COP-RCORP

Communities of Practice for Rural Communities Opioid Response Program

Core Activity 2: Needs and Gaps Assessment

Fairfield County, Ohio

Fairfield County Opiate Task Force

Fairfield County Alcohol, Drug Addiction and Mental Health (ADAMH) Board

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Acknowledgements

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The Fairfield County Opiate Task Force (OTF) acknowledges the time and efforts that consortium members and other local stakeholders contributed to this needs assessment.

Ohio University's Voinovich School of Leadership and Public Affairs (OHIO) and the Pacific Institute for Research and Evaluation (PIRE), through a shared services and braided funding approach, work directly with project directors from the five COP-RCORP backbone organizations to provide leadership, training, capacity building, technical assistance and evaluation services, and management oversight for project activities. The project directors then bring back the shared learnings and experiences from the community of practice to their respective community-specific consortium, which is responsible for leading project activities within the five Ohio communities. This needs assessment represents the shared work of the Fairfield County OTF (local consortium), the Fairfield County Alcohol, Drug Addiction and Mental Health (ADAMH) Board (backbone organization), and the COP-RCORP Training, Technical Assistance, and Evaluation Team (OHIO and PIRE).

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Fairfield County Opiate Task Force

Fairfield County Alcohol, Drug Addiction and Mental Health (ADAMH) Board

September 29, 2019

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Grant Number	G25RH32459-01-02	
Address	Building 21, The Ridges, Room 204, 1 Ohio University, Athens OH 45701-2979	
Service Area	Fairfield County, OH in HRSA-designated rural census tracts (39045030900, 39045031000, 39045031100, 39045031200, 39045031300, 39045031400, 39045031500, 39045031600, 39045031700, 39045032000, 39045032100, 39045032200, 39045032300, 39045032500)	
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Introduction

RCORP-Planning

The Rural Communities Opioid Response Program (RCORP) is a multi-year initiative supported by the Health Resources and Services Administration (HRSA), an operating division of the U.S. Department of Health and Human Services, to address barriers to access in rural communities related to substance use disorder (SUD), including opioid use disorder (OUD). RCORP funds multi-sector consortia to enhance their ability to implement and sustain SUD/OUD prevention, treatment, and recovery services in underserved rural areas. To support funded RCORP consortia, HRSA also funded a national technical assistance provider, JBS International.

The overall goal of the planning phase of the RCORP (RCORP-Planning) is to reduce the morbidity and mortality associated with opioid overdoses in high-risk rural communities by strengthening the organizational and infrastructural capacity of multi-sector consortiums to address prevention, treatment, and recovery. Under the one-year planning initiative, grantees are required to complete five core activities:

A) Develop/strengthen the consortium by drafting a memorandum of understanding (MOU);
B) Conduct a detailed opportunity and gap analysis (needs assessment);
C) Develop a comprehensive strategic plan for OUD prevention, treatment, and recovery;
D) Develop a comprehensive workforce plan for OUD prevention, treatment, and recovery services and access to care; and
E) Complete a sustainability plan for the consortium and proposed activities of the strategic and workforce development plans.

COP-RCORP Consortium

The Communities of Practice for Rural Communities Opioid Response Program (COP-RCORP) Consortium was created in 2018 when Ohio University's Voinovich School of Leadership and Public Affairs (OHIO), together with backbone organizations from Fairfield and Ashtabula counties, and the Pacific Institute for Research and Evaluation (PIRE), together with backbone organizations from Sandusky and Washington counties, each submitted and received a $200,000 RCORP-Planning grant from HRSA (grants G25RH32459-01-02 and G25RH32461-01-06, respectively). Upon receiving the two HRSA grants, OHIO and PIRE then employed a braided funding and shared services approach to collaborate and support a fifth COP-RCORP community in the master consortium – Seneca County. The COP-RCORP Organizational Chart is a visual description of how the COP-RCORP initiative functions to enhance capacity and sustainability at a local level by leveraging state and community partnerships (Figure 1). The braided funding approach ensured that OHIO and PIRE were able to provide equitable funding across five Ohio communities, while balancing backbone support with community resources.

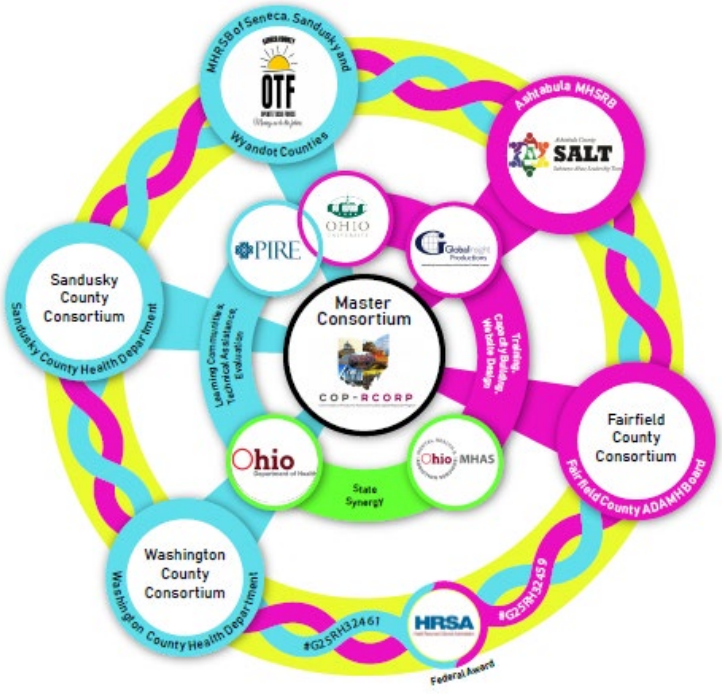

Figure 1. COP-RCORP Organizational Chart.

The COP-RCORP Consortium seeks to impact the opioid epidemic and complete the RCORP-Planning

core activities by working together as a community of practice. Through this community of practice approach, OHIO and PIRE work directly with project directors from the backbone organizations of each community to provide leadership, training, capacity building, technical assistance and evaluation services, and management oversight for project activities. The project directors then bring back the shared learnings and experiences from the community of practice to their respective community-specific consortium, which is responsible for leading project activities within the five Ohio communities.

A sharing economy is a core value of the COP-RCORP Consortium, and although not every community can have a RCORP-Planning grant, every community can benefit from the work and experience of the RCORP grantees. Therefore, OHIO and PIRE, in partnership with Global Insight Productions, a local web design company, established a project website (https://www.communitiesofpractice-rcorp.com/) to serve as a sharing and distribution center for all HRSA-planning related resources and materials. The COP-RCORP website includes community pages, background on the consortium, training and technical assistance materials and on-demand videos for each of the core activities of the RCORP-Planning grant, links to technical assistance resources provided by JBS, and a password protected site that includes video recordings of consortium meetings. The site will also include the completed RCORP-Planning work from each of the COP-RCORP communities.

Fairfield County Opiate Task Force

In Fairfield County, the Opiate Task Force (OTF) serves as the local consortium for the RCORP-Planning grant, while the Fairfield County Alcohol, Drug Addiction and Mental Health (ADAMH) Board operates as the backbone organization. In order to develop and strengthen the local consortium, the ADAMH Board entered into a memorandum of understanding with local collaborators.

Local consortium. Fairfield County's local consortium is the Opiate Task Force (OTF). The Fairfield County Opiate Task Force is charged with the responsibility of coordinating the efforts of the medical, treatment, law enforcement, community education and community relations efforts to combat the opiate and heroin addiction crisis confronting Fairfield County. As part of their participation in the RCORP-Planning grant, Fairfield County consortia will ensure that they further refine and develop their consortia across the full continuum of care (prevention, treatment, and recovery) and develop more formalized structures for their collaboration (i.e., memorandums of understanding or agreement, governing structure, etc.).

Backbone organization and project director. In Fairfield County, the backbone organization is the Fairfield County Alcohol, Drug Addiction and Mental Health (ADAMH) Board. Other key consortium members include New Horizons Mental Health Services, Ohio Guidestone, Fairfield County Job and Family Services, Fairfield County Major Crimes Unit, The Recovery Center, Fairfield County Prosecuting Attorney's Office, the Mayor of Bremen, Lancaster City School District, Fairfield County Juvenile Court, and the Mayor of Lancaster. Toni Ashton is the Prevention Coordinator for the Fairfield County ADAMH Board. She provides leadership and direction for the Fairfield County Suicide Coalition. She co-facilitates CIT for Law Enforcement Officers and is a Certified Trainer for Mental Health First Aid, as well as an instructor for Trauma Informed Care, QPR and Parent Project.

Memorandum of understanding. In order to develop and strengthen the local consortium in Fairfield County, the ADAMH Board has entered into a memorandum of understanding with the following collaborators for the RCORP-Planning grant:

- The Recovery Center
- New Horizons Mental Health
- Project F.O.R.T. (Fairfield Opiate Response Team)

Community context. Considering the cultural context of a community is vital when identifying and addressing needs and gaps within the community. Therefore, each local consortium in the COP-RCORP Project is submitting its own needs assessment to ensure that the resulting product reflects the consortium's unique context, geographic area, history, population of focus, culture, vision, and mission.

Geographical area. Fairfield County, OH in HRSA-designated rural census tracts (39045030900, 39045031000, 39045031100, 39045031200, 39045031300, 39045031400, 39045031500, 39045031600, 39045031700, 39045032000, 39045032100, 39045032200, 39045032300, 39045032500), which includes zip codes 43107, 43112, 43130, 43148, 43150, & 43155.

Population. For this grant, our community consists of Lancaster and five rural villages in Fairfield County.

Lancaster, Ohio. Lancaster is a city in Fairfield County, Ohio, in the south-central part of the state. As of the 2010 census, the city population was 38,780. The city is located near the Hocking River, approximately 33 miles (53 km) southeast of Columbus, 38 miles (61 km) miles southwest of Zanesville, and is the county seat of Fairfield County. The racial makeup of the city was 95.9% White, 1% African American, 0.5% Asian, 0.30% Native American, 0% Pacific Islander, 0.6% from other races, and 1.7% from two or more races. Hispanic or Latino of any race were 1.6% of the population. There were 16,048 households, of which 27.8% had children under the age of 18 living with them, 42.4% were married couples living together, 14.2% had a female householder with no husband present, and 38.1% were non-families. 31.7% of all households were made up of individuals and 13.8% had someone living alone who was 65 years of age or older. The average household size was 2.36 and the average family size was 2.95. In the city, the age distribution of the population shows 24% under the age of 18, and 15.7% who were 65 years of age or older. The median age was 37.5 years. For every 100 females, there were 92.3 males. For every 100 females age 18 and over, there were 88.6 males.

Bremen, Ohio (zip code 43107). As of the census of 2010, there were 1,425 people, 506 households, and 394 families residing in the village. The racial makeup of the village was 98.2% White, 0.3% African American, 0.3% Native American, 0.1% Pacific Islander, and 1.2% from two or more races. Hispanic or Latino of any race were 0.4% of the population. There were 506 households, of which 42.7% had children under the age of 18 living with them, 58.5% were married couples living together, 14.6% had a female householder with no husband present, 4.7% had a male householder with no wife present, and 22.1% were non-families. 18.4% of all households were made up of individuals and 7.3% had someone living alone who was 65 years of age or older. The average household size was 2.79 and the average family size was 3.15. The median age in the village was 34.5 years. 31.1% of residents were under the age of 18; 6.1% were between the ages of 18 and 24; 27.2% were from 25 to 44; 22.6% were from 45 to 64; and 13.2% were 65 years of age or older. The gender makeup of the village was 49.8% male and 50.2% female.

Pleasantville, Ohio (zip code 43148). As of the census of 2010, there were 960 people, 358 households, and 234 families residing in the village. The racial makeup of the village was 95.4% White, 0.1% African American, 0.5% Native American, 0.3% Asian, 0.5% Pacific Islander, 0.8% from other races, and 2.3% from two or more

races. Hispanic or Latino of any race were 0.8% of the population. There were 358 households, of which 39.4% had children under the age of 18 living with them, 45.3% were married couples living together, 14.8% had a female householder with no husband present, 5.3% had a male householder with no wife present, and 34.6% were non-families. 29.3% of all households were made up of individuals and 10% had someone living alone who was 65 years of age or older. The average household size was 2.62 and the average family size was 3.29. The median age in the village was 32.4 years. 29.9% of residents were under the age of 18; 9.5% were between the ages of 18 and 24; 28.3% were from 25 to 44; 22.2% were from 45 to 64; and 10.2% were 65 years of age or older. The gender makeup of the village was 50.0% male and 50.0% female.

Rushville, Ohio (zip code 43150). As of the census of 2010, there were 302 people, 107 households, and 81 families residing in the village. The racial makeup of the village was 96.0% White, 0.7% Asian, and 3.3% from two or more races. There were 107 households, of which 44.9% had children under the age of 18 living with them, 52.3% were married couples living together, 14.0% had a female householder with no husband present, 9.3% had a male householder with no wife present, and 24.3% were non-families. 16.8% of all households were made up of individuals and 4.7% had someone living alone who was 65 years of age or older. The average household size was 2.82 and the average family size was 3.12. The median age in the village was 32.3 years. 30.5% of residents were under the age of 18; 9.5% were between the ages of 18 and 24; 31.9% were from 25 to 44; 22.9% were from 45 to 64; and 5.3% were 65 years of age or older. The gender makeup of the village was 47.4% male and 52.6% female.

Sugar Grove, Ohio (zip code 43155). As of the census of 2010, there were 426 people, 155 households, and 123 families residing in the village. The racial makeup of the village was 98.1% White, 1.4% Native American, and 0.5% from two or more races. Hispanic or Latino of any race were 0.5% of the population. There were 155 households, of which 50.3% had children under the age of 18 living with them, 47.7% were married couples living together, 25.2% had a female householder with no husband present, 6.5% had a male householder with no wife present, and 20.6% were non-families. 18.1% of all households were made up of individuals and 4.5% had someone living alone who was 65 years of age or older. The average household size was 2.75 and the average family size was 3.00. The median age in the village was 34.8 years. 30.8% of residents were under the age of 18; 9.3% were between the ages of 18 and 24; 27.2% were from 25 to 44; 26% were from 45 to 64; and 6.6% were 65 years of age or older. The gender makeup of the village was 50.2% male and 49.8% female.

Carroll, Ohio (zip code 43112). As of the census of 2010, there were 524 people, 208 households, and 147 families residing in the village. The racial makeup of the village was 96.2% White, 0.6% African American, 0.4% Native American, 0.2% Asian, and 2.7% from two or more races. There were 208 households of which 36.5% had children under the age of 18 living with them, 45.2% were married couples living together, 18.3% had a female householder with no husband present, 7.2% had a male householder with no wife present, and 29.3% were non-families. 24.0% of all households were made up of individuals and 9.2% had someone living alone who was 65 years of age or older. The average household size was 2.52 and the average family size was 2.94. The median age in the village was 38 years. 25.4% of residents were under the age of 18; 10.1% were between the ages of 18 and 24; 26.9% were from 25 to 44; 23.9% were from 45 to 64; and 13.7% were 65 years of age or older. The gender makeup of the village was 51.0% male and 49.0% female.

Population of focus. Although we do not know the exact prevalence rate of non-fatal overdoses in Fairfield County, the number of naloxone doses administered more than doubled from 2015 to 2016 (85 to 181). We also do not know the prevalence of OUD in Fairfield County. However, 57% of client admissions (clients in treatment) in Fairfield County in 2014 were associated with a primary diagnosis of opiate abuse or dependence, while the statewide percentage for that year was only 37% (Fairfield Community Health Assessment, 2016). The assessment also found that the percentage of adults who misused prescription drugs in the past 6 months more than doubled from 2013 (4%) to 2016 (9%). Additionally, supporting data indicates that opioids are readily available in the county. For example, the number of opioid doses dispensed per

patient in Q4 of 2017 was higher than the statewide county average (142.46 v. 136.22). Under this project, we will work with local partners (the Fairfield County Health Department, emergency responders, hospitals, etc.) to obtain more localized reporting of where overdoses are occurring within the county, the outcomes of those overdoses, and the prevalence of OUD. We hope to impact the people living in the targeted areas with information and education regarding opiate use prevention, treatment and recovery supports.

Community history. Fairfield County community leaders, local government officials and agency executives have been state and national pioneers in the fight against opiate misuse. In 2009, the Fairfield County Opiate Task Force was created, and, one year later, Pickerington launched its own group to further focus efforts within its community. Both endeavors were landmark efforts and led the way for communities across Ohio to join in the cause. The public-private partnerships within Fairfield County demonstrated meeting a difficult problem head-on can make a positive difference.

In early fall 2015, a shared planning effort was sponsored by Ron Burris, representing the Fairfield County Opiate Task Force, Jeffery Fix, representing the Pickerington Opiate Task Force, and Rhonda Myers, representing the Fairfield County ADAMH (Alcohol, Drug Addiction, Mental Health) Board. Sponsors envisioned a combined effort to re-invigorate community-based efforts to fight opiate misuse. Fourteen planning team members signed-on to lend their expertise, time, and talents.

Community culture. The cultural feel of the targeted communities is similar throughout the villages. The communities are conservative, and churches and schools are the focal point of the community. Many of the longtime residents are tightknit, spanning generations. Lancaster residents embrace a sense of community and history. The city is conservative and has a large faith-based community. Poverty is common in all of the villages and parts of Lancaster.

The communities are most proud of their history and heritage. There are also many parks throughout the county. A famous Lancaster landmark is Mount Pleasant, a 250-foot high sandstone bluff called "Standing Stone" by earlier Native American peoples. It is located in Rising Park, a large city park on the city's north side. It is possible to climb to the top of Mount Pleasant by following a short-marked trail from the park through the woods that cover the bluff's other sides. The Lancaster community is proud of the Cultural Arts and Museums that are available throughout the city. There is a two-week Art and Music Festival that takes place in July with many free events such as the Downtown Artwalk. Lancaster and the villages all have a small-town feel. Community members are helpful and supportive to one another. In Lancaster and the villages, many people have been there for generations and feel a sense of ownership.

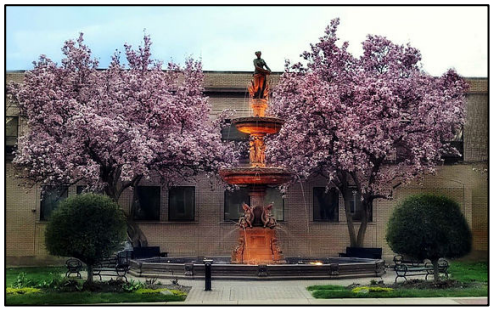

Figure 2 is of Fountain Square in downtown Lancaster. We selected it because the fountain stands in one of the original squares of Downtown Lancaster on the corner of Broad and Main Streets. The Lady Lisa Fountain has been in constant operation since the 1890s.

Figure 2.

Figure 3 is of Rock Mill Park. We selected it because the park was built in 1824 and was one of a dozen grist mills in the area whose power source was the Hocking River. The mill was in operation grinding flour and corn into wheat and meal as late as 1905.

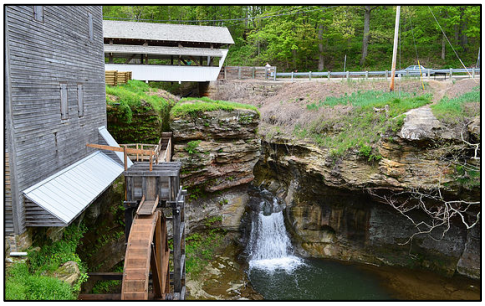

Figure 3.

Figure 4.

Figure 4 is of Fountain Square in downtown Lancaster. We selected it because the fountain stands in one of the original squares of Downtown Lancaster on the corner of Broad and Main Streets. The Lady Lisa Fountain has been in constant operation since the 1890s.

Figure 5 is of the John Bright #2 Covered Bridge at Ohio University-Lancaster. We selected because of its history. It was built in 1881 and originally spanned Poplar Creek. In April of 1988, the bridge was moved 12 miles from Poplar Creek to Fetter's Run at Ohio University-Lancaster, where preservation efforts on the bridge were undertaken. Cooperation among Ohio University-Lancaster, Fairfield County, local businesses and organizations, and volunteers enabled the completion of the project in 1990. John Bright #2 is a testament to innovative bridge building techniques in the late 19th century and community cooperation and pride more than 100 years later.

Figure 5.

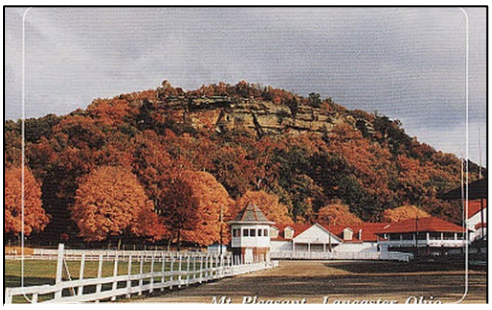

Figure 6.

Figure 6 is of The Fairfield County Fairgrounds and Mt. Pleasant. We selected it because of the history and importance of the Fairfield County Fair, which was started in 1851 and brings the county together for a week of showing animals, showing produce and having fun. Mt. Pleasant is a famous Lancaster landmark; it is a 250-foot high sandstone bluff called "Standing Stone" by earlier Native American peoples.

Vision, Mission, and Planning Values. Both vision and mission statements play an important role in the consortium's ability to plan and ensure that plans are entrenched in consistent values. The vision statement makes sure that all decisions are properly aligned with what the organization hopes to achieve. Mission statements are a way to direct a community in the right direction by providing the "big picture" goal that helps to direct the plan. Shared vision and mission statements, help ensure that local consortia can engage in strategic planning processes in a way that is consistent with their values and with the local context.

Vision. "We strive to end opiate misuse in Fairfield County."

Planners defined a vision as a concise, word picture that sets the overall direction for what the Fairfield County Opiate Task Force strives to attain in the future. A vision describes a desired state that can be made possible when aggressively pursued. Planners purposely drafted an ambitious Vision, because the problem

demands visionary action. Ultimately, ending opiate misuse, including changing how people think about pain relief, will lead to better outcomes for those who live in a county attentive to overall wellness.

Mission. "The Fairfield County Opiate Task Force raises awareness and engages in advocacy to prevent opiate use from eroding the health of the community."

The mission statement illuminates the clear, common purpose across all the individuals, programs and organizations involved with the OTF.

Planning values. The planning values will include goals, objectives and performance measures. Goals are directional statements of long-term results needed to achieve the mission and the vision. Goals are clarified by the objectives associated with them. Objectives lay out the "how to" or major action areas needing to be tackled to meet the goal. Objectives are generally more refined, measurable, and can readily be assigned completion dates. Performance measures document progress toward attaining goals. Measures usually track a percentage change, an increase or decrease in a target number, or the completion of a deliverable product. Planning values will also incorporate a data informed process. The Opiate Task Force will also continue to make collaboration a priority among agencies, organizations and community members.

Measuring Community Capacity and Readiness

COP-RCORP Capacity and Readiness Survey

As a part of the evaluation of the RCORP-P initiative, stakeholders in each of the five local consortia were asked to complete an online survey at the beginning of the project period measuring capacity and readiness. The COP-RCORP Capacity and Readiness Survey has been successfully used by the TTAE team in past projects related to substance use and abuse in Ohio. The survey was completely voluntary, and stakeholders were informed to answer as honestly as possible. The survey assessed: (1) Consortium Readiness, (2) Consortium Planning Capacity, (3) Strategic Planning Capacity, (4) Community Factors (that may have influenced opioid prevention, treatment, and recovery efforts in the community), (5) Capacity to Address Community Factors, and (6) Impact.

COP-RCORP Capacity and Readiness Survey Results

The results of the COP-RCORP Capacity and Readiness Survey for Fairfiel County are in the Appendix. The results (except for Factors and Impact) show counts and percentages of responses to each survey item where 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, and 5 = Strongly Agree. Also shown for each survey item (under the heading Aggregate) is the mean (or average) and standard deviation (S.D.). For Factors, the results show counts and percentages of responses to each survey item where 1 = No Impact, 2 = Low Impact, 3 = Moderate Impact, and 4 = High Impact. For Impact, the results show the mean, median, mode, and standard deviation (S.D.) for each survey item – on the survey the response categories ranged from 0 (not at all) to 10 (completely).

The information provided helped each consortium to identify its current strengths and needs, while working to complete its needs and gaps assessment and move forward in the planning phase of addressing opiate use disorder (OUD) across the continuum of care. Results for each of the five local consortia were shared out to project leads as a separate report in July 2019 (see Appendix).

Needs Assessment Methodologies

Strategies for Collection and Use of Quantitative Data

The TTAE team provided project leaders with a resource that delineated each area of opioid related use (prevention, treatment, and recovery) into actionable questions that could be answered using local data. The questions guided project leaders to consider how to define their populations of focus, and to articulate the impacts of OUD on those populations in terms of prevention, treatment, and recovery services. Support materials, including instructional videos and templates, were made available on the project website. Project leaders reviewed existing sources of data to identify high quality evidence to support their planning efforts. These included raw, publicly available data sets maintained by the Ohio Department of Health and other public entities, as well as community-level data collected by the county Mental Health Services Board and local mental health and addiction service providers. The Community Health Assessments were a valuable resource in this process. Prescriber data was accessed through OARRS and the SAMHSA buprenorphine waiver program. Project directors also reached out to many other partners in their relative communities to find supporting data for prevention, treatment, and recovery related services.

Strategies for Collection and Use of Qualitative Data

Similarly, Project leads were encouraged to use qualitative data to support their efforts when necessary. Qualitative data was collected through learning conversations with local consortium members and stakeholders, as well as through community forums. Project leads used this data to answer guiding questions provided by the TTAE team to consider existing assets, gaps, resources, and needs related to OUD in their community.

Method for Identifying Priorities

The TTAE team provided project leads a template to support them in developing a plan to build concurrence within the consortium and among stakeholders for setting priorities. Project leads considered how their group would identify priority needs, discuss issues, consider feasibility, and select strategies to implement.

Community-specific Prioritization Methods

Identifying needs. The Co-Chairs of each committee will review prior meetings and notes regarding community priorities around the opiate problem. This was discussed at length in the meetings for the Needs Assessment.

Involving the community. At each subcommittee meeting for the past three months, these needs have been discussed at length. First, the gaps and needs were identified, and then the committees each prioritized the needs as they related to the areas of Prevention/Education, Treatment, and Recovery Supports, as well as Advocacy. Stigma reduction was discussed in the larger full group meetings.

Feasibility. Each organization/partner represented in these meetings identified what they are able to contribute toward addressing gaps and needs, including the leadership organization, the ADAMH Board. The Co-Chairs of the Opiate Task Force have the expertise to determine if a priority is feasible and will consider operational feasibility (how well the priority need solves the problem), scheduling/time feasibility (how long it will take to complete), and financial feasibility (cost involved).

Strategies. Our subcommittees have, to some extent, discussed various strategies as we were completing the needs assessment. However, in order to have a focused effort, we will do this in a scheduled meeting and give each group time to brainstorm a list of all the possible strategies they can come up with. We will then discuss as a large group the feasibility of the strategy, given our resources and the willingness of the target

communities to participate in the strategies proposed. The group will come to consensus by using a "Fist to Five" vote to decide on the top three strategies for each area of Prevention, Treatment, and Recovery.

A misconception of consensus is that everyone has to agree. Instead, the emphasis is on allowing all perspectives to be heard. In fact, in consensus the group can proceed if everyone either affirms the choice or has reservations but is willing to stand aside. However, any one individual does have the power to block a group from proceeding if they believe a decision would cause harm (for example, using scare tactics with youth).

Results and Findings

Fairfield Opiate Task Force inventoried available data in the areas of prevention (including supply reduction, demand reduction, and harm reduction), treatment, and recovery. Using the needs assessment template provided by the COP-RCORP master consortium, local consortia used this information to determine available prevention, treatment, and recovery services, as well as gaps, assets, and resources in these areas. Below are tables detailing the impact of the opioid crisis in each area, as well as the available data to back up each claim. Where noted, data to support the impact stated is unavailable. Areas of missing data highlight additional gaps in data collection and data collection infrastructure.

Prevention: Assessing Community Needs and Resources

After communities filled in the template provided by the master consortium, the COP-RCORP TTAE team organized the Fairfield Opiate Task Force answers to the prevention template by demographic age ranges and how each age group was affected. Consortium responses to the prevention template were then inserted into a table (see Table 1) to better delineate the impacts of opioid use on each specific population and the data that each local consortium had to support their specific claims. A summary of the Fairfield Opiate Task Force work in the area of prevention is also included.

Table 1. Prevention Needs Assessment

<table>
<tr><th>Population</th><th>Impact</th><th>Data</th></tr>
<tr><td rowspan="2">Young Children

Defined
0-8 years old</td><td><u>Gap</u>: Babies are affected by NAS because of mother's SUD.</td><td>Ohio Neonatal Abstinence Syndrome County Report

• 2016: 62 newborn SUD hospitalizations
• 2017: 57 newborn SUD hospitalizations

Ohio Hospital Association

• 2013-2017: 248 newborn SUD hospitalizations

Fairfield County ADAMH provider reports

• 2016 Perinatal Program served 64 women
• 2017 Perinatal Program served 37 new women
• 2018 Perinatal Program served 37 new women</td></tr>
<tr><td><u>Gap</u>: Many children are living in either kinship placements or in foster care because of their parents SUD or because of incarceration.</td><td>Point-In-Time Homeless Survey, January 31, 2019

• 58 children placed in kinship program at Fairfield County Child Protective Service.
• 53 of these cases are due to parental SUD.
• 20 of these children are placed with relatives.
• The remaining 33 are placed with family outside of Fairfield County.</td></tr>
<tr><td rowspan="2">School-aged Children

Defined
5 to 18 years old, grades K-12</td><td><u>Gap</u>: Many children of all ages are living in either kinship placements or in foster care because of their parents Substance Use Disorder or because of incarceration.</td><td>Point-In-Time Homeless Survey, January 31, 2019

• 58 children placed in kinship program at Fairfield County Child Protective Service.
• 53 of these cases are due to parental SUD.
• 20 of these children are placed with relatives.
• The remaining 33 are placed with family outside of Fairfield County.</td></tr>
<tr><td>In most recent survey of twelfth graders, frequent use of:

<u>Gap</u>: Alcohol and marijuana have increased.

<u>Asset</u>: Tobacco and other people's prescriptions have decreased.</td><td>Fairfield County Youth Behavior Survey, 2018.

Frequent Use (30-day use) Seniors – 12th Graders

<table>
<tr><th></th><th>2004</th><th>2006</th><th>2008</th><th>2010</th><th>2012</th><th>2014</th><th>2016</th><th>2018</th></tr>
<tr><td>Alcohol</td><td>37.9</td><td>34.9</td><td>31.2</td><td>34.7</td><td>21.1</td><td>19.6</td><td>19.1</td><td>21.8</td></tr>
<tr><td>Tobacco</td><td>24</td><td>23.0</td><td>23.5</td><td>22.5</td><td>14.1</td><td>9.9</td><td>8.0</td><td>7.8</td></tr>
<tr><td>Marijuana</td><td>18.8</td><td>14.4</td><td>15.8</td><td>20.3</td><td>16.4</td><td>14.2</td><td>14.6</td><td>18.2</td></tr>
<tr><td>Other People's Prescriptions</td><td>9.3</td><td>8.5</td><td>7.2</td><td>5.7</td><td>2.4</td><td>.4</td><td>1.0</td><td>0.8</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Population</th><th>Impact</th><th>Data</th></tr>
<tr><td>School-aged Children (continued)

Defined
5 to 18 years old, grades K-12</td><td>In 2018, twelfth graders disclosed that:

<u>Gap</u>: It is easier to access to alcohol, tobacco, and marijuana as compared to 2016 survey results.

<u>Asset</u>: It is harder to access prescription drugs and heroin compared to 2016.</td><td>Fairfield County Youth Behavior Survey, 2018.

Ease of Access
Very Easy and Somewhat Easy - % Seniors
<table><tr><th></th><th>2004</th><th>2006</th><th>2008</th><th>2010</th><th>2012</th><th>2014</th><th>2016</th><th>2018</th></tr><tr><td>Alcohol</td><td>85</td><td>84.2</td><td>84.2</td><td>83.3</td><td>79.1</td><td>76.7</td><td>73.4</td><td>74.5</td></tr><tr><td>Tobacco</td><td>85.5</td><td>84.7</td><td>75.3</td><td>84.3</td><td>79.6</td><td>75.2</td><td>69.8</td><td>70.2</td></tr><tr><td>Marijuana</td><td>69</td><td>67.3</td><td>66.2</td><td>73.1</td><td>68.1</td><td>68.3</td><td>63.6</td><td>67.2</td></tr><tr><td>Illegal Rx Drugs</td><td>49</td><td>49</td><td>45.3</td><td>45.7</td><td>35.7</td><td>31.8</td><td>29.1</td><td>27.4</td></tr><tr><td>Heroin</td><td>15.6</td><td>16.2</td><td>15.9</td><td>30.4</td><td>30.3</td><td>25.5</td><td>22.6</td><td>19.7</td></tr></table></td></tr>
<tr><td>Young Adults

Defined
18 to 24 years of age</td><td><u>Gap</u>: Young adults are impacted by the opioid epidemic by lack of education including high school graduation and not attending college. Also arrests, incarceration, and unemployment.</td><td>There is no existing data in this area.</td></tr>
<tr><td>Families

Defined
Any group of persons that define themselves as family. (This includes single parent, married, unmarried, same sex, opposite sex, adoptive, biologically related, etc.)</td><td><u>Gap</u>: Many children of all ages are living in either kinship placements or in foster care because of their parents Substance Use Disorder or because of incarceration.</td><td>Point-In-Time Homeless Survey, January 31, 2019

• 58 children placed in kinship program at Fairfield County Child Protective Service.
• 53 of these cases are due to parental SUD.
• 20 of these children are placed with relatives.
• The remaining 33 are placed with family outside of Fairfield County.</td></tr>
<tr><td>Adults

Defined
18 years of age or older (unless they are in high school)</td><td><u>Gap</u>: Opioid overdoses and overdose mortality rate.</td><td>Prevalence and/or incidence rate of opioid overdoses: 2016: 147.1 per 100,000 people (OHA Drug Overdose Sharing Program)

Opioid overdose mortality rate: 2010-2016 age adjusted rate: 11.9 deaths per 100,000 people (Ohio Department of Health Drug Overdose Report)

Number of hospital system encounters where an overdose was suspected. (Ohio Hospital Association Overdose Data Sharing Program)

2014: 87 2015: 111 2016: 175 2017: 215 2018: 181</td></tr>
<tr><td>Aging Adults

Defined
55 years of age or older</td><td><u>Gap</u>: Unknown</td><td>There is no existing data in this area.</td></tr>
</table>

Prevention: Summarizing Local Context and Conditions

Most of the information collected is from the Fairfield County ADAMH Board providers quarterly report, but that is only a small section of our community. Many schools are requesting specific information on medical marijuana, vaping, juuls and e-cigarettes. There is lack of data available regarding young adults, adults, and older adults in the community. The providers are doing the best they can with the requests they receive. They cannot meet all of the needs for school-aged youth throughout the county. The Fairfield County ADAMH Board implements a Youth Behavior Survey in the schools in Fairfield County every other year. The most recent survey was completed in the Spring of 2018. A total of 2,106 students in grades 10 and 12 from nine (9) schools participated in the 2018 survey. The results of the surveys provide a benchmark for alcohol, tobacco and other drug (ATOD) use as well as an indication of negative and problematic behavior among our youth. These behaviors are self-reported. Concurrently, the survey also assesses the risk factors that are related to these behaviors and protective factors that guard against them.

Prevention: Finding Opportunities, Gaps, and Resources

As part of the template provided by COP-RCORP TTAE team, the Fairfield Opiate Task Force reviewed the prevention needs assessment and identified opportunities and gaps in Fairfield County, as well as existing and potential federal, state, and local resources that could be used to address OUD with the RCORP funding award. The opportunities, gaps, and resources for prevention-related service systems were then organized in a table (see Table 2).

Table 2. Prevention Service Systems: Opportunities, Gaps, and Resources

Prevention	
Opportunities	• Collaborations between partners in the Opiate Task Force • Community Education Forums • Family member support groups • School-based programs delivered by Fairfield County ADAMH Board provider agencies, including the Pax Good Behavior Game Training • All School Districts have some level of prevention services. • Prevention efforts include supply reduction such as Fairfield County physicians writing fewer opiate prescriptions. Also, encourage patients to be aware of alternatives to taking opiate pain medications. • Prevention efforts also include demand reduction strategies such as educating people about how to secure, monitor and dispose of unused opiate medications. The community has purchased locked boxes and Deterra bags to be dispersed throughout the county with partners at Recovery Housing, Metropolitan Housing Authority, Head Start, Meals on Wheels, and others. • Overdose reversal includes educating first responders about the disease of addiction and also providing information on compassion fatigue. • Fairfield Medical Center is a Project Dawn site and has presentations regarding Naloxone and train people how to administer the drug. • Project F.O.R.T. (Fairfield County Overdose Response Team) is a quick response team that visits people 24-48 hours after an overdose. They distribute Naloxone to people with Substance Use Disorder, family members and at Community Education Events.
Gaps	• The community does not know what services are available. • Young people have very few positive activities, especially in the villages. • There is no bus service to the villages in Fairfield County. Lack of transportation affects employment, getting to appointments for treatment, getting to the court for court hearings, and getting to recovery support activities. • Denial within the community about substance abuse. • Stigma surrounding mental health and substance abuse. • Federal and State government funding focuses on opiates and the largest problems in our community are alcohol, marijuana, and methamphetamine. • Difficulty finding licensed and certified employers. There are only a handful of certified prevention specialists in Fairfield County.
Resources	• Community Collective Impact Model for Change (CCIM4C) grant was a federal grant that came through the state. • The community does a good job of collaborating so that dollars from Criminal Justice, Family Adult and Children First Council, and United Way are braided with ADAMH Board dollars to increase our ability to receive grant funding. • Faith-based organizations such as Lutheran Social Services, churches in Bremen, Pleasantville, Carrol, Rushville and Amanda. • United Way of Fairfield County • The Fairfield County Foundation • The Columbus Foundation • Charity Newsies • Gannett Foundation

Treatment: Assessing Community Needs and Resources

After local consortia completed the treatment needs and gap assessment template provided by the COP-RCORP master consortium, the TTAE team organized the Fairfield Opiate Task Force answers by three categories—availability, accessibility, and affordability—and inserted them into a table (see Table 3) to better delineate the impacts of opioid use in the treatment sector. For treatment, data was not separated by demographic age range, as it was for prevention. A summary of the Fairfield Opiate Task Force work in the area of treatment is also included.

Table 3. Treatment Needs Assessment

Type of Need	Narrative	Data
Availability	Gap: Shortage of physicians who are able to or willing to provide MAT services.	Amongst 3 recovery centers/treatment facilities, only 4 providers are currently certified to prescribe suboxone. From these four providers, 211 persons are currently receiving suboxone.
	Gap: Shortage of psychiatrists.	3 Full Time and 3 Part Time at two facilities.
	Gap: Treatment waitlists.	The average wait from the first contact to offering assessment is 5.11 days. The average wait from the first contact to the assessment being completed is 1.65 days. The average wait from the assessment being completed and treatment being offered is 10.14 days. The average wait from treatment being offered and the start of treatment is 2.85 days. (OhioMHAS Waitlist Data for Fairfield County).
	Asset: Family Counseling and support groups are available.	New Horizons Peer Support Specialists 2 The Recovery Center Ohio Guidestone Fairfield Mental Health Consumer Group
	Gap: No local Inpatient unit.	No local Inpatient unit 2016 Fairfield Community Health Assessment, 4% of county adults reported that they had looked for alcohol or drug abuse programs for themselves or a loved one. Of those that looked for programs, almost half of respondents (44%) were unable to find a specific program.
	Asset: Intensive Outpatient is available for both men and women, as well as Outpatient.	There is no existing data in this area.
	Gap: No MAT for pregnant women.	No OB/GYN providers who are willing to work with pregnant women who are being prescribed MAT.
	Gap: Recovery Housing has a limited number of beds available.	Pearl House accepts single families but is limited to 21 apartments. Promise House and Sober Living for Men have 10 beds total and there is always a waiting list. For women's sober living there are 8 beds available, but this is not the social model of Recovery Housing; rather, these are supervised apartments where women who are working on recovery can live.
	Gap: Scarce services to family members who have taken in the children suffering as a result of parents' opiate use.	Kinship programming has many restrictions and limitations and little assistance available outside of foster care, for example if a relative takes in the children.

Type of Need	Narrative	Data
Availability *(continued)*	Gap: Shortage of safe and affordable housing and Recovery Housing.	June 2017: 32 households on the wait list for Pearl House and 144 families on the wait list for Rutherford House. 2016: Lancaster-Fairfield Community Action Agency's family shelter had 87 homeless families on the wait list. Lutheran Services, through ADAMH Board funding, provides a number of different types of housing and helps individuals find housing. 2016 Recovery Oriented Systems of Care Survey, 78.8% of respondents strongly disagreed or disagreed that recovery supports are available in the community including peer support, housing and transportation.
	Gap: No Methadone programs - have to go to COMP DRUG in Columbus every day. Job and Family Services offers a bus trip only through Medicaid.	No Methadone programs
	Gap: No one offering a specific Evidenced-Based service to address persons with Co-Occurring Disorders.	No evidence-based services exist
	Gap: Most adolescents receive their SUD treatment out of county at Nationwide Children's Hospital in Columbus, Ohio. The Recovery Center does treat a small number of adolescents with SUD, but not necessarily OUD.	There is no existing data in this area.
Accessibility	Gap: There is often a lack of transportation.	Most services are either in Lancaster and Pickerington, so to get there from one of the rural areas would be almost impossible if an individual did not have a car. Lancaster Transit offers transportation most of the day, but is not available after 5pm or on the weekends.
	Gap: ADAMH funded an employment program at the Recovery Center with the mistaken assumption that this population is the same in terms of employment skills and needs as the more traditional "recovery alcoholic" community. It is not the same.	There is no existing data in this area.
Affordability	Gap: Drug Court's restrictions are a barrier to accessing treatment.	Drug Courts often require that participants not try to hold jobs, which makes it hard for them to pay rent, feed themselves and any family, and to meet life's basic demands.
	Gap: These are younger people, often with little or no work experience or skills. They have expressed a lack of interest in working at all unless they are paid salaries which are far higher than one could expect for someone who is unskilled and unexperienced.	There is no existing data in this area.

Treatment: Summarizing Local Context and Conditions

According to service providers, the population needing treatment in Fairfield County is mostly white, younger, (between 25-45, second largest group is 18-24, then 55-69) and male. People in treatment are often not "just in treatment", rather they are involved with many systems such as the Drug Courts, Children's Services, Mental Health Centers, etc. Even in the best of circumstances, we know that it often takes 4 to 5 attempts at recovery for people to become successful. It is not unusual for persons to be turned away from a particular service because they have a history of "no-shows" or "cancellations." This is especially true of the coveted appointments with physicians prescribing MAT, and with psychiatrists. Having recently expanded MAT services, we believe that this has had a very positive impact, offering consumers more choices for where they receive services. It has negated the need for them to use physicians who only dispense the medicines without accompanying treatment services. The ADAMH Board is responsible for planning, funding, and monitoring services to persons with Substance Use Disorder and persons with Mental Illness. We have a lack of data to support our belief that the services are effective. All of our prevention programs are evidenced-based, but we are still working to require this from our treatment providers. There is a very strong "Not in My Backyard" mentality in Fairfield County, so expanding Recovery Housing has been a challenge and needs to continue to be addressed.

Treatment: Finding Opportunities, Gaps, and Resources

As part of the template provided by the COP-RCORP TTAE team, the Fairfield Opiate Task Force reviewed the treatment needs assessment and identified opportunities and gaps in Fairfield County, as well as existing and potential federal, state, and local resources that could be used to address OUD with the RCORP funding award. The opportunities, gaps, and resources for treatment-related service systems were then organized in a table (see Table 4).

Table 4. Treatment Service Systems: Opportunities, Gaps, and Resources

Treatment	
Opportunities	• The Fairfield Opiate Task Force, using the Collective Impact model, has done a great deal of planning this year. • Partners have come to an agreement that there is a need for better data collection. • The Fairfield Opiate Task Force has expanded the working committees and has brought new partners to the table including Fairfield Medical Center, Health Department, Providers, Recovery Housing Providers, 211/Information and Referral, Family Adult and Children First Council, Kroger Pharmacy, Fairfield County Sheriff's Department, The Re-entry Coalition, The Housing Coalition, Lancaster Police Department, County Commissioners, and the City of Lancaster Mayor. • The Recovery Center was one of the first programs in Ohio to offer Medication-Assisted Treatment, and Fairfield County is doing an excellent job expanding these services through work with additional providers. • Project Fairfield Overdose Response Team is the result of collaboration between local law enforcement (Major Crimes), the ADAMH Board, treatment providers, local paramedics from Fire Departments, and other community partners.
Gaps	• Lack of workforce. We lack physicians who will provide MAT, psychiatrists, chemical dependency counselors, Independently Licensed Counselors and Social Workers, and qualified Certified Prevention workers. It is harder for more rural areas to pay the same salaries as larger cities. • The amount of student loan debt for persons working in community mental health is a barrier. • Changes in Behavioral Healthcare in Ohio have created additional challenges for all our providers. If an individual has Medicaid, he or she can access treatment more easily than if private insurance is the payor source. Private Insurance companies most often require Independently Licensed providers, and even then, not all private insurance companies pay well for mental health and addiction services. • There is a lack of safe, affordable housing in the county. • The treatment providers are located in Lancaster and in Pickerington, Ohio, and so people from Bremen, Pleasantville, Rushville, Amanda, and Carrol must have transportation to get to services. Lack of transportation is a constraint for many people. • There is a need for more providers to offer evening and weekend hours. • Representatives from school indicate there is a need for more in-school treatment. • There is a need for adolescent substance use disorder treatment.
Resources	• Medication-Assisted Treatment/Prescription Drug and Opioid Addiction funds through OhioMHAS and these are federal dollars. • State Opiate Response dollars through OhioMHAS • United Way of Fairfield County • The Fairfield County Foundation • The Columbus Foundation • Faith-based organizations • Charity Newsies

Recovery Supports: Assessing Community Needs and Resources

After local consortia filled in the recovery template provided by the master consortium, the TTAE team organized the Fairfield Opiate Task Force's answers by three categories—availability, accessibility, and affordability—and inserted them into a table (see Table 5) to better delineate the impacts of opioid use in the recovery sector. For recovery, data was not separated by demographic age range, as it was for prevention. A summary of the Fairfield Opiate Task Force's work in the area of recovery is also included.

Table 5. Recovery Supports Needs Assessment

Type of Need	Narrative	Data
Availability	Gap: The biggest need is housing.	June 2017: 32 households on the wait list for Pearl House and 144 families on the wait list for Rutherford House. 2016: Lancaster-Fairfield Community Action Agency's family shelter had 87 homeless families on the wait list. Lutheran Services, through ADAMH Board funding, provides a number of different types of housing and helps individuals find housing. 2016 Recovery Oriented Systems of Care Survey, 78.8% of respondents strongly disagreed or disagreed that recovery supports are available in the community including peer support, housing and transportation.
	Gap: Shortage of Independently Licensed SUD specialists and professionals.	4 Psychiatrists, 2 Psychologists, 19 LSW, 9 LISW, 6 LCDC, 3 LICDC-CS, 6 PSS
	Gap: Peer Supporters are also in high demand, and yet, there are not enough qualified ones in the county.	199 people receiving peer support services (2018).
	Asset: Currently creating peer supports within the criminal system such as the jail and common pleas court. There are also several support groups and peer groups.	Fairfield Mental Health Consumer Group, which is run by and for consumers. Annual training by OhioMHAS staff for the persons who want to become Certified Peer Supporters. 199 people receiving peer support services (2018).
	Asset: Clinical supports, case management, vocational services, etc.	Fairfield Mental Health Consumer Group has peer support programs, including group and individual support, and payeeship. The Payeeship program where consumers have help managing their funds so they can keep up on bills and necessities. Client advocate who connects persons to services and helps them navigate to find what they need. 2018, 83 people in emergency shelter have seen the Housing Specialist.
	Asset: Supported employment program for persons with severe and persistent mental illness that is very successful and is evidenced-based.	FMHCG reported that it helped 21 people manage their spending money (2018). New Horizons Mental Health provides Evidence Based Supported Employment services.

Type of Need	Narrative	Data
Accessibility	Gap: Transportation is lacking.	Most services are either in Lancaster and Pickerington, so to get there from one of the rural areas would be almost impossible if an individual did not have a car. Lancaster Transit offers transportation most of the day, but is not available after 5pm or on the weekends.
	Asset: There are several resources to find resources in the community.	ADAMH website, the service providers' websites, advertisements (billboards, bus wraps, social media). The Fairfield ADAMH Board also hosts a Recovery Conference every year. With the Collective Impact Grant, PSAs and rack cards are being created to make the community aware of different services from emergency overdosing medication to recovery supports. The Project FORT Overdose Response Team delivers information to individuals and families within 48 hours after an overdose.
Affordability	Asset: Most of the Recovery Services in Fairfield County are provided through ADAMH Board funding and grants.	State Opiate Response grant, the Assisted Treatment Program grant, the Medication Assisted Treatment-Prescription Opiate Drug Abuse grant. The ADAMH Board owns two Recovery Houses for men which are managed and operated by Lutheran Social Services. LSS also uses ADAMH funds to provide housing to women with opiate use disorder and other substance use disorders. The ADAMH Board funds the Fairfield Mental Health Consumer Group for individual and group Peer Support, a Drop In Center, and for being the "payee" to persons who cannot manage their finances without assistance.
	Gap/Asset: Medicaid now pays for Peer Support services in some instances, but the provider must be certified to offer this service, and the individual Peer Support worker has to be certified and meet certain criteria.	To date, none of the providers are yet billing Medicaid for Peer Support with the exception of OhioGuidestone, and soon the Recovery Center.

Recovery: Summarizing Local Context and Conditions

Fairfield County has a number of recovery support services. This includes peer support in a number of settings. We are currently creating peer supports within the criminal system, such as the jail and common pleas court. There are also several support groups and peer groups. No one should be turned away from an ADAMH Board network of care provider service due to lack of ability to pay. Most of the services are on a sliding fee scale. Persons with no or low income are eligible for Medicaid. It is the person who has insurance and a low income who tends to struggle the most with fees for services. The ADAMH Board has recently begun looking into these cases and has a process for creating a "Hardship" case so that services can be delivered regardless. Increased waitlists sizes can cause relapsing if that person isn't seen in time. Lack of housing and transportation can also cause relapsing (not being able to attend services), homelessness and unemployment (not being able to attend job or interviews), child custody issues and strain on extended families, etc. (Service Provider data). Many times, individuals in the community will cycle through the recovery process because they lack adequate housing, income, etc.

Recovery Supports: Finding Opportunities, Gaps, and Resources

As part of the template provided by the COP-RCORP TTAE team, the Fairfield Opiate Task Force reviewed the recovery supports needs assessment and identified opportunities and gaps in Fairfield County, as well as existing and potential federal, state, and local resources that could be used to address OUD with the RCORP funding award. The opportunities, gaps, and resources for recovery-related service systems were then organized in a table (see Table 6).

Table 6. Recovery Supports Service Systems: Opportunities, Gaps, and Resources

Recovery Supports	
Opportunities	• 211, the ADAMH Board, and the Network of Care system, Fairfield Mental Health Consumer Group, Navigation program. • Library systems, Fairfield Medical Center, schools, Mobile Crisis and the Re-entry Coalition. • We are currently working to place peer supporters to provide services to persons leaving jail/prison and persons in common pleas court. • We are working on creating PSAs and advertisements to promote services around the community. • We are considering ways to improve access to trainings for peer support and other certifications to increase knowledge and qualifications. • A conversation on how to keep workforce within the county and not leave for bigger cities such as Columbus is also happening.
Gaps	• There is a shortage of personnel available. • There's a need for qualified peer supporters. • There is a huge need for more affordable and decent housing. • Denial and stigma – a lack of education and understanding • There is a lack of support in general for minorities and special populations within these communities. • There is a need for transportation. • Unemployment. • There is a gap in childcare supports for grandparents who are taking care of the children of people suffering from addiction.
Resources	• State Opioid Response (SOR) Peer Support grant – we asked for funding to place two peer supporters in unconventional placements to help overlooked populations with recovery supports. • Faith-based state chapters and businesses. • We would like to involve Ohio University-Lancaster to provide further education for students to become peer supporters, and if applicable, to further the education of peer supporters through a certificate. • Business owners and influential community members. • There are many groups within the community such as the Chamber of Commerce, the Rotary Club, and the Lions Club.

Workforce Development Planning

Workforce development is a key part of both the planning and implementation phase of the COP-RCORP initiative. The focus of the needs and gap assessment process was to gather data on impacts, gaps, and assets in the areas of prevention, treatment, and recovery as they affect different populations in each local consortia and the relevant service systems. Each local consortium can now use the needs assessment to guide the strategic planning process by identifying priorities in their community. Given the importance of the needs assessment to guiding strategic planning, the workforce development components of the RCORP-P grant were shifted into their own process and deliverable. Workforce development needs and strategic plans will be addressed in a separate, stand-alone document that complements the prevention, treatment, and recovery needs and gaps identified in this document.

Conclusion

COP-RCORP is focused on selecting evidenced-based strategies that are culturally competent and sustainable at a community level. The COP-RCORP initiative will use a strategic planning process grounded in logic chains and the strategic planning framework to guide this process. Using such a process sets each consortium up for success by ensuring that strategy selection is tied to data at a local level. Each local consortium will develop 5 strategic plan maps to connect the information from their needs assessment to the strategies that make the most sense for their community in the three areas of prevent (reducing supply, reducing demand, and reducing substance related deaths) as well as treatment and recovery. In developing these plans, local consortia will determine the root causes of the substance use related problems in each of these five areas and be able to identify solutions that are linked directly to community-specific and culturally relevant contexts.

Our community has some valuable data on youth and what the provider agencies collect on a regular basis. The Fairfield County Health Department along with other agencies conducts a Community Health Assessment every three years but there are only a limited number of questions related to substances. The gaps in our data involve our young adults and our senior citizens. A number of years ago, we did have data on young adults in the community, but no one was able to replicate that survey. The Opiate Task Force will reach out to Meals on Wheels and the Older Adult Network to invite them to become members of our Task Force.

This process has allowed the Fairfield County Opiate Task Force to identify the strengths and weaknesses in our current continuity of care, data collection, and collaborative efforts in addressing the opiate use disorder epidemic in our county. The process has also fostered many conversations, renewed energies and resulted in new partnerships.

APPENDIX

COP-RCORP Capacity and Readiness Survey

Table 1. Consortium Readiness.

Survey Item	N	Aggregate	
		Mean	S.D.
Our consortium's initiative for this project seems better than what we were doing in planning to address opiate use disorder (OUD).	6	3.67	0.52
Our consortium's initiative for this project is important compared with other things we do in planning to address opiate use disorder (OUD).	6	3.67	0.52
Participants are engaged in this process.	6	4.00	0.63
Stakeholders are open to change.	6	4.33	0.52
Our consortium's initiative for this project can adequately acquire and allocate resources (including time, money, effort and technology).	6	4.33	0.52
Meeting facilitators and interviewers for this project are culturally competent and speak the language(s) spoken by interviewees.	6	4.17	0.41
Facilitators and interviewers for this project are trained in moderating interviews, including keeping participants on topic, facilitating concurrence, and maintaining neutrality.	6	4.17	0.41

Table 2. Consortium Planning Capacity.

Survey Item	N	Aggregate	
		Mean	S.D.
Communication			
Members of our consortium think it is important to engage in regular structured open communication with community members and other participating organizations.	6	4.17	0.75
Members of our consortium have knowledge of or experience in engaging in regular structured open communication with community members and other participating organizations.	6	4.17	0.75
Members of our consortium regularly engage in structured, open communication with community members and other participating organizations.	6	4.00	1.10
Shared Vision / Common Agenda			
Most members of our consortium think it is important to share with other participating organizations a common understanding of a problem.	6	4.17	0.41
Members of our consortium share a common understanding of the problem.	6	4.50	0.55
Performance Management / Evaluation			
Members of our consortium think it is important to agree with other participating organizations on the ways success will be measured and reported.	6	4.00	0.63
Our consortium knows how to evaluate if our initiatives are reaching our desired outcomes and goals.	6	4.17	0.41
Our consortium has agreed with other organizations on the ways success will be measured and reported.	6	3.67	0.82
Our consortium members regularly make minor adjustments to our initiative to improve its success.	6	3.83	0.41
There is evidence that this consortium is benefiting our community.	6	4.17	0.41
Collaboration			
Members of our consortium think it is important to work with a diverse set of stakeholders to coordinate a set of activities using a plan of action.	6	4.33	0.82
Our consortium members have experience in working with a diverse set of stakeholders to coordinate a set of activities using a plan of action.	6	4.17	1.17
Members of our consortium have knowledge of or experience in using a joint approach to solve a problem through agreed-upon actions.	6	4.17	0.41
Consortium members have good relationships with others inside our organization.	6	4.33	0.52
Most members of our consortium have worked with a diverse set of stakeholders to coordinate a set of activities using a plan of action.	6	4.00	0.63
The consortium is able to use a joint approach to develop strategic plans to solve a problem.	6	4.17	0.41

Table 3. Strategic Planning Capacity.

Survey Item	N	Aggregate	
		Mean	S.D.
Strategic Planning Capacity			
Consortium Capacity for Use of Evidence-Based Strategies & Strategic Planning			
Our consortium knows how to select an evidence-based initiative that best fits with our organization and community's needs.	6	4.17	0.75
Using evidence-based strategies and strategic planning is one of the three main priorities of our consortium.	6	4.33	0.52
Most members of our consortium view evidence-based strategies and strategic planning as difficult to understand.	6	2.00	0.63
Using evidence-based strategies and strategic planning has been better than other strategies that could have been implemented to address the same problems/issues.	6	3.67	0.82
Most members of our consortium view evidence-based strategies and strategic planning as consistent with the needs of potential users in the community.	6	3.83	0.41
Most members of our consortium view evidence-based strategies and strategic planning as difficult to implement.	5	2.40	0.55
Members of our consortium have the knowledge or experience needed to implement evidence-based strategies and strategic planning.	6	4.17	0.41
Our consortium includes leaders who will use their influence to advocate for implementation of evidence-based strategies and strategic planning.	6	4.33	0.52
Strategic Prevention Framework			
Members of our consortium have the concrete skills to perform the tasks needed to implement the Strategic Prevention Framework (SPF).	6	4.17	0.41
Most members of our consortium view the Strategic Prevention Framework (SPF) as consistent with the community's values and norms.	6	4.00	0.00
Our consortium includes individuals who will be strong advocates for implementing the Strategic Prevention Framework (SPF).	6	4.17	0.75

Table 4. Factors.

Survey Item	N	Aggregate	
		Mean	S.D.
Cultural norms, attitudes, or practices favoring substance use	6	3.67	0.52
Lack of community awareness of the extent or consequences of substance abuse	6	3.50	0.84
Community disorganization	6	2.67	0.52
High poverty rates/low socioeconomic status	6	3.83	0.41
High unemployment or underemployment	6	3.33	0.82
Low literacy, lack of education, education a low priority, or high dropout rates	6	3.00	1.10
Large recent refugee/immigrant population	6	1.50	0.55
Language barriers	6	1.50	0.55
Easy access to substances for underage youth	6	3.83	0.41
Easy access to substances for adults	6	3.83	0.41
Not enough funds for prevention interventions	6	3.50	0.84
Lack of relevant prevention interventions for specific populations at risk	6	3.00	0.89
Lack of transportation, difficulty reaching some parts of the community	6	3.83	0.41
Lack of trust in law enforcement, government, social services	6	2.83	1.17
Limited legal policies/laws or enforcement	5	2.20	0.45
Lack of drug-free activities for area youth	6	2.67	0.52
Lack of supervision for area youths	6	2.67	0.52
Events that included substance use and received local media coverage and influence public opinion	6	2.17	0.75
Stressful events affecting large portions of the target population, such as large fires, hurricanes, earthquakes, or terrorist attacks	6	2.17	0.41

Table 5. Consortium Capacity to Address Factors

Survey Item	N	Aggregate	
		Mean	S.D.
Economic Opportunities			
Members of our consortium think it is important to implement strategies to improve economic opportunities to counter the symptoms of community trauma.	6	3.67	0.82
Members of our consortium have knowledge of or experience in strategies to improve economic opportunities to counter the symptoms of community trauma.	6	3.50	0.55
Members of our consortium have skills to implement strategies to improve economic opportunities to counter the symptoms of community trauma.	6	3.83	0.75
Physical / Built Environment			
Members of our consortium think it is important to implement strategies within the physical/built environment to counter the symptoms of community trauma.	6	3.33	0.82
Members of our consortium have knowledge of or experience in strategies within the physical/built environment to counter the symptoms of community trauma.	5	3.80	1.10
Members of our consortium have skills to implement strategies within the physical/built environment to counter the symptoms of community trauma.	6	4.00	0.89
Social-Cultural Environment			
Members of our consortium think it is important to implement strategies within the social-cultural environment to counter the symptoms of community trauma.	6	3.83	0.75
Members of our consortium have knowledge of or experience in strategies within the social-cultural environment to counter the symptoms of community trauma.	6	4.17	0.75
Members of our consortium have skills to implement strategies within the social-cultural environment to counter the symptoms of community trauma.	6	4.17	0.75

Table 6. Impact.

Note. Responses were on a scale of 0 (not at all) to 10 (completely).					
Survey Item	**N**	**Mean**	**Median**	**Mode**	**S.D.**
Influence					
People in the community listen to the opinion/position taken by the RCORP consortium.	6	6.33	6.50	5.00	1.21
The RCORP consortium has access to powerful people.	6	7.50	7.50	7.00	0.55
The consortium has relationships with public officials who can help the RCORP planning process in my community.	6	7.00	7.00	6.00	1.55
The RCORP consortium can gain support from political figures when needed.	6	6.83	7.00	8.00	2.23
The RCORP consortium works appropriately with influential community residents.	6	7.33	7.50	4.00	2.16
Participation					
The RCORP consortium gets its members outside the community to participate in activities when necessary.	6	6.33	6.50	7.00	0.82
The consortium gets community members to participate actively in the RCORP planning process.	6	7.00	7.50	8.00	1.79
Community members get involved in the RCORP initiative's activities.	6	7.17	7.00	7.00	1.94
The consortium has relationships with diverse groups (For example, local businesses, religious institutions, colleges, and universities.) that can help the RCORP initiative.	6	7.00	7.50	8.00	2.19
Use of Data					
Consortium members are committed to using data to set the agenda.	6	7.33	6.50	6.00	2.16
Consortium members are committed to using data to improve our work over time.	6	7.67	7.50	10.00	2.07
The RCORP consortium helps people in the community identify shared goals.	6	7.17	7.00	6.00	1.17
Community Focus					
The leadership communicates the RCORP consortium's concerns to community members.	6	6.33	5.50	5.00	1.97
The RCORP planning process helps to increase a sense of community.	6	7.17	7.00	6.00	1.17
The RCORP planning process helps people in the community work together.	6	7.33	7.50	6.00	1.21