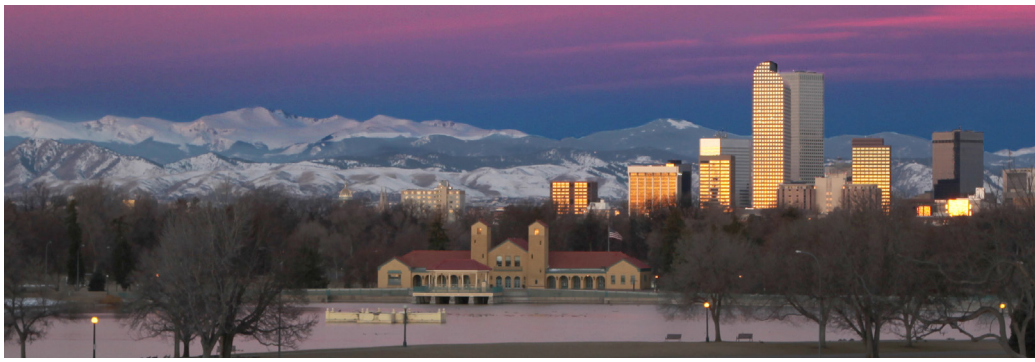
BRIDGING THE DIVIDE: ADDRESSING COLORADO'S SUBSTANCE USE DISORDER NEEDS

FEBRUARY 2017



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EXECUTIVE SUMMARY

Substance abuse is a key public health priority in the state of Colorado, having been identified as one of Colorado's *10 Winnable Battles*. A recently conducted analysis commissioned by the Office of Behavioral Health and led by the Western Interstate Commission for Higher Education documented unmet needs for substance use disorder (SUD) services across the state. This comprehensive behavioral health needs analysis also projected the extent of unmet need to increase significantly by 2025.[1] Senate Bill 16-202, passed by the Colorado General Assembly and signed by Governor John Hickenlooper, seeks to improve access to these services.

To determine how to most effectively allocate increased funding for SUD services with Colorado's Managed Service Organization (MSO) regions, the Keystone Policy Center (Keystone) conducted dozens of interviews, 10 statewide meetings, and hundreds of surveys with key stakeholders to solicit feedback on gaps in services. The meeting, interview, and survey participants worked in the following sectors and organizations: mental health centers; substance use prevention, intervention, treatment and recovery providers; behavioral health organizations; county departments of human services; local public health agencies; law enforcement; homeless and veteran serving organizations; probation; primary care providers; regional care coordination organizations; hospital systems; crisis system; and state agencies. Alongside this stakeholder feedback effort, the OMNI Institute reviewed and synthesized existing sources of information regarding the needs and priorities for SUD services in Colorado. These joint efforts identified what is working well and prioritized needs within each MSO region.

Stakeholders across Colorado emphasized that when it comes to SUD services, the gaps and needs are significant and varied and nearly every population is underserved. Most regions shared similar concerns about needs with respect to the workforce, residential treatment options, detoxification (detox) services, education and de-stigmatization, and supportive services, but — recognizing that needs vary greatly from community to community — stakeholders called for funding that is flexible at the regional and community levels, sustainable, and focused on the development of a continuum of care. Stakeholders recognized the importance of funding non-crisis services — including prevention, intervention, treatment, and recovery — if services are to be effective over the long term.

Across the state, stakeholders identified the financial challenges of building and sustaining a continuum of care due to disjointed and inflexible funding, inconsistent benefits, lack of consistent access to services, and the inability to appropriately scale capacity in both rural and urban areas.

Such variability in funding dis-incentivizes provider participation in offering these services; most providers increasingly share feedback that their services have no source of reliable funding, with all sources, including the state, competing to be the "payer of last resort." Indeed, this problem was identified by the Governor's Office of State Planning and Budgeting in the Behavioral Health Funding Study released in November 2016:

> [T]he requirement that providers use multiple methods for obtaining reimbursement for contracted services creates an administrative burden and requires more resources be directed to these administrative and billing activities when the resource may be better allocated toward providing services to clients. One of [the Office of Behavioral Health's (OBH)] reimbursement requirements, referred to as the 'capacity based protocol,' provides an example of the complexity of the system … From a provider perspective, the capacity based protocol presents challenges to plan for and provide services, as it

> creates uncertainty as to what level of revenue will be available to staff and to operate the program. This uncertainty is proportional to the percentage of non-OBH revenue (cash receipts from non-OBH payers) the program earns and the monthly or periodic variances in these non-OBH revenues. The protocol also does not allow programs to retain any excess earnings or offset expenses for capital expenditures, both critical considerations for expanding programs and maintaining or upgrading capital equipment or building new facilities.[2]

This topic has been raised during the 2017 legislative sessions — namely, the question of whether the state legislature intends funding to be restricted by the payment protocol, resulting in "reversions" (funding that had been appropriated by the legislature but that is returned or goes unused due to an inability to utilize the funding, variability in other funding sources, or other challenges). This creates the inaccurate impression that the funding is not needed. Rather, the constraints on the funding often result in these reversions. Last year alone, approximately $1.7 million in SUD funding was reverted — funding that could have gone to support prevention, intervention, treatment, or recovery services if it had not been narrowly constrained in many cases. Allowing providers and MSOs greater flexibility in how they may use funding to support their communities with needed services was a common request from stakeholders.

Lastly, stakeholders raised specific funding challenges as they relate to the sustainability of services in rural areas. Typically, services like an outpatient clinic may be easy to sustain in a larger population center, but in a rural area demand is not met by appropriate billing support. Thus, rural and frontier residents have less availability to the entire continuum of services due to the often-mistaken belief that such services are covered — sustained — by other payers. In the example of the rural outpatient clinic, that clinic may provide services to only a handful of clients, though the clinic's overhead costs remain fixed at a minimum level. Further, having qualified staff in rural areas is disproportionately challenging, with a given provider needing to offer better pay and benefits to compete against the staff leaving for a population center. As this example makes clear, service sustainability funding is needed to offset the gap in direct service reimbursement support from other payers.

This report summarizes stakeholder feedback on general needs and gaps, needs and gaps related to specific populations, funding priorities, and promising practices for SUD services across the state and within the seven MSO regions.

SUBSTANCE USE DISORDERS IN COLORADO

A rise in substance abuse poses serious challenges for Colorado families, community leaders and agencies, and treatment providers. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home." [3] Access to SUD treatment is more important than ever: More than 255,000 Coloradans misuse prescription drugs, and deaths involving the use of opioids nearly quadrupled between 2000 and 2011. [4] According to new data from the Colorado Department of Public Health and Environment, [5] overdose deaths from just one kind of opioid painkiller outnumbered all homicides in Colorado in 2015. In that same year, there were 904 drug-induced deaths and 847 alcohol-induced deaths across the state. [6] Drug- and alcohol-related deaths were most common among those aged 25-65, individuals of White, Hispanic, and American Indian/Native Alaskan descent, and those living in areas of high poverty. [6]

Indeed, this indicates the increased need for a wide range of substance use disorder services, including prevention, intervention, withdrawal management, outpatient, residential, recovery supports, and many other evidence-based aids. With respect to the opioid crisis, increased attention has been directed towards effective treatment approaches, such as medication assisted treatment, notably with buprenorphine and time-release naltrexone, which has demonstrated significant effectiveness.

In response to this growing epidemic, Senate Bill 16-202 seeks to increase access to effective SUD services, beginning with a stakeholder assessment process to identify priorities. In coordination with the statewide MSOs, Keystone conducted interviews, meetings across Colorado, and surveys with key stakeholders to solicit feedback on gaps in services, identify what is working well, and prioritize needs to determine how to most effectively allocate funding for SUD services within each MSO region.

Continuum of Care for Substance Use Disorder Treatment

Senate Bill 16-202 directed an analysis of resources available to provide a continuum of SUD services, including prevention, intervention, treatment, and recovery support. Throughout this report and the feedback process, stakeholders refer to this "continuum of care," which addresses the elements identified in the legislation as well as "enhancing health." Individuals do not always move through the SUD continuum neatly and in one direction; due to the chronicity and the related risk of relapse with SUDs, individuals often move across and within different SUD treatment services, depending upon their needs and the services available to them. For instance, many individuals will complete detox on several occasions over the course of treatment and will also utilize other services on the continuum at different points in their recovery process.

SUBSTANCE USE CARE CONTINUUM

Enhancing Health	Primary Prevention	Early Intervention	Treatment	Recovery Support
Promoting optimum physical and mental health and well-being, free from substance misuse, through health communications and access to health care services, income and economic security, and workplace certainty.	Addressing individual and environmental risk factors for substance use through evidence-based programs, policies, and strategies.	Screening and detecting substance use problems at early stage and providing brief intervention, as needed.	Intervening through medication, counseling, and other supportive services to eliminate symptoms and achieve and maintain sobriety, physical, spiritual, and mental health and maximum functional ability. Levels of care include: • Outpatient services; • Intensive Outpatient/ Partial Hospitalization Services; • Residential/ Inpatient Services; and • Medically Managed Intensive Inpatient Services.	Removing barriers and providing supports to aid the long-term recovery process. Includes a range of social, educational, legal, and other services that facilitate recovery, wellness, and improved quality of life.

Figure 1: Source: U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016.

The benefits of substance abuse treatment are well established. Numerous studies have demonstrated the positive effect of treatment on reducing substance use and improving health status and social functioning. In addition to recovery from addiction, people who comply with substance abuse treatment often experience gains in family functioning, mental health, and employment. Despite this significant and growing body of knowledge documenting that substance use addiction is a preventable, treatable and manageable disease, and despite the proven efficacy of prevention, intervention, and treatment techniques, our state continues to pay for the consequences of substance abuse and addiction: illness, injury, death, and crime, overwhelmed social service systems, impeded education — which are not an effective use of taxpayer dollars. The following graphic illustrates the situation statewide as well as through a specific lens of spending in Larimer County.

INVEST *in* SUCCESS

PREVENTION, INTERVENTION & TREATMENT

COLORADO SNAPSHOT

LOSING GROUND

Substance Use Disorder is Skyrocketing in our Communities

224K PEOPLE *in* COLORADO misuse prescription medications every year

19.1% *of all* TREATMENT ADMISSIONS are for methamphetamines

300 DEATHS/YR. are the result of painkiller overdoses

↑82% UNINTENTIONAL DRUG POISONING DEATHS from 2004 to 2013

1 IN 7 HIGH SCHOOL STUDENTS has taken prescription medications without a doctor's prescription

12TH *in the* NATION for self-reported nonmedical use of opioid painkillers in 2012-13

3X MORE *in* 4 YEARS deaths due to heroin in Colorado

Sources: Take Meds Seriously, State of Colorado, Colorado Consortium for Prescription Drug Abuse Prevention; Colorado Department of Health and Environment; National Survey on Drug Use and Health; Centers for Disease Control; Colorado Meth Project

SPENDING EXAMPLE LARIMER COUNTY

Dollars are not being used effectively. Too many substance use disorder dollars are spent on acute services rather than treatment.

spent on ACUTE SERVICES

88% **$1.71 MILLION**

Jail, emergency medical transport, hospital inpatient, emergency department, police contact and detoxification

Source: Larimer County High Utilizers Study 2015/2016, Health District of Northern Larimer County

spent on TREATMENT

$239 THOUSAND 12%

Outpatient mental health and/or substance use disorder treatment, and treatment provided through Alternative Sentencing and Community Corrections

COLORADO *can do* BETTER

SUBSTANCE USE DISORDER PREVENTION, INTERVENTION & TREATMENT STRENGTHENS COMMUNITIES & SAVES DOLLARS

$1 SPENT ON TREATMENT RETURNS AS MUCH AS **$7**

in reduced drug-related crime, criminal justice costs, and theft

WHEN YOU ADD HEALTH-RELATED SAVINGS: fewer interpersonal conflicts; greater workplace productivity; and fewer drug-related accidents, including overdoses and deaths

TOTAL SAVINGS *exceed* COSTS BY **12:1**

Source: National Institute for Health

SUBSTANCE USE DISORDERS IN COLORADO

The Colorado Office of Behavioral Health contracts with regional MSOs for the provision of SUD treatment services throughout Colorado.

Colorado Managed Service Organizations

Region 1: Larimer, Weld, Morgan, Logan, Sedgwick, Phillips, Washington, Yuma, Elbert, Lincoln, Kit Carson, and Cheyenne Counties

Region 2: Denver, Adams, Arapahoe, Broomfield, Douglas, Jefferson, Clear Creek, and Gilpin Counties

Region 3: El Paso, Teller, Park, Lake, Chaffee, Fremont, and Custer Counties

Region 4: Pueblo, Crowley, Kiowa, Huerfano, Las Animas, Otero, Bent, Prowers, Baca, Saguache, Mineral, Rio Grande, Alamosa, Conejos, and Costilla Counties

Region 5: Archuleta, La Plata, Montezuma, Dolores, San Miguel, San Juan, Ouray, Hinsdale, Gunnison, Montrose, and Delta Counties

Region 6: Mesa, Garfield, Rio Blanco, Moffatt, Routt, Eagle, Pitkin, Summit, Grand, and Jackson Counties

Region 7: Boulder County

SUBSTANCE USE DISORDERS IN COLORADO

Assessments of availability and need for SUD services underscore a shortage of SUD services across the spectrum,[7] with a particular need in many regions for additional availability of social detox models.[1] The Department of Health Care Policy and Financing reports that there are 18 detox facilities licensed by the Office of Behavioral Health in Colorado, with 409 beds available between them.[7]

Consumers in Colorado seeking SUD services can access LinkingCare.org, the directory for OBH licensed providers that allows consumers to search for some services on the SUD continuum, including: (1) emergency/medical detox providers; (2) residential treatment providers; (3) outpatient service providers; and (4) methadone clinic providers.[8] Of these four service provider types, those locally (i.e., within-county) available that consumers can find through LinkingCare.org differ considerably from one region to another.

For example, there are:[8]

- Six counties with none of these four service provider types available (Region 2: Gilpin; Region 4: Kiowa, Mineral, Dolores; Region 5: Hinsdale, San Juan);
- 12 counties with all of these four service provider types available (Region 1: Larimer; Region 2: Adams, Arapahoe, Denver, Jefferson; Region 3: El Paso, Fremont; Region 4: Alamosa, Pueblo, La Plata; Region 6: Mesa; Region 7: Boulder); and,
- 15 counties with only outpatient service provider types (i.e., no emergency medical/detox providers, residential treatment providers, or methadone clinic providers; Region 2: Broomfield; Region 3: Lake, Park, Teller; Region 5: Archuleta, Delta, Gunnison, Montezuma, Ouray, San Miguel; Region 6: Eagle, Grand, Jackson, Moffat, Rio Blanco).

Funding

For SUD treatment, state and local funding are the largest payers, followed by Medicaid and other federal spending. Total private spending makes up a smaller component of funding.

A brief examination of the distribution of SUD services funding for youth (ages 12-17) and transition-age youth (ages 18-24) conducted by the Office of Behavioral Health indicated that in FY 2011-12, the majority (80 percent) of youth SUD funding came from state funds and 37 percent of combined state and federal youth SUD funding was derived from justice-involved youth dollars. Additionally, youth mental health/co-occurring services received 1.7 times as much funding as youth SUD services, and transition-age youth received more than $1 million in SUD services than youth.

STAKEHOLDER ASSESSMENT: KEY FINDINGS AND THEMES

Key Findings/Themes

While specific priorities for funding varied across the MSO regions, Keystone observed several key findings and themes with respect to need for SUD services statewide:

Care coordination and continuity of care across phases of the continuum: SUDs seldom occur in isolation. Consequently, mental, substance-use, and general health problems and illnesses are frequently intertwined, and coordination of all these types of health care is essential to improved health outcomes, especially for chronic illnesses. Improving outcomes depends upon the effective collaboration of all mental, substance-use, general health care, and other human service providers in coordinating the care of their patients.

This disconnected care delivery system requires numerous patient interactions with different providers, organizations, and government agencies. It also requires multiple provider "handoffs" of patients for different services and transmittal of information to and joint planning by all these providers, organizations, and agencies if coordination is to occur. Overcoming these separations also is made difficult because of legal and organizational prohibitions on clinicians' sharing information about mental and substance-use diagnoses, medications, and other features of clinical care, as well as a failure to implement effective structures and processes for linking the multiple clinicians and organizations caring for patients. Stakeholders repeatedly identified the need for better linkages among mental, substance-use, and general health care and other human service agencies caring for these patients. It is critical that individuals can access the services they need in a timely manner, particularly when in treatment or at risk for relapse. Stakeholders acknowledged that SUDs have not been treated, monitored, or managed like other chronic illnesses, nor has care for these conditions been covered by insurance to the same degree.

Additionally, stakeholders acknowledged the lack of a rational, integrated approach to SUD and the importance of using evidence-based early interventions to stop the addiction process before the disorder becomes more chronic, complex, and difficult to treat. They stressed the importance of a development of and sustainable funding for a continuum of care (Figure 1), which refers to a treatment system in which clients enter treatment at a level appropriate to their needs and then step up to more intense treatment or down to less intense treatment as needed.[9] Sufficient capacity at each level of care is necessary for a well-functioning SUD treatment continuum.

Workforce: The field is experiencing high turnover rates, worker shortages, inadequate compensation, and insufficient training especially for trauma-informed care, Medication-Assisted Treatment (MAT), and treatment for adolescents. Workforce vacancies for master's-level clinicians, counselors, and social workers; nurses; peer support specialists; and mobile crisis staff all contribute to many of the service gaps identified by stakeholders across the regions.

Flexibility and sustainability in funding: Many stakeholders noted the importance of creating a continuum of care — a comprehensive array of accessible health services appropriate to an individual's needs — and a strategy for funding that continuum. They emphasized the challenge of creating a sustainable continuum with the current funding sources, in part due to the effort required for every payer or grant sought, as well as efforts to maintain, administer, and meet funders' reporting requirements. Stakeholders overwhelmingly expressed frustration that funding is often tied to specific populations or is too restrictive in scope, which limits a community's ability to target resources in the way that is right for their community.

Rural and frontier stakeholders also identified the unique barriers they face in obtaining comprehensive and convenient health care services: Services are not as readily available in rural communities and, for those that are available, their range of services may be limited; developing sustainable funds is challenging when that funding is based on a population distribution; law enforcement and prevention programs may be spread sparsely over large rural geographic areas; and patients seeking substance abuse treatment may be hesitant to do so because of privacy issues associated with smaller communities.

Residential treatment: Medicaid does not cover residential treatment except for pregnant women, via the Special Connections program, though there is limited funding for that program which limits access to providers. Stakeholders indicated the need for an expanded benefit that would include inpatient residential treatment programs (low-, medium-, and high-intensity) for periods of time that support needs of individuals as they diminish or intensify. Stakeholders talked about the importance of local transitional programs being available and a vehicle for helping people integrate back into community, following treatment at a more regionally located intensive residential program.

Detox services and detox facilities with a medical component: Two main areas of need commonly came up in stakeholder feedback with respect to detox. First, there was a general need for additional clinically managed, social model detox capacity to be added throughout the state.

Second, most detox services, when available, are for social detox; stakeholders also raised the need for a medical component, as rapid or non-medicated withdrawal from substances can produce seizures and other health complications. Stakeholders acknowledged that when there are medical complications that cannot be addressed in social detox, patients are sent to emergency departments for detox, which is neither effective nor a good avenue for connecting patients with continued care.

Overall, the mixture of static and variable payment sources challenges the sustainability of any detox, rural or otherwise. The need versus sustainability in rural areas makes such rural detoxes almost impossible to sustain. Disproportionate subsidy is required to provide local detox.

Supportive and transitional services: Stakeholders called for better availability of housing and transportation options for individuals transitioning back to their community. Individuals who struggle to access health services and stable housing that will support them through recovery may be more likely to relapse.

Agency alignment and integration: Stakeholders raised the need to enhance integration and alignment among systems of care, as well as across agencies. Stakeholders identified the lack of alignment of funding, planning, programs, and regulations among agencies as a barrier to building a continuum of care for SUD. Additionally, they called for improvements in the connections between aspects of the SUD service continuum (e.g., treatment and recovery); the integration of SUD services into primary care and mental health systems; and strengthening the continuity of care between SUD services and other social services (e.g., hospitals, police departments, emergency response, etc.). Stakeholders suggested enhancing these connections and integration through common information/data management systems and funding for care coordination or case management among the health, health care, and social services systems.

As the Department of Health Care Policy and Financing moves forward with its next iteration (Phase II) of the Accountable Care Collaborative, there should be direct inclusion of substance use services and MSOs. MSOs can help reach Medicaid members with services, like residential services, that are not currently included in their benefit so requiring the Regional Accountable Entity (RAE) to substantively coordinate with the MSOs will improve care delivery, access, and outcomes for clients.

STAKEHOLDER ASSESSMENT: KEY FINDINGS AND THEMES

Lastly, stakeholders acknowledged there is no centralized authority or group with either primary responsibility for positive outcomes and continuity of care for all clients of SUD services, or with ensuring parity (meaning they must be comparable to medical/surgical benefits) requirements are met. SUD services in Colorado will continue to be disjointed and ineffective if this role is left unfulfilled.

Stigma and lack of education: Stigma and lack of education about SUD were identified as barriers to treatment. Specifically, in rural communities, individuals dealing with SUD fear that neighbors, community members, and co-workers or employers will judge them if they seek services. Many stakeholders also identified the lack of recognition of SUD as a chronic disease within and outside the health system as a barrier to long-term care and recovery. Stakeholders highlighted the need for de-stigmatization and greater education and awareness for SUD.

The pages that follow summarize the needs, gaps, and funding priorities specific to each MSO region. The graphic summarizes the stakeholder feedback solicited by Keystone, and the text that follows supplements that feedback with secondary data gathered by the Omni Institute.

Region 1
Northeast Colorado

Larimer, Weld, Morgan, Logan, Sedgwick, Phillips, Washington, Yuma, Elbert, Lincoln, Kit Carson, and Cheyenne Counties

NEEDS/GAPS

- Workforce: Retention and training including Medication Assisted Therapy (MAT)
- Increased training in trauma-informed care
- Case or care management, system navigation
- Better information and data sharing
- Better data related to outcomes of interventions and treatment
- Crisis service alternatives and stabilization
- Funding for transitions, including kids re-entering school setting and homeless
- Continuum of housing options
- Transportation to and from treatment and recovery-oriented programs
- Short- and long-term residential treatment
- Intensive outpatient services, including sustainable rural options
- Prevention including early intervention, especially with kids
- Detox services/facilities with a medical component
- Public education
- Creating sustainability in rural communities

PRIORITIES *for* FUNDING

- Detox services/facilities with a medical component in Larimer and Logan Counties
- Workforce: Retention and training including Medication Assisted Therapy (MAT)
- Crisis service alternatives and stabilization
- Intensive outpatient services and transitions to these services
- Continuum of housing options
- Short- and long-term residential treatment (Larimer/Weld Counties)
- Transportation to and from treatment and recovery-oriented programs
- Creating sustainability in rural communities (Morgan, Logan, Sedgwick, Phillips, Washington, Yuma, Elbert, Lincoln, Kit Carson,v and Cheyenne Counties)

SUMMARY OF EXISTING REPORTS AND DATA: REGION 1

By 2025, Region 1 is expected to have the largest increase in unmet need for substance use services among children and adults in the state.[1] Substance abuse has been identified by county public health departments as a priority in Cheyenne, Kit Carson, Lincoln, and Weld counties.[10] Adult binge drinking[11] and prescription drugs[12,13] were identified as particular areas of concern.

Prevention

Prevention of substance abuse was identified as a key focus area,[14] with a need for more early intervention for youth.[1] Better community services to support school-based services were highlighted.[1] In addition, offering greater access to preventive care for uninsured and Medicare/Medicaid patients was identified as a way to decrease the number of emergency department visits for substance abuse issues that occur for this population.[15]

Intervention

Evidence suggests that there is a need for more crisis stabilization services and higher capacity for detox services in Region 1.[1] From January-October 2015, one detox facility in Region 1, serving primarily Weld and Larimer counties, was unable to admit approximately 500 clients, due to the detox facility being at capacity, a lack of transportation options, or limitations around staffing requirements due to licensing regulations. [16]

Treatment

Many communities within Region 1 see a need for more treatment services options and providers within their county.[1,12,17] Identified unmet treatment needs include intensive outpatient services and residential care.[16]

Recovery

Identified needs for recovery support in Region 1 include housing and transitional supports, peer supports, mentoring, and peer groups.[1,16]

Workforce

There is an identified need for a greater number of qualified SUD professionals.[12] In Logan County, the number of behavioral health providers is extremely low compared to the population, and primary care physicians are being tasked with providing psychiatric care that exceeds their capacity, resulting in a lower quality of care.[18] One issue that may exacerbate the lack of qualified SUD professionals is the high turnover rate in the region.[1]

Continuum of Care

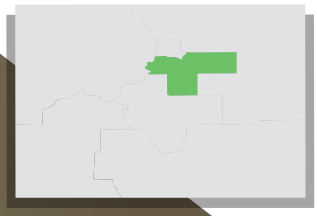
Connectedness across the continuum of SUD services was identified by many counties in Region 1 as a concern. For example, in Morgan County, the process of accessing SUD services was recognized as being disjointed and cumbersome, especially for those entering through an Emergency Department.[12] In Larimer, the lack of a continuum of care services was identified as the primary issue in SUD services.[16]

Cost

Hospitals in Weld and Larimer counties cite the high number of people using Emergency Departments as the primary access point for behavioral health care, including substance abuse, as indicative of the lack of access to affordable and/or covered SUD services.[17,19] The providers who are in the community primarily treat those who have insurance or can pay cash for their services, leaving those who cannot afford services with very limited options, including the Emergency department. [15]

Region 2
Denver Metro

Denver, Adams, Arapahoe, Broomfield, Douglas, Jefferson, Clear Creek, and Gilpin Counties



NEEDS/GAPS

- Workforce: Shortages of providers, training including Medication Assisted Therapy (MAT), certifications, access to telehealth and mobile services
- Increased training in trauma-informed care and adverse childhood experiences
- Case or care management, system navigation
- Prevention
- Support for community transitions including peer supports, family/community reconnection, and nutrition
- Better information and data sharing
- Continuum of housing options
- Transportation to and from treatment- and recovery-oriented programs, including for veterans
- Detox services/facilities with a medical component
- Intensive outpatient services
- Connecting and convening the different sectors to develop a system of care
- Treatment within the criminal justice system
- Residential treatment (short-, mid-, and long-term) and transitional residential services

PRIORITIES *for* FUNDING

- Continuum of housing options
- Workforce: Shortages of providers, training including Medication Assisted Therapy (MAT), certifications, access to telehealth and mobile services
- Residential treatment (short-, mid-, and long-term) and transitional residential services
- Better information and data sharing
- Detox services/facilities with a medical component
- Treatment within the criminal justice system
- Case or care management, system navigation

SUMMARY OF EXISTING REPORTS AND DATA: REGION 2

Projections of SUD service needs in Region 2 through 2025 are not significantly different than the state.[1] Substance abuse has been identified by county public health departments as a priority in Clear Creek,[10] and by hospitals serving Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Jefferson, and Weld counties.[17,20,21,22] Hospitals identified behavioral health and substance abuse as priorities due to substance-abuse related visits to the Emergency Department and admissions.[20,22,23,24] One hospital in Denver reported that, of substance-related visits, alcohol accounted for the most hospital admissions and Emergency Department visits, followed by marijuana, then cocaine and opioids, and finally amphetamines.[24]

Prevention

School- and family-based prevention services, including screenings, early intervention, and counseling, are needed. School-based services were identified as overtaxed, and in need of better integration with community and inpatient services.[1]

Intervention

No available information was identified in this area.

Treatment

Community members believe more substance abuse treatment services are needed.[17,25] A need for more residential and in-patient beds was identified, particularly for children, adolescents, and long-term patients.[1]

Recovery

Recovery supports were cited as a system gap in Region 2, including the need for better discharge, transitional, and follow-up services; additional family support services; and better case management.[1]

Continuum of Care

A need for a greater integration of primary care and behavioral health care was identified in Arapahoe, Broomfield, Douglas, and Jefferson counties. This integration was identified as a way to combat stigma associated with behavioral health issues such as substance abuse, to increase access to and completion of treatment, and improve the quality of treatment services.[22,23,26] More generally, increased coordination and communication between service components was identified as an area of need.[1]

Workforce

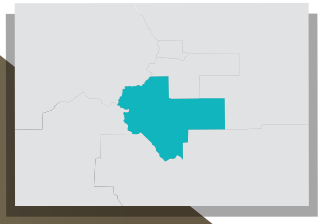
A greater number of behavioral health professionals, and substance abuse counselors in particular, was identified as a top need for Arapahoe, Adams, Douglas, Jefferson, Broomfield, and Denver counties.[1,21,23,26] One potential identified cause for the shortage of behavioral health professionals was lower insurance reimbursement for mental health care and substance use versus physical health care, which prohibits investment in behavioral health services.[22] Similarly, low funding and reimbursement for behavioral health services was identified as a major issue in Douglas county.[23]

Cost

Increasing access to affordable or no-cost SUD services was identified by the community as a primary action needed to address substance abuse.[1,25] Monetary barriers to access include coverage for those not on Medicaid and those without any insurance coverage.[1]

Region 3
Central Colorado

El Paso, Teller, Park, Lake, Chaffee, Fremont, and Custer Counties



NEEDS/GAPS

- Workforce: Access and capacity including telehealth/ mobile services, retention, more training with co-occurring behavioral health issues, and certifications vary by payer
- Affordability of treatment
- Residential treatment (short-, mid-, and long-term)
- Intensive outpatient services
- Case or care management
- Better data: Cost/benefit of treatment, and cultural needs
- Public education and awareness
- Barriers related to internal regulations
- Siloed funding and administration at state and local levels
- Continuum of housing options
- Supportive transportation
- Prevention including early intervention and in schools
- Loss of mental health court (El Paso County)
- Transitional supports, especially for those transitioning from the criminal justice system
- Increased training in trauma-informed care
- More flexibility and nimbleness in state and local funds to better meet community needs
- Effective mental health services
- Detox services/facilities with a medical component

PRIORITIES *for* FUNDING

- Residential treatment (short-, mid-, and long-term)
- Detox services/facilities with a medical component
- Continuum of housing options
- Intensive outpatient services
- Supportive transportation
- More flexibility and nimbleness in state and local funds to better meet community needs
- More affordable treatment options
- Workforce: Retention and increased access, potentially through telehealth and mobile services (Teller, Park, Lake, Chaffee, Fremont, and Custer Counties)

SUMMARY OF EXISTING REPORTS AND DATA: REGION 3

Projections of SUD service needs in Region 3 through 2025 are not significantly different than the state.[1] Substance abuse has been identified by county public health departments as a priority in Fremont, Lake, and Teller.[10] Substance use among high school students was identified as a particular concern by community members in El Paso. [27]

Prevention

There is a perceived need for more education, awareness, information about behavioral health, and resources to expand prevention services, especially for youth.[1,28] However, in Chaffee County there is concern that the prevention services that do exist are targeted primarily to adolescents and families, and more is needed for the general population.[29]

Intervention

There is a recognized need for more acute services, including crisis response, stabilization, and detox services in Region 3.[1]

Treatment

Concerns about treatment in Region 3 primarily focus on access to existing sources. In Park and Chaffee counties, there are people who need treatment but do not ever receive it, despite the fact that treatment facilities often do not have a waiting list. This highlights that while general treatment services are available, not all take insurance, and there are not enough affordable options.[29]

Recovery

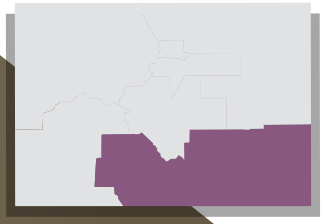
Identified recovery needs include sufficient follow-up, after-care, and transitional supports. Currently, there is inadequate transportation, supportive housing, and supports for reintegration after in-patient services.[1]

Continuum of Care

Previous needs assessments have called for a systematic approach to prevention, intervention, and treatment that improves integration and coordination of services along the continuum of care to impact substance use issues in the region.[28,29]

Region 4
Southeast Colorado

Pueblo, Crowley, Kiowa, Huerfano, Las Animas, Otero, Bent, Prowers, Baca, Saguache, Mineral, Rio Grande, Alamosa, Conejos, and Costilla Counties



NEEDS/GAPS

- Workforce: Access and capacity, certification requirements, retention, and training including Medication Assisted Therapy (MAT)
- Team-based care to address generational use
- Residential treatment (short-, mid-, and long-term)
- Transitional residential treatment
- Case or care management: Navigation and whole person care
- More flexibility and nimbleness in state and local funds to better meet community needs
- Better partnerships with law enforcement, including awareness of community resources
- Transitional services for those leaving the criminal justice system
- Continuum of housing options
- Supportive transportation
- Detox services/facilities with a medical component
- More coordination among state and local agencies related to funding, communication, and administration
- Lack of resources for those with co-occurring mental health and substance use disorders
- Prevention: Trauma-informed care, adverse childhood experiences, informed consumers, stigma, early intervention, addressing normalization of use
- Public education and awareness, personal motivation
- Intensive outpatient services, including sustainable rural options

PRIORITIES *for* FUNDING

- Residential treatment (short-, mid-, and long-term)
- Supportive transportation
- Transitional residential treatment
- Continuum of housing options
- Resources for those with co-occurring mental health and substance use disorders
- More flexibility and nimbleness in state and local funds to better meet community needs
- Detox services/facilities with a medical component
- Prevention
- Workforce: Access and capacity, certification requirements, retention, and training including Medication Assisted Therapy (MAT)

SUMMARY OF EXISTING REPORTS AND DATA: REGION 4

Currently, Region 4 has the highest penetration rates for substance use services (i.e., proportion of individuals who need a service and subsequently receive it). If service provision remains stable, the region will continue to have the highest penetration rates through 2025.[1] Substance abuse has been identified by county public health departments as a priority in Alamosa, Las Animas, and Huerfano counties[10] and by a hospital in Pueblo county.[30] In Pueblo County, mental health hospitalizations (often including co-morbid substance abuse) are double the state rate, and limited availability of and access to services is a concern.[1,30] Moreover, the opioid epidemic is particularly acute in this area of the state, with the southeast region leading the state on rates of opioid- and heroin-related poisoning deaths,[31] emergency department visits,[32] and treatment admissions.[33]

Prevention

Evidence suggests that there are insufficient prevention services in Region 4. A higher percentage of individuals reported seeking prevention resources in Region 4 (46 percent) than statewide (32 percent), and individuals in Region 4 were less likely to be successful in finding prevention services (68 percent) compared to the rest of the state (85 percent).[34] Action areas for many communities in the region fall under the umbrella of prevention, including reducing rates of use across many substances, and postponing age of initiation.[35]

Intervention

Acute services, including crisis stabilization and detox services, were identified as a key area of need by community members.[1]

Treatment

Treatment services for co-occurring mental health and substance use were identified as a particular area of need.[1]

Recovery

Identified areas of need for recovery included transportation, housing, and transitional and community integration supports.[1]

Continuum of Care

The need for greater integration of primary and behavioral health care was identified, with the possibility that such an integration may lead to decreased stigma for behavioral health care, and thus improved treatment.[30]

Cost

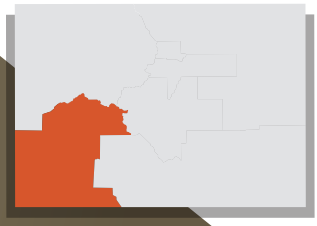
Better insurance reimbursement policies for behavioral health services are needed; low funding and low reimbursement rates for behavioral health services are considered major issues.[30]

Workforce

Substance use service agencies are understaffed, and there is a workforce shortage in Region 4 that highlights the need for more mental and behavioral health professionals.[1,30]

Region 5
Southwest Colorado

Archuleta, La Plata, Montezuma, Dolores, San Miguel, San Juan, Ouray, Hinsdale, Gunnison, Montrose, and Delta Counties



NEEDS/GAPS

- Workforce: Shortages of providers, high turnover rates, certification requirements, increased training in medication assistance, and access to telehealth and mobile services
- Increased training in evidence-based and trauma-informed care
- Case or care management, including to assist with transitions
- More flexibility in state and local funds to better meet community needs
- Creating sustainability in rural communities
- Continuum of housing options
- Transportation to and from treatment and recovery-oriented programs
- Residential treatment
- Intensive outpatient services
- Prevention, including early intervention
- Detox services/facilities with a medical component
- Addressing the festival culture
- Better access to care that reflects the culture of the region

PRIORITIES *for* FUNDING

- Creating sustainability in rural communities
- Detox services/facilities with a medical component
- Residential treatment
- Case or care management, including to assist with transitions
- Continuum of housing options
- Transportation to and from treatment and recovery-oriented programs
- Workforce: Shortages, increased training in medication assistance, and access to telehealth and mobile services
- More flexibility in state and local funds to better meet community needs

SUMMARY OF EXISTING REPORTS AND DATA: REGION 5

Currently, Region 5 has among the lowest penetration rates for substance use services; if service provision remains stable, the region will continue to have the lowest penetration rates through 2025 (along with Region 6).[1] Substance abuse has been identified by the West Central Public Health Partnership, which serves Delta, Gunnison, Montrose, Hinsdale, Ouray, and San Miguel counties,[10] and by hospitals in La Plata, Archuleta, and Montrose counties.[36,37] The high number of behavioral health patients served in Emergency Departments, and the high number of arrests/incarceration of individuals with substance abuse problems are concerns in the region.[36,38] Illicit drug use among adults is a particular concern.[38] In Montezuma and Dolores counties, mental health and substance use emerged as a top priority, but the County Health Departments determined that they had limited capacity to impact these issues.[39] Likewise, the West Central Partnership health department not only recognized that substance use is consistently identified as a top issue in their communities, but also indicated that there was limited ability to accurately assess substance use issues in the region, and therefore limited capacity to effectively target them.[38]

Prevention

Parent reports of youth substance use indicate a high level of need for youth prevention services.[34]

Intervention

There is a recognized need for acute intensive services, including crisis stabilization and detox centers.[1,38]

Treatment

The capacity for treatment services does not match the need in the Region.[1,38] Of particular concern is the need for inpatient facilities.[1] The region has the lowest reported success rate for finding treatment services; only 53 percent who sought services could successfully find them, compared to a 65 percent success rate statewide.[34]

Recovery

No available information was identified in this area.

Continuum of Care

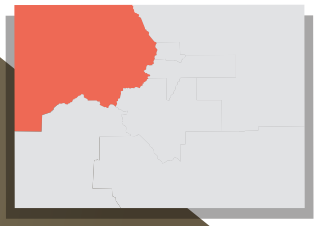
The lack of integration between physical and behavioral health care is a concern.[36]

Workforce

Workforce issues include not enough staff, high turnover rates, and the need for culturally and linguistically competent substance abuse providers.[1,38]

Region 6
Northwest Colorado

Mesa, Garfield, Rio Blanco, Moffatt, Routt, Eagle, Pitkin, Summit, Grand, and Jackson Counties



NEEDS/GAPS

- Workforce: Shortages, low salaries, and high turnover rates
- Increased training in trauma-informed care
- Case or care management
- Better information and data sharing
- More flexibility in state and local funds to better meet community needs
- Crisis service alternatives and stabilization
- Creating sustainability in rural communities
- Continuum of housing options
- Transportation to and from treatment and recovery-oriented programs
- Affordability of treatment
- Residential treatment
- Intensive outpatient services
- Prevention, including early intervention
- Detox services/facilities with a medical component
- Systems for high utilizers

PRIORITIES *for* FUNDING

- Workforce: Shortages, low salaries, and high turnover rates
- Detox services/facilities with a medical component
- Crisis service alternatives and stabilization
- Residential treatment
- More affordable treatment
- Better information and data sharing
- Intensive outpatient services
- Systems for high utilizers

SUMMARY OF EXISTING REPORTS AND DATA: REGION 6

Currently, Region 6 has among the lowest penetration rates for substance use services; if service provision remains stable, the region will continue to have the lowest penetration rates through 2025 (along with Region 5).[1] Substance abuse has been identified by county public health departments as a priority in Eagle, Grand, Pitkin, Routt, Mesa, Moffat, and Summit counties, [10,40,41] and by hospitals in Garfield and Summit counties.[42,43]

Prevention

No available information was identified in this area.

Intervention

There is a recognized need for acute intensive services, including crisis stabilization and detox centers.[1]

Treatment

Greater availability of local treatment services, and in particular inpatient substance abuse treatment, is a recognized need.[1,44]

Recovery

Not all towns have supportive recovery programs, such as Wayfinder, Alcoholics Anonymous, Narcotics Anonymous, and Al-Anon.[44]

Continuum of Care

There is need for greater integration between physical and behavioral health care.[43]

Workforce

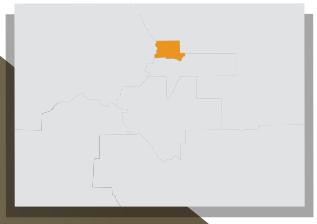
Workforce issues include the need for more mental and behavioral health professionals, and high turnover rates among the workforce.[1,43] The need for an increased number of substance abuse counselors was identified as a top need in Garfield county in particular.[42] There is also an identified need for more Spanish-speaking providers.[43]

Cost

Low funding and low reimbursement rates for behavioral health services are considered major issues,[43] along with lack of access to affordable options for SUD services in the region. For example, although there are several counseling centers and multiple private practice counselors who provide outpatient therapy related to substance abuse and addiction in Eagle County, very few of them accept Medicare, Medicaid, have a sliding-scale fee structure, or provide charity care.[44] Treatment in Summit County is identified as being expensive, in part because many are underinsured.[45] In Grand County, there are a limited number of affordable substance abuse counseling services available.[46]

Region 7
Boulder

Boulder County



NEEDS/GAPS

- Workforce: Shortage of providers, training in medication assistance, and certification requirements
- Treatment within the criminal justice system
- Transitional programs and services, including people leaving criminal justice system
- Focus on harm reduction
- Case or care management, system navigation
- Prevention: SBIRT, stigma, early intervention, and screening
- Detox services/facilities with a medical component
- Better information and data sharing
- Continuum of residential treatment (short-, mid-, and long- term) and transitional residential services
- More flexibility and nimbleness in state and local funds to better meet community needs
- Continuum of housing options
- Transportation to and from treatment and recovery-oriented programs
- Workforce development programs
- Crisis stabilization services available 24/7
- Public education, communication, partnerships (including faith community) to increase awareness of resources available
- Agency alignment of funding, administration, and rules

PRIORITIES *for* FUNDING

- Detox services/facilities with a medical component
- More flexibility and nimbleness in state and local funds to better meet community needs
- Prevention
- Transitional programs and services, including people leaving criminal justice system
- Public education, communication, and partnerships (including faith community) to increase awareness of resources available
- Better information and data sharing
- Continuum of housing options
- Focus on harm reduction

SUMMARY OF EXISTING REPORTS AND DATA: REGION 7

Projections of SUD service needs in Region 7 through 2025 are not significantly different than the state.[1] Substance abuse has been identified by the county public health department and hospitals in Boulder county as a priority.[10,21,47] In Longmont, the emergency room often serves as the primary access point for behavioral health issues. In addition, substance abuse is the leading cause of inpatient admission in the Emergency Department for patients ages 35-49, and alcohol/substance abuse is the second highest diagnosis for patients ages 35-49 (25 percent) and ages 50-64 (19 percent).[19] The need for expanded, improved, accessible, and timely SUD services is recognized.[25,47]

Prevention

Prevention was identified as a key priority for tackling SUD issues in Region 7. Areas of concern include reducing substance use, improving early detection and health promotion by reducing the stigma of SUD/behavioral health issues, increasing counseling and prevention programs in schools, teaching coping and stress reduction skills during childhood, and increasing housing support programs to decrease homelessness.[47,48]

Intervention

No available information was identified in this area.

Treatment

There is a recognized need for additional inpatient services.[47]

Recovery

No available information was identified in this area.

Continuum of Care

There are identified challenges in Region 7 with core coordination of SUD services. Issues that have been identified include high incarceration rates when SUD treatment is more appropriate, challenges in capacity for first responders to assess for SUD issues and make appropriate referrals, and lack of systematic process to connect those with acute issues to appropriate services. A lack of integration of SUD services with primary care has also been identified as an area of concern.[47]

Workforce

Workforce concerns include a lack of doctors, substance abuse counselors, and other providers to meet need for treatment.[21,47] There is also a shortage of specialized providers in the region.[47]

Cost

The costs of SUD services in Region 7 are seen as high, and there is a need for more affordable options when insurance coverage is insufficient.[47]

STAKEHOLDER PERSPECTIVES: POPULATION-SPECIFIC FEEDBACK

Population-Specific Feedback

The legislation also directed the MSOs to assess needs for five specific populations:

- Adolescents (ages 17 and younger)
- Young adults (ages 18-25)
- Pregnant women
- Women who are postpartum and parenting
- Other adults in need of SUD services

In the stakeholder interviews, community meetings, and final stakeholder surveys, Keystone asked about needs and gaps related to these specific populations. While stakeholders in all regions agreed that some of the populations needed targeting — and that there can be unique needs and gaps associated with these populations — they expressed frustration that funding is often targeted to certain populations. For instance, stakeholders rarely expressed concern about gaps for pregnant women, because they are often a target population for community health efforts; in contrast, it can be hard to access funding for adult men because they do not fit within a target population, though their SUD service needs may be great. Stakeholders emphasized that when it comes to substance use services, every population is underserved.

Stakeholders acknowledged that targeted funding and programming is essential, and the efficacy of such approaches is well-documented. In the example given, trauma-informed care and specialized services to pregnant women are justified in receiving targeted support. They wanted to recognize that other populations should not be left out.

Stakeholders in all regions strongly encouraged the MSOs to avoid tying funding to specific populations or restricting the scope of funding as that limits a community's ability to target its resources in the way that is right for their community. To the extent possible, stakeholders asked that funding remain flexible at the community level.

Still, stakeholders did identify needs and gaps specific to populations, and identified populations within or in addition to those specified in the legislation that should be carefully considered as MSOs determine how to use their funds. Below, Keystone has summarized the population-related feedback statewide, with outlying regional perspectives identified.

Adolescents

Stakeholders identified several specific gaps and needs for adolescent SUD services:

- ***Prevention, education, and early intervention, especially in schools:*** Stakeholders in every region discussed the importance of prevention, education, and early intervention for adolescents. They particularly called for more resources in schools, including School-Based Health Centers, case managers, school/provider linkages, and mental health teams in school districts. Stakeholders also discussed the importance of identifying high-risk youth, such as individuals in the child welfare system, the children of parents with SUDs, individuals with a history of juvenile delinquency, victims of human trafficking, adolescents who have dropped out of high school, and pregnant teens. For effective prevention, stakeholders called for better social supports and access to extracurricular activities, especially for low-income populations and in rural areas. They also discussed the importance of education to counter the normalization of substance abuse and ease of access to substances.

STAKEHOLDER PERSPECTIVES: POPULATION-SPECIFIC FEEDBACK

- ***Access to a comprehensive system of care, with programs that are geared towards (or at least accept) adolescents:*** Statewide, stakeholders called for access to treatment options across the continuum so that adolescents have access to the specific care they need. This includes access to detox; a range of inpatient treatment options; outpatient treatment; residential care; longer-term sober living and supportive housing; and in-home providers for multi-generational substance use. Stakeholders also emphasized the importance of supportive services like transportation, housing, mentoring, positive peer support, and family education and support.
- ***Coordination with the criminal justice system:*** Stakeholders called for better coordination between substance abuse treatment and the criminal justice system, noting that many services are only available for youth who have been in the criminal justice system, and adolescents should not have to move deeper into the system than warranted (by their risk level) to receive treatment.

Stakeholders also identified priority groups within the adolescent population:

- ***Adolescents with co-occurring disorders:*** In Region 3, stakeholders called for mobile mental health services for all counties, detox that accounts for co-occurring disorders, and substance abuse-informed psychiatric care. Stakeholders in Region 4 cited the importance of prevention and support for the children of addicts, who are likely to have multiple mental health diagnoses from enduring multi-level trauma, including exposure to drug use, domestic violence, and sexual abuse within the home. Regions 1 and 6 also identified adolescents with co-occurring disorders as a priority population.
- ***LGBTQ adolescents:*** Regions 1 and 3 called for more services for LGBTQ youth, who typically have higher rates of both substance use and mental illness and need targeted and inclusive services.

Young Adults

Stakeholders did not focus on young adults in most of the interviews and statewide meetings, but in survey responses, they were clear that the young adult population — as with all populations — is underserved and could use more funding, especially for young adults with co-occurring disorders. More services are available to the young adult population than other populations, but services are still lacking across the continuum of care, including additional supportive services such as better education, employment, housing, and peer support. Stakeholders in Region 1 noted that Colorado State University offers a comprehensive and evidence-based treatment program for students in this demographic.

Pregnant Women and Women Who Are Postpartum and Parenting

Statewide, stakeholders observed that because pregnant, postpartum, and parenting women are a target population, they receive more money and services than other populations. Still, they noted that this population — as with all populations — is underserved. In particular, stakeholders called for better screening and treatment for perinatal depression and other mental health issues. They also said the stigma and guilt surrounding pregnant women or mothers with SUD can lead to fear of seeking treatment. In Region 5, stakeholders called for more transitional housing for pregnant and parenting women. Additionally, stakeholders mentioned the importance of the provision of child care during treatment times.

STAKEHOLDER PERSPECTIVES: POPULATION-SPECIFIC FEEDBACK

Other Adults in Need of Substance Use Disorder Services

Stakeholders identified many additional populations in need of SUD services:

- ***Individuals with Co-Occurring Disorders:*** Stakeholders emphasized the importance of treating individuals with co-occurring mental illness, from mild to moderate depression to more acute diagnoses. Many stakeholders were frustrated that patients with co-occurring disorders are denied mental health treatment if they are using drugs or alcohol but cannot stop using until an underlying mental illness is addressed, leaving them with no options for treatment.
- ***Individuals with Comorbidity or Other Diagnoses:*** Stakeholders also called for special care to be taken for patients with chronic pain, developmental or intellectual disabilities, and HIV.
- ***Seniors:*** Stakeholders in Regions 1 through 6 said that older adults (65 and older) are underserved and have unique challenges to consider, including isolation, stigma, access challenges, and comorbidity (especially with conditions like mental illness, reduced motor and memory function, Alzheimer's, and dementia) that make it harder for older adults to get treatment. The workforce, especially in assisted living facilities and nursing homes, needs to be better trained to work with this population.
- ***Uninsured or underinsured populations:*** Across the state, stakeholders bemoaned the lack of services for the uninsured or underinsured working poor and middle class who do not qualify for assistance but cannot afford insurance or the co-pays and deductibles required by their insurance. Stakeholders also observed that with capitated services, low-income adults may lose benefits before developing the resources for long-term sobriety. In Region 6, stakeholders expressed concern that certain service providers, like home health agencies, may discharge clients with SUDs because of safety concerns.
- ***Homeless population:*** Stakeholders called for more services for the homeless and transient population, especially homeless individuals dealing with co-occurring disorders. They encouraged shelters to be better equipped with medications like Suboxone and Narcan, as well as recovery supports. Stakeholders in Region 7 supported a Housing First model for treatment, focusing on providing homeless individuals with housing and then addressing their SUD needs.
- ***Veterans and Active Military:*** Stakeholders in Regions 2, 3, 4, 5, and 7 said that the veteran and active military populations are underserved, especially when it comes to co-occurring mental health disorders. They called for trauma-informed care that recognizes veterans' brain trauma and post-traumatic stress disorder may drive substance use. These stakeholders noted that while the Department of Veterans Affairs makes some substance use treatments available to veterans, patients may not be able to access the full continuum of care or may be resistant to seeking services within the Department. Stakeholders called for better education of veterans on the options available to them, along with more flexibility so that veterans can take advantage of community services.
- ***Incarcerated or criminal justice-involved population*:** Stakeholders in Regions 1 through 6 emphasized the importance of offering SUD services in jails and prisons, including medication-assisted treatment, especially for inmates with co-occurring disorders. Stakeholders also called for services in the transition out of jail or prison; rates of relapse are high among recently released inmates, and

patients need ongoing care and supportive services that may not be available or covered due to lapses between when they are released from jail or prison and when they are eligible for Medicaid. Additionally, stakeholders in Regions 2, 3, and 6 noted challenges for patients with criminal records, especially sex offenders, who may not be allowed in many treatment programs or SUD-providing housing facilities.

- ***Non-English speaking, immigrant, and refugee populations***: Regions 1 through 6 called for improved services for these populations, including more bilingual and bicultural providers and services, as well as funding and training for cultural competency.
- ***Minorities***: Stakeholders in Regions 2, 3, 5, and 6 said that minority populations, including ethnic and racial minorities and the LGBTQ population, are underserved. In Regions 2 and 5, stakeholders called for culturally specific treatment, including peer support and traditional healing methods for tribal populations.
- ***Families***: Across the state, stakeholders called for better access to services for families as a unit, such as supportive housing that allows children; treatment that addresses multi-generational use; social supports like affordable preschool and childcare; resources and social supports for family members who may be caring for children whose parents have SUD; and education, support, and services for families when an individual with SUD is reintegrating into their community.
- ***Individuals with a history of trauma:*** Stakeholders in Regions 1 and 5 called for improved trauma-informed care for victims of domestic violence (especially women) and others.
- ***Adult women:*** Stakeholders in Regions 1, 2, 4, and 6 noted that single adult women are not usually a target population and thus lack gender-specific services for addiction or mental health. Stakeholders called for more sober housing and vocational training for women (including single mothers).
- ***Adult men:*** In Regions 1, 2, and 7, stakeholders observed that adult men are not usually a target population and thus may have trouble accessing treatment and support services. In Region 1, stakeholders expressed concern for the adult male population at risk for suicide and blue collar men working in construction, oil, and mining.
- ***Tourists:*** Stakeholders in Region 5 cited challenges related to tourists and festival culture that may not share the community's values and may be focused on using substances as part of their tourist experience, not considering or caring about the impact on the community. They encouraged a tourist education program.

Effective Community Strategies

Keystone interviewed stakeholders about the SUD services that are working well both within the state and across the country. Using feedback from those interviews, as well as comments from the statewide meetings and email surveys, Keystone identified the following programs and practices that stakeholders believe are working well to address SUD.

Coordination across agencies and organizations providing SUD services: Across the state, stakeholders expressed the need for coordination of care in all forms, including fully integrated care models; collaboration among state agencies that address substance use; warm referrals between providers; and coordinated transitions among facilities and levels of treatment. In cases where care is not systematically coordinated,

stakeholders identified value in care coordinators or navigators, a role that can be served by a peer or a medical professional. They cited several specific examples, including: West Pines Behavioral Health, which offers a continuum of services including psychiatric services, therapy, family involvement, exercise, medication management, and peer support (Region 2); Douglas County's multi-faceted crisis stabilization teams (Region 3); Summit County's early intervention case managers (Region 6); Cherokee Health Systems' integrated care model (Tennessee); and Medicaid's Health Homes (Section 2703), which provides a comprehensive system of care coordination for individuals with chronic conditions

Partnerships with law enforcement and judicial system: Stakeholders in regions with drug courts, problem-solving courts, and/or DUI courts said these courts are valuable, as are partnerships with law enforcement. Mental Health Partners' (Region 7) Project EDGE, for instance, offers an alternative to incarceration for individuals with behavioral health conditions, an evidence-based program that works with police officers to provide crisis support and links to supportive services.

Evidence-based care: Stakeholders encouraged the use of a wide range of evidence-based treatment options, including medication-assisted treatment (especially for detox) and harm-reduction models. For example, Colorado Coalition for the Homeless' Stout Street Health Center has a culturally competent staff trained to offer Suboxone when needed. Seattle's Law Enforcement Assisted Diversion (LEAD) program uses a harm reduction model to offer community-based treatment and support services for individuals engaged in low-level drug crimes.

Hot-spotting: Stakeholders in Regions 2, 3, and 6 found hot-spotting to be a useful tool for identifying and treating frequent utilizers. In Region 6, a pilot program funding a full-time case manager to identify and follow up with frequent utilizers resulted in a 45 percent engagement rate for treatment.

Peer support: Stakeholders encouraged better use of peer support, including the use of peer specialists to encourage follow-up and assist with navigation of care options.

Family involvement in care: Stakeholders pointed to Shields for Families in California and the Recovery Village in Florida as excellent examples of comprehensive care that involve the patient's family in treatment. Boulder (Region 7) has also seen success with a program called Genesister, which works with the siblings of pregnant youth to prevent teen pregnancy, which could be adapted to focus on the siblings of individuals with SUD.

Community involvement in care: Stakeholders in Region 3, 5, and 7 found value in community involvement in education, early intervention, and treatment. In July 2016, El Paso County (Region 3) directed grant funding to using the Communities That Care model, which mobilizes a community to identify prevention priorities, and choose and implement effective programs, policies, and strategies to address those concerns. A recent study showed that youth in these communities were up to one-third less likely to have health and behavior problems than youth in communities without these services.

Telehealth or mobile services: Rural communities face challenges in accessing substance abuse treatment services given workforce shortages. Some promising advancements in the delivery of rural health care services have been made in technology. Telehealth has been found to be a cost-effective delivery method for prevention, early diagnosis, treatment, and care coordination. These applications have the potential to reduce the disparities in the delivery of SUD services in rural and frontier communities as well as for under-

served communities, individuals with mobility issues, and in the provision of specialty care that is not widely available.

National organization resources and guidance: Several stakeholders commended best practices and resources available through the Substance Abuse and Mental Health Services Administration. Stakeholders also pointed to the Centers for Disease Control and Prevention, National Association of County and City Health Officials, and the National Institute on Drug Abuse.

CONCLUSION

It is time to change how Colorado addresses SUDs. The benefits of substance abuse treatment are well established. Numerous studies have demonstrated the positive effect of prevention, intervention, treatment, and recovery support services on reducing substance use and improving health status and social functioning. Yet most Colorado's SUD dollars are spent on acute services (ED visits, etc.) rather than on evidence-based practice.

SUD treatment is not a one-size-fits-all service or one that remains static over time for a participant. This speaks to the importance of integrating, and funding a continuum care for SUD in Colorado communities. This separation of SUD treatment from the rest of health care — both primary care and mental health care — has created challenges and barriers for those seeking care.

These identified priorities in the seven MSO regions will become the basis for action plans to address local needs in a sustainable and flexible way. Additionally, it should drive new funding allocations and inform the mechanisms by which funding should be provided. Every dollar spent on appropriate SUD treatment saves $4 in medical costs and $7 in criminal justice.[49]

At the same time, it will be important for the state to continue to provide leadership, guidance, and vision on improving the health of Coloradans by improving public education and awareness of SUDs; providing incentives, funding, and assistance to promote implementation of effective prevention, treatment, and recovery practices, policies, and programs; addressing legislative and reducing regulatory barriers; and improving coordination between health care, human services, and criminal justice agencies and organizations.

The priorities and scope of this report are intended to help support the goals and vision of the State, its partnership with its community stakeholders and providers, towards the vision of healthier Colorado.

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APPENDIX A: METHODOLOGY

Data were gathered from primary and secondary sources. The methodology for each approach is outlined below.

Primary Data Gathering

Keystone gathered qualitative input from stakeholders for this SUD report through key informant interviews, statewide meetings and an email survey. The stakeholders solicited for input included, but were not limited to, representatives from community mental health providers, SUD treatment providers, primary care providers, hospital representatives, health and human services, public health, state agencies, law enforcement, probation, problem-solving courts, first responders, veteran-serving organizations, homeless population-serving organizations, non-profits, school/education representatives, and elected officials. Keystone used the feedback from the interviews to frame the statewide meetings and used the feedback from the interviews and meetings to inform the survey, but always provided space for stakeholders to offer their thoughts on needs, gaps, and priorities not previously identified.

Key Informant Interviews

Keystone performed 40 interviews with key stakeholders from each MSO region, as identified by MSO representatives from that region. Keystone conducted the 30-minute interviews by phone and used the following template to guide the discussion:

What is your perception of substance use disorder services and resources (for prevention, intervention, and/or treatment) provided in your region?

a. What are the gaps/biggest needs in your region?

b. What programs/resources have been working well to address substance use issues?

c. What programs/resources could use improvement? What kind of improvement is needed?

What resources/ services do you have available to provide substance abuse services in your region for the following populations called out in Senate Bill 16-202, and where are the gaps?

a. Adolescents (ages 17 and younger)

b. Young adults (ages 18-25)

c. Pregnant women

d. Women who are postpartum and parenting

e. Other adults in need of substance use disorder services

In your opinion, what are the biggest needs/ priorities to you in your role? With an increase in funding, where would you direct resources (prevention/intervention/treatment or specific programs/ existing efforts or specific population)?

APPENDIX A: METHODOLOGY

What do you believe are the underlying causes for substance abuse in your areas?

Are there other Substance Use Disorder programs that you turn to for examples of best practices?

Is there anything else you would like to include to ensure we consider for this assessment?

Statewide Meetings

Over a two-week period, Keystone held meetings throughout Colorado in each of the MSO regions, with multiple meetings in some of the regions, to solicit additional feedback from representatives from various fields that deal with substance abuse. During the meetings, attendees participated in round table discussions on the most pressing needs in their region related to substance use disorder treatment, including what areas needed the most improvement, where there were gaps in providing services, and what programs that are working well. Keystone also asked participants about areas of need for specific populations affected by substance abuse. At the end of each meeting, Keystone polled participants on the priority needs and gaps for their region, as well as priorities for specific populations.

Approximately 250 stakeholders attended the 10 meetings; attendance per meeting is indicated in parentheses:

Region 1: Fort Collins (18) and Sterling (9)

Region 2: Denver (32)

Region 3: Colorado Springs (27) and Woodland Park (16)

Region 4: Pueblo (22) and La Junta (19)

Region 5: Durango (34) and Montrose (14)

Region 6: Grand Junction (24)

Region 7: Boulder (36)

Email Survey

Finally, additional stakeholders were asked to provide feedback through an email survey. Keystone tailored the surveys to each MSO region based on the needs and gaps that were identified in each region through the key informant interviews and statewide meetings. Respondents identified what they believed were the biggest needs and gaps related to SUD treatment in their region, ranked their top priorities towards which to direct resources with an increase in funding, and identified populations with the biggest needs for substance abuse treatment.

Over 500 stakeholders participated in the survey; respondents per region are indicated below:

Region 1: 36

Region 2: 101

Region 3: 93

Region 4: 153

Region 5: 28

Region 6: 96

Region 7: 18

Secondary Data Gathering

Additionally, existing sources of information regarding the needs and priorities for SUD services in Colorado were reviewed and synthesized. A search for relevant reports and databases was conducted, and 74 relevant sources were identified. Many of these sources included documentation from previous stakeholder feedback, gathered at other times prior to the beginning of SB202's community assessment. Coupling empirical data sources with previously acquired stakeholder feedback ensured a level of continuity of previous efforts.

After review, 44 sources contributed to the report. Identified resources included Community Health Needs Assessments conducted by public health departments and non-profit hospitals in Colorado, needs assessments conducted by other non-profit organizations, reports funded through or conducted by state agencies (e.g., Office of Behavioral Health, Colorado Department of Public Health and Environment), statistics collected through survey efforts (e.g., National Survey on Drug Use and Health), and a database of SUD services maintained by the Colorado Department of Human Services (www.linkingcare.org). High-level themes regarding prevalence, identified areas of need, and key populations were extracted from these sources and compiled. Statewide and regional findings are reported; county-level information was compiled into MSO regions. In cases where references included information that could not be distinguished between counties in two (or more) regions, the information was captured in all relevant regional breakdowns (e.g., information from a community health needs assessment for a hospital that serves Boulder and Broomfield counties, and did not distinguish between them, was reported in the sections for Region 2 and Region 7).

APPENDIX B: ADDITIONAL INFORMATION/ RESEARCH ON BEST PRACTICE

Additional Needs Assessment Information

Purpose

In addition to the collection of primary data from stakeholders throughout the state, a review and synthesis of prior reports and available data was conducted to further inform understanding of regional and state-level substance use disorder (SUD) priorities and needs. Key, high-level themes extracted from this secondary review are integrated throughout the primary report, particularly under the Summary of Existing Reports and Data sections provided for each region. This appendix provides a more detailed summary of the state- and regional-level findings based on the secondary review.

Method

A search for relevant reports and databases regarding the needs and priorities for SUD services in Colorado was conducted, and 74 potential sources were identified. Many of these sources included documentation from previous stakeholder feedback, gathered at other times prior to the beginning of SB202's community assessment.

High-level themes regarding prevalence, identified areas of need, and key populations were extracted from identified sources and compiled. Statewide and regional findings are reported; county-level information is compiled into Managed Service Organization (MSO) regions. In cases where references included information that could not be distinguished between counties in two (or more) regions, the information was captured in all relevant regional breakdowns (e.g., information from a community health needs assessment for a medical center that serves Boulder and Broomfield Counties, and did not distinguish between them, was reported in the sections for both Region 2 and Region 7).

A total of 46 sources were deemed to contain relevant data or information, and were included in the review. These sources span the timeframe of 2009-2017; in all cases, the most recently available data or report was used, and the majority (56%) of sources reflected information gathered or published in 2015 or later. Identified sources included: Community Health Needs Assessments conducted by public health department[i]; needs assessments conducted by other non-profit organizations, including medical centers[ii]; reports funded through or conducted by state agencies (e.g., Office of Behavioral Health, Colorado Department of Public Health and Environment); statistics collected through survey efforts (e.g., National Survey on Drug Use and Health); and a database of SUD services maintained by the Colorado Department of Human Services (www.linkingcare.org).

Some sources are heavily cited, reflecting the high relevance, comprehensiveness, and quality of the information covered. In particular, we frequently reference the study and resulting report commissioned by the Office of Behavioral Health and led by the Western Interstate Commission for Higher Education (WICHE) (entitled *Needs Analysis: Current Status, Strategic Positioning, and Future Planning*).[1] The WICHE study utilized multiple methods, data sources, and analytic approaches to assess the state's behavioral health needs, and should be considered a primary source for those seeking to understand the

[i] Public health departments are mandated by the Colorado's Public Health Act (adopted in 2008) to conduct Community Health Needs Assessments every 5 years. In cases where we could not locate the original Community Health Needs Assessment, the resulting Community Health Improvement Plan was used as the source.

[ii] Non-profit medical centers must conduct needs assessments every 3 years to maintain their 501(c)3 status per the Patient Protection and Affordable Care Act (ACA).

current and future picture of SUD service priorities at both state and regional levels. In particular, we report on the results of the projection of substance use disorder needs for Colorado through 2025, and a survey of stakeholder perceptions of the availability and adequacy of behavioral health services, barriers to receiving services, and behavioral health service gaps; these are just two components of them much larger study. In reporting regional findings, the WICHE study utilized Regional Care Collaborative Organization (RCCO) regions. Therefore, in reporting results from the WICHE study, we translated RCCO regions into MSO regions; while there is substantial overlap, there are also some key differences: MSO Region 1 corresponds to RCCO Region 2, except for Larimer and Elbert Counties, which are included in MSO Region 1 but not RCCO Region 2; MSO Region 3 corresponds to RCCO Region 7, except for Lake, Chaffee, Fremont, and Custer Counties, which are included in MSO Region 3 but not RCCO Region 7. As such, results from the WICHE report should not be considered valid for Larimer, Elbert, Lake, Chaffee, Fremont, and Custer counties.

SUMMARY OF EXISTING REPORTS AND DATA: STATEWIDE

As stated at the outset of the primary report, substance abuse is a key public health priority in the state of Colorado, and has been identified as one of Colorado's *10 Winnable Battles*. Below, we summarize key substance use trends occurring at the state, as well as identified areas of need.

Trend Statistics

Per data collected via the Vital Statistics Program at the Colorado Department of Public Health and Environment (CDPHE), there were 904 drug-induced deaths and 847 alcohol-induced deaths in Colorado in 2015.[2] These data indicate that drug- related deaths were most common among those aged 25-44 and 45-64, while alcohol-related deaths were most common among those aged 45-64. Additionally, both drug- and alcohol related deaths were most common among individuals of White Hispanic and American Indian/Native Alaskan descent, and those living in areas of high poverty (defined as census tracts where 30% or more of the residents are at or below the federal poverty level).

The National Survey of Drug Use and Health (NSDUH), sponsored by SAMHSA, is an annual survey effort that provides data on substance use trends at the state and national level. Analyses of data from 2010 to 2014 provide an understanding of rates of use and treatment in Colorado and the nation.[3] In 2013-14, of those aged 12 or older, approximately 329,000 individuals (7.5%) were dependent on or abused alcohol, and about 128,000 individuals (2.9%) were dependent on or abused illicit drugs within the year prior to being surveyed. These rates were not significantly different than nation-wide rates of dependence and abuse. However, in that same time, Colorado's past-month illicit drug[iii] use among adolescents aged 12-17 was higher than the national average by 5.5%; approximately 60,000 adolescents reported using illicit drugs in the past month, a number that has remained stable since 2010.

A recent report produced by the Retail Marijuana Public Health Advisory Committee examined trends in marijuana use specifically since legalization in 2015.[4] Compiling trends across five sources of data, including the Behavioral Risk Factor Surveillance System, the Child Health Survey, the Healthy Kids Colorado Survey, NSDUH, and the Pregnancy Risk Assessment Monitoring System, the report concluded that marijuana use among adults and adolescents has not increased since legalization.

[iii] In these findings, illicit drug use included marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or prescription-type drugs used nonmedically. Items regarding methamphetamines were not included until 2005 and 2006, so were not included in WICHE's analysis to facilitate longitudinal comparisons prior to 2005.

Treatment

Analyses conducted as part of the Behavioral Health Barometer 2014 study indicate that the number of individuals seeking substance use disorder treatment appears to be on the rise in Colorado.[5] Based on single-day counts of treatment, enrollment in substance use treatment in Colorado increased 6.3% from 2009 to 2013; of the 42,256 enrolled during the 2013 single day count, 21.9% were in treatment for drug use only, 38.4% were in treatment for alcohol use only, and 39.7% were in treatment for both drug and alcohol use. Medication-assisted treatment in particular appears to be on the rise in Colorado. Individuals enrolled in opioid treatment programs receiving methadone increased 5.6%, from 1,324 in 2009 to 2,068 in 2013. Buprenorphine-supported treatment is less frequent, but it has grown substantially; individuals enrolled in substance use treatment receiving buprenorphine has increased 300%, from 94 in 2009 to 379 in 2013.

Though the number of people receiving treatment[iv] has been increasing in recent years, the data suggest that most individuals with a substance use disorder do not receive treatment.[3] Of those aged 12 or older with alcohol dependence or abuse, about 40,000 individuals (10.9%) per year from 2010 to 2014 received treatment for their alcohol use within the year prior to being surveyed. Of those aged 12 or older with illicit drug dependence or abuse, about 19,000 individuals (15.7%) per year from 2010 to 2014 received treatment for their illicit drug use within the year prior to being surveyed. These rates are not significantly different from the national average during the same time period.

SUD Services

Assessments of availability and need underscore a shortage of SUD services across the spectrum.[6] Consumers in Colorado seeking SUD services can access LinkingCare.org, the directory for OBH licensed providers that allows consumers to search for some services on the SUD continuum, including: (1) emergency/medical detox providers; (2) residential treatment providers; (3) outpatient service providers; and (4) methadone clinic providers.[7] Of these four service provider types, those locally (i.e., within-county) available that consumers can find through LinkingCare.org differ considerably from one region to another. For example, there are:

- Six counties with none of these four service provider types available (Region 2: Gilpin; Region 4: Kiowa, Mineral, Dolores; Region 5: Hinsdale, San Juan);
- 12 counties with all of these four service provider types available (Region 1: Larimer; Region 2: Adams, Arapahoe, Denver, Jefferson; Region 3: El Paso, Fremont; Region 4: Alamosa, Pueblo, La Plata; Region 6: Mesa; Region 7: Boulder); and,
- 15 counties with only outpatient service provider types (i.e., no emergency medical/detox providers, residential treatment providers, or methadone clinic providers; Region 2: Broomfield; Region 3: Lake, Park, Teller; Region 5: Archuleta, Delta, Gunnison, Montezuma, Ouray, San Miguel; Region 6: Eagle, Grand, Jackson, Moffat, Rio Blanco).

Penetration Rates

Ten-year projections of relative need for substance use services were conducted for the state and each region in WICHE's comprehensive study.[1] A penetration rate is the proportion of individuals who need a service and subsequently receive it; therefore, high penetration rates correspond to low levels of unmet need, and low penetration rates correspond to high levels of unmet need. For the projections for OBH

[iv] Treatment is broadly defined in this case to include services intended to reduce or stop substance use or for medical problems associated with substance use; it also includes inpatient and outpatient services received at any location, such as a hospital, rehabilitation facility, mental health center, emergency room, private doctor's office, self-help group, or prison/jail.

services, WICHE paired the 2015 OBH penetration rates with county population forecast data through 2025, providing a picture of what the need would be if OBH services available remained stable, while the population increased as expected.

Results from these projections indicate that there would be an 11% increase in unmet need for child and adolescent substance use services statewide, resulting in a 2025 penetration rate of 5%. Likewise, there would be a 59% increase in unmet need for adult substance use services statewide, resulting in a 2025 penetration rate of 17%. Regionally, projections for population growth vary widely, resulting in varying degrees of change in unmet need at the local level; however, this change is not substantial enough to overcome the existing 2015 disparities in penetration rates. Therefore, WICHE concluded that those regions with the lowest penetration rates in 2015 will continue to have the lowest penetration rates in 2025 (Regions 5 and 6 for both child and adolescent and adult substance use services).

Projections for select demographics were also conducted by WICHE.[1] With respect to age, the fastest-growing age group in Colorado through 2025 is older adults; however, given that the prevalence of substance use disorder is lower among the older population, this population growth is not expected to outpace the projected need among young adults, where prevalence of substance use disorder is higher. With respect to ethnic/racial group, the Hispanic population is growing the fastest in Colorado; combined with high rates of substance use disorder, the WICHE report concludes there will be a significant increase in the need for culturally indicated services for this population.

Continuum of Care

Community health needs assessments conducted by Centura Health for medical centers serving communities across the state (including Region 1: Weld County;[8] Region 2: Jefferson, Clear Creek Arapahoe, Broomfield, Douglas, and Jefferson Counties;[9,10,11,12] Region 4: Pueblo County;[13] Region 5: La Plata and Archuleta Counties;[14] Region 6: Summit County;[15] Region 7: Boulder County[8]) cites the lack of integration of primary care and behavioral healthcare as a need in these communities and across the state. Care integration was identified in these sources to combat stigma associated with behavioral health issues such as substance abuse, to increase access to and completion of treatment, and improve the quality of treatment services.

Workforce

Community health needs assessments conducted by Centura Health also identified workforce shortages as a concern. One potential cause for the shortage of behavioral health professionals identified by these medical centers was lower insurance reimbursement for behavioral health care use versus physical health care, which prohibits investment in behavioral health services.[8,9,10,11,12,13,14,15]

SUMMARY OF EXISTING REPORTS AND DATA: REGION 1

Substance abuse has been identified by public health departments as a priority in Cheyenne, Kit Carson, Lincoln, and Weld Counties.[16] Adult binge drinking emerged as a top concern in Larimer County through a community health needs assessment conducted by a medical center, given that rates of adult binge drinking are higher in the county than statewide.[17] Prescription drug misuse and abuse were identified as a priority by a medical center in Morgan County based on input from community stakeholders,[18] and by the public health department of Kit Carson County based on rates of use.[19]

Prevention

The prevention of behavioral health issues, including substance abuse and poor mental health, was cited as a priority in the Community Health Improvement Plan for Weld County.[20] In WICHE's study, stakeholders in Region 1 expressed the need for more early intervention for youth and more support for school-based behavioral health services.[1] A community health needs assessment conducted by a medical center in Larimer County prioritized access to preventive care, particularly for uninsured and Medicare/Medicaid patients; this was identified as a way to decrease the number of emergency department visits that occur for behavioral health issues, including substance abuse.[21]

Intervention

Acute intensive services, including an insufficient number of detox and crisis stabilization services, was identified in the WICHE survey of stakeholders as a top concern about the availability and adequacy of behavioral health services in Region 1.[1] A study of behavioral health services in Larimer County commissioned by the Community Mental Health and Substance Abuse Partnership also indicated that a medical detox facility is needed for the area. Though social detox facilities that serve Region 1 exist, the Larimer County study suggests that capacity does not meet demand. From January-October 2015, one social detox facility, serving primarily Weld and Larimer Counties, was unable to admit approximately 500 clients, due to the facility being at capacity, a lack of transportation options, or limitations around staffing requirements due to licensing regulations.[22] Additionally, the study identified a need for an acute treatment unit to provide short-term crisis stabilization in a non-hospital setting.[22] Relatedly, a medical center in Morgan County identified access to early intervention as a priority for decreasing the number of patients who present in crisis.[18]

Treatment

Many communities within Region 1 see a need for more substance abuse treatment services options and providers within their county. The need for more local providers (i.e., ability to access treatment without traveling long distances) was identified in the WICHE survey of stakeholders as a top barrier to receiving services in Region 1.[1] One medical center in Morgan County raised concerns that the number of referrals to substance abuse services exceeds treatment capacity in the area, underscoring the need for more treatment services.[18] In interviews conducted as part of a community health needs assessment by a medical center in Adams and Weld Counties, health and education workers also identified a need for substance abuse treatment services.[23] The Community Mental Health and Substance Abuse Partnership study in Larimer County also identified a need to expand treatment capacity. Specifically, identified needs included outpatient services; intensive outpatient services to provide a more structured outpatient treatment experience; and residential care offering services at a variety of levels, including short-term intensive residential treatment and low intensity residential services.[22]

Recovery

Recovery support services were identified in WICHE's survey of stakeholders as a major service gap in Region 1; identified needs included housing and housing and transitional supports, peer supports, mentoring, and peer groups.[1] The Community Mental Health and Substance Abuse Partnership study in Larimer County identified a need for more independent, voluntary sober living houses to provide safe and supporting recovery environments.[22]

Continuum of Care

Continuity of SUD services was identified as a concern in multiple counties in Region 1. For example, in Morgan County, the process of accessing SUD services was characterized as disjointed and cumbersome, especially for those entering through an Emergency Department.[18] A key finding by the Community Mental Health and Substance Abuse Partnership study points to the lack of continuum of care services in

Larimer; developing a more cohesive continuum of care was identified as a need to provide individuals with the most appropriate and adequate level of care, thus facilitating recovery.[22]

Cost

Medical centers in Weld and Larimer Counties cite the high number of people using Emergency Departments as the primary access point for behavioral health care, including substance abuse, as indicative of the lack of access to affordable and/or covered SUD services.[8,23] A medical center in Larimer County cited the primary issue in behavioral health as access to affordable care, noting that many of the available services are cost-prohibitive for those who cannot afford their deductible or who do not have insurance, leading many to over-utilize Emergency Departments.[21]

Workforce

A medical center in Morgan County indicated that the lack of qualified substance abuse counselors in the area and difficulties in attracting and retaining qualified providers are directly related to the low capacity to meet SUD treatment needs.[18] A community health needs assessment conducted by a medical center found that the number of behavioral health providers in Logan County is low compared to the population. As such, primary care physicians are being tasked with providing psychiatric care that exceeds their capacity, resulting in a lower quality of care for patients.[24] One issue that may exacerbate the lack of qualified SUD professionals is the high turnover rate in the region, which was identified in the WICHE survey of stakeholders as a top barrier to receiving services in Region 1.[1]

SUMMARY OF EXISTING REPORTS AND DATA: REGION 2

Substance abuse has been determined to be an area of need by medical centers located in Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Jefferson, and Weld Counties.[9,10,23,25] and public health departments identified SUD services as a priority in Clear Creek as well.[16] The medical centers identified the need for behavioral health and substance abuse services due to substance-abuse related visits to the Emergency Department and admissions.[9,10,11,26] One medical center in Denver reported that, of substance-related visits, alcohol accounted for the most admissions and Emergency Department visits, followed by marijuana, then cocaine and opioids, and finally amphetamines.[26]

Prevention

School- and family-based prevention services, including screenings, early intervention, and counseling, were surfaced through the WICHE survey of stakeholders as a major service gap in Region 2. In addition, stakeholders cited issues with the current prevention system, including school-based services that were overtaxed and lacking integration with community and inpatient services, and a lack of knowledge about what prevention services are available and how to access them. [1] In a stakeholder survey implemented as part of a medical center's community health needs assessment, increasing prevention efforts in Broomfield County was also identified as an action needed to address substance abuse.[25]

Intervention

No available information was identified in this area.

Treatment

Substance abuse treatment services were identified as a community need for Adams and Weld Counties through interviews with health care professionals, education professionals and community members.[23] Participants in WICHE's survey of stakeholders for this region also cited a lack of residential services,

particularly in-patient beds for children, adolescents, and long-term patients, as a major service gap in Region 2.[1] Access to high-quality treatment in particular was identified as a need in a stakeholder survey implemented as part of a medical center's community health needs assessment serving Broomfield County.[25]

Recovery

A lack of recovery supports was frequently cited in the WICHE survey of stakeholders in Region 2. The need for better discharge, transitional, and follow-up services; and better case management were top concerns about the availability and adequacy of services in the region; the lack of family support services for recovery was determined to be a major service gap; and early discharge from inpatient treatment due to understaffed agencies and a corresponding lack of transitional supports were key barriers to receiving services. [1]

Continuum of Care

More generally, a lack of coordination and communication between service components, and lack of integration with primary care were top concerns of stakeholders surveyed by WICHE for Region 2.[1]

Cost

Lack of access to services due to cost was identified in the WICHE survey of stakeholders as a top concern about the availability and adequacy of services in Region 2, particularly for those not on Medicaid and those without any insurance coverage. Correspondingly, these stakeholders also identified affordability as a top barrier to accessing services in the region.[1] In a separate stakeholder survey implemented as part of a medical center's community health needs assessment, increasing access to affordable or no-cost SUD services was determined to be needed to address substance abuse in Broomfield.[25]

Workforce

Understaffing at agencies was identified in the WICHE survey of stakeholders as a top barrier to receiving services in Region 2.[1]

SUMMARY OF EXISTING REPORTS AND DATA: REGION 3

Substance abuse has been identified by public health departments as a priority in Fremont, Lake, and Teller Counties.[16] Substance use was identified as a top issue through key informant interviews and focus groups with community members in Region 3 during the development of a community health needs assessment. [27]

Prevention

A lack of education, awareness, and information about behavioral health was identified in the WICHE report of stakeholders as a top concern about the availability and adequacy of services in Region 3.[1] After identifying substance use as a key community concern, the Teller County health department identified the need for greater awareness in their strategic plan.[28]

Intervention

A major service gap identified in the WICHE survey of stakeholders for Region 3 was acute services, including crisis response, stabilization, and detox.[1]

Treatment

In Chaffee County, a community health assessment reports that there are people who need treatment but do not ever receive it, even though treatment providers report not having a waiting list. Corresponding issues include treatment services that do not take insurance, and a lack of affordable options in the area.[29]

Recovery

Inadequate recovery supports including transportation, supportive housing, and supports for reintegration after in-patient services were identified in the WICHE report of stakeholders as a top concern about the availability and adequacy of services in Region 3.[1] Further, major service gaps identified by stakeholders in that survey included recovery supports such as follow-up, after-care, and transitional supports.[1]

Continuum of Care

The Chaffee County community health needs assessment notes that previous needs assessments have called for a coalition to drive a systematic approach to prevention, intervention, and treatment that improves integration and coordination of services along the continuum of care to impact substance use issues in the region, but that no progress has been made in this area. [29] Comprehensive services along a continuum of care was identified in that report as a best practice in substance abuse treatment.[29] In addition, a systematic approach to prevention, intervention, and treatment was identified as an area that treatment providers would focus on if additional resources were available.[29]

SUMMARY OF EXISTING REPORTS AND DATA: REGION 4

Substance abuse has been identified by public health departments as a priority in Alamosa, Las Animas, and Huerfano Counties.[16] A community health needs assessment conducted by a local medical center in Pueblo County also identified substance abuse as a priority, in part based on rates of mental health hospitalizations (often including co-morbid substance abuse) that are double the state rate.[13] Limited availability of and lack of access to services was identified in the WICHE report of stakeholders as a key concern regarding the availability and adequacy of services, as well as a key barrier to receiving services in Region 4.[1] Moreover, the opioid epidemic is particularly acute in this area of the state; data from the Colorado Department of Public Health and Environment indicate that in 2013 the southeast region led the state on rates of opioid- and heroin-related poisoning deaths,[30] emergency department visits,[31] and treatment admissions.[32]

Prevention

Evidence suggests that there are insufficient prevention services in Region 4. In a statewide needs assessment conducted to identify parent and caregiver priorities for youth substance use prevention, a higher percentage of Colorado parents and caregivers surveyed reported seeking prevention resources in Region 4 (46 percent) than statewide (32 percent), and individuals in Region 4 were less likely to report being successful in finding prevention services (68 percent) compared to the rest of the state (85 percent).[33] Action areas for the Las Animas and Huerfano Counties, identified in the health department's public health improvement plan, fall under the umbrella of prevention, including reducing rates of use across many substances, and postponing age of initiation.[34]

Intervention

Acute services, including crisis stabilization and detox services, were identified in the WICHE report of stakeholders as a major service gap in Region 4.[1]

Treatment
Services for co-occurring mental health and substance use patients were identified in the WICHE survey of stakeholders as a major service gap in Region 4.[1]

Recovery
Recovery supports needed from the community, including transportation, housing, and transitional and community integration supports, were identified in the WICHE survey of stakeholders as a major service gap in Region 4.[1]

Continuum of Care
No available information was identified in this area.

Cost
Cost concerns for services, including insurance coverage and coverage limits, were identified in the WICHE survey of stakeholders as a top barrier to service in Region 4.[1]

Workforce

A workforce shortage in the region, and correspondingly understaffed agencies, were identified in the WICHE survey of stakeholders as a key concern regarding the availability and adequacy of services in Region 4. Likewise, understaffed agencies was identified in the survey as a top barrier to service in the region.[1]

SUMMARY OF EXISTING REPORTS AND DATA: REGION 5

Substance abuse has been identified as a priority by the West Central Public Health Partnership (WCPHP), the health department that serves Delta, Gunnison, Montrose, Hinsdale, Ouray, and San Miguel Counties.[16] Substance abuse has also been identified as a priority by medical centers in La Plata, Archuleta, and Montrose Counties.[14,35] A medical center serving La Plata and Archuleta Counties reports an increase in the number of substance use diagnoses in Emergency Departments.[14] WCPHP cites stakeholder concern over the high number of emergency room visits, arrests, and incarcerations of individuals with substance abuse problems are concerns in the region.[36] A particular concern identified by WCPHP was illicit drug use among adults over age 26, based on rates of use higher than the state average.[36] In Montezuma and Dolores Counties, mental health and substance use emerged as a top priority in a public health improvement plan, but the county health department determined that they had limited capacity to impact these issues.[37] Likewise, the West Central Partnership health department not only recognized that substance use is consistently identified as a top issue in their communities, but also indicated that there was limited ability to accurately assess substance use issues in the region, and therefore limited capacity to effectively target them.[36]

Prevention
In a statewide needs assessment conducted to identify parent and caregiver priorities for youth substance use prevention, parents' and caregivers' ratings of the likelihood of their children using substances (including alcohol before 21 years old, marijuana before 21 years old, tobacco before 18 years old, and other drugs like heroin/cocaine) were higher in Region 5 than statewide, indicating a high level of need for youth prevention services.[33]

Intervention

Acute services, including crisis stabilization and detox services, were identified in the WICHE survey of stakeholders as a key concern regarding the availability and adequacy of services in Region 5. Correspondingly, crisis stabilization and detox services were identified by stakeholders as major service gaps in Region 5.[1] Similarly, the WCPHP reports that there are no detoxification facilities services in Delta, Gunnison, Montrose, Hinsdale, Ouray, or San Miguel Counties (those counties served by the health department).[36]

Treatment

Access to treatment services was identified in the WICHE survey of stakeholders as a key concern regarding the availability and adequacy of services in Region 5, particularly due to the lack of beds and providers. A lack of local inpatient services in particular was identified by stakeholders as a major service gap.[1] In addition, a lack of locally available providers was identified by stakeholders as a key barrier to receiving services. Similarly, the WCPHP reports that there are no inpatient substance abuse treatment services in Delta, Gunnison, Montrose, Hinsdale, Ouray, or San Miguel Counties (those counties served by the health department).[36] The prevention-focused parent and caregiver needs assessment described above also found that parents and caregivers from Region 5 had the lowest reported success rate for finding treatment services; only 53 percent who sought services reported successfully finding them, compared to a 65 percent success rate statewide.[33]

Recovery

No available information was identified in this area.

Continuum of Care

No available information was identified in this area.

Cost

Concerns over the high cost of services and inability to pay were identified in the WICHE survey of stakeholders as top barriers to service in Region 5.[1]

Workforce

Workforce concerns, including insufficient staff and high turnover rates, were identified in the WICHE report of stakeholders as a key concern regarding the availability and adequacy of services in Region 5.[1] Based on input from key informants, WCPHP also identified the need for the need for culturally and linguistically competent substance abuse providers; this need has been recognized historically, and although Spanish language speakers have been hired at health care facilities, the increased capacity still does not meet the need of the area.[36]

SUMMARY OF EXISTING REPORTS AND DATA: REGION 6

Substance abuse has been identified by public health departments as a priority in Eagle, Grand, Pitkin, Routt, Mesa, Moffat, and Summit Counties, [16,38,39] and by medical centers in Garfield and Summit Counties.[15,40]

Prevention

No available information was identified in this area.

Intervention

Acute services, including crisis stabilization and detox services, were identified in the WICHE report of stakeholders as a key concern regarding the availability and adequacy of services in Region 6. Correspondingly, crisis stabilization and detox services were identified by stakeholders as major service gaps in Region 6.[1]

Treatment

Access to treatment services was identified in the WICHE survey of stakeholders as a key concern regarding the availability and adequacy of services in Region 5, particularly due to the lack of beds and providers. A lack of local inpatient services in particular was identified by stakeholders as a major service gap. In addition, a lack of locally available providers was identified by stakeholders as a key barrier to receiving services.[1] The need for locally available inpatient substance abuse treatment was identified in the community health needs assessment conducted by a medical center in Eagle County.[41]

Recovery

The need for recovery services was identified in the community health needs assessment of a medical center in Eagle County, pointing to the fact that not all towns in the county have supportive recovery programs, such as Wayfinder, Alcoholics Anonymous, Narcotics Anonymous, and Al-Anon.[41]

Continuum of Care

No available information was identified in this area.

Cost

A community health needs assessment conducted by a medical center in Eagle County noted that though there are several counseling centers and multiple private practice counselors who provide outpatient therapy related to substance abuse and addiction in the area, very few of them accept Medicare, Medicaid, have a sliding-scale fee structure, or provide charity care.[41] Surveyed community members in Summit County identified substance abuse as the top community priority, and respondents noted that treatment in the area is expensive, in part because many are underinsured.[42] In Grand County, there are a limited number of affordable behavioral health services, including substance abuse counseling, available.[43] Likewise, concerns over the high cost of services and inability to pay were identified in the WICHE survey of stakeholders as top barriers to service in Region 6.[1]

Workforce

Workforce concerns, including insufficient staff and high turnover rates, were identified in the WICHE report of stakeholders as a key concern regarding the availability and adequacy of services in Region 6.[1] The need for an increased number of substance abuse counselors was identified as a top need in Garfield County in particular.[40] There is also an identified need for more Spanish-speaking providers.[15]

SUMMARY OF EXISTING REPORTS AND DATA: REGION 7

Substance abuse has been identified by the public health department and medical centers serving Boulder County as a priority, and the need for expanded, improved, accessible, and timely SUD services is recognized[16,25,44,45] A medical center serving Boulder reports that the emergency room often serves as the primary access point for behavioral health issues; in addition, substance abuse is the leading cause of inpatient admission in the Emergency Department for patients ages 35-49, and alcohol/substance abuse is the second highest diagnosis for patients ages 35-49 (25 percent) and ages 50-64 (19 percent).[8]

Prevention

Prevention was identified as a key priority for tackling SUD issues in Region 7. Reducing substance abuse is one of three focus areas identified in the Public Health Improvement Plan of Boulder County Public Health.[45] Utilizing local community input, interviews, and surveys, Community of Hope (a collaboration among Boulder County Public Health, Boulder Community Services, and Boulder County Department of Housing and Human Services) identified key gaps in behavioral health prevention; specifically, improving early detection and health promotion by reducing the stigma of SUD/behavioral health issues, increasing counseling and prevention programs in schools, teaching coping and stress reduction skills during childhood, and increasing housing support programs to decrease homelessness were highlighted.[46] In a stakeholder survey implemented as part of a medical center's community health needs assessment, increasing prevention efforts in Broomfield County was identified as an action needed to address substance abuse.[25]

Intervention

No available information was identified in this area.

Treatment

The needs assessment conducted by Community of Hope identified a need for additional inpatient services, which is corroborated by the fact that the Boulder Community Health system offers the only inpatient unit in the county.[45,46] Access to high-quality treatment in particular was identified as a need in a stakeholder survey implemented as part of a medical center's community health needs assessment serving Broomfield County.[25]

Recovery

No available information was identified in this area.

Continuum of Care

The Community of Hope needs assessment identified challenges in Boulder County with core coordination of SUD services; issues include high incarceration rates when SUD treatment is more appropriate, challenges in capacity for first responders to assess for SUD issues and make appropriate referrals, and lack of systematic process to connect those with acute issues to appropriate services. A lack of integration of SUD services with primary care has also been identified as an area of concern, as many respondents to a survey indicated that their primary care physician was unable to or refused to address substance use treatment concerns.[45]

Cost

The costs of SUD services in Region 7 are seen as high, and there is a need for more affordable options when insurance coverage is insufficient based on stakeholder input in the Community of Hope needs assessment.[45] In a stakeholder survey implemented as part of a medical center's community health needs assessment, increasing access to affordable or no-cost SUD services was identified as an action needed to address substance abuse in Boulder.[25]

Workforce

The Community of Hope needs assessment noted a shortage of specialized behavioral health providers in the region.[45]

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APPENDIX C: ESTABLISHED SUPPORT AND CONSIDERATIONS FOR PRACTICE

MEDICATION ASSISTED TREATMENT: ESTABLISHED SUPPORT AND CONSIDERATIONS FOR PRACTICE

Background

Medication-assisted treatment (MAT) utilizes a combination of behavioral therapy and medication to treat substance use disorders. MAT is most commonly used to treat opioid addiction as part of an opioid treatment program (OTP) or to treat alcohol dependency. Medications can be utilized as part of detoxification to assist with medical symptoms and cravings, or integrated into a longer-term treatment plan for patients and combined with additional treatment modalities.[1] Generally, medications are classified based on how they target the brain's receptor sites. *Agonists*, which either fully or partially mimic a substance's effect by activating corresponding receptors in the brain, are used in replacement therapies to suppress withdrawal symptoms and reduce cravings. *Antagonists*, which attach to receptors (but do not activate them) and inhibit the reception of other drugs, can be prescribed as a maintenance medication that eliminates the rewards of substance use and thus help prevent relapse.[2,3] Safety and effectiveness are primary considerations for administration of MAT, along with patient characteristics such as substance use history and treatment goals.[3]

Established Support

- MAT specifically for opioid addiction has been demonstrated to extend engagement in treatment as well as to reduce drug use, drug-related mortality, and criminal behavior.[4,5]
- While several medications (e.g., methadone, buprenorphine, naltrexone, and extended-release naltrexone) are widely utilized in MAT for opioid addiction and have strong evidence for safety and efficacy, methadone has been used the longest.[5,6]
- In addition to reducing drug use and related mortality, criminal behavior, and increasing patient retention, methadone maintenance has been shown to:
  - Reduce additional drug-related health issues such as Hepatitis, HIV and cellulitis;
  - Increase functioning in employment, family and social aspects of patient lives; and
  - Increase compliance with additional therapies such as those related to HIV/AIDS. [5]
- MAT treatment of opiate addiction has been shown to yield a good return on investment, with an estimated return of $4-5 for every $1 invested.[4]

Key Considerations

- **MAT is most effective when utilized as part of a comprehensive treatment plan** that addresses social and behavioral problems as well as any co-occurring mental health disorders.[7]
- **Appropriate infrastructure is necessary to conduct MAT** and includes medication delivery, identifying funding and complying with regulatory standards, certification, and training requirements for staff and physicians.[3]
- **Office-based opioid therapy is an option for MAT** that studies have shown to be both safe and efficacious. For qualified patients that show a history of stability, prescriptions for medications such as buprenorphine can be ordered by a specially qualified physician, nurse practitioner, or physician's assistant and taken at home.[5,8,9]

- **MAT is underused for alcohol use disorders**, despite the availability of effective medications that can be administered in an outpatient setting. Medications such as extended release injectable naltrexone and acamprosate are shown to be efficacious for helping patients maintain abstinence.[3]
- **Funding sources for MAT and state-level Medicaid authorization requirements** can have great impact on patient access to services.[10]
- **It is important to consider current public and service provider attitudes toward MAT** in specific areas to ensure that implementation will be supported by service recipients as well as providers.[3,11]
- **Medications utilized in MAT should be individualized** in terms of patient goals for treatment and preferences.[7]

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SUSTAINABLE DETOXIFICATION:
CURRENT EVIDENCE AND CONSIDERATIONS FOR PRACTICE

Background

Detoxification (detox) refers to interventions aimed at managing intoxication and withdrawal from physically addictive substances as the toxins are cleared from the body.[1] The American Society of Addiction Medicine (ASAM) delineates detoxification intervention types by levels of detox that vary in both setting and intensity of monitoring.[2] Residential/Inpatient Withdrawal Management is divided into three levels. What has commonly been called "social detoxification" in Colorado corresponds to Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM) which has access to medical consultation and program supervision in a "social" withdrawal management program. Medically Monitored Inpatient Withdrawal Management (ASAM Level 3.7-WM) has a higher involvement of onsite medical professionals, and most frequently would be found in a "freestanding" withdrawal management center. Neither of these levels of care provide Medically Managed Intensive Inpatient Withdrawal Management (ASAM level 4-WM), which would be found in an acute care or psychiatric hospital inpatient unit.

Current Supporting Evidence

- "Social" detox programs have been found to have greater or equal efficacy to medical detox, and to be more cost-effective as they do not carry the significant costs of hospitalization.[5]
- Although most patients will not require medically assisted detox, it is difficult to determine which individuals will transition safely through withdrawal and which ones will require medical intervention;[3] thus, it is important that detox be provided consistent with the appropriate ASAM level of care.[2]

Key Considerations

- **Evaluation by a clinical professional experienced in substance use disorder treatment** should be part of admittance to any social detox program.[3] Early evaluation can help health care professionals anticipate medical complications associated with detox.
- **Special consideration for patients entering social detox with a history of withdrawal**, as a "kindling effect" can occur where each withdrawal is worse than the last. Patients in this category are in special need of linkage to medical detox.[1]
- **Auxiliary medical supports integrated into social detox programs are critical.** This includes ensuring that all detox personnel have medical training in basic life support and that social detox programs without onsite medical care have access to emergency medical transportation and care.[1]
- **Ongoing medical surveillance** via monitoring of vital signs is considered a critical aspect of any social detox program. For severe alcohol and opioid withdrawals not requiring the full resources of an acute care hospital or a medically managed inpatient hospital, non-hospital settings with medically monitored ASAM Level 3.7-WM care are appropriate as they are equipped with a continuous (24 hours/day) level of nursing and medical monitoring.[2,4]

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RESIDENTIAL SUBSTANCE USE DISORDER TREATMENT PROGRAMS: ESTABLISHED SUPPORT AND CONSIDERATIONS FOR PRACTICE

Background

Residential programs are a common modality for substance use disorder treatment and provide a 24-hour therapeutic milieu for patients in which a range of other rehabilitation services occur such as therapy, psychoeducational groups, 12-step meetings, and structured recreation. There is wide variation among residential programs in terms of approach to treatment, philosophy, and intensity.[1] Residential programs provide inpatient services generally for a period of 15 to 90 days, ideally followed by transfer to outpatient, as well as recovery support services. Generally speaking, the most positive treatment outcomes are observed for patients who remain in some form of treatment for three months or longer.[2]

Established Support

- Evidence of the effectiveness of residential substance use disorder treatment has been established through several large, longitudinal studies. These studies show improvements in not only drug use, but also criminal behavior and key areas of functioning such as employment.[3]
- Four levels of care within residential services (also known as inpatient services) have been defined by the American Society for Addiction Medicine based on the intensity of services that correspond to identified patient needs. Care should be provided within the guidelines of these levels of care. [4]
- A Therapeutic Community (TC) is a common structure for residential programs and has been shown to reduce drug use and criminal activity, particularly for patients with the most extreme problems. The National Institute on Drug Abuse (NIDA) sponsored the Drug Abuse Treatment Outcomes Studies (DATOS) which have demonstrated the effectiveness of TCs; patients with behavioral improvements at one year continued to show improvement after five years.[5] While determined to be effective, TCs are not as common as they once were and are now more typically implemented with justice-involved populations.

Key Considerations

- **Treatment availability** is imperative so that patients can access services immediately once expressing need and readiness. Early access to treatment can ultimately improve treatment outcomes and it is important to capitalize on an often-small window of patient willingness to seek treatment.[2]
- **Appropriate treatment settings and intensity of services** are dependent upon a range of factors including unique substance use history and personal characteristics of the client.[2] It is important to note that not every individual requires residential treatment before they enter outpatient treatment. Outpatient treatment is sufficient for many individuals.[6] Outpatient services can vary from high intensity treatment to low-frequency continued monitoring, depending upon the needs and stage of treatment of the individual.[7]
- **Considerations for clients in medication-assisted treatment programs** (e.g., methadone maintenance programs) are important, as residential programs do not always admit patients who are also involved in medication-assisted treatment.[8]
- **Residential treatment as a modality does not indicate the intensity of substance use disorder treatment**. SAMHSA makes a distinction between treatment modality and intensity – residential programs at various ASAM levels vary widely in intensity and placement of an individual in treatment should align with the unique need level of each patient.[1,4]

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TRANSITIONAL HOUSING AFTER SUBSTANCE USE DISORDER TREATMENT: ESTABLISHED SUPPORT AND CONSIDERATIONS FOR PRACTICE

Background

When patients successfully complete a substance use disorder treatment program, the transition back to everyday life can create a myriad of potential challenges. Patients often return to environments that present a high risk for relapse—places and people that can trigger cravings as well as environments that lack support and opportunities to grow in recovery. Transitional housing can offer a more structured environment for patients and, with a formal transition plan, can include appropriate supports such as counseling, peer support, and recovery programming. There are a range of models for transitional housing that provide varied structure and supports; these programs are often referred to as "sober housing," "recovery housing," or "sober living."[1] SAMHSA notes an essential requirement for successful transition is housing that is "safe, free of substance use, provides a structured environment, and supports treatment goals."[2]

Established Support

- Longitudinal studies of peer-run recovery homes have demonstrated the following outcomes:
    - Decreased substance use;
    - Decreased incarceration;
    - Higher rates of employment and income; and
    - Increased reunification with children/custody of children[3,4,5]
- Cost analyses of recovery homes have also documented savings when comparing peer-run programs to more expensive staffing models or the costs of returning to substance use and its consequences (e.g., health problems, illegal behavior, incarceration, etc.)**.**[1]

Key Considerations

- **Transitional housing programs align with current best practices of care coordination** and in addition to safe housing should include social, employment, and recovery supports such as counseling and 12-step programming.**[1]**
- **Low-income populations may have additional need for quality recovery housing** due to limited safe and affordable housing options.[6]

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SUBSTANCE USE DISORDER CARE COORDINATION:
ESTABLISHED SUPPORT AND CONSIDERATIONS FOR PRACTICE

Background

Addressing substance use disorders encompasses a broad set of services that are often disjointed from one another. The Substance Abuse and Mental Health Service Administration has identified the need for improved coordination, particularly for treatment and recovery services.[1] Effective coordination of care includes active communication and collaboration between clinical, evaluative, and administrative personnel, and the complete integration of services along the full continuum of care, from detoxification to community reintegration.[2] Barriers to coordination of care include low reimbursement or coverage of services by third party payors, unaffordability of certain services even when they are covered by insurance, fragmentation of services even within the same treatment phase (e.g., medical detox and non-medical counseling),[3] and lack of patient efficacy in accessing and properly utilizing the complex treatment system on their own.[2]

Established Support

- Coordinating care between substance use disorder, mental health, and physical health providers results in more successful recovery of substance using patients.[4]
- The Substance Abuse and Mental Health Services Administration has identified a continuum of SUD services as critical to fostering patient recovery and supporting full reintegration of the healthy, functioning individual back into the community. Comprehensive case management that is flexible, community-based, and client-oriented helps clients navigate fragmented services.[2]
- The American Society of Addiction Medicine standards of care recommend that the treatment of substance use disorders include flexibility and continuity to address the varying levels of care needed over time.[3] Current practices in care, however, typically segment services into singular modules.[5]

Considerations

- **The continuum of care should aim to provide the appropriate type and level of primary treatment services**, ensure the linkage of secondary services that support recovery and the management of long-term sobriety, and develop motivation and engagement in clients.[2]
- **Proper communication and collaboration between all parties** throughout the treatment-rehabilitation continuum fosters integrated care, shared decision making and common goals, and ensures the highest quality care.[4]
- **Third party payor policy that bundles reimbursement for all phases of treatment**, from detoxification to nonmedical counseling, can ensure the smooth delivery of services to patients as they are needed and improve individual outcomes.[1]
- **Increasing utilization of comprehensive case management** in substance use disorder treatment provides each patient with a single point of contact to support them in navigating the multitude of health and social services systems. Case management can also give each patient a sense of personal attention in a sometimes otherwise impersonal system, thus promoting treatment progress, retention, and improved individual outcomes.[2]

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RURAL AND FRONTIER SUBSTANCE USE DISORDER SERVICES:
COST-EFFECTIVE AND SUSTAINABLE PRACTICES

Background

Due to lower availability of substance use disorder services in rural and frontier areas,[1,2] access to such services is often the primary concern for these populations. Barriers to access such as lack of transportation, inadequate staffing, stigma, and absence of sustainable funding disproportionately affect individuals living in rural areas, thus cost-effective and sustainable practices are especially important in these settings.[1,3] The following approaches have been recommended to minimize the impact of locality on rural populations for improving access to substance use disorder services.[1]

Recommendations

- **Telehealth** has gained increasing support as a cost-effective way of providing prevention, intervention, and care coordination services.[4] Additionally, literature reviews and meta-analyses have found telehealth to be just as effective as traditional therapy.[5,6] Telehealth offers a particularly relevant solution to increasing access to services in rural areas that have larger underserved populations, and are more vulnerable to barriers around mobility and transportation.[1,3] Increasing utilization of telehealth also addresses other barriers to access such as staffing and patient volume issues in rural clinics.[1,3]
    - There has also been recent research suggesting the effectiveness of smart phone technology in recovery support.[7] ACHESS, a relapse prevention program delivered through a smartphone application, is now listed on the National Registry of Evidence-based Programs and Practices (NREPP) as an evidence-based practice.
- **Primary medical and behavioral health care integration** is especially important in rural settings where primary care providers may be residents' only point of contact with the health system. Training functionally independent providers in mental and behavioral health first aid could decrease community stigma related to seeking help for substance use disorders, while increasing community awareness of problem substance use warning signs.[1] The World Health Organization reports that health care integration is most effective when it is fully supported by health policy, legislative framework, and policy leadership.[8]
- **Prevention** and early intervention services are the foundation for decreasing individuals' risk of developing serious substance abuse problems and preventing the need for advanced care. This is especially true among rural communities where incidence and prevalence of substance use disorders are higher and where there tends to be a more accepting attitude toward substance use.[2] Further, a cost analysis of substance use prevention services conducted for the US Department of Health and Human Services estimated an $18 return for every $1 invested in school-based prevention programs and a total state and local government savings of $1.3 billion annually.[9]
- **Peer support services** are widely considered an important component of the recovery and reintegration process for individuals managing their sobriety. Peer-support services are based on the idea that individuals who have dealt with similar struggles can provide a more meaningful and inspiring level of social support, thus leading to an increased commitment to sobriety for themselves and the client.[10] Additionally, peer support programs may represent another cost-effective vehicle for providing higher quality behavioral health care in resource-constrained rural areas.[11]

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