USING DATA TO DEVELOP YOUR LOCAL NARRATIVE ON BEHAVIORAL HEALTH DISPARITIES

May 30-31, 2017

STRATEGIC PREVENTION FRAMEWORK
PARTNERSHIP FOR SUCCESS GRANTEE TRAINING
# Contents

THE CENTER FOR HOUSING & COMMUNITY STUDIES .................................................................................. 3  
TRAINING & TECHNICAL ASSISTANCE TEAM ...................................................................................... 4  
  Dr. Stephen J. Sills .................................................................................................................................. 4  
  Dr. Kenneth J. Gruber .............................................................................................................................. 4  
  Rachel Ryding .......................................................................................................................................... 5  
  Chase Hollemma ..................................................................................................................................... 5  
  Meredith DiMattina ............................................................................................................................... 5  
GUEST SPEAKERS AND PANELISTS ........................................................................................................ 6  
  Kenneth Shultz ........................................................................................................................................ 6  
  Dr. Jose Villalba ...................................................................................................................................... 6  
  Dr. Kathleen Egan ................................................................................................................................ 7  
  Professor Marbeth Holmes ..................................................................................................................... 7  
  Jason Yates ............................................................................................................................................. 7  
RESULTS OF TELEPHONE INTERVIEWS ................................................................................................ 8  
  Data Sources Being Used by PFS Coalitions .......................................................................................... 8  
  Profile Of Prescription Medication Misuse ............................................................................................ 9  
  Substances Being Used .......................................................................................................................... 9  
  Causal Factors ...................................................................................................................................... 9  
  Social Obstacles .................................................................................................................................. 10  
  Data Needs .......................................................................................................................................... 11  
  Populations with Disparate Access to Services ................................................................................... 11  
  Resource Needs .................................................................................................................................... 12  
NORTH CAROLINA QUICK FACTS ........................................................................................................... 13  
BRUNSWICK – PENDER – NEW HANOVER ............................................................................................... 14  
  Community Overview ........................................................................................................................... 14  
  Economy ............................................................................................................................................... 15  
  Substance Abuse Overview .................................................................................................................... 15  
  Self-Reported Profile ............................................................................................................................. 16  
  Recent News ........................................................................................................................................ 16  
BURKE ..................................................................................................................................................... 18  
  Community Overview ........................................................................................................................... 18  
  Economy ............................................................................................................................................... 19  
  Substance Abuse .................................................................................................................................. 19  
  Self-Reported Profile ............................................................................................................................. 20  
  Recent News ........................................................................................................................................ 20  
CABARRUS ................................................................................................................................................ 22  
  Community Overview ........................................................................................................................... 22  
  Economy ............................................................................................................................................... 23  
  Substance Abuse .................................................................................................................................. 23  
  Self-Reported Profile ............................................................................................................................. 24  
  Recent News ........................................................................................................................................ 24  
CLEVELAND .......................................................................................................................................... 26  
  Community Overview ........................................................................................................................... 26  
  Economy ............................................................................................................................................... 27  
  Substance Abuse .................................................................................................................................. 27  
  Self-Reported Profile ............................................................................................................................. 28  
  Recent News ........................................................................................................................................ 28  
DAVIDSON .............................................................................................................................................. 30  
  Community Overview ........................................................................................................................... 30  
  Economy ............................................................................................................................................... 31  
  Substance Abuse .................................................................................................................................. 31  
  Self-Reported Profile ............................................................................................................................. 32  
  Recent News ........................................................................................................................................ 32  
GASTON ................................................................................................................................................... 34  
  Community Overview ........................................................................................................................... 34  
  Economy ............................................................................................................................................... 35   

1
CHCS provides technical assistance to governmental and nonprofit agencies in understanding how the social, economic, environmental, and spatial aspects of communities impact health, wellbeing, and life course opportunities. We are actively engaged in regional community planning, development of health and wellbeing indicators, and studies of local community assets and resources.

The Center is equipped in many forms of in-person and remote quantitative and qualitative data collection: one-on-one interviews, focus groups, telephone interviews, postal mail surveys, electronic/web-based surveys, and computer-assisted in-person or telephone surveys. We are also able to assist with sample design, questionnaire development, qualitative and quantitative data analysis and reporting, as well as data mapping. Our team can conduct geospatial modeling and analysis, programming (Python, SQL, JavaScript, SAS, Html and CSS), web services and API configuration, as well as database development and management.

We are experienced in the design and implementation of formative and summative program evaluation, Asset-Based Community Development, Success Case Method (SCM) evaluation, needs assessment and asset mapping, and housing policy analysis.


More about CHCS may be found at https://chcs.uncg.edu/
TRAINING & TECHNICAL ASSISTANCE TEAM

The project team has been assembled to provide this project top level effort and expertise. The team has prior experience working together and includes a range of topical expertise (Opiate Task Force, Substance Abuse Treatment, Recovery, Harm Reduction, Rural Health, Behavioral Health,) as well as extensive methodological background.

**Dr. Stephen J. Sills** (PhD, Arizona State University, 2004) is Associate Professor of Sociology and Director of The Center for Housing and Community Studies. He has authored published research on immigration, poverty, immigrant access to health and social services, and social support networks for marginalized people including peer-reviewed articles on: Predictors of Drug Norms and Drug Use Among Preadolescents, Ecological Perspective on Latino/a Drug Use, Innovations in Survey Research, Methodological Issues of Mixed-Sex Focus Groups, and Culturally-specific Intervention Methods. His most recent teaching and publications are in the areas of fair housing, community-engaged research, program evaluation, and immigrant incorporation. Dr. Sills has served as an external evaluator for federal and state programs, consultant to local social service agencies and community organizations.

**Dr. Kenneth J. Gruber** (PhD, University of North Carolina at Greensboro 1981) is a social/research psychologist with over 30 years of research and program evaluation experience. He is Senior Research Scientist at the UNCG Center for Youth family and Community Partnerships. His areas of specialty include data collection design and methodology, statistical analysis, program evaluation, technical writing assistance, and grant application review. Dr. Gruber has worked with a variety of community partners covering a range of projects and issues. He also provides service to the University through consultation service to faculty and participation on student thesis and dissertation committees. His professional work is mostly in the area of program evaluation and the use of this information for program development and applied research. He has been deeply involved in community health topics publishing research on chronic illnesses, nutrition, adolescent pregnancy prevention, impact of diet on health and weight management, health access for uninsured adults, and environmental factors in the home and asthma. He has worked with a variety of communities including: older adults, immigrants, families, and low-income uninsured.
Rachel Ryding graduated summa cum laude from UNCG with a BA in Sociology and a concentration in Criminology. She is now pursuing a graduate degree in Sociology from the University of Delaware. Her primary research focus is on health disparities pertaining to substance use disorders, including: treatment access and outcomes for marginalized groups, the medicalization of drug epidemics, and the manifestation of inequalities and privilege in recovery communities. Rachel has worked with CHCS since 2015, where she served as project manager for the quality of life study in rural NC using the principles of asset-based community development. She also has experience working with collegiate recovery programs on multiple college campuses and has researched the effects of collegiate recovery programs in alleviating barriers to successful re-entry into higher education for students with a history of addiction.

Chase Holleman, MSW, CSAC is a social worker specializing in substance use and recovery. Chase graduated Summa Cum Laude from UNCG. During his time at The University of North Carolina at Greensboro Chase founded the Student Recovery Alliance, assisted with program development for the Spartan Recovery Program, and was president of the Social Work Student Organization. Chase recently completed his Master’s in Social Work at The University of North Carolina at Chapel Hill. Chase is also working as the Naloxone Program Coordinator at Caring Services, Inc. Chase assisted in the development of a community naloxone program, which he now leads. He is also a founder of the Guilford County Naloxone Task Force comprised of community leaders, concerned community members, and substance use professionals.

Meredith DiMattina is the CHCS GIS Specialist. She recently completed a Master of Geospatial Information Science and Technology at North Carolina State University. She has served as the GIS Transportation Planning Intern II for the City of Greensboro and has also worked as a Clinical Immigration Paralegal at Elon University’s School of Law. She has assisted the Center of Housing and Community Studies in developing a comprehensive online Community Asset Map for Southwestern North Carolina and is also assisting in mapping data from a census of housing conditions in Greensboro NC. She serves on the Board of Directors for JUS-NC, an immigrant and refugee resource and assistance program.
GUEST SPEAKERS AND PANELISTS

**Kenneth Shultz** is the Chief of Police in High Point, NC. He received a B.A. in Management and Ethics from Laurel University and attended the FBI National Academy in Quantico, VA. He has also received professional training through the Senior Executives in State and Local Government course offered as part of the Harvard Kennedy School of Government Executive Education Program. Chief Shultz has been a sworn officer with the High Point Police Department for over 26 years and has served in multiple capacities throughout the agency during his tenure, working on overall policy development, and planning and operations of the police department. He has experience working with the community through the development of the Victim’s Justice Center and through partnerships with service agencies such as Alcohol Drug Services and Caring Services while attempting to address chronic heroin problems.

**Dr. Jose Villalba** is a Professor of Counseling and Associate Dean for Faculty, Evaluation, and Inclusivity at Wake Forest University. Until 2013, he served as a faculty member in the Department of Counseling and also served as coordinator of the Minor in Health and Human Services. He teaches courses in multicultural counseling, career counseling, health and human services, and supervises counseling interns. His research interests included health disparities in Latina/o youth, as well as Latina/o access to and completion of higher education options. As Senior Associate Dean for Faculty, Evaluation, and Inclusivity, José facilitates the faculty recruitment process with Departments and Chairs in the College, as well as initiatives and resources that support diversity and inclusion efforts within the College. He received his M.Ed. and Ed.S. in Counseling and Ph.D. in Counselor Education from the University of Florida.
**Dr. Kathleen Egan** is a Research Associate at the Department of Social Science and Health Policy within the Division of Public Health at Wake Forest School of Medicine. Dr. Egan’s research focuses on the prevention of prescription drug, alcohol, tobacco, and other illicit drug use among youth and young adults. She is passionate about working with local organizations to translate practice into research and, subsequently, translating research back to practice. Dr. Egan has presented at the national, state, and local level and published on the topic of community-based strategies to address prescription drug abuse. She earned a PhD in Community Health Education at University of North Carolina at Greensboro in 2017 and Master of Science in Clinical and Population Translational Science at Wake Forest School of Medicine in 2011.

**Professor Marbeth Holmes** has been a Professor at Nash Community College since 1998. In 2004, she was recognized as Nash Community College’s J. Edgar and Peggie T. Moore Excellence in Teaching Award recipient. She holds a B.A. in English from Meredith College and a M.A. in English from Abilene Christian University, all with honors. She is the 2013 recipient of the UNC-CH Carroll Heins Scholarship to study at the Psychoanalysis Center of the Carolinas learning how childhood development, unconscious conflict and psychological trauma influence memory, symptoms, relationships, and a sense of self. Her recent clinical placements have been at the Duke University Infectious Disease Clinic and the Duke University Addictions Program where she has worked with patients with triple diagnoses living with HIV, Substance Use Disorder, and a variety of mental health disorders. In the context of the placement, she has also served as a behavioral healthcare provider on an Institutional Review Board (IRB) research study facilitated by the Duke Center for Health Policy and Inequalities.

**Jason Yates** is the Clinical Supervisor at Caring Services, Inc., a substance abuse treatment in High Point, NC., and an adjunct faculty member in the Department of Social Work at the University of North Carolina at Greensboro. He holds a Masters of Social Work from UNCG, and has credentials as a licensed clinical social worker (LCSW), licensed clinical addiction specialist (LCAS), and as a certified coding specialist (CCS).
RESULTS OF TELEPHONE INTERVIEWS

Telephone interviews with PFS Coordinators were conducted between 4/14/17 and 5/17/17 by Ms. Rachel Ryding and Mr. Chase Holleman. Coordinators have a range of tenures from newly hired (3 months ago) to those who have worked in the community in a variety of roles for more than 10 year. Most (72%) live in the county in which they work. The interview explored: local demographic and economic characteristics; coalition partnerships, activities, and successes; demographics of prescription medication misuse; current uses of data and data needs; obstacles to addressing local issues; and resource needs. Findings reported here include communities or populations who are experiencing disparate access to prevention/treatment/recovery and causal factors for prescription medication misuse among 12-25 year olds.

Data Sources Being Used by PFS Coalitions

PFS Coordinators have used data to garner buy-in from outside agencies, and to support their coalitions, promote their local prevent plans, and to evaluate outcomes: “We use the data to determine what strategies. Data leads us to right population of people, specific environmental factors that are relevant. They help us decide on strategies.” Coordinators were asked to identify current data sources being used to inform their partnership. The identified the following data sources:

- Court referrals from juvenile justice
- DSS
  - Foster care
  - Infants born addicted
- Emergency Department visits
- EMS naloxone administration
- Focus groups, community forums, and key informant interviews
- Health Department
- Medicaid claims
- NC Controlled Substances Reporting System (CSRS)
- NC DETECT
- Needs assessments
- Pharmacies
- Physicians
- PRIDE surveys
- Schools
  - Suspension and expulsion data
  - Referral data to social services
- Sheriff/Police/Highway Patrol/DEA
  - DUls not related to alcohol
  - Arrest data
- Young Adult surveys in the community college
- Youth Risk Behavior Surveillance System
Profile of Prescription Medication Misuse

Based on the PFS Coordinators’ perceptions of the local community (derived from OD data, law enforcement reports, hospital ED visits, and anecdotal evidence), prescription medication abuse most impacts working aged and over-65:

- **White working-aged, blue collar and white collar**
  - Mid 20’s working middle class. You will never know they are addicted because they work
  - Being white, being working age, being employed, being married are all things that increase access
  - OD deaths are White, about 38% in the age group 25-44, 33% in the age group 45-64
  - lot of men and women in their 30s
  - White males, 25-44
  - Mothers who get pregnant (20s and early 30s) have medication pushed on them by doctors
  - Haven’t identified any major race or gender disparities or SES
  - Increasing trends in adolescents, but data shows middle aged white men
  - Most overdoses are still across the board, hitting every demographic
  - In our community, more adults than youth
  - Most data supports that it is white middle aged males
  - Data from hospital, very rarely is it someone in their 20s, most of the time it is in their 30s-60s

- **Over 65**
  - over the age of 65 are most affected
  - 16% of OD deaths are seniors
  - Grandparents who are abusing medications
  - 55 and older misusing

**Substances Being Used**

Substances mentioned include opioids, tranquilizers, sedatives, and muscle relaxers, OTC medications, alcohol, marijuana, and tobacco. One coordinator explained that in her area, “Kids will take amphetamines and benzos to study and to have fun at the bonfire. “ Another coordinator said that opioids are taken more by the late 20s’ and early 30s’ and over 65 populations. Several coordinators mentioned increasing heroin use as there has been a crackdown on prescriptions. Also, OTC medications have been noted with younger populations due to ease of access.

**Causal Factors**

PFS Coordinators’ perceptions are that “prevalence of use in 12-25 is not nearly as much of a problem as for middle-aged and older adult populations.” One coordinator noted that OD deaths are 7% in the age group 19-24. They explained that kids are “more victim of parents” with parent giving them higher doses of medication prescribed making them think it is okay to take more. There was variability in prevalence among 12-25 year olds based on location. One coordinator explained that in her county “middle and high school; in high school, past 30-day use was around 20%, highest in 12 grade.” Factors that are related to use included:
• Easy access
  o friends and family members have them
  o parents and grandparents keep their medicines unlocked
  o Overprescribing for Sports injuries
  o Accessibility maybe causal factor. So easy for community to get them.
  o Doctors prescribing out the wazoo.
• Lack of opportunities for young people, boredom, and sense of hopelessness
  o Lack of resources for after school programs for youth
  o Boredom has a positive correlation with drug use, according to assessment
  o Real problem with kids who are graduating high school and aren’t plugged in to community college or furthering their education and are just hear without engaging in anything.
• Parental attitudes and behaviors
  o Kids are watching their parents doing it and increasing their risk.
  o Mom and Dad giving them the medication to calm them down, even multiple doses. If they can take one, then they can take three.
  o parents are doing it and its around, its easy access
  o parents allowing kids to use and drink at home
• Poverty among seniors
  o Seniors selling prescriptions
• Social acceptability
  o pill parties
  o Low perception of harm
  o the doctor prescribed this must be safe
  o Doctor prescribed it. Okay to share it.
• Other reasons
  o Deal with stress etc.
  o Need to sleep
  o Help with study/ concentration
  o Untreated depression or trauma

Social Obstacles

There were several attitudinal and cultural factors that play a role in the success or failure of local efforts to mobilize communities to address prescription misuse. They were identified as:

• Awareness
  o People do not understand ⅓ of the issue is heroin and ⅓ is prescription drugs
• Stigma
  o Stigma about what it means to be addicted, people who won’t seek help or admit that there is an issues because of the stigma
  o Fear, do not want it to become public that this is an issue with the schools and youth
  o Stigma, people are not willing to talk about it. Recent parents night about prevention, only 57-60 people there. Parents discussed that coming to events is an admission of a problem.
• Denial
  o Belief that “it’s not a problem here” and lingering sense of denial, especially among parents
  o Culture of not addressing the problem
  o Everyone points a finger at someone else
• **Culture of Use**
  - Alcohol is a rite of passage. First age of alcohol use in nine years old
  - Cultural norm of drinking in communities. Picking up a 12 pack is not unusual
  - A culture of sharing. People don’t think twice about it
  - Multigenerational “culture”, that doesn’t necessarily start with opioids but other medications that encourages sharing what you have

**Data Needs**

As one coordinator explained, it’s “very hard to get local data - state data is used most.” Another added, there’s “not a ton of quantifiable statistics locally.” Data on young people was especially difficult to obtain. Some of their data needs mentioned included:

• **School data**
  - more qualitative data from the schools

• **Law Enforcement**
  - demographics for those who are getting arrested with possession of prescription drugs

• **Hospital/ED/EMS**
  - specific information related to demographics.
  - demographics of people who are overdosing
  - Repeat overdose reversals
  - where people are living who are overdosing

• **CSRS**
  - easier access

**Populations with Disparate Access to Services**

Interviews yielded several populations who potentially experience disparate access to prevention, treatment, and recovery resources. This disparities included those who were geographically isolated in very rural areas, LGBTQ youth, those without insurance, Native American, and Hispanic/Latino populations.

• **Geographically Isolated**
  - Pockets of really rural economically deprived communities that they probably aren’t reaching.
  - Everyone knows that they have a very big opioid problem there, have had heroin problem for 15 years and no one has been going out there to reach out to them.
  - No mobile resources have recently started having monthly community meetings in different areas to try and increase engagement in those regions of the community. Have had good buy in from churches in the rural outlying areas, so churches are often hosting these meetings.

• **LGBTQ**
  - LGBTQ are not being served.

• **Uninsured**
  - Because so rural, there are more social determinants like lack of access to care and lack of insurance, pretty significant percentage of adults that are uninsured that perpetuates the sharing and lack of disposal.
• **Native American**
  - The native population based on drug courts. More Natives than anyone else. You can expect that population has higher use than anyone else.

• **Hispanic/Latino**
  - Try really hard to pull in Hispanic community because they are left out, pushback with stigma and history. Hispanic community claims the issue is alcohol and not prescription drugs, not aware that their youth are still using pills. Also with political climate Latino community is isolating itself from federal and professional.
  - Pretty large Hispanic community, don’t have resources in Spanish. Literacy council does a lot of work with the Hispanic population but prevention messages are limited. Burke Recovery holds a couple of treatment groups a week in Spanish.
  - While we have materials in Spanish, we do not have a “champion” from that community. Same is true of the African-American community.

**Resource Needs**

While more funding is a common resource need in any intervention, other resources needs were identified in the interviews. Most common (almost all 13 sites) was the need for rural transportation options. Few counties had mobile resources or services that could go outside of towns or cities. Many other counties recognized a need for materials in Spanish as they are experiencing demographic shifts in the population and lack outreach resources for this community. Several sites discussed the lack of local treatment options, especially for young people and those with dual diagnosis. One PFS Coordinator explained, there is a “Big gap in residential treatment for substance abuse, not as much programs for adolescents. Also a need for more family programs for families of the user.” Another Coordinator elaborated, “Better linkages to treatment! Noticing that there are people in need of detox and treatment, the demand for that isn’t reflecting in the data yet but private agencies are having issues. Only one or two agencies in the area that can provide medical detox, and for youth and women that are pregnant there are none.” A lack of incinerators for medical waste was a barrier identified to installing more drop boxes in one area. Finally, inability to address socio-economic conditions was seen as a resource need in addressing causes of misuse - lack of affordable housing and more minimum wage jobs.
## NORTH CAROLINA QUICK FACTS

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>10,146,788</td>
</tr>
<tr>
<td>Population Change</td>
<td>+11.3 % over 9 years</td>
</tr>
<tr>
<td>Median Age</td>
<td>38 years</td>
</tr>
<tr>
<td>Elderly (65+)</td>
<td>15.1%</td>
</tr>
<tr>
<td>Children (&gt;18)</td>
<td>26.8%</td>
</tr>
<tr>
<td>Non-white</td>
<td>30.5%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9.1%</td>
</tr>
<tr>
<td>Native American</td>
<td>1.2%</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>0.7%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>15%</td>
</tr>
<tr>
<td>Disabled</td>
<td>13.6%</td>
</tr>
<tr>
<td>Veteran</td>
<td>9.3%</td>
</tr>
<tr>
<td>High School Completion</td>
<td>85.8%</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>18.4%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>5.1%</td>
</tr>
<tr>
<td>Household income</td>
<td>$46,868</td>
</tr>
<tr>
<td>Households in Poverty</td>
<td>17.4%</td>
</tr>
<tr>
<td>Labor Force</td>
<td>4,875,701</td>
</tr>
<tr>
<td>Median Home Value</td>
<td>$154,900</td>
</tr>
<tr>
<td>Median Rent</td>
<td>$797</td>
</tr>
<tr>
<td>Adult Smoking</td>
<td>19%</td>
</tr>
<tr>
<td>Excessive Drinking</td>
<td>15%</td>
</tr>
<tr>
<td>Alcohol-Related Driving Deaths</td>
<td>32%</td>
</tr>
<tr>
<td>Drug Overdose Mortality per 100,000 Residents</td>
<td>13%</td>
</tr>
</tbody>
</table>
Brunswick, Pender, and New Hanover Counties in NC had a population of 409,526, growing 13.9% over a six-year period per the 2016 US Census. The median age is 43 years old with a large elderly population of 19.2% of the population and children making up 17.6%. These three counties have a calculated diversity index of 37.6 with an estimated 19.8% of the population identifying as non-white (predominantly identifying as Black). Approximately 88% of the population holds a high school diploma and 28% have at least a Bachelor’s degree. Approximately 16% of the population is uninsured.
**Economy**

Approximately 193,121 residents make up the labor force of Brunswick, Pender, and New Hanover Counties, which most recently reported an average unemployment rate of 5.4%. As of 2015 the median household income was higher than the state average at $50,226. The poverty rate is 15.5%, increasing since 2009. Housing expenses are higher than the state average with median home value at $183,400 and median rental units costing $857 per month.

<table>
<thead>
<tr>
<th>TYPE OF PILL</th>
<th>PILLS PER RESIDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines</td>
<td>28.3</td>
</tr>
<tr>
<td>Opioid</td>
<td>80.9</td>
</tr>
<tr>
<td>Stimulant</td>
<td>15.7</td>
</tr>
</tbody>
</table>

**Substance Abuse Overview**

Adult smoking represents 17% of the population, slightly below the average in North Carolina, while excessive drinking is at 17%. Alcohol related driving deaths make up 35.3% of the total driving deaths reported.

In the three counties there were 221 emergency hospital visits and 11 hospitalizations in 2014 relating to opiate poisoning. Drug overdose mortality is an estimated 21 per 100,000 residents, much higher than the state average of 13. There were 77 unintentional prescription opioid poisoning deaths in 2015.
Self-Reported Profile

According to the PFS Coordinator, Brunswick County, Pender, and New Hanover are large area geographically with both very rural farmland inland, but also beaches and islands up the coastline. Outreach in each area has to be tailored to differing populations and needs. As the Coordinator explains: “Each area has to be looked at individually and the context of a whole.” They are part of a partnership with the South East Area Health Education Center (SEAHEC) as resources are often found outside of the immediate area.

Ten years ago there was light manufacturing town. Hospital and school are currently the largest employers along with County governments. There is a mix of blue collar and white collar workers. Tourism is a large industry along the beaches. There is a large, and increasing, number of retirees over age of 65; about a third of the population. Some retirees may have part time jobs. There are few opportunities for young people. While there are some sports programs, youth may “drive an hour to play on the baseball team.” Thus, participation is difficult long term because of distances. Bonfires in the woods are popular, as well as family hunting.

According to the Coordinator, Brunswick is in the top ten for overdoses in the state: “If you ask anyone in Brunswick County, they know someone who knows someone who has a problem.” The coalition recently merged with Brunswick County opioid task force with 100 members. They work heavily with retirees who are raising their grandkids.

Locally they have developed 7 drop boxes, held 3 takeback events, held programs to strengthen families, engaged in trainings with medical professionals, conducted CSRS surveys to examine why doctors are not registering with reporting system. The local partners include: Coastal Horizons, Medical training groups, both hospitals, treatment facilities, two health departments (New Hanover and Brunswick), DSS, Sheriffs, Court system, Police department, UNCW, and the opioid task force. “Everybody is there. Literally 100 people. Anyone you can think of.”

Recent News

TASK FORCE CRITICAL TO DRUG WAR

August 16, 2016

Brunswick County suffers from two distinct drug problems: prescription and heroin.

The former is being addressed by the Brunswick Coalition, established last year and modeled after Project Lazarus to focus on prescription painkiller, or opioid, abuse, misuse and addiction. Project Lazarus is a secular public health nonprofit established in 2008 in response to extremely high drug overdose death rates in Wilkes County.

Read more at: http://www.brunswickbeacon.com/content/task-force-critical-drug-war
Community Overview

Burke County, NC had a population of 88,851, decreasing slightly from the previous year per the 2016 US Census. The median age is 43 years old with 17.7% of the population being 65 years or older and a below the state average percent of children at 20.6%. Burke has a calculated diversity index of 31.5 with an estimated 15.2% of the population identifying as non-white, half of the state average of 30.5% non-white residents. Approximately 79.1% of the residents hold a high school diploma and only 17.2% have at least a Bachelor's degree. Approximately 17% of the population is uninsured.
**Economy**

Approximately 40,123 residents make up the labor force of Burke County, which most recently reported an unemployment rate of 4.9%. As of 2015, the per capita personal income was reported at $31,458 and a median household income of $42,711, below the state average. The poverty rate in Burke is 16.7%. The housing costs in Burke are low, with median home value at $113,100 while rental units cost an average of $609 per month.

**Substance Abuse**

Adult smoking represents 19% of the population, while excessive drinking is slightly below at 14%. Alcohol related driving deaths make up 25% of the total driving deaths reported, below the state average.

In Burke there were 27 emergency hospital visits and 46 hospitalizations in 2014 relating to opiate poisoning. Drug overdose mortality is an estimated 32 per 100,000 residents, much higher than the state average of 13. There were 27 unintentional prescription opioid poisoning deaths in 2015.

<table>
<thead>
<tr>
<th>TYPE OF PILL</th>
<th>PILLS PER RESIDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines</td>
<td>42.6</td>
</tr>
<tr>
<td>Opioid</td>
<td>119.1</td>
</tr>
<tr>
<td>Stimulant</td>
<td>9.3</td>
</tr>
</tbody>
</table>
**Self-Reported Profile**

Morganton is the county seat. The area is mountainous and rural to the north, with lots of tree farms. To the west is the Lake James community; “mostly wealthy retired folks that have settled on the lake” says the PFS Coordinator. The east is more rural, another small town called Valdese. There is a lot of access to the mountains, nature, and hiking trails. It is the kind of community where you know everybody and is relatively safe with an affordable cost of living.

According to the Coordinator, there used to be a lot of manufacturing and textiles. There are lots of old mills no longer in use and a lot of people without work. There are a few major employers like Viscotec Automotive Products and a Caterpillar Plant. The school system and hospital system are the largest employers. Main Street downtown area has really picked up in the last couple of years with artist galleries, coffee shops, farm-to-table restaurants, and breweries. Yet, a lot of youth complain that there is nothing to do. Many young adults leave to pursue education and do not come back. Also, the county has one of the few state run psychiatric hospitals. Per the Coordinator, people often are discharged and then stay in the area.

The local coalition includes medical providers and hospital system, the school system, social services (DSS), law enforcement (sheriff’s office and two police departments), a youth coalition, different churches and church youth ministers, treatment providers for both mental health and Substance use disorders, individuals from the recreation sector, the business community, local media, and many other voluntary organizations, non-profits, and social services. They have had successes in changing prescribing policies at the hospital, raising awareness in the community, (from childcare providers to senior centers), distributed medication lock boxes (more than 200). The Coordinator says their coalition is their greatest resource, “because you hit a lot of providers and people at the same time to spread the message.” Even so, they would like to see more participation from the faith community and parents.

**Recent News**

**19 RECENT DEATHS ASSOCIATED WITH SYNTHETIC OPIOIDS REPORTED**

By Amanda Higgins March 30, 2016

RALEIGH – People throughout the state are dying because of synthetic opioids that are 15 times more potent than heroin.

State health officials are alerting law enforcement and medical professionals of potent synthetic opioids, including furanyl fentanyl, following at least 19 related fatalities in North Carolina since the beginning of this year, according to a press release from the N.C. Department of Health and Human Services.

In addition to acetyl fentanyl, the subject of a health alert in February 2014, and chemically similar furanyl fentanyl, the Office of the Chief Medical Examiner toxicology laboratory also has identified two other chemically similar drugs associated with recent fatalities.

Cabarrus County, NC had a population of 201,590, growing 10.8% over a six-year period per the 2016 US Census. The median age is 37 years old with approximately 12.2% of the population being 65 years or older and children making up 26.5% of the total population. Cabarrus has a calculated diversity index of 47.9 with an estimated 25.1% of the population non-white (predominantly identifying as Black). Approximately 88.3% of the residents hold a high school diploma and 27.2% have at least a Bachelor’s degree. Approximately 13% of the population is uninsured.
Economy

Approximately half of the residents of Cabarrus County make up its labor, which most recently reported a low unemployment rate of 4.5%. As of 2015, the per capita personal income was reported at $39,640 and a median household income of $57,881. The poverty rate in Cabarrus is 10.8%, which while lower than the state average, has been increasing since 2009 at a higher rate higher than the state average. The median home value in the area is $167,100 while rental units cost an average of $823 per month.

Substance Abuse

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Adult smoking represents 18% of the population, while excessive drinking is reported at 15%, both consistent with the state rates in North Carolina. Alcohol related driving deaths make up 32% of the total driving deaths reported.

In Cabarrus there were 65 emergency hospital visits and 58 hospitalizations in 2014 relating to opiate poisoning. Drug overdose mortality is an estimated 15 per 100,000 residents, just slightly above the state average of 13. There were 11 unintentional prescription opioid poisoning deaths in 2015.
**Self-Reported Profile**

The Coordinator reports that with its close proximity to Charlotte, Cabarrus is a mix of rural and urban. It is home to many of the [Charlotte Motor Speedway](#), NASCAR [race shops](#), [Concord Mills Mall](#), [Sea Life](#) and a host of other world class attractions. Cabarrus County is a clean and beautiful with trees, lakes, and green open spaces. There are 2 school districts, Cabarrus County and Kannapolis city schools, one community college, rowan Cabarrus community college and university of North Carolina within a close proximity. There are several educational, recreational and sports clubs in these educational institutions that young people can participate in. More people work in private sector as compared to public. People work for retail trade, accommodation and food services, healthcare and social assistance, public administration, manufacturing, construction, education, etc.

Their coalition includes the Health Department, law enforcement, members from the education system, Social Services, substance use prevention and treatment organizations, local pharmacies, health care providers, parents, and youth groups. Yet, after school programs are missing. They have had success with their Communication campaign strategies such as “Lock Your Meds” Billboard and Coffee News ad. They have disseminated Deterra Drug Deactivation System pouches and Lock boxes for community residents in partnerships with EMS, local pharmacies, and the Meals on Wheels Program. They have hosted successful Take Back Events and will begin an educational intervention in the schools next year utilizing Generation RX Curriculum.

**Recent News**

**HEALTHY CABARRUS WORKS TO HELP OVERDOSE VICTIMS**

By Erin Kidd July 1, 2016

CONCORD- Gov. Pat McCrory recently signed a bill that eases access to a drug that can reverse the overdose effects of heroin and opium-based drugs. The usage of these drugs is on the rise in North Carolina and Cabarrus County.

McCrory signed Senate Bill 734 at the Guilford County Sheriff’s Office. The bill creates a statewide standing order from the state’s health director for any pharmacy to prescribe naloxone, also known as Narcan. According to a press release from the Governor’s Office, this is a life-saving opioid reversal drug that has already saved 3,000 North Carolinians.

Community Overview

Cleveland County, NC had a population of 97,144 per the 2016 US Census. The median age is 41 years old with approximately 16.9% of the population being 65 years or older and an average sized population of children reported at 22.5%. Cleveland has a calculated diversity index of 41.4 with an estimated 24.2% of the population reporting as non-white (predominantly identifying as Black at 83% of non-white residents). Approximately 82.4% of the population holds a high school diploma and only 16% have at least a Bachelor’s degree. Approximately 14% of the population is uninsured.

| Veterans: | 8.3% |
| Disabled | 16.8% |
| Native American: | 0.3% |
| Hispanic: | 3.1% |
| LGBTQ: | 0.6% |
Economy

Approximately 46,944 residents make up the labor force of Cleveland County, which most recently reported an unemployment rate of 5.5%. As of 2015, the per capita personal income was reported at $33,712 and a median household income of $40,237. The poverty rate in Cleveland is 19.8%, which is higher than the state average and steadily increasing since 2009. Housing costs in the area are well below the state averages with the median home value at $104,400 while rental units cost an average of $668 per month.

Substance Abuse

Adult smoking represents 20% of the population, while excessive drinking is at 14%, both fairly consistent with the state average. Alcohol related driving deaths make up 34% of the total driving deaths reported, well below the state average of 33%.

In Cleveland there were 41 emergency hospital visits and 25 hospitalizations in 2014 relating to opiate poisoning. Drug overdose mortality is an estimated 16 per 100,000 residents, slightly above the state average of 13. There were 12 unintentional prescription opioid poisoning deaths in 2015.

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**Self-Reported Profile**

Cleveland is mostly rural with pockets of more suburban population in Shelby. There is a fairly low socio-economic status overall. The largest employers are the hospitals and the schools. There are also several large manufacturing plants and a Walmart distribution center. Manufacturing used to be dominant in the county until jobs went overseas or were replaced by machines, then unemployment rates got much higher, and only in last couple years has it begun to stabilize. There are a lot of low income households, and housing is a severe problems. There are more people leaving for job opportunities than new people moving in. People who stay don’t have resources to leave, or they have family here. Yet, it is a very family-friendly area. According to the Coordinator, the County Commissioners are working on economic development and bringing new jobs to the area. Transportation is very limited, with no organized public transport except for Transportation Across Cleveland County (TACC) which is mostly for Medicaid recipients and has a very fixed route. There are organized sports, a strong Boys and Girls Club, and faith-based organizations, but little else for young people to do.

While parents are a hard audience to reach and engage, the coalition does include the health department, law enforcement, school system, hospitals, behavioral health professionals, the local university, social services, EMS, partners behavioral health, Community Care of North Carolina, and Community and Schools of Cleveland County. They have an evidence based prevention programming in the schools and work with schools to do community events. There is also a youth council with students from all four high schools. However, they would like to see more health care providers outside of the hospital and more members of the faith-based community represented. They have successfully installed 17 medication drop boxes and hold at least 4 annual take-back days throughout the county to make sure everyone has access to them. They have a good relationship with school system, allowing for very frequent surveys and coming into the schools for a lot of other prevention education programs.

**Recent News**

**OPIOID EPIDEMIC HITS HOME IN CLEVELAND COUNTY**

By Joyce Orlando March 20, 2016

The United States Center for Disease Control and Prevention says we are in the middle of an “opioid epidemic.” This includes the use of heroin and the abuse of prescription pills.

In Cleveland County, there were two and a half opioid prescriptions prescribed for every man, women and child in 2015. Along with those prescriptions, there are also one and a half controlled substance prescriptions written for every person in the county, according to data from the Cleveland County Health Department.

DAVIDSON

Community Overview

Davidson County, NC had a population of 164,926 per the 2016 US Census. The median age is 42 years old with an average life expectancy of 63 years and approximately 16.1% of the population being 65 years or older and a population of children reported at 22.9%. Davidson has a calculated diversity index of 41.8 with an estimated 23.4% of the population identifying as non-white (predominantly identifying as Black), well below the state average of 32.5% non-white residents. Approximately 81.9% of the residents hold a high school diploma and 18.7% have at least a Bachelor’s degree. Approximately 16% of the population is uninsured.
Economy

Approximately 79,790 residents make up the labor force of Davidson County, which most recently reported a low unemployment rate of 4.8%. As of 2015, the per capita personal income was reported at $35,073 and a median household income of $46,400. The poverty rate in Davidson has been a steady 14.1%. The median home value in the area is slightly below the state average at $132,200 while median cost of rental units is $655 per month.

Substance Abuse

Adult smoking represents 18% of the population, while excessive drinking is at 14%, both consistent with the average in North Carolina. Alcohol related driving deaths make up 34% of the total driving deaths reported.

In Davidson there were 138 emergency hospital visits and 69 hospitalizations in 2014 relating to opiate poisoning. Drug overdose mortality is an estimated 19 per 100,000 residents, above the state rate of 13. There were 14 unintentional prescription opioid poisoning deaths in 2015.
**Self-Reported Profile**

Davidson is a mostly rural county with two towns - Thomasville and Lexington - and several smaller communities such as Denton. There is little diversity in the population. Like many rural NC areas, the local economy used to rely on manufacturing yet today there is little left. Major employers include the school system, Novant Health, Wake Forest Hospital, and the county government. According to the Coordinator, “People are born here, grow up here, and they just stay.” There is a strong sense of community and that small town feel. There is affordable housing, but most people work outside the county. There are few opportunities for young people - not a lot of after school activities, especially outside of Thomasville and Lexington. Kids go outside of county for any kind of activities.

Several coalition and work groups exist to address the prescription drug problem. Partners in the PFS coalition include a methadone clinic, local pharmacies, Daymark, Cardinal, hospitals, free clinics such as Medical Ministries, Senior Services, High Rock Internal Medicine, Novant Health, Wake Forest, DSS. is opening a detox facility. Missing from the coalition is support from the faith community, law enforcement, youth engagement, local businesses, manufacturing companies (workplace injuries), local government (have started their own coalition Clerk’s Commission on Opiate Use). There are tensions between the coalitions. None-the-less, successes include new drop boxes and a Thomasville fire department take back event.

**Recent News**

3 DRUG-RELATED DEATHS PROMPT TIP LINE IN DAVIDSON COUNTY

Hope Ford August 11, 2016

LEXINGTON, NC – Three deaths linked to heroin and prescription pills in Davidson County moved the Sheriff to open a 24-hour drug hotline.

In one week, three people died of drug overdoses in separate parts of the county. Sheriff David Grice said the deaths were not related. In all, 12 people have died in the county due to drug overdoses.

“We’ve been averaging about one every three weeks or one a month and then last week was just a terrible high mark for us,” said Grice.

Gaston County, NC had a population of 216,590, growing steadily over a six-year period per the 2016 US Census. The median age is 40 years old with approximately 14.6% of the population being 65 years or older and a population of children reported at 23.3%. Gaston has a calculated diversity index of 47.9 with an estimated 23.4% of the population non-white (15.2% identifying as Black). Approximately 82.9% of the residents hold a high school diploma and 19% have at least a Bachelor’s degree. Approximately 16% of the population is uninsured.
Economy

Approximately half of the residents of Gaston County make up its labor, which most recently reported an unemployment rate of 5.3%. As of 2015, the per capita personal income was reported at $36,950 and a median household income of $45,031. The poverty rate in Gaston is 17.3%, increasing since 2009 at a rate consistent with the state average. The median home value in the area is low at $125,100 while rental units cost an average of $731 per month.

Substance Abuse

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Adult smoking represents 21% of the population, slightly above the average in North Carolina, while excessive drinking is consistent with the state rate at 15%. Alcohol related driving deaths make up 34% of the total driving deaths reported.

In Gaston there were 137 emergency hospital visits and 87 hospitalizations in 2014 relating to opiate poisoning. Drug overdose mortality is an estimated 23 per 100,000 residents, much higher than the state average of 13. There were 19 unintentional prescription opioid poisoning deaths in 2015.
Self-Reported Profile

Gaston County is a retirement community and commuter/bedroom suburb just west of Charlotte. There are 12 different cities and towns in Gaston county with Gastonia being the county seat. Major local employers are the food service industry and a few plants or mills. For many, there is a lack of transportation and employment opportunities. Access care for seniors, and limited bus line in the city. There are few opportunities for young people - limited social outlets and employment. Most go outside the area for entertainment and other opportunities.

The local coalition includes Gaston County Child Collaborative, Veterans groups, group home representatives, and a court liaison. They are missing area youth and private citizens who are not providers. They have been successful in implemented provider training and have seen an increase in urine screening. They are also using the prescription registry to be able to log all prescriptions by a physician and thereby reduce doctor shopping. They have also held Town hall meetings to educate people and to give people open forum on prescription misuse.

Recent News

OPIOID DEATHS RISE IN GASTON COUNTY

By Adam Lawson May 16, 2017

Opioids contributed to 30 Gaston County deaths in 2015, a 20-percent rise from 10 years earlier.

That’s according to the N.C. Governor’s office, which reported 1,110 opioid deaths in 2015 in North Carolina, after 642 died from the drugs in 2005.

“Opioid addiction is devastating families across the nation,” Gov. Roy Cooper said in a press release. “This is a uniquely challenging crisis for our communities and will require a new level of collaboration between law enforcement, treatment providers and those in recovery.”

Of 100 counties, 69 reported an increase in deaths over 2005 totals. Just seven counties recorded more opioid deaths in 2015 than Gaston County.

HENDERSON

Community Overview

Henderson County, NC had a population of 114,209, with a much higher rate of growth than the state average at 23% since the year 2000. The median age is 46 years old with approximately 23.9% of the population being 65 years or older. A smaller than average percent of the population is made up of children reported at 19.9%. Henderson has a very low calculated diversity index of 29 with only 9% of the population reporting as non-white. Despite this, the proportion of the population identifying as Hispanic is consistent with the state average. Approximately 88.1% of the population holds a high school diploma and 28.6% have at least a Bachelor’s degree. Approximately 17% of Henderson is uninsured.
**Economy**

Approximately 52,357 residents make up the labor force of Henderson County, which most recently reported the low unemployment rate of 4.2%. As of 2015, the per capita personal income was reported at $37,558 and a median household income of $47,280. The poverty rate in Henderson is 13.1%, increasing since 2009 at a rate consistent with the state average. The median home value in the area is higher than the state average at $182,300 while rental units cost an average of $750 per month.

**Substance Abuse**

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Adult smoking represents 16% of the population, slightly below the average in North Carolina, while excessive drinking is at 14%. Alcohol related driving deaths make up 26% of the total driving deaths reported, well below the average of 33%.

In Henderson there were 32 emergency hospital visits and 50 hospitalizations in 2014 relating to opiate poisoning. Drug overdose mortality is an estimated 16 per 100,000 residents, slightly higher than the state average of 13. There were 9 unintentional prescription opioid poisoning deaths in 2015.
**Self-Reported Profile**

Henderson has a lot more retirees than a workforce with new retirees settling there because of the mountains, natural beauty, and scenery. There are very limited opportunities for young people - a few social outlets, organized sports, and church-based activities.

The coalition includes two hospitals, law enforcement, school officials (school superintendent is very involved), a school of pharmacy, community health services, the health department, faith-based community members, physicians, free clinics, people in recovery, and also some family members affected by loss or ongoing addiction issues.

There are some faith-based initiatives in the works, mental health services available, a few private behavioral health services accessed via the health department and domestic violence shelter, and some free clinics that offer Naloxone, however, people have not been going to get kits even though there are high reports of EMS use. The county has a high rate of prescriptions and when they hold take-back events they have had a lot turned in. They have been successful in partnering with the schools. They used data from the schools illustrate need and promote prevention programs. They have a STAR program in elementary schools and want to spread into Middle and High Schools. The Superintendent has allowed to make their own week of prevention (three years now) and students have named it and are really involved, organizations in the community are competing for sponsorship.

**Recent News**

**DOCTORS PRESCRIBED 64.5 MILLION OPIOID PILLS IN 2016 IN WESTERN NORTH CAROLINA**

By Aaron Adelson February 20, 2017

HENDERSON COUNTY, N.C. (WLOS) — Heroin and other opioids are taking lives across the mountains. Many of the stories we’re shared over the last few weeks began with a prescription for an opioid like OxyContin or Methadone.

In 2016, according to the State Department of Health and Human Services, doctors prescribed 64,488,991 opioid pills in the 16 counties considered Western North Carolina. That breaks down to 82.5 pills for the 781,026 people who live here.

Scotty Lewis’ decline started with a fall. After falling off a ladder in 2001, Lewis received a prescription for OxyContin. Within a few weeks, his mom said the electrician became hooked.

IREDELL

Community Overview

Iredell County, NC had a population of 172,916, growing 6.8% over the past 6 years per the 2016 US Census. The median age is 40 years old with approximately 14.1% of the population being 65 years or older and a population of children reported at 24.3%. Iredell has a calculated diversity index of 39 with an estimated 18.6% of the population identifying as non-white (12.4% of the total identifying as Black). Approximately 87.2% of the residents hold a high school diploma and 25.9% have at least a Bachelor’s degree. Approximately 15% of the population is uninsured.
**Economy**

Approximately 84,995 residents make up the labor force of Iredell County, which most recently reported a low unemployment rate of 4.8%. As of 2015, the per capita personal income was reported at $44,442 and a median household income of $55,848. The poverty rate in Iredell has slightly increased over the last several years to 14.2%. The median home value in the area is $166,300 while rental units cost an average of $796 per month.

**Substance Abuse**

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Adult smoking represents 17% of the population, slightly below the average in North Carolina, while excessive drinking is at 16%. Alcohol related driving deaths make up 31% of the total driving deaths reported, also slightly below the state average.

In Iredell there were 76 emergency hospital visits and 51 hospitalizations in 2014 relating to opiate poisoning. Drug overdose mortality is an estimated 15 per 100,000 residents, slightly higher than the state average of 13. There were 8 unintentional prescription opioid poisoning deaths in 2015.
**Self-Reported Profile**

According to the PFS Coordinator, Iredell is long county just north of Mecklenburg County. Statesville is the county seat. In the north of the county is Troutman, part on lake and partly rural. The Mooresville/Lake Norman area is growing rapidly. Southern Iredell County is wealthier, with a lot of NASCAR folks and healthcare professionals. In other regions, there are more blue-collar jobs and lots of farming and agriculture in the north. Lowe’s Corporate Center is in Mooresville. Lake Norman in southern part of county is a huge source of entertainment for young people.

Last August they started strategic planning sessions with their coalition and health department, putting together all the data they had and shared it with stakeholders and coalition members. Out of that came eight different priorities that they focused on, then narrowed down into four different subcommittees: 1) Legal - focused on drop box, drug diversion, take-back, and LEAD programs; 2) Prescribing Practices and Naloxone - working on safer opioid prescription training, use of drug recording system, hospitals adopting CDC guidelines, and educating medical providers on Naloxone; 3) Treatment, Recovery, and Case Management - focused on making a resource guide for people who don’t know where to go, and focus groups with people in the recovery community; 4) Prevention and Education - working in the schools and in other youth serving programs.

They have been successful with community learner events that have brought attention to the problem, and a lot of news media covering events. Law enforcement has conducted disposal and take-back programs including 11 take-back locations during poison awareness week.

**Recent News**

**IREDELL HEALTH PROFESSIONALS TALK WAYS TO END OPIOID ABUSE EPIDEMIC**

By James Neal February 26, 2017

Abuse of opioids is on the rise and becoming epidemic. The problem has reached alarming rates in Iredell County, according to health professionals who gathered Saturday for a conference sponsored by the Iredell County Health Department and Partners Behavioral Health Management.

Cpt. William Hamby of the Iredell County Sheriff’s Office said it’s important that events like the conference exist to highlight the problem. He said he doesn’t believe society can enforce its way out of the issue, even though enforcement will play a significant role in the solution.

Randolph County, NC had a population of 143,416 per the 2016 US Census, increasing at a rate of 1.7% as compared to the 6.2% average increase across North Carolina. The median age is 41 years old with approximately 15.57% of the population being 65 years or older and 23.8% children. Randolph has a calculated diversity index of 33.9 with only 12.53% of the population reporting as non-white, less than half of the state average, despite its larger than average percent and growing population of Hispanic residents. Approximately 79.8% of the population holds a high school diploma and only 14.5% have at least a Bachelor’s degree. Approximately 17% of Randolph’s population is uninsured.
Economy

Approximately 67,156 residents make up the labor force of Randolph County, which most recently reported an unemployment rate of 4.9%. As of 2015, the per capita personal income was reported at $33,899 and a median household income of $43,216. The poverty rate in Randolph is 16.4%, consistent with and increasing at the state average since 2009. The cost of housing in the area is low with median home values at $120,700 while median rent is $638 per month.

Substance Abuse

Adult smoking represents 20% of the population, while excessive drinking is at 15%, both fairly consistent with the state averages. Alcohol related driving deaths make up 38% of the total driving deaths reported, above the state average of 33%.

In Randolph there were 90 emergency hospital visits and 36 hospitalizations in 2014 relating to opiate poisoning. Drug overdose mortality is an estimated 16 per 100,000 residents, slightly higher than the state average of 13. There were 17 unintentional prescription opioid poisoning deaths in 2015.
Self-Reported Profile

Asheboro is in the center of Randolph County and is the largest city and county seat. Asheboro is highly segregated with white, Hispanic, and African-American populations. The city is surrounded by very rural areas and several small farming communities (such as Liberty, Franklinville, Randleman, Seagrove, Coleridge, Archdale, and Trinity). A substantial portion of the population works in city or county offices, social services, health care, the school systems. In the past, there was a significant amount of factory work, a little light manufacturing remains. In addition, there is some agricultural worker in the rural area and retail and fast food in the urban area. Opportunities for young people are limited - a movie theatre with limited options, Boys and Girls Club, the mall, and the YMCA. There are no community centers in Asheboro where kids can just go.

The coalition includes Sandhills, Randolph Community College, medical practices, Alcohol And Drug Services (ADS), Healthy Randolph, Randolph Health, Randolph Health Department, Hospice Of Randolph County, law enforcement, fire department, schools, some faith based communities, teen crisis care. However, they are missing participation from faith-based communities, more schools, people in recovery and in active use, more youth representation, and the business community. They have successfully developed a LEAD NC program where students and adult volunteers are trained for 12 hours including in strategic framework as well as 5 drop boxes and some incinerators.

Recent News

OPIOID CRISIS COMES TO RANDOLPH

By Larry Penkava November 5, 2016

ASHEBORO — The number of opioid overdoses in Randolph County rose from 190 in 2013 to 262 in 2015. As of Oct. 31 of this year, there were 242 cases reported and those just reflect cases in which the opioid blocker Naloxone was used.

The overdose epidemic has become news nationally with the high rate of increase in overdoses from opioids, an umbrella term for synthetic painkillers and illicit drugs such as heroin derived from opium. According to the Centers for Disease Control and Prevention, overdose deaths from prescription painkillers have quadrupled since 1999, which parallels an increase in prescriptions issued by doctors.

**Community Overview**

Robeson County, NC had a population of 133,235, increasing only slightly over the last six years per the 2016 US Census. The median age is 35 years old with approximately 12.6% of the population being 65 years or older and 26.1% children. Robeson is an extremely diverse county with a high calculated diversity index of 72.3 and an estimated 69.9% of the population non-white. The racial breakdown is 37.8% American Indian/Alaskan Native, 24.1% Black, 3% representing two or more races, >1% Asian, and the remainder identifying as “Other”. Approximately 75.1% of the residents hold a high school diploma and only 12.8% have at least a Bachelor’s degree. Approximately 22% of Robeson County is uninsured, higher than the state average.
**Economy**

Far less than half of the residents of Robeson County make up its labor force at 50,767. The county most recently reported an unemployment rate of 7.9%. As of 2015, the per capita personal income was reported at a low $27,487 and a median household income of $32,128. The poverty rate in Robeson is extremely high at 30.6%, increasing 6.8% since 2009. The median home value in the area is less than half of the state average at $70,200 while median rent is reported at $603 per month.

**Substance Abuse**

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Adult smoking represents 29% of the population, much higher than the average in North Carolina, while excessive drinking is slightly below at 13%. Alcohol related driving deaths make up 30% of the total driving deaths reported.

In Robeson there were 72 emergency hospital visits and 73 hospitalizations in 2014 relating to opiate poisonings. Drug overdose mortality is an estimated 17 per 100,000 residents, higher than the state average of 13. There were 11 unintentional prescription opioid poisoning deaths in 2015.
Self-Reported Profile

Robeson County is comprised of diverse rural communities with Native American, African-American, Caucasian, and a growing Hispanic population. There is a lot of poverty, low educational level, and many receiving Medicaid/Medicare benefits. The largest employer is the school system and then the hospital system and a few textile jobs. It is a rural area that is family oriented, with a low crime rate and “a lot of people who live here just don’t leave.” There are few opportunities for youth partly due to a lack of transportation.

According to the PFS Coordinator, the coalition includes police, pharmacists, substance use agencies, hospitals, public health, DSS, and the school systems. Yet, missing are Local Lumbee Tribe Council as the population is heavily affected. Schools and Public Health have been involved with prevention programs and activities. Some churches are engaged and know the importance of education. The PRIDE surveys in school system has been helpful, they have worked on registration with CSRS, as well as getting youth groups active in LEAD NC - about all 6 high schools are now represented.

Recent News

IN ROBESON COUNTY: FIGHTING GRIM STATISTICS WITH WORK AND HOPE

By Thomas Goldsmith November 28, 2016

Health outcomes in the far southeastern part of North Carolina are some of the worst in the state. But some folks are making a concerted effort to turn those numbers around.

When pediatrician Laura Gerald returned to her hometown of Lumberton as head of the Kate B. Reynolds Charitable Trust, she told the welcoming crowd that she had plenty to discuss with them.

A showing the decay of downtown Parkton, North Carolina. This town, like many others in Eastern North Carolina, is a shadow of its former bustling self. Reasons for the decline include the loss of textile mill jobs and dramatic downturn in tobacco farming.

Community Overview

Rockingham County, NC had a population of 92,393, decreasing 1% over the last six years per the 2016 US Census. The median age is 44 years old with approximately 17.7% of the population being 65 years or older and a population of children reported at 21.2%. Rockingham has a calculated diversity index of 43.1 with 24.5% of the population reporting as non-white (predominantly identifying as Black). Approximately 80.4% of the population holds a high school diploma and only 13.8% have at least a Bachelor’s degree, both below the state average. Approximately 15% of the population is uninsured.
Economy
Approximately 41,359 residents make up the labor force of Rockingham County, which most recently reported the low unemployment rate of 5.6%. As of 2015, the per capita personal income was reported at $33,916 and a median household income of $40,148. The poverty rate in Rockingham is 18.4%. The median home value in the area is low at $106,700 while median rent costs $611 per month.

Substance Abuse
Adult smoking represents 20% of the population, while excessive drinking is at 14%, both consistent with the state averages in North Carolina. Alcohol related driving deaths make up 35% of the total driving deaths reported.

In Rockingham there were 40 emergency hospital visits and 21 hospitalizations in 2014 relating to opiate poisoning. Drug overdose mortality is an estimated 14 per 100,000 residents. There were 9 unintentional prescription opioid poisoning deaths in 2015.

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<td>Stimulant</td>
<td>13.8</td>
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</table>
**Self-Reported Profile**

There are five small towns in Rockingham County including Eden, Reidsville, and Wentworth. It is a “slow moving” county where everyone knows everyone - a nice little place to stay. Not everyone has access to transportation or access to health care. There are not many people who can go to doctor or pay their premium. While the Miller Corporation just left Rockingham County, there are still factory jobs and restaurant jobs according to the Coordinator. The only opportunity for young people is the community college. It is one of the only outlets. As the Coordinator explains, “kids can get stuck here not doing too much.”

Participation is strong now in PFS coalition. The coalition includes Rockingham County School System, law enforcement, EMS, the hospitals, Cone Health, Partnership for Community Care, Daymark mental health services, the Department of Social Services, the Health Department, the community college, Lane’s Pharmacy but they are missing members of the faith community.

**Recent News**

**RX ROCKINGHAM: NEW WAYS TO FIGHT DRUGS**

By Mary Burritt August 21, 2016

Snapchat message: “I got candy. Skittles party?” Translation: “I have pills. Where’s the party?”

Not a party with Skittles candy, but a party where people, usually teens, pool and pop prescription pills at random, downing them with alcohol.

Social media and the forces of supply and demand continuously change drug-use patterns. In response, Rockingham County law enforcement and first responders are changing their tools and tactics to include prescription-drug drop boxes, a temporary antidote for overdoses, more community outreach and new partnerships.

Rowan Community Overview

Rowan County, NC had a population of 139,933, growing only 1% over the last six years per the 2016 US Census. The median age is 40 years old with approximately 15.8% of the population being 65 years or older and children making up 22.9%. Rowan has a calculated diversity index of 43.2 with 21.9% of the population reporting as non-white (predominantly identifying as Black). Approximately 82.5% of the population holds a high school diploma and 17.6% have at least a Bachelor’s degree. Approximately 17% of the population is uninsured.
Economy
Approximately 51,612 residents make up the labor force of Rowan County, which most recently reported the unemployment rate of 5.5%. As of 2015, the per capita personal income was reported at $34,348 and a median household income of $44,862. The poverty rate in Rowan is 17.3%, increasing steadily over the last six years at a rate consistent with the state average. The median home value in the area is $128,300 while rental units cost an average of $722 per month.

Substance Abuse
Adult smoking represents 20% of the population, while excessive drinking is at 13%, both fairly consistent with the averages in North Carolina. Alcohol related driving deaths make up 26% of the total driving deaths reported, much lower than the state rate.

In Rowan there were 75 emergency hospital visits and 51 hospitalizations in 2014 relating to opiate poisoning. Drug overdose mortality is an estimated 22 per 100,000 residents, much higher than the state average of 13. There were 18 unintentional prescription opioid poisoning deaths in 2015.
**Self-Reported Profile**

Salisbury is the county seat and most urban area of Rowan County. It has been hit hard by manufacturing decline and is economically depressed, yet manufacturing is still where most people are employed. Everywhere outside of Salisbury is very rural. Enochville, on the southeast side of the county bordering Cabarrus County, has had a lot of overdose deaths. There is not much for young people to do in the area. Things that are available cost money and require transportation. Transportation is an issue in the county since it is so rural and spread out.

Members of the coalition include the local college social work department, United Way, ABC Board, County govt folks, mayor, Sheriff, health department, MCO, juvenile justice, local news to help publicize strategic plan, director of DSS, Benchmarks (child welfare, mental health, and substance use advocacy org), pharmacist (owner of small pharmacy and gives out lockboxes), community care of the piedmont, chronic pain management specialist, community and schools. However, missing are faith leaders, the business community/chamber of commerce, and community members. They would like to have the voices of people living in the community represented at meetings. They have had very successful take-back evens, receiving over 162 pounds of pills at the last event. The community has been very responsive and receptive to these particular efforts.

**Recent News**

ROWAN COUNTY DUO ARRESTED FOR FORGED PRESCRIPTION SCHEME THAT WENT UNDETECTED FOR SIX YEARS

By Mark Price August 24, 2016

The Rowan County Sheriff’s Office arrested two Rockwell women Tuesday in a drug trafficking scheme that allegedly had the pair using prescription pads stolen from a Concord plastic surgeon to write fake prescriptions for pain medicines.

It had been going on since 2010, officials said.

One suspect, Renee Hale Stowe, age 42, who lived in the 200 block of Middlebrook Drive, worked as a surgical assistant for a plastic surgeon in Concord, and she stole prescription pads from the business, officials said. She then forged prescriptions using her employer as the provider, officials said.

Wilkes County, NC had a population of 68,740, decreasing just slightly over the past 6 years per the 2016 US Census. The median age is 44 years old with a large elderly population at 19.4% and 21.5% children. Wilkes has a calculated diversity index of 21.4 with an extremely low percent of the population identifying as non-white at 8.8%, and a smaller percent of the population reporting as Hispanic than the state average. Approximately 75% of the residents hold a high school diploma and only 12.8% have at least a Bachelor’s degree, both well below the state average. Approximately 18% of the population is uninsured.

**Community Overview**

**Veterans:**
8.9%

**Disabled:**
18.5%

**Native American:**
0.2%

**Hispanic:**
5.8%

**LGBTQ:**
0.5%
Economy
Approximately 30,449 residents make up the small labor force of Wilkes County, which most recently reported a low unemployment rate of 4.8%. As of 2015, the per capita personal income was reported at $32,449 and a median household income of $40,647. The poverty rate in Wilkes has slightly increased over the last several years to 18.7%. Housing costs in the area are well below the state average with the median home value at $114,800 while median rent costs $587 per month.

Substance Abuse
Adult smoking represents 20% of the population, while excessive drinking is at 13%, both fairly consistent with the averages in North Carolina. Alcohol related driving deaths make up 31% of the total driving deaths reported.

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In Wilkes there were 15 emergency hospital visits and 55 hospitalizations in 2014 relating to opiate poisoning. Drug overdose mortality is an estimated 34 per 100,000 residents, more than doubling the state average of 13. There were 22 unintentional prescription opioid poisoning deaths in 2015.
**Self-Reported Profile**

Wilkes County is a smaller, more rural community. It is nestled in foothills of the mountains. The Coordinator says that, “people like that and being close to family…. a good place to raise your family as a small, close-knit community.” There are three cities (including Wilkesboro and North Wilkesboro) but 22 different municipalities. There is a lot of farming (chicken farmers, apple orchards, corn, and other crops), but the majority of residents either work at the hospital or for the school system. There is also a branch of Lowe’s corporate office in Wilkes County and a Tyson Plant. While the high school graduation rate is fairly high, the percentages of people who have a college degree low as there are not a lot of professional job opportunities. There are few activities or opportunities for community involvement geared towards young people.

Their partnership includes schools, the Health Department, Daymark Recovery Services, the local faith community, media, youth serving organizations, real estate, insurance agents, law enforcement, hospital and other medical providers. Between 15-20 members are highly engaged and never miss a meeting with an additional 8-10 who regularly attend. They successfully have involved youth and have clubs at some of the middle and high school, each of those teams plan activities to increase awareness within their schools. Law enforcement and parental involvement has been difficult to engage. They would like a few more civic or volunteer groups.

This county has had several successes with youth - a YRBS data collection from the schools; lock your meds campaign that was able to reach every family with a middle and high school student; one student did a medication takeback for her senior project. They have increased the number of drop boxes and have partnered with local pharmacies to put drop boxes there rather than just at law enforcement agencies.

**Recent News**

50 ARRESTED, MOSTLY FOR PAIN PILLS

By Jule Hubbard May 5, 2017

The Wilkes Sheriff’s Office this week announced drug charges against 50 people as a result of investigations conducted within the last 2 ½ months.

Wilkes Sheriff Chris Shew said most of the charges involve the sale of prescription pain pills, which he said reflected their continuing prevalence in Wilkes as an abused drug.

Shew said about half of the cases resulted from citizens reporting suspicious activities, including excessive numbers of people visiting houses. He said this shows the importance of citizens being aware of activities in their communities and how they can help law enforcement fight crime.

SOCIAL DETERMINANTS

These Five Key Areas (Determinants) Include:

1. Economic Stability
2. Education
3. Social and Community Context
4. Health and Health Care
5. Neighborhood and Built Environment

Examples of Social Determinants Include:

1. Access to educational, economic, and job opportunities
2. Access to health care services
3. Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
4. Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities
5. Availability of resources to meet daily needs (e.g., safe housing and local food markets)
6. Culture
7. Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community)
8. Language/Literacy
9. Public safety
10. Quality of education and job training
11. Residential segregation
12. Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
13. Social support
14. Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany)
15. Transportation options
PHYSICAL DETERMINANTS

**Examples of Physical Determinants Include:**

1. Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change)
2. Built environment, such as buildings, sidewalks, bike lanes, and roads
3. Worksites, schools, and recreational settings
4. Housing and community design
5. Exposure to toxic substances and other physical hazards
6. Physical barriers, especially for people with disabilities
7. Aesthetic elements (e.g., good lighting, trees, and benches)
8. Availability of resources to meet daily needs (e.g., safe housing and local food markets)

**SOURCE:** https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
GLOSSARY

Diversity Index  The probability that if chosen at random two individuals would be of different races or ethnicities. This figure is based on American Community Survey 2015 five year estimates.

Poverty  Household figure. Calculated based on a household’s total income (includes social security, unemployment, child support, alimony, education assistance and additional types of funds) as compared to its standard calculated threshold for poverty based on number of adults and children in the household. Households with incomes lower than their calculated poverty threshold are considered to be in poverty.

Labor Force- All people classified as able to work, both employed and unemployed, excluding military and institutionalized individuals.

LGBTQ  Acronym representing individuals identifying as Lesbian, Gay, Bisexual, Transgender, Queer.

Non-white  percent of all people identifying as a race other than White.

Hispanic  Includes all those identifying as ethnically Hispanic, across all races.

Disabled  reporting 1 or more disabilities between 2011 and 2015 based on American Community Survey 2015 five year estimates.
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Create a free account to make interactive web maps with your own data or hosted data.

Add as many layers as you want!

Allows for customizations to symbology, labels, pop up information or online data editing.

Share or embed mobile applications with easy-to-use templates.

www.arcgis.com

Available for free in NC with a public library card.

Allows for data mapping and report generation of census and specialized variables with some customizations.

Data can be exported to shapefiles for use in other programs for analyses.

Some geographic analysis tools included.

www.simplymap.com

Build community data profiles quickly or look up fast facts without an account.

Multiple tools that provide tabular and mapped data at multiple geographic levels.

Easy to download, embed, or share reports or maps.

Allows for custom region creation and importing your own data for mapping.

www.statsamerica.org