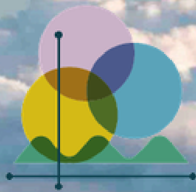

WNC HEALTH NETWORK

YOUTH MENTAL HEALTH IN WNC:

A Constant Comparative Analysis of Assets and Barriers

DATA FROM THE
2024 WNC HEALTHY IMPACT ONLINE KEY INFORMANT SURVEY

Report authored by **Meron Abebe, M.S., MBA**, WNC Health Network Director of Operations and Master of Public Health candidate and Rural Health Innovation Scholar at University of California, Berkeley School of Public Health

Disclaimer: The findings and quotes presented in this report reflect the perspectives and experiences of survey participants. These views do not represent the positions or opinions of WNC Health Network, its partners, staff, or the researcher.

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Background

The 2023 and 2025 North Carolina Child Health Report Card gave the state an "F" grade on youth (ages 12-17) mental health indicators related to suicide, depression, and access to care (NC Institute of Medicine (NCIOM) & NC Child, 2023; NCIOM & NC Child, 2025). Recent data indicate that these indicators are comparable to national averages. **Table 1** shows how North Carolina (NC) compares to the U.S. average in measures of suicide attempts, self-reported poor mental health, and difficulties accessing care. In addition, the 2025 NC Child Health Report Card states, "over 50% of children ages 3-17 have reported difficulties accessing the mental health treatment they needed" (p. 7). School-based provider shortages are also severe. In 2024, NC public schools had one psychologist for nearly 2,000 students and one social worker for almost 1,000 students. These providers' capacity was four times below the recommended levels. Similarly, the state had one nurse for 809 students and one counselor for 343 students. These numbers fall short of the provider-to-student ratios recommended by the National Association of School Nurses' (2015) and the American School Counselor Association's (2025) (1:750 and 1:250, respectively). As a result, efforts to improve youth mental health outcomes are underway across the state, including in western North Carolina (WNC).

An online key informant survey was conducted in 2024 by WNC Health Network that included a focus on youth mental health across 17 counties in WNC. The web-based, open-ended survey was administered as part of the WNC Regional Community Health Needs Assessment (CHNA). The open-ended questions sought to investigate system-level barriers as well as community assets shaping youth mental health in WNC. Key informants included healthcare providers, public health and social work professionals, and community leaders. This report presents the key themes that emerged from the analysis of the survey data.

Shortage and high turnover of mental health providers (in both schools and the community), insufficient crisis care, and long wait times were identified by survey participants as major barriers. Data on WNC student-to-provider ratios were difficult to obtain. Still, current evidence indicates rural NC has roughly one-third to one-half the behavioral health workforce of urban counties (Woolcock et al., 2025). In addition to workforce limitations, there are significant data gaps in youth mental health

surveillance in WNC due in part to community resistance to school-based data collection efforts including the Youth Risk Behavior Survey (YRBS). Parents' Bill of Rights (SB49) also mandated parental consent before schools administer the YRBS (§ 115C-76.65; North Carolina General Assembly, 2023). Unfortunately, this is expected to further reduce the availability and robustness of youth mental health data.

Given these existing limitations, this report uses qualitative data analysis to provide insights into the extent of youth mental health issues, needs for services, and access barriers in WNC. The data analysis for this report does not estimate prevalence or evaluate specific programs. Instead, it draws on stakeholder perspectives to inform understanding of how the youth mental health system functions in the region. Additional methodological information and study limitations are provided in the methodology and limitations section (p. 12).

Table 1: ***Youth Mental Health Indicators (2023)***

Indicator	United States	North Carolina	Data Source
High school students who attempted suicide	9%	9.5%	(CDC, 2024; NCIOM & NC Child, 2025)
High school students reporting mental health "most of the time or always not good"	29%	30%	(CDC, n.d.)
Percent of Children (Ages 3-17) Who Faced Difficulties Obtaining Mental Health Care	56.7%	57.6%	(KFF, n.d.)

Note: Suicide attempts and poor mental health are based on the 2023 YRBS. Estimates of difficulties accessing mental health care are based on KFF analysis of the 2023 National Survey of Children's Health.

Themes

Theme 1: Access to Care

Despite improvements in service availability, provider shortages, reimbursement challenges, and geographic barriers continue to affect youth mental health access to care.

School-Based and Community Assets

Key informants identified access to care as one of the critical factors that shape youth mental health in western North Carolina (WNC). The availability of free or low-cost school-based mental health services was noted as a strong asset. One informant stated, “This is critical as many students do not have access to transportation to go to counseling outside school hours.” In some schools, youth can access on-site counseling and are connected to community-based services, as needed. Federally Qualified Community Health Centers (FQHCs), such as Blue Ridge Health and Mountain Community Health Partnership, also provide integrated care for youth within clinical settings. Other community providers, including RHA Health Services, Spark Point, Youth Villages, St. Gerard’s House, and Appalachian Community Services, offer therapy and other specialized services for at-risk youth and adolescents with developmental disabilities, highlighting the region’s reliance on nonprofit entities to fill gaps in the mental healthcare system.

Hospital-Based and Telehealth Expansion

Recent expansions in inpatient and outpatient behavioral health services at AdventHealth Hendersonville, AdventHealth Polk, and UNC Health Pardee hospitals have improved access to behavioral health care for youth in WNC. Telehealth at schools and in the community has also increased access to care, especially in rural WNC counties. Medicaid expansion was also mentioned as having a positive impact on access to care by “supporting an infusion of dollars to increase reimbursements and fund stabilization.”

Provider Shortages and Capacity Constraints

The improvements noted above are not sufficient to offset broader workforce challenges and other access barriers. One of the issues most frequently mentioned by the key informants was the shortage of qualified youth mental health providers. A participant explained:

> These providers do not have the staff to consistently offer services to everyone who needs them. They are also not compensated enough to be able to hire, train, and retain qualified staff. Between the Medicaid rates they are offered and the reimbursements they receive from Managed Care Organizations, they can't meet the needs of the

community. They often turn people away, or people get frustrated and quit trying to access services.

School Staffing Gaps and Delays in Care

Schools are not immune to staffing problems either, as they are experiencing a shortage of counselors and social workers. This adds to the staffing gaps already described in the background section. As a result, youth cannot access timely care, and service denial is increasingly common. One healthcare provider noted, “There aren’t enough providers to meet the demand. Many students are being wait-listed for months due to volume."

Low Provider Participation in Medicaid and Financial Barriers

Many practices do not accept Medicaid or only offer limited slots for Medicaid-enrolled youth. One respondent stated, “We cannot get anyone to accept Medicaid payment, and most don't take any insurance (cash only).” Other issues affecting access to care include high costs and the lack of sliding-scale options.

Geographic Isolation and Limited Crises Infrastructure

Lack of local crisis stabilization units, limited after-hours or evening services, transportation barriers, and long travel distances are also getting in the way of addressing youth mental health in WNC. A participant noted, “If our students need inpatient mental health services, there are no facilities available locally, and families have to travel anywhere from two to six hours away for these types of services.”

Theme 2: Care Coordination & Navigation

Collaboration among schools and providers is improving, but ongoing challenges remain, including referrals, continuity of care, and care navigation.

Growing Partnership Between Schools and Providers

Key informants described a growing, but uneven, coordination among schools, nonprofit organizations, and healthcare providers to address youth mental health needs in WNC. One participant noted, “The school system has built a strong network of providers that support students for both school-based and office-based services.” Schools are also increasingly collaborating with local healthcare providers like RHA Health Services, Mountain Area Health Education Center (MAHEC), and HIGHTS (a

youth-centered non-profit with therapeutic services) to offer mental health services to students. More broadly, Vaya Health, the region's managed care organization, plays a key role in behavioral health by coordinating Medicaid services and crisis pathways, shaping how youth move between levels of behavioral health care.

Continuity of Care and Follow-Up Challenges

Participants mentioned that there is poor care coordination when transitioning between various levels of care (inpatient, outpatient, and community-based). A healthcare provider stated, "We often see kids discharged from acute psych hospitalizations, but then there is no psychiatrist to see them when they are discharged." Inconsistent follow-up is another issue mentioned by key informants as a direct byproduct of youth being unable to maintain continuity of care, either because their families are unaware of available services or are overwhelmed by the process.

Referral Challenges and Provider Capacity

Key informants identified challenges related to limited referral pathways, which highlighted the interconnectedness between limited provider capacity in the region and poor referral systems. One participant remarked, "Blue Ridge Health is not accepting outside referrals for pediatric/adolescent psych visits. MAHEC has a psych residency program, but they also do not accept any referrals. You have to be a MAHEC patient." Another participant noted, "limited understanding by providers on how to care for and refer people who need to receive mental and/or behavioral health services is leading to decreased access, and specialists are farther away."

Navigation Burden on Families

The barriers mentioned above force families to navigate the system on their own, delaying care and increasing the likelihood of incomplete follow-up.

Theme 3: Prevention, Early Intervention, and Education

Various efforts are underway, but early intervention remains limited, and schools vary widely in how they prioritize and implement trauma-based practices.

Current Efforts Across the Region

There are programs in WNC that focus on prevention and education, but their availability and reach vary across communities. A key informant noted:

> The evidence-based practices supported by TC STRONG [a community collaborative that partners with schools and local organizations to support youth emotional wellness] and the CARE Coalition [a nonprofit focused on youth substance use] provide critical upstream prevention and early response capacity (TC STRONG, n.d.; CARE Coalition, n.d.).

Participants also described additional efforts underway across the region. Early childhood prevention programs, such as those of WNC Source and resilience initiatives by Crossnore, are building youth's coping and emotional regulation skills. Some counties are also training residents in youth mental health first aid and Question Persuade and Refer (QPR) Suicide Prevention Training, to make sure adults do not miss early signs of mental health issues in youth. The youth themselves, for example, in Madison County, are receiving education about mental health through the National Alliance on Mental Health (NAMI) Ending the Silence program. Some schools also provide suicide prevention education to youth by collaborating with their local health department and Hope Coalition, a non-profit with recovery, education and prevention programming that teaches students to connect with their peers and help recognize risk. All these efforts highlighted by respondents, including 988 campaigns and substance use education, are raising awareness and combating stigma often associated with mental health.

Limited Reach of Early Intervention Efforts

Key informants noted that youth outside of public schools (in homeschool and charter) are not being reached by the programs that are currently available. In addition, participants reported that there are very few programs focused on prevention before crises occur. A key informant stated, "We desperately need services for early intervention, before it gets to the point of hospitalization." Others also emphasized that early intervention efforts should start in elementary schools.

Inconsistent Implementation of SEL

Although some schools include mental health education and social-emotional learning (SEL) - which teaches youth how to manage their emotions, form healthy relationships, and make healthy choices - in their curricula, implementation remains inconsistent across the region (NCDPI, n.d.) A participant mentioned that "fear/misinformation around social-emotional learning in schools is not helping." Overall, the uneven prioritization of prevention efforts across schools suggests varying levels of resources and community support available for the issue in the region.

Limited Adoption of Trauma-Informed Practices

While some trauma-informed initiatives exist in the region, stakeholders pointed out that there is a lack of trauma-informed training and practices in schools and law enforcement. A participant observed, "The school system has not embraced district-wide trauma-informed training and support for staff, even beyond educators in schools." A social services provider echoed this sentiment by stating, "Schools penalize kids when they leave school for services." There is also limited uptake and implementation of available programs. A participant noted:

> As a DV/SA agency [Domestic Violence/ Sexual Assault], we have offered a curriculum, but as of now, no takers. Kids need to be able to speak about these things that are bothering them. And they have no one to tell, no coping skills, no one teaching them how to think differently or react differently.

These comments highlight that WNC schools have not consistently institutionalized trauma-informed approaches.

Theme 4: Youth Engagement and Supportive Spaces

There are ongoing challenges related to insufficient spaces for teens across the region, and lack of transportation further limits engagement opportunities.

Social Connection and Skill Development

Schools and community organizations provide outlets and skill-building opportunities for youth across WNC. Key informants mentioned that programs such as those by Partners Aligned Toward Health (PATH), the cooperative extension, and

local grassroots initiatives are actively engaging youth and promoting mental and social well-being. Peer mentorship programs at schools by Noble Knights and Spark Point are also providing youth with opportunities to share experiences and access support from peers as well as adults, thereby supporting pathways to improved youth mental health. In addition, outdoor recreation and active lifestyle programs help improve youth mental health in WNC. A key informant stated, "Activities that bring kids together to create, make, learn, and experience together all improve youth mental health." Public libraries with spaces for teens and faith-based groups also provide safe environments and caring adult mentors. These initiatives play an important role in fostering youth connection, belonging, and skill development across the region.

Inadequate Safe and Supportive Youth Spaces

There is a broad consensus across participants that there are insufficient safe and supportive spaces for youth. One participant described how the lack of recreational opportunities increases contact between youth and law enforcement, potentially leading to involvement with the criminal justice system: "Teens are coming into the gym at night to play basketball, but there is no staff on site, and they have to be asked to leave by the police.... not an ideal situation." Key informants also frequently mentioned the "unchecked social media use" among adolescents and its impact on mental health, noting that rural communities often lack safe spaces for youth.

Transportation Barriers and Isolation

Other barriers to youth socializing with their peers include the lack of public transportation and the hurdles to obtaining a driver's license. A key informant noted, "The hoops to get a driver's license are significant and prolonged due to the privatization of driver's ed. This makes kids dependent on parents for transportation during most of their teen year, [which], because we don't have public transportation, limits their ability to be social." Transportation is particularly crucial for WNC residents living in counties with few to no play spaces for youth.

Need for Expanded Youth Infrastructure and After-School Opportunities

While highlighting the need for spaces for teens, one participant shared, "There is not much to do inside the county." Similarly, others reiterated the need for more after-school opportunities, recreational spaces, and "spaces for teens to go to play or

hang out." These findings point to gaps in youth infrastructure, which, when combined with rural geography and transportation barriers, can contribute to isolation among youth in the region.

Theme 5: Social Determinants of Health

Key informants emphasized that poverty, stigma, and discrimination affect youth mental health and access to care.

Poverty and Family Stress

Poverty, housing instability, and transportation barriers impact youth mental health in WNC. A key informant noted, "The majority of our youth are living in poverty situations." This sentiment was echoed by other participants. They mentioned that supporting families, through a family resource center, parental education (e.g., on proper discipline, being a role model, birth control), and other supportive services, is crucial for strengthening youth mental health. A community leader said, "I have worked with youth who were eager to work on their mental health, but being at home was a challenge." These accounts indicate that social determinants of health, such as family income, parental health and behavior, and childhood experiences) can undermine youth mental health even when youth are motivated to receive care (Velez, et al., 2022).

Family-Focused Interventions

Efforts are underway to address social and economic challenges through family-focused interventions. For example, a social services provider stated that their organization is "involved with families and working to eliminate barriers such as low income, housing and parental neglect, and abuse." The Healthy Opportunities Pilot, a Medicaid program addressing social determinants of health, is also making a difference by reducing parental stress. Despite the growing recognition of social and economic conditions in youth mental health, the scale and reach of interventions are limited relative to the level of need in the region.

At the same time, respondents described that some communities in WNC are working directly with families and providing support. For example, participants referenced a pilot group program for parents that is launched to help them understand and manage their children's mental health challenges, though program

details were not provided. Evidence-based housing programs, such as the Housing First model, are also being implemented in the region. The Housing First model, according to the National Alliance to End Homelessness (2025), is an approach to house people without any preconditions (e.g., sobriety or mental health treatment). A participant mentioned that the Housing First model "works for families dealing with mental health issues." Nonprofits such as PATH and the Y also play a crucial role in supporting families through their programs. Key informants mentioned PATH's youth-to-youth program and the Y's "no-cost out-of-school and summer programming for K-5 students, including meals, no-cost swimming lessons, and day care."

Growing Awareness of Mental Health and ACEs

Community awareness of the issues and Adverse Childhood Experiences (ACEs) are increasing around the region. A key informant said, "There has been increased discussion around the impacts of behavioral health and mental health challenges in the community. Discussions continue to revolve around ways to make improvements." There is also increased awareness in schools. A participant noted that "Public school employees are trained in youth mental health awareness and warning signs that a student may be experiencing distress." A public health representative also reiterated that "People are talking more openly about the importance of mental health."

Stigma and Community Attitudes

Awareness alone has not consistently translated into reduced stigma. Stigma and community attitudes towards youth mental health that stem from a lack of understanding still exist. A community leader noted, "Persistent stigma around mental health issues discourages youth from seeking help or discussing their struggles openly." Another one added, "Community perception [is] that youth mental health "is just a phase" or "normal part of growing up." These attitudes can result in parental reluctance to seek care.

Culturally Responsive Care Limited by Workforce Capacity

Culturally responsive youth programs are being implemented in the region. A participant noted that "Initiatives that incorporate Cherokee cultural practices and traditions into mental health services help youth connect with their heritage, fostering a sense of identity and belonging." However, there is a shortage of culturally

competent providers in the region. A key informant stated, “A shortage of mental health professionals who are familiar with Cherokee culture and traditions may impede the delivery of culturally appropriate care and support.”

Structural and Societal Stressors

Structural issues such as racism, discrimination, and immigration status are also affecting youth mental health. For instance, in migrant communities, parents work long hours and have low wages, fear deportation, lack safe housing, and other supportive resources. A community leader said, “If they live in survival mode day to day, how are they going to learn? And then they go to school and experience more trauma from their peers and their own teachers.” To address this, participants called for “a nurturing environment at school that understands intersectionality in mental health” and “more mentors/counselors at school, especially of color.” Finally, key informants also touched on broader societal stressors such as mass shootings, polarized society, and climate anxiety as additional factors that influence youth mental health. Overall, the findings underscore that social determinants of health interact with each other, affecting youth mental health and families’ abilities to engage with support and care.

Discussion

Youth mental health in WNC is shaped by several factors, ranging from access to care and care coordination to prevention and social connection, all the way to broader socio-economic conditions. Key informants described that the region has both strengths and challenges. **Table 2** summarizes the author’s synthesis of key informants’ descriptions of these relationships. It is informed by Solar & Irwin’s (2010) social determinants conceptual framework. The identified patterns show how barriers are perceived to interact and accumulate overtime.

Table 2 ***How Key Themes Relate to Youth Mental Health in WNC***

Theme	Patterns Identified by Key Informants	Key Process Highlighted
Access to Care	Low reimbursement → High provider turnover & Limited Medicaid participation → Provider shortage → Limited access to care	Key informants emphasized that healthcare financing is closely tied to provider participation in insurance networks, which in turn

		can affect perceived access to care.
Care Coordination and Navigation	Limited access to care → Gaps in referral pathways → Delayed or unmet follow-up care → Poor youth mental health outcomes	Participants described that breakdowns in the continuity of care can exacerbate perceived access to care issues.
Prevention, Early Intervention, & Education	Limited funding for schools → Limited school capacity → Missed early warning signs → Poor youth mental health outcomes	Respondents are concerned that limited school resources can reduce opportunities to identify and address needs before crises occur.
Youth Engagement and Supportive Spaces	Limited opportunities for youth engagement and transportation barriers → Reduced youth engagement & connection → Increased isolation (including heavy social media use) → Poor mental health outcomes	Informants emphasized the importance of social connection for youth mental health and noted that structural barriers can limit opportunities for connection.
Social Determinants of Health	Poverty, housing instability, food insecurity, etc. → Limited support and chronic stress → Reduced capacity to engage in care and prevention → Poor mental health outcomes	Participants noted that financial distress and poor social safety net can affect families' ability to support youth mental health, even when clinical services are available.

Note: Arrows (→) indicate informant-described sequences or patterns of co-occurring challenges, not causal relationships.

Table 2 shows how challenges at the system level shape downstream experiences for Appalachian youth and families in WNC. These insights are consistent with previous findings (Elder & Robinson, 2018, as cited in Cummings et al., 2014, & Fortney et al., 1999). In addition, the key informants noted that geographic barriers often disrupt follow-up, causing delays or disengagement from care. Stigma and misinformation about SEL and counseling were also described as factors that impact youth's ability to seek timely care.

Other structural issues mentioned by key informants include low reimbursement rates more broadly and low provider participation in Medicaid. These challenges are not unique to western North Carolina. In fact, Melek et al (2019) found that behavioral health clinicians are reimbursed 19.8% to 23.8% less than primary care providers for the same office visit codes, and in some states, more than 50% less. As a result, it is not financially viable for many of them to participate in insurance networks, which eventually leads to narrower networks and longer wait times for care (Rapfogel,

2022). This mirrors the access to care challenges summarized in Table 2, in which the structure of healthcare payers appears to shape provider financial incentives, ultimately limiting access for youth and families. These policy decisions are experienced by family and youth in terms of long wait times, frequent provider turnover, and the need to repeatedly restart care, all of which undermine continuity and trust in the healthcare system.

At the community level, the key informants expressed concerns about the impact of social media on youth mental health. Emerging evidence shows that social media presents both risks and benefits (Nesi, 2020). A review of existing literature by Anshida et al. (2025) revealed that social media can be beneficial when used for maintaining social connections, accessing information, and getting peer support. However, engaging in excessive, or what key informants referred to as "unchecked social media use," appears to be associated with higher anxiety and depression symptoms. The comparison of self with others and cyberbullying are also linked with negative mental health outcomes (Anshida et al., 2025). The authors also found that rural youth face heightened risk as a result of geographic isolation, limited access to care, and reliance on social media for connection. These findings reinforce participants' emphasis on the need to create more spaces and after-school opportunities in WNC where rural youth can play and learn together. However, social media was not framed as an isolated risk factor. Youth rely on it because transportation barriers and limited after-school options hinder their ability to be with their peers.

Finally, the participants identified social determinants of health, such as socioeconomic status and background characteristics, as factors that influence youth mental health (e.g., families' inability to take time off work to take their children to appointments). Poverty also creates chronic stress in youth (Velez et al., 2022). In addition, youth from BIPOC and LGBTQIA+ communities face additional barriers rooted in stigma and discrimination. Undocumented or mixed-status youth also experience uncertainty and fear of deportation. All of these socio-economic stressors impact youth mental health (Velez et al., 2022). Therefore, the current state of youth mental health in WNC is a result of cumulative breakdowns across systems, which shape when, how, and whether youth ultimately receive support. As such, addressing youth mental health in the region requires attention be directed not only

to service delivery by individual programs, but also to the broader social and structural contexts in which youth live. And, despite these challenges, the Appalachian region, including WNC, has existing community assets, as well as strong family, faith, and community bonds that can be built upon (Elder & Robinson, 2018). Strategies and partners identified by the key informants are presented in Appendix B.

Implications and Next Steps

Preliminary findings were shared with the WNC Healthy Impact Steering Committee. The committee comprises representatives from public health agencies, hospital systems, and key regional partners supporting the Community Health Improvement Plan process across WNC. One of the committee's goals is to "inform and identify opportunities for strategic investments to address priority health issues" (WNCHN-d, 2022, p. 2). Their reflections provided insight into how partners may use or share the findings with relevant audiences, and who else should have access to the information, to shape future work in the region.

Several committee members noted the implications of the findings in helping to raise awareness among policymakers and support conversations about funding, prioritization, and the long-term health and economic consequences of not addressing youth mental health needs. The findings were also seen as useful for program planning, particularly for designing youth mental health initiatives that are responsive to the specific needs of WNC.

Others emphasized the value of the findings for school personnel, who are on the front lines of responding to student mental health concerns and may offer additional insights from their daily experiences. Members also suggested sharing the findings with local government leaders and with organizations preparing to expand youth behavioral health services, including those launching new adolescent behavioral health units. In addition, the steering committee observed that the findings could be used to advocate for improved youth mental health data collection and targeted efforts to fill existing data gaps on this topic across the region.

Steering committee members also expressed interest in understanding the geographic distribution of assets, noting that asset mapping could help visualize strengths and gaps across counties. They emphasized the importance of engaging

youth in future work to understand what resonates with them and what may be missing from the scope of the current study. In addition, they highlighted the value of engaging school-based providers, who could offer deeper context on service capacity and barriers within school environments. Committee members noted that any WNC county or organization prioritizing youth mental health, such as Community Health Improvement Plan (CHIP) action teams, may benefit from reviewing the findings. They also recommended conducting further analyses that unpack key informant inputs by category, such as social services, healthcare providers, and community leaders, in order to identify variations in perspectives and needs.

Methodology and Limitations

An online key informant survey (OKIS) was administered from June to July 2024 as part of the 2024 WNC Regional Community Health Needs Assessment (CHNA), a mixed-method survey that allows communities to explore local health issues and incorporate community perspectives on priorities (WNCHN-a, 2025). Both were coordinated by WNC Health Network through its program, WNC Healthy Impact, a coalition of hospitals, local health departments, and key regional partners (WNCHN-b, 2025). The CHNA, which is conducted every three years, includes data from 18 WNC counties, including Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, and Yancey. CHNA does not require formal Institutional Review Board (IRB) approval.

The 2024 OKIS used purposive sampling, an approach that intentionally selects specific people to include in the study (WNCHN-c, 2018). And recruitment occurred via an email invitation that explained the purpose of the survey and provided a link. The survey asked participants about quality-of-life issues, social determinants of health, key health issues, and special topics, including youth mental health (Professional Research Consultants, 2024). Participants' names or other identifying information were not collected; however, they were asked to select a general description of their role (e.g., physicians, community leaders), which are summarized in **Table 2**. All respondents were identified by WNC Healthy Impact based on their professional roles and familiarity with the needs of communities in the region.

Accordingly, this sample reflects stakeholder perspectives, rather than a representative community sample.

Table 2: *Online Key Informant Survey Participants (2024)*

Key Informants	Number
Physicians	7
Public Health Representatives	20
Health Directors	15
Other Health Providers	70
Social Services Providers	31
Other Community Leaders	126
CHA Leads	14
Total	**283**

Note: Count reflects self-reported professional roles; categories are not mutually exclusive unless otherwise specified.

The qualitative dataset consisted of responses to open-ended questions that asked participants what is working well to support youth mental health in their communities, what is not working or missing, and what opportunities they see for improvement. Constant comparative analysis was used to analyze the data (Boeije, 2022). Survey responses were compared iteratively across participants within these domains to refine and validate themes. However, the resulting themes were extensive, so ChatGPT (OpenAI; GPT-4) was used after the primary analysis to consolidate themes, without introducing new categories or altering original interpretations. All analyses and interpretations were conducted by the author. A full listing of the themes and categories can be found in Appendix B.

This analysis is shaped by stakeholders involved in youth mental health across WNC. It does not include input from youth or their families, so the findings do not capture their lived experiences. In addition, the data were collected in a survey rather than an interview, so opportunities for follow-up or clarification were limited, and the depth of responses varied across participants. It is also possible that not all stakeholders from the 17 counties or sectors participated in the survey, so the results are not intended to be representative of all youth or communities in WNC.

Additionally, this qualitative data analysis was conducted by a single researcher, rather than a team of researchers and/or community partners. As a result, theme

interpretation may reflect the author's analytic lens. To mitigate this limitation, themes were grounded in participants' own language; and preliminary themes in Appendix B were shared with the WNC Healthy Impact Steering Committee for validation. Steering committee members were invited to reflect on what resonated with their experiences, what aligned with their understanding of current conditions, and where findings did not fully reflect realities in their communities.

The final stage of the theme consolidation was supported in part by ChatGPT (OpenAI) to assist with post-analysis organization. Although the author made analytic decisions, some loss of nuance may have occurred during the theme consolidation process. It is also important to note that the 2024 OKIS data were collected before Hurricane Helene, so this dataset does not reflect the impact of climate or natural disasters on youth mental health. It also doesn't represent the impact of recent Medicaid policy changes or program closures, such as the Healthy Opportunities Pilot, which could influence current realities. This is particularly relevant as North Carolina has not finalized a budget for 2025-2027 at the time this report was written. These contextual factors highlight the need for ongoing data collection and continued engagement with WNC Healthy Impact partners as conditions evolve.

Ethical Considerations

During theme consolidation, raw data were not entered into ChatGPT (OpenAI). Summarized theme labels created by the author during the primary analysis were used. County names were removed to protect the privacy of communities and respondents. These steps were taken to ensure the use of AI did not compromise confidentiality or ethical standards related to balanced data.

Acknowledgment

The author extends her heartfelt gratitude to WNC Health Network Executive Director Erin Braasch for making the data available for this project, and to Emily Kujawa and Jo Bradley for generously offering their time and expertise throughout.

Data Availability

Data is not publicly available due to confidentiality concerns. Given the rural context and the limited number of participating organizations, even de-identified data could compromise the anonymity of participants or their organizations.

Appendix

A. OKIS Questions Related to Youth Mental Health

Do you have any personal or professional insight, experience, and/or knowledge about youth mental health?

- What is going well or currently working in your community to improve mental health?
- What is missing or is not helping youth mental health in your community?

B. Full Themes

What is helping?

This section summarizes strategies, efforts, and features within the mental health care system that key informants identified as supporting youth mental health in their communities.

- **Access to Care**
  - Telehealth
  - Community-Based Specialized Support (at risk and autistic youth)
  - School-Based Mental Health Services
  - Needs Assessment (e.g., YRBS)
  - FQHCs
  - Trauma-Informed and Crisis Response Services (for youth impacted by abuse and/or neglect)
  - Local Health Department Services
  - Availability of Providers In-School and Community
  - Integrated Behavioral Care in Primary Care Settings
  - Community Based Youth Services (E.g., HIGHTS)
  - Quality of Care
  - Schools Making Community Referrals
  - Inpatient and Outpatient Behavioral Health Services
  - Care Coordination (Vaya)
  - General Mental Health Service Expansion
  - Community-Based Mental Health Services
  - Policy Level Improvement – Medicaid Expansion
- **Crises Intervention and Response**
  - School-Based Crisis Response Teams
  - Coordinated Crises Responses and Intervention
  - In-Home and Community Based Crisis Support
  - Child and Family Trauma Support Services
- **Programming and Community Spaces Supportive of Youth**
  - Youth Empowerment and Leadership Programs
  - Community Based Recreation and Outdoor Activities

- Mentorship and Peer Support Programs
  - Youth and Community Development (e.g., Cooperative Extension, 4-H)
  - Supportive School Environments
  - Library and Other Community Teen Spaces
- **Stigma Reduction Efforts**
  - Public Awareness Campaigns
  - Community and Coalition Efforts
  - Encouraging Help Seeking
  - Cultural Shifts and Acceptance
- **Funding and Investment**
  - State Government Investment
  - Philanthropic and Grant Support
  - County and Local Government Investment
- **Cross-Sector Partnership and Collaboration**
  - Program Specific Partnerships Supporting Youth Mental Health
  - Resource Coordination
  - Partnership with the State
  - School Community Collaboration
  - Emerging Collaborative Efforts
  - Regional and Cross-Jurisdictional Collaboration
- **Youth Mental Health Education**
  - School-Based Suicide Prevention Education
  - Community Awareness Programs
  - Implementation of Evidence-Based Programs
  - Mental Health Literacy
  - Peer-Led and Trauma Informed Education
- **Community Empathy and Support**
  - Teachers, counselors, and community organizations actively support youth through understanding, open communication, and genuine concern for their well-being.
  - Empathy and care for youth mental health
- **Workforce and Community Capacity Building**
  - Trauma Informed Workforce Development

- Mental Health First Aid and Gatekeeper Training (e.g., teachers/ other school staff, families)
- School Staff & Workforce Training
- Protocols and Structured Response Tools
- SAMHSA and Health Department Initiatives
- Support to providers

- **Advocacy**
  - Statewide and Regional Advocacy of Youth Mental Health Needs
- **Youth Engagement Through School & Community Activities**
  - Sports, fitness, and active-lifestyle programs
  - Creative and Skill Building Opportunities
  - School-Based Extracurricular Activities
  - Community-Based Youth Engagement
  - Recreation and Outdoor Activities
- **Prevention and Early Intervention**
  - Substance Use Prevention
  - Resilience and Wellbeing Initiatives
  - Early Childhood Programs
  - Community Gatekeeper Training (e.g., teachers/ other school staff)
- **Increased Attention to Social Determinants of Health**
  - Healthy Opportunities Pilot
  - Community Support for those in Need (e.g., homeless youth)
  - Basic Needs and Family Support Services (food, financial, housing, etc.)
- **Community Buy-in**
  - Leadership and institutional commitment
  - Community Awareness and Engagement
  - Shared Values
  - Cross-Sector Engagement and Alignment
- **Family Engagement and Support**
  - Support to Parents and Caregivers
- **Culturally Responsive Care**
  - Cultural integration in mental health services, e.g., incorporating Cherokee cultural practices and traditions into mental health services

    - Access to culturally competent counseling
    - Cultural lens in program design
- **Faith-Based Groups**
    - Faith-Based Youth Groups
    - Church and Jesus
    - Mental Health and Faith Community Partnerships
- **Community Education and Awareness Efforts**
    - Suicide Prevention & 988 Awareness Campaigns
    - Mental Health Messaging and Public Education
- **Increasing Community Awareness**
    - Low suicide rates
    - Community Dialogue
    - Awareness of Trauma and ACEs
    - School and Institutional Awareness

What is hurting?

This list describes barriers, gaps, and challenges that respondents reported are undermining youth mental health in their communities.

- **Workforce and Provider Capacity Challenges**
    - Low Medicaid and Insurance Reimbursement
    - High turnover
    - Houses are unaffordable in the region
    - Limited Training and Specialization of Providers
    - Lack of Culturally Competent and Bilingual Providers
- **Insufficient Inpatient and Outpatient Treatment Facilities**
    - Lack of crises stabilization and placement options
    - Lack of In-Person Clinics – Overreliance on telehealth.
    - Lack of local facilities
- **Gaps in Early Intervention and Prevention**
    - Limited early screening and prevention efforts
    - Failure to recognize early warning signs

- **Substance Use and Easy Access in the Community**
    - Easy access to substances
    - Drugs, alcohol, and vaping among youth and adults
- **Limited and Inflexible Funding**
    - Inadequate funding for school counselors
    - General lack of funding
    - Funding with restrictions
- **Inadequate Crises Response and Acute Mental Health Services**
    - Limited crisis response
    - Crisis care is unavailable to uninsured youth.
    - Lack of in-county crisis stabilization and emergency placement
- **Barriers to Access to Care**
    - Geographic Barriers and Limited Rural Infrastructure
    - Lack of Youth Mental-Health Providers
    - Parental Reluctance and Lack of Awareness
    - Fragmented Continuum of Care
    - Limited After-Hours Availability
    - Cost, Insurance, and Affordability Barriers
    - Inadequate Provider Knowledge and Referral Coordination
    - Shortage of Qualified and Specialized Mental Health Providers
    - Information and Navigation Barriers
    - Limited School-Based Mental-Health Resources
    - Service Denial and Disengagement from Care
    - Lack of Trust in the Healthcare System
    - Limited provider participation in Medicaid
    - Limited services for those with low income
    - Schools penalize kids when they leave school for services
    - Lack of Bilingual/ Culturally Responsive Mental Health Providers
    - Long wait time
    - Lack of Transportation
    - Uncoordinated and Inefficient Mental Health System
    - Shortage of School-Based Mental Health Providers

- Restricted entry (providers are at capacity, even though referrals are made)
- Limited substance use treatment resources
- Inadequate insurance coverage limits families' ability to access specialized mental health services

- **Stigma**
  - Stigma as a barrier to seeking care
  - Community stigma and silence
- **Impact of Adverse Childhood Experiences**
  - Youth are most impacted by ACEs
- **Lack of support for families**
  - No parenting education
  - Parental stress (socioeconomic stressors)
  - Lack of family resource centers
- **Gaps in Reach**
  - Homeschool and charter school youth not reached by current efforts
  - Undocumented or mixed-status families not engaging due to fear and other reasons
  - BIPOC, LGBTQIA+, and LatinX youth are disproportionately affected.
- **Distrust in the Mental Health System**
  - Breach of trust and limited confidentiality (due to legislation)
- **Adversities faced by migrant or undocumented youth**
  - Lack of shelter
  - No legal protection
  - Overwork and fear in families
  - Economic instability
  - Lack of insurance
- **Limited prevention and early intervention**
  - Limited early screening and preventive efforts
  - Failure to recognize early warning signs
- **Barriers to Social Connection and Community Engagement**
  - Lack of safe and supportive spaces
  - Transportation barriers limit youth mobility and connection

- Limited opportunities for youth engagement
- **Lack of Political Will and Community Commitment**
  - Resistance to investment
  - Community apathy
- **Shortage of Foster Placements**
  - Limited local foster homes
  - Out of county placement exacerbates trauma
- **Cultural attitudes toward health**
  - Viewing health reactively (i.e., treating illness when it occurs, but no focus on prevention)
- **Isolation and social media use**
- **Lack of Care Coordination and Collaboration**
  - Gaps in referral pathways and continuity of care
  - Isolated non-profits
  - Lack of coordination among agencies and funders
  - Lack of uptake and implementation of available programs
  - Lack of youth data and assessment (e.g., YRBS)
- **Insufficient Education Supporting Youth Social Emotional Development**
  - Lack of education on mental health
  - Fear/ misinformation about SEL
  - Lack of early recognition of distress
  - Need for compassionate/ restorative discipline

Partners that have a role to play

This table identifies organizations that key informants referenced in the survey as contributing to youth mental health efforts across WNC.

Theme	Category	Partners
Community-based nonprofit organizations	Basic needs	WNC Source Early Childhood Programs; Communities in Schools
	Youth empowerment and resilience	PATH; Spark Point; Why Us Kids; THRIVE Appalachia
	Specialized behavioral and developmental support	St. Gerard House
	Restorative and rehabilitative programs	HIGHTS
	Prevention and mental health promotion collaborative	TC Strong
	Advocacy groups	Safelight; Child Allied House; KIDS PLACE
	Early childhood organizations	Macon Program for Progress (Head Start)
	Trauma informed youth healing and resilience programs	Crossnore; Youth Villages
	Violence prevention and recovery services	REACH
Local Health Department, Social Service, and Law Enforcement	Local Health Department and staff; DSS; Guardian ad Litem	Graham County Sheriff's Department
Integrated clinical and behavioral health providers supporting youth	Comprehensive Behavioral Health Providers	RHA Health Services
	Local Hospitals	AdventHealth Hendersonville; AdventHealth Polk (St. Luke's); UNC Health Pardee
	Crises Response and Stabilization	Appalachian Community Services

	Primary and integrated care providers	Local primary care practices, pediatricians, and family medicine clinics
School-based mental health	In-school personnel supporting youth	School nurses, counselors, social workers
Organizations providing youth empowerment, connection, and positive development programs	Youth leadership and empowerment	PATH
	Recreational, faith-based, and community engagement opportunities	Cooperative Extension; Nantahala Racing Club; Public Libraries (Saluda & Polk Libraries); Churches; YMCA; Outdoor or exercise groups
Care coordination and system management	Managed Care Organizations	Vaya Health (as an organization), and Kristina Loughborough and Ronnie Beale (both at Vaya)
Funders	Local foundations	The Greate Smokies Health Foundation
	Federal and State funded initiatives	Project AWARE (SAMHSA Funded)
Faith-Based Partners	Churches and faith communities	
Coalitions and Community Partnerships	Substance Use Prevention and Recovery Coalitions	McDowell Partnership for Substance Awareness; Madison Mental Health and Substance Awareness Coalition; CARE Coalition; Hope Coalition
	Health and Wellbeing Collaboratives	Henderson County Partnership for Health; Swain Summits
Other	The NC Alliance of YMCAs	

What works to do better

This list highlights strategies that emerged from the survey responses on youth mental health improvement.

- **School based mental health services**
  - Availability of sufficient counselors, nurses, social workers, and other mental health professionals
  - Culturally responsive and inclusive school environments (*Creating nurturing environments that help address compounded effects of poverty, trauma, and racism*)
  - Schools as hubs for mental health promotion
  - Mentorship in schools
- **School-community partnerships to expand access**
  - Community programs supporting school mental health (e.g., HIGHTS)
  - Telehealth
  - Federal and state supported mental health initiatives (e.g., Project AWARE)
  - School based therapy and behavioral health services (*Partnerships with organizations like RHA and MAHEC bring licensed therapists and behavioral health staff into schools*.)
- **Access to mental health treatment services**
  - Substance use disorder treatment
  - Intensive and outpatient program options
  - Increasing workforce
  - General availability of counseling and therapy services
- **Engaging faith-based communities**
  - Church involvement in youth wellbeing
  - Youth ministry and church-based programs
  - Collaboration between faith groups and community-based organizations
- **Safe and supportive spaces for youth**
  - Dedicated youth gathering spaces
  - Recreation and social activities

- More local opportunities for youth recreation
- **Mentorship**
    - Mentorship programs (e.g., Big Brothers Big Sisters)
    - Supportive adult advocates (e.g., Guardian ad Litem)
    - Encouragement and goal setting
- **Youth empowerment and development programs**
    - Afterschool programs
    - Youth-led peer support initiatives
    - Collaborative community partnerships (*i.e., partnership among schools, local organizations (e.g., Crossnore, Hope Coalition, PATH, Western Youth Network), and faith-based groups to create programming for youth*)
    - Trauma informed mentorship programs
    - Experiential and therapeutic learning models for at-risk youth
- **Flexible/ after hour mental health services**
    - Expanded service hours across providers, including crisis care
- **Support from local health department and social services**
    - Local health department staff and nurses have a role to play (e.g., promoting youth wellness, providing preventive care, and connecting families to mental health resources)
    - Partnerships between schools, social services and community organizations
- **Supporting and engaging families**
    - Family resources centers
    - Family engagement in youth mental health
    - Addressing challenges in home environments (*Even when youth are motivated to work on their mental health, lack of supportive home environments can hinder progress*)
    - Culturally appropriate family support (*especially for Indigenous, LatinX, and Black families, in order to effectively engage caregivers and address disparities in access, trust, and care continuity.*)
- **FQHCs**
    - Integrated behavioral health within FQHCs

- Crises support and 24/7 accessibility
- Partnerships between FQHCs and regional mental health agencies expand youth psychiatry access

- **Recreation and outdoor activities**
  - Recreational and fitness opportunities
  - Outdoor programs
  - Creative, experiential and participatory learning activities (*e.g., programs that bring youth together to create, perform, and learn, such as Parkway Playhouse, THRIVE Appalachia, and participatory youth design projects*)
  - Investing in local recreation facilities and parks
- **Parental education**
  - Parenting classes
  - Education on children's mental health
  - Guidance on discipline, role modeling, and communication
  - Educational programs that include broader topics (e.*g., sexual health, birth control, and parenting through adolescence*) equip caregivers to navigate complex developmental stages.
- **Substance use prevention and early intervention**
  - Long term funding for prevention services
  - Applying comprehensive substance use frameworks (*e.g., Local partnerships addressing the full continuum, from prevention and education to treatment and harm reduction*)
- **Youth community engagement and access to enrichment opportunities**
  - Accessible community events and activities (*i.e. public events and community gatherings designed for youth*)
  - Addressing transportation and affordability barriers
  - Youth engagement in community life (*e.g., grassroots and nonprofit organizations that involve youth in community gardens and service projects*)
  - Cross-sector collaboration and local partnerships (*e.g., Partnerships between local wellness, tourism, and community groups can expand*

access to recreational or cultural activities through creative solutions such as vouchers or scholarships)

- **Mental health awareness and public education**
  - Community mental health education
  - Community events and outreach to promote awareness
  - Public and leadership understanding of public health (*Lack of mental health literacy among the general public and policymakers hinders progress.*)
- **Funding and system level commitment**
  - Stable and consistent funding from schools, counties, and foundations to maintain services and workforce stability.
  - Government and institutional (e.g., hospital) investment
  - Policy reforms (Medicaid expansion and increased reimbursement levels)
  - Philanthropic and community partnerships
  - Overall commitment to long term systemic change
- **Trauma informed training and capacity building**
  - Resilience building trainings (e.g., Crossnore's Building Trauma Resilient Communities)
  - Evidence-based prevention and early response programs (*e.g., Initiatives such as TC Strong and CARE Coalition integrate evidence-based models like Mental Health First Aid, QPR (Question, Persuade, Refer), and Reconnect with Resources for Resilience to prevent crises and strengthen community readiness.*)
  - Awareness efforts to reduce stigma
  - Cross-sector collaboration (*i.e., Partnerships among schools, coalitions, and nonprofits expand the reach of these trainings and ensure consistent, coordinated approaches to trauma-informed care across sectors.*)
- **Support for children with complex needs (e.g. autistic children, those who have experienced trauma)**
- **Promoting healthy relationships, coping, and social emotional learning**

- Education on healthy relationships and communication
- Helping youth develop patience, understanding, and inclusivity in social settings
- Coping and resiliency skills
- Group and peer interaction skills

- **Address basic needs (social determinants)**
  - Housing
  - Food
  - Integration of basic needs with behavioral health services (*i.e., linking housing and nutrition programs with mental health initiatives for a holistic approach*)
- **Increasing provider supply and reducing turnover**
  - Increasing the number of specialized youth providers (*There is a significant lack of child therapists, psychiatrists, and other professionals trained to meet the mental health needs of youth and families.*)
  - Provider retention and workforce stability
  - Address recruitment and reimbursement challenges
  - Address affordability and access to experienced clinicians (*Youth and families often struggle to find affordable providers with sufficient experience)*
  - Address concerns about provider competency and fit (*Some participants noted variability in provider quality, calling for accountability, training, and openness to feedback to ensure effective care delivery.*)
- **Innovative and coordinated approaches**
  - Structured and transparent processes for referrals and treatment navigation
  - Use of technology (*e.g., Digital platforms such as CredibleMind offer self-guided education and mental health tools that can reach individuals who are reluctant or unable to seek traditional care*)
  - Ongoing need to study and address post-pandemic effects

- Building local cultures that welcome open discussion about mental health reduces stigma and fosters supportive environments where youth feel safe to seek help

- **Cross-sector and community collaboration**
  - State-local collaboration
  - Community engagement and coordinated response (*e.g., Partnerships between the State of NC and the State Alliance of YMCAs in NC*)

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WNC Health Network
1 Haywood Street, Suite 425
Asheville, NC 28801
www.wnchn.org