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Mental Health and Suicide Prevention Assessment: Framework Development and Recommendations for Public Health Action

PREPARED FOR TRI COUNTY HEALTH DEPARTMENT

BY

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JULY 31, 2020

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Background

Tri-County Health Department (TCHD) sought to assess and describe the behavioral health assets/activities and gaps in Adams and Arapahoe Counties. This assessment, together with an assessment previously completed in Douglas County for the Douglas County Mental Health Initiative (DCMHI), will inform development of a collaborative, data-driven suicide prevention framework and a broader mental health framework within which the suicide prevention framework will be embedded. The frameworks are intended to serve as a clarifying catalyst for implementation of shared strategies and provide effective language to convey the unique public health role in improving mental health and reducing rates of suicide.

Health Management Associates, Community Strategies (HMACS) designed and implemented the assessment methodology to understand the assets and gaps in mental health and suicide prevention in Adams and Arapahoe County. HMACS leveraged its current work with the DCMHI, as well as the statewide needs assessment for behavioral health that HMACS is leading for the Colorado Department of Human Services (CDHS) Office of Behavioral Health (OBH).

Mental Health as a Public Health Strategy

Public health promotes and protects the health of people and the communities where they live, learn, work and play.[1] Public health is what is done together as a society to ensure the conditions in which everyone can be healthy.[2] The Substance Abuse and Mental Health Services Administration (SAMHSA) defines behavioral health as including "the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for mental and/or substance use disorders."[3] Public health has a role to play in addressing behavioral health because mental health is inextricably linked to physical health. Until there are improvements in all aspects of behavioral health as defined above, significant improvements in population health will not be realized. For example, individuals who have mood disorders, psychoses, anxiety disorders, developmental disorders, and substance use disorders are more likely to be addicted to nicotine than those without these disorders. The impacts of this on population health are evident, including:

> About one-third (34%) of Adams and Arapahoe County adults who reported poor mental health also smoked.
>
> Source: TCHD Community Health Assessment, 2018.

- People with mental health conditions die about five years earlier than those without these disorders; many of these deaths are caused by smoking cigarettes. Additionally, individuals with

[1] American Public Health Association. What is Public Health. Retrieved from https://www.apha.org/what-is-public-health

[2] DeSalvo KB, Wang YC, Harris A, Auerbach J, Koo D, O'Carroll P. Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century. Prev Chronic Dis 2017;14:170017. DOI: http://dx.doi.org/10.5888/pcd14.170017

[3] SAMHSA Glossary. Retrieved from https://www.samhsa.gov/grants/grants-glossary#B

serious mental health disorders who smoke die almost 15 years earlier than individuals without these disorders who do not smoke.

- The most common causes of death among people with mental health conditions are heart disease, cancer, and lung disease, which can all be caused by smoking.[4]

A person's mental health is determined by not only genetic disposition but also culture, social norms, available resources, education, and economy, as well as their natural and built environment.[5] The role of public health in these social and physical determinants of health is well understood by public health professionals and to varying extents by other county agency and community based organization professionals. A goal of this assessment and subsequent framework development is to advance understanding about the unique public health role, and specifically TCHD's role, in mental health and suicide prevention in the three counties TCHD serves.

The timing of this assessment takes place during an unprecedented time in history with the spread of COVID-19 and public health actions to prevent the spread of the virus while preserving the strength of the health system to respond. It is already clear, even though we are still in the midst of the COVID-19 crisis, the impact on the mental health of Tri-County residents will be significant and the impact on the mental health system will at best be destabilizing and at worst, catastrophic.

It has never been more important to consider the findings of this assessment and support meaningful understanding of the role of public health in the mental health system. The mental health need in Colorado, as in the Tri-County Region, has always been great and the current system has not sufficiently met the need for a variety of reasons. COVID-19 will only make that gap more glaring, especially for vulnerable populations.

Methodology

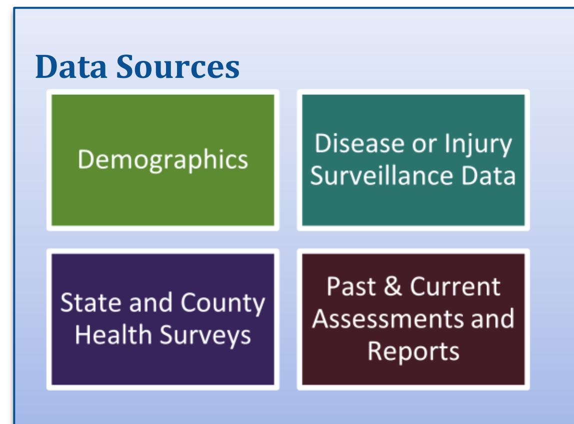
A two-pronged approach was used to inform the assessment, including to collect and review relevant county-level mental health and suicide data and conduct key informant interviews with community leaders in Adams and Arapahoe Counties.

[4]CDC. National Center for Chronic Disease Prevention and Health Promotion
Tobacco Use and Quitting Among Individuals With Behavioral Health Conditions National Center for Chronic Disease Prevention and Health Promotion. Retrieved from https://www.cdc.gov/tobacco/disparities/mental-illness-substance-use/index.htm

[5]National Network of Public Health Institutes. (2017, February). How the Framing of "Mental Health" Affects Strategies for Action at the Population Level. Retrieved from https://nnphi.org/framing-mental-health-affects-strategies-action-population-level/

Collect and Review Relevant County-level Mental Health and Suicide Data

Data sources cover three areas of interest for the assessment, including state and county demographic data, disease and injury surveillance data, and state and county health surveys. Findings from collection and review of these data are organized into the following themes:



- **Prevalence of mental health issues**, including statistics and trends on mental health and suicide
- **Needs and gaps in mental health and suicide prevention services and resources**, including findings related to behavioral health parity, integrated care, and workforce
- **Public health considerations**, including findings related to social and physical determinants of mental health concerns and the role of public health

Key Informant Interviews with Community Leaders

HMACS interviewed 23 unique organizations and 35 people. More than half of the organizations were either focused on Adams or Arapahoe County with the remainder representing both counties, the Tri-County Region, or a statewide perspective. HMACS worked with staff of TCHD to identify informants to be interviewed, ensuring representation from multiple sectors:

- Schools
- Behavioral health providers
- Integrated care providers
- Social services
- Criminal justice / Law enforcement
- Crisis services
- Adult and child protection

Key informants represented services provided to populations across the life span as well as special populations, including individuals with developmental disabilities, Veterans, pregnant and parenting people, among others. Key informant interviews focused intentionally on Adams and Arapahoe Counties as HMACS had recently completed an assessment in Douglas County that included key informant interviews. Findings from the Douglas County assessment are included in this report.

HMACS prepared an interview guide and individual as well as group interviews were conducted by one of two HMACS researchers. The interview guide included questions about mental health and suicide prevention activities, assets and gaps, equity in mental health and suicide prevention, potential frameworks and the role of public health in supporting mental health and suicide prevention related activities in the Tri-County Region. A thematic analysis of the key informant interview data was conducted, which means we examined the interview data to identify common themes – topics, ideas and patterns of meaning that come up repeatedly.

What the Asset and Gap Assessment Is and Is Not

This assessment is an illustration of where there is mental health need in Adams and Arapahoe Counties, and the mental health and suicide prevention efforts taking place, who is working on them, and where there are potential gaps. It is not a comprehensive review of all mental health efforts and suicide prevention efforts in the Tri-County Region.

Risk and Protective Factors for Poor Mental Health

The assessment begins with a description of the risk and protective factors for poor mental health as a foundational understanding for defining and assessing assets and gaps as it relates to mental health in the Tri-County Region.

According to SAMHSA*:*

> *"All people have biological and psychological characteristics that make them vulnerable to, or resilient in the face of, potential mental health issues. Because people have relationships within their communities and larger society, each person's biological and psychological characteristics exist in multiple contexts. A variety of risk and protective factors operate within each of these contexts. These factors also influence one another. Targeting only one context when addressing a person's risk or protective factors is unlikely to be successful, because people don't exist in isolation. For example:*
>
> - ***In relationships**, risk factors include parents who use drugs and alcohol or who suffer from mental illness, child abuse and maltreatment, and inadequate supervision. In this context, supportive parental involvement is an example of a protective factor.*
> - ***In communities**, risk factors include neighborhood poverty and violence. Here, protective factors could include the availability of faith-based resources and after-school activities.*
> - ***In society**, risk factors can include norms and laws favorable to substance use, as well as racism and a lack of economic opportunity. Protective factors in this context would include hate crime laws or policies limiting the availability of alcohol."* [1]

A community that seeks to promote positive mental health and wellbeing, and prevent suicide, is one that has the capacity to develop and implement strategies and opportunities that acknowledge the complex combination of events and conditions unique to each individual, relationship, environment, and community.

An extensive literature review conducted in 2019 identified how these risk and protective factors varied across the life course (Table 1).[6] The study broke the factors down into individual, family, social relationships, adverse life events, cultural factors, work and school environment, economic, and living

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[6] SaxInstitute. (2019). Evidence Check: Mental wellbeing risk and protective factors. Retrieved from https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/General/VicHealth-Attachment-1---Evidence-review-of-risk--protective-factors.pdf?la=en&hash=4CFF1B8DDED1E3CE257289448655A136AB5B4C16

environment factors. The table shows the shared risk factors across the life course, such as factors related to cultural (i.e., refugee status), living conditions (i.e., homelessness, out of home care), physical health conditions (i.e., obesity, chronic illness), and social isolation and loneliness. Unique risk factors per age group are maternal illness for children, high demand academic environments among adolescents, economic and employment factors among adults, and the death of a partner among older adults.

Table 1 Risk factors for poor mental health and wellbeing across the life course

<table>
<tr><th>Children</th><th>Adolescents</th><th>Young Adults</th><th>Adults</th><th>Older Adults</th></tr>
<tr><td colspan="3">Factors related to refugee status, including migration</td><td colspan="2"></td></tr>
<tr><td colspan="4">Homelessness</td><td></td></tr>
<tr><td colspan="2">Out of home care (child welfare)</td><td colspan="3"></td></tr>
<tr><td colspan="2">Screen time</td><td colspan="3"></td></tr>
<tr><td>Sedentary behavior</td><td colspan="4"></td></tr>
<tr><td colspan="2">Physical health conditions</td><td></td><td>Physical health conditions</td><td></td></tr>
<tr><td>Maternal illness</td><td colspan="4"></td></tr>
<tr><td></td><td>Poor family functioning</td><td colspan="3"></td></tr>
<tr><td></td><td colspan="2">Cyberbullying</td><td colspan="2"></td></tr>
<tr><td></td><td>High demand academic environments</td><td colspan="3"></td></tr>
<tr><td colspan="2"></td><td colspan="3">Social isolation and loneliness</td></tr>
<tr><td colspan="2"></td><td colspan="2">Being a sexual minority</td><td></td></tr>
<tr><td colspan="3"></td><td>Insecure employment or unemployment</td><td></td></tr>
<tr><td colspan="3"></td><td>Unsupportive work conditions</td><td></td></tr>
<tr><td colspan="3"></td><td>Economic inequality</td><td></td></tr>
<tr><td colspan="3"></td><td colspan="2">Caregiving</td></tr>
<tr><td colspan="3"></td><td>Stressful events</td><td></td></tr>
<tr><td colspan="4"></td><td>Death of a partner</td></tr>
</table>

The study also identified shared protective factors across the life span including social supports and relationships, supportive communities, and physical activity. Specifically:

- Children: Protective factors were primarily positive family functioning and supportive communities, and some evidence for physical activity.
- Adolescents: Protective factors were positive family functioning, social support (including online), community support, and physical activity.
- Young adults: Protective factors were physical activity and strong social relationships (including supportive integrated online networks for lesbian, gay and bisexual (LGB) young people.

- Adults: Protective factors were employment, physical activity, strong social relationships and networks, diet, alcohol reduction, and green space.
- Older adults: Protective factors were social support and physical activity.[7]

This assessment begins with a snapshot of the shared protective factors in Adams, Arapahoe, and Douglas counties including the following:

- Social connection
- Supportive communities and its opportunities for health and wellness services
- Physical activity

The 2018 Tri-County Health Department Community Health Assessment is a regional resource to understand the extent to which many of these other risk and protective factors exist across the region as well as within each county.

Social Connection

Social connection is itself a broad concept that speaks to the level at which community members connect and interact with one another, and access support in formal (i.e., government services) and informal (i.e., community clubs or groups) ways through sustained elements. Being a part of a social network can help people make healthier choices, through what's called social influence.[8] A strong social network can also improve mental health and lower levels of violence by boosting a person's feelings of self-worth and importance, which increases the chances that they will get the help they need when they need it.[9]

In 2017, between 80 and 90 percent of public high school students in the Tri-County area said they would have someone to talk to when feeling sad, with both Douglas (88%) and Arapahoe (86%) Counties reporting higher prevalence than students statewide (83%) (Figure 1). Fewer students, with a low in Adams County at 69 percent to a high in Douglas County at 76 percent reported having an adult to go to for help with a serious problem.

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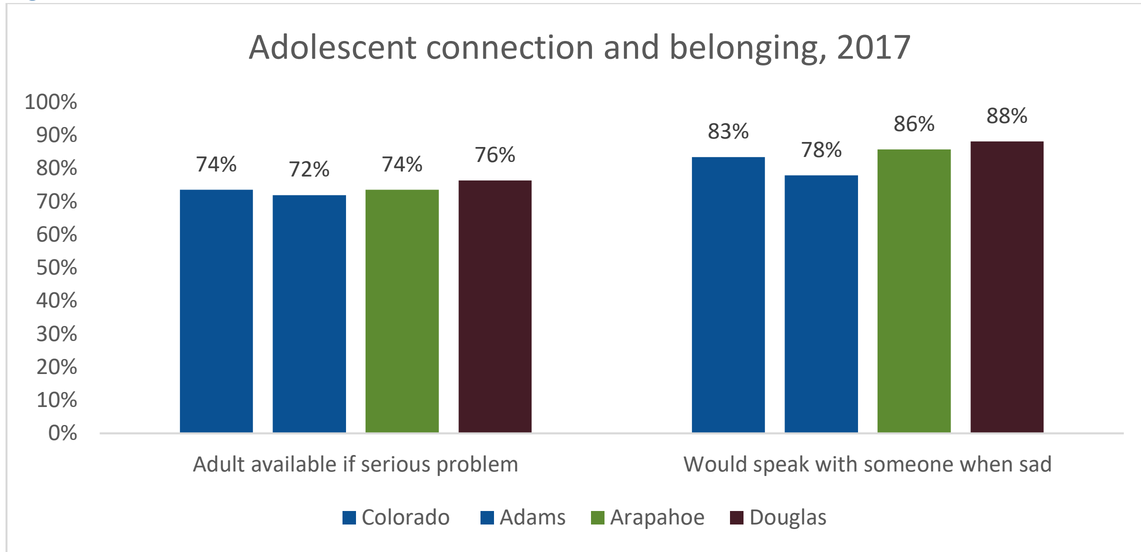
[7] SaxInstitute. (2019). Evidence Check: Mental wellbeing risk and protective factors. Retrieved from https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/General/VicHealth-Attachment-1---Evidence-review-of-risk--protective-factors.pdf?la=en&hash=4CFF1B8DDED1E3CE257289448655A136AB5B4C16

[8] Ichiro Kawachi and Lisa F. Berkman, "Social Ties and Mental Health," *Journal of Urban Health: Bulletin of the New York Academy of Medicine* 78, no. 3 (2001): 458-467, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3455910/pdf/11524_2006_Article_44.pdf

[9] Ichiro Kawachi and Lisa F. Berkman, "Social Ties and Mental Health," *Journal of Urban Health: Bulletin of the New York Academy of Medicine* 78, no. 3 (2001): 458-467, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3455910/pdf/11524_2006_Article_44.pdf

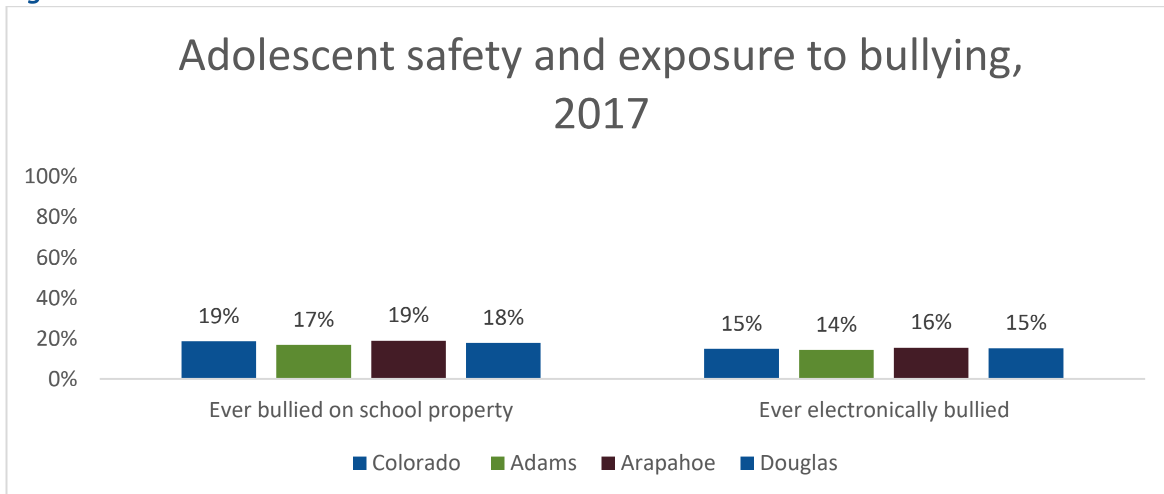
Figure 1



Source: Healthy Kids Colorado Survey (2017), Colorado Department of Public Health and Environment

Among high school students in Adams, Arapahoe, and Douglas Counties, around one in five report having ever been bullied on school property; report of electronic bullying is slightly lower (Figure 2). Females, younger students, and those who identified as LGB were more likely to report being bullied. For these young people, their access to and capacity for social connection may be hindered by the experience of bullying.

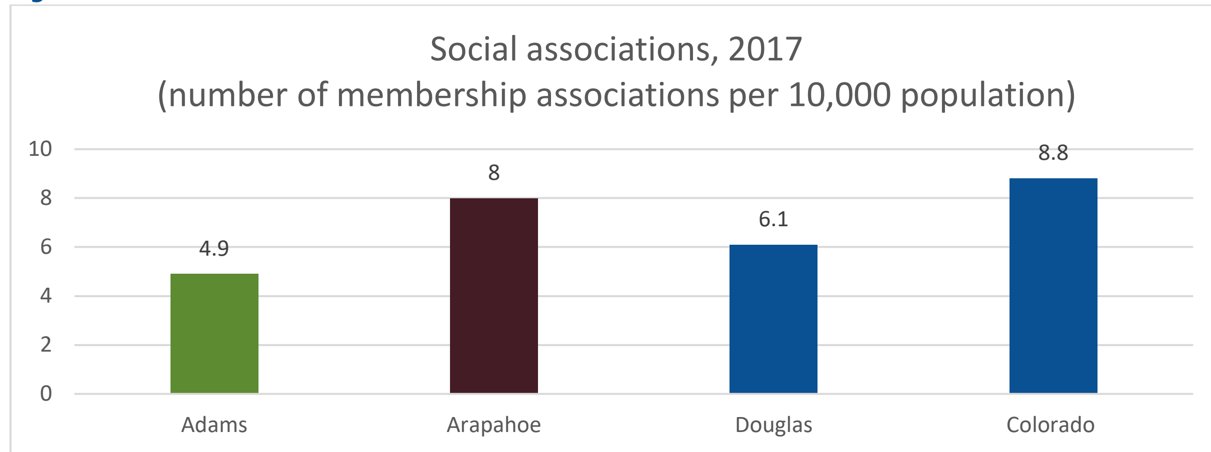
Figure 2



Source: Healthy Kids Colorado Survey (2015, 2017), Colorado Department of Public Health and Environment

A measure of social connection is the number of membership associations per 10,000 people, such as civic organizations, bowling centers, golf clubs, fitness centers, sports organizations, religious organizations, political organizations, and professional organizations.[10] Adams County residents have the fewest social associations, with 4.9 per 10,000 adults in the population, compared to Douglas County (6.1) and Arapahoe County with nearly twice as many at 8.0 per 10,000 (Figure 3).[11]

Figure 3



Source: RWJF County Health Rankings, 2020

Taken together with the adolescent connection and belonging measures, social connectedness data suggest greater need in Adams County for promotion of adult and youth social connections.

Community Support: Opportunities for Health and Wellness Services

The ability to identify and afford physical and mental health care services was one of the most important health problems identified by Tri-County community members in the 2018 TCHD Community Needs Assessment.

The federal Health Services and Resources Administration (HSRA) determines Medically Underserved Areas/Populations, which are areas or populations which have too few primary care providers, high infant mortality, high poverty, or a high elderly population (Figure 4). Areas of health and wellness

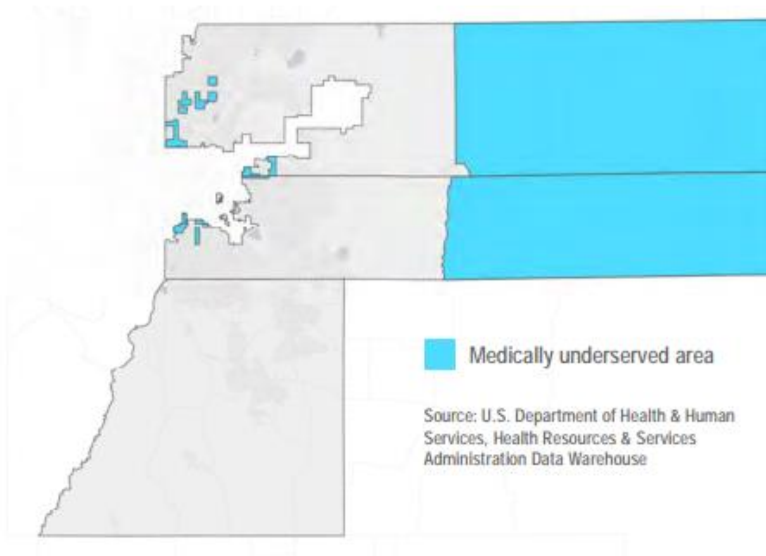
[10] County Health Rankings, 2017. Social Associations measures the number of membership associations per 10,000 population. The numerator is the total number of membership associations in a county. The associations include membership organizations such as civic organizations, bowling centers, golf clubs, fitness centers, sports organizations, religious organizations, political organizations, labor organizations, business organizations, and professional organizations. The denominator is the total resident population of a county.

[11] There is not currently a reliable, national source of data for measuring social or community support at the local level. This measure does not account for important social connections offered via family support structures, informal networks, or community service organizations, all of which are important to consider when understanding the amount of social support available within a county. It also does not account for perceived support. For instance, an individual can be a member of numerous social associations, but feel they receive no social support from those organizations.

service need appear in communities of Adams and Arapahoe Counties, with Adams County generally having a much higher need.

Figure 4

Medically underserved areas (MUAs), 2017



Source: Tri-County Health Department 2018 Community Needs Assessment

Literature suggests that populations living in medically underserved areas also experience several determinants of health known to increase the prevalence of physical and mental health issues and to widen disparities in access to needed health care. For example, national data suggest that 28.3 percent of the adult population (18+) with any mental illness in the past year is covered by Medicaid, compared to 19.1 percent of overall adult population.[12]

"Safety net population," those benefiting from Medicaid and other safety net health care options, for the sake of this assessment, was defined using the measures created by the Colorado Health Institute (CHI) for those "medically vulnerable," including the following:

- Incomes below 300 percent of the federal poverty level (FPL)
- No health insurance
- Enrollment in a publicly financed health insurance program or high-deductible health plan
- A geographically isolated location (location based on population density per square mile)

[12] SAMHSA NSDUH 2018. Table 8.2B Any Mental Illness in Past Year among Persons Aged 18 or Older, by Age Group and Demographic Characteristics: Percentages, 2017 and 2018 and
Table 8.3B Any Mental Illness in Past Year among Persons Aged 18 or Older, by Age Group and Geographic and Socioeconomic Characteristics: Percentages, 2017 and 2018

- Cultural, language, and other social barriers (defined by “speaks English not very well”)[13]

HMACS calculated a suitability (composite score) analysis for each census tract in Colorado and ranked census tracts from lowest to highest in proportion of population considered medically vulnerable by applying equal weights to measures as defined by CHI. Positive influence was selected, which means the higher the value of the variable, the greater its effect on the final score. Relative to Colorado, Douglas County has few people who fit the safety net population per square mile due to its population experiencing the lowest poverty and uninsured rates, Medicaid coverage, and the fewest cultural, language and other social barriers. Adams County has the highest safety net score within the Tri-County Region as well as higher than the state, driven in part by higher uninsured rates and percent of the population experiencing cultural, language and other social barriers. Arapahoe County has s slightly lower safety net score relative to Colorado in part due to population experiencing cultural, language and other social barriers.

Table 2

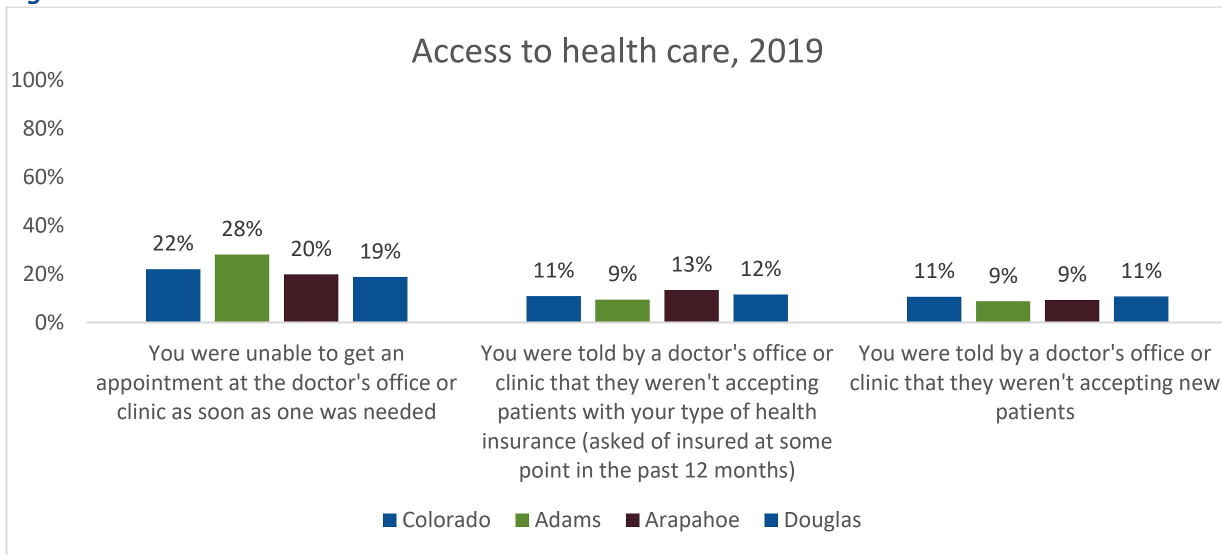
	Individual Composite Score Measures				
Geography	Safety Net Score	Population Below Poverty Level*	Uninsured*	Medicaid coverage alone or in combination*	Population 5 and Over - Speak English less than very well *
Colorado	0.2389	11.26%	9.25%	17.51%	5.64%
Adams	0.2503	12.10%	13.30%	22.40%	10.61%
Arapahoe	0.2322	9.81%	9.66%	15.98%	8.21%
Douglas	0.1955	3.63%	3.56%	6.17%	2.12%

Source: American Community Survey, Five Year Estimates 2013-2018

Residents of the Tri-County Region generally had similar experiences as other Coloradans in accessing health care, as measured by getting a doctor’s appointment as soon as one was needed, doctor’s acceptance of health insurance type, and doctor’s acceptance of new patients, with one exception. A greater proportion of Adams County residents (28%) experienced greater challenges in getting an appointment at the doctor’s office or clinic as soon as one was needed than residents across Colorado (22%), Arapahoe County (20%), and Douglas County (19%) (Figure 5). However, Adams County residents also reported being slightly less likely to hear that the doctor was not accepting new patients or accepting of their health insurance. This suggests that while there may be enough doctors accepting new patients and all types of health insurance, the capacity of providers to respond to immediate needs for appointments is limited. This pattern is also seen in Arapahoe and Douglas Counties; however, less so.

[13]Colorado Health Institute. (2019, August). Colorado’s Health Care Safety Net. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2019%20Safety%20Net%20Primer.pdf

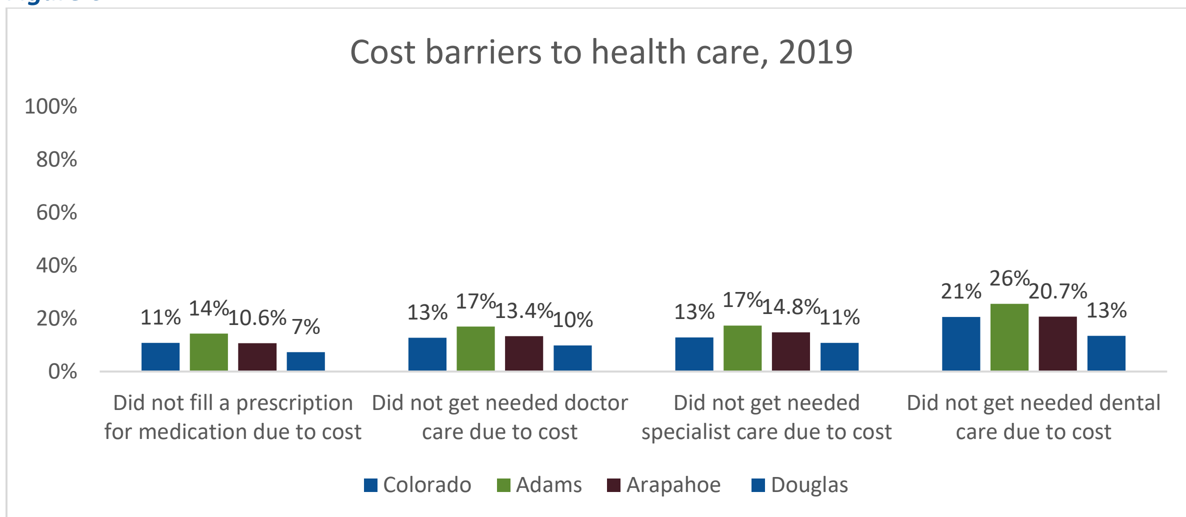
Figure 5



Source: Colorado Health Institute, Colorado Health Access Survey, 2019

In addition to identifying a provider, other challenges exist including cost regardless of insurance status. Among those with insurance, premiums, deductibles, and co-pays may force decisions upon people to choose between services, medications, and other necessities. Adams and Arapahoe County residents, both insured and uninsured, experience greater cost barriers with filling a prescription, and obtaining doctor care, specialist care, and dental care than those living in Douglas County (Figure 6). For obtaining services, residents in Adams and Arapahoe Counties also experience these cost barriers more so than others living throughout Colorado.

Figure 6

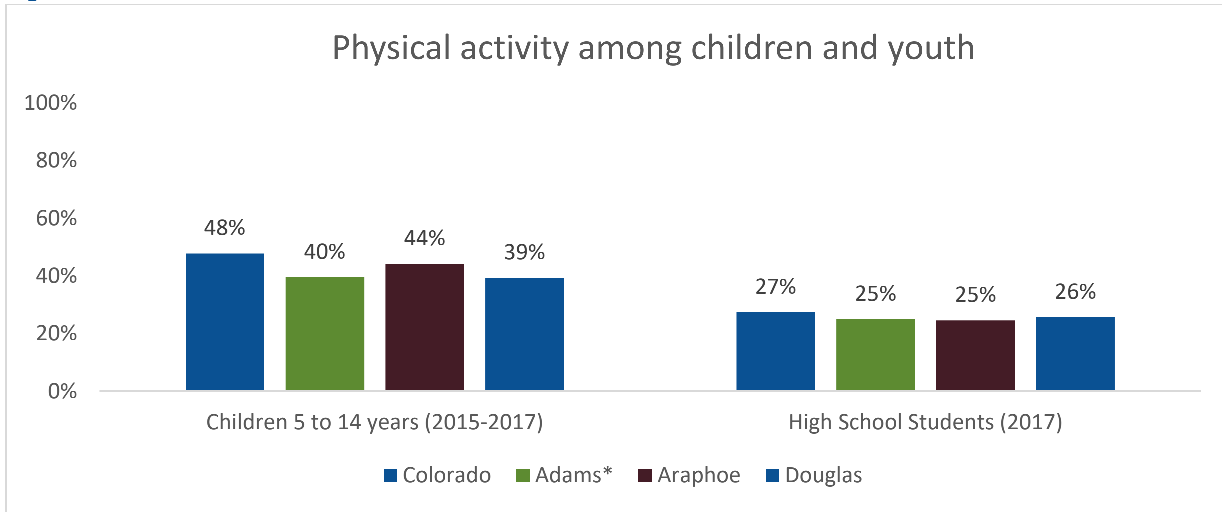


Source: Colorado Health Institute, Colorado Health Access Survey, 2019

Physical Activity

In general, physical activity levels decrease as a person ages and inactive children tend to become inactive adults. The percent of children and high school students who meet guidelines for daily physical activity (defined as physically active for 60 or more minutes on five or more days per week) is highest among children five to 14 years in Arapahoe County (44%), followed by Adams County (40%) and Douglas County (39%) (Figure 7). Among high school students, there are similar rates between the counties and overall physical activity is lower compared to children five to 14 years of age.

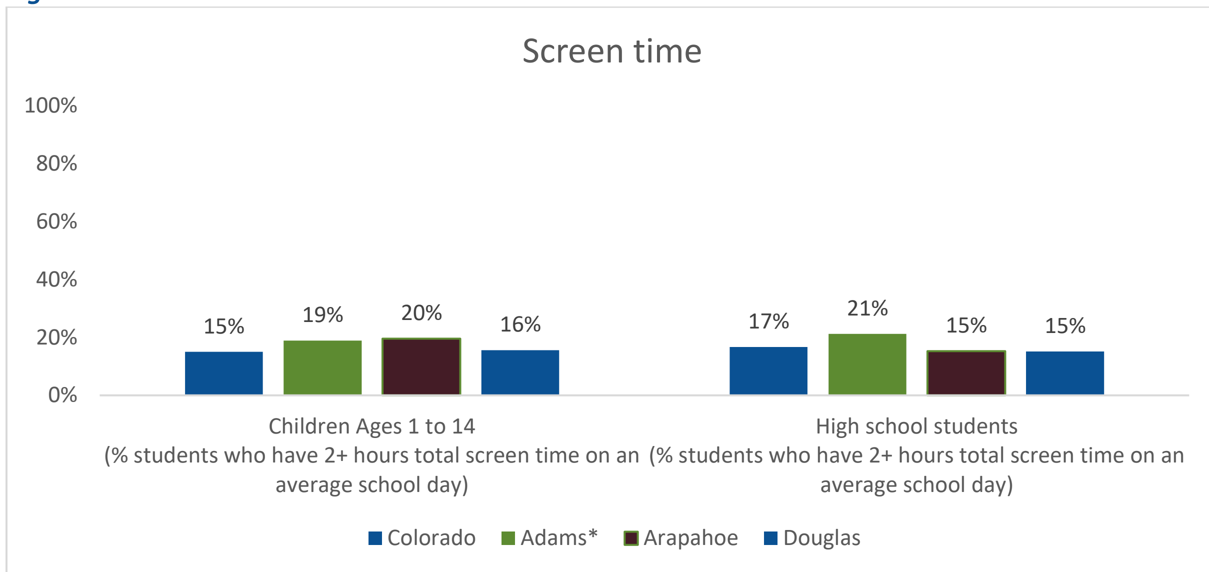
Figure 7



Note: Adams data are from 2015. Source: Colorado Child Health Survey and Healthy Kids Colorado Survey, Colorado Department of Public Health and Environment

The amount of screen time as a type of sedentary behavior may influence rates of physical activity among children and youth. It is also understood from the literature that screen time among children and adolescents is a risk factor for poor mental health. Among children ages one to 14, the percent of children experiencing two hours per day on weekdays of screen time is higher in Adams County (19%) and Arapahoe County (20%) relative to Douglas County (16%) and all children throughout Colorado (15%) (Figure 8). Among high school students, the percent of students watching television three or more hours per day on weekdays is highest in Adams County (21%) relative to Arapahoe County (15%) and Douglas County (15%) and also higher than the state (17%).

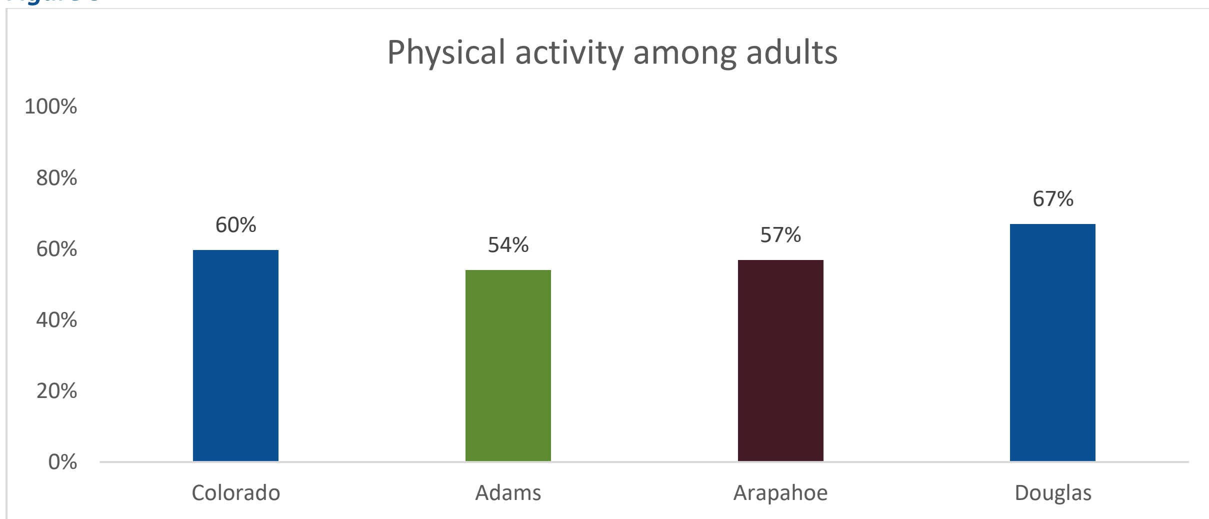
Figure 8



Note: Adams data are from 2015. Source: Colorado Child Health Survey and Healthy Kids Colorado Survey, Colorado Department of Public Health and Environment

Approximately two in three adults are physically active in Douglas County (67%) compared to just over one in two (54%) in Adams County (Figure 9). Arapahoe County is just about on par with Colorado at 57 percent compared to 60 percent of adults in Colorado.

Figure 9



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2018

The 2018 TCHD Community Health Assessment pointed out that adults living in lower socioeconomic status (SES) communities experience greater barriers to physical activity than those living in higher SES communities, citing that “lower-SES communities often must deal with the negative aspects of the environment, such as busy through streets, poor-quality bicycle and pedestrian infrastructure,

dilapidated parks and playgrounds, and crime that deters physical activity".[14] Data from the Behavioral Risk Factor Surveillance System (BRFSS) reveals that adults with lower incomes in Colorado report lower levels of physical activity than their higher income peers.

Levels of violent crime compromise physical safety and psychological wellbeing, and can also deter residents from pursuing healthy behaviors, such as exercising outdoors or gathering children together at a park. Additionally, exposure to crime and violence has been shown to increase stress and anxiety.[15]

The rate of violent crime statewide is 326 reported violent crime offenses per 100,000 people (as of 2014 and 2016).[16] Violent crimes are defined as offenses that involve face-to-face confrontation between a victim and a perpetrator, including homicide, rape, robbery, and aggravated assault.[17] In Adams County, this rate increases to 372. In Arapahoe County it is 330 per 100,000 people and in Douglas County, the rate is lower than the state at 114 violent crime offenses per 100,000 people.[18]

Another measure to assess safety is number of deaths due to injury, which is a leading cause of death among all age groups. Nationally, in 2018, the age adjusted rate for all injury deaths is 69.9 per 100,000, lower than in Colorado at 80.22 per 100,000. Among intentional injuries, that national age adjusted rate in 2018 was 47.91 per 100,000 with Colorado lower at 52.3. Violence related injury deaths was 20.3 per 100,000 In the United States, lower than in Colorado at 26.99 per 100,000. Nationally, the leading three causes of injury death in 2018 was unintentional poisoning, motor vehicle traffic deaths, and falls. However, in Colorado, firearm suicides fall within the top three causes of injury death, with motor vehicle traffic deaths ranked fourth. The top three causes of violence-related injury deaths both nationally and in Colorado were firearm suicides, firearm homicides, and suffocation suicides (however, suffocation suicides are ranked second in Colorado).

County level data are available using aggregated 2014 to 2018 data via Robert Wood Johnson Foundation's County Health Rankings. Statewide, the age-adjusted death rate due to injuries (both intentional and unintentional injuries) was 78 deaths per 100,000 population. In Adams County, the rate is 77 and in Arapahoe County it is lower at 67 per 100,000. In Douglas County, the rate is lowest at 51 per 100,000.

In summary, these measures described above offer a snapshot of important risk and protective factors for good mental health and wellbeing and the extent to which they occur by county compared to the

[14] Institute of Medicine (US) and National Research Council (US) Committee on Childhood Obesity Prevention Actions for Local Governments; Parker L, Burns AC, Sanchez E, editors. Local Government Actions to Prevent Childhood Obesity. Washington (DC): National Academies Press (US); 2009. 5, Actions for Increasing Physical Activity. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK219690/

[15] Ellen IG, Mijanovich T, Dillman KN. "Neighborhood effects on health: Exploring the links and assessing the evidence". *Journal of Urban Affairs*. 2001;23:391-408

[16] In the 2019 and 2020 County Health Rankings, only 2 years of data were used (2014 & 2016), due to non-published data in 2015. Previously 3 years of data were combined to create this measure.

[17] Information for this measure comes from the FBI's Uniform Crime Reporting (UCR) Program.

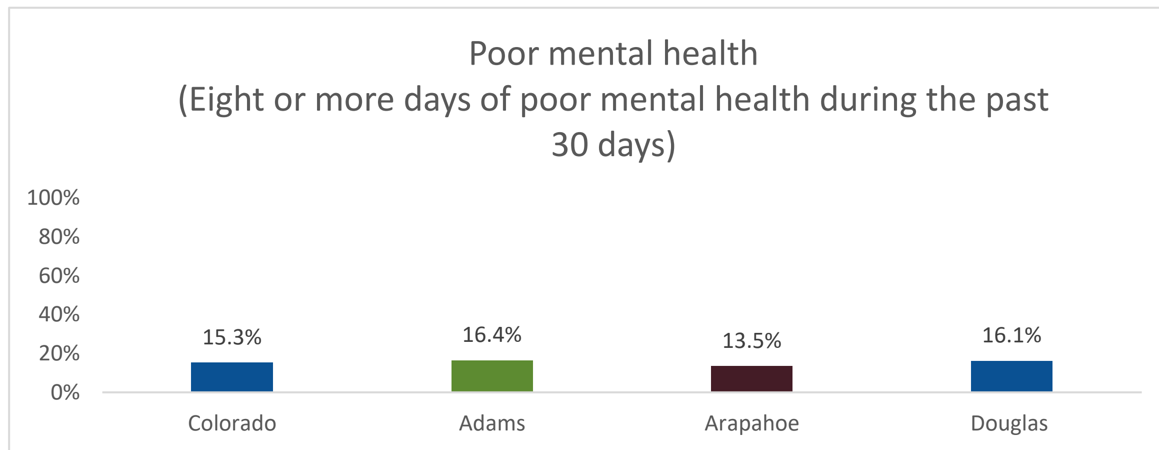
[18] RWJF County Health Rankings, 2020.

State as a whole. The prevalence of these factors is important context to keep in mind when assessing prevalence of mental health issues and suicide, as described next.

Prevalence of Mental Health Issues

According to the 2019 Colorado Health Access Survey, 15.3 percent of Coloradans reported poor mental health (defined as eight or more days of poor mental health during the past 30 days; ages five and older), compared with 11.8 percent in 2017. Adams and Douglas Counties' prevalence of poor mental health at 16.4 percent and 16.1 percent, respectively was higher than Colorado as a whole. Arapahoe County reported lower prevalence at 13.5 percent (Figure 10). Related, the percent of mothers who discussed what to do if depressed during or after pregnancy with their health care provider was highest in Arapahoe County at 75 percent in Arapahoe County, followed by 73 percent in Adams and 72 percent in Douglas Counties.[19]

Figure 10



Source: Colorado Health Institute, Colorado Health Access Survey, 2019

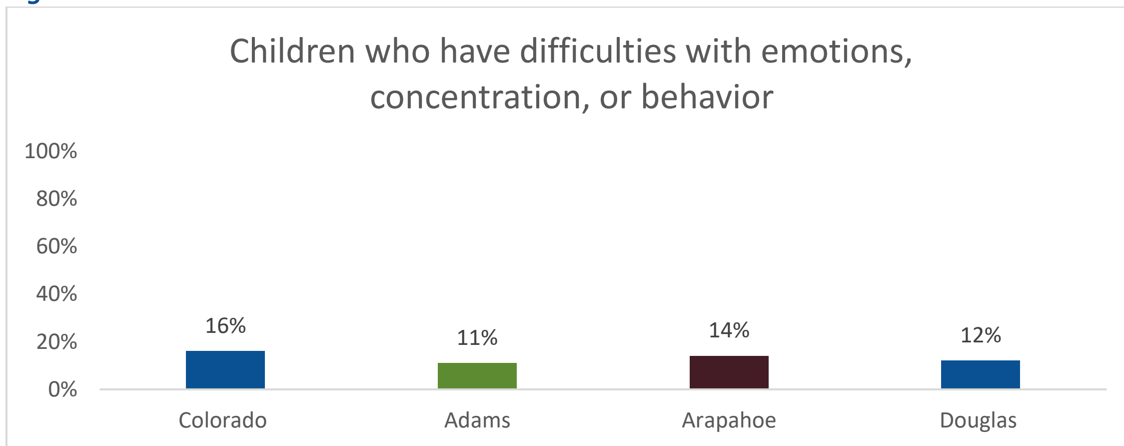
Young Children and Adolescents

It is estimated that up to one in five children in the United States experiences a mental health disorder in a given year. It is important for children to get early diagnosis and treatment so they can avoid problems in school and at home.[20] As of 2016, between 11 and 14 percent of children ages two to 14 years in Adams, Arapahoe, and Douglas Counties reported difficulties with one or more of the following areas: emotions, concentration, behavior, or being able to get along with others (Figure 11).

[19] Colorado Department of Public Health and Environment. (n.d.). 2019 County MCH trend analyses. Retrieved from https://www.colorado.gov/pacific/cdphe/mch-data-and-reports

[20] National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention Home. What Are Childhood Mental Disorders? Retrieved from https://www.cdc.gov/childrensmentalhealth/basics.html

Figure 11



Source: Colorado Child Health Survey, CDPHE, 2016.

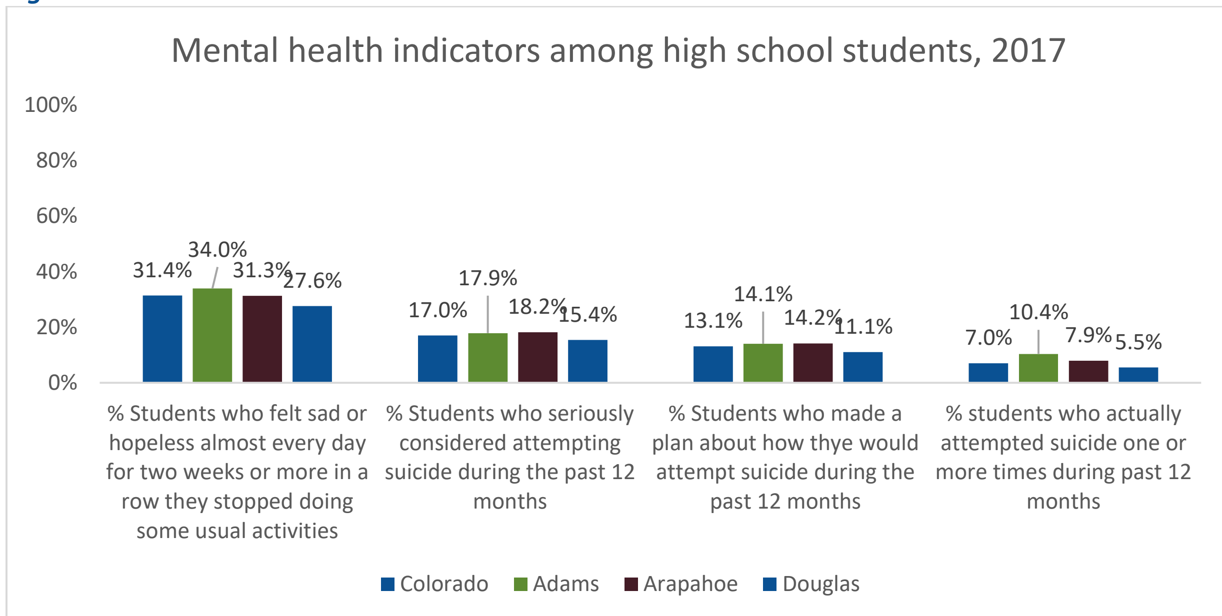
The 2017 Healthy Kids Colorado Survey (HKCS) revealed that 31.4 percent of Colorado's high school students felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the previous 12 months. For LGB students this prevalence was higher at 62.6 percent, compared to 27.0% of heterosexual peers. American Indian/Alaska Native (non-Hispanic) high school students had the highest prevalence among all races and ethnicities at 37.5 percent, followed by Hispanic or Latino students at 35.2 percent.[21]

In the Tri-County Region, between 25 percent and 32 percent of high school students reported feelings of depression impacting their daily activities, between 15 percent and 20 percent reported seriously considering suicide, and between five percent and eight percent reported that they attempted suicide in the past 12 months (Figure 12). Like the rest of Colorado, females and LGB are more likely to consider

[21] Colorado Department of Public Health and Environment. (n.d.). Healthy Kids Colorado Survey Data, 2017. Retrieved May 15, 2020 from https://www.colorado.gov/pacific/cdphe/healthy-kids-colorado-survey-data

and attempt suicide than males and heterosexual youth; however, males are more likely to die by suicide.

Figure 12

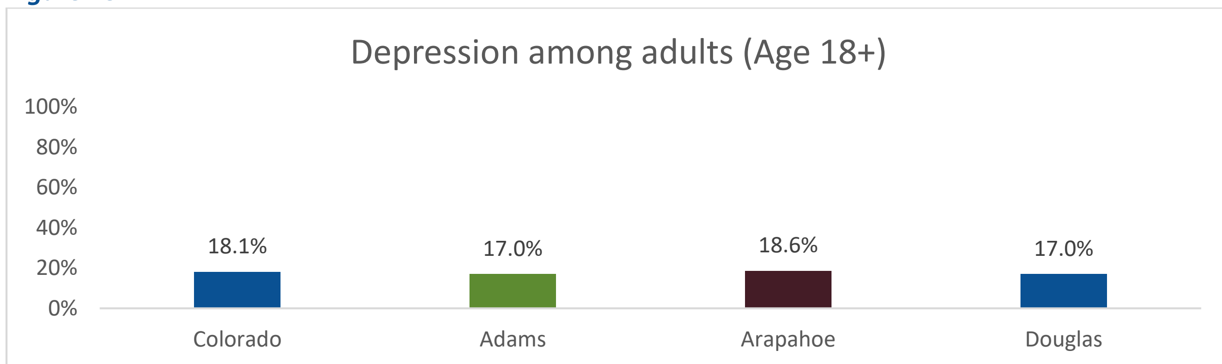


Source: 2017 Health Kids Colorado Survey, CDPHE

Adults

Between 2014 and 2017, nearly one in five (18.8%) adults in Colorado reported having experienced depression, as defined as ever being told by a doctor, nurse, or other health professional that you have a depressive disorder.[22] Adults are slightly more likely to experience depression in Arapahoe County (18.6%), compared to Adams County (17.0%), and Douglas County (17.0%) (Figure 13).

Figure 13

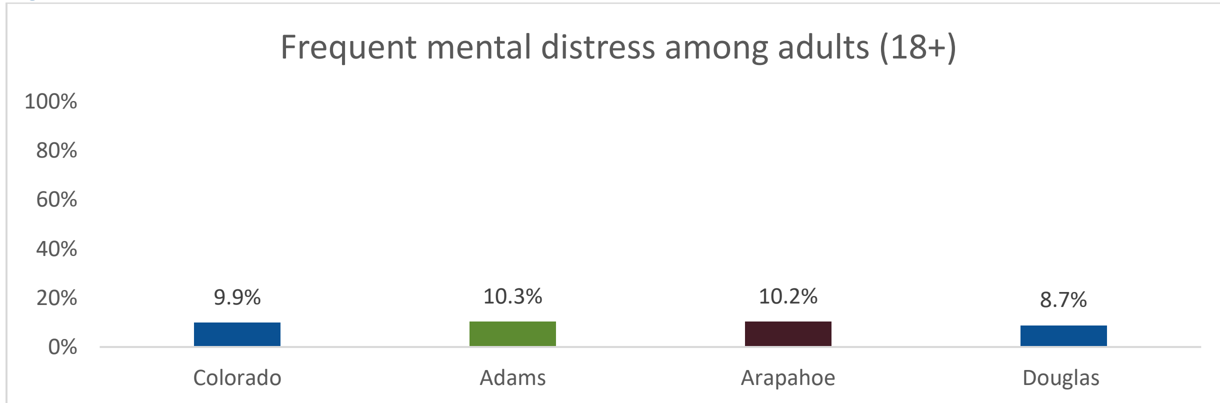


Source: BRFSS, 2014-2017

[22]BRFSS, 2014-2017. Estimates available for download at https://data-cdphe.opendata.arcgis.com/datasets/depression-in-adults-cdphe-community-level-estimates-census-tract/data

Between 2014 and 2017, approximately one in 10 adults (9.9%) in Colorado experienced frequent mental distress, defined as experiencing more than 14 days within the past 30 days in which mental health was "not good" (Figure 14).[23] Similar prevalence rates exist in Adams and Arapahoe Counties. Douglas County has slightly lower rates compared to Colorado and the lowest within the region at 8.7 percent of the adult population.

Figure 14



Source: BRFSS, 2018

Older Adults

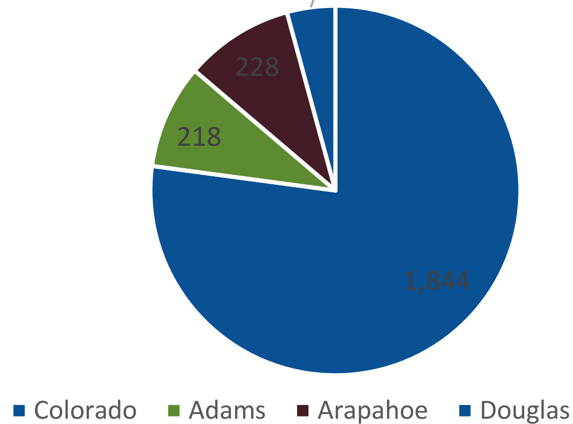
Generally, good mental health is higher among older adults (65 years or older) compared to younger populations. Statewide, just under seven percent (6.9%) of older adults reported poor mental health in 2018. This is compared to 18.5 percent of adults 18 to 24 years old, the adult age group that reported the highest prevalence of poor mental health. Similarly, older adults are less likely to report having been told by someone they have a depressive disorder (11.3% compared to 19.4% of adults 18 to 24 years).[24]

[23] BRFSS, 2014-2017 estimates. Retrieved from https://data-cdphe.opendata.arcgis.com/datasets/mental-health-in-adults-cdphe-community-level-estimates-census-tracts
[24] CDPHE Colorado Data by Demographics. BRFSS, 2018. Retrieved from https://www.colorado.gov/pacific/cdphe/vision-data-tool

Suicide Prevalence

Colorado consistently ranks in the top ten states for suicide rates.[25] Between 2017-2018, there were 2,391 suicide deaths in Colorado; 69.6 percent of those deaths occurred among those between the ages of 25 and 64; 62.7 percent of the suicide deaths occurred among men and 92.5 percent of the suicide deaths occurred among White individuals. Veterans represented 16.4 percent of suicides in Colorado during this time. The Tri-County Region experienced 547, or 23 percent of these suicides (Figure 15), similar to Tri-County's proportion of Colorado's population.

Figure 15



Between 2004 and 2018/19, the prevalence of suicide deaths in Colorado increased by 25.9 percent.[26] Similarly, the Tri-County Region has seen an increase in suicides since 2003. Between 2014–2017, the annual average prevalence of past-year serious thoughts of suicide in Colorado was 5.4 percent, higher than the national average at 4.1 percent (Figure 16).[27]

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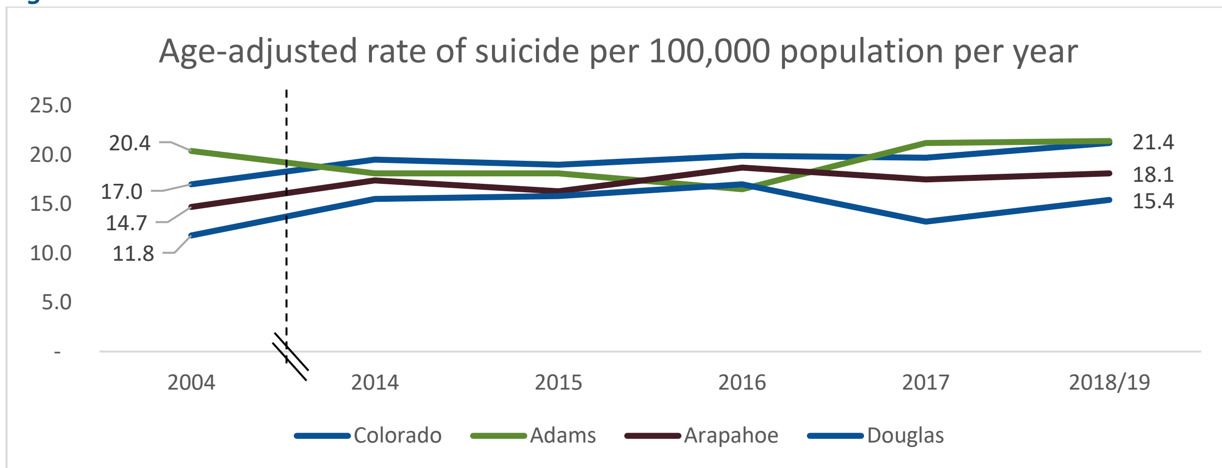
[25] Centers for Disease Control and Prevention. (April 29, 2020). Suicide Mortality by State. Retrieved May 22, 2020 from https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

[26] Colorado Department of Public Health and Environment. (n.d.). Colorado Suicide Data Dashboard. Accessed May 15, 2020 from https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/CoVDRS_12_1_17/Story1?:embed=y&:showAppBanner=false&:showShareOptions=true&:display_count=no&:showVizHome=no#4

[27] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Colorado, Volume 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA-19-Baro-17-CO. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019

Figure 16



Note: Axis is different zero to 25 to better view the trend data. Source: Colorado Violent Death Reporting System, 2004 to 2018/19

According to the Colorado Violent Death Reporting System, in 2017 there were 1,145 suicide deaths, of which 1,099 (96.0%) have known circumstances and toxicology statewide. Of those, 32.7 percent had recently disclosed their suicidal intent. Recent disclosure of suicidal intent varied greatly across the three counties, with Adams County at 31.5 percent, Arapahoe County at 21.6 percent, and Douglas County at 42.6 percent.

Of the 1,099 individuals who died by suicide with known circumstances and toxicology in Colorado in 2017, 37.3 percent had alcohol present in their system at the time of death. A higher proportion of those deaths in Adams County had alcohol present (45.7%) with Arapahoe County lower at 16.0%. Douglas County was like Colorado at 39.1 percent. Statewide, 22.6 percent had marijuana present; Arapahoe County had a much higher proportion (34.0%), with both Adams (19.0%) and Douglas (17.4%) having slightly lower proportions.

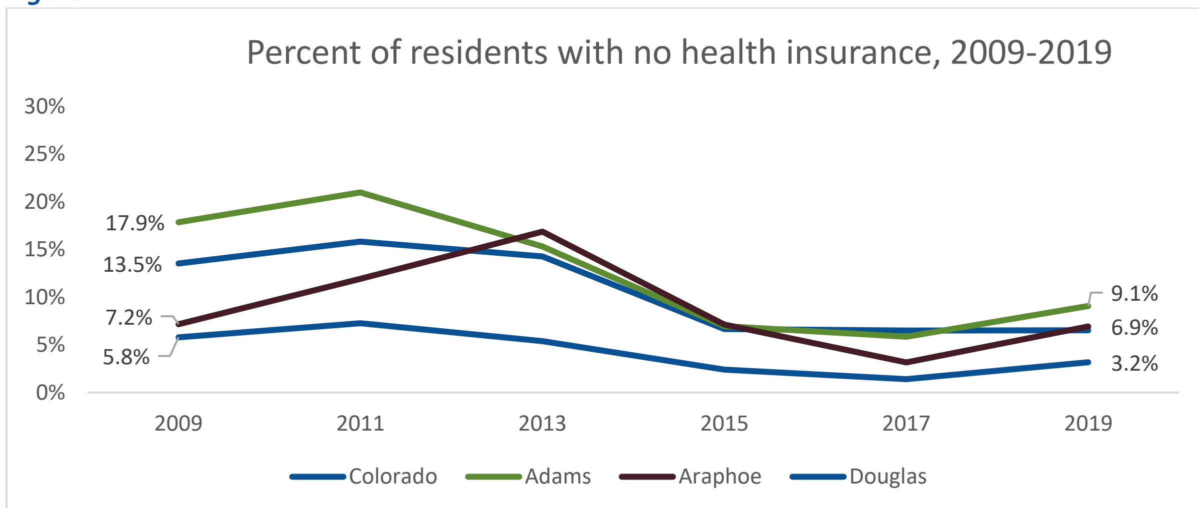
Additionally, 56.2 percent of 2017 suicide deaths in Colorado occurred among individuals with a current diagnosed mental health problem (like Adams County at 55.6% but higher in Arapahoe County at 60.4% and Douglas County at 68.1%). Of these suicide deaths, 56.1 percent had ever been treated for a mental health problem (similar to Adams County at 56.5% and Arapahoe County at 57.7%, but higher in Douglas County at 68.1%) and 34.7 percent were in current mental health treatment (similar to Adams County at 36.1%, while lower in Arapahoe County at 27.9% and much higher in Douglas County at 51.1%). Lastly, of these deaths, 43.5 percent experienced a crisis two weeks prior to their death (slightly higher in Adams County at 47.2%, much higher in Douglas County at 52.3%, and lower in Arapahoe County at 24.3%).[28]

[28] Colorado Department of Public Health and Environment. (n.d.). Colorado Suicide Data Dashboard. Accessed May 15, 2020 from

Access to Mental Health Care

Having health insurance is the main way people pay for health services, including mental health. The percentage of people without insurance in the Tri-County Region started declining after the implementation of the Affordable Care Act (ACA) in 2012. However, since people without insurance tend to be sicker and die earlier than those who are insured, lack of insurance access remains an important health issue for three to nine percent of residents in the Tri-County Region. The greatest disparity in access to health insurance exists in Adams County at 9.1 percent (Figure 17). Additionally, across all three counties, there has been an increase in residents with no health insurance between 2017 and 2019.

Figure 17



Note: Axis is different zero to 30 percent to better view the trend data. Source Colorado Health Institute, Colorado Health Access Survey, 2019

Generally, in Colorado and the Tri-County Region, the percent of residents accessing private insurance decreased between 2009 and 2019, while those benefiting from public insurance increased (Figure 18). Adams County, with the highest rates of uninsured, also has the highest rates of public insurance compared to the state or Arapahoe and Douglas Counties. Arapahoe and Douglas Counties had more people using private insurance compared to the state (and Adams County).

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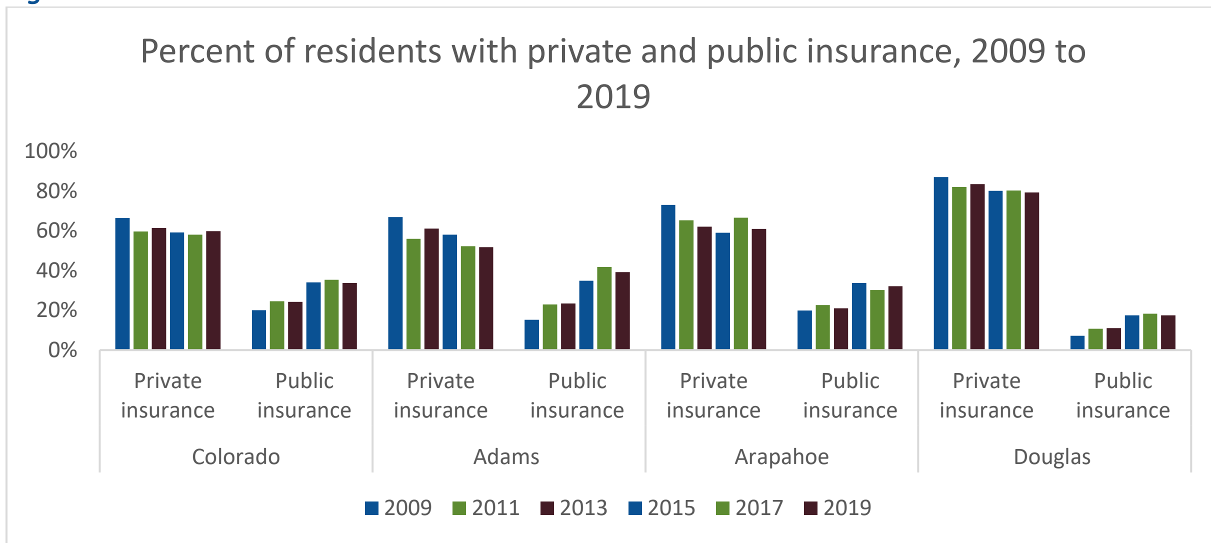
https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/CoVDRS_12_1_17/Story1?:embed=y&:showAppBanner=false&:showShareOptions=true&:display_count=no&:showVizHome=no#4

Figure 18



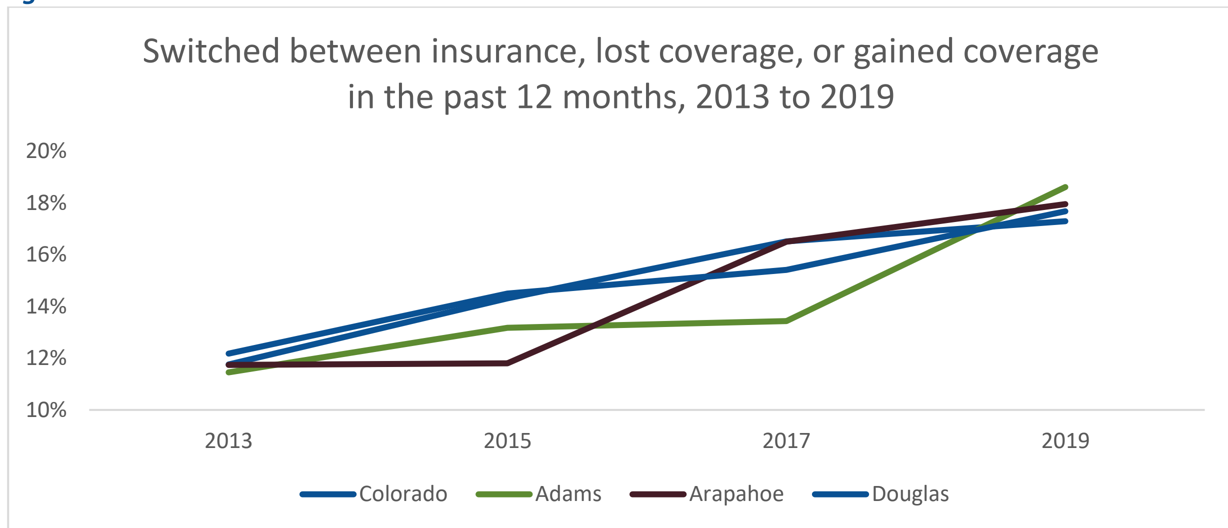
Note: Axis is zero to 30 percent to better view the trend data. Source: Colorado Health Institute, Colorado Health Access Survey, 2019

The percent of residents in both the state and the Tri-County Region who switch between insurance, lost coverage, or gained coverage in the past 12 months ("churn") increased since 2013 (Figure 19). While in some cases this may be a positive (i.e. in the event of becoming insured), many times this can be either due to a negative event and/or bring about confusion about plan benefits.

Traditionally, churn was high among lower-income families and those with irregular work. However, the ACA established a market-based system encouraging individuals to "shop around" each year to find insurance that better suited medical needs and income. While the ACA and the market-based system dramatically reduced uninsured rates, the task of finding new insurance annually may undermine the continuity of care for people with ongoing medical needs or chronic conditions.[29]

[29] Hancock, J. (2017, December) Churning, Confusion And Disruption — The Dark Side Of Marketplace Coverage. Kaiser Health News. Retrieved from https://khn.org/news/churning-confusion-and-disruption-the-dark-side-of-marketplace-coverage/

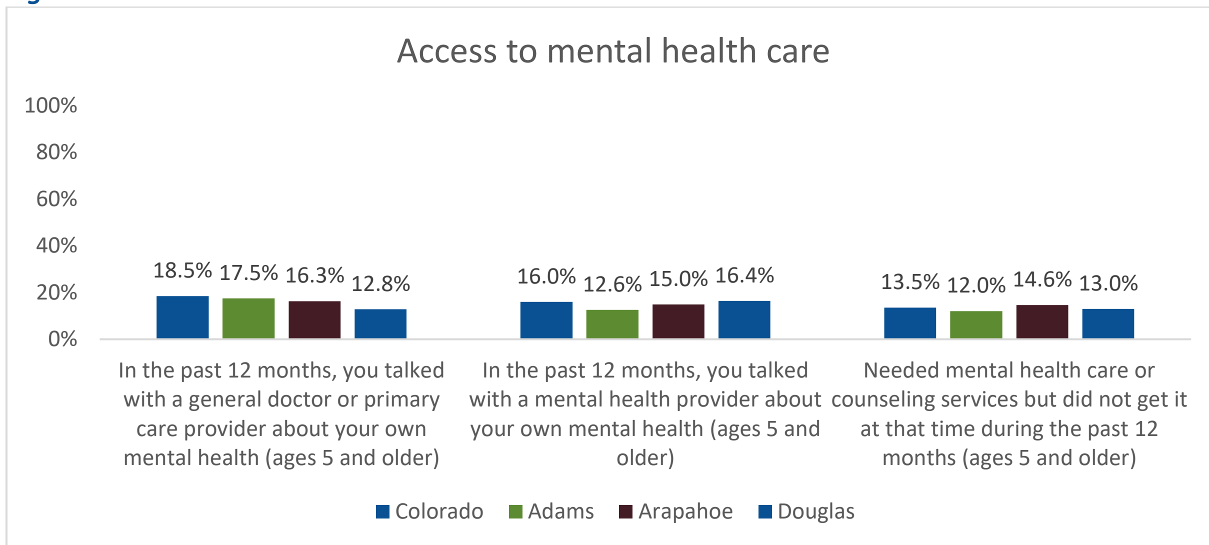
Figure 19



Note: Axis is zero to 20 percent to better view the trend data. Source: Colorado Health Institute, Colorado Health Access Survey, 2019

In 2019, 13.5 percent of Coloradans said they did not get needed mental health care in the past year, representing a significant jump from 7.6 percent in 2017. More often, Coloradans are talking about mental health concerns with a primary care doctor (18.5%) compared to a mental health provider (16.0%) (Figure 20). In Adams and Arapahoe Counties, there is a similar pattern. However, among residents in Douglas County, they are more likely to speak about their mental health concerns with a mental health provider (16.4%) compared to 12.8 percent who speak with a primary care doctor. Adams County residents are the least likely to talk with a mental health provider about their mental health (12.6%) compared to Colorado as a whole, Arapahoe, and Douglas Counties, and are least likely to have needed mental health care but did not get it at that time of need.

Figure 20



Source: Colorado Health Institute, Colorado Health Access Survey, 2019

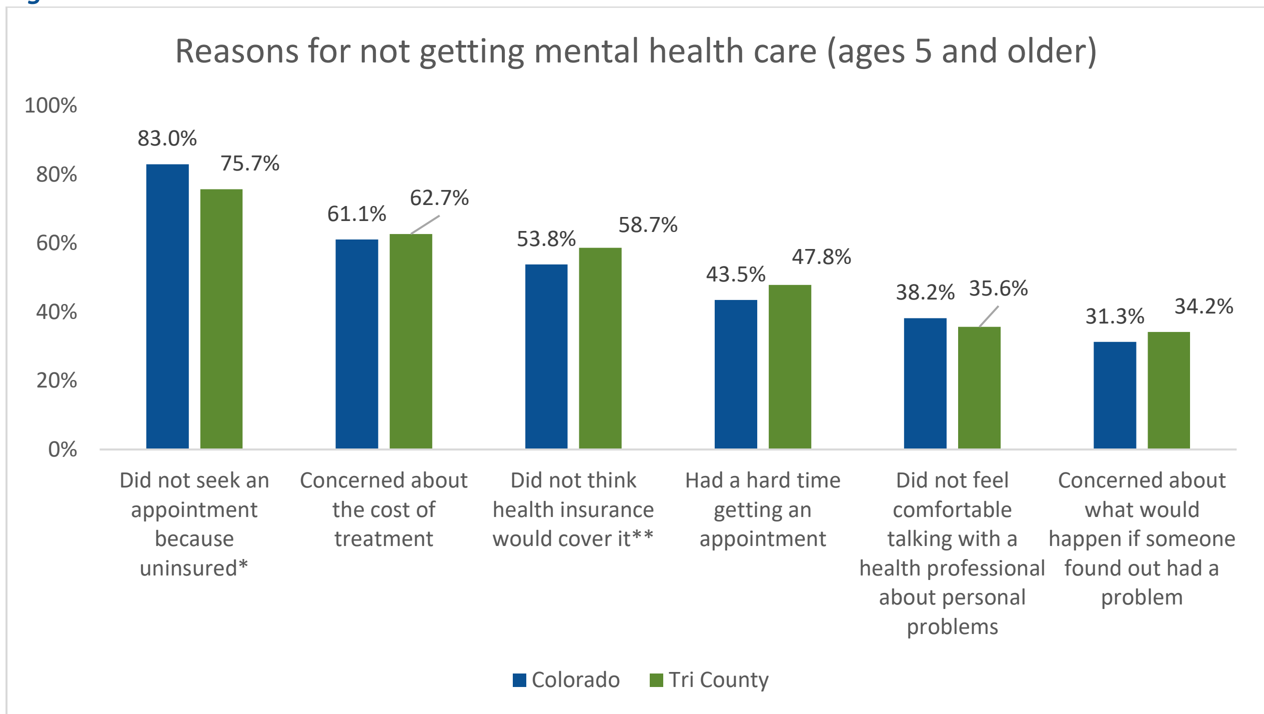
Being uninsured was the most common reason for not getting the mental health when it was needed in both Colorado and Tri-County Region. However, regardless of insurance status, the most common reason was concern about the costs of treatment. In Colorado, 61.1 percent said concerns about the cost were why they did not seek mental health care followed by 43.5 percent who said it was because they had difficulty getting an appointment. These two barriers are slightly more prevalent in the Tri-County Region, with 62.7 percent of residents concerned about cost of treatment and 47.8 percent having experienced difficulty getting an appointment.

The third most common barrier in both Colorado and the Tri-County Region is the lack of comfort talking with a health professional about personal problems, a measure of stigma. This barrier is slightly smaller in the Tri-County Region at 35.6 percent compared to 38.2 percent statewide (regardless of insurance status). Another stigma related measure is the concern what would happen if someone found out they had a mental health problem. This barrier is slightly higher in the Tri-County Region at 34.2 percent compared to statewide.

Among those with insurance, there is a slightly higher prevalence of residents in the Tri-County Region concerned about whether insurance would cover treatment, 58.7 percent in the Tri-County Region compared to 53.8 percent statewide (Figure 21). Among those without health insurance, three quarters did not seek a mental health appointment because of lack of insurance (lower than statewide at 83%).[30]

[30] Colorado Health Institute. (February 2020). 2019 Colorado Health Access Survey: Behavioral Health. Retrieved from https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-behavioral-health

Figure 21



**** Asked of those uninsured in past year** Asked of currently insured. Source: Colorado Health Institute, Colorado Health Access Survey, 2019***

Mental Health and Suicide Prevention Assets and Gaps

Preliminary findings from the OBH statewide needs assessment, as well as from interviews with community leaders in the Tri-County Region identify many successful elements of the mental health system. It is important to highlight and to celebrate these successful elements as they provide a foundation upon which to build and understand the public health role in leveraging these successes. It is also important to recognize the hard work happening across all levels of the system to provide robust and high-quality services while taking care of thousands of individuals and families each year. The following section outlines the most consistent themes that arose from interviews with Adams and Arapahoe County leaders. Findings from the Douglas County assessment are included in a separate section below.

What Is Working Well Across the Mental Health Continuum

Growing awareness of mental health as a community-wide issue

There is broad recognition across key informants that the role of mental health in overall health is heightened. There is agreement that this awareness is responsible for a reduction in stigma and greater awareness and discussion about mental health needs across the Tri-County Region and across sectors.

> *"Everyone is always willing to come to the table and keep talking. There is an assumption that mental health is not an add on." - Community Leader*

This is evident in the number of organizations talking about this topic, a "willingness to come to the table," and discuss the challenges and potential solutions. Collaborations exist that target both mental health issues across the life span as well as among certain priority populations. There is a sense from both Adams and Arapahoe County key informants that there is a lot of information and resources developed and made available on mental health topics (i.e. postpartum women, youth).

Numerous key informants (particularly related to priority populations) discussed the importance of increased community services and a movement away from brick and mortar treatment offerings. There are many examples of strong community partnerships and expansion of services in non-traditional settings. The expansion of services throughout the community into schools and jails were primary examples.

Examples of Community Wide Collaborations

Adams County

- ELEVATE in Adams12
- Adams County Colorado Criminal Justice Coordinating Council

Arapahoe County

- Cherry Creek Schools and Arapahoe County Human Services
- Aurora Health Alliance

Traditionally, schools serve as the primary setting for addressing young people's mental health needs. This is no different in Adams and Arapahoe Counties. Key informants reported momentum towards school-based mental health, with an increase in crisis response and mental health teams in schools. However, existing and new collaborations are working to understand how best to address poor mental health with a cross-sector, community-wide lens, inclusive of schools. One such collaboration in Adams County is funded by a recent county mill levy, 2018 ballot issue 5C, which provided education funding to support six focus areas of the ELEVATE plan, including social-emotional wellbeing and school safety. Other collaborations are funded in part by school-based grants supporting integration of mental health and other resources into the school setting.

For individuals with criminal justice involvement, there are many positives in Arapahoe and Adams Counties highlighted through discussions with courts and Criminal Justice Coordinating Councils (CJCC). Key informants noted greater coordination and collaboration among sectors and a concerted

commitment to divert individuals with behavioral health from jails. The addition of funding for co-responder programs (pairing law enforcement and mental health clinicians) has led to significant impact for access to services, cross-sector partnership, and quality—especially for high risk populations. Many key informants mentioned the importance of this work and the ways in which it is addressing behavioral health need and enhancing safety. Many stakeholders also believe that the program has increased law enforcement understanding of behavioral health and willingness to partner on community challenges. Generally, leadership in the criminal justice and law enforcement sector prioritize mental health and safety of individuals in custody or involved in the system.

Stigma is decreasing

Many key informants across both Adams and Arapahoe Counties indicated a sense that there is some degree of de-stigmatization of mental health issues. In part, this is evident in the more common conversations and resources available using words such as “mental health days” and “self-care”. This is seen as a “positive push to normalize mental health issues”. For example, in Arapahoe County, there is information marketed in schools about what it means to have a mental health issue and how to get help.

> *“Pushing out of resources is clear and happening all over TCHD jurisdiction.” - Community Leader*

Trauma-informed approaches

Adult and child protective services are more intentionally focusing on what is driving poor mental health in families they serve and understanding trauma-related mental health issues. In Adams County, mental health providers, deans, and administrators have all had formal training in trauma-informed care and are currently working on building professional development for trauma informed practices.

For those who access mental health services, they work

Many key informants described access to high quality services and satisfaction with care on the behalf of those they serve, stating that among those who access mental health services, the experience is generally positive. The community mental health centers were mentioned frequently as delivering high-quality treatment and providing essential services for communities. Additionally, it was clear from several interviews that providers work to find ways to partner with others to meet community mental health needs.

> *“I think there is access in Adams county – whether it is routine or emergency or integrated care settings. So as a community there is value for mental health needs and organizations are doing what they can within their domain to support that.”*
> *- Community Leader*

Key informants indicated that this access to mental health services is in many cases dependent upon an individual’s insurance coverage, acknowledging that those on Medicaid or individuals who are uninsured perhaps have an easier time identifying and accessing mental health services. In general, a greater awareness among the community about what services are available for those on Medicaid or uninsured minimizes

access barriers. The greater awareness is in part due to the attention and focus on developing the safety net of services among low income and/or uninsured individuals.

Related to satisfaction of services among those who access those services is the increased understanding of the importance of delivering person-centered care. In Adams and Arapahoe Counties, increased grant opportunities have led to a focus on trauma-informed service delivery, increased ability to work on substance use concerns with new populations, such as young people 10 to 12 years old, and increased funding for care navigation that supports the whole person.

Services that exist and are thought to be working well for those accessing them:

- Colorado Crisis Services
- Safe to Tell
- Statewide and county public mental health campaigns
- Arapahoe County child welfare staff are hired with great knowledge of mental health, conducting their work with a clinical lens
- Social emotional learning, social groups and life skills resources for people with dual diagnosis or co-occurring developmental disabilities.
- Increases in marketing, services, and accessibility in response to increases in violence in Arapahoe County
- Community mental health centers building capacity to serve both mental health and co-occurring substance use issues as Medicaid policy shifted to allow them to offer substance use disorder services

Growing focus on prevention and upstream approaches

Behavioral health has mostly been thought of as an individual issue with a focus on service delivery but increasingly conversations are taking place about behavioral health in the context of the population and prevention. This has led to more diverse, cross-sector stakeholder engagement and vision alignment with other public health issues.

What Is Working Well in Suicide Prevention

Community-wide action and support

Many key informants believe that effective suicide prevention requires a community response. Efforts are being made to ensure this community-wide action, including the following:

- Adams County stakeholders see the value in addressing issues outside of silos, for example criminal justice and social justice are parallel needs. They think about solving problems with a

larger social justice perspective which supports seeing suicide prevention as larger than just the problem of specific sectors (i.e., a school problem or a jail problem, etc.).

- Adams County public officials are modeling talking about suicide openly, asking the community to address it and prioritizing suicide as an issue on which to focus.
- Aurora Mental Health Center is approaching suicide prevention as the responsibility of more than just mental health centers and are equipping community members with Mental Health First Aid training.
- Hospital follow-up program is following up when someone is discharged post suicide attempt.
- Many health systems are implementing Zero Suicide.
- There is a shift in the thinking of law enforcement about how they handle suicide and in triaging individuals entering detention facilities.
- Multifaceted efforts across the community such as gatekeeper training, education campaigns, assessment and screening, referrals to support resources, care coordination and resource navigation.

Accessibility

With Colorado's crisis system improvements, there is greater access to the state crisis line, walk-in centers and mobile crisis services. The system is designed to be focused on the person accessing services and what they define as a crisis. No one is turned away and oftentimes providers can offer the right tools to manage the crisis and the person's life is saved.

Involvement of target populations

Campaigns targeting particular populations have been created with research that includes the voice of the target group. The Let's Talk Colorado campaign, Man Therapy, and the pregnancy related depression campaign are examples of this. This will lead to stronger likelihood that messages are reaching the intended audience. There has also been greater focus on involving young people in youth suicide prevention efforts. Youth suicide prevention is likely to be more impactful when it is led by young people, and young people are equipped to support peers.

What Is Not Working Well Across the Mental Health Continuum

Despite the many positives listed above, interviewees agreed that there are real and considerable unmet needs in Adams and Arapahoe—especially for some of the most vulnerable individuals.

Access: Limited awareness of what resources exist

From both the organizational level and the individual level, there is limited awareness of what mental health services and resources exist. It is generally reported to be hard to navigate, and when identifying resources, there is often the challenge of resources having limited capacity and consumers having limited choice. Outreach methods may be at the root of this issue as it is largely electronic and/or via social media and is not designed to reach the unique information needs of the diverse populations in the Tri-County Region. There is a community assumption that information and resources are much easier to access online. However, in light of COVID-19 and the need for schools and providers to reach families virtually, challenges with online access are being uncovered. For example, some schools in Arapahoe County report that students are not able to engage in school because they lack the technology to do so.

"In Arapahoe – there are organizations that are built to take in people. Not sure if people know about them all though. Schools have mental health service options. Faith based organizations have mental health service options. However, I don't think we have enough community awareness of the options and opportunities."
-Community Leader

"In Douglas County, they have worked as partners and mapped [mental health services] out. What does the system look like in Adams County?" – Community Leader

Another challenge is the lack of a consistent or comprehensive process for assessing and identifying mental health resources in the community, including information about paying for resources-which changes depending on the provider, individual circumstances, or insurance coverage.

Access: Limited options

"We are stuck in single minded treatment. We need innovative ways to tackle these issues. If ACT teams are not working let's do something else."

Key informants indicated that in many cases, outside of the community mental health centers, there is little else offered or accessible. If an individual is even able to access a list of providers or services, additional access barriers exist. For example, providers are not taking new patients or insurance is not accepted. Provider options may be changing in some ways in the counties. There is an increase in interest for the introduction of private providers such as Creative Treatments Options, an outpatient mental health and chemical dependency treatment agency that is currently offering telehealth options and newly has a location in Adams County in Commerce City.

Key informants expressed concern about the preventive and recovery ends of the continuum-before or after a mental health crisis. Oftentimes families don't know they have choices and don't know how to advocate for themselves as they navigate the behavioral health system. There needs to be a more concerted effort to educate individuals and families about what choices they have and how to advocate for their needs.

Some key informants offered that perhaps it is not that there are not enough options to choose from, but rather the challenge is about individuals' reluctance to engage in services. Interestingly, several key informants pointed out that since COVID-19 and the increased use of teletherapy, there has been a significant decrease in the "no show" rate at community mental health centers. This suggests that perhaps there is a need to increase options for how services are accessed.

Related, key informants shared that engagement in services is hindered by a lengthy intake process and waitlists. The time it can take not only to get an intake appointment but also to go through the intake process can be a barrier to engagement. Additionally, staff turnover may be driving low engagement in that a person who was receiving services feels they need to start over with a new person.

> *"Timeliness of care is an issue. Individuals trying to book an appointment, but they can't get one for weeks and weeks, when they need services now."*
> *– Community Leader*

Access: Understanding eligibility and "fit" with available mental health services

Finding just any provider is challenging enough. However, if an individual has co-occurring diagnoses, complex health needs, or experiences any social barriers such as language or transportation, the challenge increases. Each region has its own community mental health center, and each organization is different in the services offered. Therefore, it is difficult to figure out what center is most suited for specific needs.

> *"There are a lot of good resources but what is hard is to know what one and what is the best fit. It is hard to make that match." - Community Leader*

In some cases, services require a diagnosis, with one key informant reporting "if it isn't diagnosable then you are not eligible." Mental health diagnosis, required by payors to cover services, may become something that is viewed as a limitation or challenge that negatively affects opportunities throughout life.

Additionally, the traditional mental health setting is not always the right setting or fit for individuals or families. There is a need for greater variation in how services are delivered and the nature of those services. For some individuals, alternative therapies such as art therapy or yoga may be an important approach. For many populations, a brick and mortar setting with one-hour sessions offered during

normal working hours is not a fit for their needs. Lastly, finding providers with cultural congruence and/or capacity to offer culturally competent mental health services is challenging. There are simply not enough providers for those of diverse races, ethnicities, and cultures.

Access: cost and funding

The cost of mental health services is often prohibitive particularly among those with private insurance, with high deductible plans or poor benefit coverage. The system itself drives these cost-related challenges. The system also drives a high turnover rate in community mental health centers which compounds mistrust and problems with patient engagement.

> *"To afford mental health services, you either have good insurance or you have Medicaid. Even places that offer reduced rate services for those who are self-pay or are underinsured, costs are still too much." - Community Leader*

While funding for mental health services, and specifically funding for special priority populations, is increasing, there is a perception that it is still not enough. Funding can often dictate where and how a service can be delivered. For example, those providing family services often find a service delivered in the home would benefit the family; however, reimbursement for those services requires it to take place in a traditional mental health setting. Another example provided by key informants was group therapy in school settings. Often, the number of students available to engage in this service does not "pay off' for the provider so group therapy is not offered, despite group therapy being the modality best suited to engaging students.

Oftentimes because of payor requirements for coverage there is fail-first model so people do not get the treatment best suited to their need. Their insurance requires them to try more traditional treatments first before covering something that may be more innovative and/or a better fit. People become exhausted spending years in ineffective mental health services when professionals know of treatment modalities that will work but that insurance will not cover. This is rooted in the misguided cultural norm that if you just work hard enough things will get better.

Lack of a comprehensive, cross sector collaborative group

Within and across Adams and Arapahoe Counties, key informants reported the lack of a comprehensive, multi-sector collaborative group, such as the one found in Douglas County (Douglas County Mental Health Initiative). While there are a lot of collaborations in each county, these efforts are then not coordinated or integrated. Evidence of this gap includes the following:

> *"There are so many agencies doing so many separate things and I wish there could be more integration between systems."*
> *– Community Leader*

- Several years ago, Arapahoe County Department of Human Services used to operate a multi-stakeholder group which facilitated networks across sectors, but this group no longer convenes.

- In both Adams and Arapahoe Counties, there is reported lack of shared communication and information between systems (i.e. schools, hospitals, treatment providers, etc.) about an individual, for example a student or an individual who is criminal justice involved.
- Reports that school responses to crisis are not always coordinated with other agencies in the community, such as law enforcement or health care.

Transitions of care

As people transition between various care settings or from the criminal justice setting to a community-based setting, there are gaps in services. Medication consistency is a barrier with providers not being on the same page regarding formularies. Not exchanging information across settings is still considered a weakness of the system, as is discharge planning when options for follow-up care are limited or are unknown. Finally, critical community supports to facilitate engagement in follow up care or services are lacking - especially transportation.

Key informants also talked about challenges with turf issues which makes the creation of a "no wrong door" system of care difficult. Politics get in the way around who does what and how the money flows, which undermines the system's mission of ensuring comprehensive access to services and awareness by the public of those services.

Ongoing stigma

While it is acknowledged that stigma is decreasing in Adams and Arapahoe Counties, many key informants also indicated that it continues to be a barrier and are working to reduce stigma. Key informants acknowledged the need to continue to push the message on mental health access and needs and communicate that message in such a way that makes it like "asking for physical therapy if your kid can't walk".

Key informants stressed the importance of talking about mental health as they continue to hear young people and adults saying, "mental health treatment is for 'those' people." There continues to be a need to communicate that mental health issues can and do impact everyone. One challenge is to ensure that this message comes from different sources, particularly those sources that are not connected to providing the mental health services.

What Is Not Working Well with Suicide Prevention

Measuring success

Many key informants indicated that it is hard to tell whether anything is working well with suicide prevention efforts. From a data perspective – the data may suggest things are not working because suicides continue to increase in certain populations. The challenge is understanding how many suicides are prevented by existing efforts. As these data are hard to collect, the community needs to think about other ways to define and measure success of suicide prevention efforts.

Along these lines, one key informant discussed the focus on death prevention in suicide prevention efforts, rather than focusing on addressing and preventing the underlying issues contributing to suicidality.

Postvention

Many key informants discussed the need for post-crisis support and resources. In the aftermath of a suicide, family members and loved ones are at increased risk for suicide themselves and the stigma associated with suicide can leave them feeling very isolated. Schools are often not equipped to manage postvention and struggle with public questioning and the need to protect the privacy of those most impacted. Postvention is complicated and is an area that people stumble over.

Cost of suicide prevention programs

Most suicide prevention is happening through the schools. Whether it is Safe to Tell or Sources of Strength, or others, these programs require training of staff and an investment of not only time but also funds. These programs are expensive and often funded through time-limited grants leading to a lack of sustainability or systemic change.

Other gaps in suicide prevention

- Key informants reported that many times suicide prevention efforts are in reaction to a crisis event rather than communities being proactive, building protective factors to prevent or mitigate the risks associated with suicidality.
- Suicide prevention efforts targeted to groups with emerging risks are lacking (i.e., women of color, mothers with ante and postpartum depression).
- Many key informants expressed concern about the lack of efforts focused on means restriction and removing access.
- Training needs to be ongoing and include refresher courses to keep the skills current.
- What is often missing are the stories of recovery. There is a lot of information and resources promoting mental health awareness and how to get help, but there is a gap in information on recovery.
- Efforts need to include a greater focus on building resilience and coping skills-especially among young people.

Specific Populations or Sub-Populations for Whom Mental Health and Suicide Prevention Efforts Do Not Exist or Are Not Working

Several population or sub-population groups were identified across the key informant interviews for whom mental health and suicide prevention efforts don't exist or aren't working:

- Individuals with Social Determinants of Health (SDOH) Needs
- Older Adults

- Racial and Ethnic Minorities
- Criminal Justice Population
- Veterans
- Individuals and Families Experiencing Homelessness
- Children and Youth
- Individuals with Intellectual and Developmental Disabilities
- Middle Class Individuals
- Individuals with Serious Mental Illness
- Fathers
- Individuals who are Undocumented
- LGBTQ Individuals

Equity in Mental Health and Suicide Prevention

Several themes regarding what equity means in the context of mental health and suicide prevention emerged from conversations with key informants including the following:

- The greater the social need the greater the inequity
- Parity in insurance coverage of behavioral health services is not being enforced
- Recognizing where and among whom inequities exist and why
- Equity in access to the right services - need to move beyond traditional therapeutic interventions
- Equity of information – not everybody has information at their fingertips
- Access to mental health services in schools and variation in that access
- Removal of all barriers to any kind of treatment
- People with lived experience being given actual power in decision making and listening to people who did not have success in the current behavioral health system
- Everyone deserves access to the same level of care with a high level of quality

Findings from Douglas County Mental Health Needs Assessment

The DCMHI is a partnership of over 40 organizations committed to addressing unmet mental health needs, connecting people to mental health services, and preventing those in need from falling through the cracks of the mental health system. In the summer of 2018, Douglas County hired HMACS to support development of a community-based mental health system. As part of developing the mental health system, HMACS conducted an environmental scan of the mental health continuum of services from prevention to treatment in the County. The scan included the collection and review of data, a survey of DCMHI members, and key informant interviews and focus groups with community providers and stakeholders.

There are many strengths to the behavioral health system in Douglas County, including the DCMHI. Douglas County has a strong Community Response Team program that has shown gains in diverting people experiencing a mental health crisis from criminal justice and emergency departments. Stakeholders valued the commitment of County employees and non-traditional partners, as well as the collaboration across sectors to address gaps in the mental health continuum. There was also an overarching agreement among stakeholders to reduce stigma, discrimination, and isolation of those with serious mental illness—wanting to have a community that is more accepting of individuals across the continuum of behavioral health need.

Other areas that were noted as strengths included recent efforts by multiple providers to improve access to outpatient behavioral health services through expansion of services, opening of new offices, and work to expand access for individuals with commercial insurance coverage. Additional specific programs that were identified as strengths in the community include the following:

- Let's Talk Colorado
- Youth suicide prevention efforts
- School programming aimed at raising awareness and normalizing talking about emotions and mental health
- Expansion of Assertive Community Treatment (ACT) teams for individuals with serious mental illness and often criminal justice involvement
- Care management within judicial courts in some areas of the County

There are also gaps in the behavioral health system in Douglas County, including the need for greater prevention efforts in the County. Stakeholders also pointed out the need for more community-based and in-home services for the general population. As with Adams and Arapahoe Counties, the same populations in Douglas County are not getting their mental health needs met. There are concerns with wait times between evaluation and appointments, and stigma about mental health and suicide remains a challenge.

Preliminary Findings from OBH Statewide Needs Assessment

The statewide needs assessment for OBH will be completed by HMACS in summer 2020. Preliminary findings from the study begin with the recognition that Colorado has benefited from many diverse analyses of the behavioral health system. Across these reports and over time, there are consistent findings about behavioral health needs and gaps in existing services. Second to these longer-term trends are emerging or topical needs that may be indicative of larger gaps but where analysis has been less robust. Although there is a lot of existing data on behavioral health need and populations facing health disparities related to behavioral health, there is more that needs to be understood to provide the State with clear priorities for strategic planning.

The preliminary findings regarding what is working well with the behavioral health system across Colorado include the following:

- Expansion of behavioral health benefits under the Federal Affordable Care Act (ACA) for individuals previously uninsured or under-insured.
- Increased attention to behavioral health, as evident by increased funding for behavioral health services (including prevention) at the Federal, State, and county level.
- Broad recognition of the collaboration across sectors to improve behavioral health in the State.
- Strong sense that all stakeholders have a genuine interest in improving the system of care—increasing capacity and quality and finding ways to minimize costs to meet behavioral health needs.
- Better cross sector relationships specifically between providers working with individuals with Intellectual and Developmental Disabilities (IDD) and the Community Mental Health Centers (CMHCs).
- Greater local and community engagement and understanding of behavioral health and how to support local innovation. New payers and system builders such as cities and counties with new local solutions for improving access, collaboration, and coordination of services, such as the Douglas County Mental Health Initiative.
- Greater expansion of services and improvement in specific components of care. To some extent, the expansion of services is a result of county-led and funded initiatives developed to address gaps in the behavioral health continuum of services identified in other assessments of the behavioral health system and response.
- Across the State and across the different types of behavioral health needs HMACS examined, many stakeholders described satisfaction with their access to high quality services and care.

Findings regarding what is not working well with the behavioral health system include the following:

- Fragmentation and lack of clear authority for the system as central to the down-stream challenges in meeting Coloradans' behavioral health needs.
- A need to continue to expand integration of behavioral health and primary care across the State. Although progress has been made, there remain consistent barriers to integration. The need for enhanced access to care for mild to moderate behavioral health needs is high, particularly for children and youth. Expansion of psychiatric medications through primary care is also central to reducing the health disparity and challenges families are facing in access to child psychiatry.

- A consequence of a lack of shared vision for behavioral health in the State is separate and uncoordinated prevention efforts. Federal and State funding for substance use prevention come from varying sources and often are not well coordinated or streamlined. This can result in duplication of services, challenges with awareness and communication between efforts, and other difficulties in implementation that reduce the overall effectiveness of all efforts. There is a specific concern that it also creates regional disparity with some areas being funded by multiple sources while other regions have little to no funding. The counties that have disparate funding tend to also be rural counties where there are already concerns about regional disparities. For example, the Colorado Health Institute found that eleven counties in Colorado received four or more sources of funding for substance use prevention while six counties received no additional funding outside of statewide funds (Baca, Custer, Jackson, Kiowa, Prowers, and Rio Blanco).[31]

- The behavioral health workforce has long been a challenge in Colorado and nationally. In a recent analysis mandated by the 21st Century Cures Act, HRSA released national behavioral health workforce estimates for 2016 through 2030. The findings demonstrate that some areas of the country have few to no behavioral health providers available while other areas have providers but face shortages as well. Rural and frontier areas are particularly at risk. Other factors impacting workforce challenges include retention of providers, high turnover rates, a lack of professionals, aging workers, and low compensation. These concerns are no different in Colorado. Regardless of stakeholder type, the behavioral health workforce is a high priority and although there are unique barriers for rural communities, the pressure remains evident in urban areas of the State. Partners and community-based organizations raise specific concern about workforce gaps limiting access to services for individuals (due to capacity and wait times). The impact to individual engagement in services when there is high turnover and lack of provider choice is also a concern.

- Nationally, there is growing recognition of the role that administrative burden plays in the burnout of healthcare professionals. Many national associations such as the American Medical Association have drafted positions papers on the impact of paperwork and documentation requirements leading to burnout, provider dissatisfaction, and ultimately workforce turnover. Community partners interviewed for the assessment complained about administrative rules limiting their ability to partner with behavioral health providers or to create innovation or local solutions. At the same time individuals with lived experience, family members, community partners, and state agencies agree that the current regulatory requirements do not adequately hold providers accountable for the quality and expansion of services to meet the needs of the population.

- Colorado has many pockets of a strong and robust continuum of both mental health and substance use services as well as pockets of innovation in expanding the continuum of care. However, one of the consistent findings in the assessment is the lack of standardization of

[31]Caldwell, Alex et al. *Making the wise investment—Statewide Needs Assessment Primary Prevention for Substance Abuse.* Denver: Colorado Health Institute, 2018. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/Making%20the%20Wise%20Investment.pdf

services across the State as well as growing disparities in accessing key services across many communities. Specifically, there is a need for:
  - more community-based and co-located services rather than only providing services in a brick and mortar mental health center
  - transitional services between acute care and outpatient treatment
  - acute care access in rural communities
  - funding and support for recovery and sober housing
  - increased and standardized access to a more complete substance use treatment continuum

Preliminary findings regarding the needs of priority populations within Colorado include the following:

- Provider training in priority population-specific needs and culture are inadequate. Many of the priority populations have challenges accessing appropriate care because providers lack expertise in treatment of conditions they experience. Similarly, provider representation and diversity of workforce is low. One of the underlying causes of a workforce without cultural competence is that most providers do not represent the priority population backgrounds. Many of the priority populations described an urgent need for providers who represent their communities and who have a natural understanding of culture and community concerns. Many provider organizations and even State agencies acknowledge this challenge while also indicating it is difficult to recruit individuals with these backgrounds. Although this is a legitimate challenge, there is evidence across the State of community-based organizations who are demonstrating a commitment to programs that look and feel more accepting to priority populations and who, even without direct representation of the population, are able to offer services that are culturally responsive, engaging, and sophisticated in approach.

- Multiple identities or intersectionality of priority status create more barriers to services. For individuals in multiple priority population groups, the disparities in care grow and are experienced more acutely. For example, individuals who experience homelessness or housing instability who also have a history of criminal justice involvement, LBGTQ young people who are tribal members, and individuals with serious mental illness and developmental disability who have forensic or criminal justice backgrounds. Any single priority status creates barriers to treatment and to finding services tailored to support their needs. When these status types are combined, it becomes increasingly difficult to obtain access with added stigma, eligibility hurdles, and fewer adequately trained providers.

Evidence-Based and Research-Informed Practices in Mental Health Promotion and Suicide Prevention

Among the multitude of studies that have been done on prevention programs, there have been quite a few summary studies done on common features across effective prevention programming. While the targeted foci of the programs vary (from substance use, violence, high-risk sexual behaviors, to suicide and mental health promotion) the strategies promoted to address the variety of risk behaviors have

many features in common. One study used a review-of-reviews approach to determine nine characteristics that were consistently associated with effective prevention programs:[32]

1. Comprehensive: A program needs to address multiple domains, at multiple levels (i.e. individual, relational, societal, etc.), that help perpetuate risk behaviors.
2. Varied teaching methods: A program should utilize multiple teaching methods that focus on increasing awareness and understanding of risk behaviors or focus on teaching protective skills.
3. Sufficient dosage: A program needs to last long enough to produce the desired results, along with providing a follow-up mechanism as needed.
4. Theory driven: A program should have a theoretical justification that is supported by empirical research.
5. Positive relationships: A program should help to build relationships between peers and with adults, which can help support and perpetuate positive results.
6. Appropriately timed: A program needs to be initiated early enough to influence the development of the problem behavior, while being sensitive to the developmental needs of the individuals.
7. Socio-culturally relevant: A program needs to be tailored to the norms of the community in which the program is being implemented, which could be done via inclusion of target populations.
8. Outcome evaluation: A program should have clear goals and objectives to best evaluate the results.
9. Well-trained staff: A program should have adequate staff to support the program, with appropriate training and skills regarding implementation of the program.

Not all nine characteristics need to be met, as indicated in the study, as some may play a more important role than others (i.e. comprehensiveness, dosage, teaching methods, and timing were found to be more critical), but they offer a guideline of how to think about prevention programs.

A similar study looked more specifically at promoting mental health and reducing risk behaviors in young people. They created a list of key social and emotional learning competencies and program features and identified 17 key competencies which were organized into four categories: (1) awareness of self and others; (2) positive attitudes and values; (3) responsible decision making; and (4) social interaction skills.[33] The competencies listed are ones that the study suggests are key in crafting an effective intervention, such as teaching individuals active listening or helping them create a constructive sense of self.

[32] M. Nation et al., "What Works in Prevention: Principles of Effective Prevention Programs", *American Psychologist,* 58(2003): 449-456

[33] J.W. Payton et al., "Social and Emotional Learning: A Framework for Promoting Mental Health and Reducing Risk Behaviors in Children and Youth", *Journal of School Health,* 70(2000); 179-185

They also highlight key features of quality programs: (1) program design; (2) program coordination; (3) educator preparation and support; and (4) program evaluation. These features are very similar to the ones listed above but include creating solid school-family and school-community partnerships. The program features and competencies are a useful tool through which to view interventions and can help guide interested parties towards choosing an effective program.[34]

In general, most behavioral health promotion and prevention interventions written about in the literature are targeted towards young people, mainly children and adolescents, including suicide prevention programs. It is important to consider innovative strategies that are research-informed for implementation and evaluation in order to contribute to what is known about promoting mental health and preventing suicide.

In the state, there is a large body of programs and initiatives targeted specifically towards very young children. In large part, this is due to the easy access to large populations of children in education settings, in addition to the fact that many behavioral health issues present themselves at an early age and so prevention during childhood years is of great importance. Early childhood programs are often focused on children between birth and 8 years, along with parents, guardians, and other caregivers. Across the state there is growing attention to social and emotional wellness to increase protective factors for mental health later in a child's life. Other initiatives focused on this age group include increasing access to early screenings and interventions; preventing adverse childhood experiences by working with parents and families; training and educating providers, caregivers, and parents/guardians; integrating behavioral health into physical health; and coordinating systems across providers, schools, community organizations, and other invested parties. Program examples in Adams and/or Arapahoe County include Project LAUNCH in Adams County, Healthy Environments and Response to Trauma in Schools (HEARTS) program (in Arapahoe's Cherry Creek Schools) and LAUNCH Together (regional).

Mental health and suicide prevention programs geared towards older children and adolescents are largely implemented in school settings but can also be employed in community centers or faith-based settings, as these locations are where it is easier to target large populations of children. Often there is a bigger focus on tertiary interventions, where the focus is on those who are already displaying behavioral health issues, but there are broader initiatives that are focused on building school community and cohesion and preventing bullying (which shares risk and protective factors with mental health, substance use, and suicide). As was seen in early childhood programs, there is a lot of attention on social and emotional learning, through programs such as Positive Behavioral Interventions and Supports (PBIS), Project Aware, Caring Schools and Thriving Schools. Many programs also emphasize the adequate training of adult, and sometimes youth gatekeepers on how to monitor for behavioral health issues and suicidality among children and adolescents, as well as how to work with those who already have shown signs or symptoms. There are also many programs that work to build infrastructure by connecting schools to behavioral health systems or mental health centers. There are also a few programs and initiatives that focus on building protective factors like resiliency or changing the school climate to feel more supportive of help seeking and differences among students.

[34] Ibid

Looking beyond children and adolescents there are unfortunately fewer behavioral health promotion and prevention programs targeting adults and seniors. For adults, there has been a strong focus on maternal mental health. The Pregnancy-Related Depression and Anxiety Campaign or the Maternal Wellness Campaign are examples of this type of effort in the Tri-County Region. The Let's Talk Colorado campaign, initially led by TCHD and currently a shared effort of the Metro Denver Partnership for Health (MDPH), is an example of a stigma reduction campaign targeting adults in the general population that has been used across several communities statewide.

Other novel initiatives focused on adults are reaching people in their place of work. These programs focus on increasing access to mental health resources, encouraging the implementation of company policies regarding mental health, increasing community awareness, and increasing access to screening and counseling services to prevent the occurrence or impact of behavioral health issues. Examples include AllHealth Network's CEO Pledge and Rotary Mental Health Initiatives, which each focus on increasing community awareness about behavioral health. For older adults, mainly those 65 and older, the options are limited beyond a few community programs that look at increasing access to screenings or interventions and building social connections, such as Senior Reach Program at Community Reach Center.

Evidence-Based Programs in Suicide Prevention

The best sources for information regarding evidence-based programs are registries and literature reviews. The Suicide Prevention Resource Center provides an online searchable list of suicide prevention programs with evidence of effectiveness: https://www.sprc.org/resources-programs.

Implications for the Frameworks

The mental health and suicide prevention frameworks adopted by TCHD need to serve as an umbrella for existing frameworks, strategies and programs that are assets in the communities served by the health department. The frameworks need to also reflect what is known about the gaps that currently exist and how those gaps can be addressed across partners. Findings from the assessment suggest the frameworks should help to inform stakeholders of the physical and social determinants of mental health and translate that understanding into action. Specifically, it should articulate the need and actions for mental health stakeholders to fill the following gaps:

- Create choice for individuals seeking mental health services and resources, and ensure individuals are made aware of the options, their eligibility, and fit via multiple channels, venues, and languages.
- Support continuity of care across the mental health continuum of services and across sectors and systems, particularly among school-aged children, criminal-justice involved persons, and individuals with IDD populations.

- Unite the many collaborations that exist within each community into a cross-sector and cross system effort, unified by a shared backbone organization, mission, values, and language regarding mental health.
- Educate on social determinants of mental health to help stakeholders identify strategies at the community and societal levels of the social ecology that reduce barriers to mental health care.
- Inform public health professionals working on more traditional public health issues like obesity prevention, tobacco cessation, and chronic disease prevention and management, to integrate language and action about mental health into their vernacular about risk and protective factors and prevention strategies.
- Create opportunities to engage those with lived experience in strategic decision-making and implementation.

The frameworks should also help to articulate specifically the role of public health in these community efforts. Key informants were asked to use the 10 essential functions of public health as a starting place, to describe their perspective on what TCHD's role should be in supporting the mental health and suicide prevention efforts in the Tri-County Region. This perspective is a starting point to develop priorities for public health in improving mental health and reducing rates of suicide.

Diagnose and investigate health problems and health hazards in the community

- Collect data and telling the story with data such as the heat maps on opioid use. Working on how to tell the story of behavioral health access and where that need is.
- Convene all the relevant stakeholders and doing a needs assessment about what is needed in each community and the best way to fill gaps.
- Understand the unique needs of these communities and develop a framework for what will work in each unique community the health department serves.

> *"It is not the subtle stuff they need to do-they need to help eradicate stigma by owning mental health as a health issue same as cancer or diabetes. Public health is doing a disservice to not own behavioral health." – Community Leader*

Inform, educate, and empower people about health issues

- Reduce stigma - foundational and universal messaging that physical health and mental health are not separate.
- Help the community members understand their role in this issue and ensure their voices are at the table.
- Help the public to understand the strong relationship between mental disorders and substance use disorders and that the health department prioritizes these issues.

Mobilize community partnerships and action to identify and solve health problems

- Serve as the backbone to collective work.
- Foster community partnerships across sectors.
- Convene partners around collaborative identification of barriers and implementing strategies to address those barriers. This should be more targeted in the access and navigation of those

resources. Once someone has asked for help or identified someone who needs help – the navigation and access for that person needs to be simple.

- Be a neutral convener with a clear understanding of the data, trends, and evidence-based practices.

Develop policies and plans that support individual and community health efforts

- Advocate for what the state needs to do regarding legislation or guidance-especially around access to care.
- Bring forward a policy agenda that has a population focus.

Link people to needed behavioral health services and assure the provision of behavioral health care when otherwise unavailable

- Build and support care coordination across stakeholders and partners.
- Making sure behavioral health services are accessible, consistent, and effective.

Assure competent public and personal behavioral health care workforce

- Expand and tier the behavioral health workforce that includes paraprofessional staff.
- More funding and staffing and direct service work with school districts.
- Identify and/or provide funding and staffing in school districts (i.e. support embedded nursing with a social worker model).
- Raise awareness about training opportunities to build competence and capacity of provider workforce, such as trainings about:
    - how to work with individuals at higher risk (i.e. individual's with IDD, traumatic brain injury, and complex health needs and co-occurring behavioral health conditions and behaviors)
    - criminogenic risk and trauma resulting from incarceration
    - improving competence in treating suicide, especially with youth, youth who identify as LGBTQ, veterans and working aged men
    - treatment for trauma for multiple populations including individuals experiencing homelessness, veterans, individuals with criminal justice involvement, and children and young adults with trauma (both in and outside the child welfare system)
- Build understanding among the workforce on the importance of demographic data collection (i.e. race/ethnicity, LGBTQ+) as it relates to decreasing health inequities and competence on how to ask for demographic information in a culturally competent way.

Research for new insights and innovative solutions to behavioral health problems

- Research ways to target populations at greater risk and build in culturally relevant strategies.
- Targeted suicide prevention efforts among veterans.

Considerations for Prioritization Related to COVID-19

Below is a list of considerations for what TCHD should prioritize in light of COVID-19 as it relates to mental health and suicide prevention services and resources.

1. **Identify opportunities to address provider capacity issues or shore up more resources** to address the access issue, including supporting the system capacity for round-the-clock care once places "re-open."

2. **Support schools and community-based organizations to address trauma brought on by COVID-19 among their students as well as themselves**. School and community-based mental health providers are gearing up for response to those impacted by trauma and need support thinking through how to aid teachers in their response to traumatized students. Specifically, helping provide resources on what do teachers need to know and have in place for when kids do come back to school, have educated staff on what trauma looks like among students and how best to address it. For staff, **there may be new stresses of working in a setting where they are asked to help students and witness their peers experiencing new stresses which may result in secondary trauma. Resources will be needed for staff to recognize these traumas in not only themselves but among those they work with.**

> *"Get the message out about how to recognize and attend to trauma."*
> *– Community Leader*

3. **Develop or enhance communications regarding any new and existing resources and how to access those resources.** Individuals and families will have many more barriers after COVID-19 engaging in services – likely exacerbating the inequities that already existed before COVID-19. Public health agencies will need to think about outreach and engagement in new ways to reach those newly experiencing barriers to the things they need and those whose challenges before COVID-19 are exacerbated.

4. **Supporting communities in identifying and applying for new funding opportunities** and helping to sort out what strategies need to be funded.

5. **Continue to support telehealth and innovative thinking about how services are provided**. One key informant said, "we are a system who never thought we could go remote and yet here we are and would challenge other entities on how to think about that and be creative in reaching out to communities in need."

6. **Convening stakeholders and doing a needs assessment** about how services and resources need to change to continue to bring about protective factors in the home, especially given that the impact of social distancing is largely unknown.

7. **Identify or create opportunities for organizations and community leaders to stay connected.** COVD-19 will likely increase the volume of those with high acuity needs since they are not currently accessing the care that they need to manage their health. There is concern that when an organization or provider is experiencing a high volume of patients with high acuity needs, "the tendency is to take care of your swim lane." This will inherently have an impact on the capacity of organizations to work together and collaborate.

8. **Develop different access points with individuals (i.e. essential workers) and families.** For individuals and families struggling the most, there needs to be awareness among those who see them via ongoing virtual service provision or other means, on the ways to best support and facilitate a conversation about mental health. Other informants described this as a need to “create more supportive pathways for families.” This includes facilitating conversations about past trauma and/or trauma from impact of COVID-19 and its role in mental health.

9. **Develop communications and recommendations about accessing non-COVID-19 related physical health care**. Many individuals with physical health issues have stopped going to the doctor. There is a sense that people understand today what to do if you have COVID-19 symptoms, but they do not know if and how to access other health care services.

10. **Put out positive messages** along with those that describe the negative impacts of COVID-19.

Conclusion

In conclusion, the findings from this assessment will be used to develop a collaborative, data-driven suicide prevention framework and a broader mental health framework within which the suicide prevention framework will be embedded. HMACS will facilitate the development of these frameworks with TCHD and a steering committee of stakeholders in this process.

Thank you to the Tri-County Health Department partners and community leaders who shared their time and insight to assess and describe the behavioral health assets/activities and gaps in Adams and Arapahoe counties that will ultimately inform the development of the region’s mental health and suicide prevention frameworks. These frameworks will serve as a clarifying catalyst for implementation of shared strategies and provide effective language to convey the unique public health role in improving mental health and reducing rates of suicide.