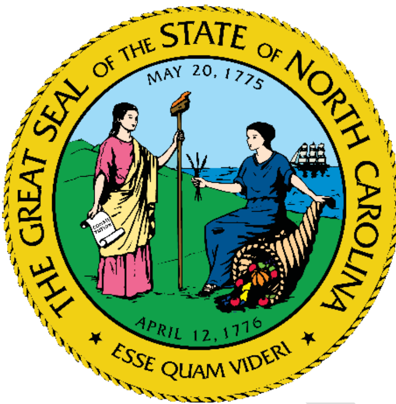

Draft North Carolina Division of Mental Health, Developmental Disabilities, and Substance Use Services Strategic Plan for 2024–2029

North Carolina Department of Health and Human Services

June 3, 2024

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Executive Summary

The 2024-2029 Strategic Plan for the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS or the Division) focuses on the most pressing issues facing North Carolinians. It also clarifies our role in serving North Carolinians in coordination with our sister Divisions under the greater umbrella of the North Carolina Department of Health and Human Services (NCDHHS).

This plan contains an updated mission that will guide our day-to-day work, an ambitious vision for the future, and a set of foundational and guiding principles we will uphold in all our efforts. It also includes six discrete but interrelated priorities, and the key goals we will pursue within each. Also included are measures that will be used to track progress on goals and priorities.

Context in North Carolina

This plan comes at a timely moment. More than four years into a pandemic, mental health care, SUD treatment services, and community supports for individuals with I/DD and TBI are more important than ever.

Across the nation, states continue to navigate rising overdose and suicide rates, waitlists for services, and provider shortages. In North Carolina, suicide is among the top five leading causes of death for people ages 10-65, and the rate of overdose deaths increased sixfold between 2000 and 2022.[1,2] As of November 2023, more than 17,000 individuals were on the Innovations waiver[i] waitlist—one of the largest waitlists in the country—and four in ten North Carolinians live in a Mental Health Professional Shortage Area.[3,4,5] DMH/DD/SUS' Strategic Plan is a commitment to all of our partners and community members that we will take on these challenges and others in our state, continue to improve the public system, and be a leader and advocate for all North Carolinians.

DMH/DD/SUS oversees and regulates North Carolina's public system for providing prevention, treatment, services, and supports to individuals with mental health needs, SUD, I/DD and TBI. The Division leverages routine funding from the state to fulfill this role and, in its day-to-day work, develops and enhances programs, provides training and technical assistance, and ensures access to critical mental health, SUD, I/DD, and TBI services for its community partners.

Funding also comes from federal sources, including two federal block grants: the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) and the Community Mental Health Block Grant (MH BG). These block grants are provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) and allow the Division to lead mental health and substance use policy change through education, policy advocacy, and pilot programs. The Division has also received grants from the Administration for Community Living (ACL) to continue building a comprehensive, whole-person health system to support individuals with TBI.[6]

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[i] The Innovations Waiver is a Federally-approved 1915(c) Medicaid Home- and Community-Based Services Waiver (HCBS Waiver) designed to meet the needs of Individuals with I/DD who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

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In State Fiscal Year (FY) 2023, the Division received targeted allocations during the annual budget process. These allocations are part of the General Assembly's historic $835 million investment in behavioral health, inclusive of mental health, SUD, I/DD, and TBI, in North Carolina. This strategic plan incorporates the portion of the funding allocated to DMH/DD/SUS, and the Division will undertake significant work to ensure these funds are spent in a meaningful and effective way. Funds from the budget process will support efforts in areas such as the behavioral health crisis system, behavioral health workforce, children's behavioral health, and services and supports for justice-involved individuals. The budget also provided authority to expand the TBI waiver statewide, which will allow the state to extend the reach of TBI services to more people, and included $5 million to support competitive integrated employment (CIE), day supports and community services for individuals with I/DD.

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The Division is building on key successes from the last few years with its partners – including during the development of this plan – which include but are not limited to:

2022	• The 988 Suicide & Crisis Lifeline launched nationwide in July 2022, making it easier for individuals to reach trained crisis counselors when in distress and to access services. NCDHHS launched a 988 performance dashboard to track volume of calls, answer speed, and more in December 2023.[7] The state also launched a Statewide Peer Warmline in February 2024, which operates in tandem with the 988 Suicide & Crisis Lifeline to offer callers the option of speaking with a Peer Support Specialist.[8] 988 and the Peer Warmline are available 24/7/365. • North Carolina was awarded a $13.8 million federal grant to complete Competitive Integrated Employment (CIE) demonstration projects;[9] using this award, North Carolina's Project Spark aims to support 300 individuals with disabilities engage in and maintain competitive integrated employment.[10] • Tailored Care Management (TCM) began in December 2022 to provide whole-person care management to eligible Medicaid recipients to address all needs, including physical health, mental health, SUD, I/DD, TBI and more.[11]
2023	• The Division awarded more than $3.2 million to nine North Carolina colleges and universities to fund Collegiate Recovery Programs (CRPs) in January 2023 to provide recovery supports and spaces to live, work, and study without drugs or alcohol for college students.[12] • The Division launched its new Behavioral Health Statewide Central Availability Navigator (BH SCAN) tool with 99 hospitals and community-based crisis providers in January 2023, allowing providers to easily find open inpatient behavioral health beds and send and receive referrals for their patients.[13,14] • The Division received a federal grant in March 2023 to begin planning for the launch of additional Certified Community Behavioral Health Clinics (CCBHCs), which will bring integrated care to more North Carolinians in future years. This grant builds on the Division's existing investment in integrated behavioral and physical health care; the Division funded five CCBHCs in 2022.[15] • North Carolina received approval for a 1915(i) state plan amendment (SPA) in July 2023, allowing more individuals to receive home and community-based services (HCBS) such as community living and support, respite, and supported employment.[16] • The Department launched Inclusion Works, a cross-divisional effort to help any individual with I/DD access competitive integrated employment (CIE, in September 2023.[17]

	• Mid-level substance use treatment services, including the Substance Abuse Intensive Outpatient Program (SAIOP), Substance Abuse Comprehensive Outpatient Treatment (SACOT), and social setting detox became available to Medicaid Standard Plan enrollees in October 2023.[18] • Medicaid expansion began in North Carolina in December 2023, expanding access to behavioral health services to newly eligible North Carolinians and allowing more people to receive state-funded services as some individuals receiving state-funded services shift to Medicaid.
2024	• The Division announced a partnership with the Division of Vocational Rehabilitation Services (DVRS), now called Employment and Independence for People with Disabilities (EIPD), in December 2023 to pilot additional Competitive Integrated Employment (CIE) projects for individuals with I/DD.[19] • The Department announced Inclusion Connects, a cross-divisional initiative to connect individuals with I/DD and their families with community-based services to support their health and wellbeing, in March 2024.[20]

We are proud of these successes, but know hard work lies ahead to continue improving the lives of all North Carolinians.

Our Mission, Vision and Principles

As we build on the work of the Division, we renew our commitment to the people we serve with a new, core mission statement that speaks to what we do on a day-to-day basis and reflects the unique role of the Division in supporting North Carolinians. We are further guided by an ambitious vision, which imagines the North Carolina of the future that we are working toward.

Underpinning our mission and vision are five cross-cutting principles. Through conversations with our partners, these principles were identified as important concepts that underly all the work the Division undertakes, and each section of the strategic plan was drafted with these principles in mind. In this way, the strategic plan is intended to be viewed as a whole, rather than in parts. Each part of the plan is a "puzzle piece" that comes together to form a greater picture.

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Our Principles

Lived Experience.[21] **We value lived experience by listening to and advocating for individuals and families, championing the expertise of peers, promoting natural and community supports, and creating opportunities for meaningful partnership.**

We know our partners have diverse perspectives, backgrounds, history, and identities that can help inform everything we do at the Division. We will center and learn from the experiences of our partners to improve the work that we do.

Equity.[22] **We create policy that helps everyone get what they need to live healthy lives in their communities, with particular focus on improving access to services for historically marginalized populations.**

Equity means ensuring, through fair and just treatment, that all North Carolinians can achieve optimal health outcomes. In alignment with the 2021-2023 DHHS Strategic Plan, we will work with partners to overcome equity barriers for historically marginalized populations.[23] We will monitor key metrics indicating the success and reach of our services across all population groups, and we will ensure that we and our partners are accountable for overcoming known, persistent health inequities.

Inclusivity.[24] **We commit to ensuring that everyone who uses our systems feels welcomed, and our policies support the health and well-being of all North Carolinians, regardless of race, ethnicity, sex, gender identity and expression, sexual orientation, age, national origin, socioeconomic status, religion, ability, culture and experience.**

We commit to ensuring that no individual feels unsupported by our services and supports, by taking steps to improve service accessibility for consumers and reduce burdens for providers.

Quality. We promote the provision of high-quality, evidence-based services and supports that leverage the expertise and best-practices of our clinical partners.

A quality-informed approach means leveraging data to perform oversight and promoting services and supports that lead to better outcomes. It includes regulating Plans and providers to ensure people receive services quickly with all rules and requirements followed. The Division will also share the data we collect so our partners can hold us accountable every step of the way.

Trauma-Informed.[25] **We recognize the reality of trauma and promote a culture of kindness, understanding, and respect for every person.**

Trauma has a real, measurable effect on the way we interact with the world around us. We commit to making sure our systems, services and supports are reactive to life experience, and we aim to resist re-traumatization .

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DMH/DD/SUS is committed to the needs of *any* North Carolinian who seeks mental wellness or lives with a mental health issue, SUD, TBI or I/DD. Within those broad categories are groups of people whose needs will be specialized and require specialized interventions. We will focus on these groups by advancing new, tailored interventions or by modifying existing interventions to better meet their needs.

- **People with Co-Occurring Disorders or Needs.** Although the goals listed in the remainder of the strategic plan generally speak to one disorder or need (e.g., individuals with an opioid use disorder (OUD)), we are aware that people often navigate multiple disorders or needs, such as I/DD and mental health needs. We recognize the necessity of helping people to bridge the gap between different services or tie several services together. Sometimes a single intervention may be adequate to support those with co-occurring disorders or needs, but often the need is for good care management to ensure that multiple treatment needs are met.

- **Low Vision or Blind; Hard of Hearing or Deaf; Those Who Speak Other Languages**. We commit to providing the tools necessary for North Carolinians to receive services inclusive of physical ability and language of preference.

- **Active Service Members and Veterans**. North Carolina is proud to have a large population of veterans and active service members. We commit to covering and promoting services that meet the specific needs of those who have served or are currently serving.

- **Older Adults**: As people across the U.S. continue to live longer, we commit to ensuring that older adults in our state have the supports they need to age in place and that providers are trained in how to care for their unique needs.

- **Historically Marginalized Populations:** We pledge to promote equitable access to quality systems, services, and supports. This means ensuring all North Carolinians, including those that have been historically excluded from full and straightforward participation in public systems, have their unique needs considered when we design and enhance our programming.

Critically, “any North Carolinian” also includes the hardworking and dedicated staff of DMH/DD/SUS and all other DHHS teams. While this plan is focused on the external groups that we serve, we also commit to looking inward and developing a culture and system of supports that enable our Divisional team and colleagues across state government to live their best lives, and as a result, do their best work for the citizens in the state. As part of the implementation of this plan, interventions that we develop relating to the promotion of mental wellness and other areas will be brought internally and adopted to ensure that each of us is supported in the way that we need to be, and that if services and supports are needed, they are available.

Our Priorities

Through intensive conversations with our partners, we identified six priorities to guide our work. Underneath each priority sit specific goals that we aspire to achieve.

Our Priorities
Promote Wellness and Recovery: We will make it easier for people to access and stay in services to increase recovery, prevent suicide, address problem gambling, and help more people live self-directed lives.
Expand Access to Quality I/DD and TBI Services: We will increase access to services so that more individuals with I/DD and TBI are able to live the lives of their choosing in their community.
Prevent Substance Misuse and Overdose: We will use primary prevention, harm reduction techniques, and increase timely access to services to prevent substance misuse and overdose.
Strengthen the Workforce: We will encourage all individuals delivering care and supporting care delivery to offer quality, evidence-based services and support them in having a clear understanding of their role and a path for professional growth.
Strengthen the Crisis System: We will develop a more robust crisis system that meets the needs of people who are in distress, so that there is always someone to talk to, someone to respond and somewhere to go.
Expand Services for Individuals in the Justice System: The Division will create alternatives to incarceration, increase access to behavioral health treatment, and develop supports to deflect and divert more individuals from the justice system, as well as maintain stability upon re-entry.

	Our Goals
Promote Wellness and Recovery	**1.1: *Increase Treatment Initiation and Retention***. Make it easier for children, adolescents, and adults of all ages – including individuals experiencing first episode psychosis – to access evidence-based services in a timely manner and stay in services for the recommended duration of treatment.
	1.2: *Prevent Suicide*. Prevent suicide at all ages through evidence-based strategies and decreasing stigma connected to seeking care.
	1.3: *Improve Quality of Out-of-Home Interventions.* Invest in access along the continuum of care for children and improve the quality of out-of-home interventions.
	1.4: *Increase Caregiver Supports.* Promote services and supports for family members and caregivers.
	1.5: *Grow Recovery Supports.* Support the expansion of recovery supports and services, including employment and housing supports, for individuals with behavioral health disorders.
Expand Access to Quality I/DD and TBI Services	**2.1: *Increase I/DD Services***. Increase the number of people with I/DD receiving high-quality services in their homes and communities.
	2.2: *Increase TBI Services*. Increase the number of people with TBI receiving high-quality services in their homes and communities.
	2.3: *Increase Employment.* Among individuals with an I/DD or TBI choosing to be employed, increase the number of people who maintain employment.
	2.4: *Increase Independent Housing.* Increase the number of people with an I/DD or TBI who are in and maintain independent housing.
Prevent Substance Misuse and Overdose	**3.1: *Increase Primary Prevention Engagement***. Delay initial substance exposure or use and deter access to substances that can be misused by children and adolescents, and use harm reduction strategies to prevent escalation and misuse in young adults.
	3.2: *Increase Public Awareness of SUD*. Raise public awareness on substance misuse and accessibility of services and supports.
	3.3: *Increase Access to Evidence Based SUD Treatment*. Increase timely access to evidence-based SUD treatment services.
	3.4: *Increase Access to SUD Services*. Increase access to SUD treatment services in geographic areas and populations with low penetration rates relative to need.
	3.5: *Reduce Overdose Deaths*. Prevent deaths due to overdose.
Strengthen the Workforce	**4.1: *Strengthen Peer Workforce***. Build a well-trained and well-utilized peer workforce whose work leverages lived experience.
	4.2: *Strengthen DSP Workforce*. Build a well-trained direct support professional (DSP) workforce.
	4.3: *Increase Licensed Providers*. Increase the number of licensed providers entering the public workforce.
	4.4: *Increase Supports for Providers*. Increase training and support for unlicensed professionals providing services to people using the public system.

	Our Goals
Strengthen the Crisis System	**5.1:** ***Connect to Crisis Care.*** Connect individuals to appropriate crisis services and facilitate seamless handoffs.
	5.2: ***Increase Timely Mobile Crisis Care***. Ensure timely, quality crisis care in the community and connect individuals to the appropriate level of care.
	5.3: ***Increase Community Crisis Facility Use***. Increase use of community-based behavioral health crisis facilities (e.g., behavioral health urgent care, facility-based crisis centers) as an alternative to higher levels of care.
	5.4: ***Decrease Inappropriate ED Stays***. Decrease inappropriate use of Emergency Departments (EDs) for children, adolescents, and adults in crisis.
Expand Services for Individuals in the Justice System	**6.1:** ***Increase Engagement in Deflection and Diversion Programs.*** Increase linkages for people with mental health needs, SUD, I/DD or TBI to evidence-based care and services to provide an alternative to incarceration.
	6.2: ***Increase Successful Community Re-engagement*****.** Ensure successful community reentry of justice-involved individuals with a broad range of needs.
	6.3: ***Increase Use of Evidenced Based Programs for Justice Involved Youth***. Increase use of evidence-based programs and practices to support justice-involved youth.
	6.4: ***Increase Access to Capacity Restoration*****.** Increase the capacity and use of detention-based and community-based capacity restoration pilots.

In the sections that follow, each priority and goal are further described. While they outline the issues we will address to realize our vision for North Carolina and the public system, we recognize that this necessary work cannot happen without our partners. This includes the state's Local Management Entity/Managed Care Organizations (LME/MCO), who ensure services are provided to many North Carolinians. It includes our agency partners across NCDHHS and the state, the provider community, and so many others who we commit to working with to make this plan a reality. And it includes our Consumer and Family Advisory Councils and other community members and advocates, who provide invaluable input rooted in their lived experience.

What are North Carolina's LME/MCOs?

Local Management Entity/Managed Care Organizations, known as LME/MCOs, are managed care entities that ensure individuals across North Carolina receive health care services, including mental health, developmental disability or SUD treatment services. There are four LME/MCOs in North Carolina, each ensuring services are provided for a set of counties throughout the state. DMH/DD/SUS contracts with the LME/MCOs to provide state-funded services to people across North Carolina, making them a key partner for advancing the work of this strategic plan.

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What We Will Achieve

By 2029, we will be on our way to more communities where all are supported to live healthier and happier lives. In addition to the metrics the Division will track to monitor progress on the strategic plan (see page 27), North Carolinians will be able to see progress in the following ways:

More children and youth will grow up in safer and healthier spaces, with a reduced need for services later in life.

More people will access quality services that meet their needs. More people will know how to access services, and a standardized array of services will be available in each community.

More people will live the life of their choosing in their communities because they have the supports they need close to home.

More people will reach recovery by being able to manage their health, have a safe and stable place to live, conduct meaningful daily activities, and have a strong community.

North Carolina will have a happier and healthier public workforce that is trained and feels supported and valued, with a clear path to professional development. This includes our own DMH/DD/SUS teams.

The 2024-2029 Strategic Plan is our promise for how we will drive innovation and positive change for all North Carolinians – especially for those living with mental health needs, SUD, I/DD, or TBI – and we look forward to working with all of our partners to realize our vision.

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Priority 1: Promote Wellness and Recovery

North Carolina is losing people to suicide; between 2016-2020, 7,122 North Carolinians died by suicide, and suicide is among the top five leading causes of death for people ages 10-65 in North Carolina.[26,27] Suicidality is an acute event that can be treated. The impacts of suicide are felt across entire communities, and the prevalence of suicide shows an ongoing need to increase the ability of all North Carolinians to recover, be well, and thrive.

The U.S. is also experiencing a rise in problem gambling, and 5.5% of adults may be dealing with a problem gambling disorder in North Carolina.[28] Problem gambling often occurs in conjunction with a mental health diagnosis and/or a SUD, indicating a need for treatment to be integrated and address the multiple challenges a person may be facing.[29]

For people experiencing challenges with their mental health, problem gambling or a SUD, recovery is a process of change through which people improve their health and wellness, live self-directed lives and strive to reach their full potential.[30] The cornerstones of recovery – being able to manage one's health, having a safe and stable place to live, conducting meaningful daily activities and having a strong community – are key areas that DMH/DD/SUS wants to promote for all North Carolinians.[31] We will do so by supporting other statewide efforts, like the statewide Suicide Action Plan, and advancing the following goals.[32]

Goal 1.1: *Increase Treatment Initiation and Retention.* Make it easier for children, adolescents and adults of all ages – including individuals experiencing first episode psychosis – to access evidence-based services in a timely manner and stay in services for the recommended duration of treatment.

Many people continue to go without mental health care in North Carolina and across the U.S. In 2022, more than 40% of adolescents with a major depressive episode and half (49.4%) of adults with any mental illness nationwide did not receive care.[33] North Carolina ranks 39th among states in access to mental health care according to Mental Health America, and in 2022, one in five adults in North Carolina showing symptoms of anxiety and/or depression reported an unmet need for counseling or therapy in 2022.[34,35] Multiple entry points to the system can make it hard to navigate and know where to get services, especially when services vary in availability by region of the state. We will work to streamline how individuals access services, make it easier to know what services are available and reduce stigma around seeking services, so people can take the necessary steps to improve their mental health and wellbeing.

In addition to making it easier to access services, we want to ensure people can get services *when* they need them. Evidence has shown that receiving services in a timely manner can prevent escalation of outcomes, such as involvement with the justice system and suicidality. Timely access is especially critical for specific populations, including individuals experiencing first episode psychosis (FEP), the early period after the onset of psychotic symptoms. Individuals experiencing FEP need specialized supports as soon as possible to allow them to achieve the life they want to lead.[36]

Goal 1.2: *Prevent Suicide.* Prevent suicide at all ages through evidence-based strategies and decreasing stigma connected to seeking care.

In 2020, 1,436 people died by suicide in North Carolina, at a rate of 15.3 deaths per 100,000 individuals.[37] Suicide rates are also higher for certain groups of people, including veterans, individuals living in rural areas, children and youth, individuals with Autism Spectrum Disorder and individuals who identify as LGBTQ.[38,39,40,41,42] Suicidality is treatable and suicides can be prevented; screening and interventions work. We commit to interventions that help to recognize when suicide is a risk and provide help.

In addition, individuals with serious mental illness (SMI) often die 10-20 years earlier than the general population, due to both unnatural causes and increased risk of some physical health conditions.[43,44] Appropriate community-based services and supports protect against SMI-related morbidity, and we are committed to expansion of services that are evidence-based to help ameliorate the impacts of mental illness for adolescents and adults.

Goal 1.3: *Improve Quality of Out-of-Home Interventions.* Invest in access along the continuum of care for children and improve the quality of out-of-home interventions.

North Carolina continues to face challenges with foster care placements and its delivery of behavioral health services to Medicaid-enrolled children and youth, as evidenced by high numbers of children placed in residential facilities, both in- and out-of-state; as well as children with high needs boarding in Emergency Departments (EDs) and staying in child and family services offices.

Removing children from homes to be placed in institutions or foster care should be an option of last resort. While there are situations in which children should be placed outside of their homes due to abuse, neglect, or needs that require more intensive treatment than can be delivered in the home, too many children in North Carolina are being removed due to inadequate community service offerings – especially those affected by co-occurring disorders – which can lead to increased trauma for an already vulnerable population. A full, high-quality community-based continuum of care is needed to ensure more children can stay home. Further, for children who require a higher-level of intervention – such as out of home interventions – they are entitled to specialized, high-quality care that is recovery-oriented and produces positive outcomes for them and their families.

Goal 1.4: *Increase Caregiver Supports.* Promote services and supports for family members and caregivers.

Family members and caregivers provide support to individuals with behavioral health conditions and other needs on a day-to-day basis and can improve treatment outcomes. Caregiving is not without challenges, however, and individuals who act as caregivers may experience higher levels of stress, anxiety and depression due to their caregiving duties. Creating additional services that allow caregivers to receive a break (e.g., respite), as well as supports that provide them with the tools and education to support the needs of the individuals they are caring for, are necessary to ensuring family members and caregivers have what they need to be successful.

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Goal 1.5: ***Grow Recovery Supports.*** **Support the expansion of recovery supports and services, including employment and housing supports, for individuals with behavioral health disorders.**

Reaching and maintaining recovery is an ongoing effort. Having appropriate supports in place along the four dimensions of recovery – health, home, purpose and community – are critical, as is seeing and working with other people who have lived experience and navigated their own recovery journey. We will work to expand recovery supports for individuals with behavioral health needs, including peer support services, housing supports and supported employment, to help more North Carolinians make progress in their recovery journey.

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Priority 2: Expand Access to Quality I/DD and TBI Services

Too few people with I/DD or TBI in North Carolina can access services in their communities that allow them to live the life of their choosing. As of November 2023, more than 17,000 individuals were on the Innovations waiver waitlist, one of the largest waitlists in the country.[45,46] Increasing access to services is a top priority for DMH/DD/SUS and our partners, and is closely linked to other Department and Division efforts, including the state's Olmstead Plan and upcoming launch of Tailored Plans.[47,48]

While recent steps have been taken to increase access to services – including the launch of Inclusion Works, approval of a state plan amendment to offer 1915(i) waiver services, expansion of the Innovations waiver and legislative approval to take the TBI waiver statewide – we know more can be done to ensure that a reliable array of I/DD and TBI services is available across the state.[49,50] Notably, expanding access to services – including existing service offerings – will also require tackling workforce shortages, which are addressed more directly in Priority 4.

To continue our commitment to expanding access to quality I/DD and TBI services in communities and not institutions, we will pursue the following goals.

Goal 2.1: *Increase I/DD Services.* Increase the number of people with I/DD receiving high-quality services in their homes and communities.

Too many individuals with I/DD in North Carolina continue to wait for services, including the thousands of individuals on the Innovations waiver waitlist.[51] Further, most individuals on the Innovations waiver waitlist are going without needed services; only 34% are receiving any Medicaid or state-funded behavioral health or I/DD services, and many individuals who are authorized for I/DD services are not able to get the full set of services they are authorized for due to workforce shortages.[52]

North Carolina's most recent National Core Indicators (NCI) results, a survey of individuals with I/DD, indicated that only 68% of people were able to choose the services they received as part of their service plan, indicating opportunities to increase choice once an individual is able to access services.[53]

Taken together, these indicate opportunities to increase both access *and* choice, with increased choice driven by making it easier for people to know what services are available and how to access them.

Goal 2.2: *Increase TBI Services.* Increase the number of people with TBI receiving high-quality services.

In state fiscal year 2019, 41,398 individuals with a TBI diagnosis in North Carolina received behavioral health services; however, the 107 slots allocated to the TBI waiver are not full.[54,55] This may be in part because the TBI waiver eligibility was initially limited to individuals living in one of six counties in the state, but the most recent budget included a provision to take the TBI waiver statewide, creating an opportunity to expand access to TBI services.[56] Like people with I/DD, people with TBI need more and better information on how and when to access services available to them.

Goal 2.3: *Increase Employment.* Among individuals with an I/DD or TBI choosing to be employed, increase the number of people who maintain employment.

Many individuals with an I/DD or TBI want to be working, but are not. According to North Carolina's NCI, 57% of individuals with I/DD surveyed in 2021-2022 did not have a paid community job of those who wanted one.[57] This discrepancy is likely due in part to the additional barriers individuals with I/DD or TBI face when seeking and maintaining employment, such as the inability to obtain necessary accommodations to work. We commit to increasing employment supports for individuals with I/DD and TBI, so that more individuals who want to work and be involved in their communities can do so.

Goal 2.4: *Increase Independent Housing.* Increase the number of people with an I/DD or TBI who are in and maintain independent housing.

Individuals with an I/DD or TBI who want to live in their chosen communities should be able to do so, yet many individuals are not able to secure housing in their communities and may instead default to living in an institutional setting. Further, 41% individuals with I/DD in North Carolina living outside of their family indicated that they did not have a choice in where they live.[58] We commit to improving and enhancing the housing array for individuals with I/DD and TBI to create more options for individuals to live in the communities of their choosing, as well as ensuring appropriate home and community-based supports are in place to allow individuals to maintain housing once in it.

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Priority 3: Prevent Substance Misuse and Overdose

Like the rest of the country, North Carolina is fighting to help more individuals reach recovery at a time when substance use overdose deaths are rising. Overdose deaths in North Carolina increased from 2000 to 2022, up from 5.8 overdose deaths per 100,000 in 2000 to 41.4 deaths per 100,000 in 2022.[59] The overdose death rate in North Carolina is also higher than the U.S. as a whole, for opioids and overall.[60,61] Other drug-related deaths are also on the rise in North Carolina: stimulant-related overdose deaths increased from 222 to 2,217 from 2012 to 2021, and the state saw similar increases in overdose deaths during that time period associated with fentanyl (140 to 3,117), methamphetamine (24 to 978), and cocaine (201 to 1,414).[62] Further, excessive alcohol use is the third leading preventable cause of death in North Carolina, and alcohol-related deaths have been increasing each year.[63,64]

Multiple cross-state efforts have launched in recent years to address the impact of substance use on communities, including a Department-wide initiative focused on the opioid epidemic that includes the Opioid and Substance Use Action Plan.[65] In addition to these efforts, we will help more individuals reach recovery by delaying initial substance use, de-stigmatizing seeking help for SUDs and providing timely access to evidence-based treatments. Key to this is our role in administering the SUPT BG, which provides federal funding for initiatives that will allow us to make progress on the following goals.

Goal 3.1: *Increase Primary Prevention Engagement.* Delay initial substance exposure or use and deter access to substances that can be misused by children and adolescents, and use harm reduction strategies to prevent escalation and misuse in young adults.

Studies have indicated that the younger an individual is when they initiate substance use, the more likely they are to develop a SUD, and a younger age of drug initiation is associated with more substances of abuse.[66,67] By delaying or preventing initial substance exposure or use in children and adolescents, North Carolina can prevent future SUDs and their impact on communities. North Carolina can also employ harm reduction strategies, which meet people where they are and empower them to live healthy, self-directed, and purpose-filled lives.

SUPT BG funds create opportunities to offer primary prevention strategies, given 20% of the grant must be spent on primary prevention for individuals not identified as needing treatment.[68] This must include retail tobacco monitoring and can include strategies like education, technical assistance to community groups or agencies, and the development of alternative activities that do not involve alcohol and drugs.

Goal 3.2: *Increase Public Awareness of SUD.* Raise public awareness on substance misuse and accessibility of services and supports.

Increasing public knowledge of the impact of substance misuse can change people's behavior toward substances and reduce stigma.[69] By raising public awareness of the impact of substance misuse, DMH/DD/SUS has the opportunity to change how people talk about and engage with substances.

Further, few individuals with SUDs are receiving services; in 2021, only 6% of people nationwide with an SUD received services.[70] While this lack of services is driven in part by provider shortages, it is also linked to a knowledge gap in how to access services, and more education on how and where to access SUD services will help people obtain services when needed.

Goal 3.3: *Increase Access to Evidence Based SUD Treatment.* Increase timely access to evidence-based SUD treatment services.

Few individuals with SUDs receive services, and across North Carolina there are gaps in where individuals can obtain key evidence-based treatments, including medications for opioid use disorder (MOUD) such as methadone and buprenorphine.[71] In 2019, 52 of North Carolina's 100 counties did not have and opioid treatment program (OTP), which are facilities that treat opioid use disorder and provide assessments, counseling and methadone, a type of MOUD.[72] Naloxone, an easy-to-deliver treatment that reverses overdoses, is also not widely available. These represent critical gaps across the state in availability of evidence-based SUD treatment.

Goal 3.4: *Increase Access to SUD Services.* Increase access to SUD treatment services in geographic areas and populations with low penetration rates relative to need.

While the opioid and drug epidemic has impacted all communities, the rate of overdose deaths in North Carolina is highest among individuals who are American Indian and Alaskan Natives (AI/AN), and the rates of overdose deaths for individuals who are Black and Hispanic climbed more than 200% between 2015 and 2020.[73,74] Overdose death disparities also exist in North Carolina based on where people live; the rate of drug overdose deaths is higher in rural counties than in urban counties.[75]

Rural counties and counties in North Carolina with higher proportions of Black or AI/AN residents are also less likely to have access to key services and providers. In 2022, most North Carolina counties without OTPs were rural, and all of the 14 counties without a provider able to prescribe buprenorphine were rural.[76] Further, 10 of the 12 counties without opioid treatment options were counties with a higher proportion of Black or AI/AN residents.[77] These trends indicate a need for focused outreach to ensure individuals from historically marginalized communities and those living in rural areas are receiving critical services to prevent overdose deaths.

Goal 3.5: *Reduce Overdose Deaths.* Prevent deaths due to overdose.

Overdose deaths in North Carolina increased from 2000 to 2022 and remain higher than the U.S. as a whole.[78,79,80] The statewide efforts described above are focused on tackling this issue, but more interventions are needed to reduce the loss of life to drug overdoses across the state.

Priority 4: Strengthen the Workforce

Some of North Carolina's access to care challenges can be traced to workforce shortages, and there is a need to ensure that the current workforce is being used to its full capacity. 40% of North Carolina residents live in a Mental Health Professional Shortage Area (HPSA), North Carolina I/DD provider agencies experience turnover rates of 30% among their DSP staff, and not enough Certified Peer Support Specialists (CPSS) are actually employed as CPSS.[81,82,83] This has to change, as a strong workforce is the foundation for ensuring a robust public treatment system.

We believe that there need to be enough providers – at all levels and for all populations – to ensure individuals across North Carolina can access services when they need them. Providers need to be well-trained to provide quality, evidence-based services that do not inflict additional trauma, and must have a clear understanding of their role, feel supported and have a path for professional growth. Furthermore, peers must have a meaningful role in the workforce to ensure that people receiving services are able to connect with those who have similar lived experience. We will pursue the following goals to strengthen the workforce in North Carolina, with an initial focus on our peer and DSP workforces.

Goal 4.1: *Strengthen Peer Workforce.* Build a well-trained and well-utilized peer workforce whose work leverages lived experience.

Peer support is a critical part of an evidence-based and recovery-oriented behavioral health system and can help individuals reach recovery and become more engaged in their communities. Yet, in North Carolina, only 39% of CPSS are currently employed as CPSS, and nearly a quarter (23%) of CPSS are seeking employment.[84] Further, many currently employed CPSS are not providing services in a way that aligns with their lived experience and expertise (e.g., by working in administrative roles instead of person care), indicating opportunities to better engage this key segment of the workforce.

Goal 4.2: *Strengthen DSP Workforce*. Build a well-trained and supported DSP workforce.

There are ongoing DSP shortages across the country, with 83% of disability providers nationwide not accepting new referrals due to insufficient staffing.[85] Disability providers also experience frequent staff turnover. Addressing the DSP crisis is a key priority not only for this strategic plan, but also in North Carolina's Olmstead Plan.[86,87] The Division will rollout standardized trainings and opportunities for career advancement that will help create a stable, high-quality DSP workforce.[88]

Goal 4.3: *Increase Licensed Providers.* Increase the number of licensed providers entering the public workforce.

Like the rest of the country, North Carolina is experiencing a shortage of licensed providers across the entire public treatment system. Because of this, some people who need services are not able to get them. The percentage of needs met by the existing mental health workforce is only 13%, compared to 28% across the U.S., and an additional 221 providers are needed to remove the HPSA designations in the state.[89] North Carolina's existing behavioral health workforce has also cited staff shortages as a key barrier to getting more people access to services.[90]

Goal 4.4: *Increase Supports for Providers.* Increase training and support for unlicensed professionals providing services to people using the public system.

Providers in the public system provide services to people with complex, individualized needs. Providers need to be trained to support those needs, especially given high rates of co-occurring diagnoses; up to 40% of individuals with I/DD have a co-occurring mental illness.[91] Furthermore, in a survey of family members of individuals with I/DD, SMI, SUD and TBI in North Carolina, respondents ranked the lack of adequate and well-trained staff as a top concern.[92]

Some services are also highly regulated – such as SUD services – and providers need readily-available supports to ensure they provide quality services in line with federal and state requirements.

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Priority 5: Strengthen the Crisis System

Crisis services are more important now than ever. Nationally, depression and anxiety rates have risen dramatically, and within North Carolina, the youth suicide rate has doubled.[93] People – including numerous children each month – experiencing mental health and other crises continue to seek care in the emergency room because they feel like there is nowhere else to go.[94]

Behavioral health crisis services can act as an entry point to other behavioral health services, including for populations with co-occurring needs.[95] North Carolina must have a robust crisis continuum that meets the needs of individuals in distress in a timely and effective manner, which includes: ensuring individuals know what services are available and who to call to receive them; training staff appropriately to effectively deescalate crisis situations; and ensuring the system has enough capacity for every person to have a safe place to go, regardless of their geographic location or specific needs. To achieve this vision, we will pursue the following goals to strengthen the state's crisis system.

Goal 5.1: *Connect to Crisis Care.* Connect individuals to appropriate crisis services and facilitate seamless handoffs.

988, a nationwide crisis number , is a one-stop entry point into the system for individuals to receive crisis services when in distress.[96] While North Carolina has seen higher 988 service utilization relative to other states, utilization has not risen to the levels it has hoped for; call volume increased minimally over the course of 2023, generally hovering at around 8,000 calls per month.[97] Across the country, most adults are not aware of 988, and of those that are, they are disproportionately white with higher incomes and more advanced education.[98] By promoting the use of 988 across the state, we can create a better front door to crisis services for individuals in need.

Goal 5.2: *Increase Timely Mobile Crisis Care.* Ensure timely, quality crisis care in the community and connect individuals to the appropriate level of care.

While mobile crisis teams are available across the state, greater investment is necessary to ensure individuals receive care in their community in a timely fashion.[99] Currently, the average response time for mobile crisis services is two hours.[100] Many individuals instead choose to go to the ED, which is not as well equipped to care for individuals experiencing behavioral health crises and can delay how long it takes for someone to get the right treatment.

Goal 5.3: *Increase Community Crisis Facility Use.* Increase use of community-based behavioral health crisis facilities (e.g., BHUCs, FBCs) as an alternative to higher levels of care.

Ensuring that individuals receive care in the appropriate setting is necessary to ensuring the care they receive is effective. On any given day, based on internal Department data, there are approximately 300 individuals held in EDs across the state, signaling low capacity in appropriate settings. In 2022, the state's psychiatric hospitals had on average a 23% staff vacancy rate, and bed wait times for these institutions was around 16 days in October 2023.[101,102] Unlike higher levels of care, crisis centers can have a greater staff mix with mid- and low-level staff providing dedicated recovery supports, allowing for a greater staff resource pool, improving service efficiency, lowering costs and helping individuals return home in a shorter amount of time.[103]

Goal 5.4: *Decrease Inappropriate ED Stays.* Decrease inappropriate use of EDs for children, adolescents, and adults in crisis.

North Carolina has a crisis of individuals inappropriately leveraging EDs for behavioral health concerns. Behavioral health-related ED visit rates have grown over the last decade, an issue exacerbated by the COVID-19 pandemic.[104] In North Carolina, this has resulted in individuals being held within EDs while they wait for available beds at appropriate placements. This is a particular crisis among children with complex needs: from January 2023 – March 2023, 27 per 10,000 children with Medicaid in crisis were inappropriately placed in EDs, around 40% of whom had Division of Social Services (DSS) involvement.[105]

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Priority 6: Expand Services for Individuals in the Justice System

Compared to the general population, a disproportionate number of youth and adults who are justice-involved, defined as having a formal association with the justice system, have SMI and/or SUD.[106,107] Of note in North Carolina:

- 60% of individuals in jail reported symptoms of a mental health issue in the previous 12 months;
- 83% of individuals in jail with mental illness did not receive mental health care after admission;
- 68% of people in jail have a history of misusing drugs and/or alcohol; and
- Compared to other North Carolinians, within the first two weeks post incarceration, formerly incarcerated people are 40 times more likely to die from an opioid overdose.

We use the Sequential Intercept Model (SIM) to organize services and supports for individuals that may come in contact with the justice system.

Figure 1. **Sequential Intercept Model**

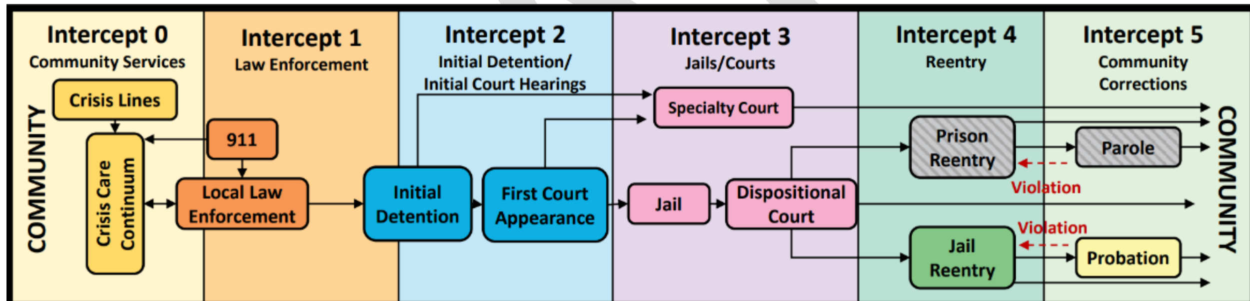

Figure 1 details how individuals with mental health disorders, SUDs, I/DD and TBI come into contact with and move through the criminal justice system. It also helps communities identify resources and gaps in services at each intercept and develop local strategic action plans. We have identified goals associated with the intercepts with the hope of improving access to alternatives to incarceration and supports to help maintain stability upon re-entry to the community.

Goal 6.1: *Increase Engagement in Deflection and Diversion Programs* (Intercepts 0-2). Increase linkages for people with mental health needs, SUD, I/DD or TBI to evidence-based care and services to provide an alternative to incarceration.

Ensuring that people with mental health disorders, SUDs, TBI and I/DD can access services prior to reaching a point of engagement with law enforcement and possible incarceration is essential. The more preventative and robust services and supports North Carolina can make available, including integrating supports into routine law enforcement and justice system processes, the more individuals will receive the interventions they need and prevent unnecessary and often harmful episodes. We will focus on

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expanding community-level programs that work alongside law enforcement to ensure that individuals who need care can be quickly matched to services that are needed instead of being arrested.

Goal 6.2: *Increase Successful Community Re-engagement* (Intercept 4). Ensure successful community reentry of justice-involved individuals with a broad range of needs.

We will build on current services and programming available to individuals leaving the justice system and re-entering society so that they may better re-integrate into communities and remain out of the justice system. Current programs such as the Department of Adult Correction (DAC)-SMI Care Coordination Initiative, the NC Formerly Incarcerated Transition (FIT) Wellness Program, the Transitions Clinic Model and the Justice Re-Entry and Reintegration Initiative will continue to be core to our work, however we seek to further expand the breadth and depth of services that are offered to individuals who need them.

Goal 6.3: *Increase Use of Evidenced Based Programs for Justice Involved Youth* (Intercepts 0-5). Increase use of evidence-based programs and practices to support justice-involved youth.

Youth and adolescents require specialized services that meet them at each point along the SIM, from community-based diversion services through re-entry. We are committed to developing the kind of tailored programming and supports as well as partnerships with community organizations necessary to meet children and adolescents where they are and ensure needed services are available.

Goal 6.4: *Increase Access to Capacity Restoration (Intercept 3)*. Increase the capacity and use of detention-based and community-based capacity restoration pilots.

People who are deemed incapable to proceed (ITP) receive services which restore a person's ability to understand trial proceedings and move forward in the justice system. Until recently only state hospitals provided these services even though the number of people needing services has increased, which has overwhelmed state hospitals. Capacity restoration programs provide an alternative to state hospitals for ITP individuals. These programs provide greater access to care for this population, reduce state hospital wait times and reduce detention time. Data from a detention-based capacity restoration pilot in Mecklenburg County has an average time to restore capacity of 43 days, compared to more than 180 days in state hospitals[108].

Measuring Progress

DMH/DD/SUS has identified the measures in *Table 1* to track progress on the goals and priorities outlined in the Strategic Plan and will report results regularly. Where possible, these measures will be stratified to show different outcomes for different populations, including by geography (e.g., urban versus rural), historically marginalized populations, age and more. Many of these measures provide a snapshot on progress across multiple goals and priority areas.

In addition to the measures described in *Table 1*, DMH/DD/SUS has also identified additional measures that it will build the capacity to report on in the coming years. These measures will capture key concepts that are not currently measured, such as wait time for crisis services, length of stay at PRTFs and rates of use of MOUD used by individuals with OUDs.

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Table 1. **Strategic Plan Measures**

	Measure	Goal Measure Direction	Data Source	Related Priority 1	2	3	4	5	6
1	Percent of persons starting a new episode of alcohol or other drug (AOD) dependence – defined as having no prior Medicaid or state-funded MH/DD/SUD service for an AOD diagnosis for at least 60 days –who receive a second service for an AOD diagnosis within 14 days of the first service.	↑	LME-MCO Quarterly Performance Measure Report Measure – Measure 4.1 DMH/DD/SUS Reports Page	✓		✓			
2	Percent of persons who, after meeting the initiation criteria, receive an additional two visits for an AOD diagnosis within the next 30 days (a total of four visits within the first 44 days of service)	↑	LME-MCO Quarterly Performance Measure Report Measure – Measure 4.1 DMH/DD/SUS Reports Page	✓		✓			
3	Number of people in community-based, high-intensity evidence-based practices and habilitative services (note: for initial reporting, one habilitative service and one evidence-based service will be reported)	↑	Medicaid and State-funded Claims	✓	✓				
4	For individuals receiving mental health or SUD services: Rate of individuals who were able to get all the services they thought they needed.	↑	Perceptions of Care Survey	✓		✓			
5	North Carolina suicide rate.	↓	Suicide Dashboard, North Carolina Violent Death Reporting System	✓				✓	
6	For individuals receiving mental health and SUD services: Rate of individuals whose housing situation improved.	↑	North Carolina Treatment Outcomes and Performance System (NC-TOPPS)	✓					
7	For individuals with I/DD: of people who do not live in the family home, the rate who reported having input in choosing where they live.	↑	National Core Indicators, In-Person Survey		✓				

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	Measure	Goal Measure Direction	Data Source	Related Priority 1	2	3	4	5	6
8	Rate of people on the Innovations Waiver waitlist receiving any Medicaid or state behavioral health or I/DD services.	↑	LME-MCO Dashboard	✓	✓				
9	Rate of overdose deaths.	↓	Opioid and Substance Use Action Plan Data Dashboard			✓			
10	Rate of CPSS employed as peers.	↑	North Carolina's Certified Peer Support Specialist Program	✓		✓	✓	✓	
11	Rate of authorized services provided to individuals receiving supports from a DSP.	↑	1915 Service Authorization Reports		✓		✓		
12	Number of 988 calls.	↑	988 Dashboard	✓				✓	✓
13	Number of mobile crisis visits.	↑	Medicaid and State-funded Claims	✓				✓	✓
14	Percent of persons admitted to an emergency department each quarter that are readmissions to an emergency department for a MH, I/DD, or SUD principal diagnosis within 30 days of a prior discharge.	↓	LME-MCO Quarterly Performance Measure Report Measure – Measure 5.5 DMH/DD/SUS Reports Page	✓		✓	✓	✓	
15	Number of individuals reentering society with SMI served by DMH/DD/SUS-funded re-entry program	↑	Reports from DMH/DD/SUS-funded programs	✓					✓
16	Number of individuals diverted from justice system in a DMH/DD/SUS-funded program [*note: diversion programs are focused on individuals following arrest*]	↑	Reports from DMH/DD/SUS-funded programs						✓
17	Number of individuals deflected from justice system in a DMH/DD/SUS-funded program [*note: diversion programs are focused on individuals prior to arrest*]	↑	Reports from DMH/DD/SUS-funded programs						✓

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Acronym List

Acronym	Definition
ACL	Administration for Community Living
AI/AN	American Indian and Alaska Native
AOD	Alcohol and Other Drug
ASAM	American Society of Addiction Medicine
BH SCAN	Behavioral Health Statewide Central Availability Navigator
BHUC	Behavioral Health Urgent Care
CCBHC	Certified Community Behavioral Health Clinic
CIE	Competitive Integrated Employment
CIT	Crisis Intervention Team
CPSS	Certified Peer Support Specialist(s)
CRP	Collegiate Recovery Program
DAC	Department of Adult Correction
DHB	Division of Health Benefits
DHHS	Department of Health and Human Services
DMH/DD/SUS	Division of Mental Health, Developmental Disabilities, and Substance Use Services
DPI	Department of Public Instruction
DSP	Direct Support Professional
DSS	Division of Social Services
DVRS	Division of Vocational Rehabilitation Services
ED	Emergency Department
FBC	Facility Based Crisis Center
FEP	First Episode Psychosis
HCBS	Home and Community Based Services
HPSA	Health Professional Shortage Area

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Acronym	Definition
LME/MCO	Local Management Entities/Managed Care Organization
I/DD	Intellectual/Developmental Disabilities
IPS	Individual Placement and Support
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning
MAT	Medication-Assisted Treatment
MH BG	Community Mental Health Block Grant
MORES	Mobile Outreach Response Engagement and Stabilization
MOUD	Medications for Opioid Use Disorder
NC	North Carolina
NC FIT	North Carolina Formerly Incarcerated Transition
NCI	National Core Indicators
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PRTF	Psychiatric Residential Treatment Facility
SAMHSA	Substance Abuse and Mental Health Services Administration
SIM	Sequential Intercept Model
SMI	Serious Mental Illness
SUD	Substance Use Disorder
SUPT BG	Substance Use Prevention, Treatment, and Recovery Services Block Grant
TBI	Traumatic Brain Injury

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Partner Engagement

Staff from the DMH/DD/SUS met with the following community partners while developing the Plan, who provided verbal and written feedback:

- The State Consumer and Family Advisory Committee
- Clinical Leadership at our LME/MCOs
- Clinical Providers

Internal DMH/DD/SUS staff also participated in working sessions and submitted written feedback to inform the development of this Plan, including, but not limited to:

- A strategic plan kick-off retreat that involved 26 DMH/DD/SUS staff and leadership
- Internal engagement sessions which involved more than 60 programmatic subject matter experts across DMH/DD/SUS
- Working sessions with DMH/DD/SUS leadership

We thank all of our partners who provided insight throughout our strategic planning process for the feedback they shared during meetings and time they took to submit written feedback. This document, and our Division's activities, are made better with your commentary and perspective.

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