



COLORADO

**Behavioral Health
Administration**

Substance Use Services Evaluation Report

House Bill 22-1326, Fentanyl Accountability & Prevention | May 31, 2023



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Executive Summary

Our state's current substance use disorder (SUD) treatment and recovery system has received an unprecedented amount of attention and, with that attention, funding. While people fall through the cracks — particularly people in rural areas and from systemically excluded populations — the state's current Managed Service Organizations (MSOs), including Signal Behavioral Health Network (Signal), Rocky Mountain Health Plans, and Diversus

Health are invested in improving access for clients. These organizations serve as third-party payers for individuals not covered by other health insurance, as well as underinsured individuals. Additionally, they identify gaps in the system of care and subsidize high-yield improvements to all parts of the continuum, ranging from prevention to recovery, neither of which are well-covered by traditional health care coverage.

Managed Service Organizations (MSOs) manage local, state, and federal substance use disorder treatment funds, many of those coming from the Behavioral Health Administration (BHA). MSOs are responsible for funding substance use disorder services by establishing and sub-contracting with a provider network.

This is the report for House Bill (HB) 22-1326, Fentanyl Accountability and Prevention. HB 22-1326 requires MSOs to provide an evaluation of specific SUD services within their region. On behalf of the MSOs, Steadman Group conducted an evaluation of the four substance use disorder treatment and recovery services denoted in HB 22-1326.

This evaluation covers fiscal year 2022 for all Sub-State Planning Areas (SSPAs), which are the regions for the MSOs. Please note that, for the year of analysis, two other organizations—Mental Health Partners and West Slope Casa—were the MSOs for SSPAs 5-7. This report evaluates the supply and necessary demand of SUD services for each region across medication for opioid use disorder (MOUD) providers, withdrawal management (WM) providers, recovery residences, and recovery support services for public high schools. Both MOUD and withdrawal management sections were expanded to include youth service availability and utilization, as well as jail-based resources for MOUD specifically. Finally, the report includes additional analysis of key informant interviews from subject matter experts, Colorado community health needs assessments and community health improvement plans, and opioid settlement governance committee spending initiatives.

This report employs a variety of assessment methods, including quantitative data from the Medicaid Regional Accountable Entities (RAEs), the MSOs, the Behavioral Health Administration (BHA), 16 qualitative key informant interviews, opioid settlement two-year plans, and community health needs assessments and community health improvement plans across Colorado. This report is divided into seven unique sections, as outlined in the Key Findings on the next page.

Key Findings

This report also weaves the findings of the key informant interviews throughout each relevant section to add context to quantitative findings. Together, these analyses have yielded the below key findings:



BEHAVIORAL HEALTH IS THE TOP PRIORITY COMMUNITY HEALTH NEED ACROSS THE STATE.

1. Statewide, 54 of 64 counties (84%) listed behavioral health as their number one priority in their public health improvement plans and 62 (97%) counties identified behavioral health in their top three priority areas.
2. 92% of urban counties and 82% of rural counties identified a behavioral health category as the number one priority. Urban counties (42%) were nearly twice as likely as their rural counterparts (22%) to identify mental health as their number one priority.
3. Community strategies to address behavioral health needs fell into five major categories, including:
 - a. **Improving collaboration, integration, and community connectedness across the region and among stakeholders**, identified by 70% of counties as a means to address capacity issues;
 - b. **Reducing stigma by increasing awareness about behavioral health issues in the community**, identified by 52% of counties. Frequently cited strategies include marketing campaigns with messaging to change perceptions of substance use and disseminating Spanish language materials;
 - c. **Improving access to behavioral health providers**, identified by 48% of counties. Strategies include improving transitions of care, increasing behavioral health providers through recruitment and reduced turnover, and improving access to culturally and linguistically competent care options;
 - d. **Improving behavioral health data collection, reporting, and surveillance** was identified by 10 counties. Strategies included standardizing behavioral health data by creating a public-facing map or dashboard to increase public awareness of behavioral health resources within the community;
 - e. **Increasing prevention and early intervention of behavioral health issues**, identified by nine counties. This theme includes screening at clinical and community-based levels, particularly for youth to ensure early detection.
 - f. **Behavioral health stakeholders identified key gaps in the continuum of care and barriers to SUD treatment, INCLUDING:**

- i. **Gaps:** Youth and adolescent services, inpatient and residential bed availability, culturally competent services, and recovery housing.
- ii. **Barriers:** Workforce shortage, limited insurance coverage for SUD services, stigma, and navigation.



MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

1. Colorado boasts above-average access to MOUD, with the MOUD system currently reaching almost two-thirds of the state's total OUD population.
2. Opioid Treatment Programs (OTPs), commonly known as methadone clinics, still disproportionately serve urban populations, even within largely rural SSPA regions.
3. OTP utilization is higher in regions where the risk of fatal overdose is higher.
4. Colorado's total MOUD capacity is robust. In SSPAs 1 and 4, prescribers already serve more than the expected number of individuals with OUD.
5. Fatal overdose among youth used to be rare. While overdoses have increased for all age ranges over the last few years, rates among youth have skyrocketed. According to 2021 CDPHE data, among youth aged 10 to 18, fatal overdoses due to fentanyl increased a staggering 600% in two years during the pandemic, from five to 35.
6. Across all dimensions of MOUD supply, youth MOUD services show the greatest unmet need, reaching less than 3% of the eligible adolescent OUD population.
7. While MOUD have expanded greatly in jails, data collection is sparse. The number of clients, while undoubtedly far higher than in prior years, is unknown.



WITHDRAWAL MANAGEMENT (WM)

1. The addition of 3.7WM as a Medicaid benefit has greatly changed the landscape of WM in Colorado, particularly in urban areas, raising Medicaid spending on this service.
2. Ambulatory WM is emerging as an option, particularly in rural areas.
3. The concentration of WM facilities in population centers remains a major concern for more rural areas of the state although some regions have very well-dispersed services.
4. Just five total providers served at least one youth (<18 years of age) client during FY 2022.



RECOVERY RESIDENCES

1. Colorado ranks highly for access to recovery residences compared to other states, averaging 6.3 recovery residences per 100,000 population.
2. 72% of the recovery residences in the state— representing 68% of the total beds— are contracted with MSOs.
3. Colorado hosts at least 370 recovery residences, comprising 3,614 beds across Oxford House and CARR-certified organizations.



RECOVERY SUPPORT SERVICES IN PUBLIC HIGH SCHOOLS

1. Colorado has just one MSO-contracted recovery support high school in the entire state, 5280 High School in the Denver area. There is just one other program that may be similar for public school students: Boulder County's Boulder Valley Halcyon.
2. Recovery support high schools are cost-effective and highly beneficial for reducing substance use in adolescents. Colorado could consider model legislation for recovery high schools and further funding to expand this evidence-based resource.



OPIOID SETTLEMENT SPEND INITIATIVES

1. Treatment is the largest spending category for regional settlement dollars across the state. In fact, 52% of the total funding – \$17,599,558.00 – was allocated to treatment initiatives.
2. Central Colorado (SSPA 3) and Northwest Colorado (SSPA 6) allocated nearly twice as much funding proportionally to prevention than any of the other SSPA regions.
3. Two-thirds of opioid governance committee members that we spoke with noted how the regional governance committee process protected rural community interests in the state.



BEST PRACTICES FOR SUBSTANCE USE DISORDER

1. Youth prevention is inexpensive and effective. Many youth prevention programs feature benefits of more than five times costs, with several exceeding a ratio of 30:1.
2. MOUD with buprenorphine or methadone are cost-beneficial on the order of 2:1. MOUD with injectable naltrexone may have more costs than benefits.
3. Jail and prison-based treatment with MOUD have demonstrated large reductions in overdose after release. Recent studies from Rhode Island suggest a 60% reduction in post-incarceration overdose after implementation of a statewide MOUD program.

4. Syringe access programs (SAPs) are cost-effective and beneficial to community health outcomes. A recent cost-effectiveness analysis found that SAPs can save over \$300,000 per 100 clients served based on hepatitis prevention alone.
5. There are a range of highly cost-beneficial clinical treatment options with benefits more than 20 times costs. Many of them already in practice, but one in particular, contingency management, is highly beneficial but not widely used.

Introduction

On a wintry morning in March 2021, an oil field worker in rural Moffat County checked on some equipment on a backcountry road near his worksite. He encountered an abandoned vehicle stuck in the mud, and two ominous, empty car seats. The worker immediately called the authorities. After an extensive search, an aircraft finally located the missing family, wandering around in the sagebrush and snow. The 35-year-old local mother and her three-year-old daughter were rushed to Memorial Regional Health, where they were treated for exposure-related injuries. Tragically, the 18-month-old daughter was declared dead at the scene. Substance use, including methamphetamine, was involved. As horrific as this incident is, it illuminates many of the issues in Colorado. Substance abuse is common, resources are scarce, and geographic limitations frequently impede progress. This report highlights areas of achievement as well as opportunity to improve the outlook for those with behavioral health conditions in our state. We must ensure this desperate scene does not happen to other families.

The COVID-19 pandemic created more than physical illness and uncertainty. It also wrought historic declines in mental health status and rapid increases in substance use for thousands of Coloradans. We are now in the midst of an unprecedented overdose and mental health crisis. Alarming, according to 2021 data from the Colorado Department of Public Health and Environment (CDPHE), 1,757 Coloradans died of drug overdoses — the most overdose deaths ever recorded in the state and an increase of nearly 70% from 2019. Fentanyl-related deaths have more than doubled in the same timeframe. Overdose fatalities related to methamphetamine and other psychostimulants have similarly surged. CDPHE's 2021 data reveals that, in just one year, Coloradans experienced a 43% increase in psychostimulant-related deaths.

Further exacerbating these alarming trends is the continued toll of alcohol on our state. A 2020 "Behavioral Health Barometer" report for Colorado by the Substance Abuse and Mental Health Services Administration (SAMHSA) reveals that Coloradans experience over 50% greater likelihood of alcohol use disorder compared to the nation. Our local vulnerability to alcohol is reflected by CDPHE data, which demonstrates an incredible 27% increase in alcohol-related deaths between 2019 and 2020. Finally, the poor indications of behavioral health are not limited to substance use, either. The most recent Colorado Health Access Survey (CHAS) reported that a quarter of Coloradans said their mental health was poor – by far the most in the 12-year history of the CHAS.

While more Coloradans recognize the benefit of behavioral healthcare than ever before, too often, they do not find what they need. According to the 2021 CHAS, about 80,000 Coloradans did not get SUD or mental health treatment when they needed it. While stigma was the main reason for not getting needed behavioral health treatment, about one in five of those people could not get an appointment soon enough with a provider. Furthermore, long intake processes, lack of access to affordable residential treatment, and lack of community-based support programs leave Coloradans turning to substances to cope. It is more important than ever to focus valuable and scarce resources on behavioral health treatment. People do not have the luxury of time in a behavioral health crisis; waiting can be a death sentence.

Reducing gaps in the continuum and barriers to SUD treatment in Colorado will help support citizens through these challenging times and pave a successful, sustainable path to recovery.

Importantly, this report delineates all results by SSPA and denotes each SSPA's unique needs and outcomes. Findings from this report will inform future investment strategies for MSO expansion based on population and need. Finally, this analysis creates a comprehensive picture of the four included services across payers and between regions. In turn, this will enable stakeholders, like those in the 2024 legislative session, to make future decisions based on an extensive inventory that encompasses the whole state.

This report examines community needs and priorities in behavioral health as well as SUD-specific resources such as MOUD, withdrawal management, recovery housing, and recovery support services in public high schools. To ensure these findings are grounded in the needs of the state's behavioral health system, we also conducted 16 key informant interviews with current leaders across the entire behavioral health continuum of care. Qualitative thematic findings are woven throughout the reports to augment quantitative analysis. Please see below for a more detailed description of the purpose and methods of the qualitative interview process.

The following section focuses on key informant interview findings, before discussing the seven primary report areas.

THE PERSPECTIVE OF THE PEOPLE

Steadman Group interviewed 16 participants that represent a broad swath of behavioral health, including people in recovery, community organizations, community mental health centers (CMHCs), MSOs, regional accountable entities (RAEs), recovery residence operators, rural providers, specialty clinics, and treatment providers. Organizations interviewed and interview guide questions are listed in **Appendix A1** and **Appendix A2**, respectively. Please note that interviewee insights are woven throughout the report to enhance quantitative analysis under each major report dimension.

Conversations with stakeholders investigated gaps in behavioral healthcare, barriers to access, and opportunities to enhance the accessibility and availability of care. Discussions surfaced two primary themes:

Gaps in the Continuum of Care	Barriers to SUD Treatment
Youth and adolescent services	Workforce shortage
Inpatient and residential bed availability	Limited insurance coverage for SUD services
Culturally competent services	Stigma

Gaps in the Continuum of Care	Barriers to SUD Treatment
Recovery housing	Navigating the behavioral health system

Theme 1: Key Gaps in the SUD Treatment and Recovery Continuum of Care

YOUTH AND ADOLESCENT SERVICES

The number one gap is services for youth and adolescents. Alarming, the RAEs noted that the number of youth (ages 0-17) who need care is increasing dramatically. In addition, the problems are increasingly complex, often featuring mental health and substance use issues simultaneously. Not long ago, it was rare for adolescents to require withdrawal management services, but this is no longer the case. The complexity of youth needs is combined with problems at home, school, and in the community, requiring individualized, wrap-around care.

“The severity and acuity of the clients that we’re getting now is way worse than even a year ago... we have to realize that our kids are dying all around us. We have to do something; we cannot have this continue.”

~ Diversus Health

Current funding is not holistic and creates barriers to individualized treatment plans. RAEs and providers voiced siloed funding between primary, secondary, and tertiary care as a major issue. Northeast Health Partners expressed how Colorado is trying to be holistic with funding, but programming is not holistic. As noted by Northeast Health Partners, if a client comes in with multiple health needs **“we want to just carve it all apart and say we don’t want to take care of this complex adolescent.”** Colorado Community Health Alliance recommends **intensive outpatient programs (IOP) in the home for substance use and mental health.** This will meet adolescents where they are and provide support for parents.

INPATIENT AND RESIDENTIAL BED AVAILABILITY

Seventy-five percent of interviewees voiced a gap in residential bed availability, specifically for the Medicaid population. As a Community Mental Health Center, Diversus Health expressed **“we have nothing in seven counties that will accept Medicaid, and that is awful.”** Organizations are getting creative with this gap in care: people who need more intensive treatment are placed in IOP or outpatient programs (OP). **The growth in IOP is partly the result of not having enough residential facilities.**

CULTURALLY COMPETENT SERVICES

The majority of interviewees (75%) voiced a need for culturally competent behavioral health services. Cultural competence requires action and structural changes that alter practices to reach different cultural groups. In practice, this involves supporting alternative and holistic approaches, human-centered design, and recruiting diverse staff.

“I’ve had clients who have actually said that they feel grateful they have somebody who looks like them and speaks like them.”

~ Services de La Raza

Language differences and cultural barriers further hamper care. Many people prefer a provider who looks and sounds like them. While most of the emphasis heretofore has been on provider language and culture, people may never reach that level if they’re not familiar with the system of care and they’re not comfortable communicating with the navigation system. Critically, they also need to know how to ask for and find that person via navigation websites and phone lines.

Notably, **interviewees voiced that there are not currently adequate culturally-appropriate services, though it is a required part of the network for Medicaid providers.** Front Range Clinic, a rural treatment provider, summarized this issue well: **“You’re working against generational and historical challenges and distrust in the medical field among the black, indigenous, and people of color (BIPOC) community. We need to be more intentional about specifically outreaching to BIPOC communities and being honest.”** Some interviewees stated they have programs and groups for special populations, but attendance is low. Building trust with these communities through dedicated partnership with already trusted local organizations is critical to changing this. Sometimes, this requires stepping outside of the treatment-heavy health care paradigm, which is difficult in the world of Medicaid and commercial insurance.

RECOVERY HOUSING

More than half of interviewees reported difficulty finding recovery housing. However, these gaps in recovery housing are not universal, as detailed in the Recovery Residence Report. Gaps in recovery residences are centered around geographic disparities and special populations. MSOs help with coordination of housing, but there are still massive barriers. Specifically, people mentioned a long waitlist for availability, **“more vouchers than facilities,”** and **“no housing even if you can pay for it”** (Northeast Health Partners). Again, urban areas typically do not experience this gap, but rural parts of Colorado often require hours of driving to reach recovery residences in their region.

Recovery housing for the general population of people with SUD is difficult, but finding housing for special populations is nearly impossible. Special populations include queer, trans, female, justice-involved, and BIPOC individuals. These populations need safe housing to recover from their trauma and addiction. Heart Mind Haven expressed that they are one of

only two safe, affirmative supportive recovery housing providers for the LGBTQIA+ community in the state of Colorado, “we’re getting dozens of referrals for safe, affordable recovery housing every week. And we just simply...**cannot accommodate all those individuals.**”

Theme 2: Barriers to SUD Treatment and Recovery

WORKFORCE SHORTAGE

Burnout and the high cost of living are primary factors in the behavioral health workforce shortage. Oftentimes, even with funding, there is no one to fill behavioral health openings. This is particularly true in rural regions. Indeed, at least two rural opioid governance committees in high-cost regions recently released funding programs for behavioral health workforce stipends to retain their workforce.

The cost of living affects staff working in rural resort regions the most, where the cost of living is the highest compared to median income. This, combined with living in a rural region with limited amenities, makes it difficult to recruit providers and clinical staff. Even in non-resort regions, providers must be creative to solve this dilemma. RESADA’S solution is building a career ladder and opportunities for certification in addiction counseling for their employees. It is not a single intervention, however; both scholarships and employer support were needed to develop this program.

Engaging and uplifting current staff is a common and successful tactic for community organizations serving hard-to-reach populations. Servicios de La Raza, one of the premier Hispanic health and community organizations in Colorado, has created a pipeline of culturally competent providers who represent the communities they serve. Specifically, Servicios de La Raza has an internship program in which their interns—who are mostly bilingual—continue on as full-time employees. Servicios is one of the only organizations interviewed whose problem is funding to hire staff, and not finding staff to hire.

“This is a place people seek out and want to work.”

~ Servicios de La Raza

LIMITED INSURANCE COVERAGE FOR SUD SERVICES

Interviewees voiced the need for MSOs to provide additional support to help the low-income population access treatment. This is a critical need given that the COVID-19 public health emergency declaration ended in May 2023. Alarming, an estimated 325,000 Coloradans may lose Medicaid coverage when the declaration ends. MSOs play a critical role supporting this population to avoid a startling decrease in access to behavioral health services.

STIGMA

Stigma persists as a primary barrier to accessing care. Stigma is present at the consumer, community, and policymaker levels. It is important to recognize stigma at the decision-making level, affecting the community and individuals in need of these life-saving services. Further highlighting this need are the number of rural opioid settlement regions that are using their funding for anti-stigma campaigns. There is opportunity and need to **educate across the community on the different pathways to recovery from addiction.**

“I think if you have less judgment, stigma, shame, that people would feel more inclined to seek treatment.”

~ Young People in Recovery

Recommendations include supporting more people with lived experience in the profession to provide community navigation and peer support and lifting up non-abstinence-based and non-12-step pathways to recovery.

NAVIGATING THE BEHAVIORAL HEALTH SYSTEM

Even for those who work in the field, our system is extremely difficult to navigate. People in crisis are less able to find the doors, much less open them after shutting in their face. Furthermore, as people transition the continuum of care, often moving from structured residential environments back into the community, they fall through the cracks. While transitions of care have been recognized as a pitfall for years, increasing funding has not solved this problem. In addition to developing more welcoming, effective places for people to go, we must attend to the spaces between those places as people transition through levels of care.

Reports

1. Medications for Opioid Use Disorder

Background

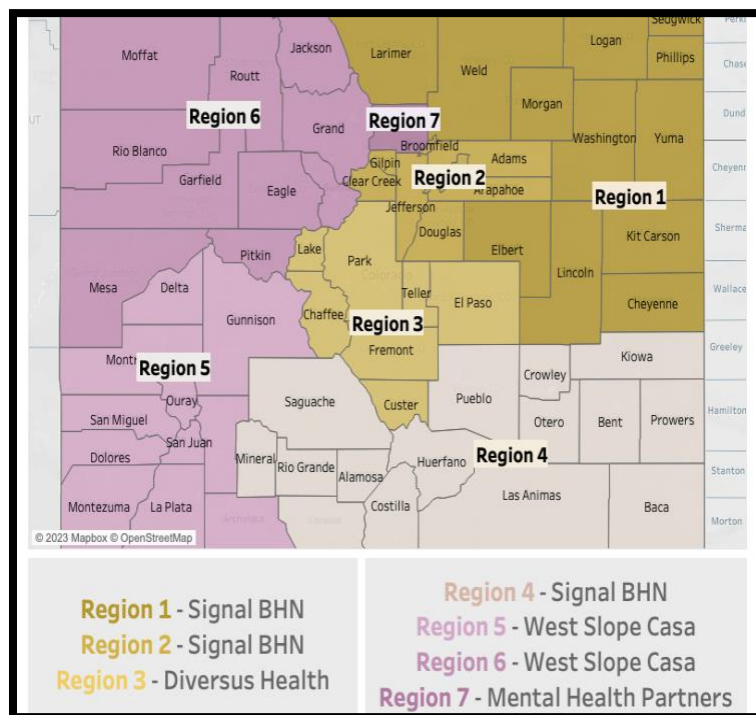
Medications for opioid use disorder (MOUD) are the gold standard for treating opioid use disorder, which is increasingly common and deadly. MOUD consist of three FDA-approved medications: methadone, buprenorphine, and naltrexone. Agonist therapy with one of the former medications — methadone or buprenorphine— manages withdrawal more effectively, demonstrates better long-term outcomes, and is preferred by most prescribers and patients, as evidenced by their far more widespread use. MOUD greatly increase a person's chances of recovery while simultaneously reducing their risk of fatal overdose.

Despite this, many areas in Colorado lack MOUD prescribers. This lack of access is especially true for methadone, which can only be dispensed to treat addiction in a state-licensed opioid treatment program (OTP). Sadly, lack of MOUD access for special populations, including youth and people in the criminal justice system, is an even more widespread challenge.

The following analysis explores current demand and supply for MOUD services statewide and broken out across all seven Managed Service Organization (MSO) regions, organized by Sub-State Planning Areas (SSPAs), as presented in Figure 1 to the right. Importantly, the allocation of SSPA regions to different MSOs changed as of January 1, 2023. However, because this analysis considers data from fiscal year 2022 (FY22, July 1, 2021 to June 30, 2022), we are using the relevant FY22 MSO map.

We also consider the above MOUD options for the subpopulations of youth and incarcerated people. Based on these findings, we then identify opportunities to improve Colorado's MOUD infrastructure and better meet the behavioral health needs of its residents.

FIGURE 1.
SSPA Regions by County and MSO (FY2022)



Methods

This analysis of MOUD services specifically reviews data from the following sources:

1. National Survey on Drug Use and Health (NSDUH) 2021 estimates of OUD prevalence.
2. Colorado Health Access Survey (CHAS) 2021 behavioral health data.
3. National Survey of Substance Abuse Treatment Services (N-SSATS) 2020 estimates of OTP service delivery.
4. MSO spending and contract performance reports across all funding streams.
5. Regional Accountable Entity (RAE) claims data for selected MOUD services.
6. Opioid treatment program (OTP) licensing and utilization data based on DACODS from the Behavioral Health Administration (BHA).
7. Anecdotal data from subject matter experts on subpopulation treatment, such as youth.
8. Jail-Based Behavioral Services (JBBS) data from the BHA on treatment during incarceration.
9. Prescription Drug Monitoring Program (PDMP) buprenorphine prescribing data from CDPHE, organized geographically by county of prescriber and reported quarterly.

NOTE: Based on reporting limitations, we relied on PDMP data from April 1, 2021 through March 31, 2022).

10. Fatal overdose data from CDPHE (2020-2021).
11. Population estimate data from the State Demography Office (2021).

Unless otherwise noted above, all data reflects fiscal year 2022, July 1, 2021 to June 30, 2022.

Findings

DEMAND

To estimate demand, we used three separate methods. Estimating demand in this fashion has previously been suggested by RAND studies of SUD treatment.

1. **Interviews:** Interviews with providers themselves as well as the community members who refer to that level of care. We asked qualitatively about the barriers to care, specifically capacity.

2. **Expert Opinion:** We searched the World Wide Web, seeking consensus guidelines or expert opinion about MOUD capacity from recognized treatment authorities.
3. **References Cases:** We looked for available rates from peer counties, states, or nations where available.

All calculations of demand use a blanket opioid use disorder prevalence of 1.53% for ages 12 and older. This figure comes from the Substance Abuse and Mental Health Services Administration's (SAMHSA) most recent (2021) NSDUH estimate for opioid use disorder in Colorado. This analysis relies on the state-level prevalence estimate because sub-state estimates are both far older and not available for large portions of the state. While we recognize that different areas of the state probably have different prevalence's of OUD, there is not enough data to accurately estimate prevalence by region.

Opioid Use Disorder is a chronic medical condition defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition as a problematic pattern of opioid use leading to problems or distress. There are 11 criteria for diagnosis, including criteria like tolerance, withdrawal, and giving up or reducing normal activities due to opioid use. People with mild OUD demonstrate two or three such criteria; moderate, four or five, and severe, six or more.

While MOUD treatment is indicated only for people with moderate to severe opioid use disorder (not mild), we have used 1.53% as a proxy for percent of people who could benefit from treatment. State and regional OUD population estimates are further based on the total count of individuals ages 14 and above due to limitations of census age group data collection categories. The estimate of individuals ages 14+ with OUD by region is presented in Figure 2 on the next page, representing an estimated total of 74,483 Coloradans.

It is widely believed that the vast majority of people with OUD do not receive treatment with medications. However, uncertainty remains around how much of this gap is due to lack of capacity versus lack of readiness for treatment. Briefly, we will revisit several estimates of treatment demand to examine whether Colorado's treatment supply meets our state's needs.

Last year, the Director of the National Institute of Drug Abuse at the National Institutes of Health, Dr. Nora Volkow, confirmed the magnitude of the treatment gap: **“Recent data from 2020 shows that only 13% of people with drug**

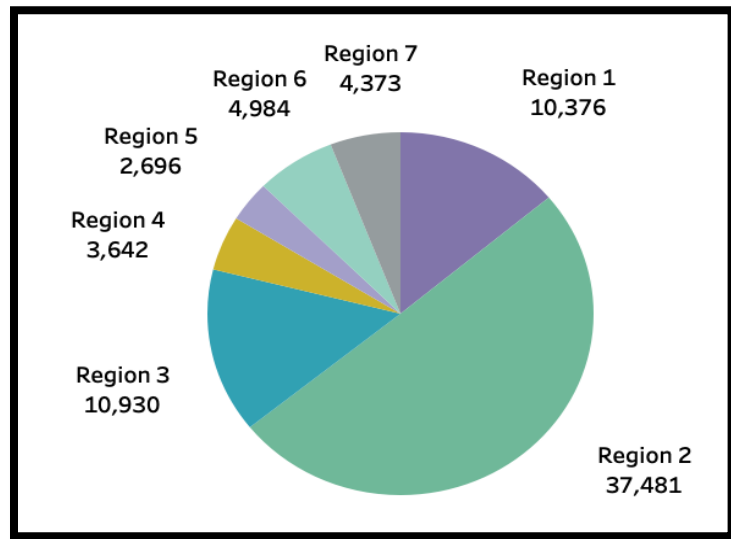
use disorders receive any treatment. Only 11% of people with opioid use disorder receive one of the three safe and effective medications that could help them quit and stay in recovery.” Fortunately, we can say confidently that a larger proportion of people with OUD in Colorado receive treatment than Dr. Volkow's cited figures. But increasing the percent of people who receive effective treatment will require a major increase in treatment-seeking, as well as improvements in availability of care.

Qualitative data from Colorado suggests that the majority of the treatment gap occurs **PRIOR TO SEEKING TREATMENT**. According to the 2021 Colorado Health Access Survey conducted by Colorado Health Institute, people who stated that they needed substance use treatment but did not receive it gave the following reasons for not receiving treatment:

1. 72.3% did not feel comfortable talking with a health professional about personal problems.
2. 51.4% were concerned what would happen if someone else found out they had a problem.
3. 36.6% did not think their insurance would cover treatment.
4. 55.9% were concerned about the cost of treatment.

Less than one-quarter — 22.8% — reported that they had sought treatment and found it difficult to get an appointment. These data indicate that capacity is perhaps not the most pressing barrier to treatment. Thus, increasing demand through anti-stigma and public information campaigns is an efficient way to boost the reach of MOUD treatment.

FIGURE 2.
*Expected Count of Individuals with OUD (ages 14+)**



**Based on 2021 State Demography Office data*

However, there are also undoubtedly shortages of MOUD providers, both geographically and among at least two important subpopulations: youth and people involved in the criminal justice system. The following section on supply will review methadone and buprenorphine utilization statewide and regionally to sort out these geographic and subpopulation differences in need.

SUPPLY

Statewide

We analyzed overall MOUD administration and prescribing for methadone and buprenorphine. An additional FDA-approved medication, naltrexone, was not analyzed because its data are not available through the Prescription Drug Monitoring Program. Furthermore, prior studies have shown that naltrexone prescriptions comprise less than 5% of MOUD. Lastly, naltrexone, is also frequently used to treat alcohol use disorder, which confounds the analysis of prescribing data trends in the context of OUD treatment.

Overall, utilization of MOUD has increased dramatically over the past 12 years in Colorado. A [2019 Urban Institute report](#) showed that Colorado went from *only 3,003 buprenorphine prescriptions in the entire state in 2011* to 13,636 in 2014 and 84,638 in 2018. By March 2022, our state had increased such prescribing by another 135% to 199,125 prescriptions. **That's a 66-fold increase in prescriptions in 10 years.** We estimate that 35,250 unique individuals received a prescription during the same year.

Similarly, our state has expanded access to methadone, another highly effective medication for OUD. The vast majority of people treated for OUD with methadone are seen in OTPs, colloquially known as methadone clinics. As recently as 2016, the [Denver Post reported](#) that our state had only 11 OTPs, climbing to 23 in 2018. This number has only grown as Medicaid in our state has grown and other payers, including MSOs, expanded coverage of OTP services and supported their growth. **As of July 2022, there were 38 licensed OTPs in Colorado, an almost four-fold increase in eight years.** Client numbers have grown similarly, from 5,100 during a week in 2018 to 12,458 unique clients in FY 22. Expansion of Medicaid, greater awareness and support of OTP services, and rule changes have exponentially increased access to OTP care in our state, a clear case study of health policy success.

While most of these increases have occurred in densely populated areas and majority populations, treatment in rural areas as well as among youth and people involved in the criminal justice system has also increased. The geographic expansions in treatment by medication type and subpopulation are further detailed and broken out by region in a later section of this report.

Methadone

Like buprenorphine, methadone is used to treat OUD. Unlike buprenorphine, which can be dispensed or prescribed in a medical office, methadone can only be dispensed through a SAMHSA-accredited and -certified, DEA-registered, BHA-licensed OTP. Because methadone

for addiction treatment can only be dispensed through OTPs, it presents more barriers to access than buprenorphine. They are also limited to on-site dispensing and takeaways, requiring the client to be physically present at the location on daily to monthly intervals. Accordingly, OTPs are less common in rural areas. However, OTPs also offer far more comprehensive services, including medication, counseling, and a variety of recovery-enabling services such as case management and peer coaching.

Of our state's 38 OTP providers, the vast majority — at least 34 — are contracted with MSOs to provide treatment to people making less than 300% of the federal poverty level (FPL) who are not covered by other health insurance or Medicaid. The non-contracted OTPs are mostly newly-opened (and yet-to-open) clinics. All OTPs serve MSO priority populations, including people who inject drugs, pregnant people, and women with dependent children. Most of these OTPs—at least 31—are also contracted with multiple RAEs to provide MOUD care for the Medicaid population. To our knowledge, there are no OTPs that do not accept Medicaid, and any disparity here is likely simply due to delays in the contracting process; that is, OTPs get licensed prior to getting in network with RAEs.

According to the 2020 N-SSATS report, the national proportion of all MOUD clients who were receiving methadone increased from 25% in 2011 to 29% in 2020. Colorado falls slightly below that average for methadone treatment — we estimate that about 26% of MOUD clients received methadone in our state.

Did you know that OTP clients can receive either methadone or buprenorphine? However, according to SAMHSA's national data, most OTP clients are treated with methadone. In 2017, more than 380,000 OTP clients received methadone, compared to 28,000 for buprenorphine.

To estimate OTP service utilization, this analysis relies on annual OTP census data compiled by the Behavioral Health Administration, which are reviewed in Table 1. Please note that the table includes a smaller number of OTPs than listed above; the claims data used in the table was from FY 2022, so some newly licensed OTPs are not included in this table.

TABLE 1.
Breakdown of OTP Service Utilization by SSPA Region (FY2022)

	SSPA 1 Northeast	SSPA 2 Metro Denver	SSPA 3 Colorado Springs	SSPA 4 Southeast	SSPA 5 Southwest	SSPA 6 Northwest	SSPA 7 Boulder
Total OTPs*	2	11	3	5	1	2	2
(% of State Total)	(7.7%)	(42.3%)	(11.5%)	(19.2%)	(3.8%)	(7.7%)	(7.7%)
Unique OTP Clients**	830	7,566	1,190	1,633	40	598	587
(% of State Total)	(6.7%)	(60.7%)	(9.6%)	(13.1%)	(0.3%)	(4.8%)	(4.7%)

	SSPA 1 Northeast	SSPA 2 Metro Denver	SSPA 3 Colorado Springs	SSPA 4 Southeast	SSPA 5 Southwest	SSPA 6 Northwest	SSPA 7 Boulder
Total Unique OTP Clients per 100,000 Population	101.7	258.4	137.9	572.8	19.5	155.1	178.1
Fatal Opioid Overdoses per 100,000 Population	14.3	22.9	17.2	24.8	12.6	10.9	10.6

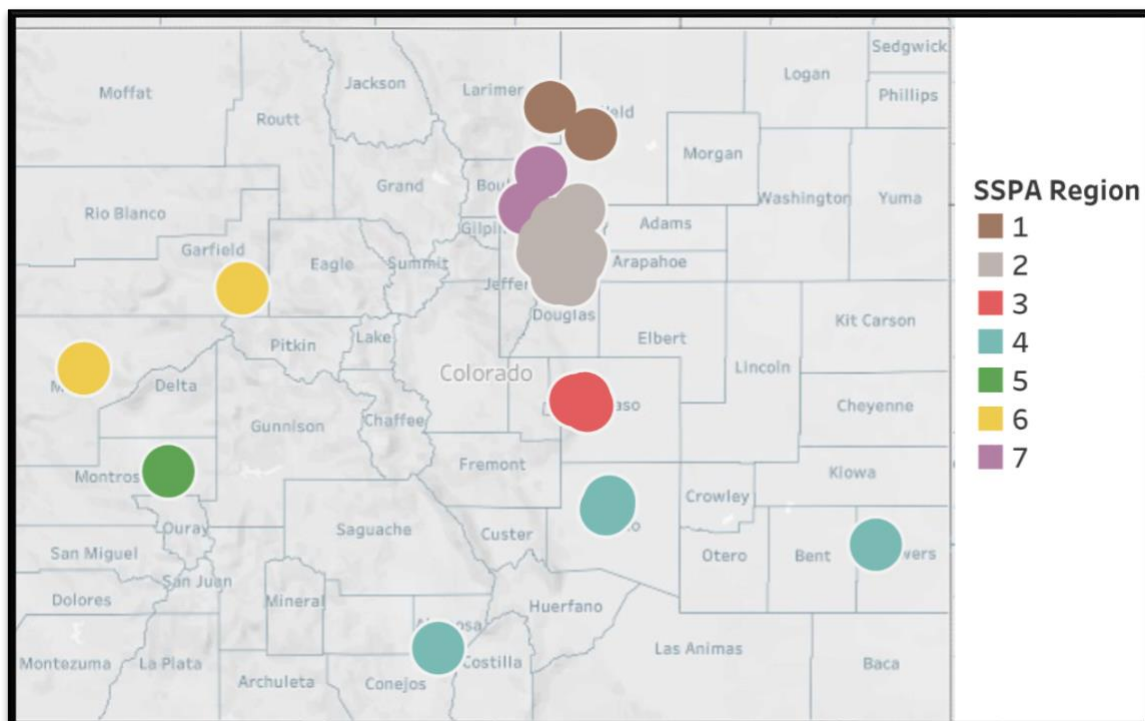
*A list of all OTPs and identified OBOTs by region and MSO contract status is included in Appendix B1.

**Data suppressed due to <30 unique clients at specific OTPs in Region 2 and Region 4.

Collectively, Colorado served 12,458 unique OTP clients. At the per capita level, Colorado demonstrated an average 214.3 OTP clients per 100,000 population, placing the state far above the 2019 national average (160.5 per 100,000).

One important takeaway is that OTPs still disproportionately serve the urban population, as demonstrated in Figure 3 below. Regional comparisons of OTP service data are detailed in a later section of this report.

FIGURE 3.
OTP Locations by SSPA Region (FY2022)



However, while OTP penetration is higher in urban areas, another important takeaway from these data is that OTP utilization is higher in regions where fatal overdose is higher. SSPA 4 serving southern and southeast Colorado, which had the highest rate of fatal opioid

overdoses in the state, demonstrated OTP service volume at over twice the state average. While much of the OTP volume in this region is driven by Pueblo, there are at least two other OTPs in rural parts of the SSPA where fatal overdoses are still more common, demonstrating that OTPs are indeed making their way into rural areas. The Denver Metro SSPA 2, which had the second-highest rate of OTP utilization, also had the second-highest rate of fatal overdoses among the SSPAs.

MSOs are major sources of funding for OTPs. While Medicaid is the largest payer for most OTPs, MSOs can cover treatment for people who do not have Medicaid, including uninsured people or underinsured people under 300% of the FPL. They can also cover costs to ensure rural OTPs are not forced to close due to lower client volumes.

In addition to BHA and MSO data, we have Medicaid-specific data for OTP utilization through the state's RAEs. As suggested above, utilization rates for Medicaid members vary significantly by region, demonstrated by Table 2. RAE regions, which are organized differently than MSO regions, are outlined in the map on the right.

In general, spending per member is higher in regions with more OTPs — RAEs 3 through 5 — and more fatal overdoses. **Higher spending in areas of more fatal overdoses suggest that OTPs are utilized in areas that have a higher need**, which is a positive. However, it also highlights the dire crisis of overdose in our state and suggests even more investment in areas with higher overdose rates should be considered.

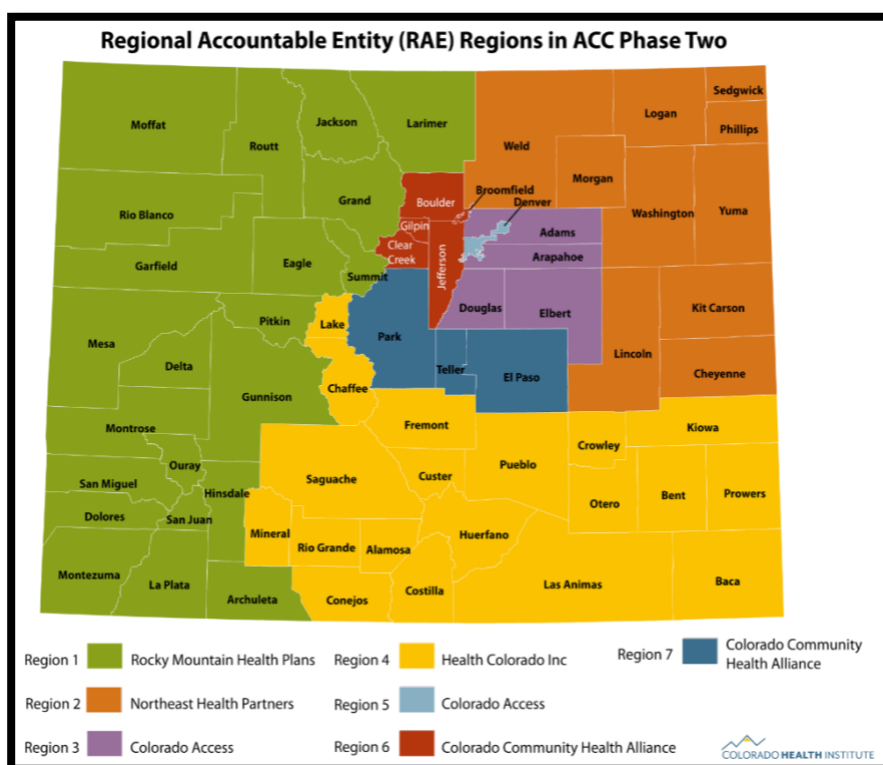


TABLE 2.
Breakdown of OTP Service Utilization by RAE Region (FY2022)

	RAE 1	RAE 2	RAEs 3 & 5	RAE 4	RAEs 6 & 7
RAE OTP Spending per Member*	--	\$5.34	\$17.04	\$23.28	\$13.58
OTP Clients	968	331	4,122	1,281	1,992
OTP Clients per 100,000 Members	385	302	766	827	468
Fatal Opioid Overdose Rates per 100,000 Population (Age-Adjusted, 2020 to 2021)	12.2	15.0	23.0	22.5	17.6

*RAE 1 OTP spending data was not available.

Buprenorphine

Buprenorphine is the primary office-based medication for OUD treatment. In fact, “Office-Based Opioid Treatment,” or OBOT, is synonymous with buprenorphine prescribing. Also known by its trade name, Suboxone, buprenorphine is prescribed by physicians, nurse practitioners, and physician assistants in both behavioral health and medical outpatient settings. It is commonly prescribed in federally qualified health centers, community mental health centers, addiction psychiatry, addiction medicine, and even general practice settings. Some emergency departments have even taken to prescribing buprenorphine.

With the recent elimination of prescribing restrictions, known as the X-waiver, any prescriber with a controlled substance license can prescribe buprenorphine without a regulatory barrier. While some coverage issues remain, Health First Colorado and many commercial insurers have improved coverage of this vital treatment in our state. As mentioned above, treatment with buprenorphine has flourished, growing exponentially over the last ten years in our state.

While buprenorphine has expanded greatly in Colorado, there are still wide geographic discrepancies in prescribing rates, as demonstrated by Table 3 on the next page.

TABLE 3.
Breakdown of Buprenorphine Utilization by SSPA Region (FY2022)

	SSPA 1 Northeast	SSPA 2 Metro Denver	SSPA 3 Colorado Springs	SSPA 4 Southeast	SSPA 5 Southwest	SSPA 6 Northwest	SSPA 7 Boulder
Estimated Total Unique Buprenorphine Clients*	6,665	15,283	5,183	3,184	639	1,813	2,486
Buprenorphine Clients per 100,000	817	522	601	1,117	311	470	754
Fatal Opioid Overdoses per 100,000	14.3	22.9	17.2	24.8	12.6	10.9	10.6

*Estimated based on the doubled quarterly average unique patients served, assuming each individual is retained in treatment for six months.

Unlike methadone, buprenorphine prescribing rates do not seem to correlate well with fatal overdoses. While SSPA 4 in the southeastern and southern part of the state still leads in per capita buprenorphine prescribing, SSPA 2 — the Denver Metro area, and the second-highest region for overdoses — drops to fifth in per capita buprenorphine prescribing. In contrast, SSPA 1 in Northeast Colorado has the second-highest prescribing rate despite its median overdose rate.

While buprenorphine prescribing rates vary almost fourfold between the lowest- and highest-prescribing SSPA, one might expect that clinic size would remain similar between regions. However, as demonstrated by Table 4, this is not the case.

TABLE 4.
Breakdown of Buprenorphine Prescribing by SSPA Region (FY2022)

	SSPA 1 Northeast	SSPA 2 Metro Denver	SSPA 3 Colorado Springs	SSPA 4 Southeast	SSPA 5 Southwest	SSPA 6 Northwest	SSPA 7 Boulder
Average Quarterly Total Unique Buprenorphine Clients	3,332	7,641	2,591	1,592	320	906	1,243
Average Quarterly Active Buprenorphine Prescribers	250	822	208	157	64	136	129
Average Quarterly Clients per Prescriber	13.3	9.3	12.5	10.1	5.0	6.7	9.6

There is a nearly threefold regional difference between client: prescriber ratio. This is an interesting finding because it implies that clinic panel sizes differ significantly between regions, a difference which appears to correlate with rural vs. urban status. **Of the four regions with large urban populations, each buprenorphine prescriber averages 11.2 clients, while in rural SSPAs 4, 5, and 6, prescribers average 7.3 clients.**

An [Urban Institute study](#) paved the way for assessing treatment capacity. They assessed the lower bound of the current treatment capacity as the current number of people in treatment: the number of patients currently receiving any buprenorphine treatment in the past year plus the current number of methadone patients at OTPs. They estimated the upper bound of capacity as the number of patients if all buprenorphine prescribers doubled their number of patients, or if counties with no active prescribers added 10 new prescribers, and OTPs operated at full capacity, assuming they currently operate at 80% capacity.

Table 5, below, reviews the estimated MOUD treatment capacity by SSPA region and statewide. Please note that a negative treatment gap means that there are more people in treatment than there are estimated with OUD; in this case, it either means that the region has a higher-than-average prevalence of OUD or fewer people were treated than estimated.

TABLE 5.
MOUD Capacity: Average Need and Treatment Gap by SSPA Region (FY2022)

	SSPA 1 Northeast	SSPA 2 Metro Denver	SSPA 3 Colorado Springs	SSPA 4 Southeast	SSPA 5 Southwest	SSPA 6 Northwest	SSPA 7 Boulder	Total
Total individuals with OUD (ages 14+)	10,376	37,481	10,930	3,642	2,696	4,984	4,373	74,483
Average Capacity	10,910	31,247	9,083	6,572	1,003	3,377	4,375	66,580
Treatment Gap	-534	6,234	1,847	-2,929	1,694	1,607	-1	7,903

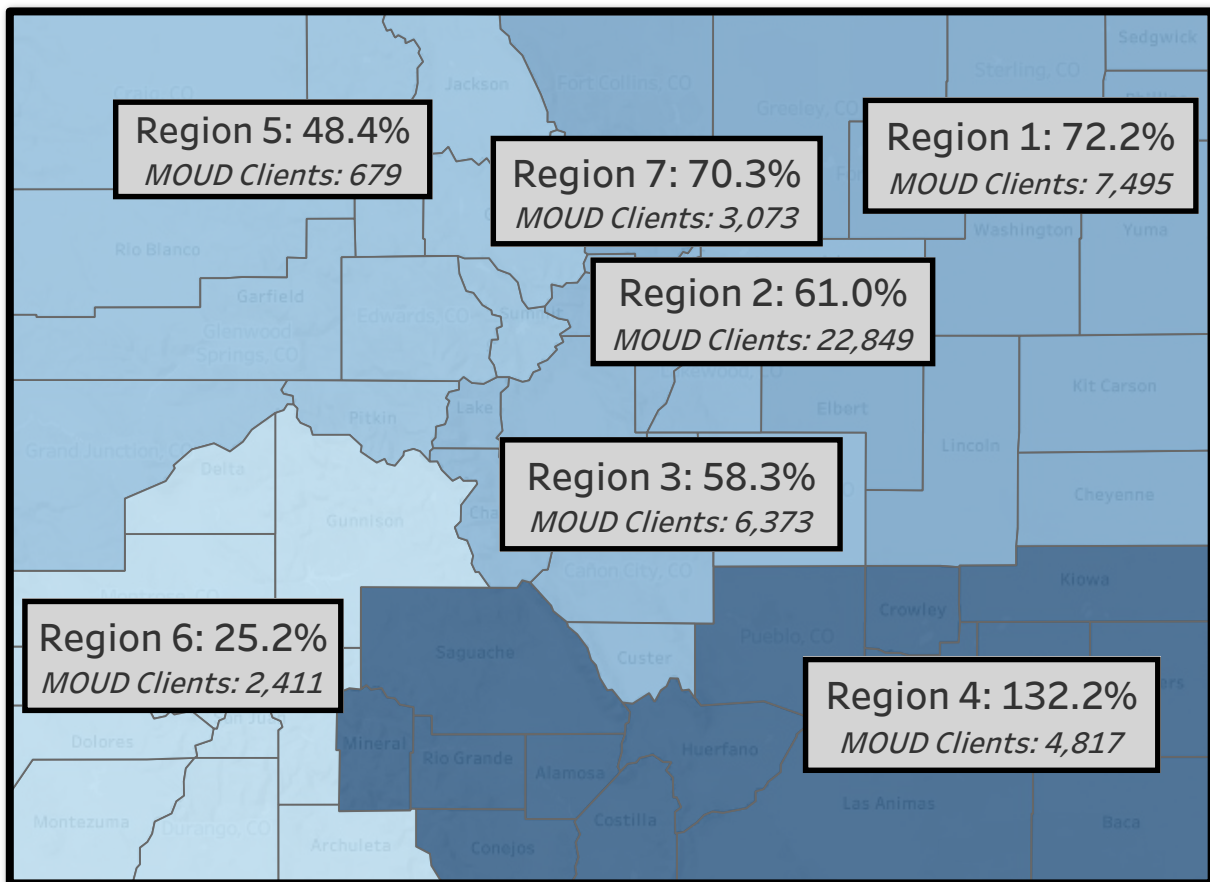
The last row shows the treatment gap— the difference between the estimated number of people with OUD and the number who could be treated (the midpoint between lower and upper bound, identified as “average capacity” in Table 5) by region.

Comparing these figures with the above self-reported data on OUD reveals a discrepancy between the number of people with OUD and our state’s treatment capacity. In comparing MOUD capacity to the state’s baseline OUD prevalence, 1.53%, and assuming that prevalence to be accurate for the state as a whole, **1 in 11 people with OUD could not find treatment right now if they sought it.** While this treatment gap is far smaller than some other states, Colorado — and some specific SSPAs — could still greatly benefit from more prescriber

capacity. At an optimal treatment capacity, Colorado would be well-equipped to meet the MOUD treatment need for people with OUD with less geographic disparity.

Compared to OTP and OBOT service utilization and contracting figures, the proportion of the state's unmet need attributable to each region demonstrates some surprising insights. First, while **Denver (SSPA 2) reports significantly higher OTP and OBOT treatment capacity than most state SSPA regions — with presumably less stigma to treatment — it remains home to the largest number of people with OUD who are not receiving treatment.** Denver's MOUD penetration rate — or the proportion of individuals with OUD who received at least one MOUD service in the past year — is 61%, below the state average of 64%. **In fact, its regional contribution to the state's MOUD treatment gap is slightly larger than what one would expect based on its population.** The MOUD penetration rate by SSPA region is presented in Figure 4 on the next page.

FIGURE 4.
MOUD Penetration and Clients by SSPA Region (FY2022)



This contrast between MOUD treatment capacity and penetration indicates that higher rates of treatment will require increases in treatment-seeking. If that occurs, our state will also need a significant increase in treatment capacity to meet that demand. Furthermore, nowhere is the need to increase treatment capacity more evident than in the youth and criminal justice-

involved populations. The remaining sections of this report will explore MOUD supply first by SSPA region and then by the youth and criminal justice sub-populations.

MOUD Supply: Geography

These descriptions rely on all data summarized in tables and figures presented in the preceding sections of this report, as well as Table 6 summarizing MSO MOUD funding and contracting below. Please note that MOUD funding was difficult to determine in some regions; this occurred when MSOs have master service agreements with a provider for several different types of treatment and we received a funding summary for multiple lines of business.

TABLE 6.
Breakdown of MOUD Dedicated MSO Funding by SSPA Region (FY2022)

	SSPA 1 Northeast	SSPA 2 Metro Denver	SSPA 3 Colorado Springs	SSPA 4 Southeast	SSPA 5* Southwest	SSPA 6 Northwest	SSPA 7 Boulder
MSO MOUD Spending	\$1,098,722	\$6,027,643	\$385,107	\$1,459,502	--	\$385,996	\$139,500
(% of State Spending)	(5.5%)	(64.5%)	(5.4%)	(18.4%)	--	(3.7%)	(2.4%)
MSO Spending per Person	\$1.35	\$2.06	\$0.44	\$5.11	--	\$1.00	\$0.42

**Unable to identify MOUD-specific MSO spending for SSPA 5, as all MOUD services were provided through OBOT programming as a subset of overall outpatient services.*

SSPA 1

SSPA 1, northeast Colorado, is home to an estimated 10,375 individuals (ages 14+) with opioid use disorder, 14% of the state total.

The penetration of MOUD — or the proportion of people with OUD who receive MOUD during the year — is high in this region with a total of 7,495 clients served, representing nearly 1% of the total population in this region. Population utilization rates of 1% or greater are considered high. The region served an estimated 918.2 people with MOUD per 100,000 residents, the second highest of all regions. According to our estimates, approximately **72.2% of MOUD-eligible adolescents and adults receive at least one MOUD per year**.

Buprenorphine accounts for more than 90% of the MOUD in SSPA 1. We estimate that 6,665 unique people received a buprenorphine prescription during the year, making SSPA 1 the

second-highest prescribing region both in overall and per capita terms. Additional data from the RAEs for the region confirm that buprenorphine is the preferred medication. RAE 1, Rocky Mountain Health Plans, which covers Larimer County, and RAE 2, Northeast Health Partners, covering the rest of the region, have the two lowest per-member OTP utilization rates. This is probably due to the absence of OTPs throughout most of the rural region. Additionally, RAE 2, covering the Eastern Plains, had the lowest per-member spending on OTPs of all RAEs, demonstrating the predominance of buprenorphine in this largely rural area.

While RAE spending on MOUD is lower than in other regions, MSO spending is more in line with the state average. The MSO for the region — Signal — spent \$1,098,722.00 on MOUD services in FY 2022. About 25% of this went to OTPs for medication and other services, which amounted to \$331.00 per client served in an OTP setting, just above the state median of \$320.00. The remaining 75% went to OBOT, usually with buprenorphine, as well as capacity expansion services related to MOUD. Overall, per capita MSO spending for MOUD in the region amounted to \$1.35, which is above the state median.

Such high treatment rates may be the tangible outcome of the region's efforts to improve treatment. CO-SLAW, a federal grant and ongoing effort in Larimer and Weld Counties managed by Northeast Colorado Health Alliance, made buprenorphine prescribing a cornerstone of their four-year effort to decrease overdose rates in the region. It is possible that their efforts led to such high treatment rates and prevented overdose deaths. At 14.3 fatal overdoses per 100,000, the region is well below the state's age-adjusted average of 18.9.

SSPA 2

SSPA 2, the Metro Denver region, is home to an estimated 37,481 individuals with opioid use disorder, **representing half of the state's total**. With 22,849 clients served with MOUD, nearly 0.8% of the local population received at least one treatment medication during the year. However, when compared to the population size, service utilization is below average with an estimated 780.4 MOUD clients per 100,000 residents, and 61% of MOUD-eligible individuals over the age of 14 receiving at least one MOUD per year.

SSPA 2 has a higher proportion of people in OTP settings than SSPA 1, with most individuals in OTPs receiving methadone. In fact, SSPA 2 had the majority (60.7%) of the OTP clients in the state. While the SSPA also has the most buprenorphine clients in the state, it is nowhere near a majority. In fact, of all the SSPAs, regions 2 and 4, with the highest treatment rates, had the largest proportions (33.1% and 33.9%) of people in OTP settings. This relatively high OTP utilization means that fewer people receive buprenorphine in outpatient settings. SSPA 2, at 522 per 100,000 people receiving at least one buprenorphine prescription, ranked fifth of seven SSPAs for per capita buprenorphine use.

Not surprisingly, **this region accounts for the highest total MSO MOUD spending at just over \$6M, representing 64.5% of total MSO dollars spent**. The MSO spending per person in this region is second-highest in the state at \$2.06. The breakdown is quite different from SSPA 1, though. More than 50% of the region's total MOUD spending by the MSO — \$3.2M

— went to OTPs. This high spending on MOUD carries over to the RAE as well. Colorado Access, which covers RAEs 3 and 5 and correspondingly SSPA 2, ranked first among RAEs in overall (\$9M+) and second in per member OTP spending, serving over 4,000 unique members in OTP settings.

There is a trend toward overdose burdens migrating from predominantly rural to urban areas. With heroin and then fentanyl becoming responsible for most overdoses, cities have suffered from more overdoses than rural areas, which previously reported more overdoses in the pre-fentanyl era of prescription drug-driven opioid use. Sadly, this trend holds in the Denver Metro area. **In 2020 and 2021, this SSPA had the second-highest age-adjusted rate of fatal opioid overdoses in the state at 22.9 per 100,000 residents.**

SSPA 3

SSPA 3, which includes the Colorado Springs Metro area and the central mountains west of El Paso County, has an estimated 10,930 individuals with OUD 15% of the state's total.

SSPA 3 reported an estimated total of 6,373 MOUD clients served, or 738.8 per 100,000 residents, representing 0.7% of the region's total population. This is slightly lower than the other predominantly urban SSPA around Denver. However, the majority of the people in the region with OUD — 58.3% — still received at least one MOUD during the year.

Despite service levels near those of SSPA 2, spending was significantly lower. The MSO for the region, Diversus spent a total of \$385,107.00, or \$0.44 per resident. This represents only 5.4% of the total spending for the state. **It is likely that this low rate of spending is due to the lack of OTP capacity in the region.** With only three OTPs, and none outside of Colorado Springs, there are fewer clients at OTPs. Of the 1,190 people served by OTPs in the region in FY 2022, about 30% were funded by MSOs, which is well above average for the regions that reported such data. The low utilization of OTPs carries over to the Medicaid world, as the RAE for this region, CCHA, has below-average spending on OTPs as well as below-average OTP utilization.

The lack of OTPs in the region was actually offset somewhat by the higher number of people on buprenorphine as compared with SSPA 2, which was about 15% higher in this region on a per capita basis. Buprenorphine utilization within this region is 601 per 100,000 clients with an estimated 5,183 total unique buprenorphine clients.

SSPA 3 reported the third-highest regional rate of fatal overdoses, at 17.2 per 100,000 residents. While in many regions overdoses are driven by urban areas, the highest overdose rates in this region are actually in the rural western counties of Lake, Park, and Teller.

SSPA 4

SSPA 4 serving southeast Colorado has an estimated 3,642 individuals with opioid use disorder, 5% of the state's total. **More than any other region, it is likely that these numbers**

underestimate the true prevalence. Other indicators, such as fatal overdose and neonatal abstinence syndrome rates hint that OUD is higher here than other regions.

That said, there is also no other SSPA with as many treatment options per capita, even those in urban areas. There are four OTPs, which does not seem like a lot for such a large area, but this number of OTPs is the second-highest of all SSPAs and the highest per capita by a wide margin. **In fact, the per capita OTP utilization (572 clients per 100,000) is more than twice as high in this region as the next-highest OTP service volume region in Denver.** This carries over to Medicaid, where Health Colorado, the RAE for this area, also demonstrates the state's highest OTP utilization.

SSPA 4 reported a total of 4,817 MOUD clients served, **representing nearly 2% of the region's population.** In fact, this number is **132.2% of the estimated MOUD-eligible individuals in the region**, indicating that the true OUD prevalence in the region is significantly higher than the estimated state average of 1.53%. Medicaid data also indicate that a majority of people with OUD in the region receive treatment, at least briefly. Health Colorado indicates that 77.8% of people diagnosed with OUD received at least one MOUD during FY 2022. **Overall, SSPA 4's MOUD service utilization is by far the highest of all regions.** With an estimated 1,689.5 MOUD clients served per 100,000 residents, **SSPA 4 demonstrates over twice as many MOUD clients per capita as the state average (820.9 per 100,000).**

With the region's high demand and rural geography comes high spending. This region accounts for 18.4% of total MSO dollars at \$1,459,502.00, representing the highest MSO per capita spending per person at \$5.11. Again, this trend is reflected in the Medicaid population. **Health Colorado spends over \$3.6M, or \$23.28 per member, on OTP services — more than twice the state average.**

While OTP services sometimes trade off with buprenorphine prescribing, that is not the case in this region. Both buprenorphine and methadone use are very high. Again, this region leads the state by a long shot in buprenorphine treatment, with 85% more per capita clients (1,117 per 100,000) than the state average of 607.

Unfortunately, the amazing efforts to increase treatment in the region have not yet stemmed the tide of fatal overdoses. In 2020 to 2021, **SSPA 4 reported the highest number of fatal overdoses at 24.8 per 100,000.** This region also bucked the trend of urban overdoses. Excluding Pueblo County, with nearly 60% of the region's population, would raise the fatal opioid overdose rate for the remaining rural counties to an astounding 35.5 per 100,000, indicating that more treatment and recovery options should be focused on the rural Arkansas and San Luis Valleys.

SSPA 5

SSPA 5 covering southwest Colorado is the state's smallest, most frontier SSPA. There are an estimated 2,696 individuals with opioid use disorder in the region, just 4% of the state's total.

That said, the smaller population with OUD in the region is quite underserved, with the lowest treatment rates in the state in both OTP and OBOT settings. SSPA 5 has the lowest total of MOUD clients served at 679, representing only 0.33% of the total region's population and only 25.2% of people with OUD, **significantly lower than other regions**. MOUD utilization is lowest in the state at an estimated 330.7 per 100,000 residents. **The region ranks lowest on virtually every measure for OUD treatment**, including clients per prescriber and prescriptions per year.

This dearth is particularly evident in OTP data. For most of the last several years, the region had a single, small OTP in Durango, which had around 40 clients in FY 2022, putting the region at just 9% of the state average for OTP utilization. However, even this resource shut down in early 2022. While another OTP is opening in Montrose, it is difficult to maintain OTP services in such a rural area.

Buprenorphine prescribing is somewhat more common, but **SSPA 5 still ranks lower than all other regions at 311 per 100,000 residents**. In FY 2022, there were an estimated 639 total unique buprenorphine clients. Again, this low utilization rate is likely due to lack of capacity. There were only two OBOTs contracted with the MSO, West Slope Casa, during the time period covered by this analysis. Due to limitations in reporting capacity, MSO spending for MOUD in SSPA 5 was unable to be determined, as OBOT services were funded as a subset of overall outpatient SUD services with these two clinics.

Additionally, while one might expect areas with fewer prescribers to have higher caseloads, that was not true in this region. There were actually 261 prescribers of buprenorphine in the region; still low, but not as low as one might expect. However, these prescribers averaged only 9.9 clients per provider, less than half of the state average of 20.

It is also possible that treatment rates are apparently low due to lower rates of OUD. While not the lowest in the state, SSPA 5 demonstrates lower-than-average fatal overdoses of 12.6 per 100,000.

SSPA 6

SSPA 6 serves the rural and frontier northwest region of Colorado. This region has an estimated 4,984 individuals with OUD, 7% of the state's total.

SSPA 6 has the second-lowest costs and utilization of MOUD services in the state, well ahead of SSPA 5 but behind other regions. The total MOUD clients served is 2,411, representing 0.6% of the region's total population and an estimated 625.3 MOUD clients served per 100,000. Only 48.4% of people with OUD received a medication for treatment during the year.

This low utilization could be due to two factors. It is possible, given the low fatal overdose rate, that there is a lower-than-average prevalence of OUD in SSPA 6. It is also possible that few treatment options lead to low utilization.

In the OTP realm, there was long only one option, in Grand Junction. While another program just opened in Glenwood Springs, that occurred after the end of the data collection period and is not reflected in these statistics. That said, with only one option, OTP utilization was greater than one might expect. With 155 clients per 100,000 people, SSPA 6 actually outpaced three other SSPAs with as many or more OTPs, ranking just below SSPA 7 in Boulder County for per capita OTP utilization.

Surprisingly, despite great efforts to improve buprenorphine prescribing in the region, SSPA 6 has a below average rate of prescribing. In fact, only 235 per 100,000 people received a buprenorphine prescription in the region, the second-lowest in the state and 20% below the state average of 305.

With low utilization, costs are also low. **This region accounts for the lowest percentage of MSO dollars spent, at 3.7% or \$385,996.00.** This represents \$1.00 per person of MSO spending.

SSPA 7

SSPA 7, serving Boulder County, has an estimated 4,373 individuals with OUD, representing 6% of the state's total. During FY 2022, 3,073 people received MOUD, representing 0.9% of the region's total population and an estimated 932.5 people treated per 100,000 residents. 70.3% of people with OUD received at least one MOUD during the year, which is above the state average of 64.1.

While there are only two OTPs in the region, on a per-square-mile basis, Boulder County has a relatively high geographic density of OTPs, which are split between Boulder and Longmont. During FY 2022, SSPA 7 served 587 clients in OTP settings. Of these, nearly half were funded by the MSO at the time, Mental Health Partners, which has a very high proportion of MSO-funded OTP clients.

Despite lower-than-average OTP utilization, SSPA 7 made up for that with higher-than-average buprenorphine prescribing. With an estimated 2,486 buprenorphine clients — 754 per 100,000 residents — SSPA 7 ranked third in the state, nearly 25% above the state average rate of buprenorphine utilization.

The Boulder region accounts for 2.4% of MSO dollars spent for a total of \$139,500.00. This represents the lowest dollars spent per resident at \$0.42. The low spending carries over to per-client numbers as well. At \$199.00 per MSO-funded OTP client, average per-client spending was exactly one-half of the state average of \$398.00 per client.

Notably, despite the average prescribing rate, SSPA 7 reports the lowest fatal overdose rate of any SSPA at 10.6 per 100,000.

MOUD Supply: Youth

While every single overdose death is a preventable tragedy, youth overdoses are especially tragic. Parents grieve along with their schools and communities. A staggering amount of potential is lost when a young person overdoses.

Fatal overdose among youth used to be rare. While overdoses have increased for all age ranges over the last few years, rates among youth have skyrocketed. **According to 2021 CDPHE data, among youth aged 10 to 18, fatal overdoses due to fentanyl increased a staggering 600% in two years during the pandemic, from five to 35. Even among young adults — those aged 19 to 24 — such deaths used to be very uncommon, going from three in 2015 to a staggering 111 in 2021— a 3,600% rise in deaths.** Additionally, while racial and ethnic data for our state were not available for youth, a nationwide [2022 study](#) suggests that overdoses have increased disproportionately among American Indian / Alaska Native-, Black-, and Hispanic-identifying youth.

Time and again, MOUD have been shown to be safe and effective at reducing overdoses and helping people recover. However, the number of youth in treatment in Colorado is surprisingly small.

Youth prescribing data, reviewed in Table 7, show that there are a relatively large number of prescribers — 85 — who prescribe buprenorphine to youth, referring to individuals under the age of 18. However, **with only 104 youth clients statewide, the most common number of clients is one, meaning that most youth are being served by non-specialty prescribers.** That these prescribers are willing to serve young clients is commendable. Increasing the number of prescribers and clients is crucial though, to stem the tide of youth overdoses.

The majority of the state's youth who received treatment with buprenorphine — 61 of the 104 — were in SSPA 2 (Denver Metro), which is not surprising, as the region comprises almost exactly half of the state's youth and contains the only two specialty adolescent addiction treatment clinics in the state.

TABLE 7.
Clients and Prescribers for Youth Buprenorphine by Region (FY2022)

	SSPA 1 Northeast	SSPA 2 Metro Denver	SSPA 3 Colorado Springs	SSPA 4 Southeast	SSPA 5 Southwest	SSPA 6 Northwest	SSPA 7 Boulder	Total
Total Youth (<18) Buprenorphine Clients*	14	61	12	3	2	9	3	104
% Youth with OUD with at Least One Prescription for MOUD	2.1%	2.6%	1.8%	1.3%	1.4%	3.0%	1.2%	2.3%
Total Youth Buprenorphine Prescribers	17	44	10	6	2	3	3	85

*Data suppressed for counties with fewer than three unique clients, impacting seven counties across all regions. We estimate one client per county with suppressed data. Additionally, prescriber numbers are greater than client numbers in some regions because the provider saw a client from outside the region.

For methadone, the data indicate there are an extremely low number of youth in treatment, far lower than buprenorphine even. **The data are censored for FY22, meaning that less than 30 youth under 18 were in treatment in OTP settings at that time.** These clients were spread over 17 different OTP locations in all SSPA regions except the southwest (SSPA 5). Even if we assumed 29 unique youth clients were engaged in OTP treatment, the state would still be reaching less than 3% of the total MOUD-eligible youth population (ages 14 to 17) as described above in Table 7. **Across all dimensions of MOUD supply, youth MOUD services show the greatest unmet need.**

While some people attribute the low numbers of youth in treatment to low rates of youth with a use disorder — anecdotally, many youth who overdosed did not have a long history of opioid misuse — self-report data demonstrate youth and especially young adult OUD rates are similar to adult rates. The capacity to treat more youth already exists.

However, the vast majority of this capacity is concentrated in eastern Colorado, specifically in Denver itself. That southeastern SSPA 4 demonstrates among the lowest youth MOUD penetration, but some of the highest general MOUD utilization and fatal overdose rates, suggests this region is especially important for early OUD intervention in the youth population. In addition to identifying youth with OUD earlier, **improving the geographic distribution of youth MOUD prescribers is a major opportunity to increase treatment rates.**

MOUD SERVICES IN JAILS

When identifying large groups of people who could benefit from substance use treatment, justice-involved populations rank very highly. Many people involved in the justice system have substance use disorders. In fact, according to a [2017 study from the Bureau of Justice Statistics](#), it's estimated that 40% to 65% of sentenced jail residents and state prisoners have a substance use disorder, and many of those without SUD committed crimes under the influence of substances.

“The incarcerated need MOUD services. It (MOUD) should be available on demand, but especially before people are released back into the community.”

~ CCJRC

Unfortunately, according to a [2010 Nation's Health Report from the American Public Health Association](#), only 11% of those people received treatment for substance use disorder. However, Colorado has seen an explosion of jail- and prison-based SUD treatment. Specifically, improved MOUD services within the criminal justice system have improved the health and recidivism probability of thousands of people. Despite this progress, there remains a shortage of support for jails and correctional staff looking to introduce or expand MOUD programming.

MOUD in jails have a short history in Colorado. Denver started the first MOUD program in 2016, then Arapahoe County started a continuation program in 2017. Next, in 2019, SB 19-008 passed, mandating a strong continuation program in the Department of Corrections, encouraging MOUD programs in jails, and providing funding for both. Notably, House Bill 22-1326, Fentanyl Accountability and Prevention, recently mandated that all jails and community corrections programs in Colorado screen people for OUD and develop a treatment program for MOUD to those in their custody by July 2023. As a result of HB 22-1326, we anticipate a much larger uptake in MOUD within the criminal justice setting in the coming years.

We attempted to catalogue the MOUD services offered by jails in Colorado. However, there is no central database of MOUD offerings. Thus, we analyzed data for Jail-Based Behavioral Services, or JBBS, which comprises funding, training, and technical assistance offered by the Behavioral Health Administration to jails in our state. JBBS has several lines of services, of which Medication-Assisted Treatment (MAT) is one.

“The state is doing a great job keeping everything in place but doesn't have a clear picture of who's doing what and what the lay of the land is for jails. We need transparency and accountability.”

~ CCJRC

Per JBBS data, during FY22, 18 county jails provided at least one type of MOUD service, comprising just under one-third (30%) of the state's total county jail system. All three

FDA-approved medications for MOUD are available across the state, with buprenorphine present in every SSPA region. We also note that there are discrepancies between these data and our knowledge of jails' actual programs. These data only cover JBBS funding and are largely self-reported by the jails to the BHA. Table 8 presents the number of counties that provided a given MOUD service for at least one unique client during FY22.

TABLE 8.
Breakdown of Supply for MOUD in County Jails by SSPA Region (FY2022)

	SSPA 1 Northeast	SSPA 2 Metro Denver	SSPA 3 Colorado Springs	SSPA 4 Southeast	SSPA 5* Southwest	SSPA 6 Northwest	SSPA 7 Boulder
Total County Jails Offering Induction through JBBS	3	2	1	2	1	3	--
Total County Jails Offering Maintenance through JBBS	2	2	1	5	--	2	--

Currently, JBBS does not centrally track the roster of OTPs and OBOTs contracted with county jails to provide MOUD services either during incarceration or post-release. Based on conversations with state JBBS leadership, such contracted MOUD provider identification would require canvassing each individual county jail to gather this information.

Conclusion

In Colorado, MOUD prescribing is increasing rapidly. Colorado exceeds expectations for OTP service volume, reaching more OTP clients per capita than the national average. Based on buprenorphine prescribing and OTP reach, **Colorado's MOUD system is reaching almost two-thirds of all adults with OUD.**

While Colorado has improved data on MOUD significantly—particularly through CDPHE's PDMP analyses and RAE and MSO reports—there are some areas where data could improve. We have no statewide mechanisms for estimating OUD rates. National rates, from the National Survey on Drug User Health, are often statewide and several years old. Additionally, our state would benefit from better data on jail's activities providing MOUD and related activities, particularly given the provisions for MOUD contained in HB 1326.

Even with the data at hand, it is clear that vast regional differences remain. The Western Slope (SSPAs 5 and 6) reaches less than half of its MOUD-eligible population. Estimates in Table 5 reveal that these two regions alone account for a significant portion of the state's total treatment

gap. And while SSPA 2, Metro Denver, treats a higher proportion of people with OUD, its sheer size means it is home to a huge number of people with OUD who are not receiving treatment. With moderate increases in either buprenorphine prescribing panels or the total number of prescribers in SSPAs 2, 3, 5, and 6, the state could improve MOUD reach in these high-need areas.

Unfortunately, it is rarely as simple as expanding a prescribing panel. Anecdotally, we know of very few, if any, prescribers who are not accepting new clients. There are certainly barriers to more people entering treatment. As suggested above, those barriers occur primarily before treatment-seeking: stigma and uncertainty about costs, to summarize the main reasons. While MSOs both support stigma-reduction campaigns and costs for people without coverage, people generally do not know about MSOs as options for payment.

Altogether, MSOs distributed \$9,496,470.00 in total funding for all MOUD services, averaging just under \$2.00 per resident and \$398.00 per unique OTP client served. While RAEs certainly spent more than MSOs on MOUD — nearly \$20M on OTP services alone, not including outpatient buprenorphine which is largely paid for by Health First Colorado — MSO spending goes to support individuals who are not eligible for Medicaid, as well as capacity for rural and frontier OTPs that might otherwise not exist and where Medicaid is the only funder.

MSO contracting reflects the importance of their role in supporting OTPs, as **MSOs are contracted with over 80% of all OTP providers**. While some untapped OTP capacity remains in SSPAs 2 and 4 — Denver and the southeastern region of the state—there are likely good reasons that they are not already contracted with MSOs. To improve OTP capacity in the highest need regions, MSOs could encourage the creation of new OTPs in rural areas, with a specific focus on the Western Slope (SSPAs 5 and 6). In fact, we know that one OTP has been added in each of these SSPAs in the last year, in Montrose and Glenwood Springs.

But the most urgent, unmet need for MOUD services is for Colorado's youth population. Less than 3% of the state's estimated adolescent population (ages 14 to 17) with OUD receives any MOUD treatment. Because there is a relatively low need to increase the overall number of MOUD providers in the state, efforts to increase youth MOUD reach should emphasize marketing and anti-stigma work to increase awareness that all licensed SUD providers may treat adolescent clients.

2. Withdrawal Management

Background

Withdrawal Management (WM), or “detox,” services are an essential component of the substance use treatment continuum. These stabilization services treat the current substance use crisis and, ideally, prevent future crises through effective service delivery and successful linkages to community-based care. To adequately support the behavioral health of Coloradans, the state must ensure widespread and equitable access to high-quality WM services.

The American Society of Addiction Medicine (ASAM) Criteria — the primary organizing framework for SUD treatment — recognizes five levels of WM services. The highest level, Level 4WM, is a hospital level of care, which is not covered in this report. The next highest level, 3.7WM, is Medically Monitored Inpatient Withdrawal Management, also known as “Medical Detox.” This level requires 24-hour care with hourly or more frequent nursing assessments. The next level is 3.2WM, Clinically Managed Residential Withdrawal Management, or “Social Detox.” This level features peer and social support and medication self-administration WITHOUT on-site 24-hour health care. Finally, our analysis combines the lowest two levels, 1 and 2, into “Ambulatory WM.” These nonresidential levels of care are largely staffed by nurses and physicians, requiring daily or less frequent monitoring and, often, medication-based therapy. While this level is not officially recognized by our state yet, MSOs do contract for these levels of care to supplement facility-based WM services.

Withdrawal management, like several other SUD treatment and recovery services, has undergone a large expansion over the last few years. In the summer of 2020, there were 23 ASAM Level 3.2WM facilities and 10 ASAM Level 3.7WM facilities. Less than three years later, in April 2023, there were 38 ASAM Level 3.2WM facilities and 33 ASAM Level 3.7WM facilities, including 10 dually-licensed facilities capable of both 3.2WM and 3.7WM. **That’s a 65% increase in Level 3.2WM and a 230% increase in Level 3.7WM.**

There are multiple reasons for the increase in facilities, perhaps the most salient of which is Health First Colorado’s decision to cover Level 3.7WM starting in 2021. Previously, Medicaid did not pay for this level of care, so facilities were limited to commercial and self-pay providers. Such providers still represent most of the new facilities in our state and some of them now accept Medicaid. At the same

“3.7WM is the most utilized service now that it’s opened — used mostly in hospital and non-hospital settings.”

~ Colorado Community Health Alliance

time, community mental health centers like Jefferson Center, Mental Health Partners in Boulder, and SummitStone Health Partners have re-licensed or opened new facilities at the higher level of care, allowing more Medicaid members in their region to be treated for more severe and acute withdrawal.

Additionally, this analysis must be considered with the understanding that Managed Service Organizations (MSOs) usually do not contract for Level 3.7 withdrawal management services. However, new 1326 funds could be used to help 3.2WM meet 3.7WM requirements. However, because MSOs do pay for Emergency and Involuntary Commitments with Level 3.7WM, you will see some MSO-contracted 3.7WM services in Table 9 further on in this report. Additionally, regarding ambulatory WM programs, such providers do not require specific state licensing.

This report will review first demand, then supply of WM services.

“We were starting to see what looks like a huge increase in 3.7 withdrawal management services. But when we dug into the data, it’s essentially some of the same people returning and readmitting for that level of care over and over again. This looks like an increase because we weren’t managing these benefits before.”

~ Colorado Access

Methods

This analysis of withdrawal management services specifically reviews services delivered during fiscal year 2022 (July 1, 2021 to June 30, 2022). We leveraged data from the following sources:

1. MSO spending and contract performance reports across all funding streams.
2. Regional Accountable Entity (RAE) claims data for WM services for Medicaid members.
3. WM data from the Behavioral Health Administration (BHA), including DACODS-based utilization data and licensing data for WM Levels 3.2 and 3.7.
4. WM facility beds data (2020) from the state Department of Health Care Policy and Financing (HCPF) and BHA licensing data for SUD WM services.
5. Anecdotal data from subject matter experts on subpopulation treatment.
6. Population estimate data from the State Demography Office.

Findings

DEMAND

Traveling throughout the state discussing people's unmet SUD needs, there is one answer that stands out above all others: "medical detox," known more formally as Level 3.7WM. Sometimes, people truly need medically-managed WM services for severe withdrawal or co-occurring medical conditions. Other times, family members or navigators want to ensure that people with substance use disorders can start taking effective long-term treatment medications during acute withdrawal, which often does not happen at the 3.2WM level. Finally, there are individuals involved with law enforcement who need a higher level of care than 3.2WM, but are not appropriate for hospital level of care. 3.7WM seems to serve as a catch-all for these clients.

"We've always had an issue with withdrawal management on a high level of care, so when we're dealing with someone with mental health issues, or they can't control their behavior, or they have high-risk medical issues, there is nowhere for these guys to go, the result of being social detox, we don't have medical staff... and what's happening right now in this area is they're overwhelming the hospitals and other medical providers because they're treating them like the detox treatment centers and really what it starts to do is start re-stigmatizing our client."

~ RESADA

Unfortunately, there are few population norms for 3.7WM vs. 3.2WM levels of care; there are no explicit recommendations about the number of licensed WM beds per capita, much less recommendations on the ratio of 3.7WM to 3.2WM beds. The best suggestions come from anecdotes from our interviews, cost report data on WM utilization, and a single in-depth study with recommendations from Sacramento.

First, anecdotally, people believe that there should be more WM services in both rural and urban areas. Some rural areas simply lack such facilities. For instance, **residents of Moffat and Routt Counties in the northwest corner of the state must travel up to two hours to reach a WM facility in Grand Junction or Frisco.** In urban areas, people demand more proximity and higher acuity of care. Even in populated areas, WM services may be temporarily overloaded during times of high demand such as nights and weekends.

However, such facilities are extremely difficult to fund and staff. In addition, **utilization data—primarily from Community Mental Health Center (CMHC) cost reports — suggest that WM facilities have low occupancy rates, making further expansion financially burdensome.** For instance, the rural Midwestern Colorado Mental Health Center, which is operated by Axis, reported an occupancy rate of 3.5% off 64 census days during the year — a cost of just over \$4,300 per patient day. Even Aurora Mental Health Center's WM facility, in a

densely populated area, was occupied just under half — 45.6% — of the time. These are not criticisms of these facilities — WM facilities all over the country experience large fluctuations in demand — peak demand occurs on the weekends and the lowest demand typically occurs midweek. As a result of these fluctuations, WM census is very difficult to average.

Thus, we turned to expert analysis. A [recent report by RAND Corporation](#) estimating SUD bed capacity in urban Sacramento, California, recommends 30 to 46.2 adult residential treatment beds per 100,000 population across all residential levels of care. At the existing proportion of WM among all residential beds — which is not necessarily ideal — that recommendation reflects 23.1% of residential beds dedicated to WM specifically. **As a result, estimates based on prior modeling propose that there should be 6.9-10.7 adult WM beds per 100,000 population. All of Colorado's Substate Planning Areas, or SSPAs, meet and exceed the high end of that estimate, many by a wide measure, although some rural localities have no local access to WM services.**

Finally, we have also broken out demand and supply for youth withdrawal management due to a special need for these services. To estimate the benchmark for youth WM services, we used the same approach as above, **estimating that there should be 2.3 to 3.6 youth (ages <18) WM beds** per 100,000. Importantly, we recognize that the relative proportion of youth with SUD in need of WM services is likely lower than the adult population. As a result, this benchmark probably overestimates the need for youth residential WM services. Notably, there have been numerous recent contracting efforts to bolster this service realm in FY23, including the Denver Health project and Jefferson Hills/Jefferson County Mental Health.

SUPPLY

Across all providers that report their utilization to the BHA, Colorado served 18,363 unique WM clients for a total of 28,275 unique admissions, an average of 1.5 unique admissions per client. **The exact number of youth clients served was censored at less than 30.**

The vast majority of WM admissions were to treat primarily alcohol (72%). This common and legal substance was followed by methamphetamines (16.6%), heroin / opiates (8.1%), and distantly by cocaine (1.4%), other substances (1.2%), and marijuana (0.7%).

State WM capacity findings for adults and youth are reviewed on the next page in Table 9. Note that, due to dually-licensed facilities, the breakdowns by level of care may not add up to the total number in a region.

TABLE 9.
Breakdown of WM Providers by Type and SSPA Region (FY2022)

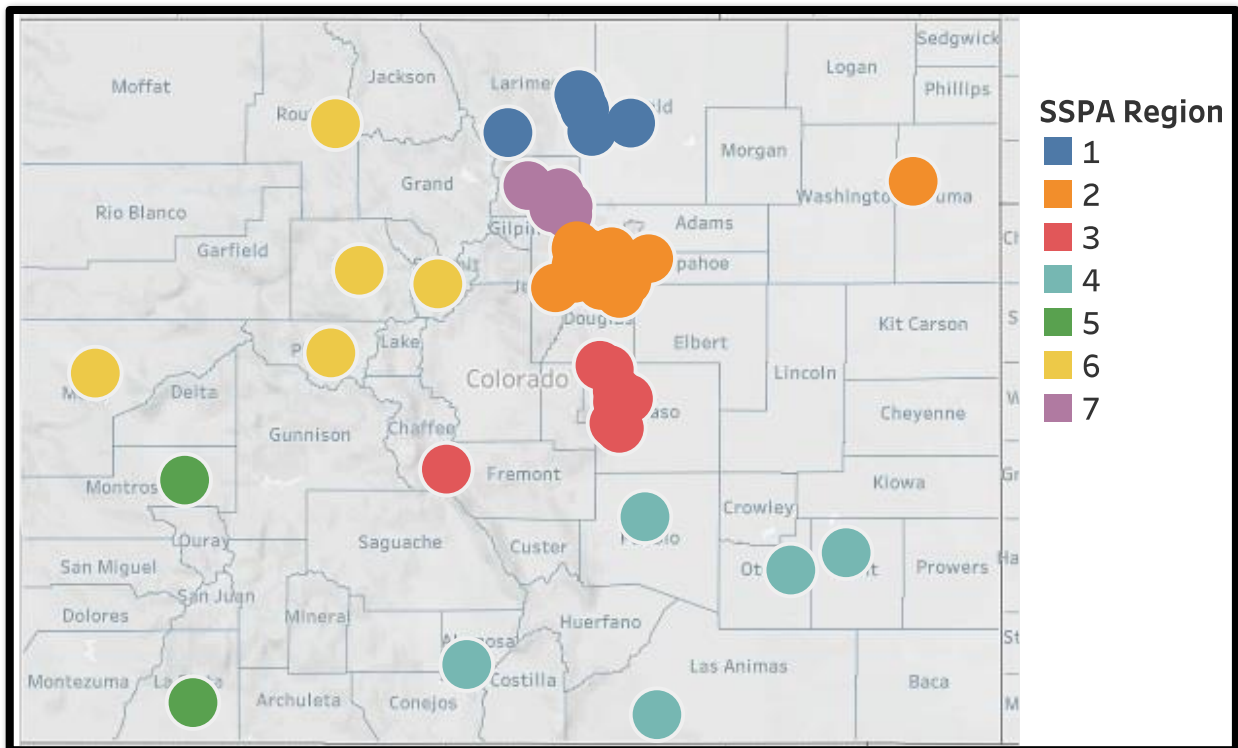
	SSPA 1 Northeast	SSPA 2 Metro Denver	SSPA 3 Colorado Springs	SSPA 4 Southeast	SSPA 5 Southwest	SSPA 6 Northwest	SSPA 7 Boulder	Total
Total WM Facilities	6	28	9	5	2	5	6	61
% of State Total	9.8%	45.9%	14.8%	8.2%	3.2%	8.2%	9.8%	100%
3.2	2	13	6	5	2	5	5	38
3.7	4	20	6	0	0	1	1	33
Total WM Beds*	126	567	176	62	26	92	89	1,138
(% of State Total)	(11.1%)	(49.8%)	(15.5%)	(5.4%)	(2.3%)	(8.1%)	(7.8%)	
WM Beds* per 100,000 Population	15.4	19.4	20.4	21.7	12.7	23.9	27.0	19.6
Total Unique Treatment Episodes	2,148	16,040	2,891	3,125	1,305	1,369	1,381	28,275
% of State Total	7.6%	56.7%	10.2%	11.1%	4.6%	4.8%	4.9%	100%

**Uses imputed data based on N=30 providers based on state average beds for Levels 3.2 and 3.7 facilities.*

WM Supply: Geography

Here, we review the takeaway findings for each SSPA. Figure 5, on the next page, provides a glance at WM facility density across the state. In each section, we will detail the capacity of the region, followed by utilization and cost data, and finally, outcomes from WM treatment. It is important to note that cost data for MSOs includes several types of costs, including per-client funding for people under 300% of FPL who are not enrolled in Medicaid; room and board for Medicaid members; per-client funding for 3.7WM on involuntary commitment; and capacity-based payments for staff and other costs.

FIGURE 5.
WM Locations by SSPA Region (FY2022)



SSPA 1

While the Eastern Plains region falls below the state average for per capita WM beds, this region remains above recommended capacity levels overall. However, this masks a huge regional disparity in the availability of beds. All six of the WM facilities in this vast region reside in Larimer (five) and Weld (one) counties, leaving large portions of the region more than two hours from any WM facility. **This region has the second-least per capita WM capacity in the state, at 15.4 beds per 100,000 people, more than 20% below the state average.**

There is one additional non-residential WM provider, though. Ambulatory WM—which is not licensed by the state, nor billable for formal reimbursement—is available through one MSO-contracted provider in this region, which might address some of the rural and frontier regions. These data are not reflected in utilization data.

Interestingly, despite its low capacity, SSPA 1 displays even lower rates of utilization. **With 14% of the state's population and 12.2% of its WM beds, SSPA 1 demonstrates only 7.6% of the unique treatment episodes in the state, just over half of what one would expect based on population alone.** Additionally, the occupancy rate at North Range, one of the two publicly-funded WM facilities in the region, was 42.5%. Finally, while there is no license specifically for youth withdrawal management, one provider did accept at least one youth client during the year.

As expected, based on service utilization, this region also spends less on WM than most others. **MSO spending, at \$1.36 per resident in the region, is the second-lowest of any SSPA.** This also jibes with findings from the Medicaid world. While there are two Medicaid plans in this SSPA (Larimer County, which is in SSPA 1, is in another RAE, or Medicaid, region), the Medicaid plan with more members in the region also shows lower-than-average utilization and spending; in fact, both figures are more than 25% below the mean for the state.

SSPA 2

The Denver Metro area has slightly above-average capacity for most WM services. While it has proportionally fewer facilities — 45.9% of the state's total number — than one might expect based on its population, it makes up for it with larger facilities, **accounting for 49.8% of the state's total beds.**

At the 3.7WM level, SSPA 2 dominates the state, with 20 of the 33 facilities in Colorado licensed at the medical level. For this reason — as a reminder, MSOs cannot contract with 3.7WM facilities in most cases — the region has a relatively low percentage of MSO-contracted WM facilities, at 35.7%. There are, however, two additional outpatient, ambulatory WM providers contracted through the MSO (Signal), adding two more options for people in the region. Also, for youth, at least one young person was admitted for WM services in the region.

Utilization rates are also higher in SSPA 2, which accounts for 56.7% of the state's unique WM treatment episodes. While still relatively low overall, two of the CMHCs in the region — Aurora Mental Health Center and Jefferson Center — display WM utilization rates in the 45% range, which is higher than many rural occupancy rates and near the top of published rates for CMHCs around the state.

This region's MSO spending on WM is near the state per capita average. At \$2.06 per resident in the region, it is just under the state mean of \$2.38. **Interestingly, in the Medicaid realm, this region — which overlaps with RAE regions 3 and 5 — has far higher spending on WM, the highest in the state by a significant margin, with a \$13.51 per-member spend on Medicaid WM services.** This is nearly 25% higher than the state average and \$3.00 per member higher than any other RAE region in the state. This could be due to the higher concentration of pricier 3.7 WM, or medical, WM services.

SSPA 3

The Colorado Springs Metro area and points west demonstrate slightly above-average capacity with significantly lower-than-average utilization for WM. The region's 176 WM beds — 20.4 per 100,000 residents — are just above the state average. Like most urban regions, SSPA 3 features a relatively high ratio of medical to social WM, with six licensed facilities at each level. It also has a high concentration of urban WM facilities, with most of the region's WM capacity in Colorado Springs. **For youth, in SSPA 3, there were no WM providers in the region that accepted a youth client during the year.**

However, with 14.8% of the population and 15.5% of the beds, SSPA 3 had only 10.2 % (2,891) of the state's WM treatment admissions in FY2022. Comparing SSPA 3 with its southern neighbor, SSPA 4, illustrates the magnitude of its low utilization. **SSPA 3 — with more than three times as many residents and nearly three times as many WM beds — has less total WM treatment admissions than SSPA 4.**

The spending for SSPA 3 is also quite informative. **The region spends only \$1.02 per resident on MSO-funded WM services, the lowest of any SSPA and less than one-ninth of its neighbor to the south (SSPA 4).** At \$881,735.00, the total magnitude of spending is less than one-sixth of the Denver Metro area and lower even than tiny SSPA 5 in southwest Colorado. This could be partially due to the relatively low percentage of MSO-contracted WM facilities, at 37.5%. This region has a relatively high number of commercially-focused WM providers, so there are only three MSO-contracted WM providers: Solvista's recently-opened Regional Assessment Center in Salida and Crossroads Turning Point and Peak View, both in Colorado Springs.

The low rate of WM spending in the SSPA could also be explained in part by higher rates of Medicaid spending in this region. While it is difficult to determine, since the RAE for the region covers both the El Paso County area (RAE 7), as well as the counties west of Denver (RAE 6, Jefferson, Gilpin, and Clear Creek Counties, as well as Boulder and Broomfield), Medicaid spending for the combined RAE regions was \$10.36 per Medicaid member, second-highest of any RAE and just below the state mean.

SSPA 4

The southeast part of the state, largely consisting of the rural Arkansas and San Luis Valleys, demonstrates slightly above-average capacity and significantly above-average utilization for WM. The region's 62 WM beds — 21.7 per 100,000 residents — are just above the state average for per capita withdrawal management beds. Impressively, though, all WM facilities are publicly-accessible, meaning they accept MSO or Medicaid funding. In fact, all five of the region's WM facilities — all social, or 3.2WM — are contracted with MSOs, several of them with multiple MSOs.

The lower costs of 3.2WM facilities and community-focused providers enable a broad geographic spread in this largely rural and frontier region. In fact, astoundingly, all five facilities are in different counties. In addition to Pueblo County, there are WM facilities in Alamosa, Bent, Las Animas, and Otero Counties, which average just under 14,000 people per county. **There is nowhere else in the state with WM facilities across such a sparsely populated region.**

And these beds get used. As mentioned above, despite having the median number of beds per capita in the state, SSPA 4 has a far higher utilization rate than other regions. With 3,125 treatment episodes, the region accounts for one-ninth of the state's WM admissions with less than one-twentieth of the population.

Having well-utilized beds in such a rural region does not come cheap, though. At Southeast Mental Health Services, the occupancy rate is 25.1%, meaning that six of their eight beds are likely unoccupied on any given night. Thus, the region spends \$9.56 per resident on MSO-funded WM services, the highest of any SSPA and more than nine times its far larger northern neighbor to the south (SSPA 3). **In fact, at \$2,726,194.00, the region spends more in total than any other SSPA, except Metro Denver.**

Interestingly — and perhaps starting to show a pattern — high WM spending in the SSPA may balance out lower rates of RAE spending on WM services. Health Colorado, the RAE for the region, entirely overlaps this SSPA. Their per-member spending on WM was just \$5.52 per member, by far the lowest in the state. In fact, it is possible (although uncertain) that this is the only region where MSO spending outpaces RAE spending on WM. However, they get a lot for their spending, reporting 1,075 admissions. The low rate of spending per admission may result from the lack of more-costly medical WM services in the area.

In addition, while ambulatory WM is not formally licensed by the state, the MSO for this region (Signal) contracts with three additional outpatient WM providers. These WM expansion contracts further extend the region's already-impressive range of WM services. Finally, despite anecdotal data lamenting the lack of youth WM in the regions, one provider did accept at least one youth client during the year.

“We only have the capacity to treat adolescents in our outpatient and peer programs. So, no detox and inpatient treatment — no resources to refer to.”

~ RESADA

SSPA 5

The sparsely-populated southwest SSPA has significantly lower capacity than any other region. **With only two WM providers, both 3.2WM, one in Montrose and one in Durango, the region's 26 WM beds are spread across more than 17,500 square miles.** At 12.7 beds per 100,000 residents, the region has less than half the per capita beds of the highest region. Fortunately, like SSPAs in other rural regions, all of its facilities are publicly-accessible by Medicaid members and MSO-funded clients.

Despite the few locations and beds, utilization is proportionally higher than one might expect. With 1,305 treatment episodes in FY 2022, the region had almost as many episodes as SSPA 6 to the north, which is nearly double the size. In fact, with 2.3% of the state's WM beds and 4.6% of its admissions, the region utilizes WM at a far higher rate than expected.

Like other rural SSPAs, WM costs relatively more because of greater fluctuations in demand. The region spends \$4.54 per resident on MSO-funded WM services, behind only SSPA 4 in per capita WM spending. Part of this spending occurs because it is expensive to keep WM facilities open in rural areas. The CMHC-operated WM facilities in the region, in Durango and Montrose, had occupancy rates of 34.4% and 3.5%, respectively.

Finally, while there is no WM provider specifically providing youth withdrawal management in the region, one provider did accept at least one youth client during the year.

SSPA 6

Northwest Colorado has above-average withdrawal management capacity with below-average utilization. The region's 92 WM beds are spread widely throughout the region, in Aspen, Edwards, Frisco, Grand Junction, and Steamboat Springs. **With 23.9 beds per 100,000 residents, this region has the second-highest ratio of WM beds to residents. However, two of its larger facilities and their 39 beds are not publicly accessible, taking a significant amount of its capacity offline.** The remaining three 3.2WM facilities, though, account for the vast majority of the region's admissions. They are dispersed across the I-70 corridor, leaving just the northwest corner of the state bare. It can take nearly two hours to get from some parts of Moffat and Routt Counties to the WM facilities in Grand Junction or Frisco. In order to make up for some of the geographic gaps in WM service, the MSO for this region, previously West Slope Casa and now Rocky Mountain Health Plans, contracts with an additional outpatient provider for ambulatory WM services.

SSPA 6, despite its above-average capacity, has a relatively lower utilization of WM facilities. With 6.6% of the state's population, it only accounts for 4.8% of the state's unique WM treatment episodes. Its 1,369 admissions in FY 2022 were only 64 more than the lowest-utilizing region, which has just over half the number of residents.

With \$1,318,041.00 in spending during the year, SSPA 6 was the median region for total spending. Its \$3.41 per resident in MSO WM spending was the third highest in the state, but still just 36% of SSPA 4's per capita spending.

There were no WM providers in the region that accepted a youth client during the year.

SSPA 7

Boulder County demonstrates a higher-than-expected number of WM facilities and beds with a lower-than-expected utilization of those beds. The region has five WM facilities, four licensed at 3.2WM and two at 3.7WM, with one dually-licensed. **Those facilities comprise 89 WM beds, or 27.0 per 100,000 residents — the highest rate in the state.**

Interestingly, though, four of these facilities are not traditional 3.2WM programs, as they are not publicly-available (no Medicaid or MSO funding accepted), leaving only a single WM provider — Mental Health Partners — that was contracted with the prior MSO, which was also Mental Health Partners. This left 69 of the total 89 beds in the region unavailable to the public, effectively cutting the capacity of beds to 6.1 per 100,000 people in the region. We understand that the incoming MSO, Signal has extended a contract for 3.7WM for involuntary commitments to another WM provider.

This effective lack of capacity may explain the region's low apparent utilization. With just 1,381 treatment episodes — 4.9% of the state total — SSPA 7 ranks just above SSPAs 5 and 6. However, since non-publicly-available providers sometimes do not report their admissions, all 1,381 treatment episodes came from the region's single MSO-funded treatment provider, Mental Health Partners, which ranked fifth in the entire state for treatment admissions. This pressure on a single provider is reflected in the utilization rate. **At 85.3%, Mental Health Partners' WM unit is astronomically high, the highest of any CMHC-operated WM facility noted during this review.**

The high occupancy rate leads to high efficiency as well. **While the SSPA 7 is on the smaller end of the SSPAs, size-wise, it has the lowest total spend of any SSPA, only \$840,295.00.** This translates to \$2.54 in MSO WM spending per resident, which is just over the state average.

While we have RAE spending for this region, Boulder accounts for a very small portion of the two RAE regions operated by Colorado Community Health Alliance, or CCHA. Therefore, analyzing RAE WM spending for this region could lead to invalid conclusions.

Finally, while there is no WM provider who provides specific services for youth withdrawal management in the region, one provider did accept at least one youth client during the year.

TABLE 10.
Breakdown of MSO-Contracted WM Providers and Funding by Region (FY2022)

	SSPA 1 Northeast	SSPA 2 Metro Denver	SSPA 3 Colorado Springs	SSPA 4 Southeast	SSPA 5* Southwest	SSPA 6 Northwest	SSPA 7 Boulder
MSO-Contracted WM Facilities*	2	10	3	5	2	3	2
% of Regional Total Providers	33.3%	35.7%	33.3%	100.0%	100.0%	60.0%	33.3%
MSO Spending	\$1,116,134	\$6,037,450	\$881,735	\$2,726,194	\$933,700	\$1,318,041	\$840,295
MSO Dollars Spent per Unique Individual Served	\$754 (statewide)						
MSO Spending per Capita	\$1.36	\$2.06	\$1.02	\$9.56	\$4.54	\$3.41	\$2.54

*All identified WM providers are listed by SSPA region and MSO-contracted status in Appendix C1.

Conclusion

Overall, MSOs contributed \$13.9M in funding for WM services across all levels of care, averaging \$2.38 per resident on WM services and \$754.00 per unique individual served. In general, RAEs spend more on WM than MSOs. This ratio has increased significantly with the addition of 3.7WM to Colorado's Medicaid SUD benefit. However, MSOs play a crucial role in supporting new facilities, rural facilities, and nontraditional ambulatory WM services. There are some clear takeaways from our analysis.

Overall, Colorado has withdrawal management capacity in line with recommended norms. It is difficult to establish adequacy or population norms as discussed above, particularly in rural areas. However, based on estimations formulated using 2020 HCPF bed registry data, Colorado has up to 1,138 licensed withdrawal management beds, which averages 19.6 WM beds per 100,000 residents across 61 separate residential WM facilities. **Based on estimates from RAND, this places Colorado well above the recommended capacity level for adult WM beds. In fact, every region in Colorado now exceeds the upper bound of the ideal capacity from this study (10.7 WM beds per 100,000).**

The addition of 3.7WM as a Medicaid benefit has greatly changed the landscape of WM in Colorado, particularly in urban areas. While the majority of state WM providers, especially publicly-funded providers, offer Level 3.2WM care, many commenters in urban areas stated that 3.7WM is now the preferred modality of care in urban areas. However, in many rural areas, 3.2WM is the only modality available. In fact, in all of western Colorado, there are just two 3.7WM facilities, neither of which accept Medicaid or MSO funds. This change in Medicaid reimbursement for 3.7WM has increased overall spending, while still leaving rural areas devoid of the higher level of care. But the MSO system works with the majority of eligible WM facilities: currently, 29 of the 38 3.2WM providers, in addition to a few 3.7WM providers specifically for people on involuntary commitments.

While our state does not specifically license WM beds for youth — making it difficult to estimate supply — youth WM is often a more acute crisis when it occurs. While overall numbers were censored, five total providers served at least one youth (<18 years of age) client during FY22. Qualitatively, people are asking for more options for youth WM, even in rural areas. Because youth WM clients are admitted at the discretion of a given provider, low youth utilization could be a consequence of overall lack of awareness of WM as a youth resource.

Ambulatory WM is emerging as an option, particularly in rural areas. MSOs have taken the lead in supporting this novel service, which can fill geographic gaps. For instance, Eagle County Paramedics have visited the homes of people in withdrawal from alcohol for several years now, with excellent outcomes. Ambulatory WM may be a viable option in regions with no facility, particularly given the widespread lack of workforce to staff residential facilities.

Concentration of WM facilities in urban areas remains a major concern. For instance, SSPAs 1 and 3 have a significant concentration of their WM facilities in urban areas, leaving large areas of those SSPAs more than an hour away from the nearest WM facility. Yet other

SSPAs, especially 4 and 6, have widely distributed WM facilities. This is a trade-off of utilization and access, since urban WM facilities tend to have higher occupancy rates.

There is an ongoing question, however, of how to measure “success” for WM as a service. The only statewide data on the success of WM demonstrates the difficulty retaining people in withdrawal in health care services. Only 11.7% of all unique WM discharges attended an outpatient follow-up appointment within seven days. At 30 days, only 13.4% had attended an appointment. Thus, in addition to filling regional gaps in WM accessibility through facilities and ambulatory care, improving follow-up care for people with a history of withdrawal is crucial to improving the continuum of treatment and recovery in our state.

3. Recovery Residences

Background

Recovery residences are a crucial part of the continuum of care for people with substance use disorders. Recovery residences, also referred to as sober living, provide a supportive environment and community during a critical period of the recovery journey.

Often, people enter a recovery residence after residential treatment, withdrawal management, or incarceration. Other people may enter withdrawal management while engaged in outpatient treatment. **The great news is that Colorado ranks highly for recovery residences as compared with other states, primarily due to rapid growth in recovery residences since 2019.** In fact, the number of recovery residences tripled between spring 2019 and 2022, with further growth in the last year. Much of this has been supported by the state, judicial districts, and cities. However, despite their importance and low-cost relative to high-intensity residential treatment, recovery residences are hard to come by in some areas of Colorado.

Methods

This analysis comprises statewide recovery residence data for FY22 and is further broken out into Colorado's seven Sub-State Planning Areas (SSPA) regions. To compile the below figures, we leveraged grant contract and spending report data from all FY22 MSOs (Signal, Diversus, West Slope Casa, and Mental Health Partners), certification reports collected through the Colorado Association of Recovery Residences (CARR), and activity reports through Oxford House (OH).

In Colorado, publicly-funded recovery residences must be affiliated with one of the following entities: Oxford House, Sobriety House, Step Denver, or CARR:

1. CARR is the certifying body for our state's recovery residences, which must follow the standards and requirements set forth in House Bill 19-2009.
2. Oxford House is a separate national nonprofit organization that issues charters for recovery residences with the support of the organization and is one of the most common recovery residences in Colorado.
3. Sobriety House is a local nonprofit treatment and recovery organization.
4. Step Denver is a local nonprofit long-term residential recovery program with several recovery residences.

Oxford House, Sobriety House, and Step Denver are exempted from CARR certification. Together, all four organizations comprise the entirety of publicly-funded recovery residences in the state.

We received data for the vast majority of residences in Colorado, including CARR-certified residences, of which there are around 240 as of May 2023, and Oxford Houses, of which there are approximately 125. First, we will briefly review the funding for residences under these two organizations, then move on to the service utilization data.

CARR itself is funded through grants and certification fees. As a certifying body, CARR does not currently operate any recovery residences itself. Operators range from a single recovery residence to more than 20 houses under an umbrella organization; each of its roughly 240 houses find funding on its own through a combination of user fees, capacity-based grants, and scholarships for individual residents. The latter two items may be funded through the state via programs like State Opioid Response, Block Grants, 1287, or 202 funding, all of which often flow through the MSOs. As mentioned above, judicial districts also fund some residences. Finally, cities and counties are also starting to fund more recovery residences, often through opioid settlement money.

Oxford Houses are funded differently. Each house is peer-run and self-sustaining, so their costs and fees are often lower than CARR-certified residences. The majority of Oxford House funding in our state goes to outreach workers, who serially develop new houses within a targeted region, as well as participant scholarships, which pay for the first two months of residents' fees. Ideally, Oxford Houses are also financially independent and self-sustaining. After a startup period that develops the peer-run model, the outreach worker moves on to a new project. The largest funder of Oxford House in our state is the Behavioral Health Administration, or BHA, through State Opioid Response grant funding.

"I think the biggest step down is from residential and back into the community. I think you really need to wrap care around those people pretty closely. I do think some facilities do a really great job in that transition and others are lacking."

~ Colorado Community Health Alliance

Findings

DEMAND

One of the primary outcomes of interest to gauge need in Colorado's recovery housing system is resident volume. Unfortunately, with its current information system, CARR is unable to systematically track resident volume, even for certified recovery residences. Furthermore, MSOs demonstrate a wide range of tracking and reporting capabilities. **Notably, only one of the state's four MSOs can provide reporting documents on unique individuals served by funded recovery services.** As a result, we are unable to ascertain MSO spending for recovery residences at a per-client level, nor understand the proportion of total recovery housing residents supported by MSO funding. The data tracking infrastructure for recovery residences presents an opportunity to streamline reporting metrics across MSOs and to

expand CARR's data tracking capabilities to better capture need and dollars spent on recovery residences in the future.

Fortunately, Oxford House demonstrates a robust residence utilization and outcomes reporting infrastructure supported by its national governing body, including monthly House Activity Reports (HAR). These reports review total residents, departures, and reasons for departure — including return to substance use — by residence by month. As a result, this analysis relies on Oxford House's HARs to approximate the demand for residential recovery support. Oxford House accounts for 30% of Colorado's recovery residence supply overall and an even greater proportion of supply in three regions (SSPAs 5, 6, and 7). As such, Oxford House provides a useful sample to understand trends in demand at the state and regional levels.

Perhaps the best way to characterize demand for this service is through occupancy levels and waiting lists. While these measures are not currently available for CARR — which is working on a soon-to-be-released bed tracker that will allow such measures — Oxford House has such numbers. According to a recent [NPR article](#), in December 2021, Oxford Houses in Colorado had an occupancy rate of 83.4%; as of May 14, 2023, it was 83.9%. Thus, **occupancy has actually increased over the last 18 months despite expanding the number of residences by more than 25%; a disproportionate amount of this expansion has occurred in rural areas.** Generally, recovery residences aim for an occupancy rate of at least 80%. Oxford House's excess, rising occupancy rate in Colorado indicates that there is still room for more such residences in our state.

SUPPLY

As displayed in Table 11 below, **Oxford House served a total of 6,542 clients in FY22, of whom a remarkable 95% maintained recovery while in residence**, as defined by adherence to the organization's abstinence policy. Across the state, including Oxford House and CARR residences, MSOs spent a total of \$5,388,377.00 on recovery residence services, less than \$1.00 per resident of state spending on recovery residences.

TABLE 11.
Breakdown of Recovery Residence (RR) Utilization and Funding by SSPA Region (FY2022)

	SSPA 1 Northeast	SSPA 2 Metro Denver	SSPA 3 Colorado Springs	SSPA 4 Southeast	SSPA 5* Southwest	SSPA 6 Northwest	SSPA 7 Boulder
Oxford House Clients Served	1,040	3,033	1,428	460	89	352	140
% of Total Volume	15.9%	46.4%	21.8%	7.0%	1.4%	5.4%	2.1%
MSO RR Spending	\$970,817	\$2,897,136	\$247,802	\$1,038,231	\$99,000	\$99,000	\$36,391

	SSPA 1 Northeast	SSPA 2 Metro Denver	SSPA 3 Colorado Springs	SSPA 4 Southeast	SSPA 5* Southwest	SSPA 6 Northwest	SSPA 7 Boulder
% of Total Spending	18.1%	54.1%	4.6%	19.4%	1.8%	1.8%	0.7%
MSO RR Spending per SSPA Resident	\$1.18	\$0.98	\$0.28	\$3.64	\$0.48	\$0.25	\$0.11

Note that not all Oxford House clients are low-income, and thus not all are supported by MSO funding, particularly for scholarships. Additionally, the spending line includes both per-person scholarships as well as capacity grants supporting recovery residences' operating costs — we could not differentiate between the two. Finally, while it is likely that other state agencies' spending brings this average up, overall recovery residence spending is likely in the single-digit dollars per Colorado resident. Unfortunately, there are no comparable data available for other states, so it is unknown how our state's spending compares to others.

As displayed in Table 12 below, the majority of recovery residences and total beds are available to MSO-funded clients. **In fact, 72% of the residences in the state — representing 68% of the total beds — are contracted with MSOs.** Of the remaining few, several have extremely high fees; one “luxury rehab” in Eagle County features sober living at more than \$50,000.00 per month, while some other faith-based recovery residences choose not to contract with MSOs. It appears that, in general, efforts to increase the number of publicly-funded recovery residences will come through greater overall capacity rather than more intensive efforts at contracting with existing residences.

TABLE 12.
MSO-Contracted Residences by SSPA Region (FY2022)

	SSPA 1 Northeast	SSPA 2 Metro Denver	SSPA 3 Colorado Springs	SSPA 4 Southeast	SSPA 5* Southwest	SSPA 6 Northwest	SSPA 7 Boulder
MSO- Contracted Recovery Residences*	21	166	55	14	2	7	2
% of Regional Total RR	80.8%	69.2%	84.6%	87.5%	100.0%	46.7%	33.3%
Total Oxford Houses**	17	46	24	10	2	7	2

**A list of all recovery residences by region and MSO contract status is included in Appendix D1. Additionally, updated CARR-certified residence data as of May 2023 are included in Appendix D2.*

***All Oxford Houses contract with MSOs.*

National Benchmarks

Colorado boasts 370 residences across the state, which means we have 6.3 residences per 100,000 residents.

For reference, as of January 2023, Virginia contained 216 accredited recovery residences, including Oxford Houses and Virginia Association of Recovery Residences (VARR)-recognized residences. Altogether, Virginia hosts an estimated 2.5 recovery residences per 100,000 residents. Washington State averaged around 5.8 residences per 100,000 people; meanwhile, Florida, the undisputed leader in recovery residences, sustained at least 9.8 per 100,000.

While national averages for recovery residence prevalence are hard to come by, Colorado definitely has an above average prevalence of recovery residences. According to correspondence with NARR, the National Association of Recovery Residences, Colorado has the 5th or 6th most in the nation, with Florida and California at the top and Colorado grouped with Michigan, Missouri, Virginia, and Washington in the next tier.

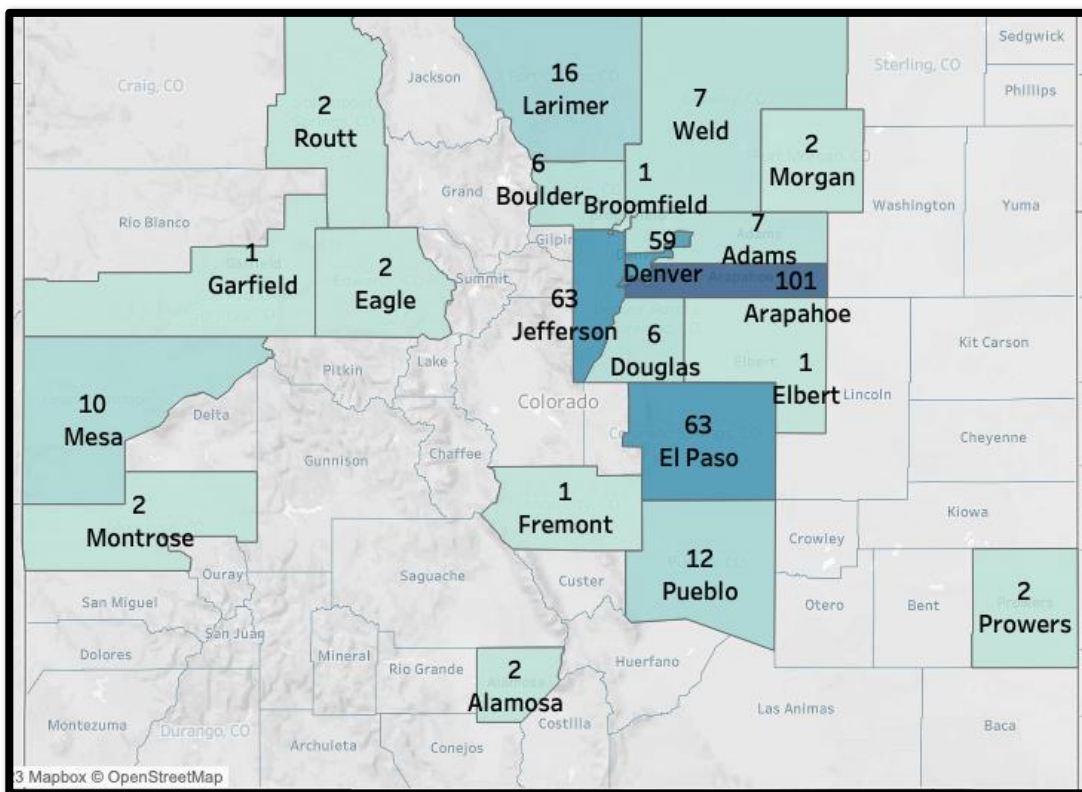
Recovery Residence Supply: Geography

Differences in utilization and MSO spending across geographic regions largely correlated to urban versus rural settings. On the following page, Table 13 reveals that service volume is most concentrated in metropolitan areas like Metro Denver (SSPA 2) and Colorado Springs (SSPA 3), which account for two-thirds of all OH clients served and nearly 60% of total MSO funding for recovery residences. In fact, recovery residences per capita are tightly correlated with the urban areas, as demonstrated by Figure 6 on the following page. The two SSPAs with the largest urban populations, SSPAs 2 and 3, have the highest rates of recovery residences (8.2 and 7.5 per 100,000 residents, respectively), while the most rural SSPA, region 5 in the southwest, has the lowest rate (1.0 per 100,000 residents). **Next, we will discuss each SSPA's recovery residence capacity, utilization, and outcomes individually.**

TABLE 13.
Recovery Residences by SSPA Region (FY2022)

	SSPA 1 Northeast	SSPA 2 Metro Denver	SSPA 3 Colorado Springs	SSPA 4 Southeast	SSPA 5* Southwest	SSPA 6 Northwest	SSPA 7 Boulder
Total Recovery Residences	26	240	65	16	2	15	6
% of State Total	7.0%	64.9%	17.6%	4.3%	0.5%	4.1%	1.6%
Recovery Residences per 100,000 Residents	3.2	8.2	7.5	5.6	1.0	3.9	1.8

FIGURE 6.
Total Recovery Residences by County (FY2022)



SSPA 1

SSPA 1, Northern Colorado and the Eastern Plains, is well below the capacity of the state average. There are only 26 recovery residences in the area — comprising 40% of the total RR volume for the similarly-populated SSPA 3 (Colorado Springs) region. Fortunately, the majority of these residences (81%) are contracted with the MSO. However, this still leaves the region with a dearth of options for recovery housing, especially when it comes to specialty beds like adults with children and mixed housing to safely and respectfully accommodate individuals across the spectrum of gender identity. As LGBTQ+ individuals are significantly more likely to experience SUD and homelessness, the complete lack of such recovery housing in SSPA 1 demonstrates an urgent need to improve capacity to support this vulnerable population.

The vast majority of beds in this region are designated for single adult men only, with fewer than half as many allocated for women and only eight beds for women with children. For men with children, there are no beds at all. Oxford House's 17 houses in SSPA 1 account for 81% of total recovery residences in this region.

TABLE 14.
SSPA 1 Recovery Residence Bed Capacity by SSPA (FY2022)

	MSO-Contracted Beds	Total Bed Capacity
Mixed	0	0
Men Only	97	128
Women Only	59	66
Men and Children	0	0
Women and Children	8	8
TOTAL	164	202
BED CAPACITY PER 100,000 RESIDENTS	20.1	24.7

Despite its below-average capacity, when it comes to utilization, SSPA 1 is the closest to the average of any SSPA in the state. With 14% of the state's population, the region hosted 1,040 Oxford House clients last year — 15.9% of total such clients in the state. MSO spending on recovery residences for the region was just under \$1M, or \$1.18 per SSPA resident, a bit higher than the state average of \$0.92 per resident.

Despite the lack of capacity, the outcomes for recovery residences in this region are quite positive. In SSPA 1, recovery residences self-reported that three-quarters of MSO-funded

clients “maintained recovery.” While this is slightly lower than the state average, it is still an excellent outcome. Meanwhile, in Oxford Houses in the region, 96% of residents maintained their recovery.

SSPA 2

SSPA 2, the Metro Denver area, contains 54% of recovery residences in the state at 240 total homes, with 44% (166) contracted with the MSO. A total of 2,437 beds are available in this region with 55% MSO-contracted. **Notably, SSPA 2 is the only region to have MSO-contracted mixed housing, with 50 beds available.** Metro Denver has the largest difference between the number of Oxford Houses (17) and other types of recovery residences (149), demonstrating greater diversity in options.

TABLE 15.
SSPA 2 Recovery Residence Bed Capacity by SSPA (FY2022)

	MSO-Contracted Beds	Total Bed Capacity
Mixed	50	105
Men Only	932	1,393
Women Only	452	577
Men and Children	18	18
Women and Children	36	40
TOTAL	1,566	2,437
BED CAPACITY PER 100,000 RESIDENTS	53.5	83.2

This region comprises over 50% of the state population and represents a relatively low utilization of Oxford House residences (46% of total Oxford House clients) and a relatively high allocation of MSO funds received (54%). However, given the high cost of living in the city, this moderate excess in funding is reasonable and expected. Because Denver is also home to the majority of the state’s non-Oxford House recovery residences, the relatively low OH utilization could be a result of Denverites having more recovery residence options to choose from. However, OH still dominated the number of clients served. Based on available MSO tracking, SSPA 2 served a total of 3,540 clients, 86% (3,033) of which were in Oxford Houses. MSO spending on recovery residences for the region was nearly \$3M, or \$0.99 per SSPA resident, slightly higher than the state average of \$0.92 per resident.

Outcomes within this SSPA are consistent with the state average. Ninety-one percent of MSO-funded clients maintained their recovery throughout their stay. Meanwhile, in Oxford Houses in the region, 95% of residents maintained their recovery.

SSPA 3

SSPA 3, the Colorado Springs area, contains nearly 18% of recovery residences in the state. Of these 65 recovery residences, the majority (85%) are contracted with the MSO. This region represents the highest number per capita of recovery residences contracted by MSO, at 6.4 per 100,000 residents, and the greatest volume of MSO-contracted available beds, at 61.2 per 100,000 residents. No mixed housing is available in this region. A balance of recovery housing options are available with a 44% / 56% split of Oxford Houses / CARR-certified homes.

TABLE 16.
SSPA 3 Recovery Residence Bed Capacity by SSPA (FY2022)

	MSO-Contracted Beds	Total Bed Capacity
Mixed	0	0
Men Only	314	401
Women Only	135	135
Men and Children	34	34
Women and Children	37	37
TOTAL	528	625
BED CAPACITY PER 100,000 RESIDENTS	61.2	72.4

With the highest capacity per population, the volume of Oxford House clients served (22%) far surpasses the region's share of the state's total residential population (15%) and regional MSO funding for recovery residences (5%). As a result of disproportionately high utilization and low funding, **SSPA 3 has some of the lowest dollars spent on recovery residences at the population level (\$0.28 per resident)**. At the time of this writing, Oxford Houses in El Paso County had an occupancy rate of 88.9%, one of the highest in the state. This high service volume suggests that the Colorado Springs area is experiencing an excessive burden of demand on recovery residences. Bringing recovery residence funding in SSPA 3 to parity with the state average — a tripling of current funding to just under \$750K — would rapidly impact a high-demand service area that also serves a significant portion (23%) of the state's total service volume.

In addition to the high capacity and utilization with the lowest dollars spent, outcomes in this region are higher than the state average with 96% of Oxford House residents maintaining recovery.

SSPA 4

SSPA 4, the mostly rural southeastern region covering the San Luis Valley, has 16 recovery residences, 14 of which are contracted with the MSO. This eastern region, buoyed by 11 Oxford Houses in the region's population center of Pueblo, has a recovery residence density (5.6 per 100,000) well above the state median of 4.8 per 100,000 residents. Oxford Houses make up 71% of recovery residences in this region.

TABLE 17.
SSPA 4 Recovery Residence Bed Capacity by SSPA (FY2022)

	MSO-Contracted Beds	Total Bed Capacity
Mixed	0	0
Men Only	53	69
Women Only	14	14
Men and Children	9	9
Women and Children	27	27
TOTAL	118	134
BED CAPACITY PER 100,000 RESIDENTS	41.4	47.0

This area of the state represents 5% of the total population and served 7% (460) of Oxford House clients and 173 MSO clients. MSO spending on recovery residences for SSPA 4 was just over \$1M, representing \$3.64 per SSPA resident—*over four times the state average*. This could be due to higher demand for services, particularly in the rural Arkansas Valley and San Luis Valley areas of the region. These two areas experienced by far the highest overdose rates of any Health Statistics Regions (HSRs) in the state: double, and even triple, those of the neighboring regions.

With average capacity and high cost, the outcomes remain similar to other regions with 95% of Oxford House residents maintaining recovery. Similar to SSPA 1, 76% of MSO-funded clients maintain recovery throughout their stay. Given the extremely high risk of overdose fatalities and the general burden of substance use disorder in the SLV area, this is a valuable investment in the recovery ecosystem for some of our most vulnerable communities.

SSPA 5

SSPA 5 exemplifies one of the highest regional needs for recovery residences. This rural southwestern region comprises less than 4% of the state's total population and has only two recovery residences — 0.5% of the state total. Both recovery residences are Oxford Houses and are contracted with the MSO. There are zero houses available for men-only, women with children, or mixed genders, demonstrating a *significant gap*. Oxford Houses made up 100% of the MSO-contracted recovery residences in this region.

TABLE 18.
SSPA 5 Recovery Residence Bed Capacity by SSPA (FY2022)

	MSO-Contracted Beds	Total Bed Capacity
Mixed	0	0
Men Only	0	0
Women Only	7	7
Men and Children	8	8
Women and Children	0	0
TOTAL	15	15
BED CAPACITY PER 100,000 RESIDENTS	7.3	7.3

Utilization in this region mirrors its recovery residence capacity, serving just over 1% (89) of all Oxford House clients. MSO spending on recovery residences for the region was similarly low at \$99,000.00, eight times less than SSPA 4 at **\$0.48 per SSPA resident, nearly half the state average**.

The low capacity and low cost of SSPA 5 results in outcomes close to the state average. With 94% of Oxford House residents maintaining recovery, continued investment and expansion are recommended to reach this historically underserved and rural region.

SSPA 6

SSPA 6, home to the highest number of ski resorts in the state, comprises 15 recovery residences, 4.1% of the state total. Nearly half of these recovery residences are contracted with the MSO and account for a total of 64 MSO-contracted beds. Of these beds, a mere seven are women's-only. Additionally, this region has no MSO-contracted mixed houses, despite the rare opportunity to reach this target population. Oxford Houses made up 100% of the MSO-contracted recovery residences in this region. However, as of FY23, Rocky Mountain Health

Plans issued an RFP and contracted with Amos Supportive Housing and A Step Up, LLC to expand recovery learning community scholarship programming. Notably, two-thirds of all of this region's recovery residences and all MSO-contracted residences are located in the population center of this region, Mesa County, leaving the rural and frontier areas largely without access to these essential spaces. Further, not all contracted recovery residences accept MOUD.

TABLE 19.
SSPA 6 Recovery Residence Bed Capacity by SSPA (FY2022)

	MSO-Contracted Beds	Total Bed Capacity
Mixed	0	18
Men Only	27	87
Women Only	7	17
Men and Children	10	10
Women and Children	20	20
TOTAL	64	152
BED CAPACITY PER 100,000 RESIDENTS	16.6	39.4

The low capacity of this region correlates with low utilization. SSPA 6 demonstrates Oxford House client volume (5%) commensurate with its proportion (6%) of the state population. The region hosted 352 Oxford House clients last year. MSO spending on recovery residences for the region was \$99,000.00, or \$0.26 per SSPA resident, significantly lower than the state average of \$0.92 per resident. This low utilization is because these Oxford Houses were opened during FY22 and were the first recovery residences in the region.

The percentage of Oxford House residents who maintained recovery remains similar to the state average at 94%. Continued efforts to expand the residential recovery infrastructure along the Western Slope, including SSPA 5, should focus on recovery residences outside of the Oxford House model to provide living environments receptive to recovery pathways beyond the abstinence-only model of Oxford House.

SSPA 7

SSPA 7, Boulder County, contains six recovery residences with only two contracted with the MSO. This region contains only 15 MSO-contracted beds with an even distribution of men's-only (seven) and women's-only (eight) beds. Notably, 70% (34) of available beds are not

MSO-contracted. Oxford Houses made up 100% of the MSO-contracted recovery residences in this region.

TABLE 20.
SSPA 7 Recovery Residence Bed Capacity by SSPA (FY2022)

	MSO-Contracted Beds	Total Bed Capacity*
Mixed	0	18
Men Only	7	23
Women Only	8	8
Men and Children	0	0
Women and Children	0	0
TOTAL	15	49
BED CAPACITY PER 100,000 RESIDENTS	4.6	14.9

*Does not consider MSO contract status.

This region hosts 6% of the state's resident population, yet reports disproportionately low utilization and funding for recovery residences. In fact, Boulder has less than 2% of the state's recovery residences, with only 1.8 residences per 100,000 — less than 40% of the median state rate. The lack of capacity may be due to funding. FY2022 MSO recovery residence spending in Boulder County — \$36,391.00 — accounted for less than 1% of the state's MSO spending on recovery residences. **This region also demonstrated the lowest per capita recovery residence spending rate, at \$0.11 per resident.** SSPA 7 would need to increase its RR spending by 344% to bring it in line with the median, and over 740% to bring it to parity with the state average of \$0.92 per resident. However, increasing spending in SSPA 7 could take some time. Currently, there are three Oxford Houses in the region and no CARR-certified residences, although one, Lion House, is pending.

Outcomes in this region are higher than the state average with 96% of Oxford House residents maintaining recovery. Please note that, as of January 1, 2023, Signal bid for and was awarded responsibility for SSPA 7's MSO (previous MSO was Mental Health Partners) and expanded recovery support service contracts, which are further detailed in the conclusion, where we give MSO FY23 contracting updates.

Conclusion

By all accounts, Colorado ranks highly for access to recovery residences compared to other states, averaging 6.3 recovery residences per 100,000 population. As demonstrated in

Table 13, Colorado hosts 370 recovery residences, comprising 3,614 beds, across Oxford House and CARR-certified organizations. Notably, SB21-137 dedicated \$4M in annual spending for housing assistance for individuals with SUD. To distribute the SB 21-137 funds, MSOs provide housing scholarships for individuals in need to live at CARR-certified or Oxford House-chartered recovery residences. The BHA also supplements these funds with block grant money to provide more people the opportunity for recovery.

With an average of 62.2 recovery beds per 100,000 residents, Colorado is a national leader in population access to this crucial resource. However, there are wide geographic disparities in the availability of recovery residences. In fact, this line of services has one of the largest regional disparities in availability of any treatment or recovery service reviewed for this report. This disparity results in predictable regional variabilities in spending on this service. That is, where there are more recovery residences, there is more spending.

As discussed throughout this report, Colorado's recovery residence infrastructure is highly dependent on the operations of Oxford Houses across the state. Oxford House is a cost-effective model for rapidly increasing recovery housing across urban and rural areas. Oxford House is also extremely effective. Oxford House reports an overall 96% success rate in their resident's maintaining recovery, defined as total abstinence from all substances with potential for abuse.

Still, Oxford House remains but one approach among many to a successful recovery lifestyle. The abstinence-only policy, along with the strict separation of gender identities, can be difficult for many individuals in recovery, and particularly among those in early recovery. The state should explore options to increase the recovery housing supply for mixed-gender families and gender non-conforming individuals.

"There needs to be queer-populated housing. I hear from a lot of folks that okay, great, I'm in this recovery-oriented housing now. However, my pronouns, and who I am as an individual aren't aligning with the people that I'm living with. These people are forced to be living in this uncomfortable situation and really try to strive for recovery and healing past trauma when the cause of that past trauma is in their face while they are trying to recover."

~ Young People in Recovery

Importantly, this analysis was limited by the lack of data collection capacity across almost the entire recovery residence infrastructure. Efforts to subsidize consistent and sustainable service volume and outcomes data collection will significantly improve the state's ability to understand the true scope of both supply and demand for recovery residences in the state of Colorado. The two primary areas in which better data could improve analysis are:

1. MSOs breaking down expenses by capacity and per-client expenses as well as breaking out expenses by SSPA region.
2. CARR keeping bed occupancy and outcomes data.

We understand that these changes are already underway.

While Colorado is endowed with a relatively large number of recovery residences, that masks regional shortages as well as subpopulation-specific residences. First, as highlighted above, SSPAs 5 (Southwest) and 7 (Boulder) have far lower per capita availability of recovery residences than other regions. Even SSPA 1, in Northeast Colorado, ranks below the state median for recovery residences.

This report should give a simple roadmap toward improving equitable geographical access to recovery residences including both Oxford House and non-Oxford options, although increasing recovery residences in rural areas may not be as simple as increasing funding. Such efforts should also address the unique and potential barriers to recovery housing in rural areas, including informing community leaders about laws regarding recovery residences and addressing community stigma around substance use and recovery. Future community education and anti-stigma campaigns should address these issues to improve community-level willingness to engage — a crucial component of a recovery-ready ecosystem.

In addition to geographic shortages, qualitative interviews revealed that additional options are needed so that everyone feels welcome in recovery residences. **In particular, adults with children and LGBTQ+ individuals have few options for recovery housing.** For LGBTQ+ individuals, this lack of safe shelter is particularly impactful, as the queer community faces excessive risks of homelessness, substance use, interpersonal violence, and incarceration. By improving capacity to serve these historically underserved groups, our state can improve the quality of recovery support available for these communities in need.

4. Recovery Support Services in Public High Schools

Background

Recovering from substance use disorders (SUD) can be extraordinarily difficult in even the most stable and supportive of circumstances. For teenagers in particular, familial and psychosocial pressures outside of their control can block the path to recovery. The influence of “peer pressure” is extraordinarily strong in this population, leading to **SUD relapse rates greater than 90% for youth who return to their previous school setting, even after completing an inpatient treatment program.**

However, in the last few years, new recovery high schools have combined novel, trauma-informed classroom learning with robust recovery supports in a school setting. Examples of school-based SUD recovery support services include: school counseling, peer support groups, prevention education, and community referrals. This environment is a safe and effective way to increase recovery support access among the highly vulnerable youth population.

Methods

To analyze how high schools in Colorado are supporting students in recovery, Steadman Group utilized data from all MSOs — including Signal, Diversus, West Slope Casa, and Mental Health Partners—for fiscal year 2022 (July 1, 2021 to June 30, 2022). With this data, we identified few recovery support services across Colorado. Further, Steadman Group analyzed 10-year trends in drug-related suspensions, expulsions, and law enforcement referrals in high schools across Colorado, recognizing that policies on suspensions have changed dramatically over the same time period.

Findings

SUPPLY

Based on extensive data review across MSO contractors, key informant interviews, and outreach to the Department of Education, we found few recovery support programs in high schools in Colorado, nor any centralized data sources that track such programming. With the limited data available about what programs exist in high schools, Steadman Group found three programs in Colorado that supported high school students in their recovery, two of which exist at public high schools and one of which has since closed.

Regarding MSO-contracted recovery support services in high schools, we found only one such program in the state, 5280 High School in the Denver area (SSPA 2). 5280 is a designated recovery high school with a variety of licensed clinicians as well as nonclinical professionals available to assist students in recovery. 5280 High School offers a substance-free environment with comprehensive recovery and mental health support designed to enable

students to still attend school and make progress toward their diplomas while receiving extra support for their substance use. At 5280, students follow a project-based learning model with professional internship and college credit learning opportunities. A key feature of 5280's recovery-oriented approach is the school's daily BOAT ("Be Open and Authentic Together") session, which includes a 45-minute session each morning for students to develop their emotional intelligence and social skills.

"High schools don't think in terms of recovery. They think in terms of clinical counseling hours, substance abuse groups. One of our leading theories is that the reason they're not knowing what to do is because they don't understand the problem. They think it's this kid needs to see the counselor, or this kid needs a 504 plan, or this kid need IEP resources, they misapply the solutions because they can't properly identify."

~ 5280 High School

As the only MSO-contracted recovery school in the state, 5280 High School received \$171,457.00 in funding from Signal Behavioral Health Network to expand school-based services internally and conduct outreach and planning efforts to expand 5280's footprint into more geographic areas across Colorado. Altogether, this funding directly served 184 unique students, averaging \$932.00 per individual served and \$5,852.00 per 100,000 residents of the Denver area (SSPA 2).

Outside of MSO-contracted recovery in high schools, Steadman Group investigated Department of Education special education data and found one other similar program for public school students: Boulder County's Boulder Valley Halcyon (SSPA 7).

Boulder Valley Halcyon offers therapeutic behavioral interventions and strategies to prevent long-term abuse of alcohol, prescriptions, illicit drugs, and marijuana. Specifically, Boulder Valley Halcyon focuses on identifying risk factors like emotional problems, rebelliousness, parental substance use, lack of supervision from parents, and antisocial behavior. To mitigate the impact of these risk factors, prevention programming focuses on building protective factors like improving personal self-esteem, emotional regulation, coping skills, and community engagement through friends, athletics, culture, religion, and more.

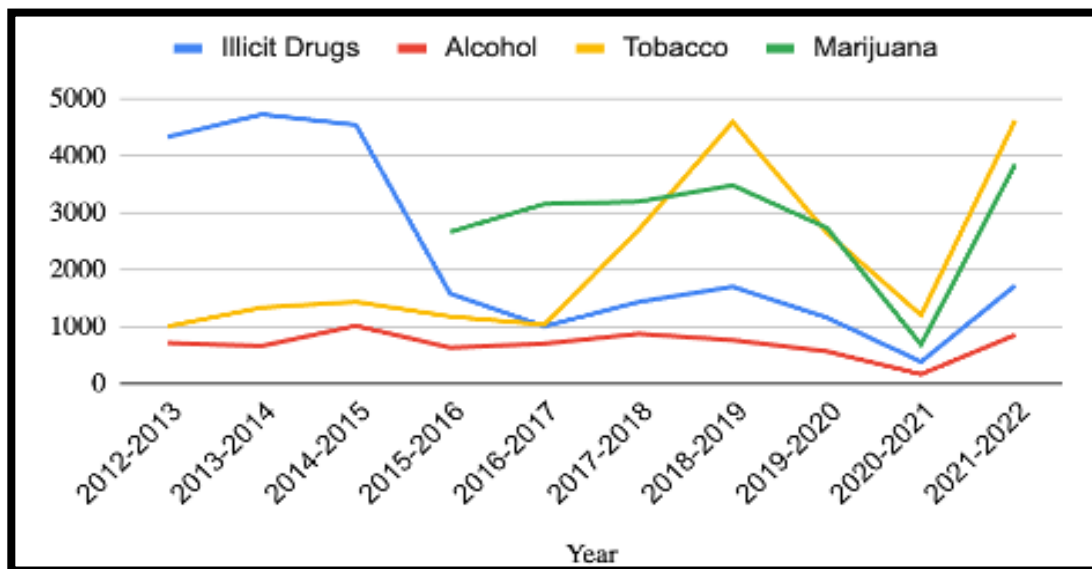
Finally, while it is not a recovery high school, TSG identified another unique program for high-school aged students that offered treatment and recovery as well as school, the Youth Recovery Center (YRC) program at Valley View Hospital in Glenwood Springs (SSPA 6). The YRC, which closed at the end of FY22, included schooling as part of its six-week integrated residential treatment program. After 36 years of service, the [Aspen Times reports](#) that Valley View closed the YRC due to inadequate staffing and onerous changes to Medicaid reimbursement. The loss of this critical resource for adolescents seeking treatment for SUD

demonstrates the urgent need for systemic investment in supporting adolescent treatment and recovery services.

Need

At the state level, Steadman Group investigated the frequency of substance use-related suspensions, expulsions, and referrals to law enforcement to approximate a baseline level of need in the public school system. Specifically, these incidents included citations related to tobacco, marijuana, alcohol, and other illicit drug use. Substance-related citations have spiked, surpassing pre-pandemic levels. Figure 7 below demonstrates disciplinary substance-related suspensions over time.

FIGURE 7.
School Suspensions by Violation Type (FY2022)



Rates for expulsions and referrals to law enforcement largely mirrored those for suspensions, with the following primary findings:

1. Rates for alcohol and illicit drug use-related referrals for discipline have largely decreased over time, expulsions for all drug use have decreased by 69% in the last decade and referrals to law enforcement for all substances, especially illicit drugs, have decreased by 55%.
2. Vaping is a primary source of substance-related discipline, with tobacco-related suspensions increasing by 359% since 2012 to 2013.
3. The legalization of marijuana led to a large decrease in illicit drug-related disciplinary actions, which were replaced on a nearly 1:1 basis by marijuana-related actions.

4. Disciplinary actions for substance use have skyrocketed since students have returned to school from the pandemic-induced lockdowns, with marijuana and alcohol-related citations increasing by 525%, tobacco citations by 382%, and other illicit drug-related citations increasing by 435%. While these sky-high increases are largely due to the return to school, the 2021 to 2022 school year nevertheless saw disciplinary actions for substances reach all-time highs for all substances except alcohol.

Evidently, the Department of Education has effectively turned away the public school system from relying on the most severely punitive responses to student substance use, at least as indicated by suspension, expulsion, and law enforcement referral incident data. Certainly, these trends could be confounded by local school district norms of “catching” students or reporting them for discipline. However, the increase in substance use-related suspensions alongside these decreases in expulsions and law enforcement referrals suggests that there has indeed been a turn away from excessively harsh punishments. Altogether, these trends demonstrate a significant need for greater investment in recovery support services in the public school system.

Conclusion

The positive news is that Colorado’s sole recovery-specific high school is thriving. Recently host to a mayoral debate and a student who presented to the city council, Denver’s 5280 is a model for blending recovery and education. Additionally, while there are only two programs in the state, Colorado is still ahead of many states; the Association of Recovery Schools lists members in just 20 states, five of which (Florida, Massachusetts, Minnesota, New Jersey, and Texas) comprise nearly 60% of the membership.

In lieu of true demand data, we found a similar state that Colorado might use as a model. Minnesota — a state with a similar area and population— counts six recovery high schools. Minnesota’s Department of Education approves recovery schools, which are then eligible for an annual grant of \$125,000.00, although this is not meant to cover all of the higher costs of recovery schools. Minnesota’s robust recovery school infrastructure also stems from its long history in the field. PEASE (Peers Enjoying A Sober Education), a recovery school in Minneapolis, is the nation’s oldest such school. At times, there have been as many as 13 recovery schools in the state. Furthermore, these programs are not limited to urban areas: Minnesota currently supports schools in rural areas such as Detroit Lakes, Waite Park, and Mankato.

“I think there’s a huge need for recovery resources in every community. The problem is we don’t have the human capital to staff them. We don’t have the funding to fund them.”

~ 5280 High School

Furthermore, both anecdotes and published research suggest that recovery high schools are effective, with very favorable cost-benefit ratios. The primary study of recovery high schools suggests that students are more likely to report abstinence, less likely to test positive for THC,

and more likely to graduate. With benefits in the tens of thousands of dollars per participant, our state should consider model legislation for recovery high schools and funding as well.

5. Evaluation of County Health Priorities — CHIP and CHNA

Background

To evaluate selected substance use disorder (SUD) service needs and gaps within Colorado, Steadman Group, on behalf of Signal, identified county health priorities through Community Health Needs Assessments (CHNAs) and Community Health Improvement Plans (CHIPs). Behavioral health was an extremely common concern in these reports. This report is exclusively focused on Colorado counties' behavioral health priorities and needs.

The purpose of a CHNA is to assess and monitor health status, factors that influence health, and community needs and assets of the county's population. The CHNA identifies priority areas and develops collaborative action plans, leading to the CHIP or Public Health Improvement Plan (PHIP). The CHNA and CHIP / PHIP is informed by community surveys, local meetings, and existing public health and socioeconomic data.

Colorado statute requires Local Public Health Agencies (LPHAs) to conduct a community health assessment and develop a CHIP every five years to address the community's health priorities. Counties can also respond as a collective; 27 of the 64 Colorado counties reported collectively within seven regions, all exclusively rural and frontier. The list of counties and collectives can be found in **Appendix E1**.

Methods

Steadman Group engaged in a robust process for data collection, management, and analysis. First, we captured the top five CHIP / CHNA priorities by county and year of report for all 64 counties. Next, we downloaded all publicly available reports and organized them by county. Notably, we investigated county-specific hospital reports if CHNAs were not found through the LPHA, as all nonprofit hospital organizations must complete a CHNA once every three years and adopt an implementation strategy. Once those methods were exhausted, we reached out to LPHAs to request the reports. Strategies and goals, where listed, were qualitatively analyzed.

The top priorities related exclusively to behavioral health were coded as follows:

1. **Behavioral Health (mental health and substance use):** Coded where counties listed behavioral health or "mental health and substance use" as a priority.
2. **Access to Behavioral Health Care:** Coded in reference to behavioral health **ACCESS**. One example includes "Health Equity — Access to medical providers, behavioral health providers, tele-health and non-siloed providers".

3. **Substance Use:** Coded where counties listed substance use or abuse specifically. Examples include “Substance use and lack of treatment resources,” “Preventing early initiation of substance use,” or “Injury prevention” where the focus is on substance use.
4. **Mental Health:** Coded where counties listed mental health specifically. Examples include “suicide prevention,” and “mental health and depression.”

Findings

Statewide, **54 of 64 counties (84%) listed some form of behavioral health or access thereto as their number one priority and 62 (97%) counties identified behavioral health in their top three priority areas.** Only Custer and Lake Counties did not identify behavioral health as a top priority. **As demonstrated in Figure 8 below, behavioral health and access to behavioral health care were identified as the most urgent public health issues across the state.**

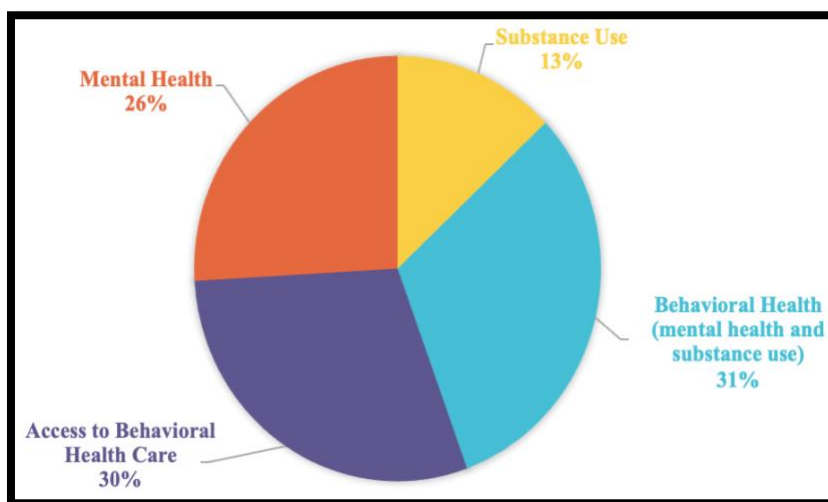


FIGURE 8.
*Distribution of Number One-Ranked Community Behavioral Health Needs
(54 counties represented)*

RURAL VS. URBAN

To compare urban vs. rural areas, Steadman Group referenced the State of Colorado Division of Housing classification of localities to determine the appropriate grouping of urban and rural counties for this report. When comparing urban to top rural priorities, the following findings emerged:

1. **Mental health and substance use are major issues in both urban and rural counties.** 92% of urban countries and 82% of rural (including frontier) counties identified a behavioral health category as a number one priority.

2. **Rural counties were more likely to identify general behavioral health and access to behavioral health.** In fact, 33% of rural counties identified behavioral health care as the number one priority, followed closely by access to behavioral health care (31%), as shown below in Figure 9.
3. **Urban counties prioritized mental health more than rural counties.** Urban counties were twice as likely as their rural counterparts to identify mental health as their number one priority (42% vs. 22%).

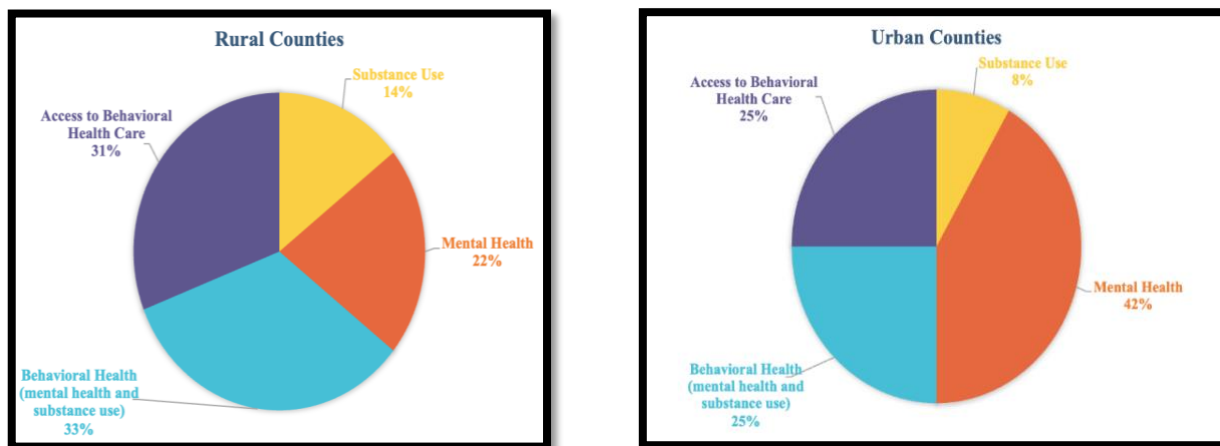


FIGURE 9.
Distribution of Number One-Ranked Community Behavioral Health Needs by Geographic Designation (54 counties represented)

SUB-STATE PLANNING AREAS

Behavioral health priorities are also explored across each of the seven SSPA regions. Further insights into each SSPA region can be found in **Appendix E2**. Notably, **all counties in SSPA regions one, four, and seven ranked a behavioral health category as their number one priority.**

Strategy Themes

Following the analysis of the overarching top priorities, Steadman Group analyzed county strategies and goals to understand what counties and community partners will do to address the identified behavioral health priority areas. The following five themes emerged.

Key Themes	
	Improve collaboration, integration, and community connectedness across the region and among stakeholders.
	Reduce stigma by increasing awareness about behavioral health issues in the community.
	Enhance and expand access and availability to behavioral health resources, programs, and providers.
	Improve or fill gaps in behavioral health data collection, reporting, and surveillance.
	Increase prevention and early intervention of behavioral health-related issues.

THEME 1: IMPROVE COLLABORATION, INTEGRATION, AND COMMUNITY CONNECTEDNESS ACROSS THE REGION AND AMONG STAKEHOLDERS

The number one county strategy to address behavioral health needs is improving collaboration between stakeholders. Notably, 45 counties (70%) mentioned this as their primary strategy. The target stakeholders include behavioral healthcare providers, schools, community organizations, and community members. Examples of strategies include integrating behavioral health into physical health settings to screen for mental health and substance use at primary care visits and in emergency departments. Collaboration and integration efforts are a means to address capacity issues and expand reach with the resources, personnel, and touchpoints available.

THEME 2: REDUCE STIGMA BY INCREASING AWARENESS ABOUT BEHAVIORAL HEALTH ISSUES IN THE COMMUNITY

The second-most identified strategy, prioritized by 33 (52%) counties, is reducing stigma by increasing community awareness about behavioral health issues. Stigma is a well-known barrier to seeking general healthcare, but it is far more insidious in behavioral health and particularly substance use disorder. Across cultural, societal, and individual levels of society, stigma around seeking help for behavioral health is deeply rooted. Though recent statewide and regional campaigns to destigmatize behavioral health help-seeking have expanded, counties voiced the need for continued action in this realm. Notably, the need for culturally competent anti-stigma programming is emphasized in county goals to address this issue. Two

frequently cited programs are, marketing campaigns to change perceptions of substance use and disseminating Spanish language materials and information on behavioral health.

By increasing awareness about mental health and substance use issues, treatment options, and recovery services within the community, counties aim to normalize help-seeking. This strategy helps community members navigate existing resources and increases community resilience through education and the ability to respond. For instance, several programs aimed to increase knowledge of signs and symptoms of mental health and substance use issues, respond appropriately, and refer people to services through offering Mental Health First Aid (MHFA) training. A critical need is offering resources, like MHFA, to special populations like LGBTQ+ people and the Spanish speaking population. Importantly, the resources or training should be offered by someone who identifies as being part of that population, and who speaks the primary language used. For instance, Tri-County Health Network is currently offering MHFA with a Hispanic-identifying trainer in Spanish to the Delta Hispanic community.

THEME 3: EXPAND ACCESS AND AVAILABILITY TO BEHAVIORAL HEALTH PROGRAMS

The third-most commonly identified strategy, reported by 31 (48%) of counties, is expanding access to behavioral health providers. This theme includes improving transitions of care, increasing behavioral health provider workforce through recruitment and reduced turnover, and improving access to culturally and linguistically competent care options. Counties emphasized addressing the behavioral health workforce and increasing the availability of SUD treatment and harm reduction services. **Specifically, PHIP / CHIP / CHNA reports cited primary care providers and community-based organizations that offer prevention activities, harm reduction services, and SUD treatment as a critical need.** In addition to the top three behavioral health-specific strategies presented above, two lower-volume themes emerged: data collection, reporting, and surveillance; and increasing prevention and early intervention for behavioral health-related issues.

THEME 4: IMPROVE OR FILL GAPS IN BEHAVIORAL HEALTH DATA COLLECTION, REPORTING, AND SURVEILLANCE

Ten counties are improving behavioral health data collection, reporting, and surveillance. Specifically, counties identified the need to collect and standardize behavioral health data through an assigned task force. Others aim to create a public-facing map or dashboard to increase public awareness of behavioral health resources and issues within the community. For example, the City and County of Denver aims to “map out all available resources and initiatives supporting behavioral health prevention and healthy environments — to ensure they are accessible and updating consistently and accurately.” At least four opioid settlement regions allocated settlement dollars to building out similar behavioral health dashboards. Improving data collection and reporting informs critical planning to help Coloradans live to their fullest health potential.

THEME 5: INCREASE PREVENTION AND EARLY INTERVENTION OF BEHAVIORAL HEALTH-RELATED ISSUES

Nine counties emphasized prevention and early intervention of behavioral health-related issues. Specifically, counties will increase behavioral health screenings for youth to ensure early detection of substance use, depression, suicidality, bullying, and violence to protect the health and safety of community members.

6. Opioid Settlement Spending

Background

The Colorado Department of Law has negotiated a settlement to address the harm caused by drug manufacturers, distributors, pharmacies, and consultants that contributed to the opioid crisis. Notably, 60% of the funds are distributed to 19 different regions across Colorado to address the opioid crisis at the local level (see Figure 10). Each designated region is required to convene a regional governance committee of elected officials and subject matter experts to decide how to spend their allotted funds.

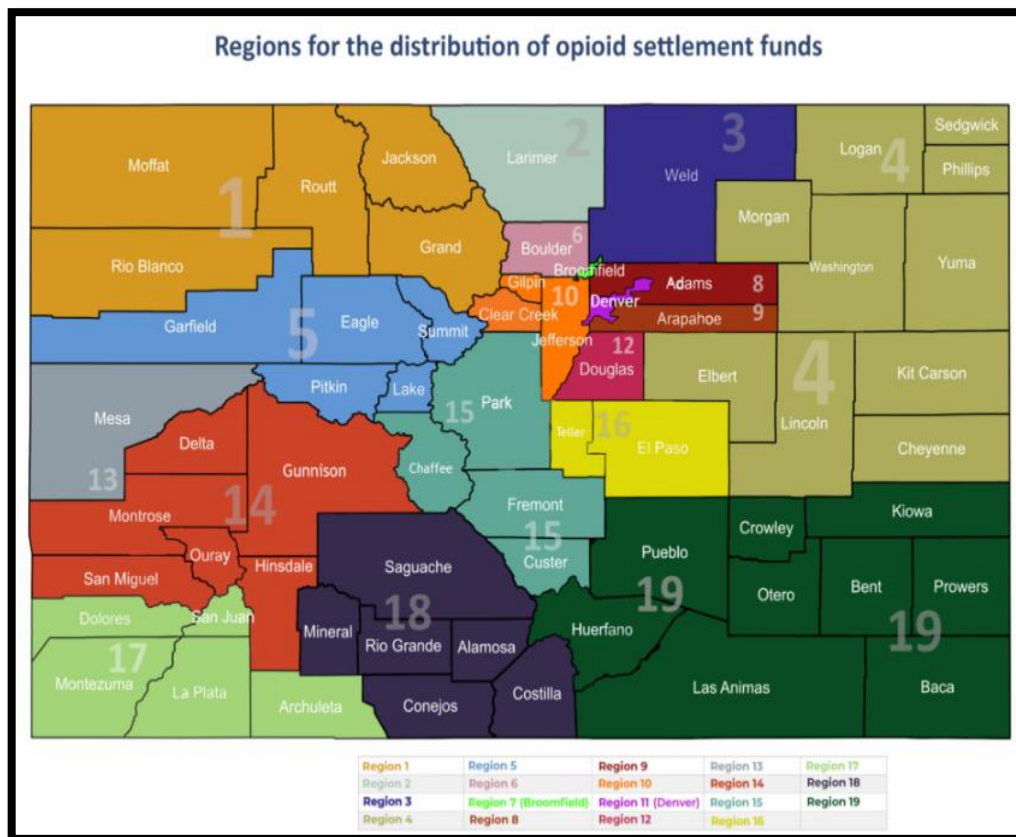


FIGURE 10.
Colorado Opioid Settlement Regions

To access funds, each region must create a two-year plan that is submitted to the Attorney General's office every two years outlining how funds will be allocated. According to the Colorado Attorney General ([COAG website](#)), Colorado will receive \$35,034,630.00 in Year One allocations from opioid settlements. This report details the use of this regional funding as well as how the regional governance committee process worked in Colorado.

Methods

To assess spending areas for each region, Steadman Group analyzed each publicly available two-year plan from the COAG website:

1. 18 of the 19 two-year plans were available for analysis. A plan was not obtained from region 17 (Southwest CO) because they had not yet submitted their plan to the state as of May 2023.
2. Within the available plans, each region allocated their funds towards three general approved use categories: treatment, prevention, and additional areas. Although typically treated as distinct categories, the state portal, COST, that regions submit their plans to is less prescriptive than typically recognized definitions of treatment and prevention.
3. Notably, Recovery is included in the treatment category and harm reduction is included in prevention. Additional areas include spending towards administrative costs, cross-system collaboration, co-responder programs, and staff training.
4. Within each approved use category, there are dozens of subcategories, and the opioid regions determined what subcategories they would distribute their allotted regional funds toward. Steadman Group analyzed allocations by comparing regional allocations to state averages and within each Sub-State Planning Area (SSPAs or “areas”), which are used by the Behavioral Health Administration to divvy up non-Medicaid government spending on substance use initiatives.

Steadman Group also conducted a secondary qualitative analysis to go into greater depth with the regional governance committees across the state. We thematically analyzed the responses from representatives from 15 of the 19 opioid abatement regions to identify preliminary themes from the governance committee process. Steadman Group used the Regional Contacts listed on the COAG website and emailed the designated points of contact for responses. See **Appendix F1** for the interview question guide. This analysis provides insight into the process of developing committees and regional efforts to create two-year plans for funding allocation, as well as highlighting community priorities.

Findings

SPEND INITIATIVES

Treatment is the largest spending category across the state. As shown in Figure 11 (below), 52% of the total funding — \$17,599,558.00 — was allocated to treatment initiatives across the state. Please note that the treatment category also included many recovery-focused initiatives and initiatives that are not strictly considered treatment because of the way the state set up the funding categories for reporting; these include workforce recruitment and retention and provider training and scholarships.

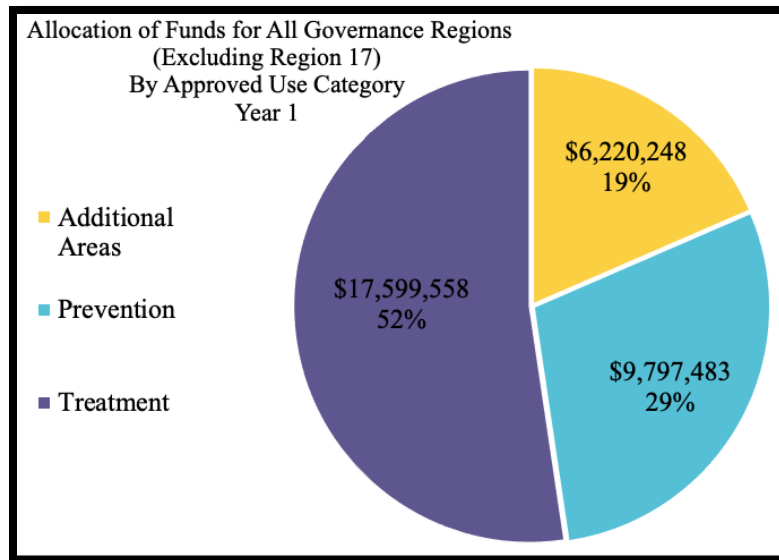


FIGURE 11.
Approved Use Category Allocation for Colorado for Year One

The prevention category included far less funding, with a total allocation of \$9,797,483.00 (29%) of the available funds. Prevention included school-based initiatives, naloxone distribution, and syringe access programs.

Lastly, the “additional areas” category was allocated \$6,220,248.00 (19%) of funds. Additional areas included initiatives like administrative costs, staff training and networking, and other approved uses. Below is an analysis of how regions within each SSPA allocated their funding across the three primary spend areas listed above. We also discuss how each SSPA’s spend compares to state averages.

Due to the vague nature of COAG’s reporting process for spending areas, regional plans differ significantly in the level of detail provided for funding uses. This report provides as much detail as possible on reported uses for funding by opioid region given these constraints.

PREVENTION INITIATIVES

Interestingly, **SSPA 3 (Central CO) and SSPA 6 (Northwest CO) allocated nearly twice as much funding proportionally to prevention than any of the other SSPA regions.** As shown on the next page in Figure 12, SSPA 3 (Central CO) allocated 49% of their funding and SSPA 6 (Northwest CO) allocated 42% of their funding to prevention, both of which are much higher than the state average of ~27%. This stark departure from the state average suggests that these two regions have a critical need for more prevention infrastructure or value prevention more than other regions do. Interestingly, SSPA 3 (Central CO) received two prevention-related infrastructure grants.

Notably, the most common prevention initiative spend area across the state was public education campaigns (33%) followed by school-based programs (31%) and syringe access

and harm reduction programs (15%). Specifically, syringe services were noted for SSPA 2 (Denver Metro), SSPA 6 (Northwest CO), and SSPA 7 (Boulder). Both SSPA 2 (Denver Metro) and SSPA 7 (Boulder) have existing robust syringe service programs in highly urban areas, but it was interesting that rural regions in SSPA 6 (Northwest CO) also noted this as a specific spend area. On the other end of the spectrum, SSPA 1 (Northeast CO) elected to spend the least on prevention initiatives, suggesting areas of treatment or recovery may be more needed in that area of the state.

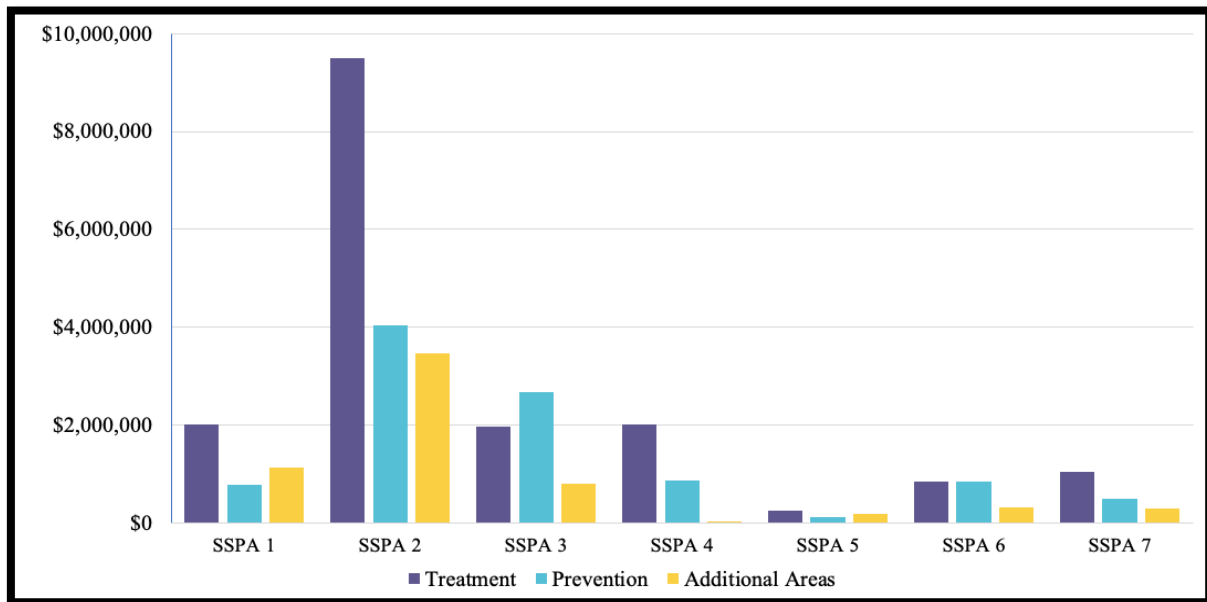


FIGURE 12.
Approved Use Category Allocations by Colorado SSPA for Year One

TREATMENT INITIATIVES

For treatment, regions in SSPA 4 (Southeast CO) spent nearly 70% of their funds in this realm, which is much higher than the state average of 52%. As seen in Table 21 on the following page, the top treatment spend areas included general recovery services, treatment expansion, and developing treatment options for persons involved in the criminal justice system. **Interestingly, SSPAs 1 (Northeast CO), 2 (Denver Metro), 3 (Central CO), and 5 (Southwest CO) included workforce recruitment, retention, or development in their allocated treatment plans.** Regions in SSPA 5 (Southwest CO) elected to spend about \$72,000.00 on a shared regional telehealth service for SUD. Finally, SSPA 6 (Northwest CO) had the lowest percentage of its dollars set aside for treatment at only 36%.

TABLE 21.
Statement Subcategory Spend Allocation Designed per Approved Use Categories

Subcategory	Regional Dollars Allocated to Spend Area Across Opioid Settlement Regions	Statewide Dollars Allocated in Approved Use Category (Prevention, Treatment, Additional Use)	Percentage of Approved Use Category*
APPROVED USE CATEGORY: PREVENTION			
Public Education Campaigns	\$3,268,377	\$9,797,483	33%
School-Based Programs	\$3,058,838		31%
Syringe and Harm Reduction Programs	\$1,465,146		15%
APPROVED USE CATEGORY: TREATMENT			
General Recovery Services	\$9,262,264	\$17,599,558	54%
Treatment Expansion	\$2,746,420		16%
Persons Involved in Criminal Justice System	\$933,521		5%
APPROVED USE CATEGORY: ADDITIONAL AREAS			
Administrative Costs	\$1,930,245	\$6,220,248	31%
Co-Responder Program	\$1,203,816		19%
Collaborative Cross Systems Funding / Coordination	\$632,054		10%

NOTE: These data are updated as of May 8, 2023 using the subcategories provided directly from each regional two-year plan published on the Colorado Attorney General's office website.

***All percentages are cumulative within each approved use category. Percentages do not sum to 100% because only the top three funding initiatives per approved use category were selected for reporting here.**

ADDITIONAL USE INITIATIVES

The additional use initiative category was used as a “catch all” category for the settlement regions. Specifically, this category was largely made up of administrative costs that each region could tap into to cover costs associated with fiscal agent responsibilities. Each settlement region could use up to 10% of their settlement funds on administrative costs:

1. Opioid region 18 in SSPA 4 (Southeast CO), used this category exclusively for administrative costs.
2. Otherwise, many regions elected to implement law enforcement initiatives. For example, councils in SSPA 1 (Northeast CO) elected to spend 60% of their additional area funds on co-responder programs. Regions in SSPA 2 (Denver Metro) also utilized this category for co-responders and harm reduction.
3. Cross-system collaboration was the third largest subcategory in additional areas. Specifically, councils within SSPA 6 (Northwest CO) elected to spend nearly 70% of their funding on cross-system coordination. For SSPA 6, this is likely aimed at connecting existing consortium work the area has through several federal opioid grants.

Please see **Appendix F2** for a detailed review of each SSPA’s spend areas.

Qualitative Analysis Findings

Three primary themes emerged from the qualitative analysis of opioid governance committees.

THEMES

1. The local focus of the councils enabled opioid regions to prioritize community goals and needs, especially in rural areas.
2. The opioid regions that were made up of multiple counties, or a mixture of urban and rural counties, experienced less cohesion in their decision-making process than homogeneous regions.
3. Urban opioid regions perceived treatment and recovery services as being adequate while rural regions noted a lack of access for treatment and recovery.

Please see below for a detailed discussion of these three themes.

Theme 1: The Governance Committee Process Prioritized Local Community Goals

Opioid settlement regions contain anywhere between one and 10 counties, meaning that some counties had to work with many other municipalities, community partners, and county representatives to align their goals and generate a shared two-year plan. **Two-thirds of respondents, the majority of those from rural communities, noted how the regional governance committee process protected rural community interests in the state.** Five respondents mentioned how this approach meant that more of the funding would actually go to where it is needed in a way that would be impactful and sustainable.

“Often, solutions designed for the entire state don’t fit rural communities, so the community-based approach can ensure we pursue high impact projects for what our local communities need most.”

~ Regional Governance Committee Member

Prioritizing local goals enables rural communities to highlight their needs, which are frequently different from urban needs, and contributes to a cohesive committee process, even among larger regions.

Theme 2: Conflicting Intra-Regional Priorities Contributed to a Less Efficient Governance Committee Process Among Heterogeneous Regions

For regions that contained more conflicting priorities and multiple counties, collaboration was less effective. This experience highlights the difficult nature of working with other county committee leaders to compromise, but the rewards of focusing the funding and action plan on local communities.

1. Four regions noted cohesion difficulties - representatives from opioid regions 1 (Northwest CO), 4 (Northeast CO), and 15 (West CO) cited communication issues due to the immense geographic span their region covered.
2. The contact from region 10 (West Metro Denver) mentioned conflicting priorities based on vast differences of urbanity within the region.

Furthermore, Colorado’s approach of disseminating opioid settlement funds placed a lot of responsibility on opioid regions to establish their own administrative processes, allocation

strategies, and measurement systems. This decentralized structure created uncertainty for councils on how to move forward with their allocation processes.

Finally, lack of direction from the state contributed to ambiguity in regional priority-setting, especially since there was no statewide standard they could look to for support. Contacts from four regions reported frustration around relationships with the state, including not having enough administrative support, unclear deadlines, and short lead times to create their plans. **“Opioid councils across the state are taking wildly different approaches to addressing the crisis locally, but it’s not clear we’ll have the baseline data or a platform with uniform definitions to measure impacts and show what’s working well (or not), and to integrate with other state agencies like the Behavioral Health Administration.”** This uncertainty was evinced by the huge temporal gap between the earliest and latest settlement plans; Mesa County largely completed their two-year plan in November 2021, while most urban counties did not submit their two-year plans until winter of 2023.

“A lack of communication and cohesive conversation among municipalities that led to some initial struggle getting signatures on agreements, but overall, the approach worked exceptionally well and allowed local decision-making.”

~ Regional Governance

Theme 3: Urban Governance Committees Perceived Treatment and Recovery Services as Adequate While Rural Regions Have Few Available Services in These Areas

Unsurprisingly, Colorado’s urban opioid regions reported adequate treatment and recovery services while the rural opioid regions noted a lack of access to these same resources. Specifically, respondents from opioid regions 6 (Boulder), 7 (Broomfield), 8 (Adams County), 9 (Arapahoe County), and 10 (West Metro Denver) stated that availability of treatment and recovery services are current strengths. Highlighted treatment services include: MOUD, increasing behavioral health care infrastructure in jail settings, access to naloxone, and criminal justice diversion programs. Recovery services were also judged a strength. Those include recovery community centers, recovery coaches, and recovery residences.

For rural opioid regions, barriers to treatment included methadone availability, few behavioral health providers, lack of peer recovery support, social stigma, and confusing care coordination systems. Many respondents cited the rural nature of their communities as the primary reason for decreased access to behavioral health services. The contact for opioid region 1 (Northwest CO) mentioned, **“We consist of rural communities who do not have access to resources that bigger cities have. There is a lack of mental health providers, treatment centers, and detox facilities.”**

Additionally, confusing care coordination systems and lack of insurance coverage contributed to financial barriers to care. A respondent from opioid region 7 (Broomfield) noted that there is

no single point of entry into the behavioral health system and that it can be difficult to navigate for an individual facing multiple challenges. Lastly, social stigma and lack of culturally sensitive care were noted in opioid regions 6 (Boulder) and 17 (Southwest CO). In opioid region 6 (Boulder), stigma contributed to a perceived lower quality in recovery and harm reduction programs, while in opioid region 17 (Southwest CO), culturally competent care for indigenous populations was a primary SUD treatment barrier.

Conclusion

While this report only includes preliminary spending across the different opioid regions, it will be fascinating to track the initiatives that this record-breaking funding supports across Colorado. The opioid settlement process will last 18 years. Colorado is in the infancy of receiving these important funds, but already these funds are supporting anti-stigma campaigns, behavioral health data dashboards, and behavioral health workforce programs, among others. Opioid regional spending is one of our best indications of local community needs in behavioral health.

7. Best Practices for Substance Use Disorder

This is a brief review of best practices and cost-benefit and cost-effectiveness data for substance use disorder interventions. We have included selected practices across prevention, treatment, recovery, harm reduction, and criminal justice sectors, with a focus on MOUD in criminal justice settings for the latter. Data for this section are largely drawn from systematic economic reviews, specifically from the Washington State Institute for Public Policy (WSIPP). Most of these data were last reviewed between 2014 and 2018, so more recent evidence may be available. For particular topics of interest and emerging therapies, we have included an expanded analysis of current studies.

Youth Prevention

While youth prevention got a very undeserved reputation for ineffectiveness as the result of Drug Abuse Resistance Education (DARE) in the 1990's, the vast majority of studies demonstrate what prevention professionals have known for a long time: **youth prevention is inexpensive and effective**. The following table shows WSIPP's 2014 to 2016 systematic review of a selection of the most popular youth prevention programs, demonstrating the majority to be financially viable and beneficial.

TABLE 22.
Cost-Benefit Analysis of Youth Prevention

Program	Total Benefits	Costs	Benefit to Cost Ratio
Brief intervention in primary care	\$7,427	-\$287	\$25.85
Teen Intervene	\$3,178	-\$405	\$7.86
Brief intervention in emergency department (SBIRT)	\$2,361	-\$457	\$5.16
Brief intervention in a medical hospital	\$1,899	-\$169	\$11.24
Brief Alcohol Screening and Intervention of College Students (BASICS): A Harm Reduction Approach	\$962	-\$77	\$12.49
Brief intervention for youth in medical settings	\$321	-\$350	\$0.92
Alcohol Literacy Challenge (for college students)	-\$106	-\$4	-\$25.64

While this review was primarily focused on youth prevention in healthcare settings, **the majority of youth prevention occurs in school-based and afterschool settings**. Fortunately, there is a review for that as well, albeit a bit older. The Substance Abuse and Mental Health Services Administration, or SAMHSA, published [Substance Abuse Prevention](#)

[Dollars and Cents: A Cost-Benefit Analysis](#) back in 2008. It features systematic reviews of the various school-based prevention programs, listing both cost per student ranging from \$60.00 to \$5,650.00, as well as the estimated benefit-cost ratio. Many of the programs feature benefits of more than five times costs, with several exceeding a ratio of 30:1. There is also a more recent, although less quantitative, review of youth prevention programs called [Blueprints](#) that rates the strength of evidence for various youth-focused programs.

To our knowledge, there have been no studies of adult prevention efforts with the exception of screening, brief intervention, and referral to treatment (SBIRT). Studies of SBIRT in the emergency department vary; one [a 2017 meta-review](#) found little evidence for reducing overall costs in the emergency department, but a [2018 Urban Institute meta-review](#) found otherwise, with estimated per-patient costs of just \$24.00 to \$173.00 with one-year savings estimated from \$1,000.00 to \$5,000.00. Primary care findings for SBIRT have been more positive, and some permutation of SBIRT is standard in most primary care settings now.

Treatment

ADULT TREATMENT

As with prevention, many people are unfamiliar with the success rates and cost-benefit ratios for SUD treatment. Many medical schools still teach that SUD is a disease prone to frequent relapse, equating relapse with failure. However, a well-known graph from SAMHSA emphasizes that SUD treatment has success rates tantamount to or exceeding those of other chronic diseases like hypertension and diabetes. WSIPP's findings emphasize the effectiveness of a wide variety of SUD treatments.

TABLE 23.
Cost-Benefit Analysis of Adult Treatment

Program	Total Benefits	Costs	Benefit to Cost Ratio
Contingency management (higher cost) for substance use disorders	\$23,617	-\$601	\$39.30
Seeking Safety	\$18,681	-\$417	\$44.85
Contingency management (higher cost) for marijuana use	\$14,045	-\$601	\$23.37
Brief marijuana dependence counseling	\$13,251	-\$586	\$22.60
Brief cognitive behavioral intervention for amphetamine users	\$11,646	-\$221	\$52.64
12-Step Facilitation Therapy	\$9,226	\$338	n/a

Program	Total Benefits	Costs	Benefit to Cost Ratio
Community Reinforcement Approach (CRA) with vouchers	\$9,550	-\$1,266	\$7.54
Motivational interviewing to enhance treatment engagement	\$6,455	-\$280	\$23.05
Cognitive-behavioral coping-skills therapy for alcohol or drug use disorders	\$6,451	-\$279	\$23.09
Relapse Prevention Therapy	\$5,982	\$0	n/a
Contingency management (lower cost) for opioid use disorder	\$4,269	-\$374	\$11.40
Individual drug counseling approach for the treatment of cocaine addiction	\$5,560	-\$2,501	\$2.22
Contingency management (lower cost) for substance use disorders	\$3,036	-\$263	\$11.54
Matrix Model Intensive Outpatient Treatment Program (IOP) for stimulant use disorders	\$3,857	-\$1,346	\$2.87
Contingency management (lower cost) for marijuana use	\$419	-\$263	\$1.59
Cognitive-behavioral coping-skills therapy for opioid use disorder	-\$487	-\$567	-\$0.86
Behavioral self-control training (BSCT)	-\$13,181	-\$166	-\$79.40

Many of these interventions like cognitive behavioral therapy and Matrix Model are mainstays of treatment in virtually all settings. Others, like Seeking Safety, are not universal but are widely utilized in community behavioral health settings. Finally, there are two—community reinforcement approach and contingency management—that are just gaining more recognition in our state. Funded by the State Opioid Response grant and MSOs, these modalities are utilized in more settings every month.

MOUD

The findings for MOUD are fewer in number and more clear-cut than for other modalities of treatment. There are three FDA-approved medications for treatment of opioid use disorder: methadone, buprenorphine, and naltrexone. The former two are agonists, with buprenorphine a partial agonist, meaning that these medications occupy the opioid receptor itself, diminishing

withdrawal symptoms. In turn, they greatly reduce use of other opioids and decrease the chance of overdose.

Naltrexone works in a different way, blocking the opioid receptor. While this also diminishes the short-term chances of overdose, people frequently stop their monthly injections, **averaging less than half the time in treatment as people on methadone and buprenorphine**. At least [one large-scale population study](#) suggested people who take naltrexone have a propensity toward more frequent withdrawal management admissions in the following three months. For these reasons, methadone and buprenorphine are the most-utilized medications for OUD treatment, and the Providers Clinical Support System, or PCSS, just recently released guidance on treatment in the era of fentanyl.

TABLE 24.
Cost-Benefit Analysis of MOUD

Program	Total Benefits	Costs	Benefit to Cost Ratio
Methadone maintenance for OUD	\$9,124	-\$3,962	\$2.30
Buprenorphine maintenance treatment for OUD	\$8,645	-\$4,859	\$1.78
Injectable naltrexone for opiates	-\$1,040	-\$17,406	-\$0.06
Injectable naltrexone for alcohol	-\$7,814	-\$17,406	-\$0.45

Additionally, there has been a significant amount of focus on MOUD in criminal justice settings. This is justified by the fact that **recently incarcerated people have an overdose rate at least 40 times higher than people who are not incarcerated people**. Often, during incarceration, people who formerly used opioids daily lose their tolerance. Upon release, they may return to use only to find that either the drug supply has changed, or their former tolerance no longer exists. For too many, this causes an overdose which is often fatal.

Starting in 2017, there was a groundswell of support for jail- and prison-based treatment of OUD when [Rhode Island published](#) their findings **suggesting a 60% reduction in post-incarceration overdose after implementation of a statewide MOUD program**. Since then, many states have taken up MOUD programs in their prisons and jails, including Colorado. This has resulted in a flood of research demonstrating higher follow-up rates, less opioid use, and reduced return to custody among people treated with MOUD in the carceral system.

The most [current research on this topic](#), again from Massachusetts, suggests that methadone and buprenorphine may be more effective at reducing both costs and overdose than naltrexone. If applied statewide, three-drug programs including methadone, buprenorphine, and naltrexone would save almost 100 lives over five years when compared with a naltrexone-only program, while saving money at the same time.

YOUTH TREATMENT

While the WSIPP review is very limited for youth-specific treatment options, it is surprisingly bearish about the effectiveness of such therapies.

TABLE 25.
Cost-Benefit Analysis of Youth Treatment

Program	Total Benefits	Costs	Benefit to Cost Ratio
Sober living houses	\$1,936	-\$302	\$6.40
Peer support for individuals with SUD	\$3,553	-\$2,961	\$1.20

This was previously a gap in the literature, with few randomized controlled trials of recovery-based interventions and no systematic reviews available to support decision-making.

Additionally, recovery got another boost in 2020 when the [Cochrane Review published](#) an updated analysis of 12-Step programs, namely Alcoholics Anonymous and 12-Step Facilitation. Previously, outcomes from community-based 12-Step Programs were unknown. **This study suggested that such programs could boost one-year abstinence rates from 35% for treatment as usual to 42% when treatment was combined with 12-Step recovery in the community.**

Harm Reduction

Harm reduction focuses on improving the health of people who use drugs rather than focusing on abstinence. Although harm reduction encompasses many different services, perhaps the two best-known discrete harm reduction-specific interventions are overdosing prevention with naloxone and syringe access.

Naloxone is the opioid overdose reversal agent. Studies have shown that distributing naloxone to high-risk populations, primarily through harm reduction agencies, saves lives in a cost-effective fashion, with the [best known study](#) coming out of Massachusetts. Other studies have focused on more broad distribution of naloxone, often with declining returns on investment.

Syringe access programs (SAPs) are also very common in harm reduction agencies. While many people focus on overdose prevention, from a cost-benefit standpoint, syringe access programs are clear winners. Both HIV and hepatitis C, despite recent advances in treatment to bring costs down, are extremely detrimental to people's health and expensive to treat. Syringe access programs [are estimated to cost between \\$400,000](#) and \$1.9M depending on the location and number of clients. **A large, well-done study on SAPs suggests that SAPs can save over [\\$300,000 per 100 clients](#) based on hepatitis prevention alone.**

Finally, there is a single program that was reviewed by WSIPP, entitled “[Holistic Harm Reduction Program](#)”, focusing on healthy behaviors among people in treatment for SUD. This included a range of strategies from syringe access to injection education and health sexual behaviors. With \$5,454.00 in benefits per client and only \$854.00 in costs, this program was found to have a \$6.39:1 benefit: cost ratio.

Conclusion

While many reports describe the current state of affairs without a normative approach, we have included estimates of demand for four highly effective, rapidly changing SUD treatment and recovery approaches. Furthermore, we utilize a plethora of varied data sources to compare geographic regions of Colorado at the SSPA level. As such, **this report serves as a short to medium-term roadmap for updating substance use disorder services.** Findings from this report will be used to inform future MSO investment areas at both the service level and the geographic level. Additionally, the report will inform future legislative spending and corresponding grant programming.

MSOs should be commended for the breadth of SUD services they provide for Coloradans. Regardless of MSO region, it is clear that Colorado's MSOs provide critical services to Coloradans in need. It should also be noted that 43% of Colorado's MSOs recently transitioned operators in January of 2023. As such, the new MSOs are readily working to expand services in their respective regions and many new service contracts have already been executed to provide increased SUD and recovery care for 2023 and beyond.

As noted earlier in the report, this evaluation focuses on data from fiscal year 2022, prior to the MSO contract changes in January 2023. This report includes data from Rocky Mountain Health Plans, Signal Behavioral Health Network, Diversus Health, West Slope Casa, and Mental Health Partners. Since most of the data in this analysis are from 2021 and 2022 — now nearly a year old in a quickly shifting landscape — we included supplemented data from the prior MSOs with brief summary updates from the incoming MSOs to ensure accurate representation of 2023 services and contracts. Please see below for an overview of 2023 updates provided by each of the MSOs.

SIGNAL BEHAVIORAL HEALTH NETWORK, SSPAS 1, 2, AND 4

In 2023, Signal dramatically expanded recovery residences in their MSO region. Newly contracted recovery residence providers include: All About Recovery, Amos Sober Housing Association, Ananeo Colorado LLC, Authentic Recovery Homes, Em's House Foundation, Empower Recovery, Helpful Heart House, Homes with Heart Foundation, House of Light, Lamar House, Lotus Lodge Sober Living, Mile High Sober Living, Mountain West Recovery, New Hope Sober Living, Purpose, Red Rocks Recovery, Route2Recovery, Step Seven, Sophrosyne Sober Living, Threshold to Recovery, Temperance Sober Living, The Promises Sober Living, Unity, and Woke AF (a.k.a. Mobarez Solutions LLC). In 2023, Signal also contracted with Green Thumb Initiative, which provides recovery support services to children, youth, and families.

DIVERSUS HEALTH, SSPA 3

Diversus did not contract with any new MOUD providers in 2023, however they expanded existing funding for several of their current MOUD providers. Similarly, no new providers were added for withdrawal management, but withdrawal management funding increased for Crossroads Turning Point by \$451,764.00 and by \$239,330.00 for Solvista.

In 2023, Diversus increased recovery support services and recovery residence funding. For recovery support services, Diversus increased funding by \$72,000.00 for Insight Services and added Recovery Support Services funds to Insight Services' contract. Notably, Diversus expanded recovery living funding by a whopping \$458,025.00 through the Behavioral Health Administration. Lastly, Diversus added a new recovery residence provider, Chance Homes, which brings the total Diversus recovery residence contracted providers to 13, each of which have multiple recovery homes for clients.

WEST SLOPE CASA / ROCKY MOUNTAIN HEALTH PLANS, SSPAS 5 & 6

Rocky Mountain Health Plans (RMHP) now holds the MSO contract for SSPA regions 5 and 6, which were formerly held by West Slope Casa. RMHP is also expanding services with new withdrawal management providers. Further, RMHP has greatly expanded their recovery support service providers. Specifically, RMHP now contracts with Advocates for Recovery Colorado, Amos Sober Housing Association, A Step Up, Watercolor Recovery, and Hard Beauty Foundation. Additionally, RMHP added several contracts for specialty populations, including Young People in Recovery and In the Weeds. Young People in Recovery provides recovery support services to youth and In the Weeds provides recovery support services to those in the hospitality industry.

Lastly, RMHP expanded recovery programs with already contracted partners. Specifically, Concentric Circles of Care is now implemented through Front Range Clinic, clients have access to new Oxford Houses funded by the BHA and Memorial Regional Health through federal grants, and River Valley Family Health Center provides co-pay support to indigent clients. Finally, Seven Cedars provides workforce development.

MENTAL HEALTH PARTNERS / SIGNAL BEHAVIORAL HEALTH NETWORK, SSPA 7 (BOULDER)

Signal, the newly awarded MSO for SSPA 7, took over Mental Health Partners' contract in 2023, and markedly increased recovery support services in the region. 2023 recovery support service contracts include the following providers: Boulder Pride (dba Out Boulder County), Hope - Homeless Outreach Providing Encouragement, high acuity peer services through Hornbuckle, Mental Health Center of Boulder County, Naropa University, two Recovery Café locations in Longmont, Sober AF Entertainment, and the Reentry Initiative. Further, Tribe Recovery Homes is opening a recovery residence in Boulder and recently received funding from Signal for scholarships. Lastly, Signal is planning to contract with Lion House once they complete their CARR certification, which would make them the only CARR-certified recovery residence in SSPA 7.

While MSO MOUD and withdrawal management contracted providers have largely remained unchanged in 2023, MSOs have universally expanded funding and contracts for recovery support services and recovery residences. As discussed in the recovery residence report section, Colorado is a national leader in population access to recovery residences. Despite this, there are wide geographic disparities in availability of recovery residences and dedicated

funding to support these services. However, as indicated by 2023 contract updates from the MSOs, MSOs are committed to expanding not only recovery residences, but also critical recovery resources, like peer support services and resources for specialty populations.

Altogether, the MSO updates for FY2023 underline Colorado's substantial commitment to a strong, accessible, and equitable behavioral health system. Recovery service contracts target high-need and high-risk populations for SUD and overdose, including rural communities, the hospitality industry, the queer community, women, and families in recovery. Colorado as a state — and MSOs specifically, which can fund services outside of the treatment continuum — are well positioned to fill gaps in a way that prioritizes health equity through a recovery-oriented system of care.

Summary

As detailed in the individual report sections earlier, we make recommendations on MSO service capacity and future areas of service expansion that would benefit people with SUD as well as their communities. However, a few of these findings bear repeating. First, Colorado has above-average access to MOUD, with the MOUD system currently reaching almost two-thirds of the state's total OUD population. Despite this, **OTPs, also known as methadone clinics, still disproportionately serve urban populations, even within largely rural SSPA regions. Further, youth MOUD services show the greatest unmet need, reaching less than 3% of the adolescent OUD population.**

Second, Colorado has withdrawal management capacity in line with available recommended norms. However, there is a major gap in levels of withdrawal management, especially in rural areas. **While level 3.2WM is reasonably accessible in most areas of the state, there is just one 3.7WM facility in all of western Colorado, which is not publicly accessible.** Notably, MSOs cannot contract with 3.7WM facilities, which is likely one of the reasons this discrepancy exists. Like MOUD, WM for youth is severely lacking with none of the state's residential WM providers providing specific youth WM. Fortunately, MSOs are helping to fill the gaps in some rural regions through lower-cost ambulatory WM services.

Third, Colorado has a robust recovery residence network, with 72% of the recovery residences in the state contracted with MSOs. Notably, Oxford House makes up an immense amount of MSO-contracted residences, including the majority of recovery residences in some rural areas. **However, Colorado has room for improvement with recovery residences for special populations, which include mixed families, gender-non-conforming individuals, and the LGBTQ+ community.** Very few recovery residences accept or cater to the above populations, which either results in special populations being unhoused, or feeling unsafe.

Fourth, recovery support high schools are nearly nonexistent in Colorado, with only one MSO-contracted school statewide. Recovery support high schools are cost-effective and highly beneficial for reducing substance use in adolescents. Expanding these schools throughout the state will hopefully curb the immense overdose rates youth are currently facing. Further, they would likely have a positive downstream effect by reducing the need for youth MOUD and WM

later on, both of which are gaping holes in the current continuum of care in our state. Colorado should consider model legislation for recovery high schools and further funding to expand this evidence-based resource.

Lastly, our qualitative work across community health improvement plans, key informant interviews, and opioid settlement spending all highlighted the immense need for behavioral health in our state. Statewide, **54 of 64 counties (84%) listed some form of behavioral health access as their number one priority in their county or regional improvement plan.** Further, as evidenced by the number of opioid settlement regions funding anti-stigma campaigns and workforce development, and from speaking with stakeholders, stigma and lack of behavioral health workforce remain substantive hurdles for people seeking SUD services. These challenges are even more pronounced in rural areas, where access and cost of living can be more challenging.

Beyond the aforementioned points, there are two other recommendations to consider, both of which focus on data. First, MSOs should consider breaking down expenses by capacity and per-client expenses as well as breaking out expenses by SSPA region. Currently, there is no standard way of collecting data by service or tracking the numbers of clients served with MSO dollars across regions and providers. This is especially true for recovery residences as our analysis was limited by the lack of data collection capacity across almost the entire recovery residence infrastructure.

MSOs also lack data on most client outcomes, which would enable much greater insight into the cost-benefit MSOs are providing with their services, although in this respect they differ little from many providers and payers in the behavioral health arena. Having standardized MSO reporting requirements and a standardized reporting platform, perhaps publicly available, would greatly ease future data requests for subsequent evaluations and would enable conclusive statements of what MSOs are funding. Finally, while bed and occupancy outcome data from CARR were not possible for this report, we understand CARR is working to enable those tracking metrics, which will greatly enhance the state's ability to understand the true scope of both supply and demand for recovery residences.

Colorado's behavioral health landscape is expansive and involves a multitude of funders and service providers. However, this report makes clear that while there remain large service gaps geographically and for special populations in some lines of SUD care, our MSOs contract with most eligible and willing service providers to provide critical care to Coloradans. In doing so, they expand the continuum of care beyond treatment to include prevention and recovery as highlighted in this report.

Behavioral health treatment and recovery have generally lagged behind their physical health counterparts. Sometimes called "invisible illnesses," mental health and substance use disorders are not evident to most observers. But they are invisible no longer. Our state has made large investments across the entire continuum, from prevention to treatment to recovery. In fact, in several of the areas reviewed in this report, Colorado is at or above national benchmarks. With continued, targeted investment in the behavioral healthcare and recovery

continuum, Colorado can create an equitable recovery-oriented system of care for people across our state.

APPENDIX A1: Key Informants

1. 5280 High School
2. Adelante Community
3. AllHealth Network
4. Colorado Access
5. Colorado Community Health Alliance
6. Colorado Criminal Justice Reform Coalition (CCJRC)
7. Denver Health and Hospital Authority
8. Diversus Health
9. Health Colorado, Inc. / Beacon Health Options
10. Heart Mind Haven
11. Mobarez Solutions
12. Northeast Health Partners
13. RESADA
14. Front Range Clinic
15. Servicios de La Raza
16. Young People in Recovery

APPENDIX A2: Key Informant Questions

1. What type of substance use treatment and recovery services / programs does your organization currently provide / who do you contract with to provide services for / who provides services in your area:
 - a. Medication-assisted treatment services (MAT / MOUD)?
 - b. Withdrawal management services?
 - c. What youth / adolescent services do you have / not have and what care coordination do you need?
 - d. Recovery support services in public high schools?
 - e. Recovery residences?
2. What type of substance use services are needed but are not currently provided?
 - a. What are the gaps in services?
3. What is the barrier to reaching this need / accessing care?
4. Are there any programs dedicated to diverse and historically underserved populations?
 - a. Are you able to reach diverse populations and historically underserved populations? If so, what do you find most effective in making these connections?
 - b. If not, what do you think will help with reaching these populations?
5. What do you recommend to enhance the accessibility and availability of care?
 - a. Are people falling through the gaps of care? And if so, how do you recommend enhancing services along the continuum? What is needed?
 - b. What is missing for your organization to make substance use treatment and recovery access timelier and more appropriate for your community?

SPECIFIC QUESTIONS BASED ON THE INTERVIEWEE

Education / High School

1. Do you know about recovery support services in high schools?
 - a. If yes, do you have a data source for recovery support services or a proxy data source?
2. What type of services / providers do you connect these students / families to?
 - a. Please provide specific names of providers / organizations and geographic locations.

RAE

1. What services are in YOUR network and how do you coordinate care?
2. In the linkage to care, who is falling in the gaps through the continuum?
3. What trends are you seeing in services requested and people served (e.g., geographic, demographic, acuity level, specific substances)?
4. What do you recommend to ensure that care is delivered efficiently and people are getting connected to culturally appropriate services?

MSO

1. What are the most funded / requested SUD treatments and services?
2. Any trends you see in funds? Specific demographics, facilities, needs, and services requested?
3. What kind of services do you see requested but not currently funded?
4. Are you contracted with any recovery support services in public schools?
 - a. Any inquiries for contracts?

Criminal Justice

1. What medication-assisted treatment services (MAT / MOUD and MAUD) do you see in jails / prisons?
 - a. If none, tell me about what you see / do to assist people who use substances in managing withdrawal, symptoms, and recovery support.
2. What policy / funding change do you think would make the quickest and most meaningful impact to reduce issues / barriers related to managing substance use withdrawal, symptoms, and recovery support?
3. Please tell me about transitions of care for re-entry clients.
 - a. Does engagement begin while in jail / prison? When?
 - b. What are specific organizations / programs clients are referred to? Types?
 - c. What is the success rate?

Recovery Residences

1. What types of recovery pathways do you support?
2. How are your residence(s) funded?
3. Do you regularly report client volume, length of stay, outcomes like employment, or cost of service to any formal entities?

APPENDIX B1: OTPs and OBOTs by Region and MSO Contract Status

The following table lists ALL OTPs in the state as of May, 2023, followed by their contracting status with any MSO. Note that these statuses are rapidly changing since many of the noncontracted OTPs are very new.

Additionally, we list only the OBOTs that are contracted with MSOs throughout the state. There are dozens of other OBOTs that prescribe MOUD but are not listed here because they are not contracted with MSOs. Prescribing data from these OBOTs is included in the data in the body of the report.

Provider	Type	SSPA Region	MSO Contract Status
Centennial Mental Health Center (CMHC)	OBOT	1	Contracted
SummitStone	OBOT	1	Contracted
Colorado Treatment Services LLC - Greeley	OTP	1	Contracted
VCPHCS X LLC - BHG Ft. Collins Treatment Center	OTP	1	Contracted
AllHealth Network	OBOT	2	Contracted
Ascent Health	OBOT	2	Contracted
Creative Treatment Options	OBOT	2	Contracted
Magnolia Medical	OBOT	2	Contracted
Mile High Behavioral Health Care (MHBHC)	OBOT	2	Contracted
Addiction Research & Treatment Services (ARTS) - Parkside Clinic	OTP	2	Contracted
Addiction Research & Treatment Services (ARTS) - Potomac Street Center	OTP	2	Contracted
Addiction Research & Treatment Services (ARTS) - Westside Center for Change	OTP	2	Contracted
Aurora Therapy Center LLC	OTP	2	Contracted
BayMark Health Services of Colorado, Inc. - 1st Ave.	OTP	2	Contracted
Comprehensive Behavioral Health Center - Champa	OTP	2	Contracted
Comprehensive Behavioral Health Center, Inc. - Alameda	OTP	2	Contracted
Crossroads Treatment Center of Denver - 13th	OTP	2	Contracted
Denver Health - Bannock	OTP	2	Contracted
Denver Recovery Group - Colfax	OTP	2	Contracted
Denver Recovery Group - Lakewood	OTP	2	Contracted
Denver Recovery Group - Littleton	OTP	2	Contracted
Denver Recovery Group - Northglenn	OTP	2	Contracted
VCPHCS XI, LLC - BHG Westminster Treatment Center	OTP	2	Contracted
VCPHCS XII LLC - BHG Centennial Treatment Center	OTP	2	Contracted

VCPHCS XII LLC - BHG Denver Treatment Center	OTP	2	Contracted
Community Medical Services- Exposition	OTP	2	Not contracted* (discussions underway)
Mile High Medical Group - Exposition Ave	OTP	2	Not contracted
Thrive Medical Group Inc. - Broadway	OTP	2	Not contracted
Centura - Catholic Health Initiatives	OBOT	3	Contracted
Colorado Treatment Services LLC - Academy	OTP	3	Contracted
Denver Recovery Group - Colorado Springs	OTP	3	Contracted
VCPHCS XII LLC - BHG Colorado Springs Treatment Center	OTP	3	Contracted
Partnership for Progress	OBOT	4	Contracted
Colorado Treatment Services LLC - Pueblo	OTP	4	Contracted
Crossroads Turning Points, Inc- Lamar: 3501 S Main	OTP	4	Contracted
Crossroads Turning Points, Inc.- Alamosa - Lava Ln	OTP	4	Contracted
Crossroads' Turning Points, Inc.- 13th St	OTP	4	Contracted
Health Solutions	OTP	4	Contracted
Elevate Healthcare, LLC	OTP	4	Not contracted* (discussions underway)
Axis Health System	OBOT	5	Contracted

APPENDIX C1: WM Providers by SSPA Region and MSO- Contracted Status

The following table lists ALL WM providers in the state as of May, 2023, followed by their contracting status with any MSO based on FY2022 contracting data. We have included all identified ambulatory WM programs to the best of our ability based on BHA DACODS claims.

Provider	Type	SSPA Region	MSO Contract Status
North Range Behavioral Health - Crisis Stabilization Services	3.2	1	Contracted
SummitStone Health Partners - Garcia House	3.7	1	Contracted
Front Range Clinic	Ambulatory	1	Contracted
A Life Worth Saving - Redwood	3.2	1	Not contracted
Harmony Foundation, Inc.	3.7	1	Not contracted
Mountain Crest Behavioral Health/UC Health/ Poudre Valley	3.7	1	Not contracted
Johnstown Heights Behavioral Health- Larimer Parkway	3.2, 3.7	1	Not contracted
Northpoint Colorado, LLC	Private pay only	1	Not contracted
Aurora Mental Health Center	3.2	2	Contracted
Denver Health and Hospital Authority	3.2	2	Contracted
Fitzsimmons Crisis Services Center	3.2	2	Contracted
Denver Springs - American Way	3.7	2	Contracted
Denver Springs - Hampden Pl	3.7	2	Contracted
Denver Springs, LLC - Northgate	3.7	2	Contracted
Valley Hope of Parker	3.7	2	Contracted
West Pines Behavioral Health	3.7	2	Contracted
Jefferson Center for Mental Health	3.2, 3.7	2	Contracted
Front Range Clinic	Ambulatory	2	Contracted
IDEA	Ambulatory	2	Contracted
The Ranch at The Raleigh House of Hope	3.2	2	Not contracted
Upson Hall LLC - Golden Peak Recovery - Balsam	3.2	2	Not contracted
Upson Hall LLC - Golden Peak Recovery - Fenton	3.2	2	Not contracted
All Points North Aurora Assessment Center	3.7	2	Not contracted
CuraWest, LLC	3.7	2	Not contracted
Footprints Recovery CO LLC	3.7	2	Not contracted
Gallus Detox Denver LLC	3.7	2	Not contracted
Highlands Behavioral Health System	3.7	2	Not contracted
Landmark Recovery of Colorado, LLC	3.7	2	Not contracted
Pathfinders Recovery Center	3.7	2	Not contracted
Rocky Mountain Detox	3.7	2	Not contracted
CeDAR, Center for Dependency Addiction and Rehabilitation	3.2, 3.7	2	Not contracted* (discussions underway)

Red Rock Recovery Centers, LLC	3.2, 3.7	2	Not contracted* (discussions underway)
Valiant DTX, LLC	3.2, 3.7	2	Not contracted
Crossroads' Turning Points, Inc. - Colo Spgs Maxwell	3.2	3	Contracted
West Central Mental Health Center dba SolvistaHealth (Regional Assessment Center)	3.2	3	Contracted
Peak View Behavioral Health	3.2, 3.7	3	Contracted
Mountain Springs Recovery LLC	3.2	3	Not contracted
Cedar Springs Hospital	3.7	3	Not contracted
Peaks Recovery Centers	3.7	3	Not contracted
Sandstone Care COS	3.7	3	Not contracted
Peaks Recovery Centers	3.2, 3.7	3	Not contracted
Recovery Village at Palmer Lake	3.2, 3.7	3	Not contracted
Crossroads Turning Points, Inc.- Alamosa - Lava Ln	3.2	4	Contracted
Crossroads Turning Points, Inc.- Trinidad: Carbon Pl	3.2	4	Contracted
Crossroads' Turning Points, Inc.- 13th St	3.2	4	Contracted
RESADA - Region Six Alcohol & Drug Abuse	3.2	4	Contracted
Southeast Mental Health Services-Regional Assessment Center	3.2	4	Contracted
Front Range Clinic	Ambulatory	4	Contracted
Partnership for Progress	Ambulatory	4	Contracted
Axis Health System Crisis Walk-In Center & CSU	3.2	5	Contracted
Center for Mental Health aka Midwestern Colorado Mental Health Center	3.2	5	Contracted
Crossroads at Grandview - Axis Health System fka Southwest Colorado Mental Health Center Inc.	3.2	5	Contracted
Mind Springs Health	3.2	6	Contracted
Recovery Resources - Castle Creek	3.2	6	Contracted
Recovery Resources - Peak One	3.2	6	Contracted
MidValley Family Practice	Ambulatory	6	Contracted
All Points North Lodge Residential	3.2	6	Not contracted
Foundry Treatment Center	3.2, 3.7	6	Not contracted
Mental Health Partners	3.2, 3.7	7	Contracted
Lookout at Choice LLC	3.2	7	Not contracted
NorthStar Transitions - 40th St.	3.2	7	Not contracted
NorthStar Transitions LLC, Ridge Rd, Ward, CO	3.2	7	Not contracted
Rose Transition Home, LLC	3.2	7	Not contracted
Centennial Peaks Hospital	3.7	7	Contracted

APPENDIX D1: Recovery Residences by Region and MSO- Contract Status

The following table lists all CARR-certified and Oxford House Recovery Residences in the state as of June 2022, followed by their contracting status with any MSO based on FY2022 contracting data. Providers with residences across multiple regions are listed with total number of residences in each relevant region. Thus, Oxford House, for example, is listed seven times—once for each SSPA region—in this table.

Provider	# Residences	SSPA Region	MSO Contract Status
Centennial Mental Health Center	2	1	Contracted
North Range Behavioral Health	2	1	Contracted
Oxford House	17	1	Contracted
AspenRidge Recovery, Fort Collins	2	1	Not contracted
Purpose House Sober Living	2	1	Not contracted
Step Seven Ministries	1	1	Not contracted
Aurora Sober Living	8	2	Contracted
Carla Vista Sober Living	10	2	Contracted
DLBC - House of RAHAB Transitional Sober Living Homes	2	2	Contracted
Elevate Recovery	4	2	Contracted
Hazelbrook Sober Living Homes	17	2	Contracted
Heart Mind Haven	1	2	Contracted
Hornbuckle Foundation	1	2	Contracted
I AM Recovery	4	2	Contracted
JCMH - Jefferson Center for Mental Health	1	2	Contracted
Just Living Recovery	1	2	Contracted
Mary's Hope Sober Homes	17	2	Contracted
Monarch Sober Living Homes	11	2	Contracted
New Beginnings Recovery Center	1	2	Contracted
Oxford House	46	2	Contracted
Satori Sober Living	1	2	Contracted
Serenity Falls	1	2	Contracted
Spero Sober Living	11	2	Contracted
Summit Healing	6	2	Contracted
Transitions Sober Living	7	2	Contracted
Tribe Recovery Homes	11	2	Contracted
Zen Mountain Sober Living	5	2	Contracted
5280 Sober Living	1	2	Not contracted
All About Recovery Inc	2	2	Not contracted
Ananeo Colorado, LLC	2	2	Not contracted
AspenRidge Recovery, Lakewood	3	2	Not contracted
Aspire Integrative Living	1	2	Not contracted
Blossom Living	1	2	Not contracted
Em's House Foundation	1	2	Not contracted
Eriks House of Healing	1	2	Not contracted
Front Range Sober Living	1	2	Not contracted
Gail's Place	1	2	Not contracted

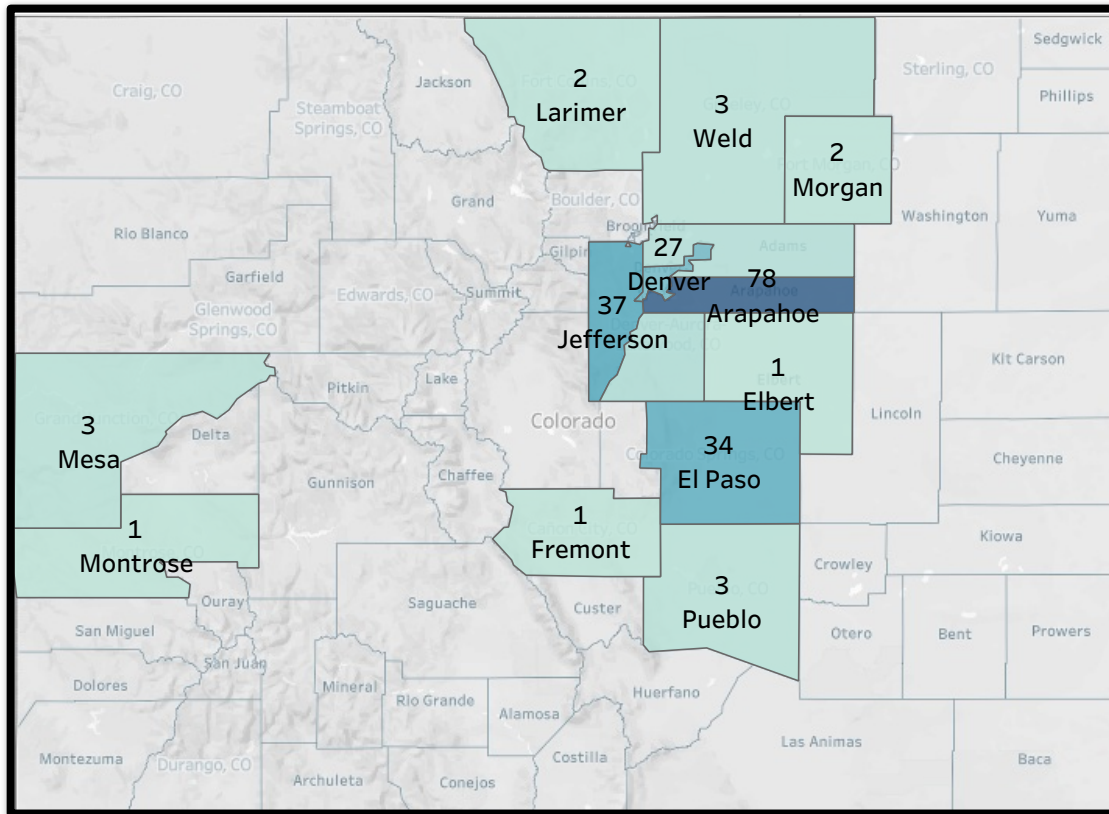
Helpful Heart House	2	2	Not contracted
Homes With Heart Foundation	1	2	Not contracted
House of Light Recovery	1	2	Not contracted
JJAX LLC	3	2	Not contracted
Kevin Fox Sober Living Ltd.	4	2	Not contracted
Lotus Lodge	3	2	Not contracted
Mile High Sober Living	9	2	Not contracted
Mobarez Solutions, LLC	1	2	Not contracted
Mountain West Recovery	1	2	Not contracted
New Hope Sober Living	1	2	Not contracted
Pathfinders Recovery Center Colorado	2	2	Not contracted
RAD Recovery	1	2	Not contracted
Red Rock Recovery Center Colorado	1	2	Not contracted
Resurge	1	2	Not contracted
Route2Recovery	3	2	Not contracted
Sophrosyne Sober Living	5	2	Not contracted
Step Seven Ministries	4	2	Not contracted
Stride Sober Living	4	2	Not contracted
Temperance Sober Living	1	2	Not contracted
The Promises Sober Living	2	2	Not contracted
The Salvation Army / Harbor Light	1	2	Not contracted
Threshold To Recovery	1	2	Not contracted
Unity Sober Living	3	2	Not contracted
Valiant Living	5	2	Not contracted
All-In Halfway, LLC	1	3	Contracted
Emersyn House	1	3	Contracted
GatewayMAT LLC	2	3	Contracted
Gospel Homes for Women	2	3	Contracted
Grit Grounds	3	3	Contracted
Hazelbrook Sober Living Homes	7	3	Contracted
Homeward Pikes Peak	3	3	Contracted
M. dangel's house	1	3	Contracted
Next Chapter	2	3	Contracted
Oxford House	24	3	Contracted
Rocky Mountain Sober Living	4	3	Contracted
Sunrise Serenity Homes	4	3	Contracted
The Step House	1	3	Contracted
A 2nd Chance Recovery Homes	3	3	Not contracted
A Wandering Life	1	3	Not contracted
Chance Homes	1	3	Not contracted
Eudaimonia Recovery Homes	4	3	Not contracted
Hope is Alive Ministries	1	3	Not contracted
Crossroads Turning Points, Inc.	2	4	Contracted
Master's Touch Healing and Deliverance Ministries (Potters House)	1	4	Contracted
Oxford House	10	4	Contracted
SLV Recovery	1	4	Contracted

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Lamar Transitional Living	2	4	Not contracted
Oxford House	2	5	Contracted
Oxford House	7	6	Contracted
All Points North Recovery Residences	2	6	Not contracted
Amos Supportive Housing Association	1	6	Not contracted
A Step Up, LLC	2	6	Not contracted
Come As You Are (CAYA)	1	6	Not contracted
Saint Paul Sober Living	1	6	Not contracted
Travis House	1	6	Not contracted
Oxford House	2	7	Contracted
Denver Recovery Center	2	7	Not contracted
Lion House, LLC	1	7	Not contracted
NorthStar Sober Living	1	7	Not contracted

APPENDIX D2: Count of CARR- Certified Recovery Residences by County (May 2023)

FIGURE 13.
CARR-Certified Recovery Residences by County (May 2023)



APPENDIX E1: PHIP Regions

The seven regions that elected to report collectively were exclusively rural and consisted of 27 of the 64 Colorado counties. Please see below for the counties that reported their CHNA and PHIP collectively:

1. **Northeast Colorado** (Logan, Morgan, Phillips, Sedgwick, Washington, and Yuma Counties)
2. **The West Central Public Health Partnership** (Delta, Gunnison, Hinsdale, Montrose, Ouray, and San Miguel counties)
3. **San Luis Valley** (Alamosa, Conejos, Costilla, Mineral, Rio Grande, and Saguache Counties)
4. **Northwest Colorado** (Moffat and Routt Counties)
5. **Regional Public Health Improvement Plan** (Eagle, Garfield, and Pitkin Counties)
6. **Regional Public Health Improvement Plan** (Crowley and Otero Counties)
7. **Regional Public Health Improvement Plan** (Las Animas and Huerfano Counties)

APPENDIX E2:

CHIP / CHNA

Sub-State Planning Areas Breakdown

TABLE 26.
Distribution of #1 Ranked Community Behavioral Health Needs Based on SSPA

Community Priority	SSPA 1 (n = 12)		SSPA 2 (n = 8)		SSPA 3 (n = 7)		SSPA 4 (n = 15)		SSPA 5 (n = 11)		SSPA 6 (n = 10)		SSPA 7 (n = 1)		Total	
	n	%*	n	%	n	%	n	%	n	%	n	%	n	%	N	%***
Access to Behavioral Healthcare	1	8%	3	29%	1	20%	6	40%	2	40%	3	33%	0	0%	16	30%
Behavioral Health (Mental Health and Substance Use)	6	50%	1	29%	2	40%	4	27%	3	60%	1	11%	0	0%	17	31%
Mental Health	3	25%	2	29%	2	40%	1	7%	0	0%	5	56%	1	100%	14	16%
Substance Use	2	17%	1	14%	0	0%	4	27%	0	0%	0	0%	0	0%	7	13%
TOTAL	12	100%	7	88%	5	71%	15	100%	5	45%	9	90%	1	100%	54	84%

n = number of counties

*Percentage denominator is sum per SSPA.

**Percentage denominator is the number of counties per SSPA.

***Percentage denominator is 54.

SSPA 1 (NORTHEAST)

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

The Northeast Colorado regions expressed the strong need for behavioral health support by **all counties identifying behavioral health as a number priority**. The two urban counties, Larimer and Weld, identified mental health as their number one priority. Six counties, inclusive of the Northeast Colorado Health Department (NCHD) Region, identified behavioral health as a number one priority. Specifically, NCHD noted **behavioral health was an issue identified at every community meeting hosted in all six counties in November of 2017**. Concerns about the **availability** of behavioral health services were also high in the NCHD community health survey.

SSPA 2 (DENVER METRO)

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

SSPA 2, Metro Denver, contains 46% of the urban counties, with two rural counties. Within this SSPA, all counties identified behavioral health priorities **within their top two priority areas**. Furthermore, **88% of these counties identified two or more behavioral health-specific priorities in their top three**. Notably, **Clear Creek County was the only county in this area to list youth in their top priorities**, specifically priority number one youth mental health, and priority number two youth substance use. **All counties listed increasing or improving access to mental health and substance use treatment within their goals.**

SSPA 3 (CENTRAL)

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

Within this region, 71% of counties listed behavioral health in their top two priorities, with 57% listing it as priorities one *and* two. In Park County, **mental health and substance use were identified by key informants as the most significant health issue Park County residents face**. The Park County community also voiced that **“one of the greatest threats to health in Park County is the lack of access to care.”** The rural counties in this region have strategies focused on improving and expanding accessibility and availability of behavioral health services, while the urban counties’ strategies are geared toward stigma reduction.

SSPA 4 (SOUTHEAST)

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

Southern Colorado region’s substantial need for behavioral health support is revealed by **all counties identifying behavioral health as a number priority**. Notably, San Luis Valley Counties — Alamosa, Conejos, Costilla, Mineral, Rio Grande, and Saguache— collected data through eight community engagement events and found **“access to behavioral health including local counseling and services” as a number one community priority**. Furthermore, Crowley and Otero Counties list their **target population as youth and young adults** in their efforts to prevent substance use issues. Pueblo County’s 2022 CHIP lists behavioral health as their number one priority with the **contributing factor of adverse childhood experiences (ACEs)** and the priority group being **youth and pregnant people and young mothers**. Further, Pueblo County’s strategy starts with improving referrals for ACEs screening, exemplifying an additional push for early preventative measures.

SSPA 5 (SOUTHWEST)

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

The Southwest region expressed significant community needs for behavioral health in that **all counties identified behavioral health as a top two priority**. This *completely rural region* reported behavioral health and access to behavioral and mental health as their top priority. The West Central Public Health Partnership — Delta, Gunnison, Hinsdale, Montrose, Ouray, and San Miguel Counties — identified early childhood and youth, elderly, low-income, geographically isolated, and LGBTQ+ populations as priority populations that are disproportionately affected by poor behavioral health within this SSPA. Key efforts throughout this region are to build capacity for behavioral health, reduce stigma, create health equity, and integrate behavioral health into primary care services.

SSPA 6 (NORTHWEST)

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

Within the Northwest region, **90% of counties identified behavioral health as their number one priority**. This SSPA has the highest community-identified need for mental health support with 56% identifying mental health as a priority. The State of Colorado Division of Housing classifies **55% of this region as rural resort, home to the highest number of ski resorts in the state**.

SSPA 7 (BOULDER)

County: Boulder

The **number one pressing need in Boulder County, identified by both Boulder County Public Health and Boulder Community Health, is mental health**. Key areas of need related to mental health in Boulder County include **access to mental health services**, specifically for **early childhood populations and people cycling through the criminal justice system**. Barriers to accessing mental health services in Boulder County include a shortage of community mental health providers that address priority populations, insufficient psychiatric care options, silos related to care, inadequate insurance coverage of mental health, and a “healthcare system that prioritizes acute care over preventive services.” Boulder Community Health’s strategy is to integrate behavioral health in primary care clinics. This will address the behavioral health needs commonly seen in primary care settings, such as insomnia, anxiety, depression, and substance use.

APPENDIX F1:

SSPA Opioid Settlement Spend Areas

SSPA 1 (NORTHEAST)

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

As of April 2023, this planning area was awarded a total of \$3,921,066.00. SSPA 1 contains three opioid regions (2, 3, and 4) and 12 total counties. This planning area proposed to distribute \$774,337.00 (20%) towards prevention, \$2,009,190.00 (51%) towards treatment, and \$1,137,539.00 (29%) towards additional areas. This was above the state average spend for additional areas, but below average for prevention. Within prevention, \$350,000.00 (45%) will be used for school-based programs and \$250,000.00 (32%) will be used for general harm reduction. **Almost half (45%) of the money going towards treatment will be going directly to general recovery services (\$898,143.00).** Also within the treatment approved use category, \$450,000.00 (22%) will be allocated to care coordination and \$300,000.00 (20%) will be given to evidence-informed treatment and harm reduction services. **Regarding the additional areas category, \$686,234.00 (60%) of these funds will be given to law enforcement - either for a co-responder program or other opioid-related expenditures — and \$291,305.00 (26%) of these funds will go towards administrative costs.**

SSPA 2 (DENVER METRO)

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

The Denver Metro planning area was awarded a total of \$17,012,539.00. This area contains six opioid regions (7, 8, 9, 10, 11, and 12) and eight counties. This area proposed to distribute \$4,039,111.00 (24%) to prevention, \$9,500,114.00 (56%) towards treatment, and \$3,473,314.00 (20%) towards additional areas. These proportions are largely congruent with state averages. Within prevention, at least \$1,823,126.00 (45%) will be given to general education programs and \$845,146.00 (20%) will be given to syringe and harm reduction services. **Within treatment, at least \$5,437,748.00 (61%) will be used for general recovery services and \$1,400,395.00 (16%) will be used for treatment expansion including MAT.** For additional areas, \$781,297.00 (23%) will be given to harm reduction and \$943,732.00 (27%) is for administrative costs.

SSPA 3 (CENTRAL)

Counties: Chaffee, Park, Fremont, Custer, Teller, El Paso, Lake*

The Central SSPA includes seven counties which comprise opioid regions 15 and 16, which includes El Paso County and the large metropolis of Colorado Springs and the community west of there. To date, this planning area will receive at least \$5,435,860.00. Most of these funds, \$2,676,012.00 (49%) will go to prevention, \$1,963,841.00 (36%) will go to treatment, and \$796,007.00 (15%) will be allocated to additional areas. These totals are below the state average for additional areas and above the state average for prevention. Within prevention,

public education programs will receive \$2,554,254.00 (95%) and school-based programs will receive \$88,781.00 (3%). Within the treatment category, \$1,384,200.00 (70%) will be allocated to general recovery services. Just over half of the funds in additional areas will be given to administrative costs (\$458,608.00, 58%) and the rest will be allocated towards victim advocate-related family supports (\$337,399.00, 42%). **This is the only region to designate funds towards victim advocate-related family supports.**

**Lake County is included in the analysis for SSPA 6 and excluded from the analysis in SSPA 3 since it is located in opioid region 5.*

SSPA 4 (SOUTHEAST)

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

The Southeast planning area includes 15 counties within opioid regions 18 and 19. SSPA 4 will be awarded \$2,891,413.00. Prevention will receive \$861,324.00 (30%), treatment will receive \$2,013,089.00 (69%), and additional areas will receive \$17,000.00 (1%). This is well above the state average spends for treatment and additional areas. **Within prevention, \$811,324.00 (94%) will be given to general prevention and education programs** while the other \$50,000.00 (6%) will be allocated to substance abuse prevention coalitions. For treatment, \$811,324.00 (40%) will be reserved for general treatment services across region 19, and the rest (\$1,201,765.00, 60%) will be reserved for recovery services for both general and priority populations. Within additional areas, all \$17,000.00 (100%) will be allocated to administrative costs.

SSPA 5 (SOUTHWEST)

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

SSPA 5, located in the southwest corner of the state, includes 11 counties divided into opioid regions 14 and 17. Region 14 is the only region included in this analysis since region 17's two-year plan was not publicly available as of May 2023. Region 14 will be awarded a total of \$549,363.00 for the first year. The funding is divided into \$116,000.00 (21%) for prevention, \$243,600.00 (44%) for treatment, and \$189,763.00 (35%) for additional areas. This is above the state average for additional areas and below the state average for prevention and treatment. Within prevention, \$55,000.00 (47%) of funds will go towards creating and implementing an application for increasing provider and SUD workforce certification, education, and supervision. Additionally, \$25,000.00 (22%) will be given to public education campaigns and \$31,000.00 (27%) will go to naloxone education, distribution, and training. **Within treatment, \$82,500.00 (34%) will be used to launch a regional shared telehealth service for SUD. Also, \$60,000.00 (25%) will be given to pre-trial services and another \$60,000.00 (25%) will be used to increase the treatment workforce in the region.** Regarding additional areas, \$127,300.00 (67%) of these funds will be used for collaborative cross-systems coordination.

SSPA 6 (NORTHWEST)

Counties: Moffat, Routt, Rio Blanco, Garfield, Mesa, Pitkin, Eagle, Summit, Grand, Jackson

This planning area is located in the northwest corner of the state and includes opioid regions 1, 5, and 13, comprising 11 counties. The planning area will be awarded \$1,992,871.00 in their first year. They proposed to allocate \$835,252.00 (42%) towards prevention, \$834,061.00 (42%) to treatment, and \$323,557.00 (16%) towards additional areas. This is well above the state average proportional spend in prevention and below the state average in treatment and additional areas. **Within prevention, \$300,000.00 (36%) will go toward public education campaigns; \$200,000.00 (24%) towards substance abuse prevention coalitions; \$133,813.00 (16%) towards naloxone data tracking, training, and education; and \$100,000.00 (12%) will go to syringe and other harm reduction services.** Within treatment, \$524,061.00 (63%) will be given to general recovery services and \$300,000.00 (36%) will be given to supportive housing, case management, and residential treatment. Among additional areas, \$186,776.00 (58%) is allocated towards collaborative cross-systems funding and \$136,781.00 (42%) is allocated towards administrative costs.

**Lake County is included in the analysis for SSPA 6 since it is located in opioid region 5.*

SSPA 7 (BOULDER)

Counties: Boulder

SSPA 7 is located in Boulder and is the only area that is both a single planning area, single county, and single opioid region. This area was awarded \$1,814,178.00 for their first-year allocation. Prevention will receive \$495,448.00 (27%), treatment will get \$1,035,662.00 (57%), and additional areas will receive \$283,068.00 (16%) of their allotted funds. Boulder is allocating an above average proportion to treatment and a below average proportion to additional areas. **Within prevention, \$270,000.00 (55%) will be given to syringe services and other harm reduction efforts, including an additional \$115,248.00 (23%) to naloxone training and education programs.** For treatment, Boulder is awarding \$283,392.00 (27%) towards evidence-based treatment, recovery, and harm reduction services regarding criminal justice and reentry programs. This region is also dedicating \$218,052.00 (21%) to pre-arrest diversion strategies, and \$218,618.00 (21%) to general recovery services. Within additional areas, \$110,250.00 (39%) will be allocated to law enforcement opioid-related expenditures and \$82,818.00 (29%) will go toward administrative costs.

APPENDIX F2:

Governance

Committee Questions

1. How did you participate in your region's opioid governance committee?
2. What are your thoughts on Colorado's regional community-based collaborative approach to opioid settlement funds allocation?
3. What worked well in your opioid governance committee?
4. What did not work well in your opioid governance committee?
5. What is going well in substance use disorder treatment, recovery, and criminal justice in your region?
6. What are some of the challenges or gaps in the following service areas in your region?
 - a. Medications for opioid use disorder services?
 - b. Recovery support services in high school?
 - c. Withdrawal management services?
 - d. Recovery residences?
7. Are there other gaps in substance use disorder services in your region that you would like to share?
8. What changes would you make to how decisions were made in your governance committee?