

Recommendations for Use of Opioid Litigation Settlement Funding and Local Prioritization Planning Model



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Community Statements from the Surry County Community on the Topic of Substance Use Disorder

“We have a merry go round that perpetuates the problem, because no recovery services are offered in most cases. It just leaves people with an illness poorer and more stigmatized leading to more employment obstacles.”

“The issue is hidden. People are scared to address it; it’s hidden and out of sight and out of mind until it’s not. Personal involvement is necessary, when drug use is not impacting the person then they don’t concern themselves much.”

“Sadly, many people in the community and our leaders say that these people don’t matter, they don’t vote. It’s the out of sight, and out of mind thought process. There is probably not a family member in Surry County that is not impacted. Stigmas exist, while we don’t want to admit it. We don’t want to talk about drug addiction. We are doing a very bad job at explaining this issue, it’s bad messaging. We have not fully explained the why and what is important about the topic of addiction.”

“There are so many people that believe recovery is not possible, even people who are using. Our community lacks hope. We need to focus more on people that are getting better. We need to focus on families that have gotten better.”

“Community members believe there is nothing they can do. They feel helpless. Families don’t understand drug addiction. Addiction needs to be treated. It’s a family driven gradual process. Addiction is a cycle.”

“There is little grasp on the Continuum of Care, we must teach people about Prevention, Intervention, Treatment and Recovery.”

“Organized recovery efforts are such a niche field, it’s hard to be perceived as part of ordinary medical care sadly. There is bias about who is venerable, the disease of addiction is not understood. We need to combat misconceptions by promoting stories of recovery that are true and accurate; people need to be exposed to recovery stories. We need to combat the idea that this won’t happen to me but happens to other people. We need to address the - it’s not my problem idea. We also need to talk with those who don’t think it’s a public health crisis. Addiction is a disease.”

“It’s rare that I don’t talk to a community leader that is not concerned. Business leaders are concerned too, the economic impact is growing and has been growing for the past two decades.”

“What should leaders do? There needs to be a change. There needs to be drug court advocacy. Opposing drug court makes little sense. Instead of trying to change the mind of current leaders we need to focus on the next generation, on upcoming leaders – the current leaders are a lost cause – put our efforts where they will be and with those who are most beneficial. There is hope in the next generation.”

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Forward

The Surry County Board of County Commissioners created a director's level office of "Opioid Response" in Fiscal Year 2017. The office was staffed with the Director in June 2018. The director's mission was to explain the genesis of the County's growing opioid problem, provide the Commissioners counsel as to how the County should respond, and implement solutions that would lead to mitigation. The Opioid Response Office – the office name was changed in 2020 to the Surry County Office of Substance Abuse Recovery (SCOSAR) - researched the problems contributing to the increasing abuse of licit substances and the increasing use of illicit substances in the County and discovered they had been escalating for decades. Most interestingly though was during that same time frame, almost all the factors that contributed to the rising epidemic of substance use had been outside of the County's ability to influence or control. Even if County leadership had been aware of these contributing factors, they would have been unable, as a local government to stop their evolution. This confluence of events, most of them independent and unrelated, combined to create the quintessential "perfect storm" for rural counties.

- In 1984 Purdue Pharma, originally known for its earwax removers and laxatives, introduced MS Contin to the medical community. Purdue Pharma incorporated in 1991 and officially dedicated itself to the production of pain management medications. By 1996 Purdue Pharma replaced MS Contin with Oxycontin, which by 2020 generated over \$24 billion in revenues.
- In 1994 the U.S. Congress passed the North American Free Trade Agreement (NAFTA). Once thriving textile, clothing, furniture, small appliance, auto parts, and tool and die plants in Surry County contributed to a 2.5% unemployment rate. By 2010 all those plants moved their operations overseas and the unemployment rate in Surry County to rose to 14%. The resulting increase in unemployment affected the entire Appalachian region, in which Surry County is included, caused the mortality rate per 100,000 working age adults to increase by almost 60% between 1999 and 2009.
- In 1995 the American Pain Society advocated to the medical community the adoption of pain as the "fifth vital sign". The first four universally accepted vital signs being body temperature, pulse rate, respiration rate and blood pressure. By 2000 the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) endorsed the American Pain Society's recommendations and incorporated into their hospital inspections a rating on how well doctors addressed their patient's pain. The unintended consequence of JCAHO's new pain rating for hospitals was the overprescribing of pain medications by physicians.
- The rise of the power of the Mexican drug cartels and the increasing sophistication of their U.S. distribution networks between 1980 and 2000 resulted in an unprecedented amount of opioids, mostly black tar heroin, available on the streets of rural America. With the acumen of formally trained businessmen, the Mexican drug cartels developed "pizza style" delivery operations in small, rural areas where local law enforcement agencies were underfunded, underfunded and inexperienced to investigate well

organized and well executed heroin distribution operations. The Drug Enforcement Administration reported heroin seizures in the U.S. increased by 450% between 2008 and 2014.

- In 2011, the North Carolina General Assembly created the Statewide Misdemeanant Confinement Program (SMCP) as a part of the Justice Reinvestment Act. The SMCP provides State funding to house misdemeanants serving sentences of more than 90 days and all impaired driving sentences, in local jails. The creation of this program allowed the State to move misdemeanants from the state prison system to the local jails.
- In 2017 North Carolina Governor Cooper signed into law the Strengthen Opioid Misuse Prevention (STOP) Act, which was intended to reduce the supply of unused, misused and diverted opioids circulating throughout the State, as well as reduce “doctor shopping” by the addicted population and help prevent inappropriate prescribing. The STOP Act, although well intentioned, certainly accomplished its “supply reduction” objectives. But without adequate treatment and recovery programs in place to assist with “demand reduction”, the addicted population - caught in the cycle of opioid addiction initiated by legitimate prescriptions provided by a doctor – turned to the cheaper and more plentiful alternative of heroin. Production and sales tracking data from the Drug Enforcement Administration revealed that between 2006 and 2014 over 55 million opioid pills were legally distributed by pharmacies in Surry County. By the end of 2018, the overdoses in Surry County reached a new high, increasing by 64% from 2017, with 60% of those overdoses involving opioids.

Introduction

Since its inception and under the guidance of the Surry County Board of Commissioners the Surry County Office of Substance Abuse Recovery (SCOSAR) has been committed to listening to community feedback, conducting research and data analysis, and recommending evidenced informed practices to our region. At its heart is the idea that a full spectrum approach requiring dedicated work on substance use prevention, intervention, treatment, and recovery will result in the greatest positive impact on the health of our citizens.

Too many times helping systems are designed and developed based on funding streams and traditional organizational practices. Yet, the needs of our citizens and communities are fluid and holistic and most often do not fit the neat boxes of current interventions or services. The results of this document titled *Recommendations for the Use of Opioid Settlement Litigation Funding and Local Prioritization Planning Model* attempts to summarize the work of the SCOSAR since 2018 and be informed by formal needs assessment processes. Funding prioritization based on community-based assessment processes and a strong evidence base will ensure fiducial and governmental accountability while promoting outcomes informed by research and experience. Such decisions when based on evidence will have a greater possible impact on the substance use epidemic in Surry County. The current document is limited to include Community Needs Assessment and Prioritization Processes while also aligning recommendations to the North Carolina Opiate Settlement Memorandum of Agreement (MOA). We believe the SCOSAR approach is innovative and exemplifies national best practices and is possible only due to the investment and support of county leadership and community members. Once formal funding priorities are identified for the use of Opiate Litigation Settlement funds, an established planning process will then be initiated to ensure program level fidelity and assurance to evidence-informed practice appropriate to Surry County.

Effective Community Needs Assessment Processes can produce the following outcomes:

- Ensure that the community meets funding requirements
- Links planning models and processes to best practices
- Ensures responsiveness to community needs
- Guides planning processes
- Provides baseline data to evaluate future success
- Enables the identification of changes in trends and needs
- Helps to focus resources on the best fit initiatives for the community
- Helps to determine what capacity exists for new initiatives
- Creation of a storyline to communicate findings to community leaders and stakeholders
- Promotes accountability and evaluation of success

Formal Needs Assessment processes result in a myriad of tangible results and outcomes, all well suited for meeting the requirements of long-term project planning as described by the North Carolina Opiate Litigation Settlement Agreement MOA. Following such structured processes of Community Needs Assessment, Identifying Capacity and Priorities, Planning, Program Implementation and finally, Evaluation provides Surry County the best chance for meeting the requirements of the Opiate

Litigation Settlement Fund and to facing the challenges of Substance Use Disorder (SUD) in our community. Therefore, the approach outlined in the current document must also be viewed via a lens of what initiatives can be sustained over the long term while also being a cultural fit for our local citizens.

The Surry County Office of Substance Abuse Recovery (SCOSAR)

Founded in 2018, SCOSAR is dedicated to building a continuum of care that eliminates impediments for residents who seek treatment and recovery from substance use disorder. Funded by Surry County Government and multiple grants, the SCOSAR is led by a director-level position whose sole mission is to reduce the impact of substance use on residents, agencies, organizations, and businesses.

SCOSAR is managed on the belief that evidence-based practices and data-driven approaches will help drive positive local policy and community change. From January to August 2021 a nine-month research-based needs assessment and planning process occurred that addressed the entire Institute of Medicine (IOM) Continuum of Care for Substance Use Response efforts (Prevention, Intervention, Treatment, and Recovery). The needs assessment process included the collection of local survey and interview data, review of national, state, and local quantitative data used to better identify, prioritize, and connect evidenced-based practices to interventions that are likely to positively impact the substance use epidemic within Surry County using the Strategic Prevention Framework (SPF) as a planning model¹.

SCOSAR achieved significant progress of late with its research and data collection efforts and new service delivery models including the creation of staff positions that support community outreach, intervention, coalition development, substance use prevention, and development of an active transportation program supporting clients to and from treatment who are suffering from substance use disorder (SUD). The office also employs a program researcher and data analyst tasked to create actionable implementation and evaluation insights to support internal and external programming efforts in the substance use space and improve cross-sector cooperation.

Mission

Build a 'Continuum of Care' for Surry County Residents with Substance Use Disorders that eliminates impediments for those seeking treatment and recovery

Objective

Decrease the population of Surry County Residents who abuse substances

Focus

*Identification of Community Needs and Serving as the Backbone
Organization for Innovative Programming*

Delivery of Primary Prevention and Community Wellness

Development of Intervention, Treatment Resources and Recovery Networks

Supporting Enhanced Community Focused Criminal Justice Initiatives

¹ Substance Abuse and Mental Health Services Administration: A Guide to SAMHSA's Strategic Prevention Framework. Rockville, MD: Center for Substance Abuse Prevention. Substance Abuse and Mental Health Services Administration, 2019.

Executive Summary

This planning model justifies how and why the Surry County Office of Substance Abuse Recovery (SCOSAR) established its mission and operationalized that mission under the Institute of Medicine framework. With the advent of funding sourced from the Opioid Litigation Settlement Fund, this document provides guidance as how to best serve the needs and requests of Surry County residents to abate the negative effects of substance use - the result being the improvement of the overall health of the community. Attachment A to this document is a chart that prioritizes the community needs assessments and cross references those needs assessments with the County's community readiness level, the Governor's North Carolina Opioid Action Plan 3.0 and the North Carolina Opioid Litigation Settlement Funding Memorandum of Agreement (MOA).

The planning model's key components were developed in multiple stages. From March through June 2021 the Volunteering Opinions and Information Concerning Eliminating Substance Use Community Survey (VOICES) was conducted utilizing an on-line format. In conjunction with VOICES, office staff and volunteers conducted fifty-five in-depth interviews of key respondents and community influencers. The results of these interviews were collected in the "Surry County Perspectives" and combined with the VOICES to produce the "Community Needs Assessment".

SCOSAR staff matched the "Community Needs Assessment" with the individual categories from the full spectrum of options offered in the Institute of Medicine model for prevention, intervention, treatment, recovery. The dimensions of readiness scale was incorporated into the "Surry County Perspectives" interview process. The planning model utilizes the readiness scale to calculate the community's "Readiness Level" to implement each option in the "Community Needs Assessment". The readiness levels are divided into three categories:

1. High Likelihood to Change and High Priority for Planning
2. High Likelihood for Change and Low Priority for Planning
3. Difficult to Change and Low Priority for Planning.

These categories are a modification of the "Risk Impact / Probability" tool, where the risk of taking an action is weighed against the probability of a successful outcome. The "Readiness Level" is a measure of how prepared the community is to take action to address a specific community need. Our community's readiness varies depending on its understanding of a problem, leader support, and resources available for solutions. Analysis of the VOICES and the "Surry County Perspectives" revealed our community is more than ready to address some issues, while being at the earliest level of readiness to address other issues. The "likelihood to change" and "priority for planning" scales are a combination of input from the VOICES, the "Surry County Perspectives" and the SCOSAR experiences with local government and private agencies.

The Governor's North Carolina Opioid Action Plan 3.0 recommended, without assigning priorities, specific approaches to prevent opioid overdoses that included:

- Reducing supply
- Prevention and supporting families
- Advancing harm reduction
- Addressing non-medical drivers of health

- Addressing the needs of the criminal justice population
- Expanding access to treatment and supports
- Creating building blocks for sustained change.

SCOSAR matched the North Carolina Governor’s Opioid Action Plan 3.0 approach with the appropriate community need.

The ranking for each “Community Needs Assessment” is found in the first column on the chart’s left side. The rankings were derived from cross referencing four priorities: The “Community Needs Assessment”, the “Readiness Level”, the needs assessment recommended in NC Opioid Action Plan, and the guidelines of the MOA. (The MOA divided actions allowed by agencies receiving Opioid Litigation Settlement Funding under “Option A” and “Option B”. “Option A” allows a recipient of litigation funding to expend funding with limited strategic planning beyond a public annual meeting with representatives from a county and municipalities within a county. “Option B” allows a county that chooses to conduct additional voluntary, collaborative, strategic planning to choose to expend funding from a broader list of activities.) Given that the SCOSAR has previously assessed community needs, evaluated available resources, and implemented multiple programs to build the full continuum of care, Surry County has the flexibility to select programs offered in the MOA from both “Option A” and “Option B”.

If the action allowed under the MOA corresponded with the action derived from the Community Needs Assessment, and the action was one in planning or implemented by SCOSAR, the action was given a green block. If the action allowed under the MOA did not correspond with an action derived from the Community Needs Assessment or was not yet in the planning or implementing phase by SCOSAR, it was assigned a black box. From this evaluation each Community Needs Assessment was assigned a weight based on the total number of green boxes. The rankings on the first column on the left resulted from the “Weight” column on the far right. Ultimately, the “Community Needs Assessment” with the highest number of green boxes was assigned the highest ranking.

Lastly, the SCOSAR will provide to the Surry County Board of Commissioners an assessment of the financial support required to implement the highest-ranking programs in the “Community Needs Assessment” and an analysis of how those programs will be integrated into the larger effort to build a Recovery Oriented System of Care (ROSC) for Surry County residents with substance use disorder that eliminates impediments for those seeking treatment and recovery.

The Importance of Systems Thinking

David Peter Stroh in 2015 published a seminal work titled *Systems Thinking for Social Change* that outlines how to avoid unintended outcomes by focusing on how systems work and operate in the community and social change environment². The book reiterates the importance of collaborative problem solving, choice making and strategic planning.

Systems planning seeks to avoid common errors in implementing social change including:

- Addressing symptoms rather than underlying problems
- Making choices that seem obvious and succeed only in the short run
- Achieving short-term gains that are undermined by longer-term impacts
- Produce negative consequences that are unintentional
- Lead communities to assume that we are not responsible when problems reoccur

Stroth quotes Lewis Thomas, an award-winning medical essayist in the book:

“When you are confronted by any complex social system...with things about it that you’re dissatisfied with and anxious to fix, you cannot just step in set about fixing it without much of hope of helping. This is one of the sore discouragements of our time. If you want to fix something you are first obliged to understand the whole system.”

The author presents valid arguments that:

- People’s good intentions to improve social systems are often undermined when they apply conventional thinking to chronic, complex social problems.
- Systems thinking is different from conventional thinking.
- A social system is always designed to achieve a purpose, although it may not be the purpose people say they want to accomplish.

The Systems Thinking for Social Change encourages communities to consider the following foundational ideas:

The Challenge	Benefits of Systems Thinking Approaches	Characteristics of a Conventional Approach
Motivation – Why should we change?	Show responsibility for current reality	Appeal to desire or fear
Collaboration – Why should we work together?	Demonstrates how people’s current ways of interacting undermine both their individual and their collective performance	Tell people they should

² Stroh, David Peter. *Systems Thinking for Social Change: A Practical Guide to Solving Complex Problems, Avoiding Unintended Consequences, and Achieving Lasting Results*. Chelsea Green Publishing, 2015.

Focus – What should we do?	Use leverage to change the few things that change everything else	Tackle many issues independently and simultaneously; attack symptoms
Learning – Why bother?	Recognize that our actions matter, and that we need to learn from the consequences of our actions	Assume that others are at fault and must learn

The national organization Innovation Associates Organizational Learning³ published information comparing Conventional Thinking to Systems Thinking as presented below:

Conventional Thinking	Systems Thinking
The connection between problems and their causes is obvious and easy to trace.	The relationship between problems and their causes is indirect and not obvious.
Others, either within or outside organizations, are to blame for our problems and must be the ones to change.	We unwittingly create our own problems and have significant control or influence in solving them through changing our behavior.
A policy designed to achieve short-term success will also assure long-term success.	Most quick fixes have unintended consequences: They make no difference or make matters worse in the long run.
To optimize the whole, we must optimize the parts.	To optimize the whole, we must improve relationships among the parts.
Aggressively tackle as many independent initiatives as possible simultaneously.	Only a few key coordinated changes sustained over time will produce large systems change.

In closing the adoption of Systems Thinking can help structure large scale change projects using evidenced based and participatory approaches. Systems Thinking teaches communities to rely on a shared language for communication, a common understanding of why a problem persists despite people’s best efforts to solve it, and sheds light on the distinction between the desired purpose people espouse and the payoffs of the system as it is currently configured. Finally, Systems Thinking allows community stakeholders to create a shared theory of change, a map how they will create success to help move from where they are to where they want to be.

Models Incorporated by the Surry County Office of Substance Abuse Recovery

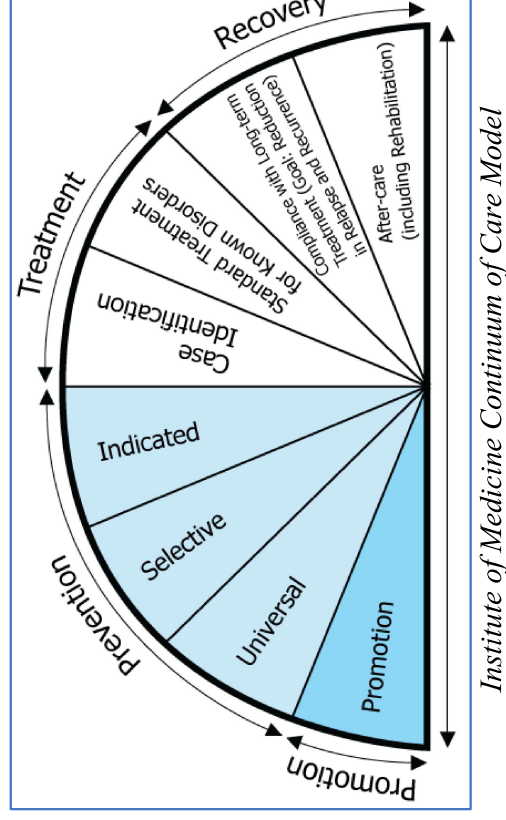
To overcome the limitations of the current care models for delivering treatment services, efforts should be shifted to a community model, where recovery-oriented services are provided in communities, in specific environments of need, and be provided by professionals, family members, and peers. Services are structured to address the long-term and complex needs of people living with addiction and mental health issues.

³ Innovation Associates. (2021). Retrieved 1 September 2021, from <http://www.innovationassociates.com/>

Substance use problems and disorders are preventable and treatable chronic conditions. One aspect of providing recovery-oriented services is the shift from acute care methods to the broader adoption of chronic care strategies throughout the systems of care. Within the recovery-oriented systems of care framework, although the treatment system is central, it is one of many important system offerings and supports.

What is the Institute of Medicine Model?

The Institute of Medicine's continuum of care (also known as the mental health intervention spectrum) is a classification system that presents the scope of behavioral health services: promotion of health, prevention of illness/disorder, treatment, and maintenance/recovery.⁴



Promotion involves interventions (e.g., programs, practices, or environmental strategies) that enable people “to increase control over, and to improve, their health.” As such, interventions that promote health occur independently as well as throughout the continuum of care as part of prevention, treatment, and maintenance/recovery. The focus of promotion is on well-being, according to the National Research Council and Institute of Medicine, with the goal of enhancing people’s ability to:

- “Achieve developmentally appropriate tasks”
- Acquire “a positive sense of self-esteem, mastery, well-being and social inclusion”
- “Strengthen their ability to cope with adversity”

The National Prevention Strategy concurs. Emotional well-being “allows people to realize their full potential, cope with the stresses of life, and make meaningful contributions to their community.”

⁴ Substance Use Prevention Skills Training (2021). Retrieved 30 August 2021, from https://collectiveimpact.mha.ohio.gov/Portals/0/assets/Project%20Information/Trainings_Materials/Continuum_of_Care-SAPST_Handout.pdf

Further, since childhood experiences can have a lasting impact on a person's life, promoting wellness in the early years can help “build a foundation for overall health.”

Prevention focuses on interventions that occur prior to the onset of a disorder and which are intended to prevent the occurrence of the disorder or reduce risk for the disorder. Prevention is also about striving to optimize well-being. The National Prevention Strategy states that “preventing drug abuse and excessive alcohol use improves quality of life, academic performance, workplace productivity, and military preparedness; reduces crime and criminal justice expenses, and motor vehicle crashes and fatalities; and lowers health care costs for acute and chronic conditions. Excessive alcohol use includes binge drinking, underage drinking, drinking while pregnant, and alcohol impaired driving. Drug abuse includes inappropriate use of pharmaceuticals and any use of illicit drugs.”

Preventive interventions, according to the Institute of Medicine, can be designed to address three levels of risk: universal, selective, and indicated.

- Universal preventive interventions focus on the “general public or a population subgroup that have not been identified on the basis of risk.” Examples: community policies that promote access to early childhood education, implementation or enforcement of anti-bullying policies in schools, education for physicians on prescription drug misuse, and social skills education for youth in schools
- Selective preventive interventions focus on individuals or subgroups of the population “whose risk of developing behavioral health disorders is significantly higher than average.” Examples: prevention education for new immigrant families living in poverty with young children, and peer support groups for adults with a history of family mental illness and/or substance abuse
- Indicated preventive interventions focus on “high-risk individuals who are identified as having minimal but detectable signs or symptoms” that foreshadow behavioral health disorders, “but who do not meet diagnostic levels at the current time.” Examples: information and referral for young adults who violate campus or community policies on alcohol and drugs; and screening, consultation, and referral for families of older adults admitted to emergency rooms with potential alcohol-related injuries

Treatment interventions include case identification and standard forms of treatment (e.g., detoxification, outpatient treatment, in-patient treatment, medication-assisted treatment).

Recovery includes interventions that focus on compliance with long-term treatment to reduce relapse and recurrence and aftercare, including rehabilitation and recovery support.

What is Prevention?

One of the major questions about addiction is why it takes hold only in some people. The changes in the brain associated with addiction do not progress in the same way in everyone who uses alcohol or drugs. For a wide range of reasons that remain only partially understood, some individuals are able to use alcohol or drugs in moderation and not develop addiction or even milder substance use disorders, whereas others—between 4 and 23 percent depending on the substance—proceed readily from trying a substance to developing a substance use disorder.

Understanding the factors that raise people's risk for substance misuse (risk factors) and those that may offer some degree of protection from these risks (protective factors) and then using this knowledge to design interventions aimed at steering people away from substance misuse are the goals of prevention science. Although research has shown strong heritability of substance use disorder, we now know that individual, family, community, and environmental risk factors play an important role in both substance misuse and substance use disorders. Being raised in a home in which the parents or other relatives use alcohol or drugs, for example, raises a child's chances of trying these substances and of developing a substance use disorder. Living in neighborhoods and going to schools where alcohol and drug use are common, and associating with peers who use substances, are also risk factors.

Another important risk factor is age at first use. The earlier people try alcohol or drugs, the more likely they are to develop a substance use disorder. For instance, people who first use alcohol before age 15 are four times more likely to become addicted to alcohol at some time in their lives than are those who have their first drink at age 20 or older. Nearly 70 percent of those who try an illicit drug before the age of 13 develop a substance use disorder in the next 7 years, compared with 27 percent of those who first try an illicit drug after the age of 17. Although substance misuse problems can develop later in life, preventing or even just delaying young people from trying substances is important for reducing the likelihood of more serious problems later on.

Prevention interventions also aim to support or bolster protective factors, which give people the resources and strengths they need to avoid substance use. Having strong and positive family ties and social connections, being emotionally healthy, and having a feeling that one has control over one's successes and failures are all protective factors. Being satisfied with one's life, having a sense of a positive future ahead, and emotional resilience are other examples of protective factors. Given the overwhelming tendency for substance use to begin in adolescence (ages 12 to 17) and peak during young adulthood, most prevention interventions have focused on teens and young adults. However, effective prevention policies and programs have been developed across the lifespan, from infancy to adulthood. It is never too early and never too late to prevent substance misuse and substance-related problems. A growing number of interventions designed to reduce risk and enhance protective factors have been scientifically tested and shown to improve substance use and other outcomes. These include interventions for all age groups (including early childhood), for specific ethnic and racial groups, and for groups at high risk for substance misuse, such as youth involved in the criminal justice system. These interventions may focus all individuals in a group (universal interventions) or specifically on at-risk individuals (selective interventions).

Importantly, interventions at the environmental or policy level can also be effective at reducing substance use. This has been shown clearly with alcohol use (especially by minors) and related problems such as drunk driving. Raising alcohol prices; limiting where, when, and to whom alcohol can be sold; raising the legal purchase age; and increasing enforcement of existing alcohol-related laws, such as the minimum legal drinking age (MLDA) of 21 and laws to prevent driving under the influence of alcohol, have successfully reduced negative alcohol-related outcomes where they have been implemented. Higher alcohol taxes have also been shown to reduce alcohol consumption. As a growing number of states allow marijuana use recreationally or therapeutically, research is ongoing to learn about the effects of these changes and policy levers that may mitigate potential harms, such as increased use by adolescents or impaired driving.

Evidence-based prevention interventions can also address a wider range of potential problems beyond just substance misuse. Alcohol and drug use among adolescents are typically part of a larger

spectrum of behavioral problems, including mental disorders, risky and criminal behaviors, and difficulties in school. Many interventions address the common underlying risk factors for these issues and show benefits across these domains, making them powerful and, in many cases, highly cost-effective investments that pay off in reduced health care, law enforcement, and other societal costs.

Prevention works. However, it must be evidence-based, and there is a need for an ongoing investment in resources and infrastructure to ensure that prevention policies and programs can be implemented faithfully, sustainably, and at sufficient scale to reap the rewards of reduced substance misuse and its consequences in communities.⁵

What is Intervention?

Many citizens who struggle with substance use and addiction understand the problems that may be occurring in their lives and seek help without the need for formal intervention. Others, are more hesitant to admit or realize that drug use is responsible for their problems, health status and family dysfunction. For those suffering from addiction, it is common to deny that substance use is the root of many problems they may be facing. There is a common belief that the substance user must reach rock bottom before they will be ready to reach out for help. Yet, research indicates that the most effective way to help someone involved in substance use is to intervene before their addiction gets worse. This is where intervention comes into play. A professional, or even family member, who is skilled at intervention efforts to help encourage the impacted individual to accept assistance.

Programs based on intervention theory use trained interventionists to ensure more successful outcomes. Common examples of interventions include assisting the citizen in meeting with substance use disorder and treatment professionals to discuss options, securing a spot in treatment, helping to reduce obstacles to saying 'yes', and ensuring adequate transportation to the treatment facility.

Unmoderated interventions can result in achieving a negative effect. This is where the professional skills of someone trained in effective intervention approaches can help. Trained staff can ensure that the conversation stays positive, effective, calm and on track by creating a safe space to allow the person to talk about their addiction.⁶

What is Treatment?

Treatment for substance use disorders can take many different forms and may be delivered in a range of settings varying in intensity. In all cases, though, the goals of treatment for substance use disorders are like treatment for any medical condition: to reduce the major symptoms of the illness and return the patient to a state of full functioning. Ideally, services are not “one size fits all” but are tailored to the unique needs of the individual. Treatment must be provided for an adequate length of time and should address the patient’s substance use as well as related health and social consequences that

⁵ Rural Prevention and Treatment of Substance Use Disorder Toolkit - RHIhub. (2022). Retrieved 28 January 2022, from <https://www.ruralhealthinfo.org/toolkits/substance-abuse>

⁶ Drug Intervention Programs, Specialists, Services & Strategies. (2021). Retrieved 30 August 2021, from <https://drugabuse.com/treatment/intervention/>

could contribute to the risk of relapse, including connecting the patient to social support, housing, employment, and other wrap-around services.

Screening for substance misuse in health care settings including primary, psychiatric, urgent, and emergency care is the first step in identifying behaviors that put individuals at risk for harms, including for developing a substance use disorder, and to identify patients with existing substance use disorders. Screening and brief intervention for alcohol in adults has been shown to be effective; and screening for substance use and mental health problems is recommended by major health organizations for both adults and adolescents. Brief advice or therapy would follow a positive screen and be tailored to an individual's specific needs; referral can be made to specialty treatment depending on severity.

Treatment for all substance use disorders—including alcohol, marijuana, cocaine, heroin or other opioid use disorders, among others—should include one or more types of *behavioral interventions* delivered in individual, group, and sometimes family settings. Evidence-based behavioral interventions may seek to increase patients' motivation to change, increase their self-efficacy (their belief in their ability to carry out actions that can achieve their goals), or help them identify and change disrupted behavior patterns and abnormal thinking.

The intensity of substance use disorder treatment services falls along a continuum. For people with mild substance use disorders, counseling services provided through primary care or other outpatient settings with an intensity of one or two counseling sessions per week may be sufficient while residential treatment may be necessary for people with a severe substance use disorder. Residential treatment was designed to provide a highly controlled environment with a high density of daily services. Ideally, people who receive treatment in residential settings participate in step-down services following the residential stay. Step-down services may include intensive outpatient or other outpatient counseling and recovery support services (RSS) to promote and encourage patients to independently manage their condition.

Medications are also available to help treat people addicted to alcohol or opioids. Research is underway to develop new medications to treat other substance use disorders, such as addiction to marijuana or cocaine, but none have yet been approved by the U.S. Food and Drug Administration (FDA). The available medications do not by themselves restore the addicted brain to health, but they can support an individual's treatment process and recovery by preventing the substance from having pleasurable effects in the brain, by causing an unpleasant reaction when the substance is used, or by controlling symptoms of withdrawal and craving. Widening access to highly effective medications for treating opioid addiction—methadone, buprenorphine, and naltrexone—has been identified by United States public health authorities as an essential part of tackling America's current prescription opioid and heroin crisis.

In summary: *Treatment is effective.* As with other chronic, relapsing medical conditions, treatment can manage the symptoms of substance use disorders and prevent relapse. Rates of relapse following treatment for substance use disorders are comparable to those of other chronic illnesses such as

diabetes, asthma, and hypertension. More than 25 million individuals with a previous substance use disorder are in remission and living healthy, productive lives.⁷

What is Recovery?

(The below section was taken directly from material published by the United States Surgeon General, 2021).⁸

Because the brain can take a long time to return to health following a long period of heavy substance use, risk of relapse is high at first. It can take a year of abstinence before an individual can be said to be in remission; for people recovering from an alcohol use disorder, it can take 4 to 5 years of abstinence for the risk of relapse to drop below 15 percent—the level of risk of individuals in the general population developing a substance use disorder during their lifetime. In addition, successful recovery often involves making significant changes to one’s life to create a supportive environment that avoids substance use or misuse cues or triggers. This can involve changing jobs or housing, finding new friends who are supportive of one’s recovery, and engaging in activities that do not involve substance use. Therefore, ongoing Recovery Supports in the community after completing treatment can be invaluable for helping individuals resist relapse and rebuild lives that may have been devastated by years of substance misuse.

Recovery has become an increasingly important concept for researchers and practitioners in the substance use disorder field, as well as in the community. It is central to a movement to bring greater awareness to the struggles and the successes of people fighting addiction and increase solidarity in overcoming the discrimination, shame, and misconceptions historically associated with substance use disorders. In general, the term sends a positive, hopeful message that recovery is possible, that there is life after even the most devastating struggles with addiction, and that people suffering with or recovering from an alcohol or drug use disorder have essential worth and dignity. It also provides a positive focus and construct for scientific, program, and policy-level thinking about substance use disorders.

Recovery support services are not the same as treatment and have only recently been included as part of the health care system. Many of these services began long before the modern era of evidence-supported interventions; some have been studied and found to be effective at maintaining abstinence and promoting other positive long-term outcomes in those who take advantage of them. The most well-known approach, *mutual aid groups*, link people in recovery and encourage mutual support while providing a new social setting in which former alcohol or drug users can engage with others in the absence of substance-related cues from their former life.

⁷ Early Intervention, Treatment and Management of Substance Use Disorders. United States Surgeon General. (2021). Retrieved 3 August 2021, from <https://addiction.surgeongeneral.gov/executive-summary/report/early-intervention-treatment-and-management-substance-use-disorders>.

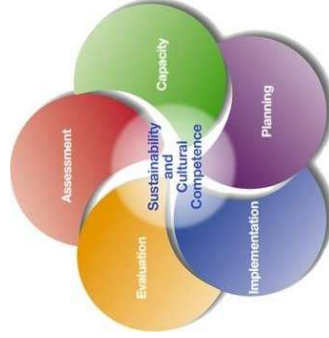
⁸Prevention Programs and Policies. United States Surgeon General. (2021). Retrieved 3 August 2021, from <https://addiction.surgeongeneral.gov/executive-summary/report/prevention-programs-and-policies>.

The best-known mutual aid groups are 12-step programs like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Narcotics Anonymous has not been extensively studied, but AA has been shown in many studies to have a positive effect in reducing a person's likelihood of relapse to drinking.⁴²⁻⁴⁶ Mutual aid groups are facilitated by peers, who share their lived experience in recovery. However, health care professionals have a key role in linking patients to these groups, and encouraging participation can have great benefit. Recovery coaches, who offer individualized guidance, support, and sometimes case management, and recovery housing—substance-free living situations in which residents informally support each other as they navigate the challenges of drug- and alcohol-free living—have led to improved outcomes for participants.

In summary: *People can and do recover*. The recovery movement offers a valuable opportunity for people with substance use disorders and their loved ones to get the support they need to gradually return to a healthy and productive life away from the destructive impact of substance use. The movement also provides an opportunity for people to advocate for improvements in prevention and treatment services. Equally, this movement can contribute to efforts to reduce negative public attitudes as well as discrimination embedded in public policies and the health care system.⁹

The Strategic Prevention Framework

To increase community understanding, SAMSHA developed the Strategic Prevention Framework (SPF) to assist communities with understanding the complex behavioral health problems inherent in resolving substance misuse among its residents.



The Five Steps of the SPF:

- Assessment
 - The identification of prevention needs based on data (e.g., What is the problem?)
- Capacity
 - Determining and building local resources and readiness to address needs (e.g., What do you have to work with?)

⁹Prevention Programs and Policies. United States Surgeon General. (2021). Retrieved 3 August 2021, from <https://addiction.surgeongeneral.gov/executive-summary/report/prevention-programs-and-policies>.

- Planning
 - Identification of what works to address community needs and how to do it well (e.g., What should you do and how should you do it?)
- Implementation
 - Delivery of evidence-based programs and practices as intended (e.g., How can you put your plan into action?)
- Evaluation
 - Examining the process and outcomes of programs and practices (e.g., Is your plan succeeding?)

Two foundational principles should be integrated into each of the SPF's five steps:

- Cultural Competence
 - The ability of an individual or organization to understand and interact effectively with people who have different values, lifestyles, and traditions based on their distinctive heritage and social relationships.
- Sustainability
 - The process of building an adaptive and effective system that achieves and maintains desired long-term results.

The SPF has defining characteristics that set it apart from other strategic planning processes, and continuous and creates an actionable feedback loop for communities. The Strategic Prevention Framework relies on the following philosophical framework supported by evidenced informed practice:

- Dynamic and Interactive
 - Assessment is the starting point, but community planners will return to this step again and again as their community's substance misuse problems and capacities evolve. Communities may also engage in activities related to multiple steps simultaneously. For example, community planners may need to find and mobilize additional capacity to support implementation once a program or practice is underway. For these reasons, the SPF is a circular rather than a linear model.
- Data-Driven
 - The SPF helps community planners gather and use data to guide decisions—from identifying which substance misuse problems to address in their communities, to choosing the most appropriate ways to address these problems, to determining whether communities are making progress.
- Reliant on and encourages a team approach
 - Each step of the SPF requires—and greatly benefits from—the participation of diverse community partners. The individuals and institutions involved in prevention efforts may change as the initiative evolves, but the need for prevention partners will remain constant.

Recovery Oriented System of Care (ROSC)

Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life. Recovery from mental illness and substance use disorder takes many forms. SAMHSA developed the following principles to help the communities understand the concept of Recovery.¹⁰

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery emerges from hope and gratitude.
- Recovery involves a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.
- Recovery is supported by peers and allies.
- Recovery involves (re)joining and (re)building a life in the community.
- Recovery is a reality.

ROSC focuses on seventeen (17) elements:

- Person-centered
- Inclusive of family and other ally involvement
- Individualized and comprehensive services across the lifespan
- Systems anchored in the community
- Continuity of care
- Partnership-consultant relationships
- Strength-based
- Culturally responsive
- Responsiveness to personal belief systems
- Commitment to peer recovery support services
- Inclusion of the voices and experiences of recovering individuals and their families
- Integrated services
- System-wide education and training
- Ongoing monitoring and outreach
- Outcomes driven
- Research based
- Adequately and flexibly financed

In a 2005 article in the *Psychiatric Rehabilitation Journal*, O’Connell, Tondora, Croog, Evans, and Davidson conducted a comprehensive review of the literature on mental illness and addictions

¹⁰ Guiding Principles and Elements of Recovery-Oriented System of Care (2022). Retrieved 28 January 2022, from https://www.naadac.org/assets/2416/sheedyckwhitterm2009_guiding_principles_and_elements.pdf

recovery that identified the elements of a supportive recovery-oriented environment. According to the authors, a recovery-oriented environment is one that:

- Encourages individuality
- Promotes accurate and positive portrayals of psychiatric disability while fighting discrimination
- Focuses on strengths
- Uses a language of hope and possibility
- Offers a variety of options for treatment, rehabilitation, and support
- Supports risk-taking, even when failure is a possibility
- Actively involves citizens accessing services, family members, and other natural supports in the development and implementation of programs and services
- Encourages user participation in advocacy activities
- Helps develop connections with communities
- Helps people develop valued social roles, interests and hobbies, and other meaningful activities.

Gagne, White, and Anthony in a 2007 article in the Psychiatric Rehabilitation Journal describe the recovery and the values of a recovery-oriented care model that intersect the addiction and mental health fields.

- Recovery is a personal and individualized process of growth that unfolds along a continuum and acknowledges multiple pathways to recovery.
- People in recovery are active agents of change in their lives and not passive recipients of services.
- People in recovery from mental illness and/or addiction disorders often note the important role of family and peer support in making the difference in their recovery.
- The values of recovery oriented mental health and addictions systems are based on the recognition that each person is the agent of his or her own recovery and all services can be organized to support recovery. Person-centered services offer choice, honor each person's potential for growth, focus on a person's strengths, and attend to the overall health and wellness of a person with mental illness and/or addiction.

Minkoff and Cline (2004) present four characteristics of the comprehensive, continuous, integrated systems of care model for organizing services for individuals with co-occurring psychiatric and substance use problems and disorders.

The model's four characteristics are as follows:

- System level of change
 - The model is implemented into the entire system of care, not only for individual programs or training initiatives.
- Efficient use of existing resources
 - The model is implemented within the context of current service resources but emphasizes strategies between each program's requirements and environments.
- Incorporation of best practices

- The model is recognized by SAMHSA as a best practice for implementation for those with co-occurring psychiatric and substance disorders.
- Integrated treatment philosophy
 - The model utilizes a common language for both the mental health and addictions fields.

Starting in the early 1990s, the mental health field oriented on the process of recovery to guide decisions related to the mental health system. A recovery mental health model puts the focus of control and decision-making in the hands of the person who has the mental health condition.

“Recovery is pushing systems, as well as providers, to see beyond the diagnostic and categorical services, to treating the individual consumer and his/her multiple needs. The [recovery] vision ... is of an external system that reflects the internal reality of its consumers.”

Research Supporting the Principles of Recovery and Systems of Care Elements outlined principles of effective addictions treatment. In 1999, the National Institute on Drug Abuse (NIDA) produced a research-based guide entitled *Principles of Drug Addiction Treatment*. It identified 13 principles that research has found to be associated with effective addictions treatment.

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. An individual’s treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person’s changing needs.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with co-existing mental disorders should have both disorders treated in an integrated way.
9. Medical detoxification is only the first stage of addictions treatment and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at the risk of infection.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

Understanding Substance Use Disorder

Flesh out this section to better describe addiction as a whole.

Addiction is a chronic disease characterized by drug seeking and use that is compulsive, or difficult to control, despite harmful consequences. The initial decision to take drugs is voluntary for most people, but repeated drug use can lead to brain changes that challenge an addicted person's self-control and interfere with their ability to resist intense urges to take drugs. These brain changes can be persistent, which is why drug addiction is considered a "relapsing" disease—people in recovery from drug use disorders are at increased risk for returning to drug use even after years of not taking the drug. It's common for a person to relapse, but relapse doesn't mean that treatment doesn't work. As with other chronic health conditions, treatment should be ongoing and should be adjusted based on how the patient responds. Treatment plans need to be reviewed often and modified to fit the patient's changing needs¹¹.

Interventions must be based on local community needs, guidelines of the MOA that are subsequently based on best practice research and national standards. There must be a national alignment of local community needs -- → identification of community capacity --- → Answer how we got to where we arrived to spend this money. Gov Plan, Needs Assessment, Guide of MOA, Selection of Interventions. After selection of interventions the next step is the creation of the implementation plans with evaluation plans and outcomes readily identified.

Insert Chart/Funnel Graphic that shows how we arrived here and the limitations of the MOA.

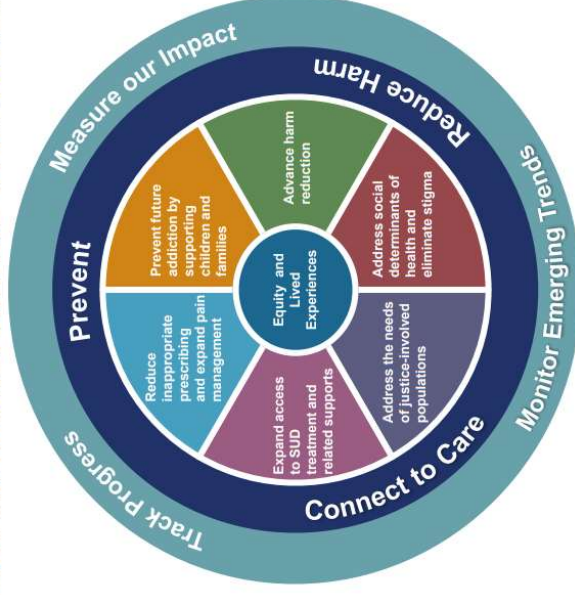
¹¹ Understanding Drug Use and Addiction Drug Facts | National Institute on Drug Abuse. (2018). Retrieved 19 November 2021, from <https://www.drugabuse.gov/publications/drugfacts/understanding-drug-use-addiction>

North Carolina's Opioid and Substance Use Action Plan

North Carolina's Opioid and Substance Use Action Plan was originally published in June 2017 with the most recent update occurring in May 2021. The intent of this Action Plan, published by the Governor's Office, is to outline local strategies that counties, coalitions and other community stakeholders can use to respond to the opioid epidemic. Sustained change, as published in the Menu of Local Actions to Prevention Opioid Overdose in North Carolina (2021 NC Opioid Action Plan) includes:

- Building a strong coalition
- Using data to inform actions
- Mapping treatment resources
- Promotion of public education and action campaigns

Opioid and Substance Use Action Plan



The **Opioid and Substance Use Action Plan** broadens its focus to include **polysubstance use** and **centers equity and lived experience**

Priorities for the North Carolina Opioid and Substance Use Action Plan includes:

- Equity and lived experiences at the center
 - Acknowledging that systems have frequently harmed marginalized persons who use drugs, and implement programs that reorient those systems toward service and treatment
 - Increase access to comprehensive, culturally competent, and linguistically appropriate drug user health services for Historically Marginalized Populations
- Prevention of future addiction and addressing trauma by supporting children and families
 - Increase judicious opioid prescribing and the use of non-opioid pain treatments

- Prevention of youth misuse by addressing the upstream causes of substance use disorders, including trauma and adverse childhood experiences (ACES)
- Reduction of harm by moving beyond opioids to address poly substance use
 - Expanding comprehensive drug user health services to encompass multiple substances
 - Increase healthcare services in low barrier and non-traditional settings
 - Expanding drug checking to prevent overdoses (allows people who use drugs to help identify the substance they intend on taking and therefore prevent harms associated with consuming an unknown substance)
- Connections to care by increasing treatment access for justice involved people and expanding access to housing and employment supports while recovering from the pandemic
 - Expand jail diversion programs to reduce incarceration for people who use drugs
 - Increase access to naloxone and overdose prevention education
 - Expand medication-assisted treatment during incarceration, upon release, and with reentry into communities
- Drivers of health include housing, employment and access to healthcare and people who use drugs are disproportionately impacted
 - Expand employment support services for people with substance use disorders, and increase workplace policies and employment assistance programs that support people with substance use disorders
 - Create a training program on Housing First principles and harm reduction for housing providers, including homeless shelter and emergency housing
 - Build local adoption of fair chance hiring, including by counties, municipalities, and companies to increase adoption of fair chance hiring practice

North Carolina's Opioid and Substance Use Action Plan served as a foundation of evidenced based practices in the construction of recommendations provided by SCOSAR. Cross alignment between the Opioid and Substance Use Action Plan and recommendations made by SCOSSR Staff are present while future data collection efforts are expected to be merged when possible, across both plans.

Opiate Litigation Settlement Funding and the North Carolina MOA

Introduction

The following information was taken from Corporate Accountability: Fighting the Opioid Epidemic in North Carolina published by the North Carolina Association of County Commissioners¹². On August 21, 2021 the Surry County Board of County Commissioners signed the North Carolina Opioid Litigation Settlement Memorandum of Agreement.

What is it?

The NC Memorandum of Agreement (NC MOA) governs how North Carolina would use the proceeds of any future national settlement or bankruptcy resolution with drug distributors Cardinal, McKesson, and AmerisourceBergen and opioid manufacturers Johnson & Johnson and Purdue Pharma. These potential settlements and resolutions could bring as much as \$850 million to North Carolina over an 18-year period to support state and local efforts to address the epidemic.

What it does

Dedicates all funds to addressing the opioid epidemic.

Enables North Carolina to maximize resources to abating the crisis. For North Carolina to receive the maximum payout under national settlements and bankruptcy resolutions, all relevant parties – including the state itself, all 100 counties, and all large- and medium-sized municipalities – must sign on to the NC MOA and the national settlement agreements. To maximize resources flowing to communities on the front lines of the epidemic, the NC MOA would direct settlement funds as follows:

- 15 percent to the state, which the General Assembly would appropriate to address the epidemic.
- 80 percent to local governments, including all 100 counties and 17 municipalities.
- An additional five percent to an incentive fund to encourage counties and municipalities to sign on to the agreement.

Ensures high levels of transparency and accountability. The agreement offers a high level of transparency into how local governments use the funds, including special revenue funds subject to audit, annual financial and impact reports, and a public dashboard showing how they are using settlement funds to address the epidemic.

¹² North Carolina Association of County Commissioners, <https://www.ncacc.org/wp-content/uploads/2021/04/Fact-Sheet-on-NC-MOA-4.30.21.pdf>

Why it Matters

Personal Cost. The opioid epidemic has taken the lives of more than 16,000 North Carolinians, torn families apart, and ravaged communities from the mountains to the coast. Just as we began to make progress in combatting the epidemic, the COVID-19 pandemic caused a new wave of isolation, despair, drug misuse, and overdose death. Individuals, families, and entire communities continue to suffer and struggle.

Accountability. The opioid epidemic was created and fueled by irresponsible marketing and inadequate monitoring on the part of opioid makers and distributors. Settlements with the big three drug distributors and Johnson & Johnson, and a resolution of the Purdue Pharma bankruptcy proceedings, have the potential to bring as much as \$850 million to North Carolina over an 18-year period to support state and local efforts to address the epidemic.

United Front to Heal North Carolina. The NC MOA is an important step forward in our collective effort to hold these companies accountable for their behavior and to secure and direct much-needed resources to communities across the state as they work to address the epidemic and its aftermath.

National Recommendations

SCOAR paid specific attention to national recommendations about how best to plan for and make recommendations to decision makers regarding how best to spend Opiate Settlement Litigation Funds. Significant national attention is being given to Opiate Settlement Legislation nationally and within North Carolina. Recommendations on the best practice use of the funding settlement are numerous and can assist local communities in developing needs assessment and planning processes that are based on proven approaches. The importance of using research driven and culturally appropriate interventions and community programming appears to be paramount in improving the health of communities. The following national groups are included in our report as an example of a growing number of professional groups and organizations weighing in on the appropriate use of settlement funds.

The SCOSAR planning process included a literature review of leading recommendations while also focusing strongly on the guidance published by John Hopkins University.

Model Opioid Litigation Proceeds Act

According to the September 2021 document Model Opioid Litigation Proceeds Act published by the Legislative Analysis and Public Policy Association and the White House Office of National Drug Control Policy, significant national attention is being paid to the opiate settlement process¹³. Based on data published in 2018, an estimated 21.2 million Americans (or 1 in every 12 people) had a substance use disorder, of whom two million had an opioid use disorder. Sadly, only seventeen

¹³ Model Opioid Litigation Proceeds Act (2021). Retrieved 1 November 2021, from <http://legislativeanalysis.org/wp-content/uploads/2021/10/Model-Opioid-Litigation-Proceeds-Act-FINAL.pdf>

percent (17%) of American's who needed it received any type of treatment. Common reasons cited for not accessing treatment includes the following:

- Not being ready to stop using (39.9%)
- Not knowing where to go for treatment (23.8%)
- Having no health care coverage and not being able to afford the cost of treatment (29.9%)

Opioid Use Disorder makes up only nine percent of substance use disorders in the United States, yet we must remember that poly substance use is generally verycommon (the use of more than one substance). Alcohol use is responsible for more than 95,000 deaths in the United States per year. Alcohol was also a factor in 15.5 percent of fatal heroin overdoses in 2017. *A growing body of research and data indicates in order to effectively address public health needs, prevention, treatment, recovery and harm reduction services must be offered to all individuals who are at risk of, or have, a substance use disorder, including during and after pregnancy, rather than solely to those with an opioid use disorder.*

The Model Opioid Litigation Proceeds Act proposal recommends ensuring that settlement proceeds be distributed to address opioid use disorder and other substance use disorders. This model publication is written to encourage the power of subject matter experts and those with lived experience to target spending for public health benefits and alignment with other efforts to address substance use disorders, overdoses, and drug-related harms.

American Medical Association

The American Medical Association (AMA) recommended in October 2020 that “any settlement or judgment stemming from opioid-related litigation be used exclusively for data collection, research, education, overdose prevention, stigma elimination, and evidence-based treatment for substance use disorders and pain.” The AMA also stated that diverting opioid litigation funds for other purposes will prolong the epidemic and too few states have taken steps to remove barriers for treatment¹⁴.

American Bar Association

The American Bar Association (ABA) House of Delegates in August 2019 recommended that any opioid settlement monies be used for drug treatment, housing programs and other social services, public education and improving healthcare infrastructure. The ABA House of Delegates stated that we should be aware of the ‘less than optimal’ outcome of the tobacco litigation of the 1990s. Often the use of tobacco funds were used for normal operations of state governments, instead of mitigating the public harms of tobacco use. Observers are concerned that something similar might happen in the current opioid litigation process as cited by the Pew Charitable Trust¹⁵.

¹⁴ AMA statement on Justice Department settlement with Purdue Pharma. (2021). Retrieved 27 August 2021, from <https://www.ama-assn.org/press-center/ama-statements/ama-statement-justice-department-settlement-purdue-pharma>

¹⁵ Laird, L. (2019). Opioid settlement money should be spent on treatment and services, ABA House of Delegates urges. Retrieved 27 August 2021, from <https://www.abajournal.com/news/article/opioid-settlement-money-should-be-used-for-direct-services-to-americans-affected-by-opioids-aba-house-of-delegates-says>

Harvard University

The FXB Center for Health and Human Rights at Harvard University published expert recommendations in the Use of Opioid Settlement Funds for Policy Makers and Advocates in December 2020¹⁶. The report takes a national approach and places an emphasis that opioid settlement funds must not replace what government agencies should already be doing but generate larger initiatives that may not be possible with current sources of funding. Recommendations include supporting the full range of care, services and support for people who use drugs and people with opioid dependence. Additional recommendations from the FXB Center include rethinking prevention activities to address underlying determinants of opioid use and dependence. Such discussions allow for conversations that include solutions related to health care, mental health, housing, employment, child welfare and criminal justice.

The Addictions Solutions Campaign

The Addictions Solutions Campaign established by the Center for Addiction, the Legal Action Center, Public Health Management Corporation and Partnership for Drug-Free Kids recently published Opioid Settlement Recommendations focusing on three impact areas¹⁷. The first recommendation is to enhance public and professional education and create informed demand for effective policies and interventions such as public awareness campaigns and data driven research practices. The second recommendation includes the implementation of evidence-based prevention and early intervention strategies to reduce substance misuse and related harms including screening and brief intervention programming. Second the last recommendation is to access to evidence-based addiction treatment services integrated with mainstream healthcare.

John Hopkins University

The Bloomberg School of Johns Hopkins University recently published a document titled Principles for the Use of Funds from the Opioid Litigation in attempts to provide guidance to local states and communities during this unprecedented time¹⁸. *Recommendations from the John Hopkins document has significantly impacted the design of this publication from SCOSAR.*

The John Hopkins University report provides five principles that are recommended to be the cornerstone of the future use of opioid litigation funds.

- Spending money to save lives
- Use evidence to guide spending
- Invest in youth prevention
- Focus on racial equity

¹⁶ FXB Center Publications. (2015). Retrieved 27 August 2021, from <https://fxb.harvard.edu/reports/>

¹⁷ Legal Action Center. Opioid Settlement Recommendations from the.... (2021). Retrieved 27 August 2021, from <https://www.lac.org/resource/opioid-settlement-recommendations-from-the-addiction-solutions-campaign>

¹⁸ Coalition Releases Principles to Guide State and Local Spending of Forthcoming Opioid Litigation Settlement Funds. Johns Hopkins Bloomberg School of Public Health. (2021). Retrieved 27 August 2021, from <https://publichealth.jhu.edu/2021/coalition-releases-principles-to-guide-state-and-local-spending-of-forthcoming-opioid-litigation-settlement-funds>

- Development of a fair and transparent process for deciding where to spend the funding

Principle 1: Spend money to save lives

Given the economic downturn, many localities will be tempted use the dollars to fill holes in their budgets rather than expand needed programs. Jurisdictions should use the funds to supplement rather than replace existing spending. At current funding levels programs seldom meet the needs of people who use drugs. For example, only an estimated 10% to 20% of people with opioid use disorder are receiving any treatment at all. Therefore, Principle 1 priorities include:

- Establish a dedicated fund that includes specific language that the money from the litigation fund is not to be used to supplant existing investments and establish specific language outlining acceptable uses of dollars available.
- Supplement rather than supplant funding. Local communities need to understand current baseline levels of funding and the capacity that additional funding from opioid litigation funds can build over the long term.
- Don't spend all the money at once. Addressing the underlying root causes of substance use in your community will require significant and sustained funding by states and localities.
- Report to the public on where the money is going. Localities must publicly report on how funds are being spent in ways that are easy to understand, with specific goals for programs and metrics that determine success.

Principle 2: Use evidence to guide spending

At this point in the overdose epidemic there is significant knowledge, research and data that demonstrates what works and what does not work. Such decisions about outcomes should be used to make funding decisions. Principle 2 priorities include:

- Direct funds to efforts and principals that are shown to work in the research. Interventions that are already identified as youth prevention efforts, harm reduction, communication campaigns and efforts to reduce stigma are proven to work. If there are funded programs that have not been studied, resources should be allocated to confirm success using long term evaluation methods.
- Planners must acknowledge that local policy change may need to occur to support evidenced based models.
- Building data capacity is important. It is important to establish evaluation processes that help support policy decisions, programs and strategies designed to address substance use across the continuum of care. Data should be published annually with public facing data dashboards.

Principle 3: Invest in youth prevention

States and localities should support children, youth, and families by making long-term investments in effective programs and strategies for community change. Principle 3 priorities include:

- Any comprehensive effort to reduce substance use must invest in primary prevention programs addressing the needs of youth. Primary prevention efforts are designed to stop use before it starts. Youth prevention programs often see a positive return on investment ranging from \$10 to \$18 per dollar invested.
- Not all prevention programs are created equal, with many youth prevention programs proving ineffective or not supported by solid evidence. Such alignment will ensure greater fidelity, access to research findings and leveraging of shared resources.

Principle 4: Focus on racial equity

Funds should be directed to communities affected by health disparities and who are experiencing substantial increases in overdoses. In recent years the rate of opioid overdose deaths has been increasing more rapidly in black populations than in white ones nationally. Minority groups are also more likely to face barriers in accessing high quality treatment and recovery services. Principle 4 Priorities include:

- Invest in communities negatively affected by federal, state, and local policies.
- Support diversion from arrest and incarceration. Increase and expand diversion programs and link community-based services with housing, employment, and other recovery services
- Investigate harm reduction efforts that support options and referrals to promote health and understanding for people that use drugs.
- Fund anti-stigma campaigns. This should be a primary focus within Surry County. People who use drugs are commonly viewed as those as ones suffering from moral failure. We must fund campaigns based on evidence that reduces stigma.
- Involve community members in solutions. We must fund programs throughout our communities that offer diverse leadership and staff and a track record of hiring from surrounding communities. Programs with diverse staff, supervisors and peers are more likely to provide relatable and effective services.

Principle 5: Development of a fair and transparent process for deciding where to spend the funding

Efforts must include leadership, active engagement of people and families with lived experience, and other key groups. Priorities for Principle 5 include:

- Data should be used to identify needs and where funds can make the biggest difference.
- Input from groups that touch different parts of the epidemic must be included such as prevention, intervention, treatment, and recovery groups. Other stakeholders such as law enforcement, social service agencies, nonprofits and business have valuable information to share. Most of all, the view and perceptions of our citizens within Surry County need to be considered and heard, making a specific effort to listen to the needs of those with lived experiences.
- Community members should be included in decision making processes. Community representatives, leaders, and residents can help leverage community resources and expertise while giving insights into community needs.

SCOSAR Planning Model

SCOSAR Staff actively conducted research and data analysis to determine the needs of the local community and identification of best practices to address substance use prevention, intervention, treatment, and recovery efforts within Surry County. Since January 2021, multiple documents have been published on the SCOSAR website (www.surrycountycares.com) for public review including the following work.¹⁹

V.O.I.C.E.S. Community Survey Data

Published in April 2021, the Surry County V.O.I.C.E.S. (Volunteering Opinions and Information Concerning Eliminating Substance Use) Community Survey, collected by the SCOSAR, received 730 responses. Eighty-seven percent (87%) of respondents indicated they knew a local family who has been negatively impacted by opioid use. In addition, 89% of individuals who responded to the survey knew a local family who has been negatively impacted by alcohol use. The document contains 114 pages of feedback coded by community sector/category.

Surry County Perspectives

The SCOSAR collected fifty-five (55) interviews during the Spring of 2021 from local citizens and leaders related to the status of substance use disorder and associated issues. The ninety-one (91) page document published in June 2021 provides a personal glimpse into the perspectives of the citizens of the county. The combination of the V.O.I.C.E.S. Survey and the Surry County Perspectives document result in the foundation of the Community Needs Assessment.

“Organized recovery efforts are such a niche field, it’s hard to be perceived as part of ordinary medical care sadly. There is bias about who is venerable, the disease of addiction is not understood. We need to combat misconceptions by promoting stories of recovery that are true and accurate; people need to be exposed to recovery stories. We need to combat the idea that this won’t happen to me but happens to other people. We need to address it’s not my problem idea. We also need to talk with those who don’t think it’s a public health crisis. Addiction is a disease.” - Surry County Citizen

¹⁹ Surry County Cares – Data Blog. (2021). Retrieved 27 August 2021, from <https://www.surrycountycares.com/blog>

Volunteering Opinions & Information Concerning Eliminating Substance Use Community Survey (V.O.I.C.E.S.)

Seven Hundred and Thirty (730) V.O.I.C.E.S. - Volunteering Opinions & Information Concerning Eliminating Substance Use Community Surveys²⁰ were collected from February 8, 2021 to April 14, 2021 using the following methodology:

1. Sponsored Facebook Posts (digital collection)
2. All-Stars Community Prevention Group Community Collection (paper and digital collection)
3. Email Distribution Collection (paper and digital collection)
4. SCORE Newsletter Collection (paper and digital collection)
5. Website Collection (digital collection)
6. The total population of Surry County based on the United States Census Estimated Population (2019)²¹ is 71,783. Since the V.O.I.C.E.S target population is Surry County Adults aged 18 and older, this reduces the Surry County Population of 18 years and older to a size of 56,720.

V.O.I.C.E.S. Survey Goals

Confidence Interval = 5

Confidence Level = 95%

Sample Size Needed = 382 (based on the eligible 18+ Surry County Population of 56,720)

Sample Size Collected = 730 (exceeded minimum sample size)

In order to ensure best practices related to survey design and promote the comparison of data to national datasets, questions originated from three primary sources:

- United States Census Bureau²² (Demographic Section)
- SAFE PROJECT Community Playbook²³ (Community Experiences Section)
- The Perceived Stigma of Substance Abuse Scale²⁴ (Community Perspectives Section)

²⁰ Surry County Cares – Data Blog. (2021). Retrieved 27 August 2021, from <https://www.surrycountycares.com/blog>

²¹ Bureau, US Census. "What Is Data.census.gov?" The United States Census Bureau, 10 Dec. 2020, www.census.gov/data/what-is-data-census-gov.html.

²² Bureau, US Census. "What Is Data.census.gov?" The United States Census Bureau, 10 Dec. 2020, www.census.gov/data/what-is-data-census-gov.html.

²³ "SAFE Community Playbook." SAFE Project, 24 Apr. 2019, www.safeproject.us/playbook/.

²⁴ "Perceived Stigma of Substance Abuse Scale (PSAS)." Publications by Scientists at Portland Psychotherapy, Portland Psychotherapy, portlandpsychotherapytraining.com/publications-by-scientists-at-portland-psychotherapy/.

The full published survey can be found at the SCOSAR website at: <https://www.surrycountycares.com/post/v-o-i-c-e-s-primary-survey-results>.

A selected excerpt of survey results can be found on the following pages.

Demographics Section

The Demographics Section of the survey collected the following information.

- Race and Hispanic Origin
- What is Your Age in Years
- Please Provide the Zip Code of Your Primary Residence in Surry County

Gender

Answer Choices		Responses
Female	80%	580
Male	20%	145
	Answered	725
	Skipped	5

Race and Hispanic Origin

Answer Choices		Responses
White	95.05%	692
Black or African American	0.55%	4
American Indian	0.27%	2
Asian	0.14%	1
Native Hawaiian	0.00%	0
Hispanic	2.47%	18
Other	1.51%	11
	Answered	728
	Skipped	2

What is Your Age in Years?

Answer Choices		Responses
18-24	4.39%	32
25-34	14.54%	106
35-44	17.83%	130
45-54	25.10%	183
55-64	24.01%	175
65+	14.13%	103
	Answered	729
	Skipped	1

Please provide the zip code of your primary residence within Surry County.

Answer Choices	Responses
27007 (Ararat)	1.68% 12
27017 (Dobson)	12.29% 88
27024 (Lowgap)	6.56% 47
27030 (Mount Airy)	56.98% 408
27031 (Mount Airy, Post Office Box)	0.28% 2
27041 (Pilot Mountain)	6.70% 48
27043 (Pinnacle)	1.96% 14
27047 (Siloam)	0.70% 5
27049 (Toast, Post Office Box)	0.00% 0
27053 (Westfield)	1.40% 10
28621 (Elkin)	8.38% 60
28676 (State Road)	3.07% 22
	Answered 716
	Skipped 14

Community Experiences Section

The Community Experiences Section of the Survey asked community members their own thoughts about substance use in the community, their experiences and perceived effectiveness of local response efforts.

At What Age Should We Start Talking to People About Drug and Alcohol Use?

Answer Choices	Responses
Elementary school aged	73.37% 496
Middle school aged	21.30% 144
High school aged	3.25% 22
College aged and older	0.44% 3
Other (please specify)	1.63% 11
	Answered 676
	Skipped 54

Are You Aware of a Drug Take-Back Program in Your Community?

Answer Choices		Responses
Yes	73.30%	497
No	26.70%	181
	Answered	678
	Skipped	52

If I Have Leftover Medication But No Longer Need It, I Am Inclined to:

Answer Choices	Responses
Sell it	0.29% 2
Save it for future use	27.43% 186
Take it to a drug take-back location	32.30% 219
Give it to a friend	0.59% 4
Throw it in the garbage	15.93% 108
Dispose of it using a disposal pack	5.16% 35
Flush it down the toilet	18.29% 124
	Answered 678
	Skipped 52

If Your Doctor or Dentist has Prescribed Opioid Pain Medication to You or a Family Member, Were You Provided Any Warning About the Dangers of Opioids by that Doctor or Dentist?

Answer Choices	Responses
Yes	43.62% 294
No	31.90% 215
Not Applicable	24.48% 165
	Answered 674
	Skipped 56

If Your Doctor or Dentist has Prescribed Opioid Pain Mediation to You or a Family Member, Were You Provided Any Warning About the Dangers of Opioids by the Pharmacist Who Filled Your Prescription?

Answer Choices		Responses
Yes	35.45%	240
No	40.47%	274
Not Applicable	24.08%	163
	Answered	677
	Skipped	53

Do You Know of a Local Family Who Has Been Negatively Impacted by Opioid Use?

Answer Choices		Responses
Yes	86.85%	588
No	13.15%	89
	Answered	677
	Skipped	53

Do You Think Your Community Has an Opioid Addiction Problem?

Answer Choices		Responses
Yes	97.77%	659
No	2.23%	15
	Answered	674
	Skipped	56

Illicit Opioids, Including Illicit Prescription Medication and Drugs like Heroin, are Readily Available in my Community.

Answer Choices		Responses
Yes	94.14%	627
No	5.86%	39
	Answered	666
	Skipped	64

Other Drugs, Such as Cocaine and Methamphetamines, are Readily Available in my Community.

Answer Choices	Responses
Yes	95.67% 641
No	4.33% 29
	Answered 670
	Skipped 60

Use of Other Drugs, Such as Alcohol, Marijuana, and Benzodiazepines, Can Lead to Misuse of Opioids, Cocaine, or Methamphetamines.

Answer Choices	Responses
Yes	86.33% 581
No	13.67% 92
	Answered 673
	Skipped 57

Do You Know of a Local Family Who has Been Negatively Impacted by Alcohol Use?

Answer Choices	Responses
Yes	88.91% 601
No	11.09% 75
	Answered 676
	Skipped 54

Addiction is:

Answer Choices	Duplicated Responses
A Choice	39.34% 264
A Moral Failing	8.94% 60
A Disease	72.73% 488
	Answered 671
	Skipped 59

Duplicated Choice Selection		Responses
Respondents Who Chose Disease Only		390
Respondents Who Chose a Choice Only		157
Respondents Who Chose A Choice and a Disease		69
Respondents Who Skipped the Question		59
Respondents Who Chose Moral Failure		30
Respondents Who Chose All Three Choices		28
Respondents Who Chose a Choice and Moral Failure		10
Respondents Who Chose a Moral Failure and Disease		1

I Believe that Law Enforcement Efforts in my Community are Effective in Limiting Substance Abuse.

Answer Choices		Responses
Strongly Disagree	24.48%	164
Disagree	40.45%	271
Agree	31.49%	211
Strongly Agree	3.58%	24
Answered		670
Skipped		60

I Believe that Court System Efforts in my Community are Effective in Limiting Substance Abuse.

Answer Choices		Responses
Strongly agree	2.51%	17
Agree	5.77%	39
Neither agree nor disagree	17.90%	121
Disagree	35.65%	241
Strongly disagree	38.17%	258
Answered		676
Skipped		54

I Would Know Where to Turn to for Addiction Help for Myself, a Family Member, or Friend.

Answer Choices		Responses
Yes	55.95%	376
No	44.05%	296

	Answered	672
	Skipped	58

My Community has Effective Programs in Place, Such as Counseling and Transition Living Services, to Support People in Recovery for Substance Use Disorder.

Answer Choices		Responses
No	74.58%	490
Yes	25.42%	167
	Answered	657
	Skipped	73

Community Perspectives Section

The Community Perspectives Section of the Survey asked community members about local community perspectives regarding substance use, treatment and recovery.

Most people would willingly accept someone who has been treated for substance use as a close friend.

Answer Choices		Responses
Strongly disagree	11.25%	73
Disagree	59.63%	387
Agree	27.27%	177
Strongly agree	1.85%	12
	Answered	649
	Skipped	81

Most people believe that someone who has been treated for substance use is just as trustworthy as the average citizen.

Answer Choices		Responses
Strongly disagree	22.92%	149
Disagree	64.62%	420
Agree	11.08%	72
Strongly agree	1.38%	9
	Answered	650
	Skipped	80

Most people would accept someone who has been treated for substance use as a teacher of young children in a public school.

Answer Choices	Responses	
Strongly disagree	36.03%	236
Disagree	54.05%	354
Agree	9.16%	60
Strongly agree	0.76%	5
	Answered	655
	Skipped	75

Most people think less of a person who has been in treatment for substance use.

Answer Choices	Responses	
Strongly disagree	2.15%	14
Disagree	16.13%	105
Agree	61.29%	399
Strongly agree	20.43%	133
	Answered	651
	Skipped	79

Most employers will hire someone who has been treated for substance use if he or she is qualified for the job.

Answer Choices	Responses	
Strongly disagree	16.49%	107
Disagree	56.55%	367
Agree	25.73%	167
Strongly agree	1.23%	8
	Answered	649
	Skipped	81

Most employers will pass over the application of someone who has been treated for substance use in favor of another applicant.

Answer Choices	Responses
Strongly disagree	1.85% 12
Disagree	11.85% 77
Agree	64.15% 417
Strongly agree	22.15% 144
	Answered 650
	Skipped 80

Most people would be willing to date someone who has been treated for substance use.

Answer Choices	Responses
Strongly disagree	12.15% 78
Disagree	62.93% 404
Agree	24.61% 158
Strongly agree	0.31% 2
	Answered 642
	Skipped 88

The Surry County Substance Abuse Recovery Office offers a variety of methods the community can get in involved. Ways to participate include community data collection, interviews, and membership in our All-Stars Prevention Group. Additional opportunities include serving as Recovery Coaches or Volunteer Transportation Drivers. If you want to be contacted about these or other opportunities to help, please make sure to include your contact information and click 'Yes' below.

Answer Choices	Responses
Yes	15.35% 72
No	84.65% 397
	Answered 469
	Skipped 261

Community Comments Section

Respondents were given an opportunity to provide comments at the end of the survey instrument.

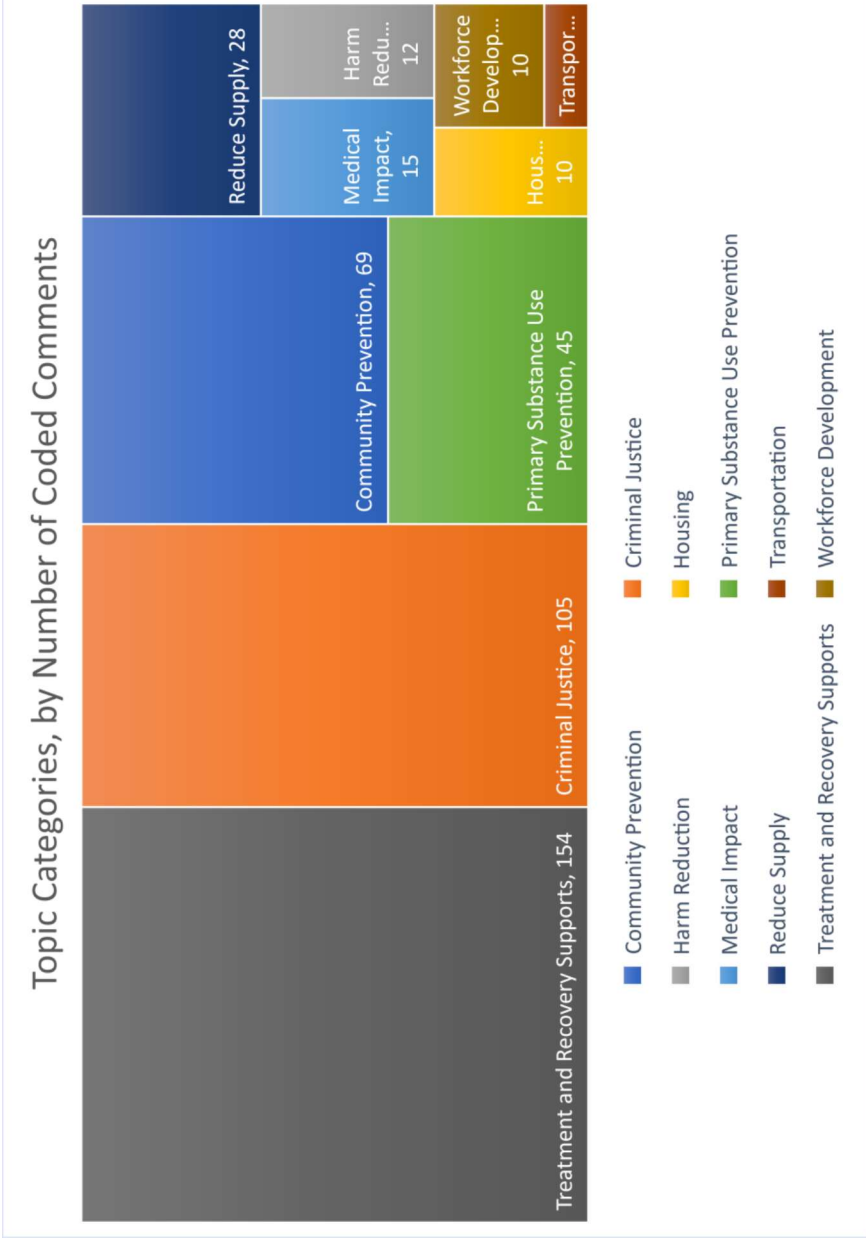
Please share other items that that important to you about the topic of Substance Use in our community. Your thoughts and opinions are very important to us.	
Answered	234
Skipped	496

Comments were classified into ten (10) duplicated categories. Duplicated categories mean that respective comments due to type or topic could be coded to multiple categories. For example, a comment such as: *“I really think that we need to utilize drug courts in the county so that we can reduce the jail population and focus more on treatment instead of penalizing people who have a disease”* belongs to two categories, in this case criminal justice and treatment and recovery supports.

Comments published in this report appear in two separate and distinct Appendices. First, Sorted Comments appear in Appendix A. Statements in Appendix A are sorted by one of the before mentioned ten categories. Each comment was assigned a primary parent category. In addition, comments are also connected to other categories using a backlinked approach and indicated by double brackets. For example, consider the comment above, *“I really think that we need to utilize drug courts in the county so that we can reduce the jail population and focus more on treatment instead of penalizing people who have a disease”*. Since the comment includes two topics, Criminal Justice and Treatment and Recovery Supports, the comment appears in both categories and therefore exist as duplicated entries in Appendix A. All comments are not only coded under their respective categories but also indicated by topic labels within double brackets ([[criminal justice]] [[treatment and recovery supports]]]. Such coding allows reviewers to easily find connections between categories and data sets. A side effect of backlink coding is that specific comments were extracted from a series of related sentences or paragraphs within the same submission; thus context of the comment may be impacted without seeing the entire conversation as submitted.

Coding breakdowns for duplicated topic categories are indicated below:

Comments	
Comment Topic Categories	Number of Comments
Community Prevention	69
Criminal Justice	105
Harm Reduction	12
Housing	10
Medical Impact	15
Primary Substance Use Prevention	45
Reduce Supply	28
Transportation	4
Treatment and Recovery Supports	154
Workforce Development	10



The secondary Appendix, Appendix B presents all comments as they were submitted within context. Topic coding within brackets were removed to increase ease of reading and to see the entire comment within the original submitted context.

Please note that comments in both Appendices were edited for minor spelling issues when correcting the spelling did not impact the meaning of the statement. During cases when spelling corrections may have changed the meaning of the comment, the narrative was left written as submitted. Every effort was made to maintain the confidentiality of private individuals included in the survey, thus there were times when identifying comments were redacted. During such times an indicator was included in the comment area.

Surry County Perspectives

The full published interview summary can be found at the Surry County Office of Substance Abuse Recovery website at <https://www.surrycountycares.com/post/surry-county-perspectives>. A selected excerpt of interview results can be found below.

Introduction

The purpose of the structured interview process was to collect detailed information about the perspective and experiences of citizens related to substance use disorder and its consequences on the Surry County Community. Two separate interview protocols were followed based on the role of the citizen that was interviewed.

What is a Structured Interview

Structured Interviews are usually defined as a conversation with a purpose. Structured Interviews are very helpful to organizations when collecting information about assumptions and perceptions of activities in communities.

Why Do We Conduct Interviews?

Structured interviews are among the best way to have an accurate and thorough communication of ideas during community focused information gathering.

Method of Collection

Two separate interview protocols were followed based on the role of the citizen interviewed. Thirty-six (36) interviews were collected from individuals throughout Surry County with a focus on personal experiences interviewees were willing to share related to substance use topics. A second series of conversations focused on community leadership characteristics within Surry County and resulted in nineteen (19) interviews. A total of fifty-five (55) interviews were completed.

Instruments Used

The first instrument, titled Community Interview Questionnaire, focused on the following topics related to substance use:

- Personal experiences
- Presence of substance use in local communities
- Youth and adult drug consumption and access patterns
- Negative impacts of substance use
- Existing resources and possible community efforts to reduce risks
- Perspectives regarding local court system efforts and the disease of addiction model

The second structured interview was created from the *Community Readiness for Community Change Model* from the Tri-Ethnic Center for Prevention Research based Colorado State University.

Identifying levels of community readiness will help to evaluate five key dimensions that Surry County Community must consider in order to address the consequences of substance use disorder. The five key dimensions reviewed with leaders of our community included:

- Community knowledge of the issue
- Community knowledge of efforts
- Community climate
- Leadership
- Resources

Please note within the Community Readiness for Community Change Model ‘leadership’ is defined as: “Those who could affect the outcome of an issue and those who have influence in the community and/or who lead the community in helping it achieve its goals.”

Question	How aware are you personally of substance use in your community?	
Number of Comments	36	
Common Themes	Only one of the collected commentors indicated no personal knowledge of substance use in their community.	
Question	Do you think that substance use is a problem in your community? If so, how do you know?	
Number of Comments	36	
Common Themes	• Impact of substance use on juveniles and influence of parental use and family relationships. • Substance use is impacting communities at large. • Business owners are being impacted. • Substance use and overdoses are being recorded in the media. • Substance use population is present at the Surry County Detention Center with the court system being clogged. • Drug transactions are occurring in neighborhoods. • Growing numbers of statistics related to substance use in Surry County. • The death toll related to substance use is growing. • The effects of substance use impact our local foster care system.	

Question	Where does substance use in your community come from? Where is it made? Can you please elaborate.	
Number of Comments	36	
Common Themes	• Substances come from everywhere, including prescription drugs, dealers, medicine cabinets, home labs. • Imports from Central America, Caribbean, Philippines, and China. • Street Dealers.	

• Doctors who have poor prescribing practices. • Southern Virginia. • Trafficking as a result of the Interstate 77 Corridor.
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Question	In your opinion what percentage of people in your community are experiencing substance use problems and why?
Number of Comments	36
Common Themes	• Answers range from 10% to 70% of the community experiencing substance use problems. • Based on total comments on average 47% of community members are experiencing some type of substance use problem. • The COVID-19 Pandemic has had significant impact on substance use patterns in the county. • Underlying mental health issues as well as poor economy and lack of opportunity is a driver. • Intervention programs are non-existent for offenders being released from jail. • Lack of education about addiction and high rates of stigma. • Issues goes hand and hand with other life problems such as homelessness, mental health, hereditary. • Lack of health insurance.

Question	What types of substances do you think youth (ages 12-17) or adults (18+) have a bigger problem within your community? Why do you think that? Have you heard/seen/read things?
Number of Comments	36
Common Themes	• Twenty-three (23) commentors indicated that the youth population tends to use Marijuana and/or alcohol at higher rates. • Adult use patterns tend to focus on harder substances such as methamphetamine, heroin, opiates (including prescription drugs).

Question	Do you think that specific population groups use substances at higher rates? Why?
Number of Comments	36
Common Themes	• Fourteen of thirty-six (36) commenters indicated they thought substance use impacts lower economic classes the most. • Citizens in their early to late twenties appeared to be most venerable.

Question	Why do you think people use substances? Please elaborate (Did they hear it/read it/etc.)?	
Number of Comments	36	
Common Themes	• Untreated mental health issues, pain, stress and issues with addictive personality characteristics impact use. • Peer pressure, friends in active use, and community norms that accept substance use. • Drugs promote positive feels initially, then the user chases the next high. • Substances help people to cover up emotions and pain. Self-medicating for other behavioral health issues occurs. • Children are seeing their parents involved in active use.	

Question	Do you think it is easier for youth to access substances more so than adults? Where do you think they get it from?	
Number of Comments	35	
Common Themes	• Fourteen of thirty-five commentors indicated that yes, it is easier for youth to access substances. Twelve of thirty-five commentors indicated that no, it is not easier for youth to access substances. • Substances are obtained from stealing from family and the home medicine cabinet. • Other sources include friends, peers from school and the local drug dealer.	

Question	Where do you think people commonly use substances in your community?	
Number of Comments	36	
Common Themes	• Twenty four of thirty-six responses indicated that people commonly use at home or in their car. • Multiple commenters indicated active use is occurring in bathrooms at local businesses.	

Question	Can you share an example of how substance use can negatively impact a person's life? Please give an example from your workplace or personal life.	
Number of Comments	36	
Common Themes	• Criminal Justice involvement is a common negative outcome because of substance use. • The entire family is impacted, just not the individual. Lost families, lost loved ones, grandparents raising their grandchildren. • Destruction of careers and physical items such as lost businesses, homes, and other belongings. • Impacted individuals often suffer from a loss of meaning, focus and dreams. The path often appears to be a dead end. • Children are impacted heavily with foster care and multiple generational families are beginning to surface who are victims of substance use. • Increasing numbers of health-related problems, overdoses and deaths.	

Question	In your opinion, are some substances more or less harmful than other substances such as Alcohol? Marijuana?	
Number of Comments	36	
Common Themes	• Respondents agreed that heroin, cocaine (and other stimulants), and opiate derived pain medications are among the most dangerous. • Alcohol and marijuana while serious in nature are less so.	

Question	Do you know of any existing local measures or community resources that help to prevent youth from accessing or using substances? How can the community reduce the risk of substance use and its harms? What programs do you think would be effective and why?	
Number of Comments	36	
Common Themes	• Local programs and agencies that provide services include Surry County Substance Abuse Recovery Office, Children's Center of Northwest North Carolina, Insight Human Services, DARE Programs, Surry Friends of Youth and Partner's Behavioral Health. • Commenters seemed to include a lack of knowledge and presence of prevention programs, even though prevention was considered extremely important. • Treatment services need expanding and increased quality.	

Question	How can the community effectively reduce the risk of substance use and its harms (i.e. limit access, stopping people from starting to use substances?) What programs do you think would be effective? Why?	
Number of Comments	34	
Common Themes	• Service accessibility must be increased. • Prevention and educational programs need expansion. • Addressing the impact of stigma and shame needs to occur. • Limiting illicit drug access. • Development of transitional housing. • We cannot arrest our way out of the problem. • Development of Community Coalitions. • Stronger law enforcement presence.	

Question	We are hoping to develop a community strategy to address this substance use problem in this community. In your opinion, what sort of local efforts or resources should go into this community strategy? Who should be involved? If we could pick out one item from the list efforts you spoke of, what is that top, number 1 thing we should do?	
Number of Comments	32	
Common Themes	• Education and Prevention are very important to the community. • Resources need to be present to serve those that are seeking help. • Community members and organizations must be involved in a response. • This is an all-hands-on deck moment. • Development of additional rehabilitation programs. • Greater involvement from the faith based community. • Increased access to mental health and substance use services. • Increase transportation. • Decrease stigma.	

Question	Do you think the court system is helpful in addressing substance use issues in our community? Why or why not?	
Number of Comments	36	
Common Themes	• Concerns about current punitive approach with little rehabilitation. • Drug court should be a option. • Increases stigmatization and is a revolving door. • Lack of empathy seems to exist in the courts. • Jail is not big enough. • Courts do not make people accountable for their actions. • Courts can't do their job; they must connect people to treatment.	

Question	When someone says that addiction is a disease what do you think about?	
Number of Comments	36	
Common Themes	- Addiction is a disease. - While it is a disease, personal responsibility is required. - There is confusion about the concept of the disease of addiction. - Addiction is a choice and disagree that it is a disease. - Stigma keeps people from accessing treatment. - The American Medical Association indicates Addiction is a disease. - Substance use starts with a choice and then transforms into an addiction.	
Question	Is there anything we have not discussed what you would like to share about the problem being addressed in your community?	
Number of Comments	32	
Common Themes	- Community focused approaches are important. - Increased punishment is needed for those that break the law. - The county needs increased opportunities for our youth. - Creation of support systems for those who are addicted to substances. - People are beginning to accept the fact that nothing is being done. - We shouldn't give up on individuals suffering from substance use disorder. - Stories of recovery should be told. - The overcrowding situation in the jail is problematic. - Increased punishments are needed.	
Question	Would you like to become involved in Substance Use Prevention efforts? What type of work would you be most interested in? (If so, collect contact information).	
Number of Comments	30	
Common Themes	- Twenty-One citizens indicated Yes. - Most common points of interest included All-Stars group, speaking opportunities, and direct service work with individuals suffering from substance use disorder.	

Community Readiness for Community Change Questionnaire

Forty (40) questions were included in the *Community Readiness for Community Change Questionnaire* with nine teen (19) Surry County Citizens being interviewed. Responses were reported using the following framework:

- Segment Representation of Interviewees
- Results of Scaling Questions
- Overview Question
- Community Knowledge Efforts
- Leadership
- Community Climate

Please note that some interviewees did not answer all questions and nor were all questions asked of all interviewees due to time limitations.

Understanding community readiness – how ready a community is to address a particular issue – is an important tool for anyone concerned with health and community development. A community can't be convinced to approach an issue until it realizes that the issue exists, and furthermore, that it affects the community. A community can't be forced into action it is not ready for, or that goes against what most of its members believe²⁵.

Segment Representation of Interviewees

A total of nine teen (19) individuals were interviewed representing the following community segments:

- Healthcare Social Worker
- Healthcare Administrator
- General Practitioner (MD)
- Emergency Department Practitioner (MD)
- Public Secondary School Principal
- Public Secondary School Administrator
- Veterans Services Professional
- Family Member of Addicted Person
- Human Services Program Manager
- Licensed Substance Abuse Counselor
- Licensed Mental Health Counselor
- Local Management Entity Administrator
- Law Enforcement Officer
- Peer Support Specialist
- Substance Use Disorder Professional

²⁵ Chapter 2. Other Models for Promoting Community Health and Development Section 9. Community Readiness. Main Section. Community Tool Box. (2021). Retrieved 19 November 2021, from <https://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/community-readiness/main>

- Home Health Agency Administrator
- Community Recovery Support/ Syringe Service Program Representative
- Vocational Rehabilitation Program Representative
- Business Owner

Interview Overview Question

For the following question, please answer keeping in mind your perspective of what community members believe and not what you personally believe.

On a scale from 1-10, how much of a concern is substance use to members of Surry Community with **1 being “not a concern at all” and 10 being “a very great concern”**?

Calculated Scores:

Mean	6.1
Median	5.5
Mode	5

Can you tell me why you think it’s at that level?

- Most people are aware there is a problem, but some people are shielded.
- People don’t realize it’s happening. They don’t realize how big of a problem there is. You don’t see it unless it impacts you. It’s a concealed problem.
- Some are interested, some are not. People are aware depending on what level of impact they have felt. Involvement is also based on how much they care about the topic and if the caring is based on if a family member was impacted or crime.
- The presence of substances in the community are creating safety issues for community focused medical staff; staff run into the effects of substance use frequently with family members of patients. Family members frequently steal medication from patients.
- Goes back to if it’s not happening to you personally, it’s not impacting you, why be concerned? If it doesn’t impact you it’s just not important. Everything is tough in this county, housing, jobs, everything. People just fend for themselves; people are just trying to take care of themselves.
- The issue is hidden. People are scared to address it; it’s hidden and out of sight and out of mind until it’s not. Personal involvement is necessary, when drug use is not impacting the person then they don’t concern themselves much.
- No one knows who to call or what to do.
- We need a little hope.
- Based off conversations outside of work, community members have a general low level of concern. People don’t want to hear about it. They get offended during discussions. Some believe that we are putting the community down. There is a disparity of knowledge and information across professions, there are the SUD professions and those outside the SUD profession who need to learn more. Community members, persons in recovery (we must turn into advocates) and employers – they all need greater understanding. We must teach others how to consume data. So many people believe that we don’t want those people around us; those people are already around us we just don’t want to admit it.
- Citizens need options. Citizens need treatment options that work for them and their families. Transportation is a major barrier.
- So many addicts think they are okay when they are not. It’s the denial that is kicking in. We have the same denial in our community setting.

- We must develop our community capacity to deliver services to youth and develop our research and needs analysis infrastructure.
- Not a day that an overdose doesn't happen in the county. The impact of substance use is significant. A law enforcement officer told me one that "you don't get over putting kids in body bags".
- I don't know anyone that hasn't been impacted one way or another by substance abuse.
- I talk to people. People I talk to tend to self-medicate. I also talk with family members of substance users. PTSD is a driver of drug use. I see the issue mentioned more in the media.
- Parents appear concerned about drug use and arrest records. I tend to visit homes. I see the impact.
- The level is low, out of sight out of mind is the thinking. If you don't have a family member involved or you have been involved. Small town mentality exist that does not help us at all with this issue. People really don't care unless it impacts them.
- Sadly, many people in the community and our leaders say that these people don't matter, they don't vote. It's the out of sight, and out of mind thought process. There is probably not a family member in Surry County that is not impacted. Stigmas exist, while we don't want to admit it. We don't want to talk about drug addiction. We are doing a very bad job at explaining this issue, it's bad messaging. We have not fully explained the why and what is important about the topic of addiction.
- We have a culture that celebrates the use of drugs, socializing and drinking. Social acceptance of use is high. Our local community culture doesn't always frown upon using. The other side is we are heavily impacted by stigma. We are also isolated, until the issue impacts you, you don't talk about it and are generally not concerned about it. When you work at this job up close, it is scary; at 500 feet it's just there and we accept the fate of the issue. We don't appreciate that the topic impacts folks from across the economic spectrum. Only poor people are impacted – that thought is incorrect.
- We are seeing patients who need transportation to treatment. Need transportation to detox. Need transportation home from medical settings. Generally, 25% of these same patients have insurance or Medicaid. 75% have no coverage and are self-pay.

Community Knowledge of Efforts

This section asks about current community efforts to address substance use. By efforts, we mean any programs, activities, or services in your community that address substance use.

Are there efforts in the county that address substance use?

- Yes, there are efforts.
- Burgess Foundation, Mount Airy Syringe Exchange Program, Narcan, Educational efforts.
- The community needs to stay strong and keep rolling.
- There is significant stigma from a provider perspective. Many don't understand prescribing issues, what to do and how to recognize stigma.
- We are stuck, there is no movement. There is a sense of desperation in Surry County, like West Virginia. We lack pro social activities, few things for teens to do. Kids have nothing to do. There is a cycle of despair. People are stuck, stuck in the middle.
- People want help, but don't know what to do. The more we talk about needs in the community the more folks get uncomfortable. No one wants to get their feet wet.
- Social Emotional Learning efforts inside of school systems is a primary way to help identify student needs. SEL efforts have helped to identify and create programs that serve Special Education Student who often have a history with substance abuse or other behavioral health issues. ACES and Trauma focused approaches can have powerful impacts on the school level. Mental Health First Aid is also an effective method to support students.
- There are systematic issues in our community, lack of resources and knowledge about the seriousness of the disease.
- This issue impacts families, neighbors, sons, farmers, and everyone in-between. I know several people are struggling on a personal level.
- Families are being impacted. You never give up on your children, they are not bad people, they are in a bad place though. Our community must learn to understand this.
- Surry County Substance Abuse Recovery Office, Veterans Administration has resources.
- DARE, Pilot Mountain Police Department, Children's Center, Surry Friends of Youth.
- Our tax money is supporting the progression of addiction when we support jails that don't include treatment.
- Government efforts.
- Surry County efforts.

Can you briefly describe each of these?

- Covenant Church caters to recovery individuals, have a special faith community halfway house.
- Surry County Substance Abuse Recovery Office has local resources to provide help and support. There is a network of people such as the Veterans Administration that provides services.
- DARE program teaches 5th and 7th grades about drugs. Pilot Mountain Police Department has a Make Better Decisions Program.
- There are agencies in our community that are aware.
- There are clinics that prescribe MAT.

How long have each of these efforts been going on?

- At least 25 years. It has progressed from only being a police problem to a problem for medical, county agencies, state agencies.
- The Syringe Exchange Program has been around about five months. We also offer Narcan distribution.
- More than three years.
- People lack awareness of anything at the state level, there is some local level efforts that create mindshare. Few people know anything about direct patient care.

Who do each of these efforts serve?

- No, they serve everyone. No one is turned down.
- Faith based communities can embrace SEP.
- Efforts although well thought of, need to be improved. People have lost trust in the helping system, they give up. It's too hard.
- Children's Center, kids have alternative place for education due to bad behavior. Surry Friends of Youth serves Department of Juvenile Justice Youth.

About how many community members are aware of each of the following aspects of the efforts - none, a few, some, many, or most?

People are learning SEP is here, but also surprised. Families need to be more involved.

Thinking back to your answers, why do you think members of your community have this amount of knowledge?

- Prevalence of efforts and how widespread the reach of substance abuse is.
- The more community members see the issue and solutions, the more they are on board.
- Community members know just enough to form a wrong opinion. Enough to make judgments or develop negative feelings and they don't know how SUD works.
- There are so many people that believe that recovery is not possible, even people who are using. Our community lacks hope. We need to focus more on people that are getting better. We need to focus on families that have gotten better.
- People don't know about treatment options unless they have been diagnosed. We continue to have confusion about where to turn for help. Most citizens don't know what happens during the referral and treatment process.
- People don't see that behavioral health is part of the greater medical condition or something covered by medical insurance.
- The community is being impacted; family members are being impacted.
- Lack of knowledge because lack of publicity. Our struggle is awareness, it's a barrier.
- Members of the community expect the schools to handle 7:30 AM to 5:00 PM. They also expect us to handle counseling in schools.
- Genetic predispositions of why some become addicted and why some do not, this is important. There are other things that impact addiction as well. The fact is it's a disease state that needs to be treated.

- Community members know about all drug related topics about the same. Since the pandemic this issue has kind've slid into the background.
- Community members believe there is nothing they can do. They feel helpless. Families don't understand drug addiction. Addiction needs to be treated. It's a family driven gradual process. Addiction is a cycle.

Are there misconceptions or incorrect information among community members about the current efforts? If yes: What are these?

- SEP – people asks why are you giving them the means to get high? The reason is we see a direct reduction in disease risk and infection. We provide a safe place for needles to be returned. We are there for people to help them get into treatment when they are ready. We impact the lower parts of society and give them a chance. Right now, the view is to lock them up, let them die, survival of the fittest. Jail.
- Addiction is connected to ideas about bad people. Community members just ask why they don't just stop. Why don't they just change. Beliefs that you can't change, that people who use just go to far.
- There are misconceptions and politics related to the understanding of addiction and influence of regulations. For example, some medical providers do not want to be allowed to use X waivers in the Emergency Department. That if Medication Assistance Treatment is available it will attract the wrong kind of person. Personal perspectives often reveal some bias in arguments against a typical person. We must build a build effective follow up services, building a good system that is sustainable. We need to include social needs screenings for help patients, while understanding it could be an expensive to sustain for patients.
- Disposal of old medicine is a serious issue. We estimate that 80% to 90% of patients hold on to old medication.
- Alcohol is and can be as dangerous as other drugs. Many people don't acknowledge this fact.
- It's okay to hold onto medication and flush it down the sewer system – when both are not okay.
- Sometimes we don't have preventative conversations with patients in healthcare because we think someone else has already had the conversation.
- Not sure the community wants to know about substance use disorder or how to understand it.
- Many believe we are wasting our time attempting to help those with SUD, but we must do something. One person saved is one person, this is the nature of the field. We must get a ball rolling at some point.
- There is an idea that people cannot recover from substance use disorder.
- Criminal justice clients have complex needs and are different from regular clients suffering from addiction – they have special needs. The community doesn't understand this.
- There is little grasp on the Continuum of Care, must teach people about Prevention, Intervention, Treatment and Recovery.
- There is also a misconception that substance abuse and mental health issues exist by themselves, when in fact they exist together.
- There are so many misconceptions about treatment, court referrals and length of successful treatment experiences.
- Our goal should be to help people, to give people the tools they need to be successful. Too often we do just the required stuff during the treatment process and don't go beyond that. We must go beyond just the requirements.

- The idea that inpatient is the only thing available; we must go beyond such simple ideas and have a complete positive assessment of what works and does not work in our community. Providers do what they can with what they have, but we must provide reasons for the community to understand inpatient treatment is not the only way.
- People don't want to engage. There is a lack of transportation and childcare. System and providers must be more responsible. Resources are not the only answer. Citizens must be involved.
- People believe that those who are addicted can just stop, just quit. They can't just stop.
- No communication about the efforts. They push it off on others.
- Medical – clinical treatment partnerships are important where MAT is provided and clinical counseling services at the same time.
- Organized recovery efforts are such a niche field, it's hard to be perceived as part of ordinary medical care sadly. There is bias about who is venerable, the disease of addiction is not understood. We need to combat misconceptions by promoting stories of recovery that are true and accurate; people need to be exposed to recovery stories. We need to combat the idea that this won't happen to me but happens to other people. We need to address, it's not my problem idea. We also need to talk with those who don't think it's a public health crisis. Addiction is a disease.

How do community members learn about the current efforts?

- Personal Experience.
- Growing up with a tough love approach or abdication from family. People feel that way until addiction hits your family. It's also about money. When money is impacted. Treatment costs money. Giving handouts cost money.
- Stigma of addiction. It's like walking down the street and avoiding the person drinking from a beer can; we avoid those people. Stigma makes us believe that it will never happen to us, and addiction occurs on the other side of the tracks and is more common. Opioids have impacted perspectives. Stigma also exist at the institutional level such as churches that frequently encourage stigma. Awareness is increasing, so people can have a better understanding.
- Peer supports are needed and other efforts when medical staff ask patients about substance use or if they are interested in help. Staff need assistance with screening and addressing other psychological complaints including paranoid thoughts and suicidality.
- They learn about the topic in a generational lens.
- Inaccurate beliefs about addiction are frequently driven by generational transfer and inaccurate teachings provided by religious groups.
- Many times, addicts don't even know addiction is a disease.
- History, people remember things from the past, clergy, and doctors impact thinking. Some receive incorrect information and may not come from high quality sources. People get information from people they trust; this creates a lens on the information and then supports certain ideologies and politics. All of which sometimes is based more on opinion than fact.
- Families must reach out to the community and build family networks – informal connections are important.
- People don't know much about this topic and don't understand what addiction really is. Many family members think they can help, but after the second or third time of trying to help, they don't know what to do. It's frustrating as a parent when there is nothing you can do.

- We have a communications specialist who does a great job getting communication out.
- We must better evaluate community knowledge about addiction topics. We must provide better education and services to families that suffer from substance abuse. Families are heavily impacted by stigma, some families are in denial, some families don't want others to know about their issues.

Do community members view current efforts as successful? What do community members like about these programs? What don't they like?

- No. At least something is begin done, at least they are perceived as doing something.
- Community tends to be open when we can develop the conversation. There is hesitancy related to helping others in need because it costs tax dollars. People are trying to assign a dollar figure on success – attempting to merge the human factor with costs.
- Members say that the treatment system doesn't work. People don't understand that treatment is a process, that it takes time.
- We must create a collation of physicians that understand what evidenced based prescribing and medical practice is and the positive impacts that it can make.
- The community judges SUD clinics and so do staff sometimes. Clinical staff must stay positive; some say if you haven't been impacted then you've been judged. Staff must remain open and there must be a perception that there is help out there if something is wrong.
- Youth under 18 who are actively battling addiction are in our community but less in numbers than adults. We need a greater diversity of youth services.
- Treatment works, but so many people don't understand what that means. There are pockets of religious groups that have responded quickly to the opiate crisis.
- We must remember why we got into the field as treatment providers. We don't do a very good job of safeguarding new staff, letting them burn out, not being brave enough to support them. Clients don't feel like they are being listened to, this turns off people from treatment. Well, we don't listen to our treatment staff either sometimes.
- Citizens only promote inpatient treatment efforts. Families don't understand the importance of and value of other services.
- Drug issues have changed so much in this county, have gotten so much worse than twenty years ago.
- Parents see DARE as successful.
- Not always. There is still significant drug seeking with pain clinics and medical establishments going around.
- Resources are limited, we rely on many community agencies and sadly get little in return in terms of success. There are system barriers. The system is too complex for families and does not drive success. Detox is hard to get a bed.

What are the obstacles to individuals participating in these efforts?

- Fear, stigma, nowhere to go. It's hard to access treatment. There is too much red tape. People just want to talk to people
- Substance Use Disorder is just not the topic, patients suffering from Dual Diagnosis issues. Patients with mental health issues can present a revolving door of service need. It is hard to find resources especially while addressing psychological issues and Meth. Coexisting social needs are real and present.
- A huge number, sometimes 40% of Emergency Department visits come in with mental health pathology. Pretty heavy in terms of needs and other factors.
- We have a large percentage of grandparents raising grandkids.
- Intergenerational trauma that is passed down from generation to generation creates hard to change perspectives when addiction has and has not impacted you personally. We need to love the person regardless and show that they are still worthy – and that we still care.

- Many don't have insurance. Few people have private insurance, but those who do, their insurance may not be accepted, or the person can't pay high deductible bills. Clients can't afford treatment, can't afford \$150 for a CCA. Probation costs. TASC costs. Court fees cost.
- The opiate crisis is impacting the early childhood population. There are neurological impacts from birth to the age of three that are often undiagnosed and not immediate visible. The pre-school group has significant needs when impacted by opiate use in their families. We must have programming ready for transient populations – there are a number of families that move in and out of the community on a frequently basis.
- School systems and teachers can be overwhelmed with the list of needs that student have.
- I'm not sure what has helped my son or family. Nothing has helped. Methadone treatment has just made things worse. We do too much enabling, we don't understand the idea of rock bottom and if it is a good thing or a bad thing. No matter what we believe or have tried, the person eventually has to want to get out of this bad place.
- Lack of knowledge about addictions is present, seeing success in the community is needed and we must lower stigma.
- There are no obstacles with DARE. Most parents want what is best for their kids. Need more engagement from community members.
- Limited detox beds. No insurance. No long-term treatment beds. Treatment providers who don't always follow up or whose systems are too complex. Even with Medicaid it's hard to find patients beds and treatment. So, patients end up in the Emergency Room to find help or detox. After local hospital detox they come back to do it all over again – while no services are offered in between. Virginia residents come to our facility, stay for several days and don't qualify for other state facilities.

What are the strengths of these efforts?

- Community outreach is required, we must look at this point using different angles. As a treatment professional sometimes we perpetrate stigma, that we don't always present ourselves as leaders of hope. You have to hold hope intentionally. People see the lack of successes everyday (at the individual client, professional and system levels). Compassion fatigue is real. We all have to keep our energy up.
- Understanding that the issues we face are just not about drug abuse.
- People need to be treated with respect. They know when respect is not present.
- We do have strong leadership in the county with programs that are progressing.
- We can get kids while they are young, can give them positive paths and educate them about the right choices.

What are the weaknesses of these efforts?

- Patients have nowhere to go; Many users are afraid to access local hospitals when they are in need due to fear of law enforcement being called. So, people don't go. This places individuals at greater risks to overdose in the community, resulting in even more pressures on limited resources.
- There are increasing rates of mental health diagnosis that we must address. Increasing rates of drinking alcohol to acute intoxication with significant numbers of young people drinking alcohol to the point of poisoning and even coughing up blood at a young age. We have no local methods to safely detox alcoholics locally. Our populations have skin conditions and Hep C rates that are untreated. Long term injection, alcohol use and Meth consumption is creating long term nerve damage in our patients. Opioids are being used across the spectrum and across all ages. Benzos are common in older populations.
- There are generational impacts. For example, the generation that is now in their 40's and below is more open than before and more open than older generations. There has been some generational shift in the acceptance substance use disorder locally.
- There is a lack of respect for those suffering from addiction. We get stuck in the legal stuff. They don't care about us.
- We need more people to help support students and their families. Stigma around substance use and mental illness is alive and well. The community doesn't understand the issue.
- There is a lack of public awareness.
- I'm not sure there is anything except weaknesses.
- People just don't want to deal with it; if it is not in your face, it is just easy to blow all this off. You are impacted or not impacted.
- I am not aware of weaknesses. We use our mistakes as learning points. The one thing is not enough people to utilize.
- Getting information out to the community and getting the data from the community to know what is working.

Are the evaluation results being used to make changes in efforts or to start new ones?

- Yes, absolutely.
- I don't know how data is being used. This is a problem.

What planning for additional efforts to address substance use is going on in Surry County?

- I don't know.
- Education, we must get the word out. MAT makes an impact; it helps to balance need at first; MAT has a great impact. One can transition from drug use to MAT to recovery.
- Family members need support, there is a total lack of support and services for a loved one in addition to the addict. The son I knew died a long time ago...even though he is still living. I've watched them gradually get deeper, move every step away from me. The person is still there, but not near the surface.
- Surry County Substance Abuse seems to be doing something constantly.
- Surry County Substance Abuse.
- We must address associated child abuse, family abuse. Addiction affects everything and the community doesn't even know what affects.

Leadership

How does leadership in Surry County perceives substance use? By leadership, we are referring to those who could affect the outcome of this issue and those who have influence in the community and/or who lead the community in helping it achieve its goals.

Using a scale from 1-10, how much of a concern is substance use to the leadership of Surry County with 1 being “not a concern at all” and 10 being “a very great concern”?

Mean	5.5
Median	5
Mode	5

Can you tell me why you think it’s at that level?

- Some leaders are not as aware. Younger leaders are more aware because they have all been affected by it.
- Some don’t carry their weight; some people just do their job. Law Enforcement takes a hard line against substances, some want to help, some don’t care. With this topic there are no absolutes.
- We must believe in the power of individuals, clients, and communities. But leaders who are not directly impacted by addiction tend to care less. The decision not to even discuss drug court as an option is proof of this.
- There is a concern, but for all the wrong reasons; it is off base. The concern is not that this is a mental health issue, it’s that it’s a criminal issue and the need to solve it as a criminal justice or punitive issue. A health approach is needed.
- The court and legal system could be do allot more than they are doing – the current approach is to lock them up. Law Enforcement only seems to care about how things look in public.
- It’s rare that I don’t talk to a community leader that is not concerned. Business leaders are concerned too, the economic impact is growing and has been growing for the past two decades.
- There is hope that leaders have. Leaders want magic though; they just want to see these issues resolved. That’s good. But it’s not easy. It takes money. We need to build quality of care. We need systems of support. We also need to support those professionals and programs who are trying to make a difference.
- Leaders must believe that getting better can happen.
- Big priority. They can be educated about severity.
- We’ve had training in the school system last year and have had education about how bad of a problem we have here.
- The community at large doesn’t understand the topic. They are isolated from the topic. We don’t do a very good job at outreach, including the medical community. Most clients have no money, this holds the process back. We have gotten too far away from helping the individual. Churches are competing just like medical groups. We have a system that lacks communication and lacks a willingness to work together.

How much of a priority is addressing this substance use to leadership? Can you explain why you say this?

- Medium priority for county leadership.
- The situation is ambivalence; some people care, some do not.
- There has been a dramatic shift in county government leadership and management. I give public health and county government a 10 out of 10. For business leaders, they are concerned but not at the level of government.
- The Surry County Substance Abuse Recovery Office is proof of county investment, post overdose response team. EMS Support on this topic is high. The county relationship with Partners LME/MCO is very progressive. There are pockets of people and programs inside the county that is getting their people on track to make a difference in the community.
- Red Tape and government often stand in the way of progress. The larger the organization, the bigger the red tape.
- Should be a very high priority because it affects so much and our community wellbeing overall.
- Understanding risk is important. Do leaders have the ability to understand risk of addiction, or do they care? Leaders are beginning to understand the impact of addiction on the workforce, it's really impacting the economy and placing our region at risk. Too often though, beyond economics, addiction is not a regular conversation. County leadership appears to understand the importance of the topic, but there are still competing priorities.

Who are groups/leaders that are supportive of addressing this issue in your community?

- United Fund
- County Commissioners
- Surry County Substance Abuse
- Specialty Churches
- Some government agencies are supportive of SEP, some local agencies and churches are more supportive than you would think.
- City Commissioners
- Business Leaders
- Non-Profit Leaders
- Civic Leaders
- School system
- County Communications/911
- Police
- Sheriff
- Surry Fiends of Youth
- Children's Center

Are there groups/leaders who might oppose addressing (substance abuse)? How do they show their opposition?

- No.
- What should leaders do? There need to be a change. There needs to be drug court advocacy. Opposing drug court makes little sense. Instead of trying to change the mind of current leaders we need to focus on the next generation, on upcoming leaders – the current

leaders are a lost cause – put our efforts where they will be and with those who are most beneficial. There is hope in the next generation.

- There probably is. Old school mentality and lack of funding.

- I don't know.

- Increasing support from the community is needed; referral sources are limited, small resources and a small community. People don't know how SUD impacts patients and the community. Stigma is common and persistent. Providers have a waiting list if they are served at all. What else is there to do? We lack resources to help. We need community involvement; we need to make plans on how to help.

For the following questions, again please answer keeping in mind your perspective of what community members believe and not what you personally believe.

How much of a priority is addressing this issue to community members? Can you explain your answer?

- Moderate
- Continued advocacy, community meetings, not much of a priority until it touches the person or family.
- As leaders we need to refocus on the community. Citizens must get involved. Community members and leaders must be involved in planning.
- Most people are not interested until impacted.
- We can't wait for the community to be ready; we must force the issue and get them ready. The currency of leadership is attention. We have to keep showing the community addition affects everyone and everything.

I'm going to read a list of ways that community members might show their support or their lack of support for community efforts to address substance use. Can you please tell me whether none, a few, some, many or most community members would or do show their support in this way? Also, feel free to explain your responses as we move through the list.

- We need recovery advocates support addicts in the community. Advocates make a difference and create domino effects. A system of advocates can make significant impacts. Those little things we take for granted can make a huge difference.
- We need traditional and non-traditional leaders at the table, we must go upstream.
- The key to improvement is transparency.

About how many community members would support expanding efforts in the community to address substance use issues? Would you say none, a few, some, many or most? If most, how might they show this support? For example, by passively than none: supporting or by being actively involved in developing the efforts?

- Some, most people have passive support.
- We need increased resources for substance abuse and co-existing resources; need to develop holistic resources and reduce other risk factors. Resources needed to be identified to help people get what they need.
- We must identify methods where we can combat misinformation.
- If we show some success a lot of people will get on board and maybe provide greater support.
- Most
- We need to expand MAT to additional doctor's clinics, with high quality prescribing practices. This will increase access for everyone. Detox options must be expanded, the Surry County Jail is not a detox facility and drug access in the jail appears to be quite high. Enhanced treatment options must be included in conversations and have increased service availability in the community and in the local jail. Case management and treatment planning

in all settings is a must.

Are there community members who oppose or might oppose addressing substance use? How do or will they show their opposition?

- People who would show opposition because of funding rehabilitation for something someone chose to do.
- Yes, they have a mentality of lock them up and throw away the key, the same people will probably oppose funding.
- Older generation may oppose.

Are there ever any circumstances in which members of Surry County might think that this issue should be tolerated? Please explain.

- No
- Yes, if they are not personally impacted.
- I don't think so, maybe depends on if efforts are effective.
-

Describe Surry County.

- Beautiful place, mountains and foothills, diverse population, a tolerant county for most people regardless of people's race or religion, Christian community; everybody knows everybody's business – good because you cannot hide.
- We have unmet needs inside the county. Stigma is alive and well. It defines the county and holds us back from getting better.
- Community based county. People still generally care about each other. Small town mentality. Open arms, but at the same time they are often hypocritical.
- Family oriented community, tight knit community who wants a healthy community – they just don't know how.

On a scale of 1 to 10, where a 1 is no knowledge and a 10 is detailed knowledge, how much do community members know about Substance Use?

Mean	4.7
Median	5
Mode	5

Why do you say it's a ____?

- ½ people know nothing and ½ the people know intimately
- They know about it because it's in the media, DARE, law enforcement reports. Building slow conversations, the more rapport the more you can talk and listen.
- Addiction is widely misunderstood. A disease model of addiction does exist.
- Management of medication is a major risk factor especially for older patients who are taking more than five medications per day. Drug safety is a major contributing factor along with having multiple doctors involved who are not sharing information.
- Ask anyone you know and they will say substance abuse is a problem; but beyond that, they just don't know what to do. They know the facts; they just have assumptions.
- They just know what they hear – if people only have government and law enforcement to tell them it's only one way, then it's set in stone and that way. Leaders set the tone; things become real even when it's not. We must paint a different picture.
- Rural areas have lack of internet access and lower educational rates. Everyone knows everyone, that is good, but we have lots of people who rely on faulty information. Being a small community, we have the opportunity and a unique strength and culture of being able to create true community change. But red tape and inefficient government systems will destroy us if we are not careful.
- The community is a big world by itself. If we focus on our communities, we can impact the whole county.
- Media coverage, arrests, they see it around.

What are the misconceptions among community members about substance use, e.g., why it occurs, how much it occurs locally, or what the consequences are?

- I don't think people realize how prevalent it is locally.
- Not understanding the power of advocates. Impacted people need advocates.
- They don't see, why don't you quit; he's just lost – something is wrong but can't be fixed.
- There are so many false beliefs about treatment, that one time in treatment and everything is fine.
- Law Enforcement thinks once an addict always an addict. This is not only wrong, it's not even in the same conversation.
- To battle misconceptions, we must never give up trying. The average person must know there is hope. Someone will help somewhere. Jail is not the answer, addicts don't belong in jail- it's keeping them from recovery.
- Misconceptions are they still think it is about alcohol and marijuana.

What type of information is available in Surry County about substance use (e.g. newspaper articles, brochures, posters)?

- All of this - stop turning a blind eye.
- Educating the community is what makes a difference. We must go beyond Facebook posts of caring. How do we increase exposure about this topic?
- There is no education going on that describes addiction as a disease and how it works. We must start the conversation during the elementary ages.
- We need to have a greater focus on the impact of health disparities on the community and SUD.
- Who knows what is needed than those involved in the conversation most? We don't include the right people at the table so often when we are discussing difficult topics.
- Word of mouth is most common and frequently most inaccurate.
- I don't know.

How are current efforts funded? Is this funding likely to continue into the future?

- Government Funds
- Partners
- Insurance
- Medicaid
- Grants, that may or may not be continued.

On a scale of 1 to 5, where 1 is no effort and 5 is a great effort, how much effort are community members and/or leadership putting into doing each of the following things to increase the resources going toward addressing the substance use issue in your community?

Mean	2.4
Median	2
Mode	2

Why?

- People don't know how to access resources.
- It takes too long for treatment referrals due to the red tape. Many users are not court involved, and fear being identified.
- In some places we are doing allot, in others not so much. If you are doing allot you are doing allot. If you are not doing allot, you are not doing much.
- We are limited by funding. We are limited by imagination with the resources we do have.

Are you aware of any proposals or action plans that have been submitted for funding to address substance use issues in Surry County?

- No
- There is change coming, you can smell it in the air, but it's not here yet. Its' going to happen somewhere big, something serious to someone, and when it does, things will change.
- Stigma around the topic is so strong and people don't want to talk about it. If this has happened in your family, you don't want people to know about it.
- Trauma is directly related to substance use issues, look at how much trauma is in this county, we need to look at trauma at the community level.

Additional Policy Related Questions

What formal or informal policies, practices and laws related to this issue are in place in your community?

- Not familiar, police slow to respond to Linville Road, its dangerous.
- People want to get clean and ask for help but they are afraid of law enforcement and the courts.
- We need to improve outcomes related to substance use disorder. We must help the person struggling to be ready and receptive to getting help and for them to understand the process, that you can recover from this. The person, themselves, they often think they are beyond hope. We must provide good help. Good help incorporates hope. Hope is a predictor for treatment success.
- Too often families don't feel empowered, feeling like they can't influence the outcome.
- We need to create community level policies and best practices that create cultural shifts at the neighborhood level.
- Alcohol consumption needs a focus, teen suicide prevention is a focus.
- We must create a policy structure and norm where providers come to the table with shared positive community outcomes.
- We need to conduct information gathering, create community conversation, development community conversations, develop the capacity of citizens to understand Substance Abuse and Mental Health. We must ask the community where we need to be in 12 months and 12 years.
- None that I know of. All formal policies, don't know about informal policies.

Are there segments of the community for which these policies, practices and laws may not apply, for example, due to socioeconomic status, ethnicity, age?

- Dangerous areas.
- The value of improving awareness is that you can involve more people in the conversation. There can be a snowball effect when we can show people there is a process and help others not get discouraged.
- Churches are always an option to impact this topic, but churches frequently lack the education to the topic that is needed. We must go beyond prayer. Leaders in this county are generally church members, they are the same people.
- No

Is there a need to expand these policies, practices, and laws? If so, are there plans to expand them? Please explain.

- Yes there is a need, don't know if there are plans.
- We must keep the conversation going. We must look at what we do well and not so well. Supporting our children, providing education and prevention. Kids go home and talk about what they have learned, we can make a impact with parents.
- Health should not be the goal. Health should be a normal baseline.

- I think it would be good, focus on more health.

How does the community view these policies, practices and laws?

- As necessary.
- There is no sense of community about Mental Health and Substance Abuse issues. We come together for other things, but not for this topic.
- The community views them in place to be safe. But you cannot enforce something if you don't have people to do it!

Importance of Data Analysis and Evaluation

Data analysis is the process of obtaining raw data and converting it into information for decision making. The gathered information is either short-term tactical value or long-term strategic value. Long-term data allows the decision makers to formulate plans for the allocation of assets for the future. To accomplish the analytical mission an analyst utilizes the “intelligence cycle” to:

1. Identify the problem
2. Decide on a plan and direction of effort
3. Collect information and data
4. Process the information and data
5. Analyze the information and data
6. Disseminate the information

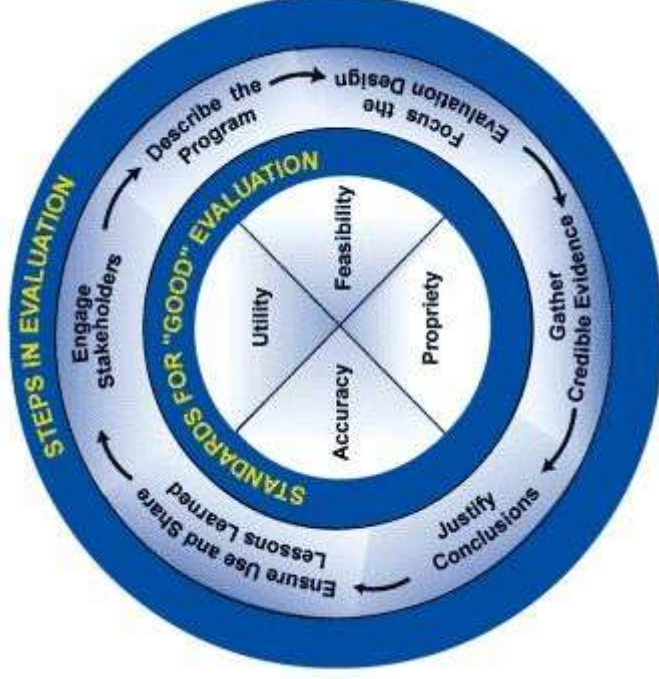
To effectively implement the “intelligence cycle,” the stakeholders must understand the short-, medium-, and long-term goals of Surry County’s substance use response program. Analysis can form a hypothesis that details how data analysis will improve the performance of the program. Data Analysis can assess the information-gathering capability and competency of the affected government and non-government organizations. Analysis can identify the quantitative and qualitative benefits of the data and statistical collection. After identifying all the available data from county, local, state, and federal sources, data analysis can operationalize the information collected into clearly defined metrics. Specifically, data review can identify what parameters establish a set of measurements that are acceptable to all participating organizations. Data analysis can standardize metrics and benchmark those metrics against the performance of other organizations. An analyst can also establish a methodology then determine the best way of measuring the required metrics and the frequency of collection. Lastly, an using data programs can monitor program objectives to ensure that it meets stated missions.

Evaluation is the systematic investigation of the effectiveness of an effort.²⁶ Evaluation is designed to be broad in nature. Regardless there are two major types of evaluation that supports work in the community setting. One type of evaluation can be closely tied to everyday program operations. One emphasis is on practical, ongoing evaluation that involves program staff, and community members. This type of evaluation can:

- Help to clarify program plans
- Improve communication among partners
- Gather the feedback needed to improve and be accountable for program effectiveness

Program evaluation offers a way to understand and improve community health and development practice using methods that are useful, feasible, proper, and accurate. A good evaluation frame includes two approaches or steps: 1) steps in evaluation practice; 2) standards for “good” evaluation.

²⁶ Chapter 36. Introduction to Evaluation. Section 1. A Framework for Program Evaluation: A Gateway to Tools. Community Tool Box. (2022). Retrieved 28 January 2022, from <https://ctb.ku.edu/en/table-of-contents/evaluate/evaluation/framework-for-evaluation/main>



The six connected steps of the above graphic are actions that should be a part of any evaluation. Although in practice the steps may be encountered out of order, it will usually make sense to follow them in the recommended sequence. However, these steps are meant to be adaptable, not rigid. Sensitivity to each program's unique context (for example, the program's history and organizational climate) is essential for sound evaluation. They are intended to serve as starting points around which community organizations can tailor an evaluation to best meet their needs. These steps include:

- Engage stakeholders
- Describe the program
- Focus the evaluation design
- Gather credible evidence
- Justify conclusions
- Ensure use and share lessons learned

The second part of the framework is a basic set of standards to assess the quality of evaluation activities. There are 30 specific standards, organized into the following four groups:

- Utility
- Feasibility
- Propriety
- Accuracy

These standards help answer the question, "Will this evaluation be a 'good' evaluation?" They are recommended as the initial criteria by which to judge the quality of the program.

Understanding the Epidemic

Nationally, the number of drug overdose deaths increased by nearly 5% from 2018 to 2019 and has quadrupled since 1991²⁷. Over 70% of the 70,630 deaths in 2019 involved an opioid. From 2018 to 2019, there were significant changes in opioid-involved death rates:

- Opioid-involved death rates increased by over 6%.
- Prescription opioid-involved death rates decreased by nearly 7%.
- Heroin-involved death rates decreased by over 6%.
- Synthetic opioid-involved death rates (excluding methadone) increased by over 15%.

Three Waves of Opioid Overdose Deaths

From 1999 to 2019 almost 500,000 people died from a overdoses involving any opioid, including prescription and illicit opioids. We have observed three distinct waves the past twenty years.

- The first wave started with increased prescribing of opioids in the 1990s with overdose deaths subsequently rising since 1999.
- The second wave started in 2010 with a rapid increase in deaths involving heroin.
- The third wave started in 2013 with increases in deaths involving synthetic opioids, particularly those involving illicitly manufactured fentanyl.

Transition Point

What started as a public health issue more than two decades ago, primarily among young and middle-aged white males, is now impacting our entire society, including the pediatric population. Millions of children and adolescents are now routinely exposed in their homes, schools, and communities to addictive drugs. The pediatric mortality rate for opioid poisonings have increased by three times in the United States between 1999 and 2016. This problem will grow unless parents, legislators, public health officials and the substance use disorder prevention and treatment community – including physicians who prescribe opioids to adults – begin to take a larger view of the systematic nature of the crisis²⁸. Isolated solutions that fail to account for how entire families and communities are affected by adult opioid use lack the ability to lead to a substantive reduction in opioid deaths for children or adults.

The Impact of COVID - 19

Documents published by the Well Being Trust (WBT) in 2021 noted that if the country fails to invest in solutions that can help heal the nation's isolation, pain, and suffering, the collective impact

²⁷ Understanding the Epidemic | CDC's Response to the Opioid Overdose Epidemic | CDC. (2021). Retrieved 27 August 2021, from <https://www.cdc.gov/opioids/basics/epidemic.html>

²⁸ Gaither, J., Shabanova, V., & Leventhal, J. (2018). US National Trends in Pediatric Deaths From Prescription and Illicit Opioids, 1999-2016. *JAMA Network Open*, 1(8), e186558. doi: 10.1001/jamanetworkopen.2018.6558

of COVID-19 will increase²⁹. Three factors, already at work, are exacerbating “deaths of despair”: unprecedented economic failure paired with massive unemployment; mandated social isolation for months and possible residual isolation for years; and uncertainty caused by the sudden emergence of a novel, previously unknown microbe. “Undeniably policymakers must place a large focus on mitigating the effects of COVID. However, if the country continues to ignore the collateral damage—specifically our nation’s mental health—we will not come out of this stronger,” said Benjamin F. Miller, PsyD, chief strategy officer, WBT. “If we work to put in place healthy community conditions, good healthcare coverage, and inclusive policies, we can improve mental health and well-being. With all the other COVID-related investments, it’s time for the federal government to fully support a framework for excellence in mental health and well-being and invest in mental health now.”

The CDC published on August 14, 2020 specific data on the increasing prevalence of mental health, substance use and suicidal ideation that communities are facing related to COVID – 19 associated with morbidity, mortality, and mitigation activities³⁰. As early as June 2020 adults were reporting increased adverse mental health conditions associated with having COVID – 19. Younger adults, minorities, essential workers, and unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance abuse and elevated suicide ideation. The CDC recommends the public health response to COVID – 19 should increase intervention and prevention efforts to address mental health conditions. Community level efforts such as communication strategies must be targeted across all segments of our community.

Diseases of Despair

Across the nation and within Appalachia communities that face significant economic challenges also struggle with greater health challenges. Surry County is no different, as one such community struggling with health disparities and outcomes that sadly lead to serious consequences. Poor health outcomes certainly impact the economic status of communities and can also serve as a barrier to continued economic growth and investment. In recent years the Appalachian Regional Commission (ARC) invested significant resources and time investigating the concept of “Diseases of Despair” and how they concept impact Appalachia as a region³¹.

“In 2017, ARC commissioned NORC to investigate “diseases of despair” in Appalachia.

Over the past several years, research conducted by health economists Anne Case and Angus

Deaton has focused on the increasing morbidity and mortality from three main causes—alcohol, prescription drug and illegal drug overdose; suicide; and alcoholic liver

²⁹ Projected Deaths of Despair During COVID-19 · Well Being Trust. (2021). Retrieved 27 August 2021, from <https://wellbeingtrust.org/areas-of-focus/policy-and-advocacy/reports/projected-deaths-of-despair-during-covid-19/>

³⁰ Czeisler, M., Lane, R., Petrosky, E., Wiley, J., Christensen, A., & Njai, R. et al. (2020). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. *MMWR. Morbidity And Mortality Weekly Report*, 69(32), 1049-1057. doi: 10.15585/mmwr.mm6932a1

³¹ Appalachian Diseases of Despair - Appalachian Regional Commission. (2020). Retrieved 27 August 2021, from <https://www.arc.gov/report/appalachian-diseases-of-despair/>

disease/cirrhosis of the liver, which have been referred to as “deaths of despair” or “diseases of despair”³².

Compared to the rest of the nation, Appalachia faces disparities related to education, employment, income, and certain health outcomes. The region also faces disparities that directly relate to mortality rates based on the level of rurality. Household income is 82.5 percent of the national average, and 16 percent of citizens in Appalachia live below the poverty line. The ARC identified as early as 2008 that treatment admission rates for the primary abuse of opiates and synthetic substances were higher in Appalachia than the rest of the nation and growing at fast pace.

Results from ARC research indicates that the group aged 25-54 years old is most impacted by causes of death related to Diseases of Despair. The 25-54 age group is the category most impacted during what is their prime working years while their engagement in the workforce is required for community development and sustainability. Accordingly, the rise of opioid overdose deaths, based on statistics from the (CDC), in 2017, was six times higher than it was in 1999. Additional data published by NORC at the University of Chicago indicates that:

“Among the three causes of death (overdose, suicide, and alcoholic liver disease/cirrhosis), the disparity between Appalachian and non-Appalachian U.S. was greatest for Overdose deaths. In 2017, the overdose mortality rate was 65% higher in Appalachia than in the non-Appalachian U.S. (48.3 deaths per 100,000 population in Appalachia compared to 29.2 deaths per 100,000 population in the rest of the U.S.) The suicide mortality rate was 30% higher in Appalachia, and the alcoholic liver disease/cirrhosis mortality rate was 10% higher.”

The University of Chicago continues by indicating that overdose mortality impacts adults in Appalachia between the ages of 25 and 54 significantly. Males, whose age was 25 to 34 (61.9 deaths per 100,000 population) and 35 to 44 years (61.0 deaths per 100,000). This same age grouping also experienced the highest mortality rates within non-Appalachian States, yet significant disparities exist upon further study. For example, the overdose mortality rate was 78% higher among those ages 35 to 44 years and 72% higher among those representing the ages of 25 to 34.

³² Appalachian Regional Commission. (2022). Appalachian Diseases of Despair. Retrieved 23 January 2022, from <https://www.arc.gov/wp-content/uploads/2020/06/AppalachianDiseasesofDespairAugust2017.pdf>

Surry County Data

Service Area

Surry County possesses numerous characteristics that render it high-risk for SUD, Overdose (OD), and OD mortality. Among these characteristics are per capita prevalence rates of risk factors that differ with statistical significance from statewide prevalence rates. Statistical significance indicates that serious underlying factors such as economic depression exist in the county and region, which contribute to the SUD epidemic. They include low educational attainment, low labor force participation, poverty, disability, and high prescription rates. Surry County has also experienced significantly higher than statewide rates of OD death, Neonatal Abstinence Syndrome in newborns, and entry into foster care due to parental substance abuse³³.

Despite its high prevalence of SUD and OD, Surry County currently lacks many services recommended by the NC Department of Health and Human Services (NCDHHS) for reducing SUD and OD. The state-recommended services that do not exist within the county are community residential treatment centers, detoxification facilities, screening and treatment during incarceration, and a structured drug court system. Additionally, Surry is surrounded by similarly rural counties experiencing high death rates from opioid-related OD, scarcity of treatment access, and rural barriers to treatment access such as widespread economic hardship and public transportation inaccessibility. A further disadvantage for Surry County is the presence of a major interstate (I-77) which allows easy access to major drug source cities for users within the county as well as dealers and transporters traveling through the county.

Surry County's population is 71,783³⁴ and suffers from the following impacts of SUD at the community level:

- High rate of primary treatment admissions, as evidenced by local Emergency Department (ED), Emergency Medical Services (EMS) responses, and treatment provider admissions³⁵.
- One of the highest per capita rates of overdose (OD) deaths in NC³⁶.
- Individuals lacking reliable public or private transportation³⁷.
- Rurality: 68.8% of County residents are designated as living in rural locations³⁸.

³³ Mrs. Kristie Preston, Director of Surry County Department of Social Services, personal communication, August 15, 2019.

³⁴ Chmura Economics and Analytics. (2020). Economic overview: Surry County. [PDF]. Retrieved from <http://www.chmuraecon.com/jobseq/>

³⁵ Surry County Cares – Data Blog. (2021). Retrieved 27 August 2021, from <https://www.surrycountycares.com/blog>

³⁶ North Carolina Department of Health and Human Services, Chronic Disease and Injury Section. (2019). Surry County overdose death slides_November2019_update. [PPS]. Retrieved from <https://www.injuryfreenc.ncdhhs.gov/DataSurveillance/Poisoning.htm>

³⁷ Surry County Cares – Data Blog. (2021). Retrieved 27 August 2021, from <https://www.surrycountycares.com/blog>

³⁸ United States Census Bureau. (2010). County rurality level: 2010. [Excel file]. Retrieved from <https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html>

- Federally designated Qualified Opportunity Zones (QOZ): The County contains two, which collectively encompass 29.8% of the ODs but only 11% of the population³⁹.

The County's population differs from statewide demographics by several statistically significant metrics. All available state-level data sources indicate the County's Substance Use Disorder (SUD) problems rank statistically among the worst per capita in NC⁴⁰. These statistics highlight both risk factors for SUD and the detrimental impacts of SUD on the wider community⁴¹. Specifically, a higher percentage of rural-dwelling residents, higher rates of poverty and disability, higher per capita cost lost to the SUD problem, fewer high school graduates, and a smaller percentage of labor force participants⁴².

County officials can easily point to state-published data in identifying the overall SA problem, but local data collection fails to maximize the treatment, recovery, and support services offered in the County. For example, SA is widely known to be correlated with property crimes, assaults, and domestic violence⁴³. As is widely acknowledged, a full spectrum of services offers the best chance of recovery from SA⁴⁴ while research on rural health cites transportation and logistics as primary obstacles to care and data collection⁴⁵.

Qualified Opportunity Zones (QOZs) also play an important role in the makeup of Surry County. The county encompasses two QOZ tracts. Combined, the Zones account for only 11% of the population, yet they have been the location of 29.8% of ODs and 24% of OD fatalities since 1/1/2017. Based on research linking SUD/Overdose risk to poverty, geographic isolation, and joblessness, it is extremely likely that residents in the QOZs would benefit greatly from effective SUD interventions, in-depth analysis, and transportation assistance.

Surry County encompasses QOZ tracts 371719310.02 and 371719306.00. The combined population numbers within these two QOZs is 11% of the County total and 9.5% of the total County land area. Overlaying the County's ODMAP map and with QOZ map illuminates a striking overlap of ODs within the QOZs. By meticulously counting the OD icons plotted on the ODMAP map, it was calculated that 29.8% of ODs, and 24% of OD fatalities happened in this relatively small area of the County. Statistically, these are significant differences. Through counting the ODs' occurring within the QOZ's from 1/1/17 to 4/20/20, the SCOSAR concluded with 97% certainty that ODs occurred in the QOZs at a higher per capita rate than in the rest of the County. The SCOSAR concluded also,

³⁹ U.S. Economic Development Administration. (n. d.). USA opportunity zones. Retrieved from <http://www.statsamerica.org/opportunity/map.aspx>

⁴⁰ T. Hopman, statistical work using state and county data, April 1, 2020

⁴¹ M. Willis, Surry County Opioid Response Director, personal communication, April 15, 2020.

⁴² Centers for Disease Control. (2017). About rural health. Retrieved from <https://www.cdc.gov/ruralhealth/about.html>

⁴³ Office of Justice Programs, Bureau of Justice Statistics. (2020). Drugs and crime facts. Retrieved from

<https://www.bjs.gov/content/duc/duc.cfm#>

⁴⁴ McGaffin, B. J., Deane, F. P., Kelly, P. J., & Blackman, R. J. (2018). Social support and mental health during recovery from drug and alcohol problems. *Addiction Research & Theory*, 26:5, 386-395. doi: 10.1080/16066359.2017.1421178

⁴⁵ Holden, R. J., McDougald S. A. M., Hoonakker, P. L., Hundt, A. S., & Carayon, P. (2015). Data collection challenges in community settings: insights from two field studies of patients with chronic disease. *Quality of Life Research: An International Journal of Quality of Life Aspects of Treatment, Care and Rehabilitation* 24(5), 1043–1055. doi: 10.1007/s11136-014-0780-y

with 99.96% certainty that, since 1/1/2017, OD fatalities have occurred in the QOZs at a higher per capita rate than in the rest of the County⁴⁶.

Substance Use Disorder Data

The National Survey on Drug Use and Health Substrate Data Report 2019 was recently published by the Substance Abuse Mental Health Services Administration (SAMHSA)⁴⁷. The findings indicate an above-average rate of risky behavior in Surry County in at least one geographic category for 25 of 27 questions posed to the citizens of our region who are over the age of 12 years old. Shockingly our region is above average, across all geographic sections (national, state, and local) in 23 of the 27 categories. These categories include data related to illicit drug use, cocaine use, heroin use, methamphetamine use, pain reliever use, and alcohol use. Residents also indicated above average rates of needing but not receiving SUD treatment, having a serious mental illness, and lack of services to address mental illness.

2019 Surry County Communicable Disease Update

Published by SCOSAR in June 2021 the 2019 Surry County Communicable Update Disease document is based on data from the 2019 *North Carolina HIV/STD/Hepatitis Surveillance Report*.

Tracking Communicable Diseases is well known to be an important part of identifying and tracking key indicators related to substance use disorder (SUD) clients and the overall impact of SUD on the community at large. The following data in this 15-page report includes:

- HIV Annual Report Data for 2019
- Sexually Transmitted Report Data for 2019
- Hepatitis B and C Annual Report Data for 2019

Impact of SUD on Employers

Addiction is an issue in every workforce sector in the United States, with one in 12 workers dealing with an untreated substance use disorder. The White House Council of Economic Advisors further estimated that the opioid crisis alone cost the U.S. economy \$696 billion in 2018. Employers are becoming more aware of the problem. In a National Safety Council survey, 86% of employers were concerned that prescription opioid use was having a negative impact on their workplace, and 74% were concerned about heroin and fentanyl having a negative impact on their workplace. The reduction of SUD in the workplace setting can:

- Increase employee productivity
- Reduce absenteeism
- Improve employee retention and decrease turnover

⁴⁶ T. Hopman, statistical work using state and county data, April 1, 2020.

⁴⁷ National Survey on Drug Use and Health. (2021). Retrieved 8 June 2021, from <https://nsduhweb.rti.org/respsweb/homepage.cfm>

- Improve community partnerships
- Reduce stigma

The National Safety Council and the National Opinion Research Center (NORC) at the University of Chicago found health care costs for employees who have a substance use disorder (SUD) are almost double the costs of an average employee with no SUD. The annual cost of an untreated SUD ranges from an average of \$8,255 to \$14,000 per employee, depending on their industry and role.

The five-page document published in March 2021 titled Impact of SUD on Employers serves as an introduction of employer costs within Surry County, assuming an Agriculture Business of 850 employees. Findings include that an employment sector of this type has an annual direct employer cost of \$347,244.

Local Drug Use Data? How Does Surry Compare?

The National Survey on Drug Use and Health (SAMHSA, 2016, 2017, 2018) publishes data based on the national, state and sub state regions related to substance use and behavioral health issues. Surry County Substate Region Data is based on the Partners Health Management Local Management Entity (LME) Catchment Grouping. Partners Health Management serves the following North Carolina Counties: Burke, Cabarrus, Catawba, Cleveland, Davie, Forsyth, Gaston, Iredell, Lincoln, Rutherford, Stanly, Surry, Union and Yadkin. *Please note that 2019 NSDUH data was used as opposed to the recently published 2020 federal data because of timing and publication requirements of the current document.*

The attached file presents NSDUH Substate Findings applicable to Surry County. These findings indicate an above average rate of risky behavior Surry County in at least one geographic category for 25 of 27 questions posed to the citizens of our region. Shockingly our region is above average, across all geographic sections (national, state and local) in 23 of the 27 categories. Five questions are part of the findings and are perceived protective in nature. For these questions we fare much better with four of the five tables indicating positive momentum.

Surry County is part of the Partners Behavioral Healthcare Management Substate Region as defined by the National Survey of Drug Use and Health. The following chart provides a general overview of how the Partners-Surry County Substate region compares to North Carolina and the United States based on percentage averages being locally Above or Below. Therefore Chart 1 should be viewed through the lens of how we are doing related to the risk factors or risky behaviors as reported by the NSDUH on a regional basis - that can also be applied statistically to Surry County. Risk Factors as defined by the National Institute on Drug Abuse are “Many factors can add to a person’s risk for drug abuse. Risk factors can increase a person’s chances for drug abuse.”⁴⁸ Please note the Risk Factors indicated in this report is not an exhaustive listing.

⁴⁸ National Institute on Drug Abuse. “What Are Risk Factors and Protective Factors?” National Institute on Drug Abuse, 25 May 2020, www.drugabuse.gov/publications/preventing-drug-use-among-children-adolescents/chapter-1-risk-factors-protective-factors/what-are-risk-factors.

Chart 1 Summary of Partners Health Management Substate Region Rates NSDUH Data (2016, 2017, 2018) Surry County is part of the Partners Substate Region Risk Factors			Partners Substate Comparison to United States Rates
Table Number/Question			Partners Substate Comparison to North Carolina Rates
Table 1. Illicit Drug Use in the Past Month among Individuals Aged 12 or Older, by State and Substate Region			ABOVE
Table 2. Marijuana Use in the Past Year among Individuals Aged 12 or Older, by State and Substate Region			ABOVE
Table 3. Marijuana Use in the Past Month among Individuals Aged 12 or Older, by State and Substate Region			BELOW
Table 5. First Use of Marijuana among Individuals Aged 12 or Older, by State and Substate Region			BELOW
Table 6. Illicit Drug Use Other Than Marijuana in the Past Month among Individuals Aged 12 or Older, by State and Substate Region			ABOVE
Table 7. Cocaine Use in the Past Year among Individuals Aged 12 or Older, by State and Substate Region			ABOVE
Table 9. Heroin Use in the Past Year among Individuals Aged 12 or Older, by State and Substate Region			ABOVE
Table 11. Methamphetamine Use in the Past Year among Individuals Aged 12 or Older, by State and Substate Region			ABOVE
Table 12. Pain Reliever Misuse in the Past Year among Individuals Aged 12 or Older, by State and Substate Region			ABOVE
Table 13. Alcohol Use in the Past Month among Individuals Aged 12 or Older, by State and Substate Region			ABOVE
Table 14. Binge Alcohol Use in the Past Month among Individuals Aged 12 or Older, by State and Substate Region			ABOVE
Table 16. Alcohol Use in the Past Month among Individuals Aged 12 to 20, by State and Substate Region			ABOVE
Table 17. Binge Alcohol Use in the Past Month among Individuals Aged 12 to 20, by State and Substate Region			ABOVE
Table 18. Tobacco Product Use in the Past Month among Individuals Aged 12 or Older, by State and Substate Region			ABOVE
Table 19. Cigarette Use in the Past Month among Individuals Aged 12 or Older, by State and Substate Region			ABOVE
Table 21. Illicit Drug Use Disorder in the Past Year among Individuals Aged 12 or Older, by State and Substate Region			ABOVE
Table 22. Pain Reliever Use Disorder in the Past Year among Individuals Aged 12 or Older, by State and Substate Region			ABOVE
Table 23. Alcohol Use Disorder in the Past Year among Individuals Aged 12 or Older, by State and Substate Region			ABOVE
Table 24. Substance Use Disorder in the Past Year among Individuals Aged 12 or Older, by State and Substate Region			ABOVE

Table 25. Needing But Not Receiving Treatment at a Specialty Facility for Illicit Drug Use in the Past Year among Individuals Aged 12 or Older, by State and Substate Region	ABOVE	ABOVE
Table 26. Needing But Not Receiving Treatment at a Specialty Facility for Alcohol Use in the Past Year among Individuals Aged 12 or Older, by State and Substate Region	ABOVE	ABOVE
Table 27. Needing But Not Receiving Treatment at a Specialty Facility for Substance Use in the Past Year among Individuals Aged 12 or Older, by State and Substate Region	ABOVE	ABOVE
Table 28. Serious Mental Illness in the Past Year among Adults Aged 18 or Older, by State and Substate Region	ABOVE	ABOVE
Table 29. Any Mental Illness in the Past Year among Adults Aged 18 or Older, by State and Substate Region	ABOVE	ABOVE
Table 30. Received Mental Health Services in the Past Year among Adults Aged 18 or Older, by State and Substate Region	ABOVE	ABOVE
Table 31. Had Serious Thoughts of Suicide in the Past Year among Adults Aged 18 or Older, by State and Substate Region	ABOVE	ABOVE
Table 32. Major Depressive Episode in the Past Year among Adults Aged 18 or Older, by State and Substate Region	ABOVE	ABOVE

Surry County is part of the Partners Health Management Substate Region defined by the National Survey of Drug Use and Health. The following chart provides a general overview of how the Partners-Surry County Substate region compares to North Carolina and the United States in general based on percentage average being locally Above or Below. Therefore Chart 2 should be viewed through the lens of how we are doing related to protective factors or behaviors that reduce risk of negative behavior as reported by the NSDUH on a regional basis - that can also be applied statistically to Surry County. Protective Factors as defined by the National Institute on Drug Abuse promotes an important goal of prevention – which is to change the balance between risk and protective factors so that protective factors outweigh risk factors.⁴⁹ Please note the Protective Factors indicated in this report are not an exhaustive listing.

Substate Region Risk Factor Comparison	Above Average Percentage of Protective Factors (presence is supported)
Substate Region Risk Factor Comparison	Below Average Percentage Indicating Protective Factors (lack of a presence)

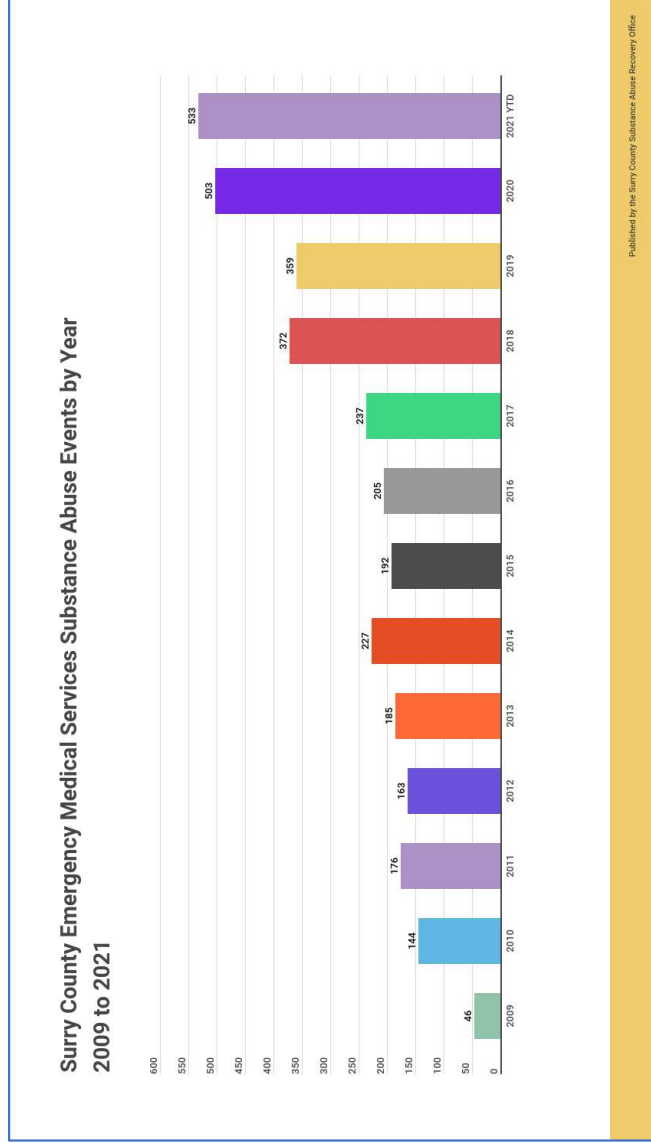
⁴⁹ National Institute on Drug Abuse. “What Are Risk Factors and Protective Factors?” National Institute on Drug Abuse, 25 May 2020, www.drugabuse.gov/publications/preventing-drug-use-among-children-adolescents/chapter-1-risk-factors-protective-factors/what-are-risk-factors.

Chart 2 Summary of Partners Health Management Substate Region Rates NSDUH Data (2016, 2017, 2018) Surry County is part of the Partners Substate Region Protective Factors			Partners Substate Comparison to North Carolina Rates	Partners Substate Comparison to United States Rates
Table Number/Question				
Table 4. Perceptions of Great Risk from Smoking Marijuana Once a Month among Individuals Aged 12 or Older, by State and Substate Region			ABOVE (Protective)	ABOVE (Protective)
Table 8. Perceptions of Great Risk from Using Cocaine Once a Month among Individuals Aged 12 or Older, by State and Substate Region			ABOVE (Protective)	ABOVE (Protective)
Table 10. Perceptions of Great Risk from Trying Heroin Once or Twice among Individuals Aged 12 or Older, by State and Substate Region			ABOVE (Protective)	ABOVE (Protective)
Table 15. Perceptions of Great Risk from Having Five or More Drinks of an Alcoholic Beverage Once or Twice a Week among Individuals Aged 12 or Older, by State and Substate Region			ABOVE (Protective)	ABOVE (Protective)
Table 20. Perceptions of Great Risk from Smoking One or More Packs of Cigarettes per Day among Individuals Aged 12 or Older, by State and Substate Region			BELOW (Protective)	BELOW (Protective)

Surry Emergency Medical Services Data

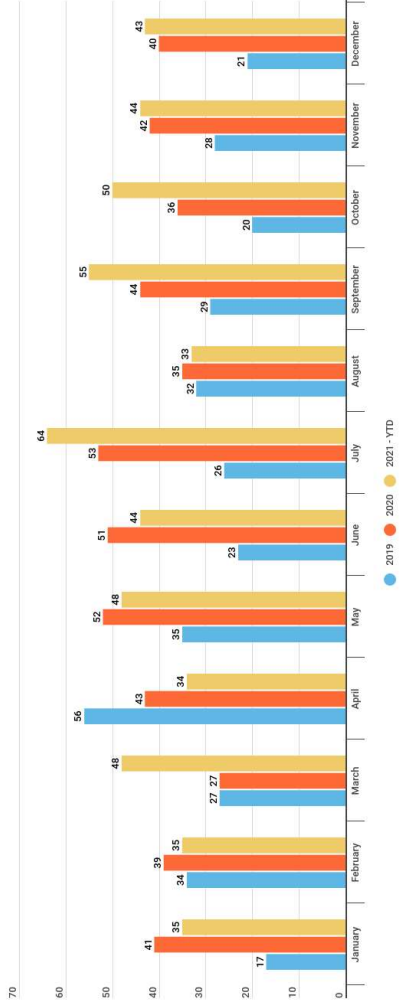
From January to December 2021, the Surry County EMS responded to 533 substance use related calls (or overdoses). Based on the current pace of calls responded to, the county exceeds the highest number of calls ever recorded which was 503 during the year 2020. For the current year, 267 of the 533 calls, or 50% impacted the age group of 25 to 54. Of the 533 overdose calls responded to forty-four resulted in a death. Seventy-three percent of all overdose deaths also fit the age group of 25 to 54.⁵⁰

The following charts provide information from Surry County Emergency Medical Services. The data presents both Substance Abuse Events Data (overdose calls) and Substance Abuse Overdose Deaths responded to by Emergency Medical Services.



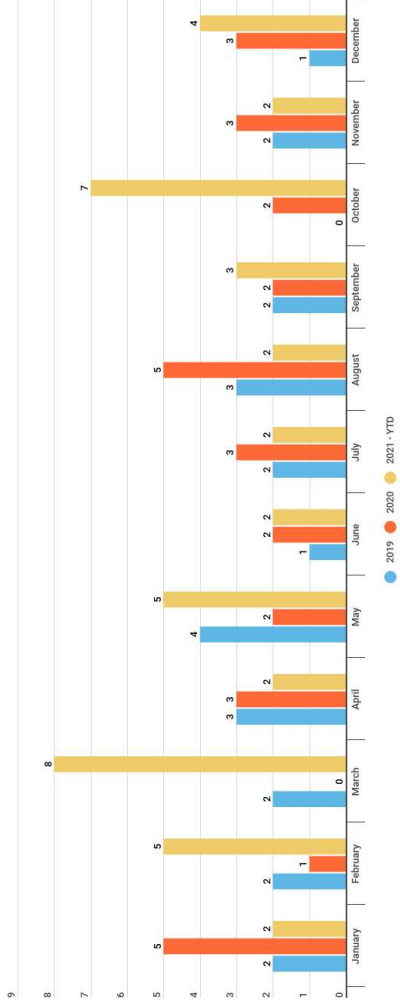
⁵⁰ Surry County Cares – Data Blog. (2021). Retrieved 27 August 2021, from <https://www.surrycountycares.com/blog>

Surry County Emergency Medical Services Substance Abuse Events by Month January 2019 to December 2021



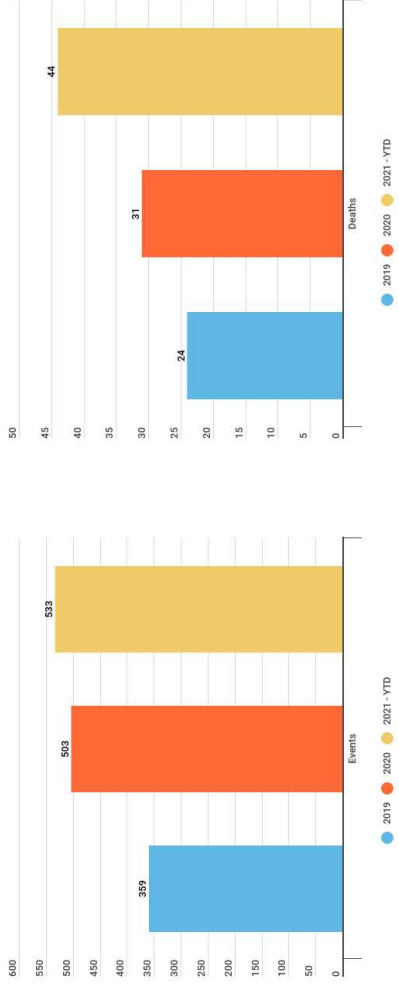
Published by the Surry County Substance Abuse Recovery Office

Surry County Emergency Medical Services Substance Abuse Overdose Deaths by Month January 2019 to December 2021



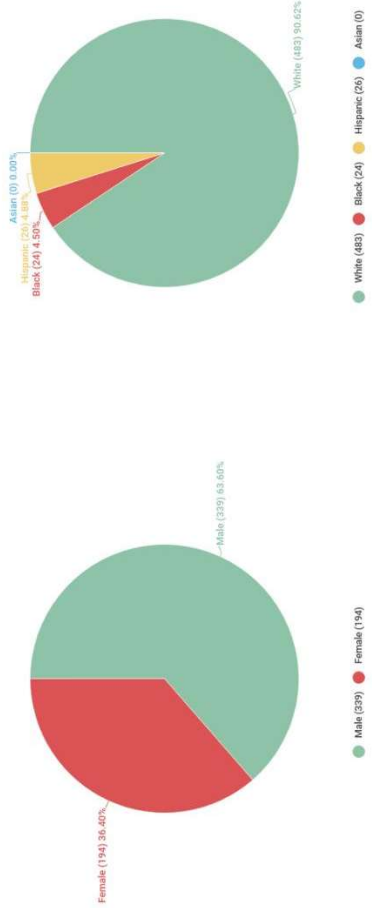
Published by the Surry County Substance Abuse Recovery Office

Surry County Emergency Medical Services Substance Abuse Events and Overdose Deaths January 2019 to December 2021



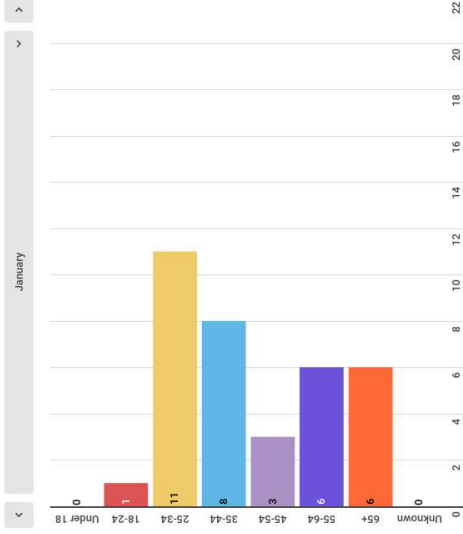
Published by the Surry County Substance Abuse Recovery Office

Surry County Emergency Medical Services Substance Abuse Events by Gender and Ethnicity 2021 (Through December 2021)

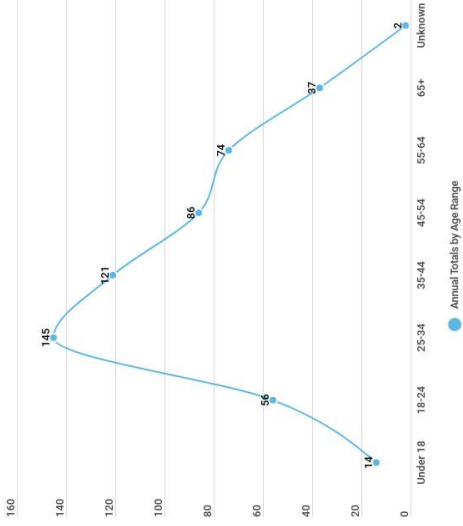


Published by the Surry County Substance Abuse Recovery Office

EMS Substance Use Events by Age by Month, 2021
Data Through December 2021

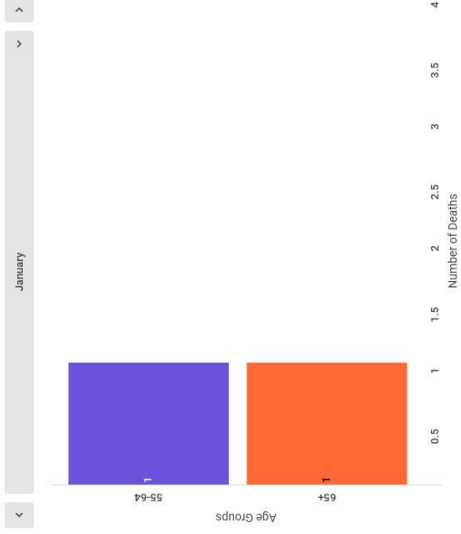


EMS Substance Use Total Events by Age Range, 2021
Data Through December 2021

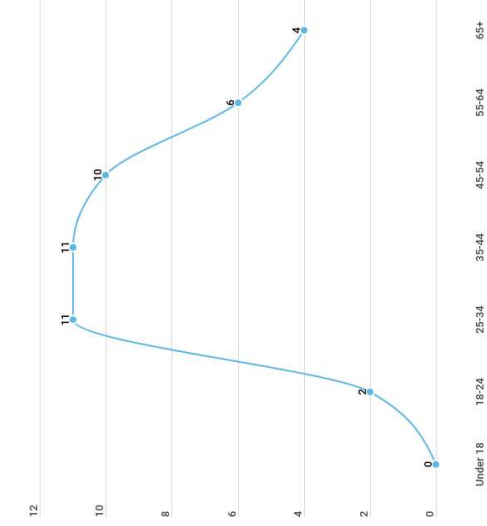


Published by the Surry County Substance Abuse Recovery Office

EMS Substance Use Deaths by Age by Month, 2021
Data Through December 2022

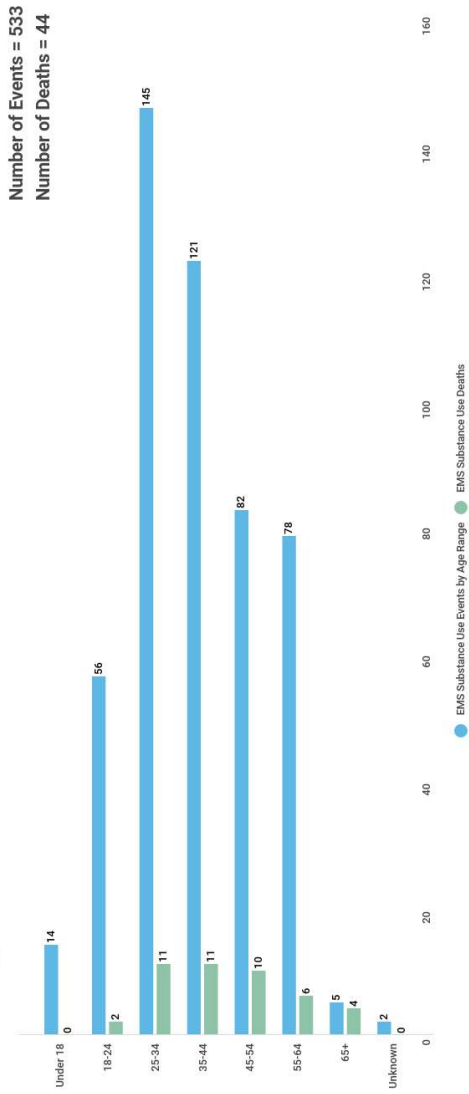


EMS Substance Use Deaths by Age Range, 2021
Data Through December 2021



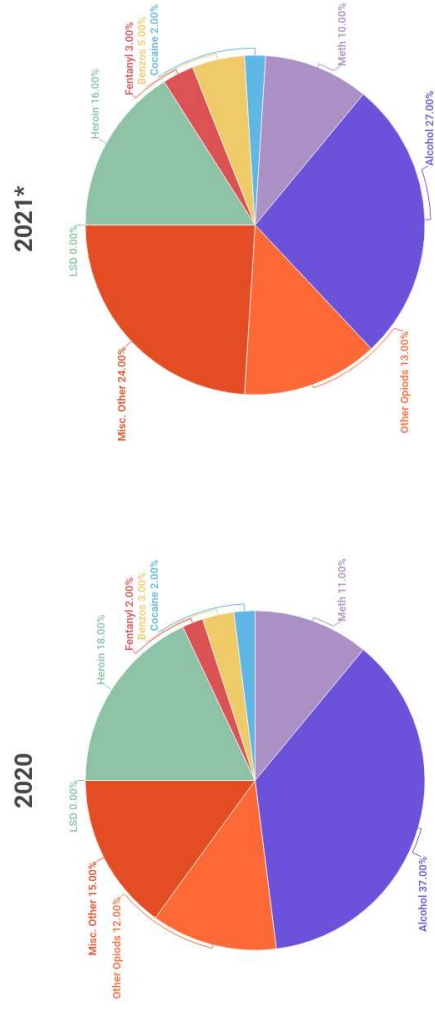
Published by the Surry County Substance Abuse Recovery Office

EMS Substance Use Events and Deaths by Age Comparison, 2021 Data Through December 2021



Published by the Surry County Substance Abuse Recovery Office

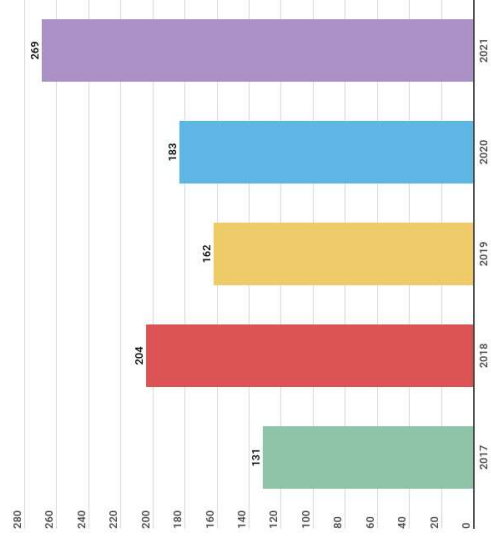
Surry County Emergency Medical Services Events - Primary Substance Abuse Drug Categories Comparison of 2020 and 2021 (Through December 2021)



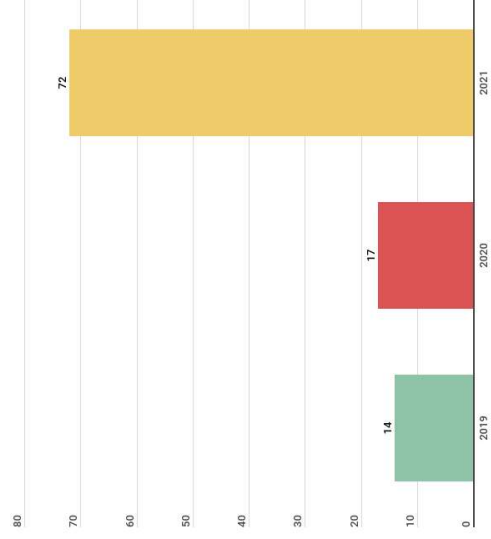
Misc. Other Category includes prescription drugs (non) narcotic, marijuana, over the counter medications or unknown substances.

Published by the Surry County Substance Abuse Recovery Office

**Narcan Administrations Annual Totals by Year
2019 - 2021**

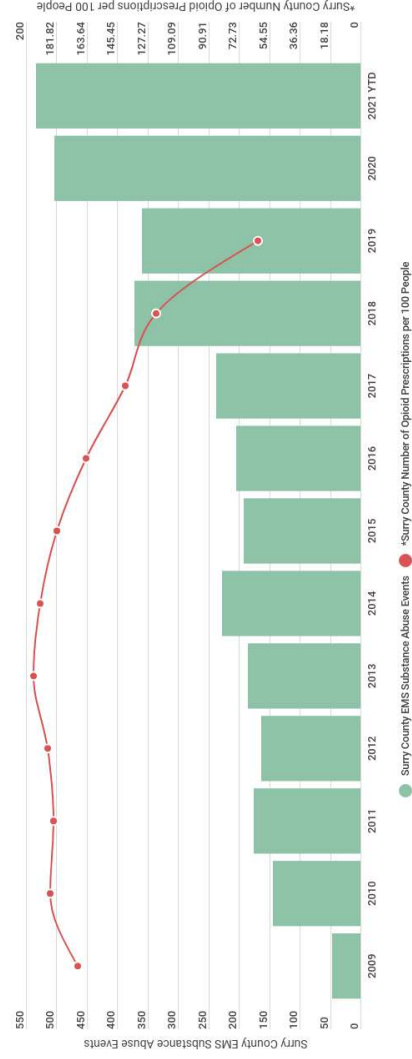


**Narcan Administrations Annual Totals by Year
By Family/Bystander 2019 - 2021**



Published by the Surry County Substance Abuse Recovery Office

**Surry County Emergency Medical Services Substance Abuse Events by Year 2009 to 2021
(December 2021) and Total Number of Opioid Prescriptions Per 100 People By Year, 2009 to 2019**



Sources: Surry County Emergency Medical Services (2021) and Centers Centers for Disease Control (2021)

*CDC Prescription Data is Only Available for 2009 to 2019

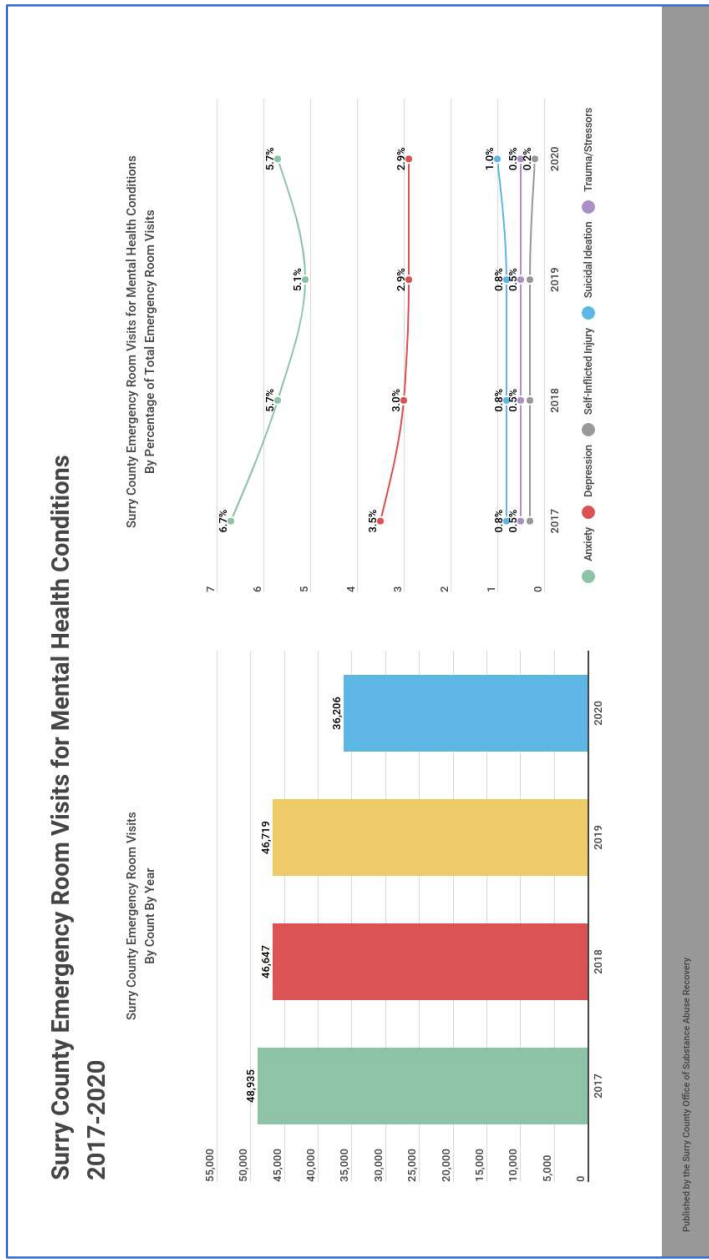
Published by the Surry County Substance Abuse Recovery Office

Surry County NC DETECT Mental Health Data

This provides an overview of emergency room (emergency department) visit trends for select mental health conditions based on ICD-10-CM codes based on the NCDETECT System provided by the North Carolina Department of Health and Human Services and the University of North Carolina School of Medicine⁵¹. Go to the NC DETECT case definitions page under the data menu to view the specific case definitions used in this dashboard. We include emergency room visits with the ICD-10-CM code of interest in any diagnosis position. These diagnosis codes may be documented as co-morbid conditions and not the primary reason for the ED visit.

Information About the Data Collection⁵²:

- County and ZIP in the ED data are based on patient residence.
 - ED visit percentages are calculated by dividing the ED visit count by the total ED visits.
- Total ED visits dropped significantly in 2020, especially at the start of the COVID-19 pandemic.
- Any count under 5 is excluded from the dashboard.
 - Trends shown may be impacted by data quality issues.

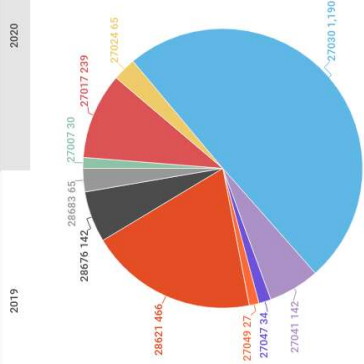


⁵¹Mental Health Dashboard, NC DETECT. (2021). Retrieved 20 October 2021, from <https://ncdetect.org/mental-health-dashboard/#resources>

⁵² Emergency Department Syndrome Definitions, NC DETECT. (2021). Retrieved 20 October 2021, from <https://ncdetect.org/case-definitions/>

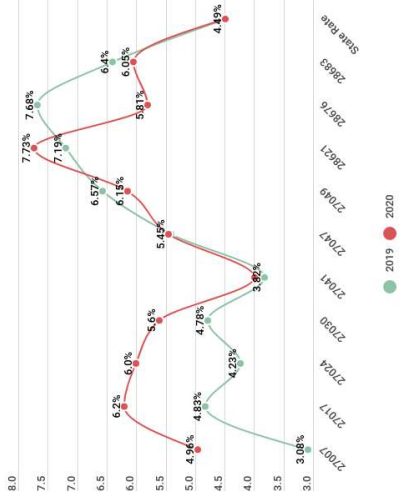
Surry County Emergency Room Visits for Anxiety by Resident's Zip Code 2019-2020

Surry County Emergency Room Visits for Anxiety
By Count By Zip Code



2019 Total Count = 2,400
2020 Total Count = 2,118

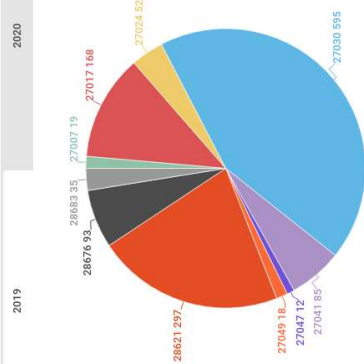
Surry County Emergency Room Visits for Anxiety
By Percentage of Total ED Visits for Zip Code



Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visits for Depression by Resident's Zip Code 2019-2020

Surry County Emergency Room Visits for Depression
By Count By Zip Code



2019 Total Count = 1,374
2020 Total Count = 1,062

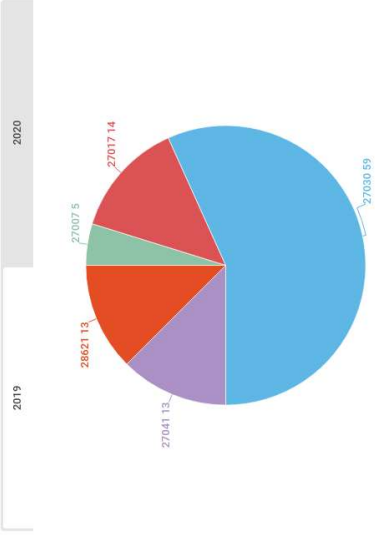
Surry County Emergency Room Visits for Depression
By Percentage of Total ED Visits for Zip Code



Published by the Surry County Office of Substance Abuse Recovery

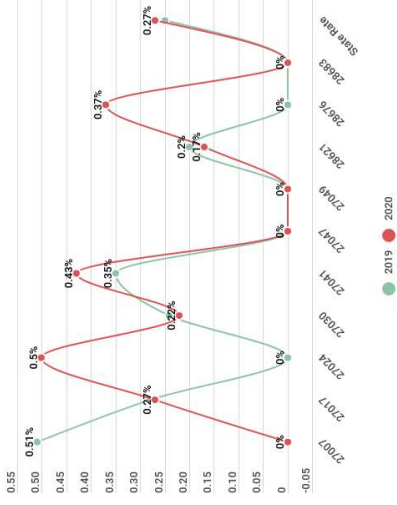
Surry County Emergency Room Visits for Self-Inflicted Injury by Resident's Zip Code 2019-2020

Surry County Emergency Room Visits for Self-Inflicted Injury
By Count By Zip Code



2019 Total Count = 104
2020 Total Count = 84

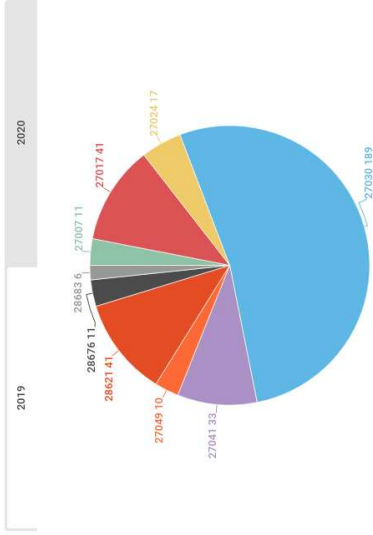
Surry County Emergency Room Visits for Self-Inflicted Injury
By Percentage of Total ED Visits for Zip Code



Published by the Surry County Office of Substance Abuse Recovery

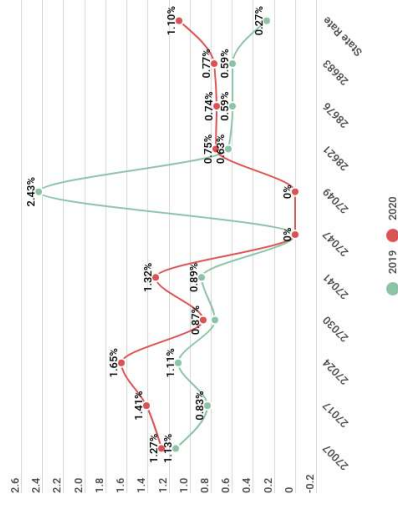
Surry County Emergency Room Visits for Suicidal Ideation by Resident's Zip Code 2019-2020

Surry County Emergency Room Visits for Suicidal Ideation
By Count By Zip Code



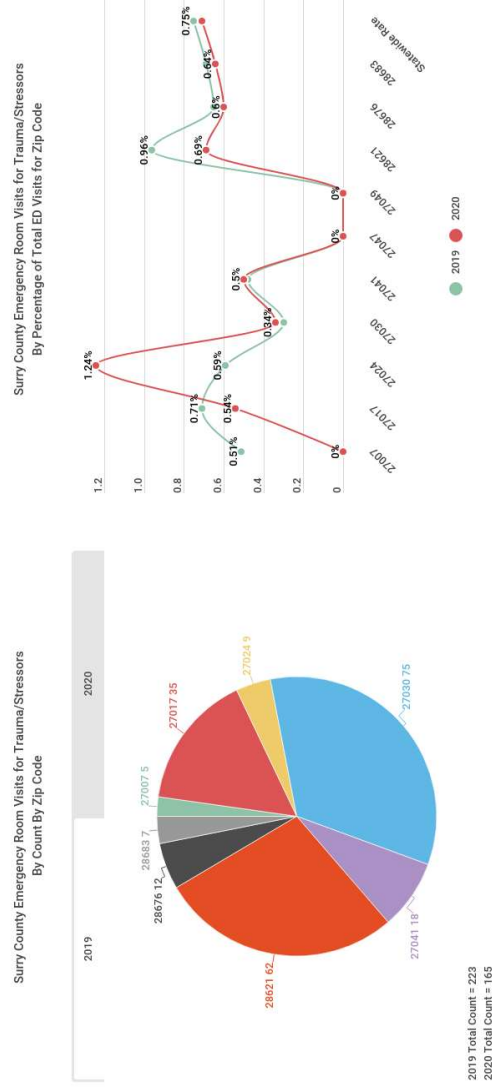
2019 Total Count = 359
2020 Total Count = 345

Surry County Emergency Room Visits for Suicidal Ideation
By Percentage of Total ED Visits for Zip Code



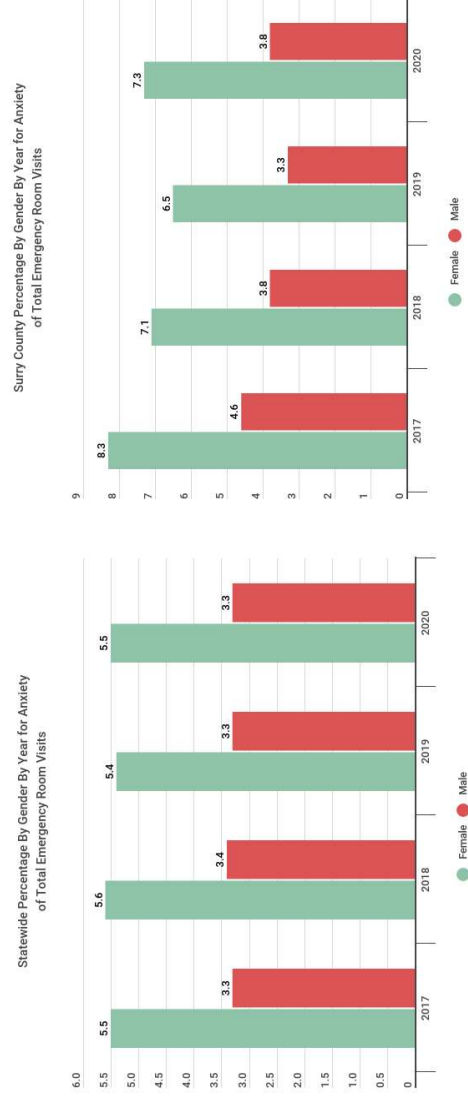
Published by the Surry County Office of Substance Abuse Recovery

**Surry County Emergency Room Visits for Trauma/Stressors by Resident's Zip Code
2019-2020**



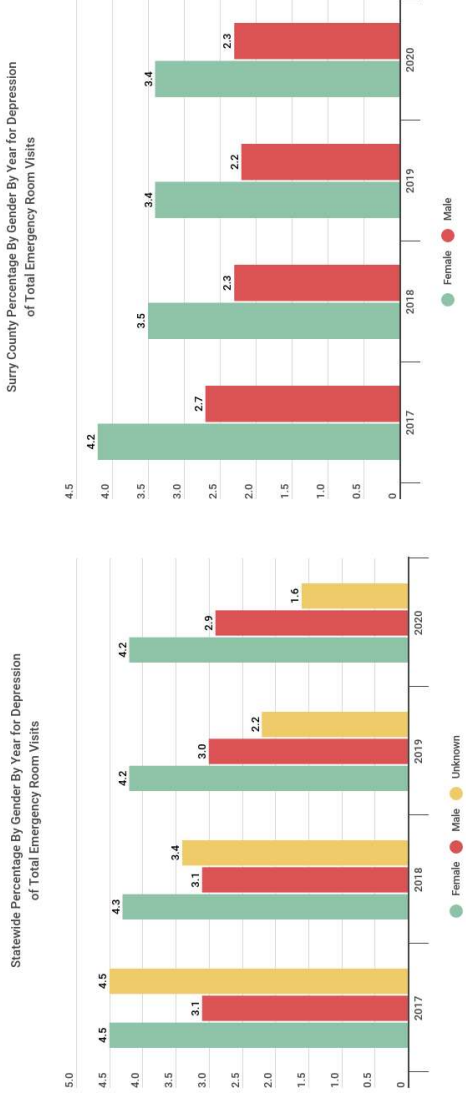
Published by the Surry County Office of Substance Abuse Recovery

**Surry County Emergency Room Visits for Anxiety by Gender
2019-2020**



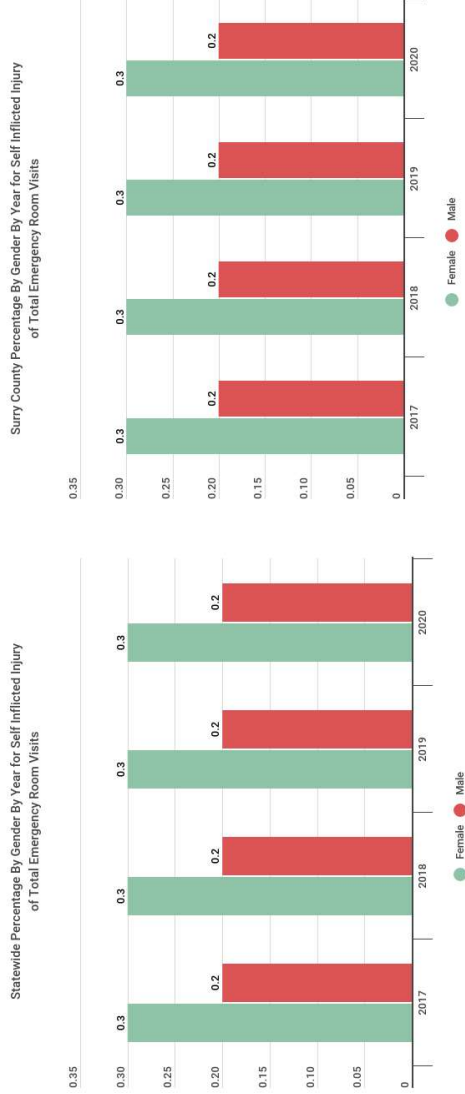
Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visits for Depression by Gender 2019-2020



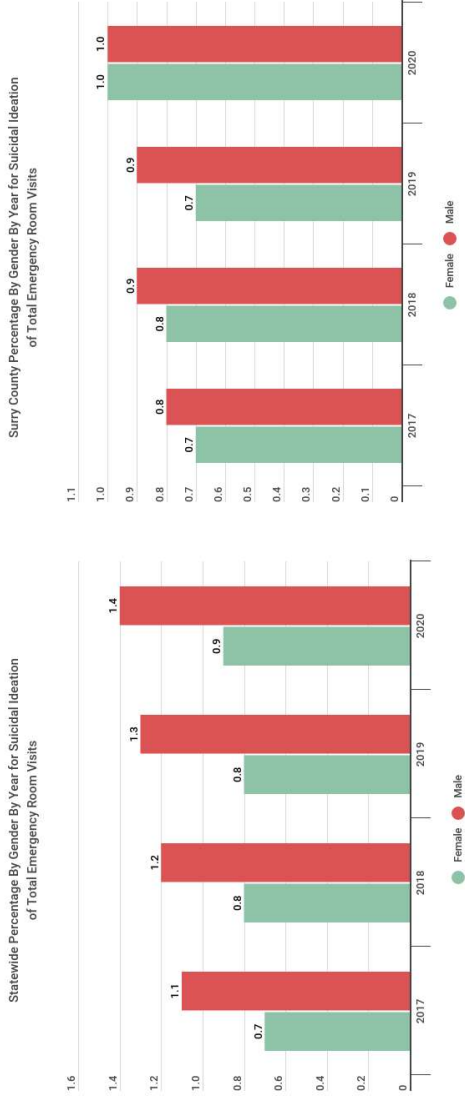
Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visits for Self Inflicted Injury by Gender 2019-2020



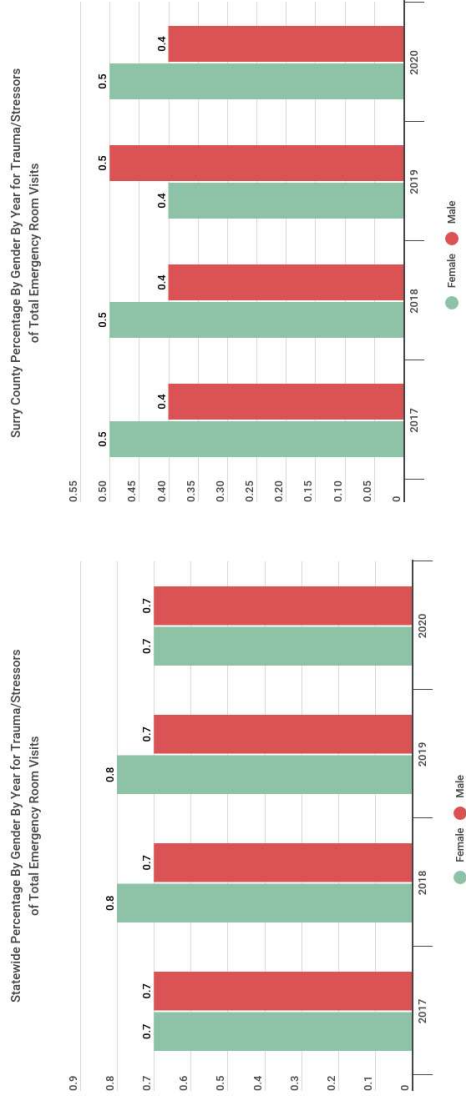
Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visits for Suicidal Ideation by Gender 2019-2020



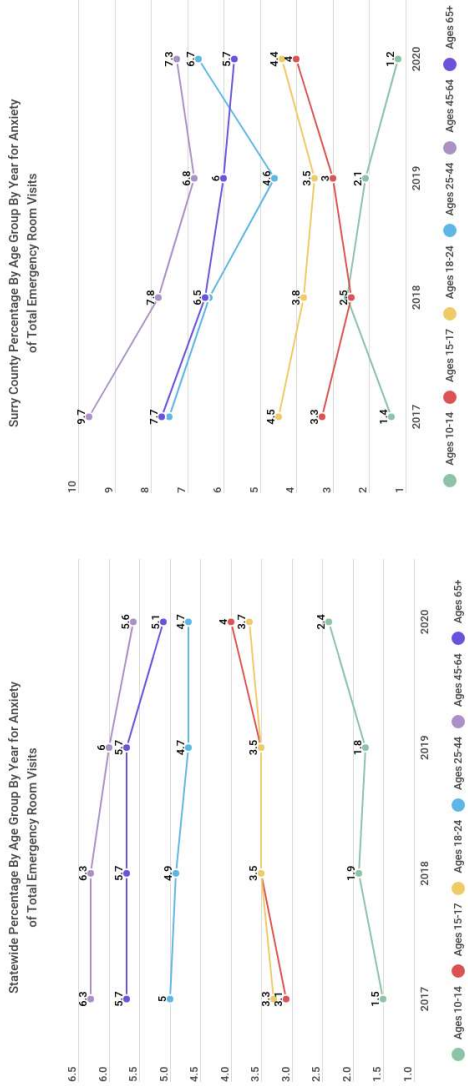
Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visits for Trauma/Stressors by Gender 2019-2020



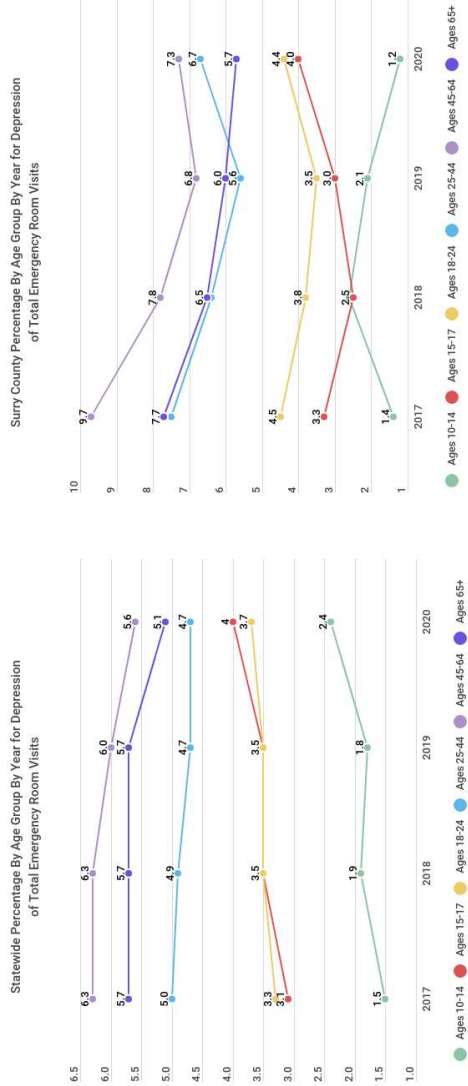
Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visits for Anxiety by Age Group 2019-2020



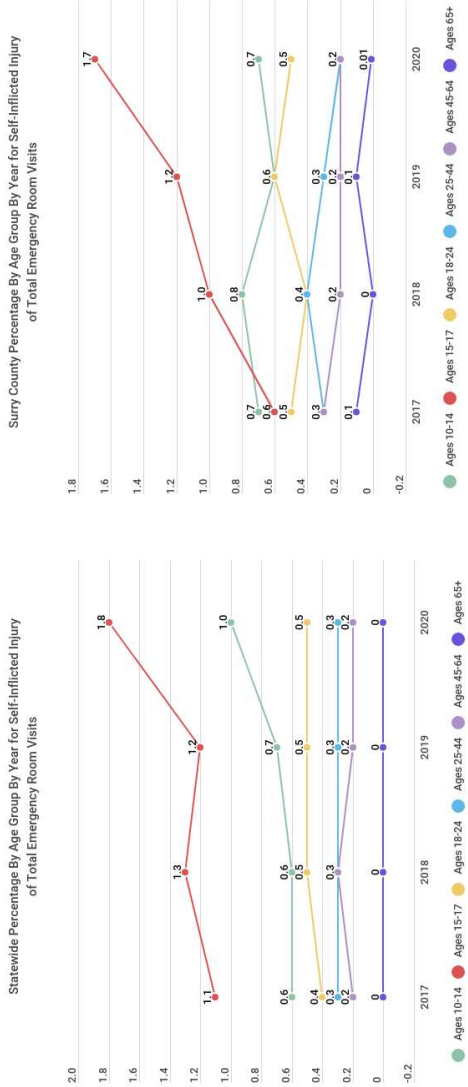
Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visits for Depression by Age Group 2019-2020



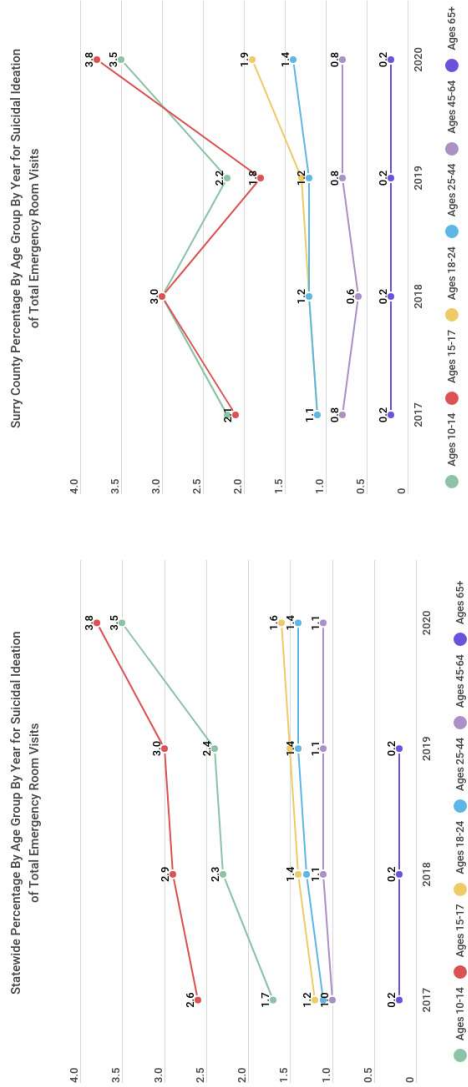
Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visits for Self-Inflicted Injury 2019-2020



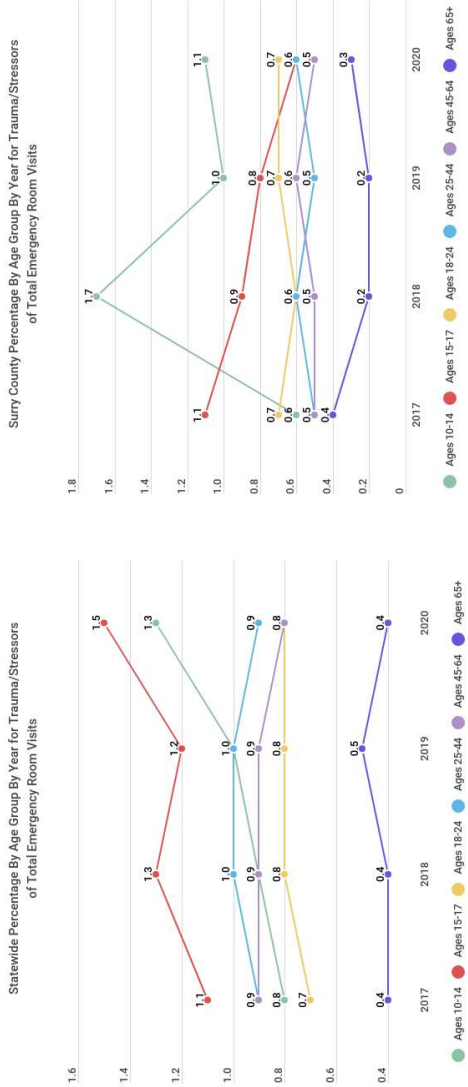
Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visits for Suicidal Ideation 2019-2020



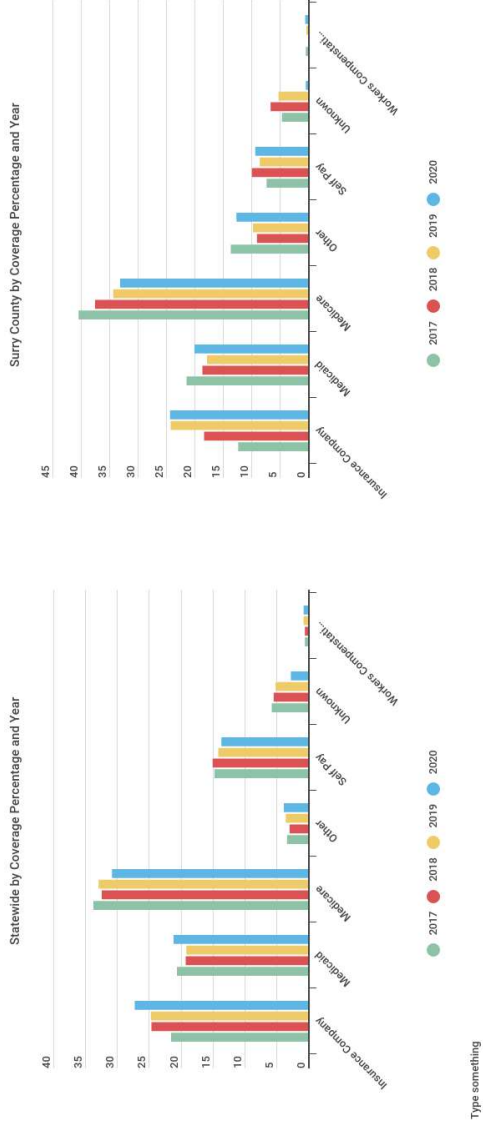
Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visits for Trauma/Stressors by Age Group 2019-2020



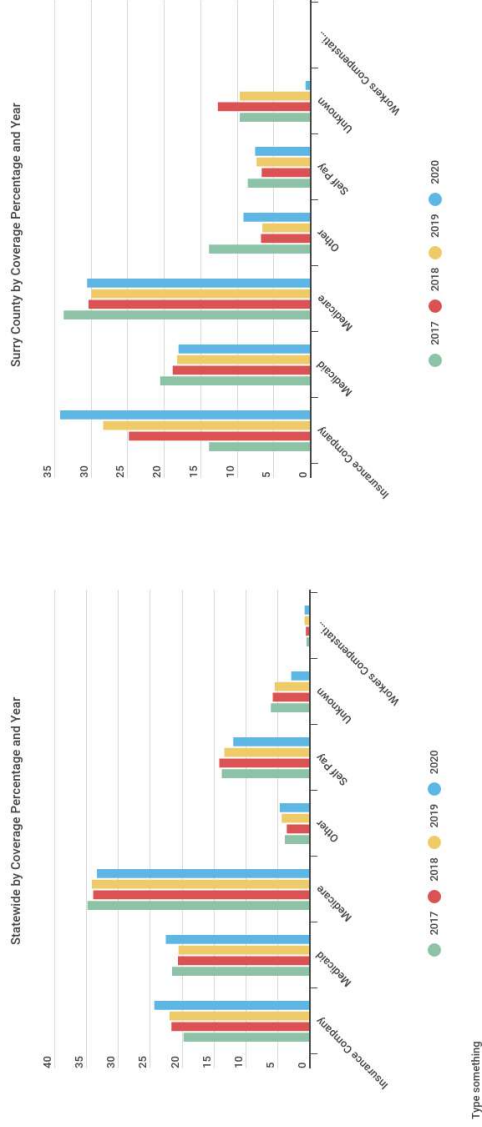
Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visit Trends with a Anxiety Diagnosis by Insurance Coverage 2017-2020



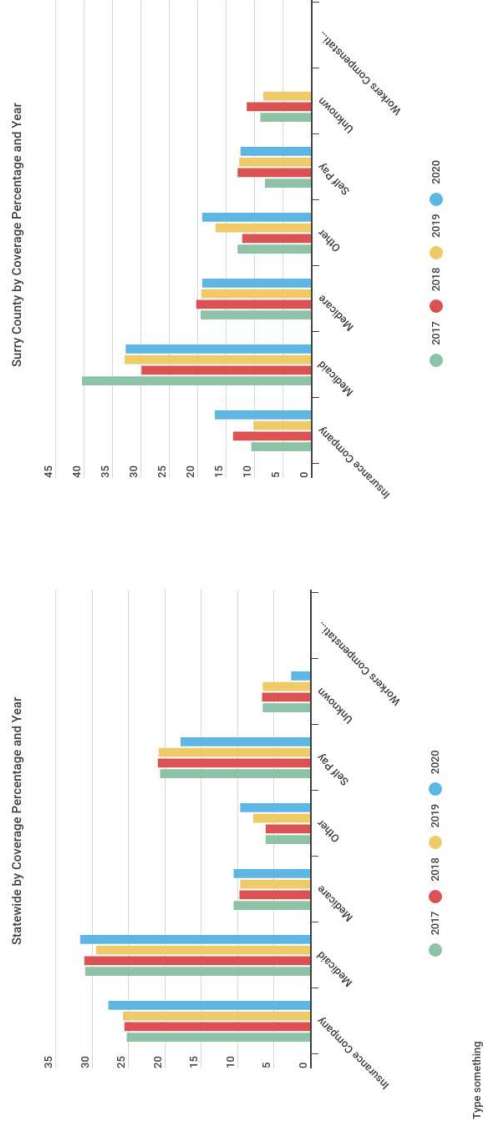
Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visit Trends with a Depression Diagnosis by Insurance Coverage 2017-2020



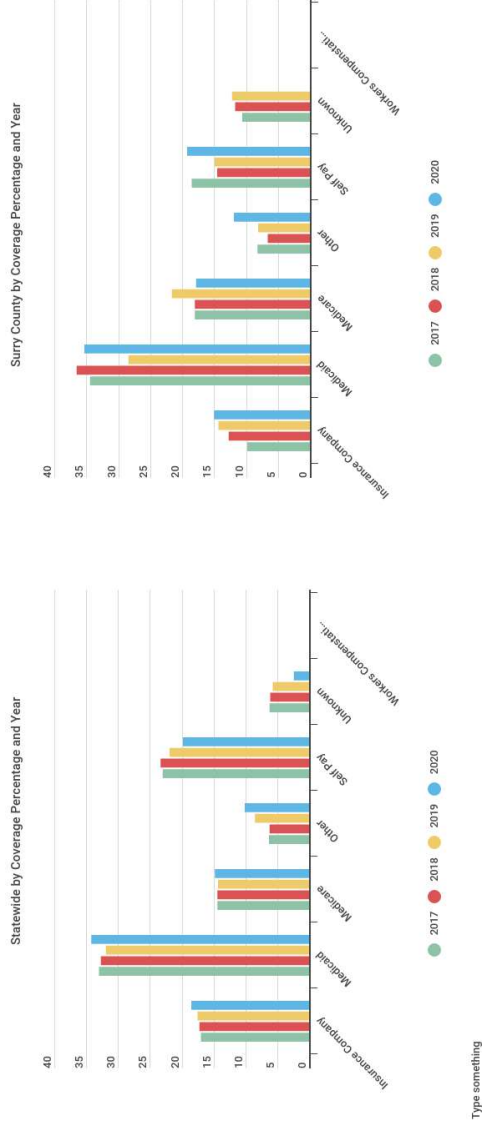
Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visit Trends with a Self-Inflicted Injury Diagnosis by Insurance Coverage, 2017-2020



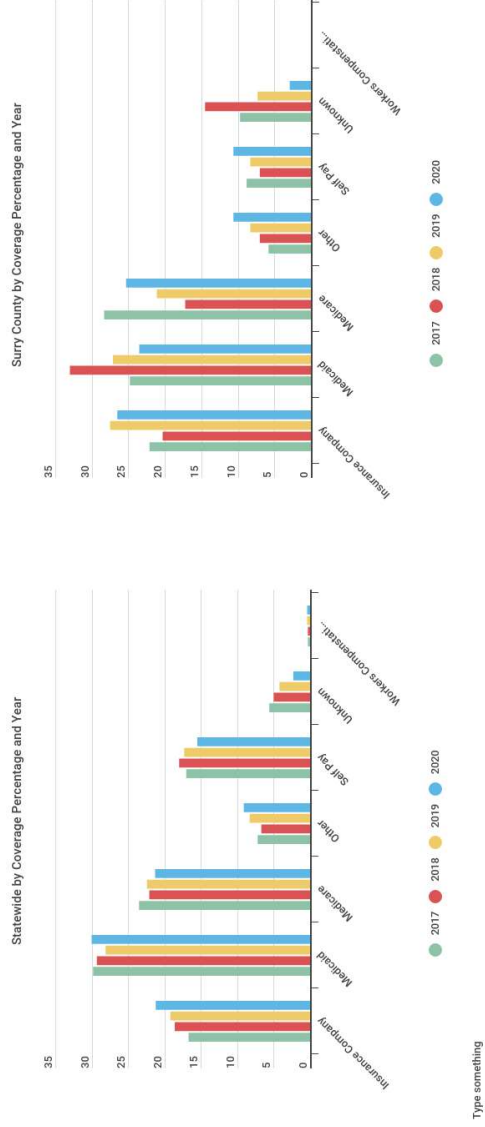
Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visit Trends with a Suicidal Ideation Diagnosis by Insurance Coverage, 2017-2020



Published by the Surry County Office of Substance Abuse Recovery

Surry County Emergency Room Visit Trends with a Trauma/Stressors Diagnosis by Insurance Coverage, 2017-2020



Published by the Surry County Office of Substance Abuse Recovery

Common Acronyms in the Substance Use Disorder Field

A

AA -Alcoholics Anonymous
AAS - American Association of Suicidology
ABCD- Asset Based Community Development
ABH – Association of Behavioral Health
ABH- Advanced Behavioral Health
ACA - American Council on Alcoholism
ACA – Affordable Care Act
ACEs – Adverse Childhood Experiences
ACoA - Adult Children of Alcoholics
ADF - Alcohol and Drug Free
ADPC - Alcohol and Drug Policy Council
AHA - American Hospital Association
AIC - Alternative Incarceration Center
ALA - American Lung Association
AMA - American Medical Association
AMSR - Assessing and Managing Suicide Risk
AOD - Alcohol and other dependence
APA - American Psychiatric Association
APA - American Psychological Association
ARRC - Adult Risk Reduction Center
ASAM – American Society of Addiction Medicine
ATOD - Alcohol Tobacco and Other Drugs
AU - Advocacy Unlimited

B

BAC - Blood Alcohol Content
BAL - Blood Alcohol Level
BHP - Behavioral Health Partnership
BP - Best Practices
BRC - Blue Ribbon Commission (on Mental Health)

C

CADCA - Community Anti-Drug Coalitions of America
CAPT - Center for the Application of Prevention Technologies
CASA - Chemical Abuse Services Agency
CBT - Cognitive Behavioral Therapy
CDC - Community Distribution Center
CIPi - Community Initiated Prevention Interventions
CMHC - Community Mental Health Center

CMHS - Center for Mental Health Services
 COA - Children of Alcoholics
 COD - Co-occurring disorder
 COSA - Children of Substance Abusers
 COSAP - Children of Substance Abusing Parents
 CPP - Certified Prevention Professional
 CPP-R - Certified Prevention Professional with Reciprocity
 CSAP - Center for Substance Abuse Prevention
 CSAPC – Certified Substance Abuse Prevention Counselor
 CSAPS – Certified Substance Abuse Prevention Specialist
 CSAT - Center for Substance Abuse Treatment
 CSRS – Controlled Substances Reporting System
 CSSD - Court Support Services Division

D

DARE - Drug Abuse Resistance Education
 DARC - Drug and Alcohol Rehabilitation Counselor
 DAS - Department of Administrative Services
 DAWN - Drug Abuse Warning Network
 DBT - Dialectical Behavioral Therapy
 DEA - Drug Enforcement Agency
 DCF - Department of Children and Families
 DDS - Department of Developmental Services
 DDW - Drugs Don't Work
 DFC - Drug Free Communities
 DFSCA - Drug-Free Schools and Communities Act
 DHHS – Department of Health and Human Services
 DMHIAS - Department of Mental Health and Addiction Services
 DOC - Department of Correction
 DOE - Department of Education
 DPH - Department of Public Health
 DSS - Department of Social Services
 DOT - Department of Transportation
 DSS - CSAP's Decision Support System
 DUI - Driving Under the Influence
 DVS – Department of Veterans' Services
 DWI - Driving While Intoxicated

E

EAP - Employee Assistance Program
 EBP - Evidence Based Program (or Practice)
 EMR – Electronic Medical Record
 EHR – Electronic Health Record
 EHS - Early Head Start
 EPA – Environmental Protection Agency

EPSDT - Early, Periodic Screening and Diagnosis Testing
ERG - Educational Reference Group

F

FDA - Federal Drug Administration
FEMA - Federal Emergency Management Agency
FY - Fiscal Year (state fiscal year: July 1 – June 30th)

G

GA - Gamblers Anonymous
GLBTQ - Gay Lesbian Bisexual Transgender and Questioning
GLSMA - Garrett Lee Smith Memorial Act
GPRA - Government Performance & Result Act
GPIY - Governor’s Prevention Initiative for Youth
GPP - Governor’s Prevention Partnership

H

HS - Head Start
HS - Healthy Start
HAS - Health Services Area and Human Service Agreement
HIS - Human Service Infrastructure
HRD - Human Resource Development
HUD - Housing and Urban Development

I

ICR - Institute for Community Research
IOM - Institute of Medicine
IOP - Intensive Out-Patient
ISPN - Interagency Suicide Prevention Network
IVDU – Intravenous drug user

J

JCAHO - Joint Commission on Accreditation of Healthcare Organizations

K

L

LFCCP - Latino Family Connection Program
LOB - Legislative Office Building
LME
LPC - Local Prevention Council

M

MAAS - Multi-cultural Ambulatory Addiction
MADD - Mothers Against Drunk Driving
MATCH - Mobilize Against Tobacco for Children’s Health
MAT – Medication Assisted Treatment
MCO – Managed Care Organization

MDS - Minimum Data Set
MI - Motivational Interviewing
MLI - Multicultural Leadership Institute
MOA - Memorandum of Agreement
MST - Multi-Systemic Therapy
MSTBSF - Multi-Systemic Therapy - Building Stronger Families

N

NA - Narcotics Anonymous
NAADAC - National Association of Alcoholism and Drug Abuse Counselors
NAC - National AIDS Clearinghouse
NACoA - National Association of Children of Alcoholics
NAMI - National Alliance for the Mentally Ill
NASADAD - National Association of State Alcohol and Drug Abuse Directors
NASW - National Association of Social Workers
NCADI - CSAP's National Clearinghouse for Alcohol and Drug Information
NF - Nurturing Families
NHTSA - National Highway Traffic Safety Administration
NIAAA - National Institute on Alcohol Abuse and Alcoholism
NIDA - National Institute on Drug Abuse
NIMH - National Institute of Mental Health
NPN - National Prevention Network
NREPP - National Registry of Evidence-based Programs and Practices

O

OJJDP - Office of Juvenile Justice and Delinquency Programs
OMH - Office of Minority Health
ONDCP - Office of National Drug Control Policy
OPM - Office of Policy and Management
OSAP - Office of Substance Abuse Prevention
OSDFS - Office of Safe and Drug-Free Schools
OSHA - Occupational Safety and Health Administration
OTPs - Opioid Treatment Programs
OUD - Opioid Use Disorder
OYYAS - Office of Youth and Young Adults

P

PCP - Primary Care Provider
PDA - Percent Days Abstinent
PDMP - Prescription Drug Monitoring Program
PEAS - Parent Education and Assessment Service
PFC - Prefrontal Cortex
PGS - Problem Gambling Services
PMP - Prescription Monitoring Program
PREVLINe - PREvention onLINE
PRISM - Partnership Resource and Infrastructure Support Monies

PSA - Personal Service Agreement

PTSD - Post Traumatic Stress Disorder

Q

R

RAC-Regional Action Council

RADAR - Regional Alcohol and Drug Awareness Resource Network

RESC - Regional Education Service Center

RID - Remove Intoxicated Drivers

RFP - Request for Proposal

RSS - Recovery Support Services

RSVP - Retired Senior Volunteer Program

S

SA – Substance Abuse

SAAC - Substance Abuse Action Council

SADD - Students Against Destructive Decisions

SALIS - Substance Abuse Librarians and Information Specialists

SAMHSA - Substance Abuse and Mental Health Services Administration

SAP - Student Assistance Program SAPTBG – Substance Abuse Prevention and Treatment Block Grant

SAT - Student Assistance Team (or School Assistance Team)

SAVE – Statewide Advocacy for Veterans’ Empowerment

SAW - State Agency Workgroup

SBI - Screening and Brief Interventions

SDE - State Department of Education

SEW - State Epidemiological Workgroup

SBIRT - Screening, Brief Intervention,
and Referral to Treatment

SIG - State Incentive Grant

SOAP – Structured Outpatient Addiction
Program

SPF SIG - Strategic Prevention Framework State Incentive Grant

SPRC - Suicide Prevention Resource Center

SSA - Single State Agency

SSRI - Selective Serotonin Reuptake Inhibitor

SUD - Substance use disorder

SUMPST – Substance Use Misuse Prevention Skills Training

T

TA - Technical Assistance

TCU - Tobacco Compliance Unit (DMHAS)

TRS - Telephone Recovery Supports

U

V

W

X

Y

YAR - Youth As Researchers

YRBS - Youth Risk Behavior
Survey

YSAB - Youth Suicide Advisory Board

YSB - Youth Service Bureau

Z

Common Definitions in the field of Substance Use Disorder Field

The following selected definitions are credited to the Addictionary.⁵³

ABSTINENCE

The absence of substance use. However, there are many different types of abstinence. Abstinence is typically interpreted as complete abstinence, defined below:

- Continuous abstinence: not consuming the drug of choice during a specified period of time
- Essentially abstinent: not consuming more than a specified amount of the drug over a period of time
- Minimal abstinence: achieving a minimal period of recovery during a period of time
- Point-in-time abstinence: not consuming the drug of choice at a single point in time (e.g., the past 30 days)
- Complete abstinence: continuous abstinence from all alcohol and other drugs
- Involuntary abstinence: enforced abstinence due to hospitalization or incarceration

ACUTE CARE

Immediate, short-term medically managed or monitored care, lasting up to 31 days in length. Most addiction treatment programs (e.g., “rehab”) follow an acute care model. Understanding substance use disorder to be a chronic illness, recovery may require ongoing continuing care beyond acute treatment episodes.

ADDICT

(Stigma Alert) A person who exhibits impaired control over engaging in substance use (or other reward-seeking behavior, such as gambling) despite suffering severe harms caused by such activity. While this language is commonly used, in order to help decrease stigma associated with these conditions, it has been recommended to use “person first” language; instead of describing someone as an “addict,” describe them as “a person with, or suffering from, addiction or substance use disorder.”

ADDICTION

According to the American Society of Addiction Medicine (ASAM), addiction is a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestation. Addiction is characterized by behaviors that include:

- Impaired control over drug use
- Compulsive use
- Continued use despite harm

⁵³ Addictionary - Glossary of Substance Use Disorder Terminology. (2022). Retrieved 28 January 2022, from <https://www.recoveryanswers.org/addiction-ary/>

- Cravings

AL-ANON

A mutual-help organization or peer support group for people who have been affected by a loved one's alcohol use disorder. Groups are based on the 12-step principles of Alcoholics Anonymous (AA), and have attendees share stories and build supportive networks to help one another cope with the difficulties of having a loved one experience an alcohol use disorder. The focus is placed more on changing oneself and one's patterns of interacting with the addicted loved one, rather than on trying to change the alcohol-addicted person's behavior directly.

ALCOHOLICS ANONYMOUS (AA)

International fellowship for individuals with problematic drinking. Founded in 1935, AA is a nonprofessional, financially self-supporting, multiracial, apolitical organization that is open to all ages, and as the largest mutual-help organization, offers meetings in most locations in North America and most countries around the world.

AA is a 12-step program that revolves around its main text, known as the Big Book (see Mutual-Help Organizations, Peer Support Group)

ALTERNATIVE PEER GROUPS (APGs)

Recovery support services for adolescents and emerging adults with substance use disorder that engage them in a community of other recovering adolescents in order to capitalize on the same desire for peer acceptance that is known to drive, in part, adolescent motivations for substance use. APGs are grounded in the theory that, if centered around fun activities with peers, recovery will be perceived as more rewarding than substance use.

AMBIVALENCE

A state of psychological tension in which one is pulled in two different directions: to stay the same or to make changes.

ANONYMOUS

Literally means having no name. In the addiction field, it is closely linked with the concept of confidentiality because people typically prefer not to have their name or addiction status known due to potential stigma and discrimination. The assurance of anonymity can help with help-seeking, as individuals are more inclined to seek help for a stigmatized condition like substance use disorder if they know such help-seeking will be kept completely private.

ASSESSMENT

An ongoing process used to determine the medical, psychological, and social needs of individuals with substance-related conditions and problems. It can take the form of biological assays (e.g., blood or urine samples), as well as clinical diagnostic interviewing and the completion of self-report measures to determine the presence of a substance use disorder or other psychiatric condition, and other symptoms and challenges with the ultimate goal of developing a fully informed and helpful treatment and recovery plan.

BEHAVIORAL HEALTH

The field of health care concerned with substance use and other mental health disorders.

BEHAVIORAL MEDICINE

An interdisciplinary field that integrates knowledge across disciplines to study the behavioral and social aspects of medical conditions and illness.

BIG BOOK

The nickname for the basic foundational text of the mutual-help organization, Alcoholics Anonymous (AA). It outlines the 12 steps that are at the core of the Alcoholics Anonymous program, as well as containing personal stories of alcohol addiction and recovery.

BUPRENORPHINE

A semisynthetic opioid to control moderate to severe pain and to treat opioid use disorder. Buprenorphine is administered by injection to control pain, is used in the form of a transdermal skin patch to control pain or treat opioid use disorder and is used alone or in combination with naloxone in the form of a dissolvable tablet placed under the tongue or film placed inside the cheek to treat opioid use disorder. Brand names include: Bunavail, Buprenex, Butrans, Subutex, Suboxone, and Zubsolv.

CLEAN

(stigma alert) A reference to a state of a person being abstinent from drugs of misuse. It may also be used in describing urine test results that are not positive for substance use. The term has been viewed as potentially stigmatizing because of its pejorative connotation, with the opposite being “dirty.” Instead, many in the field advocate for use of proper medical terminology such as describing someone as an individual in remission or recovery and describing urine toxicology test results as either negative or positive.

COLD TURKEY

Slang term for the abrupt and complete cessation in intake of an addictive substance. It stems from the appearance of goosebumps on the skin often observable in addicted individuals when physiologically withdrawing from a substance.

COMORBIDITY

The occurrence of two disorders or illnesses in the same person, also referred to as co-occurring conditions or sometimes dual diagnosis.

CONTINUING CARE

Ongoing care of patients suffering from chronic incapacitating illness or disease. Understanding substance use disorder to be a chronic illness, it requires continuing care and ongoing recovery management rather than acute care or treatment delivered in isolated episodes.

CO-OCCURRING DISORDERS

This is used most often to describe in with both mental illness & substance use disorder. Personality disorder may also co-exist with psychiatric illness and/or substance use disorders. Also known as comorbidity or dual diagnosis.

DEATHS OF DESPAIR

Deaths by drug, alcohol, and/or suicide.

DENIAL

In a psychological sense: denial describes individuals who deny substance use problems. It is the tendency of addicted individuals to either disavow or distort variables associated with their drinking or drug use in spite of evidence to the contrary. It's a common misconception that all addicted individuals with substance use disorder are "in denial." In fact, individuals have various levels of awareness of their substance use problems and readiness to change behavior. Individuals may accurately recognize certain facts concerning their use, such as number of arrests or how often they drink, while at the same time, misperceive the impact that their use has on the individuals around them, their relationships, how they feel about themselves, or the implications of their substance use history.

DETOX

Short for "detoxification," it is the medical process focused on treating the physical effects of withdrawal from substance use and comfortably achieving metabolic stabilization; a prelude to longer-term treatment and recovery.

DISEASE

A particular abnormal condition, a disorder of a structure or function, that affects part or all of an organism. It is characterized by specific signs and symptoms, generally serving as an evolutionary disadvantage.

DISEASE MODEL OF ADDICTION

Classifies addiction as a disease. There are several "disease models," but addiction is widely considered a complex disease with biological, neurobiological, genetic, and environmental influences among clinical scientists.

DOPE SICK

(stigma alert) A slang term used to reference withdrawal symptoms from opioids, such as heroin. It is preferable to use more accurate terminology such as suffering from withdrawal.

DRUG

(stigma alert) Drug can mean either a "medication" or a "non-medically used psychoactive substance." The term drug has a stigma alert due to the ambiguity of the term. This ambiguity may create a barrier to accessing prescription (psychoactive) medications in cases where their use is medically appropriate. Many advocate instead to use "medication" or "non-medically used psychoactive substances" to decrease stigma and communicate with greater specificity.

DRUG COURTS

Drug courts are problem-solving courts that operate under a specialized model in which the judiciary, prosecution, defense bar, probation, law enforcement, mental health, social service, and treatment communities work together to help non-violent offenders find restoration in recovery and become productive citizens. With an emphasis on rehabilitation and treatment, drug courts serve only a fraction of the estimated 1.2 million individuals suffering from Substance Use Disorder in the United States criminal justice system.

DSM-5

DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS – Fifth Edition: The 2013 update to the American Psychiatric Association’s (APA) classification and diagnostic tool. In the United States, the DSM-5 serves as a universal authority for psychiatric diagnosis.

DUAL DIAGNOSIS

Describes patients with both mental illness and substance use disorder. Personality disorder may also co-exist with psychiatric illness and/or substance use disorders. Also known as comorbidity or co-occurring disorders.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Voluntary work-based intervention programs offered by employers to support employees in management of issues affecting mental and emotional well-being, such as: substance use, stress, grief, family problems, trauma, and psychological disorders. While services may vary, Employee Assistance Programs (EAPs) provide employees with free and confidential assessments, short-term counseling, referrals, and follow-up services.

FENTANYL

A potent opioid synthetically produced in laboratories, that activates the reward centers of the brain to produce sensations of euphoria and provide pain relief. Side effects have included alterations in consciousness, sensations of heaviness, decreases in mental function, constipation, anxiety, changes in mood and appetite, nausea, dry mouth, intense itching, constricted pupils, and increased body temperature. Fentanyl is 50 to 100 times more potent than morphine, and is available in legal prescription form, and increasingly, in illegal illicit forms. Also known as Apache, China Girl, or Jackpot.

HARM REDUCTION

Policies, programs and practices that aim to reduce the harms associated with the use of alcohol or other drugs.

The defining features include a focus on the prevention of harm, rather than on the prevention of substance use itself, with attention and focus on the individual’s active substance use (e.g., a clean needle exchange program can reduce rates of transmission of hepatitis C, HIV, or other infectious disease for individuals suffering from heroin use disorder).

HIGHER POWER

A supreme deity or being, a malleable conception of God, or a “power greater than ourselves,” popularized by the recovery mutual-help organization, Alcoholics Anonymous.

IN-PATIENT TREATMENT

Admission to a hospital or facility for treatment that requires at least one overnight stay and typically requires medical management. (see residential treatment)

INTEGRATED HEALTH CARE

An approach characterized by a high degree of collaboration and communication among health professionals, with sharing of information among team members related to patient care and the establishment of a comprehensive treatment plan to address the physical, psychological and social needs of the patient.

The inter-professional health care team can include a diverse group of members (e.g., physicians, nurses, psychologists, social workers, and other health professionals), depending on patient needs.

INTEGRATED TREATMENT PROGRAMS

Treatment programs that work to treat substance use disorder alongside other co-occurring mental, physical, emotional or social considerations, recognizing how the presence of each can be a risk factor for relapse to either. The term is most often used to indicate the combination of addiction treatment services with mental health treatment services, or on-site pregnancy, parenting, or child-related services.

INTENSIVE OUTPATIENT TREATMENT

A time limited, intensive, non-residential clinical treatment that often involves participation in several hours of clinical services several days per week. It is a step below partial hospitalization in intensity.

INTERVENTION

A procedure of varying duration typically conducted by a clinician and implemented to stimulate, facilitate, and induce changes in signs, symptoms, or behavior.

A meeting of an individual with an identifiable substance-related problem with family or other significant others held to directly address the problems being caused by the individuals’ substance use and typically involves expression of care, concern, and explicit demands for behavioral change or the receipt of addiction treatment. Typically conducted when other attempts to influence change have failed. Also known as the Johnson Intervention.

LONG TERM RECOVERY

5 years of continued remission; the point at which the risk of meeting criteria for a substance use disorder in the following year is no greater than that of the general population.

MEDICAL MODEL

An addiction theory that considers addiction a medical, rather than social issue.

MEDICATION ASSISTED DETOX

Detoxification in a medical setting, often with use of medications to support initial withdrawal and stabilization following cessation of alcohol or other drugs.

MEDICATION ASSISTED TREATMENT

(stigma alert) Medication-assisted treatment (MAT), including opioid treatment programs (OTPs), combines behavioral therapy and medications to treat substance use disorders (see agonist; antagonist).

This term has been issued a Stigma Alert, as the term may not fully appreciate research that has shown that with or without psychosocial support, medications are effective treatments for addiction – hence, the term “assisted” may undervalue the role of the medication. In addition, this term may create a double standard for substance use disorder treatment, as no other medications used to treat other health conditions are referred to as ‘assisted’ treatment. Many advocate instead to simple state “medications for addiction treatment.”

MOTIVATIONAL INTERVIEWING (MI)

A clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health by helping them to explore and resolve ambivalence about changes.

MUTUAL HELP ORGANIZATIONS

Also known as self-help groups, peer support groups, and mutual aid, mutual help organizations are for the most part peer run volunteer organizations that focus on socially supportive communication and exchange of addiction and recovery experiences and skills.

NALOXONE

An opioid antagonist, similar to Naltrexone, that works by blocking opioid receptors in the brain, thereby blocking the effects of opioid agonists (e.g., heroin, morphine). Naloxone has poor bio-availability when taken sublingually. Naloxone has a high affinity to the mu opioid receptor, yet not as high of an affinity as buprenorphine, at the mu receptor. Brand name: Narcan.

NALTREXONE

An opioid antagonist, works by blocking opioid receptors in the brain, without activating them, therefore blocking the effects of opioids (e.g., heroin, morphine). Naltrexone has a high affinity to the Mu opioid receptor, but not as high as buprenorphine.

NAR-ANON

Nar-Anon is a mutual help organization or peer support group for people who have been affected by a loved one’s drug use disorder. Groups are based on 12-step principles and practices and have

attendees share stories and build supportive networks to help cope with the difficulties of having a loved one with a drug use disorder.

NARCOTIC

Originally, narcotic referred to psychoactive compounds with sleep inducing properties (typically opioids such as heroin). In moderate doses, narcotics will dull the senses, relieve pain, and induce sleep. In large doses, narcotics will cause stupor, coma, and death.

NIMBY ("Not In My Backyard")

A characterization of opposition by residents to a proposed development within their local area, such as for addiction treatment centers or harm reduction programs. It often correlates with strong fears of increased crime, poverty, drug use, or community degradation. The term tends to carry the connotation that residents would tolerate or even support the new development, if it was not proposed in such close proximity to themselves (i.e., “Not In My Back Yard” or NIMBY).

OXFORD HOUSES

Oxford Houses are a type of self-sustaining recovery residence, first developed in 1975. They are non-professional, and require that residents are abstinent from alcohol and other drugs. While they are not affiliated with 12-step mutual-help organizations like Alcoholics Anonymous, members are traditionally encouraged – though not mandated – to attend meetings. Members pay rent, and can stay there as long as needed, provided they follow house rules. While there is a manual that lays the initial groundwork for a new Oxford House to aid in quality control, decisions around consequences for individuals who break rules are up to the other house members. House leadership positions are limited to 6 months so that members all have a chance to be decision makers.

PARTIAL HOSPITALIZATION

A time-limited, intensive, clinical service that is often medically monitored but is a step in intensity below inpatient hospitalization. A patient may participate in clinical services all day long for days to weeks but resides at home. Definitions of levels of care may vary by state.

PEER SUPPORT GROUP

Also known as mutual help organizations, peer support groups are structured non-clinical relationships, in which individuals participate in activities that engage, educate, and support patients recovering from substance use disorder. Peer to peer groups include such organizations as: AA, NA, Smart Recovery, All Recovery groups, LIfeRing, Women for Sobriety, and online forums.

PERSON-FIRST LANGUAGE

A linguistic prescription structuring sentences to name the person first and the condition or disease from which they suffer, second. It is recommended to use “person first” language; instead of describing someone as an “addict”, for instance, to describe them as a person with, or suffering from, addiction or a substance use disorder. Person-first language articulates that the disease is a secondary attribute and not the primary characteristic of the individual’s identity.

PREVENTION PARADOX

A contradictory scenario whereby the majority of cases of substance-related harm come from a population at low or moderate risk of addiction, while only a minority of cases come from the population who are at high risk of substance-related harm.

PUBLIC HEALTH APPROACH

An approach to drug policy that is a coordinated, comprehensive effort that balances public health & safety in order to create safer, healthier communities, measuring success by the impact of both drug use & drug policies on the public's health.

PUNISHMENT

A negative consequence occurring following a behavior with the intention of decreasing the frequency of the behavior. It can take the form of “positive punishment” (e.g., the application of an adverse condition such as a mild electric shock) or “negative punishment” (e.g., the withdrawal of a privilege; “Time out” or “being grounded”) is a good example of negative punishment for children).

RAPID DETOX

Anesthesia assisted detoxification; injection of high doses of an opiate antagonist.

RECOVERY

The process of improved physical, psychological, and social well-being and health after having suffered from a substance use disorder.

RECOVERY COACH

Typically a non-clinical peer support specialist or “peer mentor” operating within a community organization (e.g., a Recovery Community Center) or a clinical organization (e.g., treatment program or hospital) and can therefore be a paid or volunteer position. Recovery coaches are most often in recovery themselves and therefore offer the lived experience of active addiction and successful recovery. They focus on helping individuals to set & achieve goals important to recovery. They do not offer primary treatment for addiction, do not diagnose, & generally, are not associated with any specific method or pathway to recovery, supporting instead an array of recovery pathways.

RECOVERY COMMUNITY ORGANIZATIONS (RCO's)

An independent, non-profit organization led and governed by representatives of local communities of individuals in recovery from a substance use disorder.

RECOVERY ORIENTED SYSTEMS OF CARE (ROSC)

A coordinated network of community based services that involve a strengths-based and personalized approach to recovery and increases in quality of life.

RECOVERY RATES

The percentage of addicted persons undergoing treatment, who achieve abstinence or remission following treatment in some stated time period (e.g., in the year following discharge from treatment) Sometimes referred to as “success rate”.

RECOVERY RESIDENCES

An alcohol- and drug-free living facility for individuals recovering from alcohol or other drug use disorders that often serves as an interim living environment between detoxification experiences or residential treatment and mainstream society. Also known as Sober Houses, Sober Living Houses (SLHs), Sober Living Homes, or Sober Living Environments.

RELAPSE

(stigma alert) Relapse often indicates a recurrence of substance use. More technically, it would indicate the recurrence and reinstatement of a substance use disorder and would require an individual to be in remission prior to the occurrence of a relapse.

The highest risk for recurrence of substance use disorder symptoms occurs during the first 90 days following the initial intervention. The risk for recurrence of symptoms decreases after 90 days. This indicates that individuals attempting to recover from substance use disorder need the most intensive support during this first 3-month period, as individuals are experiencing substantial physiological, psychological, and social changes during this early recovery phase. There is typically a greater sensitivity to stress and lowered sensitivity to reward that makes continued recovery challenging.

This term has a stigma alert, as it can imply a moral failing for some people. Instead it may be preferable to use morally neutral terms such as “resumed,” or experienced a “recurrence” of symptoms.

REMISSION

The complete absence of symptoms or the presence of symptoms but below a specified threshold. An individual is considered to “in remission” if they once met criteria for a substance use disorder, but have not surpassed the threshold number of criteria within the past year or longer.

Long-term recovery from a substance use disorder is considered by many to occur after 5 years, at which time the likelihood of meeting criteria for substance use disorder in the following year is no greater than that of the general population.

RESIDENTIAL TREATMENT

A model of care for substance use disorder that houses affected individuals with others suffering from the same conditions to provide longer-term rehabilitative therapy in a therapeutic socially supportive milieu. Also known sometimes as in-patient treatment, although more technically, is medically managed or monitored whereas residential treatment does not have to be.

RISK FACTORS

Attributes (e.g., genetics), characteristics (e.g., impulsivity) or exposures (e.g., to prescription opioids) that increases the likelihood of developing a disease or injury.

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT)

An evidence-based method used to detect, reduce, and prevent problematic substance use and substance use disorder.

SCREENING –An assessment – usually brief such as a paper and pencil self-report measures or a biological assay (e.g., urine/blood) – to help detect risky or harmful substance use. This is often conducted by healthcare professionals using standardized screening tools in a specific clinic or other setting.

BRIEF INTERVENTION –A short conversation or counseling session in which healthcare providers typically offer feedback and advice in order to motivate individuals identified as at-risk for substance-related harm to become more aware of the risk and to reduce or eliminate substance use or to seek treatment.

REFERRAL TO TREATMENT –The 3rd and final stage in the SBIRT model, when a healthcare provider formally refers a patient identified as having or is at-risk for substance use disorder to additional services such as brief therapy or longer-term treatment.

SOCIAL DETOX

Detoxification in an organized residential setting to deliver non-medical support to achieve initial recovery from the effects of alcohol or another drug. Staff provide safe, twenty-four-hour monitoring, observation, and support in a supervised environment for patients.

STIGMA

An attribute, behavior, or condition that is socially discrediting. Known to decrease treatment seeking behaviors in individuals with substance use disorders.

SUBOXONE

Approved by the FDA in 2002 as a medication treatment for opioid dependence, Suboxone contains the active ingredients of buprenorphine hydrochloride and naloxone. The mixture of agonist and antagonist is intended to reduce craving while preventing misuse of the medication.

TREATMENT

The management and care of a patient to combat a disease or disorder. Can take the form of medicines, procedures, or counseling and psychotherapy. .

WITHDRAWAL

Physical, cognitive, and affective symptoms that occur after chronic use of a drug is reduced abruptly or stopped among individuals who have developed tolerance to a drug.

Appendix A

Memorandum of Agreement Between the State of North Carolina and Local Governments on
Proceeds Relating to the Settlement of Opioid Litigation (MOA).

**MEMORANDUM OF AGREEMENT
BETWEEN THE STATE OF NORTH CAROLINA AND LOCAL GOVERNMENTS
ON PROCEEDS RELATING TO THE SETTLEMENT OF OPIOID LITIGATION**

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Background Statement

Capitalized terms not defined below have the meanings set forth in the Definitions section of the Statement of Agreement.

WHEREAS, the State of North Carolina (the “State”), North Carolina counties and municipalities, and their people have been harmed by misconduct committed by certain entities that engage in or have engaged in the manufacture, marketing, promotion, distribution, or dispensing of an opioid analgesic (“Pharmaceutical Supply Chain Participants”); and

WHEREAS, certain North Carolina counties and municipalities, through their counsel, and the State, through its Attorney General, are separately engaged in ongoing investigations, litigation and settlement discussions seeking to hold Pharmaceutical Supply Chain Participants accountable for the damage caused by their misconduct; and

WHEREAS, the State and the Local Governments share a common desire to abate and alleviate the impacts of the misconduct described above throughout North Carolina and in its local communities; and

WHEREAS, while the Local Governments and the State recognize the sums which may be available from the aforementioned litigation will likely be insufficient to fully abate the public health crisis caused by the opioid epidemic, they share a common interest in dedicating the most resources possible to the abatement effort; and

WHEREAS, settlements resulting from the investigations and litigation with Johnson & Johnson, AmerisourceBergen, Cardinal Health, and McKesson are anticipated to take the form of a National Settlement Agreement; and

WHEREAS, this Memorandum of Agreement (“MOA”) is intended to facilitate compliance by the State and by the Local Governments with the terms of the National Settlement Agreement and, to the extent appropriate, in other settlements related to the opioid epidemic reached by the state of North Carolina; and

WHEREAS, North Carolina’s share of settlement funds from the National Settlement Agreement will be maximized only if all North Carolina counties, and municipalities of a certain size, participate in the settlement; and

WHEREAS, the National Settlement Agreement will set a default allocation between each state and its political subdivisions unless they enter into a state-specific agreement regarding the distribution and use of settlement amounts (a “State-Subdivision Agreement”); and

WHEREAS, this MOA is intended to serve as such a State-Subdivision Agreement under the National Settlement Agreement; and

WHEREAS, the aforementioned investigations and litigation have caused some Pharmaceutical Supply Chain Participants to declare bankruptcy, and it may cause additional entities to declare bankruptcy in the future; and

WHEREAS, this MOA is also intended to serve as a State-Subdivision Agreement under resolutions of claims concerning alleged misconduct in manufacture, marketing, promotion, distribution, or dispensing of an opioid analgesic entered in bankruptcy court that provide for payments (including payments through a trust) to both the State and North Carolina counties and municipalities and allow for the allocation between a state and its political subdivisions to be set through a state-specific agreement (“Bankruptcy Resolutions”); and

WHEREAS, specifically, this MOA is intended to serve under the Bankruptcy Resolution concerning Purdue Pharma L.P. as a statewide abatement agreement, and under this MOA, a statewide abatement agreement is a type of State-Subdivision Agreement.

Statement of Agreement

The parties hereto agree as follows:

A. Definitions

As used in this MOA:

The terms “Bankruptcy Resolution,” “MOA,” “Pharmaceutical Supply Chain Participant,” “State,” and “State-Subdivision Agreement” are defined in the recitals to this MOA.

“Coordination group” refers to the group described in **Section E.7** below.

“County Incentive Fund” is defined in **Section G** below.

“Governing Body” means (1) for a county, the county commissioners of the county, and (2) for a municipality, the elected city council, town council, board of commissioners, or board of aldermen for the municipality.

“Incentive Eligible Local Government” is defined in **Section G** below.

“Local Abatement Funds” are defined in **Section B.2** below.

“Local Government” means all counties and municipalities located within the geographic boundaries of the State of North Carolina that have chosen to sign on to this MOA.

“MDL Matter” means the matter captioned *In re: National Prescription Opiate Litigation*, MDL 2804 pending in the United States District Court for the Northern District of Ohio.

“MDL Parties” means all parties who participated in the matter captioned *In re: National Prescription Opiate Litigation*, MDL 2804 pending in the United States District Court for the Northern District of Ohio as Plaintiffs.

“National Settlement Agreement” means a national opioid settlement agreement with the Parties and one or all of the Settling Defendants concerning alleged misconduct in manufacture, marketing, promotion, distribution, or dispensing of an opioid analgesic.

“Opioid Settlement Funds” shall mean all funds allocated by the National Settlement Agreement and any Bankruptcy Resolutions to the State or Local Governments for purposes of opioid remediation activities or restitution, as well as any repayment of those funds and any interest or investment earnings that may accrue as those funds are temporarily held before being expended on opioid remediation strategies. Not included are funds made available in the National Settlement Agreement or any Bankruptcy Resolutions for the payment of the Parties’ litigation expenses or the reimbursement of the United States Government.

“Parties” means the State of North Carolina and the Local Governments.

“Settling Defendants” means Johnson & Johnson, AmerisourceBergen, Cardinal Health, and McKesson, as well as their subsidiaries, affiliates, officers, and directors named in a National Settlement Agreement.

“State Abatement Fund” is defined in **Section B.2** below.

B. Allocation of Settlement Proceeds

1. Method of distribution. Pursuant to the National Settlement Agreement and any Bankruptcy Resolutions, Opioid Settlement Funds shall be distributed directly to the State and to Local Governments in such proportions and for such uses as set forth in this MOA, provided Opioid Settlement Funds shall not be considered funds of the State or any Local Government unless and until such time as each annual distribution is made.
2. Overall allocation of funds. Opioid Settlement Funds shall be allocated as follows: (i) 15% directly to the State (“State Abatement Fund”), (ii) 80% to abatement funds established by Local Governments (“Local Abatement Funds”), and (iii) 5% to a County Incentive Fund described in **Section G** below.
3. Allocation of funds between Local Governments. The Local Abatement Funds shall be allocated to counties and municipalities in such proportions as set forth in **Exhibit G**, attached hereto and incorporated herein by reference, which is based upon the MDL Matter’s Opioid Negotiation Class Model. The proportions shall not change based on population changes during the term of the MOA. However, to the extent required by the terms of the National Settlement Agreement, the proportions set forth in **Exhibit G** shall be adjusted: (i) to provide no payment from the National Settlement Agreement to any listed county or municipality that does not participate in the National Settlement Agreement; and (ii) to provide a reduced payment from the National Settlement Agreement to any listed county or municipality that signs onto the National Settlement Agreement after the initial participation deadline.
4. Municipal allocations. Within counties and municipalities:

- a. Local Governments receiving payments. The proportions set forth in **Exhibit G** provide for payments directly to (i) all North Carolina counties, (ii) North Carolina municipalities with populations over 75,000 based on the United States Census Bureau's Vintage 2019 population totals, and (iii) North Carolina municipalities who are also MDL Parties as of January 1, 2021.
- b. Municipality may direct payments to county. Any municipality allocated a share in **Exhibit G** may elect to have its share of current or future annual distributions of Local Abatement Funds instead directed to the county or counties in which it is located. Such an election may be made by January 1 each year to apply to the following fiscal year. If a municipality is located in more than one county, the municipality's funds will be directed based on the MDL Matter's Opioid Negotiation Class Model.
5. Use of funds for opioid remediation activities. This MOA requires that except as related to the payment of the Parties' litigation expenses and the reimbursement of the United States Government, all Opioid Settlement Funds, regardless of allocation, shall be utilized only for opioid remediation activities.
6. Relationship of this MOA to other agreements and resolutions. All Parties acknowledge and agree the National Settlement Agreement will require a Local Government to release all its claims against the Settling Defendants to receive Opioid Settlement Funds. All Parties further acknowledge and agree based on the terms of the National Settlement Agreement, a Local Government may receive funds through this MOA only after complying with all requirements set forth in the National Settlement Agreement to release its claims. This MOA is not a promise from any Party that any National Settlement Agreement or Bankruptcy Resolution will be finalized or executed.

C. Payment of Litigating and Non-Litigating Parties

No Party engaged in litigating the MDL Matter shall receive a smaller payment than a similarly situated non-litigating Party, other than as based on the Allocation Proportions in **Exhibit G** or based on the eligibility criteria for payments from the County Incentive Fund as provided by **Section G** below.

D. Special Revenue Fund

1. Creation of special revenue fund. Every Local Government receiving Opioid Settlement Funds shall create a separate special revenue fund, as described below, that is designated for the receipt and expenditure of the Opioid Settlement Funds.
2. Procedures for special revenue fund. Funds in this special revenue fund shall not be commingled with any other money or funds of the Local Government. The funds in the

special revenue fund shall not be used for any loans or pledge of assets, unless the loan or pledge is for an opioid remediation purpose consistent with the terms of this MOA and adopted under the process described in **Section E.6** below. Although counties or municipalities may make contracts with or grants to a nonprofit, charity, or other entity, counties or municipalities may not assign to another entity their rights to receive payments from the national settlement or their responsibilities for funding decisions.

3. Interest earned on special revenue fund. The funds in the special revenue fund may be invested, consistent with the investment limitations for local governments, and may be placed in an interest-bearing bank account. Any interest earned on the special revenue fund must be used in a way that is consistent with this MOA.

E. Opioid Remediation Activities.

1. Limitation on use of funds. Local Governments shall expend Opioid Settlement Funds only for opioid-related expenditures consistent with the terms of this MOA and incurred after the date of the Local Government's execution of this MOA, unless execution of the National Settlement Agreement requires a later date.
2. Opportunity to cure inconsistent expenditures. If a Local Government spends any Opioid Settlement Funds on an expenditure inconsistent with the terms of this MOA, the Local Government shall have 60 days after discovery of the expenditure to cure the inconsistent expenditure through payment of such amount for opioid remediation activities through budget amendment or repayment.
3. Consequences of failure to cure inconsistent expenditures. If a Local Government does not make the cure required by **Section E.2** above within 60 days, (i) future Opioid Fund payments to that Local Government shall be reduced by an amount equal to the inconsistent expenditure, and (ii) to the extent the inconsistent expenditure is greater than the expected future stream of payments to the Local Government, the Attorney General may initiate a process up to and including litigation to recover and redistribute the overage among all eligible Local Governments. The Attorney General may recover any litigation expenses incurred to recover the funds. Any recovery or redistribution shall be distributed consistent with **Sections B.3 and B.4** above.
4. Annual meeting of counties and municipalities within each county. Each county receiving Opioid Settlement Funds shall hold at least one annual meeting with all municipalities in the Local Government's county invited in order to receive input as to proposed uses of the Opioid Settlement Funds and to encourage collaboration between local governments both within and beyond the county. These meetings shall be open to the public.
5. Use of settlement funds under Option A and Option B. Local Governments shall spend Opioid Settlement Funds from the Local Abatement Funds on opioid remediation activities using either or both of the processes described as Option A and Option B below, unless the relevant National Settlement Agreement or Bankruptcy Resolution further limit the spending.

a. Option A.

- i. Without any additional strategic planning beyond the meeting described in **Section E.4** above, Local Governments may spend Opioid Settlement Funds from the list of High-Impact Opioid Abatement Strategies attached as **Exhibit A**. This list is a subset of the initial opioid remediation strategies listed in the National Settlement Agreement.
- ii. **Exhibit A** may be modified as set forth in Exhibit D below; provided, however, that any strategy listed on **Exhibit A** must be within the list of opioid remediation activities for the then-current National Settlement Agreement. Opioid remediation activities undertaken under a previously authorized strategy list may continue if they were authorized at the time of the Local Government's commitment to spend funds on that activity.

b. Option B.

- i. A Local Government that chooses to participate in additional voluntary, collaborative, strategic planning may spend Opioid Settlement Funds from the broader list of categories found in **Exhibit B**. This list contains all the initial opioid remediation strategies listed in the National Settlement Agreement.
- ii. Before spending any funds on any activity listed in **Exhibit B**, but not listed on **Exhibit A**, a Local Government must first engage in the collaborative strategic planning process described in **Exhibit C**. This process shall result in a report and non-binding recommendations to the Local Government's Governing Body described in **Exhibit C** (right-hand column).
- iii. A Local Government that has previously undertaken the collaborative strategic planning process described in **Exhibit C** and wishes to continue implementing a strategy listed in **Exhibit B**, but not listed in **Exhibit A**, shall undertake a new collaborative strategic planning process every four years (or more often if desired).
- iv. A Local Government that has previously undertaken the collaborative strategic planning process described in **Exhibit C** that wishes to implement a new strategy listed in **Exhibit B** but not listed in **Exhibit A**, shall undertake a new collaborative strategic planning process.
- v. Two or more Local Governments may undertake a single collaborative strategic planning process resulting in a report and recommendations to all of the Local Governments involved.

6. Process for drawing from special revenue funds.

- a. Budget item or resolution required. Opioid Settlement Funds can be used for a purpose when the Governing Body includes in its budget or passes a separate resolution authorizing the expenditure of a stated amount of Opioid Settlement Funds for that purpose or those purposes during a specified period of time.
- b. Budget item or resolution details. The budget or resolution should (i) indicate that it is an authorization for expenditure of opioid settlement funds; (ii) state the specific strategy or strategies the county or municipality intends to fund pursuant to Option A or Option B, using the item letter and/or number in **Exhibit A** or **Exhibit B** to identify each funded strategy, and (iii) state the amount dedicated to each strategy for a stated period of time.

7. Coordination group. A coordination group with the composition and responsibilities described in **Exhibit D** shall meet at least once a year during the first three years that this MOA is in effect. Thereafter, the coordination group shall meet at least once every three years until such time as Opioid Settlement Funds are no longer being spent by Local Governments.

F. Auditing, Compliance, Reporting, and Accountability

1. Audits under Local Government Budget and Fiscal Control Act. Local Governments' Opioid Settlement Funds are subject to financial audit by an independent certified public accountant in a manner no less than what is required under G.S. 159-34. Each Local Government must file an annual financial audit of the Opioid Settlement Funds with the Local Government Commission. If any such audit reveals an expenditure inconsistent with the terms of this MOA, the Local Government shall immediately report the finding to the Attorney General.
2. Audits under other acts and requirements. The expenditure of Opioid Settlement Funds is subject to the requirements of the Local Government Budget and Fiscal Control Act, Chapter 159 of the North Carolina General Statutes; Local Government Commission rules; the Federal Single Audit Act of 1984 (as if the Opioid Settlement Funds were federal funds); the State Single Audit Implementation Act; Generally Accepted Government Auditing Standards; and all other applicable laws, rules, and accounting standards. For expenditures for which no compliance audit is required under the Federal Single Audit Act of 1984, a compliance audit shall be required under a compliance supplement approved by the coordination group.
3. Audit costs. Reasonable audit costs that would not be required except for this Section F may be paid by the Local Government from Opioid Settlement Funds..
4. Access to persons and records. During and after the term of this MOA, the State Auditor and Department of Justice shall have access to persons and records related to this MOA and expenditures of Opioid Settlement Funds to verify accounts and data affecting fees or

performance. The Local Government manager/administrator is the point of contact for questions that arise under this MOA.

5. Preservation of records. The Local Government must maintain, for a period of at least five years, records of Opioid Settlement Fund expenditures and documents underlying those expenditures, so that it can be verified that funds are being or have been utilized in a manner consistent with the National Settlement Agreement, any Bankruptcy Resolutions, and this MOA.

6. Reporting.

- a. Annual financial report required. In order to ensure compliance with the opioid remediation provisions of the National Settlement Agreement, any Bankruptcy Resolutions, and this MOA, for every fiscal year in which a Local Government receives, holds, or spends Opioid Settlement Funds, the county or municipality must submit an annual financial report specifying the activities and amounts it has funded.
- b. Annual financial report timing and contents. The annual financial report shall be provided to the North Carolina Attorney General by emailing the report to opioiddocs@ncdoj.gov, within 90 days of the last day of the state fiscal year covered by the report. Each annual financial report must include the information described on **Exhibit E**.
- c. Reporting to statewide opioid settlement dashboard. Each Local Government must provide the following information to the statewide opioid settlement dashboard within the stated timeframes:
 - i. The budget or resolution authorizing the expenditure of a stated amount of Opioid Settlement Funds for a specific purpose or purposes during a specified period of time as described in **Section E.6.b** above (within 90 days of the passage of any such budget or resolution);
 - ii. If the Local Government is using Option B, the report(s) and non-binding recommendations from collaborative strategic planning described in **Section E.5.b.ii** above and **Exhibit C** (right hand column) (within 90 days of the date the report and recommendations are submitted to the local governing body for consideration);
 - iii. The annual financial reports described in Section F.6.a and **Exhibit E** (within 90 days of the end of the fiscal year covered by the report); and
 - iv. The impact information described in **Exhibit F** (within 90 days of the end of the fiscal year covered by the report).

The State will create an online portal with instructions for Local Governments to report or upload each of these four items by electronic means.

d. Copy to NCDOJ of any additional reporting. If the National Settlement Agreement or any Bankruptcy Resolutions require that a Local Government file, post, or provide a report or other document beyond those described in this MOA, or if any Local Government communicates in writing with any national administrator or other entity created or authorized by the National Settlement Agreement or any Bankruptcy Resolutions regarding the Local Government's compliance with the National Settlement Agreement or Bankruptcy Resolutions, the Local Government shall email a copy of any such report, document, or communication to the North Carolina Department of Justice at opioiddocs@ncdoj.gov.

e. Compliance and non-compliance.

- i. Every Local Government shall make a good faith effort to comply with all of its reporting obligations under this MOA, including the obligations described in **Section F.6.c** above.
- ii. A Local Government that engages in a good faith effort to comply with its reporting obligations under **Section F.6.c** but fails in some way to report information in an accurate, timely, or complete manner shall be given an opportunity to remedy this failure within a reasonable time.
- iii. A Local Government that does not engage in a good faith effort to comply with its reporting obligations under this MOA, or that fails to remedy reporting issues within a reasonable time, may be subject to action for breach of contract.
- iv. Notwithstanding anything to the contrary herein, a Local Government that is in substantial compliance with the reporting obligations in this MOA shall not be considered in breach of this MOA or in breach of contract.

7. Collaboration. The State and Local Governments must collaborate to promote effective use of Opioid Settlement Funds, including through the sharing of expertise, training, technical assistance. They will also coordinate with trusted partners to collect and share information about successful regional and other high-impact strategies and opioid treatment programs.

G. **County Incentive Fund**

A Local Government receiving Settlement Proceeds pursuant to **Section B.4.a** shall be an Incentive Eligible Local Government if every municipality in the Local Government's county with population of at least 30,000 has executed this MOA by October 1, 2021, but no later than any such deadline set in the National Settlement Agreement for the highest possible participation in incentive structures for North Carolina. Each Incentive Eligible Local Government shall receive a share of the 5% County Incentive Fund set forth in **Section B.2.iii**, distributed pro rata among only Incentive Eligible Local Governments as set forth in **Exhibit G**. For purposes of the calculations required by this Section, populations will be based on United States Census Bureau's Vintage 2019 population totals, and a municipality with populations in multiple counties will be counted only toward the county which has the largest share of that municipality's population.

H. Effectiveness

1. When MOA takes effect. This MOA shall become effective at the time a sufficient number of Local Governments have joined the MOA to qualify this MOA as a State-Subdivision Agreement under the National Settlement Agreement or any Bankruptcy Resolution. If this MOA does not thereby qualify as a State-Subdivision Agreement, this MOA will have no effect.
2. Amendments to MOA.
 - a. Amendments to conform to final national documents. The Attorney General, with the consent of a majority vote from a group of Local Government attorneys appointed by the Association of County Commissioners, may initiate a process to amend this MOA to make any changes required by the final provisions of the National Settlement Agreement or any Bankruptcy Resolution. The Attorney General's Office will provide written notice of the necessary amendments to all the previously joining parties. Any previously joining party will have a two-week opportunity to withdraw from the MOA. The amendments will be effective to any party that does not withdraw.
 - b. Coordination group. The coordination group may make the changes authorized in **Exhibit D**.
 - c. No amendments to allocation between Local Governments. Notwithstanding any other provision of this MOA, the allocation proportions set forth in **Exhibit G** may not be amended.
 - d. General amendment power. After execution, the coordination group may propose other amendments to the MOA, subject to the limitation in **Section H.2.c** above. Such amendments will take effect only if approved in writing by the Attorney General and at least two-thirds of the Local Governments who are Parties to this MOA. In the vote, each Local Government Party will have a number of votes measured by the allocation proportions set forth in **Exhibit G**.
3. Acknowledgement. The Parties acknowledge that this MOA is an effective and fair way to address the needs arising from the public health crisis due to the misconduct committed by the Pharmaceutical Supply Chain Participants.
4. When MOA is no longer in effect. This MOA is effective until one year after the last date on which any Opioid Settlement Funds are being spent by Local Governments pursuant to the National Settlement Agreement and any Bankruptcy Resolution.
5. Application of MOA to settlements and bankruptcy resolutions. This MOA applies to all settlements under the National Settlement Agreement with the Settling Defendants and any Bankruptcy Resolutions. The Parties agree to discuss the use, as the Parties may deem appropriate in the future, of the settlement terms set out herein (after any necessary

amendments) for resolutions with Pharmaceutical Supply Chain Participants not covered by the National Settlement Agreement or a Bankruptcy Resolution.

6. Applicable law and venue. Unless required otherwise by the National Settlement Agreement or a Bankruptcy Resolution, this MOA shall be interpreted using North Carolina law and any action related to the provisions of this MOA must be adjudicated by the Superior Court of Wake County. If any provision of this MOA is held invalid by any court of competent jurisdiction, this invalidity does not affect any other provision which can be given effect without the invalid provision.
7. Scope of MOA. The Parties acknowledge that this MOA does not excuse any requirements placed upon them by the terms of the National Settlement Agreement or any Bankruptcy Resolution, except to the extent those terms allow for a State-Subdivision Agreement to do so.
8. No third party beneficiaries. No person or entity is intended to be a third party beneficiary of this MOA.
9. No effect on authority of parties. Nothing in this MOA shall be construed to affect or constrain the authority of the Parties under law.
10. Signing and execution of MOA. This MOA may be signed and executed simultaneously in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same agreement. A signature transmitted by facsimile or electronic image shall be deemed an original signature for purposes of executing this MOA. Each person signing this MOA represents that he or she is fully authorized to enter into the terms and conditions of, and to execute, this MOA, and that all necessary approvals and conditions precedent to his or her execution have been satisfied.

(Signature pages follow.)

Signature pages will be structured as one page for the State of North Carolina, followed by separate signature pages for each county.

These signature pages will also include blanks for the county's municipalities.

To avoid having 101 signature pages in the middle of this file, the signature pages are in a separate document.

EXHIBIT A TO NC MOA: HIGH-IMPACT OPIOID ABATEMENT STRATEGIES (“OPTION A” List)

In keeping with the National Settlement Agreement, opioid settlement funds may support programs or services listed below that serve persons with Opioid Use Disorder (OUD) or any co-occurring Substance Use Disorder (SUD) or mental health condition.

As used in this list, the words “fund” and “support” are used interchangeably and mean to create, expand, or sustain a program, service, or activity.

1. **Collaborative strategic planning.** Support collaborative strategic planning to address opioid misuse, addiction, overdose, or related issues, including staff support, facilitation services, or any activity or combination of activities listed in Exhibit C to the MOA (collaborative strategic planning).
2. **Evidence-based addiction treatment.** Support evidence-based addiction treatment consistent with the American Society of Addiction Medicine’s national practice guidelines for the treatment of opioid use disorder – including Medication-Assisted Treatment (MAT) with any medication approved for this purpose by the U.S. Food and Drug Administration – through Opioid Treatment Programs, qualified providers of Office-Based Opioid Treatment, Federally Qualified Health Centers, treatment offered in conjunction with justice system programs, or other community-based programs offering evidence-based addiction treatment. This may include capital expenditures for facilities that offer evidence-based treatment for OUD. (If only a portion of a facility offers such treatment, then only that portion qualifies for funding, on a pro rata basis.)
3. **Recovery support services.** Fund evidence-based recovery support services, including peer support specialists or care navigators based in local health departments, social service offices, detention facilities, community-based organizations, or other settings that support people in treatment or recovery, or people who use drugs, in accessing addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need to improve their health or well-being.
4. **Recovery housing support.** Fund programs offering recovery housing support to people in treatment or recovery, or people who use drugs, such as assistance with rent, move-in deposits, or utilities; or fund recovery housing programs that provide housing to individuals receiving Medication-Assisted Treatment for opioid use disorder.
5. **Employment-related services.** Fund programs offering employment support services to people in treatment or recovery, or people who use drugs, such as job training, job skills, job placement, interview coaching, resume review, professional attire, relevant courses at community colleges or vocational schools, transportation services or transportation vouchers to facilitate any of these activities, or similar services or supports.
6. **Early intervention.** Fund programs, services, or training to encourage early identification and intervention for children or adolescents who may be struggling with problematic use of drugs or mental health conditions, including Youth Mental Health

First Aid, peer-based programs, or similar approaches. Training programs may target parents, family members, caregivers, teachers, school staff, peers, neighbors, health or human services professionals, or others in contact with children or adolescents.

7. **Naloxone distribution.** Support programs or organizations that distribute naloxone to persons at risk of overdose or their social networks, such as Syringe Service Programs, post-overdose response teams, programs that provide naloxone to persons upon release from jail or prison, emergency medical service providers or hospital emergency departments that provide naloxone to persons at risk of overdose, or community-based organizations that provide services to people who use drugs. Programs or organizations involved in community distribution of naloxone may, in addition, provide naloxone to first responders.
8. **Post-overdose response team.** Support post-overdose response teams that connect persons who have experienced non-fatal drug overdoses to addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need to improve their health or well-being.
9. **Syringe Service Program.** Support Syringe Service Programs operated by any governmental or nongovernmental organization authorized by section 90-113.27 of the North Carolina General Statutes that provide syringes, naloxone, or other harm reduction supplies; that dispose of used syringes; that connect clients to prevention, treatment, recovery support, behavioral healthcare, primary healthcare, or other services or supports they need; or that provide any of these services or supports.
10. **Criminal justice diversion programs.** Support pre-arrest or post-arrest diversion programs, or pre-trial service programs, that connect individuals involved or at risk of becoming involved in the criminal justice system to addiction treatment, recovery support, harm reduction services, primary healthcare, prevention, or other services or supports they need, or that provide any of these services or supports.
11. **Addiction treatment for incarcerated persons.** Support evidence-based addiction treatment, including Medication-Assisted Treatment with at least one FDA-approved opioid agonist, to persons who are incarcerated in jail or prison.
12. **Reentry Programs.** Support programs that connect incarcerated persons to addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need upon release from jail or prison, or that provide any of these services or supports.

EXHIBIT B TO NC MOA:

Additional Opioid Remediation Activities (“OPTION B” List)

This list shall be automatically updated to match the list of approved strategies in the most recent National Settlement Agreement.

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:¹

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration.
2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions.
3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.
4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.
5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.
6. Treatment of trauma for individuals with OUD (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.
7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

¹ As used in this Exhibit B, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs.

8. Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.
9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.
10. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.
11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.
12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.
13. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.
14. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in treatment for or recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.
2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.
3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.
4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved medication with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.
6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.
7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.
8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.
9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.
10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.
11. Training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.
12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.
13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.
14. Create and/or support recovery high schools.
15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

**C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED
(CONNECTIONS TO CARE)**

Provide connections to care for people who have – or at risk of developing – OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.
2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.
4. Purchase automated versions of SBIRT and support ongoing costs of the technology.
5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.
6. Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.
7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically-appropriate follow-up care through a bridge clinic or similar approach.
8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.
9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.
10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.
11. Expand warm hand-off services to transition to recovery services.
12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.
13. Develop and support best practices on addressing OUD in the workplace.
14. Support assistance programs for health care providers with OUD.
15. Engage non-profits and the faith community as a system to support outreach for treatment.
16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL-JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice

system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:
 - a. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);
 - b. Active outreach strategies such as the Drug Abuse Response Team (DART) model;
 - c. “Naloxone Plus” strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;
 - d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;
 - e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or
 - f. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.
2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.
3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.
4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.
5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison, have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.
6. Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.
7. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome (NAS), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.
2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.
3. Training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.
4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; expand long-term treatment and services for medical monitoring of NAS babies and their families.
5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.
6. Child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.
7. Enhanced family supports and child care services for parents with OUD and any co-occurring SUD/MH conditions.
8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.
9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including but not limited to parent skills training.
10. Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).
2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.
3. Continuing Medical Education (CME) on appropriate prescribing of opioids.
4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.
5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:
 - a. Increase the number of prescribers using PDMPs;
 - b. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or
 - c. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.
6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.
7. Increase electronic prescribing to prevent diversion or forgery.
8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund media campaigns to prevent opioid misuse.
2. Corrective advertising or affirmative public education campaigns based on evidence.
3. Public education relating to drug disposal.
4. Drug take-back disposal or destruction programs.
5. Fund community anti-drug coalitions that engage in drug prevention efforts.
6. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).
7. Engage non-profits and faith-based communities as systems to support prevention.
8. Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.
9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.
10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.
11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.
12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or other drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, individuals at high risk of overdose, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.
2. Public health entities that provide free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.
4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.
5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.
6. Public education relating to emergency responses to overdoses.
7. Public education relating to immunity and Good Samaritan laws.
8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.
9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.
10. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.
11. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.
12. Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.
13. Support screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in sections C, D, and H of this Exhibit relating to first responders, support the following:

1. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.
2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitation, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local, or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services; to support training and technical assistance; or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
2. A dashboard to share reports, recommendations, or plans to spend Opioid Settlement Funds; to show how Opioid Settlement Funds have been spent; to report program or strategy outcomes; or to track, share, or visualize key opioid-related or health-related indicators and supports as identified through collaborative statewide, regional, local, or community processes.
3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.
2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection, and evaluation of programs and strategies described in this opioid abatement strategy list.
2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.
4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.
5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.
6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7).
7. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.
8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.
9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

EXHIBIT C to NC MOA:

COLLABORATIVE STRATEGIC PLANNING PROCESS UNDER OPTION B

ACTIVITY NAME		ACTIVITY DETAIL	CONTENT OF REPORT & RECOMMENDATIONS
A	Engage diverse stakeholders	Engage diverse stakeholders, per "ITEM A DETAIL" below, throughout the collaborative strategic planning process	Report on stakeholder engagement per "ITEM A DETAIL" below
B	Designate facilitator	Designate a person or entity to facilitate the strategic collaborative planning process. Consider a trained, neutral facilitator.	Identify the facilitator
C	Build upon any related planning	Build upon or coordinate with prior or concurrent planning efforts that address addiction, drug misuse, overdose, or related issues, including but not limited to community health assessments.	Report any related planning efforts you will build upon or coordinate with
D	Agree on shared vision	Agree on a shared vision for positive community change, considering how strategic investments of Opioid Settlement Funds have the potential to improve community health and well-being and address root causes of addiction, drug misuse, overdose, and related issues	Report on shared vision for positive community change
E	Identify key indicator(s)	Identify one or more population-level measures to monitor in order to gauge progress towards the shared vision. (The NC Opioid Action Plan Data Dashboard contains several such measures.)	Report on the key indicators selected
F	Identify and explore root causes	Explore root causes of addiction, drug misuse, overdose, and related issues in the community, using quantitative data as well as stakeholder narratives, community voices, the stories of those with lived experience, or similar qualitative information	Report on root causes as described
G	Identify and evaluate potential strategies	Identify potential strategies to address root causes or other aspects of the opioid epidemic; identify these strategies (by letter or number) on EXHIBIT A or EXHIBIT B; and consider the effectiveness of each strategy based on available evidence	Identify and evaluate potential strategies
H	Identify gaps in existing efforts	For each potential strategy identified (or for favored strategies), survey existing programs, services, or supports that address the same or similar issues; and identify gaps or shortcomings	Report on survey of and gaps in existing efforts
I	Prioritize strategies	Prioritize strategies, taking into account your shared vision, analysis of root causes, evaluation of each strategy, and analysis of gaps in existing efforts	Report on prioritization of strategies
J	Identify goals, measures, and evaluation plan	For each strategy (or favored strategy), develop goals and an evaluation plan that includes at least one process measure (How much did you do?), at least one quality measure (How well did you do it?), and at least one outcome measure (Is anyone better off?)	Report on goals, measures, and evaluation plan for each chosen strategy
K	Consider ways to align strategies	For each potential strategy identified (or for favored strategies), consider opportunities to braid Opioid Settlement Funds with other funding streams; develop regional solutions; form strategic partnerships; or to pursue other creative solutions	Report on opportunities to align strategies as described
L	Identify organizations	Identify organizations and agencies with responsibility to implement each strategy; and identify the human, material, and capital resources to implement each strategy	Identify organizations and needs to implement each strategy

M	Develop budgets and timelines	Develop a detailed global budget for each strategy with anticipated expenditures, along with timelines for completing components of each strategy	Report budgets and timelines for each strategy
N	Offer recommendations	Offer recommendations to local governing body (e.g., the county board, city council, or other local governing body)	Report recommendations to governing body

ITEM A DETAIL: STAKEHOLDER INVOLVEMENT

STAKEHOLDERS		DESCRIPTION	CONTENT OF REPORT & RECOMMENDATIONS
A-1	Local officials	County and municipal officials, such as those with responsibility over public health, social services, and emergency services	Report stakeholder involvement (who and how involved in process)
A-2	Healthcare providers	Hospitals and health systems, addiction professionals and other providers of behavioral health services, medical professionals, pharmacists, community health centers, medical safety net providers, and other healthcare providers	same as above
A-3	Social service providers	Providers of human services, social services, housing services, and community health services such as harm reduction, peer support, and recovery support services	same
A-4	Education and employment service providers	Educators, such as representatives of K-12 schools, community colleges, and universities; and those providing vocational education, job skills training, or related employment services	same
A-5	Payers and funders	Health care payers and funders, such as managed care organizations, prepaid health plans, LME-MCOs, private insurers, and foundations	same
A-6	Law enforcement	Law enforcement and corrections officials	same
A-7	Employers	Employers and business leaders	same
A-8	Community groups	Community groups, such as faith communities, community coalitions that address drug misuse, groups supporting people in recovery, youth leadership organizations, and grassroots community organizations	same
A-9	Stakeholders with "lived experience"	Stakeholders with "lived experience," such as people with addiction, people who use drugs, people in medication-assisted or other treatment, people in recovery, people with criminal justice involvement, and family members or loved ones of the individuals just listed	same
A-10	Stakeholders reflecting diversity of community	Stakeholders who represent the racial, ethnic, economic, and cultural diversity of the community, such as people of color, Native Americans, members of the LGBTQ community, and members of traditionally unrepresented or underrepresented groups	same

EXHIBIT D TO NC MOA: COORDINATION GROUP

COMPOSITION

The Coordination Group shall consist of the following twelve members:

Five Local Government Representatives

- Four appointed by the North Carolina Association of County Commissioners including:
 - One county commissioner
 - One county manager
 - One county attorney
 - One county local health director or consolidated human services director
- One municipal manager appointed by the North Carolina League of Municipalities

Four Experts Appointed by the Department of Health and Human Services

- Four appointed by the Secretary of the Department of Health and Human Services, having relevant experience or expertise with programs or policies to address the opioid epidemic, or with behavioral health, public health, health care, harm reduction, social services, or emergency services.

One Expert Appointed by the Attorney General

- One appointed by the Attorney General of North Carolina from the North Carolina Department of Justice or another state agency, having drug policy or behavioral health experience or expertise.

Two Experts Appointed by Legislative Leaders

- One representative from the University of North Carolina School of Government with relevant expertise appointed by the Speaker of the North Carolina House of Representatives.
- One representative from the board or staff of the North Carolina Institute of Medicine with relevant expertise appointed by the President Pro Tem of the North Carolina Senate.

The coordination group may appoint a non-voting administrator to convene meetings and facilitate the work of the coordination group. The administrator will not be paid from the Opioid Settlement Funds distributed under this MOA.

Appointees shall have relevant experience or expertise with programs or policies to address the opioid epidemic, behavioral health, public health, health care, social services, emergency services, harm reduction, management of local government, or other relevant areas.

Those responsible for making appointments to the coordination group are encouraged to appoint individuals who reflect the diversity of North Carolina, taking into consideration the need for geographic diversity; urban and rural perspectives; representation of people of color and

traditionally underrepresented groups; and the experience and perspective of persons with “lived experience.” Those responsible for making appointments may appoint a successor or replace a member at any time. Members of the coordination group serve until they resign or are replaced by the appointer. Eight members of the coordination group constitutes a quorum.

RESPONSIBILITIES

- a. As provided in **Section F.2** of the MOA, where no compliance audit would be required under the Federal Single Audit Act of 1984 for expenditures of Opioid Settlement Funds, a compliance audit shall be required under a compliance supplement established by a vote of at least 8 members of the coordination group. The compliance supplement shall address, at least, procedures for determining:
 - i. Whether the Local Government followed the procedural requirements of the MOA in ordering the expenditures.
 - ii. Whether the Local Government’s expenditures matched one of the types of opioid-related expenditures listed in **Exhibit A** of the MOA (if the Local Government selected Option A) or **Exhibit B** of the MOA (if the Local Government selected Option B).
 - iii. Whether the Local Government followed the reporting requirements in the MOA.
 - iv. Whether the Local Government (or sub-recipient of any grant or loan, if applicable) utilized the awarded funds for their stated purpose, consistent with this MOA and other relevant standards.
 - v. Which processes (such as sampling) shall be used:
 - i. To keep the costs of the audit at reasonable levels; and
 - ii. Tailor audit requirements for differing levels of expenditures among different counties.
- b. The coordination group may, by a vote of at least 8 members, propose amendments to the MOA as discussed in **Section H** of the MOA or modify any of the following:
 - i. The high-impact strategies discussed in **Section E.5** of the MOA and described in **Exhibit A** to the MOA;
 - ii. The collaborative strategic planning process discussed in **Section E.5** of the MOA and described in **Exhibit C** to the MOA;
 - iii. The annual financial report discussed in **Section F.4** of the MOA and described in **Exhibit E** to the MOA;
 - iv. The impact information discussed in **Section F.4** of the MOA and described in **Exhibit F** to the MOA; or
 - v. Other information reported to the statewide opioid dashboard.

- c. The coordination group may, by consensus or by vote of a majority of members present and voting, work with the parties to this MOA, the North Carolina Association of County Commissioners, the North Carolina League of Municipalities, other associations, foundations, non-profits, and other government or nongovernment entities to provide support to Local Governments in their efforts to effectuate the goals and implement the terms of this MOA. Among other activities, the coordination group may coordinate, facilitate, support, or participate in any of the following activities:
- i. Providing assistance to Local Governments in identifying, locating, collecting, analyzing, or reporting data used to help address the opioid epidemic or related challenges, including data referred to in **Exhibit F**;
 - ii. Developing resources or providing training or technical assistance to support Local Governments in addressing the opioid epidemic and carrying out the terms of this MOA;
 - iii. Developing pilot programs, trained facilitators, or other resources to support the collaborative strategic planning process described in this MOA;
 - iv. Developing and implementing a voluntary learning collaborative among Local Governments and others to share best practices in carrying out the terms of this MOA and addressing the opioid epidemic, including in-person or virtual convenings or connections;
 - v. Developing voluntary leadership training programs for local officials on strategies to address the opioid epidemic, opportunities for Local Governments to harness the ongoing transition to value-based healthcare, and other relevant topics;
 - vi. Taking other actions that support Local Governments in their efforts to effectuate the goals and implement the terms of this MOA but do not in any way change the terms of this MOA or the rights or obligations of parties to this MOA.

EXHIBIT E TO NC MOA: ANNUAL FINANCIAL REPORT

NOTE: The Exhibit E Annual Financial Report was modified by the NC MOA Coordination Group on July 12, 2023 pursuant to the authority stated in MOA Exhibit D.

Local governments subject to this MOA are required to comply with the modified Exhibit E Annual Financial Report, starting with the Fiscal Year 2022-2023 report that is due no later than September 27, 2023.

To view the modified Exhibit E Annual Financial Report, visit <https://www.morepowerfulnc.org/>, click on Opioid Settlements / NC Memorandum of Agreement, and scroll down to “Exhibit E Annual Financial Report (as modified by the NC MOA Coordination Group on July 12, 2023).”

To learn more about the NC MOA Coordination Group, visit <https://www.morepowerfulnc.org/> and click on Opioid Settlements / NC MOA Coordination Group.

Any questions may be addressed to NC DOJ at opiodsettlement@ncdoj.gov.

EXHIBIT F TO NC MOA: IMPACT INFORMATION

NOTE: The Exhibit F Annual Impact Report was modified by the NC MOA Coordination Group on June 21, 2023 pursuant to the authority stated in MOA Exhibit D.

Local governments subject to this MOA are required to comply with the modified Exhibit F Annual Impact Report, starting with the Fiscal Year 2022-2023 report that is due no later than September 27, 2023.

To view the modified Exhibit F Annual Impact Report, visit <https://www.morepowerfulnc.org/>, click on Opioid Settlements / NC Memorandum of Agreement, and scroll down to “Exhibit F Annual Impact Report (as modified by the NC MOA Coordination Group on June 21, 2023).”

To learn more about the NC MOA Coordination Group, visit <https://www.morepowerfulnc.org/> and click on Opioid Settlements / NC MOA Coordination Group.

Any questions may be addressed to NC DOJ at opioidsettlement@ncdoj.gov.

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**EXHIBIT G TO NC MOA:
LOCAL GOVERNMENT ALLOCATION PROPORTIONS**

Counties:

Alamance	1.378028967612490%
Alexander	0.510007879580514%
Alleghany	0.149090598929352%
Anson	0.182192960366522%
Ashe	0.338639188321974%
Avery	0.265996766935006%
Beaufort	0.477888434887858%
Bertie	0.139468575095652%
Bladen	0.429217809476617%
Brunswick	2.113238507591200%
Buncombe	2.511587857322730%
Burke	2.090196827047270%
Cabarrus	1.669573446626000%
Caldwell	1.276301146194650%
Camden	0.073036400412663%
Carteret	1.128465593852300%
Caswell	0.172920237524674%
Catawba	2.072695222699690%
Chatham	0.449814383077585%
Cherokee	0.782759152904478%
Chowan	0.113705596126821%
Clay	0.224429948904576%
Cleveland	1.119928027749120%
Columbus	1.220936938986050%
Craven	1.336860190247190%
Cumberland	2.637299659634610%
Currituck	0.186778551294444%
Dare	0.533126731273811%
Davidson	1.940269530393250%
Davie	0.513147526867745%
Duplin	0.382785147396895%
Durham	1.797994362444460%
Edgecombe	0.417101939026669%
Forsyth	3.068450809484740%
Franklin	0.500503643290578%
Gaston	3.098173886907710%
Gates	0.079567516632414%
Graham	0.183484561708488%
Granville	0.590103409340146%

Greene	0.123274818647799%
Guilford	3.375015231147900%
Halifax	0.453161173976264%
Harnett	0.988980772198890%
Haywood	0.803315110111045%
Henderson	1.381595087040930%
Hertford	0.206843050128754%
Hoke	0.332485804570157%
Hyde	0.027237354085603%
Iredell	2.115931374540020%
Jackson	0.507757731330674%
Johnston	1.250887468217670%
Jones	0.087966986994631%
Lee	0.653115683614534%
Lenoir	0.604282592625687%
Lincoln	0.926833627125253%
Macon	0.466767666100745%
Madison	0.237776496104888%
Martin	0.232882220579515%
McDowell	0.587544576492856%
Mecklenburg	5.038301259920550%
Mitchell	0.309314151564137%
Montgomery	0.226050543041193%
Moore	0.971739112775481%
Nash	0.845653639635102%
New Hanover	2.897264892001010%
Northampton	0.120996238921878%
Onslow	1.644001364710850%
Orange	1.055839419023090%
Pamlico	0.119936151028001%
Pasquotank	0.374816210815334%
Pender	0.585749331860312%
Perquimans	0.111833180344914%
Person	0.403024296727131%
Pitt	1.369008066415930%
Polk	0.266142985954851%
Randolph	1.525433986174180%
Richmond	0.749132839979529%
Robeson	1.359735343574080%
Rockingham	1.365368837477560%
Rowan	2.335219287913370%
Rutherford	0.928941617994687%
Sampson	0.619513740526226%
Scotland	0.449148274209402%

Stanly	0.724974208589555%
Stokes	0.623953112434303%
Surry	1.410826706091650%
Swain	0.281162928604502%
Transylvania	0.497595509451435%
Tyrrell	0.041440907207785%
Union	1.466702679869700%
Vance	0.536258255282162%
Wake	4.902455667205510%
Warren	0.106390583495122%
Washington	0.074770720453604%
Watauga	0.469675799939888%
Wayne	0.970699333078804%
Wilkes	1.997177160589100%
Wilson	0.646470841490459%
Yadkin	0.562147145073638%
Yancey	0.382114976889272%

Municipalities:

Asheville	0.235814724255298%
Canton	0.011453823221205%
Cary	0.144151645370137%
Charlotte	1.247483814366830%
Concord	0.227455870287483%
Durham	0.380405026684971%
Fayetteville	0.309769055181433%
Gastonia	0.257763823789835%
Greensboro	0.527391696384329%
Greenville	0.162656474659432%
Henderson	0.032253478794181%
Hickory	0.094875835682315%
High Point	0.206428762905859%
Jacksonville	0.095009869783840%
Raleigh	0.566724612722679%
Wilmington	0.119497493968465%
Winston-Salem	0.494459923803644%

Appendix B

The Local Prioritization Planning Model Chart published by the Surry County Office of Substance Abuse Recovery provides for recommended program priorities, community readiness for change, connection to the North Carolina Opioid Action Plan 3.0 and the North Carolina MOA for Opioid Litigation Settlement supporting Option A and Option B.

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Version: 02/07/2022