March 2026

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CCBHC COMMUNITY NEEDS ASSESSMENT

A mixed-methods assessment of behavioral health needs in Aurora, Colorado, emphasizing access, service gaps, and the needs of Older Adults and Forensic populations.

Our Mission

Deeply rooted in our diverse community, we deliver state-of-the-art care and meaningful outcomes that impact emotional well-being and addiction recovery.

Our Vision

To foster hope and healing through compassionate, quality care.

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Table of Contents

Aurora Mental Health & Recovery

Aurora
Mental Health & Recovery

Introduction & Purpose

Aurora Mental Health & Recovery (AMHR) conducted the 2026 Community Needs Assessment (CNA) as part of its ongoing commitment to providing high-quality, accessible, and person-centered behavioral health services. This CNA serves as AMHR's three-year update in alignment with Certified Community Behavioral Health Clinic (CCBHC) requirements and reflects a comprehensive review of the behavioral health needs, strengths, and gaps within the communities AMHR serves.

Community Voice & Lived Experience

This assessment centers community voice and lived experience, integrating quantitative data, stakeholder and partner perspectives, and internal performance and quality information. By elevating client experiences alongside data trends, the CNA provides a balanced and meaningful understanding of how services are experienced, where barriers exist, and where opportunities for growth and improvement can be realized. This approach reinforces AMHR's mission to support recovery, resilience, and well-being across the lifespan and across diverse communities.

Findings from the CNA directly inform strategic planning, service design, expansion decisions, and continuous quality improvement (CQI) initiatives. The assessment supports AMHR in making data-informed decisions that enhance access, strengthen partnerships, improve outcomes, and ensure services remain equitable, culturally responsive, and sustainable.

Key Priority Focus Areas

Key priority focus areas for the 2026 CNA include:

- **Older Adults**, with attention to access, service models, and community-based care
- **Forensic-Involved Populations**, with a focus on coordination, continuity of care, and community reintegration
- **Geographic Expansion** into northern Adams County, addressing service availability and emerging community needs

Through this CNA, AMHR reaffirms its commitment to listening to the communities it serves, strengthening systems of care, and advancing positive outcomes for clients, families, and partners now and into the future.

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Methodology

AMHR employed a multifaceted approach to comprehensively address the needs of the Aurora community, blending data from community and client sources, document analysis, and a scientific literature review focusing on Mental Health and Substance Use.

AMHR Client and Community Demographic Comparison: Aurora Research Institute (ARI) extracted demographic data from AMHR's electronic health records and compared this with census data to analyze the representation of various groups within AMHR clients. Additional data for Aurora and the State of Colorado were sourced from the U.S. Census Bureau, Aurora city fact sheets, World Population Review, Aurora socioeconomic reports, Data USA, and the State Demography Office.

Community Member Survey: Conducted from January to February 2026 with the assistance of community partners such as the Aurora Community of Faith and the Community College of Aurora, this survey aimed to identify disparities in behavioral health needs among refugee or immigrant members of the community. It was distributed in English and Spanish.

Community Leader Survey: Running concurrently from January to March 2026, this survey targeted leaders from social service organizations to gather insights on the needs of the populations they serve. The survey was available in English and Spanish.

AMHR Client Survey: This survey, available in English, Spanish, Arabic, and Mandarin, aimed to assess the behavioral needs of AMHR clients and gather feedback on their experiences. The survey was distributed with the support of division directors and program managers at AMHR.

Literature Review: A brief and focused review of the literature was conducted by selecting a small number of relevant articles on challenges in and best practices for the mental and behavioral healthcare of older adults and summarizing their main findings. These articles were analyzed to identify insights as well as recurring themes and patterns across the sources.

Aurora
Mental Health & Recovery

Design

The 2026 Community Needs Assessment (CNA) for Aurora Mental Health & Recovery (AMHR) was designed to provide a comprehensive and data-informed picture of behavioral health needs across the communities served.

The assessment integrates multiple data sources, including client demographic and utilization data from AMHR's electronic health record (EHR), community and stakeholder survey feedback, interviews with internal clinical and operational leaders, and publicly available demographic and health indicators at the city, county, and state levels. Findings were also cross-referenced with priorities identified in statewide behavioral health needs assessments and policy initiatives led by the Colorado Behavioral Health Administration (BHA) and the Colorado Department of Health Care Policy & Financing (HCPF).

External perspectives from healthcare partners, community organizations, and regional providers were incorporated to ensure that this assessment reflects not only AMHR's internal service data but also the broader healthcare ecosystem serving the city of Aurora, and the counties of Adams, Arapahoe, and Douglas.

This multi-source approach allows AMHR to connect community needs with system-wide trends, identify alignment with state-identified behavioral health priorities, and highlight where AMHR programs and services are already addressing these needs through the CCBHC model. By integrating internal data, community voice, and regional healthcare partner insights, the CNA provides a full-picture assessment that informs strategic planning, service expansion, and coordinated population health responses across the behavioral health system.

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Service Area & Organizational Context

Aurora Mental Health & Recovery (AMHR) serves residents of the City of Aurora and surrounding communities across Adams, Arapahoe, and Douglas Counties, with focused attention on areas experiencing population growth, disparities in access, and limited availability of behavioral health services. Aurora is one of the fastest-growing and most diverse cities in the state. According to the U.S. Census Bureau, Aurora's estimated population reached approximately 403,000 residents in 2024, with continued growth projected through 2025–2026. The city spans a mix of rural, suburban, and urban landscapes—characteristics that influence transportation access, service availability, and community support. Aurora is also home to significant community assets, including Buckley Space Force Base, Aurora and Quincy Reservoirs, 103 parks, and more than 5,000 acres of trails and open space, which contribute to the quality of life and the community's regional identity.

While AMHR's primary service hub is located within Aurora, many individuals receiving services reside across Adams, Arapahoe, and Douglas Counties, reflecting the interconnected nature of the regional behavioral health system. Population density across Aurora averages approximately 2,400 residents per square mile, though density and infrastructure vary widely by neighborhood and county boundary areas. Differences in geography, transit infrastructure, and service distribution influence patterns of behavioral health access and utilization across the region. Consistent with CCBHC requirements to define and assess the needs of the service area population and Substance Abuse and Mental Health Services Administration (SAMHSA) guidance on population-based planning, the 2026 Community Needs Assessment applies this demographic and contextual lens to identify areas where behavioral health needs are most pronounced and where service gaps exist. Particular attention is given to northern Adams County and other surrounding growth corridors, which are experiencing rapid population increases and evolving service needs that may require expanded behavioral health capacity.

Image Credit: Jacob – https://stock.adobe.com/images/aerial-view-of-aurora-colorado-in-autumn/469154727

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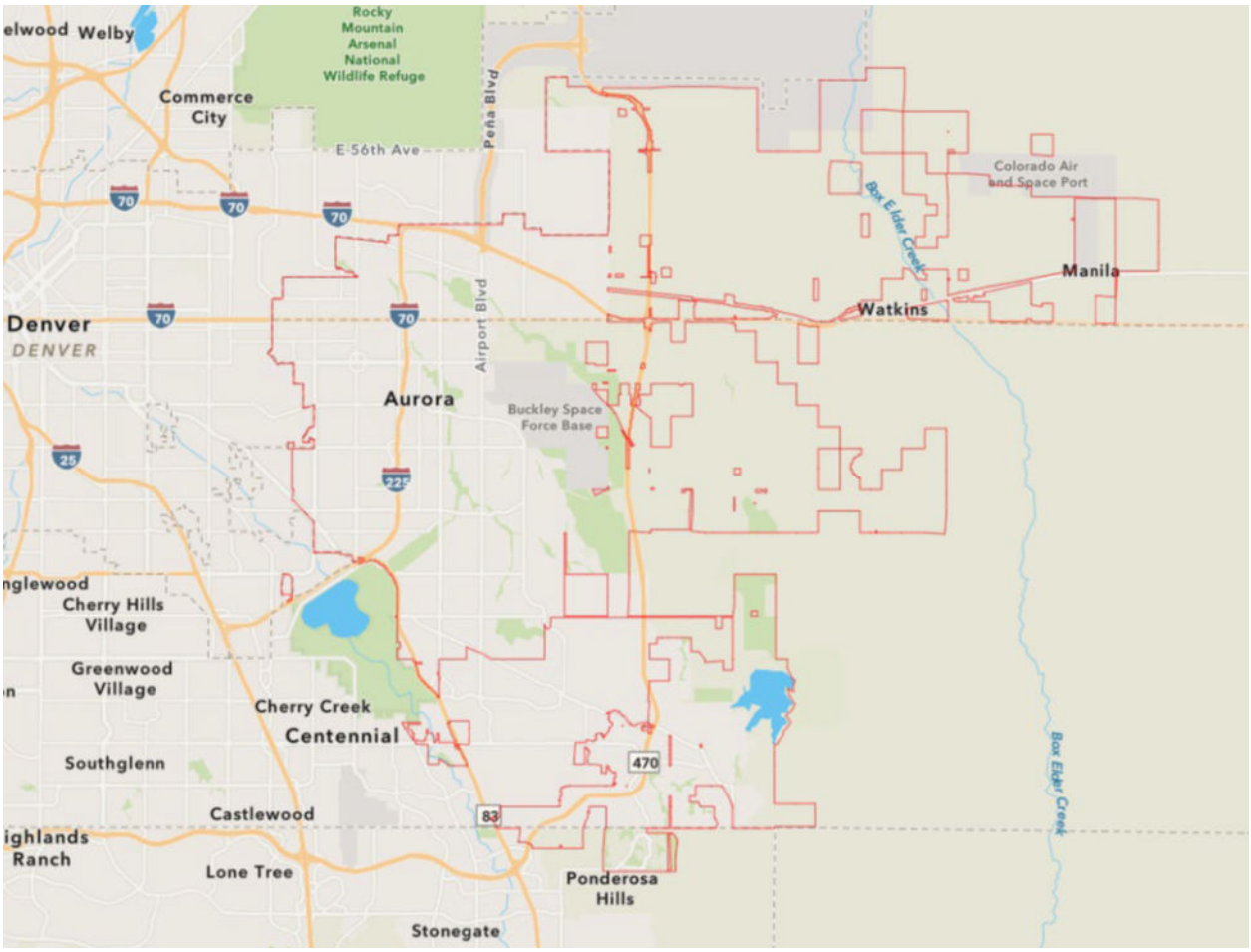
Figure 1: *Aurora City Limits*



Source: Aurora City Limits, n.d.

Maps

AMHR delivers behavioral health services through a comprehensive system that includes outpatient behavioral health clinics, residential services, a Crisis and Acute Care Center, community-embedded and outreach services. This organizational structure supports a full continuum of care responsive to varying levels of acuity and need, promotes coordination across service settings, and enhances timely access to services. The CNA evaluates how this service array functions within the community and identifies opportunities to strengthen access, care coordination, and quality improvement. Findings from this assessment directly inform AMHR's CCBHC-aligned planning, Continuous Quality Improvement (CQI) efforts, and service development priorities, ensuring that organizational capacity and service delivery remain responsive, equitable, and aligned with SAMHSA's recovery-oriented system of care principles.

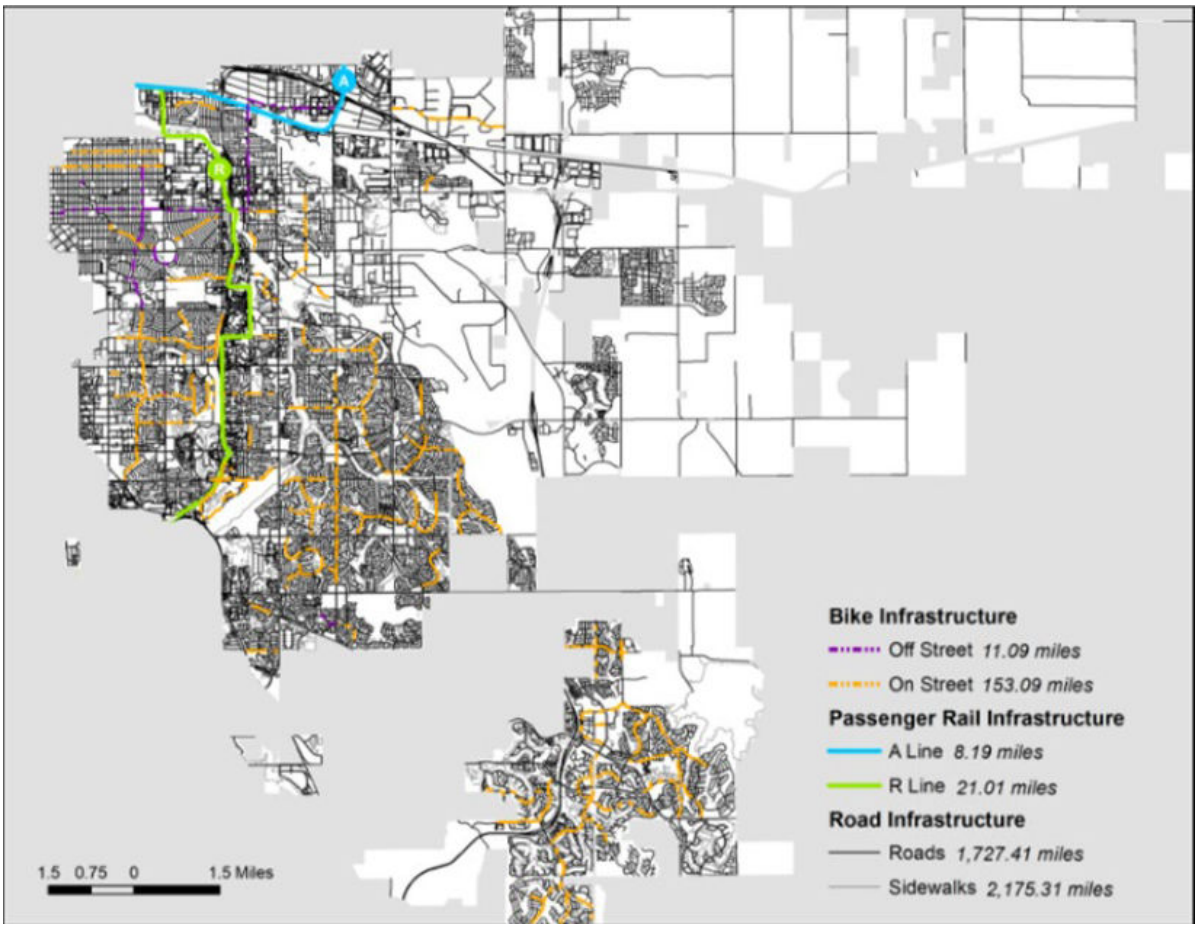
Aurora Mental Health & Recovery

Aurora, Colorado, is a thriving city located east of the Rocky Mountains. The city spans 164.7 square miles and is nestled within the boundaries of Adams, Arapahoe, and Douglas counties (City of Aurora, n.d.a; Department of Local Affairs, 2024). Elevations in Aurora range from 5,285 to 6,229 feet (City of Aurora, n.d.a).

Aurora is home to the Buckley Space Force Base, Aurora and Quincy Reservoirs, five golf courses, the Plains Conservation Center, and 103 parks (City of Aurora, n.d.b). The city boasts over 5,000 acres of trails and open spaces (City of Aurora, n.d.b). Although much of Aurora is rural, it accommodates over 414,000 residents (Planning and Development Services/Data Services, 2023). With a population density of 2,518 residents per square mile as of 2024 (United States Census Bureau, n.d.), the city combines suburban and urban characteristics, with some areas denser than others.

The distinction between rural and suburban/urban areas is also evident in Figure 2 below, which illustrate the city's road, bike, and public transportation infrastructure.

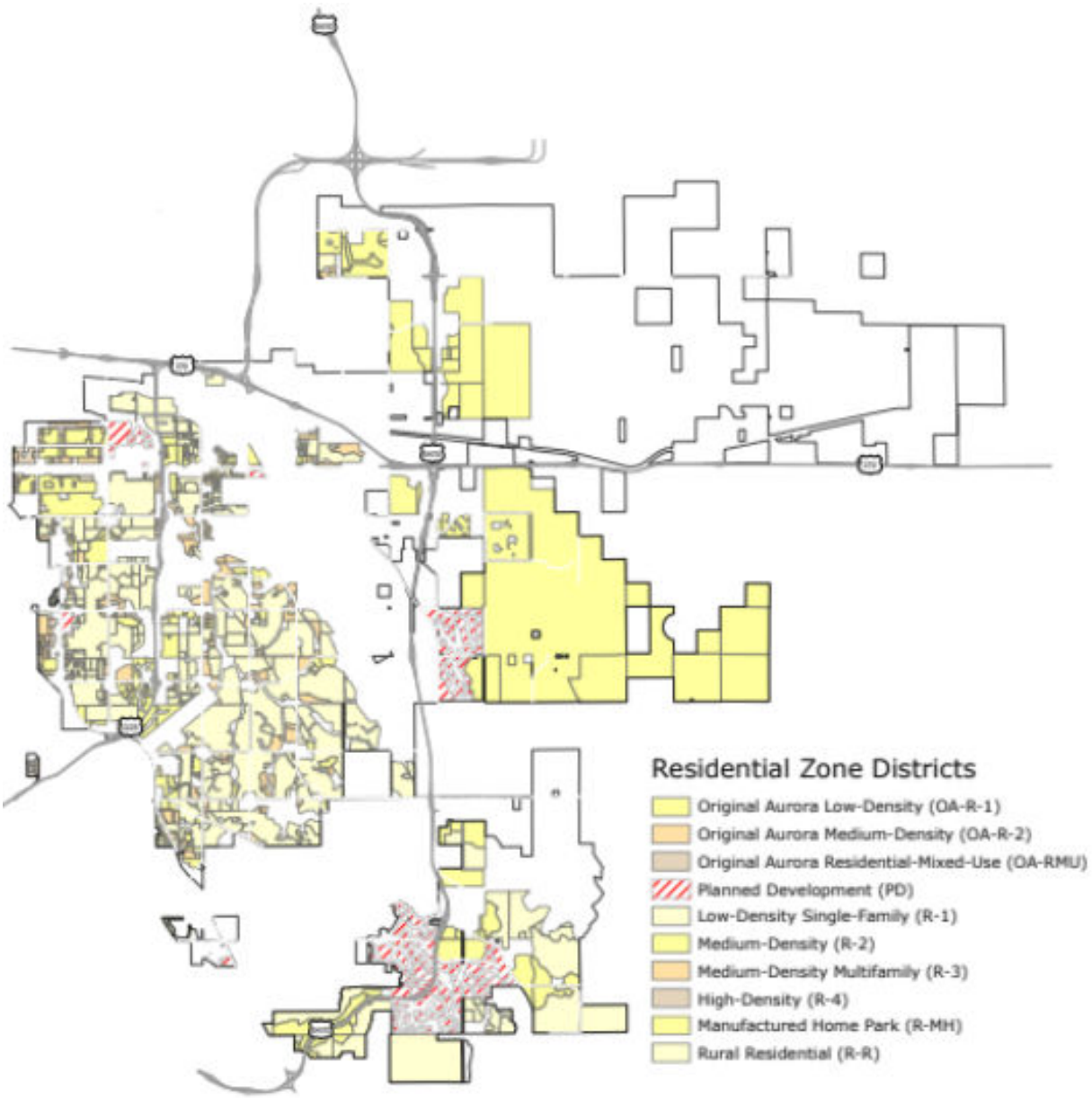
Figure 2: *City of Aurora Bike, Passenger Rail, & Road Infrastructure*



Source: City of Aurora, n.d.a

Figure 3 illustrates the residential zoning across Aurora, highlighting the rural and other zones.

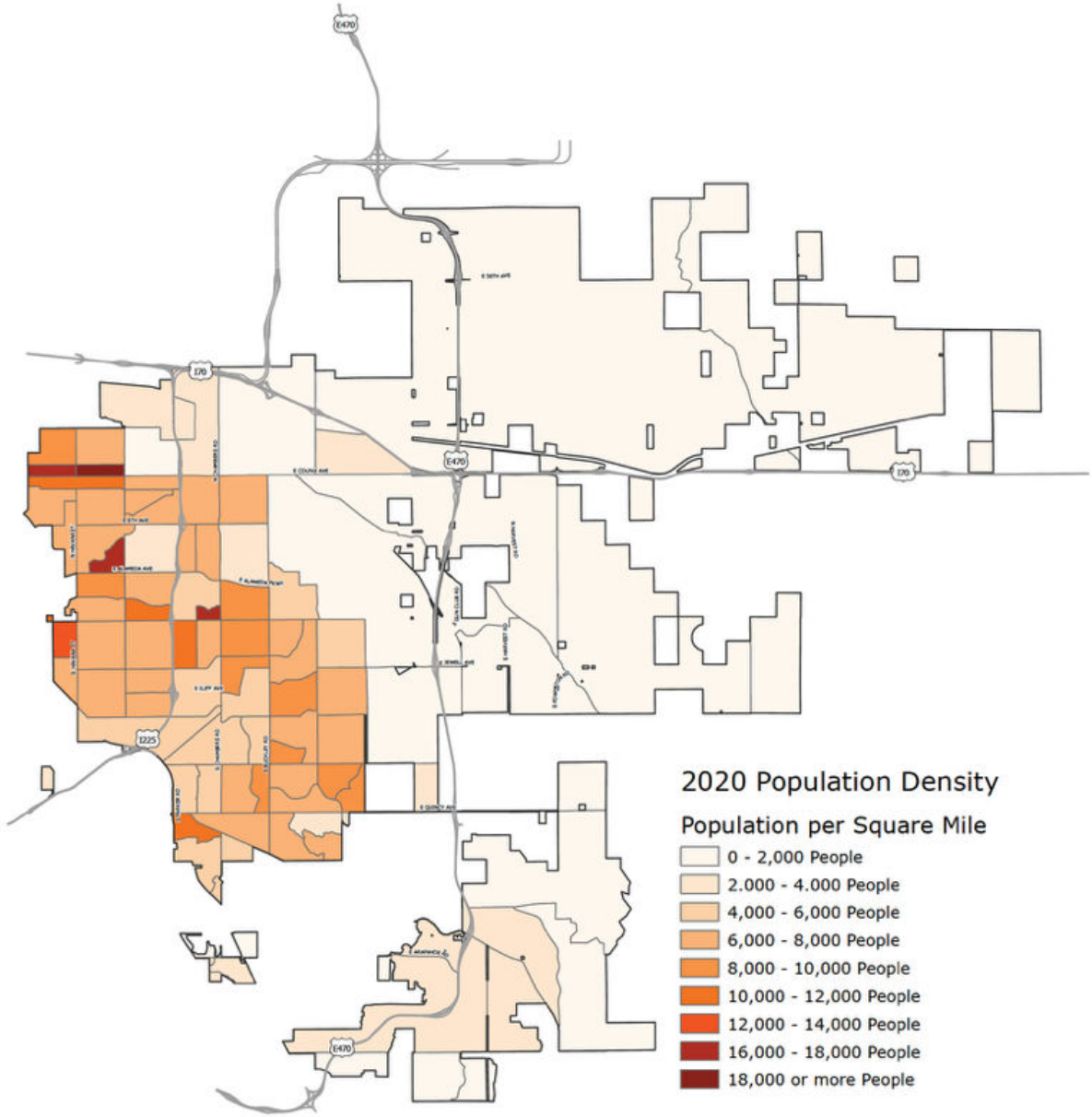
Figure 3: *Residential Zone Districts, Aurora, CO*



Source: City of Aurora. (2022). Who is Aurora? Socioeconomic report. https://cdnsm5-hosted.civiclive.com/UserFiles/Servers/Server_1881137/Image/City%20Hall/About%20Aurora/Date%20&%20Demographics/Who%20Is%20Aurora/Who%20Is%20Aurora%20FINAL.pdf

Lastly, the population density as of 2020 is depicted in Figure 4 below.

Figure 4: *Aurora Population Density, 2020*



Source: City of Aurora. (2022). Who is Aurora? Socioeconomic report. https://cdnsm5-hosted.civiclive.com/UserFiles/Servers/Server_1881137/Image/City%20Hall/About%20Aurora/Date%20&%20Demographics/Who%20Is%20Aurora/Who%20Is%20Aurora%20FINAL.pdf

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AMHR Services at a Glance

Aurora Mental Health & Recovery (AMHR) operates as a Certified Community Behavioral Health Clinic (CCBHC) grantee and participates in the Colorado Safety Net Provider system as both comprehensive and essential provider types, providing a comprehensive continuum of behavioral health services designed to respond to the evolving needs of individuals and families across Aurora and the surrounding Adams, Arapahoe, and Douglas County communities. Services are delivered across 10 locations in Aurora, structured to promote timely access, continuity of care, and coordinated responses across varying levels of behavioral health need.

AMHR has long maintained 24 hours a day, 7 days a week, 365 days a year access to crisis services, historically provided through the Crisis Walk-In Clinic (WIC), Crisis Stabilization Unit (CSU), and Withdrawal Management (Formerly East Metro Detox) services located at the Victor St. campus. In January 2026, AMHR expanded and centralized these services with the opening of the Potomac Pavilion, creating a one-stop behavioral health access point for mental health and substance use crises. Beginning January 31, 2026, the Potomac Pavilion became the location for these 24/7/365 crisis services, including Walk-In Crisis care, Crisis Stabilization, and Withdrawal Management.

Potomac Pavilion also houses Connect to Care (C2C) services, which provide rapid behavioral health assessments and navigation to ongoing treatment services during standard operating hours. While C2C itself is not a 24/7 service, individuals can access immediate behavioral health support through the Crisis Walk-In Clinic at any time.

AMHR's service system includes outpatient mental health and substance use treatment, crisis and acute care, residential programs, and community-based services tailored to children, youth, adults, older adults, and individuals involved in the justice system or experiencing housing instability. Services are delivered in a variety of settings—including outpatient clinics, crisis centers, residential programs, and community-embedded locations—to ensure care is accessible and responsive to community needs.

Care across AMHR programs is grounded in trauma-informed and culturally responsive practices, with attention to safety, dignity, and client choice. Standard outpatient services operate Monday through Friday, 8:00 a.m. to 5:00 p.m., with evening appointments available until 7:00 p.m. to improve accessibility for working individuals and families. Crisis Walk-In services, Crisis Stabilization, and Withdrawal

Aurora
Mental Health & Recovery

Management remain available 24 hours a day, 7 days a week, ensuring individuals experiencing behavioral health emergencies can access care at any time.

Together, AMHR's integrated service array supports recovery, stability, and well-being by aligning services with community needs and ensuring accessible, coordinated behavioral health care across the region.

AMHR Service Locations

AMHR's programs are administered from 9 building locations within the greater Aurora area (Figure 5).

AMHR Building Locations:

1. **Alameda**
   10782 E. Alameda Ave.,
   Aurora, CO 80012
2. **Alton**
   1537 Alton St.,
   Aurora, CO 80010
3. **Elmira**
   1544 Elmira St.,
   Aurora, CO 80010
4. **Galena**
   1504 Galena St.,
   Aurora, CO 80010
5. **Hampden**
   14301 E. Hampden Ave.,
   Aurora, CO 80014
6. **Leversee**
   1290 Chambers Rd.,
   Aurora, CO 80011
7. **Potomac Pavilion**
   1290 S. Potomac St.,
   Aurora, CO 80012
8. **Stith Center**
   791 Chambers Rd.,
   Aurora, CO 80011
9. **Victor St.**
   2206 Victor St.,
   Aurora, CO 80045

Figure 5: *AMHR Location Map, March 2026*

Aurora Mental Health & Recovery

Programs at Alameda (Forensics & Substance Use Treatment)

Forensic Services

Aurora Sustained – Provides ongoing behavioral health treatment and case management for justice-involved individuals to support stability and reduce recidivism.

Forensic Flexible Assertive Community Treatment (ForFACT) – Intensive, community-based treatment and multidisciplinary support for individuals with serious mental illness involved in the justice system.

Forensic Outpatient – A step down from ForFACT with less intensive outpatient treatment. Utilizes individual therapy, group therapy, case management, urinary analysis, and even Medication Assisted Treatment (MAT) where applicable.

Jail Based Behavioral Health Services (JBBHS) – In partnership with the Arapahoe County Sheriff's Office, provides behavioral health screening, assessment, and treatment for individuals at the Arapahoe County Detention Facility.

Reset: Recovery Services

Provides outpatient substance use treatment, including intensive outpatient programming, therapy, and Medication-Assisted Treatment (MAT) to support recovery.

Programs at Alton (Cultural Development & Wellness Center)

Cultural Development & Wellness Center (CDWC) – Exists to meet the needs of Aurora's increasingly diverse population which includes immigrants from around the world.

Programs at the CDWC Alton location provide culturally and linguistically responsive services including Behavioral Health and Health Navigation (Asian Pacific Clinic), Victim Assistance, Adult Education, Youth Leadership Academy™ (YLA), and Colorado Language Connection (CLC).

Aurora
Mental Health & Recovery

Programs at Elmira (Homeless Services & Case Management)

Homeless Services – Provides comprehensive community-based services to individuals and families experiencing homelessness through street outreach, a drop-in model, community-based care, and housing case management.

Housing Voucher Program – This program administers housing vouchers and provides case management and facility support to clients in vouchered units, including at Mrachek House and other off-site locations.

Programs at Galena (Outpatient & Cultural Development & Wellness Center)

Elmira Counseling Center | Outpatient Services – Delivers evidence-based interventions to adults in an outpatient setting, offering individual, couples, and group therapy, specializing in high-acuity cases involving severe and persistent mental illness.

Refugee & Immigrant Clinic | Cultural Development & Wellness Center – Provides culturally and linguistically responsive mental health and health navigation services to refugees and asylees, with staff fluent in 17 languages.

Programs at Hampden (Outpatient & Child Specialty Services)

Child & Family South (CFS) | Outpatient Services – Offers mental health services to children and their families, ages 6-18. It provides individual therapy, family therapy, group therapy, crisis management, and other essential services to help children and adolescents achieve their treatment goals. Common groups at CFS include Play Therapy, Parenting Support, and Social Skills. Clinicians are trained in various therapies including play therapy, parent-child interaction therapy, art therapy, Eye Movement Desensitization and Reprocessing (EMDR), Trauma Systems Therapy for Refugees (TST-R), Cognitive Behavioral Therapy (CBT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Dialectical Behavior Therapy (DBT).

Aurora Mental Health & Recovery

Intensive In-Home Team (IIH) | Child Specialty Services – Offers intensive therapeutic and behavioral coaching for youth aged 6 to 21 and their families who have experienced trauma. Utilizing Trauma Systems Therapy, this program addresses the emotional needs of children within their social environments, aiming to dismantle barriers between service systems and build on family strengths.

Autism & I/DD Counseling Center – Youth (AICC-Y) – Provides specialized behavioral health services for youth ages 6–21 with co-occurring mental health conditions and Autism or Intellectual/Developmental Disabilities (I/DD). Services include individual, family, and group therapy using adapted approaches such as trauma-informed care, DBT, CBT, play therapy, and art therapy. The program also offers medication management, case management, life skills support, and parent psychoeducation, while collaborating with providers, schools, and caregivers to support youth holistically. Services are available in-person or via telehealth, with interpretation services available to support multiple languages across the Metro Denver area.

Southeast Counseling Center (SE ADULT) | Outpatient Services – Provides evidence-based outpatient mental health services for adults, addressing a wide range of behavioral health needs. The program fosters a welcoming and respectful environment where individuals from all backgrounds feel supported and understood. Services include group therapies such as a clutter group and Mind Over Mood, with clinicians trained in CBT, DBT, and psychodynamic approaches.

Older Adult Counseling Center (OA) | Outpatient Services – Provides evidence-based outpatient therapy and outreach to older adults, addressing their unique strengths and challenges. Services include assessment, individual therapy, group therapy, and outreach to assisted living and nursing home facilities.

Programs at Leversee (Outpatient, Child Specialty, & School-Based Services)

Child & Family North (CFN) | Outpatient & School-Based Services – Provides mental health services to children and their families, ages 6-18. Services include individual therapy, family therapy, group therapy, and crisis management. Groups offered include Healing from Racial Trauma, Dialectical Behavioral Therapy for Adolescents, and Parenting Support. Clinicians are trained in EMDR, Play Therapy, TST-R, DBT, CBT, and TFCBT.

Early Childhood & Family Center (ECFC) | Child Specialty Services – ECFC offers comprehensive services to children from birth to age six with behavioral, social, or emotional challenges, along with their families. Services range from clinical

Aurora Mental Health & Recovery

interventions to prevention and early intervention programs, including an in-home program and early childhood mental health consultation.

School-Based Services (SBS) | Outpatient & School-Based Services – SBS teams at APS Northeast, APS Northwest, and APS South consist of therapists, intake coordinators, and case managers who support students, families, and schools within Aurora Public Schools. They collaborate with educators to create an optimal learning environment, offering services such as therapy, wellness support, mental health education, and crisis support. SBS therapists host various groups, including those for social skills, anxiety management, grief and loss, and trauma healing, and organize a two-week summer camp.

CCSD East & West SBS teams support students, families, and schools within the Cherry Creek School District, Bennet and Byers School Districts, and local charter schools. They provide similar services to APS teams, fostering a supportive educational environment.

Mrachek House (Residential Services)

Mrachek House – An 8-bedroom, HUD-supported housing unit, licensed as an Assisted Living Residence (ALR). It provides independent housing services to low-income clients and is staffed 24 hours a day, offering case management support for residents.

Aurora
Mental Health & Recovery

Programs at Potomac Pavilion (Connect to Care, Crisis Walk-In Clinic, Crisis Stabilization Unit, & Withdrawal Management)

In January 2026, Aurora Mental Health & Recovery (AMHR) opened the Potomac Pavilion, a centralized behavioral health hub designed to improve access to mental health and substance use services for the Aurora community. Developed in alignment with Certified Community Behavioral Health Clinic (CCBHC) principles and informed by community feedback, the Pavilion provides a single access point for individuals seeking behavioral health support, crisis services, or connection to ongoing care.

Connect to Care (C2C) – Provides same-day behavioral health care access and support. C2C helps individuals quickly access support without needing to navigate multiple systems or referral processes. Staff work with individuals and families to assess needs, provide immediate guidance, and connect them to the appropriate level of care within AMHR or the broader community.

24/7 Crisis Services
As of January 31, 2026, AMHR's existing 24/7/365 crisis services—previously located at the Victor St. building—are now centralized at the Potomac Pavilion. These services include:

- **Crisis Walk-In Clinic** – Immediate assessment and intervention for individuals experiencing a mental health or substance use crisis.

- **Crisis Stabilization Unit** – Short-term stabilization and observation services for individuals who require a safe, supportive clinical environment but may not need hospitalization.
- **Withdrawal Management (Formerly East Metro Detox)** – Clinically supported care for individuals experiencing substance withdrawal, helping them safely begin the recovery and treatment process.

Centralizing these services at the Potomac Pavilion strengthens coordination across crisis care and ongoing treatment services while reducing barriers for individuals and families seeking immediate behavioral health support. The model is designed to help divert individuals from emergency departments and the justice system whenever possible and ensure access to timely, recovery-oriented care.

Programs at Stith Center (Adult Intensive Services and Medical Programs)

Clinical Programs

Stith Center – Aurora Mental Health & Recovery

Autism & I/DD Counseling Center – Adults (AICC-A) – Provides specialized behavioral health services for adults (18+) with Autism Spectrum Disorder or Intellectual/Developmental Disabilities (I/DD) and co-occurring mental health conditions. Services include individual, family, and group therapy, adapted skills groups, comprehensive behavioral health assessments, and case management delivered by clinicians trained in working with individuals with developmental disabilities. The program also offers caregiver support and coordination of care to promote stability and independence. Services are available in-person and via telehealth, with English- and Spanish-speaking staff and interpreter services available to support clients across Aurora, the Metro Denver region, and statewide via telehealth.

Assertive Community Treatment (ACT) | Adult Intensive Services – An evidence-based treatment model for adults with severe and persistent mental illnesses who frequently utilize hospital and criminal justice systems. This program aims to reduce hospitalizations and criminal justice involvement, supporting clients to thrive in the community. Services include individual and group therapy, clinical case

management, housing support, psychosocial rehabilitation, and collaboration with external resources.

Ascent & Ascent Step-Down | Adult Intensive Services Division – Supports youth and young adults aged 15-29 experiencing their first episode of psychosis (FEP). This program, which can extend up to three years, offers community-based services including individual and group therapy, case management, recreational therapy, vocational and educational support, and peer services.

Community Connections (CC) – Provides structured, milieu-based services designed to support individuals with serious mental illness in building daily living skills, social connection, and overall stability. The program emphasizes therapeutic and recovery-oriented group environments, incorporating recreational, skill-building, and community integration activities to promote engagement and improve quality of life. Services support individuals in developing routines, strengthening interpersonal skills, and increasing independence within a supportive, team-based setting.

Community Living Program (CLP) – Supports individuals with serious mental illness in developing independent living skills and maintaining stable housing and community functioning.

Competency Restoration – Provides behavioral health services and education to individuals involved in the legal system who require restoration of competency to proceed in court.

Hospital Liaison Services (Child & Adult) – Coordinates behavioral health assessments, discharge planning, and continuity of care for individuals transitioning from hospital settings to outpatient services.

Journey: Women's Intensive Outpatient Program (IOP) – A structured treatment program designed specifically for women addressing mental health and substance use concerns through group therapy and supportive services.

Vocational Services – Provides employment readiness, job placement, and ongoing employment support to help individuals with behavioral health conditions achieve meaningful work and independence.

Medical Programs

Adult Intensive Services – Provides comprehensive psychiatric and clinical support for individuals with

complex behavioral health needs requiring a higher level of outpatient care. Offers psychiatric evaluations, medication management, and ongoing treatment planning for adults receiving behavioral health services.

Adult Outpatient Psychiatric Services – Offers psychiatric evaluations, medication management, and ongoing treatment planning for adults receiving behavioral health services.

Inpatient Nursing – Provides clinical nursing care and medical coordination for individuals receiving higher levels of behavioral health treatment.

Intensive Outpatient Psychiatric Programs – Structured psychiatric treatment programs providing more frequent therapeutic and medication support for individuals requiring intensive outpatient care. Medication services are provided in partnership with our intensive services and OP clinical teams.

Medical Support Services – Clinical support services that assist with medical care coordination and health stabilization.

Psychiatry Access Clinic (PAC) – Provides psychiatric medication access for individuals needing psychiatric medication evaluations and medication support.

Outpatient Nursing – Nursing services supporting medication administration and monitoring,

Transcranial Magnetic Stimulation (TMS) – A non-invasive treatment option for individuals with treatment-resistant depression and other behavioral health conditions.

AMHR Client & Community Demographic Comparison

Comparison of AMHR, Aurora, and Colorado Demographic Data

This report examines the characteristics of AMHR clients, residents of the city of Aurora, Colorado, and residents of Colorado. Demographics are discussed and compared below. All AMHR data were obtained from AMHR, and originate from a data pull dated February 6th, 2026. Thus, these data are accurate as of 2026. Data for the city of Aurora were obtained from multiple sources provided below. Colorado state data also originate from multiple sources, which are provided below.

Aurora Mental Health & Recovery

Population

The state of Colorado has 6,012,561 residents as of 2025.[1] Aurora has 414,283 residents as of 2024,[2] which is 6.89% of Colorado's total current residents. The total number of clients at AMHR as of 2025 is 20,671. Thus, AMHR clients make up 4.99% of Aurora residents and only 0.34% of residents of the state.

While statistics on the percentage of AMHR clients that are foreign-born were not obtainable, the percentage is 22.4% for the city of Aurora[3] and is 10.6% for the state of Colorado.[4] Aurora therefore has a higher percentage of residents that are foreign-born than Colorado.

The percentage of AMHR clients that are veterans is 1.3%, versus 5.1% of Aurora's population[3] and 5.7% of Colorado's population.[1] The state of Colorado has a greater percentage of veterans than Aurora. AMHR has a very small percentage of veterans among its clients, and thus does not serve a representative sample of the city or state's veterans.

Race & Ethnicity

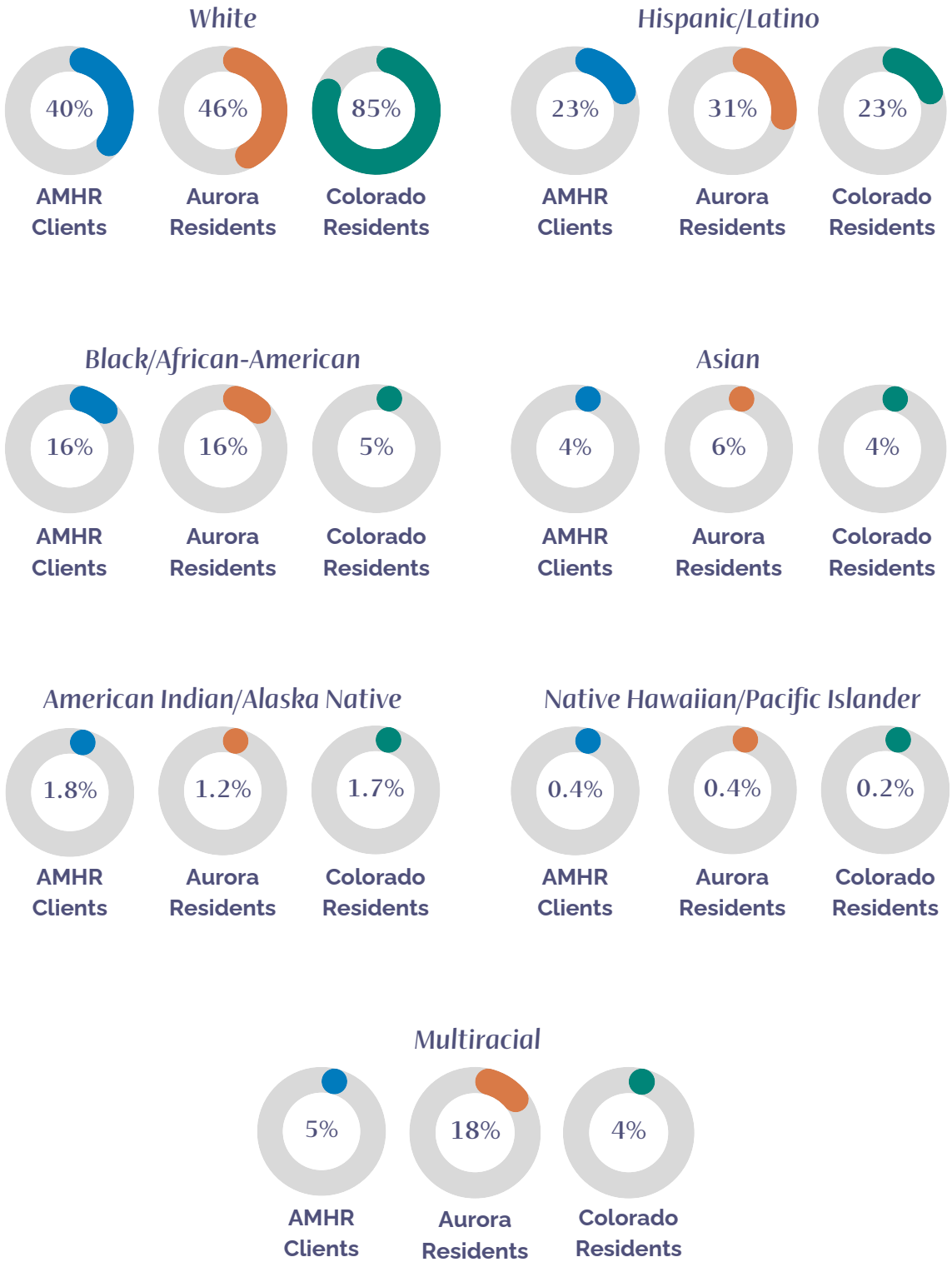
The largest proportion of AMHR clients are white, with 39.5% of clients identifying as white. 45.6% of residents of Aurora are white,[1] while 85.4% of Colorado residents are white.[2] (Figure 6) Thus, AMHR serves a lower percentage of white clients than the city or state percentage. Additionally, 23.1% of AMHR clients are Hispanic/Latino, while the percentages are higher for Aurora (31.4%)[1] and Colorado (23.2%).[2] (Figure 6)

15.9% of both AMHR clients and Aurora residents are black,[1] and 5.0% of Colorado residents are black.[2] (Figure 6) AMHR thus serves as a representative percentage of black clients in the city of Aurora, and a higher percentage of black clients than are represented in the state of Colorado.

AMHR clients are 4.2% Asian, 1.8% American Indian/Alaska Native, 0.4% Native Hawaiian/Pacific Islander, and 5.2% multiracial. (Figure 6) Comparatively, 6.1% of Aurora residents are Asian, 1.2% are American Indian/Alaska Native, 0.4% are Native Hawaiian/Pacific Islander, and 18.4% are multiracial.[1] (Figure 6) 4.1% of Colorado residents are Asian, while 1.7% are American Indian/Alaska Native, 0.2% are Native Hawaiian/Pacific Islander, and 3.6% are multiracial.[2] (Figure 6) The city of Aurora has a higher percentage of Asian and multiracial residents than either the state of Colorado or AMHR clients. Additionally, AMHR serves a representative sample of Native Hawaiian/Pacific Islander clients, and a higher amount of American Indian/Alaska Native clients than those in Aurora and Colorado state populations.

Aurora Mental Health & Recovery

Figure 6: *Race & Ethnicity*

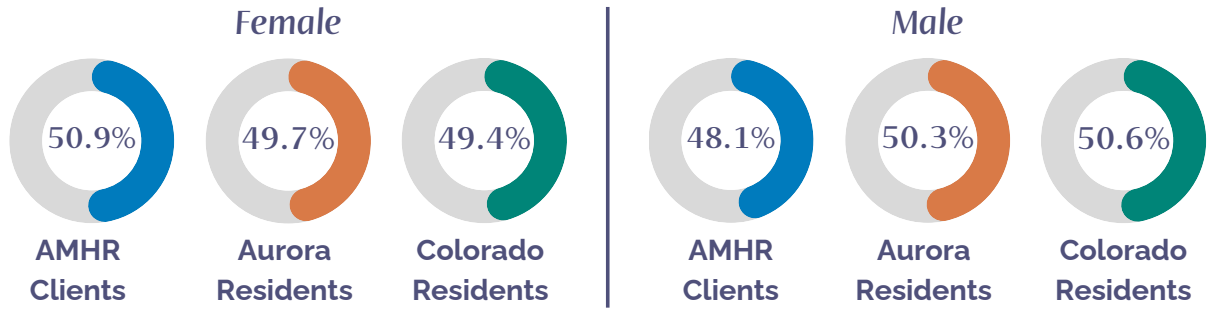


Aurora Mental Health & Recovery

Gender

Regarding gender, AMHR serves 50.9% female clients, slightly higher than the percentage of females in the city of Aurora (49.7%)[1] and the state of Colorado (49.4%).[2] (Figure 7) While males make up 50.3% of Aurora's population and 50.6% of Colorado's population, they make up a smaller percentage (48.1%) of AMHR clients. Statistics on individuals with gender identities other than male and female were only available for AMHR populations. (Figure 7) Of AMHR clients, 0.7% identify as transgender, 0.5% identify as gender queer or gender non-conforming, and 0.2% identify as a different gender identity. (Figure 7)

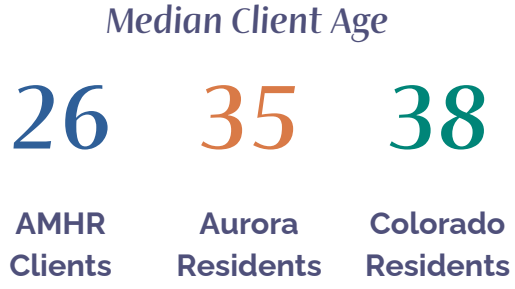
Figure 7: *Gender*



Age

The median age of clients at AMHR is 26, compared to a median age of 35 for the city of Aurora[1] and 38 for the state of Colorado.[2] (Figure 8) Aurora's residents may be slightly younger than Colorado's residents, but AMHR has many younger clients compared to both the city and the state. Since the median age of AMHR clients is 9 years less than that of the city and 12 years less than that of the state, AMHR seems to serve a younger population compared to the city and state populations.

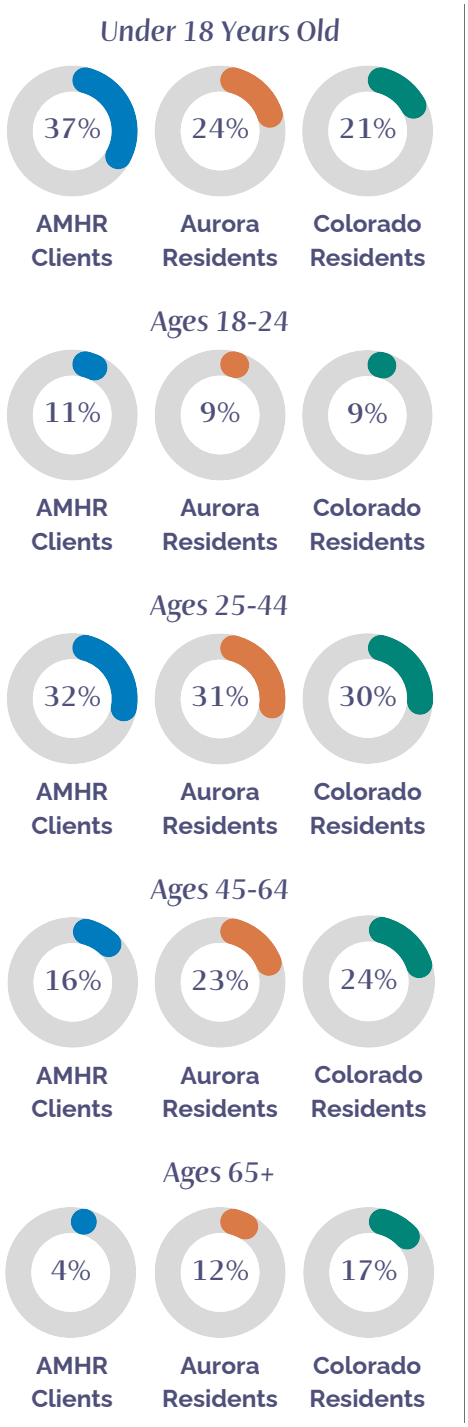
Figure 8: *Median Age*



Aurora Mental Health & Recovery

Examining age group statistics, 37% of AMHR's clients are below the age of 18, while only 24%[3] of the residents of Aurora and 21%[4] of Colorado residents are in the same age group. For both Aurora[3] and Colorado[4], 9% of the population is ages 18-24. A higher number of AMHR clients (11%) are 18-24. Of AMHR clients, 32% are ages 25-44. Similarly, 31% of Aurora residents[3] and 30% of Colorado residents are in the same age group.[4] These findings indicate that individuals below 45 years old are served at higher rates at AMHR than their representation in Aurora and Colorado state rates. A total of 72% of AMHR's clients are under the age of 40, demonstrating that AMHR has a high number of clients that fall in younger age groups. (Figure 9)

Figure 9: *Age Groups*



For individuals 45 years old and older, AMHR serves a lower rate than Aurora and Colorado state rates of individuals in the same age group. Colorado residents ages 45-64 make up 24% of the state population[4] and 23% of the Aurora city population[3], but only represent 16% of AMHR's client population. Additionally, 17% of Colorado residents[4] are 65 years old and older, while 12% of Aurora residents[3] and only 4% of AMHR clients are in the same age group. (Figure 9)

Education

The highest level of education completed by clients at AMHR was also examined. Of clients, 12% have some high school experience but no diploma, 22% hold a high school diploma or GED, 4% have some college experience but no degree, 5% have an Associate's Degree, 3% have a Bachelor's Degree, and 0.8% hold a graduate or professional degree. More clients at AMHR have high school experience or a high school diploma/GED than any other degree type. (Figure 10)

Comparatively, of Aurora residents, 7% have some high school experience but no diploma, 23% hold a high school diploma or GED, 21% have some college experience

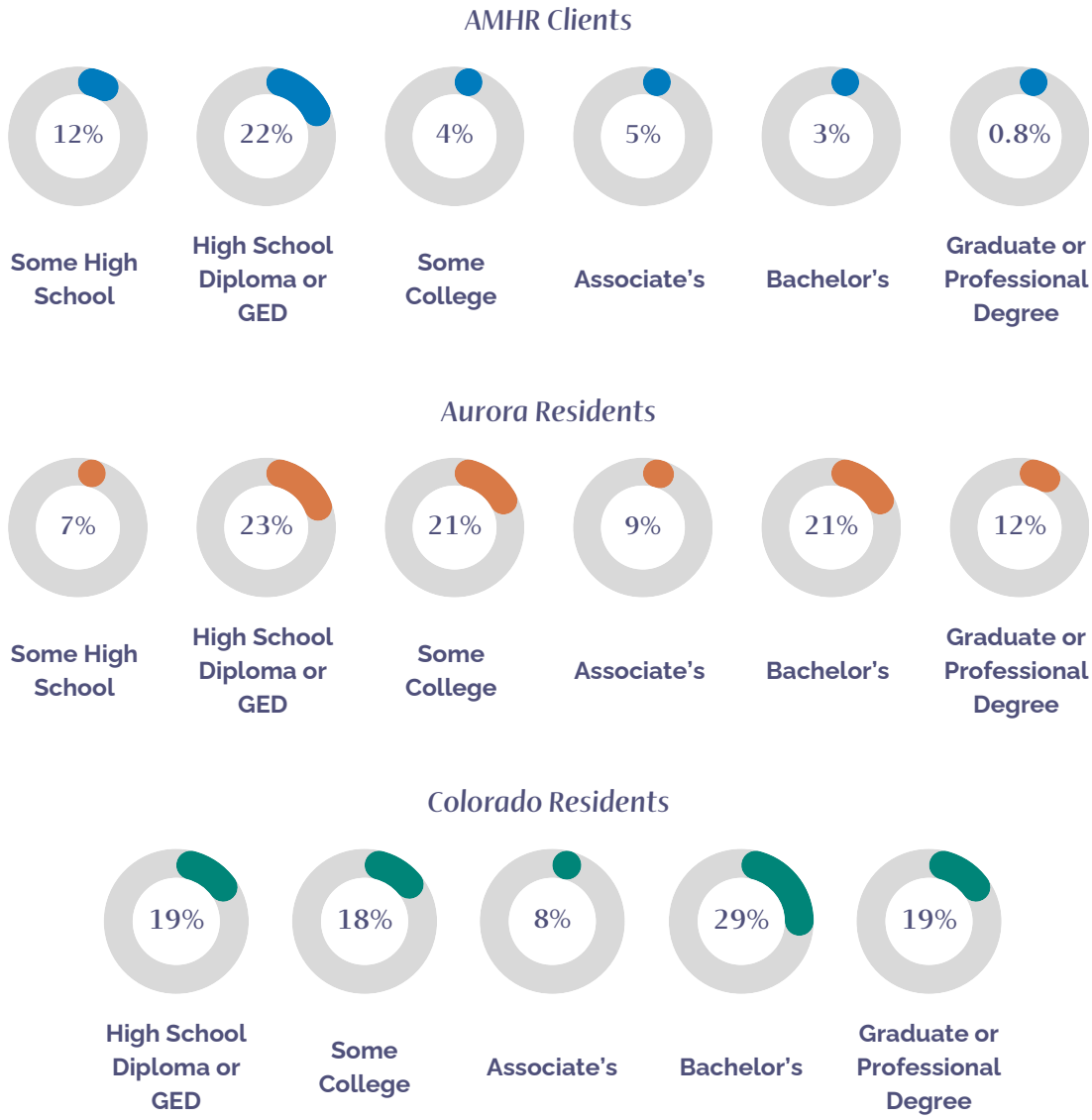
Aurora Mental Health & Recovery

but no degree, 9% have an Associate's Degree, 21% have a Bachelor's Degree, and 12% hold a graduate or professional degree.[1] (Figure 10)

Of Colorado residents, 19% hold a high school diploma or GED, 18% have some college experience but no degree, 8% have an Associate's Degree, 29% have a Bachelor's Degree, and 19% hold a graduate or professional degree.[2] (Figure 10)

Comparing education levels, AMHR's clients have lower levels of education than populations in Aurora and Colorado.

Figure 10: *Education Level*



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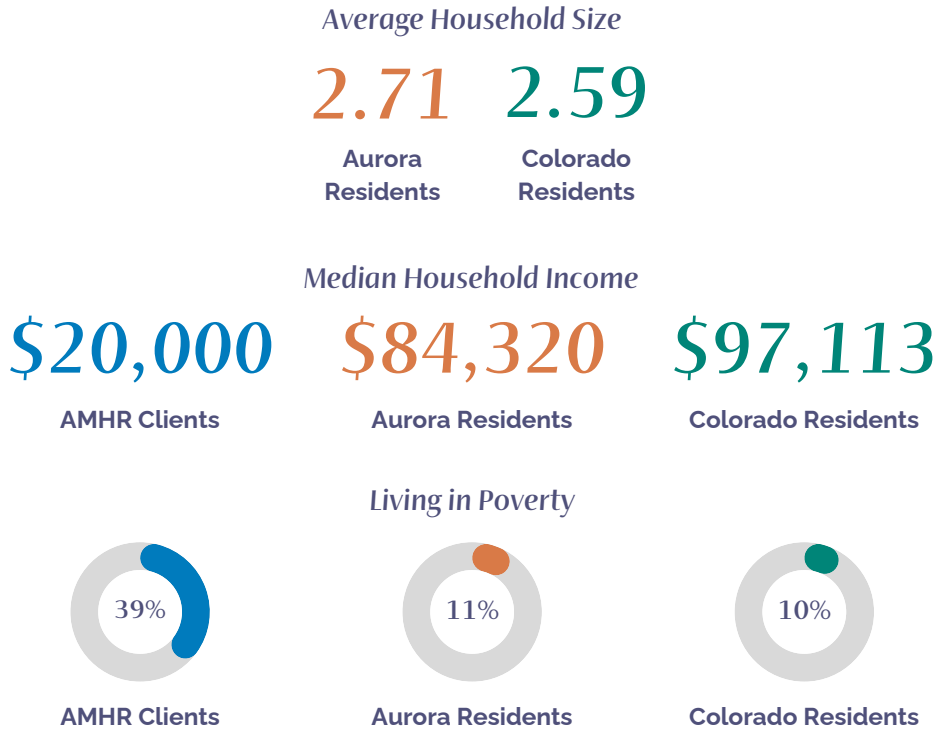
Economics

Figure 11: *Economic Status*



The average household size of residents of Aurora is 2.71[1] and is 2.42 for the state of Colorado,[2] but was not obtainable for AMHR clients. (Figure 11)

The median household income of AMHR clients is $20,000, while it is $84,320 for residents of Aurora[1] and $97,113 for the state of Colorado.[3] The median income is thus much lower for AMHR clients than it is for residents of Aurora and Colorado more generally; however, income data were not provided for all clients. (Figure 11)

Additionally, at least 39% of AMHR clients are living in poverty based on current income poverty lines, while the city and state percentages are much lower. Of Aurora residents, 11.2% are living in poverty,[1] while 9.6% of Colorado residents are living in poverty.[2] It is clear that there is a high percentage of AMHR clients experiencing poverty, and that this percentage is disproportionately higher than the percentages of individuals living in poverty in Aurora and Colorado. (Figure 11)

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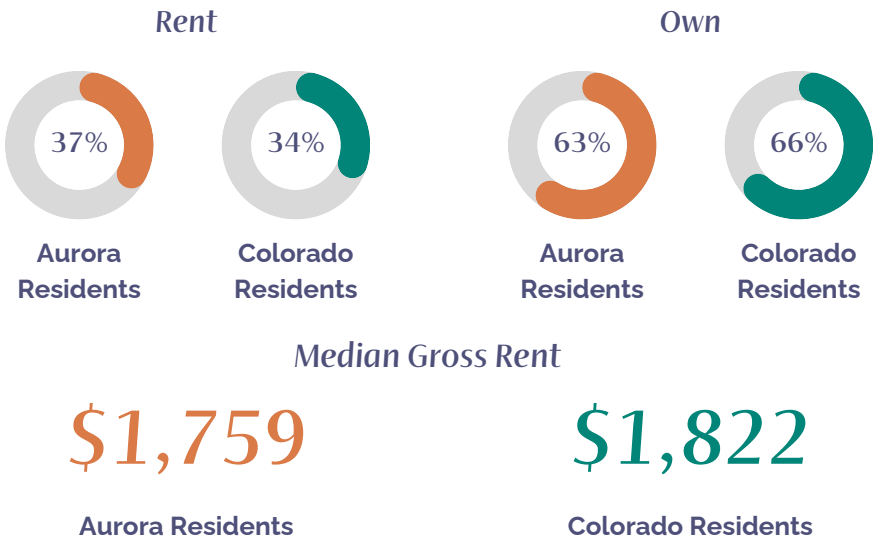
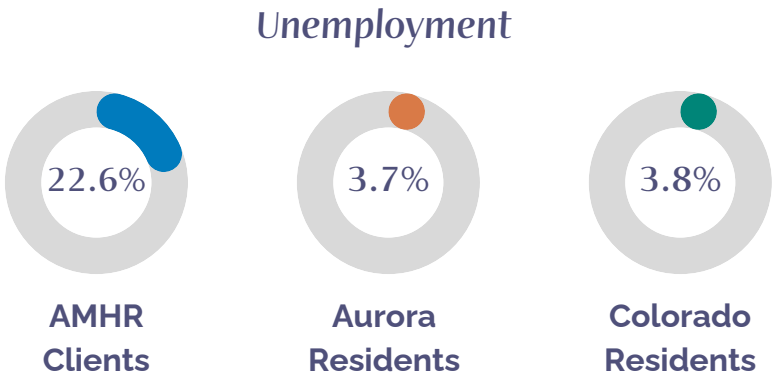
Figure 12: *Rent Statistics*



While statistics on median gross rent and on house ownership versus renting were not obtainable for AMHR clients, they were obtainable for the city and state. 63% of Aurora residents own housing, while 37% rent housing.[1] Comparatively, 66% of Colorado residents own housing, and 34% rent housing.[4] Median gross rent was $1,759 for Aurora residents[1] and $1,822 for Colorado residents.[5] (Figure 12)

Lastly, the unemployment rate among working-age AMHR clients was 22.6%, while it was only 3.7% for Aurora residents,[6] and was 3.8% for Colorado residents.[7] This rate is much higher for AMHR clients than it is for Aurora and Colorado residents. (Figure 13)

Figure 13: *Unemployment Rate*



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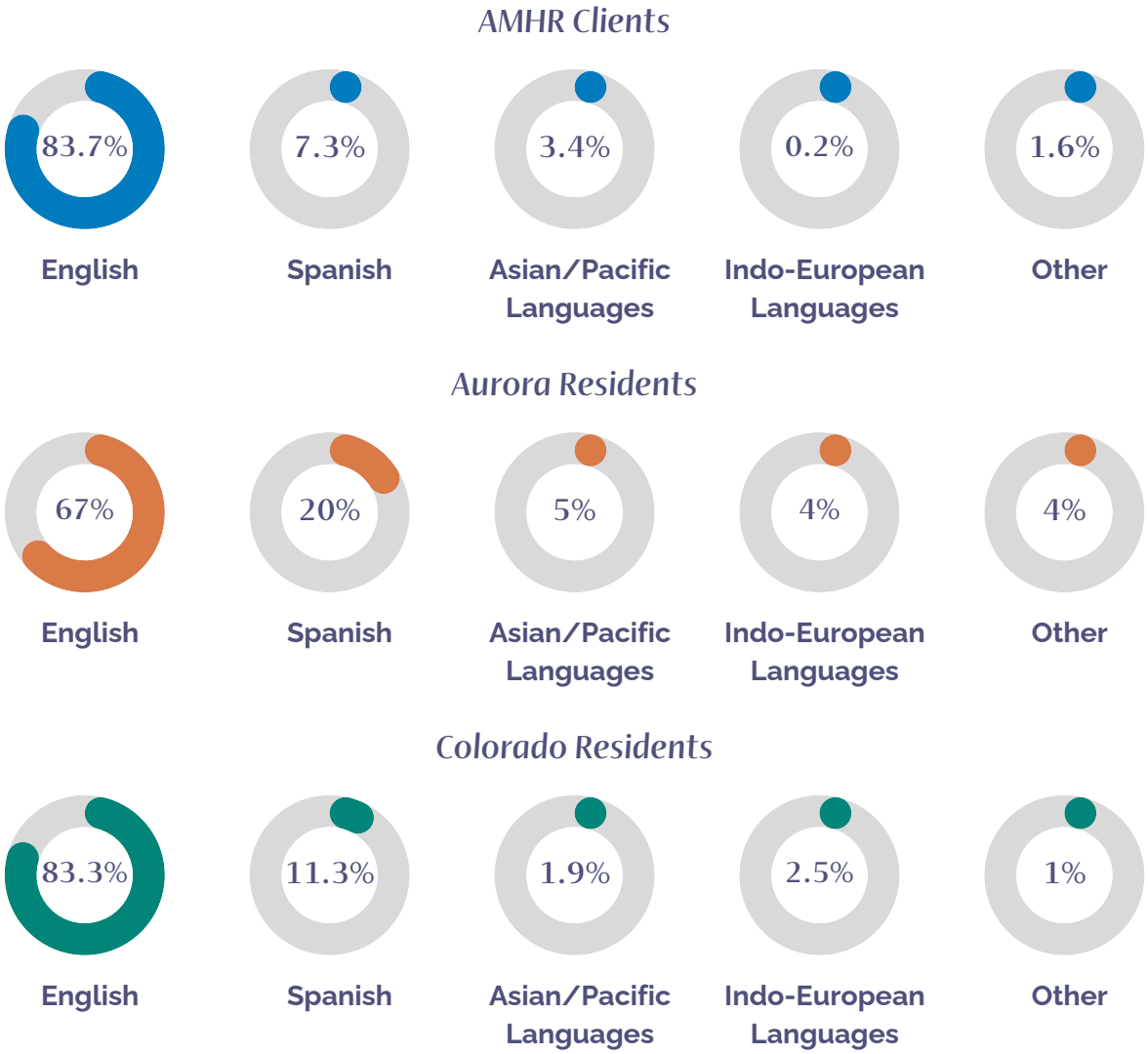
Languages

Figure 14: *Languages*



Regarding primary languages spoken, 83.7% of AMHR clients speak English, 7.3% speak Spanish, 3.4% speak Asian and Pacific Island languages, 0.2% speak other Indo-European languages, and 1.6% speak other languages. Updated data for Aurora residents were not found, so their 2022 values are provided. 67% of Aurora residents speak English, 20% speak Spanish, 5% speak Asian and Pacific Island languages, 4% speak other Indo-European languages, and 4% speak other languages.[1] For Colorado residents, 83.3% speak English, 11.3% speak Spanish, 1.9% speak Asian and Pacific Island languages, 2.5% speak other Indo-European languages, and 1% speak other languages.[2] (Figure 14)

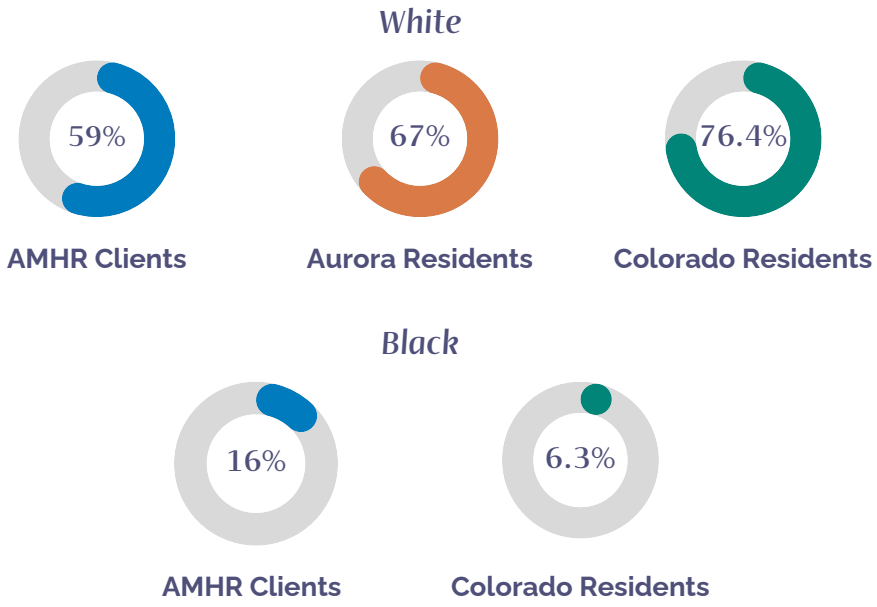
Most AMHR clients speak English, Spanish, or Asian and Pacific Island languages primarily. Aurora's language breakdown is more diverse, with a smaller percentage of primary English speakers, a higher number of Spanish speakers, and more residents speaking other languages. In Colorado, most individuals speak English, Spanish, or other Indo-European languages. (Figure 14)

Veterans

Of veterans receiving services at AMHR, 59% are white and 16% are black. Additionally, 3% of AMHR veterans are Asian, 5% are multiracial, 2% are Native American/Alaskan Native, and 0.4% are Native Hawaiian/Pacific Islander. Thus, AMHR serves a high percentage of white and black veterans. Of veterans in the city of Aurora, 67% are white and 33% are another race.[1] More specific racial breakdowns were not found on the city of Aurora. White veterans in the state of Colorado make up 76.4% of veterans in the state, while black veterans make up 6.3% of veterans in the state.[2] (Figure 15)

There are more white veterans represented in Colorado and Aurora than in the AMHR client population. Additionally, there is a greater amount of black veterans represented at AMHR than in the state of Colorado. (Figure 15)

Figure 15: *Veteran Race/Ethnicity*



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Special Populations

Forensic-Involved Populations

Forensic-involved individuals represent a priority population within the CCBHC framework due to their complex clinical needs, high risk of service disruption, and frequent intersection with the criminal justice system. Statewide data continue to demonstrate elevated rates of serious mental illness and substance use disorders among justice-involved populations, as well as increased utilization of crisis, emergency, and inpatient services when care is not well coordinated. Within Aurora and Adams County, forensic populations often face compounded barriers related to housing instability, limited access to consistent treatment, and challenges navigating transitions between correctional settings and community-based care. As a CCBHC grantee, AMHR is positioned to address these needs through coordinated outpatient services, crisis response, and partnerships that support continuity of care during reentry. AMHR data and program experience indicate that timely access, clear referral pathways, and strong collaboration with justice partners are critical to improving outcomes for this population. The 2026 CNA highlights opportunities to strengthen forensic transition services, enhance coordination with courts and community supervision, and ensure that service models remain responsive to both public safety considerations and recovery-oriented care.

AMHR's forensic services are grounded in the Sequential Intercept Model (SIM), which identifies key points across the justice system where behavioral health intervention can prevent deeper system involvement. Historically, efforts have focused on individuals already justice-involved; however, the 2026 CNA reflects a strategic shift toward prevention and early intervention, particularly at Intercepts 1 and 2 (law enforcement contact and initial court engagement). This prevention-forward approach aligns with CCBHC principles and emphasizes earlier diversion, coordinated care, and improved long-term outcomes.

Data and stakeholder input indicate that individuals presenting through forensic pathways often experience co-occurring mental health and substance use disorders, housing instability, trauma exposure, and system navigation barriers. AMHR currently supports this population through court coordination, forensic transition services, integrated outpatient treatment, peer support, and crisis diversion services. Moving forward, the organization is strengthening collaboration with law enforcement and courts, enhancing reentry planning, and incorporating demographic and state needs assessment data to guide targeted action steps. This strategic evolution positions AMHR to intervene earlier, improve continuity of care, and reduce justice system penetration while advancing equitable, recovery-oriented behavioral health services.

Aurora
Mental Health & Recovery

Older Adults

Older adults are a growing priority population for AMHR and a central focus of the 2026 CNA, consistent with state and local demographic trends indicating a steadily increasing aging population in Aurora and across Colorado. State and City of Aurora strategic studies focused on older adults—currently being reviewed by AMHR—underscore rising behavioral health needs related to depression, anxiety, cognitive decline, social isolation, and co-occurring medical conditions. AMHR program data and staff input reflect similar trends, with increasing demand for services that are accessible, age-responsive, and integrated with medical and community-based supports.

Client feedback gathered through the Older Adults (OA) Team highlights important considerations for engagement, including strong concerns about scams and digital safety; as a result, older adults often prefer paper-based surveys or direct outreach from trusted providers rather than electronic links. The OA Team has identified ongoing questions about whether current access processes are sufficiently timely, efficient, and responsive for older adults and their community partners, and whether referral pathways clearly meet stakeholder needs. In response, AMHR is exploring and piloting service models such as wellness groups, dedicated assessment days, and more rapid transitions into therapy. Significant current initiatives include expanding psychiatric care into nursing facilities—leveraging physician leadership and expertise—and increasing therapy services in community settings where older adults live and gather. The OA Team is also conducting community talks, deepening needs assessment work, and implementing staff training to support service expansion. These efforts align with CCBHC expectations to proactively identify high-need populations, reduce access barriers, and deliver coordinated, person-centered care that reflects the preferences and lived experiences of older adults in the community.

Aurora is home to a large and diverse population, with more than 399,000 residents, making it the third most populous city in Colorado. Within this context, the 2026 Community Needs Assessment identifies Older Adults and Forensic-involved individuals as priority populations due to their complex behavioral health needs,

growing prevalence, and heightened risk for barriers to timely and coordinated care. Data and community input indicate that these populations often experience challenges related to access, service navigation, and continuity of care, particularly during transitions between systems or levels of service. Feedback from clients, providers, and partners underscores the importance of service models that are responsive to age-related needs, justice involvement, medical complexity, and community-based supports. As a CCBHC Grantee, AMHR is uniquely positioned to address these needs through integrated, recovery-oriented services, strengthened partnerships, and targeted expansion efforts. Findings from this section inform service planning and quality improvement strategies aimed at ensuring Older Adults and Forensic-involved populations receive accessible, coordinated, and equitable behavioral health care aligned with community needs.

Literature Review

Older Adult Mental & Behavioral Health Needs
To better understand the challenges faced by the older adult population regarding mental and behavioral healthcare, as well as methods to improve care for this population, a literature review was conducted. For this review, five articles were examined, and themes among these articles were identified.

The literature highlighted that while older adulthood is characterized by many positive aspects such as resilience, wisdom, and finding meaning in life, it is also associated with struggles including mental health challenges. Mental health disorders commonly faced by older adults were found to be depression, anxiety, dementia, and substance use disorders. Older adults are also significantly impacted by loneliness and social isolation. Despite the high prevalence of these disorders and issues, many older adults do not receive adequate care due to barriers including stigma, ageism, financial limitations, provider shortages, inadequate screenings, and poor care coordination. Additionally, the social determinants of health – including socioeconomic status, race, gender, immigration status, and geographic location – create more challenges for older adults when accessing and receiving care.

Across the reviewed studies, the need to combat negative narratives about aging was highlighted. The importance of multidisciplinary and comprehensive teams and care was also a focus. The literature also stressed community-based approaches and engagement for older populations. Specific therapies including interpersonal therapy, problem-solving therapy, and cognitive-behavioral therapy were also found to be effective with this population. Additionally, telehealth and alternative

Aurora Mental Health & Recovery

therapies including exercise and yoga were identified as promising methods of care for older adults.

One article by Reynolds et al. (2022) studied the positive aspects of aging as well as barriers faced by older adult populations. Positive aspects were noted to be wisdom, resilience, finding meaning in life, and engaging with community and society. The article states that highlighting the positive aspects of aging can counter ageism and help change the narrative around aging and disorders that occur later in life, and that "Community engagement is a key beneficial social determinant of mental health in older adults." (Reynolds et al. 2022) Challenges faced by older adults include social determinants affecting their health and mental health, stigma, homelessness, ageism, labor market shortages, and isolation and loneliness. The authors also note the importance of multidisciplinary and comprehensive care for this population, as well as the combination of social, mental, and physical health services. Additionally, since family members are often involved in the care of older adults, the article highlights a focus on these caregivers as a way to improve older adult care. These caregivers could benefit from support and resources, as well as from being more included in the caregiving team and process. The authors also highlight physical fitness and cognitive exercise as important for older adults. (Reynolds et al. 2022)

Bartels et al. (2004) examined evidence-based practices in mental health care for older adults. Barriers to care implementation noted by the authors included organizational barriers, ageism and stigma from care providers, financial concerns, a shortage of providers trained in mental health care for older adults, and a lack of care coordination. The authors also stated that almost half of older adults with a mental health disorder are not getting their need for services met. Additionally, the article found that older adult populations suffer from dementia, substance use issues, geriatric depression, schizophrenia, and anxiety disorders – with anxiety disorders being one of the most common issues impacting this population. Regarding beneficial care practices, the authors found support for pharmacological and psychosocial interventions for depression and dementia. They additionally found that multidisciplinary and community-based treatment teams are effective for older adult populations. (Bartels et al. 2004)

Lee et al. (2020) studied mental health in older adults broadly. They identified depression, anxiety, loneliness, and social isolation as the main mental health issues experienced by older adults. Older adults also experience loss and other psychosocial stressors as they age. The authors noted that there are issues identifying these disorders in older adults, and that screening tools and interventions should be improved and tailored to this population. Additionally, the

article states that race, socioeconomic status, location, gender, and immigrant status impact mental health treatment for older adults. Regarding treatment, the authors examined psychotherapy and counseling, and found that interpersonal therapy (IPT) does improve mood disorder symptoms in older adults. They also found that problem-solving therapy (PST) helps reduce anxiety, depression, and loneliness, and can improving complex decision-making skills. Additionally, cognitive behavioral therapy (CBT) was found to help treat anxiety, depression, and insomnia in older adults. The authors also found evidence that complementary therapies are beneficial for older adults, and include exercising, yoga, and dietary changes. Phone use was also associated with less loneliness for this population. (Lee et al. 2020)

Chukrun et al. (2024) examined the efficacy of a health care model for older adults. This model is the Author Health model, and combines virtual-first care with older adult interventions and health-related social needs screenings. The authors found that older adults face barriers to accessing and staying in treatment and telehealth services. The Author Health model was effective in keeping older adults engaged in healthcare, and indicates that virtual-first behavioral health care may help combat barriers to care. Comprehensive, team-based care was emphasized. The authors state that the Author health model can be a blueprint for health services provided to older populations. (Chukrun et al. 2024)

Lastly, Elshaikh et al. (2023) employed a systematic review to identify barriers and facilitators that older adults experience when seeking mental healthcare. The authors note that older adults have a higher risk than younger populations for mental health issues, but are also less likely to seek help for these issues. The systematic review found that stigma, negative preconceptions about mental healthcare, and financial issues such as cost were major barriers for older adults in seeking out and accessing care. Stigma was a major barrier found in the review, and included concerns about what other people in the community would think of the individual seeking out help. Socioeconomic status was also found to be a barrier, as individuals with a lower socioeconomic status may have less access to care due to cost and insurance concerns, and may face stressors related to poverty. Facilitators to accessing care were found to be previous positive experiences in mental healthcare, as well as high socioeconomic status including level of education. The authors advocate for lower cost services as well as interventions that normalize the utilization of mental healthcare. (Elshaikh et al. 2023)

Aurora Mental Health & Recovery

Literature Review Summary

In summary, the reviewed literature highlighted best practices for improving mental health care in older population, as well as challenges faced by this population in receiving care. Effective strategies to improve care include implementing multidisciplinary care models; expanding access to evidence-based interventions such as cognitive behavioral therapy, interpersonal therapy, and problem-solving therapy; strengthening screening tools and efforts; and reducing financial barriers that limit service utilization. Additionally, integrating telehealth and virtual-first services can help address challenges. Supporting caregivers, promoting physical and cognitive wellness, and normalizing mental health treatment through stigma-reduction efforts are also essential. Ultimately, better mental healthcare for older adults requires a comprehensive approach that addresses barriers and highlights the positive aspects of aging.

Needs Assessment Findings

AMHR Client Survey Summary

AMHR conducted a comprehensive Client Survey to ensure that the voices, experiences, and priorities of individuals receiving services directly inform organizational planning and improvement efforts. This approach aligns with Certified Community Behavioral Health Clinic (CCBHC) requirements and SAMHSA guidance, which emphasize community engagement, population-based planning, and the incorporation of lived experience into service design. The survey was developed using a mixed-methods framework, allowing both quantitative data collection and open-ended feedback to capture nuanced client perspectives on access, service quality, barriers to care, and emerging needs.

The survey process was designed to be accessible, inclusive, and trauma-informed. Multiple distribution methods were offered—including in-person, paper-based, phone, and electronic formats—to reduce barriers and ensure broad participation across age groups, language preferences, and levels of technological access. Survey content focused on access to services, awareness of care options, satisfaction with treatment experiences, perceived gaps in care, and community-level behavioral health needs. Special attention was given to ensuring individuals felt safe providing feedback, with voluntary participation, confidentiality protections, and options to skip questions.

In alignment with CCBHC principles, survey findings are being used to identify disparities in access and outcomes, strengthen coordination across service lines,

and inform targeted strategies for priority populations, including Older Adults and Forensic-involved individuals. The Client Survey results contribute directly to the Action Plan and Continuous Quality Improvement processes, ensuring that AMHR's services remain responsive, equitable, and grounded in the real experiences of the community it serves.

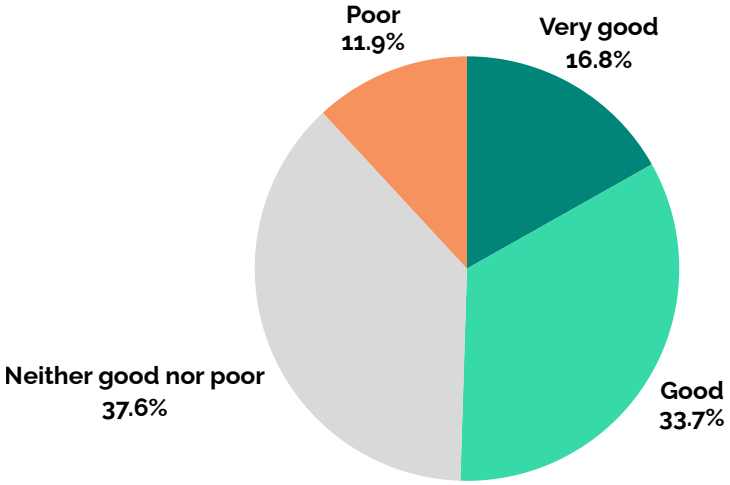
AMHR Client Survey

The AMHR Client Needs Assessment Survey was distributed center-wide and was available in English, Spanish, Arabic, and Mandarin. A total of 120 responses were provided. Among these responses, 110 were completed in English and 10 in Spanish. (Figure 16)

Overall Mental Health

Respondents were asked to rate their overall mental health. See the results in Figure 16 below.

Figure 16: *Overall Mental Health - Client Survey*



Respondents	#
Very Good	17
Good	34
Neither Good nor Poor	38
Poor	12
Very Poor	0

Social Determinants of Health

Respondents were presented with a list of social problems and asked to rate how much of an impact each had on them. Responses were recorded as Not At All (0), A Little (1), or A Lot (2). The following table contains the total score for each factor. (Figure 17)

The Top Issues are Lack of Jobs, Lack of Affordable Housing, Lack of Transportation, and Family or Partner Conflict. (Figure 17)

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Figure 17: *Social Determinants of Health – Client Survey*

Social Determinant of Health	Score
Lack of Jobs	95
Lack of Affordable Housing	94
Lack of Transportation	84
Family or Partner Conflict	74
Lack of Family Activities	62
Limited Access to Food	60
Lack of Adult Activities	60
Violence in the Community	54
Lack of Youth Activities	53
Poor Medical Care	52
Discrimination or Racism	52
Lack of Mental Health Care	52
Substance Use	45
Lack of Youth Education Programs	44
Lack of Crisis Services	43
Language Barriers	41
Lack of Adult Education Programs	38

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Current Services

Respondents were asked to endorse which services they were currently receiving. (Figure 18)

Figure 18: *Current Services – Client Survey*

Current Services	Count
Individual Therapy	78
Case Management/Health Navigation/Care Coordination	37
Psychiatric Medications	31
Group Therapy	24
Vocational/Employment Services	13
Substance Use Services	13
Community Activities	13
Education Services	8
Family Services	7
Housing Services	4

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Most Helpful Services

Respondents were asked to identify which service they felt was the most helpful. (Figure 19)

Figure 19: *Most Helpful Services – Client Survey*

Most Helpful Services	Count
Individual Therapy	54
Case Management/Health Navigation/Care Coordination	8
Group Therapy	6
Psychiatric Medications	6
Substance Use Services	3
Community Activities	2
Education Services	1
Vocational/Employment Services	1
Family Services	1

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Greater Access

Respondents were asked to select and rank their top three services for increased access. Responses were coded as First = 3, Second = 2, Third = 1. The two respondents who provided answers to this question, each selected different services from the other. The following table contains the responses to this question. (Figure 20)

Figure 20: *Requested Services – Client Survey*

Requested Services	Total
Individual Therapy	120
Group Therapy	65
Case Management/Health Navigation/Care Coordination	64
Community Activities	51
Vocational/Employment Services	48
Psychiatric Medications	44
Family Services	41
Education Services	17
Substance Use Services	15

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How can AMHR services be improved?

Respondents were asked to endorse areas of improvement for AMHR services. The majority of responses dealt with greater access to services.

The top recommendation for improving AMHR were: More Availability/Longer Hours, More In-Person Availability, Transportation Options, and More Providers. (Figure 21)

Figure 21: *Areas for Improvement – Client Survey*

Area for Improvement	Count
More Availability/Longer Hours	30
More In-Person Availability	27
Transportation Options	23
More Providers	20
More Convenient Locations	15
Better Providers	13
More Affordable/Lower Cost	13
Less Paperwork	13
More/Better Communication	12
More Virtual Availability	10
More Respectful/Caring Staff	9
Childcare Options	6
Services in My Language	5
Culturally Appropriate Services	4
More BIPOC Providers	3

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Why do you choose to receive services at AMHR?

Respondents were asked to list the reason(s) they are receiving services from AMHR. (Figure 22)

Figure 22: *Reasons for Receiving AMHR Services – Client Survey*

Reason	Count
Offer the Services I need	53
Takes My Insurance	32
Convenient Location	28
Reputation	22
Someone I Know Receives Care Here	12
Kind/Helpful Providers	11
Mandated	7
Inclusive/Speak Multiple Languages	5
Transferred to AMHR	5

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Where else do you turn for help?

Respondents were asked where else they sought behavioral health support, in addition to AMHR. Additionally, they were also asked where else they sought support for substance use support. (Figure 23)

Figure 23: *Sources of Support – Client Survey*

Source	Mental Health	Substance Use
Friends	38	14
Family	37	12
Self-Help Resources	16	4
Place of Worship	12	6
School	12	5
Support Group	10	6
Virtual/Online Services	7	3
Medical Doctor	6	3
Hospital/ER	6	3
Phone/Hotline	6	2
Another Mental Health Center	5	2
Private Provider	7	0

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Barriers to Care

Respondents were asked what barriers make it difficult for them or someone close to them to access behavioral health services (mental health and/or substance use). (Figure 24)

Figure 24: *Barriers to Care – Client Survey*

Barrier	# of Respondents
Lack of Reliable Transportation	29
Didn't Know Where to Go	25
Time/Schedule Conflict	18
Insurance Coverage	17
Cost	13
Worried Friends/Family Would Find Out	10
Lack of Childcare	7
Lack of Required Documentation	3
Didn't Speak My Language	3
Didn't Understand My Cultural Needs	3

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Needed Community Resources

Respondents were presented with a list of community resources and asked to identify the five that would be most helpful. They were further asked to rank the priority of these five resources.

The indicated priorities of the resources were coded as First = 5, Second = 4, Third = 3, Fourth =2, Fifth =1. (Figure 25)

Figure 25: *Needed Community Resources – Client Survey*

Resource	Score
Affordable Housing	232
Mental Health Services	226
Medical Care	111
Adult Education Program	95
Employment Services	88
Family Activities	80
Adult Activities	57
Youth Activities	46
Victim Advocacy	45
Substance Use Services	44
Crisis Services	44
Youth Education Programs	37
Cultural Activities	36

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Respondent Demographics

Age

Respondents were asked to identify their age range. (Figure 26)

Figure 26: *Age Range – Client Survey*

Age Range	# of Respondents
Under 18	21
18 to 45	45
46 to 64	27
65+	4

Zip Code

Respondents represented 26 different zip codes. Figure 27 contains the zip codes that had multiple respondents. (Figure 27)

Figure 27: *Zip Codes – Client Survey*

Zip Code	# of Respondents
80011	32
80010	20
80018	8
80017	6
80012	4
80014	4
80013	2
80016	2
80231	2

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Racial/Ethnic Identity

Respondents were asked to identify their racial/ethnic identities. (Figure 28)

Figure 28: *Racial/Ethnic Identity – Client Survey*

Racial/Ethnic Identity	# of Respondents
White	40
Hispanic/ Latino/a/x	37
Black/African American	28
Native American/Native Alaskan	4
Arab/Middle Eastern	1
Asian/Asian American	1
Native Hawaiian/Pacific Islander	0

Gender Identity

Respondents were asked to identify their gender identity. (Figure 29)

Figure 29: *Gender Identity – Client Survey*

Gender Identity	# of Respondents
Female	55
Male	44
Transgender	1
Non-Binary	1
Questioning	1
Gender Fluid	1

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LGBTQ+ Identity

Clients were asked whether they identify as LGBTQ+. (Figure 30)

Figure 30: *LGBTQ+ Identity – Client Survey*

Identify as LGBTQ+	# of Respondents
Yes	18
No	76
Don't Know/Questioning	2

Houseless

Clients were asked if they have experienced homelessness in the past 6 months. (Figure 31)

Figure 31: *Experienced Homelessness – Client Survey*

Experienced homelessness in the past 6 months	# of Respondents
Yes	26
No	71

Military Status

Clients were asked about their military status. (Figure 32)

Figure 32: *Military Status – Client Survey*

Active Duty, Reserve, or Veteran	# of Respondents
Yes	4
No	93

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Refugee/Immigrant Identification

Clients were asked if they or their parents were born outside the U.S. (Figure 33)

Figure 33: *Refugee/Immigrant Identification – Client Survey*

Respondent or Parent(s) Born Outside U.S.	# of Respondents
Yes	24
No	65

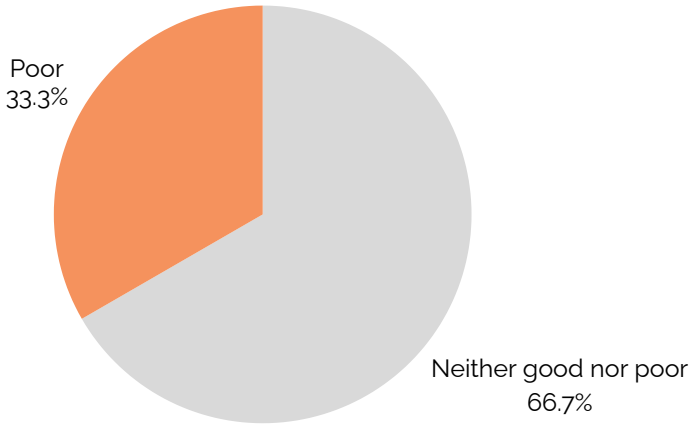
Community Leader Survey

Overall Community Mental Health

There were a total of 3 respondents to the community leader survey. Respondents were asked to rate the overall mental health of the individuals they serve. The response pattern was similar to the 2023 survey. (Figure 34)

Figure 34: *Overall Mental Health – Community Leader Survey*

Mental Health	#
Very Good	0
Good	0
Neither Good nor Poor	2
Poor	1
Very Poor	0



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Social Determinants of Health

Figure 35: *Social Determinants of Health Social Determinants of Health*

Social Determinant of Health	Score
Lack of Affordable Housing	6
Substance Use	5
Lack of Transportation	5
Family or Partner Conflict	5
Lack of Mental health Care	4
Poor Medical Care	4
Limited Access to Food	4
Lack of Jobs	4
Discrimination or Racism	3
Violence in the Community	3
Language Barriers	3
Lack of Crisis Services	2
Lack of Family Activities	2
Lack of Adult Activities	2
Lack of Youth Activities	1
Lack of Youth Education Programs	1
Lack of Adult Education Programs	1

Respondents were presented with a list of social problems and asked to rate how much of an impact each had on the individuals that they serve. Responses were recorded as Not At All (0), A Little (1), or A Lot (2). Figure 35 contains the total score for each factor.

The main issues identified were: Lack of Affordable Housing, Substance Use, Lack of Transportation, and Family or Partner Conflict. (Figure 35)

In the 2023 survey, the main problems identified were: Lack of Crisis Services, Substance Use, Lack of Transportation, Lack of Affordable Housing, Lack of Mental Health Care, and Lack of Youth Activities. (Figure 35)

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Seeking Mental Health Care

100% of community leaders surveyed knew where to advise someone to go who needs mental health services. (Figure 36)

The top services community leaders endorsed were mental health centers (including Aurora Mental Health & Recovery), Hospitals/ER, and Virtual/Online Services. (Figure 36)

In the 2023 survey advised people to seek services from Aurora Mental Health & Recovery, followed by hotlines, another mental health center, family, support groups, virtual/online services, or friends. (Figure 36)

Figure 36: *Sources of Mental Health Services – Community Leader Survey*

Source	Total
Other Mental Health Center	3
Virtual/Online Services	3
Hospital/ER	3
AMHR	2
Hotline	2
Medical Doctor	2
Private Provider	2
Place of Worship	1
Family	1
Support Group	1
Friends	1
Self-help Resources	1
School	0

Aurora Mental Health & Recovery

Seeking Substance Use Care

100% of community leaders surveyed knew where to advise someone to go for substance use services. (Figure 37)

Community leaders indicated they were most likely to send someone to Aurora Mental Health & Recovery or another mental health center, or a Hospital/ER. (Figure 37)

In 2023, leaders most commonly cited they would send someone to Aurora Mental Health & Recovery. (Figure 37)

Figure 37: *Sources of Substance Use Care – Community Leader Survey*

Source	Total
AMHR	3
Other Mental Health Center	3
Hospital/ER	3
Hotline	2
Virtual/Online Services	2
Medical Doctor	2
Support Group	1
Private Provider	1
Family	0
Friends	0
School	0
Place of Worship	0
Self-help Resources	0

Barriers to Care

What barriers make it difficult for the individuals you serve to access behavioral health services (mental health and/or substance use)?

Respondents were asked to identify which factors make it difficult for them to access behavioral health care. Figure 38 illustrates the number of respondents who endorsed each barrier.

The most commonly identified barriers were Lack of Transportation, Lack of Insurance, Cost of Care, and Providers Not Understanding Client Cultural Needs. (Figure 38)

In the 2023 survey, the most commonly cited barriers were Lack of Insurance, Cost of Care, Lack of Culturally Competent Providers, and Lack of Transportation. (Figure 38)

Figure 38: *Barriers to Care – Community Leader Survey*

Barrier	Total
Lack of Transportation	3
Lack of Insurance	2
Cost	2
Don't Understand Cultural Needs	2
Lack of Childcare	2
Don't Know Where to Go	1
Time/Schedule Conflicts	1
Lack of Required Documentation	1
Worried Friends/Family Would Find Out	1
"Distracted with meeting basic needs related to lack of affordable housing"	1
Don't Speak Their Language	0

Needed Community Resources

Leaders were presented with a list of community resources and asked to identify the five that would be most helpful. They were further asked to rank the priority of these five resources.

The indicated priorities of the resources were coded as First = 5, Second = 4, Third = 3, Fourth =2, Fifth =1. (Figure 39)

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Figure 39 contains the sum of the priority scores for each of the community resources. **The top 5 most requested services were Mental Health Services, Employment Services, Medical Care, Affordable Housing, and Substance Use Services.**

In the 2023 survey, the top 5 most requested resources are affordable housing, mental health services, employment services, medical care, and substance use services. (Figure 39)

Figure 39: *Needed Community Resources – Community Leader Survey*

Requested Resource	Overall
Mental Health Services	12
Employment Services	10
Medical Care	8
Affordable Housing	7
Substance Use Services	4
Crisis Services	2
Victim Advocacy	1
Adult Education Programs	1
Youth Activities	0
Cultural Activities	0
Youth Education Programs	0

Organizational Characteristics

Populations Served

Figure 40 contains the number of organizations which serve certain special populations.

Figure 40: *Populations Served – Community Leader Survey*

Population	# Orgs
LGBTQ+	3
Adults	3
Homeless	2
BIPOC	2
Older Adults	2
Active Duty, Reserve, or Veterans	2
Youth	1
Refugee/Immigrant	1

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Organization Location

Figure 41 contains the two zip codes where each organization is located

Figure 41: *Organization Location by Zip Code – Community Leader Survey*

Zip Code	# Orgs
80045	2
80246	1

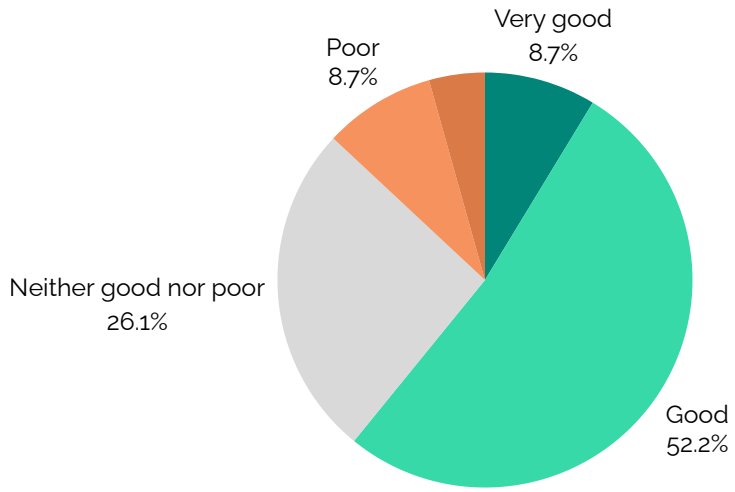
Community Member Survey

Data for this survey was collected through an online survey that was distributed with the assistance of AMHR's community partners. The survey was available in both English and Spanish; however, all respondents completed the English version. A total of 24 individuals completed the survey.

Overall Community Mental Health

Respondents were asked to rate the overall mental health of themselves, and the people close to them. The largest number of respondents rated their mental health as 'Good', followed by 'Neither good nor poor'. (Figure 42)

Figure 42: *Overall Mental Health – Community Member Survey*



All Respondents	#
Very good	2
Good	12
Neither Good nor Poor	6
Poor	2
Very Poor	1

This pattern of responses is similar to what was observed in the 2023 community survey.

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Social Determinants of Health

Respondents were presented with a list of social problems and asked to rate how much of an impact each had on them. Responses were recorded as Not At All (0), A Little (1), or A Lot (2). The following table contains the total score for each factor. (Figure 43)

The top 5 problems identified in this survey are: Lack of Affordable Housing, Poor Medical Care, Lack of Jobs, Discrimination or Racism, Limited Access to Food. (Figure 43)

In the 2023 survey, the main problems identified were: Lack of affordable housing, Lack of mental health care, Violence in the community, Discrimination or racism, and Substance use. (Figure 43)

Figure 43: *Social Determinants of Health – Community Member Survey*

Social Determinant of Health	Score
Lack of Affordable Housing	32
Poor Medical Care	32
Lack of Jobs	30
Discrimination or Racism	29
Limited Access to Food	28
Substance Use	27
Lack of Adult Education Programs	27
Lack of Youth Education Programs	27
Violence in the Community	26
Lack of Youth Activities	26
Lack of Family Activities	25
Lack of Crisis Services	25
Lack of Transportation	25
Language barriers	23
Lack of Adult Activities	23
Lack of Mental Health Care	22
Family or Partner Conflict	20

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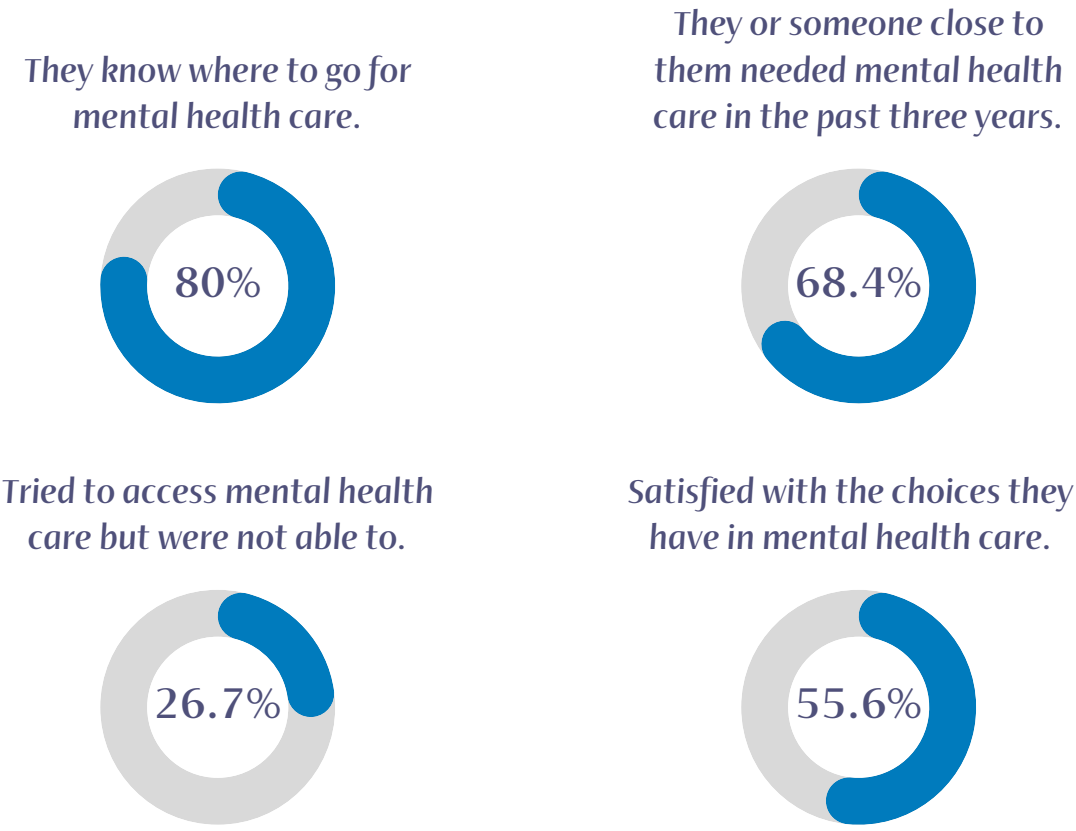
Seeking Mental Health Care

Participants were asked a series of questions about their history and experience with needing and seeking mental health care. (Figure 44)

Figure 44: *History of Seeking Mental Health Care – Community Member Survey*



Generally, respondents had sources for mental health care and were able to access them. In comparison to the 2023 survey, current respondents were more knowledgable of where to go for mental health care and more satisfied with the choices they have. (Figure 44)

Respondents were also asked where they generally turn for help with their mental health. Figure 45 illustrates the number of individuals endorsing the different sources of support.

Figure 45: *Sources of Mental Health Support – Community Member Survey*

Source of Mental Health Support	Score
Friends	11
Medical Doctor	9
Family	8
Place of Worship	8
Another Mental Health Center	5
Private Provider, not at AMHR	5
Aurora Mental Health & Recovery	4
Virtual/Online Services	4
Self-Help Resources	4
School	3
A Support Group	3
Phone/Hotline (e.g. 988)	3
Hospital/ER	2

The top sources for mental health support sought by community members are: Friends, Medical Doctors, Family, and Places of Worship. These were similar responses to the 2023 community survey.

Seeking Substance Use Care

Participants were also asked a series of questions about their history and experience with needing and seeking substance use help. (Figure 46)

Figure 46: *Seeking Substance Use Care – Community Member Survey*

Generally, respondents know where to go for substance use care and are able to access them. In comparison to the 2023 survey, current respondents are more knowledgeable of where to go for substance use care, more likely to have needed it, and more satisfied with the choices they have.

Respondents were also asked where they generally turn for help with substance use. The following table contains the number of individuals endorsing the different sources of support. (Figure 47)

Figure 47: *Sources of Mental Health Support – Community Member Survey*

Source of Mental Health Support	Score
Hospital/ ER	7
Friends	6
Family	6
Aurora Mental Health & Recovery	5
Self-Help Resources	5
Place of Worship	3
Medical Doctor	3
Phone/Hotline	3
Virtual/Online Services	3
Another Mental Health Center	3
Private Provider	3
School	2
A Support Group	2

The top sources for substance use support are the Hospital/ER, Friends, Family, Aurora Mental Health & Recovery, and Self-Help Resources. These were similar responses to the 2023 community survey.

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Barriers to Care

What barriers make it difficult for you or the people close to you to access behavioral health services (mental health and/or substance use)?

Respondents were asked to identify which factors make it difficult for them to access behavioral health care. Figure 48 illustrates the number of respondents who endorsed each barrier.

Figure 48: *Barriers to Care – Community Member Survey*

Barrier	Score
Lack of Insurance	9
Cost	8
Lack of Transportation	7
Lack of Childcare	7
Worried Friends/Family Would Find Out	6
Lack of Required Documentation	6
Time/Scheduling Conflicts	5
Don't know where to go	3
Don't Understand Cultural Needs	2
Don't Speak My Language	2

The top barriers identified are Lack of Insurance, Cost, Lack of Transportation, and Lack of Childcare. On the 2023 survey, Lack of Insurance and Cost were also the top two barriers.

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Needed Community Resources

Respondents were presented with a list of community resources and asked to identify the five that would be most helpful. They were further asked to rank the priority of these five resources.

The indicated priorities of the resources were coded as First = 5, Second = 4, Third = 3, Fourth =2, Fifth =1.

Figure 49 shows the sum of the priority scores for each of the community resources.

The top needed community resources are Affordable Housing, Mental Health Services, Adult Education Programs, and Medical Care. (Figure 49) In the 2023 survey, the top needed resources were mental health services, affordable housing, and medical care.

Figure 49: *Needed Community Resources – Community Member Survey*

Requested Resource	Score
Affordable Housing	49
Mental Health Services	33
Adult Education Programs	29
Medical Care	26
Crisis Services	20
Employment Services	20
Substance Use Services	19
Adult Activities	12
Victim Advocacy	12
Cultural Activities	11
Youth Activities	5
Youth Education Programs	5
Family Activities	4

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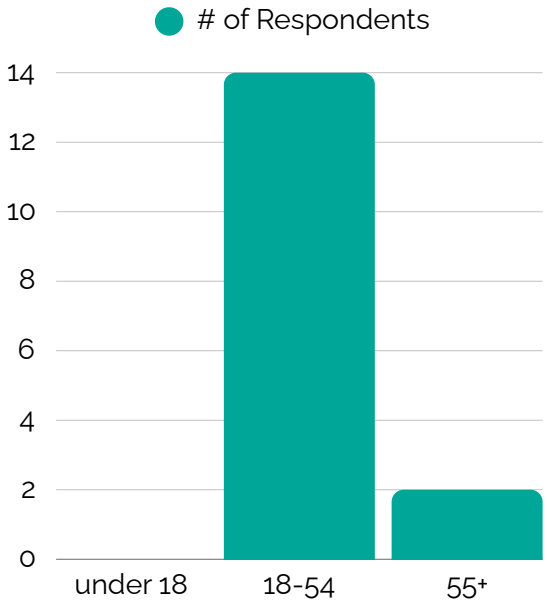
Respondent Demographics

Age of Community Member Respondents

Respondents were asked to identify their age group. (Figure 50)

Figure 50: *Age of Community Member Respondents – Community Member Survey*



Age	#
Under 18	0
18-54	14
55+	2
Did Not Disclose	8

Zip Code of Community Member Respondents

Respondents were asked to identify their zip code. (Figure 51)

Figure 51: *Zip Code of Community Member Respondent – Community Member Survey*

Zip Code	#
80014	3
80011	2
80013	2
80010	1
80015	1
80134	1
80112	1
15231	1
90056	1
80222	1
91314	1
1825	1

Racial/Ethnic Identity

Respondents were asked to identify their racial/ethnic identity. (Figure 52)

Figure 52: *Racial/Ethnic Identity – Community Member Survey*

Racial Ethnic Identity	# of Respondents
White	11
Asian/Asian American	5
American Indian/ Native Alaskan	4
Black/African American	2
Arab/Middle Eastern	1
Hispanic/Latino/a/x	1
Native Hawaiian/ Pacific Islander	1

Gender Identity

Respondents were asked to identify their gender identity. (Figure 53)

Figure 53: *Gender Identity – Community Member Survey*

Gender Identity	# of Respondents
Female	10
Male	9
Transgender	2
Non-Binary	2
Questioning	1

LGBTQ+ Identification

Respondents were asked if they identify as LGBTQ+. (Figure 54)

Figure 54: *LGBTQ+ Identity – Community Member Survey*

LGBTQ+ Identity	# of Respondents
Yes	8
No	7
Questioning	1

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Homeless in Past 6 Months

Respondents were asked if they have experienced homelessness in the past 6 months. (Figure 55)

Figure 55: *Homeless in Past 6 Months – Community Member Survey*

Homeless in past 6 months	# of Respondents
No	12
Yes	4

Active Duty Military, Reserve, or Veteran?

Respondents were asked about their military status. (Figure 56)

Figure 56: *Military Status – Community Member Survey*

Military Status	# of Respondents
No	10
Yes	7

Were you or at least one of your parents born outside of the US?

Respondents were asked if they or their parents were born outside the U.S. (Figure 57)

Figure 57: *Refugee/Immigrant Status – Community Member Survey*

Parent(s) born outside U.S.	# of Respondents
No	9
Yes	8

How did you find or receive this survey?

Of the 11 respondents who provided an answer to this question, a variety of sources were identified as having provided the survey. (Figure 58)

Figure 58: *How Respondent Found Survey – Community Member Survey*

Source	#
LinkedIn	4
Facebook	3
Friend	1
Nextdoor	1
Friend	1
Community Group	1

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Interpretation of Survey Findings Across Stakeholder Groups

The 2026 Community Needs Assessment incorporated survey feedback from three key stakeholder groups: AMHR clients, community members, and community partners. While each group brings a different perspective based on their relationship to the behavioral health system, several important themes emerged when comparing responses across the surveys. Across all three groups, common barriers to accessing behavioral health services included lack of awareness about available services, challenges navigating where to seek care, cost or insurance limitations, and transportation or logistical barriers. These shared concerns suggest that system navigation, timely access to care, and improved community awareness remain central priorities for strengthening behavioral health services in the region. Because these barriers were identified consistently across stakeholder groups, AMHR has prioritized strategies that expand access points, simplify pathways into care, and strengthen outreach and education about available services. Initiatives such as centralized access through the Potomac Pavilion, rapid access assessments through Connect to Care, and expanded outpatient and community-based services are designed to address these overlapping needs.

At the same time, the surveys also revealed differences in perspective across stakeholder groups. Clients more frequently identified barriers related to personal experience navigating services—such as appointment availability, transportation challenges, and difficulty understanding how to access services—while community members more often highlighted uncertainty about where to seek behavioral health care and concerns related to stigma or awareness. Community partners emphasized system-level barriers such as service capacity, workforce shortages, and the need for stronger coordination between healthcare, justice, and social service systems. Together, these perspectives provide a more complete understanding of how behavioral health services are experienced across the community. By integrating these viewpoints, the CNA helps ensure that both individual access challenges and broader system-level barriers are addressed in future planning and service development.

Key Insight: Shared Barriers Across Stakeholder Groups

Analysis of survey responses from AMHR clients, community members, and community partners revealed several consistent barriers to accessing behavioral health services. Across all three groups, the most commonly identified challenges included limited awareness of available services, difficulty navigating where to seek care, transportation and logistical barriers, and concerns related to cost or insurance coverage. These shared findings highlight the importance of simplifying entry points

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into care, improving community awareness of behavioral health resources, and strengthening coordination across healthcare and community systems.

In response to these findings, AMHR is prioritizing strategies that improve access and navigation through centralized entry points, expanded outreach and education, and strengthened partnerships with healthcare providers and community organizations. These efforts are intended to reduce barriers to care, improve timely access to services, and ensure individuals can connect to the appropriate level of support when they need it.

Survey Design & Question Alignment

The surveys administered to clients, community members, and community partners included several shared core questions to allow for comparison across groups, particularly related to barriers to care, awareness of behavioral health services, and perceived community needs. However, some questions differed intentionally based on the role and perspective of each stakeholder group. Client surveys focused more directly on personal experiences accessing services, satisfaction with care, and barriers encountered during treatment. Community member surveys emphasized awareness of available services and perceptions of behavioral health needs within the community. Community partner surveys were designed to capture system-level insights, including referral processes, coordination between organizations, and gaps in services observed through their work with shared populations.

This tailored approach allowed the assessment to gather meaningful feedback from each group while still maintaining areas of overlap that support cross-comparison of findings. The combination of shared questions and role-specific questions helps provide a comprehensive understanding of behavioral health needs in the community, reflecting both lived experience and system-level perspectives. Together, these insights inform AMHR's ongoing efforts to strengthen access, coordination, and service delivery across the behavioral health continuum.

What We Heard from the Community

Feedback gathered through surveys, interviews, and stakeholder engagement during the 2026 Community Needs Assessment highlighted several consistent themes regarding behavioral health needs and barriers to care in the communities served by Aurora Mental Health & Recovery.

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Key messages from the community include:

- Access to care must be easier to navigate. Many respondents shared that it can be difficult to know where to start when seeking mental health or substance use services, highlighting the need for clearer entry points and guidance.
- Awareness of available services remains limited. Community members and partners emphasized that many individuals are unaware of the behavioral health resources available in Aurora and the surrounding counties.
- Transportation and logistical barriers affect access to care. Travel distance, transportation availability, and scheduling challenges can make it difficult for individuals to attend appointments consistently.
- Capacity and workforce challenges impact service availability. Community partners noted that provider shortages and limited service capacity can contribute to wait times and barriers to timely care.
- Coordinated, community-based solutions are needed. Respondents emphasized the importance of strong partnerships between healthcare providers, schools, law enforcement, housing programs, and community organizations to support individuals across the full continuum of care.

These insights reinforce the importance of expanding access points, strengthening community partnerships, and continuing to develop a coordinated behavioral health system that meets individuals where they are and supports recovery across the community.

Culture & Language

Aurora is one of Colorado's most racially, ethnically, and linguistically diverse cities, with a population exceeding 400,000 residents and a steadily growing foreign-born community. More than one in five residents was born outside the United States, and nearly one-third of residents identify as Hispanic or Latino. Aurora's population includes long-established communities as well as newly arrived families from Latin America, East Africa, Southeast Asia, the Middle East, and other regions of the world. This demographic complexity shapes the behavioral health landscape, influencing service access patterns, engagement strategies, stigma considerations, and communication needs.

At the state level, Colorado's Behavioral Health Administration (BHA) and the Department of Health Care Policy and Financing (HCPF) emphasize equitable access, culturally responsive service delivery, and reduction of disparities in behavioral health outcomes. Certified Community Behavioral Health Clinic (CCBHC) criteria similarly require clinics to assess the needs of the entire service area population, identify barriers experienced by culturally and linguistically diverse

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communities, and ensure services are accessible and responsive to those needs. SAMHSA guidance reinforces the expectation that behavioral health organizations address language access, cultural humility, stigma reduction, and health disparities within their needs assessment and service planning processes.

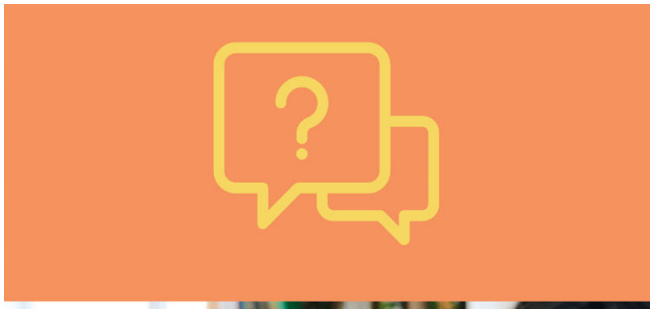
Within this context, AMHR recognizes that behavioral health needs cannot be separated from cultural identity, language access, migration experiences, aging, justice involvement, and broader social conditions. Understanding and responding to these factors is essential to improving engagement, continuity of care, and outcomes.

How AMHR Serves Our Community

AMHR operationalizes culturally affirming and linguistically responsive care across programs and service sites through intentional workforce practices, service design, and community partnerships. This work extends beyond awareness of diversity and into implementation across access points, clinical services, crisis response, and outreach initiatives.

Language Access and Communication

AMHR provides interpretation and translation services across clinical and administrative settings to ensure meaningful access for individuals with limited English proficiency. Language needs are documented within intake and electronic health record processes, allowing teams to proactively coordinate interpretation services. Materials, including surveys and key service information, are made available in multiple languages reflective of the community's needs. These efforts align with federal language access standards and CCBHC expectations to remove barriers to care.



Beyond formal interpretation, AMHR's staffing model includes multilingual clinicians, care coordinators, peer specialists, and navigators who reflect the communities served. This representation enhances trust, supports accurate communication, and improves client engagement across the care continuum.

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Alignment with CCBHC and SAMHSA Requirements

This section fulfills CCBHC and SAMHSA requirements by:

- Assessing service area demographics and identifying culturally and linguistically diverse populations
- Evaluating barriers to care related to language, stigma, and systemic factors
- Demonstrating meaningful language access and culturally responsive service delivery
- Incorporating community voice and lived experience into planning
- Linking findings to strategic action and continuous quality improvement

Through this framework, AMHR ensures that cultural and language considerations are not isolated initiatives but core components of access, quality, and accountability.

As Aurora continues to grow and diversify, AMHR will expand culturally responsive services through workforce development, targeted outreach, and strengthened partnerships. The organization will continue to integrate community-informed strategies into planning and performance monitoring to ensure services remain responsive, equitable, and grounded in the lived experiences of those served.

Strengths & Challenges

AMHR's Success in Addressing Community Needs and Barriers to Care

Strengths

Aurora Mental Health & Recovery (AMHR) demonstrates significant strengths in its ability to respond to the behavioral health needs of a rapidly growing and diverse community. As a SAMHSA Certified Community Behavioral Health Clinic (CCBHC) Grantee, AMHR operates within a model designed to increase access, integrate services, and ensure accountability for quality outcomes. Through this framework, AMHR has streamlined crisis response and intervention, strengthened care coordination, and improved access to services across the continuum of behavioral health care.

Crisis Response & Intervention

A key organizational strength is AMHR's comprehensive and integrated service system, which includes outpatient behavioral health services, crisis stabilization, withdrawal management, forensic services, specialized programming for individuals with intellectual and developmental disabilities, and community-based supports. The opening of the Potomac Pavilion in 2026 further strengthens the system by

providing a centralized entry point for services and improving the accessibility and visibility of behavioral health care within the community.

Care Coordination

AMHR also demonstrates strong community partnerships and cross-system collaboration, particularly with hospitals, law enforcement, courts, housing organizations, and community providers. These partnerships support coordinated care for individuals with complex needs, including those experiencing homelessness, justice involvement, or co-occurring behavioral health and medical conditions. Collaboration with community partners strengthens referral pathways, enhances early identification of behavioral health needs, and improves continuity of care.

Access to Services

Another notable strength is AMHR's specialized programming for priority populations, including older adults, individuals with intellectual and developmental disabilities, and justice-involved individuals. Programs such as forensic transition services, Jail-Based Behavioral Health Services, and specialized counseling programs for individuals with autism and I/DD demonstrate the organization's ability to tailor services to populations with unique needs.

Finally, AMHR benefits from a skilled and multidisciplinary workforce, including clinicians, psychiatrists, nurses, peer specialists, case managers, and care coordinators. This multidisciplinary structure supports whole-person care and allows AMHR to respond to both behavioral health needs and broader social drivers of health.

Recent regional planning and grant initiatives reinforce the importance of expanding outpatient behavioral health capacity in Adams County and surrounding communities served by Aurora Mental Health & Recovery (AMHR). Regional assessments conducted by Adams County and partner agencies identify increasing demand for accessible outpatient behavioral health services, including mental health screening, substance use treatment, and same-day access to care. In response to these identified needs, AMHR is implementing an outpatient service expansion in Adams County supported through a grant from Adams County's APA Behavioral Health Services and Supports initiative. This project includes development of a new outpatient clinic designed to provide lifespan behavioral health services, including screening, outpatient therapy, substance use treatment, medication management, and rapid access services. The expansion aims to increase service capacity, strengthen referral partnerships across the community, and improve timely access to care for underserved residents. The project also supports

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workforce development by recruiting and deploying additional behavioral health providers and expanding partnerships with community organizations to ensure coordinated care and improved behavioral health outcomes for Adams County residents.

Challenges

Despite these strengths, the CNA findings highlight several ongoing challenges that affect behavioral health access and outcomes across the Aurora region.

One of the most significant challenges identified through surveys, stakeholder interviews, and data analysis is the growing demand for behavioral health services. Population growth across Aurora, Adams, Arapahoe, and Douglas County, and surrounding areas continues to increase demand for mental health and substance use treatment, placing pressure on service capacity and workforce availability. While AMHR has expanded crisis and outpatient services, community needs continue to outpace available resources in certain areas.

Access to care also continues to be influenced by social drivers of health, including housing instability, transportation barriers, economic insecurity, and lack of insurance coverage. These factors can delay treatment engagement and complicate recovery for individuals with behavioral health conditions.

The CNA also identified challenges related to system navigation and awareness of services. Community survey responses suggest that some residents remain uncertain about where to access behavioral health services or how to enter the system. While crisis services are available 24/7, individuals and families may still experience difficulty understanding how to access ongoing care or specialty services.

Workforce capacity remains another challenge across the behavioral health system. Recruitment and retention of licensed clinicians, psychiatrists, nurses, and behavioral health specialists continues to affect service expansion efforts across Colorado. Workforce shortages may impact wait times, service availability, and the ability to scale specialized programs.

Finally, the CNA identified ongoing needs related to early intervention and prevention, particularly for individuals involved in the justice system and older adults experiencing behavioral health concerns. Expanding services upstream—before individuals reach crisis points or become justice involved—represents a critical opportunity for improving outcomes and reducing system strain.

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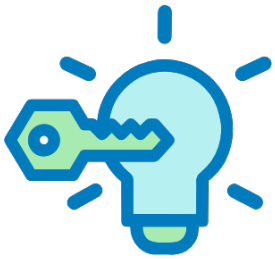
Key Takeaways from AMHR's Gaps/Challenges



Analysis of the 2026 Community Needs Assessment identified several cross-cutting themes that influence behavioral health outcomes across the Aurora community.

Demand for Behavioral Health Services

The demand for behavioral health services continues to grow faster than system capacity. Population growth, increasing awareness of mental health needs, and expanding substance use challenges have contributed to higher service utilization across crisis, outpatient, and specialty care settings.

Social Drivers of Health

Social drivers of health play a significant role in behavioral health outcomes. Housing instability, transportation barriers, and economic hardship often affect an individual's ability to engage consistently in treatment. Addressing these factors requires coordinated efforts between behavioral health providers, healthcare systems, housing organizations, and community partners.

Navigation of Behavioral Health System

Navigation of the behavioral health system remains a barrier for some community members. Even when services are available, individuals may struggle to understand where to seek help or how to access the appropriate level of care. Improving awareness, outreach, and entry points into the system will be important to improving access.

Unique Needs of Special Populations

Specific populations, including older adults and justice-involved individuals, require targeted strategies to address their unique needs. Older adults may face challenges related to isolation, mobility, and access to services within residential settings. Justice-involved individuals benefit from early intervention strategies, diversion programs, and coordinated re-entry support.

Preventative & Early Intervention

Expanding preventative and early intervention approaches will be essential for improving long-term outcomes. Strengthening services at earlier stages of need can reduce crisis utilization, improve recovery outcomes, and support community stability.

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Summary AMHR Client & Community Demographic Comparison

ARI extracted client demographic data from the AMHR electronic health record and compared it to census data to determine if there are certain groups that are under- or over-represented among the clients at AMHR. Comparison of AMHR client demographics with broader community population data highlights both areas of strong reach and opportunities for expanded engagement.

Compared to the Aurora population, AMHR clients:

Aurora is one of the most diverse cities in Colorado, with a population exceeding 400,000 residents and representing a wide range of racial, ethnic, cultural, and socioeconomic backgrounds. AMHR's client population reflects many of these community characteristics and includes individuals from diverse racial and ethnic backgrounds, as well as individuals experiencing a range of social and economic challenges.

However, the CNA analysis indicates that some populations may be disproportionately represented within behavioral health services, particularly individuals experiencing economic hardship, housing instability, or justice system involvement. This pattern reflects broader national trends in which behavioral health conditions are closely linked with social and structural factors affecting community well-being.

At the same time, the CNA suggests that certain community groups—such as older adults or individuals living in rapidly growing areas of the region—may be underrepresented in service utilization relative to population size, indicating potential barriers to access or awareness of services.

Understanding these demographic differences helps AMHR identify opportunities to expand outreach, strengthen early intervention strategies, and ensure services remain responsive to evolving community needs.

Aurora
Mental Health & Recovery

Findings from 2023 Community Needs Assessment

How Community Input Drives System Change

AMHR has also advanced targeted, culturally responsive and family-centered approaches to care for priority populations. Within the Refugee and Immigrant Clinic, the Trauma Resilience Youth Program (TRYP) reflects an intergenerational model grounded in the Two-Generation (2Gen) framework and enhanced through SAMHSA's NNEDLearn model (SITIF). This approach emphasizes family-centered engagement, recognizing the role of caregivers and community in supporting healing, while delivering trauma-informed services that honor cultural values, language needs, and lived experiences. Services are designed to support continuity across the lifespan by engaging youth and families together, strengthening long-term stability and resilience. The model incorporates multiple service modalities, including individual, family, and group-based interventions, as well as coordinated care across providers. It directly responds to needs identified in the CNA, including barriers related to language, stigma, and system navigation, while reinforcing the importance of trust, cultural understanding, and community connection. Early implementation has exceeded participation goals, and ongoing collaboration with the Aurora Research Institute is supporting the development of outcome measures to evaluate impact.

Together, these efforts reflect a deliberate and iterative response to community-identified needs, demonstrating how AMHR translates data, stakeholder input, and best practices into operational change. By emphasizing culturally responsive, family-centered care, continuity across the lifespan, and flexible service delivery models, AMHR continues to evolve its system to better meet the needs of the communities it serves. The 2026 Community Needs Assessment builds on this progress by evaluating the impact of these initiatives, incorporating updated data from internal systems and external partners, and identifying both sustained and emerging priorities to guide the next phase of strategic, community-informed service development.

Action Plan to Address Findings

The findings from the 2026 Community Needs Assessment will inform AMHR's strategic planning, program development, and continuous quality improvement initiatives. The action plan focuses on strengthening system capacity, improving access to care, and expanding preventative services.

Aurora Mental Health & Recovery

A key priority is expanding early intervention and prevention strategies, particularly for justice-involved individuals and populations at risk of behavioral health crises. Through the Sequential Intercept Model framework, AMHR will continue strengthening diversion programs, re-entry supports, and community-based services that address behavioral health needs before individuals enter deeper levels of the justice system.

AMHR will also continue optimize crisis response and access points, building upon the launch of the Potomac Pavilion to improve system navigation and provide a clear entry point for behavioral health care. Efforts will focus on strengthening community awareness of available services and ensuring individuals can access care quickly and efficiently.

Another priority is strengthening services for older adults and individuals with complex care needs, including expansion of community-based services in residential settings, partnerships with nursing facilities, and outreach to community organizations serving older adults.

Addressing workforce challenges will also remain an important focus area. AMHR will continue investing in workforce development, recruitment, training, and retention initiatives to ensure the organization maintains a strong multidisciplinary workforce capable of meeting community demand.

Finally, AMHR will continue strengthening data-driven decision-making through the CCBHC model, using quality measures, community feedback, and performance data to guide program improvements and ensure services remain responsive, equitable, and effective.

Effective Partnerships & Care Coordination

Building Community, Partnerships, & Improving Care Coordination:

Aurora Mental Health & Recovery (AMHR) recognizes that improving behavioral health outcomes requires strong partnerships and coordinated care across the broader healthcare and community service system. Consistent with Certified Community Behavioral Health Clinic (CCBHC) requirements and community needs identified through the 2026 Community Needs Assessment (CNA), AMHR will continue to strengthen collaboration with healthcare providers, community organizations, law enforcement, schools, housing partners, and social service agencies across Aurora, Adams, Arapahoe, and Douglas Counties. These partnerships help ensure that individuals experiencing mental health or substance use challenges can access services earlier, navigate systems more easily, and

receive coordinated care that addresses both behavioral health needs and the social factors that influence well-being.

AMHR's care coordination approach emphasizes seamless transitions between levels of care and stronger referral pathways among community providers. Through the expansion of centralized access points such as the Potomac Pavilion and Connect to Care services, individuals can receive timely assessments and connections to appropriate services within AMHR or through trusted community partners. AMHR will continue strengthening relationships with hospitals, primary care providers, justice system partners, schools, and housing organizations to support individuals across key system touchpoints, including crisis response, re-entry from incarceration, and transitions from emergency departments or inpatient settings. These partnerships align with the Sequential Intercept Model and statewide behavioral health priorities, ensuring that individuals receive support as early as possible and that services are coordinated across systems.

To further strengthen care coordination, AMHR will focus on improving communication pathways, expanding data-informed referral networks, and increasing engagement with community-based partners serving priority populations such as older adults, individuals involved in the justice system, and those experiencing housing instability. These efforts will include regular stakeholder engagement, shared problem-solving across systems, and continued participation in regional behavioral health planning initiatives. By building stronger partnerships and improving coordination across healthcare and community systems, AMHR aims to reduce service fragmentation, improve access to timely behavioral health care, and support more sustainable recovery outcomes for individuals and families across the region.

Staffing & Training Plan Integration

Staffing Plan

National workforce trends in behavioral health continue to highlight challenges related to workforce shortages, burnout, role clarity, and retention—particularly within crisis services and community-based care. Emerging workforce models emphasize the need for standardized role definitions, consistent training expectations, and comprehensive staff support structures to promote sustainability and quality care delivery. These models focus on ten key areas, including clearly defined roles and responsibilities, competency-based training, supervision and coaching, staff wellness and burnout prevention, career pathways, cultural and developmental responsiveness, interdisciplinary team structures, safety protocols, data-informed performance management, and alignment with evidence-informed practices. Together, these elements aim to reduce variability across roles,

strengthen workforce resilience, and ensure consistency in service delivery across behavioral health systems.

Workforce data from FY26 further reflects both the demand for services and the operational realities of staffing within a growing behavioral health system. Year-to-date, AMHR has filled 335 positions, an increase from 295 in FY25, demonstrating continued hiring momentum to meet community needs. At the same time, 193 new hires have been onboarded (compared to 253 in FY25), and approximately 60 positions remain open, indicating ongoing workforce demand. Time-to-fill metrics show averages of 61.26 days from request to hire and 47.47 days from posting to hire, both slightly higher than FY25 benchmarks, reflecting broader workforce shortages and competitive hiring environments. Active requisitions remain open for an average of 44.91 days, further underscoring the challenges of recruiting in a constrained labor market. These trends highlight both AMHR's commitment to expanding capacity and the continued need for strategic workforce planning to reduce time-to-fill and improve retention.

In alignment with these trends, Aurora Mental Health & Recovery (AMHR) continues to strengthen its workforce strategies to support staff and improve service delivery. AMHR emphasizes evidence-informed practices, including standardized care pathways, follow-up protocols, and integrated approaches that support continuity of care across the lifespan. Workforce development efforts prioritize culturally responsive and developmentally appropriate care, ensuring staff are equipped to meet the needs of diverse populations, including youth, families, older adults, and individuals involved in the justice system. Through programs such as THRIVE and ongoing training initiatives, AMHR supports staff in building clinical competencies, enhancing engagement strategies, and delivering family-centered care.

Additionally, AMHR is actively working to reduce burnout and improve retention through structured supervision, team-based care models, and ongoing support for staff well-being. Efforts include strengthening onboarding processes, clarifying roles within multidisciplinary teams, and expanding opportunities for professional growth and advancement. AMHR's approach also incorporates national workforce model standards within crisis and community-based services, promoting consistency in expectations, role clarity, and staff support across programs. By aligning staffing strategies with both national best practices and community-identified needs, AMHR is building a more resilient, supported, and responsive workforce capable of delivering high-quality, culturally responsive behavioral health services across the region.

Needs Assessment Cycle

The Community Needs Assessment (CNA) follows a structured three-year cycle aligned with CCBHC and SAMHSA requirements to ensure AMHR's services remain responsive, data-informed, and strategically aligned with community needs. In the first year, AMHR conducts a comprehensive mixed-methods assessment that includes client and stakeholder surveys, demographic and social determinants analysis, internal utilization data, and review of state and national trends. Findings are synthesized into a formal CNA that identifies priority populations, service gaps, and strategic opportunities, which directly inform the organization's Action Plan and Continuous Quality Improvement (CQI) priorities.

In years two and three, AMHR monitors progress on identified goals. Updated data, quality measures, and community feedback are reviewed regularly to assess impact, adjust strategies, and address emerging needs. This creates an ongoing feedback loop—community input and data inform action, implementation is monitored, and improvements are made in real time. The CNA therefore serves not just as a regulatory requirement, but as a living strategic planning tool that strengthens accountability, supports population health management, and ensures services remain equitable and effective.

Communication Plan

The 2026 Community Needs Assessment (CNA) communication plan includes both internal and external strategies to ensure transparency, engagement, and shared ownership of findings. Internally, updates will be provided regularly to the CCBHC Steering Committee, Executive Leadership, Board of Directors, Clinical and Medical Division leaders, and Quality Council through standing meetings, email updates, and dashboard reporting. Key findings and action priorities will be shared with staff through leadership briefings, internal newsletters, and department meetings to

Aurora Mental Health & Recovery

reinforce alignment with strategic and quality improvement efforts. Externally, AMHR will disseminate a public-facing executive summary through its website, community newsletters, partner distribution lists, and stakeholder presentations. Community partners, local agencies, and advisory groups will receive tailored summaries highlighting relevant findings and partnership opportunities. This dual communication approach ensures that the CNA remains transparent, accessible, and actionable, strengthening trust and collaboration across the communities AMHR serves.

Integration of the Needs Assessment Action Plan with the Continuous Quality Improvement Plan (CQIP)

The 2026 Community Needs Assessment (CNA) Action Plan is intentionally integrated into AMHR's Continuous Quality Improvement Plan (CQIP) to ensure identified priorities translate into measurable performance outcomes. Key goals emerging from the CNA—such as access improvements, service expansion for priority populations, and care coordination enhancements—are incorporated into CQI dashboards, performance indicators, and committee review structures. Progress is monitored through routine data reporting, quality measure tracking (including CCBHC metrics), and leadership oversight, creating a feedback loop that allows for course correction and sustained improvement. This integration ensures the CNA is not a stand-alone document, but a living driver of operational excellence and accountable, data-informed service delivery.

Aurora Mental Health & Recovery

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