Responding to Behavioral Health Needs

An Evaluation of the Colorado Office of Behavioral Health's Co-Responder Program

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COLORADO
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EXECUTIVE SUMMARY

Communities are changing how they respond to behavioral health crises. Historically, law enforcement has been first to field behavioral health calls through the 911 system. Today, some communities pair officers with behavioral health clinicians to respond to mental health emergencies and get people the help they need.

This shift has come in response to the number of people involved with the criminal justice system who have behavioral health and substance use issues. In Colorado, for example, 35 percent of the inmate population has a mental health need, and 74 percent has a substance use disorder.[1]

The Colorado Co-Responder Program, administered by the Colorado Department of Human Services Office of Behavioral Health (OBH), supports communities that want to take a different approach to calls with a suspected behavioral health component. Over the past two years, OBH has granted funding in 25 counties to implement co-responder teams of officers and behavioral health professionals. However, due to staffing needs and start up delays, only some programs have been operational for the whole two years.

Although relatively new, these programs are already demonstrating positive outcomes for law enforcement and people with behavioral health conditions. The goals are to prevent unnecessary incarceration and hospitalization of people with behavioral health conditions, identify opportunities to provide alternative community-based care, and to return law enforcement officers to one of their primary functions — patrolling the streets.[2]

The Office of Behavioral Health contracted with the Colorado Health Institute (CHI) to evaluate eight of the Co-Responder Program's first two years.

Evaluation highlights include:

- Co-responder teams contacted between 16 and 103 individuals per month during response calls from August 2018 to August 2019. Overall, the co-responder teams responded to 4,357 calls.

- Over time, co-responder teams were more likely to report success in diverting community members from formal actions (arrests, mental health holds, and emergency department transports).

- Co-responder teams were more likely to connect with and effectively serve community members in need of support over time.

- The co-responder program improved interactions between law enforcement and community members.

Co-responder programs have realized many successes. But CHI's evaluation also identified barriers to implementing the model, ranging from a lack of policy alignment between law enforcement and behavioral health providers, data collection challenges, and limited resources to increase staff.

This evaluation has limitations, given the newness of the program in Colorado. The initial data available were aggregate results of co-responder team activities rather than individual-level outcomes, such as data on how the co-responder program impacted each person served. A lack of client-level information and an absence of data on costs associated with services detracts from a full understanding of the costs and benefits of the program.

In response, the OBH team has improved and advanced data collection efforts. Over the past six months, OBH has created a new tool that collects data on individuals who are served by co-responders. This information includes the location of each individual after an emergency call or if the co-responder was able to contact the individual with a follow-up call. Better data allows for a deeper understanding of individual outcomes, including for people who frequently interact with emergency services. As the program continues to expand and adapt to community needs, OBH will provide more robust data to illuminate the programs' impacts. This will be supported by ongoing evaluation efforts through February 2021.

Introduction

People with behavioral health conditions may find themselves involved with law enforcement if their symptoms trigger a need for services. Law enforcement officers may arrest a suspect or take them to a hospital, rather than refer them to a community-based behavioral health program, because officers don't have enough training or resources.

The co-responder model pairs law enforcement officers with a behavioral health provider to respond to calls for service.[3] The Office of Behavioral Health provides funding in 25 counties to implement co-responder programs, which are designed to prevent unnecessary incarceration and hospitalizations of individuals with a behavioral health condition, identify opportunities to provide alternative community-based care, and facilitate the return of law enforcement to patrol activities.[4]

Three funding streams support co-responder services in Colorado. Senate Bill 17-207 authorized the development of eight co-responder programs with a total budget of $2.9 million. The Offender Behavioral Health Services program, also administered by OBH, funds 10 community behavioral health centers to support co-responders. Additionally, $400,000 has been allocated from the Mental Health Block Grant (MHBG), which is given to states by the Substance Abuse and Mental Health Services Administration, to help support two co-responder programs. More recently, OBH received $1.5 million from the state general fund to expand the co-responder program to more counties starting in 2020.

This evaluation focuses on co-responder programs that are funded through SB 17-207 and MHBG. The list below highlights the name of each program and the organizations it is affiliated with. Throughout the document, CHI refers to the counties where co-responder teams operate listed below when discussing community-specific findings.

- **BCORE:** Broomfield Police Department
- **Douglas County Crisis Response Team:** Parker Police Department
- **Behavioral Health Connect (BHCON):** El Paso County Sheriff's Office
- **Greeley Evans Mobile (GEM):** Evans and Greeley Police Departments
- **Crisis Support Team:** Grand Junction Police Department and Mesa County Sheriff's Office

Evaluation Framework

This report uses the RE-AIM Framework to guide our evaluation, which examines a program's Reach, Effectiveness, Adoption, Implementation, and Maintenance. The evaluation looks at several aspects, including:

- **Reach:** How many Coloradans with behavioral health conditions have been reached by a co-responder program?

- **Effectiveness:** What percentage of all first responder calls are answered by a co-responder team? How many people use behavioral health services after engaging with co-responders?

- **Adoption:** Does a co-responder program impact first responders' knowledge and attitudes toward people with behavioral health conditions?

- **Implementation:** Were there barriers during implementation that impact program outcomes?

- **Maintenance:** What savings have been realized through the diversion of formal actions such as hospitalizations or arrests?

This framework is traditionally used to evaluate health-related programs and associated outcomes. Each co-responder site has flexibility in how it implements its program, so this evaluation uses an adapted version of the framework to evaluate the OBH Co-Responder Program and identify lessons learned.

- **Larimer Interagency Network of Co-Responders (LINC):** Larimer County Board of County Commissioners (Fort Collins and Loveland Police Departments; Larimer County Sheriff's Office)
- **Crisis Outreach Response and Engagement (CORE):** Longmont Police Department
- **Pitkin Area Co-Responder Team (PACT):** Pitkin County Public Health, Aspen and Snowmass Village Police Departments, and Pitkin County Sheriff's Office

Evidence in states that have co-responder programs suggest they reduce the use of deadly force,[5,6] improve interactions between community members and law enforcement[7], and increase connections to appropriate services[8].

Communities are still learning about the opportunities and challenges of implementing a co-responder program. Local law enforcement and behavioral health leaders have expressed interest in understanding the programs' impacts on residents and staff. This evaluation provides initial findings on these and other critical issues to inform local and state activities.

Methods

This report uses a mixed-methods approach for evaluating the OBH Co-Responder Program by combining quantitative data with qualitative insights from participating law enforcement and behavioral health specialists. This approach provides a more comprehensive analysis of the impact on communities where programs operate.

Key Informant Interviews and Focus Groups

CHI conducted 12 key informant interviews and one focus group with law enforcement officers and behavioral health specialists involved with the program.

Literature Review

CHI conducted a literature review to identify benefits and drawbacks of a co-responder program for law enforcement and individuals served by police-clinician teams, as well as opportunities to learn from other co-responder programs. The literature review did not identify any systematic assessments that met the CHI review criteria, likely due to the relative newness of these programs. The findings of the literature review are woven throughout this report.

Co-Responder Survey

CHI fielded a survey to collect quantitative and qualitative data on program impacts. The survey asked people who serve on co-responder teams to answer questions about how responses to behavioral health calls have changed over time, barriers to implementing the program, interactions with community members, and knowledge of and attitudes toward people with behavioral health conditions.

New Co-Responder Data Reporting Tool

In addition to the co-responder activity log data reporting tool used to inform this evaluation, OBH developed a second, more robust tool for co-responder sites that provides more data about the impact of the program. This tool was piloted beginning in July 2019.

The new tool captures data at an individual, instead of aggregate, level. This means data is available about each individual served, including what services were provided, how the call was resolved, and if the person was contacted during follow-up calls. This level of detail illustrates how individuals engage over time with co-responders in their community. It also facilitates assessment of the programs' impacts on individual-level outcomes.

Agencies in four co-responder jurisdictions started using this new tool in July 2019. These sites are: Douglas County Crisis Response Team: Parker Police Department; Greeley Evans Mobile (GEM): Evans and Greeley Police Departments; Crisis Support Team: Grand Junction Police Department and Mesa County Sheriff's Office; and Pitkin Area Co-Responder Team (PACT): Pitkin County Public Health, Aspen and Snowmass Village Police Departments, and Pitkin County Sheriff's Office.

For this report, CHI analyzed the collected data from September 2019 - January 2020 and applied the RE-AIM evaluation framework. Insights based on this additional data collection tool are included in blue boxes, labeled "Pilot Site Finding," throughout this report. These data offer a more detailed look at how the co-responder program is working in four jurisdictions. They also offer insight into how the program is working in 2019 and 2020, while the rest of the analysis focuses on data from activity logs between August 2018 and August 2019. This tool will be used by all sites starting in July 2020.

Co-Responder Activity Log Data Reporting Tool

Each co-responder team was asked to provide monthly data on its activities. This includes but is not limited to the total number of calls they responded to, demographics of the individuals they served, and the number of times a formal action was diverted. Each of the eight sites provided aggregate data. CHI analyzed data collected between August 2018 and August 2019. Sites commonly had missing data in their monthly activity logs, which resulted in some sites not being included in aggregate data analysis. Some of these missing months of data might be due to staffing turnover at the co-responder sites.

Roles and Responsibilities of a Co-Responder Team

Colorado's co-responder programs are relatively new, and each Colorado community implements the program differently. Some have a dedicated team of officers and behavioral health specialists who respond to emergency calls during their shifts. Others deploy a behavioral health specialist to a scene if an officer requests their assistance. Any time a co-responder is deployed — either as first response or in response to a request for help — it is considered an on-scene response call in the co-responder vocabulary, and services provided are considered on-call services.

When co-responders are unable to respond to an emergency call, the person with a mental health problem may later be directed to the team or the team may reach out to the person in what's called an after-the-fact referral.

And finally, co-responder teams follow up with individuals to assess if they are enrolled in behavioral health services and if they need other services. These are considered follow-up calls.

Agencies provide different types of assistance depending on the co-responder team setup and the capacity of each team. Examples of different types of assistance include behavioral health assessment, de-escalation, and referral/resource to community services.

Types of assistance provided by co-responder teams differ by site and time of year. These differences could be due to the needs of a community, the skill set of the team, and how each site chooses to deploy and utilize its team. Changes to services provided over time may reflect staff turnover and other capacity issues.

Evaluating the Co-Responder Program

Reach

Guiding Question: How many Coloradans with behavioral health conditions have been reached by the co-responder program?

Key Finding 1: Co-responder teams contacted between 16 and 103 individuals per month during response calls from August 2018 to August 2019. Overall, the co-responder teams responded to 4,357 calls.

Table 1. Volume of Calls Varies Across Co-Responder Sites

Co-Responder Site	Average Number of Calls Responded to by Co-Responder Team per Month	Average Number of Individuals Contacted by Co-Responder Team per Month	Rate of Calls Responded to by Co-Responder Program (per 1,000 calls)
Broomfield	19.2	19	3.1
Douglas	36.4	35	17.1
El Paso	45.2	36	2.9
Larimer	164.9	103	9.1
Longmont	110.9	84	18.3
Pitkin	32.4	16	7.9
Weld	23.3	33	11.0*

* Calculated using the average number of emergency response calls from county with a similar population size.
Data for Mesa County is unavailable. • Average number of calls and number of individuals contacted per month may differ due to more than one individual contacted on a call or individuals were gone upon police arrival.

Smaller communities, such as Pitkin County, reached about one person every other day on response calls. However, larger areas such as Larimer County and the City of Longmont reached about three people every day.

Reach is defined in two ways: the volume of calls a co-responder team responds to and the number of people who are connected to those calls. Both the volume of calls and the number of individuals contacted varies (See Table 1).

The co-responder teams collectively contacted 3,079 individuals during on-scene response calls from August 2018 to August 2019.

The Broomfield County program responded to an average of 19 calls per month and contacted an average of 19 individuals per month during these calls.

Compared with that tally, the Larimer County co-responder program responded to 165 calls and 103 individuals per month, on average.

Co-responder teams are not always able to respond to every crisis call because of staffing and capacity issues. It is also difficult to establish how many calls to dispatchers are behavioral health-related, because often that is not determined until officers are at the scene.

CHI used the average number of emergency calls each police department responded to each month as the total number of calls a co-responder could respond to, even if they were not related to behavioral health. Then, we calculated a rate per 1,000 calls responded to by the co-responder team to demonstrate reach.

Douglas County's co-responder program responded to 17.1 calls per 1,000 total calls that resulted in a response by law enforcement. Co-responder teams in El Paso responded to 2.9 calls per 1,000. Such differences may rest in how individual programs operate; for example, some counties are more likely to do after-the-fact referrals rather than on-scene responses.

Key Finding 2: After-the-fact referrals boost the reach of co-responder programs. Between August 2018 and August 2019, co-responder teams received 1,520 after-the-fact referrals.

Douglas and Broomfield counties reported more after-the-fact referrals than response calls per month. But other counties reported receiving more response calls than after-the-fact referrals (see Table 2).

Table 2. Broomfield and Douglas Respond to More After-the-Fact Referrals Than Response Calls

Co-Responder Site	Average Number of After the Fact Referrals sent to Co-Responder Team per Month
Broomfield	44.0
Douglas	90.8
El Paso	5.3
Larimer	43.3
Pitkin	19.3
Weld	1.4

*Longmont did not report these data.

Douglas County reported nearly 91 after-the-fact referrals on average each month, compared with just over one after-the-fact referral per month in Weld County.

Co-responder programs throughout the state serve different communities with different characteristics and needs. The number of after-the-fact referrals depends on the community and the type of co-responder model implemented in each county.

After-the-fact referrals are helpful for people in need, but they can be time consuming and compete with a team's ability to de-escalate a behavioral health crisis as it is happening. On the other hand, teams are unable to respond to every crisis, so after-the-fact referrals are an important avenue to reach additional community members in need of behavioral health services.

Key Finding 3: In some places, "high utilizers" make up a substantial portion of individuals contacted by co-responder teams — nearly 30 percent in Broomfield County but only 6 percent in Douglas County.

High utilizers are people who come in contact with co-responder teams through law enforcement agencies more than once a month.

Using data from the co-responder activity log, CHI identified the number of individuals who were contacted more than once per month. CHI calculated the percentage by dividing this count by the total number of unduplicated individuals contacted per month. As there was variation in reporting over time, estimates were aggregated into a reported average.

Table 3. High Utilizers Are a Substantial Portion of Individuals Contacted by Co-Responder Teams at Some Sites

Co-Responder Site	Average Number of Individuals with Repeat Calls for Co-Responder Team/Clinician per Month	Percentage of Individuals Contacted by Co-Responder Team/Clinicians on Calls Who Are High Utilizers
Broomfield	6	29.7%
Douglas	2	5.8%
El Paso	3	7.3%
Larimer	16	15.7%
Longmont	20	23.3%
Pitkin	1	21.9%
Weld	1	6.1%

*Data from Mesa County is unavailable.

Broomfield, Longmont, and Pitkin County co-responder teams report that, on average, more than one in five people they contacted were high utilizers.

Larimer County and Longmont reported the highest number of high utilizers contacted by a co-responder team on average per month, 16 and 20, respectively. Broomfield has the highest percentage of individuals who were contacted more than once at 29.7 percent. (see Table 3).

Assessing the programs' reach among high utilizers over time is important. A decrease in high utilizers over time could mean they have been enrolled in services and are not likely to be the subject of an emergency call to police. If the number of high utilizers increases, it could mean individuals now see a co-responder team as a trusted resource for behavioral health services. It could also mean that individuals in crisis are not getting the help they need and are repeatedly involved in emergency incidents.

Better data reporting will increase confidence in estimates of the number of individuals served by the co-responder program as well as understanding if and when these individuals were connected to community services. The updated reporting tool, which provides individual-level data, will improve data collection about high utilizers and more accurately address outcomes for individuals served by the co-responder program. This tool will hopefully encourage more complete, robust data that more effectively answers these questions.

Effectiveness

Guiding Questions: What percentage of all first responder calls are answered by a co-responder team? How many people use behavioral health services after engaging with the co-responder program?

Key Finding 1: Over time, co-responder teams were more likely to report success in diverting community members from formal actions (arrests, mental health holds, and emergency department transports).

Diversions of formal actions by co-responders may result in better outcomes for individuals, especially if they are connected with behavioral health services in their communities.

Survey respondents were asked how often they were able to redirect a person in crisis from a formal action when their program started and how often these diversions occurred over the past 30 days of operation (See Table 4).

In the first 30 days, 35.7 percent of programs reported always or often being able to divert people from hospital emergency rooms. This rate jumped to 53.6 percent in the past 30 days of operation. Diversions from an arrest also improved over time.

As for mental health holds, always or often diverting a person increased 7 percentage points from implementation to the past 30 days. A mental health hold is a procedure "which allows for a person to be involuntarily held for a 72-hour period of treatment and evaluation if he or she appears to have a mental illness and, due to the mental illness, appears to be an imminent danger to self or others, or appears to be gravely disabled."[9]

The findings on diversions suggest that co-responders improved their ability to divert individuals from formal actions. But they also highlight a systemic issue that could impact the ability of a program to achieve its intended goals. Certainly, a mental health hold or arrest are appropriate responses in some circumstances. And people in crisis may be best served by the emergency room. But survey respondents suggested that their impact

Table 4. Survey Respondents Reported That They Are More Likely to Divert Formal Actions in the Last 30 Days Compared With First Implementation of the Program.

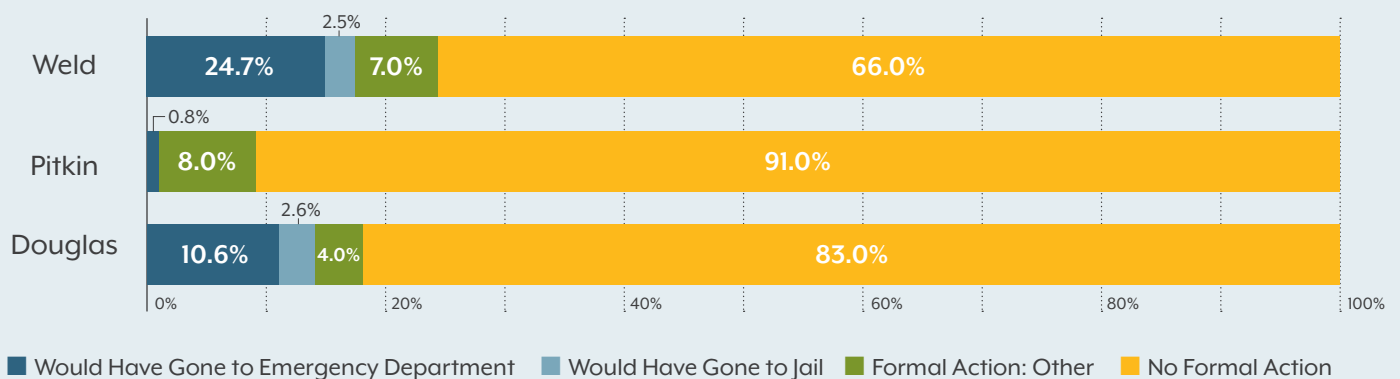| Frequency	Diverted from Arrests		Diverted from Transport to Emergency Departments		Diverted from Mental Health Holds	
	First Implemented	Last 30 days	First Implemented	Last 30 days	First Implemented	Last 30 days
Always	17.9%	17.9%	3.6%	3.6%	7.1%	7.1%
Often	17.9%	28.6%	32.1%	50.0%	25.0%	32.1%
Sometimes	14.3%	17.9%	28.6%	10.7%	39.3%	28.6%
Not Often	25.0%	17.9%	17.9%	17.9%	10.7%	14.3%
Never	7.1%	3.6%	0.0%	0.0%	3.6%	0.0%
Unsure	17.9%	14.3%	17.9%	17.9%	14.3%	17.9%

Pilot Site Finding:

Pilot sites reported diverting 13 percent of individuals contacted by co-responder teams from a hospital emergency department.

Pilot sites reported how many subjects of emergency calls were diverted from emergency departments and jail. This data source looks specifically at each individual served by the co-responder team to see if they were diverted from a formal action, rather than the survey data described above that asks about diversions at the aggregate level.

Weld County reported the highest rate of emergency department diversions (see Figure 1). Jail diversions there and in Douglas County were just under 3 percent. Pitkin County reported less than 1 percent of its calls resulting in emergency room diversions, while 8 percent of individuals were diverted from "other" undefined formal actions.

Data reporting became more accurate over time as sites became familiar with the pilot reporting template. More months of data collection may be needed to understand the scope of diversions in each pilot site (107 records were excluded from this analysis because of inconsistent reporting within the data collection tool.)

Figure 1. Percentage of Calls That Were Diverted by Co-Responder Teams, by County, September 2019 to January 2020

Legend: ■ Would Have Gone to Emergency Department   ■ Would Have Gone to Jail   ■ Formal Action: Other   ■ No Formal Action

on diversions could be even greater with more resources dedicated to less restrictive and perhaps more effective community behavioral health options.

This data is based on the co-responder team's perception of their ability to divert individuals from formal actions. However, data collected on each individual suggests these diversions do not happen as often as perceived by co-responders (see breakout box on page 8).

Finding 2: Co-responder teams were more likely to connect with and effectively serve community members in need of support over time, suggesting that initial implementation barriers were resolved.
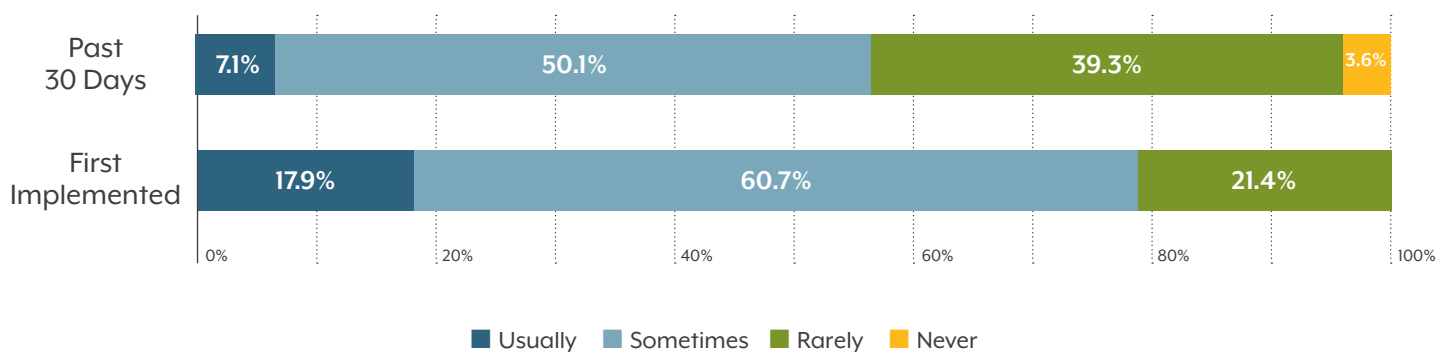
Survey data suggest that co-responder teams improved their ability to connect with community members in need of services as the programs worked through challenges and barriers. When

their programs launched, 18 percent of respondents reported they were usually unable to reach people who would benefit from intervention; only 21 percent of teams said they rarely missed engaging with community members in need.

However, when asked about the situation in the last 30 days, only 7 percent of respondents reported their co-responder teams were usually unable to reach people in need and 40 percent said they rarely or never missed interventions. This finding is supported by the literature. A North Carolina analysis suggested that co-responder teams facilitate the connection of people who need behavioral health or substance use treatment to appropriate services.[10]

Future data analysis will provide information about where people end up after contact with co-responders.

Figure 2. Co-Responder Teams Were Less Likely to Report They Were Unable to Reach People Who Could Benefit from Intervention Over Time

Legend: ■ Usually ■ Sometimes ■ Rarely ■ Never

Past 30 Days: 7.1% | 50.1% | 39.3% | 3.6%
First Implemented: 17.9% | 60.7% | 21.4%

Key Finding 3: Less than one-third of individuals who were contacted during follow-up calls reported being enrolled in behavioral health services.

Enrollment data provided from four of the eight sites suggest that co-responder sites had mixed success following up with individuals in need of help and enrolling them into behavioral health services (see Table 5).

Pitkin and Weld counties' co-responder teams reported a 28 percent enrollment rate among individuals they were able to contact. El Paso County's co-responder team enrolled about 30 percent of those contacted.

The limited data available suggests that some sites do not have the capacity to do follow-up calls and outreach. It is also possible that some sites do provide follow-up calls, but did not report on the success of those encounters in the data reporting tool.

Data provided about behavioral health enrollment is about enrollment in services due to engagement with the co-responder team during follow-up. Co-responders might not know if individuals are enrolled in behavioral health services for a variety of reasons, including if they enroll in services outside of the behavioral health agency providing co-responder clinicians or if the co-responder team is unable to connect with the individual after the initial interaction. This means that though only one-third of individuals were reportedly enrolled in behavioral health services, others might be enrolled, but the co-responder was not involved in enrolling them in services or were unaware that they are receiving services.

Table 5. Less Than One-Third of Individuals Were Successfully Enrolled in Behavioral Health Services Ater Attempted Follow-Up From Co-Responder Teams

Co-responder site	Percentage of successful follow up calls by co-responder team/ clinician	Percentage of successful follow- up calls resulting in individuals enrolled in behavioral health services
El Paso	66.1%	30.5%
Longmont	74.6%	—
Pitkin	68.1%	27.0%
Weld	49.0%	28.6%

* Broomfield, Douglas, and Larimer did not report follow-up data in monthly reports.

Pilot Site Finding:

Individuals in contact with co-responders are most likely to be enrolled in a community-based setting after resolution of a call, followed by medical-based settings.

Data from the pilot sites show where people ended up after a co-responder intervention. Locations were grouped into community-based (resolved on scene, community-based organization, and walk-in crisis center), medical-based (emergency department/ hospitals, mental health centers, and withdrawal management services), and jail.

Douglas County drastically reduced the number of calls that ended with individuals in medical-based settings. From September to January, most calls were resolved on scene (64.0 percent). A fourth of individuals were transported to hospital emergency departments (27.9 percent), but hospital transport was used much less in December and January. Douglas did not report any calls resulting in jail time (see Figure 3).

In Pitkin County, individuals were most likely to be at community-based organizations after calls (47.8 percent), although over one-third (35.7 percent) of location data was missing for Pitkin County. It reported the highest percentage of people in jail after an emergency call at 8.4 percent.

Weld County did not see major changes over the five-month period in calls that ended in community-based, medical-based, and jail settings. Individuals contacted by co-responders were most likely to have calls resolved at the scene (46.9 percent), with another 18.2 percent transported to emergency departments/ hospitals.
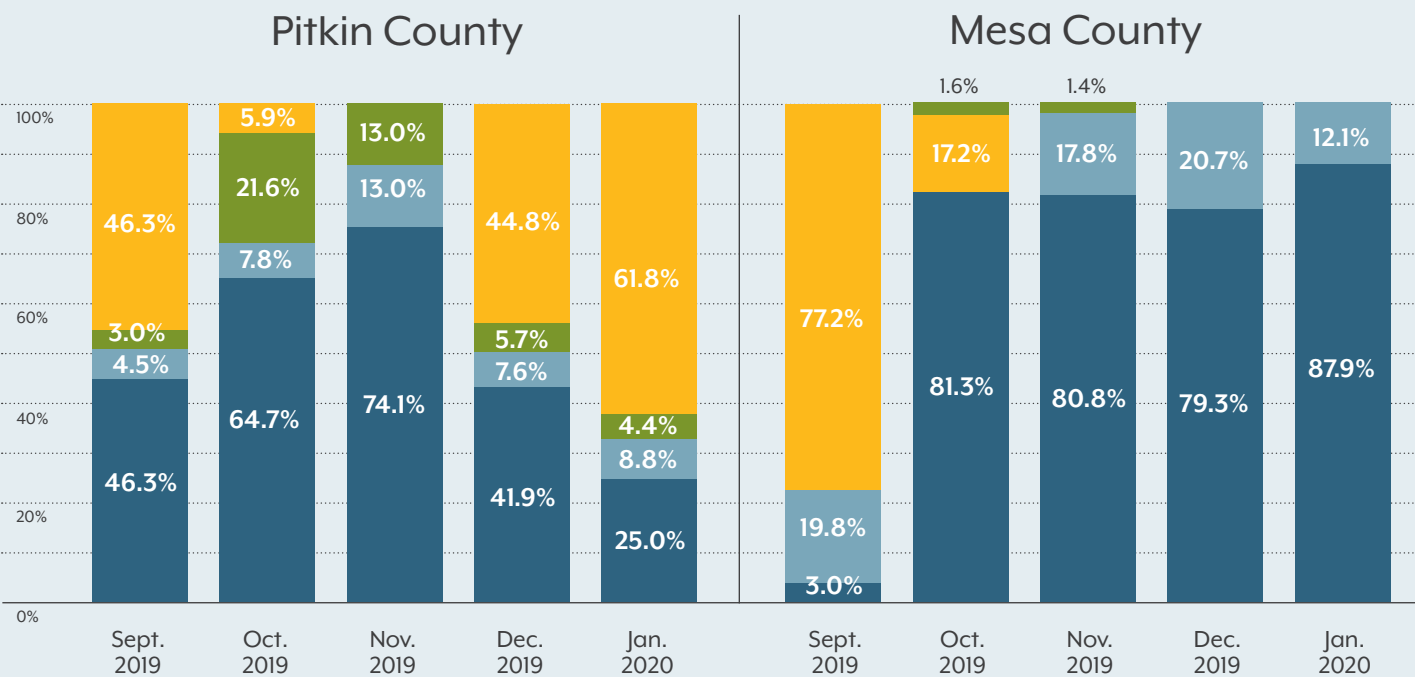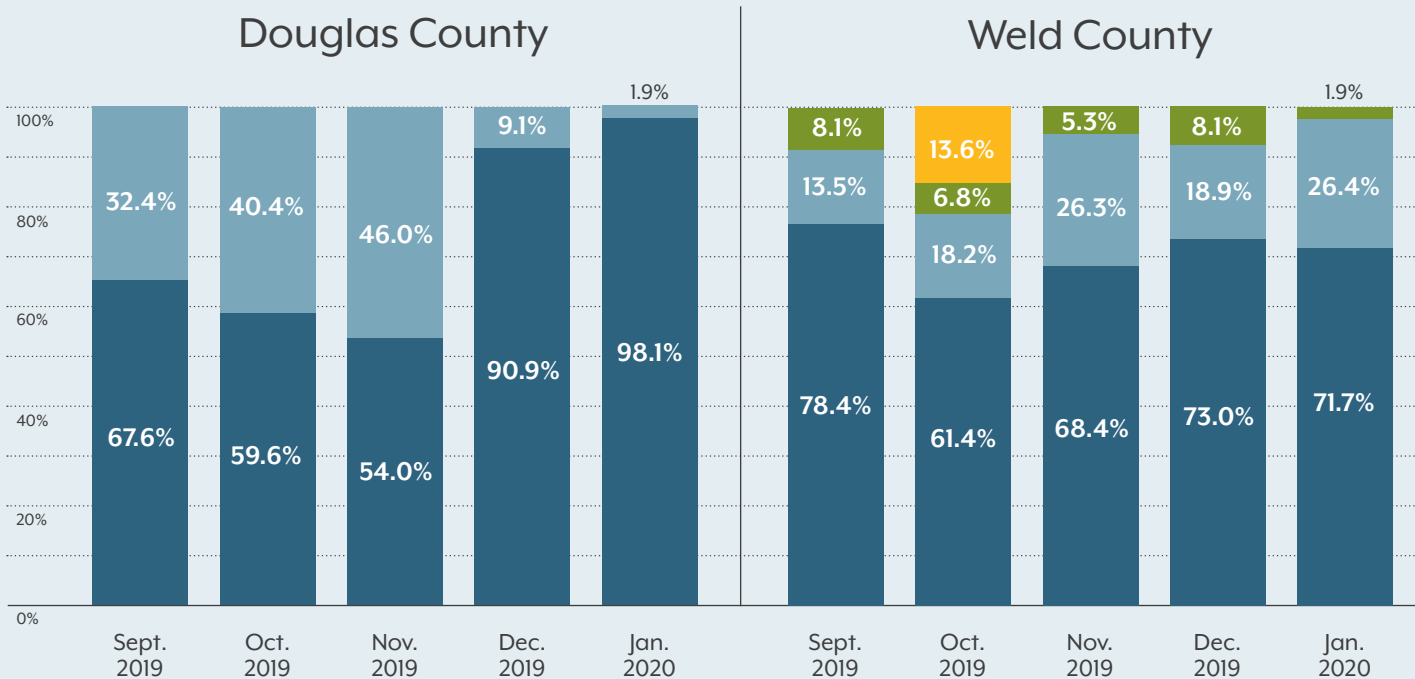
Mesa County saw little change in the number of individuals in medical-based settings, with a slight decrease in January. More than half of calls (53.6 percent) were resolved on scene, while another 13.3 percent resulted in transport of individuals to hospital emergency departments.

Across all pilot sites, data showed that about 31 percent of contacts with high utilizers resulted in the individual being connected to a community-based service, and 16.5 percent of calls were resolved at the scene. However, 31.2 percent of duplicate calls had missing post-call location data.

Figure 3. A Majority of Individuals in Douglas County and Weld County Were Connected With Community-Based Services After Engaging With Co-Responder Teams

Distribution of Location of Individual After Call

■ Community ■ Medical ■ Jail ■ Unknown

Douglas County

	Sept. 2019	Oct. 2019	Nov. 2019	Dec. 2019	Jan. 2020
					1.9%
Medical	32.4%	40.4%	46.0%	9.1%	
Community	67.6%	59.6%	54.0%	90.9%	98.1%

Weld County

	Sept. 2019	Oct. 2019	Nov. 2019	Dec. 2019	Jan. 2020
					1.9%
Jail	8.1%		5.3%	8.1%	
Unknown		13.6%			
Jail		6.8%			
Medical	13.5%	18.2%	26.3%	18.9%	26.4%
Community	78.4%	61.4%	68.4%	73.0%	71.7%

Pitkin County

	Sept. 2019	Oct. 2019	Nov. 2019	Dec. 2019	Jan. 2020
Unknown	46.3%	5.9%	13.0%	44.8%	61.8%
Jail	3.0%	21.6%			
Medical	4.5%	7.8%	13.0%	5.7%	4.4%
				7.6%	8.8%
Community	46.3%	64.7%	74.1%	41.9%	25.0%

Mesa County

	Sept. 2019	Oct. 2019	Nov. 2019	Dec. 2019	Jan. 2020
Jail		1.6%	1.4%		
Unknown	77.2%	17.2%	17.8%	20.7%	12.1%
Medical	19.8%				
Community	3.0%	81.3%	80.8%	79.3%	87.9%

Pilot Site Finding:

About 82 percent of response calls ended in a voluntary placement by the individual involved.

Co-responder sites reported whether an individual's post-call placement was voluntary or involuntary. The majority were voluntary, but 17 percent were involuntarily placed on a mental health hold, and 1 percent were placed on an involuntary hold due to alcohol or drugs.

A majority of people held involuntarily (86.5 percent) were taken to a hospital emergency department. Another 7.3 percent were taken to a walk-in crisis center, and just a small percentage were taken to a jail, withdrawal management facility, or mental health center.

Data provided by pilot sites provide additional insights about mental health holds (see Figure 4).

Douglas County reported a dramatic decrease in the number of 72-hour mental health holds after a call for service, from 16.2 percent in September 2019 to 5.8 percent in January 2020.

Pitkin County reported a low percentage of post-call mental health holds throughout the entire pilot period, around 2 percent on average, with a spike in October. Mesa County reported an overall decrease in the percentage of post-call mental health holds throughout the entire pilot period.

A different trend emerged in Weld County. The percentage of calls that result in a mental health hold tripled between September 2019 and January 2020 even though the rate of calls stayed relatively constant. This could be due to a lack of community-based providers who offer behavioral health services in the area.

Figure 4. Reported Percentage of Calls That Resulted in Mental Health Holds Across All Pilot Sites
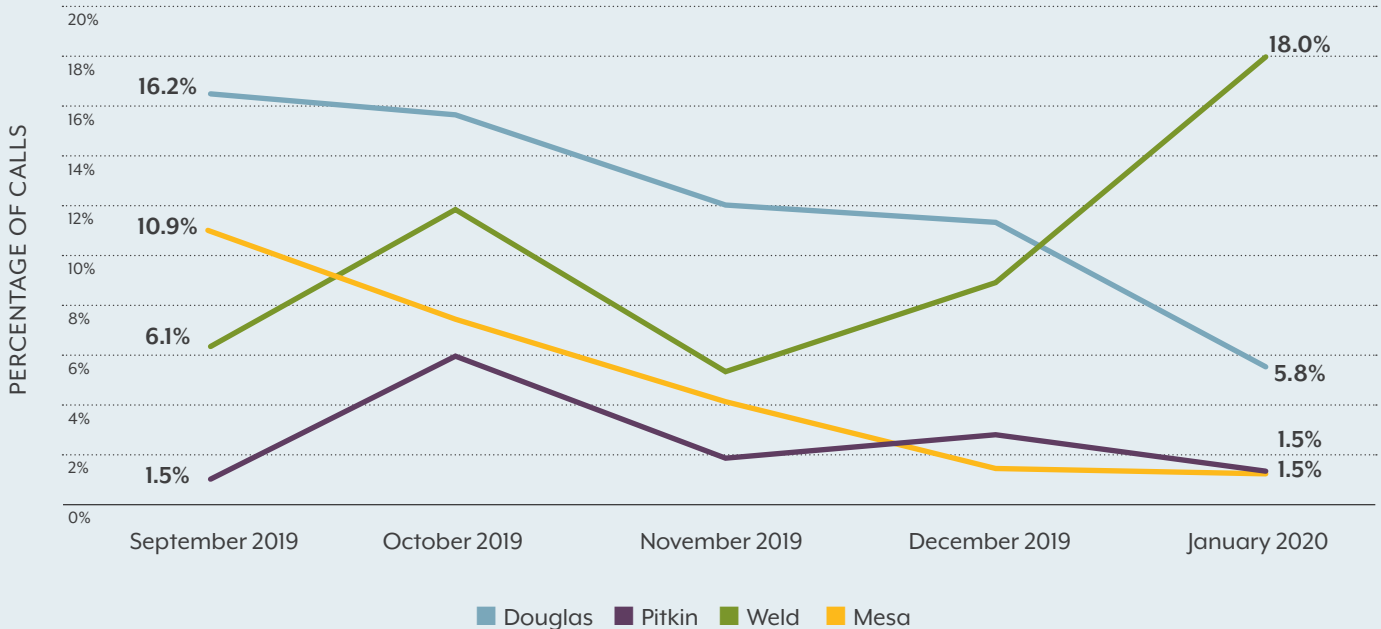
Pilot Site Finding:

Individuals who have three or more touchpoints with a co-responder team may have a greater need for social and community supports.

Just over half of high utilizers were enrolled in behavioral health services at any given time during the pilot period. Another 30.8 percent were never enrolled in behavioral health services, while 18.3 percent of high utilizers had missing or not applicable behavioral health enrollment data (see Figure 5). High utilizer enrollees in behavioral health services had four contacts with the co-responder program on average, compared with three contacts among those who were never enrolled.

Individuals who come in contact with the team through emergency response more than two times may have different needs such as for more intensive community-based supports. Even those who are connected to behavioral health services are still likely to frequently encounter a co-responder team (see Figure 6).

Evaluation data suggest that individuals who come in contact with co-responders at least three times a month may benefit from receiving some additional attention and support. This analysis suggests that there is a need for case management and social supports, such as housing
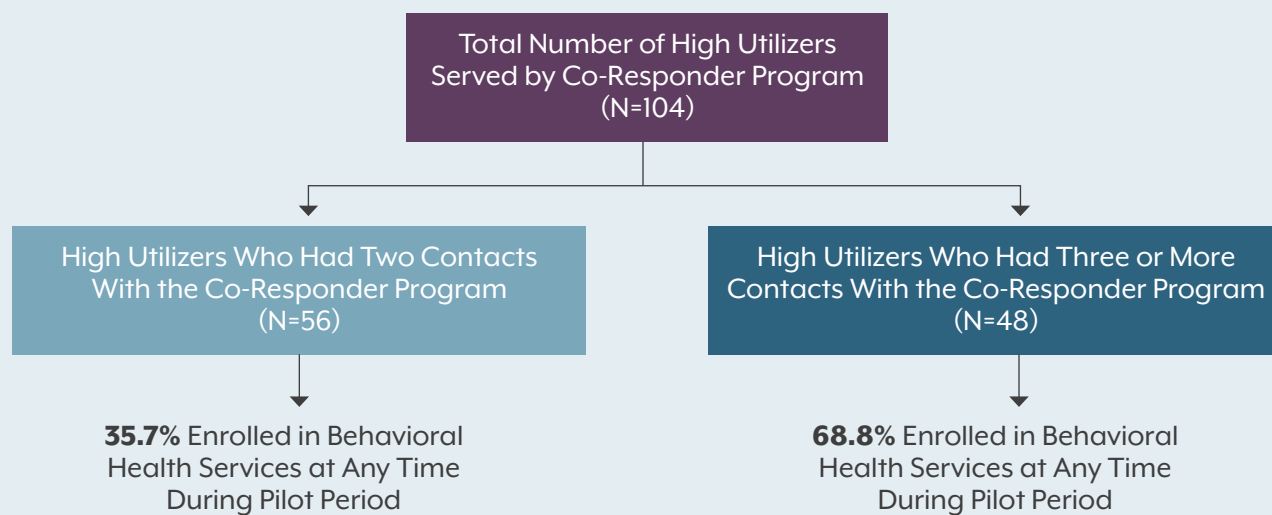
Figure 5. The Majority of High Utilizers Were Enrolled in Behavioral Health Services While in Contact With Co-Responder Teams

18.3% Unknown (or Not Applicable)

51.0% Enrolled

30.8% Never Enrolled
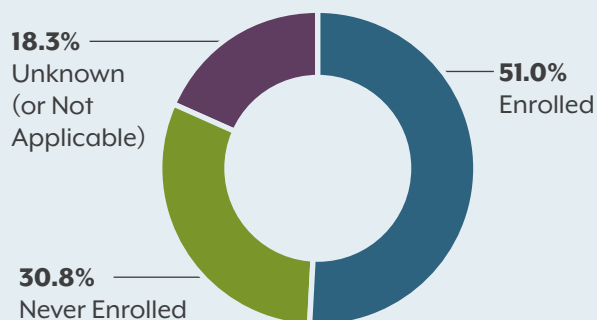
or transportation services, need to be addressed along with providing behavioral health services. Co-responder teams will need to engage more community partners and services to support these high utilizers.

Further, this analysis might suggest that individuals who frequently come in contact with co-responders are more likely to accept help and enroll in a behavioral health program compared to those who have fewer contacts with the co-responder teams. This suggests that the co-responder is a valued and trusted community resource.

Figure 6: Behavioral Health Services Enrollment Among High Utilizers, September 2019 to January 2020

Total Number of High Utilizers Served by Co-Responder Program (N=104)

High Utilizers Who Had Two Contacts With the Co-Responder Program (N=56)

High Utilizers Who Had Three or More Contacts With the Co-Responder Program (N=48)

35.7% Enrolled in Behavioral Health Services at Any Time During Pilot Period

68.8% Enrolled in Behavioral Health Services at Any Time During Pilot Period

Key Finding 4: Survey respondents say the program would be more effective if teams could increase their capacity to reach at-risk community members.

Survey respondents were asked to identify ways to mitigate obstacles and more effectively reach people in the community who frequently use emergency services.

Our analysis found that resource issues were top of mind. For example, respondents cited the relationship between staffing and capacity to serve people in need. One respondent said, "We need more than one team for a 2,100-square-mile county. We have approximately 150-200 behavioral health calls a month at least. Our team can only respond when they are available."

Another issue involved case management and follow-up. One respondent said co-responder teams should have "continual engagement with the individuals pre- and post-crisis [and] work really hard with local community behavioral health to have them step in. Many of these individuals are resistant and are difficult to engage, which is why they continue to use emergency services."

Adoption

Guiding Question: Did the co-responder program impact first responders' knowledge of and attitudes toward people with behavioral health conditions?

Key Finding 1: The co-responder program improved law enforcement attitudes toward people with behavioral health conditions, but feelings about behavioral health professionals were less favorable.

Law enforcement officers often must confront behavioral health crises. Key informant interviews and focus groups suggest that prior to having a co-responder team, officers felt frustrated about fielding behavioral health-related calls but being unable to address a person's needs. Lack of training and support may contribute to law enforcement's perception of people with behavioral health conditions.

That said, the co-responder program changed attitudes toward people with behavioral health conditions. The findings vary by profession. Fifty-seven percent of law enforcement perceived a positive change in attitudes, compared with 90 percent of behavioral health professionals and 100 percent of administration/managers.

However, when asked about attitudes toward

behavioral health professionals, just over 50 percent of law enforcement officers said there was a positive change, 14 percent perceived no change, and nearly 30 percent of perceived a negative change. This could be due to the different approach to work by police and clinicians or a communication gap between the two cultures.

As one respondent put it, "Clinical staff continually insert themselves in situations they are not needed or welcome in. Even after direction from patrol officer and police supervisors, clinical staff will insert themselves in places they don't belong."

Creating structure and standardizing policies for how co-responder teams operate may reduce negativity between police and clinicians.

Key Finding 2: The co-responder program improved interactions between law enforcement and community members.

This evaluation also sought to understand how interactions have changed between law enforcement and community members in places with a co-responder program.

A majority of law enforcement officers and administrators/managers reported improved interactions between community and law enforcement, at 86 and 100 percent respectively. Slightly fewer behavioral health professionals (82 percent) reported improved interactions. Only a small percentage of law enforcement officers reported no improvement.

One officer said the co-responder program has led to a "different approach to policing" that builds rapport and trust with community members. Evidence from the literature supports this finding. Furness et al. (2016) found that people who experienced a behavioral health crisis and were contacted by a co-responder team reported greater procedural justice (feeling an officer treated them respectfully or went out of the way to help) compared with people who interacted with a police officer alone.[11]

Additionally, police-community relations benefit from connecting people in need with appropriate services. This was described by a survey respondent as building "rapport and trust, and (having) someone who cares enough about the person to check-in." A law enforcement officer shared that their department gets more calls from family and friends because "they know we have the program."

One positive unintended consequence reported by survey respondents is that a better understanding of behavioral health within departments led to additional staff for some co-responder programs.

Implementation

Guiding Question: Were there barriers during implementation that impacted program outcomes?

Key Finding 1: Most teams reported challenges in implementing the program. The most frequently reported barrier involved unclear policies and procedures, followed by data sharing and data collection. Just 6 percent of survey respondents reported that there were no challenges to implementation.

Survey respondents identified the top three barriers to implementing the co-responder program as lack of clear policies and procedures (56 percent), data sharing challenges between programs and agencies (47 percent), and inconsistent data collection methods (38 percent).

There was some variation in responses based on profession (see Table 6). Law enforcement respondents were more likely to report not enough familiarity with co-responder teams and lack of clear policies and procedures as main barriers to implementation (67 percent) and data sharing issues (33 percent). Behavioral health professionals were more likely to report their top three barriers to implementation were lack of clear policies and procedures (67 percent), data sharing issues (50 percent), and lack of familiarity with co-responder teams (42 percent).

Clear policies and procedures: Fifty-six percent of survey respondents reported the lack of clear policies

and procedures as a barrier. One law enforcement officer described the importance of policies and standard operating procedures, saying bringing a civilian clinician into a law enforcement agency was like "fitting a square peg into a round hole."

A structure and foundation for everyone to follow are critically important. The literature supports this finding. An evaluation of a co-responder program in Indianapolis recommended developing a systemic set of procedures and resources to build consistency among teams.[12]

Data sharing between programs and agencies and data collection methods: Forty-seven percent of survey respondents cited data sharing, such as sharing protected information across agencies, as a barrier to implementation and 38 percent reported that data collection itself was a barrier. Findings from key informant interviews suggest that data issues were one of the greatest barriers to effectively implementing and running a co-responder program.

Key Finding 2: A common perception among co-responder teams is that law enforcement time on calls was reduced, allowing quicker return to patrol duties.

Overall, 61 percent of respondents reported that the co-responder program reduced the average time law enforcement officers spent on behavioral health-related calls. For example, one respondent credited the program for being "able to handle behavioral health-related calls and relieve already scarce patrol resources back into the field to handle other calls."

The perceived improvement on the time spent on calls is somewhat supported in the quantitative data. The length of time spent on calls showed some reductions over time, but there was not a consistent trend among the sites (see Page 16). Improvements in data collection

Table 6. A Lack of Clear Policies Was the Most Frequently Reported Barrier Among Behavioral Health Professionals and Law Enforcement, Co-Responder Survey, 2019

Profession Type	Data Sharing	Data Collection	Lack of Familiarity	Lack of Clear Policies	No Challenges
Administrator	50.0%	50.0%	10.0%	40.0%	0.0%
Behavioral Health Professional	50.0%	33.3%	41.7%	66.7%	16.7%
Law Enforcement	33.3%	33.3%	66.7%	66.7%	16.7%
Other*	50.0%	25.0%	50.0%	50.0%	0.0%

*There were seven other responses. Dispatch and jail administrators also completed the survey.

Pilot Site Finding:

Officer time spent on calls decreased over time in Douglas County.

Co-responders might not always be first on the scene of a mental health crisis, but their arrival can speed the return of law enforcement and other first responders to patrol or other activities.

Douglas County saw a noticeable decrease between the amount of time officers spent on calls between November and January. However, more data is needed to understand if this reported decrease will stay consistent through 2020 (see Figure 7).

Weld County did not experience any substantive changes in time spent on calls by officers throughout the pilot period (see Figure 8). However, there was a decrease in time spent on calls between December and January, a trend similar to Douglas County's experience.

Pitkin and Mesa counties were missing a large majority of data for time spent on calls, so they were excluded from this analysis.

This analysis of five months of data for two pilot sites is not enough to establish a positive or negative trend in the amount of time law enforcement officers spent on calls.

Figure 7. Officer Time Spent on Calls Decreased Over Time in Douglas County

■ 0-30 Minutes ■ 31-90 Minutes ■ 91+ Minutes ■ Missing
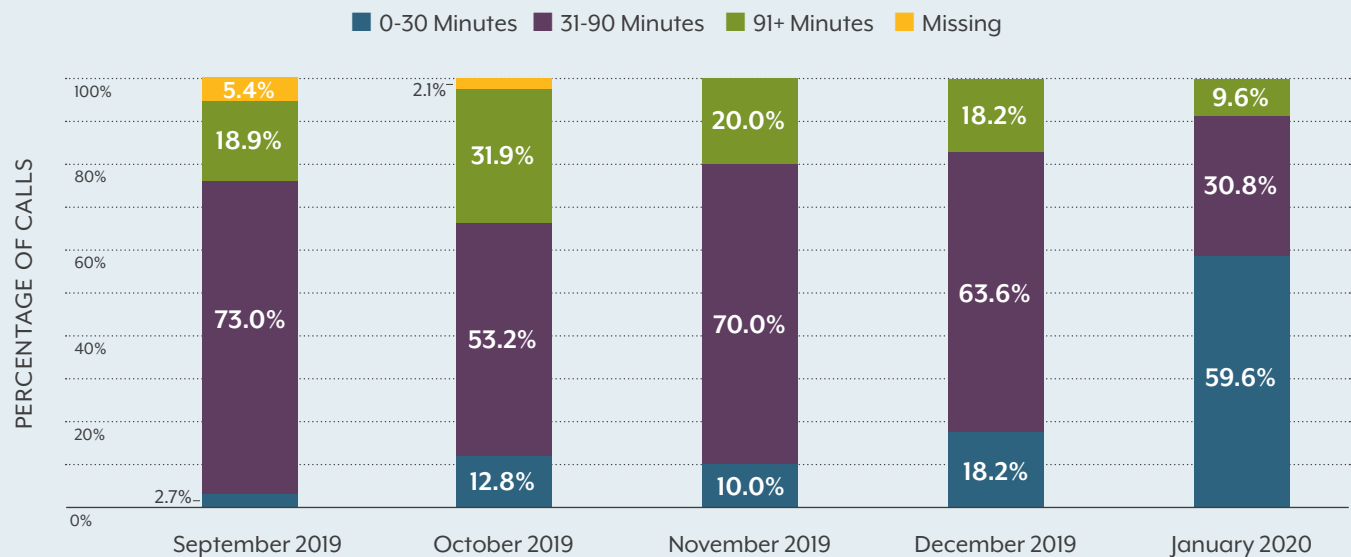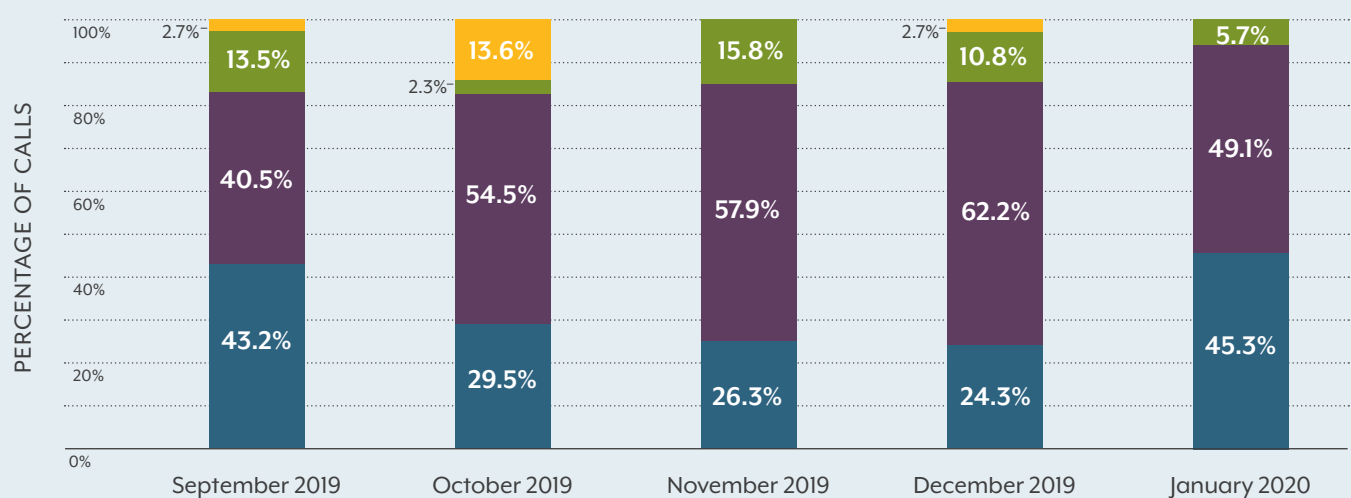

Figure 8. Officer Time Spent on Calls Stayed More Consistent Over Time in Weld County

thanks to the new reporting tool will provide a better understanding of the time spent on calls. Data reported will allow for individual-level reporting of time spent on each active call.

Key Finding 3: Co-responder teams partnered with various organizations in implementing a program.

Community behavioral health centers were most likely to be identified as a partner (78 percent), followed by hospitals (59 percent) and local public health departments (56 percent).

Nearly three of four (78 percent) of co-responder programs in rural communities reported jails as a main partner, compared with one of three (35 percent) co-responder programs in urban/suburban communities.

Maintenance

Guiding Question: What savings were realized through the diversion of formal actions such as hospitalizations or arrests?

Key Finding 1: Co-responder programs likely save money by connecting people to appropriate, less intensive services. Co-responder teams in Pitkin, Douglas, and Weld counties estimate one of every five calls (21 percent) resulted in diversions. (107 records were excluded from this analysis because of inconsistent reporting within the data collection tool. Mesa County was excluded because of missing data.)

Of these calls, an estimated 62 percent were diverted from the emergency department, and 9 percent were diverted from jail.

Data were not available to calculate the potential costs or savings of the co-responder program. To do that would require information about each individual's circumstances and a way to estimate what types of services they would have needed. Additionally, data were not available on the potential intensity of service an individual would have needed in an emergency department or the length of a jail stay.

But national and state estimates of the cost of hospital admissions and jail stays provide some context for avoided costs.

An analysis of National Inpatient Sample by the Healthcare Cost and Utilization Project estimates that the average cost per day for a hospital inpatient stay

Table 7. The Majority of Formal Diversions Reported by Co-Responder Teams Were Diversions From the Emergency Department

	Sept. 2019 – Jan. 2020 Total	Per Month Average
Individual would have gone to emergency department	56	11.2
Individual would have gone to jail	8	1.6
Other*	27	5.4

*Sites were given the option to select other but were not asked to define what these actions were.

in the United States was $1,400 for individuals with a primary mental health and/or substance use disorder diagnosis.[13]

A total of 56 individuals were diverted from emergency departments by three co-responder teams from September 2019 to January 2020 (see Table 7). Assuming these individuals would have entered inpatient care for at least one day, it is estimated that the co-responder program avoided at least $78,400 in hospital costs. However, this report suggests that the average length of stay is 6.4 days. Assuming that the average stay in Colorado is 6.4 days, the co-responder program avoided over $500,000 in hospital costs.

County Sheriffs of Colorado estimates that the average cost per day at a jail ranges from $20 to $250, depending on the county.[14] The co-responder teams report that they diverted eight people from the jail system, creating the potential for avoided costs.

Synthesizing the RE-AIM Framework: Six Cross-Cutting Themes

The impacts of co-responder teams have been demonstrated through improved attitudes and interactions between law enforcement and the people they serve, and by connecting people to appropriate services and resources.

Analysis of the qualitative data also supports

the quantitative data, but also provides more nuanced insights into issues related to program implementation and outcomes.

This evaluation identified six themes that cut across each of the elements of the RE-AIM Framework. The six major themes are: 1) resource issues, 2) engagement with community members, 3) partner and agency engagement, 4) communication issues, 5) culture (including stigma and attitudes) and, 6) data issues. (See Appendix 1 for a detailed methodology).

The cross-cutting analysis stitches together common themes using data from each section of the RE-AIM Framework. As the OBH Co-Responder Program evolves, these elements can inform ongoing activities and increase understanding of issues raised by co-responder teams.

Setbacks and Successes: A Closer Look at Implementation

Co-responders were asked to identify the greatest challenge to implementing the program and the greatest success of implementing the program. *Though barriers are discussed elsewhere in this report, this section discusses the single greatest challenge and the single greatest success identified by survey respondents.*

Key Finding: Nearly one-third of survey respondents reported partner engagement or resource issues as the greatest barriers to implementing the program. A slightly smaller percentage cited communication issues as barriers. Inadequate community resources may also be a barrier.

Digging In

Law enforcement personnel and behavioral health workers have different concerns about the co-responder program. Behavioral health professionals were more likely to say communication issues were the primary implementation barrier (33 percent), while law enforcement cited partner engagement, such as relationships with behavioral health and other community providers (43 percent). One law enforcement officer described the need to have "clinical staff understand the role of law enforcement and respecting the law enforcement culture." A behavioral health specialist commented

that "it seems like mental health and law enforcement each want these programs, but don't know how to work collaboratively."

Administrators and program managers were more likely to respond that resource issues were the primary obstacle (50 percent).

Respondents in rural communities also were more likely to report that resource issues were the main barrier (67 percent) while urban areas cited communication issues and partner engagement as equal challenges to implementation (32 percent for both).

Partner engagement was often described as a challenge to creating "buy-in." Respondents said police departments, law enforcement officers not involved in the co-responder program, and agencies that serve multiple jurisdictions needed to be more engaged in implementation.

Resource challenges included shortages of behavioral health clinicians and staffing and training difficulties. Both rural and urban communities cited short staffing, as well as challenges in retaining staff due to low pay and difficult work.

Key Finding: Co-responders report that as awareness of the program grows, they are better able to serve people who frequently come in contact with police and need behavioral health services. About 66 percent of respondents said their co-responder programs have helped people get the care they need, including diverting people from formal actions.

Digging In

Co-responder teams create collaborative relationships with individuals and stakeholders in their communities. These partnerships, in turn, promote access to behavioral health services.

Engagement with community members was reported as the top success across rural and urban communities and by different professional types. Of respondents who identified this as the primary success, 42 percent (8 of 19) said engagement leads to better access to services for their community members.

"I think our greatest success is that trust and partnership are being built with our law enforcement," one respondent said. "This allows the (behavioral health) co-responder to be able to give the best to other individuals in need."

In addition, several team members noted a reduction in formal actions, calling it a huge success that has lowered costs and cut referrals to hospital emergency departments.

"We are able to divert 94 percent of calls from the emergency departments, and we only have a 2 percent arrest rate," one respondent said.

Key Finding: Survey respondents described ways that law enforcement interactions with the community are improving through engagement with community members (44 percent) and a positive change in stigma, attitudes, and culture (48 percent).

Digging In

Both law enforcement and behavioral health professionals credited the way co-responders connect with people with improving police and community relations (67 percent and 60 percent, respectively).

A law enforcement respondent said people in their community know "a trained co-responder officer as well as a behavioral health professional are available and will specifically request them when calling 911." Awareness of the program allows the team to "slow down and take the time to build relationships to help reduce and redirect behavioral health calls."

Behavioral health professionals also cited positive community engagement resulting from the co-responder program. One behavioral health professional said, "People in the community are viewing law enforcement officers as people who are trying to better understand and interact with people with behavioral illness/substance use."

Administrators and managers indicated that the program has reduced the stigma often attached to people with behavioral health conditions, changed law enforcement attitudes towards individuals with these conditions, and improved the relationship between police and the community at large. Three of seven administrator and manager respondents said the program has heightened trust in police, while others noted that police are increasingly seen as a resource to help the community.

Law enforcement attitudes toward behavioral health also have shifted. "Officers see mental health as a resource, a partner, and a help." one administrator

said. "They understand the depth and breadth of the behavioral health system more fully now."

Implication and Impact:
A Closer Look at Reach and Effect

Co-responder programs were asked to assess their impact in reaching people and the effect of the program on individuals with behavioral health conditions.

Key Finding: Survey respondents report that their teams need more resources, such as funding for a larger staff, to reach more people with behavioral health issues. They also cited the need for increased awareness about co-responder teams and more community-based services.

Digging In

Over half of respondents identified resource needs to improve programs' reach, particularly to those who frequently use behavioral health services.

Law enforcement, behavioral health professionals, and administrators and managers had different ideas about what is needed most to improve the reach of the program.

Law enforcement officers were more likely to report greater engagement with community members as most important (50 percent); behavioral health professionals and administrators/managers cited resource issues as major concerns (60 percent and 67 percent, respectively).

Attitudes and Education:
A Closer Look at Adoption

Key Finding: Changes related to law enforcement culture and attitudes towards people with behavioral health conditions were highlighted by a majority (86 percent) of survey respondents.

Digging In

Behavioral health professionals said education changes attitudes. As one respondent put it, "The co-responder program has allowed an opportunity to educate deputies about behavioral health issues, bust myths that they might have previously had, and allow for them to meet people with behavioral illness who are able to live a 'normal' life."

Law enforcement officers shared similar sentiments, with one respondent saying that the program "allows for education both for the deputies as well as the members of the community." Another respondent said officers "are looking at things more holistically when it comes to behavioral health and behavioral health calls. Some of the newer officers are seeing that not every call they go on has a criminal offense."

Key Finding: While respect has grown between law enforcement and behavioral health professionals, there is still a need for role clarity. This includes understanding each person's unique expertise and establishing clear lanes of work for each role.

Digging In

Mutual respect does not address the larger cultural issue of blending law enforcement with behavioral health providers.

This points to a need for role clarity and an understanding of everyone's unique experience. Each profession has been trained to respond to a crisis differently, and this creates challenges when developing processes and protocols for responses in the field.

This is a critical finding that could influence how co-responder teams are adopted in other places. Having policies and procedures spelling out how members of the team are expected to work together might mitigate obstacles up front.

One respondent said, "The behavioral health agency I work for used to butt heads with (the) law enforcement agency I'm contracted with because they didn't understand each other's side of things when handling calls. My being here has helped with this at times by helping each side see why the other side is handling things the way they are."

Conclusion

In the first two years of implementation, OBH's support of local co-responder teams has successfully diverted people from unnecessary arrests and hospitalizations by connecting people with community-based care.

Initial evaluation findings also suggest that the program has been successful in facilitating the return of law enforcement to patrol activities. Additionally, the program has identified opportunities to invest in new data collection tools that can reveal individual outcomes for those who interact with co-responder teams.

There are ways to improve implementation of the program in new communities. Establishing standard operating procedures can smooth coordination and communication between law enforcement and behavioral health providers.

Further, this evaluation also points to systemic issues that may impact implementation. A lack of behavioral health providers in the community could impede the ability of co-responder teams to connect people to appropriate community-based services. Communities should take this into account as they prepare to implement a co-responder program.

Future evaluation will provide an opportunity to understand the effects that co-responders have on individuals with behavioral health conditions. The initial pilot effort to collect data on individuals served by the program is a first step to fully assessing the continued impact of co-responder teams.

OBH can facilitate improved linkages with other data sources such as Colorado COMPASS, the state's integrated mental health and substance use disorder treatment data system, to understand the impact of co-responder teams.

Appendix 1: Methods

Cross Cutting Thematic Analysis

CHI identified major themes that came up across all respondents' free response survey entries. To do this, CHI manually flagged all survey free responses with a category tag that identified major themes within each free response entry. This led to six primary themes: 1) resource issues, 2) engagement with community members, 3) partner and agency engagement, 4) communication issues, 5) culture (including stigma and attitudes), and 6) data issues.

Each free response entry was then manually categorized into one of the six main themes for analysis. These themes were counted to identify frequency within each survey question. In addition to counting the frequency for each theme, individual responses were used as quotes to identify opinions within each coded theme.

Endnotes

[1] Colorado Department of Corrections. (2019). "Departmental Reports and Statistics." Retrieved from: https://www.colorado.gov/pacific/cdoc/departbehavioral-reports-and-statistics

[2] Colorado Office of Behavioral Health. (2020). "Co-Responder Programs." Retrieved from: https://www.colorado.gov/pacific/cdhs/co-responder-programs.

[3] Colorado Office of Behavioral Health. (2020.) "Co-Responder Programs." Retrieved from: https://www.colorado.gov/pacific/cdhs/co-responder-programs.

[4] Colorado Office of Behavioral Health. (2020). "Co-Responder Programs." Retrieved from: https://www.colorado.gov/pacific/cdhs/co-responder-programs.

[5] Kerle, K. (2016). "The behaviorally ill and crisis intervention teams: Reflections on jails and the U.S. behavioral health challenge." The Prison Journal, 96(1), 153-161.

[6] Wood, J. D., & Watson, A. C. (2017). "Improving police interventions during behavioral health-related encounters: Past, present and future." Policing and Society, 27(3), 289-299.

[7] Morabito, M. S., Savage, J., Sneider, L., & Wallace, K. (2018). "Police response to people with behavioral illnesses in a major U.S. city: The Boston experience with the co-responder model." Victims & Offenders, 13(8), 1093-1105.

[8] Furness, T., Maguire, T., Brown, S., & McKenna, B. (2016;2017). "Perceptions of procedural justice and coercion during community-based behavioral health crisis: A comparison study among stand-alone police response and co-responding police and behavioral health clinician response." Policing, 11(4), paw047. doi:10.1093/police/paw047

[9] Colorado Legislative Council Staff. (2017). "Issue brief: Emergency mental health holds." Retrieved from: https://leg.colorado.gov/sites/default/files/ib_17-38_mental_health_holds_2.pdf

[10] Lord, V.B., & Bjerregaard, B. (2014). "Helping persons with behavioral illness: Partnerships between police and mobile crisis units." Victims & Offenders, 9(4): 455-474.

[11] Furness, T., Maguire, T., Brown, S., & McKenna, B. (2016;2017). Perceptions of procedural justice and coercion during community-based behavioral health crisis: A comparison study among stand-alone police response and co-responding police and behavioral health clinician response. Policing, 11(4).

[12] Bailey, K., Paquet, S.R., Ray, B.R., Grommon, E., Lowder, E.M., and Sightes, E. (2018). "Barriers and facilitators to implementing an urban co-responding police-behavioral health team." Health and Justice, 6(1), 1-12.

[13] Healthcare Cost and Utilization Project. (2019). "Inpatient stays involving mental and substance use disorders, 2016." Retrieved from: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb249-Mental-Substance-Use-Disorder-Hospital-Stays-2016.jsp.

[14] Colorado Legislative Council Staff. (2017). "Overview of County Jails." Retrieved from: https://leg.colorado.gov/sites/default/files/overview_of_county_jails_7122017.pdf.

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