Community Needs Assessment and Gap Analysis

Southwestern Colorado Opioid Overdose Planning (SCOOP) Consortium

Durango, Colorado

March 1, 2021

Grantee Organization	Catholic Health Initiatives (CHI) Foundation / Mercy Regional Medical Center	
Grant Number	G25RH40030	
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	Community Member (3 individuals)	
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	Four Corners Diversity Alliance	
	Young People in Recovery	
	Advocates for Recovery Colorado	
	Durango Police Department	
	La Plata County Commissioner	
	La Plata County City Council	
	6th Judicial District Probation	
	Bayfield School District Superintendent	
	Ignacio Schools Counselor	
	Community Compassion Outreach	

	Celebrating Healthy Communities ED
	La Plata County Department of Human Services
	Planned Parenthood
	Colorado Office of Behavioral Health
	Rocky Mountain Health Plan
	Uncommon Health Solutions
	Unclouded Communications
	Centura Health Subject Matter Experts (2)
	Resilient Colorado
	West Slope CASA
	Front Range Clinic
	Colorado Consortium for Prescription Drug Abuse Prevention
	Rocky Mountain Health Plan
	Southwestern Colorado Area Health Education Center
	San Juan Basin Public Health Department
	Emergency Department Physician at Mercy
	Manna Community Kitchen
	Neighbors in Need Alliance
	Axis Health System

A. Introduction/Background Information

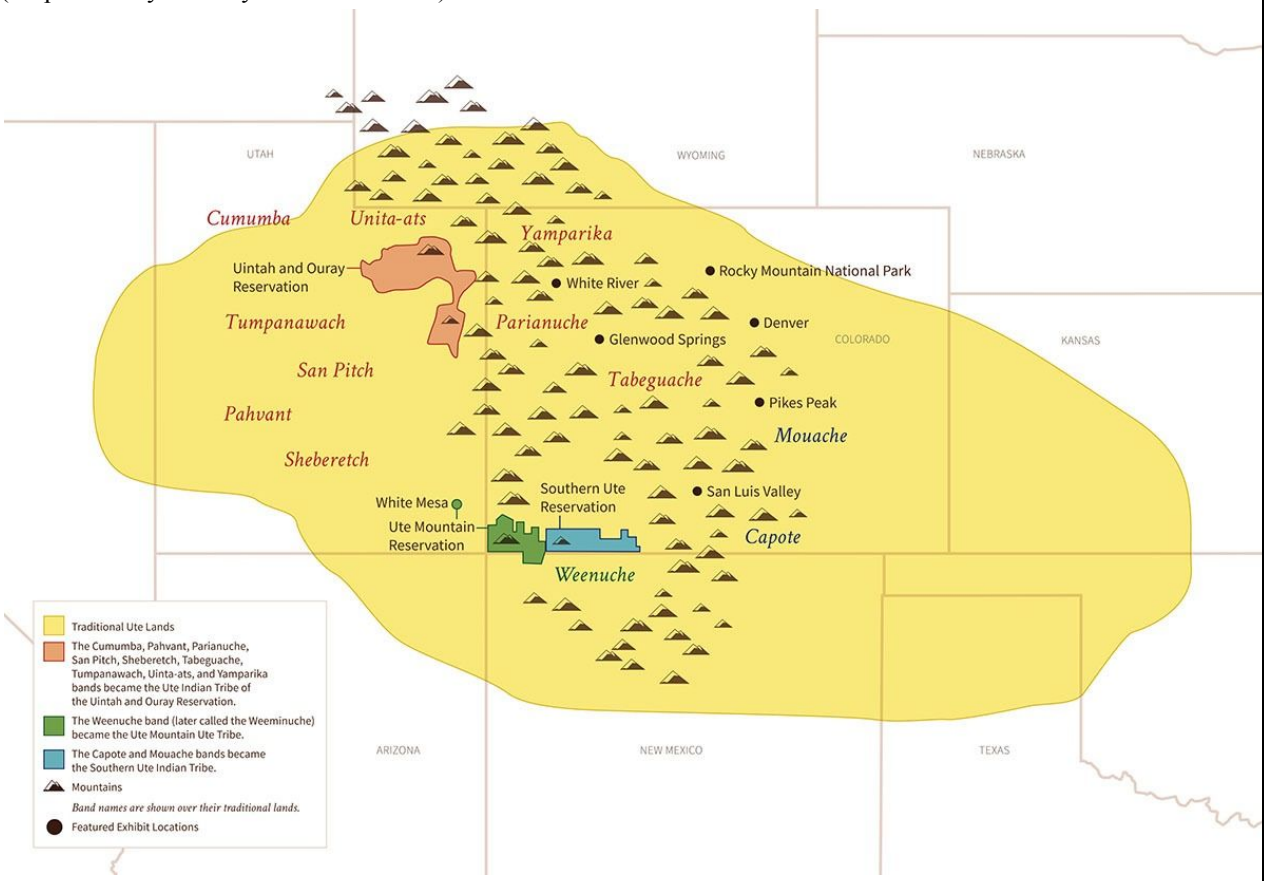
Include a summary of the geographical areas addressed in this needs assessment, including community culture and history.

One of our priority populations is Native Americans. As such, it is important that we understand their history, culture and stories. Recognizing this section may be longer than expected and you have much to read through, we are grateful that you are taking the time to consider this important foundation to our work. We also begin each consortium meeting with the land acknowledgement.

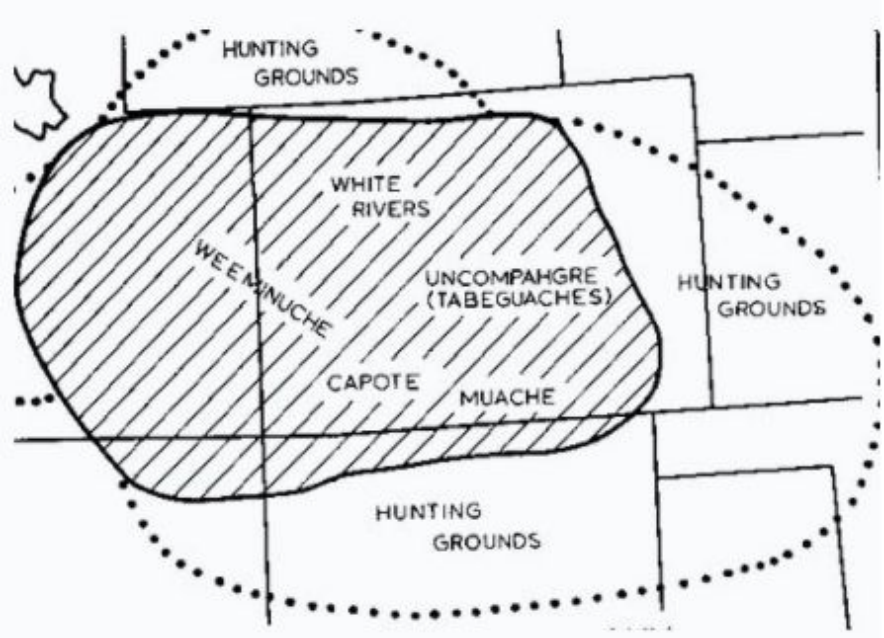
Land Acknowledgement (provided by Imo Succo, Consortium Member):

"We acknowledge that the ground beneath our feet is historically the home of indigenous peoples. It is the ancestral lands of the Puebloan, Ute tribes and Dine, who have occupied this land before colonization. The Weenuchiu band are now recognized as Ute Mountain Utes who are located in Towaoc and the Mouache and Caputa bands make up the Southern Ute Indian Tribe of Ignacio. Hesperus Peak, located just west of Durango, is the tallest peak in the La Plata mountain range and also one of the four sacred mountains identified by the Dine people, also known as the Navajo. The history of these lands have been told from a western perspective for many years, without fully acknowledging the indigenous people who occupied this land before it was La Plata County and Montezuma County. It is imperative to know that we are living and working on stolen lands. We are here to create a peaceful environment for all and to be inclusive of history, culture, and humanity. Thank you for acknowledging the history of lands with me today."

Núu-agha-t~~u~~vu-p~~u~~ (Ute)
(Map Courtesy: History Colorado Center)



Hunting Grounds Map Source: www.native-land.ca



Today, according to the American Community Survey 5-year (2014-2019) estimates, approximately 3,600 American Indian and Alaska Native Peoples live in La Plata County. Of those, almost 1,500 are Navajo, almost 1,000 are Ute (anecdotally, the Southern Ute Tribe has approximately 1,400 members with many living out of the area), and at least 17 other Tribes are represented. This representation may be due to local Fort Lewis College (FLC) having a Native American Tuition Waiver. According to the FLC website, a full 41% of the student body is Native American or Alaska Native and 177 Native American tribes and Alaska Native villages are represented. This is all significant for many reasons, among them this means many graduates likely stay or would stay in the area. It also means many are here and disconnected from their tribal community.

It is important to recognize that the many Native American and Alaska Natives in La Plata County each have their own history and experience that is not shared in this document. Our work is fully incomplete without it. Later we discuss the concept of a Native American Cultural Center. A program such as that would allow the community to fully recognize and learn from all of the different histories and experiences. Sharing the Southern Ute story and experience serves as recognition of their culture and that La Plata County is a product of that history… much of which involved colonists intentionally destroying their lives, land, and culture. We should recognize that many of us here benefit from that history while they survived it. This survival is a testimony to their strength and resilience. It should further be viewed as an example of the kinds of things we could be sharing about all of the tribes represented here, and for each of us and our unique histories and experiences.

In order to respect Tribal history and be fully aligned, the following is drawn verbatim from sections on the Southern Ute website.

The Utes do not have a migration story. The Utes have always lived here in the mountains. This is the Ute Creation Story as told by Alden Naranjo, a revered Southern Ute Elder and a member of the Mouache and Caputa bands.

Ute Creation Story, as told by Alden Naranjo in Ute Indians Art and Culture, from Prehistory to the new Millennium, Edited by William Wroth. Published by the Colorado Springs Fine Arts Center Copyright 2000

In the ancient times only Sinawav, the Creator and Coyote lived on the earth. They had come out of the light so long ago, that no one remembered when or how. The Earth was young and the time had come to increase the people.

Sinawav gave a bag of sticks to Coyote and said, "Carry these over the far hills to the valleys beyond." He gave specific directions Coyote was to follow and told him what to do when he got there. "You must remember, this is a great responsibility. The bag must not be opened under any circumstances until you reach the sacred grounds."

"What is this I carry?" asked Coyote
"I will say no more. Now be about your task" Sinawav answered.
Coyote was young and foolish, consumed with curiosity. "What is this I carry?" he kept asking himself.


Coyote

As soon as he was over the first hill and out of sight, he stopped. He was just going to peek in the bag. "That could hurt nothing." He thought. Just as he untied the bag and opened a small slit they rushed for the opening. They were people. These people yelled and hollered in strange languages of all kinds. He tried to catch them and get them back into the bag. But they ran away in all different directions. From how full the bag was after he had gotten it closed he could tell there was only a fraction of what he had started out with. He went to the sacred valley and dumped them out there. There was a small number of these people. But those few ones were the Utes, the real Utes from around here.

Coyote then returned and told Sinawav that he had completed the task. Sinawav searched Coyote's face. "I know," Sinawav sighed. "You foolish thing, you do not know what a fearful thing you have done."
Coyote finally confessed. "I tried to catch them. I was frightened. They spoke in strange tongues that I could not understand."

"Those you let escape will forever war with the chosen ones, They will be the tribes which will always be a thorn in the sides of the Utes," said Sinawav.

"The Utes, even though they are few in number, will be the mightiest and most valiant of heart."
Sinawav then cursed the Coyote "You are an irresponsible meddler. From this time on you are doomed to wander this earth on all fours forever as a night crawler."

Early History

The Ute people are the oldest residents of Colorado, inhabiting the mountains and vast areas of Colorado, Utah, Wyoming, Eastern Nevada, Northern New Mexico and Arizona. According to tribal history handed down from generation to generation, our people lived here since the beginning of time.

Prior to acquiring the horse, the Utes lived off the land establishing a unique relationship with the ecosystem. They would travel and camp in familiar sites and use well established routes such as the Ute Trail that can still be seen in the forests of the Grand Mesa, and the forerunner of the scenic highway traversing through South Park, and Cascade, Colorado.

The language of the Utes is Shoshonean, a dialect of that Uto-Aztecan language. It is believed that the people who speak Shoshonean separated from other Ute-Aztecan speaking groups, such as the Paiute, Goshute, Shoshone Bannock, Comanche, Chemehuevi and some tribes in California. The Utes were a large tribe occupying the great basin area, encompassing the Numic speaking territories of Oregon, Idaho, Wyoming, Eastern California, Nevada, Utah, Colorado and Northern Arizona and New Mexico.

Tribes living in this area, ancestors of the Utes were the Uto-Aztecs, who spoke one common language; they possessed a set of central values and had a highly developed society. Traits commonly attributed to people possessing a civilization. The Ute civilization spoke the same language, shared values, observed the same social and political practices, in addition to inhabiting and holding a set territory.

The Utes settled around the lake areas of Utah, some of which became the Paiute, other groups spread north and east and separated into the Shoshone and Comanche people, and some traveled south becoming the Chemehuevi

and Kawaiisus. The remaining Ute people became a loose confederation of tribal units called bands. The names of the bands and the areas they lived in before European contact are as follows:

The Mouache band lived on the eastern slopes of the Rockies, from Denver south to Trinidad, Colorado, and further south to Las Vegas, New Mexico.

The Caputa band lived east of the Continental Divide, south of the Conejos River and in the San Luis Valley near the headwaters of the Rio Grande. They frequented the region near Chama and Tierra Amarilla. A few family units also lived in the shadow of Chimney Rock, now a designated United States National Monument.

The Weenuchiu occupied the valley of the San Juan River and its north tributaries in Colorado and Northwestern New Mexico. The Uncompahgre (Tabeguache) were located near the Uncompahgre and Gunnison, and Elk Rivers near Montrose and Grand Junction, Colorado.

The White River Ute (Parianuche and Yamparika) lived in the alleys of the White and Yampa river systems, and in the North and middle park regions of the Colorado Mountains, extending west to Eastern Utah. The Uintah lived east of Utah Lake to the Uinta Basin of the Tavaputs plateau near the Grand and Colorado River systems.

The Pahvant occupied the desert area in the Sevier Lake region and west of the Wasatch Mountains near the Nevada boundary. They intermarried with the Goshute and Paiute in Southern Utah and Nevada.

The Timonogots lived in the south and eastern area of Utah Lake, to North Central Utah. The Sanpits (San Pitch) lived in the Sapete Valley, Central Utah and Sevier River Valley. The Moanumts lived in the upper Sapete Valley, Central Utah, in the Otter Creek region of Salum, Utah and Fish Lake area; they also intermarried with the Southern Paiutes. The Sheberetch lived in the area now known as Moab, Utah, and were more desert oriented. The Comumba/Weber band was a very small group and intermarried and joined the Northern and Western Shoshone.

Today, the Mouache and Caputa bands comprise the Southern Ute Tribe and are headquartered at Ignacio, Colorado. The Weenuchiu, now known as the Ute Mountain Utes are headquartered at Towaoc, Colorado. The Tabeguache, Grand, Yampa and Uintah bands comprise the Northern Ute Tribe located on the Uintah-Ouray reservation next to Fort Duchesne, Utah.

As the Utes traveled the vast area of the Great Basin, large bands would breakup into smaller family units that were much more mobile. Camps could be broken down faster making travel from one location to another a more efficient process. Because food gathering was an immense task, the people learned that by alternating hunting and food gathering sites the environment would have time to replenish. The Nuche only took what they required, never over harvesting game or wild plants. These principles were closely adhered to in order for the people to survive.

In early spring and into the late fall, men would hunt for large game such as elk, deer, and antelope; the women would trap smaller game animals in addition to gathering wild plants such as berries and fruits. Wild plants such as the amaranth, wild onion, rice grass, and dandelion supplemented their diet. Some Ute bands specialized in the medicinal properties of plants and became expert in their use, a few bands planted domestic plants.

Before they acquired the horse, the Utes used basic tools and weapons which were made of stone and wood. These tools included digging sticks, weed beaters, baskets, bows and arrows, flint knives, arrow heads, throwing sticks, matates and manos for food preparation. They traded with the Puebloans for pottery to use for food and water storage and transport. They became very skilled at basket weaving, making coiled containers sealed with pitch for water storage. As expert hunters they used all parts of the animal. Elk and deer hides were used for shelter covers, clothing and moccasins. The hides the Utes tanned were prized and a sought after trade item. The Ute women became known for their beautiful quill work, which decorated their buckskin dresses, leggings, moccasins, and cradleboards.

Late in the fall, family units would begin to move out of the mountains into sheltered areas for the cold winter. Generally, the family units of a particular Ute band would live close together. The family units could acquire more

fuel for heating and cooking. The increased family units would also allow for a better line of defense from enemy tribes seeking supplies for the harsh winter weather. The Caputa, Mouache and Weenuchiu wintered in northwestern New Mexico; the Tabeguache (Uncompahgre) camped near Montrose and Grand Junction; the Northern Utes would make their winter camps along the White, Green and Colorado Rivers.

Winter was a time of rejuvenation and the Utes would gather around their evening fires visiting and exchanging stories about their travels, social, and religious events. This was a time to reinforce tribal custom, as well as repairing tools, weapons and making new garments for the summer.

The Chiefs would announce plans for major events. A primary event that marked the beginning of spring was the annual Bear Dance. The Bear Dance is still considered a time of rejuvenation by the tribe. It is in essence, the Tribes' New Year, when Mother Earth begins a new cycle, plants begin to blossom, animals come out of their dens after a long cold winter.

The Bear awakens from his winter's sleep and celebrates by dancing to welcome the spring. This dance was given to the Ute people by the bear. The Bear Dance is the most ancient dance of the Ute people and continues to be observed by all Ute bands. When many of the various bands gathered for the Bear Dance it allowed relatives to socialize, while at the same time providing an opportunity for the young people to meet and for marriages to be negotiated. On the last day of the Bear Dance, the Sundance Chief would announce dates of the Sundance.

Bear Dance – Jeremy Wade Shockley | Southern Ute Drum

The Ute people lived in harmony with their environment. They traveled throughout Ute territory on familiar trails that crisscrossed the mountain ranges of Colorado. They came to know not only the terrain but the plants and animals that inhabited the lands. The Utes developed a unique relationship with the environment learning to give and take from Mother Earth.

They obtained soap from the root of the yucca plant. The yucca was used to make rope, baskets, shoes, sleeping mats, and a variety of household items. The three leaf sumac and willow were used to weave baskets for food and water storage. They learned how to apply pitch to ensure their containers were water-tight. They made baskets, bows, arrows, other domestic tools, and reinforcements for shade houses.

Chokecherry, wild raspberry, gooseberry, and buffalo berry were gathered and eaten raw. Occasionally juice was extracted to drink and the pulp was made into cakes or added to dried seed meal and eaten as a paste or cooked into a mush. Ute women would use seeds from various flowers or grasses and add them to soup. The three leaf sumac would be used in tea for special events.

The people would harvest roots with a tool called a digging stick. The digging stick was pointed and about three to four feet long. Roots collected were the sego (mariposa) lily, yellow pond lily, yampa or Indian carrot. The amaranth plant was gathered and the seeds were obtained with a tool called a seed beater, similar to winnowing. Amaranth seeds were often eaten raw, the Indian potato (Orogenia linearifolia) and wild onion were used in soups or eaten raw. They could be dried for later use or ground into a flour to make stews thicker. Utes would use earthen ovens to cook food. They would prepare the food items and place them into a four-foot deep hole lined with stones.

A fire was built on top of the stones and the food was placed in layers of damp grass and heated rocks. These items would then be covered with dirt to cook overnight. The prickly pear cactus was another food source. The flower and fruit were either eaten raw or boiled or roasted.

The inner bark of the tree is very nutritious and was yet another food source for the people. The Utes harvested the inner bark of the ponderosa pine for making healing compresses, tea and for healing. The scarred ponderosa trees are still visible in Colorado forests. The healing trees are evidence of the Utes early presence in the land and their close relationship to their ecosystem.

When the Ute people were forcibly placed [on] reservations they could no longer travel on their familiar trails, to gather or hunt for food. As more and more elders pass they take traditional knowledge about plants and their uses with them. In the past the Ute vocabulary included many words and their uses for plants. Unfortunately, these ancient words have been lost.

A medicinal plant used by the Utes is Bear root (Ligusticum portieri) also commonly known as osha. Bear root grows throughout the Rocky Mountains, in elevations over 7,000 feet. The plant has antibacterial and antiviral powers and continues to be used to treat colds and upper respiratory ailments. It can be chewed or brewed into teas. It can be used topically, in baths, compresses, and ointments to treat indigestion, infections, wounds and arthritis. Some southwest tribes use it before going into the desert areas to deter rattlesnakes. The Utes have a special relationship with the plant and treat it with great respect, harvesting only what they need and always giving prayers before they harvest.

Ute elders knew which plants should be gathered and which plants were dangerous. One has to be very careful when harvesting wild plants as many toxic plants can be mistaken for wild onion or bear root. Poison hemlock (Conium macalatum) appears much the same as the bear root but is dangerous. Peppermint and wild tobacco were collected and used in many important ceremonies.

The routes the Utes established were used by other Native American tribes and Europeans. The Ute Trail became known as the Spanish Trail used by Spanish explorers as early as the fifteenth century when Alvar Nunez Caveza de Vaca (1488-1558) and Juan de Onate (1550-1630) were sent from Spain to explore the uninhabited areas of Texas and New Mexico, claiming vast lands for their Spanish rulers.

During the sixteenth century Spaniards began to colonize New Mexico, establishing their domination wherever possible. As the Spanish advanced northward into Ute territory, the customs, livestock, and language they brought began to influence the Ute's way of life. These changes were to have far reaching impacts upon the Ute people. Not only did the European bring livestock and tools, they also brought smallpox, cholera and other diseases that would decimate the population of the Ute people. The European's never-ending quest for land was in direct contrast to the Native American's reverence for Mother Earth. The Utes believed that they didn't own the land, but that the land owned them. Contact with the European was to end a way of life the people had known for centuries.

Contact between the Southern Utes and the Spanish continued, with trade soon developing. Utes were known for their tanned elk and deer hides which they traded along with dried meat tools and weapons. However, as the Spanish became more aggressive conflicts began to arise. When Santa Fe was established as the northern capital of the Spanish colonists they captured Utes and other Native Americans as slave laborers to work in their fields and homes. Around 1637 Ute captives escaping from the Spanish in Santa Fe fled, taking with them Spanish horses, thus making the Utes one of the first Native American tribes to acquire the horse. However, tribal historians tell of the Utes acquiring the horse as early as the 1580s.

Already skilled hunters, the Utes used the horse to become expert big game hunters. They began to roam further away from their home camps to hunt buffalo that migrated over the vast prairies east of their mountain homes and explore the distant lands.

The Utes began to depend upon the buffalo as a source for much of their items. It took only one buffalo to feed several families, and fewer hides were required to make structures and clothing.

The Utes already had a reputation as defenders of their territories now became even fiercer warriors. Women and children were also fierce and were known to pick up a lance and defend their camps from attacking enemies. Ute men were described by the Spanish as having fine physiques, able to withstand the harsh climate, and live off the land in sharp contrast to the European who often had to depend upon Native Americans and their knowledge about plants, animals and the environment. They became adept raiders preying upon neighboring tribes such as the Apache, Pueblos and Navajo. Items obtained from their raids were used to trade for household items, weapons, horses and captives. Owning horses increased one's status in the tribe.

Encounters with the Spanish began to occur more frequently, and trade increased to include Spanish items such as metal tools and weapons, cloth, beads and even guns. The bounty collected from raiding expeditions was used to trade for horses, which were considered a valuable commodity. Captives from raids were also used as barter items.

In November 1806 Zebulon Pike entered the eastern boundaries of Ute lands proclaiming one of the Ute's most sacred sites as "Grand Peak", now known as Pike's Peak. Prior to this, Ute territory had not been explored on a large scale because of the rugged terrain and high mountain passes. Europeans began to take notice of the land's bounty, timber, wildlife and abundant water. What they did not take into account was that the land was already inhabited by the Ute people, who considered the land their home.

As westward expansion increased and eastern tribes were displaced and relocated to barren lands in the west, pioneers began to travel west. Gold and silver were discovered in the San Juan Mountains and the Utes soon found themselves in a losing battle to retain their homelands.

Treaties and Agreements with the Utes

In the 1700s the Ute and Comanche tribes began peace negotiations to ensure peace between two powerful tribal allies that reigned over the southwestern plains, however, peace talks were interrupted and a fifty-year war followed. Peace talks began again and in 1977 the Ute Comanche Peace Treaty was finalized. Representatives of the Comanche Tribe traveled to Ignacio, Colorado to finalize the Ute Comanche Peace Treaty.

On December 30, 1849 a peace treaty was signed between the United States and the Utes at Abiquiu, New Mexico. The treaty forced the Utes to officially recognize the sovereignty of the United States and established boundaries between the U.S. and the Ute nation.

In 1863 another treaty was signed at Conejos terminating all Ute claims to mineral rights and lands in the San Luis Valley that had been settled by Europeans.

In 1868 the U.S. government began another treaty to terminate the rights of the Confederated Ute Indians to other lands; however this effort failed as the Utes refused to relinquish their rights to the lands in question. In 1873 the government began new efforts to negotiate for these lands and a new commission was appointed by the Interior in 1873 to enter into negotiations for a new agreement. The Brunot agreement of 1873 was negotiated with the Confederated Utes and the U.S. government, represented by Felix R. Brunot, at the Los Pinos Agency on September 13, 1873. Ute chiefs, headmen and other members of the Tabeguache, Mouache, Caputa, Weenuchiu, Yampa, Grand River and Uintah bands of Ute Indians were present when the Agreement was signed.

The Brunot Treaty was ratified by the United States in 1874, and is most often remembered by Utes as the agreement when their land was fraudulently taken away. The Utes were led to believe that they would be signing an agreement that would allow mining to occur on the lands located only in the San Juan Mountain area, the site of valuable gold and silver ore. About four million acres of land not subject to mining would remain Ute territory under ownership of the tribe. However, they ended up forcibly relinquishing the lands to the U.S. government. Many years later, and after meeting with the State of Colorado, a successful negotiation of a Memorandum of Agreement was signed in 2009. The MOA assured the tribe with hunting and fishing rights in the off-reservation Brunot area, including rare game species. Tribal hunters participate in the hunt with special permits.

In 1895 the Hunter Act was passed opening up the Ute strip to homesteading and sale to non-Indians. The Utes residing on the small strip of reservation land north of the New Mexico state boundary and into the four corners area became divided. The Weenuchiu under the leadership of Chief Ignacio agreed that land could not be owned individually, but instead was owned in commonality by tribe. The Weenuchiu moved westward and settled on a dry arid piece of land now known as Towaoc. The Southern Utes (Mouache and Caputa bands) agreed to take land into ownership under the allotment process. Unfortunately many allotments were either sold to non-Indians or the tribe. Around the 1940s about 300 allotments were owned by Southern Ute Tribal heads of household. This number has dwindled considerably.

Ute Water Rights

As the federal government established sites (reservations) for displaced Native American tribes, the government soon realized they had to have adequate water supplies in order to survive. Without water the red man could not learn how to farm and become a productive member of society, or become totally assimilated into American culture. Although there is an implied water right of Native American tribes on reservations that supersedes water rights of non-Indians, the issue was bitter, and proved to be a long and expensive legal battle.

In 1988 the Colorado Ute Indian Water Rights Settlement Act was approved by the United States government. Its primary objective was to supply irrigation, municipal and industrial water to the Ute Mountain Ute and Southern Ute Tribes of Colorado from the Animas La Plata water project. The downsized project known as Animas Plata light was completed in 2009 and water filled Nighthorse Reservoir. The 1988 Act resolved water rights claims of the Colorado Ute Tribes to water they considered inherently theirs. The Ute tribes have not yet formulated specific plans concerning their water needs, and there are no federal funds available to construct the pipelines necessary to convey water from Nighthorse Reservoir to either the Ute Mountain Ute or Southern Ute reservations.

The Southern Utes

The Southern Ute Tribe is composed of two bands, the Mouache and Caputa. Around 1848 Ute Indian Territory included traditional hunting grounds in Wyoming, Utah, Arizona, New Mexico, Oklahoma and Texas. In 1868 a large reservation was established for the Southern Utes that covered the western half of Colorado consisting of 56 million acres. In 1873, after gold and silver was discovered in the San Juan Mountains, the Brunot Agreement was created. The Agreement substantially diminished Southern Ute lands, depriving the tribe of seasonal camps, and annual elk and deer harvests. Around 1895 the Southern Ute reservation was created. It was 15 miles wide and 110 miles long. In 1895 the Hunter Act enabled lands within the Ute Strip to be allotted to tribal members, and the surplus lands homesteaded and sold to non-Indians.

The Southern Ute reservation consists of timberlands on high mountains with elevations over 9,000 feet in the eastern portion, and flat arid mesas on the west. Seven rivers run through the reservation, the Piedra, San Juan, Florida, La Plata, Animas, Navajo and Los Pinos. Water is a valuable resource, and its ownership became a central issue between the Ute people and non-Indians who lived on free lands on the checker boarded Southern Ute Reservation and for the Ute Mountain people who were surrounded by non-Indians who deprived them of water for their people. The conflicts were ultimately settled by the 1988 Ute Water Rights Settlement Act.

The Southern Ute Tribe has approximately 1,400 tribal members, with half the population under the age of 30. The Southern Ute Reservation is situated on a 1,064 square mile (681,000 acres) reservation. The tribe is governed by a seven member Tribal Council elected by the membership. Principal officers include the Chairman, Vice-Chairman and Treasurer, with all council members serving three-year staggered terms. Tribal government is based on a Tribal Constitution adopted November 4, 1936, that was revised in September 1975. Although the tribe strives to provide strong social welfare and education programs, they also emphasize the importance of the traditional way of life. They sponsor the annual Sun Dance and Bear dance. Tribal members of all ages participate in Pow-wows. Tribal Council recognized the importance of traditional healing and has incorporated this method into the health services program.

Tribal government includes the Executive staff (Tribal Council, Executive Officers and support staff), administrative personnel, natural resources, education, utilities, judicial branch, health and social services, a culture department, and many more departments. In 2001 Sun Ute Community Center opened its doors. It houses a

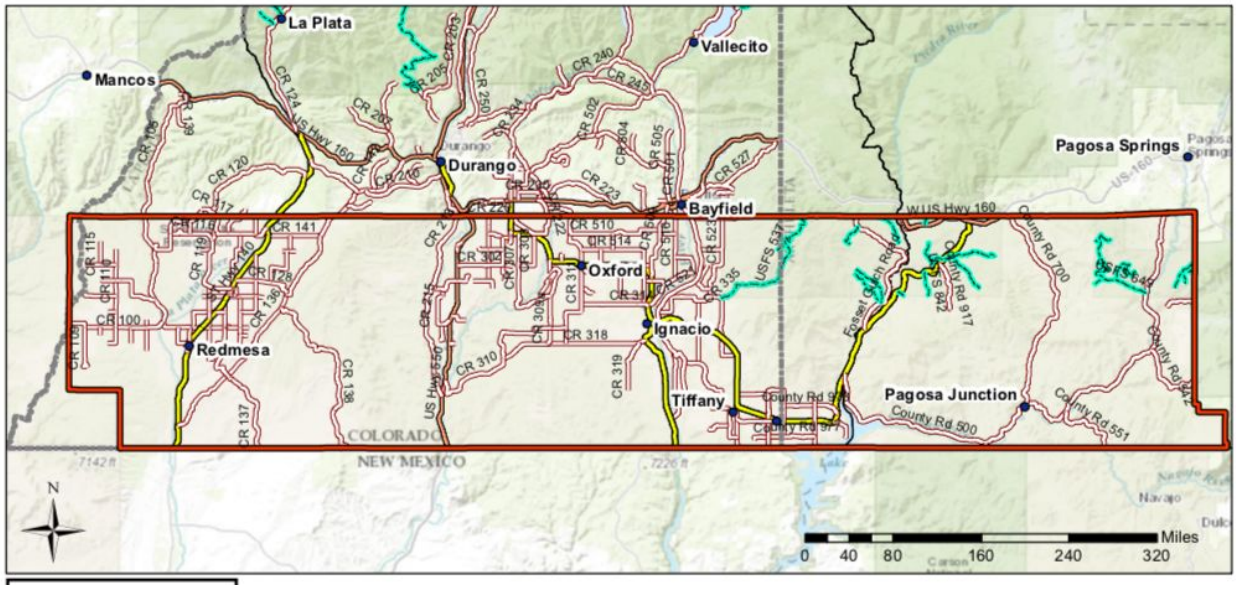
gymnasium, fitness center, and swimming pools, all at no charge to the tribal members. The center also houses the local Boys and Girls club.

The Southern Ute Tribal Academy opened in August 2000. The Academy is a private school that provides education and day care for children from the ages of six months to the sixth grade. Its curriculum includes a comprehensive Ute language program.

At one time the Town of Ignacio as well as the surrounding land around the town was owned by Southern Ute tribal members. There are a few private homes owned by tribal members within town limits. Shoshone Town Park is tribal land leased by the Town of Ignacio; the Southern Ute Education offices are located within city limits, as is the Tribal Housing entity and rental homes located on reservation lands that border town limits.

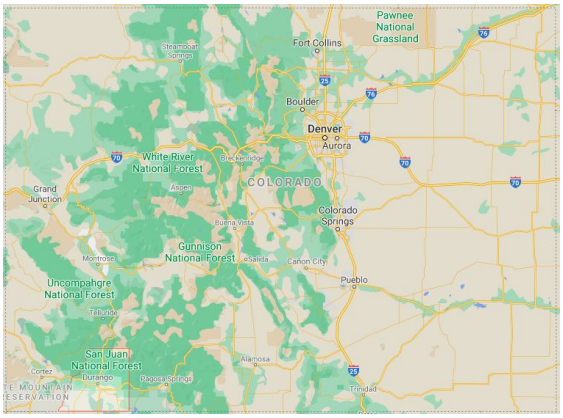
Many tribal members lived in and around the Ignacio area in the early 1900s on up to the 1950s, and others lived on the reservation outside of town. Housing sites were established in the 1970's under the Federal Department of Housing and Urban development (HUD), one of the many programs established to alleviate poverty in cities and on Indian reservations. Under HUD, rental and private housing was constructed, however, as federal housing budget cuts increased the tribe sought ways to assist tribal members in obtaining affordable housing. This resulted in a new housing development called Cedar Point Housing subdivision, financed in part by the Southern Ute Tribe, with qualifying tribal members purchasing homes. Cedar Point East began as rental units and converted to tribal member owned homes. Cedar Point West is comprised of privately owned homes, modular and trailer homes. There is still a constant demand for affordable homes for the membership.

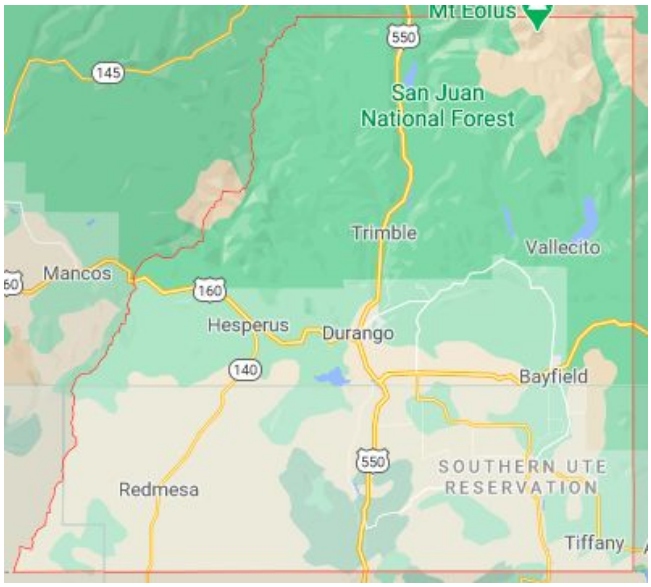
Southern Ute Indian Reservation Jurisdictional Boundaries



A more colonized and commonly viewed version of our history follows here.

Today, La Plata County, Colorado sits 330 miles southwest of Denver on the southern border of Colorado, bordering New Mexico. It is a six-hour drive over several mountain passes from the nearest metropolitan areas of Denver and Colorado Springs. Durango, a Qualified Opportunity Zone in a Health Professional Shortage Area, serves as the county seat. Mercy Regional Medical Center (MRMC) in Durango receives patients from a 5-county area including the Southern Ute Indian Reservation, the Ute Mountain Reservation, Navajo Nation, and Jicarilla Apache Reservation.

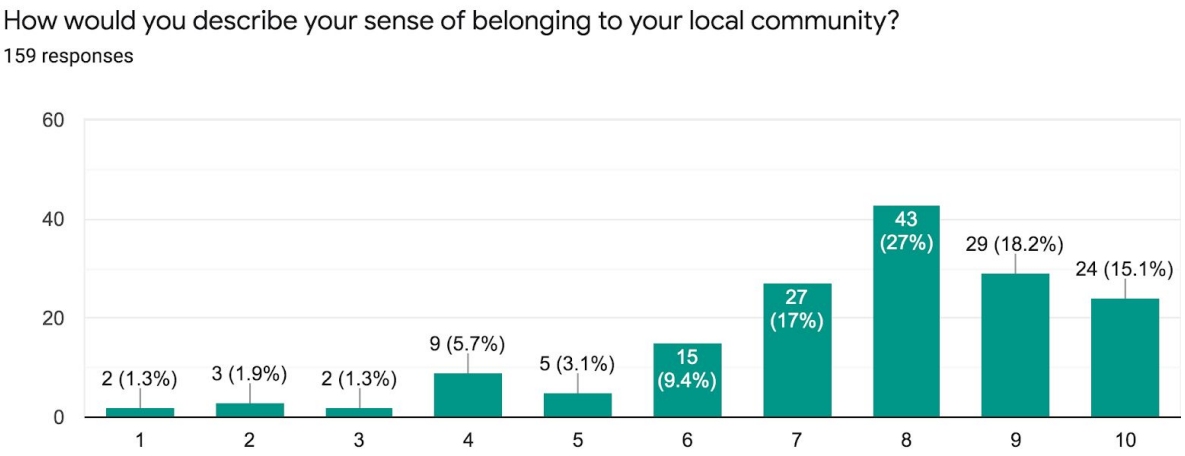




La Plata County is a sparsely populated but relatively diverse area. According to 2018 U.S. Census data, La Plata has approximately 31 people per square mile, about half the density of Colorado as a whole. Mercy serves large populations of Latinx and American Indian/Alaska Natives, with 12.37% and 7.7% of the county identifying with those ethnicities.

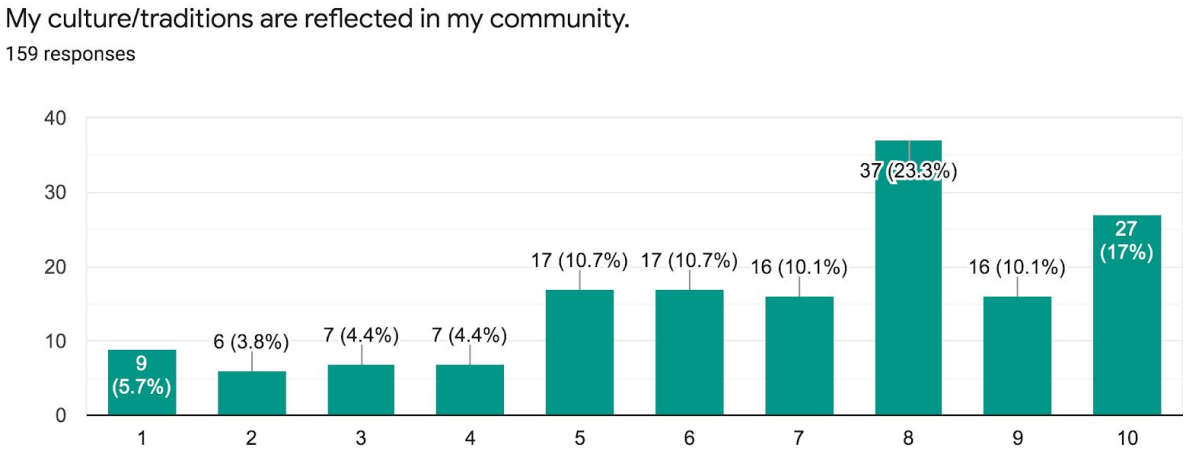
Durango, Colorado is home to 14,000-foot snowcapped peaks, the Weminuche Wilderness area, world-class skiing, and a historic narrow gauge railroad. For many residents and thousands of tourists, Durango, located in La Plata County, is an idyllic outdoor paradise. However, for some residents, the realities of substance use and overdose lurk in close proximity to the beauty and remoteness of La Plata's many quiet mountain towns. The remote nature of La Plata County also means there are few substance use resources and places to turn for help for those who need it. This is especially true for the more remote communities in the county.

Similarly, many would describe the La Plata county cultural identity as a beautiful, outdoor, active community that likes to party / celebrate. While accurate, this is fully incomplete. When we look deeper, as we have through this Southern Colorado Opioid Overdose Prevention (SCOOP) effort we find many who live here do so without a feeling of belonging. We see this in our recent community survey where people were asked to rate their sense of belonging on a scale of 1-10 with 1 being 'very weak' and 10 being 'very strong'. A full 40% responded 7 or below and only 24 people suggested a very strong sense of belonging. This is a big deal. The survey is still in the field so we will learn more as we get more responses and when we disaggregate by demographics.



It also came out in interviews. Many don't feel seen or appreciated or understood or valued for who they are, their history, their identity, or their experiences. Many struggle to simply get by with basic needs of food and housing and jobs. In some cases, as in the Lesbian, Gay, Bisexual, Transgender, Queer and other gender identities (LGBTQ+) community, strong sub-cultures have emerged to provide a community of belonging. In others, as with Native Americans in Durango, there is a prolific experience of exclusion and racism with no structure to provide ways for people to connect. For those who experience addiction, the stigma is keenly felt and finding those places that offer a non-judgmental community of people with a shared experience can be lifesaving. For these three sub-communities, the identities can be multiple and overlapping… when this happens the challenges are exacerbated and the healing spaces are harder to find.

Our recent community survey (1 = strongly disagree; 10 = strongly agree) also illustrates this with only 17% suggesting that their culture and traditions are reflected in the community.



Rural communities in general face many challenges compared to urban areas of Colorado. Rural Colorado has 32% higher rates of public insurance than urban Colorado. According to Robert Wood Johnson Foundation's 2018 County Health Rankings, La Plata County has twice the rate of uninsured residents as the statewide average. In addition, health outcomes in rural areas of Colorado are worse than urban areas. For example, the premature death rate for residents under the age of 75 whose deaths are attributed to causes such as heart disease, accidents, and intentional self-harm, is also higher than the state average. Unfortunately, rural areas such as La Plata County also face the scourge of the opioid crisis and our community has not escaped its wrath.

La Plata's challenges with OUD were magnified between 2006 and 2012, when nine million prescription opiates were distributed in our rural community of just 50,000 residents. In La Plata County, that's enough pills for each resident to take about 30 pain pills per year. In 2014, the Durango area was rocked by the overdose deaths of two men within just 10 days of each other.

While prescription rates have dropped in recent years, the county is still battling the aftermath. In 2018, Mercy Regional Medical Center (MRMC) implemented the Alternative to Opioids (ALTO) program to limit the number of opioids prescribed in our community. Although ALTO has succeeded in decreasing opioid use in MRMC's facilities by 11%, opioid overdose rates in the community have risen by 33.33% since program onset.

Most recently, a January 21, 2021 article in the Durango Herald headlined "COVID-19 pandemic may be driving rise in opioid deaths." In this article Dan Caplin, Medical Director with Durango-based Colorado Addiction Treatment Services was quoted as saying "What my patients are reporting to me is a very high increase in overdose deaths," He went on to say "I had two patients, each lost four friends over the holidays from overdoses. I've had

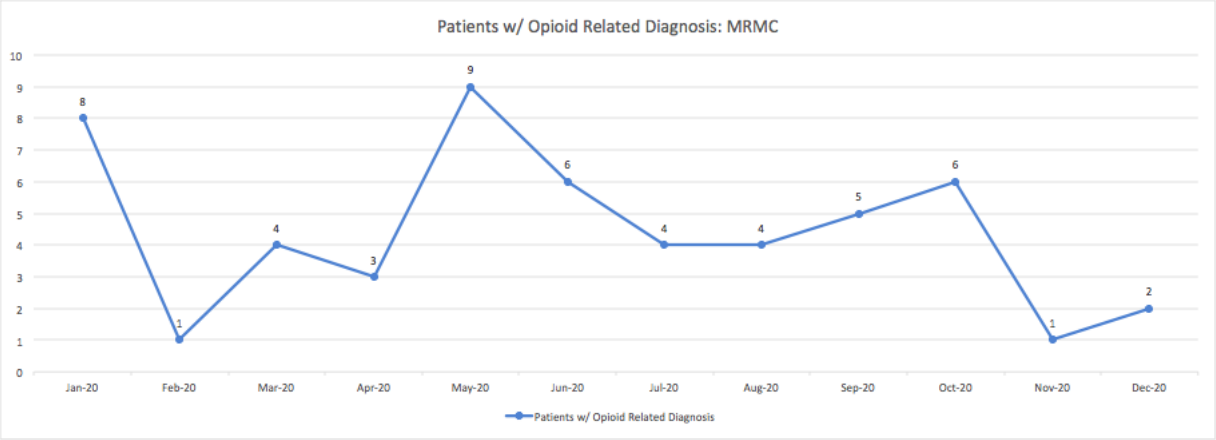
plenty of patients who've lost 10 friends in 10 years. Four in a week is devastating." Finally, he shared "We've had a number of our formerly stable patients also relapse, and they're really struggling to get back on track."

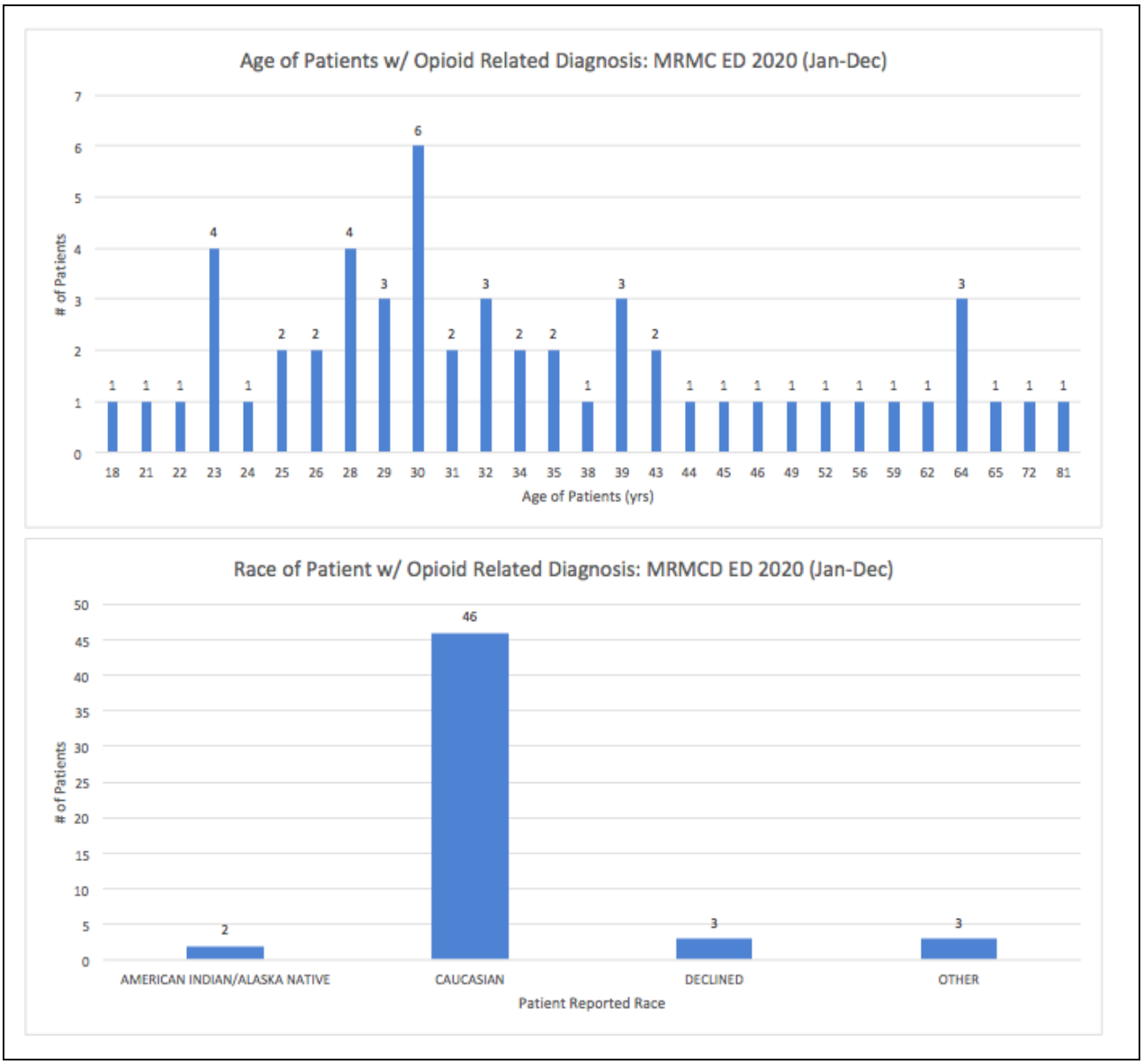
Opioids are not the only substance affecting La Plata County residents. There is a 29% higher rate of motor vehicle crashes in rural Colorado involving alcohol, and 18% of adult rural Coloradans report drinking excessively. Further compounding the problem, La Plata County lacks any inpatient residential treatment facilities for drugs or alcohol, yet 20.8% of La Plata residents drink excessively, compared to 19.1% of Coloradans. Mental and behavioral health services in rural Colorado are also particularly difficult to access. La Plata County is one of 11 Colorado counties with no mental health treatment beds.

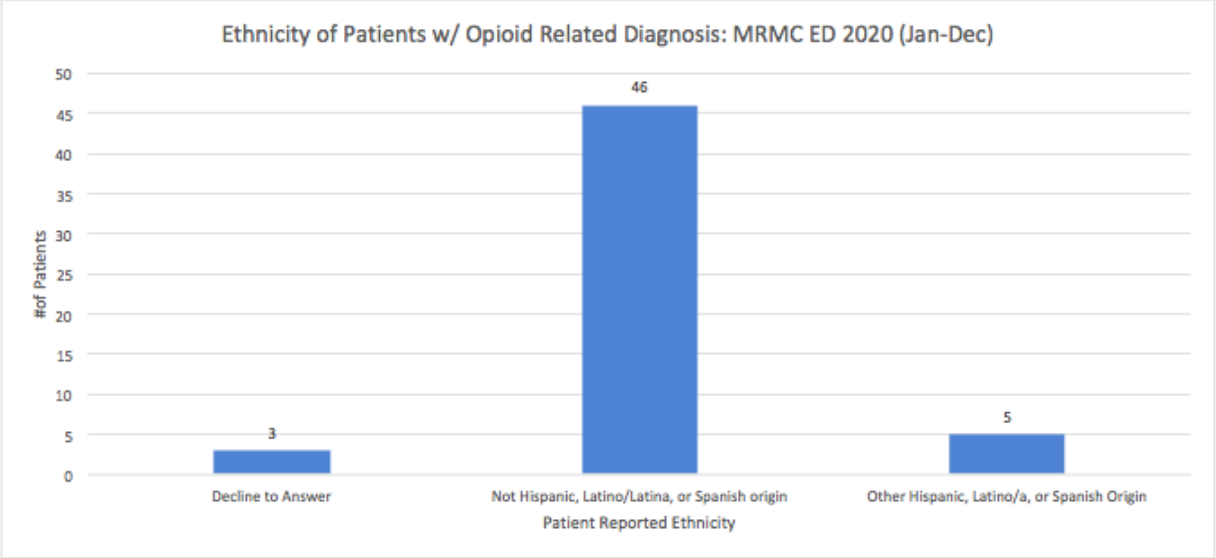
As the largest healthcare provider and only hospital in La Plata County and having recently completed a Community Health Needs Assessment for the region, Mercy Regional Medical Center attends to the health care needs of La Plata County's population. Mercy has organizational expertise in substance use disorder prevention, treatment, and recovery, having pioneered Medication Assisted Treatment (MAT) in emergency departments at other hospitals in Colorado. Mercy is the lead organization now working with the community to reduce morbidity and mortality due to opioid and substance use disorders.

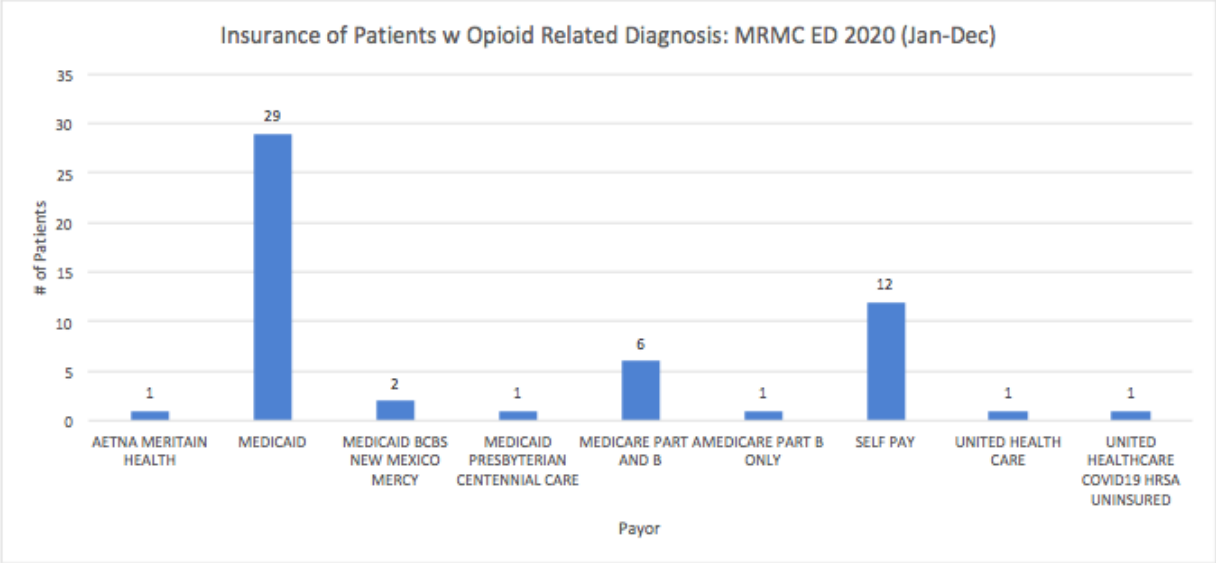
A new report has just been designed by Centura Health for their local Durango area Mercy Regional Medical Center. It shows the following for opioid related diagnosis / demographics and alcohol related diagnosis / demographics.

Opioid related diagnosis / demographics

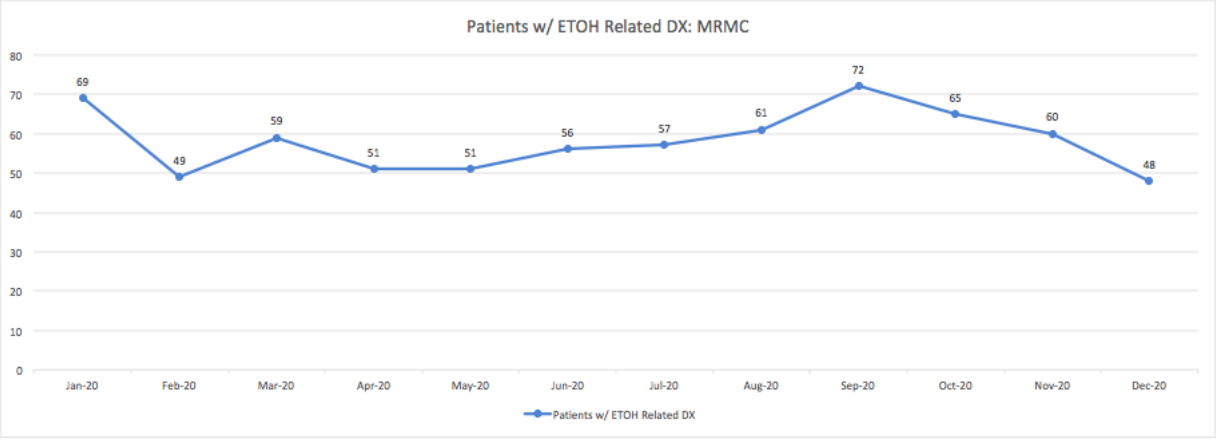


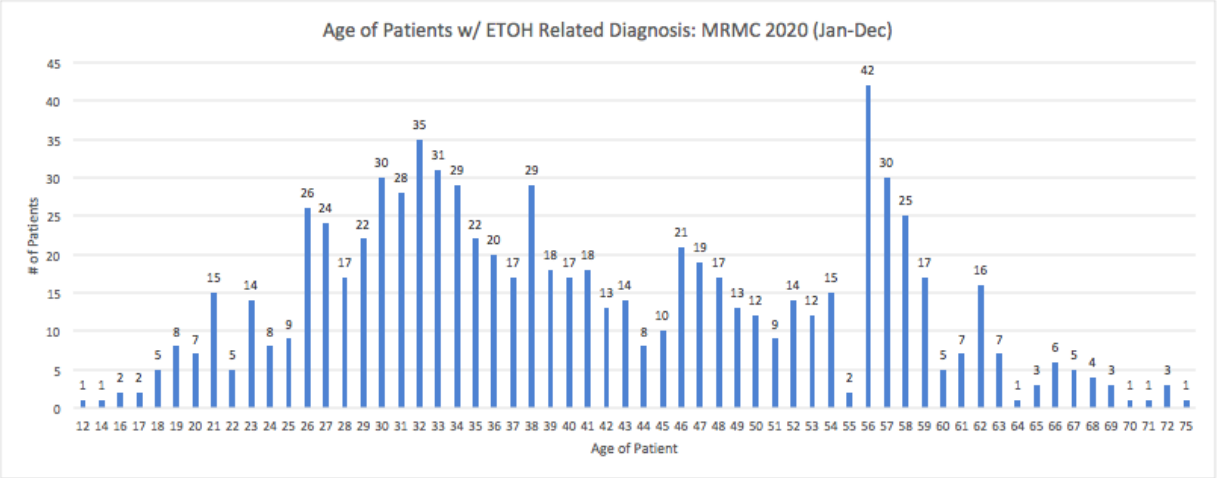

Age of Patients w/ Opioid Related Diagnosis: MRMC ED 2020 (Jan-Dec)
# of Patients
Age of Patients (yrs)
18 21 22 23 24 25 26 28 29 30 31 32 34 35 38 39 43 44 45 46 49 52 56 59 62 64 65 72 81
1 1 1 4 1 2 2 4 3 6 2 3 2 2 1 3 2 1 1 1 1 1 1 1 1 3 1 1 1
Race of Patient w/ Opioid Related Diagnosis: MRMCD ED 2020 (Jan-Dec)
# of Patients
Patient Reported Race
AMERICAN INDIAN/ALASKA NATIVE
CAUCASIAN
DECLINED
OTHER
2
46
3
3

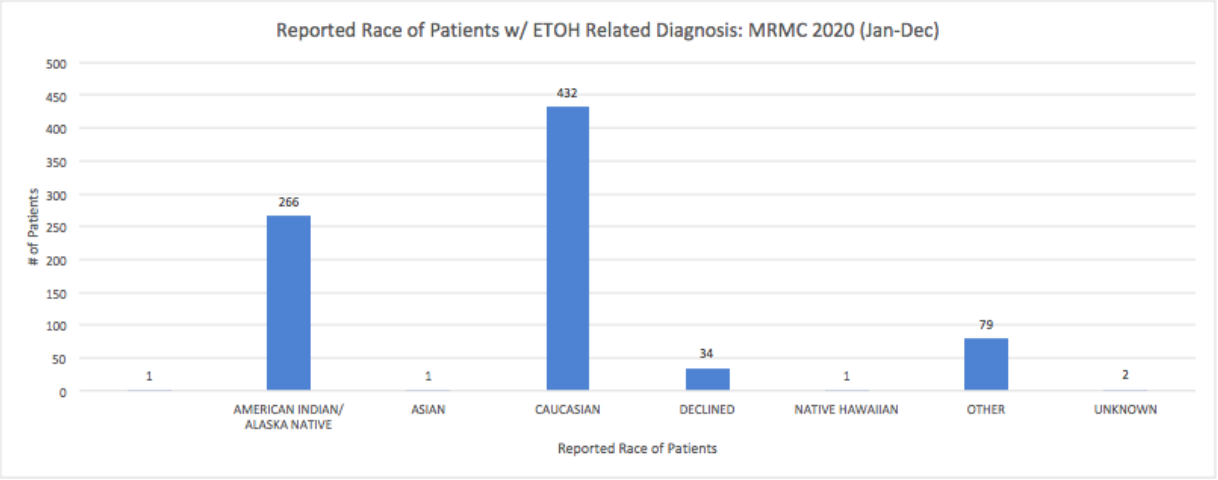


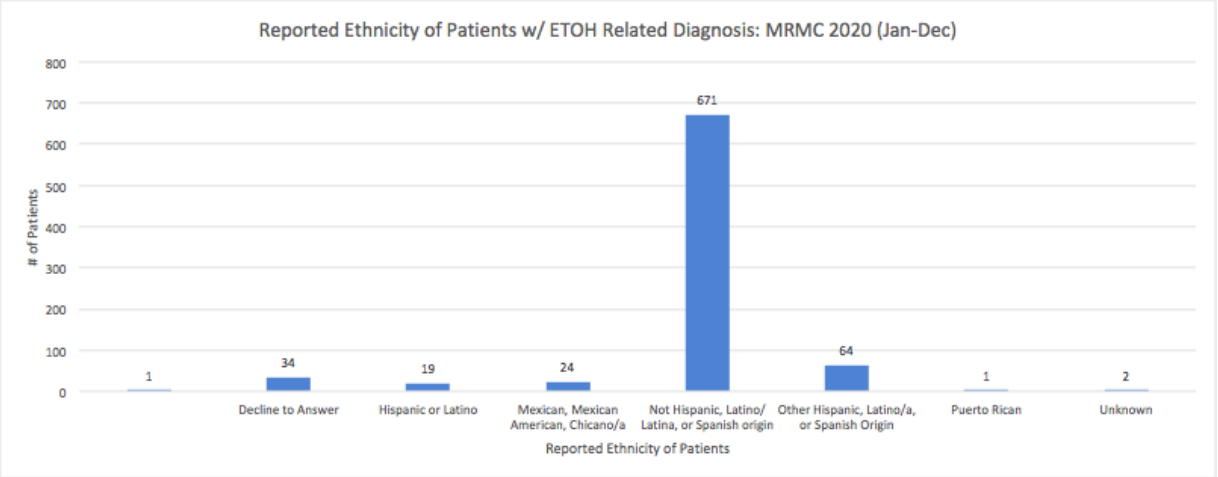


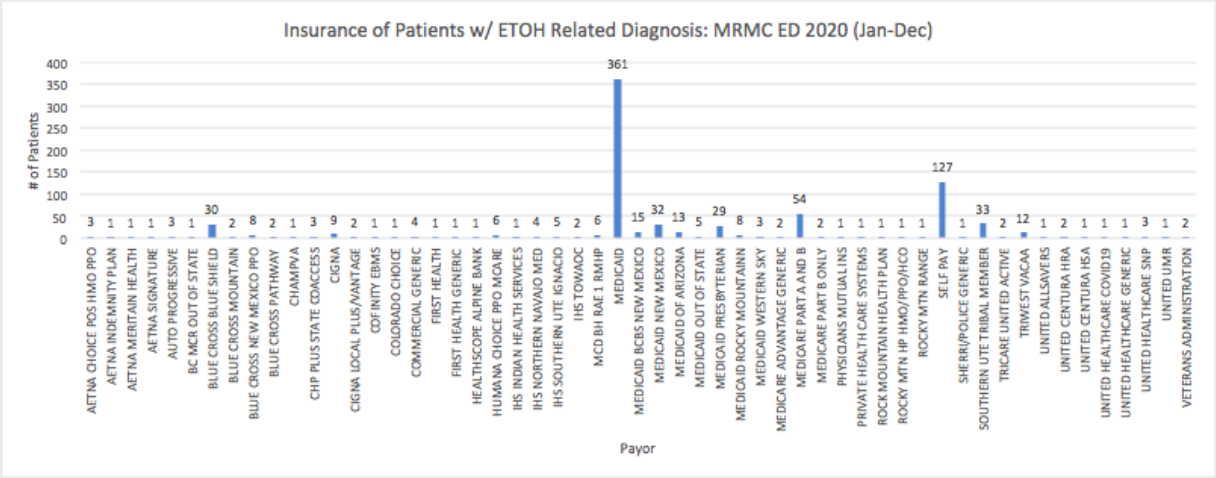
Alcohol related diagnoses / demographics




Age of Patients w/ ETOH Related Diagnosis: MRMC 2020 (Jan-Dec)
# of Patients
Age of Patient


Reported Race of Patients w/ ETOH Related Diagnosis: MRMC 2020 (Jan-Dec)
# of Patients
AMERICAN INDIAN/ ALASKA NATIVE
ASIAN
CAUCASIAN
DECLINED
NATIVE HAWAIIAN
OTHER
UNKNOWN
Reported Race of Patients


Reported Ethnicity of Patients w/ ETOH Related Diagnosis: MRMC 2020 (Jan-Dec)
# of Patients
Decline to Answer
Hispanic or Latino
Mexican, Mexican American, Chicano/a
Not Hispanic, Latino/ Latina, or Spanish origin
Other Hispanic, Latino/a, or Spanish Origin
Puerto Rican
Unknown
Reported Ethnicity of Patients



As evidenced by participation in the Southwestern Colorado Overdose Opioid Planning (SCOOP) consortium, La Plata County does have many existing substance use and opioid use disorder resources available in our community and they are doing really good things. That said, we clearly have gaps and we have not yet approached the problem of opioids in a unified way. The SCOOP consortium is already showing great potential. In fact, we recently had a 'quick win' when a consortium member shared an urgent challenge; seeing firsthand an uptick in sharps at parks and construction sites. Another member with Colorado Consortium for Prescription Drug Abuse Prevention was able to connect them quickly with a state sharps collection program.

B. Vision/Mission/Planning Values

Example of your values may include transparency, community input, equity, and data-informed processes.

La Plata County SCOOP Consortium
Community Substance Abuse Prevention / Treatment / Recovery Program

Mission / Vision / Values

Every relationship I had was in turmoil. Friends, family and my jobs started to openly recognize my drinking problem. I was okay with dying, the whisky gave me oblivion and I welcomed it.

I was finally able to quit drinking and it was not the consequences or the thousands of issues my drinking and drugging caused. It was two individuals and the support and unconditional love they showed me. Sure I always had support from my family, but nothing like these two. They knew exactly what I was going through.

Today is almost 1,500 days since my last drink. What was the catalyst that finally caused me to stay sober? You would think everything before my 4th D.U.I. would have been enough to quit, or the fact that I knew I was killing myself, but honestly the punishments, the shame and me committing a slow suicide were never enough to curb my addiction. It took me building a support system and finding like minded individuals, cutting the negative (ALL THE NEGATIVE) relationships from my life, creating a healthy environment, healthy friendships and surrounding myself with people in recovery.

A healthy environment, community and connection is what has kept me sober.

Though I had been in and out of support group rooms my whole adult life. It never worked for me. It was court ordered and they were not my people and the structure and shame there was not appealing to me at all. These two people and three of our friends met that July (2017) and discussed different avenues to help us stay sober. There was not much in Durango. We created "Plan B". A small group of like-minded individuals. We hit the ground running. Started organizing BBQ's and pro-social events, supporting each other. It worked! We connected with one another.

My life had purpose again.

The ones who have been able to stay on track are such an inspiration; the connection that happens when we are not afraid to share our stories is invaluable. This is why I am not afraid to share my story, if I learned one thing in the last 4 years of my sobriety it is – Addiction is not something to be ashamed of and we MUST break that stigma. I would scream my story from the mountaintops if I could. I know it helps people. I get messages all the time.

We should be finding people like me and countless others celebrating our accomplishments publicly. "This is what Recovery Looks like," "We do Recover," "We are not ashamed," Being sober is looked down on in society, as is addiction. Sobriety is "boring;" We have to change this view. Being sober is a beautiful thing.

Do I identify as an Alcoholic or Drug addict? NO, I am a father, brother, son, friend, professional, mentor and I am in Recovery.

I have a huge social media following and it is a window into what a sober life looks like. It gives people hope and shows them being sober is fun.

- Cruz Baca, father of three, brother, son, friend, professional, mentor, person in recovery

****

These words guide us

VISION

La Plata County will be a place where people of all walks of life will maintain the ability to thrive without the use of substances.

What we mean by this:

We mean that our community has a shared set of values around human worth and potential. We mean that our community bases all planning and decisions on the foundational idea that everyone has value, nobody is a 'bad' person, and many have had bad things happen to them or have not had conditions that support a full life. We mean we all have a responsibility to each other to create conditions where we all can thrive. And we mean that thriving for only those with means is not acceptable.

Our vision means that historically marginalized communities feel acknowledged, present, and valued.

It means that addiction and recovery stories are commonly shared so there is always a place for connection and inspiration. It means employers have clear programming to support recovery. It means that when someone is ready to move into recovery, the path is clear and services are accessible. Everybody knows how to take the first step and there is a judgment free, culturally sensitive, trauma-informed place to connect at that moment.

This means that inpatient residential treatment is available locally and with robust transitions in and out of care. It means that Peer Support of all kinds are found throughout the community and are compensated with a living wage. It means that Recovery Housing and a Recovery Community Organization have been designed by those with lived experience and are both in place with sustainable funding.

It means that people living with addiction can do so safely with harm reduced in ways that show them they are human with value and that when they are ready, people who understand their struggle with substance use will receive them in that moment without judgment.

It means that there is a group of people - peers - who gather regularly and know the situation of every person experiencing addiction and recovery. This group works together with family and friends to coordinate and make it as easy as possible for that person and their family to navigate the community of support and services that are available.

We will accomplish this vision through our work together.

MISSION

We exist simply to collectively understand and remove the conditions in our community that contribute to the use of substances for coping and increase the conditions that allow all of us to thrive.

VALUES

We value safety. (physical, social, moral, psychological, emotional safety). This means we take time to familiarize people with the physical environment. We ask about comfort level with lighting and environmental surroundings. We share control and show respect. We use a warm and compassionate manner to build rapport. We speak in a calm, caring tone. We actively listen without judgment.

We value trustworthiness. This means we foster genuine relationships and practices that build trust, making tasks clear, maintaining appropriate boundaries and creating norms for interaction that promote reconciliation and healing. We understand and respond to ways in which explicit and implicit power can affect the development of trusting relationships. We know this includes acknowledging and mitigating internal biases and recognizing the historic power of majority populations.

We value choice, voice & empowerment. We recognize the role of addiction and trauma and know that by their very nature, they rob us of our choices and our sense of personal power. So, we maximize choice and address how privilege, power, and historic relationships impact both perceptions about and ability to act upon choice. We encourage self-efficacy, identifying strengths and building skills that lead to individual pathways for healing while recognizing and responding to the impact of historical trauma, abuse, neglect, inequities, marginalization and oppression.

We value collaboration, mutuality & peer support. We honor transparency and self-determination and seek to minimize the impact of the inherent power differential while maximizing collaboration and sharing responsibility for making meaningful decisions.

We value cultural, historical & gender humility. There are numerous factors that can directly or indirectly influence the attitudes, beliefs, behaviors, resources and opportunities within a given culture, subculture, or racial and/or ethnic group. We don't know what we don't know. Therefore, we will be humble and ask for feedback/input from those who can see our blind spots. We will continually adapt our approaches and learn along the way.

C. Needs Assessment Methodologies

Include strategies for collection and use of quantitative and qualitative data.

Qualitative
Thirty-one key informant interviews were conducted with consortium members prior to our first official consortium meeting. Several more interviews have occurred more informally based on specific questions or areas of emerging interest… particularly community conditions and early childhood / family resources. These interviews guided the way in which consortium meetings were conducted. With this work being focused on addiction and priority populations being LGBTQ+ and Native American Communities, our first meeting began with a land acknowledgement shared by a Native American consortium member and was followed by introductions that included a sharing of pronouns and any story of connection to addiction a consortium member wanted to share. This approach to introductions was incredibly powerful and consumed the entirety of the meeting and the beginning of the next. One might have expected in the closing debrief to have heard complaints about not getting any work done…. But the only comments were about how much the group appreciated both the opportunity to share and the opportunity to hear from others in this much more personal way. We were proud to have about a half dozen people serving in the role of 'lived experience'…. What we found was that every single consortium member has been touched by addiction in some way. Normalizing this from the very first moment was also likely an important way to illustrate the potential power of story sharing/telling in the community.

We chose to wait to design our community survey until later in the needs assessment process. Partially out of logistics of needing to work through other items, but also out of a need to better understand collectively what we needed to know and what we would do with the information received. A community survey has now been designed and will be disseminated in the community in February. We learned through the interviews that things like purpose, relationships, belonging, and basic needs were factors related to addiction. For this reason we chose to use The Well-Being Assessment (Adult - 24 items) developed through a joint collaboration between members of the Institute for Healthcare Improvement's 100 Million Healthier Lives metrics team and The Human Flourishing Program at Harvard's Institute for Quantitative Social Science. We are supplementing it with a series of questions informed and adapted from validated measures shared in Stigma and Substance Use Disorders: An International Phenomenon to understand the responder's personal connection to substance use disorder and stigma. Notably, due to data and interviews showing that we have a great need for more recovery housing, we included the survey question 'I would support a recovery housing facility within 5 miles of my home.'

Quantitative
Although our team is currently administering a community survey and will incorporate survey results (primary data) into the final draft of this needs assessment, as it stands all quantitative data are secondary (administrative data) data. Data were sourced from myriad publicly available (national, state, and regional/local) sources. Where available, data are shared at the county level, and some data are shown at the regional level (i.e. Health Statistics Region 9). We've also included available state and national benchmarks for comparison and sense-making. Indicator selection was guided by needs assessment requirements, data availability, prominent themes coming out of qualitative data analysis, and consortium member feedback, as well as incorporating available data from the Opioid & Substance Misuse Framework.

D. Overview of Results/Findings

Provide an overview of the findings from your needs assessment. The overview should include both quantitative and qualitative data drawn from relevant, timely, and reliable sources, including community members impacted by OUD/SUD. Data should be gathered using a variety of methods including review of the available data sets, review of existing community resources and services, surveys, focus groups, and key informant interviews. Please include citations for all data sources, and be sure to address each of HRSA's requirements below:

- Availability of and access to OUD/SUD prevention, treatment and recovery services;
- Availability of and access to OUD/SUD harm reduction services, including human immunodeficiency virus/hepatitis C (HIV/HCV) testing and treatment;

- Opportunities and gaps in local systems for engaging of people who use drugs, screening, diagnosing, and referring to treatment and other support services;
- Issues impacting the OUD/SUD health workforce, including recruitment, retention, and worker capacity/skills;
- Needs of special/vulnerable groups within the target rural service area, such as pregnant/parenting women, adolescents, racial/ethnic minorities, incarcerated/formerly incarcerated individuals, etc.;
- Underlying social determinants of health that are most significantly relevant to SUD/OUD within the target rural service area (reference pg. 17 of this onboarding package for resources on social determinants);
- Presence and impact of stigma, including health worker and community perceptions/biases of people who use(d) drugs;
- Existing resources that could be leveraged within the target rural service area, including existing federal, state, or local funding opportunities; and
- Opportunities and challenges related to maintaining a consortium and sustaining SUD/OUD services in the target rural service area.
- A description of the methods used to engage community members and key stakeholders in the target rural service area. A good faith effort must be made to engage directly impacted individuals, such as people in recovery from substance use disorder, impacted family members, people who use drugs, etc., through focus groups, surveys, personal interviews, or other methods as appropriate;
- A list of community members and stakeholders in the target rural service area that participated in data collection (organization name or individual descriptor – i.e., “person in recovery” – is sufficient; individual names are not required).

Needs Assessment: Summary of Findings

1. Availability of and access to OUD/SUD prevention, treatment and recovery services;
(Note: We've included each question in blue to make it easier for the reader to see that the question is answered. This section for sub-bullet 1 is long and incorporates answers to several of the following questions.)

OVERVIEW

SUMMARY

To summarize the big take-aways from our needs assessment & gap analysis…

We have:
- Incredible peer support models
- Committed and capable organizations
- People in recovery ready and willing to share their stories

We need more:
- Affordable Housing
- Living Wage Jobs
- Relationships/Connection/Sense of Belonging
- Access to treatment services and access to recovery services for diverse populations

We need to reduce:
- Social and self-perceived stigma
- Disparities

Overall, the long-term news is good. We know what works. We are doing what works. It is working. We just need to make sure people are connected to existing services and supports; and, in some cases, find a way to do more of it.

There are two important categorical exceptions to this:
1. Services (Treatment and Recovery): Inpatient Residential Treatment and Recovery Housing. A positive change in substance use treatment is that as of January 1, 2021, Colorado is covering the cost of inpatient residential treatment services for Medicaid enrollees. While this is great news, for individuals living in La Plata county, they will still need to travel long distances to access it. Distance - even when transportation is provided - has been shown to be a major barrier to accessing treatment. To the end, these are two big gaps that need to be filled.
2. Conditions (Prevention): The biggest gap is one that has been elusive for years: shortage of affordable housing and living wage jobs.

Without addressing these two categories, our other efforts - no matter how heroic - will be constantly undermined. The ultimate question for the SCOOP consortium will be to figure out how to use what we have (peer support models, committed and capable organizations, people in recovery willing to share stories) to find more of what we need (housing, jobs, relationships, access) and reduce what we don't need (stigma, disparities).

While many are working to provide OUD/SUD prevention, treatment, and recovery services in La Plata County, there is no current coordinated effort and no (subjective or objective) feedback loop to know whether there is enough (in sheer numbers) and whether what is provided is trauma-informed, culturally sensitive, or simply involves the appropriate skills / experiences for the service. The scale of the challenge and the fact that it is so intertwined with other issues (suicide prevention, housing, jobs,...) in our community warrants consideration of such an effort. Important to this consideration is coordinating with the intertwined issues so as not to spread people and resources too thin and to help the community connect the dots to investments that support multiple outcomes and greater return to the community experience.

We will frame our summary with the perspectives of those with lived experience who participated via 1on1 interview, SCOOP consortium meetings, and a few follow-up interviews based on specific questions / needs that came up through consortium work. Data and other insights will be included where appropriate. As you read through the summary below, take note of the fact (as we did) that almost all assets mentioned by those with lived experience were related to community organizations and peer support services. It was notable that while medical providers are working really hard and spending a

lot of time trying to be responsive, very little medical care was mentioned during our key informant interviews. When it was, it was often with a sense of not being seen or understood and not having access to health care treatment. It appears that investing upstream could significantly reduce the stress on the medical and justice systems, possibly allowing them to provide the service experience they desire within their operating constraints. Additionally, addressing the inpatient residential and recovery housing gaps would reduce the strain throughout by supporting more people in the transition to full recovery faster and without cycling repeatedly through the system.

TRAUMA

When we talk about availability and access to treatment and recovery support services, we have to talk about trauma. Both from the standpoint of trauma leading to a much higher likelihood of substance use and also related to the need for providers to be knowledgeable about the topic. Because of this, we have a full section dedicated to the relevance of the topic.

Note: this draws almost entirely from the Center for Trauma Informed Policy and Preventions policy brief: Trauma-Informed Approaches Need to be Part of a Comprehensive Strategy for Addressing the Opioid Epidemic. Our consortium aligns fully with what is outlined in the brief. It's importance warrants placing it within our deliverable vs as a referenced source.

Like other communities, we have a hidden threat of trauma. A 2016 study demonstrated a clear dose response relationship between the number of traumatic experiences and increased risk of prescription drug misuse in adults. Individuals who reported five or more adverse childhood experiences (ACEs) were three times more likely to misuse prescription pain medication and 5 times more likely to engage in injection drug use. Another study found that over 80% of the patients seeking treatment for opioid addiction had at least one form of childhood trauma, with almost two-thirds reporting having witnessed violence in childhood. Among the different forms of adverse childhood experiences, sexual abuse and parental separation (for women) and physical and emotional abuse (for men) appear to be particularly highly correlated with opioid abuse.

The ACEs study is widely referenced and the data is compelling. It is also incomplete. There are many traumas not included in the study. Among them, and relevant to our priority population of Native Americans, is historical trauma. Historical trauma is the cumulative, multigenerational, collective experience of emotional and psychological injury in communities and in descendants. One of the most familiar examples of historical trauma is that experienced by Native Americans. SAMHSA's GAINS Center for Behavioral Health and Justice Transformation writes, "This population has been exposed to generations of violent colonization, assimilation policies, and general loss." As a result, many Native American people, cultures, and traditions suffered over time. The effects of historical trauma among Native Americans include changes in the traditional ways of child rearing, family structure, and relationships. Some observed responses to historical trauma may include signs of overall poor physical and emotional health, such as low self-esteem, depression, substance abuse, and high rates of suicide. In many cases, historical trauma has also disrupted the sense of community within the tribe itself. There is a well-founded mistrust of outsiders and government providers based on long-term negative experiences with non-Native Americans.

> *"It's short sighted to think that giving someone housing and food is not worthy. From where we sit, when people are housed and fed along with having treatment options and dedicated case management, they can start the process of healing. Lots of healing has to happen. When someone is away from the environment where drugs and stealing is happening, when they are stable, they are now away from the system that creates more victims. From where we are, it's worth the investment and energy. It reduces crime and victims. Many don't see the benefit in how many fewer victims we would have in the world."*
>
> - Commander Ray Shupe, Durango Police Department

General population surveys have estimated that 75% of individuals with substance use disorders have experienced trauma at some point in their lives; rates are even higher among populations seeking treatment for opioid addiction.

We know what works related to trauma:

Prevention of trauma

Prevention is evidence-based. The Surgeon General's recent report *Facing Addiction in America* concluded that science strongly supports the possibility of preventing addiction.

Home Visiting Programs, where a trained home visitor provides services to pregnant women and families with young children, have proven effective at reducing child abuse, neglect, and domestic violence and improving health outcomes for children and parents. One such program is the Nurse Family Partnership (NFP), which has been shown in experimental trials to reduce state verified rates of abuse and neglect by 48%, reduce emergency room visits by 56%, and produce a 79% reduction in the number of days that children were hospitalized with injuries and ingestions during the first two years of life.16 A number of other long term benefits are linked to the NFP including improved maternal life course and infant school readiness.

The Positive Parenting (Triple P) Program is an intervention that provides parents with tools to raise healthier children and deal with stressors. Triple P was demonstrated in an experimental trial to reduce the rates of child maltreatment in the counties in which it was implemented relative to control counties by over 20% while it also decreased out of home placements and childhood injuries.

Parent Child Interaction Therapy is a tool that assists parents in improving the quality of the parent-child interaction and relationship. It was shown in an experimental trial to reduce reported child abuse in participants (19% reported abuse) versus individuals in the control conditions (49% reported abuse) at a median follow-up of up of 850 days.

Several states are taking statewide action because of the broad reaching positive impacts of addressing childhood trauma. As an example, the State of Tennessee, a state hard-hit by the opioid epidemic, has launched an ACE-based initiative to revise all child-serving state programs and policies to focus on prevention of childhood trauma. The effort is expected to avoid significant costs to children and families, taxpayers and the community. It costs almost $200,000 to house a juvenile in custody and $40,000 - $50,000 to house an adult who is in custody because of addiction, while programs to prevent the child from being subjected to adversity cost just a fraction of that amount.

Treatment of trauma

Treatment providers have long understood that childhood trauma contributes to adult substance use and increased risk of severe trauma for the children of addicted parents, and that addiction treatment should address these issues. A 2007 Substance Abuse, Mental Health and Services Administration (SAMHSA) five-year, ten-site outcome study of women with histories of violence and co-occurring mental health and substance use disorders showed that approaches that included trauma (rather than just mental health and addiction) were more helpful than programs treating them separately.

More recently, a number of studies have evaluated trauma-informed approaches to treat addiction, including opioid addiction. The program that has been most extensively implemented and evaluated is *Seeking Safety*, an approach developed by Dr. Lisa Najavits. Seeking Safety is a coping skills approach that addresses trauma-related problems and substance use at the same time. It was identified as having the highest level of evidence by the International Society for Traumatic Stress Studies, is the only model developed thus far that has outperformed a control or comparison on both trauma symptoms and substance abuse, and is the most evidence-based model for people with both trauma and addiction. Seeking Safety can be delivered by peers as well as by counselors or other professionals. A recent randomized controlled trial found that both peers and professionals produced positive outcomes on both trauma problems and addiction, with no difference between peers and professionals. **Seeking Safety is also the lowest-cost evidence-based model available for trauma and addiction, and has shown especially strong results for heavy drug users.**

Seeking Safety provides education and coping skills to help clients attain safety from trauma and addiction. It was designed for flexible use: group or individual format; males and females; all levels of care (e.g., outpatient, inpatient, residential); all types of trauma and substances; and has been studied in both adults and adolescents. It covers issues such as safety, help-seeking, setting boundaries, emotional regulation, re- traumatization, self-care and recovery. Seeking Safety builds hope and

uses simple, emotionally engaging language. It has been translated into 12 languages and can be used with people who are illiterate or have cognitive impairment as well.

Other substance abuse treatment programs addressing trauma listed in SAMHSA's National Registry of Evidence-Based Programs and Practice (NREPP) include: A Womens' Path to Recovery, Mind-Body Bridging Substance Abuse Program, and Sobriety Treatment and Recovery Teams.

Another anecdote worth mentioning is about Dr. Daniel Sumrock, a Tennessee physician who has treated over 1200 individuals in his addiction clinic. According to a recent article: "Dr. Sumrock has pieced together the ingredients for a revolutionary approach to addiction. It is an approach that's advocated by many of the leading thinkers in addiction and trauma, including Drs. Gabor Mate, Lance Dodes and Bessel van der Kolk. Surprisingly it is a fairly simple formula: Treat people with respect instead of blaming or shaming them. Listen intently to what they have to say. Integrate the healing traditions of the culture in which they live. Use prescription drugs, if necessary. And integrate adverse childhood experience science: ACEs." While this approach may seem like common sense, it is "revolutionary" in a society that stigmatizes addiction and is still largely in denial about the role that violence, trauma and adversity play in the development of substance use disorders.

Policy related to trauma

The evidence is clear: (1) there is a strong correlation between traumatic experiences, particularly in childhood (ACEs), and opioid addiction; (2) there are programs available and being used right now that can reduce traumatic exposure and build resilience; and (3) for those needing treatment for opioid addiction, trauma-informed interventions are effective. It is time to begin applying this evidence to our policies and practices for addressing the opioid addiction epidemic in this country.

The first thing to recognize is that traumatic experiences are pervasive. Traumatic events are common across the lifespan, with estimates of lifetime prevalence of 60.7% for men and 51.2% for women. Almost 90% of respondents to the National Stressful Events Survey reported exposure to at least one traumatic event; 30% reported six event types. Reducing the overall level of violence and trauma across the lifespan and ensuring that every child grows up in a safe and nurturing environment would begin to reduce the risk factors for addiction.

We also need to ensure that the basic building blocks for resilience are in place in every community, and that access to effective treatment is universally available. All forms of health insurance should cover evidence-based, trauma-informed addiction treatment and prevention programs. Public insurance programs such as Medicaid should prioritize these types of addiction treatments.

At the state and local levels, more communities need to follow the lead of Kansas City, St. Louis, Philadelphia, Tarpon Springs Florida, Camden N.J., Buncombe County N.C., the States of Tennessee and Oregon, the Menominee Tribe of Wisconsin, and many others that, recognizing that no single institution in the community can, by itself, effectively address the causes and effects of childhood adversity, are creating broad coalitions that bring together the many different institutions in their community – the schools, law enforcement, health and mental health, businesses, the courts, and others -- to develop and implement comprehensive community-wide trauma- informed initiatives.

The current efforts to address the opioid crisis will only be as effective as our ability to provide treatment that acknowledges the roots of addiction and make investments in both proven and promising prevention and treatment strategies. Efforts to prevent and treat opioid addiction that fail to acknowledge what the studies cited above show will spend a great deal of money and produce inadequate results. It is time to apply what neuroscience and social science have taught us about the implications of trauma and childhood adversity for opioid addiction so that our money, energy and resources are spent effectively.

Now that we have a good sense of how trauma fits into the picture, we can look at assets and challenges in our community from the perspective of those with lived experience.

OVERARCHING ASSETS

Those with lived experience share that we have many assets to draw from. Some of the most often mentioned by this group include services that involve:

1. Peer involvement!!!
2. People who are in recovery…. as models showing that recovery is indeed possible
3. Authentic belief that people are humans (not to be defined as 'addicts') with value
4. Opportunities for prosocial activities and interactions
5. Opportunities to provide value to the world in some way (often through some sort of work)

OVERARCHING CHALLENGES

In terms of challenges, people with lived experience repeatedly mentioned:

1. Lack of affordable housing
2. Lack of living wage jobs
3. Lack of recovery housing
4. Not enough culturally sensitive services (especially for the LGBTQ+ and Native American experiences)
5. Not enough trauma-informed services
6. Not enough peer support (broadly defined)
7. Not enough resources in Ignacio or Red Mesa
8. A lot of stigma in the community
9. Culture that normalizes alcohol consumption as part of every social event
10. Care or treatment that is not available when needed, where needed or for as long as is needed
11. Lack of robust care transitions makes recovery more difficult

DATA

Short Indicator Title	Indicator Description	Catchment Area Value	State Benchmark	National Benchmark	Data Source	Geography
Opioids						
Opioid hospitalizations/ emergency room visits		22.5 per 100,000	27.6 per 100,000		Colorado Consortium for Prescription Drug Abuse Prevention Dashboard (2018) - HSR 9	La Plata County (LPC)
Opioids: Youth Prescription misuse Rates		HSR 9: 11.9%	12.40%		Healthy Kids Colorado (adult SUD prevalence not available)	LPC
Percent of patients prescribed long-duration opioids who were opioid-naive		21%	12%		https://public.tableau.com/profile/lina.brou#!/vizhome/RXConsortiumdashboard_15811198671000/Readmefirst	
Opioid prescription fills per 1,000 residents (2018)		456	582.5		https://public.tableau.com/profile/lina.brou#!/vizhome/RXConsortiumdashboard_15811198671000/Readmefirst	

Percent of patients receiving more than 90 morphine milligram equivalents		5%	7%		https://public.tableau.com/profile/lina.brou#!/vizhome/RXConsortiumdashboard_15811198671000/Readmefirst	
Heroin hospitalizations/ emergency room visits		Suppressed	17.4 per 100,000		Colorado Consortium for Prescription Drug Abuse Prevention Dashboard (2018) - HSR 9	
Alcohol						
Youth binge drinking		HSR 9: 20.7%	16%		Youth binge drinking (HKCS 2018)	
Fatal alcohol overdoses		HSR 9: 6.8 overdoses per 100,000	1 overdose per 100,000		Colorado Drug Overdose Dashboard; CDPHE Jan-Dec 2018	
Binge drinking among adults	Percentage of adults aged 18 years and older who report binge drinking (five or more drinks for men, or four or more drinks for women) on an occasion in the past month	17.40%	21.50%	18.20%	500 Cities (2019)	County
Excessive drinking	Percentage of adults who report binge or heavy drinking in the past month	75.90%	60.10%	62.90%	County Health Rankings (2019)	County
Alcohol use disorder deaths	Age-adjusted number of alcohol use disorder deaths per 100,000 population	6.4 per 100,000	4.0 per 100,000	3.0 per 100,000	Institute for Health Metrics and Evaluation (2019)	County
Other Drugs						
Drug overdose deaths	Number of deaths due to drug poisoning per 100,000 population	24.0 per 100,000	39.9 per 100,000	20.6 per 100,000	County Health Rankings (2019)	

Drug use disorder deaths	Age-adjusted number of drug use disorder deaths per 100,000 population	9.8 per 100,000	11.8 per 100,000	9.9 per 100,000	Institute for Health Metrics and Evaluation (2019)	County
Psychostimulants: (methamphetamine and other psychostimulants with abuse potential)		HSR 9: 10.3 overdoses per 100,000	5.7 overdoses per 100,000		Jan-Jul 2019 overdose death rates; CDPHE (SUD prevalence not available)	

Adolescent Data (Healthy Kids Colorado Survey, 2019)		
Alcohol-Related Data		
Health Measure	**Region 9 Percent (includes LPC)**	**State Percent**
Among students who drank alcohol during the past 30 days, the percentage who had 3 or more drinks in a row within a couple hours	**65.2**	62.4
Among students who reported current alcohol use, the percentage who usually drank in a public setting, on school property, or riding in a car	6.5	10.3
Among students who reported current alcohol use, the percentage who usually got the alcohol they drank from someone who gave it to them during the past 30 days	38.5	39.7
Percentage of students who binge drank (4+ drinks for females, 5+ drinks for males, within a couple of hours) on one or more of the past 30 days	**17.5**	14.2
Percentage of students who feel it would be sort of easy or very easy to get alcohol if they wanted	**60.4**	59.0
Percentage of students who had at least one drink of alcohol on one or more of the past 30 days	**35.6**	29.6
Percentage of students who had their first drink of alcohol, other than a few sips, before age 13	**20.6**	17.6
Percentage of students who have ever had a drink of alcohol other than a few sips	**59.8**	54.9
Percentage of students who said parents or guardians would catch them if they drank beer, wine or hard liquor without permission	43.7	46.8
Percentage of students who think adults (over 21) in their neighborhood think it is wrong/very wrong for kids to drink alcohol	74.4	78.0
Percentage of students who think it is wrong or very wrong for someone the same age to drink alcohol regularly (at least once or twice per month)	58.6	62.2
Percentage of students who think people who have one or two drinks nearly every day have moderate or great risk of harm	**70.7**	69.6

Percentage of students who think police would catch kids drinking alcohol in the neighborhood	18.4	22.2
Percentage of students who think their parents or guardians would feel it is wrong or very wrong if they drank alcohol regularly (at least once or twice per month)	81.5	82.1
Percentage of students who thought 5 or more out of every 10 students in the same grade had 5 or more drinks on at least one day in past 30 days	**47.4**	40.6
Marijuana-Related data		
Among students who used marijuana in past 30 days, the percentage that usually got it from an adult	**24.8**	22.1
Among students who used marijuana in past 30 days, the percentage that usually smoked it	54.5	56.5
Among students who used marijuana in the past 30 days, the percentage who ate it	27.6	35.6
Among students who used marijuana in the past 30 days, the percentage who dabbed it	50.2	52.0
Among students who used marijuana in the past 30 days, the percentage who smoked it	75.9	77.9
Among students who used marijuana in the past 30 days, the percentage who used it some other way	6.3	8.4
Among students who used marijuana in the past 30 days, the percentage who vaporized it	20.6	34.3
Percentage of students who feel it would be sort of easy or very easy to get marijuana if they wanted	**59.5**	51.4
Percentage of students who think adults (over 21) in their neighborhood think it is wrong or very wrong for kids to use marijuana	73.8	79.0
Percentage of students who think it is wrong or very wrong for someone of the same age to use marijuana	56.5	58.9
Percentage of students who think people who use marijuana regularly have moderate or great risk of harm	48.4	50.1
Percentage of students who think police would catch kids using marijuana in their neighborhood	23.2	28.8
Percentage of students who think their parents or guardians feel it is wrong or very wrong if they used marijuana	82.1	85.5
Percentage of students who thought 5 or more out of every 10 students in their grade used marijuana in the past 30 days	**55.6**	48.4
Percentage of students who tried marijuana for the first time before age 13	**9.3**	6.7
Percentage of students who used marijuana one or more times during the past 30 days	**24.7**	20.6
Percentage of students who used marijuana one or more times during their life	**42.0**	35.8
Mental Health Data		
Percentage of students who actually attempted suicide one or more times during the past 12 months	**7.7**	7.6
Percentage of students who felt so sad or hopeless and stopped doing usual activities almost every day for 2+ consecutive weeks during the past 12 months	30.5	34.7
Percentage of students who have an adult to go to for help with a serious problem	**73.6**	72.7

Percentage of students who made a plan about how they would attempt suicide during the past 12 months	**14.2**	13.4
Percentage of students who seriously considered attempting suicide during the past year	16.4	17.5
Tobacco-Related Data		
Among students who have used vapor products in the 30 days, the percentage that used products with pre-filled pods	49.4	61.9
Among students who have used vapor products, the percentage who tried it for the first time before age 13	**13.6**	13.2
Among students who have used vapor products, the percentage who used them because friend(s) or family used them	43.1	45.5
Among students who have used vapor products, the percentage who used them because it is easier to get them than other tobacco products	4.6	6.1
Among students who have used vapor products, the percentage who used them because they are allowed in areas where other products are not	**8.5**	7.3
Among students who have used vapor products, the percentage who used them because they are flavored	**21.5**	18.4
Among students who have used vapor products, the percentage who used them because they are less harmful than other tobacco products	**12.6**	12.3
Among students who have used vapor products, the percentage who used them because they cost less than other tobacco products	2.7	3.5
Among students who have used vapor products, the percentage who used them because they were trying to quit other tobacco	**5.0**	4.2
Among students who reported current cigarette use, the percentage who ever tried to quit smoking cigarettes during the past year	44.5	48.1
Among students who smoked in the past 30 days, the percentage who smoked menthol cigarettes	29.0	29.9
Among students who used electronic vapor products in the past 30 days, the percentage who often or always reach for them without thinking about it	**24.7**	17.1
Among students who used electronic vapor products in the past 30 days, the percentage who sometimes, often or always had intolerable cravings after a few hours	**25.6**	19.0
Among students who used electronic vapor products in the past 30 days, the percentage who tried to quit in the past year	**53.9**	53.4
Among those underage students who tried to buy tobacco or vaping products in a store, the percent who were not refused because of age	45.1	63.5
Among underage students who smoked cigarettes in the past 30 days, percentage who borrowed them from someone else	45.4	45.4
Among underage students who smoked cigarettes in the past 30 days, percentage who gave someone else money to buy them	32.7	33.1
Among underage students who smoked cigarettes in the past 30 days, percentage who got them from someone else who can legally buy them	**32.6**	29.8

Among underage students who smoked cigarettes in the past 30 days, percentage who got them on the internet	5.3	6.5
Among underage students who smoked cigarettes in the past 30 days, percentage who got them some other way	**40.3**	32.4
Among underage students who smoked cigarettes in the past 30 days, percentage who stole them from a store or another person	**18.3**	16.5
Among underage students who smoked cigarettes in the past 30 days, the percentage who bought them from a store (convenience, supermarket, discount, gas station)	**12.4**	10.8
Among underage students who used electronic vapor products in the past 30 days, percentage who got them in another way	18.0	21.4
Among underage students who used electronic vapor products in the past 30 days, the percentage who borrowed them from someone else	48.0	50.3
Among underage students who used electronic vapor products in the past 30 days, the percentage who bought them in a store	4.5	5.6
Among underage students who used electronic vapor products in the past 30 days, the percentage who gave someone else money to buy them	29.3	29.8
Among underage students who used electronic vapor products in the past 30 days, the percentage who got them on the internet	**6.1**	4.8
Among underage students who used electronic vapor products in the past 30 days, the percentage who stole them	3.4	3.5
Among underage students who used electronic vapor products in the past 30 days, the percentage who were given them by a person who can legally buy them	29.1	23.6
Percentage of students who definitely or probably will use an electronic vapor product anytime in the next year	**31.5**	26.7
Percentage of students who feel it would be sort of easy or very easy to get electronic vapor products if they wanted	**66.0**	63.2
Percentage of students who have ever smoked a cigarette, even one or two puffs	**26.2**	20.7
Percentage of students who have ever used an electronic vapor product	**52.5**	45.9
Percentage of students who have not seen ads for electronic vapor products in the past 30 days	**32.9**	26.8
Percentage of students who have seen ads for electronic vapor products in the past 30 days	67.1	73.2
Percentage of students who have used bidis or small brown cigarettes wrapped in a leaf in the past 30 days	**1.2**	0.8
Percentage of students who have used chewing tobacco, snuff, dip, snus, or dissolvable tobacco products, such as Copenhagen, Grizzly, Skoal, or Camel Snus in the past 30 days	**4.1**	2.6
Percentage of students who have used cigars, chewing tobacco, hookah or bidis in the past 30 days	**9.4**	7.2
Percentage of students who have used cigars, cigarillos, or little cigars in the past 30 days	**4.6**	4.0
Percentage of students who have used smoking tobacco from a hookah, narghile, or other type of waterpipe in the past 30 days	1.7	1.7

Percentage of students who have used smoking tobacco from a pipe that was not a hookah, narghile, or other type of waterpipe in the past 30 days	**1.4**	1.3
Percentage of students who heard ads for electronic vapor products on the radio in past 30 days	9.8	19.7
Percentage of students who saw ads for electronic vapor products in magazines in past 30 days	11.6	11.8
Percentage of students who saw ads for electronic vapor products in stores in past 30 days	35.0	38.6
Percentage of students who saw ads for electronic vapor products on billboards in past 30 days	9.2	13.3
Percentage of students who saw ads for electronic vapor products on the internet in past 30 days	35.7	43.6
Percentage of students who saw ads for electronic vapor products on TV in past 30 days	38.1	42.0
Percentage of students who smoked a cigarette, even one or two puffs, for the first time before age 13	**9.3**	7.6
Percentage of students who smoked cigarettes on 20 or more days of the past 30 days	**2.2**	1.5
Percentage of students who smoked cigarettes on one or more of the past 30 days	**8.0**	5.7
Percentage of students who think 5 or more out of every 10 students at school use electronic vapor products	**70.2**	64.1
Percentage of students who think adults in their neighborhood think it is wrong or very wrong for kids to smoke cigarettes	82.9	87.5
Percentage of students who think breathing second hand vapor has a moderate or great risk	54.9	55.1
Percentage of students who think it is wrong or very wrong for someone of the same age to use electronic vapor products	64.7	65.5
Percentage of students who think it is wrong/very wrong for someone the same age to smoke cigarettes	78.8	81.3
Percentage of students who think it would be sort of easy or very easy to get cigarettes if they wanted	**56.8**	52.3
Percentage of students who think most adults in their neighborhood think kids using electronic vapor products is wrong or very wrong	80.1	81.9
Percentage of students who think parents or guardians would feel it is wrong or very wrong for you to use electronic vapor products	87.2	90.3
Percentage of students who think people who smoke one or more packs of cigarettes per day have a moderate or great risk of harm	**87.8**	85.6
Percentage of students who think people who use electronic vapor products every day have a moderate or great risk of harm	72.3	73.0
Percentage of students who think they would definitely or probably smoke a cigarette in the next year	**12.3**	8.8
Percentage of students who used an electronic vapor product in the past 30 days	**31.6**	25.9
Percentage of students who were inside their car while their parent or guardian was smoking a cigarette, cigar, pipe, or using an electronic vapor product for one or more days in the past week	**13.0**	11.8
Percentage of students who were inside their home while someone was smoking a cigarette, cigar, pipe, or using an electronic vapor product for one or more days in the past week	17.7	18.5

Percentage of students who would definitely or probably smoke a cigarette offered by one of their best friends	**13.3**	9.6
Percentage of students who would definitely or probably use an electronic vapor product if offered one of their best friends	**34.2**	28.2

Secondary Data RCORP Core Measures			
Indicator	**Indicator Description**	**Catchment Area Value/Statistic**	**Source**
Total Population	Total Population	56,221	US Census Bureau QuickFacts
SUD Screening Rate	Rate of individuals screened for SUD	69.99% across 10 clinics in RAE Region 1 were screened for unhealthy alcohol use	RMHP RAE Data (2019) - Adult Preventative Guidelines Alcohol Use Assessment
Non-fatal opioid overdoses		Rx Opioid = 20.2 per 100,000 *Above rate refers to any opioid including from prescription sources, fentanyl and heroin	CDPHE Drug Overdose Dashboard (2018) - HSR 9
Fatal opioid overdoses		8.9 per 100,000 residents in 2019	CDPHE Drug Overdose Dashboard (2019) - LPC
Fatal methamphetamine overdoses		7.1 per 100,000	CDPHE Drug Overdose Dashboard: 2019 - LPC
Healthcare providers with a DATA waiver	Provider takes an additional 8 hours of training to be able to prescribe buprenorphine	7 providers *May not include every provider in LPC with a DATA waiver, since some people don't list DATA waiver online	SAMHSA Buprenorphine Waiver Locator
Healthcare providers in consortium who have a DATA waiver. Specify by provider type.	Provider takes an additional 8 hours of training to be able to prescribe buprenorphine	3 providers: 2 NPs and 1 psychiatrist	SAMHSA Buprenorphine Waiver Locator
Average annual crude rate of opioid analgesic prescriptions dispensed per 1,000 residents		409 per 1,000 residents	CDPHE Drug Overdose Dashboard: 2019 - LPC

The objective data above and the subjective data from both those with lived experience and those who serve them largely align. The one exception may be where people who have experienced addiction reported a service to be non-existent, the service may in fact exist but is either unknown, unavailable at the time needed, or in some way doesn't meet the full needs of the person seeking support.

Below we look at assets and challenges in each phase: prevention, treatment, and recovery.

PREVENTION / TREATMENT / RECOVERY SECTION

PREVENTION

Prevention Related Organizations	
Celebrating Healthy Communities	Celebrating Healthy Community supports two community (one regional, one countywide) coalitions that address our marijuana and alcohol culture. Recognizing Opportunities Around Resilience (ROAR) and the Coalition On Responsible Driving. ROAR focuses on youth substance use prevention and CORD works to decrease impaired driving by providing community education and alternative transportation opportunities where needed.
Southern Colorado Community Action Agency (SoCoCAA)	Serves Ignacio. SoCoCAA's mission is to empower community members of all ages to recognize and reach their full potential by providing select programs and services in order to create better communities.
La Plata Youth Services (Katy Pepinsky)	La Plata Youth Services (LPYS) supports and advocates for youth facing challenges in school, home, or court. Programs include: Diversion, Radical Possibilities Mentorships, Community in Schools Partnerships, Restorative Justice Programs, and serves as the backbone organization for the La Plata County Collaborative Management Program.
Resilient Colorado (Doty Shepard)	Trauma informed wellness building and implementation. Programs include: Early childhood caregivers, support for restaurant and hospitality workers, Drug Free Communities Trauma Informed Care (TIC), Suicide Prevention TIC, Virtual Room of Refuge.
Pine River Shares (Pam Willhoite)	Pine River Shares is a community-based leadership project that brings together the knowledge, skills and resources of people in the Pine River Valley to increase our collective power and bring about positive social change resulting in healthy, thriving Pine River Valley communities. Programs include: Backpack food program, weekly food share, community dinners, and freecycle clothing.
Neighbors in Need Alliance (NINA)	Provides outreach services to the homeless at Purple Cliffs and in town. Services include transportation to medical appointments, bringing food, providing camping supplies, building showers and warming tents, working with the city and county to establish permanent camp, assist with motel rooms this winter, and other services as needed.
La Plata Family Center	Family Support Services (peer advocate program) uses the Family Strengthening Pathway model….which uses the Colorado Family Support Assessment tool (includes all the SDOH over 14 domains). Parents as Teachers also follow the model. New program "Circle of Parents in Recovery" is also worth considering for small investments. Center does a LOT on a very small budget. Investments here could carry significant ROI.
Good Food Collective (Rachel Landis)	Exists to strengthen our regional food system through efforts to address food security, food justice & equity, and our regional food economy. Programs include: Fruit tree harvesting, Food for All, Fruit for Good, Food and Health Coalition. GFC partnered with Mercy to implement the Roots of Health (ROH) in order to address food insecurity among workforce members.

San Juan Basin Public Health (SJBPH)	Preventing disease & disability, Promoting healthy lifestyle choices; Preserving and restoring the environment; Assuring basic health services for all people. Also HIV / HCV testing and treatment and needle exchange sites
Planned Parenthood of the Rocky Mountains	Offers family planning, reproductive health, gynecological and STD services. Also, HIV/HCV testing and treatment and needle exchange sites
Four Corners Alliance for Diversity	Works to create a safe, welcoming and empowering community for all LGBT people in the Four Corners Region.
Southern Ute Community Action Program	Provides a variety of community programs: including Peaceful Spirit, a (recently closed) residential and outpatient substance abuse treatment program, Colorado Preschool Program, Youth Drop In Center, Senior programs, Native American job training and employment services and programs for families.
Manna Soup Kitchen	Provides meals and fresh food, support services (ID, employment, navigation center, transportation assistance, clothing, AXIS), backpack programs for kids, CSA, and a street outreach program that will provide these resources to people on the street and Purple Cliffs. Manna will also be developing a Coordinating Council for Homelessness composed of officials from all key agencies in La Plata County to examine data and develop approaches to preventing and dealing with homelessness.
Other community organizations: Boys and Girls Clubs, Big Brothers Big Sisters, The Hive	Prosocial youth / adolescent activities and mentorship
Colorado Crisis Services 1-844-493-8255 Text “TALK” to 38255	It may have started socially, in response to stress, or with what you thought would be a one-time experiment, but now it completely consumes everything. If you or someone you love is suffering from substance abuse, reach out. You’re not alone. Support is just a call or text away. Whatever you need, whenever you need it, we’re here to help. Experiencing any of these issues? We're here to help.
Schools:	Durango School District (5,000 students) Bayfield School District (1,600 students) Ignacio School District (700 students)

Assets

Interestingly, almost no real upstream prevention assets or gaps or even real awareness of its relevance were mentioned in conversations or brought forward in the data. Our trauma-informed trainer prompted us however to include questions about childhood experience in our interviews. Most interviewees shared some significant childhood trauma combined with a lack of people or places to turn to for non-substance involved activities or relationships. This then prompted us to learn more about what works in trauma prevention and find out what is or is not happening in our community.

The good news is that we have some excellent support locally. Top among them is our **LaPlata Family Center** which is being recognized regularly for their **Family Support Services program** which uses the (with the help of a research grant and capacity building...moving toward) evidence-based Family Strengthening Pathway model which in turn uses the Colorado Family Support Assessment tool which includes all of the Social Determinants of Health over 14 domains! The Family Center is also launching a proven **Circle of Families in Recovery** model for peer support. From a coalition and systems standpoint, **Celebrating Healthy Communities** is doing some incredible work. For over two decades Celebrating Healthy Communities has worked to improve the quality of life for Southwest Colorado residents through community collaboration, social norming, and youth adult partnerships. They partner with local organizations, schools, businesses,

active coalition members, and volunteers across the Southwest region. They act to increase protective factors and decrease risk factors that contribute to problem behaviors that our communities prioritize. All of their messaging uses the Science of the Positive framework which is based on the core assumption that the positive is real and is worth growing – in ourselves, our families, our workplaces, and our communities.

As we think about prevention, we know that school matters. School experience can involve protective factors that nurture belonging, resilience, and healing...or not. When it doesn't, students can be bullied or excluded and use substances to dull the pain, or (often related to exclusion) be recruited into groups where substance use is the norm. Schools are constantly looking for ways to ensure students are in the classroom ready to learn. In all three districts in La Plata County, every school has a counselor and there is a strong understanding of the importance of mental health. In all three districts also, the elementary schools are learning about trauma informed and restorative practices. In some cases, staff are applying them in small ways like through connection circles, restorative conversations and mindfulness practices. The general language and approach supports the science that relationships help with regulation. Counselors in every school in Durango are receiving 15 hours of training in the neurosequential model of education.

We also have one of the most well-versed trauma-informed / resilience nurturing organizations in the country in **Resilient Colorado**. Having trained over 3,400 people and developed relationships with important demographics related to this work (Native Americans, LGBTQ+), they will be an important asset to think about in our strategic plan particularly as it relates to their capacity to do the needed work.

One of our Native American consortium members - Imo Succo, MSW / Member of Navajo Nation - has, through an educational course, already developed a concept for a **Native American Cultural Center** that will be an important consideration in our strategy. Details are below in the Priority Population section.

Informal networks of peer support. Also relevant to treatment and recovery is the informal network of people in recovery who get to know individuals and families who are in situations that involve drugs and alcohol. They show up at people's homes, on the street, in the jail, at homeless locations etc. They know where to go, and what is needed, and when for support and recovery services throughout the system. This network has an unusual and extraordinary level of trust with people. They engage without judgement, fully understanding the individual's experience, and knowing that the people they connect with are humans with value and not simply 'addicts'. They also come in with credibility, usually informally connected so the trust is immediately transferred from the known referral source (usually a friend vs organization). They provide an often 24/7 crisis support, a source of resources available when someone is ready for treatment, and a trusted contact when readiness to enter recovery occurs.

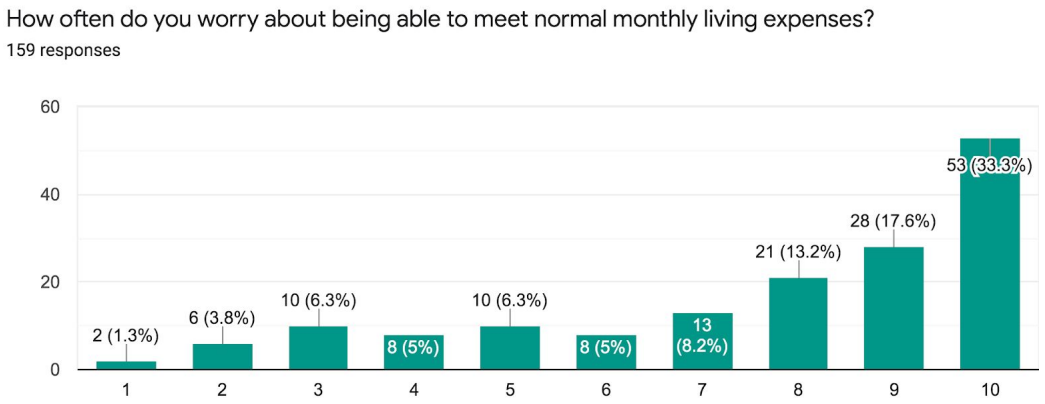
Short Indicator Title	Indicator Description	Catchment Area Value	State Benchmark	National Benchmark	Data Source	Geography
Population with any disability	Percentage of the civilian non-institutionalized population with a disability	11.90%	37.00%	16.70%	American Community Survey	LPC
Poor mental health days	Age-adjusted average number of reported mentally unhealthy days per month	3.8	4.7	3.9	County Health Rankings	LPC
Children in single-parent households	Percentage of the population under 18 years of age in households who are in single-parent households	28.10%	30.80%	30.50%	ACS	LPC
Violent Crimes	Number of reported violent crime offenses per 100,000 population	216.8	232.9	252.6	County Health Rankings	LPC

Inadequate social and emotional support	Percentage of adults 18 years and over who report not receiving adequate social-emotional support	17.30%	20.00%	19.40%	County Health Rankings	LPC

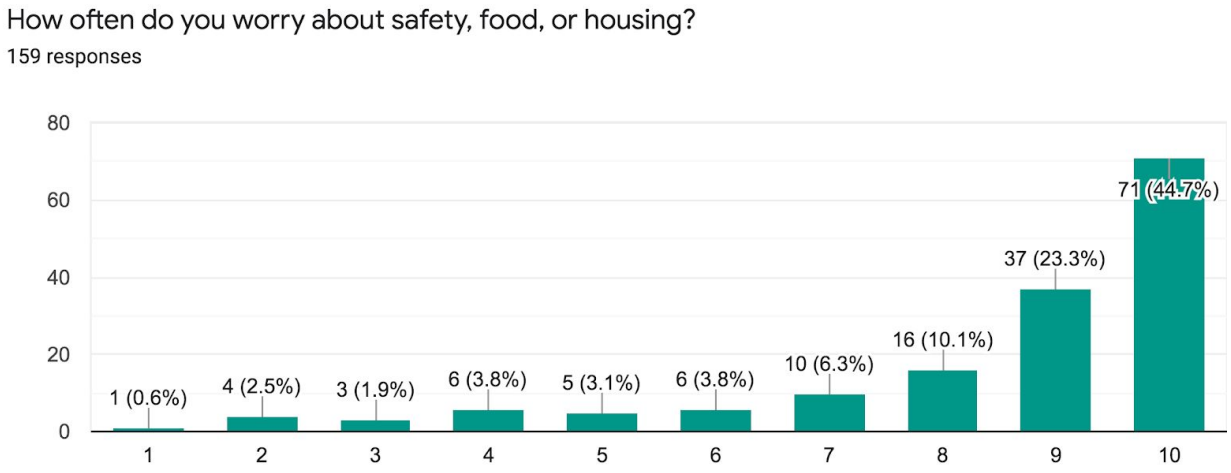
Challenges

Before we begin to look into SUD/OUD specific needs, overwhelmingly the general need for **affordable housing** and **living wage jobs** was shared as foundational. Without these basic needs, anything else is like icing a non-existent cake.

We have an **economy** that is mismatched. Available jobs simply do not pay enough to cover the cost of living. **This challenge cannot be overstated and it has many nuances.** Our recent community survey illustrates this vividly with only one-third of the respondents suggesting they don't worry about being able to meet *normal monthly living expenses*. In the chart below, 1 means 'worry all the time' and 10 means 'do not ever worry.'



Only 45% never worry about safety, food or housing. Here too, one means 'worry all the time' and 10 means 'do not ever worry.'



Short Indicator Title	Indicator Description	Catchment Area Value	State Benchmark	National Benchmark	Data Source	Geography
Residential Segregation - Non-White/White	Index of dissimilarity - between 0 (complete integration) and 100 (complete segregation) - representing residential segregation between non-white and white county residents	41.5	38.7	41.5	County Health Rankings, 2019	LPC
Income Inequality - Gini Coefficient	Gini Index of income inequality, a measure of statistical dispersion representing income distribution	0.4	0.4	0.4	American Community Survey, 2019	LPC
Housing						
High housing costs	Percentage of households paying 30% or more of their income for housing	29%	20.50%	23.80%	American Community Survey, 2019	LPC
Overcrowded households	Percentage of households with more than one persons per room	2.40%	1.00%	2.40%	American Community Survey, 2019	LPC
Severe Housing Problems	Percentage of occupied housing units with one or more of the following severe problems: 1) lacks complete kitchen facilities; 2) lacks complete plumbing facilities; 3) is overcrowded; and /or 4) cost burden is greater than 50%	15%	10.80%	13.70%	CHAS (Comprehensive Housing Affordability Strategy) Consolidated Planning Data, 2019	LPC
Homeownership	Percentage of households with owner-occupants	72%	76.50%	73.70%	American Community Survey, 2019	LPC
High Housing Costs Among Renters	Percentage of renter-occupied housing units for which housing costs amount to 30% or more of household income	41.80%	32.90%	33.90%	American Community Survey, 2019	LPC
Food						

Food Environment Index	Food Environment Index number - between 0 (worst) and 10 (best) - representing factors that contribute to a healthy food environment	6.8	7.7	7.5	County Health Rankings, 2019	LPC

The bulk of our community's economy rests on the shoulders of **restaurant and hotel, local boutique and outdoor recreational activities** like skiing/rafting industries where the wages can't keep up with the cost of living. When workers in these industries have strong support, they are able to survive and sometimes thrive. But it is a precarious existence at best. Coupled with **a culture that celebrates with and normalizes use of alcohol and drug use,** for many we've created a slippery slope into addiction.

The less often cited challenges include the **construction and oil & gas jobs** where we see isolated job sites, boom and bust cycles, and industries that normalize drinking. These industries create significant stress on individuals and are literally feeding our clinics, hospitals and morgues. This stress comes from not being able to pay basic bills. Stress from not knowing if one will have a job. And too often, unbearable stress from feeling like one has no value because they can't provide.

The other big challenge is that, with the major exception of housing and jobs, it seems we have the right prevention assets in our community and they are doing a great job... but, as evidenced by the data around substance use, they are either not resourced or not coordinated / connected at a level that would allow our community to truly have conditions that allow everyone to thrive.

More detailed description on the prevention-related Social Determinants of Health (SDoH) can be found below in that section.

As for challenges in the schools, the good progress being made in elementary needs to continue to deepen; and it is not yet moving into the middle and high schools. In middle schools it's really difficult due to the developmental changes that take place during these years. Leaders throughout the schools see the challenge of the developmental differences at this age. Can we even talk about drugs and alcohol? Can we have a Gay Straight Alliance? Many parents disapprove. Vaping is rampant and the schools have not found any way to address it. Some programming exists but leaders are very interested in having more. Further complicating the challenge is the difficulty of recruiting and retaining for all staff positions. One person stated, "in my 20 years working here, we've never started the year fully staffed in the region". This is also highlighted in that of the 9 superintendents in the region 5 are retiring this year. Those remaining all have less than 2 years tenure in their role. Finally and importantly, we are moving into a year where resources are likely to be considerably reduced. In Colorado, school funding is tied directly to the economy. As taxable income falls, so too will funding available to schools. The next three years will be a challenge.

Relatedly, currently there are 5-hour energy drinks containing kratom being sold across from Durango High School and powdered kratom being sold at Gandolph's Smoke Shop in Durango (unsure if people are carded for purchase of this). Kratom, although having some stimulant effects at a certain dose, should really be considered an opioid. According to one provider, they are seeing many patients try to get off pills/heroin with kratom and then have to use buprenorphine to get off kratom. Or people start with kratom and can't stop. One of the biggest reasons many people decide to use kratom is that they believe it won't show up on drug tests. And this is true for many drug tests. Very significantly is that this is a gateway drug. Kratom withdrawals are only alleviated by more kratom or an opioid. One thing we could do immediately is limit accessibility of this to anyone under 18 years old.

Note: HRSA Reviewers asked if there were services that exist to support families through a family member's SUD/OUD, accidental overdose, or suicide… especially if the children / youth are left to manage a parent's SUD/OUD. The answer is no, there are no formal or, to our knowledge, informal services like that.

TREATMENT

Treatment Related Organizations	
Axis Healthcare System	Integrated Health Provider Details: - Treatment Provider - serve individuals across the lifespan Services Provided: Primary Care, Oral care, Mental Health & Substance Use Treatment, Crisis Care, Care Coordination, Acute Treatment Unit, withdrawal treatment (Social), Drug & Alcohol Monitoring, MAT, Community Services, Healthcare for the Homeless, Peer Recovery, Senior Reach, Insurance Enrollment Services, and Jail-Based Behavioral Health Service.
Front Range Clinic	Medical Assisted Recovery - suboxone, oral % injectable naltrexone
Colorado Addiction Treatment Services	Opiate Treatment Provider**.** Provides assisted therapy, Behavioral Health substance use counseling
6th Judicial District / Wellness Court	Problem Solving Court, the program serves offenders actively being supervised by probation - The mission of the La Plata County Wellness Court is to integrate substance abuse treatment, mental health treatment, intensive supervision and judicial oversight to promote public safety and individual responsibility, to reduce crime, and to improve the quality of life for participants and their families. The team consists of the Judge, District Attorney, Public Defender and/or other Defense Counsel, Problem Solving Court Coordinator, Law Enforcement, Treatment Providers and Probation.
Mercy Regional Medical Center	Mercy Regional Medical Center is an 82-bed, acute-care hospital in Durango, Colorado. Mercy was founded in 1882 but has grown to become Southwest Colorado's largest and most technologically advanced medical facility. It is the only hospital in the region to receive from Medicare a five-star rating for overall hospital quality. Mercy's areas of specialty include orthopedic and spine surgery, cardiology, emergency and trauma care, cancer care, and more. Mercy currently does not provide ED MAT services, however, it treats individuals with alcohol use by managing their withdrawal symptoms and once stable, discharges them to Crossroads, the social detox program managed by Axis.
Regional Accountable Entity	The Regional Accountable Entity (RAE) in region 1 which includes La Plata county, provides care coordination for individuals enrolled in Medicaid. The following four entities have the ability to refer patients/clients to the RAE for care coordination: hospitals, our public health department, social service agencies and FQHC (Axis Health System). They provide care coordination for individuals with social, emotional and medical needs, including individuals with a substance use disorder. Care coordinators can screen for substance use and connect individuals with treatment or recovery services in their community. They collaborate with the referring agency and the services are voluntary and for as long as the patient/client needs them.

Assets

Providers really want to do the right thing for people. There is a willingness to adapt and an honesty around the barriers they face. Mercy and Centura have goals that prioritize this work which means it is more likely that attention, time and resources will be put toward the strategy.

Durango is the center of the county for healthcare services with Mercy being the hospital provider and sponsor of this SCOOP initiative. Other than the named challenges below, people from all over the county can receive medical and behavioral health care in Durango. Three stand out assets / programming are noted below.

1. We are very excited about the Community Counseling Program (crisis response teams) that has just begun in Durango. This aims to connect people to the support they need vs sending them to withdrawal treatment and jail.

This program involves a strong partnership between Axis and the police department and is fully supported by city council and public opinion.

2. Mercy now has peer support in the Emergency Department which allows someone a private room to tele-connect with a peer who would then serve as a guide for post-hospital care.

The opportunities in local systems for engaging people who use drugs, screening, diagnosing, and referring to treatment and other support services are described below.

The Regional Accountable Entity (RAE) in region 1 which includes La Plata county, provides care coordination for individuals enrolled in Medicaid. The following four entities have the ability to refer patients/clients to the RAE for care coordination: hospitals, our public health department, social service agencies and FQHC (Axis Health System). They provide care coordination for individuals with social, emotional and medical needs, including individuals with a substance use disorder. Care coordinators can screen for substance use and connect individuals with treatment or recovery services in their community. They collaborate with the referring agency and the services are voluntary and for as long as the patient/client needs them. A gap in La Plata county is a choice where individuals want to go for treatment.

Mercy Regional Medical Center serves a high volume of Medicaid and Medicare patients and is presently exploring establishing an acute medical management withdrawal unit and intensive outpatient program (IOP) to better serve patients admitted to the hospital with a substance use disorder. Later this year, Mercy will be implementing SBIRT screening in their ED and primary care clinics so they can formally screen patients for substance use.

Not too long ago, Mercy had a treatment model (LINK) that many referenced as having worked well for tracking and coordinating care. This was a 3-year program funded by a grant from Mercy Health Foundation utilizing CHI Mission and Ministry funds. On July 1, 2019, Mercy adopted the LINK program so we could continue caring for patients with complex medical, behavioral, and social needs. The purpose of the LINK program was to help patients with high ED utilization achieve stability by providing intensive care management, care coordination, financial assistance, connection to local resources, and behavioral health services. The LINK social worker engaged frequently with LINK participants and worked in collaboration with RAE care coordinators and other partners in our community to address social determinants of health. While this program is no longer in place, several people mentioned that it had worked well and they would like to see it come back.

We have one Behavioral Health Organization (BHO), Axis Health System, serving our 5-county region. It is the primary provider of behavioral health services for individuals enrolled in Medicaid.

Axis provides many services and rises to the challenge of 'growing their own' team members due to the challenge of recruiting and retaining credentialed SUD providers in our rural setting. AHS strives to recruit and retain qualified, compassionate, mission driven health care providers by promoting the following strategies:

- Competitive Salary and Benefits - Axis Health System offers competitive salaries and a great benefits package. For instance, we have a 401(k) plan, health insurance, health savings account, dependent care account, wellness benefit, paid holidays and more. Some of our health care jobs are approved for loan-repayment programs.
- Supportive Care Teams - AHS includes many types of health care jobs. For example, doctors, nurses, physician assistants and medical assistants therapists, case managers, and psychiatric providers. These health care jobs form a care team. Teams encourage patients to take an active role in their health and wellbeing. Each care team has a different mix of people. They lean on each other to share specialized skills. As a result, patients have a wide network of support to help them get well and stay well and providers have high satisfaction in their work.
- Training and Professional Opportunities - AHS is committed to training and ongoing professional development of its workforce. Behavioral health staff develop a professional learning plan and choose a training track offered by AHS internal, certified trainers. Training tracks include learning a new Evidence Based Program (Dialectical Behavioral Therapy, Trauma Focused CBT, Parent-Child Interaction Therapy, Matrix model for Substance Use Treatment, Marijuana Brief Intervention, Integrated Dual Diagnosis Treatment, Assertive Community Treatment, Solution Focused Brief Therapy), Certified Addiction Counselor training, learning how to be a clinical supervisor, and for more advanced clinicians, a personalized plan that meets employee goals and increases the quality of care for AHS patients.

- Environment of Continued Learning and Improvement - AHS offers a range of supports and opportunities to obtain clinical supervision, consultation and peer support in service of high quality healthcare. Employees early in their career are assigned a clinical supervisor who provides ongoing training, observation/feedback, and consultation in the application of effective treatment models for a diverse population of patients. Supervision meets requirements for Mental Health (Clinical Social Workers, Professional Counselors, Marriage and Family Therapists, Psychologists) and Addiction Counselor licensure supervision to ensure employees are eligible for licensure after completing required hours. AHS also has a collaborative interdisciplinary environment in which formal and informal consultation on patient care plans and the application of effective treatment approaches are part of daily work. All sites hold regular interdisciplinary meetings, including huddles, clinical staff review meetings and consultation meetings. This provides opportunities for learning as well as improving the quality of patient care.

  Further, all staff participate in regular training in both areas focused on behavioral health services, and are also trained in communication and de-escalation skills. While each AHS workplace and team has its own unique characteristics, AHS provides interpretive services and strives to promote the following practices in service of creating a trauma informed and culturally sensitive environment.
  - Listen to hear, not to respond
  - Model and support vulnerability
  - Interact with integrity
  - Employ kindness, respect and honesty in all interactions

Challenges

Three of the most often cited challenges in the treatment experience was that treatment:

1. <u>Wasn't available at the moment it was needed and desired.</u> The context here is that the moment when need and desire are both happening, we need to be able to offer a path for treatment. This frustration was also felt by providers who knew this and wanted to fix it but were constrained by reimbursement models. That moment where need is joined by desire can be fleeting and the opportunity is lost… sometimes over and over. Ideas offered related to this included funding peer services to help bridge the availability of clinical treatment availability and ensuring greater broad public knowledge and openness to connect people to services. Limitations that contribute to this include:
   1. Time and Transportation. This also included comments around finding time and transportation to get to appointments. For people who do not live in Durango (especially those living in Ignacio, Bayfield and Red Mesa), the logistical challenge of time and transportation is limiting.
   2. Inpatient Residential Services. For those needing inpatient residential services, the absence of that service in our region - even when transportation is figured out - means that making the choice to go is just too difficult.
   3. Recovery Housing. Without this service, people are transitioning back into the environment they came from, making it difficult to continue on a path of recovery. Story after story was shared about this being the moment where recovery stopped and addiction again took hold.
   4. Qualifiers. This includes services that are available but only if you are in a severe enough crisis (i.e. 'actively intoxicated'). These 'gates' meant that people who would want and benefit from the care, were not able to qualify.
   5. Child care. Comments were not made by those with lived experience around the availability of childcare being a limitation, but providers did note that they had clients where this was a recurring challenge.

   Related to this experience was the experience of providers where it was shared that they were frustrated that they couldn't spend as much time with people as they would like. Reimbursement limitations were cited as a barrier. They also shared the sense that all of the above made recovery difficult for their clients and they would like to see investments in inpatient residential, recovery housing, and upstream services, peer support, housing and jobs. One provider commented, "I feel like the blame lands on us but even if we do everything perfectly, the clients don't have what they need." Another threw up their hands while saying, "The whole system is broken. It needs to be integrated… addiction, mental health, physical health. We're treating symptoms instead of the underlying issues. It's an abomination. Here's an example: almost all of my female patients at some point disclose that they have

experienced sexual abuse. We have zero easily accessed mental health care, no adequate residential, no psych center, no detox program with case management and placement and a revolving door of providers. I feel so sorry for my patients. If they have to tell their story more than twice they're done."

2. Wasn't long enough. People mentioned that they only had x appointments and that wasn't enough or 30/60 days of treatment wasn't enough. These constraints are often beyond the control of the provider and limited by reimbursement requirements (often Medicaid).
   Notable:
   a. Medicaid Residential benefit is based on medical necessity, not clinical necessity. Clinical necessity would allow more flexibility to consider things like social conditions.
   b. We often think of inpatient residential as being 30-90 days when it may be appropriate for it to only be 2-3 weeks or alternatively, much longer. Each individual situation may be different.
3. Wasn't provided by someone with enough cultural sensitivity or trauma-informed perspective. People mentioned that they wouldn't even seek care or go to appointments because they felt judged or weren't understood at all. Providers expressed some awareness of this and a willingness (sometimes eagerness) to learn.
4. Ended with a transition into a setting that didn't allow for sustainability. "I was just put back out into the same world I'd come from so I just picked up where I had left off." Over and over again, people mentioned the need for better transitions from treatment to recovery.

This was true across treatment settings: behavioral health, emergency, inpatient residential, and even jail. The Emergency Department is well aware of the challenges and eager to support.

> *"In the Emergency Department (ED), our training and mindset is to fix things quickly and move on to the next crisis. ED clinicians can become frustrated when their limited resources are diverted from acute emergencies and attribution bias can lead to blaming the person rather than their situation. Substance use disorder is a chronic problem that can't be "fixed" – it requires incremental interventions like an oncologist treating cancer. We need to build a system that provides direct patient access to programs staffed by those who specialize in this disease process."*
>
> - John (Jack) McManus, MD, Emergency Department, Mercy Hospital

Mercy Regional Medical Center does not currently formally screen nor provide treatment or support services for individuals with OUD or SUD, including alcohol use. Though as noted above, these are in motion for future services.

For Behavioral Health there are indeed barriers with accessing timely services as well as a related workforce shortage to meet the need for these services in La Plata county. People don't have a choice of where they want to receive behavioral health services unless they have money and can afford a private therapist. Axis also offers intensive outpatient treatment, however, according to their director of clinical services, it is under-utilized.

Other/related notable challenges:

- Reimbursement models often fund treatment at the detriment of prevention so while there may be money to reimburse for treatment, we may want to think hard about how we might fund more upstream work so we can use less money (reimbursement) in treatment.
- Not enough Drug Addiction Treatment Act (DATA) waivered providers.
- No inpatient residential option within a reasonable travel distance (it *is* paid for now as of January 1 for Medicaid beneficiaries as long as there is capacity and they meet the ASAM criteria for inpatient residential treatment)

Geographical Considerations

- Ignacio is short on services in every area: prevention, treatment and recovery. We know this from interviews. We also know that the area receives funding to support the Native American community but most services for other populations never reach the community… and if they do, they may be underutilized because access is limited. Some attention has been given to improving transportation to Durango services, but this is problematic because of the logistics and time commitment of making this happen.
- Bayfield. Similarly while there are some services in Bayfield, many travel to Durango for their care. This was not identified as a major challenge but we should continue to inquire in case we are missing input.

- Red Mesa. This is an interesting one. This is noted here because in three interviews, it was mentioned in passing, "I grew up in Red Mesa." Looking at a map, Red Mesa is Southwest of Durango (near Hesperus), small and remote. When asking around about this, nobody really knew anything about it or that it was even on the map. We are documenting it here for the purposes of further exploration. Is this a community in need of early childhood / family / adolescent services and care? It's also mentioned here to encourage us to figure out ways to learn more about where people spent their childhood. We know zip code matters. Are there ways we can better understand and support the micro-communities in our county?

In terms of data,

- According to data in the 2020 Colorado Rural Health Snapshot, in La Plata County there are:
  - two intensive outpatient treatment facilities
  - two withdrawal treatment facilities (same organization, two locations)
  - one community mental health center
  - one acute treatment unit (which, anecdotally, is known to be very hard to get into so many who would benefit don't)
  - zero hospital inpatient treatment facilities
  - zero residential inpatient treatment centers

- According to SAHMSA's facility locator, in La Plata County there are
  - Five substance use facilities: Axis Health System Detox Unit, Axis Health System Columbine Behavioral Healthcare, Colorado Addiction Treatment Services. Front Range Clinic (on Florida Road), and Axis Health System La Plata Integrated Healthcare
  - Two mental health care facilities: Axis Health System Crossroads at Grandview and Axis Health System Columbine Behavioral Healthcare
  - One opioid treatment program in Durango: Colorado Addiction Treatment Services

- There are three MOUD / MAT clinics: Colorado Addiction Treatment Services, Axis at the La Plata Integrated Health Clinic and Front Range Clinic

Short Indicator Title	Indicator Description	Catchment Area Value	State Benchmark	National Benchmark	Data Source	Geography
Insured adults	Percentage adults with current insurance	84.80%	89.40%	85.40%	ACS	LPC
Recent primary care visit	Percentage of adults aged 18 years and older who report having been to a doctor for a routine checkup in the past year	60.50%	75.80%	70.20%	500 Cities	LPC
Fair or Poor Health	Age-adjusted percentage of adults who report having fair or poor health	13%	15.70%	17.50%		
Health Professional Shortage Area - Mental	Federally-designated area that indicates health provider shortages in mental health care; Indicator displays the percent of population that is underserved	51.90%	32.60%	63.40%	HHS	LPC

Health Professional Shortage Areas - Primary Care	Federally-designated area that indicates health provider shortages in primary care; Indicator displays the percent of population that is underserved	65%	52.10%	48.10%	HRSA	LPC
Mental Health Providers	Ratio of population to mental health providers	260:1	290:1		County Health Rankings	LPC

RECOVERY

Recovery Related Organizations	
Young People in Recovery	Community Mutual Aid. Supports young people in or seeking recovery by empowering them to obtain stable employment, secure suitable housing, and explore continuing education. Chapters also advocate on the local and state levels for better accessibility of these services and other effective recovery resources.
12 step NA/AA - District 18	Community Mutual Aid. Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership; we are self-supporting through our own contributions. A.A. is not allied with any sect, denomination, politics, organization, or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes… Narcotics Anonymous is the same model for narcotics.
Animas Alano Club	home to many different recovery-based programs and groups via rental agreements, thereby acting as landlord to those individual groups. The Club serves its purpose by providing an outwardly healthy environment, a venue that is conducive to recovery, a physical location where each group can hold its meetings that allows for fellowship activities before, after, and in between those meetings.
Community Compassion Outreach	Community Compassion Outreach is made up of concerned individuals, faith & nonprofit groups, and local/state/national organizations working together to craft permanent & real solutions to end homelessness.
Manna Soup Kitchen	Food access and resource support. Programs include: Daily meals, job training and life skills, fresh food garden, meals for local students, catering for a cause, and helping hands (resource management). In terms of substance use, before COVID-19, Axis was providing a peer support group on Wednesday nights. These services stopped in March 2020 and have not re-started yet.
In The Weeds	Recovery and additional support for Restaurant Service Industry

Assets

Specific mention was made repeatedly of **Young People in Recovery, Alcohol and Narcotics Anonymous, activity groups (like sober motorcycle clubs), and faith communities**. Each is mentioned as having all or most of the attributes cited earlier as important and helpful by people in recovery. It is notable that clinical care and medication were not mentioned in anyone's view of elements that ultimately made the biggest difference in their recovery path. This is not to say that clinical care and medication doesn't matter but it is important to note that the things that are top of mind fall outside what we traditionally think of within the system of care.

Importantly, as mentioned in the prevention section, there exists an **'underground' peer support network** where people in recovery are connected with each other and with people who are or may seek to move into recovery. 24/7 support is provided behind the scenes (and with little to no compensation) through this network. Incredibly detailed knowledge is also held in this network. This works because trust exists and the power differential is removed; and because there is no threat of judgment or being 'turned in'. "I've been there. You can do this. We'll be alongside you." It seems to work.

Another interesting mention was related to time spent in jail. It was shared that the jail experience allowed them to meet many others in addiction. Getting to know each other, it was clear that nobody wanted the life they had, but they didn't see a way out. As a response, people in recovery now visit the **jail** regularly to talk about what it's like 'at release' and try to connect them to support when release happens.

Below, the need for recruiting, hiring and training is called out as a key challenge. We are fortunate to have at least two groups that will be helpful in this regard. Both Southwest Colorado AHEC and Resilient Colorado have the credibility, experience, and interest in addressing these issues.

Below too, the need for recovery community organization is mentioned. And here too we have some great resources. One of the consortium members leads the state organization and is already working to find funding and bring this to our community. Several other consortium members are also in the loop and ready to work on this. This is just in the early stages, but will allow us to move more quickly.

Challenges
By far, the most oft-mentioned challenges were related to a) Safe, respectful (culturally sensitive, trauma-informed) access at the moment of readiness and b) transitions back into the community that offered social support (including pro-social activities), belonging, purpose. The clinical need most often mentioned was long-term inpatient care. It's simply not existent in any geographically reasonable way.

Access. People mentioned several missed opportunities when they were ready for recovery but the appointment was too far away or they were waiting to be invited to a faith community or they didn't know who to call to get help for their friend / relative. Others mentioned avoiding treatment (that could have led to recovery) because they felt judged or misunderstood. Relatedly, providers varied in their responses to questions about cultural sensitivity. Some were eager to learn more about how they could be responsive but more than a few felt that treating everyone the same and with respect was what really matters. This was often coupled with a desire to amplify the real need as being inpatient care.

"Could more providers here get more culture sensitivity training myself included - Yes! Do I think it even comes close to 5 percent of the issues facing the people in this area in getting the appropriate access to or continuing with help for alcohol and substances - No."

- anonymous provider

"Native Americans are the 2nd largest population of patients coming to Mercy for substance use,... I haven't heard from physicians saying they'd like to receive culturally competent training"

- anonymous manager

"Overall, in La Plata County I would like to see an umbrella training initiative that is a combination of increased awareness around issues such as intersectionality, microaggressions, cultural humility, etc. in the service delivery setting, and also more opportunities for providers to explore their own values and beliefs and also identify how those sometimes fuel provider agenda rather than focusing on client agenda. One of the positive (?) things to come out of COVID is more attention being placed on the painfully apparent disparities in healthcare which exist across our nation. More focus is being directed to delivering culturally competent behavioral & physical healthcare than ever before."

- anonymous provider

One consideration offered to address the simple access component of this within the many constraints would be to amplify the work of the formal and informal peer support networks, perhaps combined with a well-publicized 'hotline'. Beyond that, lots of recruiting, hiring, and training efforts are needed throughout the system.

A note on recruiting efforts for each provider:

a. Axis Health System employs many provider recruitment strategies including the agency website, internal postings, and the pool of qualified interns placed at all Axis locations. Externally we use national job posting sites such as Indeed and Glassdoor, the HRSA workforce recruiter, and posting with the National Health Services Corp (as we are an approved NHSC provider shortage area and serve as a site for loan forgiveness programs).
b. Mercy Regional Medical Center does not recruit specifically around OUD/SUD services.
c. Front Range Clinic recruits through Indeed.com.
d. Colorado Addiction Treatment Services has a small team recruited from the founder's network of clinicians.

Transitions. When people move through a treatment path of any sort in the system, so often they are then simply returned to the environment from which they came. This makes it extremely difficult to maintain sobriety and relapse is occurring. Most lived experience stories shared cited several relapses and this as the primary reason. A huge barrier in this area is the lack of Recovery Housing in our area. This kind of housing need was mentioned by almost every person who shared a story of addiction AND almost every provider of care. Oxford House was mentioned as a model that might fit well in our community. When transitions do work, Young People in Recovery and AA/NA and Faith communities were cited as crucial. Importantly, finding the right match for the person is especially important… any of the three groups mentioned, may not work for some and may work really well for others. There is a lot of agreement that something like a Recovery Community Organization (RCO) could fill this need. A "Recovery Community Organization" is a Colorado concept defined as an independent, nonprofit organization led and governed by representatives of local communities of recovery that organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, or provide peer-run recovery support services.

Inpatient residential care. While this is a treatment, it certainly impacts recovery so we are mentioning it here as well. Like recovery housing, inpatient residential care (up to 6 months) was mentioned by almost every person who had experienced addiction and almost every provider of care. Unlike the other challenges noted in this section, there are no realistic thoughts about how to bring this level of care to our area ...as yet. What we do know is these services are now (as of January 1, 2021) covered for Medicaid enrollees and that there are levels of care involved that providers will need to be aware of when considering IP/residential services for a client. Rocky Mountain Health Plan (RMHP) and the Colorado Department of Healthcare Policy and Financing (HCPF) are working closely to determine reimbursement rates for these services and train and enroll treatment providers. RMHP participates in our consortium so is a good resource to track opportunities. Ideally, we would have a continuum of care/recovery proactively managed by a case manager (or similar) to meet the unique needs of each individual.

ADDITIONAL INFORMATION

(from specific questions and items that cross over prevention / treatment / recovery)

Access to OUD/SUD harm reduction services including human immunodeficiency virus/hepatitis C (HIV/HCV testing and treatment

- What assets exist that can be built upon?

  Both San Juan Basin Public Health and Planned Parenthood provide harm reduction services and are consortium partners interested in supporting any of our strategies that speak to this issue. Additionally, we have a strong network of people 'in the field' (visiting parks and streets where people may appreciate having harm reduction strategies in place). These individuals have created trust that will be helpful with strategies.

  Needle Exchange Sites.

The closest Needle exchange sites are Grand Junction, Carbondale and Del Norte, Colorado. Planned Parenthood and San Juan Basin Public Health are both exploring options for this locally. Through the consortium work, we were connected to a state offered mail-in sharps program that will help us locally address an immediate uptick in need.

HIV/HCV testing and treatment.
These are available through Planned Parenthood and San Juan Basin Public Health.

Medication Assisted Treatment.
MAT services are offered at La Plata Integrated Health Clinic, Front Range Clinic (MAT available to youth who are 'emancipated' (homeless / pregnant) or come with parental consent), and Colorado Addiction Services (which also does Methadone maintenance). Axis also has an Integrated Dual Diagnosis Treatment program that focuses on harm reduction for those with co-occurring disorders, and the Axis general SUD treatment program does not require complete abstinence, taking a harm reduction approach when appropriate.

Naloxone Distribution and Access

SWCAHEC has a standing order for Naloxone and currently has free Naloxone (Nasal Narcan and injectable Naloxone) from the Colorado Department of Public Health and the Environment to distribute free of charge to participants attending our Naloxone training. They provide training to healthcare professionals and community members (target groups including people experiencing homelessness and area tribal partners). They are also reaching out to the homeless population in Durango and educating them about opioids.

According to SAMHSA's Buprenorphine Practitioner Locator, there are 6 practitioners within 25 miles of the 81301 zip code who are authorized to treat opioid dependence with buprenorphine. All 6 of these providers are located in Durango.

On September 1, 2020 all Centura Health hospitals, including Mercy Regional Medical Center in Durango began providing free Narcan/Naloxone take home kits to patients.

Walmart pharmacy (Durango) is providing Narcan.

Law Enforcement Agencies Trained/Receiving Narcan (Date First Trained/Given Narcan)
- Bayfield Marshal (2018)
- Durango Police Dept (2016)
- Fort Lewis College Police (no date)
- Ignacio Police Dept (2019)
- La Plata County Sheriff's Office (2016)
- Southern Ute Division of Game (2016)

The good news is that while the Colorado Department of Public Health and Environment (CDPHE) has not had any luck getting a new medication drop box site, they are interested and available to support moving this forward for Durango. We know that Lynette Myers would be the point of contact for getting more drop boxes into La Plata County.

Colorado Consortium for Prescription Drug Abuse Prevention
- 2017: Conducted a Narcan training at southwest AHEC in Sept. Small attendance. Participated in a Community Health Coalition meeting and gave a really brief overview of what the Consortium is/resources available. Distributed naloxone brochures and Take Meds Seriously brochures at both of these events.
- 2018: Conducted a community Narcan training at the Durango library to community members. Distributed naloxone brochures and left some with community agencies who attended. Held a Provider Education event that was well-attended in Durango on chronic pain and opioid prescribing. Passed along IT MATTRS info along for distribution to area providers about getting trained on MAT. Along with Chief Brandt, provided training at the Southern Ute Detention center in Ignacio

- 2019: Front Range Clinic gave a Narcan training for International Overdose Awareness Day in Durango in Buckley Park.

- Is there an unmet need i.e. are more people seeking services than can access them? How do you know?
  Interviews suggest that there are people who have interest in seeking services but are either unaware that they exist, where they exist, or the offering of the service isn't at the ready when they are ready. Interviews also suggest that providers have a really really hard job and huge hearts. Oftentimes policies are necessary *and* get in the way of recovery paths. Having a group where the system impacts can be reviewed will be important. Case studies could be really helpful with families and providers across the continuum can share their experiences. Examples are below.

  Provider perspective: Inability to access services includes lack of financial resources, inability to access frequent transportation for MAT dosing, and unwillingness to participate in accompanying counseling for participation in a MAT program.

  Family perspective:
  "As I think of harm reduction I think it is important to highlight the harm reduction philosophy as being a cornerstone of our needs/plans to reduce barriers to treatment that are currently present. I can list examples of barriers my son encountered when he tried to get help with his opiate addiction that did not follow a harm reduction model. He was turned away from the MAT program at Colorado Addiction Treatment Services because he was having trouble staying off alcohol while in treatment for his opioid addiction. He was told he would have to talk to the doctor to be able to continue getting his suboxone from them but the doctor was not readily available so his treatment plan fell apart and he resorted to buying suboxone from friends instead of getting help with his co-occurring opiate and alcohol addiction. He also reached out to our family doctor but was just referred back to CATS/SRATS and no further help explored or offered. He would have been about 26 or 27 when all this happened.

  When a person is at *any* stage of considering or participating in treatment for OUD/SUD there should be no barriers or obstacles to getting treatment. If an individual is not able to stay clean we should not turn them away and consider them as having failed, instead the providers should research other ways to help that person and consider that the root cause of their use is not being addressed. A program with harm reduction would not turn people away for continuing to use or struggle in any way but would allow a second chance and a third chance and more. Treatment is not a one size fits most approach. Warm handoffs are imperative to connect people with OUD/SUD to appropriate treatment providers and there should be subsequent follow up to be sure the connections were made and relationships and treatment is being fostered."

- Are there barriers that keep people from accessing naloxone, needle exchange, and HIV/HCV testing and treatment?
  Yes, stigma and distribution of services. There are no local needle exchange sites.

  There are no outreach testing services so transportation becomes challenging. Further the reimbursement structure seems to be a barrier to having this more widely available. One provider commented "I tried to get testing done in my clinic over 2 years ago however, due to Medicaid's reimbursement structure, we would lose money giving the tests. I currently have many untested very high risk patients."

  Narcan is currently carried by first responders (Fire / EMS / LEO). However, there is a belief that it creates capacity to increase use so there is little interest in providing it.

Opportunities and gaps in local systems for engaging of people who use drugs, screening, diagnosing, and referring to treatment and other support services;

See above in Treatment Section

Include number and description of agencies that screen, diagnose, and refer to treatment

Mercy Regional Medical Center	Mercy Regional Medical Center is an 82-bed, acute-care hospital in Durango, Colorado. Mercy was founded in 1882 but has grown to become Southwest Colorado's largest and most technologically

	advanced medical facility. It is the only hospital in the region to receive a five-star rating for overall hospital quality. Mercy's areas of specialty include orthopedic and spine surgery, cardiology, emergency and trauma care, cancer care, and more.
Axis Healthcare System	Integrated Health Provider Details: - Treatment Provider - serve individuals across the lifespan Services Provided: Primary Care, Oral care, Mental Health & Substance Use Treatment, Crisis Care, Care Coordination, Acute Treatment Unit, withdrawal treatment (Social), Drug & Alcohol Monitoring, Community Services, Healthcare for the Homeless, Peer Recovery, Senior Reach, Insurance Enrollment Services, and Jail-Based Behavioral Health Service.
Regional Accountable Entity (RAE)	The Regional Accountable Entity (RAE) in region 1 which includes La Plata county, provides care coordination for individuals enrolled in Medicaid. The following four entities have the ability to refer patients/clients to the RAE for care coordination: hospitals, our public health department, social service agencies and FQHC (Axis Health System). They provide care coordination for individuals with social, emotional and medical needs, including individuals with a substance use disorder. Care coordinators can screen for substance use and connect individuals with treatment or recovery services in their community. They collaborate with the referring agency and the services are voluntary and for as long as the patient/client needs them. A gap in La Plata county is a choice where individuals want to go for treatment.
San Juan Basin Public Health	Preventing disease & disability, Promoting healthy lifestyle choices; Preserving and restoring the environment; Assuring basic health services for all people. Also HIV / HCV testing and treatment and needle exchange sites

Issues impacting the OUD/SUD health workforce, including recruitment, retention, and worker capacity/skills;

- Is there a shortage of mental health and substance use workforce? If so, why? Salary, benefits, training, etc.

We are a HRSA-designated health professions shortage area and behavioral health services are included in that designation. It is actually the health profession with the highest ratio of patients to providers.

According to the SWCAHEC clinical partners and conversations in the Southwest Colorado Healthcare Sector Partnership Alliance, the issues related to recruitment and retention are related to:

- Salary to cost of living ratio (unfavorable in our area),
- Lack of resources for referral, case management and follow-up,
- Little training in the area of healthcare provision in rural settings,
- Difficulty with insurance reimbursement and PPOs, etc.

According to the 2018 Bureau of Labor Statistics Colorado Healthcare Salaries, the annual mean wage for "Clinical, Counseling, and School Psychologists" in Southwest Colorado nonmetropolitan area was $62,760, as compared to $88,340 in the Denver/Aurora/Lakewood area of the state.

- Are there Drug Addiction Treatment Act (DATA) waivered physicians in your area?

As noted above, according to SAMHSA's Buprenorphine Practitioner Locator, there are 6 practitioners within 25 miles of the 81301 zip code who are authorized to treat opioid dependence with buprenorphine. All 6 of these providers are located in Durango.

- Are there credentialed individuals in your area: counselors, psychiatrists, Nurse Practitioners, licensed alcohol and drug counselors

In February of 2021, the Colorado Department of Public Health and Environment (CDPHE) reported an estimated:

- 6 licensed addiction counselors in LPC, which is a rate of .1 per 1,000 residents
- 25 certified addiction counselors, which is .5 per 1,000 residents

- 125 licensed professional counselors, which is a rate of 2.2 per 1,000 residents
- 4 advanced practice nurses with a speciality of psychiatric / mental health which is .07 per 1,000 residents
- 28 registered psychotherapists, which is .5 per 1,000 residents
- 112 licensed clinical social workers which is 2 per 1,000 residents
- 14 psychiatrists which is .25 per 1,000 residents
- 26 clinical psychologists which is .46 per 1,000 residents
- 11 marriage and family therapists which is .2 per 1,000 residents

Note: while these numbers are better than the majority of other rural counties, they are still likely not sufficient.

More above in the Treatment section for additional info about the challenges and efforts related to recruiting and retaining credentialed individuals.

- What are the workforce's training needs?

Training needs are many and include:

- Trauma-informed care
- Cultural sensitivity
- Motivational Interviewing
- Latest therapies to treat/heal from trauma and substance use
- Substance use screening such as SBIRT
- Promoting diversity in healthcare and behavioral healthcare professions
- Effective management of chronic pain (we have a high percentage of patients prescribed long duration opioids who had not had an opioid script before). This would include physician prescribing and conversation and reviews of the CDC guidelines about prescribing long term opioids for non-cancer pain syndromes and the very small population of patients for which it is indicated. This would be part of a physician-led training about prescribing guidelines and best practices (SWCAHEC does one and it is well received) – there is still work to be done about prescribing opioids in our region.
- When a PCP should refer to a specialist. It would be important here to use someone who understands practicing in rural areas with few specialists and what the options are (ie telehealth – keeping in mind the special needs around prescribing controlled substances via telehealth post- COVID-19 waivers, etc). As of right now, we have few pain specialists and, though Mercy is trying to rectify this through training their staff, it is still difficult to refer.
- How to discontinue/taper Benzos. This is also related to prescribing guidelines- there is also the issue of having patients on both Benzos and Opioids which is dangerous but still happening in some practice arenas.
- Managing ADHD with Rx stimulants. Primary care providers come down on different sides of this.
- Treating stimulant disorders (need to vet this with Dr. Caplan)

The Southwestern Colorado Area Health Education Center (SWCAHEC) has initiatives to create, recruit, and retain healthcare workforce. SWCAHEC works with area high schools, community members, health professions students and healthcare professionals to provide education and training related to serving rural and underserved populations in all areas of healthcare. Supported by HRSA funding from the University of Colorado for their pipeline work, SWCAHEC also has HRSA funding for Opioid Education, Naloxone training, substance abuse stigma reduction, and Opioid use prevention and training with tribal communities. They have physician-led training about the opioid topics and would be happy to offer it when needed. They would also promote and support training in any areas we feel are relevant to our work ahead.

Additional workforce statistics include:

- Less than 40% of rural primary care providers* remain in the same rural community for 5 consecutive years.
  *Indicates providers placed and surveyed by the Colorado Rural Health Center.
- Of all active, licensed registered practitioners, rural Colorado receives only:
  - 10% of the dentists (18% less than urban)
  - 9% of the physicians (33% less than urban)
  - 5% of the psychologists (67% less than urban)

The Colorado Behavioral Health Assessment recently summarized their findings in this way. There is strong alignment to what we have found locally:

- The need for more community based and co-located services
- "The middle is missing": Subacute services, or those that fall between traditional outpatient and more intensive inpatient services
- Acute care in rural communities
- Recovery and sober housing – including for individuals with criminal justice involvement.
- Crisis services – concerns or confusion over shifts to the ASO system
- More complete and standardized SUD continuum of care including MAT.
- Robust outpatient care management programs and expanded high intensity treatment programs such as outlined in SB19-222.

Since the COVID pandemic hit, per interviews, it seems that resources have become less available due to agencies experiencing resignations, layoffs and overworked healthcare professionals and community health workers, as well as case managers. This makes it difficult for people to thrive in a professional working environment by overload of client care. It also makes it difficult for clients to have access to care.

Needs of special/vulnerable groups within the target rural service area, such as pregnant/parenting women, adolescents, racial/ethnic minorities, incarcerated/formerly incarcerated individuals, etc.

- Pregnant / parenting women… are there locations and specialty services for pregnant / parenting women who need treatment?

The rate of newborns addicted to opiates rose 83% in Colorado from 2010-2015. The problem is even more critical in portions of southern Colorado. (2020 Colorado Rural Health Snapshot)

While notable in Colorado generally, this was not raised as an issue here through subjective or objective data sources. That said, we want to keep it on our radar in case it has simply slipped through the cracks.

- Are there locations and specialty services for adolescents who need treatment?

Not in our region or La Plata county. The closest inpatient residential treatment centers for mental health issues are in Utah and Denver.

- Racial/ethnic minorities: what are the trends? Are there groups that are under or overrepresented in the treatment population?

According to EMR data from Mercy Regional Medical Center, the hospital serving La Plata County, the American Indian/Alaska Native racial group makes up 29% of alcohol and drug-related abuse/use/dependence, while making up only 7.7% of the general population. An entire section below is dedicated to this priority population.

While not a race/ethnicity, LGBTQ+ is a priority population and this demographic information is not collected in EMR data. The question is complex as well. Data does show that this population avoids seeking care due to fear of mistreatment. In a 2015 Transgender Survey, 23% avoided seeking care for this reason. Anecdotally locally this is supported and may be particularly so with the only available medical center not yet having any LGBTQ related policies in place. The R9 School District data is heart-breaking and shared in the LGBTQ specific section below.

Native American Community

Challenges: Native Americans are rarely if ever able to see a Native American clinician or a culturally informed clinician for any type of clinical care. Native Americans report feeling most comfortable at Tribal meetings where there are many Native people and least comfortable at meetings off reservation where they are often the only Native American at the table.

It was universally shared that moving through the very white community was uncomfortable... palpably. This is more than notable and evidence shows that this kind of stress impacts the length of telomeres which impacts length of life.

Further, outside of the Reservations, there are no treatment or recovery options specific to this population. A recent stakeholder meeting by Health First Colorado, the state Medicaid agency, found that there are no culturally-sensitive residential treatment centers for Native Americans in this area. While there is a Cultural Center(s?) on Tribal land, there is no place like this in Durango for people who live there.

On the Southern Ute Reservation, it was shared that for some time a structure to support healing didn't exist. Now the Southern Ute Health Center has such a structure. The tools available for community input are new to the Tribes and it takes time. Time is needed to build trust and get community input before jumping to solutions. Often, the funding requirements don't allow for this investment of time. Dominant culture values of moving quickly to action are missing the beauty and strength of Native culture that values relationship, trust, and responsibility.

In the Tribal workforce, many are not Native American and are Anglo. In Durango, there is a lack of diversity in many substance use and behavioral health professions, as well as healthcare professions. Both situations create an additional hurdle of educating around cultural sensitivity and historical trauma.

According to one interviewee from Ignacio, "There's an invisible wall between Ignacio and Durango. Durango has so many resources and an interest in helping. So much training and meetings and resources. But somewhere in that 20 miles between towns, that connection is missed."

The local newspaper, The Durango Herald has addressed issues of racial tensions within the community of Durango, in an article written in 2015 by Ann Butler, headlined as "It is time to start the conversation." In this article, there is a brief historical analysis of how racial tensions begin in Durango and La Plata County. There are four different groups that were mentioned, African-American, Hispanic, Native- American and Asian. In the article, the Director of the Native American Center (NAC) at Fort Lewis College addressed that Fort Lewis College offers the Native American Tuition waiver for students. The director shared that most Native American people come to the NAC for support regarding issues within the community. This supports the idea that Native Americans of all ages should have access to a Native American Center off a college campus, and within the community of Durango.

Five years after the above article, a meeting took place with the Community Relations Commission and a dozen community members of Durango. In the article, it stated the following, "Community members gave personal examples of institutionalized racism in Durango, including the totem man sculpture on Ninth Street just west of Main Avenue, a lack of inclusiveness at the Durango Welcome Center and a shortage of law enforcement who empathize or identify with people of color." At the same meeting, a community member shared, "Do we continue with the same mindset or do we decolonize ourselves?" Brown said. "There's no one to blame, there's only opportunity to do better and think outside the box."

Native Americans expressed feeling unseen or excluded in almost every non-Tribal setting. Providing a center off tribal lands, could be used as a gathering place for Native Americans, while offering a sense of belonging, and would provide opportunities for healing and resilience. Using this space to create and offer education / training / experiences for non-Natives to learn about cultural sensitivity could be an important contribution to fighting stigma in a meaningful and lasting way.

Assets: The Native American community here is strong and resilient having survived the many and generational traumas inflicted through colonization. One of our consortium members already has a program plan for a Cultural Center which would create more spaces for self-determined approaches to healing.

Structures exist. Southern Ute Tribe does have a Native Connections Coalition but it stopped because of COVID-19. The plan was to build the advisory group for strategic planning using the SPF framework or Communities that Care Framework. This work intends to get as many people as possible to discuss the issues and lay out the foundation of how to start resolving it and put in the work to build those strategies which include the readiness survey and other things. But, the Tribes need time, space and resources to do the necessary educating around trauma and historical oppression and to build trust to get authentic input about what to do.

Models exist. In one interview, someone shared an experience participating in a Navajo Nation Behavioral and Mental Health weeklong summit where clients shared their experiences as losing a sense of self, where they came from and who

their Native American relatives were, also loss of language and cultural teachings. Some of the treatments for SUDs were sweat lodges, talking circles and even gaining cultural awareness to establish cultural identity that was not felt by clients who struggled with addiction. Learning or relearning their language, cultural teachings and getting connected with the Native American traditional counselors helped them establish cultural identity. This was the beginning of their pathway to sobriety. Maintaining sobriety was difficult and it took guidance and attending Native American influenced SUDs treatment to assist them in their addictions and recovery.

Resilient Colorado's training, when offered collaboratively with the Tribes, have shown they can support healing, pride and self-determination. When offered to non-Native community members and providers can improve the understanding of the impact of colonization and thus contribute to reducing stigma experienced by this demographic. All of this could lead to more awareness of, and actions taken on, the barriers that need to be removed for prevention, treatment and recovery.

We even have an actual program plan for a Native American Cultural Center (NACC) conceived of and developed by Imo Succo, MSW / Member of Navajo Nation, a consortium member.

In general, the goals of the NACC are to build a sense of community by creating inclusivity with NA populations among the community of Durango and to build professional relationships with community organizations throughout Southwest Colorado. The vision is to provide a safe mental space for Native American populations when they are having a difficult time adjusting to social interactions within the community.

The NACC would provide Native Americans (NA) and those who have interest in NA communities, with understanding of acclimating to the City of Durango. The program will provide information to NA clients for community resources to meet their basic needs, have access to an onsite therapist or counselor, promote cultural awareness and traditional elder teachings universally. The center's onsite certified counselor or therapist may see clients to address any behavioral health or substance use disorders and refer them out to agencies who may assist clients on a regular basis. The therapist may also assist other therapists in connecting with a Native American client. The therapist should have a Native American/Alaskan Native or Indigenous background. The center will sell Native American cuisine daily, profits will go back to the center and possibly assist NA families when emergent needs arise. The center will also provide culturally relevant material and training to those who seek knowledge of NA communities. Cultural gatherings and events will be held in honor of surrounding NA tribes in the southwest. The estimated budget for such a center is approximately $500,000.

Further, SAMHSAs Native Connections 2017 Fact Sheet "Opioid Misuse and Overdose Prevention in Native Communities"
offers a list of prevention practices, recommended by experts and tribal leaders, being used across the country in Native communities. Practices cited include:

- ***Institute overdose protection programs.*** Raise community awareness about using life-saving drugs for opioid overdoses and for recovery from opioid addiction with involvement from medical providers, first responders, and law enforcement are effective strategies.

- ***Strengthen culture.*** Methods for strengthening culture include a campaign to encourage participation in cultural activities, creating communal/community gathering spaces, promoting traditional foods with cooking and health education, and sponsoring sober community events and cultural ceremonies. Additionally, integrating ceremonies and language into everyday life strengthens culture, as do language immersion opportunities.

- ***Reach youth early.*** Research shows substance misuse rates for AI/AN youth are significantly higher than national averages. For example, binge drinking and OxyContin use among AI/AN youth start earlier than non-AI/AN youth. Given these elevated risk factors, reaching AI/AN youth before eighth grade for prevention activities should be considered.

- ***Address chronic pain.*** Availability of alternative pain management strategies and Chronic Pain Agreements helps moderate prescription drug use.

- ***Strengthen culture in educational settings.*** Including cultural elements in school curriculums and afterschool programs is an effective strategy. Fostering better relationships between tribes and public schools may be

necessary before these goals can be achieved. Programs such as youth mentoring and parent education through culture can also be developed via educational settings.

- ***Improve access to culturally-based services.*** Medical services providing chemical dependency, mental health, and suicide prevention assistance can add a cultural perspective to treatment. Traditional healers can be employed to reduce harm, promote health, and encourage self-care for practitioners.

- ***Strengthen community leadership.*** Focus on strengthening leadership through elder wisdom, youth experiences, pairing elders and youth, building community organizing skills, and celebrating and recognizing individual and community achievements and successes. Raising tribal leadership awareness of prevention efforts may help contribute to sustainability.

- ***Collect specific data.*** Tribes and other organizations should invest in data collection on prevention practices and outcomes, so leaders and decision-makers can access, analyze, and evaluate strengths and risks for programs and populations. Evaluation research on culturally-specific practices needs to occur so best practices can be established.

- ***Address trauma in community.*** Promote understanding of trauma-informed practices in agencies and tribal leadership. A guide for trauma-informed care can be found at https://store.samhsa.gov/shin/content/SMA14-4816/SMA14-4816.pdf. Also, consider Adverse Childhood Experiences (ACEs) when planning prevention practices. Additionally, understanding trauma and traumatic experiences can be incorporated in family and community education. More information about ACEs can be at https://www.cdc.gov/violenceprevention/acestudy/index.html.

- ***Intentionally organize for change.*** Convene summits around prevention that include stakeholders, government agencies, and community entities.

LGBTQ+ Community

Challenges:

The data in this area are heart-breaking. This information is from the Healthy Kids Colorado 2017 survey specific to the R9 School District.

Measure	**Heterosexual**	**Not sure**	**GLB**
Skipped school due to feeling unsafe in the last month	4.4%	14.1%	7.9%
Been electronically bullied last 12 months	16.5%	25.5%	27.8%
Been bullied on school property last 12 months	20.3%	27.8%	32.3%
Could ask parents / guardians for hep w personal problem	86.6%	78%	67.5%
Have chances to do fun things with parents / guardians	81.6%	79.1%	65.6%
Parents ask them what they think before family decisions	71.1%	68.9%	46.7%
Self-harmed without wanting to die	13.2%	NA	42.9%
Felt sad or hopeless almost every day or 2+ weeks	26.5%	48.5%	68.6%
Seriously considered attempting suicide in the past 12 months	13.5%	26.3%	40.3%
Attempted suicide in past year	6.1%	17.5%	25.1%

Mostly As and Bs in past year	77.5%	79.4%	68.6%
Feel safe at school	89.6%	83.9%	79.5%
Hated being in school over the last year	39.4%	33.9%	48.2%
Try to do their best work over the last year	75.3%	80%	54.8%
Ever used cocaine	5.5%	10.6%	14.1%
Ever used inhalants	4.4%	10.4%	16.1%
Ever used heroin	1.6%	5.3%	4.3%
Ever used methamphetamines	2.5%	5.9%	5.8%
Ever used ecstasy	3.8%	11.2%	13.5%
Alcohol use in past month	31.3%	30.7%	49%
Cigarette use in past month	11.2%	13.2%	28.2%
Marijuana use in past month	23%	24%	43.9%
Prescription meds w/o prescription	10.1%	17.7%	21.4%

When the word thriving came up in the context of our vision, the LGBTQ input was "we're barely surviving much less thriving… we need basic needs met." The Health First Colorado stakeholder meeting noted above still holds that there are no treatment or recovery options specific to this population either. The Office of Behavioral Health for the Colorado Department of Public Health and Environment worked with Omni to do focus groups across the state. One of our consortium members facilitated some of these groups. One of the themes shared in these groups was that people want to see providers that reflect the community: LGBTQ+, Black, Indigenous and People of Color (BIPOC) and others. For LGBTQ+, these people and their loved ones often become educators and are often not ready for, or desire, this role.

Resilient Colorado serves on our consortium and has done training with several LGBTQ groups. Through that experience we also understand that there is a severe lack of providers who understand queer people in this region. Recognizing that straight people can provide sensitive care, there will always be a barrier. One person shared, "The last time I went to my provider, the intake form asked about my sexual preferences and history- Good for them for not assuming they know. I clearly marked that I am a lesbian and am exclusively with women. However, when I got to the exam room my provider asked me what I use for birth control. Clearly, my provider was trying to make an effort. However, they missed the boat because the entire clinic isn't culturally responsive. Providers are overwhelmed and encouraged to get patients in and out at a rapid pace. Even at the best clinics in town, implicit bias, heteronormativity, and cisnormativity are blatantly obvious." Some have shared that they can navigate it just fine, but many don't have the resources or they simply tolerate it. Another interview statement, "Our entire healthcare system needs to be revamped for trans folks. Everything is binary M/F. Even the healthcare data we have shows statistics for "GLB" (Gay, Lesbian, Bisexual) … no T (Transgender), or understanding of Nonbinary, Intersex etc. if this were to happen, it would improve patient outcomes for all patients, not just transgender patients. Culturally responsive healthcare should be the norm for all people, not the exception.

From an October 2020 American Heart Association article: "More than half (56%) of LGBTQ adults and 70% of those who are transgender or gender non-conforming report experiencing some form of discrimination, including the use of harsh or abusive language, from a health care professional." It goes on to say, "Accrediting bodies and organizations responsible for health care professional curricula have not specifically required LGBTQ-related content, thus very little exists in health professional education training. A 2018 online survey of students at 10 medical schools found approximately 80% of students did not feel competent to provide care for transgender patients. Another study of more than 800 physician residents

across 120 internal medicine residencies in the U.S. found no difference in knowledge between the baseline and post-graduate years when it came to LGBTQ-specific health topics. The statement notes that the Accreditation Review Commission on Education for the Physician Assistant began requiring LGBTQ curricular content in September 2020."

Further, parents of Transgender youth are really on their own to piece together resources. It's exhausting. There are only two queer therapists (known to our sources) regionally and anecdotally they are overworked. People on hormone replacement therapy (HRT) also have limited (no?) resources. If they go to a general care doc it's not within their training or experience and so they don't know how things interact with HRT.

There are a lot of subgroups within the queer community, especially locally. Young adults, Fort Lewis College students, older adults. They each have very different experiences. While some have figured out how to navigate the obstacles, others with limited resources struggle daily. This is especially true for LGBTQ+ people who are also BIPOC (Black and Indigenous People of Color) and/or disabled. Constantly advocating for yourself and educating others can be exhausting. They are also very likely not to get service from either medical providers or call the police when needed. Mainly because they "get treated like shit when they do."

People are looking for a place where they feel recognized, safe and respected. There will be opportunities through this project to identify clinics and hospitals in our community that can be responsive to the unique needs of the LGBTQ community. MRMC has provided physician training around treating transgendered individuals and time will tell if it will be able to fully meet the unique needs of the LGBTQ community due to its Catholic beliefs.

Assets: From an LGBTQ+ perspective, resources DO exist. Rainbow Youth Center of Durango, the Four Corners Diversity Alliance, Southwest Rainbow Youth, and Prism Flc (Queer / Straight Alliance at Fort Lewis College) are active both in person and through Facebook Groups and other virtual offerings. Additionally, the 4 Corners Support for Transgender people, Allies, and Relatives program (4STAR) is active and founded by the only trans provider in the area. Investment in the support and growth of these may be worth considering. Also, Resilient Colorado training for the community could have a significant impact on reducing stigma.

Another asset is the LGBTQ+ community itself. Even though there are lots of sub-groups within this community, there is good support for one another. If we could weave this internal support and connection with community resources that are culturally responsive, positive things could happen to support the entire community at large.

Resilient Colorado also has colleagues at Truman Medical Centers in Missouri who have opened an LGBTQ integrated healthcare clinic. It is culturally responsive and trauma-formed throughout the clinic. For example, Transgender people answer phones and do patient intakes. Imagine how much more comfortable one might feel when someone with a similar life experience is the very first person you interact with? We have the contacts and opportunity to learn from this model and possibly replicate it in La Plata county.

- Incarcerated / formerly incarcerated individuals: are there linkage services available? Are there MAT services available?

From an interview, "When I did get into the jail system with significant time, it really opened my eyes to all these men who are people, sons, fathers, professionals, community members…. immediately classified as criminals. I've been looked at that way my whole life. It's hard to get away from that… to get back into society and have that support after the fact. Right now, there is no support AND everyone is looking at you as the enemy."

This person went on to observe, "There is this jail to prison moment. Recidivism is high. BUT while in jail, maybe 10% actually want that life. Most really do NOT want it. They want happiness. While in jail many are sober and that's what they want to continue. But the only thing that awaits them when they get out is the same lifestyle they had. There is no new world. Recovery Housing and support services would be huge!"

And here is where it is well worth sharing a longer version of this person's story in their words. It speaks to the jail experience, to community (peers), to purpose and more….

In July of 2017 at around 9 months of being sober (not by choice and definitely not wanted) I met Candice through another friend. Though I had been in and out of A.A. and N.A.'s rooms my whole adult life, they never worked for me. It was court ordered and the approach was not appealing to me at all. Candice, I and 3 of our friends met that July (2017) and discussed different avenues to help us stay sober. There was not much in Durango. We created "Plan B". A small group of like-minded individuals. We hit the ground running. Started organizing BBQ's and pro social events, supporting each other. It worked! We connected with one another. My life had purpose again.

Unbeknownst to Candice in late August I was sentenced to 12 years (7 months County time, 2 years of work release and 9 years' probation). I was ashamed of what I had done and was too embarrassed to share that with most people. While incarcerated, however, I did keep close tabs on Candice and she had kept our vision rolling and founded Young People In Recovery, a nationally recognized non-profit organization that aligned with our morals, values and mission statement.

While I was incarcerated in La Plata County I worked very hard on my sobriety. I read so much on addiction and self-development and started mentoring other inmates. I found my calling. My 12-year sentence still loomed over my head, but what I was doing for our inmates in county jail was not going unnoticed. I filed for reconsideration and got it! I was to be released and had to do 2 years at Hilltop House (Community Corrections) with 10 years' probation.

I was so excited for the opportunity to link back up with Candice and help her against this Monster that had almost killed us both. I was back! I was on a short leash, but I was able to contribute again to Young People in Recovery. I kept mentoring individuals at the Hilltop House and it worked! I had met most of these men while incarcerated. A handful of them are still sober today. This did not go unnoticed either. After a year, I filed for another reconsideration and received it, with the condition that I go back to Albuquerque and deal with the consequences of my 3rd D.U.I.

After doing 60 days in an Albuquerque jail cell I was back in Durango and flourishing in my recovery. Addiction had taken everything from me: my job as a manager at Purgatory, the relationship with my children and loved ones, all my earthly belongings, and my reputation. After incarceration, I came into our society with nothing except my recovery and the support of Y.P.R and all of the people struggling to stay sober. Hilltop house was a blessing. Without a roof over my head and coming back into society with nothing, I am not sure I would have been able to stay sober. This is where I was lucky. The two major keys to a successful recovery are a healthy environment and support. Getting sober is by far the hardest thing I have ever done in my life.

Keeping the above story in mind (which is indicative of several we heard), we now turn to the provider side of things where we find many resources in place. While it seems we do have programming, there is certainly room to learn more about how we might enhance care transitions. It seems peer recovery supports and recovery housing would be critical for consideration.

<u>Jail Based Services (provided by Axis Behavioral Health)</u>
A major goal of this program is building relationships to help inmates engage with support systems after release. Services include initial assessment of all inmates' behavioral health needs, established groups based upon assessment, with a focus on criminal thinking- strategies for self-improvement and change. The jail population is made up of three primary groups: individuals awaiting trial, conviction, or sentencing, sentenced to a period of incarceration, or those accused of violating probation or parole. A team of behavioral health providers provides services.

This mixed population can make planning for programs, release, and reentry challenging because each group has a different set of needs. Programming space had been an issue until last fall when the jail administration was able to locate space in an adjacent facility. An overwhelming majority of the jail population is in jail only briefly and unpredictable release dates for individuals in jail adds another challenge to delivering programming and devising a post-release treatment plan.

Note: From a lived experience perspective, the mixed population is important but in a different way. Read on…

"When I was incarcerated in La Plata County I was classified and housed in the 1100 cell block. Which is kind of a non-violent classification pod. I think they are able to house 74 inmates there. It is an open pod with no privacy. No doors except the one you enter to gain entry into the pod. There was everything from people with possession charges to people awaiting trial for armed robbery or even rape. Men who were going to be released within 24 hours to those sentenced to the

maximum one can be sentenced to in-county jail, 3-years. One thing I noticed is the ones that were serious about their recovery or trying to work on bettering themselves were often sucked back into "criminal thinking" by the other inmates. I also had the pleasure of going through a recovery coach training with Ed Aber (sheriff's department) and 2 correctional officers. This was back in Jan of 2020. I know Ed would support something in terms of in house treatment. I think if possible having a separate pod. A "Recovery Pod" would be amazing to have. For those who are serious about getting and staying sober this could be a game changer. Putting them in a healthy environment with other like-minded individuals. Where Axis or Y.P.R or whomever could provide some type of recovery program while in the jail system until they are released. Then hitting a possible jail transition program."

The jail also has a third-party contractor providing Medication Assisted Treatment (MAT) services, and the County is considering pursuing the implementation of a MAT program in the jail.

Jail Transitions Program (provided by Axis Behavioral Health)
The goal of the program is to intensively support inmates upon their release from county detention facilities, with the goal of successful engagement in outpatient services and reduced recidivism. The Jail Transitions team is also available to support youth coming out of detention or youth corrections, and working with the local SB94 (SB94 refers to the Colorado Youth Detention Continuum) team to divert youth out of corrections and into treatment. This program targets inmates and youth with mental health, substance use disorder, and co-occurring diagnoses and provides intensive support to individuals upon their release for up to three months with referral and warm hand-offs to ensure a comprehensive care plan for their release. Upon release, intensive services will be provided to support behavioral health recovery and to ensure there are no gaps in care (i.e.: obtaining needed psychiatric medication).

Jail Based Behavioral Health Services (JBBS) staff screens / evaluates patient needs during incarceration at the county jail and, as they are released, sets them up with follow up appointments for recommended treatment, which might include MAT. They are then followed by the Jail Transition Team. If they are from SW Colorado and do not already have a MAT provider, they are referred to La Plata Integrated Health in Durango, Archuleta Integrated Health in Pagosa Springs or Cortez Integrated Health in Montezuma County. In La Plata County, if they do not already have a general SUD provider, they are referred to Axis Health System (at La Plata Integrated Healthcare or Columbine) for Enhanced Outpatient (EOP), Peer recovery support, Integrated Dual Diagnosis Treatment (IDDT), Women's Group, etc. If a patient has a very severe OUD or requests methadone maintenance, a patient may be referred to the Colorado Addiction Treatment Services (CATS) program for methadone. Many times a person is released unexpectedly, which can be a common occurrence at a county jail. When this happens, we also have the Jail Transition team to outreach the individual, do an initial evaluation if one has not been completed, and make recommendations/referrals. The majority of patients coming out of jail have NO insurance/payer source, so we usually set them up with AHS while we work to see what resources they are eligible for, which is often Medicaid.

Services Provided: Intensive case management and therapeutic intervention post release, identifying and addressing any barriers to treatment and developing a comprehensive treatment plan to be implemented upon release. Case management supports are key, including finding housing, employment, filling basic needs, benefits acquisition and accessing medical care. Treatment plans target mental health, substance use treatment and co-occurring needs, medical care, basic needs, vocational supports and social supports.

As for the details, yes, there are 3 MAT providers, now called Medication Opioid Use Disorder (MOUD), in La Plata county. One is with Axis Health System (our FQHC) and another one is with The Front Range Clinic and one is with the Colorado Treatment and Addiction Services (CATS).

As noted above, there is an informal network of people in recovery who visit the jail regularly to share the care transition experience and where to find services. That said, this is not formalized or resourced.

Underlying social determinants of health that are most significantly relevant to SUD/OUD within the target rural service area

Economic Stability	Education	Health and Healthcare	Social and Community Contexts	Neighborhood and Built Environment
• Employment status • Expenses/ debt • Food security • Housing stability • Income level • Occupation • Poverty	• Access to quality education • Access to media and emerging technologies (e.g., cell phones, the internet, and social media) • Early childhood education and development • Educational attainment • Language/literacy • Vocational training	• Access to health care services • Access to primary care • Care affordability • Culturally and linguistically appropriate services • Healthcare coverage • Health literacy • Quality of care • Provider availability • Stigma	• Citizenship status • Civic participation/ community engagement • Culture • Discrimination • Hunger • Incarceration • Race and ethnicity • Racism • Segregation • Sexual orientation/ gender identity • Social cohesion/ community inclusivity • Support systems	• Affordable housing • Access to nutritious food choices • Access to safe drinking water, clean air, toxin-free environments • Adequate community infrastructure • Availability and access to safe affordable transportation • Community-based resources • Crime and violence • Environmental conditions • Geographic location • Quality housing • Parks • Playgrounds • Public safety • Walkability • Workplace safety

Economic Stability. Economic stability is at the foundation of our SUD/OUD epidemic. Mentioned in almost every interview were a shortage of living wage jobs and affordable housing in our community. There are efforts in place and people working on the housing issue. Among many efforts and starting in February, the Interfaith Alliance of Colorado Housing Development Series is hosting a virtual training series on affordable housing development for faith communities, nonprofits and local governments located in Southwest Colorado or on the Western Slope. Focusing on developing and supporting projects that build equity and opportunity, they will cover a wide range of topics including how to site a project or develop ones' own real estate, finding development partners, community engagement best practices, financing and ownership opportunities, and more.

Education.

This is covered above in the Prevention section. Quick summary here.

> Durango. The schools are consumed with COVID-19 logistics, however, the San Juan Board of Cooperative Educational Services (BOCES) was able to share the good work happening throughout the region related to relationships being the key to empowering self-regulation. In summary, good work is beginning and has not yet become normalized. The data shared from the Healthy Kids Survey definitely warrants more exploration.
>
> Ignacio. The school counselor has a trauma informed schools background, therefore, is well versed on what needs to happen for protective factors (prevention), treatment and recovery. Students at Ignacio recently asked Superintendent candidates what they were going to do about the drug problem in the school.
>
> Bayfield. The school district understands that school climate matters and has a superintendent who has experience leading a school into the top 10 for school climate and is fully committed to this effort. The district embraces programs like Sources of Strength and a focus on a loving, supportive environment for students and families.

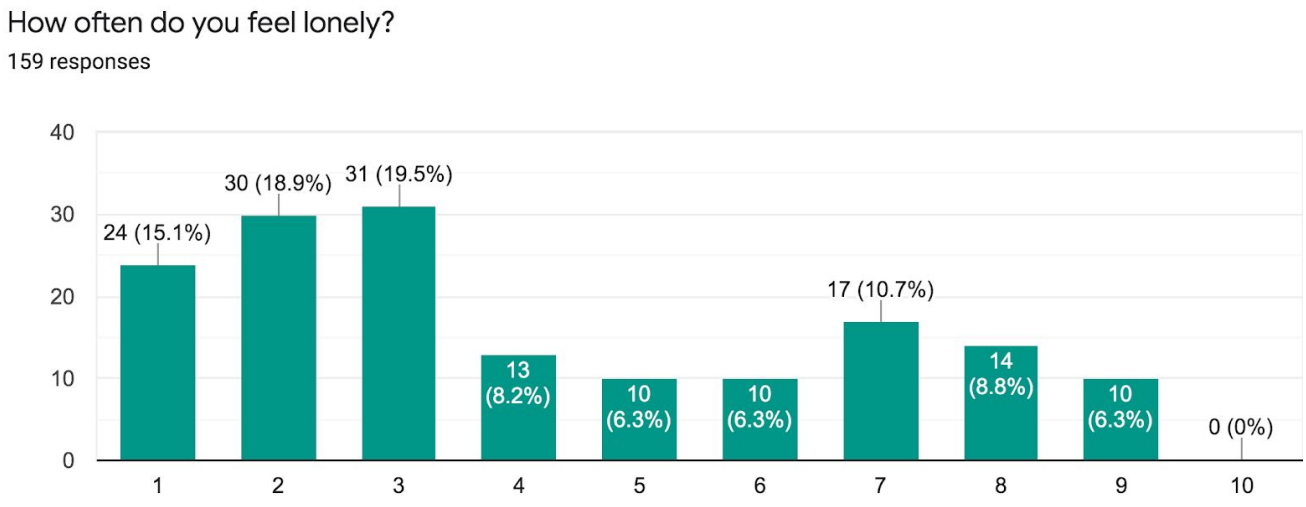
Health and Healthcare. Access to health care services (including primary care and especially behavioral health care services) and specific to the issues of timely access to services when and where they are needed, for the duration they are needed and at an affordable price. There is only a single Behavioral Health provider option in the area---Axis Health System with some private therapists, however, many do not accept Medicaid. Inpatient SUD treatment isn't available at all. Less visible and compounding these are the complete lack of culturally and linguistically appropriate services and a complete vacuum of community based resources and care for Non-Native Americans living in Ignacio. Transportation is a barrier though having services better located should be considered when looking at expanding treatment and recovery services. When we start the strategic planning process it will make sense to have a current list of providers (which we have begun… 200 providers listed thus far) especially for training purposes that seem likely.

Social and Community Contexts.

Culture, discrimination, hunger, incarceration, race and ethnicity, racism, sexual orientation / gender identity, social cohesion / community inclusivity, and support systems have all been addressed throughout this document in relation to the challenges we face as a community right now. "Belonging" is how it was articulated in several interviews.

There is one related point that hasn't come up but that is relevant and mentioned in several key informant interviews. With the technology age coupled with COVID-19, people are more disconnected and feel more isolated. This is exacerbated for those who have been marginalized in any way (addressed elsewhere in this document). Drugs and alcohol are a way to cope with that disconnection and isolation. Furthermore, COVID-19 has moved in person group meetings to online or they've stopped altogether, perpetuating feelings of isolation that increase one's risk for anxiety and depression. In one anecdote, someone so craved their support group that wasn't meeting anymore that they exclaimed to their parent, "I'm just going to lead one myself in a parking lot if I have to!"

Our community survey also indicated this as being an issue. On a scale of 1-10 with 1 being 'never and 10 being always, only 24 of 159 people said they never felt lonely. That's a pretty big deal. Our survey is still in the field and we will soon be able to disaggregate the data to better understand the nuances.



From the University of Washington Center for the Science of Social Connection, we found the following.

The value of close relationships is substantiated by science as well. In terms of risks associated with lack of close relationships, chronic loneliness increases risk for cardiovascular problems, causes chronic activation of the body's threat-response system, impairs immune functioning, causes depression and other mental health problems, impairs executive functioning and accelerates cognitive decline in the elderly (Hawkley & Cacioppo, 2010). Overall, poor social relationships produce downstream effects on mortality that are equivalent to smoking 15 cigarettes daily (Holt-Lunstad & Smith, 2012) and double the influence of obesity (Holt-Lunstad, Smith, & Layton, 2010).

British behavioral economists quantified adding a friend to day-to-day life as worth up to £85,000 (approximately $120,000) a year in terms of life satisfaction for the loneliest 1% of adults, and up to £15,500 (approximately $22,000) for the average adult (Powdthavee, 2008).

One interviewee recalled that in Great Britain, the government created a Ministry of Loneliness as they realize both the physical and mental effects of loneliness. Housing, jobs, and more treatment are tough issues to resolve. But finding ways for those with substance abuse problems to reconnect is a possibility. Social isolation and loneliness are both a cause and effect of substance abuse. But there are solutions and we find this very aligned with so much of what is pointing toward peer support related solutions.

Community based resources weren't mentioned as a *gap* generally (beyond Ignacio) but were mentioned by those in recovery as crucial to their recovery. It is worth exploring whether an increase of resources (especially peer supports and pro social events) could lead to earlier movement into recovery.

Neighborhood / Built Environment. Several interviews mentioned the prevalence of substance use in their home, neighborhood and social circle as being a vivid memory associated with their first experience. Once in addiction, the social circle began to solely consist of others using drugs and alcohol and it became seemingly impossible to break away without something very accessible, welcoming, and inspiring to replace their existing 'knowns'.

Uniquely, repeated mention was made of the 'culture of alcohol and substance use as being normal and expected' beyond that of other communities. This was attributed to the resort community identity and the service worker and seasonal economy. Parents of children in addiction found it difficult to discern whether their child's use was within the range of 'community normal' or would benefit from active support.

Presence and impact of stigma, including health worker and community perceptions/biases of people who use(d) drugs.

One of the most complicating factors is the experience people have with feeling judged for an addiction. While this feeling is pretty prolific as an experience and most severe for those in populations that have been marginalized, the solution here is pretty straightforward. Almost to a person, those with lived experience say that when there are more people simply talking about their addiction and recovery publicly, then the experience becomes more normalized and accepted and most importantly, supported for recovery.

In the interviews, stigma was mentioned over and over again in several forms….

- Parents feeling alone and isolated and avoiding the threat of shame in seeking support for their children
- Those in addiction feeling like the community saw no value in them as humans which then led to them seeing themselves this way and without hope or confidence in recovery, and
- Those in addiction feeling judged by clinicians

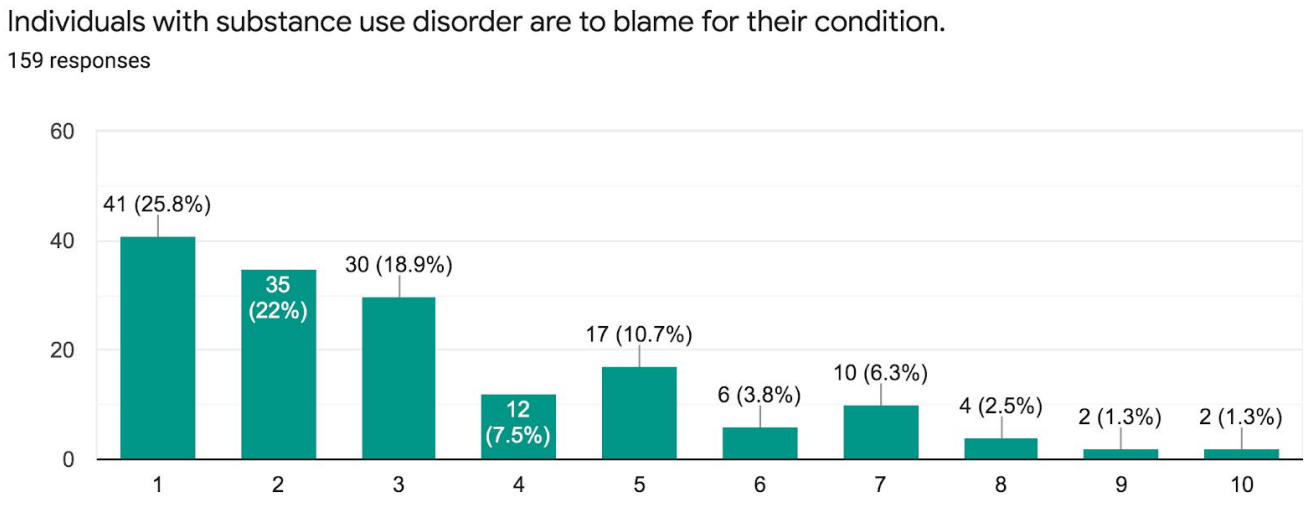
The data supports this:

- Between 2017 and 2019, the CHAS recorded a statistically significant increase in the percentage of Coloradans who did not get needed substance use treatment services because of stigma. Of those who reported they did not get help in 2019, 72.8% said that they were not comfortable talking with a health professional about personal problems, up from 41.3% two years prior (see Figure 2). Similarly, there was a sizable jump in the proportion of Coloradans who did not seek out treatment services because they were worried about what would happen if

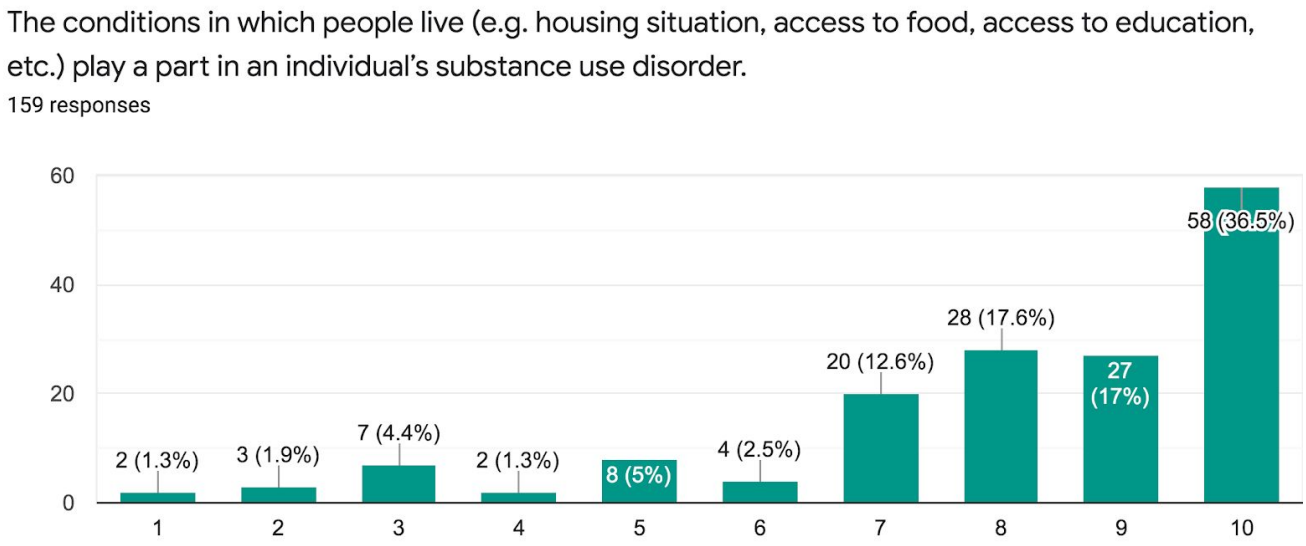
someone found out they had a problem, increasing to 72.4% in 2019 from 43.9% in 2017.(Colorado Health Access Survey from Colorado Health Institute, 2020)

- Men, millennials, and those with lower incomes were demographic groups more likely to need, but go without, receiving mental health services. (Colorado Health Access Survey from Colorado Health Institute, 2020)

Our recent community survey also supports this. When asked whether individuals with substance use disorder are to blame for their condition, and on a scale of 1-10 with one being strongly disagree and 10 being strongly agree, about one-third answered 4 or more expressing that the individual had a role and about 10% answered 7 or more suggesting the individual had close to full responsibility.



When asked about whether community conditions played a role (again with a scale of 1-10 with 1 being strongly disagree and 10 being strongly agree), a similar story plays out. About 10% answered 1-4 suggesting community conditions have little to do with it and about one-third answered 7 or less. The good news is that over a half view community conditions as being a part of the cause.



Our community survey has several additional questions on it around stigma that all show about 10-30% of respondents having some negative views of people with SUD/OUD. As the survey gets more time in the field and as we disaggregate by demographic, we will have good information to inform a campaign and strategy to address this stigma.

Existing resources that could be leveraged within the target rural service area, including existing federal, state, or local funding opportunities; and...

What prevention, treatment, recovery providers: https://findtreatment.samhsa.gov/

- HRSA Grant Website: https://data.hrsa.gov/geo
- State Licensing websites
- Single State Agency websites

What coalitions / collaboratives already exist?
Are there other efforts where there is synergy?
Assets examples: human resources, physical resources, informational resources, political resources, existing intervention resources

These resources are noted above in each of the prevention, treatment, and recovery sections.

Opportunities and challenges related to maintaining a consortium and sustaining SUD/OUD services in the target rural service area.

Are these 8 things in place:

- Environmental Support. Do we have a supportive internal and external climate for your program? Yes and no. As for yes, the consortium members are fully committed and willing to do the work related to expanding prevention, treatment and recovery services in La Plata county. In fact, consortium members are ready to roll up their sleeves and get to work sooner rather than later. That said, obviously COVID-19 is a challenge. The biggest challenge will definitely be the political will to address some basic needs in our community such as living wage jobs and affordable housing. These issues simply haven't seen the momentum needed to really get us where we need to go. We're hopeful, however, that in the strategic planning phase, we can discuss how our work might infuse energy and meaningful action into these areas. Politically, the energy hasn't lined up either but maybe we can influence that now that we have a city council member and county commissioner on the SCOOP consortium. There may also

be some businesses that will join the consortium as our work progresses and this gives us some momentum and support to advocate for changes in these areas.

- Partnerships. Cultivating connections between our program and its stakeholders.
  There are many strong partnerships among the SCOOP consortium and some individuals on the consortium are strong relationship builders. There are also some historical silos, turf issues, too much separation and not enough collaboration. We believe we can overcome those silos and continue to build strong relationships so collectively we can improve the continuum of care for individuals impacted by substance use. Within the consortium, many new partnerships are emerging. An example is Young People in Recovery and the state organization that has supported Recovery Community Organizations (RCO) in other Colorado communities. These two groups will begin discussing how the two models align and intersect as we consider establishing an RCO in La Plata county. The SCOOP consortium itself is turning out to be a great venue for relationship building. People continue to show up to meetings and engage in the planning work and conversations. One gap we see is that we don't currently have a strong partnership connection with the largest school district in the county. They are obviously consumed with COVID-19 adaptations. That said, we do have partners who can work to make this connection as we move into the strategic planning phase, and with a new superintendent starting in June, we are hopeful they will join the SCOOP consortium.

- Funding Stability. Do we have a consistent financial base for our program?
  Yes and no. There are many organizations already doing this work well and the simple coordination and sharing of information will not require additional funding. That said, many of these organizations are constantly spending a lot of time and energy patching together small grants over short periods of time, in some cases unintentionally competing against each other. Medicaid reimbursement is beginning to cover more and more upstream interventions, however, some of the most effective and long-term cost effective models like early childhood and family programming still fall outside the Medicaid model. Early indications from our needs assessment and gap analysis are that we would seek funding to create some recovery housing, establish a Recovery Community Organization (RCO), and increase financial support for interventions such as peer recovery supports, early childhood / family programming, provider education, a public relations/stigma reduction campaign and trauma-informed care training (within the context of substance use). Some of the strategies we are considering include: in-kind and aligned efforts funding some of these interventions, partnerships/pilots with Rocky Mountain Health Plan (RMHP) who provides care coordination services for Medicaid enrollees, local funder involvement, a more informed public could influence elected officials and state budgets, and of course, an ongoing partnership with HRSA.

- Organizational Capacity. Do we have the internal support and resources needed to effectively manage our program?
  Many of our community organizations will say that they are well-resourced and don't need additional funding. However, after doing some digging, we find that people are working far more hours than they are being paid for, and a lot of energy is spent on finding and securing funding (which pulls from programming and partnerships), for their respective programs. There is a large reliance on volunteers which is both wonderful and inequitable, and while many programs are offered, they don't always reach everyone who might benefit. While there is an interest in providing trauma-informed, culturally sensitive services, it is not yet found in all settings nor is there always funding or time allocated / available.

  In the healthcare industry, often the regulatory requirements prohibit meeting the expectations of patients for time spent with providers. Capacity for ensuring trauma-informed, culturally sensitive care is not yet in place across the board.

  We simply don't have any inpatient residential treatment capacity.

  The good news is for almost every area of opportunity identified, we know what we need to do, how to do it and it feels within reach. The other good news is that there seem to be funding sources possible for many of the identified needs. Inpatient residential treatment continues to be the exception.

- Program Evaluation. Assessing our program to inform planning and document results.

Individuals with lived experience shared that some of the most effective interventions that helped them are informal networks and activities that are not evaluated within current data collection systems. Examples of areas we will examine for evaluation include peer supports, care transitions and sustained recovery. Through the strategic planning process, we look forward to determining the evaluation needs that align to the strategy. We have strong evaluation support for this phase and are confident we can develop an equitable approach to program evaluation.

- Program Adaptation. Taking actions that adapt our program to ensure its ongoing effectiveness.
  SCOOP consortium members are eager to grow and/or adapt to meet needs associated with our grant deliverables. That said, any programming that is developed for the purposes of increasing our community's capacity for the prevention, treatment and recovery services will be adapted as needed to ensure it is effective and done with fidelity.

- Communications. Strategic communication with stakeholders and the public about our program.
  Many of our SCOOP consortium members have newsletters and use social media platforms such as Facebook and Twitter. Each is sharing information related to this substance use, however, we have opportunities to coordinate messaging. Celebrating Healthy Communities and their many partners have experience with this and will be a strong asset for this portion of the work.

- Strategic Planning. Using processes that guide your program's directions, goals, and strategies.
  We haven't historically done any collaborative strategic planning specifically for SUD/OUD. That said, many SCOOP consortium members have strategic plans that currently do have SUD / OUD as priority areas. We can use these plans to organize our work around shared measures and aligned core activities. The SCOOP strategic planning process will be an important process for providing a shared strategy each can contribute to and benefit from. Our project facilitator is well trained and experienced in strategic planning as is our project evaluator. We are committed to using the Strategic Planning for Rural Health Networks model by the Academy for Health Services Research and Health Policy to guide our strategic planning process.

  While there have been several attempts to address affordable housing and other related issues in our community, there is no standing community group 'owning' the work around housing, living wage jobs, or SUD/OUD. It may be worth creating a county or region-wide health partnership or alliance with a broad social mission that includes specific targets for housing, living wage jobs, suicide prevention, SUD/OUD and similar where we connect the dots and fully understand the connections between upstream intervention and downstream impacts. Establishing a regional health partnership would also create funding opportunities for the entire region which would result in making a deeper impact in these areas of our community's health.

A description of the methods used to engage community members and key stakeholders in the target rural service area.

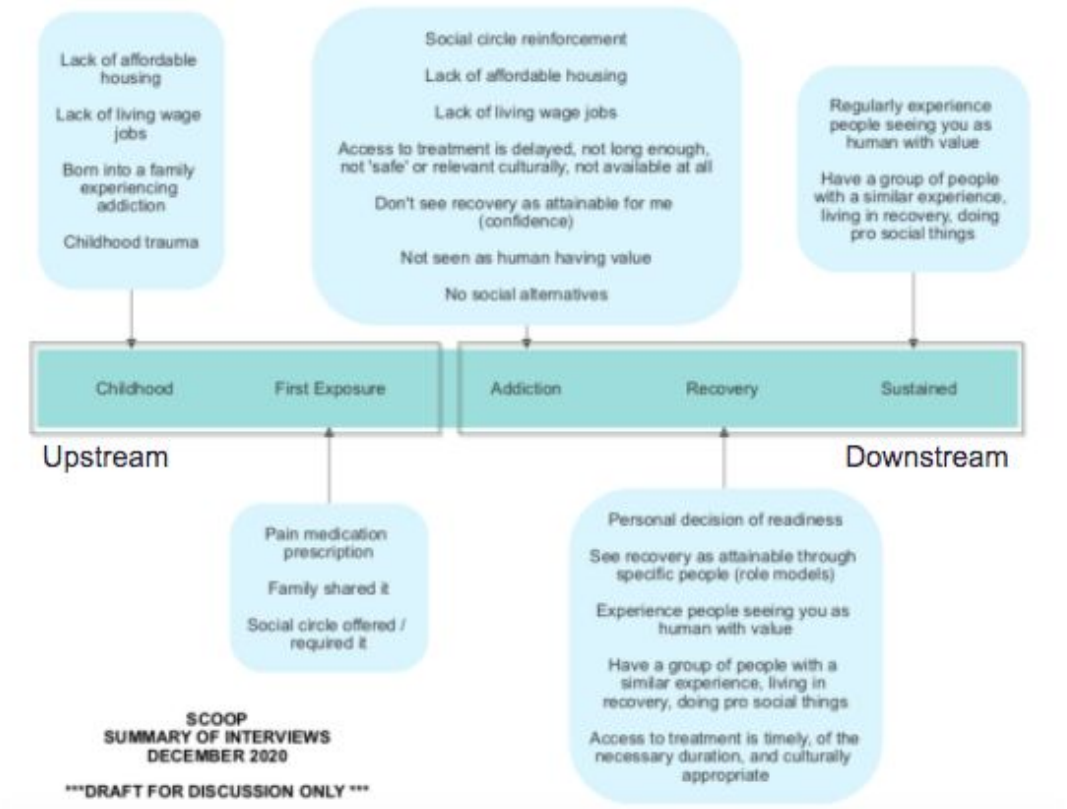
- Key Informant Interviews of all consortium members and several referrals
- Sharing of previously conducted survey and focus group reports from Consortium member organizations
- Community Survey

A good faith effort must be made to engage directly impacted individuals, such as people in recovery from substance use disorder, impacted family members, people who use drugs, etc., through focus groups, surveys, personal interviews, or other methods as appropriate.

Because our consortium was so populated with lived experience including people in recovery, impacted family members, people using drugs, and 31of them participated in the initial key informant interview process, our starting point was rich with information to inform everything that followed. Below are examples of how several of them helped with gathering additional information:

- Resilient Colorado shared subjective and objective data from their local training evaluations
- Four Corners Diversity Alliance shared subjective and objective data from their local focus groups and state partner work
- Several individuals with lived experience shared many aspects of their personal stories to support various sections of this needs assessment and also reviewed the relevant sections for accuracy and additional comment

- Several consortium members will be central to gathering community input when we launch that shortly (ex. One person with lived experience has offered to share it with people who have experienced incarceration)
- Based on the themes shared from the initial interviews, consortium members selected which workgroup they wanted to be part of and then had assignments:
    - Workgroup Choices: Upstream, Downstream, Resources
    - Assignments:
        - Identify providers of services and describe services provided
        - Inform the community survey purpose and questions



        - For the first one (Identify providers of services and describe services provided) the fields requested are noted below and full spreadsheet is available and being used as a working document as we continue to learn more:
            - Describe the services provided and include any relevant details about the group/organization providing services.
            - Phase (prevention, treatment, or recovery)
            - Type of Group or Organization
            - For whom do they design their services?
            - Are the services this group/organization provides enough to meet the existing community need?
            - Are there enough staff and sufficiently trained staff to meet community needs?
            - This group / organization offers services specifically designed to meets the needs of:
                - People without food access
                - People without a home
                - People with Disabilities
                - Pregnant / Parenting People
                - Adolescents

- LGBTQIA+ Community
- Native American Community
- LatinX Community
- People who speak languages other than English

- How do people find out about the services this group/organization provides?
- This service manages after-care by....

o Once the above information was pulled into draft form, SCOOP consortium members also chose which of the following to work on:
- Review Mission, Vision, Values
- Review the Overview of Results and Findings
- Review the draft community input survey
- Identify additional information needed from priority populations (Native American and LGBTQ+)
- Initial review of priority activities

Seven directly impacted individuals were included on our steering committee. And, as we did inclusive introductions, it became apparent that almost everyone on the steering committee was directly impacted. Parents of people in addiction or recovery, friends of people in addiction or recovery, people in recovery doing work that brought them to the table. People also thanked the consortium for being a safe place to share their story …. several for the first time ever.

A list of community members and stakeholders in the target rural service area that participated in data collection.

For this work, the consortium members were the primary contributors to the data and pointed us to sources of information relevant to priority populations in particular. The broader community will be involved in the coming community survey. Consortium members are listed below.

1. Lived Experience (7)
2. Community Member (3)
3. Southern Ute Health Center
4. Four Corners Diversity Alliance
5. Young People in Recovery
6. Advocates for Recovery Colorado
7. Durango Police Department
8. La Plata County Commissioner
9. 6th Judicial District Probation
10. Bayfield School District Superintendent
11. Ignacio Schools Counselor
12. Community Compassion Outreach
13. Celebrating Healthy Communities ED
14. Department of Human Services
15. Planned Parenthood
16. Colorado Office of Behavioral Health
17. Rocky Mountain Health Plan
18. Uncommon Health Solutions
19. Unclouded Communications
20. Centura Health Subject Matter Expert
21. Resilient Colorado
22. West Slope CASA
23. Front Range Clinic
24. Colorado Consortium for Prescription Drug Abuse Prevention
25. Rocky Mountain Health Plan

26. Southwestern Colorado Area Health Education Center
27. San Juan Basin Public Health Department
28. Emergency Department Physician at Mercy
29. Manna Community Kitchen
30. Neighbors in Need
31. Axis Health System
32. La Plata County City Council

CLOSING

To move forward, we've included some of the obvious areas of work along with some areas where we would like to continue to learn more.

Obvious areas of work include:

- Inpatient long-term treatment for adolescents and adults. There is a clear need for this and maybe with the right people we can get creative and figure it out. That said, there is no clear path on this one…. Perhaps it will continue to be too expensive and out of reach? If so, the below investments will be crucial to reduce the number who need inpatient services and we could focus on better supporting those who do need inpatient services in having their needs met out of our area. When asked, providers serving this population resoundingly agree that this is a top priority and typically emphasize it with multiple exclamation points.
- Recovery Housing and Recovery Community Organization… both have logical pathways and possible existing funding sources. When asked, people in recovery resoundingly agree that this is a top priority.
- Community Education and Training. Trauma-informed culturally sensitive training for community members and providers is both desired and we have the expertise and (with some investment) the capacity. Knowledge shared throughout a community can create a culture. When asked, people in our priority populations agree that this is a top priority.
- Native American Cultural Center. With the existing Native designed program plan this would provide a central location and safe space from which to launch the other recommendations for this priority population.
- Peer Support Coordination. With all of the peer support happening throughout the community, better understanding and coordinating this network with some investment could have massive impacts. Impacts could be expected in prevention, connection to resources earlier and more quickly, and smoother transitions throughout the system.
- Community Break the Stigma Campaign. We have people willing to share their stories, models exist for campaigns like this and they've been shown to be effective in decreasing mental health and substance use stigma.
- Policy work. Both legislative and organizational policy. The community education and training should lead to policy changes that support the interests (basic needs: jobs, housing, food; stigma: trauma informed / cultural sensitivity; etc.) of this work. We will also continue to engage with the Colorado Consortium for Drug Abuse Prevention and the Office of Behavioral Health for legislative updates and learn about opportunities for advocacy on legislation pertaining to treatment services that may impact our region.

For future study:

- How might we support, inform, coordinate with, and expedite(!) the community-wide work around jobs and housing and food?
- Learn more about the LatinX demographic.
- Using the Colorado Healthy Kids Data and using multivariate analysis to look at multiple demographic characteristics, behaviors and outcomes. This might help us with targeted strategies.

- Micro-geographies… learning more about the smaller communities in the county (Red Mesa, etc.). Again, to help us with targeted strategies.
- More study of early childhood and family resources. Time limited us to doing the work that would be most beneficial in understanding how best to support families and children so that protective factors are in place and addiction can be avoided entirely.
- Explore the need for another special population of people who are pregnant