

# Community Assessment of Behavioral Health Care Continuum

Randolph County, NC  
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Written by Suzanna Powell, Brandn Green, and Steven Fuller



This report was prepared for Randolph County Public Health by Suzanna Powell, Brandn Green, and Steven Fuller (JG Research & Evaluation).



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# Introduction

This report presents an assessment of the capacity of the organizations in Randolph County that work to respond to the needs of the substance-using population in the county. The needs assessment utilized the Calculating an Adequate System Tool (CAST) assessment methodology, which produces capacity estimates of existing services to identify areas of need within a local care system. The goal of CAST is for community decision-makers to be able to look comparatively across their substance misuse continuum of care to understand areas of greatest need. For this assessment, estimates of capacity were created for 34 interventions across the continuum of care (prevention, harm reduction, treatment, recovery and supports). This report is the first of two reports being completed by JG Research & Evaluation (JGRE) for Randolph County. The second report will produce capacity estimates for the youth and adult behavioral health care system and mental health services. These reports were completed by JGRE in coordination with Randolph County Public Health, with the explicit goal of informing future program planning and the strategies for distributing opioid settlement funding.

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## Key Findings

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- An estimated 14,803 residents in Randolph County need treatment for a substance use disorder but are not receiving care. This treatment gap is driven by both structural limitations (e.g., workforce shortages, housing, transportation) and cultural barriers (e.g., stigma).
- Randolph County scores low for social determinants of behavioral health risk when compared to national benchmarks. However, college education levels and association rates indicate potential higher-than-average emergency department use, highlighting the need for preventive and early intervention services.
- Several themes emerged consistently in interviews with key informants and people with lived experience: limited capacity among providers and wraparound services; cultural barriers—including stigma surrounding substance use disorder (SUD) treatment (particularly harm reduction interventions) and differing views on evidence-based interventions; and ongoing efforts to expand services, address barriers, and broaden engagement.
- There are shortages across Levels I–IV recovery residences, especially Levels III and IV where no beds are available at all. Level I residences have a combined 32 beds meeting 57% of estimated need and Level II has 20 beds, meeting 48% of the estimated need. Seventy-seven additional beds are needed to meet estimated demand across the four levels of recovery residences.
- Prevention programs in schools and communities are partially meeting needs, lacking about half of school-based sessions and 40% of community-based sessions.
- For harm reduction, naloxone and test strip distribution is strong (around 90–95% of need met). However, major gaps remain in other harm reduction strategies: no overdose response teams, only half the needed medication disposal locations, and very limited medication take-back events.

- Regarding diversion, medication-assisted treatment in correctional settings meets estimated need (100%), whereas adult specialty courts are less robust, with 50% of the needed programs in place.
- Local treatment services have mixed capacity. Outpatient and detox services show mixed coverage (some over 60% capacity), but critical gaps exist in inpatient detox beds (0% of need met), outpatient day treatment (0% of need met), and short- and long-term residential treatment (0% of need met). Additionally, counseling and treatment providers are insufficient, with only 37% of substance abuse counselors available, 20% of abstinence-based counseling capacity met, and opioid treatment programs (OTPs) meet only 50% of need.
- Some recovery supports (e.g., transportation and peer support groups) have relatively good coverage (approximately 80%). However, shortages exist in faith-based recovery supports (12% of need met), rental deposit assistance (48% of need met), job training programs (43% of need met), and recovery drop-in centers and peer support locations (half in place).
- Despite the barriers, local organizations are working to expand capacity, adding transitional housing beds, engaging in community education, and exploring cross-sector engagement. However, coordination between secular and faith-based groups remains limited.

# Methodology and Assessment Approach

## CAST 2.0

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CAST is a software tool that applies social determinants of behavioral health and social disparities in behavioral health outcomes to provide insight into the chronic social conditions that may be contributing to behavioral health outcomes in a community. In addition, CAST produces estimates of program saturation in a local substance use care system across the continuum of care.

Program saturation can inform planning for the development of additional services in geographic areas. In CAST, program saturation is defined as the capacity of a geographic region to provide a service to likely users. Once the CAST equation has been applied to the population in need for a given intervention or service, the CAST generated total is compared with the prevalence data for the given intervention within the study community. Prevalence data is collected through multiple data sources, and these sources are outlined in the subsequent section of the report.

The logic of CAST is to use federal data sources to produce estimates of the likely population of service users in a bounded geography. With this estimate as the base-population of potential users of services, the CAST approach then applies algorithms developed by JGRE to produce estimated service needs. For this study, Randolph County was the unit of analysis.

The following equation is used for CAST estimates:

$$\frac{\text{Relevant Population} * \text{Program usage rate} * \text{Frequency}}{\text{Group size}}$$

**Relevant population** – Estimate of the total number of individuals in a county who could use the intervention (broken down further below)

**Usage rate** – Estimate of the eligible population who are likely to use the service

**Frequency** – Estimate of the frequency with which the population will use the service in one year

**Group size** – Estimate of the total number of individuals who are served by an intervention (units vary by intervention type)

The relevant population is an estimate based upon specific measures from the National Survey on Drug Use and Health (NSDUH). Usage rate is based upon the existing research literature on intervention utilization. The frequency of use was based upon the existing research literature on the frequency of engagement for clients of each intervention and was modified with data provided by Randolph County providers. Group size was based upon data from Randolph County providers.

For this project, CAST was used to:

- Assess the presence of chronic social and community conditions that contribute to an increased risk of hospitalization for substance use

- Identify potential gaps and potential redundancies in the substance use disorder care system
- Generate estimates of program saturation or need that can help to inform community or organizational planning efforts

CAST is designed to assist with short and long-term planning for improving the behavioral health of communities. Program saturation, estimated with CAST algorithms, should be interpreted as a guide for decision-making, not a rigid boundary for program activity levels. CAST is predicated on the assumption that resources are finite, requiring decisions to be made about how financial and human capital are allocated within a given community. It is important to note that CAST estimates are based upon data that was provided by community organizations and not all organizations that answered the survey provided program activity information. When it was clear that an organization provided a given service and the research team was unable to collect specific capacity data, an estimated capacity total was applied to create overall intervention capacity totals. Appendix A presents response patterns across all data sources, including information on patterns of missing data across the universe of organizations that provide the types of services included in this assessment within Randolph County.

## Data Sources

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There were three sources of data used to complete this assessment.

1. Primary data collection occurred through an email-based survey sent directly to 75 organizations within the County. The survey asked organizations to provide detailed information about the activities they have undertaken across the substance use treatment continuum of care, this included recovery residences, prevention programming, harm reduction services, diversion programs, treatment, and recovery supports. In total, 35 organizations completed the survey for a response rate of 46.7%.
2. The National Substance Use and Mental Health Services Survey (N-SUMHSS) supplemented primary data collection. N-SUMHSS is an annual, national survey administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) for the creation of a data set that offers information about the number and characteristics of public and private substance use and mental health facilities nationwide.
3. Web-based searches by the research team to confirm the existence of providers and to collect annual reports and organization specific utilization and capacity data.

## Methods: Outreach for CAST Survey

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### Substance Use Disorder Service Providing Organizations for Survey

To identify all eligible organizations operating across the substance use continuum of care in Randolph County, NC, JGRE staff collaborated with representatives from Randolph County Public Health. During the initial phase of outreach, Randolph County Public Health staff

distributed a recruitment email to contacts at each organization. If there was no response to this initial email, a reminder was sent approximately one week later. On approximately the eleventh business day following the first email, SUD providers who had not responded were contacted by phone. For organizations that continued to be unresponsive or had started but not completed the survey, Randolph County Public Health staff conducted an additional two to three rounds of follow-up phone calls. In total, non-respondents received up to four contacts.

Following the primary data collection period, JGRE staff supplemented the survey data with additional information obtained from the National Substance Use and Mental Health Services Survey (N-SUMHSS) and other complementary sources. These sources included publicly available materials such as organizations' annual reports, websites, and service directories, as well as other relevant documents that provided further detail on program offerings, capacity, and contact information. This supplementary data helped to ensure a more comprehensive understanding of the substance use services landscape in Randolph County.

## **| Data Quality**

All source lists of SUD providers were combined and reviewed for duplicates and missing information. For this project, we required the name of the organization and contact information, including email address and telephone number. There were 31 unduplicated organizations in the final survey contact list. Details on the data collected by intervention are included in Appendix A.

# Population-based Estimates of Prevalence of Substance Use Disorder

Surveillance and monitoring of substance use and misuse in communities is accomplished through a variety of federal, state, and local data collection efforts. In this section, we provide an overview of prevalence estimates based on federal and state data collection, as well as provide context on current efforts to bolster county-level surveillance and monitoring of prevalence, incidence, and service utilization.

## Prevalence Estimates - Federal and State Data Sources

**Prevalence:** We can understand the burden of substance use in Randolph County by analyzing the prevalence of misuse. When we count the number of people who misuse substances at a particular moment, that is called prevalence. We are not looking at the number of new cases for a specified timeframe – that is called incidence. There are limits to the reliability of prevalence estimates for SUD at the county-level (ASPE, 2019). The most widely utilized source for population-level measures of prevalence is the National Survey on Drug Use and Health (NSDUH).

### NSDUH

NSDUH is intended to create state and national estimates of substance use behavior. It is not designed to produce county-specific prevalence estimates. However, with these limitations of NSDUH in mind, it can be used to produce general estimates of the prevalence of SUD within Randolph County. We do so by applying the state-level percentages from model-based statewide NSDUH 2021-2022 to the Randolph population.

**Table 1. NSDUH-Based Prevalence Estimates (Age 18 - 65) for North Carolina Applied to the Population of Randolph County**

Outcome	North Carolina Prevalence Estimates 2022	Estimated Population in Randolph County 2024
Past Month Illicit Drug Use*	13.22%	12144
Past Month Illicit Drug Use Other than Marijuana	3.01%	2750
Past Year Heroin Use	.33%	288
Past Year Methamphetamine Use	.70%	611
Past Year Misuse of Pain Relievers	3.25%	2837
Substance Use Disorder in the Past Year	16.06%	14021
Alcohol Use Disorder in the Past Year	10.32%	9009
Drug Use Disorder in Past Year	8.21%	7167

Notes: \*SAMHSA includes marijuana utilization in their definition of illicit drug use. Population aged 18 – 65 years is 87,306.

**Table 2. NSDUH-Based Prevalence Estimates (Age 12-17) for North Carolina Applied to Randolph County Youth Population (Age 10-17)**

Outcome	North Carolina Prevalence Estimates	Estimated Population Randolph County (2024)
Past Month Illicit Drug Use*	6.26%	1996
Past Month Illicit Drug Use Other than Marijuana	1.61%	513
Past Year Methamphetamine Use	0.11%	35
Past Year Misuse of Pain Relievers	1.97%	628
Substance Use Disorder in the Past Year	7.58%	2417
Alcohol Use Disorder in the Past Year	2.46%	784
Drug Use Disorder in the Past Year	6.16%	1964
<i>Notes: *SAMHSA includes marijuana utilization in their definition of illicit drug use. Population aged 10 – 17 is 19,169</i>		

## NSDUH - Treatment Need

As part of the NSDUH survey, interviewees are asked whether or not they have received treatment for a SUD over the past year. These responses are then cross-tabulated against those who reported substance use behaviors that would qualify as a diagnosable substance use disorder<sup>1</sup> and weighted to produce state-level estimates of those who needed treatment but did not receive it in the past year.

As shown in Table 3, approximately 19,470 individuals in Randolph County were estimated to need treatment for substance use, with 4,667 individuals having received treatment, producing a difference of about 14,803 individuals in the county that could have needed but did not receive treatment for SUD during the 2022 NSDUH estimation period.

<sup>1</sup>“Respondents were classified as needing substance use treatment if they met Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) criteria for a drug or alcohol use disorder or received treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medication-assisted treatment; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center. Substance use treatment questions are asked of respondents who used drugs or alcohol in their lifetime.” Accessed: <https://www.samhsa.gov/data/sites/default/files/reports/rpt44484/2022-nsduh-sae-tables-percent-CSVs/2022-nsduh-sae-tables-percent.pdf>

**Table 3. NSDUH-Based Estimates of Past Year Substance Use Disorder Treatment for North Carolina Applied to the Randolph County Adult Population (Age 12+)**

Outcome	North Carolina Prevalence Estimates	Estimated Population in Randolph County (2024)
Received Substance Use Disorder Treatment in Past Year	4.02%	4667
Needing Substance Use Disorder Treatment in Past Year	16.77%	19470
<i>Notes: Population aged 12+ is 116,103</i>		

### **Social Determinants of Health in Randolph County**

Identification of the social determinants of behavioral health in the population of Randolph County residents accomplishes two interrelated goals. First, an understanding of the characteristics and need patterns of the population can help to inform the composition of the continuum of care for the region. Second, identification of social determinants of behavioral health can inform long-term strategies for addressing root causes of misuse of substances and ultimately decrease the prevalence of substance use disorder in the county.

It is important to note that the social determinant risk factors identified in this model are for increased use of the emergency department due to substance use and are not a comprehensive list of social determinants that may increase risk for the development of a substance use disorder. The research literature on social determinants related to developing a substance use disorder is complex, as it is difficult to disentangle cause and effect. For example, a person may be experiencing homelessness due to substance use or may begin to use substances as a coping strategy due to experiencing homelessness. With this caveat in mind, the scientific literature on social determinants has identified correlations in populations with risk for developing substance use disorders among: individuals in families with substance use disorders, trauma, housing status, socioeconomic status, employment and job stability, educational attainment, engagement with the foster care system, and access to quality health and behavioral health services.<sup>2</sup> Consideration of efforts to address social determinants in the County should consider how best to engage these factors, while avoiding stigmatization and stereotyping of the population groups.

In this assessment, we review eight social determinants that have demonstrated a relationship with an increased likelihood for emergency department utilization due to substance use at the community-level. The original analysis and development of the social determinants risk modeling was completed by staff of JG Research and Evaluation.

The risk score estimates the likelihood (risk) that a county’s emergency department utilization rate due to substance use will be above the national median. To create the risk score estimates, we used a full multivariate logistic regression equation and then classified

<sup>2</sup> Baffour, T.D. Addressing the social determinants of behavioral health for racial and ethnic minorities: Recommendations for improving rural health care delivery and workforce development. *J Best Pract Health Prof Divers.* 2017;10(2): 111-126.

coefficients into reference values to then produce an estimate of risk for each county in the United States.

**Table 4. Social Determinants of Behavioral Health Applied to Randolph County**

Community Characteristic	Measure	County Risk Score
Percent of adult population that is male	0.489	0
Percent of adult population that is non-white	0.095	0
Percent of county that is rural	0.562	0
High school dropout rate	0.161	0
Percent of households with income below \$35,000	0.326	0
Percent of population with a college degree	0.262	5
Percent of population that is widowed or divorced	0.115	0
Percent of the population that is uninsured	0.008	0
Association rate per 100,000 people*	124.029	2
Region designated as a high incidence drug trafficking area	1	0
Violent crime rate per 100,000 people	156.14	0
Percent of the population that is aged 17 or below	0.221	0

*Note: \* The association rate per 100,000 people is a social capital factor based on multiple variables (e.g., religious organizations, civic and social associations, business associations, political organizations, professional organizations, labor organizations, bowling centers, physical fitness facilities, public golf courses, sport clubs, managers, and promoters, voter turnout, census response rate, and number of non-profit organizations).*

The risk score compares a county’s likelihood of emergency department visits for alcohol or drug issues to other counties nationwide. Randolph County has a low risk, meaning its key factors don’t suggest a higher-than-average chance of such visits. The only social factors that may influence this in Randolph County are the percentage of people with a college degree and the association rate per 100,000 residents.

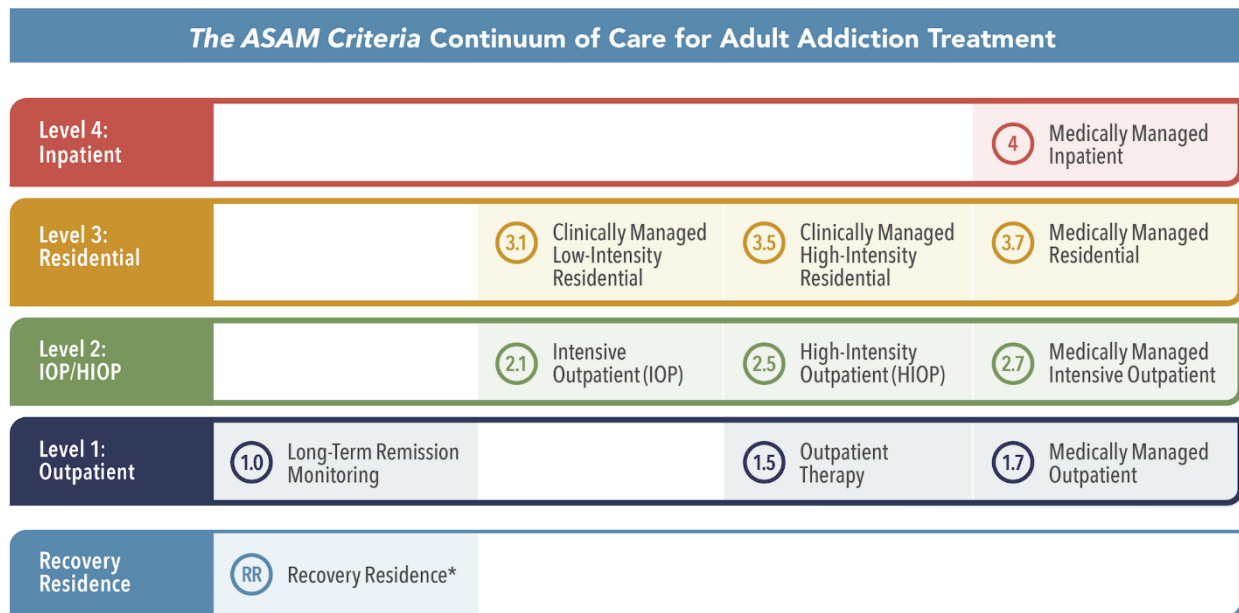
It is important to note that the causal processes for creating an increased risk are not embedded within this analysis. For example, the relationship between the percentage of the community population with a college degree and the increased risk of higher-than-average county-level emergency department utilization could be due to several factors, not all of which would need to be remediated. It is important, however, to examine how social determinants of behavioral health extend across socio-economic population groupings and present opportunities for engagement among different populations within Randolph County.

# Characteristics of Participating Organizations in Randolph County

Participating organizations were classified by type which included Government (10), Nonprofit (5), Behavioral Healthcare Provider (4), Faith-based (3), Primary Care Provider (2), Law Enforcement (2), Federally Qualified Health Center (1), Local Management Entity/ Managed Care Organization (LME/MCO) (1), Mental Healthcare Provider (3), Hospital (1), and Opioid Treatment Program (1).

The American Society of Addiction Medicine (ASAM) Criteria Continuum of Care for Adult Addiction Treatment organizes treatment services into a structured progression of care levels. These levels range from less intensive outpatient services to the most intensive inpatient treatment (Figure 1). Level 1 includes outpatient options such as long-term remission monitoring (1.0), outpatient therapy (1.5), and medically managed outpatient services (1.7). Level 2 covers intensive outpatient (2.1), high-intensity outpatient (2.5), and medically managed intensive outpatient care (2.7). Level 3 describes residential services, from clinically managed low-intensity (3.1) to high-intensity (3.5) and medically managed residential treatment (3.7). Level 4 represents medically managed inpatient care. Recovery residences provide supportive housing outside of the formal treatment continuum. Not all organizations participating in CAST have a corresponding ASAM level. Nineteen of the participating organizations in Randolph County offer services aligning with a specific ASAM level.

**Figure 1. ASAM Criteria Continuum of Care for Adult Addiction Treatment<sup>3</sup>**



In Randolph County, the most commonly available service was ASAM Level 1.0 (long-term remission monitoring), offered by 53.8% of organizations. This was followed by Level 1.7

<sup>3</sup> American Society of Addiction Medicine. (2023). The ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions (4th ed.).

medically managed outpatient care (38.5%), Level 2.1 intensive outpatient (23.1%), and Level 3.1 clinically managed low-intensity residential services (15.4%). Less frequently available were Level 3.5 high-intensity residential and Level 3.7 medically monitored intensive inpatient services, each provided by 7.7% of organizations (Table 5).

**Table 5. ASAM Levels for Randolph County Organizations Participating in CAST**

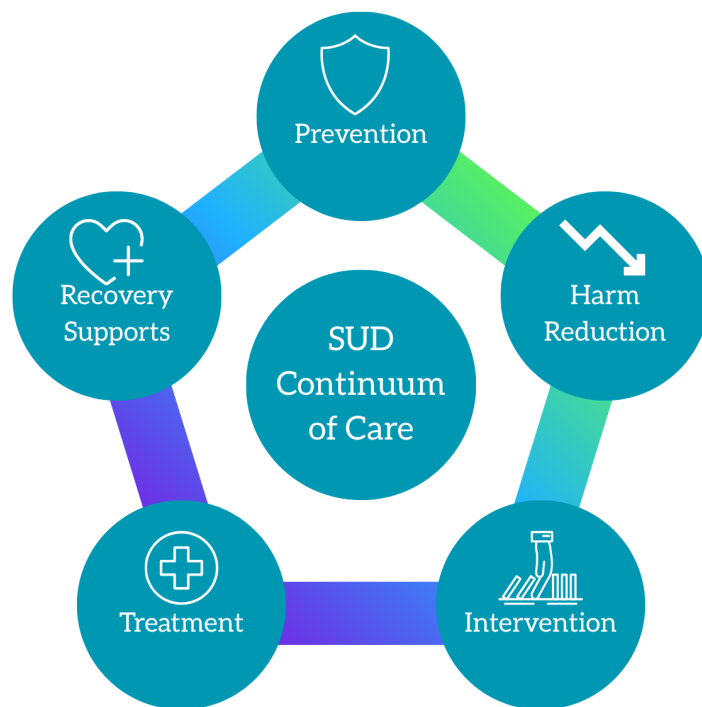
ASAM Level	%	n
ASAM Levels 1.0, long-term remission monitoring	53.8%	7
ASAM Level 1.7, medically managed outpatient	38.5%	5
ASAM Level 2.1, intensive outpatient	23.1%	3
ASAM Level 3.1, clinically managed, low-intensity residential which is staffed with non-licensed staff – typically allied professionals such as peers	15.4%	2
ASAM Level 3.5, clinically managed, high-intensity residential which is staffed with licensed staff – typically clinical social workers or professionally licensed counselors	7.7%	1
ASAM Level 3.7, medically monitored intensive inpatient services	7.7%	1
<i>Note: levels 1.5, 2.5, 2.7, &amp; 4 are not available based on the participating organizations</i>		

# Capacity Assessment Results

The goal of CAST is to create a method for community decision-makers to look comparatively across their local continuum of care to identify areas of greatest need.

The CAST Community Capacity Calculator uses algorithms to estimate the numerical totals for core components of the SUD prevention, treatment, and recovery continuum in a county. There are two core components to the instrument – 1) estimate of need and 2) observed levels of service provision. When the estimate of need is compared to the observed levels of service provision, the instrument generates a proportion of capacity. The proportion of capacity is the metric for demonstrating if the observed capacity of the intervention meets the needs of the estimated population within the county.

**Figure 2. Substance Use Disorder Continuum of Care**



**Prevention** aims to stop substance use before it starts through education to reduce risk factors and promote protective factors against substance use.

**Harm Reduction** aims to reduce the negative health consequences of substance and alcohol use through policies, programs, and practices.

**Intervention** aims to identify and address substance use problems or mild disorders early on to prevent more severe substance use disorders.

**Treatment** includes a range of services tailored to an individual's needs, including medications, counseling, and behavioral health services, to support them in achieving and maintaining recovery and improving well-being.

**Recovery supports** empower individuals to develop coping skills, rebuild relationships, and pursue education and employment opportunities.

It is important to note that the calculation reflects a minimal level of care, and communities may decide to prioritize specific populations or types of interventions. Across multiple assessments, communities have decided that although CAST suggests a particular intervention is in adequate supply, there are clear reasons why that intervention should be provided at greater than 100% capacity. This could include a county that provides services to population groups who do not reside in the county, or it could be due to the specific purpose and design of a given intervention.

For each portion of the continuum, results include a full list of organizations that responded to the survey with information about the broad categories of services and programs that they provide, as well as a detailed estimate of program saturation within each broad category when these estimates are possible. Not all program types are conducive to program saturation estimates, and in some cases incomplete data on program activities made it impossible to produce full CAST estimates.

**Table 6. Capacity Across the Continuum of Care in Randolph County**

Intervention	Estimate	Current Capacity (% of capacity met)	Unit
<b>Prevention</b>			
School-Based Classroom Prevention	65	31 (47.76%)	sessions
Community-Based Prevention Programs	67	40 (59.65%)	sessions
<b>Harm Reduction</b>			
Syringe Service Programs	3	1 (33.33%)	programs
Opioid Overdose Response Team	1	0 (0.0%)	teams
Prescription Drug Disposal Locations	8	10 (125.0%)	locations
Medication Take Back Events	5	2 (40.0%)	events
Naloxone Units	5684	5382 (94.68%)	2mg/4mg units
Fentanyl and/or Xylazine test strips	2459	2202 (89.55%)	strips
<b>Diversion</b>			
Medication Assisted Treatment (MAT) in Jails and Prisons	1	1 (100.0%)	programs
Adult Specialty Courts	2	1 (50.0%)	programs
<b>Treatment</b>			
Detox - Ambulatory	9	5 (55.56%)	beds
Detox - Free Standing	17	16 (94.12%)	beds
Detox - Hospital Inpatient	3	0 (0.0%)	beds
Regular Outpatient	9	6 (66.67%)	locations
Intensive Outpatient	3	2 (66.67%)	locations
Outpatient Day Treatment or Partial Hospitalization	1	0 (0.0%)	locations
Short-Term Residential (non-hospital, 30 days or less)	5	0 (0.0%)	beds

Intervention	Estimate	Current Capacity (% of capacity met)	Unit
Long-Term Residential (non-hospital, 30 days or more)	5	0 (0.0%)	beds
Substance Abuse Counselor	35	13 (37.14%)	providers
Abstinence-Based Counseling	10	2 (20.0%)	providers
Mental/Behavioral Health Counseling	10	9 (90.0%)	providers
Opioid Treatment Program	4	2 (50.0%)	locations
Treatment of Other Substance Use Disorders (e.g., stimulant use disorder, alcohol use disorder)	19	12 (63.16%)	providers
<b>Recovery Supports</b>			
Transportation	563	450 (79.93%)	clients
Rental Deposit Assistance	620	298 (48.0%)	clients
Job Training	7	3 (42.85%)	programs
Peer/Mutual Aid Support Groups	396	312 (78.77%)	sessions
Religious Advisors with Specialization in SUD/MH	8	1 (12.5%)	providers
Recovery Drop In Centers	2	1 (50.0%)	locations
Peer Support	6	3 (50.0%)	locations
<b>Recovery Residences</b>			
Level I Recovery Residences (peer-run)*	56	32 (57.14%)	beds
Level II Recovery Residences (managed)	42	20 (47.62%)	beds
Level III Recovery Residences (supervised)	23	0 (0%)	beds
Level IV Recovery Residences (clinical, have licensed staff )	8	0 (0%)	beds
<p><i>Notes: *Level I – III Recovery Residence reflect NARR certification definitions and standards. While we believe they meet the requirements, they have not obtained NARR certification. Level I (peer-run) facilities are fully peer-managed homes with no paid staff. Residents govern themselves, share responsibilities, and support each other in recovery. No clinical services are provided onsite. Level II (managed) facilities are similar to Level I but with a house manager or senior resident providing oversight. Rules are more structured, and drug testing or house meetings may be required. No formal clinical services onsite. Level III (supervised) facilities are staffed by paid professionals who provide structure, support, and life skills training. Clinical services may be accessed offsite. More rules and supervision than Levels I–II. Level IV (clinical) facilities are organizationally structured programs with licensed staff offering clinical services such as counseling or treatment onsite. These residences resemble treatment programs with a strong focus on recovery support.</i></p>			

# Prevention

Incorporating prevention programs that address different levels of risk of substance use are key to reaching as many people as possible. The Institute of Medicine has identified three categories of prevention interventions - universal, selective, and indicated.

**Universal** prevention programs target everyone in a population regardless of risk of developing a substance use disorder. Examples of universal prevention includes setting minimum ages for purchasing alcohol or tobacco products, and school- or community-based programs that promote social and emotional competencies to reduce stress, express emotion appropriately, and resist negative influences.

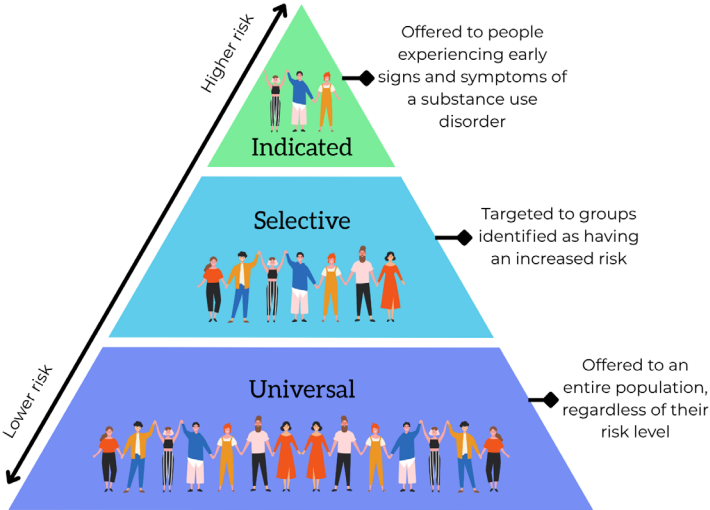
**Selective** prevention interventions are provided for specific groups that have been determined to be at greater risk of substance use. Risk factors that would increase risk of substance use may be used as criteria for enrolling program participants. These programs aim to reduce risk factors and increase protective factors.

**Indicated** prevention programs are targeted to individuals who are already using substances but have not developed a substance use disorder. Individuals may be identified through school, justice system involvement, or medical screening. These programs are more intensive and require greater investment.

For this assessment, no organizations reported whether their programs were universal, selective, or indicated. We recommend further investigation into the types of prevention efforts active in Randolph County. Overall, there is partial capacity to deliver prevention services in both school and community settings, but significant gaps remain. To fully address estimated needs, an additional half of the required school-based sessions and over 40% of community-based sessions would need to be implemented. This underscores the importance of expanding prevention programming to reach more students and community members. School-based prevention efforts typically involve structured education delivered in classrooms to help students build skills and knowledge related to substance use prevention. Community-based prevention initiatives often include outreach, education, and engagement activities offered in settings outside of schools to reach youth and families.

For school-based classroom prevention, there is an estimated need for 65 sessions, and the current capacity is 31 sessions, reaching 47.76% of the estimated need is being met, leaving over half of the necessary sessions unaddressed. Community-based prevention programs show a somewhat higher level of coverage. There is an estimated need for 67 sessions, with 40 sessions currently available, meeting about 59.65% of the projected demand.

Figure 3. Types of Prevention Programs



**Table 7. Inventory of Prevention Services Provided by Organizations in Randolph County Included in CAST Assessment**

Organization	School-Based	Community	Other
Brightview			X
Insight Human Services	X	X	
Juvenile Day Reporting Center			X
Keaton's Place			X
Randolph County Public Health	X	X	
Randolph County Sheriff's Office/ Detention Center			X
Unchained Ministry Randolph County, NC		X	
Zen Counseling, PLLC		X	

## Harm Reduction

Harm reduction is an evolving set of practical strategies that reduce the negative consequences of high-risk behaviors through policies, programs, and tools. Examples include overdose prevention education and tools, safe storage of medications, and rapid response teams to meet needs of high-risk populations.

Naloxone and test strip availability is relatively strong; however, there are significant gaps in other harm reduction strategies, particularly in establishing overdose response teams, increasing opportunities for safe disposal of prescription medications, and expanding syringe service programs. Addressing these gaps will be important for building a more comprehensive continuum of care.

Naloxone distribution is meeting nearly all estimated need. Out of 5,684 units needed, 5,382 have been supplied, meeting 94.68% of the estimated needs. Similarly, distribution of fentanyl and/or xylazine test strips is also high, with 2,202 strips distributed out of an estimated 2,459 needed, meeting 90% of demand.

In the case of opioid overdose response teams, there is an estimated need for one team, but one does not currently exist. Prescription drug disposal locations exceed the estimated need, reflecting strong coverage for this harm reduction strategy. With an estimated need for eight locations, there are currently ten active disposal sites, meeting 125% of the identified need. Of note, it is beneficial for harm reduction resources like disposal sites to exceed capacity. Over-saturating the community with accessible disposal options increases the likelihood that unused or expired medications are safely discarded, helping to prevent misuse and reduce overdose risk. For medication take-back events, two have been implemented, covering 40% of need, which is five annual events.

**Table 8. Inventory of Harm Reduction Services Provided by Organizations in Randolph County Included in CAST Assessment**

Organization	Fentanyl and/or Xylazine Test Strips	Naloxone Units	Prescription Drug Disposal Locations	Medication Take Back Events	Opioid Overdose Response Team	Syringe Service Programs	Education on Safer Drug Use/ Overdose Safety Planning	Other
Brightview							X	
Community Hope Alliance	X	X				X	X	X
Daymark Recovery Services		X						X
Keaton's Place		X						
Kintegra Health								X
Randolph County Public Health		X					X	X
Randolph County Sheriff's Office/ Detention Center		X	X	X			X	X

*Notes: Additional prescription drug disposal locations are located at several municipal police departments and pharmacies in the county.*

## **Diversion**

Diversion and deflection programs aim to provide alternatives to traditional justice system involvement for individuals with mental health or substance use needs. These programs, including jail diversion, pre-arrest diversion, and reentry programs, focus on connecting individuals with community-based treatment and support services instead of incarceration.

Medication-assisted treatment availability in detention settings is fully aligned with estimated need (one program, meeting 100% of demand); however, the limited number of adult specialty courts leaves room for additional investment to enhance diversion options in the community. Adult specialty courts, which provide structured judicial oversight and

treatment-focused alternatives for individuals with substance use disorders, show a partial gap. There is an estimated need for two specialty court programs, while only one is operating, meeting 50% of the projected capacity. There is an additional adult specialty court for veterans, which has overlap with the substance use disorder population but has a broader scope.

**Table 9. Inventory of Diversion and Deflection Services Provided by Organizations in Randolph County Included in CAST Assessment**

Organization	Adult Specialty Courts	Medication Assisted Treatment (MAT) in Jails & Prisons	Other
District Attorney’s Office			x
Juvenile Day Reporting Center			x
Randolph County Adult Day Reporting Center	x		
Randolph County Sheriff’s Office/Detention Center		x	
Unchained Ministry Randolph County, NC			x
Zen Counseling, PLLC			x

## Treatment

Treatment for substance use disorders may include clinical assessments, therapies, counseling, medications, and recovery supports. The National Institute on Drug Abuse advises any type of treatment administered be tailored to the individual’s needs. Acknowledging there are many pathways to recovery, this assessment included clinical and non-clinical service providers.

While some outpatient and detox services have partial or substantial coverage, there are significant gaps in inpatient detox, outpatient day treatment, residential care, and access to certain types of counseling. Addressing these shortages will be essential to establishing a more comprehensive treatment continuum that meets the full range of needs for individuals with substance use disorders.

For ambulatory detox services, there is an estimated need for nine beds, with five currently available, meeting about 55.6% of capacity. Free-standing detox services are more adequately resourced, with 16 of the 17 beds needed in place, representing nearly 94% of demand. However, hospital inpatient detox services have no beds available, leaving the entire estimated need for three beds unmet.

Regular outpatient treatment locations meet roughly two-thirds of estimated need, with six of nine treatment sites. Intensive outpatient services are also partially covered, with two of

the three locations established, or about 66.67% of capacity. In contrast, outpatient day treatment or partial hospitalization programs have no locations operating, meaning the full estimated need for one program remains unaddressed.

Residential treatment capacity is particularly limited. Both short-term residential services (five beds needed) and long-term residential services (five beds needed) currently have no beds, resulting in 100% unmet need in these categories. These gaps highlight a critical shortage of local residential treatment options for individuals who require more intensive, structured care settings.

The availability of qualified and/or licensed providers widely varies. Among substance abuse counselors, there are 13 of the 35 needed providers available, covering just over 37% of estimated need. Abstinence-based counseling shows the lowest coverage, with only 2 of 10 required providers, meeting just 20% of demand. In contrast, mental and behavioral health counseling is much better resourced, with 9 of 10 providers in place, reflecting 90% of the necessary capacity.

For opioid treatment programs (OTP) offering U.S. Food and Drug Administration approved medications, including methadone, buprenorphine, or naltrexone, there is an estimated need for four locations. Two programs are currently operating, meeting 50% of projected demand. Treatment services for other substance use disorders, including stimulant and alcohol use disorders, are somewhat better resourced, with 12 of 19 providers in place (approximately 63.16% of capacity).

**Table 10. Inventory of Treatment Services Provided by Organizations in Randolph County Included in CAST Assessment**

Organization	Opioid Treatment Program	Detox — Ambulatory (outpatient)	Detox — Free Standing	Office-Based Opioid Treatment	Outpatient	Intensive Outpatient	Long-Term Residential	Substance Use Disorder Counseling	Treatment of Other Substance Use Disorders	Mental/Behavioral Health Counseling	Abstinence-Based Counseling	Other
American Healthcare Systems Randolph Health Internal Medicine				x								
Alcohol and Drug Services of Asheboro					x							

Organization	Opioid Treatment Program	Detox — Ambulatory (outpatient)	Detox — Free Standing	Office-Based Opioid Treatment	Outpatient	Intensive Outpatient	Long-Term Residential	Substance Use Disorder Counseling	Treatment of Other Substance Use Disorders	Mental/Behavioral Health Counseling	Abstinence-Based Counseling	Other
Brightview	x			x	x			x	x	x		
Caring Services, Inc.					x	x		x	x			
Chatham Recovery/Morse Clinic of Asheboro	x											
Daymark Recovery Services			x	x	x			x	x	x	x	
Juvenile Day Reporting Center					x							x
Path of Hope, Inc.							x	x	x			
Randolph County Adult Day Reporting Center						x						
Randolph County Sheriff's Office/Detention Center		x						x	x	x	x	
Randolph Health Senior Care		x			x			x	x	x	x	
Zen Counseling, PLLC					x			x	x	x		

## Recovery Supports

Recovery supports are non-clinical services that address psychological and social factors in an individual's environment and provide emotional practical supports to strengthen recovery. These may include integration of trained peer support specialist in programs, rental assistance, or transportation support.

For recovery supports, while some services such as transportation and peer support groups are relatively well-developed, there are critical gaps in specialized clinical recovery supports, faith-based services, and housing and employment-related assistance. Expanding these areas would strengthen the continuum of recovery supports and help ensure individuals

have the resources needed to sustain long-term recovery.

Regarding transportation assistance, there is an estimated need to serve 563 clients, and capacity currently reaches 450 individuals, covering about 80% of demand. While this reflects relatively strong coverage, some additional resources would be needed to ensure transportation is available to all who require it. Rental deposit assistance shows a more significant gap. Out of 620 clients estimated to need support, only 298 are currently served, meaning less than half (48%) of the need is met. Given the importance of stable housing in sustaining recovery, this shortfall points to a priority area for expansion. Job training programs are also limited. Seven programs are estimated as necessary and three are in place, addressing about 43% of demand. This gap suggests that more investment in employment-focused recovery supports could help individuals build skills and economic security.

Peer and mutual aid support groups have relatively strong coverage, with 312 sessions available compared to the estimated need for 396, meeting nearly 79% of demand. Religious advisors with specialization in substance use disorder and mental health are also in short supply. Out of the eight needed providers, only one is available, meeting just 12.5% of the estimated demand. This suggests limited access to faith-based recovery support options tailored to behavioral health.

Recovery drop-in centers show partial coverage, with one of the two needed locations established, reaching 50% of projected capacity. Similarly, peer support services are available in three of six estimated locations, also meeting 50% of demand.

**Table 11. Inventory of Recovery Support Services Provided by Organizations in Randolph County Included in CAST Assessment**

Organization	Rental Assistance	Job Training Programs	Recovery Drop In Centers	Religious Advisors with Specialization in SUD/MH	Peer/Mutual Aid Groups	Transportation Assistance	Peer Support	Other
Brightview					x			
Caring Services, Inc.								x
Daymark Recovery Services								x
Division of Employment and Independence with People Disabilities								x
First United Methodist Church Asheboro				x			x	x
Goodwill Industries of Central North Carolina		x						
Grace Given								x

Organization	Rental Assistance	Job Training Programs	Recovery Drop In Centers	Religious Advisors with Specialization in SUD/MH	Peer/Mutual Aid Groups	Transportation Assistance	Peer Support	Other
Keaton's Place			x		x	x	x	x
North Ridge Church								x
Path of Hope, Inc.								
Randolph County Adult Day Reporting Center		x				x		
Randolph County Public Library - Community Navigator	x	x				x		x
Randolph Health Senior Care								x
Unchained Ministry Randolph County, NC						x	x	
Zen Counseling, PLLC								

## Recovery Residences

There is moderate capacity for Levels I and II recovery residences, but a large gap remains for Level III and Level IV recovery residences. In total, the estimated need is for 129 beds (56 for Level I, 42 for Level II, 23 for Level III, and 8 for Level IV), but the current capacity across all levels is 52 beds (32 in Level I, 20 in Level II, none in Level III nor Level IV). This leaves a shortfall of 77 beds needed to fully meet the demand.

Level I recovery residences, which typically provide peer-run housing without formal treatment services and emphasize a self-governed recovery environment, are currently meeting 57% of their estimated need, with 32 out of 56 beds available (leaving a gap of 24 beds). Level II recovery residences, usually offering monitored housing with structured supports and house rules, are addressing 48% of the demand by providing 20 of the 42 required beds, resulting in a deficit of 22 beds. In contrast, Level III recovery residences, which generally involve more structured recovery support, including life skills development and access to clinical services, have no current capacity to meet the estimated need of 23 beds. Capacity for Level IV recovery residences, which involve licensed professional staff providing structured services, is also lacking. There are no beds in the county, with an estimated need of 8 beds.

## Qualitative Results

JGRE completed a total of nine interviews that included both individuals with lived experience (2) and providers/key stakeholders (7) to better understand the contextual nature of the substance use disorder continuum of care and lived experts and key stakeholders' perspectives on gaps and barriers within the continuum in the County. Regarding gaps in the continuum, the participants expressed a general lack of capacity (common in similar counties) across the continuum of care, including an acute lack of capacity in mental healthcare resources, housing, and transportation. Additionally, the interviews revealed cultural barriers that greatly impact those experiencing SUD and those serving them in the community: stigma around SUD, SUD treatment, and harm reduction strategies, which arise from differing perspectives between those who promote faith-based practices and those who promote evidence-based practices. While these gaps and barriers appear embedded in the culture of Randolph County, the interviews pointed toward improvements and genuine, practical efforts to address these concerns and respond as a community to the overwhelming effects of the opioid epidemic.

### | General Lack of Capacity

Providers and key stakeholders described a wide range of gaps in the SUD continuum of care in Randolph County, intimating a general lack of capacity across the continuum that is common in rural communities. Two providers described “the lack of detox centers” and the need to send clients outside of the county for inpatient treatment. Following detox, providers and lived experts described how people suffering from SUD face a gap in supportive housing capacity. As one provider said,

*“There’ll be people who they’re trying to get sober, and they will be at Daymark, for instance, and go through a detox. Well, they’re there for seven days. Well, the bed that they want and they have been able to secure for them ain’t going to be ready for eight or nine days. What are they going to do in the meantime? They have nowhere to go.”*

*–Provider/key stakeholder, Randolph County*

Upon re-entering the community, providers noted that clients would still face a lack of medications for opioid use disorder (MOUD) prescribers, psychiatrists, pediatric behavioral healthcare, and mental health care, which are necessary to support people suffering from SUD following the most acute stages of treatment and recovery. One provider said, “We do have [mental health providers], but it’s their bandwidth and their capacity is stretched as is, and it’s an ongoing need.” Another provider summed up the lack of capacity for SUD services, saying, “I think the big gap that I’ve seen is that our current systems are stretched way beyond their ability from a capacity standpoint,” and he went on to add, “the same thing is true with their mental health system. I mean, really, we’re beyond the breaking point for capacity for what the need is.”

### | Barriers to Accessing Care: Housing and Transportation

Participants described how these gaps in the SUD continuum of care are exacerbated by barriers to accessing care in the community, such as a lack of housing and transportation.

*“There simply are not enough beds”* for people who are unhoused in the community, one provider said. Regarding transportation, another provider said, *“The biggest gap is also the biggest barrier. There is no public transportation here, and the county is so spread out that a lot of individuals have a very difficult time accessing services.”* While many are able to access services despite these barriers, including through telehealth services, one provider noted that *“I still have to have them come in for a drug screen, and I’ll have people on a regular basis tell me that they’re not able to make it in for a drug screen because they have no transportation.”*

## **Barriers to Accessing Care: Stigma**

Participants also described cultural barriers that people who suffer from SUD and those who serve them face in Randolph County. Every participant described, in some form or fashion, how the stigma surrounding SUD in Randolph County affects those who suffer from SUD and those who serve them. One lived expert described their negative experience with a first responder whom they felt treated them condescendingly because of their drug use and how it led to them not seeking help in future circumstances, saying,

*“Even if I did do drugs, it’s your job to treat us like everybody else. It’s not your job to judge us and what we do. And then on top of that, especially if I didn’t call you out there for a drug overdose or anything like that, I called you out there because I actually needed help. So ever since then, I’ve never went by ambulance.”*

*—Lived expert, Randolph County*

One provider went as far as to say that stigma would be *“the first thing I would address”* regarding the SUD continuum of care in Randolph County. They went on to say, *“I think until people start viewing this as a disease on a much wider scale, it’s very difficult to get the public support, you get the public outcry, but you don’t get the support. I think that would be an enormous benefit to being able to actually encourage people to access some of these resources.”*

In addition to affecting how people in the community treat those suffering from SUD, participants described how stigma acts as a barrier to providing evidence-based practices and resources that could save lives. Interviewees described the stigma associated with naloxone distribution, providing medication assisted treatment, syringe service programs, and other general efforts to feed or house those suffering from SUD. A community-based organization providing critical support services for people with SUD expressed surprise at the community response to meeting community members’ basic needs.

## **Barriers to Accessing Care: Different Perspectives on Evidence-based and Faith-based Practices**

Differing perspectives on evidence-based practices, such as medication assisted treatment (MAT) and naloxone, showed up among the lived experts as well. One lived expert, who was currently using MAT as part of her treatment plan, described her recovery, saying, *“let me tell you, it’s a completely different life and it’s a whole lot better life, that’s for sure.”* The other lived expert, while having come around to seeing naloxone as a life-saving resource, described her reasons for refusing MAT, saying, *“they [SUD treatment providers] talked about*

*getting me on Suboxone or methadone, but in all honesty, I think it's not worth it because you're giving up one drug for another. And I don't want to get back addicted to nothing else because you're going to get addicted to Suboxone."*

Interview participants often connected the stigma surrounding SUD to the diverse perspectives in the community concerning faith-based and evidence-based approaches to harm reduction, treatment, and recovery. Interviews contrasted the perspectives of those who see evidence-based practices, such as naloxone, MAT, and syringe service programs, as life-saving interventions that make recovery possible for those suffering from SUD against those who see such practices as enabling addiction and causing harm to the community.

One provider who promoted evidence-based practices described the perspective of those promoting faith-based practices, saying, *"They don't want anything to do with MAT. They're saying you're swapping one drug for another. Half of them are fighting against Narcan...They don't even want Narcan because it enables them to go use again."*

Another provider/key stakeholder who is an active leader in the religious community summarized the different approaches in the county, saying:

*"There are those that, I would say [believe] that the only way to treat substance use disorder is going to be through things like MAT, and medications, and these needle exchange programs, the harm reduction sort of thing. And that's more a secular approach. And then you've got the faith-based community here that really want a faith-based option, but they don't want any part of that. And so, then you end up with two groups of folks, both of which are parallel playing, that aren't talking to each other. Where I see there being some common ground there, where you might say maybe somebody does need a medication option as they transition, but with the ultimate [goal] that you're going to get them to an abstinence program."*

*—Provider/key stakeholder, Randolph County*

While there are people in the county, and among those interviewed, who voiced support for evidence-based interventions as expressive of their religious commitment to care for others, thus denying it as a purely "secular" perspective, several interviewees described the stigma against evidence-based interventions arising from "traditional beliefs" related to religion. Most participants noted the different perspectives' effect on the conversation in the community around the SUD continuum of care. For one provider, the different perspectives pointed to a need for more education about SUD treatment and harm reduction services, saying, *"I still see a huge need in the community to be educated about harm reduction and to change mindsets about harm reduction."* This provider went on to say that *"pulling [the religious organizations] in and getting them on board would serve us really well in trying to make more strides, because I feel that's where the roadblocks are."* Similarly, another provider/key stakeholder said *"just getting everybody to sit at the table and start discussing the options"* was the best path to improving the SUD continuum of care in Randolph County.

## | Addressing the Gaps and Barriers

The interviews connected the gaps and barriers in the SUD continuum of care to the rural nature and religious culture of Randolph County. And while such gaps and barriers may be hard to overcome, the interviewees also described actions being taken to do so. In response to the broad recognition of Randolph County's lack of transitional housing, Keaton's Place has been working to provide new housing for men and women. Similarly, as one key stakeholder said, "*there's also more educational services for folks in the community to learn,*" addressing the stigma and lack of understanding around SUD. While there's stigma related to MAT and other harm reduction strategies, the lived experts we interviewed said they had easy access to naloxone and a syringe service program. Regarding the different perspectives on evidence-based and faith-based practices, one provider described how recent efforts to overcome barriers have improved "*communication, transparency, and understanding,*" which he hopes will increase engagement and build trust in the community.

# Cost Modeling

For interventions that have an identified capacity gap, JGRE staff produced estimates of the investment that would be required to fill the gap by service line. When available, the estimates were based upon local cost data. When local cost data was not available, JGRE staff first sought out North Carolina specific per unit costs and then supplemented any remaining intervention cost data with national per-unit averages. Sources for per unit costs are included in Appendix A. Of note, these costs only include the cost per treatment episode or per program, not overhead costs of program administration, facility maintenance, staff training, capital investments, or other infrastructure and indirect expenses that organizations may incur to sustain or expand service delivery over time. As such, these estimates should be interpreted as minimum costs associated with direct service provision rather than the full financial requirements of scaling capacity comprehensively. The formula used by JGRE for cost modeling:

$$\text{Capacity Gap in Units} * \text{Per Unit Cost} = \text{Estimated total costs to fill capacity gap}$$

**Table 12. Cost Modeling for Selected Interventions**

Service	Estimated Need	2024 Capacity Estimate	Capacity Gap in Units	Per Unit Cost	Estimated Total Cost To Fill Gap
<b>Prevention</b>					
School-Based Prevention – SUD/MH/Wellness	65	31	34	\$ 985.00	\$ 33,490.00
Community-Based Prevention Programs	67	40	27	\$ 985.00	\$ 26,595.00
<b>Harm Reduction</b>					
Syringe Service Programs	3	1	2	\$ 400,000.00	\$ 800,000.00
Opioid Overdose Response Teams	1	0	1	\$173,568.00	\$173,568.00
Prescription Drug Dropoff Locations	8	4	4	\$ 2,000.00	\$ 8,000.00
Medication Take Back Events	5	1	4	\$ 640.00	\$ 2,560.00
Naloxone	5684	5382	302	\$ 35.00	\$ 10,570.00
Access to Fentanyl Test Strips	2459	817	1642	\$ 1.00	\$ 1,642.00
<b>Diversion</b>					

Service	Estimated Need	2024 Capacity Estimate	Capacity Gap in Units	Per Unit Cost	Estimated Total Cost To Fill Gap
MAT in Jails/Prisons	1	1	0	\$3,769.07	\$0.00
Adult Specialty Courts	2	1	1	\$3,942.00	\$3,942.00
Youth Specialty Courts	0	0	0	\$3,942.00	\$0.00
<b>Treatment</b>					
Inpatient Services (Hospital Based)	5	0	5	\$ 32,523.00	\$162,615.00
Detoxification – Non-Residential*	2	1	1	\$141,000.00	\$141,000.00
Regular Outpatient Services	9	6	3	\$586,000	\$1,758,000.00
Substance Use Disorder Counselors	35	13	22	\$50,000.00	\$1,100,000.00
Opioid Treatment Program	4	2	2	\$3,769.07	\$7,538.14
Behavior Analysts	0	0	0	\$50,000.00	\$0.00
<b>Recovery Supports</b>					
Transportation Supports	563	450	113	\$100	\$11,300.00
Rental Deposit Assistance	620	298	322	\$4,500.00	\$1,449,000.00
Job Training	7	3	4	\$ 86,550.00	\$346,200.00
Peer Support Groups	6	3	3	\$3,992.00	\$11,976.00
<b>Recovery Residences</b>					
Level I Recovery Residences	7	4	3	\$46,000.00	\$138,000.00
Level II Recovery Residences	5.25	2	3.25	\$120,000.00	\$390,000.00
Level III Recovery Residences	3.8	0	3.8	\$254,000.00	\$965,200.00
Level IV Recovery Residences	1	0	1	\$3,790,828.00	\$3,790,828.00

## Conclusion

The CAST assessment of Randolph County's substance use disorder continuum of care highlights areas of both progress and opportunity across prevention, treatment, harm reduction, and recovery support services. While many residents experience challenges accessing care due to limited service availability, logistical barriers such as housing and transportation, and stigma, there are promising efforts underway to strengthen the local response.

Notable strengths include the widespread distribution of naloxone and test strips, emerging investments in recovery housing, and increased community education aimed at improving understanding and reducing stigma. At the same time, the assessment points to areas where additional resources and collaboration could help further expand capacity, particularly in prevention programming, residential treatment options, supportive housing, and transportation services.

Effectively addressing these needs will benefit from sustained partnership across sectors, shared learning among providers, and constructive dialogue among community members, including those with diverse perspectives on recovery approaches. Enhancing capacity is not only about expanding service provision but also fostering trust, coordinating efforts, and ensuring support is accessible, welcoming, and responsive to individuals and families affected by substance misuse.

As Randolph County continues this work, this assessment can serve as a roadmap for setting priorities, guiding resource allocation, and tracking progress toward a more comprehensive, coordinated, and equitable system of care that meets the needs of individuals and families across the community.

# Appendix A

**Table 13. List of Organizations Who Responded to the Randolph County SUD CAST Survey**

Organization	Type
AHS Randolph Health Internal Medicine	Primary Care Provider
Alcohol and Drug Services of Asheboro	Behavioral Healthcare Provider
Asheboro Mind & Body Wellness PLLC	Mental Healthcare Provider
Brightview	Behavioral Healthcare Provider/Opioid Treatment Program
Caring Services, Inc.	Behavioral Healthcare Provider
Chatham Recovery/Morse Clinic of Asheboro	Opioid Treatment Program
Community Hope Alliance	Nonprofit
Daymark Recovery Services	Mental Healthcare Provider
District Attorney’s Office	Government
First United Methodist Church Asheboro	Faith-based
Goodwill Industries of Central North Carolina	Nonprofit
Grace Given	Faith-based
Insight Human Services	Nonprofit
Juvenile Day Reporting Center	Government
Keaton’s Place	Nonprofit
Kintegra Health	Federally Qualified Health Center (FQHC)
NC Division of Employment and Independence for People with Disabilities (EIPD)	Government
NC Works Career Center of Randolph County	Government
North Ridge Church	Faith-based
Path of Hope, Inc.	Behavioral Healthcare Provider
Project Safe Randolph	Law Enforcement
Randolph County Adult Day Reporting Center	Pretrial Release Program
Randolph County Emergency Services	Government
Randolph County Public Health	Government
Randolph County Public Library	Government
Randolph County Sheriff’s Office/Detention Center	Law Enforcement/Government
Randolph Health Hospital	Hospital
Randolph Health Senior Care	Primary Care Provider

Organization	Type
Trillium Health Resources	Local Management Entity/ Managed Care Organization
Unchained Ministry Randolph County, NC	Nonprofit
Zen Counseling, PLLC	Mental Healthcare Provider

**Table 14. Sources for County Social Determinants of Health Characteristics**

County Characteristics	Source
Total population	Oregon Public Health Assessment Tool Portland State University (OPHAT PSU) Population Estimates (2020)
Percent of adult population that is male	OPHAT PSU Population Estimates (2020)
Percent of population that is non-white	National Center for Health Statistics Population Estimates (2020)
Percent of county that is rural	American Community Survey (ACS) 5-Yr Estimates (2020)
High school dropout rate	ACS 5-Yr Estimates (2020)
Veteran population	ACS 5-Yr Estimates (2020)
Percent of households with income below \$35,000	ACS 5-Yr Estimates (2020)
Percent of population with a college degree	ACS 5-Yr Estimates (2020)
Percent of population that is widowed or divorced	ACS 5-Yr Estimates (2020)
Percent of population that is uninsured	ACS 5-Yr Estimates (2020)
Association rate per 100,000 people	County Business Patterns, US Census (2020)
County designated as a high incidence drug trafficking area	Office of National Drug Control Policy, HIDTAs (2024)
Alcohol outlet density rate per 100,000 people	County Business Patterns, US Census (2020)
Violent crime rate per 100,000 people	County Health Rankings
Percent of population with access to physical activity	Behavioral Risk Factor Surveillance System (BRFSS) (2021)
Percent of population that is age 18 or below	ACS 5-Yr Estimates (2020)

**Table 15. Sources for Cost Modeling**

Service	Sources
<b>Prevention</b>	
School-based Prevention – SUD/MH/Wellness	<a href="https://pmc.ncbi.nlm.nih.gov/articles/PMC3174026/">https://pmc.ncbi.nlm.nih.gov/articles/PMC3174026/</a>
Community-based Prevention Programs	<a href="https://pmc.ncbi.nlm.nih.gov/articles/PMC3174026/">https://pmc.ncbi.nlm.nih.gov/articles/PMC3174026/</a>
<b>Harm Reduction</b>	
Syringe Service Programs	<a href="https://pmc.ncbi.nlm.nih.gov/articles/PMC6485753/#:~:text=The%20estimated%20costs%20ranged%20from,for%20economic%20evaluation%20of%20SSPs.">https://pmc.ncbi.nlm.nih.gov/articles/PMC6485753/#:~:text=The%20estimated%20costs%20ranged%20from,for%20economic%20evaluation%20of%20SSPs.</a>
Opioid Overdose Response Team	<a href="https://www.jsatjournal.com/article/S2949-8759%2824%2900229-7/abstract">https://www.jsatjournal.com/article/S2949-8759%2824%2900229-7/abstract</a>
Prescription Drug Dropoff Locations	<a href="https://americansecuritycabinets.com/products/medication-disposal-boxes/?srsltid=AfmBOopalnaIn-sVqwyNcGIP60T5LU9ToueTGpJCF_xiiVzt5f00Wo8A">https://americansecuritycabinets.com/products/medication-disposal-boxes/?srsltid=AfmBOopalnaIn-sVqwyNcGIP60T5LU9ToueTGpJCF_xiiVzt5f00Wo8A</a>
Medication Take Back Events	<a href="https://www.ncdoi.com/osfm/safekids/Documents/OMD/Safe%20Drug%20Disposal%20Fact%20Sheet.pdf">https://www.ncdoi.com/osfm/safekids/Documents/OMD/Safe%20Drug%20Disposal%20Fact%20Sheet.pdf</a>
Naloxone	Remedy Alliance
Access to Fentanyl Test Strips	<a href="https://www.lochnessmedical.com/Product/fentanyl-test-strips-10-pack">https://www.lochnessmedical.com/Product/fentanyl-test-strips-10-pack</a>
<b>Diversion</b>	
MAT in Jails/Prisons	<a href="https://www.thenationalcouncil.org/wp-content/uploads/2022/02/MAT_in_Jails_Prisons_Toolkit_Final_12_Feb_20.pdf?">https://www.thenationalcouncil.org/wp-content/uploads/2022/02/MAT_in_Jails_Prisons_Toolkit_Final_12_Feb_20.pdf?</a>
Adult Specialty Courts	<a href="https://addictionpolicy.stanford.edu/drug-courts-alternative-incarceration?utm">https://addictionpolicy.stanford.edu/drug-courts-alternative-incarceration?utm</a>
Youth Specialty Courts	<a href="https://addictionpolicy.stanford.edu/drug-courts-alternative-incarceration?utm">https://addictionpolicy.stanford.edu/drug-courts-alternative-incarceration?utm</a>
<b>Treatment</b>	
Inpatient Services	<a href="https://drugabusestatistics.org/cost-of-rehab/">https://drugabusestatistics.org/cost-of-rehab/</a>
Detoxification – non-residential*	<a href="https://drugabusestatistics.org/cost-of-rehab/">https://drugabusestatistics.org/cost-of-rehab/</a>
Outpatient Services	<a href="https://drugabusestatistics.org/cost-of-rehab/">https://drugabusestatistics.org/cost-of-rehab/</a>
Substance Use Disorder Counselors	<a href="https://www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm?">https://www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm?</a>

Service	Sources
Opioid Treatment Program	<a href="https://pmc.ncbi.nlm.nih.gov/articles/PMC2614666/">https://pmc.ncbi.nlm.nih.gov/articles/PMC2614666/</a>
Behavior Analysts	<a href="https://www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm?">https://www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm?</a>
<b>Recovery Supports</b>	
Peer Support Groups	<a href="https://www.osbm.nc.gov/peer-support-services-rf-summary/download?attachment">https://www.osbm.nc.gov/peer-support-services-rf-summary/download?attachment</a>
Transportation Supports	<a href="https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-5-Mandated-Report-on-Non-Emergency-Medical-Transportation.pdf?utm_">https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-5-Mandated-Report-on-Non-Emergency-Medical-Transportation.pdf?utm_</a>
Rental Subsidies	<a href="https://www.urban.org/policy-centers/research-action-lab/projects/sizing-federal-rental-assistance/north-carolina">https://www.urban.org/policy-centers/research-action-lab/projects/sizing-federal-rental-assistance/north-carolina</a>
Rental Deposit Assistance	<a href="http://www.ncleg.net/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_42/Article_6.pdf">www.ncleg.net/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_42/Article_6.pdf</a>
Job Training	<a href="#">Piedmont Triad Regional Council Workforce Innovation &amp; Opportunity Act (WIOA) FY24 RFP budget</a>
<b>Recovery Residences</b>	
Level I Recovery Residences	<a href="https://www.ohiorecoveryhousing.org/_files/ugd/58fa82_eaab548e46c43d694345ff8960a1f36.pdf">https://www.ohiorecoveryhousing.org/_files/ugd/58fa82_eaab548e46c43d694345ff8960a1f36.pdf</a>
Level II Recovery Residences	<a href="https://www.ohiorecoveryhousing.org/_files/ugd/58fa82_eaab548e46c43d694345ff8960a1f36.pdf">https://www.ohiorecoveryhousing.org/_files/ugd/58fa82_eaab548e46c43d694345ff8960a1f36.pdf</a>
Level III Recovery Residences	<a href="https://www.ohiorecoveryhousing.org/_files/ugd/58fa82_eaab548e46c43d694345ff8960a1f36.pdf">https://www.ohiorecoveryhousing.org/_files/ugd/58fa82_eaab548e46c43d694345ff8960a1f36.pdf</a>
Level IV Recovery Residences	<a href="https://www.ohiorecoveryhousing.org/_files/ugd/58fa82_eaab548e46c43d694345ff8960a1f36.pdf">https://www.ohiorecoveryhousing.org/_files/ugd/58fa82_eaab548e46c43d694345ff8960a1f36.pdf</a>

## Appendix B

**School-based prevention program:** evidence-based, universal, selective, or indicated substance use prevention or mental health promotion programs delivered within a school setting. (“Universal” refers to strategies aimed at the entire population; “selective” targets specific subgroups identified as having a higher risk of substance abuse; and “indicated” focuses on individuals showing early signs of substance use problems but not yet diagnosed with a disorder).

**Community-based prevention program:** evidence-based, universal, selective, or indicated substance use prevention or mental health promotion programs intended for community members delivered by non-profit or social services agencies. (“Universal” refers to strategies aimed at the entire population, “selective” targets specific subgroups identified as having a higher risk of substance abuse, and “indicated” focuses on individuals showing early signs of substance use problems but not yet diagnosed with a disorder).

**Fentanyl and/or xylazine test strips:** fentanyl test strips (FTS) are small strips of paper that can detect the presence of fentanyl in different kinds of drugs (cocaine, methamphetamine, heroin, etc.) and drug forms (pills, powder). Similarly, xylazine test strips (XTS) are small strips of paper that can detect the presence of xylazine.

**Naloxone units:** the number of units and locations where naloxone units (2 doses in each kit; commonly referred to as Narcan) are provided at no cost.

**Prescription drug disposal locations:** registered locations to manage the disposal of prescription drugs for the purpose of decreasing the availability of prescription drugs in the community that may be used for illicit purposes.

**Medication take back events:** a program that coordinates events for the disposal of prescription drugs for the purpose of decreasing the availability of prescription drugs in the community that may be used for illicit purposes.

**Post overdose response team (PORT):** an overdose follow-up program with trained team members that allows agencies to visit a person who experienced an overdose within 24-72 hours of the incident.

**Syringe service programs:** community-based programs that provide a range of services aimed at reducing the harms associated with drug use, particularly injection drug use.

**Education on safer drug use/overdose safety planning:** a safety plan is used to identify overdose risk factors, prevention and coping strategies, as well as supports and resources with patients at risk of accidental overdose.

**Opioid Treatment Program (OTP):** location or provider licensed by federal and state authorities for prescribing and dispensing of the U.S. Food and Drug Administration approved medications including methadone, buprenorphine, and naltrexone for the treatment of opioid use disorder (OUD).

**Detox - ambulatory:** outpatient detoxification; per ASAM criteria, detox is integrated into all levels of care.

**Detox - free standing:** medical acute care services in non-hospital, free-standing residential setting for safe withdrawal and transition to ongoing treatment that operates 24-hours.

**Detox - hospital inpatient:** medically managed or monitored inpatient detoxification.

**Office-based opioid treatment (OBOT):** a provider who actively prescribes buprenorphine or naltrexone in a primary care setting.

**Outpatient:** outpatient treatment, non-intensive, in which individuals receive regularly scheduled services, such as individual or group counseling, education, and recovery support, while living at home and maintaining daily responsibilities.

**Intensive outpatient program (IOP):** clinical outpatient services requiring a minimum of 9 hours per week of programming.

**Partial hospitalization:** highly structured outpatient day treatment or partial hospitalization with 20 or more hours per week of programming.

**Short-term residential (non-hospital, 30 days or less):** residential treatment program that provides intensive care for a period of 30 days or less outside of a hospital setting.

**Long-term residential (non-hospital, 30 days or more):** residential treatment program that involves living in a facility for more than 30 days outside of a hospital setting.

**Hospital inpatient treatment:** medically managed or monitored intensive inpatient treatment.

**Substance use disorder counseling:** also known as addiction counselors, are licensed/certified mental health professionals who help people with substance use disorders recover from addiction and modify behaviors.

**Treatment of other substance use disorders (e.g., stimulant use disorder, alcohol use disorder):** also known as addiction counselors, are licensed/certified mental health professionals who help people with recover from addiction and modify behaviors.

**Mental/behavioral health counseling:** licensed professionals who treat the cognitive, behavioral, and emotional aspects of mental health and substance use conditions.

**Abstinence-based counseling:** substance use disorder treatment services in which clients must completely abstain from drugs and alcohol while receiving services.

**Adult specialty court:** provision of substance use disorder treatment in combination with collaborative case management and supervision as an alternative to incarceration for adults with substance use disorders who become involved in the criminal justice system.

**Medication-assisted treatment (MAT) in jails and prisons:** provision of pharmacotherapy (e.g., buprenorphine, methadone, naltrexone) for opioid dependence in jail and prison settings.

**Recovery residences, including sober living houses, for adults:** recovery residences provide safe, healthy living environments based on a social model of recovery for adults living with substance use disorder; National Association of Recovery Residences standard level: 1 - 4, or uncertified recovery residence.

**Rental assistance:** funding that helps program participants pay rent and other housing

costs to obtain stable housing.

**Job training programs:** programs aimed at boosting workers' employability and earnings through training and/or certification.

**Recovery drop-in centers:** a place where people in recovery, their friends, family, and other supportive services can come together to connect, develop peer networks, and receive mutual support.

**Religious advisors with specialization in SUD/MH:** spiritual leaders or clergy who have expertise in addressing the intersection of faith, addiction, and mental health challenges. They provide spiritual guidance, emotional support, and counseling to individuals with SUD and/or mental health.

**Mutual aid groups** (such as AA/NA/MARA): peer support groups and community-based gatherings of individuals who share a common goal of overcoming challenges related to addiction or other life struggles (e.g., alcoholics anonymous, narcotics anonymous, medicated assisted recovery anonymous).

**Transportation assistance:** services, programs, or initiatives designed to address transportation barriers (e.g., providing gas cards, volunteer drivers to connect people to services, Uber/Lyft gift cards).

**Peer support specialist (PSS):** a person in with 18+ months in recovery from serious mental illness and/or substance use disorder who received training in how to support others seeking recovery.