



**DENVER**  
PUBLIC HEALTH &  
ENVIRONMENT



# Behavioral Health Needs Assessment Project: Final Report

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*#Live Better*

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The project team would like to thank the many Denver area community members, behavioral health service provider personnel and people within the Colorado Behavioral Health Administration (BHA),<sup>1</sup> who all made this project possible. Nearly 100 Denver community members spent several hours each participating in focus groups while being open to sharing their personal experiences seeking mental health and substance use services. Hundreds more Denver community members took a survey about their experiences seeking behavioral health services for themselves or while helping another person to get needed services. Also, dozens of Denver area behavioral health service provider representatives spent significant time being interviewed and providing the project team with information about the capacity and capabilities of their organizations to meet the behavioral health needs of the communities they serve. Finally, the BHA provided the project team with valuable information on the number of people from a variety of Denver communities receiving mental health and substance use services over the past two years.

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<sup>1</sup> The BHA is within the Colorado Department of Human Services

## Executive Summary

The Denver Department of Public Health & Environment (DDPHE) had three primary objectives for the Behavioral Health Needs Assessment (BHNA) Project

1. Understand the type and level of behavioral health service needs in Denver
2. Determine the type and level of behavioral health services available in Denver
3. Identify behavioral health service gaps and recommendations

The overall approach for the BHNA project was to review the relevant literature, design and implement acquisition of qualitative and quantitative data to inform the project objectives, analyze and summarize findings, and then formulate recommendations based on project findings. The project team reviewed literature and background resources related to this project to provide context for the project and findings relevant to the current BHNA project. This context provided input into the design of the interviews and focus groups which, in turn, informed the design and approach to the quantitative survey. Recommendations were based on all project main findings.

Below are the primary findings for this project that are supported by analyses of data across multiple primary sources. Example supporting information is provided for these findings, but greater detail is presented later in this report for each of these findings:

1. Accessing behavioral health services is very difficult (e.g., 41% of people who sought behavioral health services in the past 12 months indicated in a survey they had not obtained any type of service yet).
2. COVID-19 has negatively impacted behavioral health and service access (e.g., 61% of survey respondents said that the COVID-19 pandemic had made looking for mental health or substance use services “somewhat harder” or “much harder.”)
3. Financial, timing and convenience factors are the most urgent barriers to address in order to improve access to needed behavioral health service (e.g., between 27% and 36% of survey respondents mentioned at least one of these factors as needing to be addressed urgently).
4. Behavioral health service access issues are significantly higher for some groups (e.g., people experiencing poverty, without health care insurance, experiencing homelessness / unstable housing, and / or who identify as Black / African American, LGBTQ+, non-binary, essential worker, veteran and / or a person of color).
5. There is very high demand for behavioral health services that providers cannot meet (e.g., about one-third of provider organizations interviewed indicated their organization is only able to meet 50% or less of the demand for their services from the Denver communities they serve).
6. Workforce recruiting, burnout, and retention challenges have had a negative impact on provider service capacity (e.g., insufficient staff was ranked number one 45% of the time regarding providers’ top factor impacting their ability to provide services).
7. Providers have high workforce training needs (e.g., 61% of provider representatives noted staff training and support as a leading issue impacting their ability to provide services to their intended communities).
8. Inadequate provider technology limits delivery of services (e.g., over four in 10 provider interviewees mentioned “technology” when asked what they needed to better address COVID-19 for both them and the communities they serve).

9. There are limited funding sources available to smaller service providers (e.g., 26% of provider interviewees mentioned challenges with the lack of diversified funding including the need to reduce competition among providers).
10. Low workforce diversity limits ability to meet some community needs (e.g., 59% of provider interviewees said “lack of diversity” when asked about the challenges in providing culturally and linguistically appropriate services to the communities they serve).

Based on these project findings, the project team recommends that DDPHE develop plans for and act on the following topics:

1. Provide leadership to engage critical stakeholders to improve behavioral health services
2. Increase awareness of and improve provision for language access services
3. Increase the number of providers (including Medicaid providers) and ensure that existing providers are maintained, within the City and County of Denver
4. Provide coordination and policy support to improve case management utilization
5. Educate and raise awareness for consumers around mental health treatment service options and how to connect to them
6. Increase culturally and linguistically responsive community outreach and involvement
7. Improve access to services by encouraging extended hours and weekends

# Introduction and Background

This Final Report for the Denver Department of Public Health & Environment (DDPHE) Behavioral Health Needs Assessment (BHNA) project brings together information gathered and analyzed for the entire project. This report summarizes the project background, describes the project methods, main findings, recommendations, and contains several appendices that provide detail supporting the main body of the report. Throughout this report the phrase “behavioral health” refers to peoples’ potential experiences of mental health and substance use issues, unless otherwise noted. A list of acronyms found in this report and their meaning can be found in Appendix 1.

Project Objectives – The three overall project objectives were to:

- Understand the type and level of behavioral health service needs in Denver
- Determine the type and level of behavioral health services available in Denver
- Identify behavioral health service gaps and recommendations

## **A Behavioral Health Crisis**

### ***Nationally***

Several national government organizations consistently found elevated and growing levels of substance use and mental health issues in the United States. Additionally, access to behavioral health care for these conditions is often limited<sup>1</sup>. For example, the most recent available National Survey on Drug Use and Health (NSDUH)<sup>2</sup> data indicated more than 20% (21.4% or 59.3 million) of people aged 12 years and over reported using illegal drugs in 2020<sup>2</sup>. This same report found that 21.0% of adults (52.9 million) reported having a mental illness and 5.6% (14.2 million adults) reported having a serious mental illness in 2020. While the US has experienced significant issues with behavioral health condition prevalence and limited access to effective treatments for decades, the COVID-19 pandemic made the situation worse. A review of the Center for Disease Control and Prevention’s Morbidity and Mortality Weekly Reports (MMWR) from August 2020<sup>3</sup> (early in the COVID-19 pandemic) to February 2021 (in the middle of a major surge in COVID-19 infections and hospitalizations) found increases in the following behavioral health conditions:

- Anxiety disorders increased 5.5% points from August to December 2020
- Depressive disorders increased 5.7% points from August to December 2020
- The percent of people who took medication or saw a mental health counselor increased 3.0% points from August 2020 to November 2020
- People needing to see a counselor but did not see a counselor increased 3.2% points from August 2020 to December 2020
- Unmet mental health needs increased 2.5% points from August 2020 to February 2021
- Unmet mental health needs of adults aged 18 to 29 years increased 7.2% points from August 2020 to February 2021
- Unmet mental health needs for respondents without a high school diploma increased 4.3% points from August 2020 to February 2021<sup>3</sup>

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<sup>2</sup> The definition for illegal drugs in the 2020 NSDUH survey says that “illegal drug use” includes marijuana. The survey item itself does not ask if marijuana is legal in the state of residence. Although marijuana use is legal in several states, including Colorado, the overall impact on the “illegal drug use” federal percentage would be small. Also, underage use of marijuana is illegal in all states.

### **Colorado**

Colorado has experienced many of the same mental health issues that are found at the national level (e.g., increasing prevalence and limited access to treatment) and has seen mental illness rates increase during the COVID-19 pandemic. For example, the Kaiser Family Foundation<sup>4</sup> reported that in 2018 and 2019, approximately 23% of adults in Colorado had a mental illness of some type. This was slightly above the national average of about 21%. However, reported rates of mental illness during September and October of 2021 showed that Colorado had increased to 32.0%, an increase of about 9% points. A 2021 Colorado Health Institute report<sup>5</sup> indicated that mental health difficulties reached an unprecedented high in the 12 years that they conducted the Colorado Health Access Survey (CHAS), with nearly one quarter of Coloradans reporting poor mental health. Young adults were most affected, with approximately 50% reporting a decline in their mental health during the pandemic.

Additionally, the Kaiser Family Foundation fact sheet<sup>4</sup> reported that in 2019, cost was a significant barrier to accessing mental health services, noting “Among these adults in Colorado who reported an unmet need for mental health treatment in the past year, 41.8% (170,000) did not receive care because of cost, which was similar to the U.S. share of 39.7% (6.1 million).” Also, the Surveillance System (BRFSS) Telephone Survey<sup>6</sup> indicated that about 11% of respondents said they could not see a doctor because of the cost.

### **Denver**

Denver has had similar behavioral health issues and trends as noted nationally and in Colorado. This includes a large need for behavioral health services that were only partially met, with some behavioral health needs and gaps worsening during the COVID-19 pandemic. Denver also has documented differences in behavioral health conditions and access to services by race, ethnicity, age, income, and insurance status. Finally, Denver residents experienced many barriers to receiving needed behavioral health services such as cost, inadequate cost coverage by insurance, and long wait-times for service appointments.

A 2021 Colorado Health Institute (CHI)<sup>5</sup> report indicated that over 110,000 Denver residents needed mental health care but did not receive it and over 11,600 needed services for substance use but did not receive any. Over one-third of those who did not receive care reported that not wanting to talk about personal issues was the reason for not seeking services.

Comparison of 2019 and 2021 CHI<sup>5</sup> data showed that some of Denver’s mental health metrics improved from 2019 to 2021 (e.g., increases in talking to a general doctor about mental health in the past 12 months, and reductions in saying “hard time getting an appointment” was a reason for not getting behavioral health treatment). However, several behavioral health indicators changed over the same period:

- People reporting eight or more days poor mental health in the past 30 days (increased by 9.9% points to 26.9% in 2021)

- People who talked to a mental health or substance use specialist in the past 12 months (increased by 1.8% points to 20.9% in 2021) indicating a greater need for services
- People did not get treatment because:
  - They did not feel comfortable talking about their condition (increased by 3.1% points to 40.5% in 2021)
  - They had concerns about cost (increased by 2.9% points to 65.6% in 2021)

In conclusion, people who live in Denver have high rates of behavioral health needs with many not able to access the services they need. These Denver issues are consistent with national and Colorado statistics on the prevalence of people needing behavioral health services with many people not being able to access appropriate care.

## **Barriers to Accessing Behavioral Health Services**

Based on the relevant literature, some of the barriers people encounter when looking for needed behavioral health services include:

### **High Service Costs and Inadequate Health Insurance Coverage**

- Results from a 2021 / 2022 DDPHE Anti-Stigma survey of Denver residents with a behavioral health condition indicated that the top two “provider-oriented” barriers to obtaining services were that services cost too much and that insurance did not adequately cover behavioral health service costs<sup>7</sup>.
- Results from the 2020 Behavioral Risk Factor Surveillance System (BFRSS) Telephone Survey<sup>6</sup> indicated that about 11% said they could not see a doctor because of the cost.
- Results from the Kaiser Family Foundation fact sheet<sup>4</sup> suggested that in 2019, cost was one of the most significant barriers to accessing mental health services.
- Survey data reported by the Joint Denver Community Health Assessment (JDCHA)<sup>8</sup> indicated that lack of accessibility and affordability were key barriers to receiving timely care for individuals struggling with their mental health.

### **Wait Times to Receiving Services**

- Results from a 2021 / 2022 DDPHE Anti-Stigma survey of Denver residents suggested that long wait times for receiving behavioral health services was the third largest barrier to obtaining services<sup>7</sup>.

### **Stigma Associated with Behavioral Health Issues**

- Using data from the 2019 CHAS, the Colorado Health Institute (CHI)<sup>5</sup> reported that over one-third of those who did not receive care said that not wanting to talk about personal issues was the reason for not seeking services.
- Additional recent CHI reports<sup>9,10</sup> noted that stigma surrounding help-seeking for mental health and substance use conditions was a significant barrier for people to receive help.
- While not at the top of the list, findings from the 2021 / 2022 DDPHE Anti-Stigma survey of Denver residents noted above found that stigma-oriented barriers like “scared to admit I may need help” and “would feel worse about self” were considered small to medium-sized barriers to seeking services<sup>7</sup>.



### **Lack of Linguistically and Culturally Appropriate Care**

- Findings from a survey in the JDCHA<sup>8</sup> project indicated that a lack of linguistically and culturally appropriate care was also a key barrier to receiving timely care for individuals struggling with their mental health.
- Also, a recent CHI study<sup>9</sup> noted there is a relative lack of provider diversity in Colorado often resulting in lower cultural responsiveness.

## **Group Differences in Behavioral Health Service Needs and Access**

A variety of studies demonstrated that the risk of having a behavioral health condition and the barriers to accessing services to address those conditions differs by many group characteristics, including group / gender identity, ethnicity, income, and severity of behavioral health condition.

Several recent Colorado and Denver community behavioral health reports highlight the racial disparities in behavioral health conditions and access to behavioral health services. A JDCHA report<sup>8</sup> found that 10% of Denver residents do not have health insurance, the majority of whom are people of color. Additionally, this report noted that people of color are far more likely than whites not to seek medical care due to cost. Similarly, a recent CHI report<sup>9</sup> noted that stigma surrounding help-seeking for mental health and substance use conditions is a significant barrier for people to receive help. The report highlights the disproportionate rates of criminalization for drugs among people of color<sup>3</sup> (likely a form of discrimination and / or racism) that often deters people of predominantly non-white communities from seeking help for substance use issues. Also, a Kaiser Family Foundation report<sup>4</sup> noted that an overall behavioral health provider shortage and the lack of racially diverse provider staff are likely barriers for people of color seeking or obtaining services. The report noted that people of color often discover that they cannot find someone who looks and sounds like themselves, and with whom they can easily connect. A 2020 journal article<sup>11</sup> also noted that African American children of essential workers had significantly higher odds of abuse and depression than White children. This same article found that stress and anxiety was significantly higher among Hispanic children of essential workers compared to White children.

A recent DDPHE Anti-Stigma Campaign Project survey<sup>7</sup> assessed the impact of the COVID-19 pandemic on respondents' mental health and substance use in addition to the size of seven "provider-oriented" barriers to obtaining behavioral health services. The summary below describes the subgroups of people found to have significantly higher barriers to receiving needed behavioral health services or whose behavioral health has been significantly more impacted by COVID-19:

**LGBTQ+** – People identifying as LGBTQ+ rated a wide variety of barriers to receiving behavioral health services, which is significantly higher than their non-LGBTQ+ counterparts (e.g., services cost too much, insurance not adequately covering costs, long wait times to receive services and providers not understanding their situations). They also rated COVID-19 as having a significantly higher impact on their mental health or substance use compared to others.

**Serious Mental Health Conditions** – People experiencing a serious mental health condition in the past 12 months (e.g., schizophrenia, bipolar disorder) also rated a wide variety of barriers

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<sup>3</sup> People of color are convicted of drug offenses at higher rates than others.

to receiving behavioral health services, which is significantly higher than people experiencing a non-serious mental health condition (e.g., long wait times to receive services, not liking the service options available, and providers not understanding their situations).

**People of Color** – People who identify as a person of color rated two specific barriers to receiving behavioral health services significantly higher than their non-person of color counterparts: (1) providers do not look like me, and (2) providers do not speak my language. This same pattern was also true of people identifying specifically as Black or African American. Consistent with conclusions from other behavioral health research projects<sup>8,10</sup>, these findings suggest that some people of color experience discrimination and / or racism coming from providers.

## **The Current Behavioral Health Needs Assessment Project**

There is little doubt that Denver, like Colorado and the entire United States, is experiencing a behavioral health crisis. The best estimates indicate that about one-third of all people living in Denver have experienced mental health or substance use issues over the past 12 months. The current level of behavioral health issues has accelerated in recent years because of many factors, including the COVID-19 pandemic. Some of the largest barriers inhibiting people who need behavioral health services from getting them are: high service costs, no insurance or inadequate insurance coverage of costs, long wait times to receive services, stigma around having or getting services for a behavioral health condition, and the lack of linguistically and culturally appropriate services. Many subgroups of people needing behavioral health services the most have the hardest time accessing them, including people with no health insurance, people with lower incomes, people identifying as LGBTQ+, people of color (especially people identifying as Black or African American), and people with more serious mental health conditions.

DDPHE initiated the current behavioral health needs assessment project to gain better insights into, and estimate the magnitude of, the gap between the behavioral health service needs of people living in Denver with the capacity and capabilities of the Denver behavioral health service providers to meet those needs. DDPHE can use these insights, quantified gaps, and the recommendations that come from this project to invest in projects to help close this gap.

## Methods

The overall approach to the current project was to assess the behavioral health needs of people living in Denver, assess the capacity and capability of Denver providers to deliver behavioral health services, determine gaps between Denver community behavioral health needs and what Denver providers can deliver, and to make recommendations to DDPHE regarding how to address and close the highest priority Denver community behavioral health service gaps. Below is more information around each major component of the overall project approach:

### **Assess Denver Community Needs**

The project gathered and analyzed relevant information allowing for an understanding of the type and level of behavioral health service needs for people living in Denver. This was done by:

- Reviewing recent reports and literature describing the type and nature of needs that people have when experiencing behavioral health issues.
- Facilitating 10 focus groups, with a total of 95 people from diverse community groups in Denver, to hear in rich detail the kinds of experiences, needs and challenges they have when addressing their behavioral health needs.
- Gathering survey data from 601 people living in diverse Denver communities through online and in-person recruiting events.
- Integrating, analyzing, and summarizing findings and insights from all data gathered.

### **Assess Denver Provider Capacity and Capability**

The project gathered and analyzed relevant information allowing for a determination of the type and level of behavioral health services available in Denver by:

- Reviewing recent reports, literature and publicly available data describing the type, nature and volume of behavioral health services delivered by Denver providers.
- Facilitating a focus group with Denver provider representatives to learn their experiences, needs and challenges when delivering behavioral health services to their communities.
- Gathering detailed information through 21 structured interviews with 33 representatives from Denver behavioral health service providers regarding their organizational capacity and capabilities, including requesting detailed information in advance of scheduled interviews to populate a set of Denver Provider Profiles.
- Integrating, analyzing, and summarizing findings and insights from all data gathered.

### **Determine Denver Service Gaps**

The project organized, compared, and analyzed relevant information to reveal the most prominent gaps between Denver behavioral health service needs and provider capacity and capabilities by:

- Summarizing insights from people living in Denver that highlight the gaps they experience when looking for behavioral health services.
- Summarizing insights from Denver behavioral health service providers that highlight the gaps they encounter when delivering services to their intended Denver communities.

- Assessing the difference (i.e., the gap) between the estimated number of Denver community members needing behavioral health services and the estimated number of people in Denver receiving services.

## Make Recommendations to Address Service Gaps

The project culminated in recommendations to DDPHE focusing on potential investments to address high priority behavioral health service gaps. This process included:

- Organizing all detailed project findings into broad categories to identify major themes.
- Drafting recommendations that address the largest number of major finding themes possible.
- Splitting each draft recommendation into two subtypes:
  1. *Early Action Steps* – This part of the recommendation would allow DDPHE to take fairly independent, fast action that would be at a lower time, resource and cost level. This would enable quick momentum to be built towards tackling the systems-level part of the recommendation.
  2. *Systems-Level* – This part of the recommendation could be done in parallel with, or as a follow-up to the “early action steps” part of the recommendation. This part of the recommendation would likely require more collaboration and coordination with stakeholder groups outside of DDPHE, would be at a higher time, resource and cost level that could on the build on momentum from the other part of the recommendation.
- Mapping each overall recommendation to the major findings it would address.

Additional information is available on how data were gathered, organized, and analyzed, which elaborates on the methods summary above. For the sake of brevity and readability, methods details for the interviews, focus groups, surveys and related information are available in Appendix 3 at the end of this report.

## Findings

The findings section starts by outlining and describing the main integrated project findings that have convergence across multiple information sources (i.e., interviews, focus groups and / or survey findings). These 10 main findings are broken into two subsections: (1) Denver Community Behavioral Health Service Needs (four main findings) and (2) Denver Behavioral Health Service Provider Capacity and Capability (six main findings). Reference is sometimes made to how a given main finding is consistent with or different from other behavioral health initiatives noted in the Introduction and Background section of this report. Next, findings unique to each primary data source in the current project are described in their own separate subsection. The last subsection describes findings regarding estimates of the number of people living in Denver who are not getting the behavioral health services they need. We calculated these estimates by combining data from external sources with the quantitative survey findings from this project.

### Integrated Findings

#### **Denver Community Behavioral Health Service Needs**

Below are four main findings from the current project regarding Denver community behavioral health service needs.

1. **Accessing Behavioral Health Services is Very Difficult** – People responding to the survey seeking behavioral health services indicated that: it often takes considerable time and effort to look for services; they experience a variety of barriers to obtaining services; many are not finding the services they seek; and those finding services experience long wait times once they contact a service provider. For example, 41% of people seeking behavioral health services over the past year said they had not yet obtained any type of behavioral health service. Depending on the specific type of service sought, the rate of not obtaining a specific type of service was between 25% (virtually delivered substance use program) and 64% (in-patient substance use facility).

Regarding wait times, the time to receive services after contacting a service provider averaged 19 days, with 6% to 8% of people waiting two months or more, depending on the type of service sought. Across all service types, the average number of days looking for services is 27 days, with 24% of respondents saying they had been looking for four weeks or longer. On average, people spent about 12 hours looking for services, with about 18% of them spending 20 or more hours on their search. People seeking both mental health *and* substance use services spent *much more* time and effort looking for these services than people looking for just one category of services. These people averaged over 20 hours and 51 days looking for services. These same “dual service” seekers obtained some specific services (e.g., in-person mental health support group and in-person professional substance use services) at significantly lower rates than people looking for just one category of services. Findings on this topic from the current project are consistent with other sources noted in the background section of this report.

Additional challenges related to accessing behavioral health services were identified when listening to diverse Denver community members participating in focus groups and provider representatives during interviews. All 95 participants in the 10 focus groups were asked how

organizational factors (e.g., cost, time, location) impacted their ability to access behavioral health services. The top three factors noted were distance to provider locations / transportation issues (20%), followed by costs/insurance (16%), and inaccessible hours (15%). When providers were asked about their ability to deliver services with their current workforce, 58% of those that responded (19 of 33) disagreed or strongly disagreed that they had the workforce needed to meet service delivery needs. This likely contributed to the long wait times reported by survey respondents. Providers also indicated workforce limitations issues such as insufficient staff (45%), lack of resources (27%), incongruences between providers and the service population (23%), and education and training (5%) contributing to their challenges in addressing consumer demand for behavioral health services. Findings on this topic from the current project are consistent with other sources noted in the background section of this report.

2. COVID-19 Has Negatively Impacted Behavioral Health and Service Access – Another main finding is that the COVID-19 pandemic has had a negative impact on mental health and substance use issues, making it harder for people seeking behavioral health services to obtain them. Nearly one-third (31%) of all survey respondents indicated that the COVID-19 pandemic had a “high” or “extremely high” negative impact on their mental health or substance use”, and 61% said that the COVID-19 pandemic had made looking for mental health or substance use services “somewhat harder” or “much harder.” These findings were strongly supported by comments from many focus group participants, with 69% (66 of 95) indicating that COVID-19 had an impact on their mental health and substance use. In a follow-up question, these same focus group participants noted that isolation, depression and anxiety (54%), lack of information and services (13%), and increased substance use (13%) were the most common COVID-19 effects on their mental health and substance use. Caregivers in focus groups shared their experiences with increased anxiety due to navigating working from home and overseeing remote learning for school-aged children. COVID-19 also had an impact on providers, with 94% (31 of 33 respondent) indicating that the pandemic had impacted their service delivery. Findings on this topic from the current project are consistent with other sources noted in the background section of this report.
3. Financial, Timing and Convenience Factors Are the Most Urgent Barriers to Address in order to Improve Access to Needed Behavioral Health Service – People seeking behavioral health services encounter a variety of barriers. Data from the survey and themes identified in the focus groups demonstrate that financial, timing of access, and location convenience of behavioral health service providers are significant barriers for many people seeking services. For example, the top five most frequently cited “urgent” topics to address that would most help people obtain needed behavioral health services were (in decreasing order of frequency cited):
  1. Wait time to receive services (36%)
  2. Services cost too much (35%)
  3. Insurance not adequately covering costs (33%)
  4. Taking care of basic needs is a higher priority (31%)
  5. Inconvenient provider location (27%)

Although not in the “top five”, addressing COVID-19-related issues ranked eighth in the list of “urgent” topics to address, with 22% of all respondents indicating it should be addressed.

Focus group findings align with some of these survey findings. In addition to the organizational factors outlined above, focus group participants indicated several barriers in their personal lives

affecting their ability to access behavioral health services. The top three barriers mentioned in this category were financial (16%), followed by stigma (12%) and racism (11%). Also, nearly all focus group participants (80 out of 81) said "yes" when asked if things like costs and transportation impacted their ability to access mental health and substance use services in Denver. The findings on this topic from the current project are consistent with other sources noted in the background section of this report.

4. Behavioral Health Service Access Issues are Significantly Higher for Some Groups – The findings noted above make it clear that many people find obtaining behavioral services very difficult, the COVID-19 pandemic made their behavioral health worse and finding services more difficult, and some of the largest barriers to getting needed services are related to financial, timing of access, and provider location convenience factors. As challenging as it is for most people to obtain needed behavioral services, some groups of people typically have an *even more* difficult time accessing these services. The summary below lists the groups having significantly<sup>4</sup> more challenging experiences and/or outcomes when searching for behavioral services compared to others. Please see Appendix 8b for elaboration on these three outcome groupings and the statistical details.

***Groups with Significantly More Challenges Accessing Mental Health Services***

- Time, Effort and Success in Finding Services – The people who spend significantly more time and have less success in finding services:
  - Live below the federal poverty line (*See Appendix 8a for further description*)
  - Identify as Black or African American
  - Are homeless or have unstable housing
  - Have no insurance
  - Have Medicaid insurance
  
- Seeking But Not Obtaining Specific Services – Important findings include:
  - Youth ages 15 to 17 years have significantly greater difficulty obtaining in-person therapists and support group services
  - In-person therapists are significantly harder to find for people who
    - Have no insurance
    - Identify as non-binary / other
    - Identify as LGBTQ+
  
- Barriers to Obtaining Services – The people who are more negatively impacted by a variety of barriers to obtaining services:
  - Identify as Black or African American
  - Have a gender identity of non-binary or other
  - Identify with a specific group (separately or in combination) of:
    - Essential worker
    - Homeless or unstable housing
    - LGBTQ+
    - Veteran

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<sup>4</sup> Statistically different group means with 95% confidence or higher.

- Person of color
  - Who have no insurance
  - Who identify as male

### ***Groups with Significantly More Challenges Accessing Substance Use Services***

- **Time, Effort and Success in Finding Services** – The groups having significantly more challenging outcomes with these topics are people:
  - Who are homeless or have unstable housing
  - Who have no insurance
  - Who live below the federal poverty line
  - Who identify as female
- **Seeking But Not Obtaining Specific Services** – Below is a summary of the group differences found for some of these outcomes:
  - Youth under 18 have great difficulty accessing a variety of services even with others helping
  - Virtual substance use harm reduction programs are most difficult to access for people from the following groups (separately or in combination):
    - People who identify as Hispanic
    - People who are homeless or have unstable housing
    - Veterans
- **Barriers to Obtaining Services** – The groups experiencing significantly larger barriers to accessing behavioral health services are people:
  - Who identify as a veteran
  - Who have Medicare insurance
  - Who identify as Black or African American
  - Who have no insurance
  - Who identify as LGBTQ
  - Who are younger than 55 years of age.

Focus group findings are consistent with this main finding, indicating certain groups of people had more challenging experiences. When participants from diverse backgrounds were asked about the barriers they encountered while seeking mental health and substance use services, one of the three most often noted barriers was racism (11%). As noted in the Background section of this report, discrimination and / or racism from multiple sources, including providers, may be a barrier to people obtaining needed services, especially for people of color. Similarly, 12% of focus group participants noted the cultural and linguistic needs of diverse communities as their top recommendation in addressing mental health and substance use services in Denver. On a related point, when providers were asked about the challenges their organizations had faced in providing culturally and linguistically appropriate services, the top two reported challenges were lack of diversity in workforce representation and cultural care (59%), as well as not being able to meet the language needs of diverse communities (53%). Additionally, 23% of providers interviewed noted a misalignment between provider and service population characteristics (e.g., race and ethnicity) as a factor in their workforce limitations to fully meet the behavioral health needs of their communities.



### ***Denver Behavioral Health Service Provider Capacity and Capability***

Below are six main findings from the current project regarding Denver behavioral health service provider capacity and capability.

1. There is Very High Demand for Behavioral Health Services that Providers Cannot Meet –There is a provider capacity issue that is probably a primary driver of why consumers of behavioral health services find that accessing these services is very difficult (the number one Denver community behavioral health service needs finding presented in the last section). For example, about one-third (32%) of interviewed providers said they met 50% or less of service demand, and about 60% of these same providers said they met 75% or less of service demand. This leaves a very large gap of people who must wait a very long time to get services or who may not obtain their needed services at all.

It is also clear that the COVID-19 pandemic made the issue of an inadequate number of providers to meet demand even worse. 94% of providers interviewed stated that COVID-19 impacted their service delivery. Also, over two-thirds (69%) of focus group participants indicated that the COVID-19 pandemic had mostly negative effects on their mental health. And, as mentioned earlier in this report, about six in 10 people responding to the survey (61%) said that the COVID-19 pandemic had made looking for mental health or substance use services “somewhat harder” or “much harder”, probably at least partly because of the increased demand for behavioral health services with the limited number of available providers.

Additional support for this main finding (i.e., providers are not meeting the very high consumer demand for their services) comes from provider interviews and focus groups. For example, 22 interviewed provider representatives gave the project team information when asked to rank a list of factors that had the greatest impact on their organization's ability to provide services to their intended communities. Of five options listed, “insufficient staff” had the highest ranking 45% of the time – the highest of all the options. Also, “more therapy services” was the most often noted response of focus group participants (18%) when asked what additional mental health or substance use services were needed most to address their behavioral health service needs.

Although the connection is less direct, it seems logical that challenges noted by behavioral health services consumers on the survey with obtaining behavioral health services are symptoms of a very high demand for services that providers cannot meet. Recall that consumer survey respondents indicated: it took a long time and much effort just looking for services; they experienced a variety of barriers to obtaining services; many did not find the services they sought; and those finding services experienced long wait times to receive services once they contacted a service provider.

2. Workforce Recruiting, Burnout, and Retention Challenges Have a Negative Impact on Provider Service Capacity – Information gathered from provider interviews and focus groups highlight the challenges providers face with hiring and retaining the needed number of people in their organizations. During interviews, representatives from many provider organizations cited challenges like recruitment, retention, staff burnout, and a shrinking workforce as impacting their capacity and ability to deliver services. As noted above, insufficient staff was ranked number one 45% of the time regarding providers’ top factor impacting their ability to provide services,

followed by lack of resources (27%), incongruencies between provider and the service population (23%), and the need for education and training (5%). Over half (19 out of 33) of responding provider representatives interviewed said “disagree” or “strongly disagree” when asked if their organization had the staff needed to meet the service delivery demands for their intended communities. Staff burnout from chronic understaffing were frequently noted as a cause of high staff turnover. These situations, in turn, could be a primary cause of long wait times for behavioral health services reported by community survey respondents.

3. Providers Have High Workforce Training Needs – An experienced and well-trained workforce is essential to a provider organization’s ability to deliver high quality services. Evidence from provider interviews and the focus group suggests that many provider organizations have a large number of staff members who lack essential hands-on experiences due the pandemic limitation around providing services in-person and have greater challenges keeping up with staff support and supervision. For example, across interviews, most provider representatives (61%) noted staff training and support as the second leading issue impacting their ability to provide services to their intended communities in the past year. Other factors included:
- Lack of staff motivation due to COVID-19 impacts
  - The need for longer and more hands-on onboarding support for new staff
  - The need for increased supervision and support because of pandemic stressors
  - The need for a more diverse workforce as well as bilingual or multilingual providers
  - Lack of diversity among new graduates

Further supporting this finding are the responses from focus group participants who cited stigma and racism as barriers to accessing services and the desire for addressing the cultural and language needs of communities as their top recommendations. In combination, these focus group findings suggest that provider staff need additional and more effective training on these topics.

Although the connection is less direct, survey responses from some community subgroups indicate that they view provider staff diversity issues as high barriers to obtaining acceptable services. Survey respondents who identify as Black or African American or Person of Color rated the barriers of “Providers do not understand my culture” and “No providers look like me” as significantly higher barriers to receiving mental health services compared to people not identifying in those ways. Also, people identifying as Black / African American rated the barriers of “No interpreter provided” and “No providers speak my language” as significantly higher barriers to receiving mental health services than others. It is likely that additional and more effective provider training could help close the gap in some of these areas.

4. Inadequate Provider Technology Limits Delivery of Services – Adoption of remote / virtual / telehealth behavioral health services has provided opportunities and challenges for service providers. Many providers stated in the interviews that their organizations have technology issues such as lack of devices for staff and clients. For example, in interviews, over one-third (38%) of provider representatives noted that they faced significant challenges with providing telehealth services in the past year. In fact, over four in 10 provider interviewees (41%) mentioned “technology” when asked what they needed to better address COVID-19 for both them and the communities they serve. On a positive note, some provider interviewees noted the

positive effects of recent telehealth developments, such as reaching individuals outside of the metro area, including rural communities.

5. There are Limited Funding Sources Available to Smaller Service Providers – Nine provider interviewees (26%) mentioned challenges with the lack of diversified funding, including the need to reduce competition among providers. These barriers can be particularly hard on smaller organizations, which lack the capacity to effectively seek funds, especially when those funding sources put them in direct competition with larger providers. The competitive funding environment often pits organizations against each other and stifles collaboration efforts that would better serve those needing behavioral health services. There are several less direct but supporting reasons why this is a substantial finding.

Several aspects of the national and Colorado State behavioral health funding systems severely limit access to a variety of resources for smaller providers. For example, there are many grant opportunities that are either not available or very difficult for smaller providers to obtain. SAMHSA provides mental health and substance abuse block grants<sup>5</sup>. These grants are provided to state central offices for use in the public sector (e.g., Community Mental Health Centers for services that are not otherwise reimbursed, such as case management), but this type of funding is not available for smaller providers. Subsequently, there are some foundations based in Colorado (e.g., Caring for Colorado, the Colorado Trust) that provide grants for mental health and substance use services. These grants are theoretically available to smaller providers. However, as mentioned above, it is difficult for organizations without grant writing staff to obtain these grants.

Given direct feedback from providers themselves and the nature of supplemental funding sources favoring larger behavioral health service providers, smaller providers are often starved of the resources they need to survive and meet the needs of their communities.

6. Low Workforce Diversity Limits Ability to Meet Some Community Needs – Somewhat related to the finding that service providers have high training needs, multiple sources of information from the current study indicate that low provider workforce diversity often limits their ability to meet the needs of some of the diverse communities they serve. These unmet community behavioral health service needs are often cultural and linguistic. Among the provider representatives interviewed, there was broad recognition that while the majority (74%) of respondents felt that they did provide culturally and linguistically appropriate services to their intended communities, they could not or did not serve all communities. When providers were asked about the challenges and changes their organizations faced in the past year regarding provision of culturally and linguistically appropriate services, lack of diversity (59%), unmet language needs (53%) and lack of diversity among workforce applicants (50%) were the most often noted challenges.

Additional support for this finding comes from the community focus groups. As indicated, previously stigma (12%) and racism (11%) were noted as two of the top three barriers to obtaining behavioral health services, and participants also noted language barriers among the organizational factors impacting access to services. Some survey findings also bolster this main finding. As mentioned earlier in this report, survey respondents identifying as a Black or African

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<sup>5</sup> <https://www.samhsa.gov/grants/block-grants>

American or Person of Color rated the barriers of “Providers do not understand my culture”, “No providers look like me”, “No interpreter provided”, or “No providers speak my language” as significantly higher barriers to receiving mental health services than people not identifying as Black or African American or a Person of Color.

## Focus Groups

Consolidated, detailed findings from all 10 focus groups can be found in Appendix 7 of this report.

## Interviews

Consolidated, detailed findings from all 21 provider interviews can be found in Appendix 7 of this report.

## Provider Profiles

Thirteen provider profiles were created for this project and have been provided directly to DDPHE as a separate document.

## Surveys

### **Sample Demographics and Groups**

The sample of 601 surveys completed by people living in Denver analyzed for this project had demographic and group distributions that were reasonably representative of the overall Denver population. A summary of key sample demographics and groups, including comparison to the latest available US Census American Community Survey (ACS) findings from 2021<sup>13</sup>, or other sources, when available, can be found on slides 3 through 17 within Appendix 8a of this report.

### **Question-by-Question Findings**

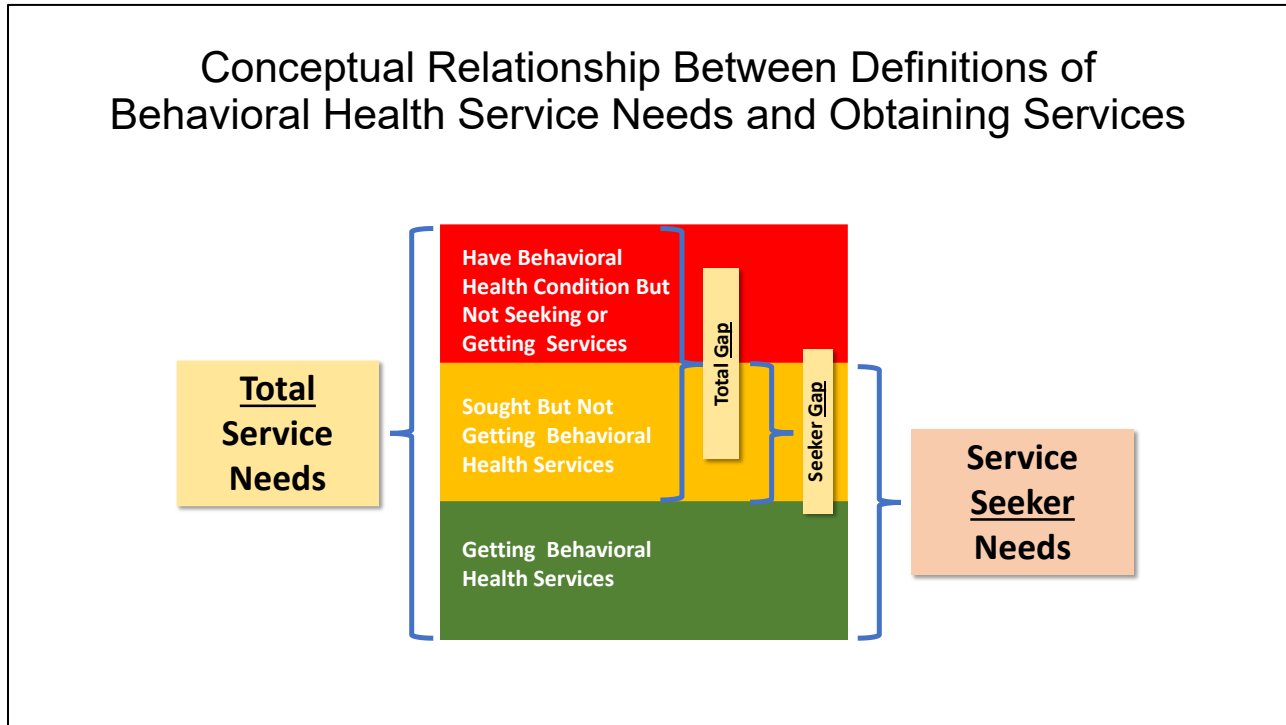
All main survey findings relevant to this project were presented in the Integrated Findings section above or the Behavioral Health Service Gaps section below. Question-by-question response distributions can be found in Appendix 8a in this report.

## Behavioral Health Service Gaps

### **Behavioral Health Service Need and Gap Framework**

Before summarizing initial estimates of the Denver behavioral health service gaps, it is important to describe a framework for the different types of behavioral health services needs and gaps. At the highest level, the total behavioral health service needs for a community is the number of people experiencing a behavioral health condition. The total behavioral health service gap is the number of people who have a need but are not receiving any services. Additionally, the behavioral health service seeker needs are the number of people actively seeking services (including people getting assistance from another person), with the seeker gap being the number of people seeking services who are not able to get them. This framework (see Figure 1 for a visual summary) notes that there are likely a number of people needing behavioral health services who are not even seeking them.

Figure 1

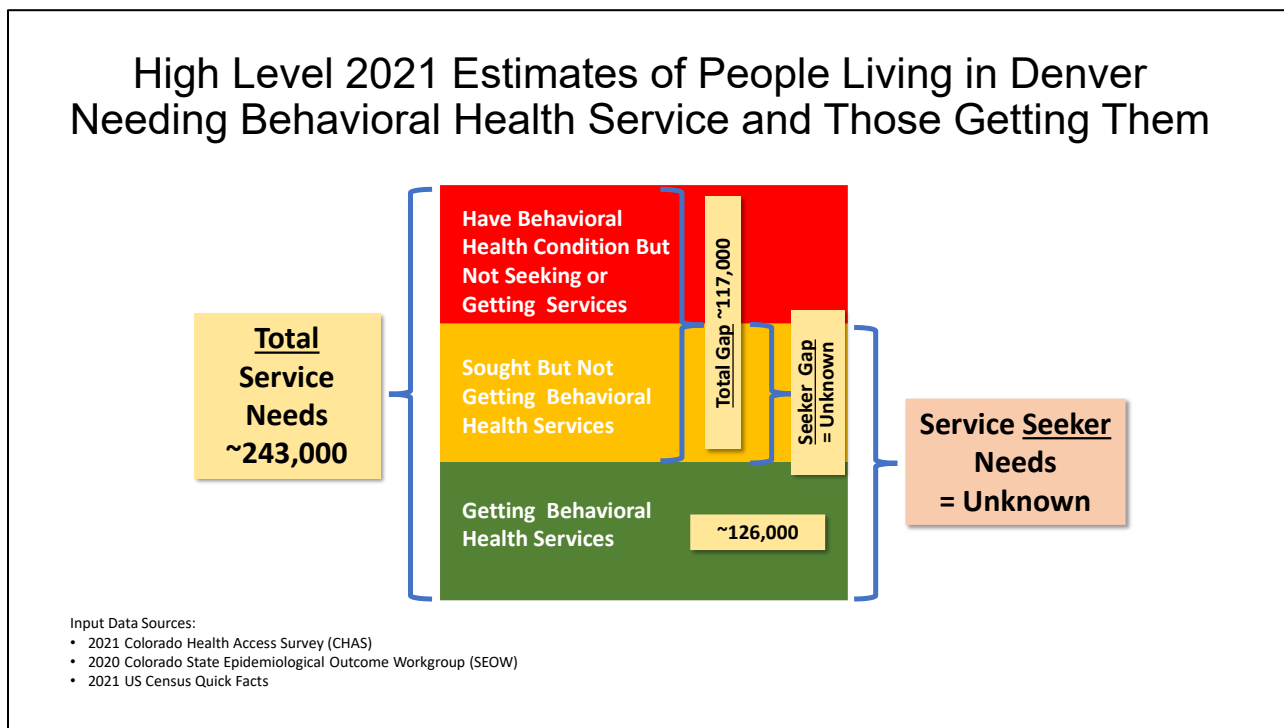


**Preliminary Estimates of Denver Behavioral Health Service Gaps**

Applying the conceptual framework above to the Colorado and Denver statistics noted earlier, it is estimated that there are between 243,000 and 280,000 Denver residents who have a behavioral health service need of some kind. The lower estimate of 243,000 comes from combining two sources of information. The first source is the Colorado Health Access Survey CHAS<sup>5</sup> which estimates that 26.9% of people living in Denver in 2021 had eight or more days of poor mental health in the past 30 days, which can be used as a proxy for the number of people having a mental health condition. The second source is from the Colorado State Epidemiological Outcome Workgroup (SEOW: 2020)<sup>12</sup> that estimates 11.9% of Coloradans have a substance use disorder, and 4.6% have co-occurring mental health and substance use disorders. Using the latest published estimates from the US Census that there are 711,463 people living in Denver<sup>13</sup>, this equates to about 243,000 people in Denver needing behavioral health services (see the “Behavioral Health Service Gaps” section at the bottom of Appendix 3 at the end of this report for calculations). The higher estimate of 280,000 comes from the Kaiser Family Foundation estimate that about 32% of people living in Colorado in 2021 have a mental illness<sup>4</sup>. Using that as an estimate of the percent of people living in Denver who have a mental health condition (and using the same SEOW estimates) and multiplying that by the US Census population estimate for Denver noted above, we arrive at an estimated 280,000 people living in Denver with a need for behavioral health services. Also, as mentioned earlier, the 2021 (CHAS)<sup>5</sup> report indicated that an estimated 110,181 people living in Denver needed mental health care but did not receive them, and 11,648 needed services for substance use but did not receive them.

Figure 2 summarizes the number of people in Denver with service needs and those receiving behavioral health services. The values in Figure 2 use the inputs described above (the lower bound estimate of total service needs) and assumes that about 39% of people seeking substance use services also seek a mental health service (based on estimates from the SEOW<sup>12</sup>). The details of this calculation can be found in the “Behavioral Health Service Gaps” section at the bottom of Appendix 3 at the end of this report. This summary clearly shows there are many people living in Denver needing services who are not getting them.

Figure 2.



The approach described above found that about 126,000 people living in Denver received needed behavioral health services in 2021. The project team used independent data from the Colorado Behavioral Health Administration (BHA) attempting to validate this estimate. Using an approach described in Appendix 9, the estimated number of people receiving behavioral health services in FY2022 (July 1, 2021 through June 30, 2022) using BHA data was 72,736. This value is much lower than the estimate described above. If the BHA derived estimate were true, that would imply that the total behavioral health service gaps might be even larger than reported here. Although the two independent approaches to estimating the total number of people receiving behavioral health services in Denver do not align, the project team uses the initial larger value (126,000) given that fewer assumptions are made with that approach, and it is based on survey data of all people potentially receiving services.

**Refining Estimates of Denver Behavioral Health Service Gaps**

Survey findings from the current project suggest that about 41% of people actively seeking behavioral health services in Denver are not finding the services they need. Although the estimate of the service

gap from the current project is lower than from previous reports (41% vs 48%), results from the current project are likely an underestimate because we are only examining people who have the time, resources and motivation to actively look for services, thus increasing their chances of getting the services they need. Using this logic, any service gap measured in the current project (i.e., the “service seeker gap”) underestimates the full or total service gap by about 15% (see end of Appendix 3 for how this correction factor was calculated).

The quantitative survey for the current project asked people living in Denver three questions about the behavioral health services they looked for in the past 12 months:

- preference ratings for several behavioral health service types if needed (1 to 5 rating scale, with 5 being highest preference);
- behavioral health service types they looked for but did not obtain (check boxes); and
- behavioral health service types they looked for and did obtain (check boxes).

The survey data allowed the project team to address several questions central to the objectives of this project:

- Which behavioral health service types are most preferred when needed?
- Which service types are sought most often?
- Which service types are most often not found when sought (i.e., specific service type gaps)?

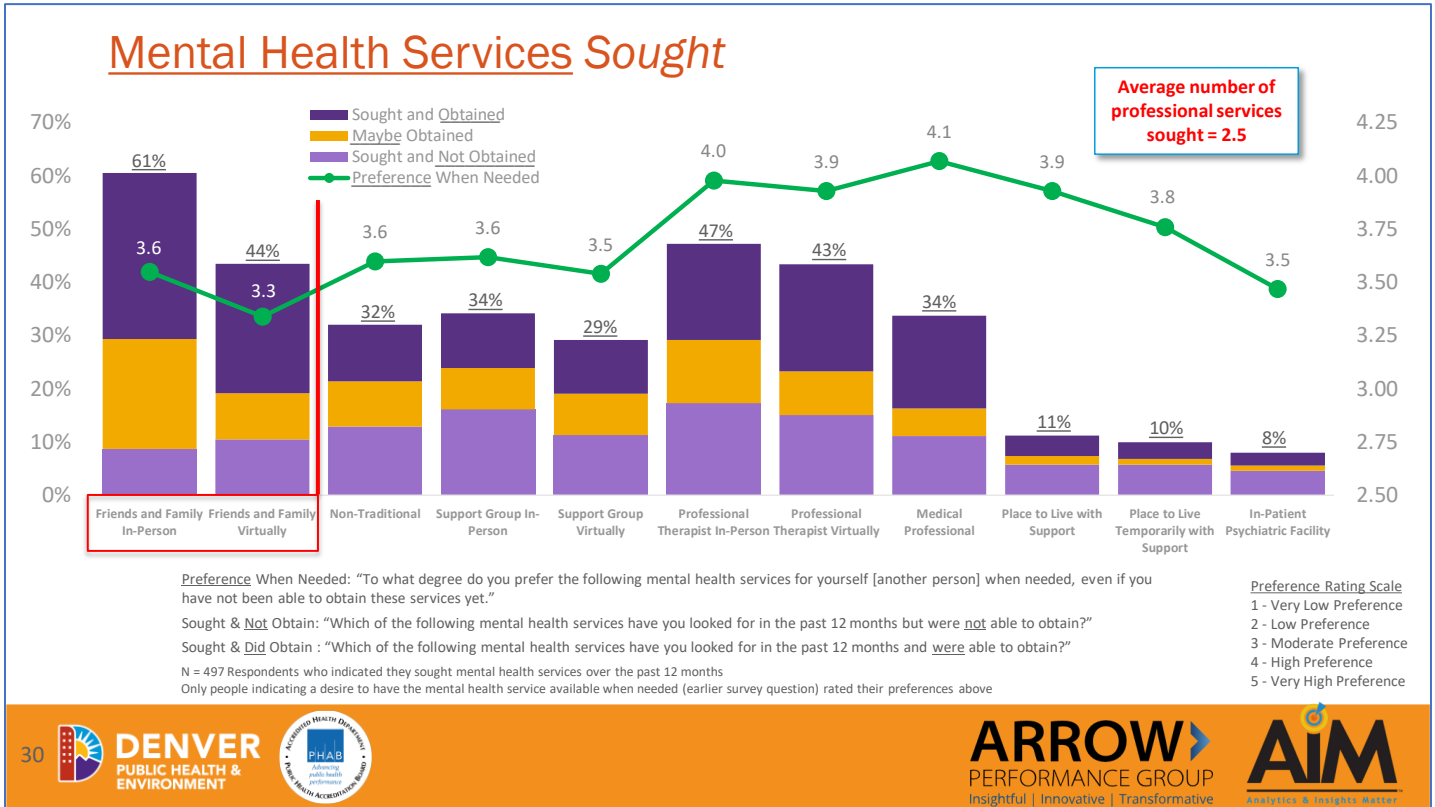
It is important to note the survey findings may solely represent a person’s perception of the type of service needed and not reflect the service needed based on a clinician’s assessment. For example, a person may respond that they are seeking and need services from an in-patient psychiatric facility when in fact a clinical assessment would indicate they do not meet medical necessity for hospitalization. Conversely, a person may indicate they need a prevention program when in fact they would meet the criteria for inpatient substance use treatment.

### Mental Health Services

Figure 3 shows results for people seeking mental health services in the past 12 months (with a small number of them also seeking substance use services). There are several key findings to highlight in Figure 3:

- Friends and family are often engaged when looking for “help” with mental health issues (61% seeking out friends or family in-person)
- Medical professionals (4.1), therapists (3.9 to 4.0) and a place to live with support (3.9) are the most preferred services when needed
- Therapists (43% to 47%), medical professionals (35%) and support groups (29% to 34%) are the most frequently sought professional services (i.e., not friends or family)
- The average number of professional services sought in the past 12 months was 2.5 per person

Figure 3.

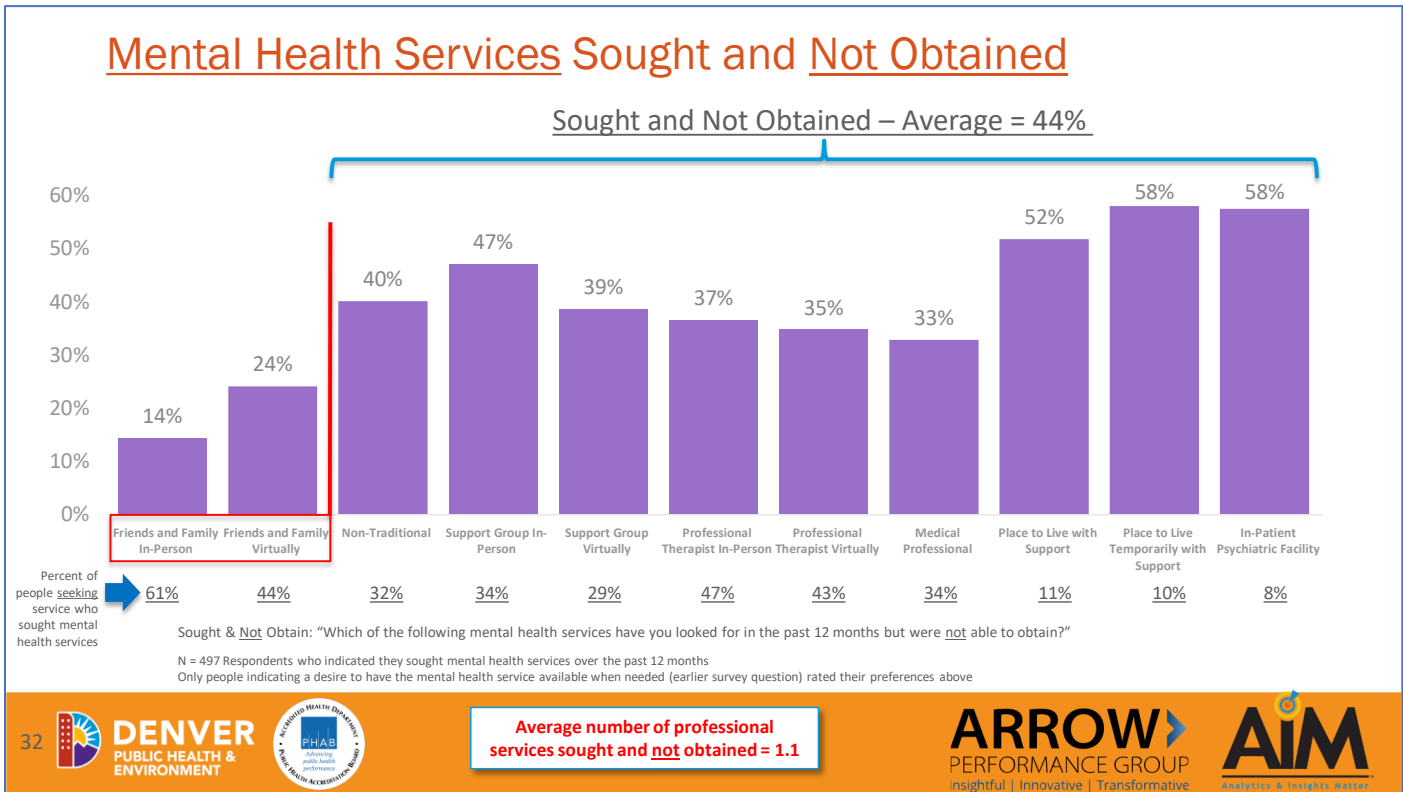


Using the same mental health survey data, Figure 4 shows the percent of respondents that indicated they did not obtain the services sought. There are a few key findings regarding professional services to highlight in Figure 4:

- For any given professional service sought (i.e., excluding friends and family), almost half (44%) did not obtain the service they sought.
- Of the people seeking a particular service, those with the highest rates of “not obtained” are in-patient psychiatric facility (58%) and places to live with (temporary) support (52% to 58%). Similarly, in-person support groups have the next highest level of services sought and not obtained (47%).
- An average of 1.1 mental health services are sought and not obtained per person.



Figure 4.



### Substance Use Services and Programs

Slides 22 through 25 in Appendix 8a show the same information for substance use services and programs as shown for mental health services in the last section.

### Estimating Denver Behavioral Health Service Gaps

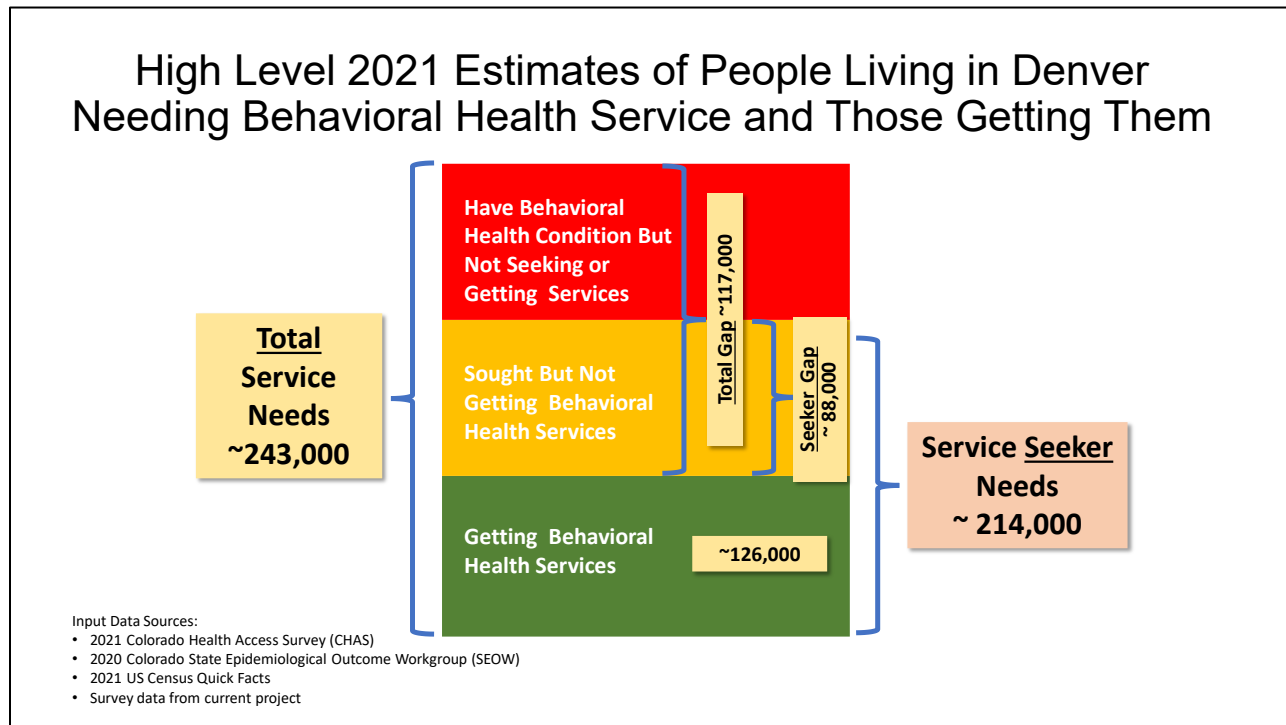
#### Scaling Up Survey Findings Across All Behavioral Health Service Types

Before analyzing behavioral health service gaps for specific service types, revisiting the high-level service gap summarized in Figure 2 of this report will provide context for the more detailed findings. The overall service seeker gap from the survey findings is 41%, with the remaining 59% finding the services they sought. The 126,000 people in Denver who are getting behavioral health services represent the 59% in the survey findings. Dividing the 126,000 value by 59% (.59) gives us an estimated total number of people living in Denver who looked for services ("service seeker needs" = 214,000 people). Subtracting the 126,000 from this value provides the estimated "seeker gap" for Denver of 88,000 people. By subtracting the service seeker needs from the total service needs we get an estimated 29,000 people living in Denver who have a behavioral health condition who are not even seeking the behavioral health services they need. These insights can be summarized as follows (as summarized in Figure 5 below):

- About 243,000 people in Denver need behavioral health services
- Of these people with a behavioral health service need

- about 126,000 (52%) are receiving the services they need;
- about 88,000 (36%) have looked for services but cannot obtain them over the past 12 months; and
- about 29,000 (12%) are not even looking for the services they need.

Figure 5.



### Scaling Up Survey Findings for Specific Behavioral Health Services

As already noted, The Colorado Health Institute<sup>5</sup> estimated that about 117,000 people in Denver need behavioral health services in Denver who are not receiving services (110,181 for mental health services and 11,648 for substance use services, with some degree of overlap between the two categories). Survey data from the current project were used to estimate the proportion of people in Denver seeking specific types of behavioral health services who are not able to obtain them. Based on a comparison of the current project findings and the CHI report, “service seeker gaps” can use the correction factor noted early in this report to estimate the “total service gap” for each service type. An example of how the project team calculated specific service gap estimates can be found towards the end of Appendix 3.

Table 2 provides estimates for the number of people seeking each type of mental health service in Denver who were not getting the service they sought. The sampling confidence interval for the estimates in Table 1 (given a survey sample size of 497 mental health service seeking respondents) is +/- 4.4% with 95% confidence.

Table 1.  
Mental Health: Estimated Number of People Living in Denver Not Receiving Services Sought

| Mental Health Services  | Denver Survey Data |            |                         | Calculated        |                  |
|---|--------------------|------------|-------------------------|-------------------|------------------|
|   | Seeking Service    | Seeker Gap | Gap Percent All Seekers | Denver Seeker Gap | Denver Total Gap |
| Non-Traditional   | 32%                | 40%        | 13%                     | 14,218            | 16,727           |
| Support Group In-Person   | 34%                | 47%        | 16%                     | 17,748            | 20,880           |
| Support Group Virtually   | 29%                | 39%        | 11%                     | 12,451            | 14,648           |
| Professional Therapist In-Person  | 47%                | 37%        | 17%                     | 19,074            | 22,440           |
| Professional Therapist Virtually  | 43%                | 35%        | 15%                     | 16,641            | 19,577           |
| Medical Professional  | 34%                | 33%        | 11%                     | 12,215            | 14,371           |
| Place to Live with Support  | 11%                | 52%        | 6%                      | 6,392             | 7,520            |
| Place to Live Temporarily with Support  | 10%                | 58%        | 6%                      | 6,390             | 7,518            |
| In-Patient Psychiatric Facility   | 8%                 | 58%        | 5%                      | 5,068             | 5,963            |
|   |                    |            |                         | <b>110,198</b>    | <b>129,645</b>   |
| <b>Number of People Not Getting Needed Mental Health Services (CHAS 2021)</b> | <b>110,181</b>     |            |                         | <b>Sum</b>        |                  |

Seeking Services: Percent of survey respondents seeking the noted service

Seeker Gap: Percent of survey respondents seeking the noted service who were not able to obtain it

Gap Percent All Seekers: Seeking Services multiplied by Seeker Gap

Denver Seeker Gap: Number of people not getting needed mental health service multiplied by Gap Percent All Seekers

Denver Total Gap: Denver Seeker Gap after applying correction factor

Below are a few key things to note about the mental health service gap findings in Table 1:

- Each of the mental health services noted above are overlapping since survey respondents often sought two or more services. Therefore, the sum of the calculated gaps can be more than the total number of people not receiving any type of service.
- The services estimated to have the largest “service gap”, in descending order of numbers of people are (with seeker gap amount shown in parenthesis):
  - Professional Therapist: In-Person (19,074)
  - Support Group: In-Person (17,748)
  - Professional Therapist: Virtual (16,641)
  - Non-Traditional (14,218)
  - Support Group: Virtual (12,451)
  - Medical Professional (12,215)
- Not all service gaps are created equal: Although the three lowest service gaps are much smaller than the others (see bullets below), these services tend to be the most resource intensive and may have more of a negative impact on people who need these services and do not receive services.
  - Place to Live with Support (6,392)
  - Place to Live Temporarily with Support (6,390)
  - In-Patient Psychiatric Facility (5,068)

- Although the project team calculated the most direct service gap estimates for seekers, these numbers are likely underestimated because they are only examining people who have the time, resources and motivation to actively look for services. The Denver Total Gap estimates in Table 1 may be closer to what really needs to be addressed.

Using the same logic noted for mental health services above, Table 2 provides estimates of the number of people seeking each type of professional substance use service in Denver who are not getting the service they seek. The sampling confidence interval for the estimates in Table 2 (given a survey sample size of 138 substance use service seeking respondents) is +/- 8.3% with 95% confidence.

Table 2.  
Substance Use: Estimated Number of People Living in Denver Not Receiving Services Sought

| Substance Use Services  | Denver Survey Data |            |                         | Calculated        |                  |
|---|--------------------|------------|-------------------------|-------------------|------------------|
|   | Seeking Service    | Seeker Gap | Gap Percent All Seekers | Denver Seeker Gap | Denver Total Gap |
| Non-Traditional   | 29%                | 40%        | 12%                     | 1,350             | 1,588            |
| Substance Use Program In-Person   | 39%                | 35%        | 14%                     | 1,607             | 1,891            |
| Substance Use Program Virtually   | 32%                | 25%        | 8%                      | 933               | 1,097            |
| Substance Use Professional In-Person  | 30%                | 38%        | 12%                     | 1,353             | 1,591            |
| Substance Use Professional Virtually  | 36%                | 37%        | 13%                     | 1,513             | 1,780            |
| Medical Professional  | 28%                | 39%        | 11%                     | 1,269             | 1,493            |
| Place to Live Temporarily with Support  | 17%                | 50%        | 9%                      | 1,013             | 1,192            |
| In-Patient Substance Use Facility   | 16%                | 64%        | 10%                     | 1,176             | 1,384            |
|   |                    |            |                         | <b>10,214</b>     | <b>12,017</b>    |
| <b>Number of People Not Getting Needed Substance Use Services (CHAS 2021)</b> | <b>11,648</b>      |            |                         | <b>Sum</b>        |                  |

Seeking Services: Percent of survey respondents seeking the noted service

Seeker Gap: Percent of survey respondents seeking the noted service who were not able to obtain it

Gap Percent All Seekers: Seeking Service multiplied by Seeker Gap

Denver Seeker Gap: Number of people not getting needed substance use service multiplied by Gap Percent All Seekers

Denver Total Gap: Denver Seeker Gap after applying correction factor

Below are a few key things to note about the substance use service gap findings in Table 2:

- Each of the substance use services noted above overlap with each other since survey respondents often sought two or more services. Therefore, the sum of the calculated gaps can be more than the total number of people not receiving any service.
- The services estimated to have the largest “service gap”, in descending order of numbers of people are (with seeker gap amount shown in parenthesis):
  - Substance Use Program: In-Person (1,607)
  - Substance Use Professional: Virtual (1,513)
  - Substance Use Professional: In-Person (1,353)
  - Non-Traditional (1,350)
  - Medical Professional (1,269)

- In-Patient Substance Use Facility (1,176)
- Place to Live Temporarily with Support (1,013)
- Substance Use Program: Virtual (933)
- Not all service gaps are created equal: Although some of the service gaps are much smaller than others (e.g., In-Patient Substance Use Facility), these services can be much more resource intensive with the potential for more negative impact on individuals not getting them when needed.
- Although the project team calculated the most direct service gap estimates for seekers, these numbers are likely underestimated because they are only examining people who have the time, resources and motivation to actively look for services. The Denver Total Gap estimates in Table 2 may be closer to what really needs to be addressed.

### Limitations

The estimated number of people seeking and not obtaining each specific service noted above has several limitations to keep in mind when interpreting and potentially using these findings:

- *Definition of Service Need* – Just because someone seeks a behavioral health service does not mean they need that service, using the definition of having a service need used in this project. They may need a more or less intensive service, or they may not need any service at all.
- *Specific Service Needs* – Similarly, even if someone really does need a service using the current project definition, they may not know what type of service they need without an assessment conducted by a trained behavioral health professional.
- *Survey Sample Representativeness* – The survey sample roughly matches the demographic profile of the entire Denver population in many ways (e.g., most race / ethnicity categories, gender, veterans) but it over-represents other groups to some degree (e.g., no insurance, low income, LGBTQ+, Black / African American). These differences can lead towards biasing estimates of service gaps for the entire Denver population.
- *Correction Factor* – The correction factor calculated to adjust seeker gap estimates to total gap estimates is based on CHI estimates from 2021 while the survey data used was gathered in 2022. The total service gap may have shifted between 2021 and 2022, and that would introduce inaccuracies in the correction factor. Also, the correction factor calculated is across all behavioral health service types. It is likely that there are “service-specific” correction factors that are not known and not applied to these estimates.
- *Sampling Error* – Due to the number of surveys obtained, the point estimates in Table 1 and Table 2 are not exact. The actual values could fall within a confidence interval band of +/- 4.4% for mental health services and +/- 8.3% for substance use services, both with 95% confidence.

Despite the potential limitations outlined above, the service gaps noted can be used by DDPHE in prioritizing which gaps to address most aggressively in the near- and long-term, when used in conjunction with other relevant information available to DDPHE.

### Estimating Denver Behavioral Health Provider Staffing Gaps

Using estimates of the Denver behavioral health service gaps described above, with additional reference information it would be possible for DDPHE to make high-level estimates for the number of provider staff needed to address the consumer gaps noted in the report above. One very useful resource is a SAMHSA workforce study<sup>14</sup> that provides project team estimates needed to provide services at varying levels of intensity for a given number of people needing services within each service intensity band.

# Recommendations

As previously described in the method section of this report, the recommendations noted below were created using the following systematic process:

1. Organized all detailed project findings into broad categories to identify major themes.
2. Drafted recommendations that address the largest number of major finding themes possible.
3. Split each draft recommendation into two subtypes:
  - *Early Action Steps* – This part of the recommendation would allow DDPHE to take fairly independent, fast action that would be at a lower time, resource and cost level that would enable quick momentum to be built towards tackling the systems-level part of the recommendation.
  - *Systems-Level* – This part of the recommendation could be done in parallel with, or as a follow-up to the “early action steps” part of the recommendation. This part of the recommendation would likely require more collaboration and coordination with stakeholder groups outside of DDPHE, and would be at a higher time, resource, and cost level that could build on momentum from the other part of the recommendation.
4. Mapped each overall recommendation to the major findings it would address.

## The Recommendations

The following seven recommendations have been listed in order of how many findings they address and are not further prioritized

|  |   |
|--|---|
| <b>#1. Provide leadership to engage critical stakeholders to improve behavioral health services</b>  |   |
| Early Action Steps   | Convene City human service provider agencies to discuss coordination of provider resources and obtain additional funding for direct services.   |
| Systems-Level Change   | Work with other provider groups and collaborations to convene a broader partnership discussion for planning to address systemic gaps, especially for underserved communities (e.g., Metro Denver Partnership for Health - Behavioral Health Workgroup). |
| <p><i>This recommendation would address all 10 findings (see Appendix 10). For example, DDPHE may want to partner with, or provide support to, providers to apply for one or more of the recently released RFPs for Behavioral Health Administration community grants (Senate Bill 22-196 and House Bill 22-1281) and other funding sources for smaller service providers.</i></p> |   |

**#2. Increase awareness of and improve provision of language access services**

|                      |  |
|----------------------|--|
| Early Action Steps   | Increase awareness of community members that there are qualified interpreters available along with behavioral health services offered. Increase awareness of behavioral health workforce for importance of having medical interpreter services available as well as provide resources for how to offer these services.   |
| Systems-Level Change | Increase awareness among funding recipients about the federal requirement (Title XI; EO 13166; Section 1557 ACA) for provision of language access services by including easy to follow reporting requirements for language access (line items for translation, interpretation, and bilingual staff). Provide training to staff related to reporting requirements for language access services. |

*This recommendation would address all 10 findings (see Appendix 10). In particular, increasing language access will address the ability to meet non-English speaking community member needs.*

**#3. Increase the number of providers (including Medicaid providers) and ensure that existing providers are maintained**

|                      |  |
|----------------------|--|
| Early Action Steps   | Contract with additional providers to be staffed at a variety of organizations, including smaller organizations, who could provide services for underserved populations. Efforts should be made to ensure these organizations employ providers that are representative of the community they serve.  |
| Systems-Level Change | Partner with other Denver agencies (e.g., DHS) to hire additional clinical providers to provide direct services to the community. Fund administrative support for providers to become Medicaid eligible. Coordinate with HCPF and the Regional Accountable Entities (RAEs) to streamline the Medicaid reimbursement process, especially for smaller providers. |

*This recommendation addresses nine out of 10 findings. For example, increasing providers will decrease wait times and increase access for all community members and especially underserved groups who reported challenges with finding providers that 'look and sound like me'.*



**#4. Provide coordination and policy support to improve case management<sup>6</sup> utilization**

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|----------------------|--|
| Early Action Steps   | Provide technical assistance to smaller providers to establish or improve case management utilization. DDPHE could provide stipends to smaller providers to supplement case management staff. Require funded case managers to include peer support as part of referrals. |
| Systems-Level Change | Advocate at the state and federal level so that more Medicaid entities fund case management. Staff case managers at DDPHE.   |

*This recommendation addresses nine of the 10 findings. For example, many smaller providers expressed a need for more case management and indicated that current funding sources are limited for small providers.*

**#5. Educate and raise awareness for consumers around mental health treatment service options and how to connect to them**

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|----------------------|--|
| Early Action Steps   | Early action step examples of this recommendation include: leverage and expand mental health first aid training for community members; amplify Anti-Stigma and other efforts to continue to increase awareness and education around mental health and substance use issues; focus existing Anti-Stigma campaign on additional diverse community groups in different languages; And post QR codes throughout the City leading to a culturally and linguistically appropriate information page on the DDPHE website. |
| Systems-Level Change | Host culturally and linguistically appropriate community training programs to increase education and awareness around financial benefits. Create a long-term stigma reducing strategic plan that includes metrics to track progress. Implement Anti-Stigma campaigns and/or efforts directed at multiple intended diverse community groups.  |

*This recommendation addresses nine of the 10 findings. For example, increasing awareness around service options would help increase access for all community members, especially those that have been historically underserved.*

<sup>6</sup> Case management is a professional and collaborative process that assesses, plans, implements, coordinates, monitors and evaluates to improve outcomes, experiences and value. Patients with case management experience both advocacy and better access to care, providers have complex cases facilitated, care is improved, and costs reduced<sup>15</sup>.

**#6. Increase culturally and linguistically responsive community outreach and involvement**

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|----------------------|--|
| Early Action Steps   | Establish neighborhood-based community supportive groups for identified cultural/linguistic groups. Create various opportunities for more peer support services to be available; establish programs to conduct outreach to diverse communities.  |
| Systems-Level Change | Develop more neighborhood-based access points for clinician and non-clinical services (e.g., expand Wellness Winnie and at-home services). Increase community-led informal support groups to fit different cultural and linguistic needs. Engage with the community to identify and provide alternatives to conventional “Western” treatment options to match a variety of cultural and linguistic needs (e.g., talking circles, healers, yoga, and meditation). |

*This recommendation addresses seven of the 10 findings. For example, connecting with underserved communities will increase awareness of treatment options and access to services.*

**#7. Improve access to services by encouraging extended hours and weekends**

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| Early Action Steps   | Provide funding to support alternative staffing programs to address availability and costs. Fund pilot programs in underserved communities. Track outcomes from pilot projects and increase funding as improvements are documented.   |
| Systems-Level Change | Work with accrediting organizations to mandate after hour and weekend services (beyond emergency services) and costs. Incentivize extended hours by reimbursing a differential for mental health providers. Promote collaboration and coordination among agencies to increase hours, including telehealth. Reduce barriers by increasing accessibility through things such as providing on-site childcare, transportation (including RTD Access-a-Ride), ride sharing and vouchers. Increase use of telehealth during weekends and off-hours. |

*This recommendation addresses seven of the 10 findings. For example, increasing access to after-hours and weekend services would reduce timing and convenience barriers for accessing services for working community members and especially parents.*

## Additional Topics to Explore

As follow-up to the current project, DDPHE may want to consider exploring the following topics related to deeper insights into the needs and implications of acting on these recommendations:

1. **Estimate Number and Cost of Provider Staff to Address Gaps in Community Behavioral Health Service Needs** – Recommendation #3 above (increase the number of providers [including Medicaid providers] and ensure that existing providers are maintained, within the City and County of Denver) is related to nearly all main findings in this project. A follow-up project could focus on estimating the number and cost of behavioral health service provider staff that would be needed to address the community behavioral health service gaps identified in the current project.
2. **Additional Survey Data Analyses** – All survey data analyses were prioritized to focus on the core project objectives. Many additional insightful analyses can be conducted as follow-ups that can address questions like:
  - What are key drivers of increasing community success in obtaining needed behavioral health services?
  - What are key drivers of reducing the time and effort associated with finding desired behavioral health services?
  - What are key drivers of reducing the wait for behavioral health services once an appointment is made?
  - What are key drivers of the number and size of barriers encountered when seeking behavioral health services?
  - How large an impact did COVID-19 have on all the above?