COP-RCORP

Communities of Practice for Rural Communities Opioid Response Program

Core Activity 2: Needs and Gaps Assessment

Ashtabula County, Ohio

Ashtabula County Substance Abuse Leadership Team

Ashtabula County Mental Health Recovery Services Board

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The Ashtabula County Substance Abuse Leadership Team (SALT) 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 Ashtabula's SALT (local consortium), the Ashtabula County Mental Health and Recovery Services Board (backbone organization), and the COP-RCORP Training, Technical Assistance, and Evaluation Team (OHIO and PIRE).

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Ashtabula County Substance Abuse Leadership Team

Ashtabula County Mental Health Recovery Services Board

September 29, 2019

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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.

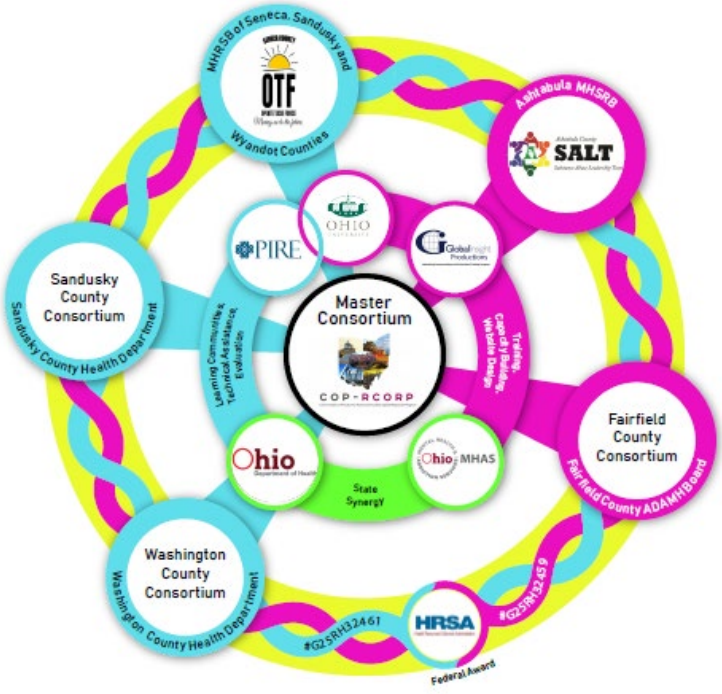

Figure 1. CoP-RCORP Organizational Chart.

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.

Ashtabula County Substance Abuse Leadership Team

In Ashtabula County, the Substance Abuse Leadership Team (SALT) serves as the local consortium for the RCORP-Planning grant, while the Ashtabula County Mental Health and Recovery Services Board (MHRSB) operates as the backbone organization. In order to develop and strengthen the local consortium, the MHRSB entered into a memorandum of understanding with local collaborators.

Local consortium. The Ashtabula County Substance Abuse Leadership Team (SALT) serves as the local consortium in Ashtabula County for the RCORP-Planning grant. SALT was formed in March 2017 to address the complex issues of opioid use, misuse, abuse, and overdose deaths in the county, as well as to gather information for coordinated responses to all substance abuse problems the county may face now and in the future. The work of SALT includes: reducing the number of drug overdoses; increasing public safety; increasing public education and information; and improving a coordinated response to promote prevention, intervention, treatment, and recovery support efforts.

Backbone organization and project director. The Ashtabula County Mental Health and Recovery Services Board (MHRSB) operates as the backbone organization in Ashtabula County for the RCORP-Planning grant. Miriam Walton, Executive Director of the Ashtabula MHRB Board, is Ashtabula's project director for the grant.

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

- Ashtabula County Board Commissioners
- Ashtabula County Health Department
- Community Counseling Center
- Northwest Ambulance District

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. The entire county of Ashtabula is being included for the RCORP-Planning grant. Ashtabula County is the northeastern most county in the state of Ohio, encompasses 702 square miles, and is the largest county in Ohio by area. It is a federally designated Appalachian Region and is struggling with many of the same economic and educational deficits found in other Appalachian regions of the state.

Population. According to population estimates by the U.S. Census Bureau, the 2018 population estimate is 97,483. 5.6% of residents are under the age of 5, 22.2% are under the age of 18, and 18.6% are persons 65 years of age and older. The racial makeup of the county is 93.2% White, 3.8% Black/African American, 0.3% Native American, 0.5% Asian, and 2.2% two or more races. 4.2% of the population is Hispanic or Latino and 6.6% reside in homes where a language other than English is spoken. Median household income for 2013-2017 was $43,017 and 19.3% of persons were living in poverty. According to the Robert Wood Johnson Foundation 2019 County Health Ranking Report: 28% of children live in poverty compared to 20% for Ohio and 36% of children live in single-parent households. 88% have a high school diploma and 46% have some college, compared to 65% for Ohio.

Population of focus. The population we hope to impact are persons at risk for substance abuse and addiction, persons who have a substance use disorder, their families/significant others, and community members affected by substance abuse.

Community history. Ashtabula County has attempted to address substance use disorders throughout its entire system of care, from prevention to treatment and recovery supports. We have also attempted to address its effects on family members/significant others and the community.

The community has grown from extensive collaborations with traditional and non-traditional partners and participation in various initiatives such as collective impact; obtaining special or grant funding for high need populations such as criminal justice; expanding access to services by providing services where clients are such as jails and immediate access clinic; and bringing the entire community together to provide the Remote Area Medical event for the past two years.

Community culture. The overall culture of the county is diverse. 46.4% of the county is rural and the remainder can be described as micro-urban, which encompass small sections of the county, yet have the same issues as large urban areas without the advantages of resources available to those areas. Ashtabula is the largest county in the state of Ohio and there are cultural differences in the northern and southern sections of the county. The cities of Conneaut and Ashtabula have high concentrations of poverty, and a qualified opportunity zone is located within each of those cities. The city of Geneva has the most concentration of persons of Hispanic descent due to the large number of agricultural jobs in and around the city. Ashtabula is classified as an Appalachian county and has a small Amish population. Although the visitors bureau provides information about the many tourist attractions in the county, the poverty rate of many of its members result in residents not taking advantage of those resources.

The community is proud of the tourism that it attracts. The county is situated along the Lake Erie shoreline on the glaciated terrain of Ohio's North coast. Ashtabula County covers 26 miles of the Lake Erie shoreline, and has Ohio's largest viticulture district. It also has the largest collection of covered bridges in the state,

including the longest and shortest bridges in the United States. Ashtabula County also promotes Geneva State Park and its 23 wineries, as 50% of the grapes grown in Ohio are found in Ashtabula County.

Figure 2. Ashtabula County Courthouse.

Figure 2 is of the Ashtabula County Courthouse. We selected it because it is the county seat and the center of the county.

Figure 3 is of the Lake Erie shoreline. We selected it because Lake Erie's shoreline encompasses 26 miles in Ashtabula County and is a large part of our tourism.

Figure 3. Lake Erie shoreline.

Figure 4 is of Red Ribbon Week, Conneaut. We selected it because it represents the efforts of an entire community, including grassroots organizations, to promote substance abuse prevention.

Figure 4. Red Ribbon Week, Conneaut.

Figure 5 is of Pinwheels for Prevention. We selected it because we believe that it is important to reduce all risk factors for substance abuse.

Figure 5. Pinwheels for Prevention.

Figure 6 is of a covered bridge. We selected it because the county's covered bridges are one of the things the county is known for and is part of our history and tourism.

Figure 6. Covered bridge.

Vision/Mission/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. "To be the primary coordinating body that promotes and removes barriers to substance abuse prevention, treatment, and recovery support initiatives and resources for Ashtabula County residents."

Currently, the Consortium has accomplished:

1. Community education and outreach: Education for the community via social/print media, pamphlets, videos, and radio/TV.
2. Supply reduction: Distribution of Deterra drug disposal bags, promotion of drug drop off boxes.
3. Overdose reversal: Quick Response Team, distribution of Narcan.
4. Increase treatment access: Satellite offices, increased access to detox and residential treatment.
5. Recovery supports: Increased availability of peer support services.
6. Prevention: Implementation of PAX Tools training for the community.

In the short term, the Consortium is planning to address stigma and increasing the connectedness of residents across the lifespan.

In the long term, the Consortium is planning to increase workforce shortage areas, increase access to treatment and recovery supports, promote prevention across the lifespan, decrease overdose deaths, and increase community connections.

Mission. "The Ashtabula County Substance Abuse Leadership Team (SALT) was formed in March 2017 to address the complex issues of opioid use, misuse, abuse, and overdose deaths in the County as well as gather information for coordinated responses to all substance abuse problems the county may face now and in the future. The work of the Ashtabula County Substance Abuse Leadership Team includes: reducing the number of drug overdoses; increasing public safety; increasing public education and information; and improving a coordinated response to promote prevention, intervention, treatment and recovery support efforts."

Planning values. The Leadership Team aims to take a collaborative, community-wide approach to combat the drug epidemic plaguing Ashtabula County. The core values agreed upon by the Leadership Team are:

1. Addiction is our community's problem and requires collective and coordinated community solutions.
    - This value is important to our consortium because we want all members of our community to view substance abuse as a problem that affects everyone and that everyone can be helpful in solving the problem.
2. Addiction is a major health problem that affects the community at every social-economic level and at every level of community development.
    - This value is important to our consortium because we would like our community to view addiction as a disease and reduce the stigma associated with persons who have substance use disorders.
3. Through collaboration and the wise use of resources, we can make a difference.
    - This value is important to our consortium because we want to instill hope that persons can recover from substance abuse and that, through our work, we will improve the problem.

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 Ashtabula 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 COP-RCORP Training, Technical Assistance, and Evaluation (TTAE) team provided project leads 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 leads 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 leads 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.

Community-specific Data Collection Methods

The Ashtabula County SALT utilized focus groups and key informant interviews to gather qualitative data to gain a greater understanding of local quantitative data.

Method for Identifying Priorities

The TTAE team provided a template to project leads 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

The strategy used for building concurrence within the consortium and among stakeholders for setting priorities was to have the Substance Abuse Leadership Team COP-RCORP Subcommittee meet to review updated needs assessment documents, information from local plans, including the Board's Fiscal Years 2019/2020 Community Plan and the Ashtabula County Community Health Assessment, information obtained through work completed for the Collective Impact (CCIM4C) project, and guiding principles of the Substance Abuse Leadership Team.

The Subcommittee reviewed the six Collective Impact Strategic Plans to determine if the goals and strategies reflected current priority needs and how the issues in the community relate to the priority needs. Each identified priority was also evaluated to determine if they could be measured and assessed when current data is applied. Strategies were reviewed against evidence-based practices, resources available, and collaborations that could be utilized to maximize implementation.

Once the Subcommittee reached consensus, a representative of the subcommittee presented a draft of the recommended priorities to the full Substance Abuse Leadership Team for review, input, and agreement on final recommendations.

Results and Findings

The Substance Abuse Leadership Team 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 Substance Abuse Leadership Team 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 Substance Abuse Leadership Team work in the area of prevention is also included.

Table 1. Prevention Needs Assessment

Population	Impact	Data
Young Children **Defined** Children up to the age of 5	Gap: There have been significant increases in the number of children removed from their homes by Children Services due to parental substance abuse.	Ashtabula County Children Services Board (ACCSB) reported receiving 2,554 reports of suspected child abuse and neglect (CA/N) in calendar year 2018. The total number of children involved with the agency throughout the year was 1,131, while the average number of children in placement was 237. Of the 227 children who were actually removed during the calendar year, 85 were removed due to SUD by the parent/caregiver. However, ACCSB worked with Supervisors and Caseworkers to improve the consistency of reporting SUD as the primary cause of removal, as neglect was often documented when SUD was a root cause. Therefore, there are likely more than the 85 reported removals due to SUD by the parent/caregiver. The Ohio Department of Job and Family Services Data Dashboard reports that the percentage of children removed with Parental Drug Use/Abuse as a removal reason has increased from 25% in January of 2014 to 59.3% in January of 2019. ACCSB experienced the most significant increase in that percentage from January 2018 (43.9%) to January 2019 (59.3%). In calendar year 2018, the total number of drug-exposed babies was 57, with 34 children under the age of 1 year removed due to parental drug use.
	Asset: There have been increased efforts to increase protective factors and decrease the risk factors of substance abuse later in life. There has also been an increased focus on parents who abuse substances to intervene and prevent child maltreatment.	Head Start and other preschool providers are looking for tools and resources to use for this age group, as many of their students are dealing with trauma on a regular basis and often need help learning self-regulation. We are informing the adult population that everyone plays a role in prevention for youth by decreasing risks and increasing or improving assets for the young people of our community. PAX Tools Training is being provided to families and persons who interact with youth.
School-aged Children **Defined** Youth between the ages of 6 and 18	Gap: The Substance Abuse and Mental Health Services Administration reports that 'children with a parent who has an SUD are more likely than children who do not have a parent with an SUD to have lower socioeconomic status and increased difficulties in academic and social settings and family functioning.[1] Children having a parent with an SUD are at risk of experiencing direct effects, such as parental abuse or neglect, or indirect effects, such as fewer household resources'.	18% of youth in grades 7, 9, and 10 reported living with someone who used illegal drugs or abused prescription medications.

Population	Impact	Data
School-aged Children (continued) **Defined** Youth between the ages of 6 and 18	Gap: Significant increases in the number of children being removed from their homes due to parental substance abuse.	Ashtabula County Children Services Board (ACCSB) reported receiving 2,554 reports of suspected child abuse and neglect (CA/N) in calendar year 2018. The total number of children involved with the agency throughout the year was 1,131, while the average number of children in placement was 237. Of the 227 children who were actually removed during the calendar year, 85 were removed due to SUD by the parent/caregiver. However, ACCSB worked with Supervisors and Caseworkers to improve the consistency of reporting SUD as the primary cause of removal, as neglect was often documented when SUD was a root cause. Therefore, there are likely more than the 85 reported removals due to SUD by the parent/caregiver. The Ohio Department of Job and Family Services Data Dashboard reports that the percentage of children removed with Parental Drug Use/Abuse as a removal reason has increased from 25% in January of 2014 to 59.3% in January of 2019. ACCSB experienced the most significant increase in that percentage from January 2018 (43.9%) to January 2019 (59.3%).
Young Adults **Defined** Persons aged 18-25	Gap: Increased incarceration rates for drug-related crimes.	According to the County Prosecutor, felony drug cases filed continues to rise from 343 in 2016 to 436 in 2018. According to the Sheriff's Department, the prevalence of drug trafficking, including opiate trafficking, coupled with an under-resourced policing structure has contributed to an increase in violent crime in Ashtabula County. In 2016, Ashtabula County's murder rate was 11 per 100,000 residents. For reference, the national average was just under 5 in 2015, the most current year for UCR data. In addition, during 2016 and 2017, the Ohio Attorney General reported that Ashtabula County had the second highest number of Methamphetamine labs in the State of Ohio.
	Gap: Fatal and non-fatal drug overdoses by persons aged 18 and older.	459 Ashtabula County adults responded to the Community Health Status Assessment and identified the following: 4% of adults had used medication not prescribed for them or took more than prescribed to feel good or high and/or more active or alert during the past 6 months, increasing to 6% of those ages 30-64. Adults who misused prescription medication obtained their medication from the following: primary care physician (80%), bought from a drug dealer (7%), free from friend or family member (7%), from multiple doctors (6%), bought from friend or family member (6%), and from ER or urgent care doctor (4%). Information provided by the Ashtabula County Sheriff's Office indicates there were 117 total overdoses in 2017 and 41 were fatal. In 2018, there were 254 overdoses and 25 were fatal.

Population	Impact	Data
Young Adults (continued) **Defined** Persons aged 18-25	Gap: Community trauma due to increased crime and overdoses.	Information obtained from the 2019 Community Health Assessment indicates that: • 23% of Ashtabula County adults had four or more adverse childhood experiences (ACEs) in their lifetime • In the past year, 15% of Ashtabula County adults had a period of two or more weeks when they felt so sad or hopeless nearly every day that they stopped doing usual activities • 6% of Ashtabula County adults considered attempting suicide in the past year • 12% reported that people in their neighborhoods are afraid to go out at night due to violence • 4% reported gangs are a serious problem in their neighborhood. According to the Sheriff's Department, the prevalence of drug trafficking, including opiate trafficking, coupled with an under-resourced policing structure has contributed to an increase in violent crime in Ashtabula County. In 2016, Ashtabula County's murder rate was 11 per 100,000 residents (Ashtabula County Coroner's Office). For reference, the national average was just under 5 in 2015, the most current year for UCR data.
Families **Defined** Our community defines family as a social unit that consists of parents and children, whether living together or not.	Gap: Increasing numbers of parents have lost custody of their children through involvement with Children Services.	The Ohio Department of Job and Family Services Data Dashboard reports that the percentage of children removed with Parental Drug Use/Abuse as a removal reason has increased from 25% in January of 2014 to 59.3% in January of 2019. ACCSB experienced the most significant increase in that percentage from January 2018 (43.9%) to January 2019 (59.3%).
	Gap: Financial status of families reduces when a family member is incarcerated.	There is no existing local data in this area, however according to the Ella Baker Center for Human Rights, Forward Together, and Research Action Design 'many families lose income when a family member is removed from household wage earning and struggle to meet basic needs while paying fees, supporting their loved one financially, and bearing the costs of keeping in touch. Nearly 2 in 3 families (65%) with an incarcerated member were unable to meet their family's basic needs. Forty-nine percent struggled with meeting basic food needs and 48% had trouble meeting basic housing needs because of the financial costs of having an incarcerated loved one'.
	Gap: Fatal and non-fatal drug overdoses impact children, spouses, significant others, parents, and grandparents.	Information provided by the Ashtabula County Sheriff's Office indicates there were 117 total overdoses in 2017 and 41 were fatal. In 2018, there were 254 overdoses and 25 were fatal. A report in the 2007 Journal of Psychoactive Drugs indicates that 'death by overdose is loaded with social/moral stigmas, in addition to strong feelings of anger, helplessness, guilt and shame in the families'. The 2018 -2019 PCSAO Factbook, there were 1,182 Ashtabula County grandparents raising grandchildren.

Population	Impact	Data
Adults **Defined** Persons aged 18- 64	Gap: Increased incarceration rates for drug-related crimes.	According to the County Prosecutor, felony drug cases filed continues to rise from 343 in 2016 to 436 in 2018. According to the Sheriff's Department, the prevalence of drug trafficking, including opiate trafficking, coupled with an under-resourced policing structure has contributed to an increase in violent crime in Ashtabula County. In 2016, Ashtabula County's murder rate was 11 per 100,000 residents. For reference, the national average was just under 5 in 2015, the most current year for UCR data. In addition, during 2016 and 2017, the Ohio Attorney General reported that Ashtabula County had the second highest number of Methamphetamine labs in the State of Ohio.
	Gap: Fatal and non-fatal drug overdoses by persons aged 18 and older.	459 Ashtabula County adults responded to the Community Health Status Assessment and identified the following: 4% of adults had used medication not prescribed for them or took more than prescribed to feel good or high and/or more active or alert during the past 6 months, increasing to 6% of those ages 30-64. Adults who misused prescription medication obtained their medication from the following: primary care physician (80%), bought from a drug dealer (7%), free from friend or family member (7%), from multiple doctors (6%), bought from friend or family member (6%), and from ER or urgent care doctor (4%). Information provided by the Ashtabula County Sheriff's Office indicates there were 117 total overdoses in 2017 and 41 were fatal. In 2018, there were 254 overdoses and 25 were fatal.
	Gap: Community trauma due to increased crime and overdoses.	Information obtained from the 2019 Community Health Assessment indicates that: • 23% of Ashtabula County adults had four or more adverse childhood experiences (ACEs) in their lifetime; in the past year • 15% of Ashtabula County adults had a period of two or more weeks when they felt so sad or hopeless nearly every day that they stopped doing usual activities • 6% of Ashtabula County adults considered attempting suicide in the past year • 12% reported that people in their neighborhoods are afraid to go out at night due to violence • 4% reported gangs are a serious problem in their neighborhood. According to the Sheriff's Department, the prevalence of drug trafficking, including opiate trafficking, coupled with an under-resourced policing structure has contributed to an increase in violent crime in Ashtabula County. In 2016, Ashtabula County's murder rate was 11 per 100,000 residents (Ashtabula County Coroner's Office). For reference, the national average was just under 5 in 2015, the most current year for UCR data.
Aging Adults **Defined**: Persons 65 years of age and older	Gap: Caregiver burden exists when grandparents take custody of their grandchildren due to a parent's substance abuse.	A January 2019 Point in Time study of Ashtabula County Children Services reports that 45% of children were placed in kinship care.

Prevention: Summarizing Local Context and Conditions

The Ashtabula County Prevention Coalition has been funded by a Drug Free Communities Grant and the misuse of prescription opiates is a major focus of the Coalition's efforts and work plan. The PAX Good Behavior Game is provided in pre-schools and Head Start schools. All teachers in grades K-5 in the Conneaut and Buckeye school districts have been trained in the PAX Good Behavior Game. Grades K-3 at Jefferson Area Local Schools have been trained, and kindergarten and first grade teachers in the Ashtabula City school district have also been trained. Geneva Area City Schools will also have all staff of grades K-5 trained by August. Head Start, which has satellite offices in the cities of Conneaut and Ashtabula, staff have been trained. In addition, PAX Tools Training for families, after-school programs, and community members have been provided. Botvin Lifeskills Training is provided to grades 3 through 12. Rachel's Challenge is in all Ashtabula County middle and high schools, Ohio Teen Institute (OTI) is at one high school, After-school programs like One Step and After School Discovery, and programming provided by Ashtabula County District Libraries in Ashtabula and Geneva, provide pro-social activities for youth to participate in, as well as the Ashtabula YMCA before-school program.

We are informing the adult population that everyone plays a role in prevention for youth by decreasing risks and increasing or improving assets for the young people of our community. Some needs are being met. However, feedback from community key informants and youth focus groups indicates that social conditions such as poverty, lack of access to pro-social activities, lack of supervision by parents, and access to opioids continue to impact the opioid epidemic. Businesses are requesting information regarding substance misuse and abuse, Your Life Matters Calls, and information about the safe storage and disposal of medications. Adult Career Center and the Youth Opportunities Program have requested speakers and information. Additional work is needed to address the prevention needs of the young adult population. We have begun to reach out to this population through the local branch of the university, but more efforts are needed. Public awareness regarding the opiate epidemic, its consequences, and current resources to address it has increased. Additional work is needed in stigma reduction to ensure that persons in need of services will ask for them and families needing support will be comfortable with seeking assistance. More resources for families, particularly those living in poverty are needed to encourage connection to the community, services, and pro-social activities that will increase their resilience and reduce risk factors. Senior Citizen Centers request educational presentations regarding substance misuse and abuse and drug disposal mechanisms. Aging adults often have prescription drugs that can be misused and, generally due to the cost of their prescriptions, do not always dispose of unused medications.

Prevention: Finding Opportunities, Gaps, and Resources

As part of the template provided by COP-RCORP TTAE team, the Substance Abuse Leadership Team reviewed the prevention needs assessment and identified opportunities and gaps in Ashtabula 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 community groups and organizations such as the Ashtabula County Prevention Coalition and the Ashtabula County Substance Abuse Leadership Team. • Evidence-based school programs including Botvin Lifeskills Training and the PAX Good Behavior Team. • Ashtabula Quick Response Team • Community Counseling Center Prevention initiatives • Financial and in-kind support provided by the MHRS Board • Grassroots efforts in local communities • The County Health Department's Tobacco Prevention Program
Gaps	• Not enough certified Prevention Specialists for the county. • Spotty internet connections limit efforts. • Lack of programming and resources to reach multiple cultures in the county. • Funding and resources to address the root cause of substance abuse in the county. • Funding and resources to increase opportunities for all community members to connect to the people, processes, and systems they need to lead meaningful and productive lives.
Resources	• Currently in Year Five of a Drug Free Communities grant and will be applying for a Drug Free Community Continuation Grant. • Community Collective Impact Model for Change (CCIM4C) Initiative • Foundation Youth-Led Prevention in Appalachia Ohio grant • Potential funding may come through OhioMHAS and ODE for school prevention efforts. • The Ashtabula County Prevention Coalition and Substance Abuse Leadership Team has donated human resources time and money. • Ashtabula Foundation • Robert S. Morrison 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 Substance Abuse Leadership Team 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 Substance Abuse Leadership Team work in the area of treatment is also included.

Table 3. Treatment Needs Assessment

Type of Need	Narrative	Data
Availability	Gap: Co-occurring disorders are prevalent. Co-occurring disorders often require the conflation of treatment modalities or even providers. If both disorders are not appropriately addressed, treatment can be rendered ineffective for both.	Historically approximately 75% of the individuals released from the state hospital have a co-occurring mental health and substance abuse diagnosis. Information obtained from performance reports of Drug and Mental Health Court Specialized Dockets, as well as Children's Services, also document a high percentage of persons served as having co-occurring disorders.
	Gap: Quality Housing is a consistent need for individuals in treatment, as many individuals are homeless or unable to return to previous their residence at the time of discharge from treatment.	Approximately 50% of those in the Board's Shelter Plus Care Housing Voucher Program, which is targeted to individuals with a Severe and Persistent Mental Illness (SPMI) and are homeless, have a co-occurring Substance Use Disorder (SUD) diagnosis of abuse or addiction and are in recovery. Approximately 85% of individuals served through the Board's Mental Health Emergency Assistance funding needed assistance with emergency housing or rent.
	Gap: Capacity concerns exist in that individuals are at times wait-listed for inpatient/residential services.	One local residential treatment provider has a waiting list of seven individuals for men's residential treatment. The local provider for detoxification services has a daily waitlist for services. The waitlist is typically 6-7 males, 2 females per day. For jail treatment services, the most recent group of participants (November 2018-February 2019) had an average wait of 56 days between referral and entry into the program. The previous group of participants (August 2018-November 2018) had an average wait of 14.8 days between referral and entry into the program.
	Gap: Detoxification and residential treatment beds are sometimes difficult to secure at the time a need is identified.	Everyone enters at detoxification-level services then transitions when the treating physician recommends a different level of care, so as assessments are completed, individuals are in a queue for entry. Bed space opens daily, and varies, but the current wait is approximately 2 days from assessment to admission.
	Gap: Weekend availability of services is limited to primarily crisis services.	Three local providers have walk-in availability at which an individual is asked to provide identification, proof of residency, and any insurance information available at the time.

Type of Need	Narrative	Data
Accessibility	Gap: Employment is often a need when individuals are transitioning from in-patient or Intensive Outpatient Program (IOP) treatment to aftercare or discharge.	Employment during treatment is often difficult for those in IOP, though local treatment providers schedule IOP groups at varying times throughout the day/week to accommodate employed individuals. Individuals need supported employment opportunities to enhance skills and assist in maintaining work.
	Gap: Transportation is a significant need as only Ashtabula city has consistent public transportation available during limited hours. The remainder of the county has transportation by arranged ride through County Transportation or through Medicaid if it is for medical and BH appointments. Additionally, Ashtabula County is the largest county by square miles in the state. Further, lack of reliable, sober support transportation from one phase of treatment (i.e. detoxification) to another (i.e. IOP or residential) can be the point of attrition for many individuals with Opiate Use Disorder (OUD).	Ashtabula city has consistent public transportation available during limited hours (6a to 6p M-F and shorter hours on Saturday). Individuals cannot get transportation to non-behavioral health or non-medical treatment appointments such as court hearings or probation appointments. This can lead to further involvement in the criminal justice system
Affordability	Asset: The MHRS Board provides funding for treatment services for indigent and uninsured individuals. The MHRS Board provides the sliding fee scale and contracts with local providers for services. Services can be tracked through the SmartCare system.	Local providers have sliding fees for this population whose income is less than 200% of poverty. Assistance is also available through case management to obtain entitlements.

Treatment: Summarizing Local Context and Conditions

Two provider agencies administer mental health (MH) and substance use disorder (SUD) assessments for adults and children. Two local providers administer only SUD services. All four local providers serve individuals with co-occurring disorders; however, only three local providers provide services specific to this population. The fourth provider refers individuals with MH concerns to other providers for MH services, but continues to provide SUD services concurrently. According to the 2017 Ashtabula County Health Department's Health Needs Assessment, 75 % of adults went outside of Ashtabula County for health care services within the previous year. This report does not distinguish behavioral health from physical health services. In SFY 2017, 615 adults and 302 children received public behavioral health system-billable behavioral health services outside of Ashtabula County. In 2018, 1,703 adults and 509 children received behavioral health services outside of Ashtabula County. The statistic for 2018 only includes services billed through SmartCare and does not include services rendered outside of the SmartCare billing system. Therefore, the actual 2018 numbers are likely higher.

Treatment: Finding Opportunities, Gaps, and Resources

As part of the template provided by COP-RCORP TTAE team, the Substance Abuse Leadership Team reviewed the treatment needs assessment and identified opportunities and gaps in Ashtabula 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	• Use of evidence-based practices including Motivational Interviewing, CBI-SA, CBI-CC, EMDR, DBT, and CBT • Grants for programs featuring evidence-based practices for specific populations • Ohio SOR funding allows the Connection Center to provide services to individuals involved in the criminal justice system using the One-Stop model for service provision. • Jail-based services include evidence-based practices for persons with behavioral health disorders involved in the criminal justice system. • Community desire and commitment to spread trauma-informed care. • Four specialized dockets are certified through the Ohio Supreme Court. • Common Pleas Mental Health Court and Municipal Drug court adhere to the best practice indicated through their certification by the Ohio Supreme Court. • Ashtabula County Family and Children First Council has a trauma-informed care subcommittee, Building Resiliency Together (BRT), which serves as a networking and learning community to promote Trauma-Informed Care throughout the community and increase community connectedness. • The BRT plans to implement the THRIVE model to further evaluate the county and identify action steps to increase resiliency at the community level.
Gaps	• Lack of eligible candidates willing to fill open positions in the behavioral health treatment field in Ashtabula County. • Attempts to address barriers to services (i.e. transportation, location of service) have frequently been undermined by a lack of participation. • Need to address stigma in a comprehensive manner. • Waitlists for detoxification services and residential treatment services are a barrier. • Additional treatment services for the county jail population are limited due to physical facility constraints.
Resources	• Bureau of Justice grant for Adult Common Pleas Drug Court • Office and Juvenile Justice and Delinquency Prevention grant for the Family Drug Court • Medicaid expansion has been used to significantly bolster treatment efforts. • Continuum of Care General Revenue Funds (GRF) for MH, AOD, and Medication assistance • GRF Community Investments • Problem Gambling and Addictions funding • MH Services Block Grant funds (through state's Federal Block Grant Base) • Substance Abuse Prevention and Treatment (SAPT) Block Grant • Addiction Treatment Program (ATP) funding • State Opioid Response funding • Department of Youth Services (DYS) grant for Multi-systems Therapy for youth • Other grant applications in process

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 Substance Abuse Leadership Team'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 Ashtabula's Substance Abuse Leadership Team's work in the area of recovery is also included.

Table 5. Recovery Supports Needs Assessment

Type of Need	Narrative	Data
Availability	Gap: Recovery housing	Focus groups with persons in treatment or involved in specialized dockets, Management Information System data for Emergency Assistance and Recovery Housing. Some wait for recovery housing beds.
	Gap: Permanent housing	Focus groups with persons in treatment or involved in specialized dockets, Management Information System data for Emergency Assistance and Recovery Housing. Waiting list for permanent housing.
	Gap: Employment	Focus groups with persons in treatment or involved in specialized dockets, Management Information System data for Emergency Assistance and Recovery Housing. According to a 2018 Community Action Agency Needs Assessment: Local employers still report that they have many jobs that they are unable to fill due to a lack of skilled workers. There are several factors that contribute to the issue; first the need to develop a qualified workforce, second the need to keep talented, educated workers from leaving the area, and third replacing the number of baby boomers who will be retiring. Many of the available jobs are not entry-level and require some kind of technical training. Anecdotally, the biggest problem cited in the survey for our community, Drug Use (and Alcohol), contributes to the problem for employers. Local economic development professionals reported to the Star Beacon (the major daily newspaper for Ashtabula County) a common complaint from businesses is they struggle to find people who can pass a drug screen.
	Gap/Asset: Job training and education	According to the 2017-2018 U.S. Census Update for Ashtabula County 85.7% of residents have a high school/GED; 13.4% have a Bachelor's Degree or above; 54.5 percent of Ashtabula County residents age 16 and older are in the labor force. According to Community Action Agency's Needs Assessment, employers are having difficulty filling positions due to a lack of skilled workers indicating gaps in job training and education. ATECH school-based career education programs for students in high school and adult education programs, Youth Opportunities for persons who have dropped out of school ages 16-21, Kent State University Ashtabula Branch, Ohio Means Jobs- Workforce Development, Community Action Agency Job Training programs, Supported Employment services.
	Gap/Asset: Medical needs	We have 2 federally qualified health centers and one large dental clinic. Eye care for those without Medicaid still severe.
	Gap: Co-occurring disorders	Historically approximately 75% of the individuals released from the state hospital have a co-occurring mental health and substance abuse diagnosis. Information obtained from performance reports of Drug and Mental Health Court Specialized Dockets, as well as Children's Services, also document a high percentage of persons served as having co-occurring disorders.
	Gap: Peer coaches	There are no certified peer supporters in the county, and training has not been provided since FY 2016.
	Gap/Asset: Legal support	Residents access both Public Defender and Legal Aid services but there is no data on the percentage of those that qualify that access those services.
	Gap: Case management	During SFY 2018, 6801 units of Case Management service were delivered to Ashtabula County residents. This was 12.19% of the total amount paid for SUD treatment services for SFY 2018. Agencies report difficulty in finding and retaining SUD case managers.

Type of Need	Narrative	Data
Accessibility	Gap: Transportation	The location of most human service resources are primarily in the northern part of the county including all comprehensive behavioral health agencies, Job and Family Services, Children's Services, and Emergency Medical Services Limited public transportation: The only regular bus route in the county runs in the City of Ashtabula 6 a.m. to 5 p.m. Monday through Friday with shorter hours on Saturday. Transportation can be arranged through public transportation for free or a fee for the remaining areas of the county but there can be extensive wait times between the time a person is dropped off, their appointment time and the time they are returned home. Senior levy pays for some additional transportation for seniors. Medicaid pays for some transportation to medical appointments. Limited resources and the vast area to be covered have curtailed expansion of the public transportation system in the county.
Affordability	Asset: The MHRS Board pays for recovery support services.	During SFY 2019 the MHRS Board purchased the following Recovery Support Services: Supported Employment, Recovery Housing; Parenting Classes; Housing Assistance; Transportation; Emergency Assistance.
	Gap/Asset: Some individuals pay for their own recovery housing after the initial 90 days with funds from family members or from their employment.	LA02 Report demographic data and CURES report. There is no local data regarding how much individuals pay for their own recovery housing. However, the Board paid $75,293 for Recovery Housing in Fiscal Year 2019 (first 90 days of recovery housing). Will pay $45,000 in FY 20.
	Asset: Job programs are funded through Job and Family Services.	Job and Family Services
	Asset: Citizen Circle assists with recovery support services, as does Catholic Charities.	Environmental scans, needs assessment surveys and collaboration with partners. We do not have data on Citizen Circle or Catholic Charities, except for budgeted amounts for recovery support services for FY 2020: • Citizen Circle- $10,000 • SUD Emergency Assistance- $10,000 • MH Emergency Assistance- $40,000
	Asset: Food is obtained through SNAP or from local food pantries.	Environmental scans, needs assessment surveys and collaboration with partners.
	Gap/Asset: Transportation to medical appointments can be billed to Medicaid. Medical can be paid for through Medicaid or by going to one of the county's federally qualified health center.	The MHRS Board SUD Resource Manual provides information on how someone can access transportation assistance through the Ashtabula County Job and Family Services office to schedule in-county and out-of-county rides paid for by Medicaid as well as how to access reimbursement for gas to and from medical appointments if you have transportation and are on Medicaid. During 2018, Job and Family Services reported there were 975 one way trips for 50 passengers who qualified for Medicaid and the transportation was billed to Medicaid. There is not local data that demonstrates if this is meeting the needs of all persons on Medicaid.

Recovery: Summarizing Local Context and Conditions

Ashtabula County currently has a number of OUD-related health and social services available in the county but continues to struggle with behavioral health workforce capacity issues, as well as gaps in services and programs, particularly across its large geographic area. In the current environment, individuals in recovery are mostly individuals with an opiate use disorder or polysubstance abuse disorder. Most often, they also have a co-occurring mental health disorder. There must be proof of residency for the services paid for by the MHRS Board. Minimal requirements for others which may include a state ID or Driver's License, as in the case of the homeless shelter. Of the needs listed above, these are the priorities:

Severe

1. Transportation—to treatment, employment, training and court
2. Permanent housing
3. Not enough peer coaches
4. Child care

Moderate

1. Recovery housing—more severe need for men
2. Employment
3. Job training
4. Education
5. Co-occurring disorders—a lot of people with this issue; some treatment available
6. Recovery/Sober Club or Drop-in Center

Mild

1. Case management
2. Caregiver support
3. Legal support
4. Medical needs—we have 2 federally qualified health centers and one large dental clinic. Eye care for those without Medicaid still severe.
5. Transportation to self-help groups

Recovery Supports: Finding Opportunities, Gaps, and Resources

As part of the template provided by COP-RCORP TTAE team, the Substance Abuse Leadership Team reviewed the recovery supports needs assessment and identified opportunities and gaps in Ashtabula 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	• Recovery housing options • Robust Supported Employment Program • Bridges out of Poverty • Getting Ahead Classes • Strong collaborations between criminal justice and behavioral health
Gaps	• Not enough men's recovery beds • Not enough recovery housing options for families • Inability to meet transportation needs due to the size of the community and lack of funding • Reluctance among partners to embrace evidence-based practice • Treatment providers are unwilling to employ peer supporters due to low reimbursement rates
Resources	• State Opiate Response funding • 21st Century CURES funding • BJA and OCJS grants that permit the inclusion of funding for peer support services. • Federal Housing and Urban Development Grant • CJBH can be accessed for services in the county jail that include recovery support. • Local MHRS Board levy dollars match state and federal grants • Donations from local donors, including OhioCAN Ashtabula, for recovery support services, housing, food shelf items, hygiene products and cleaning supplies.

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.

The Ashtabula County Mental Health and Recovery Services Board serves as the backbone organization for the Ashtabula County Substance Abuse Leadership Team. The Board views needs assessment as a continuous, ongoing process. The Board ensures regular input from people in recovery and stakeholders and utilizes quantitative and qualitative data. The Board has engaged a number of different local planning bodies in assessing needs. For example, the Board has significant collaborations with the criminal justice system and is

a member of the Collaboration Boards for the: Ashtabula County Drug Court, Criminal Justice Behavioral Linkages Project, and Residential Substance Abuse Services Project. These Boards meet at least quarterly to plan and evaluate services to ensure the behavioral health treatment needs of adults with mental illness and/or addictions are addressed. The Board is a key member of the Family Drug Court Leadership Team and identifies the needs of parents and children as a result of substance misuse and involvement with Children Services. The Board Executive Director is a member of the Family and Children's First Council, Community Corrections Board, Health Department Needs Assessment Committee, Ashtabula County Prevention Coalition, Ashtabula County Suicide Prevention Coalition, Job and Family Services Transportation Advisory Committee, and the Child Fatality Review Board. The Board's Program Director is a member of the Building Resilience Together Committee, Family and Children First Council Public Information Committee, Advisory Committee and Service Coordination Team as well as a member of the Supported Employment Steering Committee and Ashtabula County Public Health Advisory Team.

The COP-RCORP needs assessment process helped focus the Substance Abuse Leadership Team's efforts in using data to determine the nature and extent of the opiate use problem in Ashtabula County. Although the Board has numerous partnerships, this project brought together representatives from all of them to address the specific problem of reducing opiate misuse and deaths in Ashtabula County. The methodology worked well to create community ownership of the problem and in identifying solutions. It pushed us to look deeper at root causes and analyze relevant social determinants of health and utilize the Tool for Health and Resilience in Vulnerable Environments (THRIVE)[1] that we were introduced to during the Community Collective Impact Model for Change Initiative. This process assisted us in identifying previous gaps in data collection such as the prevention needs of youth under the age of five and senior citizens. It also helped us look deeper into issues related to opiate abuse such as how the trauma of addiction is affecting families and the community. This process will help us work with partners as a community of health providers versus just behavioral health providers. We intend to use this document as a baseline that we will continue to update and add to as we obtain additional data. We will also utilize needs assessment data to keep our partners engaged in identifying issues related to opiate use and in assisting with the implementation of evidence-based strategies.

[1] Davis, R., Cook, D., & Cohen, L. (2005). A community resilience approach to reducing ethnic and racial disparities in health. *American Journal of Public Health, 95*(12), 2168-2173. doi: 10.2105/AJPH.2004.050146

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).	5	3.40	0.55
Our consortium's initiative for this project is important compared with other things we do in planning to address opiate use disorder (OUD).	5	3.60	0.55
Participants are engaged in this process.	5	4.20	0.45
Stakeholders are open to change.	5	4.20	0.45
Our consortium's initiative for this project can adequately acquire and allocate resources (including time, money, effort and technology).	5	4.00	0.71
Meeting facilitators and interviewers for this project are culturally competent and speak the language(s) spoken by interviewees.	5	3.60	0.55
Facilitators and interviewers for this project are trained in moderating interviews, including keeping participants on topic, facilitating concurrence, and maintaining neutrality.	5	3.40	0.55

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.	5	4.40	0.89
Members of our consortium have knowledge of or experience in engaging in regular structured open communication with community members and other participating organizations.	5	4.20	0.45
Members of our consortium regularly engage in structured, open communication with community members and other participating organizations.	5	4.40	0.55
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.	5	4.60	0.55
Members of our consortium share a common understanding of the problem.	5	4.20	0.45
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.	5	4.40	0.55
Our consortium knows how to evaluate if our initiatives are reaching our desired outcomes and goals.	5	4.40	0.55
Our consortium has agreed with other organizations on the ways success will be measured and reported.	5	4.00	0.71
Our consortium members regularly make minor adjustments to our initiative to improve its success.	5	4.20	0.45
There is evidence that this consortium is benefiting our community.	5	4.20	0.84
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.	5	4.40	0.55
Our consortium members have experience in working with a diverse set of stakeholders to coordinate a set of activities using a plan of action.	5	4.60	0.55
Members of our consortium have knowledge of or experience in using a joint approach to solve a problem through agreed-upon actions.	5	4.40	0.55
Consortium members have good relationships with others inside our organization.	5	4.20	0.45
Most members of our consortium have worked with a diverse set of stakeholders to coordinate a set of activities using a plan of action.	5	4.20	0.45
The consortium is able to use a joint approach to develop strategic plans to solve a problem.	5	4.20	0.45

Table 3. Strategic Planning Capacity.

Survey Item	N	Aggregate	
		Mean	S.D.
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.	5	4.60	0.55
Using evidence-based strategies and strategic planning is one of the three main priorities of our consortium.	5	4.60	0.55
Most members of our consortium view evidence-based strategies and strategic planning as difficult to understand.	5	2.40	0.55
Using evidence-based strategies and strategic planning has been better than other strategies that could have been implemented to address the same problems/issues.	5	3.80	0.45
Most members of our consortium view evidence-based strategies and strategic planning as consistent with the needs of potential users in the community.	5	4.40	0.55
Most members of our consortium view evidence-based strategies and strategic planning as difficult to implement.	5	2.00	0.71
Members of our consortium have the knowledge or experience needed to implement evidence-based strategies and strategic planning.	5	4.60	0.55
Our consortium includes leaders who will use their influence to advocate for implementation of evidence-based strategies and strategic planning.	5	4.40	0.55
Strategic Prevention Framework			
Members of our consortium have the concrete skills to perform the tasks needed to implement the Strategic Prevention Framework (SPF).	5	4.40	0.55
Most members of our consortium view the Strategic Prevention Framework (SPF) as consistent with the community's values and norms.	5	4.00	0.71
Our consortium includes individuals who will be strong advocates for implementing the Strategic Prevention Framework (SPF).	5	4.00	0.71

Table 4. Factors.

Survey Item	N	Aggregate	
		Mean	S.D.
Cultural norms, attitudes, or practices favoring substance use	5	4.00	0.00
Lack of community awareness of the extent or consequences of substance abuse	5	2.80	1.10
Community disorganization	5	2.40	0.89
High poverty rates/low socioeconomic status	5	4.00	0.00
High unemployment or underemployment	5	3.40	0.89
Low literacy, lack of education, education a low priority, or high dropout rates	5	3.20	0.45
Large recent refugee/immigrant population	5	2.60	0.55
Language barriers	4	2.25	0.50
Easy access to substances for underage youth	5	3.60	0.55
Easy access to substances for adults	5	4.00	0.00
Not enough funds for prevention interventions	5	3.20	0.84
Lack of relevant prevention interventions for specific populations at risk	5	3.00	0.71
Lack of transportation, difficulty reaching some parts of the community	5	3.80	0.45
Lack of trust in law enforcement, government, social services	5	2.40	0.55
Limited legal policies/laws or enforcement	5	2.60	0.55
Lack of drug-free activities for area youth	5	3.00	0.71
Lack of supervision for area youths	5	3.40	0.55
Events that included substance use and received local media coverage and influence public opinion	5	2.80	0.84
Stressful events affecting large portions of the target population, such as large fires, hurricanes, earthquakes, or terrorist attacks	5	2.20	1.30

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.	5	3.60	1.52
Members of our consortium have knowledge of or experience in strategies to improve economic opportunities to counter the symptoms of community trauma.	5	4.20	0.45
Members of our consortium have skills to implement strategies to improve economic opportunities to counter the symptoms of community trauma.	5	4.00	0.71
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.	5	3.80	0.45
Members of our consortium have knowledge of or experience in strategies within the physical/built environment to counter the symptoms of community trauma.	5	4.20	0.45
Members of our consortium have skills to implement strategies within the physical/built environment to counter the symptoms of community trauma.	5	4.20	0.45
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.	5	4.40	0.55
Members of our consortium have knowledge of or experience in strategies within the social-cultural environment to counter the symptoms of community trauma.	5	4.00	0.00
Members of our consortium have skills to implement strategies within the social-cultural environment to counter the symptoms of community trauma.	5	4.20	0.45

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.	4	7.00	7.00	7.00	0.82
The RCORP consortium has access to powerful people.	4	9.00	9.00	9.00	0.82
The consortium has relationships with public officials who can help the RCORP planning process in my community.	4	9.75	10.00	10.00	0.50
The RCORP consortium can gain support from political figures when needed.	5	9.00	9.00	9.00	0.71
The RCORP consortium works appropriately with influential community residents.	5	8.80	9.00	8.00	0.84
Participation					
The RCORP consortium gets its members outside the community to participate in activities when necessary.	4	5.25	5.00	2.00	2.99
The consortium gets community members to participate actively in the RCORP planning process.	4	6.50	6.50	4.00	2.08
Community members get involved in the RCORP initiative's activities.	5	6.40	6.00	6.00	1.14
The consortium has relationships with diverse groups (For example, local businesses, religious institutions, colleges, and universities.) that can help the RCORP initiative.	5	8.60	8.00	8.00	0.89
Use of Data					
Consortium members are committed to using data to set the agenda.	5	8.40	8.00	8.00	0.89
Consortium members are committed to using data to improve our work over time.	5	9.00	9.00	8.00	1.00
The RCORP consortium helps people in the community identify shared goals.	5	8.20	8.00	8.00	1.10
Community Focus					
The leadership communicates the RCORP consortium's concerns to community members.	5	8.00	8.00	8.00	1.87
The RCORP planning process helps to increase a sense of community.	5	7.80	8.00	5.00	1.92
The RCORP planning process helps people in the community work together.	5	7.60	8.00	8.00	1.82