fellowship hall

Alcohol & Addiction Treatment

# 2026 COMMUNITY HEALTH NEEDS ASSESSMENT

*Substance Use, Behavioral Health, Treatment Access, and Recovery in Guilford County*

September 2026

# Acknowledgements

Fellowship Hall thanks the community members, family members, healthcare professionals, behavioral health professionals, substance use treatment providers, public health professionals, social service providers, and nonprofit and community representatives who contributed their perspectives. The assessment was developed to support organizational learning, community partnership, and practical action across the treatment and recovery continuum.

# Statement from Fellowship Hall Leadership

Substance use disorder does not occur in a vacuum. The ability to enter treatment and sustain recovery is shaped by mental and physical health, housing, transportation, economic stability, family relationships, community support, and access to appropriate care. Fellowship Hall undertook this assessment to listen more intentionally, identify barriers and service gaps, and strengthen collaboration. These findings will aid us in understanding our community better and therefore serving the community better.

Fellowship Hall Leadership

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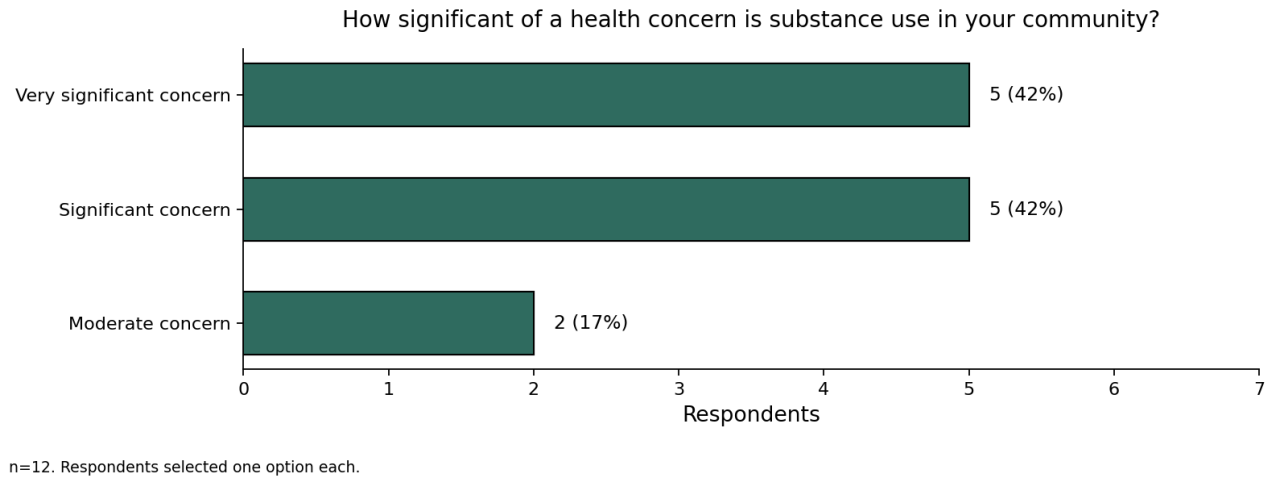
# Executive Summary

Fellowship Hall conducted this Community Health Needs Assessment to better understand substance use, treatment barriers, behavioral health needs, overdose prevention, recovery supports, social determinants, stigma, and community coordination. The report incorporates 12 anonymous stakeholder responses collected in September 2026.

10 of 12 respondents (83.3%) rated substance use as a significant or very significant health concern. 10 of 12 (83.3%) rated co-occurring mental health conditions as very or extremely significant, and 11 of 12 (91.7%) rated stigma as very or extremely significant.




n=12. Respondents selected one option each.

**Figure 1. Stakeholder assessment of substance use as a community health concern.**

## Adopted CHNA Priority Framework

- Treatment access and navigation
- Recovery continuum and housing
- Integrated behavioral healthcare
- Social drivers of recovery
- Stigma reduction and overdose prevention

The priorities are based on stakeholder evidence and are intended as a practical planning framework. They should be reviewed annually as new response, service-utilization, and community health data become available.

# 1. Understanding Substance Use and Recovery Through a Health-Equity Lens

Substance use disorder is a health condition whose outcomes are shaped by access to care and by the conditions in which people live. This assessment applies a health-equity lens by examining barriers related to insurance, affordability, housing, transportation, employment, geography, family responsibilities, justice involvement, mental health, and stigma.

Equity in this report means reducing avoidable differences in the ability to obtain timely treatment, receive integrated care, transition safely between levels of care, and sustain recovery. The recommended measures therefore include both clinical access and social stability.

# 2. Community and Service-Area Profile

The stakeholder-defined service community is Guilford County, with specific references to Greensboro, High Point, southeast Greensboro, and northwest Greensboro. One response described a suburban or mid-sized-city context. The assessment therefore uses Guilford County as its primary planning geography while recognizing that Fellowship Hall may serve people from a wider region.

The community profile is intentionally bound to evidence available in this assessment. The report identifies the local conditions stakeholders identified as most important: housing instability, transportation, insurance, low income, unemployment, behavioral-health access, and geographic access to services. Future annual updates should add current county indicators from verified public sources and Fellowship Hall for patient-origin data.

## Guilford County Data (Latest Available as of September 2026)

The table below presents the most recent publicly available county data as of September 2026, including 2025 U.S. Census Bureau population and small-area estimates, 2020–2024 American Community Survey (ACS) 5-year estimates, Bureau of Labor Statistics Local Area Unemployment Statistics, and selected 2023–2024 Guilford County CHA figures where newer county-level data were not available. Reporting periods are identified for each measure because the figures should not be treated as if they describe the same year. Race and ethnicity percentages may overlap because Hispanic or Latino origin is reported separately from race. None of these figures are derived from Fellowship Hall's 12 stakeholder responses and should not be averaged or combined with stakeholder percentages.

| Indicator | Guilford County value |
|---|---|
| Total population | 562,234 (July 1, 2025 estimate; 3rd-largest county in NC); up 3.9% from the 2020 Census base of 541,254 |
| Principal cities | Greensboro and High Point, plus Gibsonville, Jamestown, Oak Ridge, Pleasant Garden, Stokesdale, Summerfield, and Whitsett |
| Urban / rural residence | 86% urban; 14.2% rural (about 76,000 residents), based on the 2020 Census; no more recent county-level breakdown published |
| Median age | 37.5 years (2020–2024 ACS 5-year estimate) |
| Race / ethnicity | 52.7% White alone, 35.2% Black/African American alone, 11.1% Hispanic/Latino, 6.2% Asian alone, 4.6% two or more races (2025 Census Bureau population estimates) |
| Median household income | $68,642 (2020–2024 ACS 5-year estimate, in 2024 dollars) |
| Population below 100% of Federal Poverty Level | 13.5% (2025 Small Area Income and Poverty Estimates) |
| Population below 200% of Federal Poverty Level | 30.9% (Healthy NC 2030 target: 27%), from the 2023–2024 CHA; a more recent county-level figure has not yet been published |
| Uninsured, under age 65 | 10.1% (2025 Small Area Health Insurance Estimates), down from 11.5% reported in the 2023–2024 CHA |
| Unemployment rate | 4.2% (September 2025, not seasonally adjusted; up about 0.4 percentage points from a year earlier). Racial breakdown not yet updated beyond the CHA's 2018–2022 average (7.2% Black, 3.9% White, 3.3% Hispanic) |

Geographic distribution matters for a service-area profile like this one: the CHA documents substantial variation by census tract, with parts of Southeast Greensboro and Central High Point showing higher concentrations of Black residents, lower homeownership, and higher social vulnerability than Northwest Greensboro and rural areas of the county. This is directly relevant to the stakeholder references to Greensboro, High Point, and northwest Greensboro in Section 2 above, and should inform how Fellowship Hall targets outreach and navigation resources across the county.

**Note: The Census Bureau cautions that different vintages of population and ACS estimates are not directly comparable, so year-over-year comparisons above should be read as directional rather than precise.**

**Sources: U.S. Census Bureau, QuickFacts and Small Area Income, Poverty, and Health Insurance Estimates (2025 vintage; 2020–2024 ACS 5-year estimates); U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics (September 2025); Guilford County Division of Public Health, 2023–2024 Guilford County Community Health Assessment (for indicators not yet updated).**

# 3. Assessment, Methodology, and Limitations

The assessment used a 30-question anonymous Microsoft Forms survey. 12 responses were available for analysis, matching the form total of 12. Questions included single-choice, multiple-choice, and open-text items.

Counts and percentages use the number of respondents who answered each question. Multiple-choice percentages can exceed 100%. Open-text responses were reviewed for recurring service needs and illustrative quotations.

This is a stakeholder listening assessment, not a prevalence study. Limitations include the small, nonprobability sample, uneven stakeholder representation, perception-based measures, missing answers, and no independent validation of community-resource availability. Findings are therefore presented as directional evidence for planning.

# 4. Fellowship Hall Patient Data (FY2025)

Fellowship Hall's own guest population is one of the strongest sources of local evidence available for this assessment: it reflects people who actually entered treatment, not stakeholder perception. The figures below are aggregated, de-identified data drawn from Fellowship Hall's FY2025 Impact Report (October 1, 2024-September 30, 2025), covering 708 guests served across all programs. They are presented alongside, not combined with, the stakeholder survey findings and Guilford County Data elsewhere in this report.

## Patient Origin

Fellowship Hall's FY2025 Impact Report tracks guest origin at the state level only.

| State | Share of Guests |
|---|---|
| North Carolina | 93% |
| Virginia | 2.6% |
| South Carolina | 1.9% |
| West Virginia | 0.7% |
| All other states combined | 3.7% |

### County-Level Discharge Geography

A separate FY2025 discharge extract provides county-level geography for 720 discharge records from October 1, 2024 through September 30, 2025. North Carolina accounted for 670 records (93.1%). The five highest-volume counties were Guilford, Wake, Forsyth, Mecklenburg, and Alamance. Together, those counties represented 363 records (50.4% of all discharge records). These figures describe discharge records and should not be interpreted as unique guests or combined with the FY2025 Impact Report's 708 guests served.

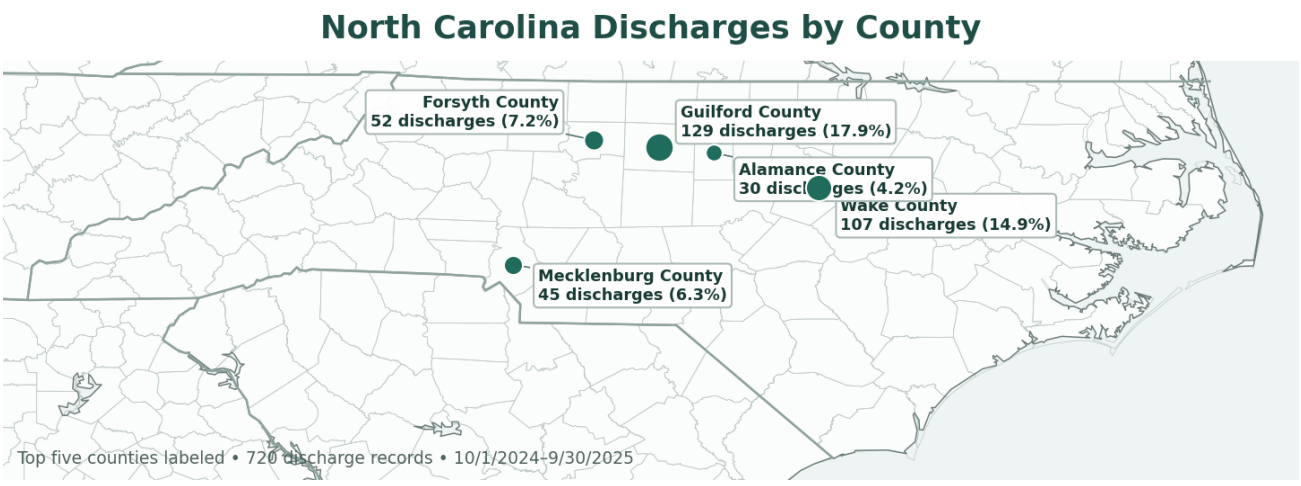



*Figure 2. Geographic distribution of FY2025 discharge records, with the five highest-volume counties labeled.*

| County | Discharge records | Share of all discharge records |
|---|---|---|
| Guilford County | 129 | 17.9% |
| Wake County | 107 | 14.9% |

| | | |
|---|---|---|
| Forsyth County | 52 | 7.2% |
| Mecklenburg County | 45 | 6.3% |
| Alamance County | 30 | 4.2% |

*Source: Fellowship Hall discharge extract, October 1, 2024–September 30, 2025. Percentages use all 720 discharge records as the denominator. County totals represent discharge records rather than unique guests.*

The county-level discharge extract supplements the state-level FY2025 Impact Report by showing where discharge records originated. Because the extract counts discharge records rather than unique guests, the two sources are presented separately and should not be combined.

**Source: Fellowship Hall, FY2025 Impact Report (October 1, 2024 – September 30, 2025); n=708 guests served across all programs. Figures are aggregated and de-identified.**

## Payer Mix

Fellowship Hall's FY2025 payer mix shows that the top five payors accounted for 90.0% of revenue, with all remaining payors grouped together for reporting clarity.

| Payor | Percent of revenue |
|---|---|
| BCBS NC | 38.6% |
| AETNA | 16.8% |
| Self-Pay | 15.4% |
| OPTUM UHC | 11.2% |
| CIGNA | 8.0% |

**Note: Top five payors are shown individually; all remaining payors are grouped together as All other payors. Percentages are based on percent of revenue and may not total exactly 100% due to rounding and negative adjustments in the source data.**

## Primary Substance at Admission and Co-occurring Diagnoses

| Primary Diagnosis at Admission | Share of Guests |
|---|---|
| Alcohol | 80% |
| Opioids | 8% |
| Other | 8% |
| Stimulants | 4% |

93% of Fellowship Hall guests had a co-occurring mental health diagnosis alongside their substance use disorder, directly corroborating stakeholders' emphasis on integrated, whole-person behavioral healthcare (Sections 6 and 8).

**Source: Fellowship Hall, FY2025 Impact Report (October 1, 2024 – September 30, 2025); n=708 guests served across all programs. Figures are aggregated and de-identified.**

### Patient Demographics

| Age Group | Share of Guests |
|---|---|
| 25–44 | 49% |
| 45–64 | 39% |
| 18–24 | 8% |
| 65+ | 4% |
| **Gender** | **Share of Guests** |
| Male | 70% |
| Female | 30% |
| **Household Income** | **Share of Guests** |
| $20,000 or less | 20% |
| $21,000–$40,000 | 15% |
| $41,000–$60,000 | 19% |
| $61,000–$90,000 | 24% |
| $90,000+ | 20% |
| Unknown | 2% |

55% of guests reported household income at or below $60,000, and men ages 25-64 made up 88% of guests, patterns consistent with stakeholders' emphasis on cost, insurance, and employment as barriers to treatment (Section 6).

**Source: Fellowship Hall, FY2025 Impact Report (October 1, 2024 – September 30, 2025); n=708 guests served across all programs. Figures are aggregated and de-identified.**

## Why This Corroborates Stakeholder Findings

Taken together, this patient-level evidence substantiates several stakeholder-identified priorities elsewhere in this report: the high rate of co-occurring mental health conditions, the concentration of guests in lower income brackets, and the predominance of guests in their prime working years align closely with the access, insurance, and behavioral-health findings described above. Two gaps remain for future updates: county/ZIP-level patient origin and payer mix. Both would meaningfully strengthen the connection between Fellowship Hall's own population and the countywide social-determinant findings in this report.

# 5. Social Determinants Affecting Treatment and Recovery

## Why This Matters

Recovery occurs within daily living conditions. Stakeholders connected treatment and recovery with housing, healthcare access, employment, transportation, financial stability, food, family support, and recovery support. Eleven of the 12 survey participants answered this multiple-selection question, and respondents could select every option that applied. The counts therefore total more than the number of people who answered and should not be interpreted as a single-choice ranking.

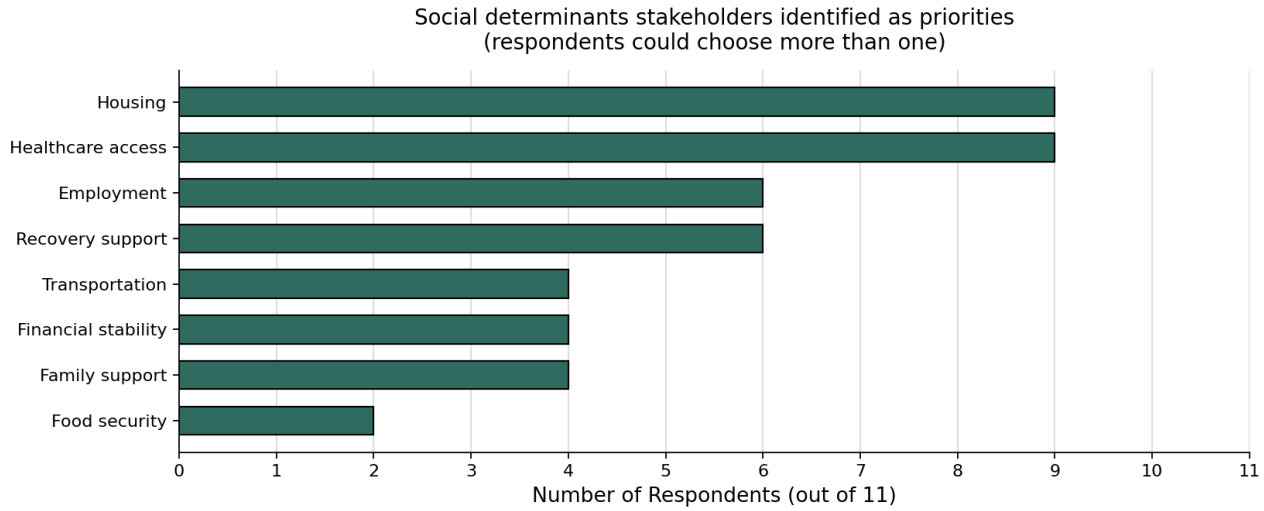



*Figure 3. Social determinants affecting treatment and recovery selected by stakeholders.*

| Response option | Respondents selecting (of 12) |
|---|---|
| Housing | 9 |
| Healthcare access | 9 |
| Employment | 6 |
| Recovery support | 6 |
| Transportation | 4 |
| Financial stability | 4 |
| Family support | 4 |
| Food security | 2 |

**Note: n=11. Respondents could select more than one social determinant, so counts add to more than 11.**

# What the Data Show

Housing and healthcare access were the most frequently selected social determinants, each identified by 9 respondents, followed by employment and recovery support with 6 each. Transportation, financial stability, and family support were each selected by 4 respondents, and food security by 2. The pattern indicates that stakeholders view recovery as dependent on both access to care and the social conditions needed to sustain it. Because respondents could select multiple options, the results show overlapping priorities rather than the prevalence of these conditions in Guilford County.

# From Findings to Action

- Formalize housing and recovery-housing navigation.
- Embed healthcare access, transportation, benefits, employment, food, and family support referrals into care planning.
- Monitor stable housing and completed social-service connections.

## Guilford County Data

County-level data reinforce and quantify the social determinants stakeholders raised in the survey:

| Domain | Guilford County indicator |
|---|---|
| Housing cost burden | 13% of households spend 50%+ of income on housing; 32% (about 65,211 households) are cost-burdened at 30%+ |
| Rent | Fair market rent: $1,170/month; up 13% in the past year and 52% over five years (2019–2024) |
| Homelessness | 641 people counted in the 2024 Point-in-Time Count (350 in emergency shelter, 50 in transitional housing, 5 in a safe haven, about 230 unsheltered), up from 452 in 2023; the 2023 count also found 108 chronically homeless, 70% Black/African American |
| Transportation | 23.6% of 2023 GCCH Survey respondents reported a transportation issue in the past year (vehicle cost/repairs, no vehicle, inconvenient or unfamiliar public transit, lack of sidewalks) |
| Health insurance | 10.1% of Guilford County residents under 65 were uninsured as of the 2025 Small Area Health Insurance Estimates (Healthy NC 2030 target: 8%), down from 11.5% in 2022 |
| Employment | 4.2% county unemployment rate (September 2025, BLS, not seasonally adjusted), up from 3.9% in 2023; racial breakdown not yet updated beyond the 2023 disparity ratio of 1.8 |
| Childcare costs | Households spend an average of 32% of income on childcare for two children (about $19,338/year) |

**Sources: Guilford County Continuum of Care, 2024 Point-in-Time Count; U.S. Census Bureau, Small Area Health Insurance Estimates (2025 vintage); U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics (September 2025); Guilford County Division of Public Health, 2023–2024 Guilford County Community Health Assessment (for indicators not yet updated).**

# 6. Access to Treatment

## Why This Matters

Treatment must be available, affordable, understandable, and reachable when a person is ready for help. Lack of insurance was the most frequently selected barrier, identified by 11 of 12 respondents. Stigma was selected by 8 respondents; lack of knowledge about available services, transportation, fear of seeking treatment, family responsibilities, and treatment cost were each selected by 7; and housing instability or homelessness was selected by 6. One respondent separately identified limited insurance coverage and gatekeeping tied to enablement, codependency, or entitlement dynamics as additional barriers to treatment. Because respondents could choose more than one barrier, these counts describe overlapping concerns rather than mutually exclusive groups.

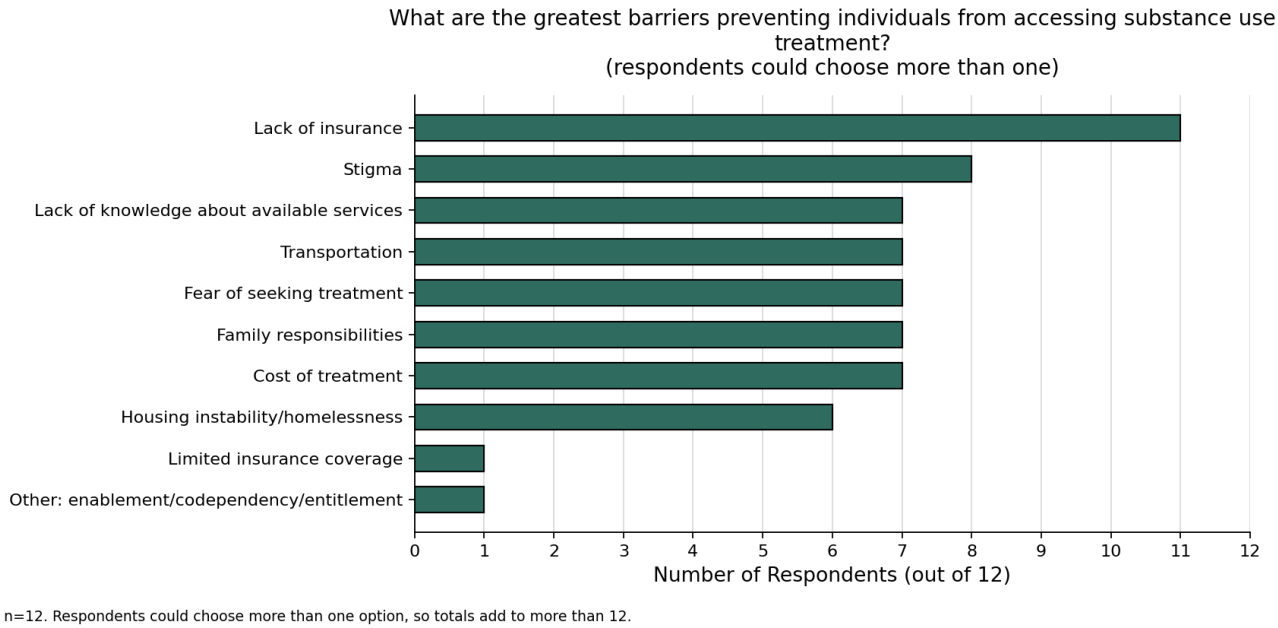



*Figure 4. Barriers affecting access to substance use treatment selected by stakeholders.*

| Tier | Response option | Respondents |
|---|---|---|
| **Near-universal (11 of 12)** | Lack of insurance | 11 |
| **Strong majority (8 of 12)** | Stigma | 8 |
| **About 60% (7 of 12)** | Lack of knowledge about available services | 7 |
| | Transportation | 7 |
| | Fear of seeking treatment | 7 |
| | Family responsibilities | 7 |
| | Cost of treatment | 7 |
| **About half (6 of 12)** | Housing instability/homelessness | 6 |
| **Emerging concern (1 of 12)** | Limited insurance coverage | 1 |

| | | |
|---|---|---|
| | Other: enablement/codependency/entitlement dynamics | 1 |

**Note: n=12. Respondents could choose more than one option, so counts add to more than 12.**

# What the Data Show

The chart shows that access barriers are layered. Lack of insurance was selected by 11 of 12 respondents, making it the most widely identified obstacle. Stigma followed with 8 selections, while lack of knowledge about services, transportation, fear of seeking treatment, family responsibilities, and treatment cost each received 7. Housing instability or homelessness was selected by 6 respondents, and one respondent separately raised limited insurance coverage and enablement/codependency/entitlement dynamics as additional gatekeeping barriers. The clustering of these results indicates that improving access will require coordinated insurance, navigation, transportation, housing, affordability, and stigma-reduction strategies rather than a single intervention.

# From Findings to Action

- Develop rapid-access pathways.
- Strengthen insurance and benefits enrollment, service navigation, transportation assistance, housing referrals, affordability supports, and planning for family responsibilities.
- Standardize warm handoffs across levels of care.

## Guilford County Data

The CHA's access-to-care chapter documents the structural barriers behind stakeholders' top-ranked concern, lack of insurance:

| Indicator | Guilford County value |
|---|---|
| Uninsured, under age 65 | 10.1% (2025 Small Area Health Insurance Estimates; Healthy NC 2030 target: 8%), down from 11.5% in 2022 |
| Uninsured by race/ethnicity | White 4.3%; Black 7.1%; Hispanic 25.3% |
| Primary care physician ratio | 1 physician per 1,260 residents (2020) |
| Mental health provider ratio | 1 provider per 310 residents (2022) |
| Dentist ratio | 1 dentist per 1,650 residents |
| Medical debt in collections | 7% of Guilford households (vs. 5% nationally); 10% of non-White households vs. 6% of White households |
| Reported any barrier to care (2023 GCCH Survey) | 29.6%; most common barriers were appointment availability, provider not in-network, no insurance, and cost |

The CHA also notes that parts of Guilford County are federally designated Health Professional Shortage Areas for primary care, dental, and mental health providers, which is consistent with stakeholders' emphasis on geographic access, especially for High Point residents.

**Source: Guilford County Division of Public Health, 2023–2024 Guilford County Community Health Assessment; U.S. Census Bureau, Small Area Health Insurance Estimates (2025 vintage, for the uninsured rate above).**

# 7. Substance Use and Overdose

## Why This Matters

Stakeholders described overlapping concerns involving alcohol, opioids and fentanyl, polysubstance use, stimulants, cannabis, prescription drugs, and emerging substances. Open-text responses also referenced kratom, 7-OH, new psychoactive substances, xylazine, and medetomidine. Respondents could choose more than one substance, so the chart below shows how many of the 12 respondents selected each option.

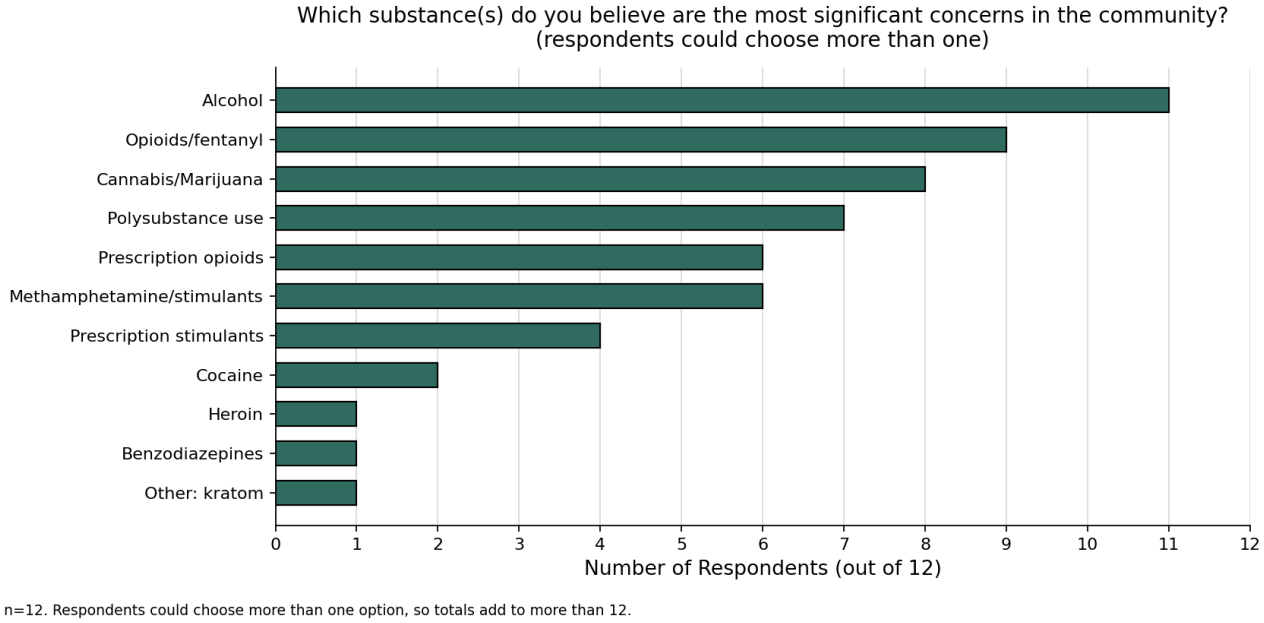



*Figure 5. Substances of greatest community concern selected by stakeholders.*

| Response option | Respondents selecting (of 12) |
|---|---|
| Alcohol | 11 |
| Opioids/fentanyl | 9 |
| Cannabis/Marijuana | 8 |
| Polysubstance use | 7 |
| Prescription opioids | 6 |
| Methamphetamine/stimulants | 6 |
| Prescription stimulants | 4 |
| Cocaine | 2 |
| Heroin | 1 |
| Benzodiazepines | 1 |
| Other: kratom (write-in) | 1 |

**Note: n=12. Respondents could choose more than one option, so counts add to more than 12.**

# What the Data Show

Alcohol was the most frequently selected substance of concern, identified by 11 of 12 respondents. Opioids or fentanyl followed with 9 selections, cannabis or marijuana with 8, and polysubstance use with 7. Prescription opioids and methamphetamine or other stimulants were each selected by 6 respondents, and prescription stimulants by 4. Cocaine was selected by 2 respondents, and heroin, benzodiazepines, and an open-text mention of kratom were each selected by 1. These responses support a broad substance-use and overdose strategy, but they represent stakeholder perceptions and should not be interpreted as estimates of local substance-use prevalence.

# From Findings to Action

- Use a broad prevention strategy that addresses alcohol, opioids and fentanyl, cannabis, polysubstance use, stimulants, prescription drugs, and emerging substances rather than relying on a single-substance approach.
- Expand naloxone and overdose-prevention education, fentanyl and emerging-substance awareness, MOUD information, peer support, and post-overdose referral.
- Review local overdose and drug-supply data at least annually.

## Guilford County Data

Drug overdose deaths increased from 53 in 2012 to a peak of 249 in 2021, then declined to 238 in 2023 and an estimated 213 in 2024. During the later portion of this period, settlement-funded harm-reduction and treatment initiatives expanded. The available figures show that these developments occurred concurrently; they do not by themselves establish that the program expansion caused the decline.

| Indicator | Guilford County value |
|---|---|
| Drug overdose deaths, 2012 vs. 2021 | 53 deaths (2012) rose to a peak of 249 (2021), then declined to 238 (2023, all-intent) and an estimated 213 in 2024 (rate 38.7 per 100,000) as settlement-funded harm reduction programs expanded |
| Opioid overdose mortality vs. NC | Higher than the state average every year since 2018 |
| 2023 overdose mortality by sex | Men: 62.9 per 100,000 (165 deaths); women: 25.1 per 100,000 (73 deaths), down from 69.6/24.6 in 2021 |
| 2023 overdose mortality by race | White: 42.8 per 100,000 (128 deaths); Black: 46.3 per 100,000 (93 deaths). The racial gap has narrowed and reversed since 2021 (62.2 vs. 41.2) |
| Age pattern | Highest among ages 25–44; also elevated among ages 45–64 |
| County ranking (2018–2022) | 2nd-highest poisoning mortality rate among peer counties, behind Forsyth County |
| Binge drinking, past 30 days (2023 GCCH Survey) | 21.2% of respondents |
| Tobacco/nicotine use, past 30 days (2023 GCCH Survey) | 22.2% of respondents |

Opioid settlement funds are a significant, time-limited resource for the priorities in this section: Guilford County is scheduled to receive $40,750,701, the City of High Point $6,367,847, and the City of Greensboro $2,492,468 over 2022–2038. As of the county's third annual settlement stakeholder session (June 2025), local settlement-funded

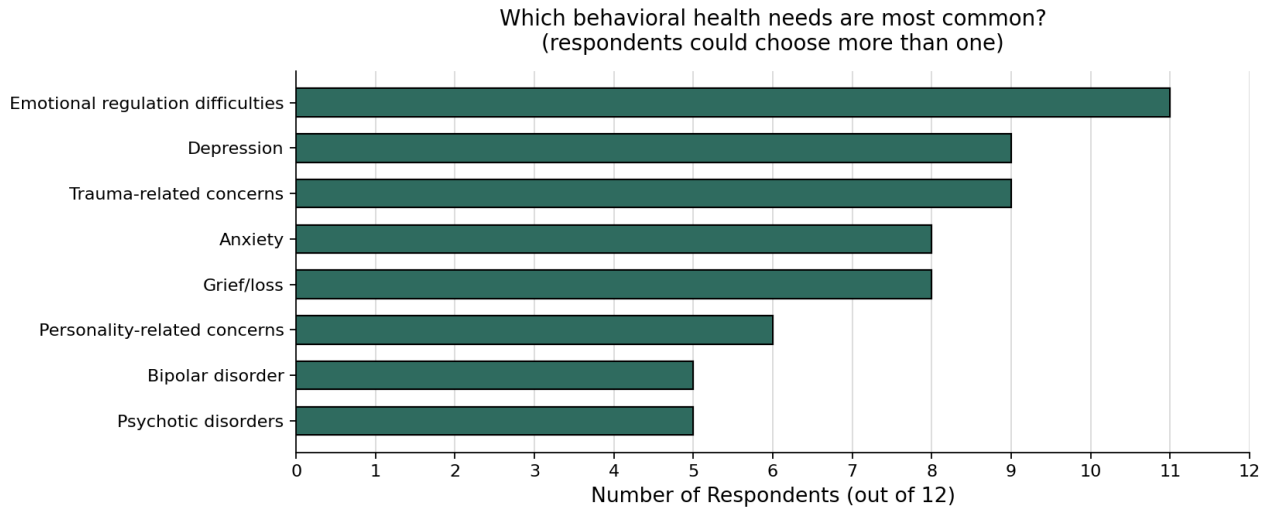
initiatives underway include the Guilford Overdose Prevention and Education Collective (GOPEC), which trained 2,144 participants in harm reduction, overdose prevention, and naloxone use; naloxone and fentanyl/xylazine test-strip distribution; expansion of GCSTOP's low-barrier medication-for-opioid-use-disorder clinic and community-based Post Overdose Response Team; the NC Survivors Union low-barrier health hub; construction beginning on a residential treatment facility at the Lees Chapel site; and completed facility design and dedicated funding for a Women with Children Recovery Center.

**Sources: Guilford County Division of Public Health, 2025 Injuries Data Brief (2023 finalized mortality data); Guilford County, third annual opioid settlement stakeholder session (June 2025); Guilford County Division of Public Health, 2023–2024 Guilford County Community Health Assessment (for indicators not yet updated).**

# 8. Co-occurring Mental and Behavioral Health

## Why This Matters

Stakeholders emphasized emotional regulation, depression, anxiety, trauma, grief and loss, bipolar disorder, personality-related concerns, psychotic disorders, and suicidal thoughts or behaviors. Comments called for affordable, timely, whole-person care. Respondents could choose more than one need, so the chart below shows how many of the 12 respondents selected each option.




n=12. Respondents could choose more than one option, so totals add to more than 12.

*Figure 6. Behavioral-health needs identified by stakeholders.*

| Response option | Respondents selecting (of 12) |
|---|---|
| Emotional regulation difficulties | 11 |
| Depression | 9 |
| Trauma-related concerns | 9 |
| Anxiety | 8 |
| Grief/loss | 8 |
| Personality-related concerns | 6 |
| Bipolar disorder | 5 |
| Psychotic disorders | 5 |

**Note: n=12. Respondents could choose more than one option, so counts add to more than 12.**

## What the Data Show

Emotional regulation difficulties were the most frequently identified behavioral-health need, selected by 11 of 12 respondents, followed by depression and trauma-related concerns with 9 each. Anxiety and grief or loss were each selected by 8 respondents. Personality-related concerns were selected by 6, and bipolar disorder and psychotic

disorders were each selected by 5. The results point to a broad need for integrated behavioral healthcare that addresses common emotional and mood concerns while maintaining capacity for more complex psychiatric conditions.

# From Findings to Action

- Strengthen integrated screening, psychiatric assessment, medication management, and trauma-informed care, including services that address emotional regulation, depression, anxiety, grief and loss, and complex psychiatric conditions.
- Improve access for uninsured and underinsured individuals.
- Track behavioral-health wait time and completed referrals.

## Guilford County Data

County-level mental health data show a pattern consistent with stakeholders' emphasis on co-occurring conditions:

| Indicator | Guilford County value |
|---|---|
| Ever told had anxiety or depression (2023 GCCH Survey) | 25.1% of respondents (25.1% in 2023 vs. 24.5% in 2016) |
| Self-rated mental health | 86.3% excellent/very good/good; 12.7% fair/poor |
| Suicide deaths, 2023 | 71 deaths; rate of 12.8 per 100,000, up from 10.8 in 2019; 303 residents were lost over the prior 2017–2021 five-year window |
| Suicide by sex and race, 2023 | Men: 21.0 per 100,000 (55 deaths); women: 5.5 per 100,000 (16 deaths). By race: 68% of 2023 suicides were White, 24% Black, 4% Hispanic, 3% Asian |
| Mental health provider ratio | 1 provider per 310 residents (2022); mid-range among peer counties |
| State access ranking | NC ranked 39th of 50 states + DC for access to mental health services (Mental Health America, 2023) |
| Perceived good mental health services in community | 41.6% agree/strongly agree; 19.2% disagree/strongly disagree, with lower agreement among Black and Hispanic respondents and renters |
| Reported a barrier to accessing a mental health provider | 12.8% of those reporting any health care barrier |
| High stress (most days very/extremely stressful) | 14.2% of respondents |
| Often feel lonely or isolated | 31.8% of respondents |

**Source: Guilford County Division of Public Health, 2025 Injuries Data Brief (2023 finalized suicide data); Guilford County Division of Public Health, 2023–2024 Guilford County Community Health Assessment (for indicators not yet updated).**

# 9. Recovery, Continuing Care, and Housing

## Why This Matters

Stakeholders described managing stress, stable housing, employment, transportation, recovery housing, financial instability, recovery support, and return to substance-using environments as post-treatment challenges. Respondents could choose more than one challenge, so the chart below shows how many of the 12 respondents selected each option.

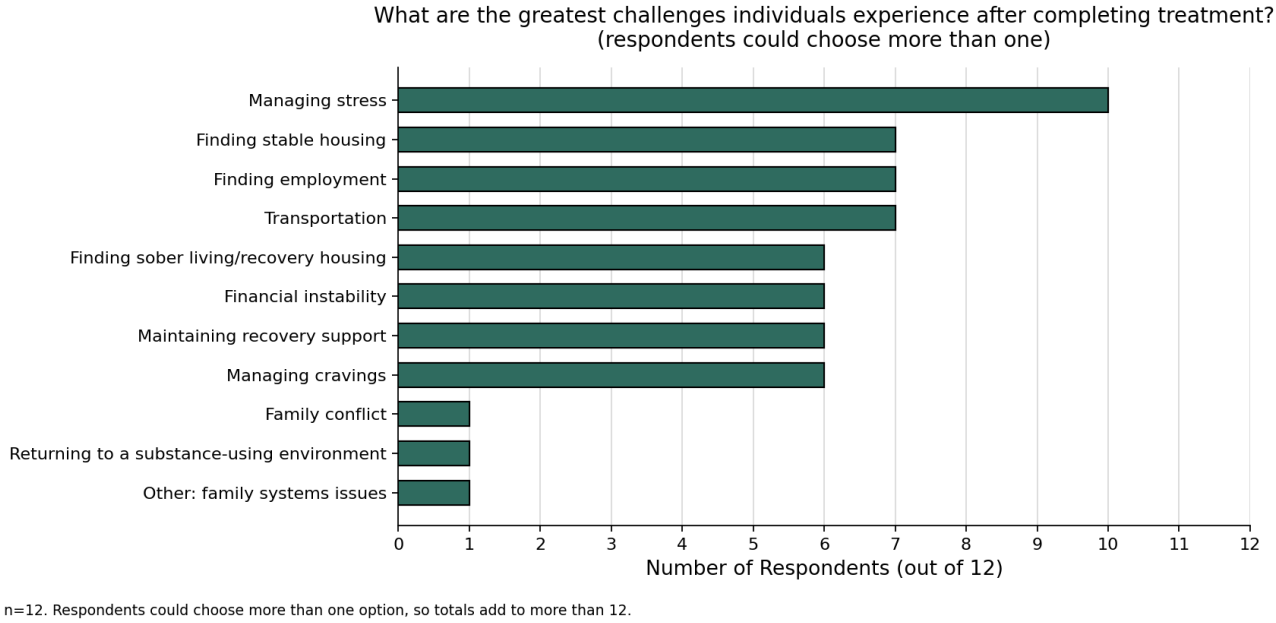



*Figure 7. Post-treatment recovery challenges selected by stakeholders.*

| Response option | Respondents selecting (of 12) |
|---|---|
| Managing stress | 10 |
| Finding stable housing | 7 |
| Finding employment | 7 |
| Transportation | 7 |
| Finding sober living/recovery housing | 6 |
| Financial instability | 6 |
| Maintaining recovery support | 6 |
| Managing cravings | 6 |
| Family conflict | 1 |
| Returning to a substance-using environment | 1 |
| Other: family systems issues (write-in) | 1 |

Note: n=12. Respondents could choose more than one option, so counts add to more than 12.

# What the Data Show

Managing stress was the most frequently selected post-treatment challenge, identified by 10 of 12 respondents. Stable housing, employment, and transportation were each selected by 7 respondents; and sober living or recovery housing, financial instability, maintaining recovery support, and managing cravings were each selected by 6. One respondent also identified family conflict, returning to a substance-using environment, and broader family-systems issues as post-treatment challenges. The results show that respondents view recovery challenges as a combination of coping needs, economic and housing stability, mobility, family dynamics, and ongoing support rather than as clinical symptoms alone.

# From Findings to Action

- Schedule continuing-care appointments before discharge.
- Expand stress-management support, peer and family navigation, alumni support, employment and transportation referrals, financial-resource connections, and longitudinal follow-up.
- Build inclusive recovery-housing partnerships that support evidence-based pathways, including MOUD and necessary mental health medications.

## Guilford County Data

Housing instability, named by stakeholders as the top social driver of recovery, is well documented at the county level:

| Indicator | Guilford County value |
|---|---|
| Homeownership rate | 59.9% county-wide (2020–2024 ACS 5-year estimate); race/ethnicity breakdown not yet updated beyond the CHA's White 70.6%, Hispanic 49.4%, Black 42.7% |
| Severe housing cost burden | 13% of households spend 50%+ of income on housing |
| Cost-burdened households (30%+ of income) | 32% of families, about 65,211 households |
| Fair market rent / median gross rent | $1,163/month (2020–2024 ACS 5-year estimate), consistent with the CHA's reported 52% five-year increase |
| 2024 Point-in-Time Count | 641 people counted (350 emergency shelter, 50 transitional housing, 5 safe haven, about 230 unsheltered), up from 452 in 2023; the 2023 count found 108 chronically homeless (19% under 18, 71% ages 18–64, 10% 65+; 70% Black/African American) |
| Severe housing problems (overcrowding, cost, lacking kitchen/plumbing) | 16% of households (Healthy NC 2030 target: 14%) |
| Perceived availability of affordable housing | Only 36.9% of 2023 GCCH Survey respondents agreed affordable housing meets their community's needs; 38.2% disagreed |

Sources: Guilford County Continuum of Care, 2024 Point-in-Time Count; U.S. Census Bureau, QuickFacts (2020–2024 ACS 5-year estimates); Guilford County Division of Public Health, 2023–2024 Guilford County Community Health Assessment (for indicators not yet updated).

# 10. Stigma and Community Awareness

## Why This Matters

Stakeholders described shame, judgment, labeling, concealment, social isolation, and avoidance of care. Education, recovery stories, and framing addiction as a health-condition were widely supported.

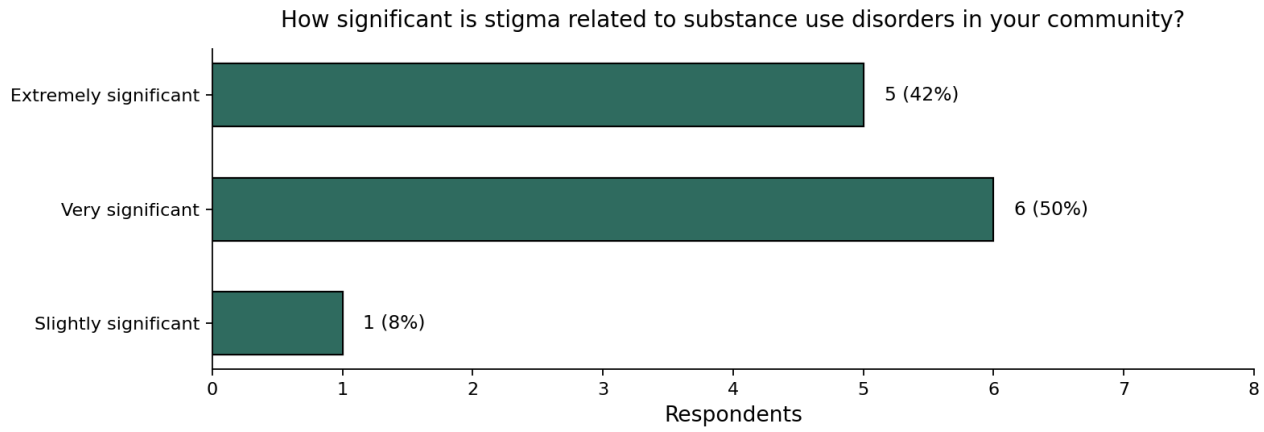



*Figure 8. Stakeholder ratings of stigma as a barrier to treatment and recovery.*

| Response option | Respondents | Percent |
|---|---|---|
| Extremely significant | 5 | 41.7% |
| Very significant | 6 | 50.0% |
| Slightly significant | 1 | 8.3% |

**Note: n=12. Respondents selected one option each.**

## What the Data Show

Eleven of 12 respondents rated stigma as very or extremely significant, including 6 who selected very significant and 5 who selected extremely significant. One respondent rated it slightly significant, and no respondent selected a lower category shown in the results. This near-consensus supports treating stigma reduction as a central component of treatment access, community education, and recovery support.

## From Findings to Action

- Use lived experience and recovery stories in education.
- Provide stigma-reduction education for healthcare providers, families, employers, schools, and the community.
- Measure participation and changes in knowledge or confidence following education.

## Guilford County Data

The county CHA does not include a standalone measure of substance use stigma comparable to Fellowship Hall's stakeholder question, so the figures below are the closest available proxies rather than a direct match:

| Indicator | Guilford County value |
|---|---|
| Experienced discrimination in the past 12 months (2023 GCCH Survey) | 17.3% of respondents (of those, racism was the most-cited reason, followed by physical appearance and income) |
| Disagree there are good mental health services in the community | 19.2% of respondents, with Black and Hispanic respondents significantly less likely to agree than White respondents |
| Community perceived as welcoming to all races/ethnicities | 85.8% agree/strongly agree |

The CHA's behavioral health chapter separately notes that stigma around medications for opioid use disorder (MOUD), specifically the belief that they are “exchanging one addiction for another,” remains a documented barrier to treatment engagement in the county, reinforcing stakeholders' emphasis on stigma reduction as a priority.

**Source: Guilford County Division of Public Health, 2023–2024 Guilford County Community Health Assessment.**

# 11. Community Partnerships, Assets, and Service Gaps

## Why This Matters

Stakeholders described community coordination as mixed rather than uniformly strong. Among the 11 respondents who answered this question, 5 rated coordination effective or very effective, 5 rated it somewhat effective, and 1 rated it ineffective. This distribution indicates that coordination is generally present but leaves substantial room for stronger cross-sector connections among healthcare, behavioral health, substance use treatment, harm reduction, schools, law enforcement, recovery organizations, housing, and social services.

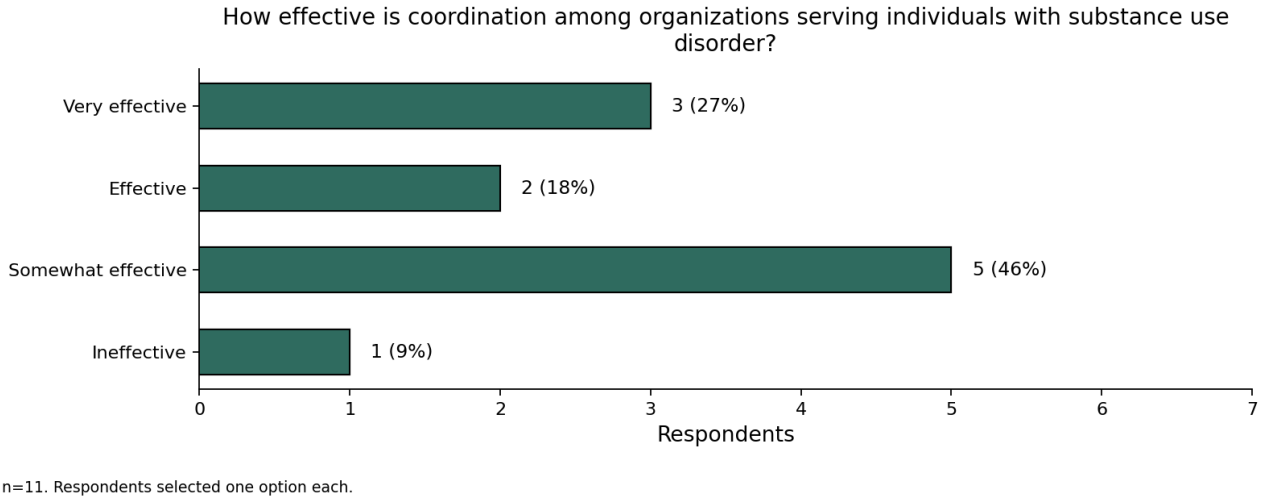



*Figure 9. Stakeholder ratings of community coordination effectiveness.*

| Response option | Respondents | Percent |
|---|---|---|
| Very effective | 3 | 27.3% |
| Effective | 2 | 18.2% |
| Somewhat effective | 5 | 45.5% |
| Ineffective | 1 | 9.1% |

**Note: n=11. Respondents selected one option each; one respondent did not answer this question.**

## What the Data Show

Among the 11 respondents who answered the coordination question, 5 rated community coordination somewhat effective, 2 rated it effective, 3 rated it very effective, and 1 rated it ineffective. Thus, 10 of 11 respondents perceived at least some effectiveness, but only 5 of 11 rated coordination effective or very effective. The results support strengthening existing connections and referral processes rather than describing the current system as either wholly ineffective or fully coordinated.

# From Findings to Action

- Adopt standardized warm-handoff expectations and track referral acceptance, completion, and time to connection across participating organizations.
- Maintain a current service and referral directory.
- Convene cross-sector partners and people with lived experience at least annually.

# Resources and Systems Named by Respondents

| Resource or system | Stakeholder-described relevance |
|---|---|
| Behavioral-health crisis access | Behavioral Health Urgent Care and Facility-Based Crisis services were referenced in relation to geographic access for High Point residents. |
| Public funding navigation | IPRS funding and the need to identify participating agencies were referenced. |
| Peer and community support | Peer support services, community support, and family support were requested. |
| Community resource centers | The Interactive Resource Center and similar centers were referenced as models to expand. |
| Treatment continuum | Detoxification, residential, PHP, IOP, outpatient, psychiatric services, MOUD, recovery housing, and aftercare were repeatedly named. |

## Guilford County Data: Verified Treatment and Recovery Assets

The 2023–2024 Guilford County CHA independently documents several of the resources stakeholders named, along with additional county assets Fellowship Hall may wish to include in a validated referral directory:

| Organization | Role in the continuum |
|---|---|
| Fellowship Hall | Detoxification, residential treatment, PHP, IOP, outpatient treatment, and family therapy for substance use and co-occurring disorders |
| Guilford County Solution to the Opioid Problem (GCSTOP) | Syringe services, post-overdose response team, justice-involved reentry support, naloxone distribution |
| Daymark Recovery Services | Residential substance use treatment; construction underway (as of June 2025) on a new residential site at Lees Chapel, plus a dedicated, fully designed Women with Children Recovery Center |
| Alcohol and Drug Services (ADS) | Prevention, early intervention, individual/group counseling, and specialized services across the Piedmont Triad |
| Caring Services, Inc. | Transitional and supportive housing, outpatient treatment, relapse prevention, and employment assistance |
| NC Survivor's Union | Peer-led harm reduction: syringe services, drug checking, wound care, and a low-barrier Suboxone clinic |
| Guilford County Formerly Incarcerated Transition (FIT) Program | Peer navigation connecting justice-involved individuals to primary care, insurance, and medication assistance |

| | |
|---|---|
| Behavioral Health Hospital (Cone Health) | Adult, child, and adolescent inpatient behavioral health; integrated outpatient behavioral health care |
| Federally Qualified Health Centers (6 sites) | Integrated primary, dental, pharmacy, and behavioral health care on a sliding fee scale for underserved residents |

Guilford County's opioid settlement allocation ($40.75 million to the county, plus $6.4 million to High Point and $2.5 million to Greensboro through 2038) is funding several of these initiatives directly and is a relevant, time-bound resource for the partnerships and service gaps discussed above. As of the county's June 2025 settlement stakeholder session, this funding has also supported 2,144 people trained in harm reduction and overdose prevention through GOPEC and expansion of GCSTOP's low-barrier medication-for-opioid-use-disorder clinic.

**Sources: Guilford County Division of Public Health, 2023–2024 Guilford County Community Health Assessment; Guilford County, third annual opioid settlement stakeholder session (June 2025).**

# 12. Priority Selection

Priorities were scored using an evidence index derived from related stakeholder survey selections. For each priority, endorsement proportions from the relevant questions were averaged and converted to a 0–100 index. The resulting order summarizes the relative strength of support within this 12-response stakeholder sample; it is not a population-health rate, a statistical test, or evidence that small differences between index scores are meaningful. The index should therefore be used as one planning input alongside organizational data, county indicators, partner feedback, and future survey results.

| Rank | Priority | Stakeholder evidence index (0–100) |
|---|---|---|
| 1 | Integrated behavioral healthcare | 78.2 |
| 2 | Stigma reduction and overdose prevention | 65.2 |
| 3 | Social drivers of recovery | 63.9 |
| 4 | Treatment access and navigation | 59.7 |
| 5 | Recovery continuum and housing | 58.2 |

# 13. Strategic Priorities and Measures

| Priority | 2026 baseline indicator | Baseline | Initial performance direction |
|---|---|---|---|
| Improve treatment access and navigation | Treatment access rated fair, poor, or very poor | 7 of 12 (58.3%) | Reduce proportion; establish target after first annual update |
| Strengthen the recovery continuum | Recovery housing rated somewhat or very inadequate | 8 of 10 (80.0%) | Reduce proportion; supplement with stable-housing-at-discharge measure |
| Integrate behavioral healthcare | Co-occurring mental health conditions rated very or extremely significant | 10 of 12 (83.3%) | Use as need indicator; add referral-completion and wait-time measures |
| Address housing and social drivers | Housing selected as a community intervention priority | 9 of 12 (75.0%) | Use as need indicator; add stable housing and resource-connection measures |
| Reduce stigma and prevent overdose | Stigma rated very or extremely significant | 11 of 12 (91.7%) | Reduce proportion; add naloxone, education, and post-overdose connection measures |

## Operational Measures for Annual Reporting

| Domain | Measures |
|---|---|
| Treatment access | Referral-to-admission time; successful referral rate; warm-handoff completion; access by payer type |
| Recovery continuum | Continuing-care appointment completion; stable housing at discharge; follow-up engagement |
| Behavioral healthcare | Assessment completion; psychiatric referral completion; wait time; medication continuity |
| Social drivers | Housing placements; transportation connections; employment referrals; benefits enrollment |
| Stigma and overdose | Naloxone distribution; education participation; post-overdose treatment connection; provider training |

# 14. Conclusion: A Path Forward

The assessment describes substance use and recovery as interconnected clinical, behavioral, social, and community health issues. The central opportunity is to strengthen the pathway from recognition of need to timely treatment, appropriate level of care, integrated behavioral healthcare, safe discharge, stable housing, continuing care, and long-term recovery support.

Fellowship Hall should use this report as the baseline for an annual learning cycle: update response and service data, validate findings with partners and people with lived experience, review priority measures, publish progress, and adjust action plans.

# References and Data Sources


- Fellowship Hall. 2026 Community Health Needs Assessment stakeholder survey. Microsoft Forms. Responses collected September 2026.
- Fellowship Hall. FY2025 Impact Report (October 1, 2024 – September 30, 2025). Aggregated, de-identified guest data for 708 guests served across all programs; used as the source for Section 4, Fellowship Hall Patient Data.
- Guilford County Division of Public Health. 2023–2024 Guilford County Community Health Assessment. Used as a structural and methodological model for this report, and as the source for county indicators not yet updated by a newer publication below.
- Guilford County Division of Public Health. 2025 Injuries Data Brief. 2023 finalized county mortality data for overdose and suicide.
- Guilford County Continuum of Care. 2024 Point-in-Time Count of homelessness.
- Guilford County. Third annual opioid settlement stakeholder session (June 2025).
- U.S. Census Bureau. QuickFacts, Small Area Income and Poverty Estimates, and Small Area Health Insurance Estimates (2025 vintage; 2020–2024 American Community Survey 5-year estimates).
- U.S. Bureau of Labor Statistics. Local Area Unemployment Statistics (September 2025).


Stakeholder survey findings (all percentages reported as "X of Y respondents" or tied to the 2026 Fellowship Hall survey) were calculated from the Fellowship Hall stakeholder survey. Population-level statistics labeled "Guilford County Data" throughout this report are drawn from the most recent publicly available county, state, and federal sources as of September 2026, cited at the end of each such section; they are not derived from or combined with the Fellowship Hall stakeholder survey. Where a newer figure was not available, the 2023–2024 Guilford County Community Health Assessment figure is used and marked accordingly. Patient-level statistics in Section 4, Fellowship Hall Patient Data, are aggregated, de-identified figures from Fellowship Hall's own FY2025 Impact Report; they describe guests actually served, not stakeholder perception or countywide population estimates, and are kept separate from both other sources. No demographic or prevalence estimate in this report is unsourced.

# Appendix A: Survey Instrument

The survey contained 30 questions across the following sections: About You; Community Substance Use Concerns; Access to Treatment; Behavioral and Mental Health; Overdose and Harm Reduction; Recovery and Discharge Needs; Social Determinants of Health; Stigma and Community Awareness; Community Partnerships; and Overall Community Priorities.

# Appendix B: Question-Level Reporting Notes

| Analysis field | Answered responses | Response type |
|---|---|---|
| role | 12 | Multiple selection |
| familiar | 12 | Single selection |
| concern | 12 | Single selection |
| substances | 12 | Multiple selection |
| populations | 12 | Multiple selection |
| access | 12 | Single selection |
| barriers | 12 | Multiple selection |
| continuum | 12 | Single selection |
| levels | 12 | Multiple selection |
| cooccur | 12 | Single selection |
| bhneeds | 12 | Multiple selection |
| mhaccess | 12 | Single selection |
| overdose | 12 | Single selection |
| odresources | 12 | Multiple selection |
| post | 12 | Multiple selection |
| housing | 10 | Single selection |
| social | 11 | Multiple selection |
| priority | 12 | Multiple selection |
| stigma | 12 | Single selection |
| stigreduce | 12 | Multiple selection |
| coord | 11 | Single selection |

# Appendix C: Publication Governance

- Report owner: Fellowship Hall Leadership.
- Data steward: Fellowship Hall Quality Assurance and/or Process-Improvement lead.
- Review cycle: Every three years, or sooner when new community evidence materially changes priorities.
- External publication check: Verify all named organizations, program availability, eligibility criteria, and referral contacts.
- Privacy standard: Report anonymous findings in aggregated and avoid publishing personally identifying information.