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nciom.org | September 2025

Confronting North Carolina's Behavioral Health Crisis

Access to behavioral health services is a critical component of overall well-being, yet many North Carolinians face significant barriers in obtaining the care they need, including fragmentation in services and delays in timely treatment . Across the state, shortages of mental health and substance use treatment providers, long wait times, insurance coverage limitations, and geographic disparities create challenges for individuals and families seeking support.

These barriers are particularly pronounced in rural communities, where access is often limited due to workforce shortages and a lack of local treatment options. As demand for services continues to rise, especially in the wake of increased mental health needs among children and youth, North Carolina should seek strategic policy solutions to strengthen its behavioral health system, expand provider capacity, and improve equitable access to care.

These systemic access challenges are reflected in stark data that highlight the widespread unmet need across the state. Behavioral health disorders affect 1 in 5 adults in North Carolina and 1 in 6 youth ages 6-17,[1] yet the state's mental providers meet only 13% of the mental health needs. As a result, North Carolina ranks last in the nation for access to behavioral health care.[2]

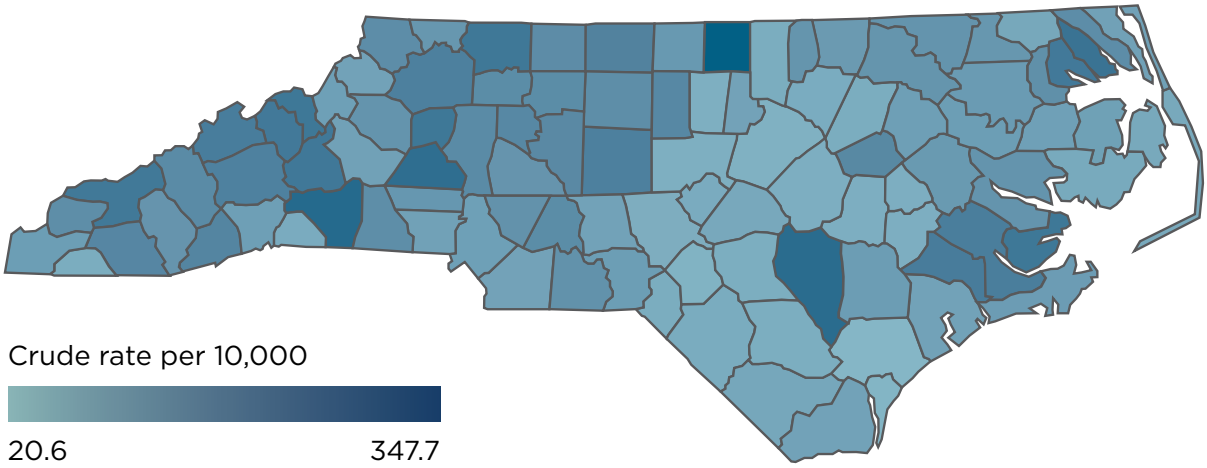
Behavioral health involves the prevention and treatment of mental health conditions and substance use disorders. Behavioral health brings together the fields of psychology, psychiatry, social work, counseling, and related disciplines to address a wide range of issues, including anxiety, depression, addiction, stress management, and effective coping strategies.[3]

As of July 2023, approximately 1 in 18 adults in North Carolina live with a serious mental illness,[4] which is defined as a mental, behavioral, or emotional disorder that results in serious impairment and interferes with or limits one or more major life activities.[5]

In North Carolina, psychiatric patients seeking help in an emergency department spend a median of 5.25 hours in the emergency room before leaving without receiving treatment.[5] This is due to factors such as shortages of psychiatric inpatient beds and challenges with access to community outpatient care. Only 10 other states have longer average emergency room wait times, which are often a result of inadequate inpatient psychiatric capacity,[6] limited availability of outpatient crisis services,[7] and workforce shortages that delay timely evaluations and placements. These delays not only strain emergency departments—many of which are not equipped to provide specialized psychiatric care due to lack of services and staffing—but also increase stress and risk for individuals in crisis.

Figure 1. ED visit rates for depression (2023)

Annual emergency department (ED) visit crude rate per 10,000 person-years



Note: Person-years is a measurement that combines the number of individuals with the time each individual spends under observation (in this case in an emergency department).
Source: https://ncdetect.org/mental-health-dashboard/

In addition to the prevalence of serious mental illness, substance use disorders present another significant behavioral health challenge in North Carolina. Many individuals with a primary substance use disorder have co-occurring mental health conditions. In 2021, 76% of patients discharged from the hospital with a substance use disorder had secondary mental health diagnoses.[8]

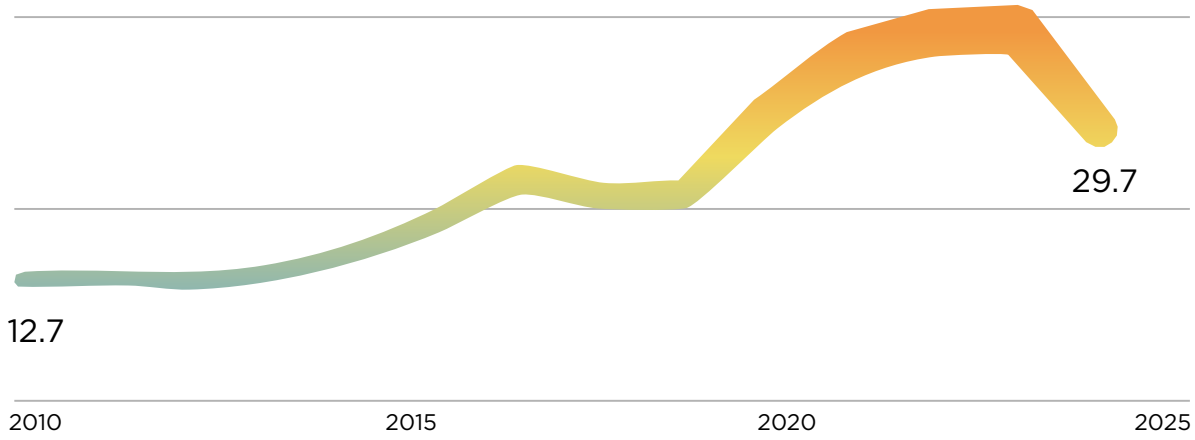
As of July 2023, 1 in 6 adults and 1 in 13 children aged 12-17 in North Carolina were estimated to have a substance use disorder.

Source: https://www.ncdhhs.gov/standard-data-points-2024-04-01/download?attachment

In 2023, more than 12 North Carolinians died each day from drug overdoses,[9] underscoring the devastating toll of the overdose crisis. While early data indicate a slight decline in overdose deaths since 2022, rates remain well above pre-pandemic levels. Despite the growing need, many North Carolinians continue to face significant barriers to accessing timely, evidence-based treatment for substance use disorders, including a shortage of providers, limited insurance coverage, and stigma. Expanding access to care is critical to sustaining progress and preventing further loss of life.

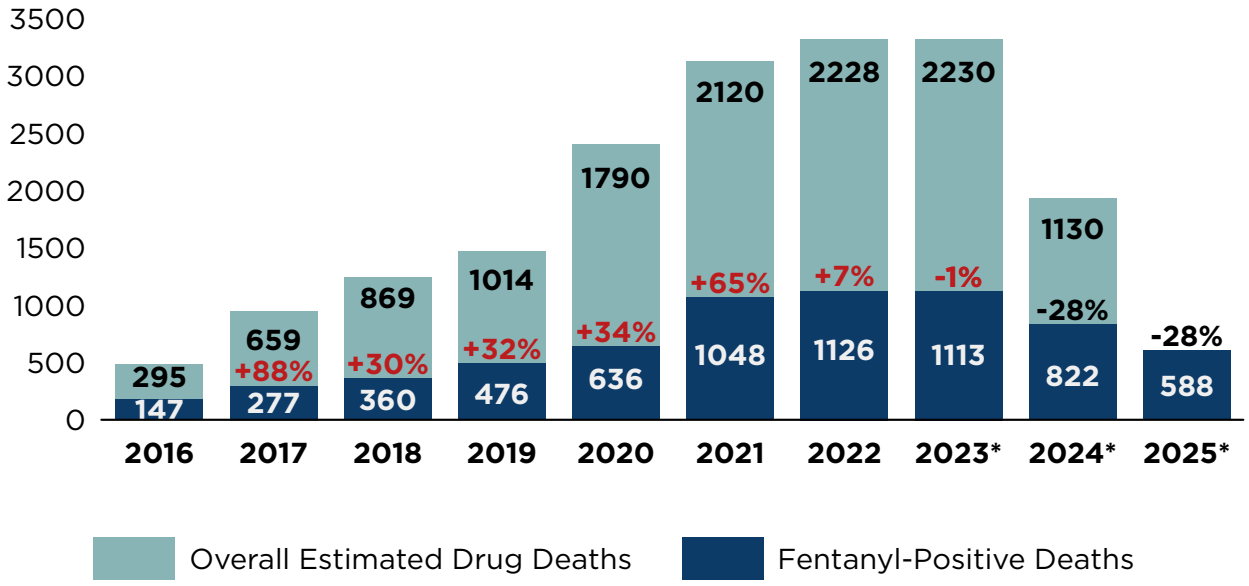
Figure 2. Estimated overdose deaths in North Carolina, 2010-2024

Annual overdose death rates per 100,000 residents per year



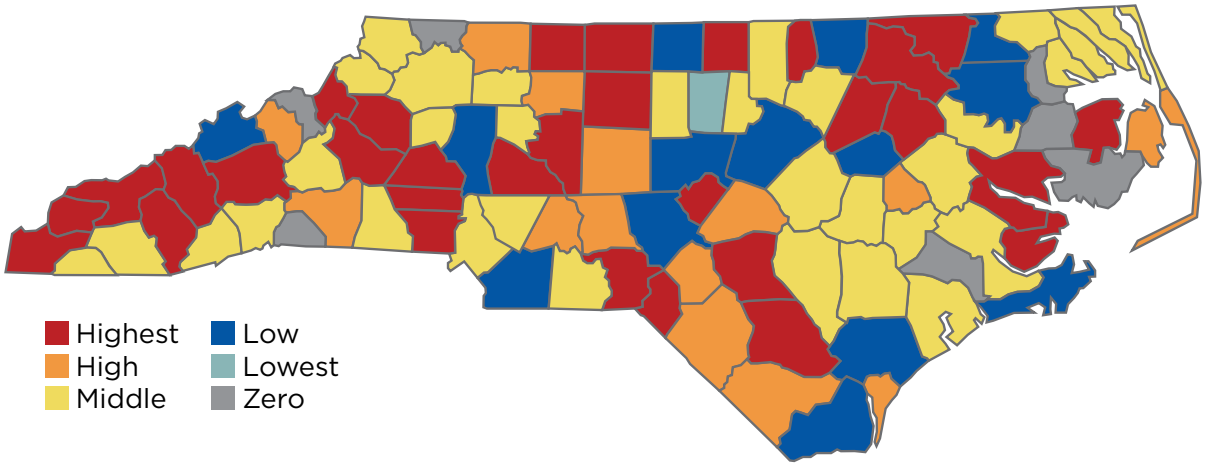
Source: https://www.dph.ncdhhs.gov/programs/chronic-disease-and-injury/injury-and-violence-prevention-branch/north-carolina-overdose-epidemic-data

Figure 3. Number of fentanyl-positive deaths in North Carolina (2016-2025)



Note: Data are provisional and subject to change. 2025 data are through February.
Source: https://digital.ncdcr.gov/Documents/Detail/fentanyl-positive-deaths-north-carolina-office-of-the-chief-medical-examiner-ocme-toxicology-data-2025-april/6204130

Figure 4. Overdose death rates by county (2024, projected)



Source: https://www.dph.ncdhhs.gov/programs/chronic-disease-and-injury/injury-and-violence-prevention-branch/north-carolina-overdose-epidemic-data

These statewide data points underscore the urgent need to address the complex and interrelated barriers that prevent North Carolinians from receiving timely, appropriate behavioral health care. Behind these numbers are systemic challenges that affect specific populations in distinct ways:

- Workforce shortages, especially in rural and underserved areas, continue to limit access to care and contribute to long wait times.
- Geographic disparities mean that where someone lives often determines whether they can access services at all.
- Stigma and cultural barriers discourage individuals from seeking care.
- Financial hurdles—such as lack of insurance or high out-of-pocket costs—further restrict access.
- Certain groups face compounded challenges, including children and adolescents, older adults, LGBTQ+ individuals, and people who are pregnant or postpartum.[10]

Each of these populations faces unique behavioral health needs and obstacles that must be understood to develop effective, equitable policy solutions. The following sections explore these challenges in greater depth.

Workforce Shortages

The behavioral health workforce encompasses a diverse array of professionals dedicated to supporting mental health and well-being, from psychiatrists, psychologists, clinical social workers, and nurses, to paraprofessionals such as peer recovery specialists, case managers, and psychiatric aides.[11] Despite this diversity, the state is currently experiencing severe shortages across every role, significantly impacting access to behavioral health services. **Currently, 94 out of 100 counties are designated professional mental health shortage areas.**[12]

Multiple factors contribute to this workforce crisis. Low reimbursement rates, particularly in Medicaid, continue to be a barrier. From 2012 through Jan 1, 2024, Medicaid rates remained stagnant, with some services and types of facilities still not seeing an increase as of August 2025.[13] The administrative burden of claims processing and billing has been cited by providers as a barrier to accepting Medicaid beneficiaries and often privately insured individuals as well.[14,15] Limited network participation often forces individuals needing mental health services to pay out-of-pocket or forgo treatment altogether, disproportionately impacting low-income and vulnerable populations.[16]

Recruiting and retaining qualified professionals, particularly in rural and underserved communities, is especially difficult. Many behavioral health professionals face demanding workloads, limited career advancement, and substantial emotional strain, all of which can contribute to burnout and high turnover. Additionally, inadequate training opportunities and limited exposure to behavioral health careers during professional education further constrain workforce growth.[17]

The shortage directly impacts vulnerable populations, including children and adolescents, individuals experiencing substance use disorders, and marginalized communities. When behavioral health services are scarce or unavailable, individuals often experience worsening mental health conditions, increased emergency department visits, and elevated risks for crisis situations.

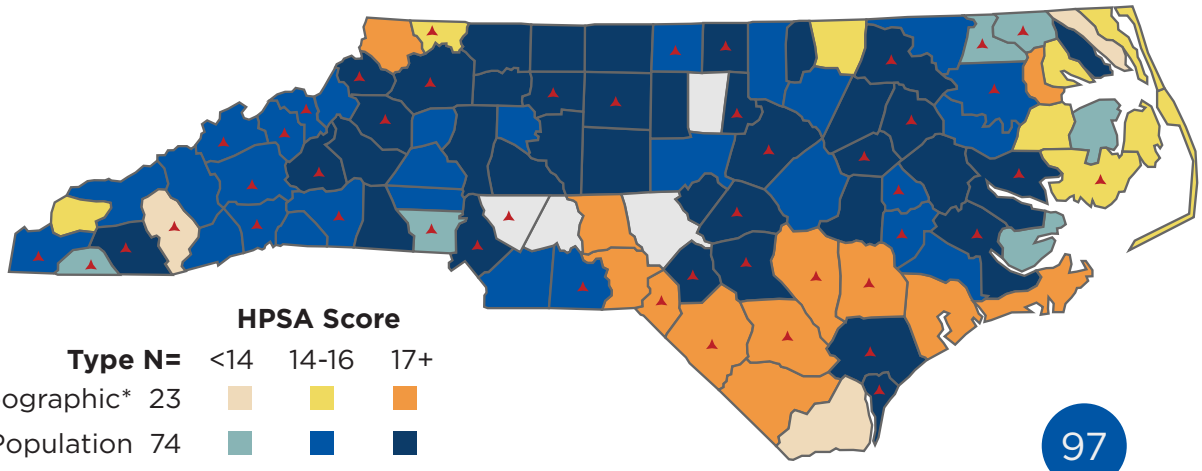
Low reimbursement rates may discourage mental health professionals from accepting Medicaid patients, further exacerbating provider shortages, particularly in underserved and rural communities.

As of September 2024, there were 347.1 behavioral health providers per 100,000 people in North Carolina. These providers include psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care.

Source: https://www.americashealthrankings.org/explore/measures/MHP/NC

In January 2024, North Carolina Medicaid implemented an increase in minimum reimbursement rates for the first time since 2012. These rates applied to most Medicaid-covered treatments for mental health and substance use disorder, and individuals with intellectual and developmental disabilities.[18] For example, psychiatrists will see more than double the reimbursement rate for psychological assessments. However, many providers have noted that the updated rates still fall short of covering the actual cost of care, limiting the extent to which the increases can improve provider participation or expand access to services.[18]

Figure 5. North Carolina Health Professional Shortage Areas (HPSAs), 2024 Profile



HPSA Score

Type	N=	<14	14-16	17+
Geographic*	23			
Population	74			
No HPSA	3			
Facility	47			

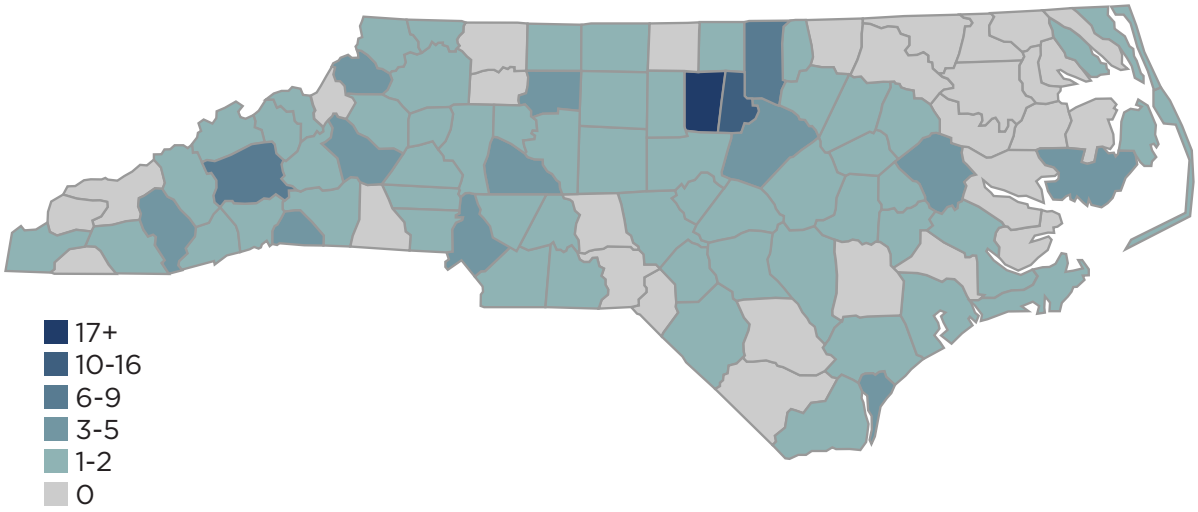
Indicates at least one HPSA facility, does not include correctional facilities or Federally Qualified Health Center (FQHC) satellite sites.

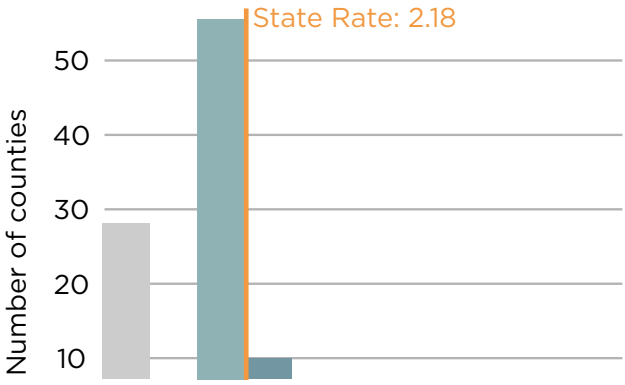
97

Counties with a geographic or population HPSA for **mental health**

Note: The higher the HPSA score, the greater the need for providers in a given area.
Source: https://www.ncdhhs.gov/nc-dhhs-orh-hpsa-one-pager/open

Figure 6. Psychologists per 10,000 people by county, North Carolina (2024)





Source: https://nchealthworkforce.unc.edu/interactive/supply/

Other states, such as Minnesota and Arizona, have seen positive impacts on provider participation and access after increasing Medicaid behavioral health reimbursement rates. For instance, Minnesota's 2021 rate increases for outpatient mental health services were followed by a reported rise in the number of enrolled providers,[19] while Arizona's targeted investments in behavioral health rates helped stabilize the provider network during the pandemic and improve service availability in rural areas.[20]

Geographic Disparities

While the prevalence of mental illness has been found to be similar between rural and urban residents, service availability varies widely. Physical location significantly influences both the type and extent of services available related to accessibility, availability, affordability, and acceptability.[21] Acceptability refers to the perceptions of an individual or community associated with the need and use of mental health services. Factors that impact acceptability include stigma, mental health literacy, and culturally appropriate care.[22]

In North Carolina, rural areas have fewer mental health resources compared to their urban counterparts.[23] **In 2022, there were 30 counties with no active licensed psychologist and 25 counties with no active licensed psychologist associate.**[24] Research has also found that people who live in rural areas have less access to health care, are less likely to have health insurance, and face unique structural barriers to care.[25]

In addition, rural counties frequently lack specialized behavioral health services, such as child psychiatry or substance use treatment programs, further constraining care options.[26,27] Historically, a strategy has been to attempt to increase the number of people earning credentials and gaining licensure in rural areas; however, this approach alone has not been sufficient to meet demand, as rural providers often face professional isolation, lower pay, fewer training opportunities, and limited supervision capacity—barriers that contribute to high turnover and difficulty retaining a stable workforce.[26]

Nationwide, older male adults living in rural areas are among those at highest risk for suicide. Part of this can be attributed to the greater perceived stigma for seeking help in older populations and higher rates of social isolation among older adults.[26]

Stigma and Cultural Barriers

Misconceptions, myths, and stigma associated with mental illness are significant barriers to care. Stigma can lead to feelings of shame, fear of discrimination, and social isolation, making individuals reluctant to disclose their conditions even to close friends, family members, or health care providers. This reluctance can also lead to worsened symptoms due to the delay in diagnosis, creating a more complex path to recovery.[28]

Discrimination extends beyond health care and can manifest in bias in employment and interpersonal relationships. In interpersonal contexts, misconceptions about mental health can also lead to strained relationships, loss of social connections, or exclusion from social activities, further exacerbating isolation and emotional distress.[28]

Cultural values and norms significantly shape individuals' perceptions of mental health, often influencing whether symptoms are openly acknowledged or suppressed. In some cultures, mental health concerns are viewed as a source of family shame, personal failure, or moral weakness, causing individuals to internalize negative beliefs about themselves and their conditions.[28] Consequently, this internalization can lead to

denial, self-stigma, increased psychological distress, and reluctance to seek professional help. Additionally, cultural factors may dictate preferred methods of coping or seeking support, including reliance on community elders, religious leaders, or traditional healing practices rather than formal mental health services.[28]

While stigma continues to pose a barrier to care, public attitudes have shifted. Research and program evaluations suggest that stigma is declining, especially among younger cohorts and in settings like colleges, leading more individuals to seek help.[29] As openness increases, so does service demand. Recent federal estimates show an approximately 40% increase in US adults accessing mental health care between 2019 and 2022.[30] However, this rise in help-seeking has outpaced system capacity, contributing to longer wait times, provider shortages, and increased financial strain, particularly for families seeking children's mental health services.[29]

Financial Barriers

Historically, behavioral health has been treated separately from physical health, resulting in a lack of parity in coverage. This leads to delayed treatment and higher out-of-pocket costs. Financial obstacles can compound existing access issues, particularly for low-income individuals and families navigating complex behavioral health needs.

While cost burdens disproportionately affect those without insurance, those with insurance often also encounter significant challenges. Many face challenges finding mental health providers who are in their network or accept Medicaid, and they are more likely to go out of network or pay out of pocket for mental health services compared to medical care.

A person with major depression can spend an average of $10,836 per year on health costs.[31]

Low-income individuals who do not qualify for Medicaid often enroll in high-deductible health plans to minimize monthly premium cost. Unfortunately, these plans have high out-of-pocket costs, making care unaffordable even for those with private insurance.[32]

Limited insurance participation, particularly among psychiatrists and psychologists, compounds the issue. This often forces individuals to pay out of pocket for services or forgo care.

North Carolinians are 5x more likely to be forced out-of-network for mental health care than for primary care

Source: https://www.nami.org/wp-content/uploads/2025/05/NorthCarolina-GRPA-Data-Sheet-8.5-x-11-wide.pdf

Table 1. Average therapy costs in major areas of North Carolina (2024)

City in North Carolina	Average Cost per Therapy Session
Charlotte	$139
Raleigh	$147
Greensboro	$145
Durham	$144
Winston-Salem	$143

Source: https://www.sarahjthompsontherapy.com/post/how-much-does-therapy-cost-in-nc

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and insurers to provide mental health and substance use disorder benefits on par with medical and surgical benefits. This means plans cannot impose more restrictive limitations, such as higher copayments, stricter visit limits, or narrower provider networks, for mental health or addiction services than for physical health care.[33]

In 2024, the US Departments of Health and Human Services, Labor, and the Treasury released new rules regarding MHPAEA. These rules aimed to strengthen enforcement of mental health and substance use disorder parity by requiring health plans to conduct meaningful comparative analyses of their nonquantitative treatment limitations and demonstrate compliance with parity standards.[33] However, self-insured private employer plans have no requirements to cover behavioral health services.[34]

Challenges for Children

Children in North Carolina face several significant behavioral health access issues, which impact early identification, timely treatment, and long-term well-being. Over 68 counties in North Carolina do not have a practicing child psychiatrist, leading to many children receiving psychotropic medications from providers without specialized pediatric mental health training.[11,35] Due to limited outpatient services, families often turn to emergency departments for pediatric behavioral health care. This reliance strains hospital resources and may not provide comprehensive care for children in crisis.

More than 70% of children with a mental health diagnosis in North Carolina are not receiving treatment.

Source: https://ncmedicaljournal.com/article/87514

Nearly 130,000 children aged 12-17 in North Carolina have been diagnosed with depression.

Source: https://www.nami.org/wp-content/uploads/2023/07/NorthCarolinaStateFactSheet.pdf

Across the United States, the cost associated with caring for a child with a mental health condition increased by nearly a third between 2017 and 2021, costing an average of $4361 more per year.[36] In North Carolina, where nearly half of all children are enrolled in Medicaid or CHIP,[37] access to affordable behavioral health services is critical.

Children in the juvenile justice systems are particularly vulnerable. Seven in 10 youth in the system have a mental health diagnosis, yet many do not receive timely or adequate treatment, exacerbating behavioral challenges and increasing the risk of repeated system involvement.[1]

Geographic disparities also impact outcomes. Children and adolescents living in rural areas are twice as likely to die by suicide as their urban counterparts.[24] This alarming disparity is linked to a range of access-related barriers, including limited availability of mental health providers, reduced access to crisis intervention services, and greater social isolation.

Rural youth may also face heightened stigma around seeking behavioral health care and have fewer opportunities for early identification and support through schools or primary care. In North Carolina, many rural counties lack adequate child and adolescent behavioral health resources, making it difficult for families to access timely, developmentally appropriate care that could prevent mental health crises. Addressing these disparities requires targeted investment in school-based services, telehealth infrastructure, and rural behavioral health workforce capacity.

Challenges for Older Adults

As of 2024, 88 out of 100 counties in North Carolina had more people above the age of 60 than people under the age of 18.[38] This demographic shift underscores the importance of addressing the unique mental health challenges specific to older adults such as increased social isolation, loneliness, mobility limitations, and chronic health conditions.[39,40] This combination of factors contributes to a heightened vulnerability in this population.[41]

Across the United States, 1 in 4 older adults live with a mental health or substance use disorder.[42]

Older adults are at an increased risk of experiencing depression,[41] yet they face significant barriers to accessing behavioral health care. Mental health needs among older adults are often unmet due to a combination of stigma, transportation limitations, workforce shortages, and a lack of providers trained in geriatric behavioral health. Depression is frequently attributed to physical illness or the aging process itself placing older adults at increased risk for social isolation, hospitalization, and suicide.[41]

In North Carolina, 9.4% of adults aged 65 or older reported that their mental health was not good for 14 or more days in the past 30 days in 2023.[43]

Challenges for LGBTQ+ Individuals

Individuals who identify as LGBTQ+ are three times more likely to experience a mental health disorder than those who identify as heterosexual.[44] Despite this elevated risk and the need for unique treatment options, needs are often grouped together and are oversimplified or treated as a single uniform category.[44] This lack of variation can lead to inadequate or inappropriate care that fails to reflect the diverse experiences within the community, including varying levels of stigma, discrimination, family rejection, and trauma.

In a 2019 survey, 100% of Black transgender North Carolinians reported experiencing depression.[45]

41% of LGBTQ+ people aged 13-24 in North Carolina seriously considered suicide in the 2024, including 47% of transgender and nonbinary young people.[46]

LGBTQ+ people in North Carolina aged 13-24 who wanted health care but were unable to get it cited the following top 5 reasons:

- I was afraid to talk about my mental health concerns with someone else.
- I could not afford it.
- I did not want to have to get my parent's/caregiver's permission.
- I was afraid I wouldn't be taken seriously.
- I was afraid it wouldn't work.[46]

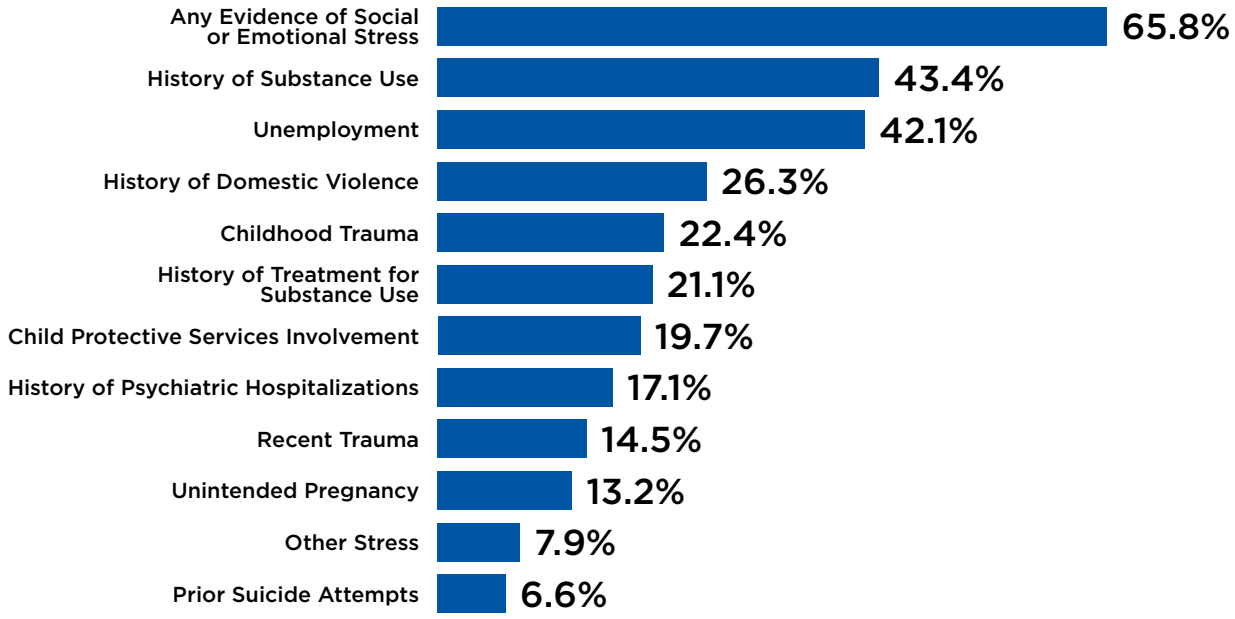
Intersection with Maternal Health

Maternal mental health is a critical, often overlooked concern in North Carolina. Depression and anxiety in the perinatal period—encompassing pregnancy and the year after delivery—is common.[47] Despite this, 85% of birthing people do not receive care for perinatal depression. Barriers to care include access and stigma; consequently, untreated perinatal mental health conditions pose substantial risks to maternal well-being, family stability, and infant development and mortality.[47]

10.7% of people with a recent live birth reported experiencing depressive symptoms in North Carolina.[48]

North Carolina's Maternal Mortality Review Committee (MMRC) found that among 76 deaths deemed pregnancy-related in 2018-2019, mental health conditions were the overall leading cause. These included deaths related to substance use, suicide, and other mental health diagnoses, many of which occurred in the postpartum period. The MMRC concluded that nearly 90% of these deaths were preventable, underscoring the urgent need to strengthen access to perinatal behavioral health care, including screening, treatment, care coordination, and follow-up during and after pregnancy.[49]

Figure 7. Pregnancy-related deaths by evidence of social or emotional stress, North Carolina residents (2018-2019)



Source: https://wicws.dph.ncdhhs.gov/docs/MMRCReport.pdf

A fragmented health system often results in missed opportunities for screening, referral and intervention. Many OB/GYN and primary care providers lack training, time, or reimbursement incentives to conduct behavioral health screenings or provide follow-up care. This is especially problematic in Medicaid programs, where reimbursement for mental health services during and after pregnancy is often limited. In North Carolina, postpartum health coverage is available for eligible beneficiaries for 12 months following birth.[50]

Initiatives Underway

Recognizing the growing demand for mental health and substance use services, as well as the longstanding barriers rooted in stigma, cost, provider shortages, and systemic inequities, North Carolina has launched a range of initiatives aimed at expanding access to behavioral health care. These efforts reflect a statewide commitment to strengthening the continuum of prevention, early intervention, treatment, and recovery services. The following examples highlight ongoing strategies to address gaps in care and improve outcomes for individuals, families, and communities across the state.

Medicaid Behavioral Health Tailored Plans

Launched in July 2024, North Carolina Medicaid Tailored Plans are designed to provide integrated physical health, behavioral health, intellectual/developmental disability (I/DD), and traumatic brain injury (TBI) services for individuals with more complex needs. These plans are operated by local management entities/managed care organizations (LME/MCOs) and aim to better coordinate care while maintaining access to specialty services.

988 Suicide & Crisis Lifeline Expansion

North Carolina has expanded support for the 988 crisis line with investments in local call centers, mobile crisis teams, and crisis stabilization units. The North Carolina General Assembly appropriated $10 million in FY2023 to support crisis response infrastructure, including community-based alternatives to emergency departments.

EarlyWell Initiative

Led by NC Child, the EarlyWell initiative promotes behavioral health prevention and early intervention for children from birth to age 8. The work focuses on expanding developmental screenings, integrated care models in pediatric settings, and family-focused behavioral health supports.

North Carolina Behavioral Health Strategic Plan (2024–2026)

In response to growing behavioral health needs, the state released a multi-year strategic plan prioritizing workforce expansion, crisis system improvements, parity enforcement, and services for children and youth. The plan includes increased investments in community-based services and school-based mental health supports.

Title V Maternal and Child Health Block Grant Program

The Title V Maternal and Child Health (MCH) Block Grant Program is a federal-state partnership program administered by the Health Resources and Services Administration (HRSA) that aims to improve the health and well-being of mothers, infants, children, including children with special health care needs, and their families. In North Carolina, the program is administered by the North Carolina Department of Health and Human Services (NCDHHS) Division of Public Health, and funds are used to support initiatives like Healthy Start, early childhood systems, and maternal and infant health improvements.

Caronova Youth Mental Health Initiative

CaroNova is leading a statewide initiative to reimagine North Carolina's youth mental health system by developing and piloting a new integrated care model that brings services to where youth already are, such as schools and community organizations. The model aims to bridge the gap between clinical care and community supports by enabling collaboration among pediatric providers, behavioral health specialists, school staff, and youth-serving agencies. Informed by youth and family voices, the approach emphasizes upstream prevention, early intervention, and cross-sector coordination to better support youth mental health and well-being. This work is part of a broader strategy to address urgent behavioral health needs through systems innovation, with a focus on creating scalable, community-centered solutions.

NCDHHS Suicide Prevention Action Plan

The NCDHHS recently released a draft Suicide Prevention Action Plan for 2026–2030, which outlines statewide strategies to reduce suicide through cross-sector coordination, evidence-based practices, expanded training, and safer storage of lethal means. It prioritizes high-risk groups such as youth, veterans, and rural residents. In parallel, NCDHHS developed a Black Youth Suicide Prevention Action Plan to address alarming trends among Black youth, with targeted actions like peer support models, culturally responsive care, and the COPE (Community of Practice and Education) initiative. Both plans reflect a broader shift toward equity-focused, community-informed suicide prevention across the state.

NC Integrated Care for Kids (NC InCK)

The NC InCK model, launched in January 2022 in five central NC counties (Alamance, Durham, Granville, Orange, Vance), embeds family navigators and pediatric care teams into Medicaid-managed-care clinics to address both behavioral and physical health needs. It enhances whole-child care through prevention, early identification, integrated care coordination with schools and community data sources, and value-based payment rewards tied to child well-being outcomes.

1 in 18
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1 in 6
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has a substance use disorder.

1 in 13
North Carolina Children
has a substance use disorder.

130K
North Carolina Children Aged 12-17
have been diagnosed with depression.

70%
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94 of 100
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30
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Conclusion

Behavioral health care remains inaccessible and unaffordable for many. Addressing this critical issue requires targeted policies, strategic investments, and collaborative efforts across systems to ensure equitable access to essential services. By prioritizing comprehensive screening, early interventions, and coordinated care, stakeholders can break down systemic barriers and improve outcomes for individuals, families, and communities. Creating a more accessible and affordable behavioral health system is fundamental to fostering healthier communities and building resilience for future generations.

Contributors

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This issue brief was prepared for the 2025 Legislative Health Policy Fellows Program, supported by the Blue Cross and Blue Shield of North Carolina Foundation, Cone Health, and The Duke Endowment.

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