

# Community Assessment of Mental Health Care Continuum

Randolph County, NC  
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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 mental healthcare needs of the county's youth and adult populations. 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 mental health continuum of care to understand areas of greatest need. For this assessment, estimates of capacity were created for 28 interventions for youth and 28 interventions for adults across the continuum of care. This report is the second in a series completed by JG Research & Evaluation (JGRE) for Randolph County Public Health to inform resource planning within the county. The first report focused on the capacity of the existing Substance Use Disorder Care Continuum.

One note, this assessment was completed using 2024 organizational capacity data. During the writing of this report, there were changes in the nature of grant making and investment by Federal agencies. It is important to recognize that existing programs included in this report are reliant on Federal funding, and if these funds are removed, it will greatly impact the capacity of the Randolph County care system to support residents with mental health needs.

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## Key Findings

### Youth Key Findings

- There is a general lack of promotion, prevention, and early intervention programming. Prevention programs meet about half of the estimated need in the county.
- School-based mental health promotion, prevention, and early intervention services could not be fully included in this assessment due to lack of data. However, capacity estimates suggest 34 school-based programs are necessary.
- Medication therapy and intensive outpatient treatment are mostly adequate, but most other services (screening, outpatient therapy, trauma treatments) fall short of estimated needs, and many (family/group therapy, care coordination, integrated treatment, mental health consultation) are absent from this assessment, thus shown not meeting the estimated needs within the county.
- Parent/youth peer support and many home/community supports are unavailable or very limited.
- Specialized services for transition age youth (education, employment, housing, peer support) are absent.

### Adult Key Findings

- For awareness and prevention, general mental health promotion and education programs are moderately established, meeting about 63–70% of estimated needs. However, suicide prevention resources are limited, with suicide awareness events and prevention programs covering about 10–13% of need. Other prevention programs reach about 35% of demand, suggesting room for expansion across all prevention services.
- Screening in primary care for depression, anxiety, and substance use is partially

implemented, meeting roughly 57% of estimated need.

- The mental health workforce is adequate but does not fully meet the needs of the county. Social workers are the most available treatment providers, covering 83% of the need. Counselors meet just over half of the estimated demand, while psychiatrists, nurse practitioners, and medication management services each meet only about 22–29%.
- There is a lack of psychologists, intensive outpatient programs (IOP), ACT teams, or inpatient psychiatric beds available locally, leaving critical service gaps.
- Partial hospitalization and assisted outpatient treatment are also less robust, with less than 15% of need met.
- Transportation support is limited (12% of need met), and there are no guardianship services or community paramedicine programs, highlighting important access barriers for ongoing support.

### **Crisis Services - Youth and Adults Key Findings**

- Randolph County currently meets the estimated need for 988 call services. However, there is no local crisis hotline apart from 988, highlighting an opportunity to broaden crisis response options beyond the national line.
- Mobile response could be implemented in the county to ensure in-person response by mental health professionals for people experiencing a mental health crisis event.
- There is a lack of available services that provide crisis receiving and/or crisis stabilization.

# Methodology and Assessment Approach

## CAST 2.0

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The Calculating an Adequate System Tool (CAST) produces estimates of program saturation in a local mental health system across the continuum of care. For this assessment, we distinguished between services for youth (up to age 18) and adults (age 18+).

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 of 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 for the mental health services assessment is an estimate based upon four types of potential users of the mental health care system:

- Population 1 – Individuals with a diagnosed mental health disorder in the past 12 months
- Population 2 – Individuals with a diagnosed disorder, lifetime
- Population 3 – Individuals identified needing treatment, excluding those in populations 1 or 2
- Population 4 – Individuals not identified as needing treatment, and using a mental health provider

These estimates are based upon scholarship undertaken by Bruffets et al. (2015) and offset by population-based estimates compiled in the National Survey on Drug Use and Health

(NSDUH) and the Youth Risk Behavior Survey (YRBS). 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 report, CAST was used to:

1. Identify potential gaps and potential redundancies in the mental health disorder care system for youth and adults.
2. 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 mental health services 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.

## 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 that covered adult and youth mental health services. The survey asked organizations to provide detailed information about the activities they have undertaken in the adult mental healthcare continuum (i.e., awareness and prevention programs, screening and identification in primary care, treatment providers and levels of care, ongoing support services, and emergency response) and the youth mental healthcare continuum (i.e., promotion, prevention, and early intervention services; home- and community-based treatment; supportive resources for youth and families; and specialized supports designed to help young people transition to adulthood). The survey was directly sent to 17 organizations, and 11 completed the survey for a 65% response rate. Table 1 shows the organizations included in the sample as well as the populations they serve (i.e., youth and/or adult).
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. No additional mental health providers (for adults or youth) were identified through N-SUMHSS.

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.

Data from 11 organizations working within the mental health care continuum in Randolph County were included in this assessment. Additional data was provided by Randolph County Public Health about service provision in the county. Each of these organizations provided primary data through surveys administered during the study period. The survey covered youth services (n = 8) and adult services (n=9); 6 organizations provide both youth and adult mental health services.

**Table 1. List of Organizations Who Responded to the Randolph County Mental Health CAST Survey**

Organization	What Best Describes Your Organizational Type?	Youth (0 - 17 years)	Adults (18 years +)
AKB Counseling	Mental Health Provider	x	x
Asheboro Counseling and Wellness	Mental Health Provider	x	x
Connecting Bridges, LLC	Behavioral Health Provider		x
Marc Lewis, LCSW, PLLC	Behavioral Health Provider	x	x
New Horizons Treatment Center	Behavioral Health Provider		x
Randolph Counseling Center	Mental Health Provider	x	x
Randolph Health	Hospital	x	x
Wildflower Counseling and Consulting PLLC	Mental Health Provider	x	x
Youth Haven Services	Behavioral Health Provider	x	
Youth Unlimited Inc.	Mental Health Provider	x	
Zen Counseling, PLLC	Mental Health Provider		x

To identify all eligible organizations working across the mental health continuum of care in Randolph County, North Carolina, JGRE staff worked directly with members of Randolph County Public Health. For the survey outreach, county staff distributed recruitment emails to organization contacts and completed two follow-up e-mails for reminders and called organizations who did not respond to the e-mail requests.

Following the period of primary data collection, JGRE staff collected supplementary information from N-SUMHSS, NSDUH, YRBS, and complementary sources.

# Population-Based Estimates

Surveillance and monitoring of mental health conditions 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

### NSDUH

The National Survey on Drug Use and Health (NSDUH) is intended to create state and national estimates of substance use and mental health outcomes for adults. 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 mental health conditions (e.g., suicidal ideation, depression) within Randolph County.

We do so by applying the state-level percentages from the model-based statewide NSDUH 2021-2022 to the Randolph County population, as demonstrated in Table 2. For these estimates, the total population of those age 18-65 = 87,306, and the total population of those age 12-17 = 19,169, based upon 2024 U.S. Census population estimates.

For the current assessment, the most recent NSDUH estimates (2022) were applied to the Randolph County population. It is important to note that the 2020 NSDUH estimates were impacted by data collection restrictions associated with the COVID-19 pandemic. SAMHSA has recommended that organizations limit direct comparisons between estimated population totals from 2020.

**Table 2. NSDUH-Based Prevalence Estimates (age 18 - 65) for North Carolina Applied to the Population of Randolph County**

Outcome	North Carolina	Estimated Population
	Prevalence Estimates 2022	in Randolph County 2024
Serious Mental Illness in the Past Year	5.38%	4,697
Any Mental Illness in the Past Year	21.32%	18,547
Major Depressive Episode in the Past Year	8.69%	7,586
Co-Occurring Substance Use Disorder and Any Mental Illness in Past Year	7.53%	6,574
Had Serious Thoughts of Suicide	4.45%	3,885
Made Any Suicide Plans in Past Year	1.35%	1,178
Attempted Suicide in Past Year	0.64%	559

Outcome	North Carolina Prevalence Estimates 2022	Estimated Population in Randolph County 2024
Received Mental Health Services in the Past Year	22.8%	19,905

**YRBS - Adolescent Mental Health**

The Youth Risk Behavior Survey (YRBS), conducted by the CDC, includes high school students from both private and public schools within the U.S. and aims to measure and understand many health-related topics affecting American youth, including mental health. The YRBS collects data from students in grades 9–12. Like NSDUH, the YRBS does not produce county-specific prevalence estimates, but it can be used to produce general estimates of the prevalence of youth mental health conditions (e.g., suicidal ideation, feeling sad or hopeless) within Randolph County. The same methodology as NSDUH is applied to YRBS to create prevalence estimates. The most recent YRBS estimates (2023) were applied to the Randolph County population. Table 3 demonstrates the estimated youth population in the county.

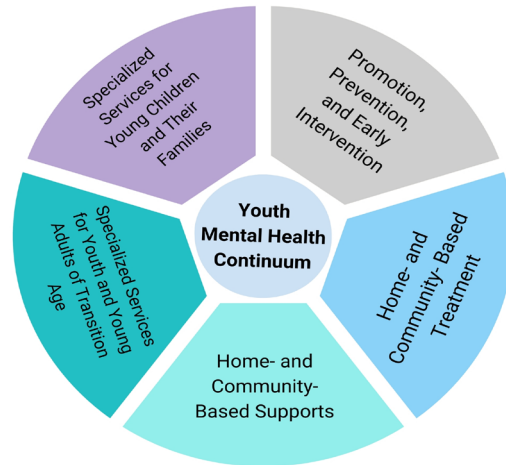
**Table 3. YRBS-Based Prevalence Estimates; High School Youth Risk Behavior Survey (2023)**

Outcome	North Carolina Prevalence Estimates 2023	Estimated Population in Randolph County 2024
Mental health was most of the time or always not good	30%	5,750
Felt sad or hopeless	39.1%	7,495
Seriously considered attempting suicide	18.2%	3,488
Made a plan about how they would attempt suicide	15.9%	3,047
Actually attempted suicide	9.5%	1,821
Suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse	2.2%	421

# Youth Mental Health Continuum of Care

The current landscape of youth mental health services in Randolph County has areas of both strengths and gaps across the continuum of care. The analysis includes promotion, prevention, and early intervention services; home- and community-based treatment; supportive resources for youth and families; and specialized supports designed to help young people transition to adulthood. While some core treatment services, such as assessment, medication management, and intensive outpatient care, are relatively well established, many other interventions, particularly those focused on early prevention, coordinated care, peer support, and transitional services, are limited. The data included in this assessment illustrates the proportion of estimated need currently being met for each intervention area and underscores opportunities to expand capacity and strengthen supports for children, youth, and young adults across Randolph County.

**Figure 1. Youth Mental Health Continuum of Care**



**Table 4. Youth Mental Health Current Capacity and Estimated Capacity Needs for Randolph County**

Intervention	Unit	Observed	Estimated Need	Proportion of Need Being Met
<b>Promotion, Prevention, and Early Intervention</b>				
Prevention – Universal	Programs	2	4	50.0%
Prevention – Selective	Programs	1	5	20.0%
Prevention – Indicated	Programs	3	6	50.0%
Early Intervention – School-Based	Programs	0	34	0.0%
<b>Home- and Community-Based Treatment</b>				
Screening	Providers	11	31	35.1%
Assessment and Diagnosis	Providers	11	14	78.6%
Outpatient Therapy – Individual	Providers	4	13	30.8%
Outpatient Therapy – Family	Providers	0	2	0.0%
Outpatient Therapy – Group	Providers	0	2	0.0%
Medication Therapies	Providers	1	1	100%
Tiered Care Coordination	Providers	0	28	0.0%
Intensive Care Coordination (e.g., using Wraparound)	Providers	0	20	0.0%

Intervention	Unit	Observed	Estimated Need	Proportion of Need Being Met
Intensive In-Home Mental Health Treatment	Providers/ Teams	8	15	53.3%
Trauma-Specific Treatments	Providers	1	4	25.0%
Intensive Outpatient and Day Treatment	Locations	1	1	100%
Integrated Mental Health and Substance Use Treatment	Providers	0	7	0.0%
Mental Health Consultation (e.g., to primary care, education)	Providers	0	40	0.0%
Telehealth (video and audio)	Providers	4	30	13.3%
<b>Home- and Community-Based Supports</b>				
Parent Peer Support	Providers	0	21	0.0%
Youth Peer Support	Providers	0	15	0.0%
School-Based Mental Health Services	Providers	1	4	25.0%
Behavior Management Skills Training	Providers	1	10	10.0%
Youth and Family Education	Providers	1	8	12.5%
<b>Specialized Services for Youth and Young Adults of Transition Age</b>				
Supported Education	Providers	0	16	0.0%
Supported Employment	Providers	0	13	0.0%
Supported Housing - Temporary	Providers	0	6	0.0%
Supported Housing - Long-Term/ Permanent	Providers	0	4	0.0%
Young Adult Peer Support	Providers	0	8	0.0%

## Promotion, Prevention, and Early Intervention

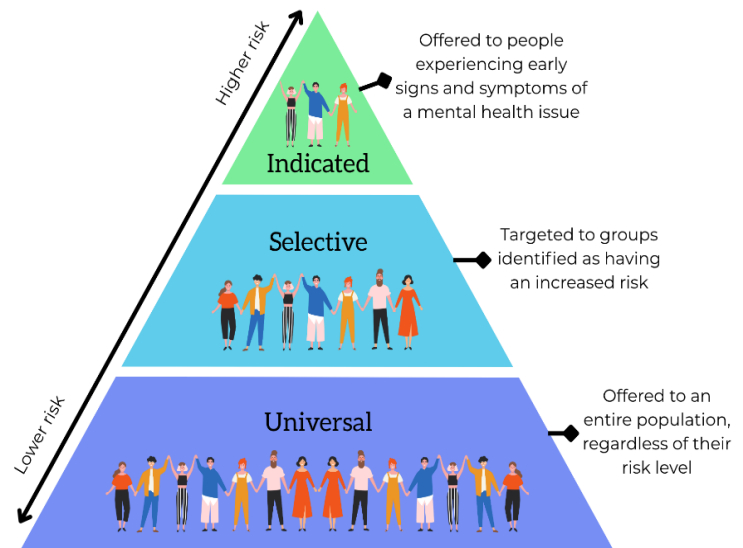
Randolph County has limited availability of mental health promotion and prevention programs for youth, with few options in place to support early wellness and reduce risk factors broadly. Prevention programs are more robust for children and youth already identified as at risk or showing early signs of concern, although some gaps remain. This pattern suggests a need to strengthen universal promotion and prevention efforts while continuing to expand early intervention supports.

For prevention programs (see Figure 2), **universal programs** refer to those designed for all children and youth, regardless

of individual risk factors. These efforts aim to promote mental well-being and prevent problems before they arise. Examples include school-wide social-emotional learning curricula or public education campaigns that encourage healthy coping skills. **Selective programs** target groups of young people who are at higher risk of developing mental health concerns due to factors such as exposure to trauma, family history of mental illness, or economic hardship. These programs provide additional support and resources tailored to help reduce the likelihood of more serious issues developing over time. And third, **indicated programs** focus on children and youth already showing early signs or mild symptoms of mental health challenges but who do not yet meet full diagnostic criteria for a disorder. These services aim to address concerns promptly to prevent them from becoming more severe. School-based programs can include any prevention or early intervention activities delivered within schools. These can be universal, selective, or indicated, and are designed to make prevention and early support more accessible by integrating them into the school day. Indicated prevention programs are often called early intervention.

Youth-focused promotion, prevention, and early intervention services in Randolph County are unevenly available. Universal prevention programs meet 50% of estimated need and indicated prevention programs cover half of the demand. Selective prevention is more limited, with only about 20% of need met (Table 4). One limitation is that we did not receive data for school-based promotion, prevention, or early intervention programs, leaving a significant gap in estimates and unable to assess services that could reach youth in educational settings.

Figure 2. Prevention Programs by Risk Level



**Table 5. Inventory of Youth Promotion, Prevention, and Early Intervention Services Provided by Organizations in Randolph County Included in CAST Assessment**

Organization	Prevention - Universal	Prevention- Selective	Prevention - Indicated
Asheboro Counseling and Wellness			x
Marc Lewis, LCSW, PLLC	x		
Randolph Counseling Center			x
Youth Unlimited Inc.	x	x	x

### Home- and Community-Based Treatment

Randolph County has a mix of established and limited home- and community-based mental health treatment services for youth. Screening is available through 11 providers, meeting about 35% of estimated need, while assessment and diagnosis services are stronger, covering nearly 78% of demand with the same number of providers. Outpatient individual therapy is offered by four providers, reaching around 30% of the estimated need, but family and group therapy are currently not as robust. However, this data may not have been provided for the CAST assessment.

Medication therapies and intensive outpatient or day treatment are close to full capacity, meeting over 80% and 95% of need, respectively. Intensive in-home treatment is provided by eight teams or providers, meeting about 55% of estimated need. In contrast, tiered care coordination, intensive care coordination, integrated mental health and substance use treatment, and mental health consultation are not available, or data was not able to be found for this assessment. Trauma-specific treatments are limited, with one provider covering about 23% of demand, and telehealth services are provided by four organizations but meet only about 13% of estimated need. Overall, while certain core services are well developed, several specialized supports and coordinated care options remain areas for growth.

**Table 6. Inventory of Youth Home- and Community-Based Treatment Services Provided by Organizations in Randolph County Included in CAST Assessment**

Provider	Screening	Assessment and Diagnosis	Outpatient Therapy—Individual	Outpatient therapy—Group	Medication Therapies	Tiered Care Coordination	Intensive Care Coordination	Intensive In-Home Mental Health Treatment	Trauma-Specific Treatments	Intensive Outpatient and Day Treatment	Integrated Mental Health and Substance Use Treatment	Mental Health Consultation	Telehealth
Marc Lewis, LCSW, PLLC	X	X	X						X			X	X
Youth Unlimited Inc.	X	X	X	X			X	X	X			X	X
Youth Haven Services	X	X	X		X			X		X			X

## Home- and Community-Based Supports

There are limited home- and community-based supports for youth and families in the county. No providers that participated in the CAST assessment offer parent peer support or youth peer support, despite estimated needs for 21 and 15 providers, respectively. School-based mental health services are available through one provider, covering about 24% of the need. Behavior management skills training is also offered by one provider but meets only about 10% of the estimated demand. Similarly, youth and family education services are limited, with one provider meeting roughly 12% of the need. Overall, most of these supports are either unavailable or operating below capacity of what is needed.

**Table 7. Inventory of Youth Home- and Community-Based Supports Services Provided by Organizations in Randolph County Included in CAST Assessment**

Organization	Parent Peer Support	Youth Peer Support	School-Based Mental Health Services	Behavior Management Skills Training	Youth and Family Education
Youth Unlimited			X	X	X

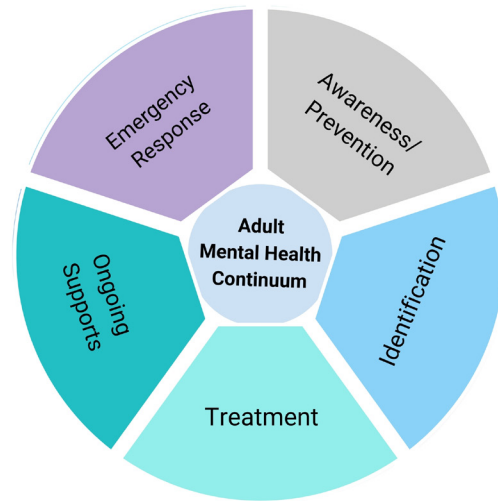
### **Specialized Services for Youth and Young Adults of Transition Age**

No capacity data was provided for specialized services for youth and young adults of transition age interventions. Randolph County currently lacks specialized services for youth and young adults of transition age across several key areas. No providers are offering supported education, where an estimated 16 providers are needed. Supported employment also has no available providers, despite an estimated need for 13. Similarly, there are no services in place for supported housing, either temporary (with an estimated need for 6 providers) or long-term/permanent (estimated need of 4). The need for young adult peer support is an estimated 8 providers. As a result, these gaps mean that all estimated needs in this area of the youth mental health continuum are unmet, underlining opportunities to develop services that can help young people successfully transition to adulthood.

# Adult Mental Health Continuum of Care

Randolph County’s mental health and crisis services for adults show a mix of strengths and areas for improvement when compared to estimated community needs. The data highlight capacity across awareness and prevention programs, screening and identification in primary care, treatment providers and levels of care, ongoing support services, and emergency response resources. Together, these findings illustrate where services are relatively well established and where additional investments or partnerships could help build a more complete continuum of care.

**Table 8. Adult Mental Health Continuum**



## Capacity Estimates

**Table 9. Adult Mental Health Current Capacity and Estimated Capacity Needs for Randolph County**

Intervention	Unit	Randolph Capacity	Estimated Need	Proportion of Need being Met
<b>Awareness/Prevention</b>				
Mental Health Promotion/Literacy Programs	Programs	4	6	66.7%
Mental Health Education Programs (e.g., MHFA)	Providers	4	6	66.7%
Suicide Awareness Events	Events	1	8	12.5%
Suicide Prevention Programs (e.g., QPR – question, persuade, refer)	Programs	2	19	10.5%
Other	Programs	4	11	36.3%
<b>Identification</b>				
Screening for Depression in Primary Care	Providers	3	5	60.0%
Screening for Anxiety in Primary Care	Providers	3	5	60.0%
Screening for Substance Use in Primary Care	Providers	3	5	60.0%
<b>Treatment</b>				
Counselors	Providers	18	34	52.9%

Intervention	Unit	Randolph Capacity	Estimated Need	Proportion of Need being Met
Social Workers	Providers	20	24	83.3%
Psychologists	Providers	0	17	0.0%
Psychiatrists	Providers	5	17	29.4%
Psychiatric Nurse Practitioners	Providers	1	4	25.0%
Medication management	Providers	1	4	25.0%
Case Management (e.g., QBHS)	Providers	1	5	20.0%
Intensive Outpatient Program (IOP)	Providers	0	11	0.0%
Partial Hospitalization Program (PHP)	Providers	1	11	9.0%
Inpatient Psychiatric Beds	Beds	0	10	0.0%
Assisted Outpatient Treatment	Providers	2	14	14.3%
Assertive Community Treatment (ACT) Programs	Providers	0	5	0.0%
Other	Providers	2	9	22.2%
<b>Ongoing Supports</b>				
Family Support Services/Support Groups	Providers	2	3	66.7%
Religious/Spiritual Advisors	Providers	1	2	50.0%
Transportation Supports	Providers	1	9	11.1%
Guardianship Services	Providers	0	14	0.0%
Community Paramedicine	Providers	0	414	0.0%
<b>Emergency Response</b>				
988 Call Utilization	Lines	1	1	100%
Local Crisis Hotline Utilization - Not 988	Lines	0	1	0.0%

## Awareness and Prevention

For awareness and prevention there is moderate coverage of general mental health awareness and education but more limited resources for suicide prevention in Randolph County. Mental health promotion programs and education efforts, like Mental Health First Aid, are meeting about 63–70% of estimated need. In comparison, suicide awareness events and prevention programs are less available, covering only about 10–13% of what is needed. Other prevention programs are meeting roughly 35% of demand. Overall, while some areas are relatively well established, there are opportunities to expand efforts, particularly around suicide prevention.

**Table 10. Inventory of Adult Awareness and Prevention Services Provided by Organizations in Randolph County Included in CAST Assessment**

Provider	Mental Health Promotion, Literacy Programs	Mental Health Education Programs	Suicide Awareness Events	Suicide Prevention Programs	Other
Asheboro Counseling and Wellness	x				x
Marc Lewis, LCSW, PLLC	x				
New Horizons Treatment Center					x
Randolph Counseling Center				x	
Wildflower Counseling and Consulting PLLC					x
Zen Counseling, PLLC					x
Trillium		x			
Mental Health Collaborative		x			
Veteran Services			x		

## Identification

Screening for depression, anxiety, and substance use in primary care settings in Randolph County are operating at similar levels. Each area has three providers conducting screenings, meeting about 57% of the estimated need. This suggests that while screening services are established, there is room to expand capacity to better reach individuals who could benefit from early identification.

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

Provider	Screening for Depression in Primary Care	Screening for Anxiety in Primary Care	Screening for Substance Use in Primary Care
Asheboro Counseling and Wellness	X	X	X
Marc Lewis, LCSW, PLLC	X	X	X
Randolph Health - Hospital	X	X	X

## Treatment

Randolph County has varied capacity across adult mental health treatment services. Social workers are the most available, meeting about 83% of need, while counselors are covering just over half. Availability of psychiatrists, psychiatric nurse practitioners, and medication management is more limited, each meeting roughly 22–29% of estimated demand. Notably, there are no psychologists, inpatient psychiatric beds, assertive community treatment (ACT) programs, or intensive outpatient programs currently in place, leaving significant gaps in these areas. Partial hospitalization and assisted outpatient treatment are also limited, with less than 15% of need met. Overall, while some provider types are relatively accessible, many specialized services remain scarce or unavailable.

**Table 12. Inventory of Adult Treatment Services Provided by Organizations in Randolph County Included in CAST Assessment**

Provider	Counselors	Social Workers	Psychologists	Psychiatrists	Psychiatric Nurse Practitioners	Medication Management	Case Management	Intensive Outpatient Program (IOP)	Partial Hospitalization Program (PHP)	Inpatient Psychiatric Beds	Assisted Outpatient Treatment	ACT Programs	Other
AKB Counseling	x												x
Asheboro Counseling and Wellness						x					x		
Connecting Bridges, LLC	x				x				x				
Marc Lewis, LCSW, PLLC		x					x						
New Horizons Treatment Center	x												

Provider	Counselors	Social Workers	Psychologists	Psychiatrists	Psychiatric Nurse Practitioners	Medication Management	Case Management	Intensive Outpatient Program (IOP)	Partial Hospitalization Program (PHP)	Inpatient Psychiatric Beds	Assisted Outpatient Treatment	ACT Programs	Other
Randolph Counseling Center											X		
Zen Counseling, PLLC	X												

## Ongoing Supports

Randolph County has some ongoing support services in place but also notable gaps. Family support services are meeting about 58% of estimated need, and religious or spiritual advisors cover nearly half of the estimated demand. Transportation supports are more limited, with only about 12% of need met. There are no guardianship services or community paramedicine programs currently available, indicating areas where additional resources could help improve access to ongoing support.

**Table 13. Inventory of Ongoing Supports Adult Services Provided by Organizations in Randolph County Included in CAST Assessment**

Provider	Family Support Services / Support Groups	Religious / Spiritual Advisors	Transportation Supports	Guardianship Services	Community Paramedicine
Asheboro Counseling and Wellness	X				
Marc Lewis, LCSW, PLLC	X	X	X		

## Emergency Response

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Randolph County fully meets the estimated need for 988 call services. However, there is no local crisis hotline separate from 988, suggesting an opportunity to expand crisis response options beyond the national line. Additionally, mobile response teams could be developed in Randolph County to provide in-person assistance from mental health professionals when individuals experience a mental health crisis. At present, there are no services available locally that offer crisis receiving (provide immediate, walk-in access to evaluation and short-term care for individuals experiencing a behavioral health crisis ) or crisis stabilization (offer short-term, clinically supervised care in a safe, structured environment to help individuals de-escalate, stabilize, and connect with ongoing treatment or support services), leaving a critical gap in the continuum of crisis care. Establishing these resources would help ensure that individuals in crisis have timely access to appropriate support and a safe environment for stabilization.

## Conclusion

This assessment underscores that, while Randolph County has several established mental health services for both youth and adults, gaps remain across the continuum of care for both populations. For youth, the county has relatively strong capacity in some treatment areas, such as assessment, medication management, and intensive outpatient care. However, promotion and prevention programs are limited; early intervention efforts meet only a portion of estimated needs; and essential supports, including school-based services, peer supports, care coordination, and specialized services for young adults, largely fall below estimated need.

For adults, general mental health promotion and screening services are moderately developed. Core outpatient treatment providers, such as counselors and social workers, are in place although still insufficient to fully meet demand. More specialized treatment services, especially psychologists, intensive outpatient and partial hospitalization programs, ACT teams, and inpatient psychiatric care, are less robust. Suicide prevention resources, transportation assistance, guardianship services, and crisis stabilization options are also lacking.

Together, these findings point to areas where expanding mental health promotion, early identification, a range of treatment options, and crisis response services could make a meaningful difference. Enhancing these resources will help more residents receive timely and effective care that supports long-term well-being.

# Appendix

## Definitions

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### | Youth Continuum

**Prevention – Universal:** Programs and services aimed at the general population with the goal of enhancing overall mental wellness and resilience.

**Prevention – Selective:** Programs and services aimed at specific groups or populations deemed at higher risk for development of mental/behavioral health disorders.

**Prevention – Indicated:** Programs and services aimed at individuals who display early signs or symptoms of a mental/behavioral health disorder. Indicated prevention programs are often called early intervention.

**Screening:** use of a standardized tool for the early identification of individuals potentially high risk for a specific condition or disorder. Typically, brief and narrow in scope. This is not diagnostic.

**Assessment and diagnosis:** Process to determine whether a child or youth has a mental health disorder; determine if treatment is necessary, functioning level, and the diagnosis; assessment may also include the child and family's strengths, needs and situation.

**Outpatient therapy—individual, family, or group:** Specific counseling and psychotherapeutic services to youth aged 18 or younger, in accordance with the needs and treatment goals identified in the individual's treatment/recovery plan; therapy services provided when the individual is not admitted to a hospital or other inpatient setting. It can be individual, family, or group level therapies.

**Medication therapies:** Treatment plan that combines medication management with therapy to address mental health conditions.

**Tiered care coordination:** Care systems that organize people or resources into levels to improve communication, collaboration, and outcomes.

**Intensive care coordination (e.g., using Wraparound):** Programs with case management service that help children and youth access, coordinate, and monitor mental health and other services.

**Intensive in-home mental health treatment:** Provides counseling and support in a child's home to address mental health, behavioral, or substance use disorders.

**Trauma-specific treatments:** Therapies or treatments that involve helping youth understand how trauma impacts their mental, behavioral, emotional, physical, and spiritual well-being.

**Intensive outpatient and day treatment:** Provides intensive therapy and support while allowing the individual to live at home; differs from regular outpatient treatment in terms of the amount of hourly engagement of the youth per week.

**Outpatient substance use disorder services:** Treatment for youth with substance use disorders that do not require overnight stays in a hospital or residential facility.

**Integrated mental health and substance use treatment:** Combines behavioral health and primary care to treat mental health and substance use disorders.

**Mental health consultation:** Assessment of child or adolescents mental state to determine whether they have or are at risk of developing any mental disorder and to identify and address issues that may have a negative impact on their mental development.

**Telehealth (video and audio):** Sessions with a behavioral health provider that happen via technology instead of in person, usually video calls, phone or via text chat.

**Parent peer support:** Provides support and peer-connections to parents and caregivers of children and youth who are receiving services from mental health, substance use, and related service systems.

**Youth peer support:** Service that connects young people with peers who have experienced similar challenges and can offer support and encouragement.

**School-based mental health services:** School-based programs that provide interventions to help students improve their social, emotional, and behavioral functioning.

**Behavior management skills training:** Training which entails a combination of skills that help people work well with others and perform well, helps people analyze their current behavior patterns, and develop new habits.

**Youth and family education:** Programs and practices that aim to improve the quality of life for individuals and families, such as family life education and positive youth development.

**Supported education:** Programs that help people with disabilities or mental illnesses achieve their educational goals.

**Supported employment:** Programs that help people with disabilities or mental illnesses achieve their employment goals.

**Supported housing - temporary:** Temporary housing option that provides affordable, permanent housing and services to help young people in need.

**Supported housing - long-term/permanent:** Long-term or permanent housing option that provides affordable, permanent housing and services to help young people in need.

**Young adult peer support:** A type of non-clinical mental health support that connects young people with others who have experienced similar challenges.

## | **Adult Continuum**

**Mental health promotion/literacy programs:** Programs aim to help people understand mental health, reduce stigma, and increase help-seeking for mental health concerns.

**Mental health education programs (e.g. mental health first aid):** Seeks to raise awareness around mental health issues, informing people about common challenges and conditions, coping strategies, and resources available to help.

**Suicide awareness events:** In-person or virtual gatherings designed to increase public understanding of suicide risk, reduce stigma, and promote available resources and help-seeking behavior.

**Suicide awareness advertisements/campaigns:** Public messaging efforts, such as social media, billboards, or radio ads, that aim to raise awareness about suicide prevention and promote mental health resources.

**Suicide prevention programs (e.g. QPR – question, persuade, refer):** Structured interventions

or services that aim to reduce suicide risk through education, screening, early intervention, safety planning, and connection to support.

**Screening for depression, anxiety, and substance use in primary care:** Routine use of validated tools by medical providers to identify symptoms of mental health or substance use conditions during regular health visits.

**988 call utilization:** Number of calls made to the national 988 Suicide & Crisis Lifeline, which connects individuals in emotional distress to trained crisis counselors.

**Local Crisis Hotline utilization - not 988:** Use of regionally operated crisis lines (separate from the 988 Lifeline) that offer immediate support, resource connection, or mobile crisis response for individuals experiencing mental health emergencies.

**Counselors:** Include licensed providers such as Licensed Professional Counselor (LPC), Licensed Mental Health Counselor (LMHC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT).

**Social Workers:** Includes licensed providers such as Licensed Social Worker (LSW) and Licensed Clinical Social Worker (LCSW).

**Psychologists:** Licensed mental health professionals who assess, diagnose, and treat emotional and behavioral disorders through therapy and psychological testing; they typically hold a Ph.D. or Psy.D. and do not prescribe medication.

**Psychiatrists:** Medical doctors (M.D. or D.O.) who specialize in diagnosing and treating mental health conditions, including prescribing and managing psychiatric medications.

**Psychiatric Nurses:** Registered nurses with specialized training in mental health who provide psychiatric care, support medication administration, and assist with crisis intervention under clinical supervision.

**Psychiatric Mental Health Nurse Practitioners (PMHNP):** Advanced practice nurses who are licensed to assess, diagnose, and treat mental health conditions, including prescribing medications and offering psychotherapy.

**Psychiatric Physician Assistants/Associates (PA-C):** Licensed medical professionals who work under the supervision of a psychiatrist or physician to diagnose mental health conditions, prescribe medications, and provide treatment.

**Medication management:** Ongoing evaluation and adjustment of psychiatric medications to ensure effectiveness and minimize side effects, typically provided by psychiatrists, PMHNPs, or PA-Cs.

**Case management:** Coordinated service that connects individuals with mental health needs to appropriate care and community resources, including housing, benefits, and treatment, while supporting continuity and follow-up.

**Intensive Outpatient Program (IOP):** Programs that serve as a transition from inpatient or more structured care or may offer additional structure and monitoring when more support than outpatient visits is necessary.

**Partial Hospitalization Program (PHP):** A structured, intensive treatment program for individuals with mental health conditions.

**Inpatient psychiatric:** Highly structured level of care designed to meet the needs of individuals

who have emotional and behavioral manifestations that put them at risk of harm to self or others or otherwise render them unable to care for themselves.

**Assisted Outpatient Treatment:** Court-ordered, community-based treatment for adults with severe mental illness or substance use disorders who are unwilling or unable to engage in voluntary treatment.

**Assertive Community Treatment (ACT) programs:** Program that offers treatment, rehabilitation, and support services to people with severe and persistent mental illness.

**Family support services/support groups:** Groups that provide support through peer relationships in group meetings.

**Religious/Spiritual advisors:** Counselors or clergy members with training in mental health.

**Transportation services:** Programs that help individuals access healthcare, treatment, or support services by providing non-emergency rides, including mental health or substance use appointments.

**Guardianship services:** Legal arrangements in which a designated guardian is appointed to make decisions on behalf of an adult who is unable to manage their personal, medical, or financial affairs due to incapacity or disability.

**Community Paramedicine:** A healthcare model in which paramedics provide in-home or community-based care beyond emergency response — such as wellness checks, chronic disease management, or behavioral health support — to reduce unnecessary hospital visits and improve access to care.