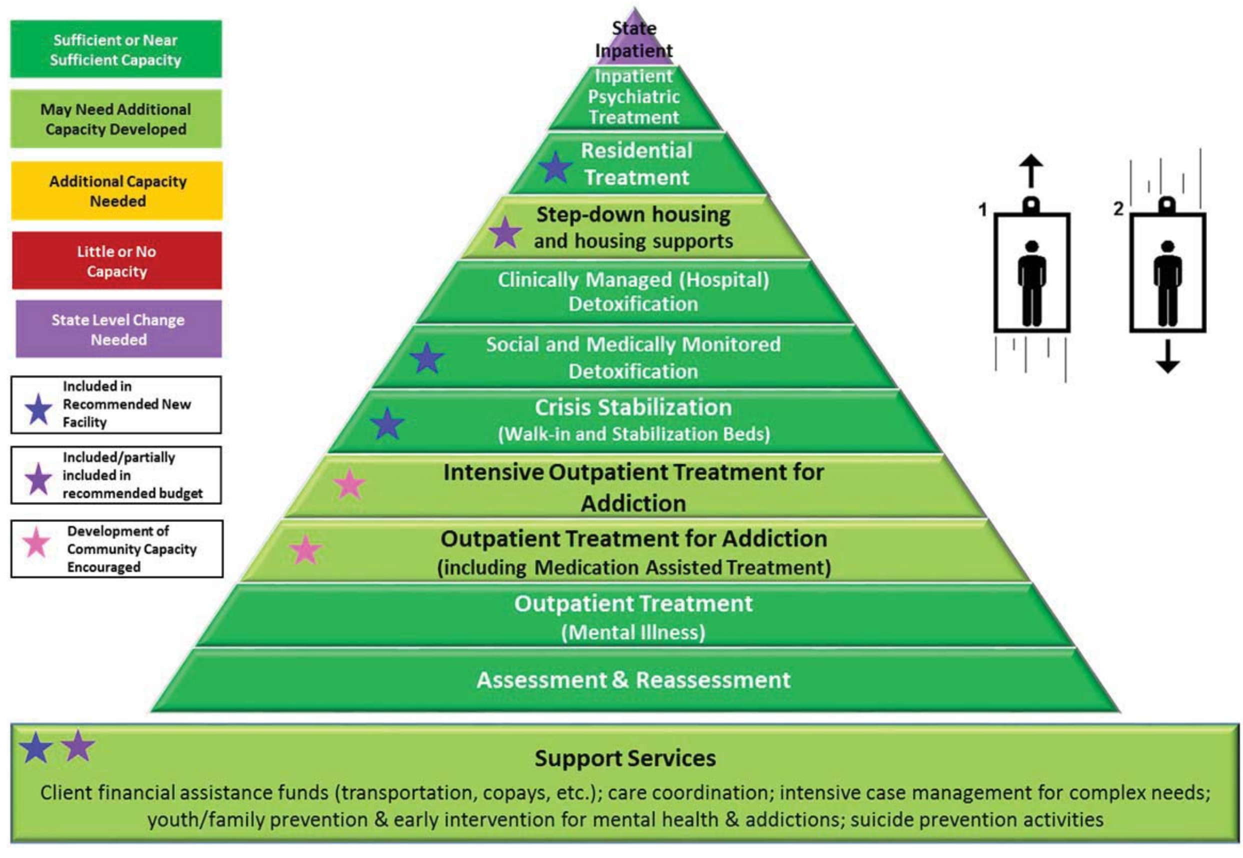


Figure 15: Current Behavioral Health Service Capacity in Larimer County

Sufficient or Near Sufficient Capacity

Additional Capacity Needed

Little or No Capacity

State Level Change Needed

Included in Recommended New Facility

Included/partially included in recommended budget

Development of Community Capacity Encouraged

State Inpatient

Inpatient Psychiatric Treatment

Residential Treatment

Step-down housing and housing supports

Clinically Managed (Hospital) Detoxification

Social and Medically Monitored Detoxification

Crisis Stabilization (Walk-in and Stabilization Beds)

Intensive Outpatient Treatment for Addiction

Outpatient Treatment for Addiction (including Medication Assisted Treatment)

Outpatient Treatment (Mental Illness)

Assessment & Reassessment

Support Services

Client financial assistance funds (transportation, copays, etc.); care coordination; intensive case management for complex needs; youth/family prevention & early intervention for mental health & addictions; suicide prevention activities

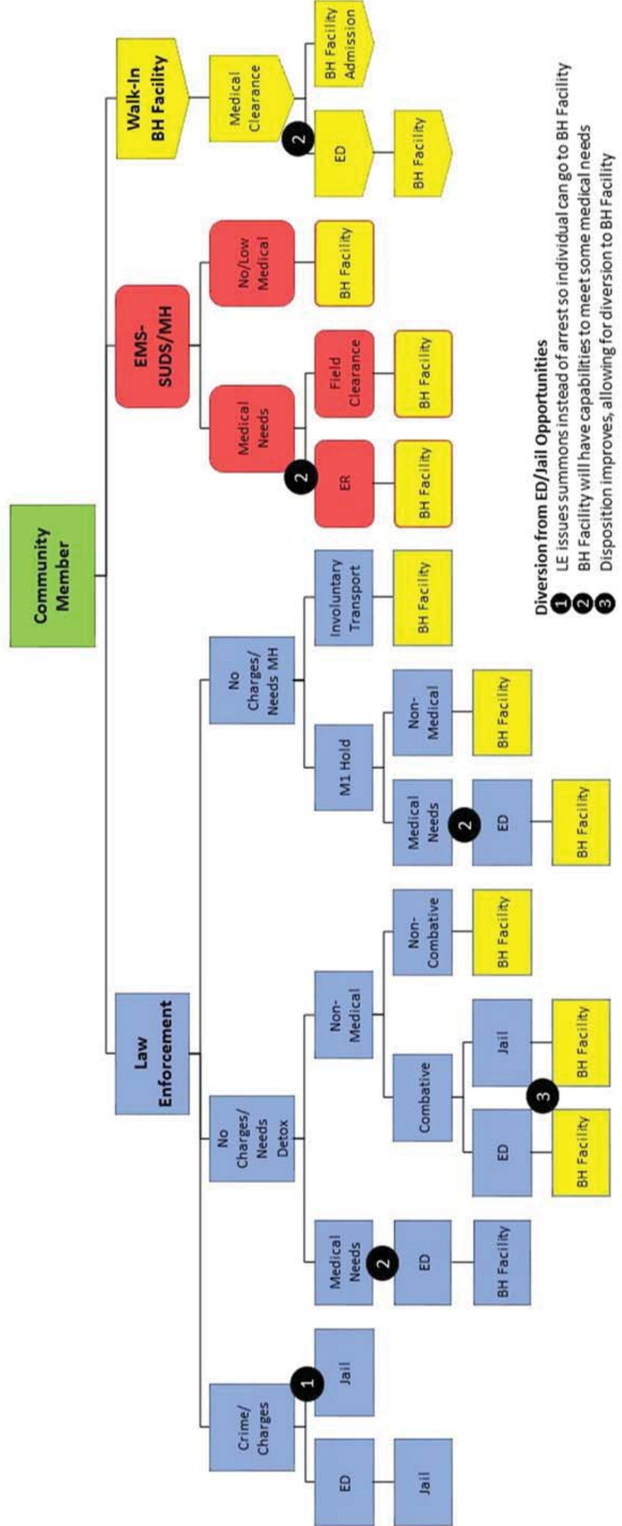
1

2

Impact on Other Community Services and Organizations

Having the recommended service array available in a 24/7 Behavioral Health Service facility will also have key impacts on other local community services and organizations. Figure 14 below illustrates the many opportunities for earlier diversion to the new treatment facility and away from our more costly jail and emergency departments. These opportunities for diversion to the facility, where a range of detoxification services can be provided as a potential entry point into other treatment services in the facility and/or community, represent a key reason for configuring the services in the facility so that medical clearance, mental health and substance use related crises, and treatment are all available in one location. During this investigation of need for services, our local law enforcement, emergency responders, and hospital ED staff continually stressed how critical this expansion of services would be for their day to day operations. By creating a dedicated detox and crisis stabilization center under one roof, first responders will have a place to bring individuals where they can be properly assessed and housed. This will help reduce "bouncing" of individuals between various locations in the community and free up law enforcement and EMS to respond to more calls. It will also reduce the current reliance on jails and Emergency Departments to no longer have to provide this low-level of detoxification that generally does not result in connection to other levels treatment or follow-up care and is much more costly.

Figure 16: Diversion to Behavioral Health Facility Flow Chart



Financial and Facility Needs

Financial Resources Needed

A comprehensive budget has been developed, and the estimated annual cost to provide these services is $15.2 million (taking into account an anticipated $6.5 million in client and payer revenues). For more detailed budget information, see Appendices D and E.

Projected Overall Operating Budget	
Personnel	$11.7 million
Operational (operational costs, maintenance, equipment, contracted services, etc.)	7.2 million
Client Assistance	2.3 million
Family and Youth Resources and Suicide Prevention Resources	0.5 million
TOTAL	**$21.7 million**
Less Client and Payer Revenues	6.5 million
Needed Annual Funding	**$15.2 million**

Facility Needs and Associated Costs

Estimates for facility space and costs are based on providing many services in one facility. Based on current estimates, a 60,000-square-foot facility is needed. Total facility and project land costs are estimated at $33.4 million if built in 2020. Facility costs have not been estimated for low-intensity residential services. Land costs will depend on the site selected.

Similar to other dedicated, state-of-the-art health facilities in the area, such as the $20M Cancer Center built by UCHealth in 2014, this facility will house key treatment services in one place. One key difference is that the services provided by other healthcare facilities, such as the Cancer Center, are paid for by health insurance; while only about 30% of costs of the recommended behavioral health treatment services would receive insurance reimbursement. This results in the funding gap of about $15 million a year.

For a more detailed list of recommended services, see Appendix A(List of Recommended Services and Capacity). For information on how proposed services impact local service capacity, See Appendix B. For a comparison of 2018 service recommendations to 2016 service recommendations, See Appendix C. For more detailed facility and budget information, see Appendices D and E.

Benefits and Value to the Community *(From the "Development of Critical Behavioral Health Services Report by NIATx Group, February 19, 2016)*

There is ample evidence to demonstrate significant value and benefits of behavioral health disorder treatment. Patients and families benefit from increased health, well-being and ability to function in their family, work, community and society (similar benefits as those seen for managing symptoms of diabetes or hypertension). Communities realize reductions in related costs. Additionally, the National Institute of Health estimates that every dollar spent on addiction treatment yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft. When healthcare related savings, such as savings from reduced use of emergency departments, ambulance and inpatient treatment are included, total savings can exceed costs by a ratio of 12 to 1.

Benefits to the Community

Substance abuse costs our nation over $600 billion annually.[70] However, adequate treatment can help reduce these costs:

- Drug addiction treatment has been shown to reduce associated health and social costs by more than the cost of treatment and to be much less expensive than its alternatives, such as incarcerating those with addictions.[71] [72]
- According to several conservative estimates, every dollar spent on addiction treatment programs yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to healthcare are included, total savings can exceed costs by a ratio of 12 to 1.[73]
- For those who received treatment, the likelihood of being arrested decreased 16 percent and the likelihood of felony convictions dropped 34 percent, further contributing to cost savings for the state.[74] Washington State estimated that it will save $2.58 in criminal justice costs for every dollar spent on treatment, and realize an overall $3.77 offset per dollar of treatment costs.[75]
- Over the first four years of operation, the Community Dual Disorder Treatment (CDDT) program in Larimer County, an Integrated Dual Disorder Treatment (IDDT) program, significantly reduced overall inappropriate service usage by 58 percent. ER visits among participants fell by 84 percent, ambulance usage went down by 78 percent, in-patient psychiatric treatment was reduced by 92 percent, and arrests were lowered by 62 percent,

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[70] National Institute for Health. (2012).
[71] National Institute for Health. (2012).
[72] Anglin, M. D., Nosyk, B., Jaffe, A., Urada, D., & Evans, E. (2013). Offender Diversion Into Substance Use Disorder Treatment: The Economic Impact of California's Proposition 36. *American Journal of Public Health*, *103*(6), 10.2105/AJPH.2012.301168. http://doi.org/10.2105/AJPH.2012.301168
[73] National Institute for Health. (2012).
[74] Estee, S. and Norlund, D. (2003). Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report. R.a.D.A. Division and W.S.Do.S.a.H. Services, Washington State.
[75] Mancuso, D., & Felver, B. (2010). Health Care Reform, Medicaid Expansion and Access to Alcohol/Drug Treatment: Opportunities for Disability Prevention. (RDA Report No. 4.84) Olympia, WA: Washington State Department of Social and Health Services.

resulting in savings to the community of over $174,000 after program costs were factored in.[76]

- A 2013 study found that people receiving medication for their mental health disorder were significantly less likely to be arrested, and that receipt of outpatient services also resulted in a decreased likelihood of arrest. The researchers also compared criminal justice costs with mental health treatment costs. Individuals who were arrested received less treatment and each cost the government approximately $95,000 during the study period. Individuals who were not arrested received more treatment and each cost the government approximately $68,000 during the study period.[77]

Benefits to Payers

There are also proven benefits of effective behavioral health disorder treatment to those organizations that pay for healthcare, such as health insurance companies and state and federal healthcare plans such as Medicaid and Medicare. Values reaped by payers may result in helping to reduce growth in premiums for individuals and organizations as well as controlling taxpayer costs for federal and state programs.

- In one study of four different modalities of substance abuse/use treatment, including inpatient, residential, detox/methadone and outpatient drug-free modalities; when compared to other health interventions, all of the substance abuse treatment modalities examined appear to be cost-effective when compared to ongoing substance abuse/use.[78]
- Some states have found that providing adequate mental health and addiction-treatment benefits can dramatically reduce healthcare costs and Medicaid spending. A study of alcohol and drug abuse treatment programs in Washington State found that providing a full addiction-treatment benefit resulted in a per-patient savings of $398 per month in Medicaid spending.[79]
- Kaiser Permanente Northern California analyzed the average medical costs during 18 months pre and post substance use treatment and found that the SU treatment group had a 35% reduction in inpatient cost, 39% reduction in ER cost, and a 26% reduction in total medical cost, compared with a matched control group.[80] [81]
- Kaiser also found that family members of patients with substance use disorders had high healthcare costs and were more likely to be diagnosed with a number of medical conditions than family members of similar persons without a substance use condition.[82]

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[76] Cooper, Bruce. (2013). *Larimer County Community Dual Disorder Treatment Program, Program Evaluation of First Four Years*. Fort Collins, CO: Health District of Northern Larimer County.
[77] Van Dorn, R. A., Desmarais, S. L., Petrila, J., Haynes, D., & Singh, J. P. (2013). Effects of outpatient treatment on risk of arrest of adults with serious mental illness and associated costs. *Psychiatric Services*. Retrieved from http://focus.psychiatryonline.org/doi/10.1176/appi.ps.201200406
[78] Mojtabai, R., & Graff Zivin, J. (2003). Effectiveness and Cost-effectiveness of Four Treatment Modalities for Substance Disorders: A Propensity Score Analysis. *Health Services Research*, *38*(1p1), 233–259.
[79] Estee, S. and Norlund, D. (2003). Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report. R.a.D.A. Division and W.S.Do.S.a.H. Services, Washington State.
[80] Weisner C. Cost Studies at Northern California Kaiser Permanente. Presentation to County Alcohol & Drug Program Administrators Association of California Sacramento, California. January 28, 2010
[81] Weisner C, Mertens J, Parthasarathy S, et al. Integrating primary medical care with addiction treatment: A randomized controlled trial. Journal of the American Medical Association, 2001; 286: 1715-1723.
[82] Weisner C, Mertens J, Parthasarathy S, et al. 2001.

> For families of SU patients who were abstinent at one-year after treatment began, the healthcare costs of family members were no longer higher than other Kaiser members.[83]

Conclusions on Value and Benefits of Effective Substance Use Disorder Treatment

In the 21st century there is ample evidence that substance use disorders are treatable health conditions. There is also a strong body of evidence that treatment of substance use disorders is cost-effective and results in significant benefits to patients, families, the community, and payers. For an additional review of value and benefits, see Appendix F: Treatment is Cost Effective, and Benefits are Spread Between Many Different Pockets.

[83] Ray GT, Mertens JR, Weisner C. The excess medical cost and health problems of family members of persons diagnosed with alcohol or drug problems. Medical Care. February 2007. Vol. 45 Issue 2: 116-122.

Appendix G

HDR

Larimer County Behavioral Health Masterplan Design Charrette Report

Land Use Planning for Proposed Behavioral Health Campus

October 20, 2017

Overview

In March 2017, Larimer County retained HDR to provide professional services for their Regional Wasteshed Planning Study – Phase 2. Larimer County (County) has initiated a multi-year Regional Wasteshed Planning Study to identify and analyze options in developing a future regional solid waste infrastructure system through the establishment of goals and objectives, population and waste projections, resource needs, capital costs and a sustainable return on investment analysis. The proper management and disposal of solid waste and residual materials in an integrated solid waste management system are critical to the protection of public health, environmental and economic well-being of the citizens in the Wasteshed region. In addition, as part of the Phase 2 Study, HDR is conducting a series of Stakeholder meetings to actively engage and solicit input and feedback from the stakeholders and community members to assist in determining what the sustainable and achievable future regional solid waste infrastructure system should include.

Simultaneously with the Phase 2 Study, the County is evaluating the potential of a behavioral health facility which will serve the local community and fill the gap of services offered within the county. One possible location for this facility is land adjacent to the existing Larimer County landfill. As such, the County amended HDR's contract to include a high level master plan of the behavioral health facility to be considered with the Phase 2 Study to avoid conflicts and identify synergies. The objective of the amended scope of work is to assist Larimer County with facility and site planning for a proposed behavioral health campus in preparation for a potential second ballot initiative in 2018 by completing preliminary planning for behavioral health services and site concept development. Tasks involved researching, collecting, and analyzing relevant information as well as leading a three day design charrette to assist Larimer County and potential project partners to develop a common vision and develop a preliminary service plan for a new behavioral health campus. The purpose of this document is to summarize results of the design charrette, site planning efforts, and coordination with adjacent land uses.

Design charrette attendees consisted of three primary groups: HDR representatives, Larimer County representatives, and community stakeholders. A list of attendees is provided below:

HDR Representatives
Doug DeCesare, Sr. Project Manager
Andy Schwabe, Sr. Project Manager
Julianne Scherer, Managing Principal
Brian Giebink, Behavioral Health Planner
Christopher Kleingartner, Design Architect
Booker Tieszen, Site Design Coordinator
Wesley Kay, Design Coordinator

Larimer County Representatives
Laurie Stolen, Larimer Co. BH Director
Jennifer Johnson, Larimer Co. Facilities
Ken Cooper, Larimer Co. Facilities
Ron Gilkerson, Solid Waste Project Director

Community Stakeholders
Michael Allen, SummitStone Health Partners
David Bragg, Larimer Co. Facilities
Gary Darling, Director, Criminal Justice Services
Connie Gunter, Larimer Co. Facilities
Brooke Lee, Director of Access and Adult Services
Janice M. Mierzwa, Sr. Dir. Emergency Services
Ann Noonan, Health District BH Change
Carol Plock, Health District Executive Director
Michael Ruttenberg, L. Co. Clinical Director
Monica Smith, Director, UC Health Beh. Health
Lin Wilder, Health District, CIT Director

Mission and Vision

The first part of the charrette was focused on establishing a mission and vision for the collaborative effort between Larimer County and Community Stakeholders to meet the increasing needs for a continuum of behavioral health services in the Larimer County community. Through an exercise led by HDR, Larimer County representatives and Community Stakeholders established a mission and vision for this collaborative effort:

Mission

To ensure accessible behavioral healthcare is available when it is needed. To provide the right level of care at the right time, every time.

Vision

A collaborative effort of diverse community stakeholders will identify gaps in service and develop an efficient and effective continuum of affordable, accessible behavioral healthcare to enable our community the opportunity for improved well-being.

Proposed Site for Behavioral Health Facility/Campus

Background

Larimer County has identified the potential use of up to 40 acres of land to the northwest corner of the intersection of South Taft Hill Road and Trilby Road between Fort Collins and Loveland. The 40 acre tract was identified as a part of this study to review and consider the best possible location for the proposed behavioral health facility. Upon completion of the preliminary architectural master plan, it is anticipated that the acreage needs for this facility and associated infrastructure will likely be less than 40 acres. The identified area on the 160 acre site is currently in the allocated borrow area for the Larimer Landfill/Recycling Facility which is located about ¼ mile to the north (See Appendix A). The site is relatively flat with a gradual slope to the northeast towards South Taft Hill Road. It is currently undeveloped but has convenient access to existing utilities. Power lines run parallel to Trilby Road and fiber optic lines run parallel to Taft Hill Road. Water and sewer lines will need to be added to accommodate development of the site. Solar panels have been installed to the west end of the site beyond the identified potential area for the behavioral health campus.

Although there are no known definite plans for future development of the 160 acre site there is significant consideration of utilizing portions of the site for future solid waste management infrastructure once the current landfill reaches capacity around 2025. Solid waste management infrastructure under consideration as part of the Phase 2 Study includes a central transfer station, compost facility, C&D recycling, and/or material recovery facility. Each facility being evaluated may include processing associated with yard waste, municipal solid waste, food wastes, and other organic materials. It should be noted that the Phase 2 Study is considering other infrastructure options such as energy-from-waste incinerator, refuse derived fuel processing facility, and anaerobic digestion facility, however, these options are less likely to be co-located at the site. Other uses of the site may include continued excavation/borrow of area's north and west of the proposed behavioral health facility and the construction of a new Verizon cell phone tower on the west edge of the site.

Because of the proximity to the landfill and the site's use as a borrow area, the landfill operation could potentially pre-develop the site by strategically grading an area for a new behavioral health facility/campus. There are specific requirements for landfill closure and post-closure that would likely alleviate any concern for visual impact or smell coming from the landfill once it is closed. However, with the potential of future solid waste infrastructure post landfill closure, certain concessions will need to be determined and implemented to permit coexistence between the solid waste infrastructure and a behavioral health facility/campus.

Feasibility of Proposed Site

A large portion of the charrette was focused on site selection and availability, discussing the best available location for a new behavioral health facility/campus as well as the pros and cons of the identified area at the site to determine if this location is in fact suitable for a behavioral health campus. When determining the ideal site for a behavioral health campus, Larimer County representatives and community stakeholders discussed the possibility of renovating an existing property to save construction costs associated with building a new facility. While reusing an existing building could possibly result in reduced construction costs, depending on the building selected, renovation may not produce substantial cost savings and would impose compromises such as limiting creative flexibility to design the optimal behavioral health facility with necessary adjacencies to serve the full continuum of care. Reusing an existing building would also restrict future partnership opportunities to provide additional services on one campus, a feature the stakeholders and Larimer County representatives deemed as important for the future vision of behavioral health services in Larimer County. Additionally, a Larimer County Facilities representative indicated property up to 40 acres of land in this area could have a value of approximately $8 million. By collaborating within the County's government departments it's possible to save on costs utilizing County owned property.

Charrette participants reviewed population densities in Larimer County and identified nearby medical facilities and travel distances to help inform their decision. An analysis by HDR on both population density (see Appendix B) and travel distances to nearby medical facilities (see Appendix C) demonstrate that the proposed site at the intersection of South Taft Hill Road and Trilby Road is near the population center of Larimer County and has convenient access to numerous medical facilities within the area. Because the potential site is not located in a dense urban location, transportation will need to be arranged for many people visiting the new facility to be comprehensive. However, if the potential new site does in fact support a full continuum of services, transportation to Greeley or other facilities would be avoided and could offset perceived additional transportation needs. Further investigation is required to determine transportation solutions.

Below is a summary of Pros and Cons charrette participants identified for the area within the site for a potential behavioral health facility/campus.

Pros and Cons of the site located at Taft Hill Road and Trilby Road

Pros	Cons

• An open site
  o provides opportunity for outdoor activities
  o potential for future growth / future services
• County owned property minimizing cost for the land
• Fewer immediate neighbors with nearby protected land
• Timing – land is available
• Equidistant
  o “mid-county”
  o equidistant from Fort Collins and Loveland
  o relatively equidistant from nearest medical providers
  o near the population center of Larimer County
• Views
• Connection to nature
• Utilities are near the site
• Fiber optics are on Taft (adjacent to site)
	• Transportation to location
	• Travel distance for first responders
	• Sewer needs do not run to site
	• Presence of prairie dogs
	• New construction rather than renovation (potential increase in cost)
	• Equally inconvenient for all
	• Future solid waste infrastructure

Future Service Opportunities at Taft Hill Road and Trilby Road

In addition to reviewing pros and cons, Larimer County representatives and Community Stakeholders explored future service possibilities and partnerships that could be located on the site to support the community beyond meeting the initial need to create a continuum of care. While these services require further investigation for feasibility and necessity on the proposed site, they offer a possible vision for the future campus.

- Dental*
- Vision*
- Veteran Services*
- Permanent Supportive Housing*
- Medical*
- Food bank
- Child care
- Donation center
- Gym / Fitness Center
- Emergency shelter
- Clubhouse
- Walking trails
- Equine assisted therapy
- Hair salon
- Garden
- Nondenominational chapel

* denotes high priority

Service Needs

Existing and Future Service Demands

HDR led a review of existing and future service demands and corresponding facility needs for behavioral health services in Larimer County as identified in the document “What Will It Take? Solutions to Mental Health Service Gaps in Larimer County,” a study commissioned by the Community Mental Health and Substance Abuse Partnership of Larimer County and completed by the NIATx Foundation. The study

recommends adding or expanding four key levels of behavioral health care and a range of support services in order to provide adequate standards of care in Larimer County:

- Withdrawal Management (Drug/Alcohol Detoxification) services
- Residential Treatment for substance use disorders
- Acute Treatment Unit (ATU) for just-under-hospitalization level of care
- Intensive Outpatient Treatment services (IOP)
- Support services (moderately intensive to intensive care coordination, medications, and support services in Permanent Supportive Housing, assessment, and client assistance funds).

While the report identifies a need to better treat substance abuse in Larimer County, Larimer County representatives and community stakeholders agree that the focus should be on both mental health and substance use disorder treatment to provide an adequate continuum of services in Larimer County. Currently, patients are sent to Greeley and other communities to receive services along the continuum of care, however, the ultimate goal and need for Larimer County is to provide services locally, not relying on sending patients to other communities who require behavioral health services.

During the charrette, the Director of Emergency Services indicated there are at times 15 or more people waiting for a bed in emergency departments requiring mental health or substance abuse services. It was also reported that a reasonable amount of detox services are provided in Larimer County, however patients are discharged once they become sober and do not receive necessary continued care.

Precedent Study

To inspire thoughts of an ideal campus for Larimer County, HDR presented, at the request of the Larimer County Behavioral Health Director, a successful campus model in San Antonio. The Restoration Center in San Antonio, Texas provides a one stop shop for people in crisis, keeping them out of jail and providing treatment they need in a medical setting. It is an integrated clinic where people can receive psychiatric care, substance abuse services, general health care and transitional housing. There is a Sobering Unit, an Extended Observation Unit, a Detox Room, and other programs such as the “Mommies Program,” which treats pregnant women addicted to heroin, a Crisis Care Center, an Injured Prisoners and Minor Medical Clinic, Opioid Addiction Treatment Services, and Outpatient Transitional Services.

While local regulations and rules regarding staffing, access to information, firewalls, and shared entry points need to be explored further, Larimer County representatives as well as community stakeholders agree The Restoration Center is an inspiring model of care that could be replicated to an extent in Larimer County, understanding that the population of San Antonio largely exceeds the population of Larimer County.

Service Needs for Larimer County

Overall, the various agency partners are in agreement that there is a need to provide a continuum of behavioral health services in Larimer County and determined that it is necessary to add a social detox unit that will provide a range of detoxification services and crisis care services, including walk-in services and crisis stabilization beds, to the list of crucial services identified in the document “What Will It Take? Solutions to Mental Health Service Gaps in Larimer County” in order to provide a full continuum of care in the community. 24/7 medical screening with skilled providers is also an essential component that must occur at the new facility. To support the continuum of services in a stand-alone facility, additional common space will be required. See Appendix E for proposed space requirements for a new behavioral health facility in Larimer County. The space requirements represent the ideal state of the behavioral

health facility; Larimer County must work with agency partners and stakeholders to align budget with available services.

Guiding Principles

HDR worked with Larimer County representatives and community stakeholders to identify guiding principles for the new behavioral health facility. Charrette participants collaboratively identified key attributes of a new behavioral health facility and found commonalities between them to establish five guiding principles. The guiding principles identified should be used to guide decisions related to the new behavioral health facility including site selection, financial, administrative, operational, planning, and design decisions, and should be applicable to patients, visitors, and staff at the new facility. The guiding principles established during the charrette are listed below:

Welcoming Environment – The new behavioral health facility should welcome patients, visitors, and staff. It should be warm and inviting, providing opportunities for interaction with nature, and promote healing. The facility should not appear or feel institutional.

Collaborative – the facility should promote collaboration between staff members and patients where appropriate to inspire healing and provide support. The facility should be connected to and collaborate with the community to create a positive image and reduce stigma.

Safe & Secure – a safe environment allows patients and staff to feel secure and free from harm or injury by providing good visibility, unimpeded sightlines, and few blind spots. A safe environment enables rapid emergency response. A secure environment uses passive and active strategies to prevent elopement.

Recovery – an environment supports recovery by engaging patients in self-healing. The new facility should be therapeutic, rejuvenating, and promote healthy behavior so patients can succeed in society. Recovery can be achieved through supportive staff, a connection to nature and daylight, and access to the outdoors.

Flexible/Adaptable – The facility should be able to adapt over time to accommodate changes in community needs. Maintaining a flexible environment will allow the facility to provide new or different services in the future.

Campus and Facility Masterplan

Larimer County representatives and community stakeholders shared their wants and needs for a new facility/campus with HDR through an interactive exercise to guide HDR in developing a high-level facility and campus masterplan. Discussions focused around the location of the facility on the site, access, adjacencies of different services, staff and visitor flow, and access to the outdoors. In addition to and supporting the guiding principles, charrette participants identified the following as key attributes of the facility:

- Dedicated drop off area for first responders and law enforcement
- Dedicated entrance for outpatient services
- Dedicated private staff entrance
- Higher acuity services should be adjacent to one another for increased efficiency and security
- Adjacently locating social detox and medically monitored detox beds could improve efficiency
- Access to nature and views

- Walking trails
- Secure access to the outdoors
- Welcoming / pleasant approach to the facility

HDR used the guidance provided to develop campus plan options for the charrette participants to review. Upon review, Larimer County representatives and community stakeholders provided HDR a clear direction forward to develop a departmental floor plan and site plan for the new facility (see Appendix D). The conceptual facility layout encompasses an area of approximately 28 acres, which is the minimum area required to accomplish the initial desired outcomes and future expansions and/or services.

The coexistence of potential future solid waste infrastructure and a behavioral health facility within the 160 acre site must be considered. A majority of solid waste facilities typically consist of large operating equipment, large hauling vehicles, processing equipment, significant vehicular traffic, windblown litter, and industrial type buildings. Though the solid waste infrastructure that could potentially operate at the site has not been determined, accommodations should be made in the event one or multiple facilities will be selected. Each of the options under consideration will likely consist of an enclosed building with the exception of a compost facility. Typically compost facilities are open land areas used for processing organic materials that if managed improperly can have strong odors. It is possible for compost facilities to be enclosed facilities however, capital costs are higher as well as operating costs depending on the composting process selected.

One of the most common methods of enhancing the potential coexistence of a variety of types of facilities is the use of screening berms and vegetation. The behavioral health facility, at a minimum, would incorporate landscape screening berms to impair visual contact with the industrial use of the solid waste infrastructure as well as reduce ambient noise. The industrial type buildings (pre-engineered metal buildings) can be architecturally enhanced to improve surrounding aesthetics. As an example, a transfer station can be designed to look like a barn in a farm setting such as the Delaware Solid Waste Authority's Milford transfer station in Milford, Delaware. It was designed to blend in with the community.

Significant consideration must also be given to each waste facility's orientation to respect the coexistence of the behavioral health facility on the site. Each facility may be oriented such that a majority of the operations would occur away from the behavioral health facility where the backside of the waste facility building is facing the behavioral health facility. However, prevailing winds and winter conditions for operations must also be considered for safe and efficient operations of the waste facility.

Vehicular access to the solid waste infrastructure would need to be arranged to have adequate queuing distance from South Taft Road with visual considerations for the behavioral health facility. Tree plantings and adequate privacy fencing would help shield the traffic noise and aesthetics of the vehicular traffic. The privacy fencing would also serve as litter fence preventing wind blown debris from reaching the behavioral health facility.

Locating a behavioral health facility with solid waste infrastructure may not be ideal, but it is possible. Each facility could meet its individual goals and objectives by collaborating through a well planned process that identifies potential shared resources, operational requirements, vehicular demands, buffer opportunities, and design enhancements.

Recommendations

As a result of the discussions, decisions, and information provided during the design charrette, HDR makes the following recommendations to Larimer County:

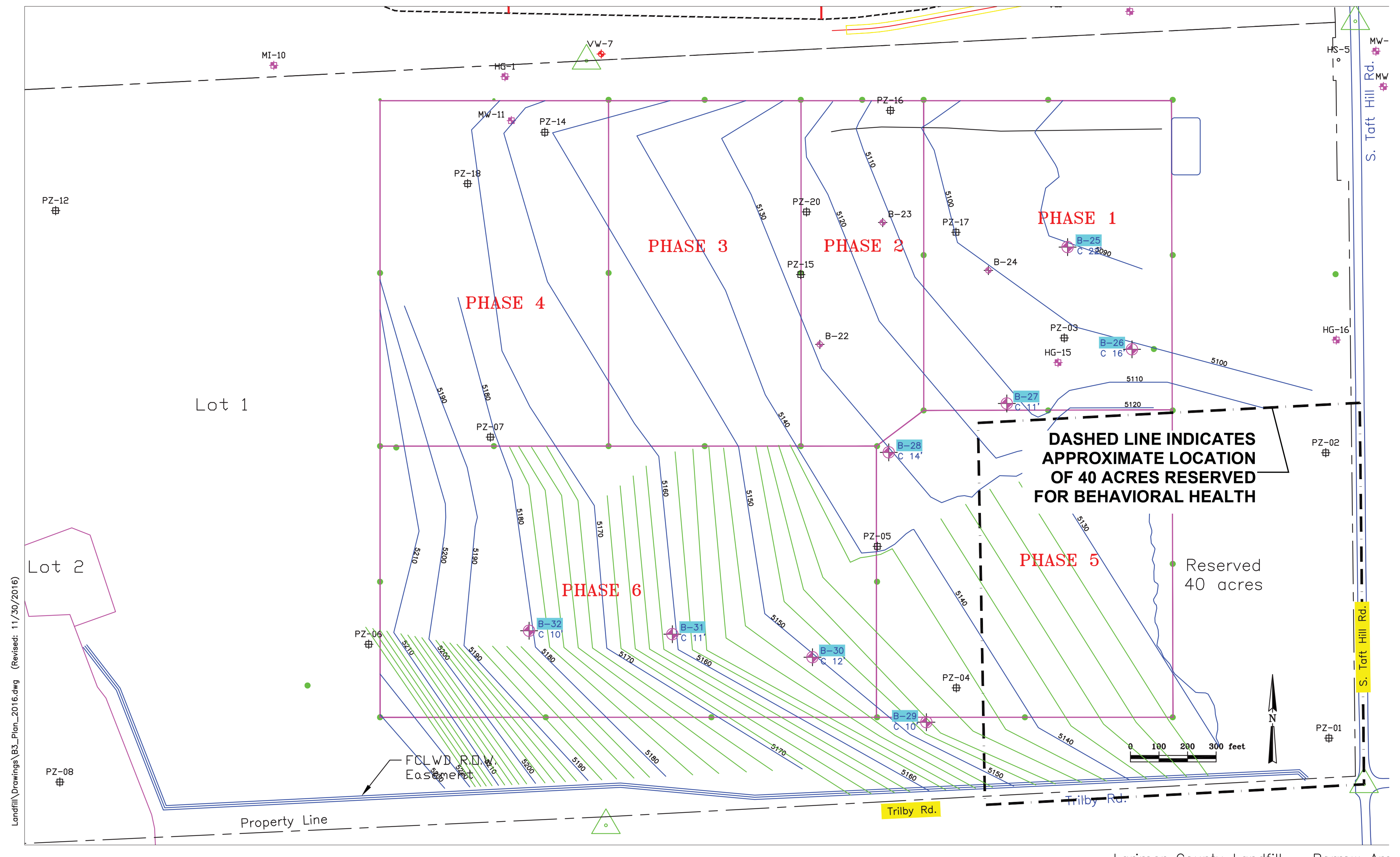
1. To provide a more complete continuum of care in the community, Larimer County should add a social detox unit and crisis care services (including walk-in and crisis stabilization) along with the ability to do 24/7 medical clearance to the list of crucial services identified in the document “What Will It Take? Solutions to Mental Health Service Gaps in Larimer County.”

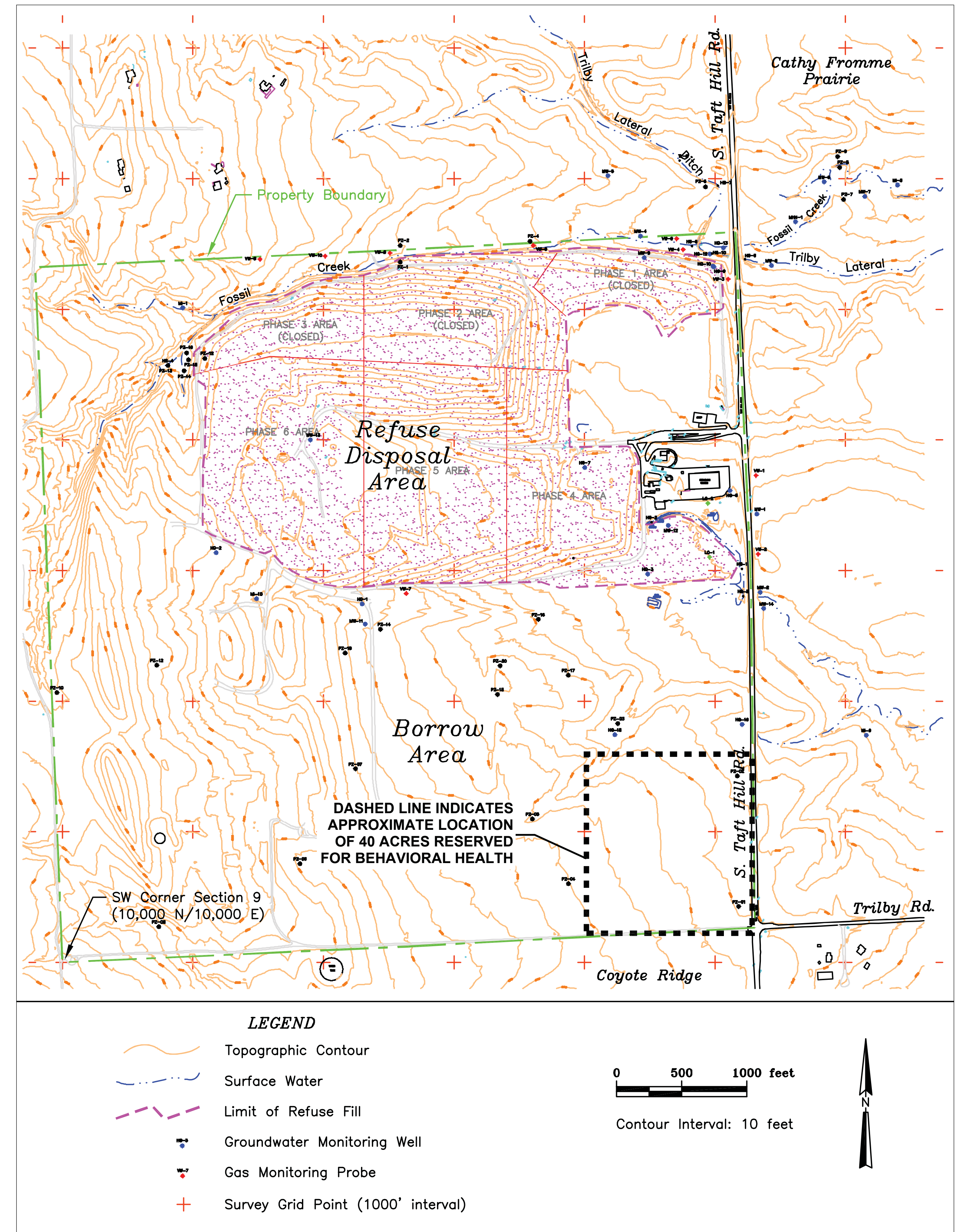
2. Based on HDR’s understanding of potential available land and budget for the new facility, HDR recommends the area identified within the 40 acre site at the intersection of South Taft Hill Road and Trilby Road for a new behavioral health campus with appropriate screening and buffers to coexist with potential future solid waste infrastructure. Considering the preliminary behavioral health facility layout, associated infrastructure, and desired future services, a minimum of 28 acres will be needed to accomplish the master plan development. The greenfield site and opportunity for new construction will optimize control and flexibility for development of the new campus. However, determining transportation solutions is crucial to the success of the proposed site.

3. HDR encourages Larimer County and community stakeholders to continue to explore future opportunities and partnerships for the campus beyond the initial facility including shared resources with solid waste infrastructure. Additional services could drive development of the site and help erase the stigma of behavioral health in Larimer County.

Appendix A

Existing Site Plans


PHASE 1
PHASE 2
PHASE 3
PHASE 4
PHASE 5
PHASE 6
DASHED LINE INDICATES
APPROXIMATE LOCATION
OF 40 ACRES RESERVED
FOR BEHAVIORAL HEALTH
Reserved
40 acres
Lot 1
Lot 2
S. Taft Hill Rd.
Trilby Rd.
Property Line
FCLWD R.O.W.
Easement
0 100 200 300 feet
N
B-25
B-26
C 16'
B-27
C 11'
B-28
C 14'
B-29
C 10'
B-30
C 12'
B-31
C 11'
B-32
C 10'
B-22
B-23
B-24
PZ-01
PZ-02
PZ-03
PZ-04
PZ-05
PZ-07
PZ-08
PZ-12
PZ-14
PZ-15
PZ-16
PZ-17
PZ-18
PZ-20
HG-1
HG-15
HG-16
HS-5
MI-10
MW-11
VW-7
5100
5110
5120
5130
5140
5150
5160
5170
5180
5190
5200
5210
Larimer County Landfill – Borrow Are
(South 1/2 of Section 9, T6N, R69W)
Landfill\Drawings\B3_Plan_2016.dwg (Revised: 11/30/2016)

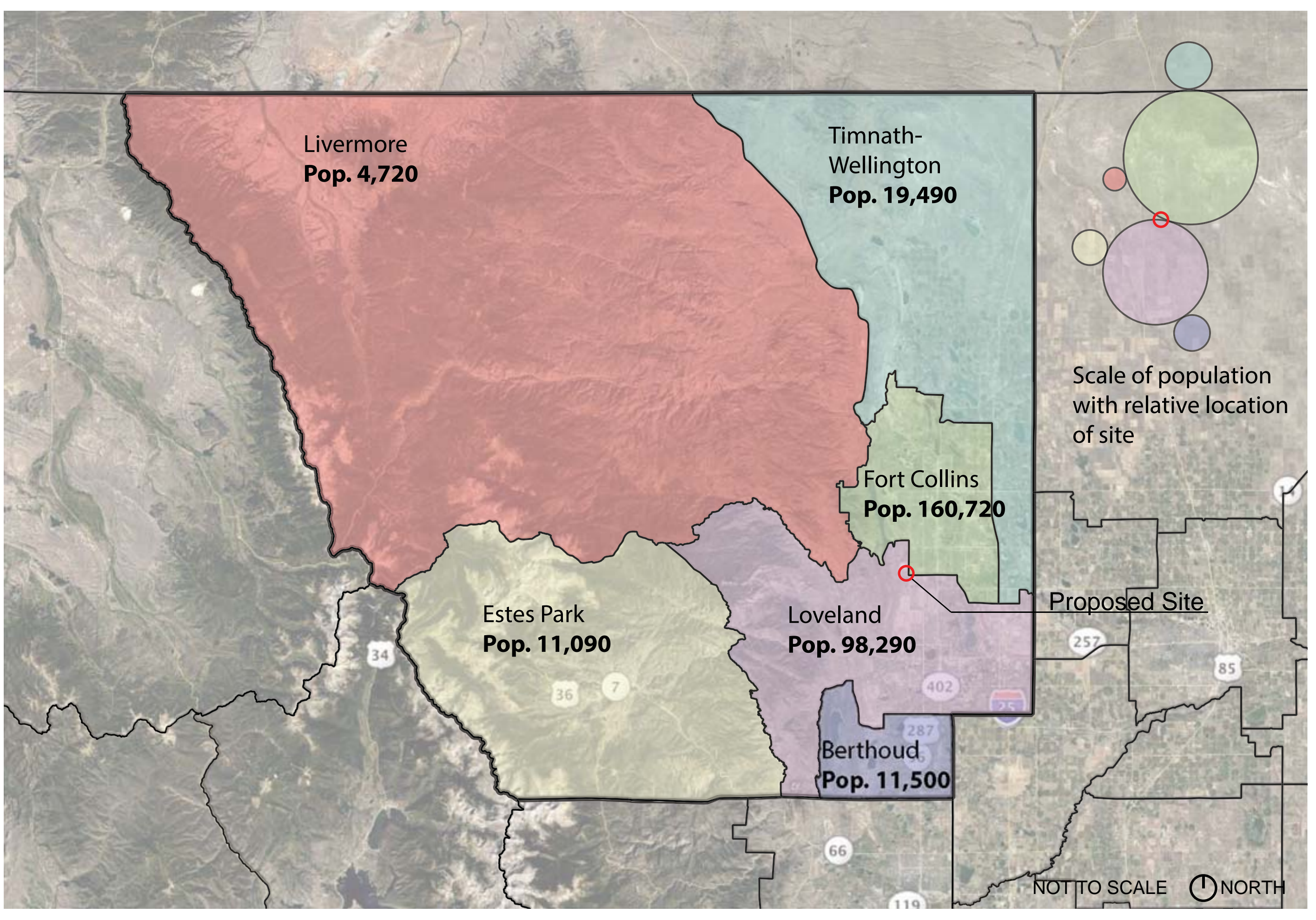


C:\Landfill\Drawings\LF_SitePlan_08.dwg

FIGURE 1.
LARIMER COUNTY LANDFILL
SITE PLAN

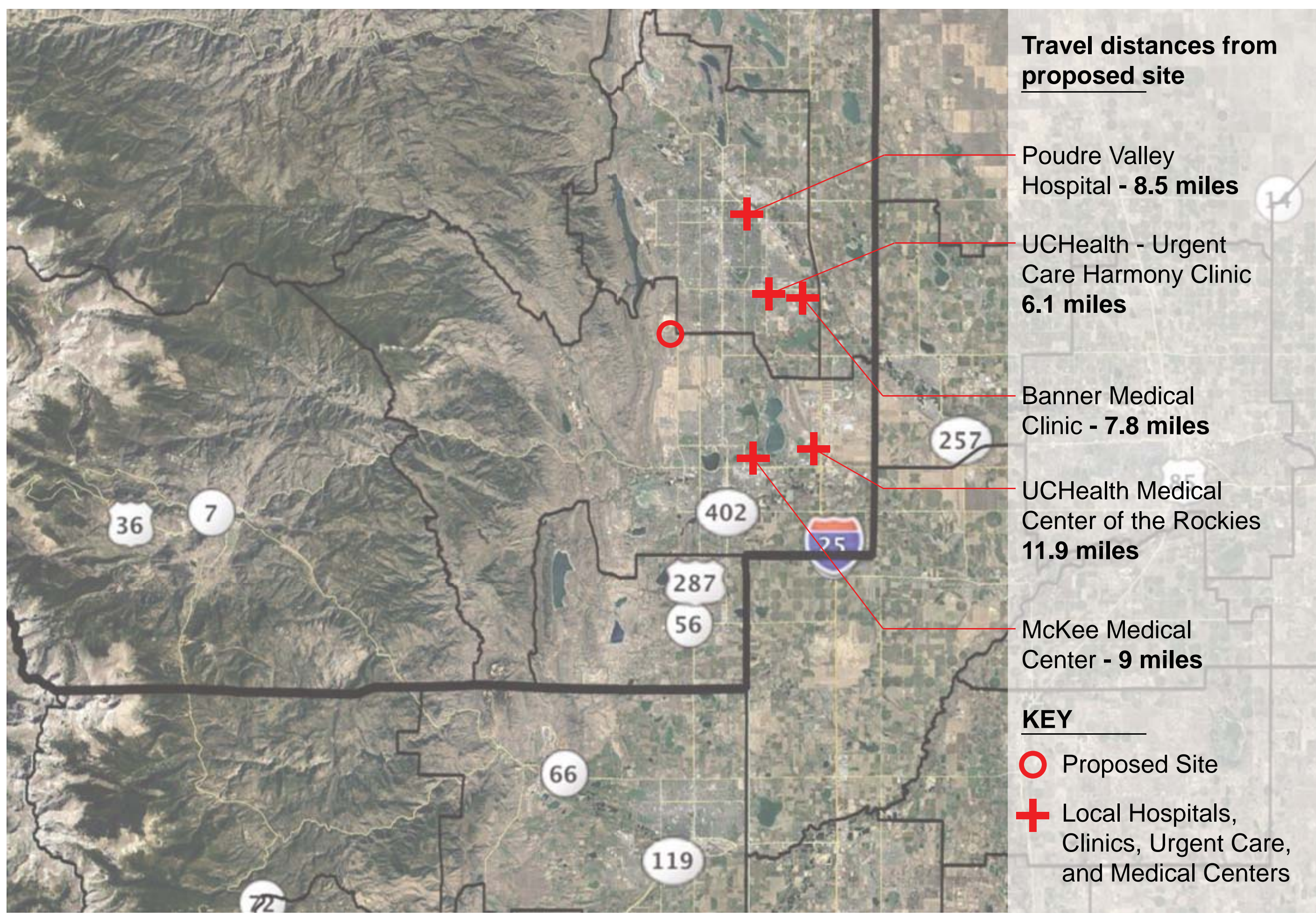
Appendix B

Population Density Map


Livermore
Pop. 4,720
Timnath-
Wellington
Pop. 19,490
Scale of population with relative location of site
Fort Collins
Pop. 160,720
Proposed Site
Estes Park
Pop. 11,090
Loveland
Pop. 98,290
Berthoud
Pop. 11,500
NOT TO SCALE
NORTH

Appendix C

Travel Distance to Medical Facilities



Travel distances from proposed site
Poudre Valley Hospital - 8.5 miles
UCHealth - Urgent Care Harmony Clinic 6.1 miles
Banner Medical Clinic - 7.8 miles
UCHealth Medical Center of the Rockies 11.9 miles
McKee Medical Center - 9 miles
KEY
Proposed Site
Local Hospitals, Clinics, Urgent Care, and Medical Centers
36
7
402
287
56
257
25
66
119

Appendix D

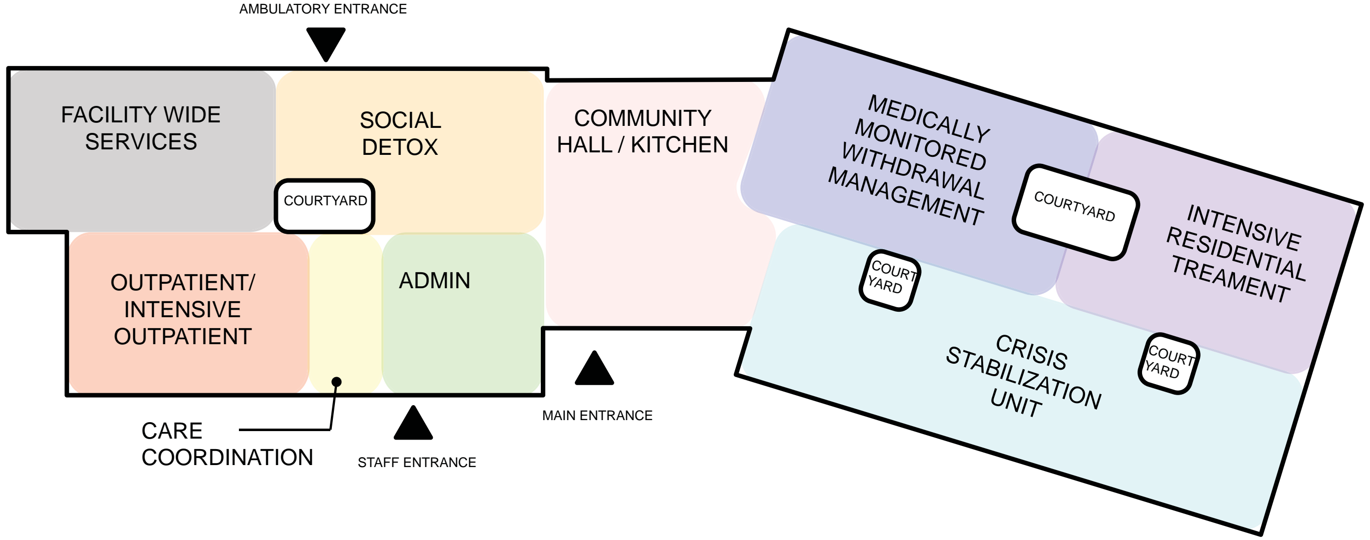
Conceptual Site Plan and Departmental Floor Plan

Larimer County
Behavioral Health Center
Site Plan - Phase 1

Larimer County Behavioral Health Center

Site Plan - Phase 2

DEPARTMENTAL FLOOR PLAN



SCALE 1" = 64' - 0"

NORTH

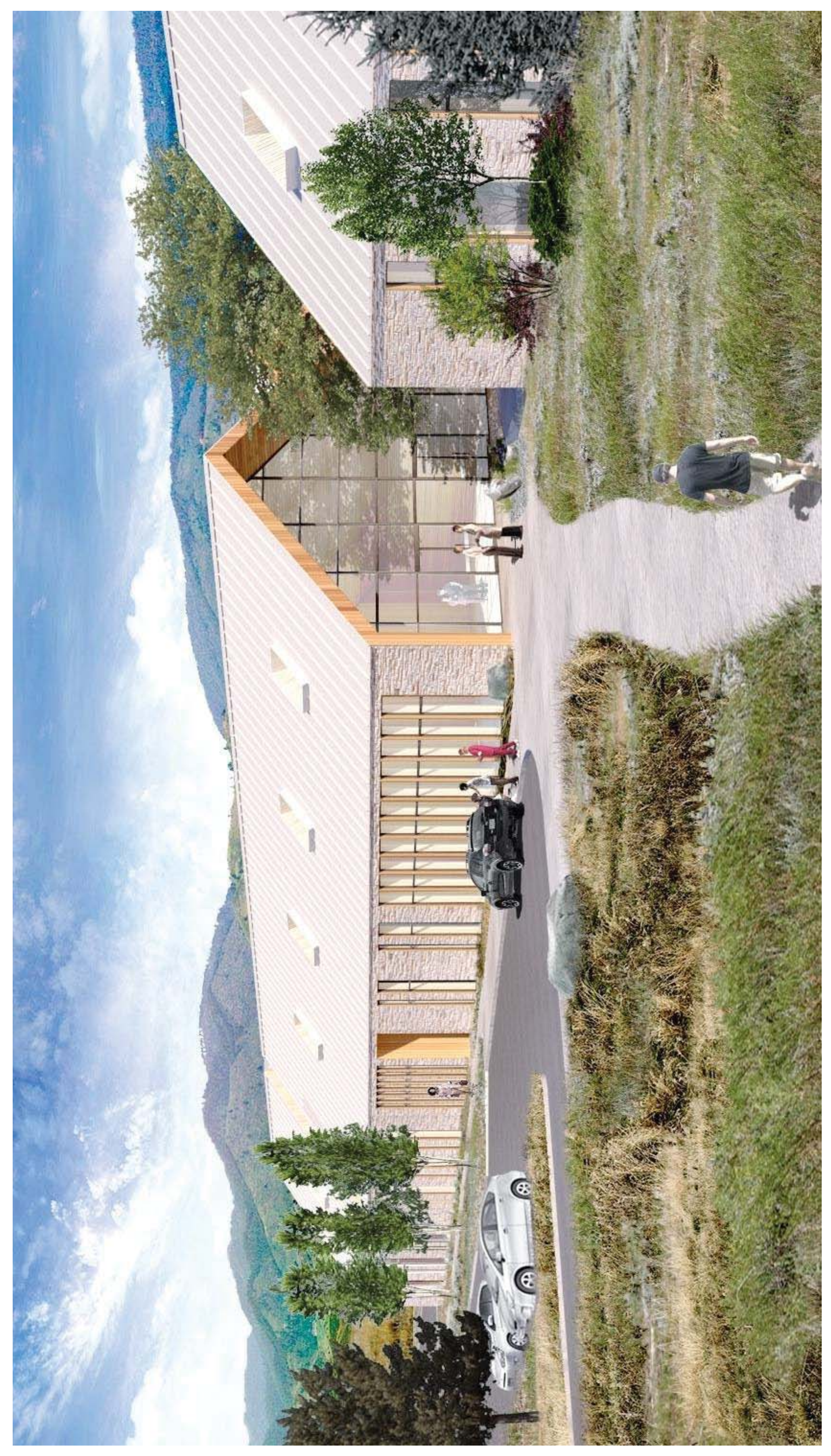
Appendix E

Proposed Facility Space Program and Cost Estimate

	Notes	Common Space			Community Hall / Kitchen			OP/IOP Shared Space			General Admin / Operation / Support			Facility Wide Services & Assessment			3.7 Medically Monitered Withdrawal Mgmt			3.5 Intensive Residential Treatment (IRT) - Short Term			Care Coordination			Crisis Stabilization Unit			Social Detox			Totals	
Space		Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	**Rms**	**Tot Sq Ft**
Reception											1	200	200													1	200	200	1	200	200	**3**	**600**
Reception/Separate door/small wait area for Detox, IRT																	1	200	200													**1**	**200**
Waiting area(s)	For main building. With child play space included.	1	400	400																						2	150	300	2	150	300	**5**	**1,000**
Medical Clinic/Med Rooms	Shared by RN, MD & STIR, do we need one in ATU and one for whole facility? Probably clinic area would need 2 rooms, one for sterilization or other needs?	1	150	150																												**1**	**150**
Intake/Admit/Assessment	3.7, 3.5 & ATU							2	200	400				3	200	600	1	200	200	1	200	200										**7**	**1,400**
Large conference room	Big enough for all staff meetings of over 50 people													1	1000	1000																**1**	**1,000**
Group/Conference/Community Mtg	Dividable; Shared by 3.7, 3.5 & ATU				1	600	600	2	600	1200										1	600	600										**4**	**2,400**
Counseling Office (shared)	3.7, 3.5 & ATU																1	100	100	1	100	100	1	100	100							**3**	**300**
Counseling rooms (scheduled)	Scheduled clinical space							8	100	800																						**8**	**800**
Family counseling room																				1	200	200										**1**	**200**
Cubicle	3.7, 3.5 & ATU										1	75	75	1	80	80	1	80	80	1	80	80	1	80	80							**5**	**395**
Bullpen space														4	36	144	2	36	72	2	36	72	6	36	216	11	36	396	11	36	396	**36**	**1,296**
Serving Space/Dining/Cafeteria	Serving space/dining/food storage/meetings for approximately 20 people. Expandable particularly if this is a campus may need to grow. Doesn't include kitchen…recommended to bring food in				1	700	700																									**1**	**700**
Staff offices (shared cubicles)	Cubicles shared space, community staff							2	150	300																						**2**	**300**
Community shared private offices	MD and Supervisory staff share							2	200	400	4	150	600	7	150	1050							1	150	150							**14**	**2,200**
Confidential shared office space																							4	100	400	1	120	120	1	120	120	**6**	**640**
Medication/medical	Potential for MAT and FQCHC outreach							1	250	250																						**1**	**250**
Bedrooms (Double)																	6	300	1800	6	300	1800				8	300	2400	4	300	1200	**24**	**7,200**
Bedrooms (Single)																	4	150	600	4	150	600				16	150	2400	8	150	1200	**32**	**4,800**
Bathrooms (Shared)																										12	85	1020	6	85	510	**18**	**1,530**
Bathrooms	4 ptnt, 2 staff/guest																8	150	1200	7	150	1050										**15**	**2,250**
Medical/UA space	do we need lab													1	250	250																**1**	**250**
Special clinic/med rooms														2	150	300																**2**	**300**
Maintenance closet											2	100	200																			**2**	**200**
Housekeeping closet											2	100	200																			**2**	**200**
TV room/Groups	1 or 2																1	300	300													**1**	**300**
Nurses station	1 atu 1 med mgt													1	100	100	1	100	100													**2**	**200**
Medication closets	3, one facility wide/assessment, one detox/irt, one ATU													1	50	50	1	50	50													**2**	**100**
Staff break rooms	With fridge, microwave, coffee maker, tables, sink	2	350	700																												**2**	**700**
Visitation	Family friendly space with children's play area, plus adult section				1	700	700																									**1**	**700**
Child play area	Play equipment				1	200	200																									**1**	**200**
Gym/physical fitness area	Some equipment				1	750	750																									**1**	**750**
Recreation Room	Pool tables, ping pong, etc.				1	750	750																									**1**	**750**
Loading Dock/Shipping and Mailing	Transport and staging of supplies, etc.	1	600	600																												**1**	**600**
Laundry	Linens outsourced? Part of program to self provide? 4 stackable machines?																4	50	200													**4**	**200**
Storage														1	100	100																**1**	**100**
Other							2654																									**0**	**2,654**
Total Rooms		**5**			**6**			**17**			**10**			**22**			**31**			**24**			**13**			**51**			**33**			**212**	
Total Square Feet				**1850**			**6354**			**3350**			**1275**			**3674**			**4902**			**4702**			**946**			**6836**			**3926**		**37,815**
Other Space (for facilities people)		Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	Rms	Sq Ft	Tot Sq Ft	**Rms**	**Tot Sq Ft**
Department spacing factor	per department hallway spaces, wall separations, etc	30%		2405			8260			4355			1658			4776			6373			6113			1230			8887			5104		**49160**
Building grossing factor	Assumption is single story. Mechanical shafts, utility closets, IT routing, facility wide restrooms, etc	35%																															**66,366**
Grand Total Square Feet																																	**66,366**
Facility Project Costs																																	
Design (7%)																																	$ 1,742,100
FF&E (16%)																																	$ 3,981,944
Land																																	$ 2,036,430
Soft Costs Subtotal																																	**$ 7,760,474**
Construction - Building & Infrastructure/Site ($2.5)																																	$ 24,887,149
Design Contingency (10%)																																	$ 2,488,715
Contractor - General Conditions, OH&P (10%)																																	$ 2,488,715
Escalation Contingency (5.5%)																																	$ 1,795,619
Construction Costs Subtotal																																	**$ 31,660,198**
Construction - Cost Per Square Foot																																	**$ 477.06**
Grand Total Facility and Land Cost	Based on today's costs. Recommend 10% increase per year beginning in 2017																																**$ 39,420,672**

Appendix F

Architectural Rendering



Treatment is Cost Effective, but Benefits go to Many Different Pockets, 2016

The National Institutes of Health (NIH) concludes that research shows for every $1 spent on SUD treatment there are about $4 to $7 in economic benefits (National Institute for Health. (2012). Principles of Drug Addiction and Treatment: A research-based guide/third edition).

The same report concludes that economic costs of substance abuse (illicit drug, alcohol and tobacco) are about $600 billion per year, or nearly $2,000 per person in the US. The economic cost of mental disorders is cited by the National Institute on Mental Illness at over $300 billion per year, or almost $1,000 per person in the US. The cost per person with SUD or a mental disorder is literally tens of thousands of dollars per year, depending on their diagnosis, severity, age, and treatment status.

These costs come in many forms, affect many institutions, and permeate society and communities:

- Nearly half of costs fall on the nearly 50 million experiencing mental disorders and over 20 million with SUD disorders in terms of impaired workplace and household productivity, lost jobs and derailed careers. Workplaces are harmed when workers develop mental or SUD disorders.
  - This impacts tax payers through lost tax revenues and social assistance payments.
- Families (spouses, children) of those with mental disorders and SUD also bear unfathomable impacts, often have their own health and emotional problems and require assistance from communities (health, housing, food, school supports, etc.).
- About a third of mental illness costs and 10 percent of SUD costs are for treatment (hospital care, doctors, therapists, medicines).
  - Most of these costs are paid through public and private insurance, although States and communities pay a significant share, as well as families.
- Tragically, un/undertreated mental disorders and SUD is associated with a great deal of disruption and harm in the broader community through public disturbances, status offenses, violence (actual as well as threatened), theft/burglary and system crime.
  - These impact police, jails, prisons, courts, prosecutors, probation and parole, across local, State and federal authorities.

Both cost of illness and cost-offset studies include the entire range of impacts and costs, which yield both large aggregate costs as well as sizeable estimates of benefits from treatment services.

Treatment is Cost Effective, but Benefits go to Many Different Pockets, 2016

Unfortunately, the diverse and diffuse nature of the impacts and the costs means that no single agency or institution can capture a meaningful share of the economic benefits. The economic rewards are spread throughout the community, and on to the State and federal levels.

Accordingly, although MH and SUD treatment is cost effective in the largest sense, it is usually not cost effective in the budget of a single agency in a given community.

According to several conservative estimates, every dollar spent on addiction treatment programs yields a return of between $4 and $7 in reduced health, crime, criminal justice costs, and impaired work.

Washington State estimated that it will save $2.58 in criminal justice costs for every dollar spent on treatment, and realize an overall $3.77 offset per dollar of treatment costs

A 2013 study found that people receiving medication for their mental health disorder were significantly less likely to be arrested, and that receipt of outpatient services also resulted in a decreased likelihood of arrest. The researchers also compared criminal justice costs with mental health treatment costs. Individuals who were arrested received less treatment and each cost the government approximately $95,000 during the study period. Individuals who were not arrested received more treatment and each cost the government approximately $68,000 during the study period.

Kaiser Permanente Northern California analyzed the average medical costs during 18 months pre and post substance use treatment and found that the SU treatment group had a 35% reduction in inpatient cost, 39% reduction in ER cost, and a 26% reduction in total medical cost, compared with a matched control group.

Kaiser also found that family members of patients with substance use disorders had high healthcare costs and were more likely to be diagnosed with a number of medical conditions than family members of similar persons without a substance use condition.91 For families of SU patients who were abstinent at one-year after treatment began, the healthcare costs of family members were no longer higher than other Kaiser members.

2007: In a replication of CALDATA a team at UCLA found that, on average, substance abuse treatment costs $1,583 and is associated with a monetary benefit to society of $11,487, representing a greater than 7:1 ratio of benefits to costs. These benefits were primarily because of reduced costs of crime and increased employment earnings.

Washington:

Treatment is Cost Effective, but Benefits go to Many Different Pockets, 2016

- 1997: Studied 557 indigent clients with SUD and estimated that those that got SA TX had Medicaid expenses $4,500 less than similar untreated individuals, which compared favorably to the $2,300 TX cost. Savings were consistent across the 5 years.
- Studied SSI enrollees in need of SA TX. 50% got TX. Those treated achieved: lower medical costs of $311/month; reduced: arrests of 16%, convictions of 15% felony convictions of 34%
- Analyzed impact of $21 million treatment expansions in FYs 2005-07. Realized savings in Medicaid of $17.8 million

South Dakota: Before treatment (based on more than 1000 persons followed 12 months after treatment), The cost of treatment ($1,382) was significantly less than the benefits ($11,653), resulting in a very favorable cost-benefit ratio. The cost benefit in this study was $8.43 for every dollar invested. The cost benefit results presented here are similar (although somewhat higher- $8.43 compared to $7.00) to those reported elsewhere.

Oregon: a cohort of treatment completers produced cost savings of $83,147,187 for the two and a half years following treatment. The cost for treating all adults in 1991–92 was $14,879,128. ♦ Thus, every tax dollar spent on treatment produced $5.60 in avoided costs to the taxpayer

Louisiana: we conclude that for each dollar the state puts into alcohol and drug abuse treatment programs, it will reduce future expenditures on criminal justice, medical care, and public assistance by approximately $3.83.

Kentucky: The reductions in self-reported arrests for Kentucky clients, combined with cost estimates for their crimes and increased earnings and tax revenues, suggest a cost benefit for Kentucky taxpayers estimated at a ratio of 4.98 to 1. In other words, Kentucky saved $4.98 for every dollar spent on treatment.

Written and compiled by:
Rick Harwood
Deputy Executive Director/Director of Research and Program Applications
National Association of State Alcohol and Drug Abuse Directors

Appendix I

Estimated 5-Year Mental Health Budget - Subject to Change

Last Update: August 10, 8:49 AM

Beginning Balance						
ITEM	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Beginning Balance	0	$9,300,000	$1,150,000	$5,750,000	$6,075,000	$6,525,000
EXPENSES						
ITEM	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Facility Construction	$5,000,000	$21,100,000	$2,900,000			
Administration & Operations	$400,000	$850,000	$875,000	$900,000	$925,000	$950,000
Community Services	$1,000,000	$2,500,000	$2,600,000	$2,700,000	$2,800,000	$3,000,000
Client Assistance & Care Coordination		$0	$3,250,000	$3,300,000	$3,400,000	$3,500,000
Crisis Services		$0	$4,150,000	$13,500,000	$13,750,000	$14,000,000
TOTAL EXPENSES	**$6,400,000**	**$24,450,000**	**$13,775,000**	**$20,400,000**	**$20,875,000**	**$21,450,000**
REVENUES						
ITEM	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Sales Tax (see Note) & Interest	$15,700,000	$16,300,000	$16,725,000	$17,325,000	$17,825,000	$18,300,000
Patient & Payer Revenue	$0	$0	$1,650,000	$3,400,000	$3,500,000	$3,600,000
TOTAL REVENUES	**$15,700,000**	**$16,300,000**	**$18,375,000**	**$20,725,000**	**$21,325,000**	**$21,900,000**
Ending Balance						
ITEM	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Ending Balance	$9,300,000	$1,150,000	$5,750,000	$6,075,000	$6,525,000	$6,975,000

Note:

Sales tax is difficult to predict because it is dependent upon many factors, such as consumer confidence, population growth, and single-year spikes in local development. The Mental Health ballot question contains a *maximum* first year sales tax estimate of $19 million based on a .25% sales tax. This maximum estimate is required by the State constitution. The budget above uses a more conservative and typical revenue estimate for a .25% sales tax so as to not overstate potential available resources.

LARIMER
COUNTY