North Carolina Division of Mental Health, Developmental Disabilities, and Substance Use Services

Strategic Plan 2024–2029

North Carolina Department of Health and Human Services

September 2024

Letter from the Director

To Our Partners:

Everyone deserves to live a healthy, happy, and productive life of their choosing, and a good system can make all the difference. That is especially true for the public system of supports for mental health (MH), substance use (SU), intellectual/developmental disability (I/DD), and traumatic brain injury (TBI).

I am pleased to present to you the Division of Mental Health, Developmental Disabilities, and Substance Use Services' (DMH/DD/SUS) 2024–2029 Strategic Plan. It describes our mission to build systems, services, and supports that improve the well-being of all North Carolinians, with a focus on MH, SU, I/DD, and TBI. It reflects our vision for communities without stigma where all are supported to live healthier and happier lives. The plan includes all new behavioral health, I/DD, and TBI investments, plus additional priority interventions critical for improving access, quality, and outcomes. It is the plan for our continued transformation.

Community partnership has been central to developing our plan and our behavioral health investments. These collaborative partnerships are an extension of our guiding principles: 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 promote evidence-based, high-quality services by leveraging the expertise of our clinical partners; we recognize the reality of trauma and champion a culture of kindness, understanding, and respect for every person; and we ensure that our policies meet people where they are, and commit to enhancing services to support the wellbeing of all North Carolinians, especially those who have been marginalized.

Some strategic plans are filled with flowery language and say little. Some are "kitchen sink" plans seeking to do it all. In my experience those plans sit on the shelf, and no one ever touches or uses them. This plan is not that; instead, it is our promise to you. It is direct and directive, pushing positive change in the areas that DMH/DD/SUS has the knowledge and power to do to so, focusing especially on the areas of the continuum where the people of North Carolina have directed us to do meaningful work. We are committed to delivering whole-person care, when and where people need it – with an approach that is both data-driven and community-informed.

I am proud of this plan, and I hope that as a community partner you will be, too. It represents my commitment to lead positive change for all of you.

Warmly,

Kelly Crosbie, MSW, LCSW
Director, Division of Mental Health, Developmental Disabilities, and Substance Use Services

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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 the Division's role in serving North Carolinians in coordination with sister Divisions under the greater umbrella of the North Carolina Department of Health and Human Services (NCDHHS).

The Division built this plan with our partners. In August 2023, DMH/DD/SUS began discussions to identify initial priorities and goals to drive the work of the Division. Through workshops and regular meetings with our partners—including with the State Consumer and Family Advisory Committee (S-CFAC), clinical leadership at Local Management Entity/Managed Care Organizations (LME/MCOs) and clinical providers, the Division developed a draft Strategic Plan which was released for public comment in June 2024. The Division received over 130 responses from partners through the public comment process that were analyzed and incorporated to finalize the strategic plan. For example, A new strategic priority was added in response to public comments.

This plan comes at a timely moment. More than four years into a pandemic, mental health care, substance use disorder (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, continue to improve the public system, and be a leader and advocate for all North Carolinians.

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. To accomplish its mission of serving all North Carolinians and our vision of building healthier and happier communities, the Division will focus its work across seven priorities.

[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

DMH/DD/SUS Strategic Priorities (2024-2029)

These priorities and their supporting goals and metrics are described in detail in proceeding document. In the next five years, DMH/DD/SUS aims to:

- **Increase Access to Care Across the State:** We will make it easier for people to access and stay in services to promote wellness, prevent suicide, address problem gambling, and live self-directed lives.
- **Improve 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.
- **Build the Workforce:** We will encourage all individuals delivering care and supporting care delivery by offering 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 implement our Crisis to Care vision to meet the needs of people in distress across the state, ensuring that every North Carolinian has someone to contact, someone to respond, and a safe place for help.
- **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.
- **Amplify Recovery and Community-Based Services:** We will strengthen the continuum of care for children and adults living with serious and complex mental health and substance use issues, including co-occurring I/DD and TBI.

Context in North Carolina

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. To fund and deliver services, the Division partners closely with the Division of Health Benefits (DHB), which oversees NC Medicaid, and the Local Management Entity/Managed Care Organization (LME/MCOs), which manage the delivery system across the state.

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]

In State Fiscal Year 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 is undertaking 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 state budget also provided $5 million to support the Division's planning efforts with consumers for statewide expansion of the TBI Waiver and included $10 million to support competitive integrated employment (CIE).

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 Division awarded $6.8 million to community-based mental health providers to support programs for individuals with serious mental illness (SMI) involved with the criminal justice system. These include Police and Mental Health Collaborations for Diversion Programs (community-based early diversion programs) and Jail-Based Treatment for SMI.[7] • The Division awarded $16 million in grants across 20 health care centers, treatment clinics and community-based providers to be used to support opioid use disorder (OUD) treatment services, as well as employment, housing and transportation supports.[8]

	• 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.[9] • The Department and Mecklenburg County Detention Center offered NCDHHS's first capacity restoration pilot, NC Rise. The program serves defendants with a mental illness for whom the court has determined they are incapable to proceed to trial.[10]
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 for college students' recovery supports and spaces to live, work, and study without drugs or alcohol.[11] • 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.[12,13] • 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.[14] • 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.[15] • The Department launched Inclusion Works, a cross-divisional effort to help any individual with I/DD access CIE in September 2023.[16] • The Alliance for Disability Advocates North Carolina program received additional funding to provide individualized re-entry services and supports for people with I/DD and TBI being released from prison.[17] • Governor Roy Cooper and the General Assembly approved a historic $835 million to invest in behavioral health and resiliency within NCDHHS.[1819] • 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 them shift to Medicaid. Beyond Medicaid expansion, North Carolina increased Medicaid reimbursement rates for most mental health, substance use, intellectual and developmental disabilities (I/DD) and traumatic brain injury (TBI) services for the first time in a decade.[20]

2024	• The State's budget investments in behavioral health access included crisis investments to support crisis response centers (Behavioral Health Urgent Care (BHUC) and Facility-Based Crisis (FBC) Centers) and programs for justice-involved individuals like the Formerly Incarcerated Transition (FIT) program.[21] • 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.[22] 988 and the Peer Warmline are available 24/7/365. • The Department invested $38.5 million in North Carolina's crisis system to expand BHUC capacity by 50%, community-crisis center capacity by 20%, and begin piloting trauma-informed mobile crisis and crisis co-responder services.[23, 24, 25] • The Department invested $5.5 million into the FIT Wellness program, part of the North Carolina FIT Program in the University of North Carolina School of Medicine, to improve re-entry services for the justice-involved population.[26] • In the five years since 2019, the Department has invested $26 million to strengthen services and supports for justice-involved individuals including capacity restoration, pre- and post-arrest diversion, detention-based treatment, community-based re-entry programming, juvenile justice behavioral health partnerships, and the Department of Adult Corrections – SMI Program. Over 10,000 individuals have been served through the pre- and post-arrest re-entry program and over 11,000 individuals have been served by the re-entry program. • 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.[27] In addition, the Department released the 2024-25 Olmstead Plan to improve community inclusion for people with disabilities and launched its comprehensive, multi-year *Direct Support Professional (DSP) Workforce Plan* to address the critical shortage of DSPs who provide HCBS for individuals with I/DD.[28, 29] The state launched Tailored Plans, which offer specialized coverage for NC Medicaid members with serious mental health or substance issues, I/DD or a TBI.[30] • The Department announced $4.5 million in grants for community-based initiatives to expand peer support services and strengthen family and caregiver support services. Certified Peer Support Specialists, who provide trauma-informed services supported by their lived experiences, help create community-based alternatives to emergency departments or hospitals.[31]

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 (Noted on the next page). 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.

Our Principles

Lived Experience.[32] **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.[33] **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.[34] 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.[35] **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.[36] **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.

Our Commitment to Serving Any North Carolinian

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.

Beyond interventions specifically serving these specialized groups, we will take action with our business practices. We will ensure that our competitive procurement and contractual processes include marginalized populations. Whenever possible, we will ensure that the measures that we track are stratified by race, ethnicity, gender identity, age, socioeconomic status, and geographic location. That way, we can have a pulse of the impact of our programs on the intended populations and take swift action if we need to change course.

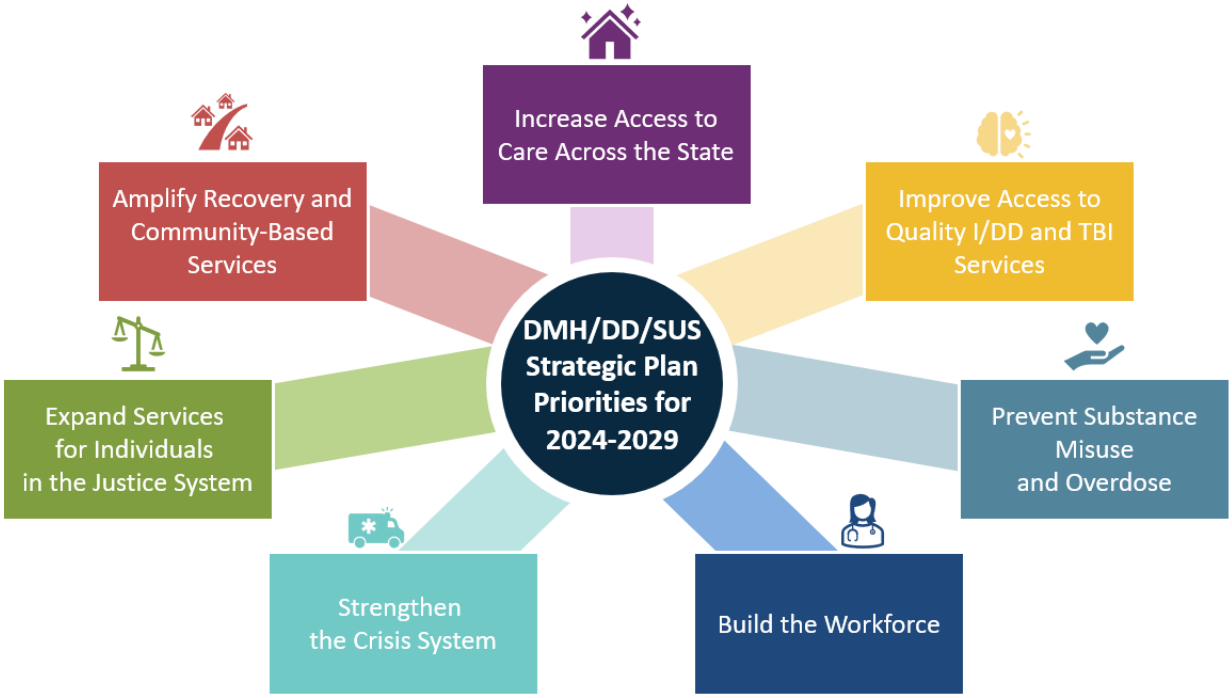
Critically, "any North Carolinian" also includes the hardworking and dedicated staff of DMH/DD/SUS and all other DHHS teams. While this plan is focused on the external groups that we serve, we also commit to looking inward and developing a culture and system of supports that enable our Divisional team 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.

Specialized Groups

- **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.

Our Priorities

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



Our Priorities
Increase Access to Care Across the State: We will make it easier for people to access and stay in services to promote wellness, prevent suicide, address problem gambling, and live self-directed lives.
Improve 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.
Build the Workforce: We will encourage all individuals delivering care and supporting care delivery with offering 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 implement our crisis to care vision to meet the needs of people in distress across the state, ensuring that every North Carolinian has someone to contact, someone to respond and a safe place for help.
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.
Amplify Recovery and Community-Based Services: We will strengthen the continuum of care for children and adults living with serious and complex mental health and substance use, including co-occurring I/DD and TBI.

	Our Goals
Increase Access to Care Across the State	**1.1: *Increase Treatment Initiation and Retention***. Make it easier for children, adolescents, and adults of all ages to access evidence-based services in a timely manner and stay in services for the recommended duration of treatment.
	1.2: *Promote Access to Integrated Care*. Expand care models that promote integrated behavioral health care across the continuum and with primary care.
	1.3: *Increase Caregiver Supports.* Promote services and supports for family members and caregivers.
Improve 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 Community Living Supports.* Increase the number of people with an I/DD or TBI who access and maintain independent housing and supported employment.
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 Access to Evidence Based SUD Treatment*. Increase timely access to SUD services, especially for geographies and populations with low penetration rates.
Build 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 Unlicensed Providers*. Increase training and support for unlicensed professionals providing services to people using the public system.
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 as an alternative to higher levels of care.

	Our Goals
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 re-entry 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.
Amplify Recovery and Community-Based Services	**7.1: *Increase Early Detection and Recovery Services.*** Promote early detection and service provision to prevent serious mental illness and substance use.
	7.2: *Grow Peer Recovery Supports.* Support the expansion of recovery supports and services for individuals with mental illnesses and SUD.
	7.3: *Improve Quality of Residential Interventions for Children with Complex Needs.* Invest in access and quality along the continuum of care for children and reduce duration of residential interventions.

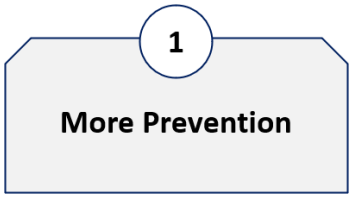
In the sections that follow, each priority and goal are further described. While they outline the issues we will address to realize our vision for North Carolina and the public system, we recognize that this necessary work cannot happen without our partners. This includes the state's Local Management Entity/Managed Care Organizations (LME/MCOs), which 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.

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 that 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. To support our strategic plan, we will develop a robust end-to-end outcome measurement system to track outcomes and impact.

Priority 1: Increase Access to Care Across the State

Because of deep-rooted stigma, North Carolinians are not seeking treatment as often as they could. National Survey on Drug Use and Health data estimates that 1 in 5 adults in North Carolina have a mental illness and 51% of them do not receive treatment for their mental illness.[3738] For youth with major depressive episode, this number was even more staggering with 62% not receiving care. Stigma also impacts SUD treatment. Seventeen percent of North Carolinians over 12 years of age were classified as needing substance use treatment in 2022 and of those, 79% did not receive treatment.[39] Young adults who are 16-25 are particularly vulnerable with 25% of them needing treatment and 87% not receiving it.[40]

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.[41,42] Suicidality is an acute event that can be treated. 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.[43,44,45,46,47] 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.[48] 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.[49]

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.[50] 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.[51] We will do so by supporting other statewide efforts, like the statewide Suicide Action Plan, and advancing the following goals.[52]

Goal 1.1: *Increase Treatment Initiation and Retention.* Make it easier for children, adolescents, and adults of all ages 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.[53] 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.[54,55] 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. 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.

The Impact of Stigma. One reason people do not get the help that they need is stigma. Public stigma is especially powerful at preventing people from seeking behavioral health care, and stigma can also prevent primary health care professionals, parents, teachers, and friends from asking about need. DMH/DD/SUS seeks to promote active reduction in stigma so that people can get necessary help. Stigma campaigns will tackle the different stereotypes and prejudices associated with different types of stigma – public, self-, and structural.

Similarly, increasing public knowledge of the impact of substance misuse can change people's behavior toward substances and reduce stigma.[56] 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. 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 1.2: *Promote Access to Integrated Care.* Expand care models that promote integrated behavioral health care across the continuum and with primary care.

Close to half of adults living with SMI have a co-occurring SUD, and only few among those who received mental health treatment received any substance use treatment.[57] North Carolina is committed to integrating mental health and SUD treatment throughout its behavioral health service array, including investing in the integrated CCBHC model. CCBHCs are designed to ensure access to coordinated comprehensive behavioral health care, providing 24/7 crisis services, comprehensive behavioral health and SUD services, and care coordination. They serve anyone regardless of their ability to pay, place of residence, or age.

Also important is the integration of the behavioral health services into a primary care setting, which is the entry point for most people into the health care delivery system. Increasingly, providing support for mental health and SUD conditions has become a core part of a primary care provider's role. Evidence-based models like Collaborative Care Model will be implemented in North Carolina, which provides enhanced financial support and operational supports for primary care practices to integrate behavioral health care services to their practices.

Goal 1.3: *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.

Measuring Progress:

We will measure progress toward these goals with the following measures:

Measure	Goal
Percentage of individuals who begin mental health treatment	↑
Percentage of individuals who continue in mental health treatment	↑
Number of individuals using Collaborative Care	↑
Number of individuals receiving services at CCBHCs	↑

Focused Interventions

The following are a list of focused interventions the Division will pursue to achieve its goals. This should not be considered an exhaustive list of all interventions DMH/DD/SUS will implement.

- **Accessible Communications Campaign:** Re-design website and develop accessible, consumer-facing communication to help members with SMI, SUD, TBI, and/or I/DD better understand Tailored Plans, Tailored Care Management, Innovations Waiver, and 1915(i) services.
- **Easier Access to Public Systems**
    - **Care Directory Online**: Launch a state-wide public-facing "Network of Care" website with a directory of walk-in clinics, crisis service providers, behavioral health outpatient providers, and substance use treatment providers.
    - **Open Access Appointments/Next Day Network**: Build a network of providers that have open access hours and next-day services serving as a community-based entry point into care.
    - **CCBHCs:** Create a safety net of behavioral health providers who provide evaluation, outpatient mental health and substance use, care management, and crisis services.
- **UNSHAME NC:** Launch a state-wide anti-stigma campaign for OUD by providing education on OUD-related topics and sharing the stories of people whose lives have been affected by opioid use disorder and those who serve those communities.
- **Integration of Behavioral and Primary Care:** Continue to support integrated behavioral health and primary care models in the delivery system including the continued implementation of the Collaborative Care Model, NC-PAL pediatric and perinatal mental health consultations, and the implementation of the CCBHC model.
- **Statewide partnerships to promote wellness and treatment:** Play a leadership role in forging partnerships with law enforcement to build better understanding about mental illness and expand interventions such as Crisis Intervention Teams, Mental Health First Aid, and Applied Suicide Intervention Skills Training statewide.
- **Access in Other Spaces**
    - **Community MH BG Access Grants:** Expand comprehensive community mental health services for targeted populations – individuals who are immigrants/have English as a second language, LGBTQ+, deaf/hard of hearing, aging, veterans, and caregivers. Expand faith-based services.
    - **NAMI on Campus:** Increase resources to bolster counseling services and expand the National Alliance on Mental Illness (NAMI) program *NAMI on Campus* – student-led and -run mental health clubs on college campuses.

Future Focus

- **Mental Health Stigma Campaign:** Launch an Anti-Stigma Campaign to promote public awareness, education, and advocacy, and hold open conversations about mental health.
- **Maternal Mental Health:** Launch a mental health focused program to encourage help seeking, screening, and treatment seeking in the critical window during pregnancy and postpartum.
- **Third Space Projects:** Develop "Third Spaces" where individuals can receive behavioral health treatment outside of the home or clinic office, utilizing community assets like libraries, community centers, and restaurants.

Priority 2: Improve 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.[58,59] 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.[60,61]

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.[62,63] 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.[64] 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.[65]

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.[66]

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.[67,68] 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.[69] 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 Community Living Supports.* Increase the number of people with an I/DD or TBI who access and maintain independent housing and supported employment.

Many individuals with an I/DD or TBI want to be working but are not. According to North Carolina's NCI results, 57% of individuals with I/DD surveyed in 2021-2022 did not have a paid community job of those who wanted one.[70] 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 like CIE for individuals with I/DD and TBI, so that more individuals who want to work and be involved in their communities can do so.

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 have limited choice in where they live. 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.

Measuring Progress:

We will measure progress toward these goals with the following measures:

Measure	Goal
Percentage of people on the Innovations Waiver waitlist receiving a State-funded or Medicaid-funded home and community-based (HCBS) or mental health or substance use service	↑
Percentage of authorized community living supports, community networking, supported employment, and supported living services that are delivered	↑
Number of individuals that receive a TBI service (TBI Waiver or the State-funded TBI service)	↑
Number of individuals with I/DD receiving Supported Employment	↑

Focused Interventions

The following are a list of focused interventions the Division will pursue to achieve its goals. This should not be considered an exhaustive list of all interventions DMH/DD/SUS will implement.

- **Inclusion Connects:** Continue the implementation of the Inclusion Connects program, which was launched in March 2024 to connect people with I/DD and their caregivers to services and supports.
    - **HCBS Service Access:** support individuals on the Innovations Waiver waitlist and, where possible, enroll eligible individuals in the 1915(i) state plan amendment (SPA) or other home and community based service.
    - **TCM Engagement:** Launch an education campaign in partnership with DHB and LME/MCOs to enroll beneficiaries with I/DD and TBI to receive whole-person care management.
    - **Waitlist Monitoring & Outreach:** Support individuals on the Innovations Waiver waitlist by conducting outreach to better understand individual needs and directing them to available services, where possible.
    - **CIE:** Expand CIE program's services and support to help individuals with I/DD find and maintain jobs in the community at competitive wages.
- **Expansion of TBI Waiver:** Partner with DHB to expand the TBI Waiver statewide and advocate to the legislature for additional funds to support service provision.

Future Focus

- **Individual and Family Service Direction:** Revitalize the approach and policies that facilitate managing care under consumer-direction.
- **Housing Plan:** Establish a framework to support the transition of individuals with I/DD from institution to community-based care and inventory housing options; assess needs, barriers, and interests of individuals with I/DD who are institutionalized; ensure accessible and affordable housing is available to individuals with I/DD who are interested in transitioning; develop and coordinate transition process for individuals with I/DD; identify an oversight process to review the quality and level of care provided in the community-based setting.
- **Intimate Partner Violence (IPV):** Require that all I/DD service providers complete a mandatory annual training on IPV prevention and make available an accessible curriculum with IPV prevention, healthy relationship, and sexual health information for people with I/DD and their families. Build reciprocal resource and referral partnerships between I/DD providers and IPV providers.
- **I/DD Peers:** Define peer support designation in residential facilities and expand coverage for care to support community inclusion.

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.[71] The overdose death rate in North Carolina is also higher than the U.S. as a whole, for opioids and overall.[72,73] 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).[74] Further, excessive alcohol use is the third leading preventable cause of death in North Carolina, and alcohol-related deaths have been increasing each year.[75,76]

Multiple efforts across the state 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.[77] 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 SUPTRS 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.[78,79] 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.

SUPTRS 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.[80] 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. Initiatives that build healthy communities to naturally deter children and adolescents from using alcohol and drugs are also evidence-based and should be employed more often in North Carolina.

Goal 3.2: *Increase Access to Evidence Based SUD Treatment*. Increase timely access to SUD services, especially for geographies and populations with low penetration rates.

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.[81] While there are service gaps across the board, services targeted for adolescents is a particular gap that needs to be filled. Services targeting adolescents such as the Substance Abuse Intensive Outpatient Program, withdrawal management, and

residential services for adolescents/teens continue to have access challenges.

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.[82,83] 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.[84] 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.

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 opioid treatment programs (OTPs) were rural, and all of the 14 counties without a provider able to prescribe buprenorphine were rural.[85] Further, 10 of the 12 counties without opioid treatment options were counties with a higher proportion of Black or AI/AN residents.[86] 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.

Measuring Progress:

We will measure progress toward these goals with the following measures:

Measure	Goal
Number of individuals served by OTP programs and Office-Based Opioid Treatment (OBOT)	↑
Number of individuals served by Collegiate Recovery Programs (CRPs) and Recovery Community Centers	↑
Percentage of children (13-17) who begin treatment for SUD	↑
Percentage of adults (18+) who begin treatment for SUD	↑
Number opioid overdose emergency department visits	↓

Focused Interventions

The following are a list of focused interventions the Division will pursue to achieve its goals. This should not be considered an exhaustive list of all interventions DMH/DD/SUS will implement.

- **Prevention:** Create a state-wide prevention program aimed at **i**mplementing evidence-based substance misuse prevention models at the community level, especially programs focused on socialization for teens.
- **Updated Naloxone Saturation Plan and Distribution:** Update the naloxone plan and take a leadership role to increase naloxone availability by paying for the medicine, by supporting training, and by including it in the service definitions for crisis response teams.
- **MOUD Saturation Plan:** Work with providers to increase counties and programs with MOUD coverage.
- **OBOT Expansion with North Carolina Behavioral Health Consultation Line (NC-PAL):** Expand NC-PAL program, to include MOUD supports for physicians providing Office Based Opioid Treatment (OBOT).
- **Mobile OTP Implementation:** Launch additional mobile OTP units to expand the reach of opioid treatment to marginalized individuals, the homeless, rural communities, and other underserved communities. OTPs are programs that treat OUD and provide assessments, counseling, MOUD, and other treatment services.
- **Expand SUD Treatment Access for Adolescents:** Expand services to specifically target adolescents and build programs tailored to the unique needs of this population. This may include approaches to care that are intentionally integrated with existing mental health services.

Future Focus

- **Collegiate Harm Reduction:** Fund CRPs that provide support to students in their recovery journey while undergoing higher education. CRPs differ by campus but can involve recovery housing, staff dedicated to support student recovery and regular recovery meetings.
- **Post Overdose Recovery Team (PORT):** Expand the utilization of PORTs across the state.
- **Recovery Communities and Workplaces:** Modernize and re-vamp approach to prevention to promote healthy communities and socialization for teens using proven strategies.

Priority 4: Build 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. Forty percent 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 (CPSSs) are actually employed as a CPSS.[87,88,89] 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 CPSSs are currently employed as CPSS, and nearly a quarter (23%) of CPSSs are seeking employment.[90] Further, many currently employed CPSSs 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.[91] 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.[92,93] The Division will rollout standardized trainings and opportunities for career advancement that will help create a stable, high-quality DSP workforce.[94]

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.[95] North Carolina's existing behavioral health workforce has also cited staff shortages as a key barrier to getting more people access to services.[96]

Goal 4.4: *Increase Supports for Unlicensed 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.[97] 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.[98]

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.

Measuring Progress:

We will measure progress toward these goals with the following measures:

Measure	Goal
Number of scholarships given by DMH/DD/SUS for DSP training programs	↑
Number of scholarships given by DMH/DD/SUS for Peer Support Specialist training programs	↑
DSP turnover compared to historic baseline for providers receiving retention and recruitment incentives	↓
Number of CPSSs who are employed as a peer support specialists	↑

Focused Interventions

The following are a list of focused interventions the Division will pursue to achieve its goals. This should not be considered an exhaustive list of all interventions DMH/DD/SUS will implement.

- **Certification for Peer Support Specialists (CPSSs):** Support the development of a single, free or low-cost certification curriculum, with an exam, for CPSSs, with add-on courses for special populations (such as for I/DD, aging, and justice populations) and care settings. Prioritize job placement for the 4,000 already trained CPSSs and create professional advancement opportunities for CPSSs, including a definition for peer supervisors that requires lived experience.
- **Direct Support Professionals (DSP) Workforce Plan:** Implement DSP Workforce Plan[99] and continue to support the development of a professional pathway for DSPs, including certification to ensure a consistent, high-quality workforce. Priority actions include partnering with the community college system to develop a DSP focused curriculum; providing recruitment and retention grants to provider agencies, launching a DSP directory to facilitate easy matching of DSPs to beneficiaries; and improving DSP compensation.
- **Qualified Professional (QP) certification in partnership with the North Carolina Community College System:** Advocate to update the North Carolina's QP certification rules and partner with the community college system to develop a focused recruitment program and core competency curriculum. Develop standardized mental health and SUD trainings tailored to the Division's workforce needs, apprenticeships, and work placements to better prepare the QPs for their on-the-job demands.
- **Consolidate "Training" Programs across DMH/DD/SUS:** Create one or more Centers of Excellence that provide no-cost training, technical assistance, comprehensive practice support (e.g., review roles / responsibilities of practices and determine what supports are needed for greater efficiency and provision of services), information on evidence-based practices, and peer-to-peer networking opportunities and mentorship programs to support the workforce across the state. The Center(s) will be inclusive of the populations DMH/DD/SUS serves and support the workforce providing I/DD, TBI, mental health, and SUD services. Funding to support these Center(s) was provided in the latest budget.
- **Create State Infrastructure and Oversight of Crisis and First Response Programs:** Ensure consistency of course content and curriculum in crisis trainings provided across the state – Crisis Intervention Team training; Applied Suicide Intervention Skills Training; Question, Persuade, Refer; and Mental Health First Aid.

Future Focus

- **Licensed Professional Incentives/Engagement:** Partner with providers to remove barriers in participating in the public network and explore programs like scholarships, tuition assistance, technical assistance for contracting/compliance and other supports (e.g., counselling, supervisory, and programs to address burn-out).

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.[100] 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.[101]

Mental health crisis services can act as an entry point to other mental health, substance use, intellectual and developmental disability and traumatic brain injury services, including for populations with co-occurring needs.[102] 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. The crisis system needs to be able support special populations like those with I/DD and TBI, who might have unique needs in a time of crisis. 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.[103] While North Carolina has seen higher 988 service utilization relative to other states, call volume increased minimally over the course of 2023, generally hovering at around 8,000 calls per month.[104] Across the country, awareness of 988 is low, and of those who are aware of 988, they are disproportionately white with higher incomes and more advanced education.[105] By promoting the use of 988 across the state, we can create a better front door to crisis services for individuals in need and provide them with seamless linkage to supports.

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.[106] Currently, the average response time for mobile crisis services is two hours.[107] 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 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 emergency departments 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.[108,109] 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.[110]

Measuring Progress:

We will measure progress toward these goals with the following measures:

Measure	Goal
Number of calls to 988	↑
Number of Medicaid or DMH/DD/SUS-funded crisis response visits (mobile crisis, Mobile Outreach Response Engagement and Stabilization (MORES), and co-response)	↑
Number of people served by an FBC or BHUC	↑
Average number of people with mental health needs held in an emergency department each day	↓
Number of Medicaid children with mental health needs held in an emergency department or boarded in DSS office	↓

Focused Interventions

The following are a list of focused interventions the Division will pursue to achieve its goals. This should not be considered an exhaustive list of all interventions DMH/DD/SUS will implement.

- **"Crisis to Care":** Create a public education campaign promoting options for where to receive crisis services so North Carolinians – including individuals with I/DD, TBI, and co-occurring conditions – know how and where to access services when in crisis.
- **Invest in high quality crisis services statewide in a financially sustainable manner:** Enhance funding for programs to fully staff services and address capacity challenges.
    - **BHUC:** Fund new BHUC centers across the state, via funding provided in the latest budget.
    - **FBC:** Fund additional beds for people with I/DD, TBI, SUD, and co-occurring disorders at FBCs via funding provided in the latest budget. Increase the number of FBC centers that have capacity to initiate buprenorphine induction for individuals with OUD, with connections to ongoing care.
    - **Mobile Crisis Management**: Fund new mobile crisis teams across the State, with a specific focus on high-needs (e.g., rural) areas, via funding provided in the latest budget. Work with the Division of Health Benefits to release a revised Mobile Crisis Clinical Coverage Policy that updates the types of licensed practitioners that must be included on mobile crisis teams.
    - **MORES**: Fund new MORES teams across the state, with a specific focus on high-needs (e.g., rural) areas, via funding provided in the latest budget.
- **988 Suicide and Crisis Lifeline Expansion:**
    - Build tools to dispatch and get people into appointments immediately
    - Integrate 988, Standard Plan, and LME/MCO crisis call lines into a single, consolidated point of entry.
    - Work with partners to support 988 and 911 integration at the local level.
    - Train providers and staff on providing care that is culturally relevant to one's race, ethnicity, sex, gender identity and expression, sexual orientation, age, national origin, socioeconomic status, religion, ability, culture, and experience.
- **Peer Line Expansion:** For calls routed to the Peer Warm Line, support peers playing an active role in providing all crisis services through training, education, and professional development opportunities.
- **Behavioral Health Statewide Central Availability Navigator (SCAN) Expansion:** Enable centralized mobile crisis deployment and tracking. Continue to on-board additional facilities into the system. Implement real-time bed tracking across the state.
- **Crisis Services for Individuals with I/DD:** The Division seeks to improve how crisis teams and facilities serve individuals with I/DD and how these services and supports can be bolstered.
- **Co-Responder Models Expansion:** Increase funding for co-responder models and enhance their visibility to ensure that community members can easily and utilize them.

Future Focus

- **Non-Law Enforcement Transportation Pilot:** Many individuals experiencing a BH crisis go to emergency departments, which is not always the appropriate level of care. To secure transport to an appropriate level of care, individuals are placed under involuntary commitment even if they are willing to receive treatment voluntarily. The non-law

enforcement transportation pilot will offer an alternative to law enforcement, making it both less traumatizing and quicker for individuals to receive the right level of care.

- **Psychiatric Emergency Departments and Emergency Psychiatry Assessment, Treatment and Healing (EmPATH) Units:** Psychiatric Emergency Departments provide a dedicated space for individuals experiencing a psychiatric emergency in a distinct and separate space than a hospital's general emergency department treating all conditions. EmPATH units deliver acute interventions for behavioral health care patients by moving them out of hectic emergency departments into a calm, therapeutic setting. As a result, patient agitation and aggression is dramatically reduced and the need for coercive interventions like involuntary medications and physical restraints drops to nearly zero. The Division will explore addition of psychiatric emergency departments and EmPATH units into the state's crisis delivery system.
- **Suicide Interventions:** Integrate a Suicide Prevention Coordinator role into DMH/DD/SUS to increase programming around education, prevention, follow-up, and family/community supports.
- **Involuntary Commitment Revamp:** Re-design involuntary commitment policies and procedures that emphasize therapeutic efficacy and beneficiary choice.

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.[111,112] 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 with the general population of North Carolina, within the first two weeks post incarceration from prison, formerly incarcerated people are 46.6 times more likely to die from an opioid overdose[113].

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**

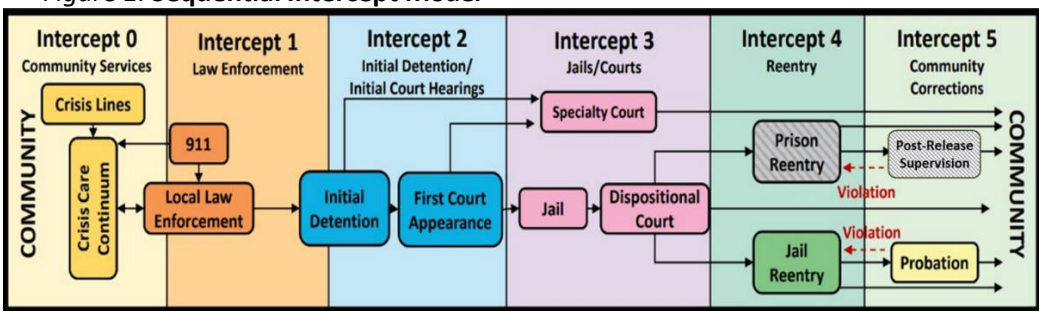


Figure 1 details how individuals with mental health disorders, SUDs, I/DD, and TBI come into contact with and move through the criminal justice system. It also helps communities identify resources and gaps in services at each intercept and develop local strategic action plans. We have identified goals 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

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 re-entry 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 Corrections (DAC)-SMI Care Coordination Initiative, the NC 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 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 incapable to proceed 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[114].

Measuring Progress:

We will measure progress toward these goals with the following measures:

Measure	Goal
Number of individuals with mental health or substance use needs served by a deflection or diversion program	↑
Number of individuals with mental health or substance use needs served by a re-entry program	↑
Number of justice-involved youth receiving evidenced based deflection/diversion, treatment, or re-entry services	↑
Number of individuals who receive detention and community-based capacity restoration services	↑

Focused Interventions

The following are a list of focused interventions the Division will pursue to achieve its goals. This should not be considered an exhaustive list of all interventions DMH/DD/SUS will implement.

- **Expand Law-Enforcement Assisted Diversion:** Expand diversion program to all counties and enhance partnerships between law enforcement, counties and behavioral health providers.
- **Investment in Programs that Support Individuals with SMI:**
    - Add new Forensic Assertive Community Treatment (FACT) teams linked to recovery courts/capacity restoration pilots working with existing ACT teams. FACT teams serve justice-involved individuals with SMI and provide care management, individualized psychiatric treatment and social services to address immediate needs and improve stabilization.
    - Expand the workforce of the DAC-SMI re-entry program so it can serve more individuals and provide transitional housing.
    - Expand the NC FIT Wellness program, which is part of the North Carolina FIT program that provides psychiatric and physical health care and connections to community supports to people with a serious mental illness leaving the state prison system.
- **Transitional Housing and Employment:** Expand the capacity of transitional housing and employment vendors to serve individuals with SMI and SUD by funding the cost of additional beds, staffing, and treatment services.
- **Investment in Programs that Support Individuals with I/DD and TBI:** Invest in and scale re-entry program run by the Alliance of Disability Advocates North Carolina that supports the creation of individualized re-entry plans for individuals with I/DD or TBI. The Division will also offer transition expand housing supports for individuals with I/DD or TBI re-entering the community.
- **JJBH Teams:** Increase quality and consistency of behavioral health programs for youth involved in the juvenile justice system. Through the existing network of JJBH Teams, invest in enhanced screening, assessment, care coordination, and treatment services for justice-involved youth statewide.
- **Partner with and Support Justice System Partners:** Provide information, education, and training targeted to the needs of justice system partners (e.g., correctional facility staff, sheriffs, police officers, court officials) on how to meet the needs of different populations with behavioral health, I/DD, and TBI. Educate law enforcement and officers of the court on which services are available and how they can connect individuals to services.

Future Focus

- **Treatment Accountability for Safer Communities (TASC):** Provide additional funding and supports to jails to build up the TASC program and strengthen its relationship with TCM services.
- **Start Re-Entry Peer Support Program for Special Populations:** Define role of peer supports in the re-entry programs for individuals with special needs or who are from marginalized communities.

Priority 7: Amplify Recovery and Community-Based Services

As of July 2023, 5.4% of adults (1 in 18.5) in NC had SMI and 12% of children and adolescents (1 in 8) in NC had serious emotional disturbance (SED).[115] 15.6% of adults and youth ages 12+ (1 in 6) in NC were estimated to have a SUD (945,363 people). In addition, individuals with SMI often die 10-20 years earlier than the general population due to both unnatural causes and increased risk of some physical health conditions.[116,117] 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.

For many North Carolinians living with significant behavioral health needs, community-based treatment remains out of reach. Resulting from this treatment inaccessibility, children, youth, and adults with significant needs seek psychiatric treatment in emergency departments, become incarcerated and/or experience homelessness. The number of children and youth reporting mental health and/or substance use related diagnoses has increased significantly over recent year.[118]

Goal 7.1: *Increase Early Detection and Recovery Services.* Promote early detection and service provision to prevent serious mental illness and substance use.

The Division anticipates that its investments in strengthening the use of evidence-based practices will result in a decrease of inpatient and residential care for individuals with significant behavioral health needs. In particular, the Division will focus on timely access to services for 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.[119]

Goal 7.2: *Grow Recovery Supports.* Support the expansion of recovery supports and services for individuals with mental illnesses and substance use 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.

Across the country there is recognition that people get better when they have help and support from others who have walked in the same shoes. Peer-led services can play a key role in partnering with clinical services to help people who are in crisis or who are recovering from a mental illness or SUD. DMH/DD/SUS will endeavor to work with our community-based experts to build a sustainable system of peer-run supports.

Goal 7.3: Improve Quality of Residential Interventions for Children with Complex Needs.

Invest in access and quality along the continuum of care for children and reduce duration of residential interventions.

North Carolina will ensure that children, youth and adults with any behavioral health need, including those with significant behavioral health needs, have access to care in least restrictive settings appropriate to meet their needs. North Carolina recognizes that individuals with behavioral health needs may require residential or inpatient care when clinically appropriate that prepares them to return to community settings. To meet this goal, DMH/DD/SUS will work to improve the ability of residential facilities to screen and treat an individual's physical, mental health and SUD needs, as well as the discharge processes and policies to connect children, youth, adults and their families to community-based treatment, housing and social supports.

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 for 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. DMH/DD/SUS is working to improve the environment and quality of care for children in residential settings, including psychiatric residential treatment facilities (PRTFs).

Measuring Progress:

We will measure progress toward these goals with the following measures:

Measure	Goal
Number of individuals served by a Peer Respite, Living Room, or Recovery Center	↑
Number of individuals enrolled in a First Episode Psychosis (FEP) program	↑
Number of individuals receiving a service at a Clubhouse	↑
Number of children served in an out-of-state Psychiatric Residential Treatment Facility (PRTF)	↓
Average length of stay for children in PRTFs	↓

Focused Interventions

The following are a list of focused interventions the Division will pursue to achieve its goals. This should not be considered an exhaustive list of all interventions DMH/DD/SUS will implement.

- **Expansion of Peer Respite, Living Room and Recovery Centers:** Peer respite, living room, and recovery centers are voluntary programs staffed by Certified Peer Support Specialists (CPSSs) that provide short-term, overnight support to individuals who are experiencing a behavioral health crisis. Supported by a Request for Applications announced in August 2024[120], The Division will expand these peer respite, living room, and recovery center programs.
- **Expansion of FEP programs:** Increase awareness of FEP programs and Connect people experiencing FEP, or prodromal symptoms, to coordinated specialty care for FEP.
- **Child Residential Redesign:** Enhance residential child behavioral health services by implementing a quality improvement program, maintaining family connections while children are in care, and shortening the duration of residential treatment.

Future Focus

- **Modernizing Clubhouses:** Revitalize, modernize, and better fund clubhouses, which provide community-based, psychosocial rehabilitation services for people living with mental illness. In addition to opportunities for community-building and socializations, clubhouses provide employment, education, skill development, housing, and wellness services.

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.

Table 1. **Strategic Plan Measures**

	Measure	Goal	Related Priority						
			1	2	3	4	5	6	7
1	Percentage of individuals who begin mental health treatment	↑	✓						
2	Percentage of individuals who continue in mental health treatment	↑	✓						
3	Number of individuals using Collaborative Care	↑	✓						
4	Number of individuals receiving services at CCBHCs	↑	✓						
5	Percentage of people on the Innovations Waiver waitlist receiving a State-funded or Medicaid-funded home and community-based (HCBS) or mental health or substance use service	↑		✓					
6	Percentage of authorized community living supports, community networking, supported employment, and supported living services that are delivered	↑		✓					
7	Number of individuals that receive a TBI service (TBI Waiver or the State-funded TBI service)	↑		✓					
8	Number of individuals with I/DD receiving Supported Employment	↑		✓					
9	Number of individuals served by OTP programs and Office-Based Opioid Treatment (OBOT)	↑			✓				
10	Number of individuals served by Collegiate Recovery Programs and Recovery Community Centers	↑			✓				
11	Percentage of children (13-17) who begin treatment for SUD	↑			✓				
12	Percentage of adults (18+) who begin treatment for SUD	↑			✓				
13	Number opioid overdose emergency department visits	↓			✓				
14	Number of scholarships given by DMH/DD/SUS for DSP training programs	↑				✓			
15	Number of scholarships given by DMH/DD/SUS for Peer Support Specialist training programs	↑				✓			
16	DSP turnover compared to historic baseline for providers receiving retention and recruitment incentives	↓				✓			
17	Number of CPSSs who are employed as a peer support specialists	↑				✓			
18	Number of calls to 988	↑					✓		
19	Number of Medicaid or DMH/DD/SUS-funded crisis response visits (mobile crisis, Mobile Outreach Response Engagement and Stabilization (MORES), and co-response)	↑					✓		
20	Number of people served by a FBC or BHUC	↑					✓		
21	Average number of people with mental health needs held in an emergency department each day	↓					✓		

	Measure	Goal	Related Priority						
			1	2	3	4	5	6	7
22	Number of Medicaid children with mental health needs held in an emergency department or boarded in DSS office	↓					✓		
23	Number of individuals with mental health or substance use needs served by a deflection or diversion program	↑						✓	
24	Number of individuals with mental health or substance use needs served by a re-entry program	↑						✓	
25	Number of justice-involved youth receiving evidenced based deflection/diversion, treatment, or re-entry services	↑						✓	
26	Number of individuals who receive detention and community-based capacity restoration services	↑						✓	
27	Number of individuals served by a Peer Respite, Living Room, or Recovery Center	↑							✓
28	Number of individuals enrolled in a First Episode Psychosis (FEP) program	↑							✓
29	Number of individuals receiving a service at a Clubhouse	↑							✓
30	Number of children served in an out-of-state Psychiatric Residential Treatment Facility (PRTF)	↓							✓
31	Average length of stay for children in PRTFs	↓							✓

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
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
FACT	Forensic Assertive Community Treatment
FBC	Facility Based Crisis Center
FEP	First Episode Psychosis
HCBS	Home and Community Based Services
HPSA	Health Professional Shortage Area

Acronym	Definition
LME/MCO	Local Management Entities/Managed Care Organization
I/DD	Intellectual/Developmental Disabilities
IPS	Individual Placement and Support
IPV	Intimate Partner Violence
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
OBOT	Office-Based Opioid Treatment
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PRTF	Psychiatric Residential Treatment Facility
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SIM	Sequential Intercept Model
SMI	Serious Mental Illness
SUD	Substance Use Disorder
SUPTRS BG	Substance Use Prevention, Treatment and Recovery Services Block Grant
TCM	Tailored Care Management
TBI	Traumatic Brain Injury

Partner Engagement

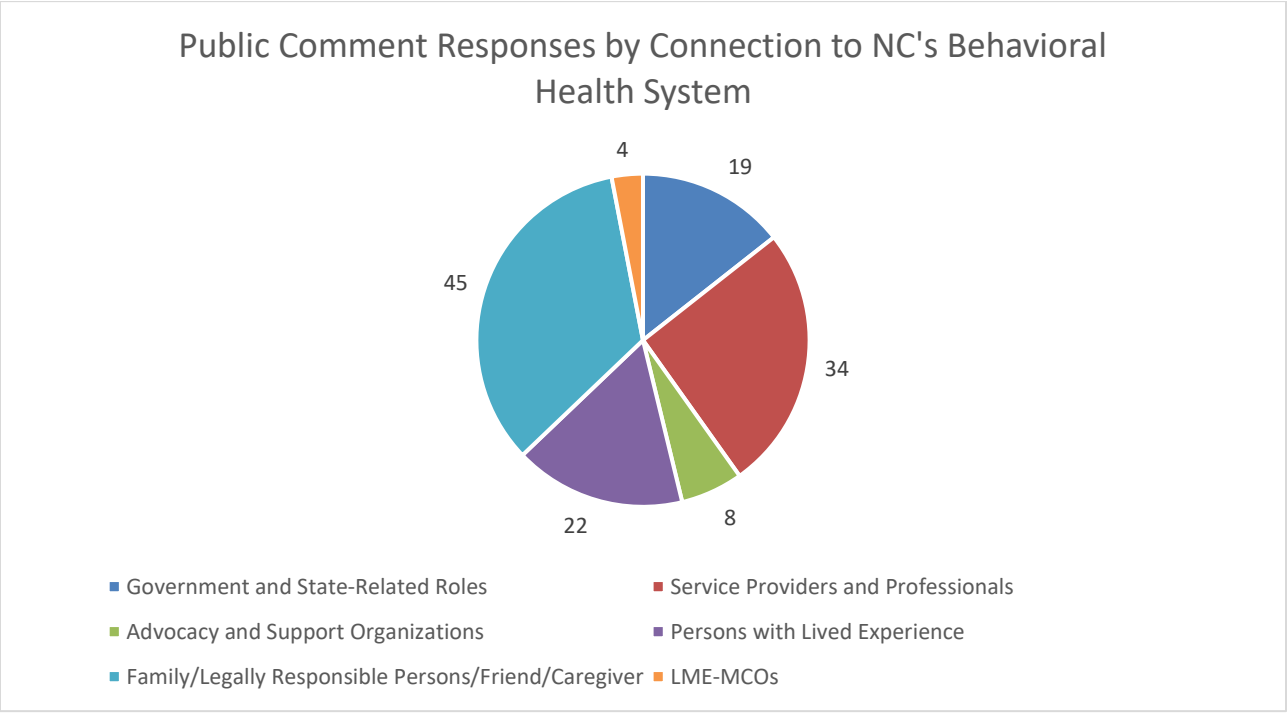
Staff from the DMH/DD/SUS met with the following community partners while developing the Plan, who provided verbal and written feedback:

- People with Lived Experience
- The State Consumer and Family Advisory Committee
- Executive and Clinical Leadership at our LME/MCOs
- Treatment Providers
- Hospital Behavioral Health Executives
- Advocacy Groups

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.

Public Comments

The public comment period for the strategic plan was open from June 3 to July 17, 2024. During this time, we received 132 comments and letters from a diverse range of stakeholders, including individuals with lived experience, service providers, family members and legally responsible persons, LME-MCOs, and representatives of state government agencies. Our team carefully considered each and every comment, leading to revisions in goals, initiatives, measures, and future focus areas. Several public comments highlighted the need to focus more on accessibility of community-based treatment for individuals with SMI, SED, and severe SUD,. We added a new priority area, "Amplify Recovery and Community-Based Services," in direct response to this feedback. DMH/DD/SUS greatly appreciates the engagement and feedback from everyone who provided input during the public comment period and hopes to continue this relationship as we consider future iterations of the plan.



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