STATE OF NORTH CAROLINA'S MENTAL HEALTH AND SUBSTANCE USE SERVICES WORKFORCE:

Need, Supply, and Distribution Landscape Assessment

UNIVERSITY OF NORTH CAROLINA
BEHAVIORAL HEALTH WORKFORCE
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Brianna Lombardi, PhD, MSW[1]; Jennifer Headley, MSW[1]; Monica P Jimenez, PhD, MPH[1]; Roxana Keesler, MSW Candidate[1]; Adote Junior B. Akue-ka, MPS[1]; Regan Gregory, MPH[1]; Evan Galloway, MPS[1]; Lisa de Saxe Zerden, PhD, MSW[1]; Erin Fraher, PhD, MPP[1]

[1]Program on Health Workforce Research & Policy, Cecil G. Sheps Center for Health Services Research

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INTRODUCTION

North Carolina faces a critical challenge in meeting the mental health and substance use (MH/SU) services needs of its residents. With over one in five adults experiencing a mental health challenge and approximately 16% of the adult population affected by substance use disorders, the demand for MH/SU services has never been greater.[1] This report provides a comprehensive analysis of North Carolina's MH/SU services workforce in 2024 and examines the supply, distribution, characteristics, and capacity of professionals who serve individuals with mental health and substance use disorders across the state.

The MH/SU services workforce encompasses an array of professionals — from prescribers such as psychiatrists and psychiatric mental health nurse practitioners to graduate-level clinicians including psychologists, clinical mental health counselors, marriage and family therapists, and social workers; from specialized addiction counselors to allied health professionals like occupational therapists and speech-language pathologists; and from certified peer support specialists to MH/SU services support specialists who provide essential direct care services. Each occupation plays a distinct role in North Carolina's MH/SU services care delivery system. Understanding how these professions work together to meet population MH/SU service needs requires a systematic analysis of workforce supply and distribution patterns.

This report synthesizes data from multiple sources — including state licensure and certification boards, the National Plan and Provider Enumeration System, the Medicaid Provider Enrollment File, the Bureau of Labor Statistics, and the American Community Survey — to provide the most complete depiction possible of the North Carolina's MH/SU services workforce. The analysis examines the credentialing requirements, educational preparation, supply, demographic composition, and geographic distribution of the MH/SU services workforce in the state's nine Area Health Education Center (AHEC) regions, four Behavioral Health and Intellectual/Developmental Disabilities Medicaid Tailored Plan catchment areas, and in NC's metropolitan and nonmetropolitan counties.

Assessing MH/SU services workforce supply alone provides an incomplete picture. Thus, this report also documents the MH/SU services needs of North Carolina's population, including prevalence rates of mental health and substance use disorders, patterns of treatment utilization, barriers to accessing care, and indicators of unmet need such as emergency department visits, crisis calls, and overdose and suicide deaths. By examining both workforce capacity and population needs, this analysis identifies geographic gaps in MH/SU services workforce supply.

The findings presented in this report are intended to inform policy decisions, workforce development initiatives, and strategic planning efforts aimed at strengthening North Carolina's MH/SU services system. Understanding the state of North Carolina's MH/SU services workforce can help target policies and interventions toward communities that need it most. As North Carolina continues to address the state's ongoing MH/SU crises, data-driven insights about workforce capacity and distribution are essential to ensure all residents have access to the care they need, when and where they need it.

NEED FOR MENTAL HEALTH AND SUBSTANCE USE SERVICES IN NORTH CAROLINA

Describing the need for mental health and substance use (MH/SU) services in North Carolina is critical for assessing if gaps exist in the MH/SU services workforce. This report utilizes the term MH/SU to include both mental health disorders and substance misuse/addiction, including substance use disorders. To describe the need for MH/SU services in North Carolina, the report first summarizes rates of mental health disorders and substance use disorders for adults and youth along with mental health distress indicators, followed by treatment utilization. Unmet MH/SU service need is included, as measured by mental health-related emergency department visits, use of 988 crisis calls, rates of deaths by suicide, and drug overdose deaths.

Rates of Mental Health Disorders in North Carolina

Of North Carolinians 18 and older, 21.3% reported a mental health condition and 5.4% reported a serious mental illness in the 2022 and 2023 National Survey on Drug Use and Health (NSDUH; Table 1).[1] Close to 9% of adults experienced a major depressive episode and 4.5% had serious thoughts of suicide. These rates were more pronounced for young adults aged 18–25, almost a third of whom reported having a mental illness (30.6%) and 10.0% of whom experienced a serious mental illness. The young adult age group also had the highest rates of major depressive episodes (17.8%) and suicidal ideation (11.3% reported serious thoughts, 4.2% made plans, 1.8% attempted suicide). Youth aged 12–17 also had higher percentages of those who experienced a major depressive episode in the past year (19.1%) and reported serious thoughts of suicide (12.5%).[1]

There was also a co-occurrence of mental health and substance use disorders in North Carolina, particularly among young adults; 12.9% experienced both a mental illness and a substance use disorder, and 5.5% had both a serious mental illness and a substance use disorder. Of all adults, 7.5% experienced both any mental illness and substance use disorder and 2.6% had both a serious mental illness and a substance use disorder.[1]

Table 1. Prevalence of Mental Health and Co-Occurring Substance Use Disorders in the Past Year by Age Group, North Carolina, 2022–2023

	Percent of Age Group (%)			
Mental Health, Past Year	**12–17**	**18–25**	**26+**	**18+**
Any Mental Illness [c]	--	30.58	19.89	21.32
Serious Mental Illness	--	9.95	4.67	5.38
Co-Occurring Substance Use Disorder and Any Mental Illness[a,b,c]	--	12.86	6.70	7.53
Co-Occurring Substance Use Disorder and Serious Mental Illness [a,b,c]	--	5.51	2.22	2.66
Major Depressive Episode[d]	19.14	17.78	7.28	8.69
Had Serious Thoughts of Suicide	12.51	11.33	3.39	4.45
Made Any Suicide Plans	5.81	4.17	0.91	1.35
Attempted Suicide	3.50	1.81	0.46	0.64

Note. Estimates are based on the survey-weighted hierarchical Bayes small area estimation approach. SUD=Substance use disorder. DSM-5=Diagnostic and Statistical Manual of Mental Disorders, 5th edition. SMI = Serious mental illness. AMI = Any mental illness. MDE = Major depressive episode.
[a] SUD estimates are based on DSM-5 criteria. SUD is defined as meeting the criteria for drug or alcohol use disorder.
[b] Drug use includes the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year or any use (i.e., not necessarily misuse) of prescription pain relievers, tranquilizers, stimulants, or sedatives in the past year.
[c] Mental illness aligns with DSM-4 criteria and is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. SMI is limited to people with AMI that resulted in serious functional impairment. These estimates are based on indicators of AMI and SMI rather than direct measures of diagnostic criteria.
[d] MDE is based on the DSM-5 definition, which specifies a period of at least 2 weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. There are minor wording differences in the questions in the adult and adolescent MDE modules. Therefore, data from youths aged 12–17 were not combined with data from adults aged 18+ to produce an estimate for those aged 12+.
Source. SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2022–2023.

Rates of Substance Use Disorders in North Carolina

Of all adults in North Carolina, 16.0% reported a substance use disorder in the past year with 10.3% reporting an alcohol use disorder, 8.2% reporting a drug use disorder, 2.3% reporting a pain reliever use disorder, and 2.4% reporting an opioid use disorder. Young adults aged 18–25 had higher rates of substance use (24.8%), alcohol use (14.1%), and drug use (15.6%) disorders; however, they had lower rates of pain relief and opioid use disorders. Adults over 26 years reported the highest percentages of pain reliever (2.4%) and opioid use disorders (2.6%).[1]

Youth (aged 12–17) reported lower rates of all substance use disorders in the past year in North Carolina but had concerning rates of substance misuse. Almost 8% of youth reported having a substance use disorder in the past year, 2.5% with an alcohol use disorder, and 6.2% with a drug use disorder. Youth were less likely to report alcohol use than adults.[1]

Table 2. Prevalence of Substance Use Disorders in the Past Year by Age Group, North Carolina, 2022–2023

	Percent of Age Group (%)				
Substance Use Disorder, Past Year	**12+**	**12–17**	**18–25**	**26+**	**18+**
Substance Use Disorder[a]	15.29	7.58	24.74	14.72	16.06
Alcohol Use Disorder[a]	9.61	2.46	14.08	9.74	10.32
Alcohol Use Disorder[a] (People Aged 12 to 20)	4.82	--	--	--	--
Drug Use Disorder [a,b]	8.02	6.16	15.62	7.06	8.21
Pain Reliever Use Disorder [a]	2.17	0.89	1.37	2.44	2.29
Opioid Use Disorder [a,c]	2.23	0.89	1.20	2.55	2.37

Note. Estimates are based on the survey-weighted hierarchical Bayes small area estimation approach. SUD=Substance use disorder. DSM-5=Diagnostic and Statistical Manual of Mental Disorders, 5th edition. Because of the high proportion of respondents in the "substance unspecified" category for treatment, the estimates in this table have added uncertainty.
[a] SUD estimates are based on DSM-5 criteria. SUD is defined as meeting the criteria for drug or alcohol use disorder.
[b] Drug use includes the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year or any use (i.e., not necessarily misuse) of prescription pain relievers, tranquilizers, stimulants, or sedatives in the past year.
[c] Opioid use disorder is defined as meeting the criteria for heroin or pain reliever use disorder.
Source. NSDUH 2022–2023.[1]

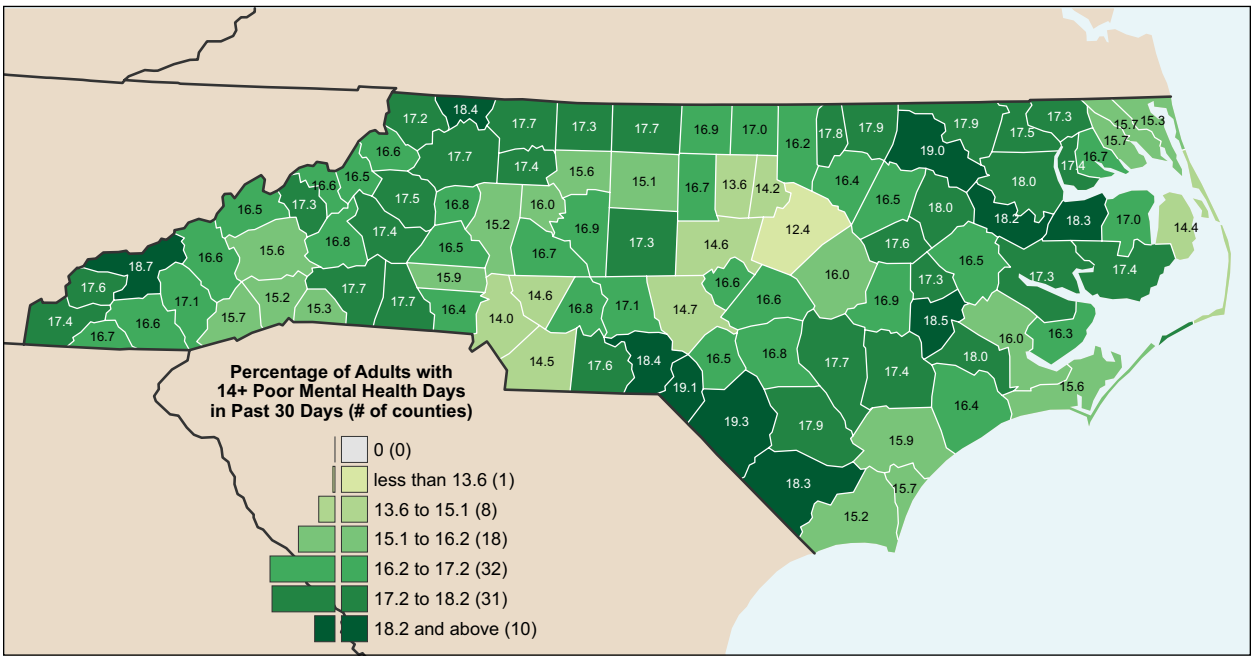
Indicators of Mental Health Distress

Indicators of Mental Health Distress for Adults

Based on the 2021 Behavioral Risk Factor Surveillance System (BRFSS), 16.7% of adults in North Carolina reported experiencing frequent mental distress, defined as experiencing poor mental health for at least 14 days of the last month.[2] The proportion of adults who reported frequent mental distress varied across the state, ranging from 12.4% of adults in Wake County to 19.3% in Robeson County reporting at least 14 poor mental health days in the last month.[2]

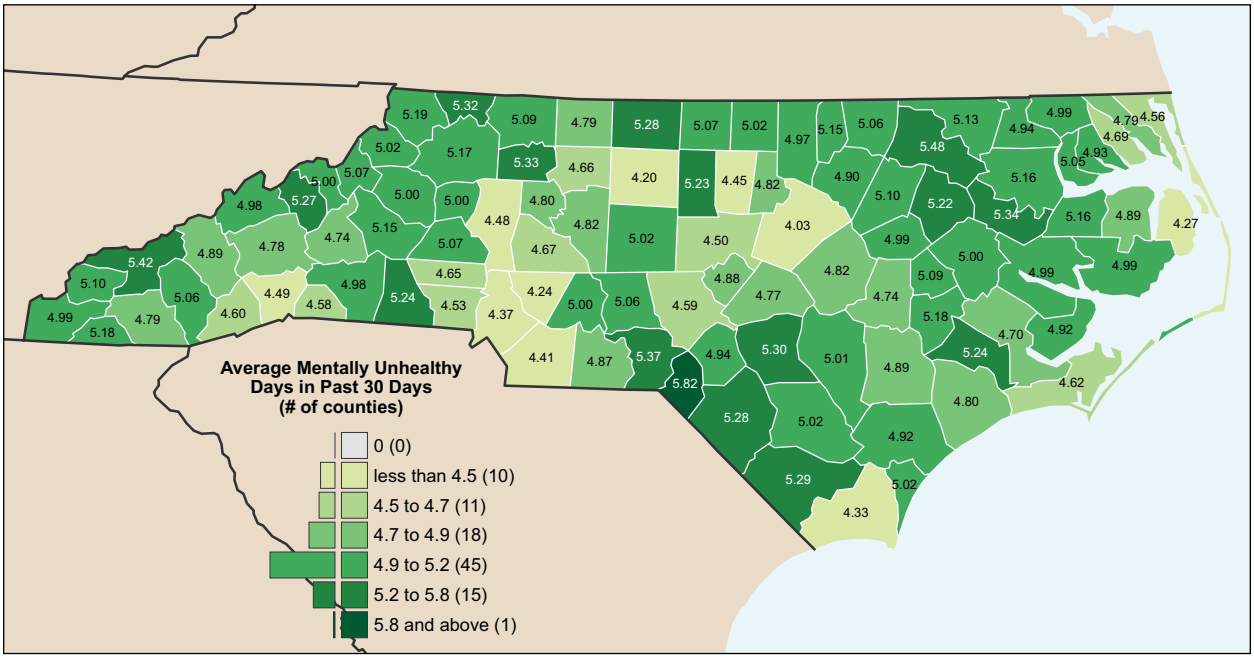
The BRFSS asks adults to report on the number of days each where their mental health was not good. Throughout the state, adults in 2021 reported their mental health was not good for 4.9 days out of the last month, ranging by county from 4.0 days per month in Wake County to 5.8 in Scotland County.[3]

Figure 1. Adults with Frequent Mental Distress, North Carolina, 2021



Source: County Health Rankings and Roadmaps, North Carolina 2024, using 2021 BRFSS.

Figure 2. Average Number of Poor Mental Health Days in Past 30 Days for Adults, North Carolina, 2021



Source: County Health Rankings and Roadmaps, North Carolina 2024, using 2021 BRFSS.

There were also regional differences in both the proportion of adults who experienced frequent mental distress and the number of poor mental health days. For both indicators, Area L Area Health Education Center (AHEC) region, followed closely by Southern Regional AHEC, had the greatest percentage of adults reporting mental distress (17.8% and 17.4%, respectively) and poor mental health days (5.2 and 5.1, respectively) in 2021. Charlotte AHEC had the lowest percentage of mental distress at 15.9%, and the fewest poor mental health days at 4.7 in 2021. Among Tailored Plan catchment areas, Trillium had the greatest percentage of mental distress in 2021 (17.1%), and both Vaya and Trillium reported an average of 5.0 poor mental health days, the highest among the Tailored Plan catchment areas.[2,3,4,5]

The rate of frequent mental distress experienced by adults in North Carolina has increased since 2014, when BRFSS data reported 11.5% of adults in the state had frequent mental distress, ranging from 9.7% adults in Camden County to 16.3% in Robeson County.[4] Similar to the frequent mental distress indicator, the average number of poor mental health days increased since the 2012 BRFSS, at which time the average number of poor mental health days was 3.4, ranging from 2.0 days in Greene and Perquimans Counties to 6.2 days in Jones County.[3]

Table 3. Frequent Mental Distress and Poor Mental Health Days by Region, North Carolina, 2012 or 2014 vs 2021

	% Reporting Frequent Mental Distress		Average Number of Poor Mental Health Days	
	2014[a]	2021[b]	2012	2021[b]
Statewide	11.50	16.72	3.40	4.93
By AHEC Region				
Area L	13.26	17.80	3.24	5.18
Charlotte	11.33	15.94	3.94	4.66
Eastern	11.97	16.86	3.31	4.91
Greensboro	11.71	16.13	3.48	4.85
Mountain	11.74	16.71	4.05	4.93
Northwest	11.69	16.91	3.88	4.98
South East	12.16	16.50	3.32	4.89
Southern Regional	13.23	17.44	3.77	5.12
Wake AHEC	11.79	16.06	3.48	4.85
By Tailored Plan Catchment Area				
Alliance	11.19	14.80	3.29	4.65
Partners	11.33	16.42	3.94	4.83
Trillium	12.44	17.05	3.39	4.97
Vaya	11.82	16.80	3.94	4.98
By County Urbanicity				
Metro	11.45	16.04	3.52	4.79
Nonmetro	12.43	17.27	3.76	5.04

Note. AHEC=Area Health Education Center.
[a] Anson (Charlotte AHEC, Trillium), Madison (Mountain AHEC, Vaya), and Currituck, Hyde, Martin, Pamlico, and Tyrrell (all Eastern AHEC, Trillium) did not have a measure for poor mental health days in 2014.
[b] Statewide estimates calculated as an average of county values, differs from published estimates which are based on population weighted statistical models.
Source. County Health Rankings and Roadmaps, North Carolina, using 2012, 2014, and 2021 BRFSS.[2,3,4,5]

Indicators of Mental Health Distress for Youth

Mental health indicators from the Youth Risk Behavior Surveillance System (YRBSS) mirror the trends reported in other data sets with youth in North Carolina experiencing significant mental health distress. Among high school students in NC in 2021, 33.5% reported their mental health as either not good most of the time or always, with female high school youth (46.1%) more than twice as likely to report poor mental health than males (20.9%). There was modest racial/ethnic variation in the proportion of high school youth that reported poor mental health, ranging from 27.9% (Hispanic or Latino) to 37.7% (white non-Hispanic).[6]

Table 4. High School Youth Reporting Poor Mental Health by Sex and Race/Ethnicity, North Carolina, 2021

High School Youth Reporting Poor Mental Health[a] Most of the Time or Always	
	% (SE)
Total	33.53 (2.07)
Sex	
Female	46.10 (2.88)
Male	20.89 (1.36)
Race/Ethnicity	
American Indian or Alaska Native	N/A
Asian NH	29.45 (6.88)
Black or African American NH	28.60 (2.06)
Hispanic or Latino	27.88 (3.16)
Native Hawaiian or Other Pacific Islander NH	N/A
White NH	37.69 (5.19)
Multiple races	34.54 (7.33)

Note. N = 1,612 Respondents. NH=Non-Hispanic. N/A=<30 respondents for the subgroup. SE=Standard Error.
[a] Poor mental health includes stress, anxiety, and depression, during the 30 days before the survey.
Source. YRBSS, 2021.[6]

MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT USE

Nearly a quarter (22.8%) of adults 18 or older in North Carolina reported receiving mental health treatment in the past year in 2022/2023.[1] Younger age groups had higher rates of obtaining mental health treatment. Of youth aged 12–17 years, 29.1% reported receiving mental health treatment in the past year, and of young adults aged 18–25 years, 26.7% reported receiving mental health treatment in the past year.[1] Data from the Kaiser Family Foundation on the 2023 National Survey of Children's Health (NSCH) indicate that 12.9% of children aged 3–17 received treatment or counseling from a mental health professional in 2023.[7]

Almost 4% of adults 18 years and older in North Carolina received substance use treatment in the past year.[1] Younger age groups had slightly higher percentages of receiving substance use treatment at 4.5% for 18 to 25-year-olds and 4.7% for 12 to 17-year-olds.[1] Treatment rates for mental health treatment or substance use treatment is not available at the regional or county-level.

Table 5. Treatment Use in the Past Year by Age Group, North Carolina, 2022/2023

	Percent of Age Group (%)				
Treatment Use in Past Year	**12+**	**12–17**	**18–25**	**26+**	**18+**
Received Any Mental Health Treatment[b]	--	29.05	26.72	22.19	22.80
Received Substance Use Treatment[a]	4.02	4.67	4.54	3.86	3.95

Note. Estimates are based on the survey-weighted hierarchical Bayes small area estimation approach.
[a] Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medication-assisted treatment; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center. Substance use treatment questions are asked of respondents who used alcohol or drugs in their lifetime. Substance use treatment measures include data from respondents who indicated that they received treatment but did not specify the substance(s) for which it was received.
[b] Mental health treatment includes treatment for mental health, emotions, or behavior through inpatient treatment/counseling; outpatient treatment/counseling; use of prescription medication; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center. In general, adolescent and adult estimates are reported separately for mental health measures; thus, 12 or older estimates were not produced.
Source. SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2022 and 2023.

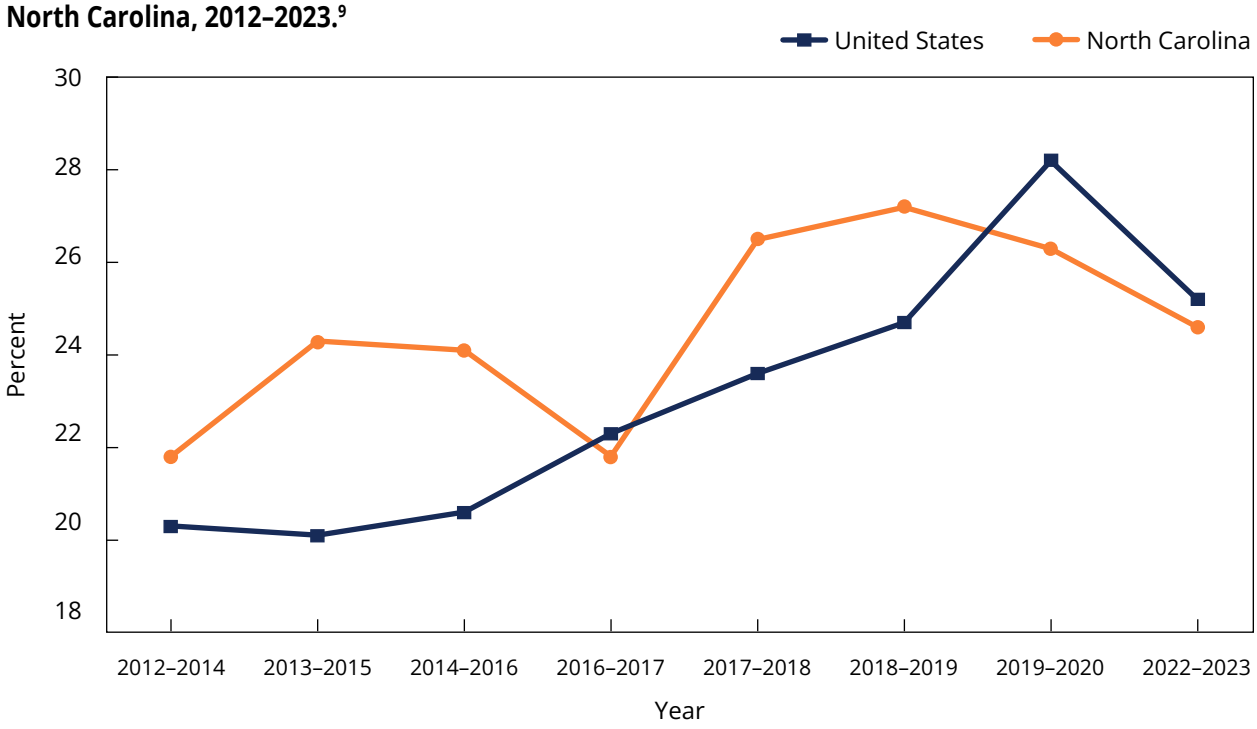
UNMET MENTAL HEALTH OR SUBSTANCE USE SERVICE NEED

To provide a more complete picture of unmet need in North Carolina, this analysis defines unmet mental health or substance use service as including both patients' perceived unmet need for MH/SU treatment as well as indicators that demonstrate an individual did not receive needed care, including mental health-related emergency department visits, crisis calls to 988, death by suicide rates, and drug overdose deaths.

Unmet Mental Health Treatment Need

According to the 2023 NSDUH, 23.8% of all US adults with any mental illness had a perceived unmet need for mental health services.[8] Of adults with a serious mental illness, the percent almost doubled to 45.2%.[8] State-level data from the 2023 NSDUH estimated 24.6% of adults in 2023 in North Carolina with any mental illness reported an unmet service need, which closely aligned with the 2022–2023 national estimate of 25%.[9] This suggests that about a quarter of all adults in North Carolina have an unmet mental health service need. Rates of unmet mental health service need have increased over time, with 21.8% of adults reporting an unmet need in 2012 to 24.6% in 2022–2023.[9]

Figure 3. Adults Age 18 and Older With Any Mental Illness Reporting Unmet Need, United States and North Carolina, 2012–2023.[9]



Source. The Commonwealth Fund, Adults age 18 and older with any mental illness reporting unmet need, 2012–14 to 2022–23, using 2023 NSDUH.

Unmet Need for Substance Use Disorder Treatment

A high percentage of youth and adults in North Carolina who were classified as needing substance use disorder treatment did not receive it. While 17.4% of adults in North Carolina (18 and older) were classified as needing substance use treatment, more than three-fourths (78.5%) did not receive treatment. Among the 10.3% of youth 12–17 years that were classified as needing substance use treatment, 57.3% did not receive services.[1]

Table 6. Substance Use Treatment by Age Group, North Carolina 2022 and 2023[1]

	Percent of Age Group (%)				
Substance Use Treatment in Past Year	**12+**	**12–17**	**18–25**	**26+**	**18+**
Classified as Needing Substance Use Treatment[a,b,c,d]	16.77	10.32	25.50	16.16	17.41
Not Receiving Substance Use Treatment among those Classified as Needing Substance Use Treatment[a,b,c,d]	77.26	57.32	83.82	77.19	78.45

Note. Estimates are based on the survey-weighted hierarchical Bayes small area estimation approach. SUD=Substance use disorder. DSM 5=Diagnostic and Statistical Manual of Mental Disorders, 5th edition.
[a] SUD estimates are based on DSM-5 criteria. SUD is defined as meeting the criteria for drug or alcohol use disorder.
[b] Drug use includes the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year or any use (i.e., not necessarily misuse) of prescription pain relievers, tranquilizers, stimulants, or sedatives in the past year.
[c] Because of the high proportion of respondents in the "substance unspecified" category for treatment, the estimates in this table have added uncertainty.
[d] Respondents were classified as needing substance use treatment if they met DSM-5 criteria for a drug or alcohol use disorder or received treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medication-assisted treatment; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center. Substance use treatment questions are asked of respondents who used drugs or alcohol in their lifetime.
Source. SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2022 and 2023.

Mental Health-Related Emergency Department Visits in North Carolina

The North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT) is North Carolina's statewide syndromic surveillance system created by the Division of Public Health and the Carolina Center for Health Informatics (CCHI). The NC DETECT Mental Health Dashboard provides the number of emergency department (ED) visits and reasons for those visits.

In 2024, anxiety was the leading reason for ED visits in North Carolina related to mental health, with 143.9 ED visits per 10,000 population related to anxiety.[10] There were 109.6 ED visits per 10,000 population for depression, 11.8 per 10,000 for a self-inflicted injury, and 53.8 per 10,000 for suicidal ideation.

Regionally, there were large variations in the rate per 10,000 population of ED visits for mental health needs. Wake AHEC had the lowest rate of ED visits for anxiety at 62.2 and Mountain AHEC had the highest at 246.7, nearly a four-fold difference. Northwest AHEC had the highest rate of depression as an ED visit reason (184.2) while Area L had the highest rate for self-inflicted injury as an ED visit reason (14.8). The rate per 10,000 population for an ED visit for suicidal ideation was highest in Area L (84.4), compared to South East AHEC, with the lowest rate (43.4). Wake AHEC had the lowest rate for depression as an ED visit reason (50.7) and South East AHEC had the lowest rate for self-inflicted injury as an ED visit reason (7.5).[10]

Among Tailored Plan catchment areas, Alliance was notably lower across all mental health reasons for ED visits, particularly anxiety and depression. Alliance and Trillium are both below the state average for self-inflicted injury and suicidal Ideation as reasons for ED visit. Partners and Vaya had the highest rates across all mental health reasons. Generally, nonmetro counties had higher rates of ED visits per 10,000 population

for anxiety (201.0), depression (137.5), and suicidal ideation (55.0). Metro counties showed a rate of 11.9 for self-inflicted injury visits, compared with 11.7 in nonmetro counties.[10]

Table 7. Mental Health-Related Emergency Department Visits by Region, North Carolina, 2024

	Population[a]	Rate Per 10,000 Population			
		Anxiety	Depression	Self-Inflicted Injury	Suicidal Ideation
Statewide	10,984,106	143.93	109.64	11.83	53.77
By AHEC Region					
Area L	285,994	162.63	107.66	14.76	84.44
Charlotte	2,231,872	138.31	103.83	11.97	51.95
Eastern	1,060,329	131.17	100.70	10.72	43.80
Greensboro	1,256,677	175.69	144.23	13.27	47.34
Mountain	827,070	246.70	170.43	14.32	63.24
Northwest	1,691,002	233.88	184.18	13.57	65.08
South East	578,697	85.97	62.17	7.48	43.37
Southern Regional	939,130	90.64	61.92	13.07	63.06
Wake AHEC	2,113,335	62.23	50.74	9.26	46.35
By Tailored Plan Catchment Area					
Alliance	3,635,141	72.39	57.84	11.02	50.24
Partners	2,277,684	224.89	171.68	12.75	61.19
Trillium	3,208,448	140.67	104.92	11.37	50.86
Vaya	1,862,833	190.19	142.99	13.07	56.61
By County Urbanicity					
Metro	8,761,216	129.46	102.59	11.86	53.47
Nonmetro	2,222,890	200.99	137.45	11.71	54.96

Note. ☐ Light blue cells for any value lower than the state average. AHEC=Area Health Education Center.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NC DETECT, 2024.[12]

Demographic Characteristics of Individuals Receiving Mental Health-Related Emergency Department Visits

To better understand who uses ED services for mental health-related reasons, ED visits were examined across key demographic characteristics. The following sections describe ED visits by sex, race, and age groups.

A greater proportion of females received ED services for mental health needs than males except for suicidal ideation, for which males had a greater proportion of ED visits than females. Of the statewide reported ED visits for suicidal ideation, 54.4% were males and 45.6% were females. In contrast, anxiety (65.7%), depression (62.3%), and self-inflicted injury (60.7%) each showed a higher proportion of female visits than male visits, respectively reported at 34.4%, 37.7%, and 39.3%.

This pattern (higher proportions of females receiving ED services for anxiety, depression, and self-inflicted injury than males and of males receiving ED services for suicidal ideation) was consistent across each AHEC region and by county urbanicity. Southern Regional AHEC showed the highest proportion of female ED visits for anxiety (68.4%), nearly 3% above the statewide average. Mountain region had the greatest proportion of males that sought ED services for anxiety at 36.6%. For depression, Eastern AHEC had the highest percentage of female visits at 65.1% and South East AHEC region had the highest percentages of male visits at 41.7%. Area L reported the highest percentage of males receiving ED services for both self-inflicted injury (42.2%) and for suicidal ideation (59.8%). For females, Northwest region had the highest percentages of women at ED visits for self-inflicted injury (62.0%) and Eastern AHEC region the highest rate for suicidal ideation (48.4%). In Tailored Plan catchment areas, Partners had the highest proportion of female ED visits across three conditions: anxiety (66.6%), depression (63.6%), and self-inflicted injury (62.5%). Trillium, followed by Alliance, had the highest proportions of male ED visits for suicidal ideation at 55.6% and 55.1% respectively. Of those with an ED visit reason in nonmetro counties, 67.1% visits due to anxiety and 64.4% visits due to depression were female, both about 2% above the statewide average. For self-inflicted injury and suicidal ideation, both metro and nonmetro proportions among males and females were within one to two percent of the statewide average. In metro counties, 34.9% of ED visits for anxiety were for males, the lowest among metro counties across all mental health-related reasons.

Table 8. Emergency Department Visits by Mental Health Condition and Sex, North Carolina, 2024

	Anxiety		Depression		Self-Inflicted Injury		Suicidal Ideation	
	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)
Statewide[a]	34.35	65.65	37.66	62.34	39.28	60.72	54.40	45.60
By AHEC Region								
Area L	31.78	68.22	38.13	61.87	42.18	57.82	59.75	40.25
Charlotte	34.76	65.24	38.11	61.89	38.73	61.27	53.19	46.80
Eastern	31.77	68.23	34.86	65.14	39.65	60.35	51.58	48.42
Greensboro	36.05	63.95	38.56	61.44	38.36	61.64	54.31	45.69
Mountain	36.57	63.43	37.16	62.84	40.80	59.2	52.10	47.92
Northwest	33.77	66.23	36.95	63.05	38.05	61.95	54.51	45.49
South East	35.41	64.59	41.65	58.35	38.11	61.89	57.83	42.17
Southern Regional	31.65	68.35	38.10	61.90	39.72	60.28	52.80	47.20
Wake AHEC	33.81	66.19	38.94	61.06	40.49	59.51	57.12	42.88
By Tailored Plan Catchment Area								
Alliance	34.89	65.11	39.48	60.52	39.09	60.91	55.13	44.87
Partners	33.38	66.62	36.37	63.63	37.52	62.48	53.18	46.82
Trillium	33.72	66.28	38.15	61.85	39.81	60.19	55.58	44.42
Vaya	36.15	63.85	37.50	62.50	40.91	59.09	52.95	47.05
By County Urbanicity								
Metro	34.93	65.07	38.35	61.65	38.88	61.12	54.59	45.41
Nonmetro	32.86	67.14	35.65	64.35	40.85	59.15	53.70	46.30

Note. AHEC=Area Health Education Center. M=Male. F=Female.
[a] Statewide proportions are calculated as an average of county values.
Source. NC DETECT, 2024.

Tables 9 and 10 present the racial demographics of individuals who had an emergency department visit for a mental health need in 2024. Among ED visits for patients with a reported race, 74.2% of individuals who had an anxiety-related ED visits statewide were white. Likewise, those who self-identified as white constituted 72.9% of visits for depression, 63.8% for self-inflicted injury, and 66.5% for suicidal ideation visits. Next highest were those who identified as African American/Black, who represented 19.3% of patients with an ED visit for anxiety, 22.1% of patients with depression, 24.5% of visits for self-inflicted injury, and 24.2% for suicidal ideation ED visits.

At the AHEC regional level, variations in ED visits by race reflect, in part, differences in the racial composition of the population between AHEC regions. Those who self-identified as African American/Black made up 51.4% of ED visits for suicidal ideation in Area L, over double the reported state average. In contrast, 43.3% of visits for suicidal ideation were white, nearly 24% less than the state average. Among the reported ED visits for depression in the Mountain AHEC region, 90.3% self-identified as white, with only 5.9% of visits from those self-identifying as African American/Black.

Table 9. Emergency Department Visits Related to Anxiety or Depression by Race and Region, North Carolina, 2024

	Anxiety					Depression				
	AI/AN	AAPI	Black	White	Other	AI/AN	AAPI	Black	White	Other
	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)
Statewide[a]	0.66	0.53	19.30	74.17	5.34	0.59	0.51	21.11	72.87	4.92
By AHEC Region										
Area L	0.67	--	39.49	54.29	5.55	0.46	--	37.80	56.74	5.00
Charlotte	0.79	0.84	25.63	67.46	5.27	0.83	0.72	28.55	64.86	5.04
Eastern	0.06	0.51	21.26	72.23	5.95	--	0.23	20.47	73.31	5.99
Greensboro	0.21	0.53	23.39	70.79	5.07	0.33	0.49	24.57	70.30	4.32
Mountain	0.36	0.20	5.96	89.69	3.80	0.39	0.23	5.86	90.26	3.26
Northwest	0.24	0.37	10.85	85.05	3.50	0.24	0.50	13.26	82.30	3.69
South East	0.14	0.12	14.71	78.49	6.55	0.20	0.22	13.96	80.30	5.32
Southern Regional	5.95	0.32	30.62	53.12	9.99	4.97	0.72	32.13	51.76	10.42
Wake AHEC	0.19	1.24	28.82	59.99	9.76	0.16	0.90	34.13	57.63	7.18
By Tailored Plan Catchment Area										
Alliance	0.89	1.44	33.99	54.41	9.25	0.80	1.26	38.31	51.78	7.85
Partners	0.32	0.43	13.20	82.51	3.53	0.32	0.49	15.17	80.34	3.68
Trillium	1.20	0.40	25.31	66.97	6.11	1.69	0.33	28.17	59.86	9.94
Vaya	0.26	0.15	9.54	85.98	4.08	0.29	0.15	11.41	84.67	3.48
By County Urbanicity										
Metro	0.42	0.67	20.59	72.57	5.75	0.43	0.65	22.81	70.82	5.30
Nonmetro	1.25	0.16	16.03	78.26	4.30	1.06	0.11	16.09	78.93	3.80

Note. AHEC=Area Health Education Center. AI/AN=American Indian/Alaska Native. AAPI=Asian American/Pacific Islander. Other=Other race and unknown combined.
[a] Statewide proportions are calculated as an average of county values.
-- No data reported.
Source. NC DETECT, 2024.

Table 10. Emergency Department Visits Related to Self-Inflicted Injury or Suicidal Ideation by Race and Region, North Carolina, 2024

	Self-Inflicted Injury					Suicidal Ideation				
	AI/AN (%)	AAPI (%)	Black (%)	White (%)	Other (%)	AI/AN (%)	AAPI (%)	Black (%)	White (%)	Other (%)
Statewide[a]	0.87	0.92	24.46	63.82	9.93	3.18	0.12	24.22	66.49	5.99
By AHEC Region										
Area L	0.48	--	40.77	51.08	7.67	0.38	--	51.38	43.33	4.92
Charlotte	1.05	0.98	29.37	57.24	11.37	1.21	0.83	36.10	54.69	7.17
Eastern	--	--	22.70	64.79	12.51	--	0.13	27.28	63.47	9.12
Greensboro	0.48	1.09	29.73	59.46	9.24	0.30	0.59	35.03	56.82	7.26
Mountain	0.26	0.60	5.95	88.01	5.18	0.23	0.14	7.71	87.75	4.17
Northwest	0.35	0.48	15.18	76.76	7.22	0.20	0.55	21.64	72.55	5.06
South East	--	--	17.25	74.83	7.93	--	0.28	20.22	73.01	6.49
Southern Regional	5.10	1.07	33.33	50.45	10.04	7.55	0.66	36.78	46.07	8.94
Wake AHEC	0.05	2.20	28.64	55.17	13.93	0.17	1.33	41.11	47.36	10.02
By Tailored Plan Catchment Area										
Alliance	0.92	2.02	33.41	50.22	13.42	0.96	1.37	43.50	44.66	9.51
Partners	0.38	0.62	17.50	73.94	7.55	0.42	0.60	23.43	70.25	5.29
Trillium	1.69	0.33	28.17	59.86	9.94	2.52	0.21	33.54	56.16	7.57
Vaya	0.13	0.29	12.24	80.39	6.96	0.20	0.12	15.14	79.37	5.17
By County Urbanicity										
Metro	0.59	1.10	25.80	61.60	10.91	0.60	0.78	32.73	58.37	7.52
Nonmetro	2.00	0.16	19.01	72.83	6.00	3.18	0.12	24.22	66.49	5.99

Note. AHEC=Area Health Education Center. AI/AN=American Indian/Alaska Native. AAPI=Asian American/Pacific Islander. Other=Other races and unknown combined.
[a] Statewide proportions are calculated as an average of county values.
-- No data reported.
Source. NC DETECT, 2024.

Differences exist between age groups in the likelihood of receiving care at an ED for various types of mental health needs (Table 11). A greater proportion of adults 65 and older were cared for at the ED for anxiety and depression (29.3% and 32.7% respectively) than self-inflicted injury and suicidal ideation (5.0% and 6.6% respectively). By contrast, youth (i.e., those younger than 18) represented a higher proportion of ED visits for self-inflicted injury and suicidal ideation (25.7% and 16.6%, respectively) than for anxiety and depression (4.4% and 6.4%, respectively).

ED visits for mental health needs at the regional level for different age groups mirrored state trends but there were a few key differences. When looking at those 65 and older across all AHEC regions, Greensboro had the highest proportion of ED visits for anxiety (37.1%) and depression (41.1%). In the same age group, Area L had the highest proportion of ED visits for self-inflicted injury (7.2%) and suicidal ideation (7.86%). Among those aged 18 to 64, Area L also had the highest proportion of visits for suicidal ideation (80.2%). Southern Regional reported the highest proportion of ED visits for both anxiety (74.2%) and depression (71.7%) for those aged 18 to 64. For those younger than 18 years of age, Southern Regional reported the highest proportion of visits for depression (9.8%) and suicidal ideation (19.1%), and the second highest percentage for anxiety (5.8%). In Northwest AHEC, 30.4% of ED visits for self-inflicted injury were attributed to individuals aged less than 18 years, nearly 5% above the state average.

Table 11. Emergency Department Visits Related to Mental Health Needs by Age and Region, North Carolina, 2024

	Anxiety			Depression			Self-Inflicted Injury			Suicidal Ideation		
	<18 (%)	18–64 (%)	65+ (%)	<18 (%)	18–64 (%)	65+ (%)	<18 (%)	18–64 (%)	65+ (%)	<18 (%)	18–64 (%)	65+ (%)
Statewide[a]	4.40	66.32	29.28	6.38	60.91	32.71	25.70	69.31	5.00	16.59	76.79	6.62
By AHEC Region												
Area L	2.98	71.29	25.73	4.67	68.08	27.25	20.43	72.36	7.21	11.96	80.18	7.86
Charlotte	5.93	66.39	27.68	7.99	60.71	31.29	28.63	67.42	3.95	17.93	75.75	6.32
Eastern	3.77	69.71	26.52	5.43	63.78	30.79	24.84	70.94	4.22	17.56	76.77	5.67
Greensboro	2.94	59.97	37.09	3.69	55.19	41.11	22.07	72.83	5.09	14.37	78.47	7.16
Mountain	3.32	65.73	30.95	5.43	58.90	35.67	21.40	72.13	6.47	13.29	79.18	7.53
Northwest	4.54	65.07	30.39	6.91	60.60	32.49	30.44	64.71	4.85	18.49	74.52	6.99
South East	3.71	67.04	29.25	8.63	62.71	28.67	20.23	73.49	6.28	15.64	76.69	7.66
Southern Regional	5.76	74.19	20.05	9.76	71.70	18.54	25.43	70.45	4.12	19.13	75.69	5.18
Wake AHEC	5.04	70.96	24.00	5.94	63.25	30.80	24.78	69.37	5.85	15.39	78.11	6.51
By Tailored Plan Catchment Area												
Alliance	6.07	71.91	22.02	8.12	65.30	26.58	24.86	70.52	4.62	15.75	78.26	5.99
Partners	4.79	64.58	30.64	6.86	59.72	33.42	32.12	63.41	4.47	19.73	73.55	6.72
Trillium	3.51	66.82	29.67	5.29	61.98	32.73	22.39	72.64	4.97	15.46	77.93	6.61
Vaya	3.71	64.01	32.29	5.66	57.78	36.56	24.30	69.42	6.28	15.62	76.77	7.62
By County Urbanicity												
Metro	4.81	65.88	29.31	6.88	60.81	32.30	26.07	69.03	4.90	16.69	76.76	6.55
Nonmetro	3.33	67.48	29.19	4.86	61.19	33.95	24.16	70.44	5.40	16.21	76.87	6.92

Note. AHEC=Area Health Education Center.
[a] Statewide proportions are calculated as an average of county values.
Source. NC DETECT, 2024.

Crisis Calls in North Carolina

The 988 Suicide and Crisis Lifeline offers 24/7 call, text, and chat access to trained crisis counselors who can help people experiencing suicidal, substance use, and/or mental health crisis, or other emotional distress. The North Carolina 988 Performance Dashboard from NCDHHS provides data on the contact volume, reasons for contacting 988, and more. In 2024, NCDHHS tracked 128,385 total contacts to 988 in North Carolina. Among the top five reasons callers reported for contacting 988, the second, third, and fourth ranked reasons are all related to mental health needs including depression, anxiety, and threat to self (Table 12). Of all the reasons tracked for calling 988 (89,122), MH/SU-related concerns constituted 43% of all reasons given.[11]

Table 12. 988 Contacts and Documented Reasons for Call, North Carolina, 2024[11]

Number of Contacts (N)	
	128,385
Reasons for Contacting 988[a]	
Interpersonal/Family	34,572
Depression	13,752
Anxiety	11,293
Threat to Self	9,023
Daily Support	5,998
Victimization	4,970
Substance Use	4,242
Medical	1,755
Grief	1,254
Job/Financial	1,146
Housing/Domestic Violence	588
Youth Concern	529

[a] Callers can report multiple reasons for contacting.
Source. NCDHHS 988 Performance Dashboard, 2024.

Death by Suicide in North Carolina

The North Carolina Violent Death Reporting System (NC-VDRS) is a population-based, public health reporting system that captures information on violent deaths including homicides, suicides, and unintentional firearm deaths. NC-VDRS is operated by the Division of Public Health, Injury and Violence Prevention Branch. There were 1,593 deaths by suicide in 2023 in North Carolina. The state average suicide rate is 1.66 deaths per 10,000 population. Both the count of suicides and ratio of suicide deaths to the population increased between 2014 and 2023. (Table 13)

County and regional differences were observed in the rate of death by suicide to the population. The county rate ranged from zero deaths by suicide in Greene and Tyrrell Counties to 5.53 deaths per 10,000 in Graham County.[12] In 2023, Southern Regional AHEC region had the highest rate of suicides at 2.15 deaths per 10,000 population. Wake AHEC had the lowest rate at 1.25 per 10,000 population. Tailored Plan catchment areas ranged from a high of 2.01 suicide deaths in the Vaya area to a low of 1.34 suicide deaths

in the Alliance catchment area. There were more suicide deaths per the population in nonmetro counties than metro counties (1.95 per 10,000 in nonmetro vs. 1.59 per 10,000 in metro).

Table 13. Death by Suicide Counts and Rates per the Population by Region, North Carolina, 2014 and 2023[12]

	2014 Total[a]	2014 Rate per 10k Population[b]	2023 Total[a]	2023 Rate per 10k Population[b]
Statewide[a]	1,310	1.51	1,593	1.66
By AHEC Region				
Area L	28	1.05	50	1.96
Charlotte	221	1.35	256	1.34
Eastern	159	1.74	183	1.96
Greensboro	126	1.23	166	1.49
Mountain	139	2.00	158	2.11
Northwest	252	1.81	299	2.01
South East	87	1.92	82	1.60
Southern Regional	112	1.43	171	2.15
Wake AHEC	186	1.22	228	1.25
By Tailored Plan Catchment Area				
Alliance	305	1.15	418	1.34
Partners	276	1.56	344	1.74
Trillium	426	1.56	497	1.76
Vaya	303	1.96	334	2.01
By Urbanicity				
Metro	964	1.44	1,207	1.59
Nonmetro	346	1.73	386	1.95

Note. AHEC=Area Health Education Center. 10k=10,000.
[a] Sum of all regions and catchment areas does not equal the state total as one death is not attributed to any county.
[b] Population accounts only for those 10 years and older, where deaths by suicide are tracked.
Source. NC-VDRS, 2024.

Throughout North Carolina, the proportion of deaths by suicide among underrepresented minorities varied, likely related to the demographic profile of each region (Table 14). At the state level, 21.2% of all suicide deaths were individuals from a minority race or ethnicity. Southern Regional (37.4%) and Wake (27.2%) had the highest proportion of underrepresented minority deaths by suicide, while Mountain AHEC (10.1%) had the lowest suicide deaths among this group. There were also differences among Tailored Plan catchment areas. Vaya (12.3%) had the lowest proportion of suicide deaths among underrepresented minority populations and Alliance (33%) reported the highest proportion of suicide deaths among individuals from minority backgrounds.[12]

The percent of deaths by suicide among males was higher than females, with 78.4% of all suicide deaths were male. Within the AHEC regions, Wake AHEC (74.6%) had the lowest rate of male deaths by suicide while Northwest (81.3%) and Southern Regional (81.3%) reported the highest rates. Tailored Plans varied by a 6 percentage point difference between the highest and lowest area with male suicide deaths, with Alliance reporting a rate of 74.2% male deaths by suicide and Trillium reporting a rate of

80.3% male deaths by suicide.[12] Metro counties had a lower rate of deaths by suicide among males (77.5%) than nonmetro counties (81.4%).

Table 14. Demographic Characteristics of Deaths by Suicide by Region, North Carolina, 2023[12]

	Population[a] (2023)	Total (N)	Rate per 10k Population	Minority Status		Sex		
				Under-represented Minority[b] (N)	*% Under-represented Minority*	Female (N)	Male (N)	*% Male*
Statewide	9,590,036	1,593	1.66	337	*21.16*	344	1,249	*78.41*
By AHEC Region								
Area L	254,999	50	1.96	13	*26.00*	4	46	*92.00*
Charlotte	1,913,919	256	1.34	60	*23.44*	61	195	*76.17*
Eastern	934,300	183	1.96	37	*20.22*	38	145	79.23
Greensboro	1,113,120	166	1.49	39	*23.49*	42	124	*74.70*
Mountain	748,508	158	2.11	16	*10.13*	35	123	*77.85*
Northwest	1,485,284	299	2.01	34	*11.37*	56	243	*81.27*
South East	513,323	82	1.60	12	*14.63*	18	64	*78.05*
Southern Regional	796,503	171	2.15	64	*37.43*	32	139	*81.29*
Wake AHEC	1,830,080	228	1.25	62	*27.19*	58	170	*74.56*
By Tailored Plan Catchment Area								
Alliance	3,124,383	418	1.34	138	*33.01*	108	310	*74.16*
Partners	1,977,881	344	1.74	44	*12.79*	69	275	*79.94*
Trillium	2,824,241	497	1.76	114	*22.94*	98	399	*80.28*
Vaya	1,663,531	334	2.01	41	*12.28*	69	265	*79.34*
By Urbanicity								
Metro	7,606,309	1,207	1.59	269	*22.29*	272	935	*77.46*
Nonmetro	1,983,727	386	1.95	68	*17.62*	72	314	*81.35*

Note. AHEC=Area Health Education Center.
[a] Population accounts only for those 10 years and older, where deaths by suicide are tracked.
[b] Underrepresented minorities include individuals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
Source. NC-VDRS, 2024.

Drug Overdose Deaths in North Carolina

The NC Department of Health and Human Services' Division of Public Health Inquiry & Violence Prevention Branch provides data on overdose deaths in North Carolina at the state, regional, and county-levels.[13] Through a data request, the Division of Public Health Inquiry & Violence Prevention Branch shared demographic details at the county-level not available through the interactive website; these data provide insight into regional differences in medication and drug overdose by demographic characteristics.[13,14]

There were 4,442 drug overdose deaths in North Carolina in 2023, one of the leading causes of death in the state.[13,15] Death by medication or drug overdose in NC in 2023 varied by age, AHEC region, and Tailored Plan catchment areas. Statewide, adults aged 22–64 constituted 90.1% of all overdose deaths, with AHEC

regional variation ranging from 88.9% in Wake AHEC to 91.1% in Greensboro AHEC. Among Tailored Plan catchment areas, Alliance had the lowest percentage of overdose deaths among adults aged 22-64 (88.4%) but had higher proportions of overdose deaths among those 21 years and younger (5.4%) than any other catchment area (state average of 3.8%).[14]

Table 15. Overdose Deaths (Medication or Drug) by Age Group and Region, North Carolina, 2023[14]

	Total	Age			
		<19 N (%)	19–21 N (%)	22–64 N (%)	65+ N (%)
Statewide	4,442	64 (1.44)	106 (2.39)	4,001 (90.07)	271 (6.10)
By AHEC Region					
Area L	137	^	^	124 (90.51)	6 (4.38)
Charlotte	738	16 (2.17)	22 (2.98)	659 (89.30)	41 (5.56)
Eastern	444	^	8 (1.80)	404 (90.99)	31 (6.98)
Greensboro	529	6 (1.13)	13 (2.46)	482 (91.12)	28 (5.29)
Mountain	412	^	6 (1.46)	372 (90.29)	32 (7.77)
Northwest	817	13 (1.59)	16 (1.96)	742 (90.82)	46 (5.63)
South East	238	^	8 (3.36)	215 (90.34)	13 (5.46)
Southern Regional	544	10 (1.84)	7 (1.29)	485 (89.15)	42 (7.72)
Wake AHEC	583	11 (1.89)	22 (3.77)	518 (88.85)	32 (5.49)
By Tailored Plan Catchment Area					
Alliance	1,089	26 (2.39)	33 (3.03)	963 (88.43)	67 (6.15)
Partners	969	13 (1.34)	21 (2.17)	885 (91.33)	50 (5.16)
Trillium	1,501	18 (1.20)	33 (2.20)	1,354 (90.21)	96 (6.40)
Vaya	883	7 (0.79)	19 (2.15)	799 (90.49)	58 (6.57)
By Urbanicity					
Metro	3,281	50 (1.52)	82 (2.50)	2,960 (90.22)	189 (5.76)
Nonmetro	1,161	14 (1.21)	24 (2.07)	1,041 (89.66)	82 (7.06)

Note. AHEC=Area Health Education Center.
^Data suppressed with any n<5.
Source. 2025 NCDPH analysis of NC State Center for Health Statistics, Vital Statistics Death Certificate Data, 2023.

In 2023, most deaths from medication or drug overdose were male, at 69.3% statewide.[14] Slight variations in overdose deaths for males and females were observed across AHEC regions. Of all overdoses in Mountain AHEC (71.6%), Eastern AHEC (71.0%), and Wake AHEC (70.2%), more than 70% of deaths were male. South East AHEC was the lowest percentage of male overdose deaths (66.4%), indicating more female overdose deaths throughout the region. Tailored Plan catchment areas and metro and nonmetro counties had similar rates of overdose deaths for males and females.

More than a third of overdose deaths statewide were from underrepresented minorities (35.2%), slightly less than overall population of underrepresented minorities in North Carolina (39.4%).[14,16] Of overdose deaths in Wake AHEC more than 50% were of an underrepresented minority background. Less than 20% of overdose deaths in Mountain AHEC were from an underrepresented minority background.[14] Alliance Tailored Plan catchment area had the highest proportion of overdose deaths from an underrepresented

minority background (53.0%), while Partners and Vaya both had overdose deaths for underrepresented minorities below the state average. Metro and nonmetro counties in North Carolina had similar rates of overdose rates for underrepresented minority populations.

Table 16. Demographic Characteristics of Overdose Deaths (Medication or Drug) by Region, North Carolina, 2023[14]

	Total (N)	Sex			Race/Ethnicity		
		Female (N)	Male (N)	*% Male*	White Non-Hispanic (N)	Under-represented Minority[a] (N)	*% Under-represented Minority*[a]
Statewide	4,442	1,366	3,076	*69.25*	2,839	1,562	*35.16*
By AHEC Region							
Area L	137	43	94	*68.61*	72	63	*45.99*
Charlotte	738	226	512	*69.38*	445	286	*38.75*
Eastern	444	129	315	*70.95*	273	166	*37.39*
Greensboro	529	165	364	*68.81*	357	168	*31.76*
Mountain	412	117	295	*71.60*	327	82	*19.90*
Northwest	817	261	556	*68.05*	627	185	*22.64*
South East	238	80	158	*66.39*	178	56	*23.53*
Southern Regional[b]	544	171	373	*68.57*	275	264	*48.53*
Wake AHEC	583	174	409	*70.15*	285	292	*50.09*
By Tailored Plan Catchment Area							
Alliance	1,089	323	766	*70.34*	496	577	*52.98*
Partners	969	297	672	*69.35*	761	204	*21.05*
Trillium	1,501	469	1,032	*68.75*	913	572	*38.11*
Vaya	883	277	606	*68.63*	669	209	*23.67*
By Urbanicity							
Metro	3,281	996	2,285	*69.64*	2,080	1,169	*35.63*
Nonmetro	1,161	370	791	*68.13*	759	393	*33.85*

Note. AHEC=Area Health Education Center.
[a] Underrepresented minorities include individuals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
[b] Robeson County, in Southern Regional AHEC, has the largest American Indian and Alaska Native (AI/AN) population in NC. Of 118 deaths in Robeson due to overdose, 69 (58.5%) are from A/IAN.
Source. 2025 NCDPH analysis of NC State Center for Health Statistics, Vital Statistics Death Certificate Data, 2023.

Barriers to Receiving Mental Health and Substance Use Services

Based on NSDUH 2023 data, 23.8% of adults who had a mental illness in the previous year did not receive mental health treatment. This group is inclusive of those who sought treatment and did not receive it (3.5%) and those who did not seek it, but thought they should get treatment (20.3%).[8] Two primary reasons are cited by those with a perceived unmet need for mental health treatment in the NSDUH included: 1) thinking they should be able to handle their mental health, emotions, or behaviors on their own, and 2) the cost would be too much.[8]

Among adults who had any substance use disorder and did not receive substance use treatment in the past year, 94.7% did not perceive a need for treatment.[8] Among the 4.8% who perceived an unmet need (who did not receive treatment, but thought they should), the top reason cited for not receiving substance treatment matched that for mental health treatment, in thinking they should be able to handle it on their own. Two other most common reasons included: not being ready to start treatment, and not being ready to stop or cut back on alcohol or drugs.[8]

Not Receiving Mental Health Treatment and Difficulty Receiving Mental Health Treatment

Data from the 2016–17 National Survey of Children's Health (NSCH) reported that 49.4% of all US youth under 18 with a mental health disorder did not receive needed treatment or counseling from a mental health professional.[17] States ranged in the proportion of youth who did not receive care. The percentage of unmet mental health care for youth was the highest in NC, with states ranging from 29.5% in Washington, DC to a high of 72.2% in NC.[17] Additionally, the 2023 NSDUH reported 41.5% of adolescents aged 12–17 with a major depressive episode in the previous year had a perceived unmet need for mental health services.[8]

For youth aged 3–17, the 2022–23 NSCH reports that 2.6% of children overall in North Carolina (an estimated population of 50,581) needed to see a mental health professional in the past year but did not (Table 17).[18] NSCH reports a weighted percentage estimate of 54% of children (aged 3–17) experienced difficulty obtaining needed mental health treatment or counseling. About 21% of children found it either very difficult to obtain treatment (19.2%) or it was not possible to obtain care (2.1%).[18] The percentage of children not receiving mental health treatment remained stable from 2016–17 to 2022–23 at 2.6% while those reporting any difficulty receiving treatment increased over that time (from 38.3% to 51.9%).[18,19]

Table 17. Children Receiving Mental Health Treatment or Difficulty Receiving Treatment, North Carolina, 2016–2017 and 2022–2023

Has This Child Received Any Treatment or Counseling From a Mental Health Professional (Past 12 Months)?	2016–2017	2022–2023
	%	%
Yes	9.62	12.50
No, but needed to see a mental health professional	2.65	2.63
No, did not need to see a mental health professional	87.73	84.87
Difficulty Getting Needed Mental Health Treatment or Counseling ?		
Received or needed mental health care and did NOT have problem getting it[a] (2016–17)	61.70	N/A
Did not have difficulty (2022–23)	N/A	45.97
Received or needed mental health care but had a small problem getting it[a] (2016–17)	25.77	N/A
Somewhat difficult (2022–23)	N/A	32.66
Received or needed mental health care but had a big problem getting it[a] (2016–17)	12.53	N/A
Very difficult (2022–23)	N/A	19.24
It was not possible to obtain care (2022–23)	N/A	2.13

Note. N/A= Not Applicable. Pop.Est=Population estimates. Percentages and Pop.Est are weighted to represent child population in US.
[a]The majority of NCHS measures have missing values less than 2% (unweighted). This measure has >=2% of missing cases.
Source. Data Resources Center for Child and Adolescent Health, using NCHS, 2021 and 2023.[18,19]

DEFINING THE MENTAL HEALTH AND SUBSTANCE USE SERVICES WORKFORCE IN NORTH CAROLINA

North Carolina's mental health and substance use (MH/SU) services workforce encompasses an extensive group of occupations who provide essential mental health, substance use disorder, and related services across the state. This section profiles the occupations that comprise the MH/SU workforce, detailing their certification or licensing body, educational and credentialing requirements, and scope of practice.

The MH/SU services workforce includes professionals ranging from doctoral-level providers such as psychiatrists and psychologists to paraprofessional roles like certified peer support specialists and community health workers. Many of these professionals hold state-specific licenses or certifications issued by North Carolina licensing or regulatory boards, while others operate under national certifications or voluntary credentials. Some roles within the state's Division of Mental Health, Developmental Disabilities, and Substance Use Services system, such as qualified professionals and associate professionals, are currently classified based on education and experience rather than formal credentialing. Although many fields contribute to caring for individuals with mental health and substance use conditions, this report focuses on occupations that specialize in delivering MH/SU services.

CATEGORIES OF MENTAL HEALTH AND SUBSTANCE USE SERVICES WORKFORCE

To organize the multiple occupations that contribute to the MH/SU services workforce in North Carolina, this report categorizes the MH/SU services workforce into six groups.

- **PRESCRIBERS** include physicians (i.e., psychiatrists, child and adolescent psychiatrists, addiction medicine physicians, addiction psychiatrists), nurse practitioners (i.e., psychiatric mental health nurse practitioners), and physician assistants who have prescriptive authority and can diagnose and treat mental health and substance use conditions.
- **GRADUATE-LEVEL CLINICIANS** encompass psychologists, psychological associates, clinical mental health counselors, marriage and family therapists, clinical social workers, and pastoral counselors, who hold at least a master's or doctoral degree and provide therapy and assessment.
- **ADDICTION COUNSELORS** represent a specialized subset of clinicians focused on substance use disorders, including licensed clinical addiction specialists, clinical supervisors, certified alcohol and drug counselors, certified criminal justice addictions professionals, and certified prevention specialists with varying levels of education and supervision requirements.
- **HEALTH/ALLIED HEALTH PROFESSIONALS** include licensed registered nurses, licensed practical nurses, occupational therapists, speech-language pathologists, licensed recreational therapists, and behavior analysts who provide supportive clinical services within the MH/SU services system.
- **CERTIFIED PARAPROFESSIONALS** include peer support specialists and community health workers who bring lived experience and community connections to support recovery.
- **MENTAL HEALTH AND SUBSTANCE USE SERVICES SUPPORT SPECIALISTS** include qualified professionals, associate professionals, certified mental health technicians, certified psychiatric technicians, and behavior technicians who provide direct care and support services under varying levels of supervision.

REGULATION AND SCOPE OF PRACTICE FOR MENTAL HEALTH AND SUBSTANCE USE SERVICES OCCUPATIONS

Understanding the regulation, credentialing, and scope of practice of the MH/SU workforce is essential because these factors determine what services can be provided by different MH/SU professionals and therefore influence how various MH/SU professionals are deployed and utilized within North Carolina's MH/SU service delivery system.

Professional practice acts and state statutes establish the minimum educational qualifications and supervision requirements to practice in a MH/SU profession. State regulatory bodies implement statutory requirements through licensure and certification standards, administrative rules, and oversight. Supervision requirements determine how many hours of oversight professionals need before being able to practice independently and therefore affect the ability to deploy clinicians in settings where there is limited or no supervisors available. Together, regulatory boards and credentialing bodies shape the pathway of available workers and the roles that can be filled by individuals with different degrees and training. A health professional's scope of practice, established through state legislation, defines who can diagnose MH/SU conditions and prescribe medications. Independent practice authority, defined in this report, is the ability of a professional to provide MH/SU services, like diagnosing conditions or prescribing medication, without required supervision, which varies by profession and licensure. Medicaid billing authority — the ability of a professional to directly enroll in Medicaid and bill for services under their own credentials — influences workforce utilization by determining which professionals can generate Medicaid revenue, affecting both employment opportunities and access to care for Medicaid beneficiaries. Together, these characteristics shape workforce deployment, care team composition, the capacity of the workforce to deliver different types of services, and ultimately determine how effectively North Carolina can match available professionals to community needs across care settings.

For each occupation in the six workforce categories, this report provides detailed information on these key elements shaping the workforce. Appendix I provides more detailed profiles.

- **Credentialing Title and Licensing Body:** The occupational title and regulatory body/bodies overseeing entry into the profession, credentialing, disciplinary action, and ethics.
- **Educational Requirements:** The minimum degree or coursework required for initial licensure, certification, or role eligibility in North Carolina. Requirements range from high school diplomas to doctoral degrees.
- **Supervised Practice Requirements:** The clinical hours, practicum experiences, internships, or supervised work experience necessary to obtain initial credentials or meet licensure qualifications. These requirements vary significantly across professions, from 100 hours for some certifications to several years of supervised practice for others.
- **Scope of Practice:** The specific services, interventions, and responsibilities that each professional is authorized to provide as defined by North Carolina General Statutes, Administrative Code, or relevant regulatory bodies. This report section summarizes two allowances: the ability to diagnose mental health and substance use disorders and the ability to prescribe medications.
- **Independent Practice Authority:** Whether a professional may independently deliver MH/SU clinical services, such as diagnosing mental health and substance use disorders or prescribing medications, without required supervision or collaborative oversight; defined in this report as the ability of a professional to practice autonomously in this capacity without supervision from another professional. This section includes details about supervision requirements, collaborative practice agreements, and conditions for independent practice.
- **Medicaid Billing Authority:** The ability to independently bill North Carolina Medicaid for MH/SU services provided, which varies significantly across professions and affects access to care for Medicaid beneficiaries.

Mental Health and Substance Use Services Workforce Category: Summary of Regulation and Practice Scope

The following section provides overview summaries for each of the MH/SU services occupations, organized by the six MH/SU services workforce categories. To facilitate comparisons of the occupations within each of the six categories, an overview table and brief summaries are provided. The summaries and tables allow readers to understand areas of overlap and differences in the educational requirements, licensure, practice authorities, supervision requirements, and billing allowances between occupations in a category. For more detailed information on credentialing requirements and scope of practice see Appendix I.

PRESCRIBERS

The prescriber category consists of six credentials within the North Carolina MH/SU services workforce that all possess diagnostic authority, prescriptive authority, and can bill Medicaid directly.

Physician specialties in MH/SU services workforce require a doctoral degree in medicine. Psychiatrists complete four years of residency training following medical school. Child and adolescent psychiatrists require the same four-year psychiatry residency plus two additional years of subspecialty training. Child and adolescent psychiatrists can do a combined three years of general psychiatry and two years of child and adolescent psychiatry training for five years of residency education. Addiction psychiatrists complete four years of psychiatry residency followed by one year of fellowship training. Addiction medicine physicians complete 3–7 years of residency in their primary specialty area (i.e., Family Medicine, Internal Medicine, Preventive Medicine), then complete a one-year addiction medicine fellowship. All physicians are required to be licensed by the North Carolina Medical Board (NCMB) to practice in North Carolina. Licensed physicians practice independently without supervision requirements.

Psychiatric Mental Health Nurse Practitioners (PMHNPs) require at least a master's degree but they may also receive a Doctorate of Nursing Practice. PMHNPs are required to have completed at least 500 faculty-supervised clinical hours during masters training. PMHNPs are licensed as RNs by the North Carolina Board of Nursing (NCBON) and granted approval to practice as nurse practitioners by the NCBON in conjunction with the NCMB. PMHNPs can diagnose MH/SU conditions and prescribe medication. PMHNPs must maintain collaborative practice agreements with supervising physicians and cannot practice independently.[20]

Physician Assistants (PAs) specializing in psychiatric practice require master's degree education and 2,000 hours of clinical rotations during PA training. PAs can also obtain 2,000 hours of psychiatry-specific practice experience to receive advanced certification (Certificate of Added Qualifications [CAQ]). PAs are licensed by the NCMB and must practice under the supervision of a physician. Per Session Law 2025-37, PAs practicing in a team-based setting who have more than 4,000 hours of clinical practice experience and more than 1,000 hours of clinical experience within their medical specialty will be able to practice without a primary supervising physician.[21] The law goes into effect June 30, 2026 or when the NCMB adopts rules. NCMB rules are pending but will require a registration process to acquire team-based status.

Table 18. Prescriber Overview: Licensure Requirements and Practice Authority in North Carolina

Credential	Certifying Body	Minimum Education	Supervised Practice Hour Requirements	Scope of Practice		Independently practice (without supervision)?	Bill Medicaid?
				Diagnose MH/SU Conditions?	Prescribe?		
Psychiatrist	NCMB	Doctorate	4 years of residency	Yes	Yes	Yes	Yes
Child Psychiatrist	NCMB	Doctorate	4 years of residency & 2 years of subspecialty training (Can be completed in five years)	Yes	Yes	Yes	Yes
Addiction Psychiatrist	NCMB	Doctorate	4 years of residency & 1 year of fellowship	Yes	Yes	Yes	Yes
Addiction Medicine Physician	NCMB	Doctorate	Residency & 1 year fellowship	Yes	Yes	Yes	Yes
Psychiatric Mental Health Nurse Practitioner (PMHNP)	NCBON & NCMB	Master's	500–750 faculty-supervised clinical hours	Yes	Yes	No	Yes
Psychiatric Physician Assistant	NCMB	Master's	2,000 hours of PA program clinical rotations CAQ: 2,000 hours of practice experience in psychiatry	Yes	Yes	Conditional[a]	Yes

Note. NCMB=North Carolina Medical Board; NCBON=North Carolina Board of Nursing. CAQ=Certificate of Added Qualifications
[a] Team-based PAs who meet certain conditions can practice without supervision per Session Law 2025-37, as of 10/1/25. They must be practicing in a team-based setting, have > 4,000 clinical practice hours and >1,000 clinical practice hours within the specific medical specialty of practice with a physician in that specialty.[21] Law goes into effect on or after June 30, 2026, when NCMB adopts rules. There will be a registration process for those seeking team-based status.
Source. See Appendix I for details and citations.

GRADUATE-LEVEL CLINICIANS IN MENTAL HEALTH AND SUBSTANCE USE SERVICES WORKFORCE

The graduate-level clinician category consists of 14 credentials that provide therapy and assessment, with varying levels of diagnostic authority and supervision requirements. None of these professionals have prescriptive authority.

Psychology professionals include four credentials regulated by the North Carolina Psychology Board. Licensed Psychologists (LP) must hold a doctoral degree, complete a 1,500-hour pre-doctoral internship, and have 1,500 post-doctoral hours of supervised experience. LPs possess diagnostic authority for MH/SU conditions and can provide psychological testing and evaluation for other diagnoses, such as ADHD, autism, and neuropsychological conditions. LPs can practice independently and bill Medicaid. Provisionally licensed psychologists are individuals who have completed their doctoral training in psychology and a pre-doctoral internship but are in the midst of completing their supervised practice experience. Provisionally licensed LPs can diagnose and bill Medicaid but cannot practice independently. Licensed Psychological Associates (LPA) require master's degrees and 500 hours of supervised training during their degree program. LPAs have diagnostic authority and can provide psychological testing, and can bill Medicaid. LPAs cannot practice independently. As of October 2025, LPAs can apply for Independent Practice if they have at least 4,000 post-licensure supervised practice hours over a 24–60 month period with at least average performance ratings and a Health Services Provider-Psychological Associate (HSP-PA) certification.[21] Independent LPAs do not require supervision to practice.

School Psychologists require a master's degree or doctoral degree from an accredited National Association of School Psychologists (NASP) program and 1,200 internship hours (master's/specialist) or 1,500 internship hours (doctorate). School psychologists' licensing body depends on the school system's contracting entity. Any school psychologist employed within public schools is required to be licensed with NC Department of Public Instruction (NC DPI). If a contract is between a school system and an agency, NCPB must provide the license. However, either NCPB or NC DPI may provide licensure if the contract is between a school system and an individual psychologist. School psychologists licensed by NC DPI lack diagnostic authority for MH/SU conditions and cannot bill Medicaid independently. The NCPB does not license school psychologists separately from other licenses.

Clinical Mental Health Counselors are regulated by the North Carolina Board of Licensed Clinical Mental Health Counselors. Licensed Clinical Mental Health Counselors (LCMHC) require a master's degree and 3,000 hours of post-graduate supervised practice experience, have MH/SU diagnostic authority, practice independently, and can bill Medicaid. Licensed Clinical Mental Health Counselor Associates (LCMHCA) require a master's degree with 100 practicum hours and 600 internship hours during their degree program, lack diagnostic authority, cannot practice independently, but can bill Medicaid. Licensed Clinical Mental Health Counselor Supervisors (LCMHCS) must hold an independent, unrestricted LCMHC license and they are approved by the board to provide clinical supervision for LCMHCAs after verifying professional counseling experience (2,500 direct contact hours).

Social Work professionals are overseen by the North Carolina Social Work Certification and Licensure Board. Licensed Clinical Social Workers (LCSW) require a master's of social work degree and 3,000 hours of post-graduate supervised clinical practice. LCSWs have diagnostic authority for MH/SU conditions, practice independently, and can bill Medicaid. Licensed Clinical Social Worker Associates (LCSWA) are individuals that are provisionally licensed working toward full independent licensure. LCSWAs require a master of social work degree. LCSWAs cannot practice independently but can directly bill Medicaid and diagnose MH/SU conditions under supervision.

Marriage and Family Therapists are regulated by the North Carolina Marriage and Family Therapy Licensure Board. Licensed Marriage and Family Therapists (LMFT) require master's degrees and 1,500 direct, face-to-face clinical hours with 200 clinical supervision hours. LMFTs have diagnostic authority for MH conditions, practice independently, and can bill Medicaid. Licensed Marriage and Family Therapist Associates (LMFTA) are provisionally licensed working toward independent practice. LMFTAs lack diagnostic authority, cannot practice independently, unless approved by the AAMFT licensure supervisors and the board, and can independently bill Medicaid."

Fee-Based Pastoral Counselors are overseen by the North Carolina Board of Fee-Based Practicing Pastoral Counselors. Fee-Based Practicing Pastoral Counselors require a master's degree in divinity (or its equivalent), a master's or doctoral degree in pastoral counseling, have at least three years of full-time experience as a religious leader and be an ordained minister, experience providing 1,375 pastoral counseling hours, and at least 250 hours of supervision. Fee-Based Pastoral Counselors have limited diagnostic authority, practice independently, and can bill Medicaid. Fee-Based Practicing Pastoral Counseling Associates are working toward independent practice, require one master's degree and religious training, totaling 375 pastoral counseling hours, lack diagnostic authority, cannot practice independently, and cannot bill Medicaid.

Table 19. Graduate-Level Clinicians in Mental Health and Substance Use Services Workforce Overview: Licensure Requirements and Practice Authority in North Carolina

Credential	Certifying Body	Minimum Education	Supervised Practice Requirements Post-Program	Scope of Practice		Independently Practice (without supervision)?	Bill Medicaid?
				Diagnose MH/SU?	Prescribe?		
Licensed Psychologist (Permanent)	NCPB	Doctorate	1,500 (post-doctoral) hours of supervised experience	Yes+	No	Yes	Yes
Licensed Psychologist (Provisional)	NCPB	Doctorate	In process of obtaining 1,500 (post-doctoral) hours of supervised experience	Yes+	No	No	Yes
Independent Licensed Psychological Associate	NCPB	Master's	4,000 hours of supervised experience	Yes+	No	Yes	Yes
Licensed Psychological Associate	NCPB	Master's	500 hours of supervised training during degree program	Yes+	No	No	Yes
School Psychologist	NCPB / NC DPI	Master's	MA/Specialist: 1,200 internship hours during or after degree program Doctoral: 1,500 during program	No	No	Dependent	No
Licensed Clinical Mental Health Counselor	NCBLCMHC	Master's	3,000 hours of supervised practice , including 2,000 hours direct counseling and 100 hours of clinical supervision	Yes	No	Yes	Yes
Licensed Clinical Mental Health Counselor Supervisor	NCBLCMHC	Master's	3,000 hours of supervised practice, at least 2,500 hours direct client contact, and 3 semester graduate credits in clinical supervision	N/A	N/A	N/A	N/A
Licensed Clinical Mental Health Counselor Associate	NCBLCMHC	Master's	No practice hour requirement	No	No	No	Yes
Licensed Clinical Social Worker	NCSWCLB	Master's	3,000 hours of supervised clinical practice with 100 hours of LCWS supervision	Yes	No	Yes	Yes
Licensed Clinical Social Worker Associate	NCSWCLB	Masters	No practice hour requirement	Yes	No	No	Yes
Licensed Marriage & Family Therapist	NCMFTLB	Masters	1,500 clinical hours with 200 approved supervision hours	MH only	No	Yes	Yes
Licensed Marriage & Family Therapist Associate	NCMFTLB	Master's	At least 1,000 clinical hours post-masters	No	No	No	Yes
Fee-Based Practicing Pastoral Counselor	NC Pastoral Counseling Board	Two Master's degrees (MDiv and Pastoral Counseling) and one unit of Clinical Pastoral Education	At least 1,375 pastoral counseling hours with 250 hours of supervised pastoral counseling	Yes	No	Yes	Yes
Fee-Based Practicing Pastoral Counseling Associate	NC Pastoral Counseling Board	Master's (MDiv) and one unit Clinical Pastoral Education	At least 375 pastoral counseling hours and three years as a religious leader	No	No	No	No

Note. NCPB=North Carolina Psychology Board; NC DPI=North Carolina Department of Public Instruction; NCBLCMHC=North Carolina Board of Licensed Clinical Mental Health Counselors; NCSWCLB=North Carolina Social Work Certification and Licensure Board; NCMFTLB=North Carolina Marriage and Family Therapy Licensure Board; NC Pastoral Counseling Board=North Carolina Board of Fee-Based Pastoral Counselors; N/A=Not applicable.
+Psychologists also diagnose conditions requiring psychological testing and evaluation, such as ADHD, autism, and neuropsychological conditions.
Source. See Appendix I for details and citations.

ADDICTION COUNSELORS

The addiction counselor category consists of six credentials specializing in substance use disorder services, with varying educational requirements and supervision structures. All roles are regulated by the North Carolina Addictions Specialist Professional Practice Board (NCASPPB). None of these professionals have prescriptive authority.

Licensed Clinical Addiction Specialists (LCAS) represent the credential with the highest educational requirement within this category. LCAS require master's degrees and 4,000 hours of postgraduate supervised substance use disorder counseling experience, though this requirement may be reduced for applicants meeting alternative criteria. LCAS have diagnostic authority for MH/SU conditions but must refer any client to an appropriate MH provider if there is only an MH diagnosis.[22] LCAS practice independently and can bill Medicaid. Licensed Clinical Addiction Specialist Associates (LCASA) are provisionally licensed individuals working toward independent LCAS licensure. LCASA require master's degrees and 300 hours of supervised practical training, have MH/SU diagnostic authority, cannot practice independently, but can bill Medicaid. Certified Clinical Supervisors (CCS) supervise LCASA as they work toward LCAS licensure. CCS scope does not pertain to client practice. CCS must have LCAS licensing and two years of supervised clinical experience to become a supervisor.

Certified Alcohol and Drug Counselors (CADC) require high school education, 270 hours of didactic training (190 substance use-specific hours), and 6,000 hours of supervised experience. CADC can assess and contribute to a diagnosis of SU conditions, cannot practice independently, and cannot bill Medicaid.

Certified Prevention Specialists (CPS) require high school education, 270 hours of didactic training (170 primary prevention-specific, 100 substance use-specific hours), and 4,000–6,000 hours of supervised experience depending on educational background, plus 300 hours of supervised practical training. CPS cannot diagnose, cannot practice independently, and cannot bill Medicaid.

Certified Criminal Justice Addictions Professionals (CCJP) require high school education. Since October 2017, all CCJP must first obtain an LCAS or CADC credential. To become a CCJP, experience in criminal justice or addiction services is required and hours vary depending on level of education or credentialing status. CCJP can diagnose SU conditions if the individual simultaneously holds an LCAS, cannot practice independently, and cannot bill Medicaid.

Table 20. Addiction Counselor Overview: Credentialing Requirements and Practice Authority in North Carolina

Credential	Certifying Body	Minimum Education	Supervised Practice Hour Requirements	Scope of Practice		Independently practice (without supervision)?	Bill Medicaid?
				Diagnose MH/SU?	Prescribe?		
Licensed Clinical Addiction Specialist	NCASPPB	Master's	4,000 hours substance use disorder counseling experience (or less if applicant meets other criteria)	Yes	No	Yes	Yes
Certified Clinical Supervisor	NCASPPB	Master's	2,500 direct contact hours of experience	N/A	N/A	N/A	N/A
Licensed Clinical Addiction Specialist Associate	NCASPPB	Master's	300 hours of supervised practical training	Yes	No	No	Yes
Certified Alcohol and Drug Counselor	NCASPPB	High School	6,000 hours of supervised experience (4,000 hours with a Bachelors)	No[a]	No	No	No
Certified Prevention Specialist	NCASPPB	High School	4,000–6,000 hours of supervised experience depending on education degree and 300 hours of supervised practice	No	No	No	No
Certified Criminal Justice Addictions Professional	NCASPPB	High School	300 hours of supervised practical training and at least 1,000 hours of direct work experience	Con-ditional[b]	No	No	No

Note. NCASPPB=North Carolina Addictions Specialist Professional Practice Board; N/A=Not applicable.
[a]CADC can contribute to assessment and diagnosis but cannot independently diagnose.
[b]CCJP can diagnose if they simultaneously hold a LCAS.
Source. See Appendix I for details and citations.

HEALTH/ALLIED HEALTH PROFESSIONALS

The health/allied health category consists of 11 credentials that provide clinical and rehabilitative services within MH/SU services settings, with varying educational requirements and practice authority. None of these professionals has prescriptive authority.

Nursing Professionals include three roles regulated by the North Carolina Board of Nursing. Psychiatric Mental Health Clinical Nurse Specialists (CNSs) require master's degrees and 500 faculty-supervised clinical hours, have diagnostic authority, lack prescriptive authority, and can bill Medicaid. While a CNS can independently perform nursing functions, they do not have independent practice authority to diagnose or prescribe medications. Psychiatric-Mental Health Registered Nurses (RN) require at least an associate degree in nursing and 2,000 hours of clinical practice. RNs do not have diagnostic authority, cannot prescribe, and cannot bill Medicaid. While RNs can independently practice nurse functions within their scope of practice, RNs cannot independently deliver MH/SU services inclusive of MH/SU diagnosis or treatment. Licensed Practical Nurses (LPNs) must graduate with a certificate or diploma from a community college or private nursing program that is approved by the NC Board of Nursing. LPN programs are typically 12 months in duration and must include at least 90 hours of focused client care experience in their final semester. LPNs lack diagnostic authority, cannot prescribe, cannot practice independently, and cannot bill Medicaid.

Speech-Language Pathology Professionals (SLPs) are regulated by the North Carolina Board of Examiners for Speech and Language Pathologists and Audiologists. Speech-Language Pathologists require master's degrees with 400 supervised clinical practicum hours and nine months of full-time supervised professional experience. SLPs have limited diagnostic authority, can practice independently, and can bill Medicaid. Speech-Language Pathologist Assistants (SLPAs) require associate degrees and 100 supervised clinical fieldwork hours with 80% direct patient services, lack diagnostic authority, cannot practice independently, and cannot bill Medicaid.

Occupational Therapy Professionals (OTs) are overseen by the North Carolina Board of Occupational Therapy. Occupational Therapists require master's degrees and Level I and II fieldwork equivalent to 24 weeks full-time. OTs lack diagnostic authority for MH/SU conditions but can practice independently and can bill Medicaid. Occupational Therapist Assistants (OTAs) require associate degrees and Level I and II fieldwork equivalent to 16 weeks full-time, lack diagnostic authority, cannot practice independently, and cannot bill Medicaid.

Recreational Therapy Professionals (RTs) are regulated by the North Carolina Board of Recreational Therapy Licensure. Licensed Recreational Therapists require a minimum of a bachelor's degree with an RT major or specialization and a 560-hour, 14-week internship. Licensed Recreational Therapists lack diagnostic authority, can practice independently, and generally do not bill Medicaid for MH/SU, though can bill Medicaid through private practice, or can bill Medicaid for providing service for intellectual/developmental disabilities at an agency through NC Innovations Waivers. Licensed Recreational Therapist Assistants (RTAs) require associate degrees and 380-hour internship/field placement, lack diagnostic authority, and cannot practice independently.

Behavior Analyst Professionals (BAs) include two roles regulated by the North Carolina Behavior Analyst Licensure Board. Behavior Analysts require master's degrees and 1,500–2,000 supervised fieldwork hours, have dependent practice authority, and can bill Medicaid. Assistant Behavior Analysts (ABAs) require bachelor's degrees and 1,000–1,300 supervised fieldwork hours, cannot practice independently, and cannot bill Medicaid.

Table 21. Health/Allied Health Overview: Credentialing Requirements and Practice Authority in North Carolina

Credential	Certifying Body	Minimum Education	Supervised Practice Hour Requirements	Scope of Practice		Independently practice (without supervision)?	Bill Medicaid?
				Diagnose MH/SU?	Prescribe?		
Psychiatric Mental Health Clinical Nurse Specialist (PMH-CNS)	RN License & CNS recognition: NCBON & recognition Certification: AACN or ANCC	Master's	500 faculty-supervised clinical hours	Yes	No	Ŧ	Yes
Psychiatric-Mental Health Registered Nurse (PMH-RN)	RN License: NCBON Certifications: AACN or ANCC	Associates	2,000 hours of clinical practice	No	No	Ŧ	No
Licensed Practical Nurse	NCBON	12-month certificate or diploma program	Varies by state and program. At least 90 hours in last semester in focused client care experience.	No	No	No	No
Speech-Language Pathologist	NCBOESLPA	Master's	400 supervised clinical practicum hours and nine months full-time supervised professional experience	Limited	No	Yes	Yes
Speech-Language Pathologist Assistant	NCBOESLPA	Associates	100 supervised clinical fieldwork hours, with 80 being direct patient/client services	No	No	No	No
Occupational Therapist	NCBOT	Master's	Level I and Level II fieldwork as part of graduate program. At least equivalent to 24 weeks' full-time.	No	No	Yes	Yes
Occupational Therapist Assistant	NCBOT	Associates	Level I and Level II fieldwork as part of program. At least equivalent to 16 weeks' full-time.	No	No	No	No
Licensed Recreational Therapist	NCBRTL	Bachelor's	560-hour, 14- week internship	No	No	Yes	Yes*
Licensed Recreational Therapist Assistant	NCBRTL	Associates	380-hour field placement	No	No	No	No
Behavior Analyst	NCBALB	Master's	1,500–2,000 supervised fieldwork hours	No	No	Yes, if licensed by NCBALB	Yes
Assistant Behavior Analyst	NCBALB	Bachelor's	1,000–1,300 supervised fieldwork hours	No	No	No	No

Note. NCBON=North Carolina Board of Nursing; AACN=American Nurses Credentialing Center; AACN=American Association of Critical-Care Nurses Certification Corporation; NCBOESLPA=North Carolina Board of Examiners for Speech-Language Pathologists and Audiologists; NCBOT=North Carolina Board of Occupational Therapy; NCBRTL=North Carolina Board of Recreational Therapy Licensure. NCBALB=North Carolina Behavior Analyst Licensure Board.
Ŧ=CNSs and RNs practice nursing autonomously but cannot independently diagnose MH/SU disorders or prescribe medications.
*LRTs can bill Medicaid through private practice, or can bill Medicaid for providing service for intellectual/developmental disabilities at an agency through NC Innovations Waivers.
Source. See Appendix I for details and citations.

CERTIFIED PARAPROFESSIONALS AND MENTAL HEALTH AND SUBSTANCE USE SERVICES SUPPORT SPECIALISTS

The paraprofessional and support specialist categories consist of seven roles that provide direct care, peer support, and specialized services within MH/SU services settings. None of these professionals has diagnostic or prescriptive authority.

Certified Paraprofessionals include two groups that bring lived experience and community engagement to their roles.

Certified Peer Support Specialists (CPSSs) require high school education and are certified through the North Carolina Certified Peer Support Specialist (NCCPSS) Program through either Certification Track A (60 hours training) or Certification Track B (50 hours of approved training), both requiring an additional 20 hours of ethics and boundaries training. The certification process is transitioning, with plans for Track B to be phased out by 2029. CPSSs cannot practice independently and cannot bill Medicaid.

Community Health Workers (CHWs) require either training or professional experience of 0–4,000 hours depending on their certification pathway, are certified through the North Carolina Community Health Worker Association (NCCHWA), do not provide direct clinical services, and cannot bill Medicaid.

MH/SU Services Support Specialists encompass seven roles with varying educational and credentialing requirements. Due to the Qualified Professional (QP) initiative, a recent North Carolina General Assembly legislative rule updated the educational requirements to an associate degree in human services with two years of experience (from a bachelor's degree with 1–4 years of supervised experience depending on their educational background and credentials). The rule change will be enacted once officially activated by the Mental Health Commission.[23] QPs have no formal credentialing entity. QPs cannot practice independently, prescribe, or diagnose. Associate Professionals (APs) require bachelor's degrees with less than 1–4 years of supervised experience depending on their background, have no formal credentialing, cannot practice independently, and cannot bill Medicaid.

Certified Mental Health Technicians require high school education with no supervised practice hours, have optional national certification through the National Career Certification Board, cannot practice independently, and cannot bill Medicaid. Nationally Certified Psychiatric Technicians have educational requirements ranging from high school (Level 1) to bachelor's degrees (Level 4), with corresponding work experience requirements of 1-3 years for Levels 2-4, have optional national certification through the American Association of Psychiatric Technicians (AAPT), cannot practice independently, and cannot bill Medicaid.

Registered Behavior Technicians (BTs) require high school education and 40 hours of training, are certified nationally through the Behavior Analyst Certification Board (BACB), cannot practice independently, and cannot bill Medicaid.

Table 22. Certified Paraprofessionals and Mental Health and Substance Use Services Support Specialists Overview: Credentialing Requirements and Practice Authority in North Carolina

Credential	Certifying Body	Minimum Education	Supervised Practice Hour Requirements	Scope of Practice		Independently practice (without supervision)?	Bill Medicaid?
				Diagnose?	Prescribe?		
Certified Peer Support Specialist	NCCPSS Program	High School or equivalent	Track A: 60 hours training Track B: 50 hours training Both Tracks: 20 hours Ethics and Boundaries training	No	No	No	No[Ŧ]
Community Health Worker	NCCHWA		0–4,000 hours of experience depending on CHW pathway	No	No	N/A - no direct clinical services	No
Qualified Professional	No credentialing	*Currently:* Bachelor's Degree *Pending:* Associates	Dependent on education and credentials: 1–4 years full-time accumulated supervised experience with the population or in alcoholism and drug abuse counseling	No	No	No	No
Associate Professional	No credentialing	Bachelor's	Dependent on education and credentials: From <1 year to 4 years full-time accumulated supervised experience	No	No	No	No
Certified Mental Health Technician	Optional: NCCB	High School or equivalent	None	No	No	No	No
Nationally Certified Psychiatric Technician	Optional: AAPT	Varies from: Level 1: High School or equivalent, to Level 4: Bachelors	If certified: Level 1: none Levels 2–4: 1–3 years of work experience	No	No	No	No
Registered Behavior Technician	National: BACB	High School	40-hour Board training	No	No	No	No

Note. NCCPSS=North Carolina Certified Peer Support Specialist; NCCHWA=North Carolina Community Health Worker Association; NCCB=National Career Certification Board; AAPT=American Association of Psychiatric Technicians; BACB=Behavior Analyst Certification Board.
[Ŧ]=Peer support services are a Medicaid billable service, though CPSS cannot bill independently.
Source. See Appendix I for details and citations.

MENTAL HEALTH AND SUBSTANCE USE SERVICES PRESCRIBER WORKFORCE SUMMARY

North Carolina's MH/SU services prescriber workforce includes 1,568 MH/SU services physicians (1.43 per 10,000 population), 576 MH/SU services physician assistants (PA; 0.52 per 10,000), and 1,461 MH/SU services nurse practitioners (NP; 1.33 per 10,000). In total, there were 3,605 MH/SU services prescribers in North Carolina in 2024, a rate of 3.28 per 10,000. Growth of the prescriber workforce between 2014 and 2024 varied by prescriber type: The supply of MH/SU physicians increased by 26% since 2014, while the MH/SU PA workforce grew fivefold (483% growth) and MH/SU NPs grew by 431%.

Table 23. Mental Health and Substance Use Services Prescriber Workforce Summary of Findings, North Carolina

	MH/SU Services Physicians[a]	MH/SU Physician Assistants[c]	MH/SU Nurse Practitioners[b]
Supply (2024)	1,568	576	1,461
Rate per 10k Population (2024)	1.43	0.52	1.33
% Growth since 2014	+26%	+483%	+431%
% Increase in Rate per 10k Pop since 2014	+16.7%	+379.8%	+378.0%
Average Age	51.3 years	39.3 years	46.1 years
% Over Age 65	22.5%	4.3%	4.9%
% Female	46.4%	76.1%	87.5%
% Underrepresented Minority	28.3%	19.2%	40.2%
% Trained Out-of-State	76.2%	59.0%[d]	65.4%
Metro & Nonmetro Distribution	Metro: 1.64/10k Nonmetro: 0.59/10k	Metro: 0.61/10k Nonmetro: 0.18/10k	Metro: 1.49/10k Nonmetro: 0.72/10k
Counties with No Prescriber Type	25 counties	50 counties	23 counties

Note. MH/SU=Mental Health/Substance Use Services; N/A=Not Available.
[a] MH/SU Services Physicians include Psychiatrists, Child Psychiatrists, Addiction Medicine Physicians, and Addiction Psychiatrists.
[b] MH/SU Nurse Practitioners include Psychiatric Nurse Practitioners or NPs practicing in a mental health setting.
[c] MH/SU Physician Assistants include Psychiatric Physician Assistants, Child Psychiatric Physician Assistants, Addiction Medicine Physician Assistants, and Addiction Psychiatric Physician Assistants.
[d] n=15 for Physician Assistants who did not provide training information.
Source. NCMB and NCBON Licensure Data.

Demographic Characteristics and Training Location of the MH/SU Services Prescriber Workforce

- MH/SU clinicians average age was 51.3 years with 22.5% of the workforce over age 65. MH/SU PAs were 39.3 years on average with 4.3% over age 65. MH/SU NPs were an average age 46.1 years with 4.9% over age 65.
- Nearly half (46.4%) of MH/SU services physicians were female, while 76.1% of the MH/SU services PA and 87.5% of NP workforces were female.
- MH/SU services NPs had the highest diversity with 40.2% of the workforce identifying as an underrepresented minority. MH/SU services physicians report 28.3% underrepresented minority representation. MH/SU services PAs reported 19.2% underrepresented minority representation.
- Out-of-state training was high across all prescriber types: 76.2% of MH/SU physicians, 59.0% of MH/SU physician assistants, and 65.4% of MH/SU nurse practitioners were educated in an out-of-state program.

Geographic Distribution of Mental Health and Substance Use Services Prescriber Workforce

All prescriber clinician types showed substantial geographical differences in supply (Table 24). Cells that are shaded orange have rates lower than state average and cells shaded blue indicate rates higher than the state average.

- The combined state rate per 10,000 population for all MH/SU services prescribers was 3.28. This total included 1.43 MH/SU physicians per 10,000 population, 0.52 for MH/SU PAs, and 1.33 for MH/SU NPs.
- Metro counties have a combined rate of 3.74 MH/SU prescribers per 10,000 compared to 1.49 in nonmetro counties.
- Wake AHEC has the highest overall prescriber supply at 4.55 per 10,000 population, with MH/SU physicians at 2.11, MH/SU PAs at 0.71, and MH/SU NPs at 1.74. There was regional variation by clinician type; Wake AHEC and Mountain AHEC had above average supply of all three prescriber types, while Eastern, Northwest, and Southern Regional AHEC had below average supply..
- There were 15 NC counties with no MH/SU prescribers, 25 counties without a MH/SU physician, 50 counties without a MH/SU PA, and 23 counties without a MH/SU NP.

Table 24. Supply of Mental Health and Substance Use Services Prescriber Workforce by Geographic Region, North Carolina, 2024

	Rate per 10,000			
	All MH/SU Prescribers	MH/SU Physicians[a]	MH/SU PAs[b]	MH/SU NPs[c]
Statewide	3.28	1.43	0.52	1.33
By AHEC Region				
Area L	1.92	0.31	0.21	1.40
Charlotte	3.15	1.19	0.63	1.33
Eastern	2.33	0.97	0.24	1.12
Greensboro	4.16	2.54	0.33	1.30
Mountain	4.09	1.78	0.65	1.66
Northwest	2.44	0.96	0.47	1.01
South East	3.35	1.02	0.79	1.54
Southern Regional	1.81	0.63	0.36	0.82
Wake AHEC	4.55	2.11	0.71	1.74
By Tailored Plan County Catchment Area				
Alliance	4.91	2.45	0.79	1.68
Partners	2.46	0.82	0.49	1.15
Trillium	2.34	0.79	0.33	1.22
Vaya	2.72	1.27	0.39	1.06
By County Urbanicity				
Metro	3.74	1.64	0.61	1.49
Nonmetro	1.49	0.59	0.18	0.72

Note: MH/SU=Mental Health and Substance Use Services; AHEC=Area Health Education Center; PA=Physician Assistant; NP=Nurse Practitioner; ☐ Pale orange = lower than state average, ☐ Light blue = higher than state average
[a] MH/SU Services Physicians include Psychiatrists, Child Psychiatrists, Addiction Medicine Physicians, and Addiction Psychiatrists.
[b] MH/SU Physician Assistants include Psychiatric Physician Assistants, Child Psychiatric Physician Assistants, Addiction Medicine Physician Assistants, and Addiction Psychiatric Physician Assistants
[c] MH/SU Nurse Practitioners include Psychiatric Nurse Practitioners or NPs practicing in a mental health setting.
Source. NCMB, NCBON Licensure Data.

MENTAL HEALTH AND SUBSTANCE USE SERVICES PRESCRIBER WORKFORCE

Physicians, nurse practitioners, and physician assistants all have the authority to diagnose mental health and substance use disorders and prescribe psychiatric medications as part of their scope of practice, allowing them to provide comprehensive psychiatric care including both diagnosis and medication management.

PSYCHIATRISTS, CHILD AND ADOLESCENT PSYCHIATRISTS, ADDICTION MEDICINE PHYSICIANS, AND ADDICTION PSYCHIATRISTS

All physicians, regardless of specialty, play an important role in providing MH/SU services care in North Carolina; for example, primary care physicians often serve important roles in diagnosis and treatment of mental health conditions. Psychiatrists, child and adolescent psychiatrists, addiction psychiatrists, and addiction medicine physicians have a focused role of addressing MH/SU service needs.

Of the 28,709 total physicians in active practice in NC in 2024, 5.5% reported a primary practice area of psychiatry, child and adolescent psychiatry, addiction medicine, or addiction psychiatry; these four specialties have been grouped together in this report as "MH/SU services" physicians. In 2024, there were 1,568 physicians across all four specialty types with 1,245 working as psychiatrists, 219 working as child and adolescent psychiatrists, 79 working in addiction medicine, and 25 in addiction psychiatry. This translates to a rate of 1.43 MH/SU services physicians per 10,000 people in North Carolina, 1.13 psychiatrists per 10,000 people, 0.07 addiction medicine per 10,000 people, and 0.02 addiction psychiatrists per 10,000 people. There were 0.93 child and adolescent psychiatrists for every 10,000 aged 0-17 population in North Carolina.

Table 25. All Physicians and Mental Health and Substance Use Services Physician Specialties by Primary Area of Practice, North Carolina, 2014 and 2024

All Physicians & MH/SU Specialties	2014 N	2014 Rate per 10k	2024 N	2024 Rate per 10k NC Population
All Physicians	23,063	23.34	28,709	26.14
MH/SU Physicians Total	1,245	1.26	1,568	1.43
Psychiatrist	951	0.96	1,245	1.13
Child Psychiatrist	216	0.22/0.95[a]	219	0.20/0.93[a]
Addiction Medicine	49	0.05	79	0.07
Addiction Psychiatry	29	0.03	25	0.02

Note. MH/SU=Mental Health/Substance Use Services; 10k=10,000; Pop=Population.
[a] Rate is per 10k child and adolescent population 0-17
Source. NCMB Licensure Data.

From 2014 to 2024, the MH/SU services physician workforce in North Carolina increased by 26% from 1,245 MH/SU physicians in 2014 to 1,568 in 2024. This rate of growth is slightly higher than the total physician workforce growth rate of 24.5% during the same period. However, not all MH/SU services physician workforce categories increased during this period. There were only three more child and adolescent psychiatrists working in NC in 2024 compared to 2014, which resulted in a decrease in the ratio of child psychiatrists per 10K population. The result is that while psychiatrist and addiction medicine physician supply grew slightly faster than population, the child psychiatry supply did not keep pace with population growth. Similarly, there was a decrease in the proportion of individuals with a primary area of practice as addiction psychiatry From 2014 to 2024. However, there was an increase in physicians with a primary area of practice as addiction medicine during the same period.

Demographic Characteristics of Psychiatrists, Child and Adolescent Psychiatrists, Addiction Medicine Physicians, Addiction Psychiatrists

The 1,568 MH/SU services physicians in North Carolina had a mean age of 51.3 years (SD=14.4), with nearly a quarter (22.5%) over age 65. The workforce was 46.4% female, and 28.3% of the MH/SU services physicians were from underrepresented minority backgrounds.

There were regional differences in the demographic characteristics of the MH/SU services physician workforce. Age varied significantly across AHEC regions, with Area L having the oldest MH/SU services physician workforce with a mean age of 59.8 and Greensboro AHEC having the youngest workforce with a mean age of 49.1 years. In Wake AHEC, only 18.2% MH/SU services physician workforce was over 65 in 2024 compared to 37.3% in South East AHEC and 34.6% in Northwest AHEC. Female representation ranged widely from 27.6% of the MH/SU services physicians in South East AHEC to 51.3% in Wake AHEC. Underrepresented minority representation in the MH/SU services physician workforce was highest in Charlotte (43.7%) and lowest in Mountain AHEC (14.7%).

The MH/SU services physician workforce in NC's nonmetro counties were older, with a mean age of 55.3 years compared to 51.0 years in metro counties. Nonmetro counties had lower female representation (36.2% vs. 47.3%), and lower racial diversity (22.5% vs 28.9%) than metro counties.

Table 26. Demographics of Mental Health and Substance Use Services Physicians by Region, North Carolina, 2024

MH/SU Physicians	N	Age		% >65 years	% Female	% Under-represented Minority[a]
		Mean (SD)	Range			
Statewide	1,568	51.34 (14.4)	27-89+	22.45	46.36	28.34
By AHEC Region						
Area L	9	59.78 (14.1)	44-87	^	^	^
Charlotte	265	50.24 (12.6)	30-80	18.11	45.08	43.70
Eastern	103	52.99 (15.4)	30-89+	28.16	42.72	34.65
Greensboro	319	49.09 (15.8)	27-89+	19.75	49.84	21.73
Mountain	147	52.00 (14.6)	29-81	23.81	45.21	14.69
Northwest	162	56.23 (14.4)	29-89+	34.57	41.88	32.70
South East	59	58.00 (14.1)	34-89+	37.29	27.59	17.54
Southern Regional	59	52.27 (15.0)	29-86	27.12	41.38	22.41
Wake AHEC	445	50.04 (13.1)	29-89+	18.20	51.25	27.59
By Tailored Plan County Catchment Area						
Alliance	890	49.15 (14.1)	27-89+	18.09	50.17	29.13
Partners	187	54.78 (13.6)	29-89+	28.88	40.00	35.87
Trillium	254	55.12 (14.5)	29-89+	30.31	36.80	30.24
Vaya	237	52.79 (14.5)	29-89+	25.32	47.23	17.32
By County Urbanicity						
Metro	1,436	50.98 (14.3)	27-89+	21.73	47.29	28.88
Nonmetro	132	55.27 (14.4)	30-86	30.30	36.15	22.48

Note. MH/SU=Mental Health/Substance Use Services; AHEC=Area Health Education Center; Missing values are excluded from percentage calculations.
[a]Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
^Data suppressed with any n<5.
Source. NCMB Licensure Data.

Geographic Practice Characteristics of Psychiatrists, Child and Adolescent Psychiatrists, Addiction Medicine Physicians, Addiction Psychiatrists

MH/SU services physician workforce increasingly utilizes telehealth and remote service delivery to provide care. This report analyzed the primary practice location of MH/SU services physician workforce to characterize where MH/SU physicians may be in North Carolina.

The nine AHEC regions ranged from having nine to 445 MH/SU services physicians reporting a primary practice location. Rates per the population varied dramatically from 0.31 physicians per 10,000 people population (Area L) to 2.54 per 10,000 population (Greensboro). Wake AHEC reported the largest MH/SU services physician workforce (445 physicians) while Area L had the fewest MH/SU services physicians (nine physicians).

The four Tailored Plan catchment areas ranged from having 187 to 890 MH/SU services physicians, with Alliance reporting the highest concentration (890 physicians, 2.45 per 10,000) and Trillium reporting the lowest rate (254 physicians, 0.79 per 10,000) despite serving the most counties.

Metro counties had 1,436 MH/SU services physicians (1.64 per 10,000) serving 8.76 million residents, while nonmetro counties had 132 physicians (0.59 per 10,000) serving 2.22 million residents, showing that metro counties had three times as many MH/SU services physicians as rural counties in North Carolina.

Table 27. Supply of Mental Health and Substance Use Services Physicians by Region, North Carolina, 2024

MH/SU Physicians	N	Population[a]	Rate per 10,000 population
Statewide	1,568	10,984,106	1.43
By AHEC Region			
Area L	9	285,994	0.31
Charlotte	265	2,231,872	1.19
Eastern	103	1,060,329	0.97
Greensboro	319	1,256,677	2.54
Mountain	147	827,070	1.78
Northwest	162	1,691,002	0.96
South East	59	578,697	1.02
Southern Regional	59	939,130	0.63
Wake AHEC	445	2,113,335	2.11
By Tailored Plan County Catchment Area			
Alliance	890	3,635,141	2.45
Partners	187	2,277,684	0.82
Trillium	254	3,208,448	0.79
Vaya	237	1,862,833	1.27
By County Urbanicity			
Metro	1,436	8,761,216	1.64
Nonmetro	132	2,222,890	0.59

Note. MH/SU=Mental Health/Substance Use Services; AHEC=Area Health Education Center.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data. Urbanicity population based on 2023 data.
Source. NCMB Licensure Data.

There were differences in the rate of MH/SU services physicians in nonmetro counties by specialty. While the rate of all MH/SU services physicians in metro counties was 2.8 times that of nonmetro counties, child and adolescent psychiatrists had a larger difference between metro and nonmetro. There were more than four times as many child and adolescent psychiatrists to the child population in metro counties than nonmetro counties. Addiction medicine physicians had the least disparity between metro and nonmetro counties with 0.08 addiction medicine physicians per 10,000 people in metro counties and 0.05 in nonmetro counties.

Table 28. Supply of Mental Health and Substance Use Services Physicians in Metro Compared to Nonmetro Counties by Specialty Type, North Carolina, 2024

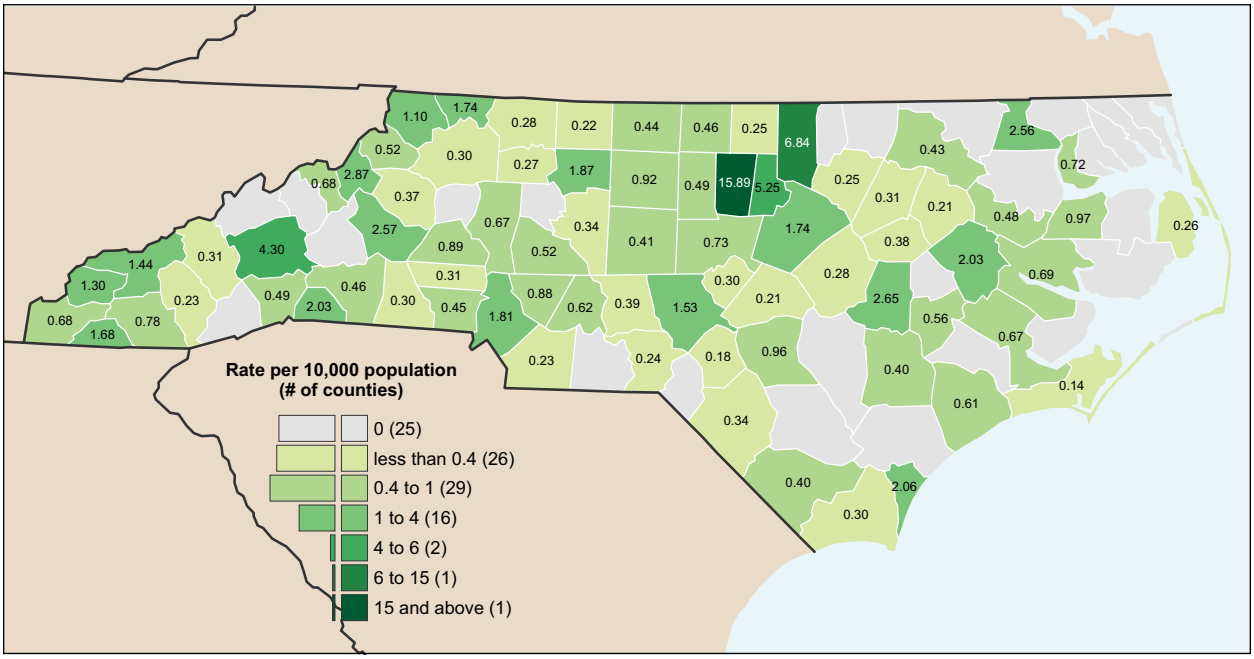
	All MH/SU Physicians	Psychiatrist	Child Psychiatrist	Addiction Medicine	Addiction Psychiatrist
	Rate per 10k	Rate per 10k	Rate per 10k population 0–17	Rate per 10k	Rate per 10k
	n=1,568	n=1,245	n=219	n=79	n=25
By County Urbanicity					
Metro	1.64	1.30	1.09	0.08	0.03
Nonmetro	0.59	0.48	0.26	0.05	^
Number of Counties with No Physicians					
	25	31	67	72	89

Note. MH/SU=Mental Health/Substance Use Services.
Source. NCMB Licensure Data.

Over half the counties in North Carolina reported either no MH/SU services physician coverage or minimal coverage. Twenty-five counties (25%) in North Carolina had no MH/SU services physicians reporting a primary practice location, while an additional 26 counties (26%) had rates below 0.4 per 10,000 population. Orange County had 15.89 MH/SU services physicians per 10,000 population which is more than 10 times the state average of 1.43. Orange County, along with three other counties (Granville [6.84], Durham [5.25], Buncombe [4.30]), reported more than double the state average, skewing the statewide average of MH/SU services physicians as a result. Almost three-fourths, or 72 counties in North Carolina, had a supply of MH/SU services physicians per 10,000 population that is less than half the state average (<0.72 MH/SU Services Physicians per 10,000 population).

By MH/SU services physician specialty type, there were 31 counties without a psychiatrist, 67 counties without a child and adolescent psychiatrist, 72 counties without an addiction medicine physician, and 89 counties without an addiction psychiatrist.

Figure 4. Mental Health and Substance Use Services Physicians per 10,000 Population by County, North Carolina, 2024



Source. NCMB Licensure Data.

Location of Undergraduate Medical Education Training of Psychiatrists, Child and Adolescent Psychiatrists, Addiction Medicine Physicians, and Addiction Psychiatrists

Over three-quarters (76.2%) of MH/SU services physicians in North Carolina attended medical school out-of-state. The proportion of physicians who went to medical school out-of-state was comparable across specialty types: 82.3% of addiction medicine, 76.7% of psychiatrists, 72.2% of child psychiatrists, and 68% of addiction psychiatrists went to medical school outside North Carolina.

Table 29. Training Location of Mental Health and Substance Use Services Physicians, North Carolina, 2024

	All MH/SU Physicians N (%) n=1,568	Psychiatrist N (%) n=1,245	Child Psychiatrist N (%) n=219	Addiction Medicine N (%) n=79	Addiction Psychiatry N (%) n=25
Education					
In-State	373 (23.79)	290 (23.29)	61 (27.85)	14 (17.72)	8 (32.00)
Out-of-State	1,195 (76.21)	955 (76.71)	158 (72.15)	65 (82.28)	17 (68.00)

Note. MH/SU=Mental Health/Substance Use Services.
Source. NCMB Licensure Data.

Supply of Physicians with a Secondary Areas of Practice in Psychiatry, Child and Adolescent Psychiatry, Addiction Medicine, and Addiction Psychiatry

Physicians in North Carolina may also report a secondary area of practice in addition to their primary specialty. A secondary area of practice may represent an additional role physicians fill in their clinical work, such as providing mental health or addiction services alongside their primary clinical focus. In 2024, 396 physicians in North Carolina had a secondary area of practice focused on addiction or mental health.

Among these 396 physicians, 183 (46.2%) had a mental health-focused secondary practice area, while 213 (53.8%) had an addiction-focused secondary practice area. Physicians with mental health-focused secondary practices primarily worked in pediatric non-surgical specialties (23.0%), neurology (22.4%), and general pediatrics (15.3%). In contrast, those with addiction-focused secondary practices were predominantly in family medicine (39.4%), general internal medicine (23.0%), or pain medicine (7.0%).

Table 30. Primary Area Physician Specialty of Physicians with a Secondary Area of Practice in Mental Health and Substance Use Services, North Carolina, 2024

Primary Area Physician Specialty of Physicians with a Secondary Area of Practice in MH/SU Services	N	%
Addiction or Mental Health Focused Secondary Area of Practice	396	100
Mental Health Focused Secondary Area of Practice	183	46.21
Pediatric Non-Surgical Specialties	42	22.95
Neurology	41	22.40
General Pediatrics	28	15.30
Family Medicine	22	12.02
General Internal Medicine	16	8.74
Other	34	18.58
Addiction Focused Secondary Area of Practice	213	53.79
Family Medicine	84	39.44
General Internal Medicine	49	23.00
Pain Medicine	15	7.04
Emergency Medicine	11	5.16
General Obstetrics & Gynecology	10	4.69
Other	44	20.66

Note. MH/SU=Mental Health/Substance Use Services.
Source. NCMB Licensure Data.

MENTAL HEALTH AND SUBSTANCE USE SERVICES PHYSICIAN ASSISTANTS

As with physicians, all physician assistants, regardless of area of practice, play an important role in providing mental health and substance use services in North Carolina. Physician assistants (PAs) may diagnose and prescribe medication to their patients in a general or primary care setting. MH/SU services PAs work collaboratively with physician supervision to diagnose and treat MH/SU conditions, prescribe psychiatric medications, and provide comprehensive MH/SU service care in both inpatient and outpatient settings.

Of the total 9,650 PAs actively working in North Carolina in 2024, 576 PAs reported working in a MH/SU services specialty area (6% of all PAs). PAs working in a psychiatric specialty (n=519; 90%), addiction medicine (n=34; 6%), addiction psychiatry (n=17; 3%) and child psychiatry specialty (n=6; 1%) were grouped together in this analysis as "MH/SU services physician assistants."

The PA MH/SU services workforce in North Carolina experienced dramatic growth over the past decade, with the number of MH/SU services PAs increasing more than five-fold from 108 in 2014 to 576 in 2024, representing a rate increase from 0.11 to 0.52 MH/SU services PAs per 10,000 population. This growth paralleled the overall expansion of the PA workforce in North Carolina, which doubled from 4,790 to 9,650 practitioners during the same period. Psychiatry PAs showed the most substantial growth from 89 to 519 practitioners (a 483% increase), while their supply per 10k population increased from 0.09 to 0.47. Addiction medicine PAs almost tripled from 12 to 34 practitioners, with their rate increasing from 0.01 to 0.03 per 10,000 population, though child psychiatry PAs remained in short supply, growing from 3 to 6 practitioners.

Table 31. All Physician Assistants and Mental Health and Substance Use Services Physician Assistants by Primary Area of Practice, North Carolina, 2014 and 2024

All PAs & MH/SU PAs	2014 N	2014 Rate per 10k NC pop	2024 N	2024 Rate per 10k NC pop
All PAs	4,790	4.85	9,650	8.79
Total MH/SU PAs	108	0.11	576	0.52
Psychiatry	89	0.09	519	0.47
Child Psychiatry	3	0.00/0.01[a]	6	0.01/0.03[a]
Addiction Medicine	12	0.01	34	0.03
Addiction Psychiatry	4	^	17	0.02

Note. MH/SU=Mental Health/Substance Use Services; PA=Physician Assistants; 10k=10,000. Pop=Population.
[a] Rate is per 10k child and adolescent population 0-17
^Data suppressed with any n<5.
Source. NCMB Licensure Data.

Demographic Characteristics of Mental Health and Substance Use Services Physician Assistants

North Carolina's 576 MH/SU services PAs represent a young, predominantly female workforce with a mean age of 39.3 years (SD=11.6) and 76.1% female representation. Less than 5% of the MH/SU services PA workforce is 65 years or older. Close to 20% of the MH/SU services PA workforce were from an underrepresented minority background in 2024.

Regional differences exist in the demographic characteristics of the MH/SU services PA workforce. MH/SU services PAs showed significant age variations across regions, with Charlotte AHEC reporting the youngest workforce at 35.7 years and Mountain AHEC the oldest at 45.2 years, a 9.5-year difference that suggests varying career stages and potentially different recruitment patterns. The Alliance and Partners Tailored Plan areas had a younger PA workforce (37.5 and 37.6 years, respectively) while Vaya had notably older PAs (44.7 years). Rural areas may face challenges given nonmetro PAs average eight years older than their metro counterparts (46.5 vs. 38.7 years), indicating potential difficulties attracting younger providers to practice in nonmetro areas.

Female representation among MH/SU services PAs varies across AHEC regions, ranging from 59% in Southern Regional AHEC to 82.6% in South East AHEC, with most regions showing 70-80% female representation. Rural counties reported a similar gender balance (75% female) to metro areas (76.2% female).

Underrepresented minority representation in the MH/SU services PA workforce was different across AHEC regions, ranging from 5.6% in Mountain AHEC to 33.3% in Area L AHEC. There were also differences by Tailored Plan area. Alliance area had the highest minority representation at 22.5% and Vaya showed the lowest at 11.1%. There was a negligible difference in the underrepresented minority representation of the MH/SU PA workforce between rural and metro counties.

Table 32. Demographics of Mental Health and Substance Use Services Physician Assistants by Region, North Carolina, 2024

MH/SU PAs	N	Mean Age (SD)	Age Range	>65 Years %	Female %	Underrepresented Minority[a] %
Statewide	576	39.27 (11.6)	24–77	4.34	76.09	19.16
By AHEC Region						
Area L	6	40.17 (10.6)	29–53	--	^	33.30^
Charlotte	141	35.65 (9.7)	24–72	^	78.01	23.02
Eastern	25	41.76 (12.5)	26–63	--	68.00	8.00^
Greensboro	41	39.95 (12.6)	25–76	^	77.50	28.21
Mountain	54	45.24 (11.9)	28–77	^	62.96	^
Northwest	80	39.59 (13.2)	24–77	8.75	78.48	16.46
South East	46	41.39 (11.5)	26–64	--	82.61	13.33
Southern Regional	34	44.35 (15.2)	27–75	14.71	58.82	26.47
Wake AHEC	149	37.90 (9.6)	25–71	^	81.76	20.95
By Tailored Plan County Catchment Area						
Alliance	286	37.51 (10.1)	24–74	2.45	77.89	22.54
Partners	111	37.60 (12.4)	25–77	7.21	80.00	16.51
Trillium	107	42.05 (12.5)	25–76	^	71.70	18.27
Vaya	72	44.68 (12.4)	27–77	8.33	69.44	11.11
By County Urbanicity						
Metro	536	38.73 (11.1)	24–77	3.73	76.17	19.09
Nonmetro	40	46.45 (15.3)	25–77	12.50	75.00	20.00

Note. MH/SU=Mental Health/Substance Use Services; AHEC=Area Health Education Center; SD=Standard Deviation; PA=Physician Assistants; Missing values are excluded from percentage calculations.
[a] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
^Data suppressed with any n<5.
Source. NCMB licensure data, NPPES.

Geographic Practice Characteristics of Mental Health and Substance Use Services Physician Assistants

MH/SU services PA distribution varied significantly across North Carolina's AHEC regions, with rates ranging from 0.21 per 10,000 population in Area L to 0.79 per 10,000 in South East AHEC, representing nearly a four-fold difference in workforce density. Wake AHEC had both the largest absolute number (149 PAs) and a high practitioner to population rate (0.71 per 10,000), while several regions including Southern Regional (34 PAs), Eastern (25 PAs), and Area L (six PAs) showed lower workforce shortages relative to their population sizes.

Alliance Tailored Plan area demonstrated the largest PA workforce with 286 providers practicing in Alliance catchment counties at a rate of 0.79 PAs per 10,000 population, while Trillium counties faced a lower supply of MH/SU services PAs with 107 PAs at a rate of 0.33 per 10,000, indicating substantial differences across Tailored Plan catchment areas.

The most pronounced geographic differences existed between metro and nonmetro areas for MH/SU services PAs, with rural counties having substantially lower PA density (0.18 per 10,000) compared to metro counties (0.61 per 10,000), representing more than a three-fold difference.

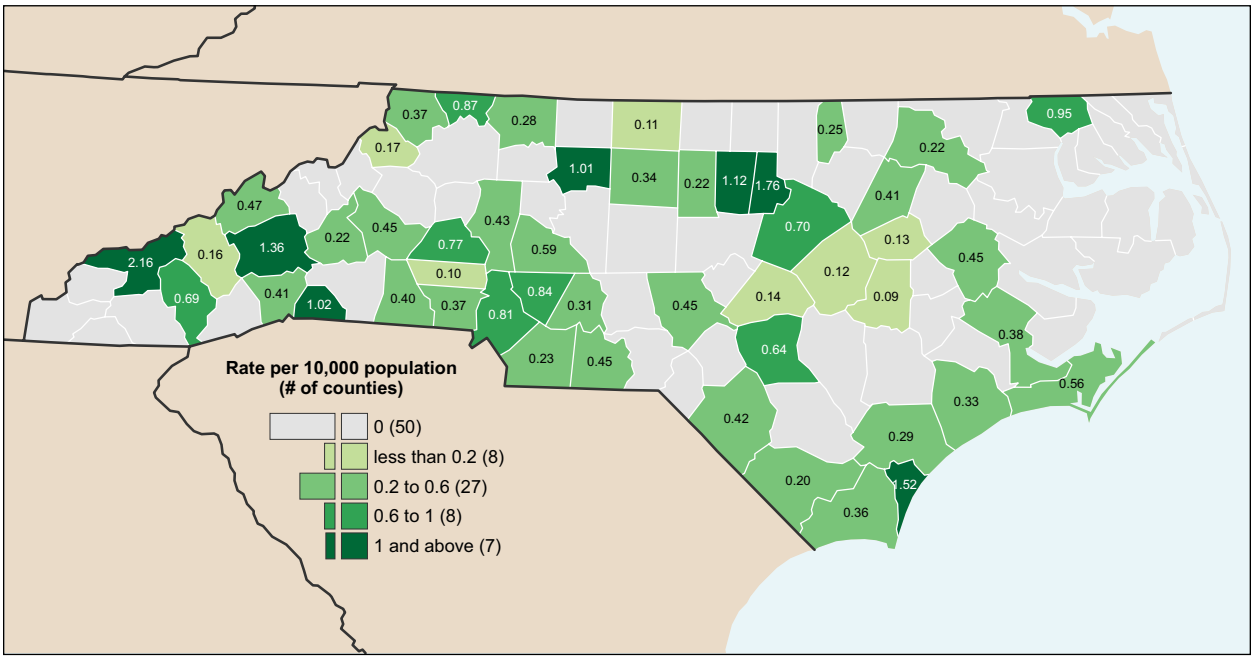
Table 33. Supply of Mental Health and Substance Use Services Physician Assistants by Region, North Carolina, 2024

MH/SU Physician Assistants	N	Population[a]	Rate per 10,000 population
Statewide	576	10,984,106	0.52
By AHEC Region			
Area L	6	285,994	0.21
Charlotte	141	2,231,872	0.63
Eastern	25	1,060,329	0.24
Greensboro	41	1,256,677	0.33
Mountain	54	827,070	0.65
Northwest	80	1,691,002	0.47
South East	46	578,697	0.79
Southern Regional	34	939,130	0.36
Wake AHEC	149	2,113,335	0.71
By Tailored Plan County Catchment Area			
Alliance	286	3,635,141	0.79
Partners	111	2,277,684	0.49
Trillium	107	3,208,448	0.33
Vaya	72	1,862,833	0.39
By County Urbanicity			
Metro	536	8,761,216	0.61
Nonmetro	40	2,222,890	0.18

Note. MH/SU=Mental Health/Substance Use Services; AHEC=Area Health Education Center.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data. Urbanicity population based on 2023 data.
Source. NCMB Licensure Data.

Fifty counties (50%) had no MH/SU services PAs reporting a primary practice location and (58%) had rates below 0.2 per 10,000 population, and 27 counties had between 0.2 to 0.6 per 10,000 population, indicating that 83% of counties had no, or were below, the state average in MH/SU services PA coverage. Seven counties had the top quartile of MH/SU services PAs to 10,000 population, including: Swain (2.16), Durham (1.76), New Hanover (1.52), Buncombe (1.36), Orange (1.12), Forsyth (1.01), and Polk (1.02). These seven counties had two-times the state average of MH/SU services PAs practicing per the population.

Figure 5. Mental Health and Substance Use Services Physician Assistants per 10,000 Population by County, North Carolina, 2024



Source. NCMB Licensure Data.

Location of Educational Training of Mental Health and Substance Use Services Physician Assistants

Close to two thirds of the practicing MH/SU services PAs were trained out-of-state (n=331; 59%) and 41% were trained statewide. There were small differences across the four specialty areas of MH/SU services PAs for in- or out-of-state training. Addiction medicine PAs had the highest proportion trained out-of-state (n=23; 69.7%) and addiction psychiatry had the most trained statewide (n=9; 52.9%).

Table 34. Location of Educational Training of Mental Health and Substance Use Services Physician Assistants, North Carolina, 2024

	Total MH/SU PA	Psychiatry	Child & Adolescent	Addiction Medicine	Addiction Psychiatry
	N (%) n = 576	N (%) n=519	N (%) n=6	N (%) n=34	N (%) n=17
Education					
In-state	230 (41.00)	209 (41.39)	^	10 (30.30)	9 (52.94)
Out-of-state	331 (59.00)	296 (58.61)	^	23 (69.70)	8 (47.06)
Not Reported	15 (--)	14 (--)	--	1 (--)	--

Note. MH/SU=Mental Health/Substance Use Services. PA=Physician Assistant. Missing values are excluded from percentage calculations.
^Data suppressed with any n<5.
Source. NCMB Licensure Data.

Supply of Physician Assistants with a Secondary Areas of Practice in Psychiatry, Child and Adolescent Psychiatry, Addiction Medicine, and Addiction Psychiatry

PAs in North Carolina may also report a secondary area of practice within licensure data in addition to their primary specialty. A secondary area of practice may represent an additional role PAs fill in their clinical work, such as providing mental health or addiction services alongside their primary clinical focus. In 2024, 247 PAs in North Carolina had a secondary area of practice focused on addiction or mental health.

Among the 247 PAs reporting a secondary area of practice in addiction or mental health, the majority (57.9%) had a secondary area focused on mental health, while 42.1% had a secondary area in addiction-related care. PAs with mental health-focused secondary practice areas most commonly had primary specialties in family medicine (33.6%), followed by neurology (13.3%), general internal medicine (7.7%), and emergency medicine (7.0%). Among PAs with addiction-focused secondary practice areas, family medicine was again the most common primary specialty (45.2%), followed by pain medicine (16.4%), general internal medicine (7.7%), emergency medicine (5.8%), and general pediatrics (3.9%).

Table 35. Physician Assistant Specialty by Areas of Practice, North Carolina, 2024

Primary Area Physician Assistant Specialty	N	%
Addiction or Mental Health Focused Secondary Area	247	100
Mental Health Focused Secondary Area of Practice	143	57.89
Family Medicine	48	33.57
Neurology	19	13.29
General Internal Medicine	11	7.69
Emergency Medicine	10	6.99
General Pediatrics	6	4.20
Geriatrics	6	4.20
Other	43	30.07
Addiction Focused Secondary Area of Practice	104	42.11
Family Medicine	47	45.19
Pain Medicine	17	16.35
General Internal Medicine	8	7.69
Emergency Medicine	6	5.77
General Pediatrics	4	3.85
Other	22	21.15

Source. NCMB Licensure Data.

NURSE PRACTITIONERS

Nurse practitioners (NPs) assess, facilitate, and manage the psychiatric and mental health care needs of individuals, families, groups and communities in a variety of public, private, community, inpatient, and multidisciplinary practice settings. NPs in North Carolina have prescriptive authority and practice within a collaborative practice agreement with physicians to prescribe and monitor the impact of psychiatric medications.

NPs can hold more than one certification and can work across multiple settings. This report defines MH/SU services NPs as NPs who have a psychiatric mental health Nurse Practitioner (PMHNP) certification or who work in a mental health setting.

As of 2024, North Carolina's MH/SU services NP workforce totaled 1,461 active practitioners, representing a rate of 1.33 MH/SU services NPs per 10,000 population. This is 10.7% of the total NP workforce in North Carolina, as there are 13,719 NPs active statewide in 2024. Of the 1,461 NPs included in the analysis, 1,324 (90.6%) had a PMHNP certification and 137 did not have a PMHNP certification but worked in a mental health setting (9.4%). Of the 137 NPs working in mental health settings, 77.3% (n=102) had a Family Nurse Practitioner (FNP) certification.

The MH/SU services NP workforce experienced dramatic growth between 2014 and 2024, growing from 275 practitioners in 2014 to 1,461 in 2024. This development represents a 431% increase that far exceeded North Carolina's 11.2% population growth during the same period. Growth accelerated in recent years, with a 56% growth between 2021 to 2022 from 662 to 1,025 practitioners and continued robust expansion through 2024. The workforce rate per 10,000 population increased from 0.28 in 2014 to 1.33 in 2024, representing a 378% growth rate.

Table 36. Supply and Underrepresented Minority Status of Mental Health and Substance Use Services Nurse Practitioner Workforce in North Carolina, 2014 to 2024

Year	Total Active MH/SU NPs	% Increase (relative to 2014)	Rate per 10k NC pop	NC Pop[a]	% Increase of MH/SU NPs per 10k growth (relative to 2014)	% NC Pop increase (relative to 2014)	% Under-represented Minority[b]
2014	275	--	0.28	9,881,906	--	--	20.44
2015	329	19.64	0.33	9,968,747	18.59	0.88	20.12
2016	367	33.45	0.36	10,080,436	30.83	2.01	22.83
2017	427	55.27	0.42	10,181,491	50.70	3.03	21.41
2018	Data Not Available						
2019	448	62.91	0.43	10,381,670	55.07	5.06	23.06
2020	519	88.73	0.50	10,472,553	78.08	5.98	27.04
2021	662	140.73	0.63	10,571,934	125.02	6.98	30.80
2022	1,025	272.73	0.96	10,705,403	244.06	8.33	36.32
2023	1,220	343.64	1.13	10,842,949	304.32	9.73	38.50
2024	1,461	431.27	1.33	10,984,106	377.96	11.15	40.15

Note. MH/SU=Mental Health/Substance Use Services; NP=Nurse Practitioner; Pop=Population; Missing values are excluded from percentage calculations.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on US Census data.
[b] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
Source. NCBON Licensure Data.

Demographic Characteristics of Mental Health and Substance Use Services Nurse Practitioner

In 2024, MH/SU services nurse practitioners had a mean age of 46.1 (SD=10.1) and only 4.9% of the workforce was over the age of 65. Within this workforce, 87.5% were female and 40.2% came from an underrepresented minority group.

The MH/SU services NP workforce has increased noticeably in diversity in the last decade. In 2014, 20.4% of the workforce identified as being from underrepresented background compared to 40.2% in 2024.

Age varied modestly across AHEC regions from 44.6 years in Charlotte to 47.3 years in Mountain AHEC region, with the proportion of MH/SU services NPs over age 65 remaining low across all regions (2.3% [Northwest AHEC] to 9% [South East AHEC] over age 65). Similarly, there are minimal differences in MH/SU services NP age in Tailored Plan catchment areas and metro-nonmetro counties in North Carolina.

There were no differences in the proportion of the MH/SU services NP workforce that is female by AHEC region, Tailored Plan catchment area, or metro-nonmetro counties.

Underrepresented minority representation in the MH/SU services NP workforce showed geographic differences. The proportion of the MH/SU services NP workforce from an underrepresented background ranged from 10.7% in Mountain AHEC region to 57.1% in the Area L region. Trillium Tailored Plan region showed the highest proportion of the workforce who come from an underrepresented background at 44.0%, while Vaya demonstrated the lowest at 25.7%. Metro counties showed slightly higher underrepresented minority representation (40.6%) compared to nonmetro counties (37.0%).

Table 37. Demographic Characteristics of Mental Health and Substance Use Services Nurse Practitioners by Region, North Carolina, 2024

MH/SU NP (PMHNP or in MH Setting)	N	Mean Age (SD)	Range	N (%) ≥65 years	N (%) Female	N (%) Under represented Minority[a]
Statewide	1,461	46.09 (10.1)	25–89	72 (4.93)	1,271 (87.47)	440 (40.15)
By AHEC Region						
Area L	40	46.25 (8.0)	33–67	^	35 (87.50)	20 (57.14)
Charlotte	297	44.57 (9.4)	25–71	8 (2.69)	265 (89.53)	106 (47.11)
Eastern	119	46.97 (10.9)	25–76	8 (6.72)	103 (89.57)	34 (38.20)
Greensboro	163	46.98 (10.8)	26–77	12 (7.36)	136 (84.47)	56 (45.90)
Mountain	137	47.34 (10.8)	25–74	11 (8.03)	118 (86.13)	11 (10.68)
Northwest	171	45.86 (9.8)	25–89	4 (2.34)	147 (86.47)	40 (33.33)
South East	89	47.28 (11.1)	26–72	8 (8.99)	80 (89.89)	21 (32.81)
Southern Regional	77	46.58 (9.5)	29–69	^	68 (88.31)	33 (53.23)
Wake AHEC	368	45.87 (10.0)	25–77	17 (4.62)	319 (86.68)	119 (43.12)
By Tailored Plan County Catchment Area						
Alliance	610	45.43 (9.9)	25–77	22 (3.61)	531 (87.19)	204 (43.78)
Partners	263	45.52 (9.9)	25–89	10 (3.80)	232 (88.55)	69 (36.51)
Trillium	390	46.96 (10.6)	25–77	29 (7.44)	341 (88.80)	129 (44.03)
Vaya	198	47.17 (10.1)	25–74	11 (5.56)	167 (84.34)	38 (25.68)
By County Urbanicity						
Metro	1,302	45.92 (10.2)	25–89	64 (4.92)	1,131 (87.40)	393 (40.56)
Nonmetro	159	47.50 (9.9)	25–73	8 (5.03)	140 (88.05)	47 (37.01)

Note. MH/SU=Mental Health/Substance Use Services; AHEC=Area Health Education Center; NP=Nurse Practitioner; PMHNP=Psychiatric Mental Health Nurse Practitioner; SD= Standard Deviation; Missing values are excluded from percentage calculations.
[a] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
^Data suppressed with any n<5.
Source. NCBON Licensure Data.

The diversity of the MH/SU services NP workforce increased significantly over the decade between 2014–2024. The proportion of the MH/SU services NP workforce identifying as white declined from 76.3% to 58.6% while the proportion of other racial/ethnic groups increased during this time. Black/African American representation in the MH/SU services NP workforce more than doubled from 15.7% to 32.6%. Asian representation also increased notably from 2.2% to 4.6%, while Hispanic or Latino representation stayed stable from 1.8% to 2.0%.

The gender makeup of the MH/SU services NP workforce remained stable between 2014 and 2024, with female representation increasing slightly from 86.6% to 87.5% and male representation correspondingly declining from 13.5% to 12.5%.

Table 38. Race/Ethnicity of Mental Health and Substance Use Services Nurse Practitioners by Region, North Carolina, 2014 and 2024

MH/SU NPs	2014 NP N (%) N =275	2024 NP N (%) N = 1,461
Race/Ethnicity		
American Indian/Native American	^	9 (0.82)
Asian	6 (2.19)	50 (4.56)
Black or African American	43 (15.69)	357 (32.57)
Hawaiian Pacific Islander	0 (--)	^
Hispanic or Latino	5 (1.82)	22 (2.01)
White	209 (76.28)	642 (58.58)
Other	9 (3.28)	14 (1.28)
Missing	1 (--)	365 (--)
Sex		
Female	238 (86.55)	1,271 (87.47)
Male	37 (13.45)	182 (12.53)
Not Reported	--	8

Note. MH/SU=Mental Health/Substance Use Services; NP=Nurse Practitioner. Missing values are excluded from percentage calculations.
^Data suppressed with any n<5.
Source. NCBON Licensure Data.

Geographic Practice Characteristics of Mental Health and Substance Use Services Nurse Practitioners

MH/SU services NP distribution showed moderate variation across North Carolina's nine AHEC regions, with rates ranging from 0.82 per 10,000 population in Southern Regional AHEC to 1.74 per 10,000 in Wake AHEC. Wake AHEC demonstrates both the largest workforce (368 MH/SU services NPs) and highest rate to the population, followed by Mountain AHEC (1.66 per 10,000) and South East AHEC (1.54 per 10,000). Southern Regional AHEC reported the lowest workforce, while Area L AHEC, though small in absolute numbers (40 NPs), maintains a strong rate of 1.40 per 10,000 population.

Alliance Tailored Plan area contained the largest MH/SU services NP workforce with 610 practitioners at a rate of 1.68 per 10,000 population. Trillium followed with 390 MH/SU services NPs but a lower rate of 1.22 per 10,000, with 263 MH/SU services NPs at 1.15 per 10,000 practicing in the Partners catchment area. Vaya region reported the lowest concentration with 198 MH/SU services NPs at 1.06 per 10,000 population.

Geographic differences in the size of the MH/SU services NP workforce between metro and nonmetro counties are substantial, with 1,302 MH/SU services NPs practicing in metro counties (1.49 per 10,000) compared to 159 in rural counties (0.72 per 10,000).

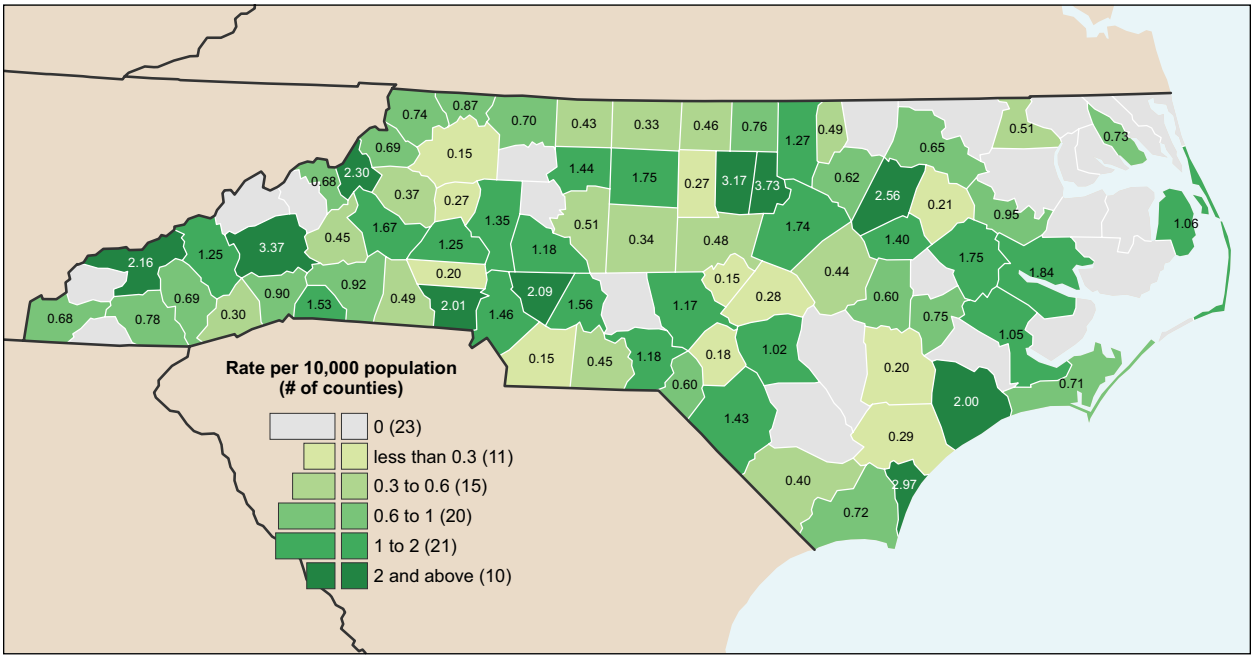
Table 39. Supply of Mental Health and Substance Use Services Nurse Practitioners by Region, North Carolina, 2024

MH/SU NP (PMHNP or in MH settings)	N	Population[a]	Rate per 10,000 population
Statewide	1,461	10,984,106	1.33
By AHEC Region			
Area L	40	285,994	1.40
Charlotte	297	2,231,872	1.33
Eastern	119	1,060,329	1.12
Greensboro	163	1,256,677	1.30
Mountain	137	827,070	1.66
Northwest	171	1,691,002	1.01
South East	89	578,697	1.54
Southern Regional	77	939,130	0.82
Wake AHEC	368	2,113,335	1.74
By Tailored Plan County Catchment Area			
Alliance	610	3,635,141	1.68
Partners	263	2,277,684	1.15
Trillium	390	3,208,448	1.22
Vaya	198	1,862,833	1.06
By County Urbanicity			
Metro	1,302	8,761,216	1.49
Nonmetro	159	2,222,890	0.72

Note. MH/SU=Mental Health/Substance Use Services; AHEC=Area Health Education Center; NP=Nurse Practitioner; PMHNP=Psychiatric Mental Health Nurse Practitioner.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data. Urbanicity population based on 2023 data.
Source. NCBON Licensure Data.

Twenty-three counties (23%) had no MH/SU services NPs reporting a practice location, while thirty-four counties had fewer than 0.3 MH/SU services NPs per 10,000 population. Thirty-five counties (35%) had rates between 0.3 to 1 MH/SU services NPs to 10,000 population. In total, these 69 counties had a lower supply of MH/SU services NPs to the state average of 1.33 MH/SU services NPs to 10,000 population. About one-third of counties had greater than the state average. Twenty-one counties (21%) had between 1 to 2 MH/SU services NPs per 10,000 population. Ten counties (10%) had MH/SU services NP rates exceeding 2.0 NPs per 10,000 population.

Figure 6. Mental Health and Substance Use Services Nurse Practitioners per 10,000 Population by County, North Carolina, 2024



Source. NCBON Licensure Data.

Location of Educational Training of Mental Health and Substance Use Services Nurse Practitioners

Two-thirds of MH/SU services NP workforce were trained out-of-state in 2024. The MH/SU services NP workforce showed increasing reliance on out-of-state training over the decade, with out-of-state educated practitioners rising from 52.0% in 2014 to 65.4% in 2024 and statewide educated NPs declining from 48.0% to 34.6%.

Table 40. Training Location of Mental Health and Substance Use Services Nurse Practitioners in North Carolina, 2014 and 2024

	2014 MH/SU NP	2024 MH/SU NP
	N (%), N =275	N (%), N = 1,461
Education		
In-state	132 (48.0)	459 (34.62)
Out-of-state	143 (52.0)	867 (65.38)
Not Reported	--	135

Note. MH/SU=Mental Health/Substance Use Services; NP=Nurse Practitioner. Missing values are excluded from percentage calculations.
Source. NCBON Licensure Data.

Practice Settings of Mental Health and Substance Use Services Nurse Practitioners

Among MH/SU services NPs in North Carolina in 2024, over half (52.3%) worked primarily in mental health specific settings. The remainder were distributed across a variety of practice settings, including group medical practices or physician offices (11.6%), hospital inpatient units (8.6%), and outpatient departments (4.7%). Smaller proportions were self-employed (4.4%), working in public or community health (3.8%), emergency departments (3.6%), or long-term care facilities (3.5%). Less than 2% practiced in settings such as group nursing practices, home health care, retail clinics, schools, academic institutions, industry, or insurance entities.

Table 41. Practice Settings of Mental Health and Substance Use Services Nurse Practitioners in North Carolina, 2024

MH/SU NP (PMHNP or in MH setting)	(N = 1,461)	
	N	%
Mental Health	764	52.29
Group Medical Practice/Physician Office	170	11.64
Hospital Inpatient	126	8.62
Hospital Outpatient	68	4.65
Self Employed NP	64	4.38
Other	63	4.31
Public/Community Health	56	3.83
Hospital Emergency	52	3.56
Long Term Care	51	3.49
Group Nursing Practice	16	1.10
Hospital (Other than IP, ED, OPD)	9	0.62
Home Health Care	6	0.41
Retail Clinic	5	0.34

Note. MH/SU=Mental Health/Substance Use Services; AHEC=Area Health Education Center; NP=Nurse Practitioner. PMHNP=Psychiatric Mental Health Nurse Practitioner; MH=Mental Health. IP=Inpatient; ED=Emergency Department; OPD=Outpatient Department.
^Data suppressed with any n<5.
Source. NCBON Licensure Data.

COMPARISON OF SUPPLY AND GEOGRAPHIC DISTRIBUTION OF THE MENTAL HEALTH AND SUBSTANCE USE PRESCRIBER WORKFORCE

North Carolina had 3,605 mental health and substance use services prescribers in 2024, representing a rate of 3.28 per 10,000 population. Physicians comprised the largest share of the prescriber workforce (n=1,568; 43.5%; 1.43 per 10,000), followed by nurse practitioners (n=1,461; 40.5%; 1.33 per 10,000) and physician assistants (n=576; 16.0%; 0.52 per 10,000).

There were geographic differences in the primary practice location of the MH/SU services prescriber workforce by occupation type. Wake and Mountain AHEC regions had higher rates of all three prescriber types to the population than the state average. Northwest, Eastern, and Southern Regional had lower rates of prescriber types to the population. The other AHEC regions had varied rates to the population, showing a mix of prescriber types present in these areas. For example, the Charlotte AHEC area had lower MH/SU services physician workforce to average, while the region had higher than average MH/SU services PA and NP workforces to the population. While Area L had a higher MH/SU services NP workforce to the population, it also had a lower-than-average MH/SU services physician and PA workforce to the population.

The Alliance Tailored Plan catchment area had the highest supply of all three prescriber types to the population, while Partners, Trillium and Vaya all had lower supply of the three prescriber types to the population. The differences are most notable for physicians and PAs in MH/SU services, where Partners, Trillium, and Vaya all reported half as many providers as Alliance. MH/SU services NPs had a lower supply in Partners, Trillium, and Vaya Tailored Plan catchment areas but the difference in the average supply to the population was more modest.

Metro and nonmetro county differences in the supply of prescribers were pronounced across all categories. There were three times as many MH/SU services physicians in metro counties (1.64 per 10,000 population) compared to nonmetro counties (0.59 per 10,000). MH/SU NPs were more evenly distributed than physicians but there were still twice as many NPs in metro counties (1.49 per 10,000 population) compared to nonmetro counties (0.72 per 10,000 population).

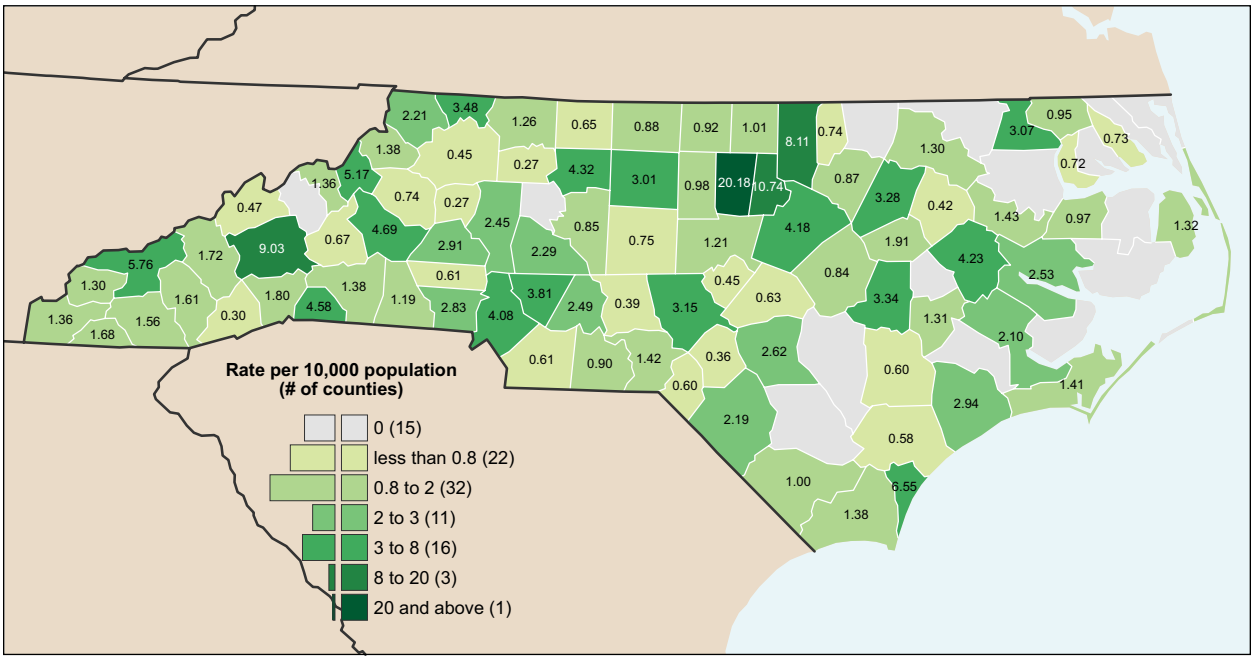
Table 42. Supply and Geographic Distribution of Mental Health and Substance Use Services Prescriber-Workforce, North Carolina, 2024

	Mental Health and Substance Use Services Prescriber Workforce							
	All Prescribers (N)	All Prescribers Rate per 10,000	Physician[a] N	Physician Rate per 10k	PA[b] N	PA Rate per 10k	NP[c] N	NP Rate per 10k
Statewide	3,605	3.28	1,568	1.43	576	0.52	1,461	1.33
By AHEC Region								
Area L	55	1.92	9	0.31	6	0.21	40	1.40
Charlotte	703	3.15	265	1.19	141	0.63	297	1.33
Eastern	247	2.33	103	0.97	25	0.24	119	1.12
Greensboro	523	4.16	319	2.54	41	0.33	163	1.30
Mountain	338	4.09	147	1.78	54	0.65	137	1.66
Northwest	413	2.44	162	0.96	80	0.47	171	1.01
South East	194	3.35	59	1.02	46	0.79	89	1.54
Southern Regional	170	1.81	59	0.63	34	0.36	77	0.82
Wake AHEC	962	4.55	445	2.11	149	0.71	368	1.74
By Tailored Plan County Catchment Area								
Alliance	1,786	4.91	890	2.45	286	0.79	610	1.68
Partners	561	2.46	187	0.82	111	0.49	263	1.15
Trillium	751	2.34	254	0.79	107	0.33	390	1.22
Vaya	507	2.72	237	1.27	72	0.39	198	1.06
By County Urbanicity								
Metro	3,274	3.74	1,436	1.64	536	0.61	1,302	1.49
Nonmetro	331	1.49	132	0.59	40	0.18	159	0.72

Note. MH/SU=Mental Health/Substance Use Services; AHEC=Area Health Education Center; NP=Nurse Practitioner; PA=Physician Assistant.
[a] MH/SU Services Physicians include Psychiatrists, Child Psychiatrists, Addiction Medicine Physicians, and Addiction Psychiatrists.
[b] MH/SU Physician Assistants include Psychiatric Physician Assistants, Child Psychiatric Physician Assistants, Addiction Medicine Physician Assistants, and Addiction Psychiatric Physician Assistants.
[c] MH/SU Nurse Practitioners include Psychiatric Nurse Practitioners or NPs practicing in a mental health setting.
Source. NCMB and NCBON Licensure Data.

Fifteen counties (15%) had no reported MH/SU services prescribers of any type, while thirty-seven percent of counties in the state had fewer than 0.8 prescribers per 10,000 population. Thirty-two counties (32%) had between 0.8–2.0 per 10,00 population, 11 counties between 2.0–3.0 per 10,000 population, and 16 counties between 3.0–8.0 per 10,000 population. This suggests that only 4% of counties in the state reported above 8 prescribers per 10,000 population. Buncombe (9.03), Durham (10.74), and Granville (8.11) reported between 8.0–20.0 per 10,000 population and Orange County the highest at 20.18 per 10,000 population.

Figure 7. Mental Health and Substance Use Services Prescribers per 10,000 Population by County, North Carolina, 2024



Source. NCMB and NCBON Licensure Data

GRADUATE-LEVEL CLINICIANS IN MENTAL HEALTH AND SUBSTANCE USE SERVICES WORKFORCE SUMMARY

North Carolina's MH/SU services graduate-level clinician workforce consisted of approximately 30,804 clinicians in 2024, across six types: Psychologists (2,398), psychological associates (709), marriage and family therapists (1,427), mental health counselors (12,280), social workers (13,945), and fee-based pastoral counselors (45). Licensed Clinical Social Workers (LCSWs) represented the largest segment of the graduate-level clinicians in the MH/SU services workforce at 12.70 LCSW per 10,000 population, followed by Licensed Mental Health Counselors (LCMHCs) at 11.18 and licensed psychologists (LPs) at 2.18 per 10,000 population.

Table 43. Graduate-Level Clinicians in Mental Health and Substance Use Services Workforce Summary of Findings, North Carolina

	Supply (2024)	Rate per 10k	Counties with No Coverage	% Female
Psychologists	2,398	2.18	29	70.20
Psychological Associates	709	0.65	31	81.36
All Licensed Marriage & Family Therapists	1,427	1.30	23	80.34
All Licensed Clinical Mental Health Counselors	12,280	11.18	2	83.69
All Licensed Clinical Social Workers	13,945	12.70	2	85.59
Fee-Based Pastoral Counselors	45	0.04	85	50.50

Source. NCPB, NCMFTLB, NCBLCMHC, NCSWCLB, and NC Pastoral Counseling Board Licensure Data. NPPES.

Demographic Characteristics of Graduate-Level Clinicians in Mental Health and Substance Use Services Workforce

- The MH/SU services graduate-level clinician workforce was predominantly female. More than two-thirds of psychologists (70.2%), psychological associates (81.4%), MHCs (83.7%), MFTs (80.3%), and social workers (85.6%) were female, while half of fee-based pastoral counselors (50.5%) were female.
- Licensed Psychologists' average age was 52.9 years, with 23.9% over 65. Licensed psychological associates' average age was 50.7, 17.2% over 65. Data to estimate the age of social workers, MHCs, MFTs, and fee-based pastoral counselors is currently unavailable.
- More than 10% of the licensed psychologist workforce were from an underrepresented minority background, with more diversity among younger cohorts. Licensed psychological associates were more diverse than licensed psychologists with 13.3% of the LPA workforce coming from an underrepresented background. Currently, data to estimate the race/ethnicity of social workers, MHCs, MFTs, and fee-based pastoral counselors is unavailable.

Geographic Distribution of Graduate-Level Clinicians in Mental Health and Substance Use Services Workforce

All graduate-level clinician types in the MH/SU services workforce showed substantial regional differences. Table 44 describes the supply and clinician to population ratio for each AHEC region, Tailored Plan catchment area, and metro-nonmetro county for each of the six graduate-level clinician types in MH/SU services. Cells shaded in orange represent rates lower than the state average, cells shaded in blue represent rates higher than the state average, and cells in white are equal to the state average.

- The combined state rate per 10,000 population for all graduate-level clinicians in the MH/SU services workforce was 28.04.
- Wake and Mountain AHEC regions had higher rates of all six graduate-level clinician types than the state average. Northwest and Area L AHEC region had lower rates for all graduate-level clinicians in MH/SU services to the population than the state average.
- The other AHEC regions had varied rates to the population, showing a mix of graduate-level clinicians present in these areas. For example, the Charlotte AHEC area had a lower rate of psychologists, psychological associates, and social workers to the state average, while the region had higher MFT, MHC, and fee-based pastoral counselor workforce rates to the population.
- Metro-nonmetro county differences were pronounced across all graduate-level clinician types in MH/SU services, with the total supply of graduate-level clinicians in MH/SU services in metro counties almost doubling the rate of graduate-level clinicians in MH/SU services in nonmetro counties (30.90 in metro counties vs. 16.39 in nonmetro counties).

Table 44. Supply of Graduate-level Clinicians in Mental Health and Substance Use Services Workforce by Geographic Region, North Carolina, 2024

	All Graduate-Level Clinicians in MH/SU (N)	Rate per 10,000 Population						
		All Graduate-level Clinicians in MH/SU	LP	LPA	MFT[a]	MHC[a]	SW[a]	FBPC
Statewide	30,804	28.04	2.18	0.65	1.30	11.18	12.70	0.04
By AHEC Region								
Area L	333	11.64	0.35	0.38	0.17	3.99	6.71	0.03
Charlotte	6,162	27.61	1.73	0.43	1.50	12.40	11.49	0.06
Eastern	2,248	21.20	1.13	0.75	1.13	7.91	10.26	0.01
Greensboro	3,597	28.62	3.00	0.48	0.93	10.88	13.28	0.06
Mountain	3,388	40.96	2.95	0.69	1.73	18.50	17.04	0.06
Northwest	3,435	20.31	1.30	0.61	1.02	9.80	7.58	0.02
South East	1,707	29.50	1.87	1.43	1.11	10.13	14.95	0.02
Southern Regional	2,055	21.88	0.98	0.33	0.72	7.96	11.87	0.01
Wake AHEC	7,791	36.87	3.98	0.88	1.74	12.44	17.75	0.06
By Tailored Plan County Catchment Area								
Alliance	13,750	37.83	3.96	0.73	1.74	13.84	17.49	0.07
Partners	4,515	19.82	0.84	0.47	1.01	9.44	8.03	0.03
Trillium	7,282	22.70	1.15	0.71	0.87	8.89	11.06	0.02
Vaya	5,169	27.75	2.14	0.59	1.33	11.85	11.80	0.04
By County Urbanicity								
Metro	27,072	30.90	2.54	0.68	1.43	12.22	13.99	0.05
Nonmetro	3,644	16.39	0.79	0.52	0.64	6.91	7.54	0.01

Note. MH/SU=Mental Health/Substance Use Services; AHEC=Area Health Education Center; MH/SU=Mental Health and Substance Use Services; LP=Licensed Psychologist; LPA=Licensed Psychological Associate; MFT=Licensed Marriage and Family Therapist and Licensed Marriage and Family Therapy Associates; MHC=Licensed Clinical Mental Health Counselors and Licensed Clinical Mental Health Counselor Associates; SW=Licensed Clinical Social Worker and Licensed Clinical Social Worker Associate; FBPC=Fee-based Pastoral Counselor.
a= All licensed MFTs combined, all licensed MHCs combined, and all licensed social workers combined.
☐ Pale orange = lower than state average, ☐ Light blue = higher than state average
Source. NCPB, NCMFTLB, NCBLCMHC, NCSWCLB, and NC Pastoral Counseling Board Licensure Data.

GRADUATE-LEVEL CLINICIANS IN MENTAL HEALTH AND SUBSTANCE USE SERVICES WORKFORCE

Graduate-level clinicians in MH/SU services play an important role in treating mental and substance use conditions in North Carolina. They serve as the backbone of community mental health service delivery in the state. Graduate-level clinicians have at least a master's degree and often hold state licensure that is required to provide therapy, diagnosis, and treatment for individuals, families, and groups experiencing mental health, substance use, and behavioral disorders.

In this section, data on six types of graduate-level clinicians are presented: 1) Psychologists; 2) psychological associates; 3) marriage and family therapists; 4) mental health counselors; 5) social workers; and 6) fee-based pastoral counselors.

PSYCHOLOGISTS

Licensed psychologists provide comprehensive mental health and substance use services, including psychological assessment, testing, diagnosis, and therapy interventions. Psychologists in North Carolina must complete a doctoral degree (PhD or PsyD) in psychology from an American Psychology Association (APA)-accredited program, pass both national and state licensing examinations, and complete 1,500 post-doctoral hours of supervised experience.

Using 2024 North Carolina licensure data, there were 2,398 active and statewide practicing psychologists (permanent and provisional) in the state. Of those 2,398 licensed psychologists, 25 were provisionally licensed. On average, there were 2.18 licensed psychologists per 10,000 people in the population. The majority of licensed psychologists in North Carolina reported they were clinical psychologists (n=1,730; 72%), followed by counseling psychologists (n=308; 13%) and school psychologists (n=214; 9%).

Since 2014, the licensed psychologist workforce had grown by 260 practitioners, yet the ratio of the workforce to the population had remained relatively stable from 2.16 in 2014 to 2.18 in 2024. Clinical psychologists showed the most significant growth, increasing from 1,437 to 1,730 practitioners between 2014 and 2024 to represent a growth of 1.45 to 1.58 per 10,000 population. Counseling psychologists remained unchanged at 308 practitioners, and their rate slightly decreased from 0.31 to 0.28 per 10,000 population, while school psychologists grew minimally from 200 to 214 practitioners with rates declining from 0.20 to 0.19 per 10,000 population.

Table 45. Licensed Psychologists by Primary Area of Practice, North Carolina, 2014 and 2024

Active, Statewide Psychologists	2014	Rate Per 10k (2014)	2024	Rate Per 10k (2024)
Total	2,138	2.16	2,398	2.18
Clinical	1,437	1.45	1,730	1.58
Counseling	308	0.31	308	0.28
School	200	0.20	214	0.19
Other	120	0.12	78	0.07
No Specialty Reported	73	--	68	--

Note. 10k=10,000.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2014 and 2024 US Census data
Source. NCPB Licensure Data.

Demographic Characteristics of Licensed Psychologists

North Carolina's licensed psychologists were, on average, 52.9 (SD=13.8) years old, with nearly a quarter (23.9%) over age 65. More than two-thirds of licensed psychologists were female (70.2%) and 11.8% reported being from underrepresented minority background.

Regional age variations were substantial, with Area L having the oldest workforce (mean age 64.5 years, 60% over 65) and Wake AHEC the youngest (mean age 50.5 years, 18.4% over 65). Tailored Plan catchment areas had a comparable mean age of licensed psychologists; however, significant variations in the proportion of the workforce over the age of 65 were evident, with Trillium having 32.6% of the workforce over 65 as compared to 20.1% for Alliance. Nonmetro counties similarly had an older workforce compared to metropolitan counties, with nonmetro practicing psychologists reporting an average age of 54.9 years compared to 52.7 years in metro areas; nonmetro areas also had a higher proportion of population over 65 (29.7% vs. 23.9%).

Underrepresented minority representation in the licensed psychologist workforce widely varied, ranging from a low percent of the workforce in Mountain AHEC and South East AHEC to higher representation in Southern Regional AHEC (23.9%). Alliance Tailored Plan area demonstrated the highest proportion of underrepresented minority licensed psychologists at 15.0%, while Vaya showed the lowest at 3.6%. Nonmetro counties had notably lower minority representation (7.8%) compared to metro counties (12.1%).

Table 46. Demographic Characteristics of Licensed Psychologists by Region, North Carolina, 2024

Active, Statewide Psychologists	N	Mean (SD)	Range	% ≥65 years	% Female	% Underrepresented Minority[a]
Statewide	2,398	52.9 (13.8)	28–89+	23.9	70.20	11.76
By AHEC Region						
Area L	10	64.50 (13.6)	46–83	60.00	70.00	^
Charlotte	386	51.27 (12.6)	29–82	17.36	72.47	18.33
Eastern	120	56.43 (14.1)	30–80	32.50	62.50	10.75
Greensboro	377	54.51 (14.3)	30–89+	28.65	71.09	9.43
Mountain	244	57.45 (14.7)	30–89+	35.25	65.57	^
Northwest	219	52.97 (14.4)	29–89+	26.94	63.47	5.39
South East	108	54.44 (14.3)	29–81	29.63	62.04	^
Southern Regional	92	54.68 (12.4)	3–84	22.83	65.22	23.94
Wake AHEC	842	50.54 (13.1)	28–85	18.41	74.55	13.91
By Tailored Plan County Catchment Area						
Alliance	1,439	51.45 (13.3)	28–89+	20.14	74.39	14.97
Partners	192	54.76 (14.2)	29–89+	29.17	60.94	7.48
Trillium	368	55.73 (14.1)	29–84	32.61	60.87	9.86
Vaya	399	54.55 (14.4)	30–89+	29.32	68.17	3.64
By County Urbanicity						
Metro	2,223	52.74 (13.8)	28–89+	23.88	70.64	12.09
Nonmetro	175	54.85 (14.3)	30–84	29.71	64.57	7.80

Note. AHEC=Area Health Education Center; Missing values are excluded from percentage calculations.
[a] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
^Data suppressed with any n<5.
Source. NCPB licensure data, NPPES.

The licensed psychologist workforce showed a modest increase in diversity between 2014 and 2024. The proportion of the reporting workforce that were Black or African American grew from 6.5% to 9.1%, the percent reporting as Asian increased from 0.5% to 1.9%, and Hispanic or Latino psychologists tripled to 0.5%. Although this represents an increase, the total counts of Asian and Hispanic/Latino psychologists remains relatively small at 35 (Asian) and 10 (Hispanic/Latino) to the total psychologist workforce of 2,398. American Indian representation in the licensed psychologist workforce remained at less than 1% over the 10-year period. Diversity varied significantly across specialties, with counseling psychologists showing the highest minority representation (Black/African American at 15.4%, Asian at 3.3%) compared to all other psychology specialties that remain predominantly white, particularly school psychologists (87.1% white).

Age differences among psychologists by race/ethnicity reveal generational patterns of the workforce, with Asian (mean age 43.6 years), Hispanic/Latino psychologists (mean age 40.8 years), and Black/African American psychologists (mean age 51.7) representing notably younger cohorts compared to white psychologists (mean age 57.0 years).

The substantial increase in missing race/ethnicity data from 3.3% of licensed psychologists in 2014 to 22.4% in 2024 suggests potential reporting or data collection challenges that may affect the accuracy of diversity trend analysis.

Table 47. Race/Ethnicity and Age of Licensed Psychologists by Specialty, North Carolina, 2024

	2014 (N = 2,138)	2024 (N = 2,398)	2024				
			Age	Clinical (N = 1,730)	Counseling (N = 308)	School (N = 214)	Other[a] (N = 78)
	N (%)	N (%)	Mean (SD)	N (%)	N (%)	N (%)	N (%)
American Indian	^	^	55.50 (21.7)	^	^	^	--
Asian	11 (0.53)	35 (1.88)	43.56 (10.9)	25 (1.87)	8 (3.32)	^	--
Black or African American	135 (6.53)	170 (9.13)	51.69 (13.6)	110 (8.21)	37 (15.35)	13 (7.60)	^
White	1,862 (90.04)	1,592 (85.50)	57.01 (12.6)	1,164 (86.87)	180 (74.69)	149 (87.13)	68 (98.55)
Hispanic or Latino	^	10 (0.54)	40.80 (10.0)	9 (0.67)	--	^	--
Other	55 (2.66)	51 (2.74)	50.71 (9.4)	31 (2.31)	14 (5.81)	5 (2.92)	--
Missing	70 (--)	536 (--)	42.04 (11.2)	390 (--)	67 (--)	43 (--)	9 (--)

Note. SD=Standard Deviation. Missing values are excluded from percentage calculations.
[a] Other includes Industrial & Organizational specialty.
^Data suppressed with any n<5.
Those with missing race/ethnicity were excluded from the denominator.
Source. NCPB licensure data, NPPES.

Geographic Practice Characteristics of Licensed Psychologists

Psychologist distribution across North Carolina's nine AHEC regions showed differences, with rates ranging from 0.35 psychologists per 10,000 population in Area L to 3.98 per 10,000 in Wake AHEC. This represents a more than 11-fold difference in supply between the two regions. Wake AHEC had both the largest supply of the workforce (842 psychologists) and highest practitioner to population ratio, followed by Greensboro (3.00 per 10,000) and Mountain AHEC (2.95 per 10,000).

Alliance Tailored Plan area had the majority of the psychologist workforce with 1,439 providers serving 3.6 million residents, a rate of 3.96 psychologists per 10,000 population, while Partners had 192 psychologists serving 2.3 million residents, a rate of 0.84 per 10,000. Trillium reported 1.15 psychologists per 10,000 population, while Vaya had 2.14 psychologists per 10,000.

Pronounced geographic differences were revealed between metro and nonmetro counties, with metro counties having more than three times the psychologist density (2.54 per 10,000) compared to nonmetro counties (0.79 per 10,000).

Table 48. Supply of Licensed Psychologists by Region, North Carolina, 2024

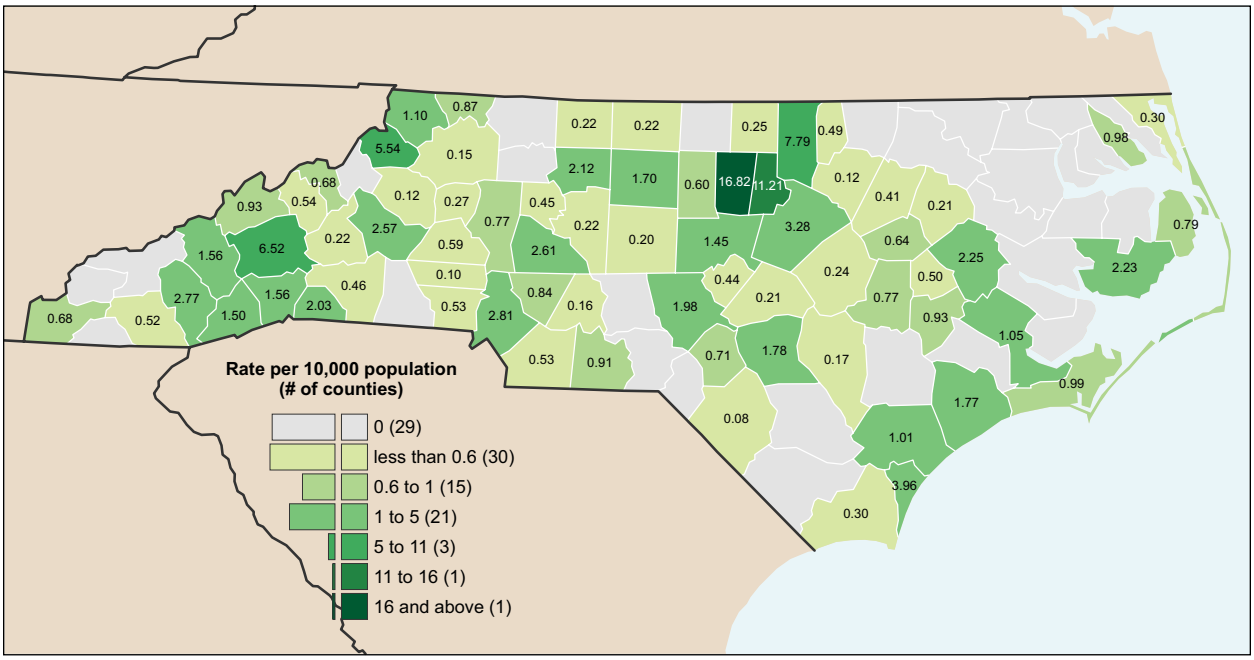
Active, Statewide Psychologists	N	Population[a]	Rate per 10,000 population
Statewide	2,398	10,984,106	2.18
By AHEC Region			
Area L	10	285,994	0.35
Charlotte	386	2,231,872	1.73
Eastern	120	1,060,329	1.13
Greensboro	377	1,256,677	3.00
Mountain	244	827,070	2.95
Northwest	219	1,691,002	1.30
South East	108	578,697	1.87
Southern Regional	92	939,130	0.98
Wake AHEC	842	2,113,335	3.98
By Tailored Plan County Catchment Area			
Alliance	1,439	3,635,141	3.96
Partners	192	2,277,684	0.84
Trillium	368	3,208,448	1.15
Vaya	399	1,862,833	2.14
By County Urbanicity			
Metro	2,223	8,761,216	2.54
Nonmetro	175	2,222,890	0.79

Note. AHEC=Area Health Education Center.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data. Urbanicity population based on 2023 data.
Source. NCPB Licensure Data.

Twenty-nine counties (29%) had no licensed psychologists who reported working there as their primary practice location. Fifty-nine counties (59%) had rates below 0.6 per 10,000 population, and 15 counties (15%) fell within the 0.6-1.0 psychologists per 10,000 population range. This indicates that 74 of the 100 counties in North Carolina had rates less than the state average of 2.18 psychologists per population.

The psychologist workforce in North Carolina is relatively concentrated in a few counties. Three counties had double the state average of psychologists practicing: Buncombe, Watauga, and Granville. Durham County had five times the state average (11.21 psychologists per 10,000), and Orange County had 16.82 psychologists per 10,000 population, nearly eight times the state average.

Figure 8. Licensed Psychologists per 10,000 Population by County, North Carolina, 2024



Source. NCPB Licensure Data.

Location of Educational Training of Licensed Psychologists

The majority of licensed psychologists in North Carolina were trained out-of-state. The proportion of out-of-state educated psychologists increased from 81.8% in 2014 to 84.7% 2024. The degree composition of psychologists also shifted during this time, with PhD holders declining from 79.9% of the workforce in 2014 to 73.6% in 2024. PsyD holders increased in the workforce from 18.0% to 25.6%.

There were differences in statewide training across the psychologist specialist types. Close to half of school psychologists were trained statewide (46.7%), while only 6.8% of counseling psychologists and 12.6% of clinical psychologists were trained statewide.

Table 49. Training Location of Licensed Psychologists by Year and Degree Type, North Carolina, 2014 and 2024

	2014 (N = 2,138)	2024 (N = 2,398)	2024				
			Age	Clinical (N = 1,730)	Counseling (N = 308)	School (N = 214)	Other[a] (N = 78)
	N (%)	N (%)	Mean (SD)	N (%)	N (%)	N (%)	N (%)
Education							
In-state	385 (18.18)	368 (15.35)	53.44 (15.0)	218 (12.60)	21 (6.82)	100 (46.73)	14 (17.95)
Out-of-state	1,733 (81.82)	2,029 (84.65)	52.79 (13.6)	1,512 (87.40)	287 (93.18)	114 (53.27)	64 (82.05)
Missing	20 (--)	1 (--)	55 (--)	--	--	--	--
Degree Type							
PhD	1,708 (79.89)	1,764 (73.56)	54.40 (14.1)	1,171 (67.69)	283 (91.88)	189 (88.32)	72 (92.31)
PsyD	385 (18.01)	613 (25.56)	47.83 (11.2)	559 (32.31)	13 (4.22)	18 (8.41)	^
Other	45 (2.10)	21 (0.88)	74.61 (7.7)	--	12 (3.90)	7 (3.27)	^

Note. SD=Standard Deviation; PHD=Doctorate of Philosophy; PsyD=Doctorate of Psychology. Missing values are excluded from percentage calculations.
[a] Other includes Industrial & Organizational specialty.
^Data suppressed with any n<5.
Source. NCPB Licensure Data.

Practice Setting of Licensed Psychologists

Close to half of all psychologists reported working in private and group practice settings, accounting for 44.8% of clinical psychologists' practice, 45.5% of counseling psychologists, 46.7% of school psychologists, and 65.4% of other psychologists. Analysis of practice settings among North Carolina's licensed psychologists reveals distinct employment patterns across specialty areas. School psychologists work in settings aligned with their specialized training, with close to 40% working in public schools (18.2%) and educational institutions (20.1%). Clinical psychologists and counseling psychologists do commonly work in educational institutions, though not public schools, possibly indicating they work in University settings.

Table 50. Practice Setting of Licensed Psychologists by Specialty, North Carolina, 2024

	Clinical	Counseling	School	Other	Missing
	N (%) N=1,730	N (%) N=308	N (%) N=214	N (%) N=78	N (%) N=68
State or Local Government	99 (5.72)	17 (5.52)	8 (3.74)	6 (7.69)	7
Federal	289 (16.71)	32 (10.39)	^	^	9
Public School	7 (0.40)	--	39 (18.22)	^	0
Non-Governmental Health Care	152 (8.79)	20 (6.49)	6 (2.80)	7 (8.97)	4
Private/Group Practice	775 (44.80)	140 (45.45)	100 (46.73)	51 (65.38)	35
Educational Institution	303 (17.51)	87 (28.25)	43 (20.09)	5 (6.41)	8
Business/Industry	15 (0.87)	^	^	^	0
Other	42 (2.43)	7 (2.27)	10 (4.67)	^	2
Not Reported	48 (2.77)	^	6 (2.80)	^	3

Note. SD=Standard Deviation.
^Data suppressed with any n<5.
Source. NCPB Licensure Data.

Licensed Psychologists Average Active Practice Length in North Carolina

On average, licensed psychologists in North Carolina had been in practice an average of 15.8 (SD=11.9) years, though the range includes newly licensed psychologists just entering the workforce up to those with 55 years of active and in-state practice. Psychologists with different doctoral degrees had different average lengths of active and in-state practice. Ed.D. holders had the most experience at 31.2 (SD=12.9) years on average, PhD holders at 17.1 (SD=12.4) years, and PsyD holders being the least experienced at 11.3 (SD=8.7) years on average.

Table 51. Average Years of Active and In-State Psychologist Licensure by Degree Type, North Carolina, 2024

	Mean	SD	Range
Overall	15.76	11.95	0–55
PhD	17.14	12.41	0–5
PsyD	11.26	8.71	0–40
EdD	31.24	12.85	1–49

Note. SD=Standard Deviation; PhD=Doctor of Philosophy in Psychology; PsyD=Doctor of Psychology; EdD=Doctor of Education in Education Psychology.
Source. NCPB Licensure Data.

Provisionally Licensed Psychologists

Active and in-state licensed psychologists are composed of both those who are permanently licensed and those provisionally licensed. Permanently licensed psychologists are independent. Provisionally licensed psychologists are working toward post-doctoral requirements of supervision. After meeting post-doctoral supervised practice requirements, provisionally licensed psychologists can apply for a permanent license.[24] Permanently licensed psychologists must renew their license each even numbered year to remain active.[25]

The supply of provisionally licensed psychologists in the state stayed relatively stable from 2014 to 2024 except for a dip in 2020 (Table 52). Provisionally licensed psychologists have typically made up 1–2% of all licensed psychologists in NC.

Table 52. Supply of Licensed Psychologists, Fully- and Provisionally- Licensed, North Carolina, 2014–2024

Year	Licensed Psychologists (Permanent)	Licensed Psychologists (Provisional)	Licensed Psychologists Total
2014	2,116	22	2,138
2015	2,211	49	2,260
2016	2,159	26	2,185
2017	2,234	24	2,258
2018	2,205	24	2,229
2019	2,305	29	2,334
2020	2,259	9	2,268
2021	2,344	20	2,364
2022	2,296	16	2,312
2023	2,399	24	2,423
2024	2,373	25	2,398

Source. NCPB Licensure Data.

PSYCHOLOGICAL ASSOCIATES

Licensed Psychological Associates (LPAs) conduct psychological assessments, provide therapy and counseling, and deliver other clinical psychological services. LPAs in North Carolina are at a minimum master's-level practitioners who have completed at least 45 semester credit hours in psychology and 500 hours of supervised practice experience. LPAs provide psychological services under supervision. Due to the recently signed Session Law 2025-37/HB 67, effective October 1, 2025, LPAs who meet certain requirements (i.e., 4,000 hours of post-licensure psychological services provided, performance rating of at least average, and completed application for independent practice) can practice independently.

North Carolina's LPA workforce totaled 709 active licenses in 2024, a rate of 0.65 LPAs per 10,000 population. Clinical LPAs represented the largest specialty group (431 practitioners, 0.39 per 10,000), followed by school LPAs (138 practitioners, 0.13 per 10,000), other specialties (90 practitioners, 0.08 per 10,000), and counseling LPAs as the smallest group (47 practitioners, 0.04 per 10,000).

The LPA workforce experienced an overall decline from 834 to 709 practitioners between 2014 and 2024, representing a 15% decrease in the total supply of LPAs and a decrease from 0.84 LPAs to 0.65 per 10,000. All specialty areas showed workforce reductions: clinical LPAs decreased from 485 to 431 practitioners (rate declining from 0.49 to 0.39 per 10,000), school LPAs dropped from 155 to 138 practitioners (0.16 to 0.13 per 10,000), counseling LPAs fell from 61 to 47 practitioners (0.06 to 0.04 per 10,000), and other LPA specialties declined from 129 to 90 practitioners (0.13 to 0.08 per 10,000).

Table 53. Supply of Licensed Psychological Associates by Primary Area of Practice, North Carolina, 2014 and 2024

LPA Primary Area of Practice	2014	Rate per 10k (2014)	2024	Rate per 10k (2024)
Total	**834**	**0.84**	**709**	**0.65**
Clinical	485	0.49	431	0.39
Counseling	61	0.06	47	0.04
Schools	155	0.16	138	0.13
Other	129	0.13	90	0.08
No Specialty Reported	4	--	3	--

Note. NC=North Carolina; 10k=10,000; Pop=Population; Other= Self-reported as 'Other' specialty and includes industrial and organizational psychologists.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2014 and 2024 US Census data.
Source. NCPB Licensure Data.

Demographic Characteristics of Licensed Psychological Associates

North Carolina's LPA average age was 50.7 (SD=12.3) years with 17.2% of the workforce over age 65. The majority of LPA the workforce identified as female (81.4%). More than a tenth (13.3%) of the LPA workforce identified as an underrepresented minority.

The Southern Regional AHEC region had the oldest LPA workforce (mean age 55.7 years) while South East AHEC had among the youngest (48.8 years; SD=11.7). The proportion of the LPA workforce over age 65

also varied across regions with Area L having the lowest proportion over 65 (9.1%) and Eastern AHEC with the highest (23.8%). There were no differences in age of LPA workforce across the Tailored Plan areas. Nonmetro areas showed slightly older LPAs (52.8 years) compared to metro areas (50.3 years).

Female representation in the LPA workforce varied substantially across regions, ranging from 67.7% in Southern Regional AHEC to 90.9% in Area L AHEC. Alliance Tailored Plan area had high female representation (81.5%), while Partners showed the lowest at 77.4%. Nonmetro areas demonstrated slightly higher female participation (84.4%) than metro areas (80.8%).

Underrepresented minority representation in the LPA workforce showed significant geographic differences, with Wake AHEC having the highest proportion of the workforce from underrepresented minority backgrounds (25.8%). Two-thirds of regions had lower rates of underrepresented minority individuals in the LPA workforce, with either no underrepresented minority individuals in the LPA workforce or so few the data are suppressed. Metro counties demonstrated notably higher minority representation in the LPA workforce (14.8%) compared to nonmetro counties (6.4%).

Table 54. Demographics of Licensed Psychological Associates by Region, North Carolina, 2024

Active, Statewide Psychological Associates	N	Mean (SD)	Range	% ≥65 years	% Female	% Underrepresented Minority[a]
Statewide	709	50.70 (12.3)	24–84	17.20	81.36	13.34
By AHEC Region						
Area L	11	50.55 (9.1)	39–72	9.09	90.91	--
Charlotte	97	51.75 (11.5)	29–77	18.56	79.38	17.98
Eastern	80	52.79 (12.6)	29–77	23.75	83.75	^
Greensboro	60	48.52 (14.2)	25–83	18.33	76.67	17.31
Mountain	57	49.18 (13.6)	24–80	17.54	84.21	^
Northwest	103	52.18 (12.71)	27–84	19.42	76.70	^
South East	83	48.78 (11.7)	29–78	13.25	83.13	^
Southern Regional	31	55.68 (10.9)	28–79	19.35	67.74	^
Wake AHEC	187	49.66 (11.8)	26–76	13.90	86.02	25.75
By Tailored Plan County Catchment Area						
Alliance	266	50.14 (12.2)	26–76	18.53	81.51	23.11
Partners	106	53.21 (12.6)	27–84	18.87	77.36	5.49
Trillium	227	50.48 (12.5)	25–83	15.42	81.50	7.21
Vaya	110	50.10 (12.0)	24–80	13.64	84.55	10.00
By County Urbanicity						
Metro	594	50.29 (12.6)	25–84	15.15	80.78	14.80
Nonmetro	115	52.83 (10.8)	24–76	13.91	84.35	6.36

Note. AHEC=Area Health Education Center. SD=Standard Deviation. Missing values are excluded from percentage calculations.
[a]Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic. ^Data suppressed with any n<5.
Source. NCPB licensure data, NPPES.

Geographic Practice Characteristics of Licensed Psychological Associates

Licensed Psychological Associate distribution across North Carolina's AHEC regions showed significant variation, with rates ranging from 0.33 LPAs per 10,000 population in Southern Regional AHEC to 1.43 LPAs per 10,000 population in South East AHEC, more than a four-fold difference. Wake AHEC had the highest supply of LPAs (187 practitioners) with a rate of 0.88 LPAs per 10,000, while several regions including Area L (11 LPAs), Southern Regional (31 LPAs), and Greensboro (60 LPAs) had lower rates per 10,000 population.

Alliance Tailored Plan area had the largest LPA workforce with 266 clinicians in 2024, a rate of 0.73 per 10,000 people, followed by Trillium with 227 LPAs serving its 46-county region at a similar rate of 0.71 per 10,000. Partners and Vaya regions showed lower workforce densities at 0.47 and 0.59 per 10,000 population, respectively.

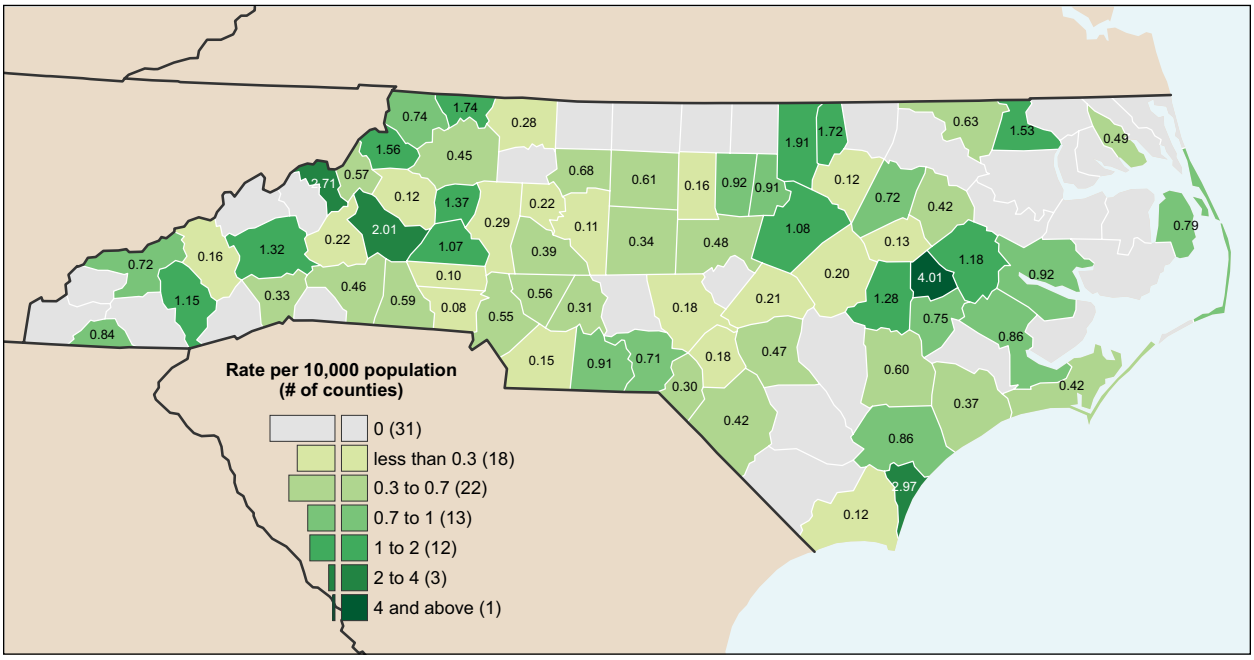
Table 55. Supply of Licensed Psychological Associates by Region, North Carolina, 2024

Active, Statewide Psychological Associates	N	Population[a]	Rate per 10,000 population
Statewide	709	10,984,106	0.65
By AHEC Region			
Area L	11	285,994	0.38
Charlotte	97	2,231,872	0.43
Eastern	80	1,060,329	0.75
Greensboro	60	1,256,677	0.48
Mountain	57	827,070	0.69
Northwest	103	1,691,002	0.61
South East	83	578,697	1.43
Southern Regional	31	939,130	0.33
Wake AHEC	187	2,113,335	0.88
By Tailored Plan County Catchment Area			
Alliance	266	3,635,141	0.73
Partners	106	2,277,684	0.47
Trillium	227	3,208,448	0.71
Vaya	110	1,862,833	0.59
By County Urbanicity			
Metro	594	8,761,216	0.68
Nonmetro	115	2,222,890	0.52

Note. AHEC=Area Health Education Center; SD=Standard Deviation.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCPB Licensure Data.

Of North Carolina's 100 counties, there were 31 counties with no LPAs reporting it as their primary practice location. Within the remaining 69 counties, the ratio of LPAs to population ranges: 18 counties (18%) have LPA rates between 0 and 0.3 per 10,000 population, 22 counties (22%) fell within the 0.3-0.7 LPAs per 10,000 people, 13 counties (13%) had LPA rates between 0.7 and 1.0 per 10,000, while only 16 counties (16%) had rates of 1.0 or higher per 10,000 population. This indicates that about 30 counties had above the state LPA average of 0.65 per 10,000, and 70 counties are below the state LPA average.

Figure 9. Licensed Psychological Associates per 10,000 Population by County, North Carolina, 2024



Source. NCPB Licensure Data.

Location of Educational Training and Degree Type of Psychological Associates

Educational patterns shifted between 2014 and 2024 with an increase in the proportion of the LPA workforce being trained out-of-state. Statewide educated LPAs decreased from 58.0% of the workforce in 2014 to 51.3% in 2024 while out-of-state educated LPA increased from 42.0% in 2014 to 48.7% in 2024.

The degree composition of the LPA workforce also changed between 2014 and 2024. The proportion with a master's degree declined from 95% to 90.5% while doctorate degree holders nearly doubled from 5.1% to 9.5%.

Table 56. Training Location of Licensed Psychological Associates by Year and Degree Type, North Carolina, 2014 and 2024

		2024					
	2014 Total (N=834)	Total (N=709)	Age	Clinical (N = 431)	Counseling (N = 47)	School (N = 138)	Other[a] (N = 90)
	N (%)	N (%)	Mean (SD)	N (%)	N (%)	N (%)	N (%)
Education							
In-state	402 (58.01)	364 (51.34)	49.33 (12.4)	265 (61.48)	^	46 (33.33)	51 (56.67)
Out-of-state	291 (41.99)	345 (48.66)	52.15 (12.2)	166 (38.52)	45 (95.74)	92 (66.67)	39 (43.33)
Not Reported	141 (--)	--	--	--	--	--	--
Degree Type							
Master's	789 (94.95)	637 (90.48)	51.26 (12.3)	410 (95.79)	39 (86.67)	98 (71.01)	88 (97.78)
Doctorate	42 (5.05)	67 (9.52)	44.78 (10.7)	18 (4.21)	6 (13.33)	40 (28.99)	^
Not Reported	3 (--)	5 (--)	58.80 (17.3)	3 (--)	2 (--)	--	--

Note. SD=Standard Deviation. Missing values are excluded from percentage calculations.
[a] Other includes Industrial & Organizational specialty.
^Data suppressed with any n<5.
Source. NCPB Licensure Data.

Licensed Psychologists and Licensed Psychological Associates Credentialed to Provide Services to North Carolina Medicaid Beneficiaries

While North Carolina has 2,398 psychologists and 709 psychological associates, not all licensed professionals are credentialed to serve Medicaid beneficiaries. Using the North Carolina Medicaid provider enrollment file, we examined the proportion of licensed psychologists and psychological associates enrolled to provide services to Medicaid beneficiaries and their enrollment patterns across the state's four Tailored Plans.

The Medicaid provider enrollment file does not distinguish between licensed psychologists and licensed psychological associates, reporting both professions under a single provider classification – Psychologist (Taxonomy code:103T00000X). Of the 3,107 licensed psychologists and psychological associates combined in North Carolina in 2024, 1,046 (33.7% of all LPs/LPAs) are enrolled as Medicaid providers.

Across the four Tailored Plans each had 500 or more psychologists credentialed, with Trillium having the most credentialed psychologists (n=565) followed closely by Vaya (n=552), Partners (n=544), and Alliance (512). There were 372 psychologists enrolled to deliver services to Medicaid beneficiaries but were not credentialed to one of the four Tailored Plans. Most psychologists were credentialed with all four Tailored Plans (n=415, 39.7%).

Table 57. Licensed Psychologists and Licensed Psychological Associates Credentialed to Deliver Services to Medicaid, North Carolina, 2024

	N	%
Licensed Psychologists and Licensed Psychological Associates in Active Practice in North Carolina, 2024	3,107	
Unique Psychologists (Inclusive of LP and LPA) with an address in NC in the Provider Enrollment File	1,046	33.67%
Credentialed with a Tailored Plan, by Type of Tailored Plan		
Alliance Health	512	48.95%
Partners Health Management	544	52.01%
Trillium Health Resources	565	54.02%
Vaya Health	552	52.77%
Number of Tailored Plans a Unique ID is Credentialed with		
4 Tailored Plans	415	39.67%
3 Tailored Plans	90	8.60%
2 Tailored Plans	74	7.07%
1 Tailored Plans	95	9.08%
No Tailored Plans	372	35.56%

Note. LP=Licensed Psychologists. LPA=Licensed Psychological Associates. NC=North Carolina.
Source. Provider Enrollment File, 2024.

Comparisons of Data Sources to Estimate the Size of the Psychologist & Psychological Associate Workforce

Data used for this Psychologist and Psychological Associate workforce analysis were drawn from licensure data collected by the North Carolina Psychology Board and maintained in the NC HPDS. This section compares the supply of psychologists and psychological associates across other publicly available data sources.

Substantial discrepancies exist in psychology workforce estimates across data sources. For 2024, total psychologist counts ranged from 2,398 (licensure data for active, statewide licensed psychologists only) to 5,000 (Bureau of Labor Statistics [BLS] estimates), representing more than a two-fold variation. The American Community Survey (ACS) showed the highest estimate at 7,793 psychologists in 2023, while NC Commerce data indicated 5,516 psychologists in 2022.

Specialty-specific variations are particularly pronounced for school psychologists, where estimates ranged from 214 (licensure data) to 2,100 (BLS) in recent years. Clinical and counseling psychologist estimates varied from 2,038 (licensure data) to 2,420 (BLS) in 2024. The psychological associate workforce showed 709 active, statewide practitioners in licensure data for 2024.

The psychologist workforce growth rate also varied across the data sources. BLS data showed consistent growth from 2,860 total psychologists in 2014 to 5,000 in 2024, almost doubling the size of the psychologist workforce. ACS data increased from 5,620 to 7,793 suggesting a 39% growth of the workforce. Licensure data for active, statewide licensed psychologists showed more modest growth from 2,138 in 2014 to 2,398 in 2024, while psychological associates declined from 834 to 709 over the same period. The combined LP and LPA licensure data increased from 2,972 in 2014 to 3,107 in 2024. North Carolina General Assembly

(NCGA) data showed fluctuation from 4,100 in 2014 to 4,444 in 2024, with a peak in the size of the workforce in 2022 (4,527).

Table 58. Psychology Workforce Estimates by Data Source and Specialty, North Carolina, 2014–2024

		Psychologists						
		Total	**Clinical, counseling, & school psychologists+**	**Clinical & counseling psychologists+**	**Industrial & organizational psychologists**	**School psychologists**	**Other**	**Missing**
BLS (N)	2014	**2,860**	2,540	N/A	**	N/A	320	--
	2022	**3,500**	--	1,820	70	1,160	450	--
	2023	**4,150**	--	2,260	40	1,370	480	--
	2024	**5,000**	--	2,420	N/A	2,100	480	--
NC Commerce (N)	2022	**5,516**	--	1,957	505	1,134	1,920	--
ACS* (N)	2018	**5,620**	--	904	N/A	992	3,724	--
	2023	**7,793**	--	886	N/A	1,474	5,433	--
Licensure Data (N, LPs and LPAs active, statewide)	2014	**2,972**	--	2,291	11	355	238	77
	2022	**3,025**	--	2,427	3	338	174	83
	2023	**3,152**	--	2,552	3	352	174	71
	2024	**3,107**	--	2,516	2	352	166	71
(N, LPs active, statewide)	2014	**2,138**	--	1,745	9	200	111	73
	2022	**2,312**	--	1,948	1	206	80	77
	2023	**2,423**	--	2,062	1	211	81	68
	2024	**2,398**	--	2,038	1	214	77	68
(N, LPAs active, statewide)	2014	**834**	--	546	2	155	127	4
	2022	**713**	--	479	2	132	94	6
	2023	**729**	--	490	2	141	93	3
	2024	**709**	--	478	1	138	89	3
NCGA Oversight Committee Licensing Annual Report LPs & LPAs (N)	2014	**4,100**	--	--	--	--	--	--
	2022	**4,527**	--	--	--	--	--	--
	2023	**4,255**	--	--	--	--	--	--
	2024	**4,444**	--	--	--	--	--	--

Note. BLS=Bureau of Labor Statistics; ACS=American Community Survey; LP=Licensed Psychologists; LPA=Licensed Psychological Associates; NCGA= North Carolina General Assembly; N/A=Not Applicable. *ACS 5-Year Estimates Public Use Microdata Sample (2018=2014–2018; 2023=2019–2023)
+SOC Codes revised between 2014 and 2018. In 2014, 19-3031 combined clinical, counseling, and school psychologists together. In 2018, 19-3033 and 19-3034 used for clinical and counseling psychologists and school psychologists separately.
Source. BLS, NC Commerce, ACS, NCPB Licensure Data, and NCGA.

MARRIAGE AND FAMILY THERAPISTS

Licensed Marriage and Family Therapists (LMFTs) in North Carolina specialize in providing professional marriage and family therapy services to individuals, couples, families, or groups. LMFTs are required to receive a master's degree from an accredited program and at least 1,500 hours of documented clinical experience in face-to-face therapy focused specifically on marriage and family therapy to practice independently. As an individual works to become an independently licensed LMFT, they must maintain a provisional license as a licensed marriage and family associate (LFMTA).

According to licensure data from the North Carolina Marriage and Family Therapy Licensure Board (NCMFTLB), there were 1,317 LMFTs in active practice in North Carolina in 2024, with a statewide rate of 1.20 LMFTs per 10,000 population. Based on NCMFTLB licensure data, there were 110 LMFTAs as of 2024, with a statewide rate of 0.10 LMFTAs per 10,000 population.

Licensed Marriage and Family Therapists

There were 1,317 LMFTs in active practice in North Carolina in 2024, with a statewide rate of 1.20 LMFTs per 10,000 population. There were differences among regions, with Mountain (135 LMFTs, 1.63 per 10,000) and Wake AHEC (324 LMFTs, 1.53 per 10,000) indicating the highest rates of LMFTs, compared to Area L (5 LMFTs, 0.17 per 10,000) and Southern Regional (61 LMFTs, 0.65 per 10,000) with the lowest rates of LMFTs. Charlotte had 313 LMFTs with a rate of 1.40, South East had 64 LMFTs with a rate of 1.11, Eastern had 114 LMFTs with a rate of 1.08, Northwest had 160 LMFTs with a rate of 0.95, and Greensboro had 105 LMFTs with a rate of 0.84 per 10,000 population.

Among the four Tailored Plan catchment areas, Alliance had 577 LMFTs serving residents at a rate of 1.59 per 10,000 population. Vaya had 222 MMFTs with a rate of 1.19 LMFT per 10,000. Partners had 216 LMFTs at 0.95 per 10,000, and Trillium reported the lowest count at 266 LMFTs with 0.83 LMFTs per 10,000. There was also a difference in LMFT rates between metro (1,149 LMFTs, 1.31 per 10,000) and nonmetro (132, 0.59 per 10,000) areas.

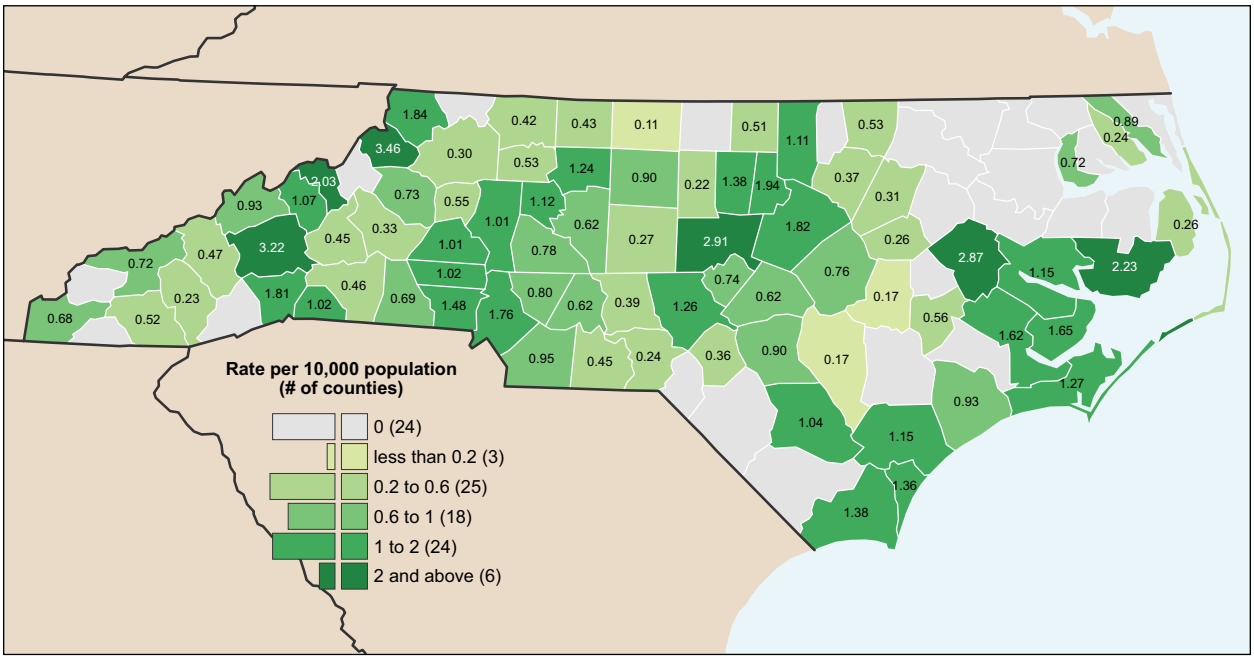
Table 59. Licensed Marriage and Family Therapists Distribution by Geographic Region, North Carolina, 2024

Licensed Marriage and Family Therapists			
	N[a]	Population[b]	Rate per 10,000 population
Statewide	1,317	10,984,106	1.20
By AHEC Region			
Area L	5	285,994	0.17
Charlotte	313	2,231,872	1.40
Eastern	114	1,060,329	1.08
Greensboro	105	1,256,677	0.84
Mountain	135	827,070	1.63
Northwest	160	1,691,002	0.95
South East	64	578,697	1.11
Southern Regional	61	939,130	0.65
Wake AHEC	324	2,113,335	1.53
By Tailored Plan County Catchment Area			
Alliance	577	3,635,141	1.59
Partners	216	2,277,684	0.95
Trillium	266	3,208,448	0.83
Vaya	222	1,862,833	1.19
By County Urbanicity			
Metro	1,149	8,761,216	1.31
Nonmetro	132	2,222,890	0.59

Note. AHEC=Area Health Education Center.
[a] N=36 missing county information in dataset.
[b] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data. NPPES Taxonomy=106H00000X.
Source. NCMFTLB Licensure Data.

North Carolina counties ranged between having zero to 3.46 LMFTs per 10,000 population. Twenty-four counties had no LMFTs working as their reported practice address. Twenty-seven counties had fewer than 0.2 LMFTs per 10,000 population, and twenty-five counties had between 0.2 and 0.6 LMFTs per 10,000 population. Eighteen counties had between 0.6 and 1 LMFTs per 10,000 population, and 24 counties had between 1 and 2 LMFTs per 10,000 population. Six counties had more than 2 LMFTs per 10,000 population, including Buncombe, Mitchell, Watauga, Chatham, Pitt, and Hyde. (Figure 10)

Figure 10. Licensed Marriage and Family Therapists per 10,000 Population by County, North Carolina, 2024



Source. NCMFTLB Licensure Data.

Licensed Marriage and Family Therapist Associates

Based on NCMFTLB licensure data, there were 110 LMFTAs in active practice in North Carolina in 2024, with a statewide rate of 0.10 LMFTAs per 10,000 population.

There were reported differences among regions, with Wake AHEC (44 LMFTAs, 0.21 per 10,000) having the highest rates of LMFTAs, compared to Area L (0 LMFTAs, 0.00 per 10,000) and South East (0 LMFTAs, 0.00 per 10,000) having the lowest rates of LMFTAs. Greensboro AHEC had 12 LMFTAs with a rate of 0.10 per 10,000, Mountain had 8 LMFTAs with 0.10 per 10,000, Charlotte had 21 LMFTAs with 0.09 per 10,000, Northwest had 12 LMFTAs with 0.07 per 10,000, Southern Regional had 7 LMFTAs with 0.07 per 10,000, and Eastern had 6 LMFTAs with 0.06 per 10,000 population.

Among the four Tailored Plan catchment areas, Alliance had 56 LMFTAs serving residents at a rate of 0.15 per 10,000 population. Vaya had 26 LMFTAs with a rate of 0.14 LMFTAs per 10,000. Partners had 14 LMFTAs at 0.06 per 10,000, and Trillium reported the lowest count at 14 LMFTAs with 0.04 LMFTAs per 10,000. There was also a difference in LMFTA rates between metro (0.11) and nonmetro (0.04) areas.

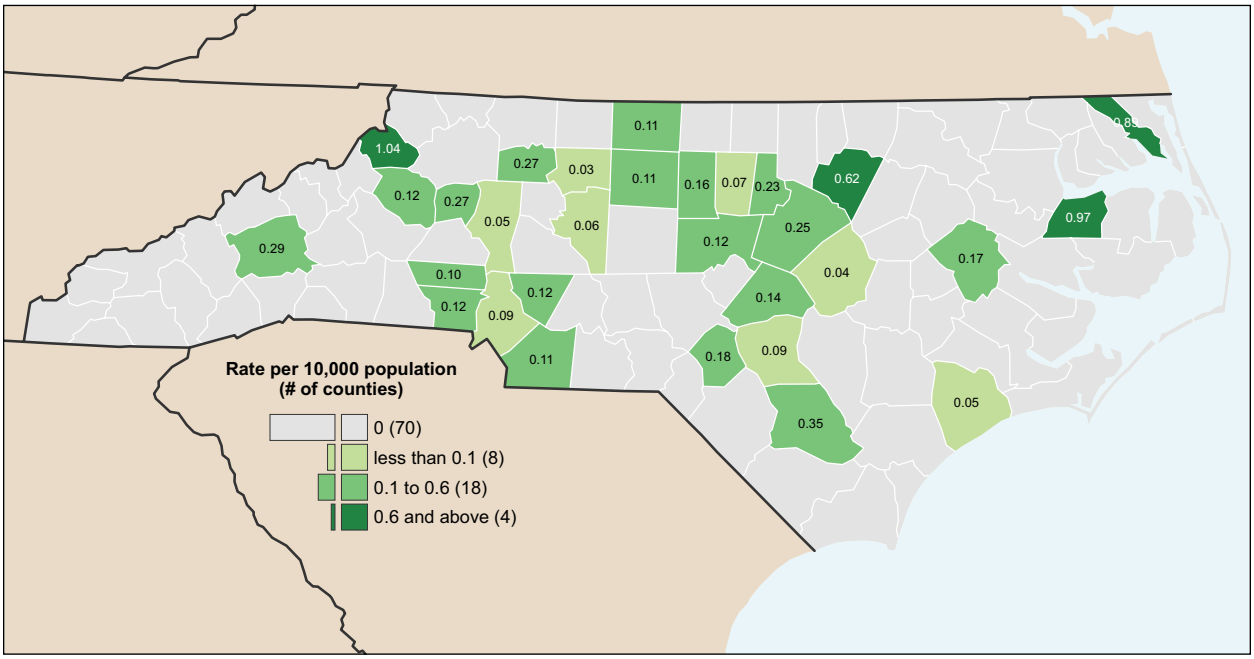
Table 60. Licensed Marriage and Family Therapist Associates Workforce Distribution by Geographic Region, North Carolina, 2024

Licensed Marriage and Family Therapist Associates			
	N	Population[a]	Rate per 10,000 population
Statewide	110	10,984,106	0.10
By AHEC Region			
Area L	0	285,994	0.00
Charlotte	21	2,231,872	0.09
Eastern	6	1,060,329	0.06
Greensboro	12	1,256,677	0.10
Mountain	8	827,070	0.10
Northwest	12	1,691,002	0.07
South East	0	578,697	0.00
Southern Regional	7	939,130	0.07
Wake AHEC	44	2,113,335	0.21
By Tailored Plan County Catchment Area			
Alliance	56	3,635,141	0.15
Partners	14	2,277,684	0.06
Trillium	14	3,208,448	0.04
Vaya	26	1,862,833	0.14
By County Urbanicity			
Metro	100	8,761,216	0.11
Nonmetro	10	2,222,890	0.04

Note. AHEC=Area Health Education Center.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data. NPPES Taxonomy=106H00000X.
Source. NCMFTLB Licensure Data.

North Carolina counties range from reporting 0 LMFTAs to 1.04 LMFTAs per 10,000 population. The most counties (n=70) had 0 LMFTAs working as their reported practice address. Seventy-eight counties had fewer than 0.1 LMFTAs per 10,000 population, and 18 counties had between 0.1 and 0.6 LMFTAs per 10,000 population. Four counties had more than 0.6 LMFTAs per 10,000 population, including Camden, Washington, Franklin, and Watauga. (Figure 11)

Figure 11. Licensed Marriage and Family Therapist Associates per 10,000 Population by County, North Carolina, 2024



Source. NCMFTLB Licensure Data.

All Graduate-Level Licensed Marriage and Family Therapists

The combined graduate-level licensed marriage and family therapist workforce in North Carolina in 2024 was 1,427 clinicians with a rate of 1.30 LMFT/LMFTAs per 10,000 people.

Geographic Distribution of All Graduate-Level Licensed Marriage and Family Therapists in 2024

The distribution of LMFT/LMFTAs across North Carolina's nine AHEC regions showed variation in workforce supply. Wake AHEC had the highest rate at 1.74 MFTs per 10,000 population with 368 MFTs. Mountain (143 MFTs, 1.73 per 10,000) and Charlotte AHECs (334 MFTs, 1.50 per 10,000) also exceeded the state average of 1.30. Six AHEC regions have rates below the state average. The Eastern region had 1.13 per 10,000 with 120 MFTs, South East AHEC had 1.11 per 10,000 with 64 MFTs, Northwest had 1.02 per 10,000 with 172 MFTs, Greensboro had 0.93 per 10,000 with 117 MFTs, and Southern Regional had 0.72 per 10,000 with 68 MFTs. Area L reported the lowest rate at 0.17 MFTs per 10,000 population, with 5 MFTs.

Among the four Tailored Plan catchment areas, Alliance had 633 MFTs, with a rate of 1.74 per 10,000 population. Vaya had 248 MFTs with a rate of 1.33 MFT per 10,000. Partners had 230 MFTs at 1.01 per 10,000, and Trillium had 280 MFTs with 0.87 MFTs per 10,000 population.

Metropolitan counties had 1,249 graduate-level licensed marriage and family therapists, yielding a rate of 1.43 per 10,000 population. Nonmetropolitan counties had 142 MFTs, with a rate of 0.64 MFTs per 10,000 population.

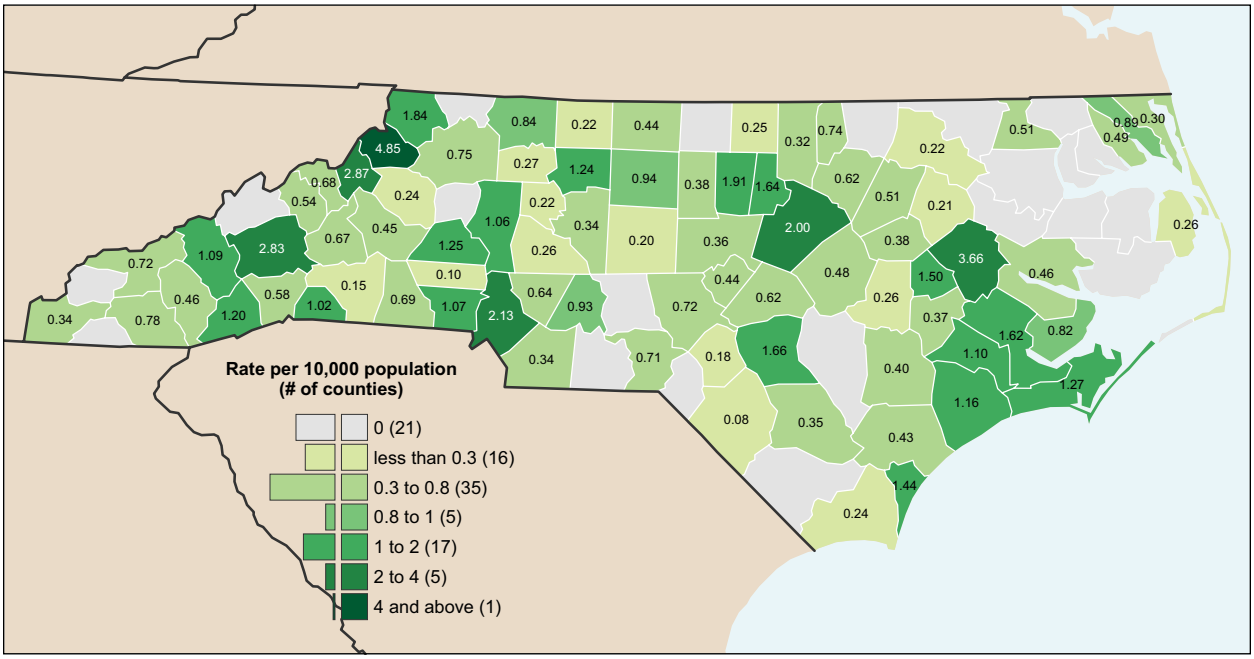
Table 61. All Graduate-Level Licensed Marriage and Family Therapists Distribution by Region, North Carolina, 2024

All Licensed Marriage and Family Therapists[a]			
	N[b]	Population[c]	Rate per 10,000 population
Statewide	1,427	10,984,106	1.30
By AHEC Region			
Area L	5	285,994	0.17
Charlotte	334	2,231,872	1.50
Eastern	120	1,060,329	1.13
Greensboro	117	1,256,677	0.93
Mountain	143	827,070	1.73
Northwest	172	1,691,002	1.02
South East	64	578,697	1.11
Southern Regional	68	939,130	0.72
Wake AHEC	368	2,113,335	1.74
By Tailored Plan County Catchment Area			
Alliance	633	3,635,141	1.74
Partners	230	2,277,684	1.01
Trillium	280	3,208,448	0.87
Vaya	248	1,862,833	1.33
By County Urbanicity			
Metro	1,249	8,761,216	1.43
Nonmetro	142	2,222,890	0.64

Note. AHEC=Area Health Education Center.
[a] All MFTs licensed, LMFT and LMFTA combined
[b] N=36 missing county information in dataset.
[c] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCMFTLB Licensure Data.

When examining the combined LMFT and LMFTA geographic distribution, North Carolina counties ranged from having 0 MFTs to 4.85 MFTs per 10,000 population. While twenty-one counties had 0 MFTs, 37 counties overall reported fewer than 0.3 MFTs per 10,000 population. The most counties (n=35) had between 0.3 and 0.8 MFTs working as their reported practice address. Five counties had between 0.8 and 1 MFTs per 10,000 population. Seventeen counties had between 1 and 2 MFTs per 10,000 population, and 5 counties had between 2 and 4 MFTs per 10,000 population. One county, Watauga (4.85), reported more than 4 MFTs per 10,000 population, which is more than three times the state average. (Figure 12)

Figure 12. All Graduate-Level Licensed Marriage and Family Therapists per 10,000 Population by County, North Carolina, 2024



Source. NCMFTLB Licensure Data.

Demographic Characteristics of Marriage and Family Therapists in 2024

Data used to identify demographic characteristics of the marriage and family therapist workforce were drawn from NPPES. As such, the total numbers of MFTs are different than the licensure data and the differences between LMFTs and LMFTAs is not available.

As of 2024, the MFT workforce was 80.3% female (n=1,030). There were differences in the proportion of the MFT workforce that is female across AHEC region, Tailored Plan area, and metro/nonmetro counties. Female representation among MFTs ranged from 70% in the Southern Regional AHEC to 85% in Charlotte AHEC. Female representation across the Tailored Plan areas ranged from 76.3% in Vaya to 82.6% in Alliance. Female representation in the MFT workforce was 80.6% (n=908) in metropolitan counties and 78.7% (n=122) in nonmetropolitan counties.

Table 62. Marriage and Family Therapists Workforce Distribution and Demographics by Geographic Region, North Carolina, 2024

Marriage and Family Therapists	
	Female N (%)
Statewide	1,030 (80.34)
By AHEC Region	
Area L	8 (80.00)
Charlotte	271 (84.95)
Eastern	107 (79.85)
Greensboro	82 (83.67)
Mountain	83 (74.11)
Northwest	124 (77.50)
South East	35 (79.55)
Southern Regional	56 (70.00)
Wake AHEC	264 (81.23)
By Tailored Plan County Catchment Area	
Alliance	545 (82.58)
Partners	138 (78.41)
Trillium	205 (78.85)
Vaya	142 (76.34)
By County Urbanicity	
Metro	908 (80.57)
Nonmetro	122 (78.71)

Note. AHEC=Area Health Education Center.
* NPPES Taxonomy=106H00000X.
^N=36 missing county information in dataset.
Source. NPPES.

All Graduate-Level Licensed Marriage and Family Therapists Credentialed to Provide Services to North Carolina Medicaid Beneficiaries

While North Carolina licenses 1,317 LMFTs and 110 LMFTAs, not all licensed professionals are credentialed to serve Medicaid beneficiaries. Using the North Carolina Medicaid provider enrollment file, we examined the proportion of all graduate-level licensed marriage and family therapists enrolled to provide services to Medicaid beneficiaries and their enrollment patterns across the state's four Tailored Plans.

The Medicaid provider enrollment file does not distinguish between LMFTs and LMFTAs, reporting both professions under a single provider classification – Marriage & family therapist, taxonomy code (106H00000X). Of the 1,427 LMFTs and LMFTAs combined in North Carolina in 2024, 262 are enrolled as Medicaid providers (18.4% of all LMFT/LMFTAs).

Vaya Health Tailored Plan credentialed the most LMFT/LMFTAs (n=110), followed closely by Partners (n=108). There were 118 LMFTs/LMFTAs enrolled to deliver services to Medicaid beneficiaries but were not credentialed to one of the four Tailored Plans. Most LMFT/LMFTAs were credentialed with all four Tailored Plans (n=58, 22.14%).

Table 63. Licensed Marriage and Family Therapists Credentialed to Deliver Services to Medicaid, North Carolina, 2024

Marriage & Family Therapist	N	%
LMFT and LMFTA in North Carolina in 2024	1,427	
Unique LMFT/LMFTAs with an address in NC in the Provider Enrollment File	262	18.36%
Credentialed with a Tailored Plan, by Type of Tailored Plan		
Alliance Health	88	33.59%
Partners Health Management	108	41.22%
Trillium Health Resources	99	37.79%
Vaya Health	110	41.98%
Number of Tailored Plans a Unique ID is Credentialed with		
4 Tailored Plans	58	22.14%
3 Tailored Plans	32	12.21%
2 Tailored Plans	23	8.78%
1 Tailored Plans	31	11.83%
No Tailored Plans	118	45.04%

Note. LMFT=Licensed Marriage and Family Therapist. LMFTA=Licensed Marriage and Family Therapist Associate. NC=North Carolina.
Source. Provider Enrollment File, 2024.

Comparisons of Data Sources to Estimate the Size of the Marriage and Family Therapy Workforce

This section compares the supply of MFTs across a number of publicly available data sources including licensure, BLS, Commerce, ACS, NCGA Annual Report, and NPPES.

The size of the MFT workforce in North Carolina estimates ranged from 721 (ACS data) to 2,110 (BLS data). BLS data show a dramatic growth from 310 marriage and family therapists in 2014 to 2,110 in 2024, representing a 581% increase over the decade. However, the BLS data are inconsistent between years with a reported decline from 960 in 2022 to 900 in 2023 before jumping to 2,110 in 2024. The North Carolina General Assembly Oversight Committee data showed more modest but steady growth from 1,427 in 2021 to 2,026 in 2024, representing a 42% increase over three years. ACS data showed a substantial decline in the MFT workforce from 1,379 in 2018 to 721 in 2023. Licensure data showed an LMFT count of 1,317, LMFTA count of 110, and total MFT estimate of 1,427.

Table 64. Marriage and Family Therapist Workforce Estimates by Data Source, North Carolina, 2014–2024

	Licensure (N)	BLS (N)				NC Commerce (N)	ACS[a] (N)		NCGA Oversight Committee Licensing Annual Report (N)				NPPES (N)
	2024	2014	2022	2023	2024	2022	2018	2023	2021	2022	2023	2024	April 2024
LMFTs	1,317												
LMFTAs	110												
Marriage and family therapists	1,427	310	960	900	2,110	Not Available	1,379	721	1,427	1,446	1,845	2,026	1,282

Note. BLS=Bureau of Labor Statistics; ACS=American Community Survey; NCGA=North Carolina General Assembly; NPPES=National Plan and Provider Enumeration System; LMFT=Licensed Marriage and Family Therapist; LMFTA=Licensed Marriage and Family Therapy Associate.
[a] ACS 5-Year Estimates Public Use Microdata Sample (2018=2014–2018; 2023=2019–2023)
Source. NCMFTLB Licensure Data, BLS, NC Commerce, ACS, NCGA, and NPPES.

CLINICAL MENTAL HEALTH COUNSELORS

In North Carolina, licensed clinical mental health counselors (LCMHC) play a vital role in promoting the psychological well-being of individuals, families and communities by providing assessment, diagnosis, and treatment of mental health conditions through evidence-based counseling practices. To become an LCMHC an individual must graduate with a master's degree from a Council for Accreditation of Counseling and Related Educational Programs (CACREP)-accredited program and have at least 3,000 hours of supervised practice experience. As an individual works to become an independently licensed LCMHC, they must maintain a provisional license as a licensed clinical mental health counselor associate (LCMHCA). Additionally, counselors with additional experience may become licensed clinical mental health counselor supervisors (LCMHCSs) who can supervise LCMCHAs.

Using 2024 licensure data for LCMHCs, LCMHCAs, and LCMHCSs, there were 12,280 mental health counselors in active practice in North Carolina, resulting in a statewide rate of 11.18 clinical mental health counselors per 10,000 people. There were 9,205 LCMCHs (Inclusive of LCMHCs and LCMHCSs) and 3,075 LCMHCAs in active practice in North Carolina in 2024.

Licensed Clinical Mental Health Counselors

There were 9,205 Licensed Clinical Mental Health Counselors in active practice in North Carolina in 2024. The rate of LCMCHs to the population was 8.38 per 10,000.

The distribution of LCMHCs across North Carolina's AHEC regions varied. The Mountain AHEC region had the highest rate of LMCHCs to the population with 13.83 LCMHCs per 10,000 (n=1,144), followed by Charlotte AHEC at 9.47 LCMHCs per 10,000 (n=2,114) and Wake AHEC at 9.12 LCMHCs per 10,000 (n=1,927). Five AHEC regions had LCMHC rates below the state average. South East AHEC region had 7.67 LCMHCs per 10,000 (n=444), Northwest AHEC had 7.49 LCMHCs per 10,000 (n=1,266), Southern Regional AHEC had 6.08 LCMHCs per 10,000 (n=571), Eastern AHEC had 5.92 LCMCHs per 10,000 (n=628), and Area L AHEC region had 2.83 LCMCHs per 10,000 (n=81), the lowest in the state.

Among the four Tailored Plan catchment areas, Alliance had the highest LCMHC rate per 10,000 population at 10.36 (n=3,765), followed by Vaya at 8.74 LCMHCs per 10,000 (n=1,628), then Partners at 7.24 LCMHC per 10,000 (n=1,648). Trillium had the lowest LCMHC rate per 10,000 population at 6.63 (n=2,128).

LCMHC distribution showed metro-nonmetro county differences, with metropolitan counties reporting 8,032 LCMCHs (9.17 per 10,000 population) compared to 1,137 LCMHCs in nonmetropolitan counties (5.11 per 10,000 population).

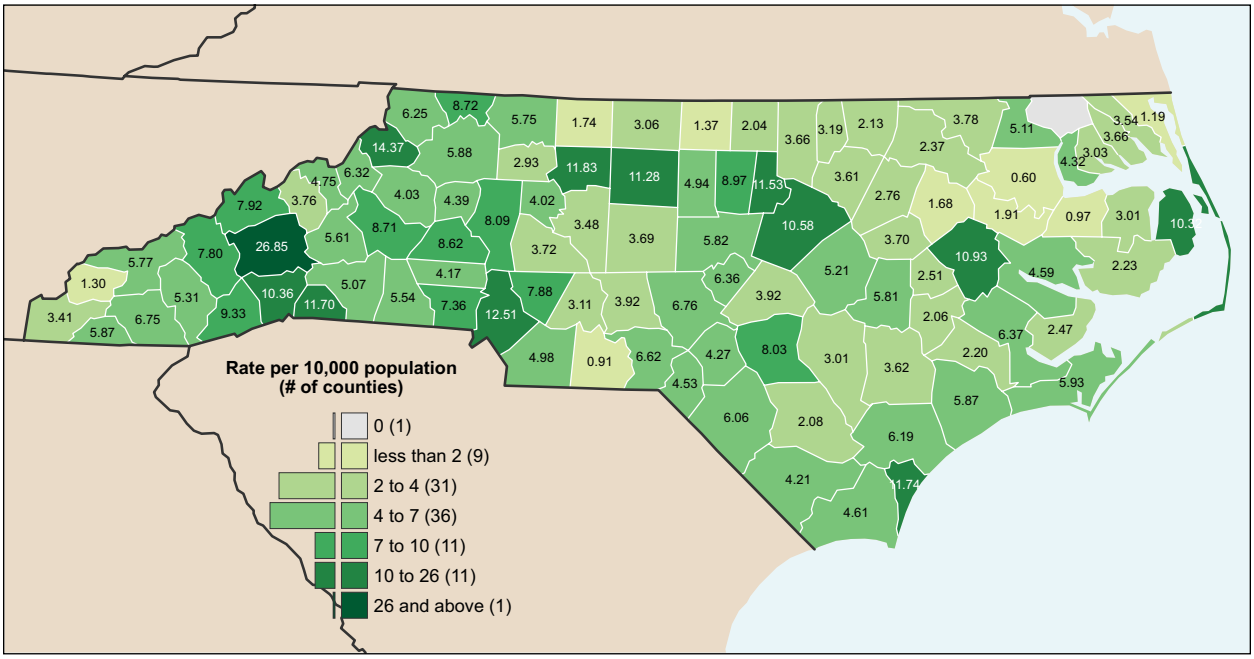
Table 65. Active, In-State Licensed Clinical Mental Health Counselor Workforce in North Carolina by Geographic Region, North Carolina, 2024

LCMHCs	N[a]	Population[b]	Rate per 10,000 population
Statewide	9,205	10,984,106	8.38
By AHEC Region			
Area L	81	285,994	2.83
Charlotte	2,114	2,231,872	9.47
Eastern	628	1,060,329	5.92
Greensboro	994	1,256,677	7.91
Mountain	1,144	827,070	13.83
Northwest	1,266	1,691,002	7.49
South East	444	578,697	7.67
Southern Regional	571	939,130	6.08
Wake AHEC	1,927	2,113,335	9.12
By Tailored Plan County Catchment Area			
Alliance	3,765	3,635,141	10.36
Partners	1,648	2,277,684	7.24
Trillium	2,128	3,208,448	6.63
Vaya	1,628	1,862,833	8.74
By County Urbanicity			
Metro	8,032	8,761,216	9.17
Nonmetro	1,137	2,222,890	5.11

Note. AHEC=Area Health Education Center.
[a] N=36 LCMHCs are missing county data.
[b] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data. Urbanicity population based on 2023 data.
Source. NCBLCMHC Licensure Data.

One county (Gates) had no LCMHCs. Ten counties had rates less than 2.0 per 10,000 population. Most counties (n=67) had rates between 2.0-7.0 per 10,000 population. Just over 10% of counties (n=11) had 7.0-10.0 LCMHCs per 10,000 population. Eleven counties had a rate per 10,000 population between 10.0 and 26.0. Buncombe County had the highest rate at 26.85 LCMHCs per 10,000 population. (Figure 13)

Figure 13. Licensed Clinical Mental Health Counselors per 10,000 Population by County, North Carolina, 2024



Source. NCBLCMHC Licensure Data.

Licensed Clinical Mental Health Counselor Associates

There were 3,075 Licensed Clinical Mental Health Counselor Associates in active practice in North Carolina in 2024. The rate of LCMCHAs to the population was 2.80 per 10,000.

There were differences among AHEC regions in rates of LCMHCAs per the population. Mountain (4.67 per 10,000) and Wake (3.32 per 10,000) AHEC areas reported the highest rates of LCMHCAs, compared to Southern Regional (1.88 per 10,000) and Area L (1.15 per 10,000) with the lowest rates of LCMHCAs.

Among the four Tailored Plan catchment areas, Alliance had the highest rate of LCMHCAs at 3.48 per 10,000 population. Partners reported the lowest rate of LCMHCAs at 2.20 per 10,000 population. Metro (3.05) and nonmetro counties (1.79) had a notable difference in LCMHCA rates per 10,000 population.

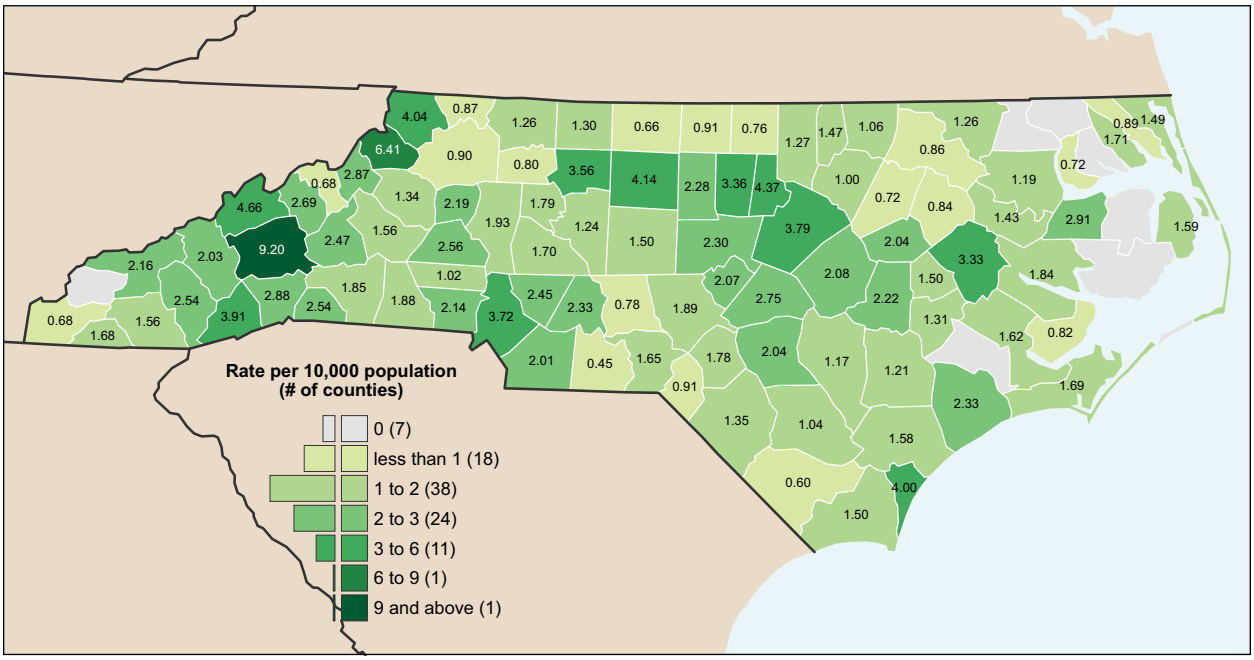
Table 66. Licensed Clinical Mental Health Counselor Associates Workforce in North Carolina by Geographic Region, North Carolina, 2024

LCMHCAs	N[a]	Population[b]	Rate per 10,000 population
Statewide	3,075	10,984,106	2.80
By AHEC Region			
Area L	33	285,994	1.15
Charlotte	654	2,231,872	2.93
Eastern	211	1,060,329	1.99
Greensboro	373	1,256,677	2.97
Mountain	386	827,070	4.67
Northwest	391	1,691,002	2.31
South East	142	578,697	2.45
Southern Regional	177	939,130	1.88
Wake AHEC	702	2,113,335	3.32
By Tailored Plan County Catchment Area			
Alliance	1,265	3,635,141	3.48
Partners	502	2,277,684	2.20
Trillium	723	3,208,448	2.25
Vaya	579	1,862,833	3.11
By County Urbanicity			
Metro	5,753	8,761,216	3.05
Nonmetro	745	2,222,890	1.79

Note. AHEC=Area Health Education Center.
[a] N=6 missing county data.
[b] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data. Urbanicity population based on 2023 data.
Source. NCBLCMHC Licensure Data.

The map in Figure 14 shows LCMHCA rates per 10,000 population across North Carolina with reported addresses corresponding to a county. Of the 100 counties, seven counties do not have any LCMHCA with a reported address in that county. A quarter of counties, (n=25) had a rate below 1.0 per 10,000 population. More than half of the counties (n=62) had rates between 1.0-3.0 per 10,000 population. Thirteen counties had a rate higher than 3.0 per 10,000 population, with Buncombe the highest at 9.20 per 10,000 which is more than three times the state average of LCMHCAs. (Figure 14)

Figure 14. Licensed Clinical Mental Health Counselor Associates per 10,000 Population by County, North Carolina, 2024



Source. NCBLCMHC Licensure Data.

Licensed Clinical Mental Health Counselor Supervisors

There were 1,470 Licensed Clinical Mental Health Counselor Supervisors (LCMHCSs) in North Carolina in 2024. LCMHCSs, who also hold an LCMHC, had a rate of 1.34 per 10,000 population throughout North Carolina. LCMHCS are critical to growing the LCMHC workforce, as LCMHCS supervise LCMCHAs in practice. There were about two LCMHCAs to every one LCMHCS in North Carolina.

Mountain AHEC area (1.91) had the highest rate of LCMHCSs, compared to Area L (0.28) with the lowest rate of LCMHCSs to the population. Charlotte and Wake AHEC areas had the next highest rates per 10,000 at 1.48 for both areas and Eastern AHEC had the next lowest rate at 1.06 per 10,000. Notably, the regions with the highest LCMHCA supply also had the highest LCMCHS supply, which bodes well that the supervisors are in areas of individuals with provisional counseling licenses. However, this also suggests that there are fewer supervisors in some AHEC regions to support LCMHC growth.

Among the four Tailored Plan catchment areas, Alliance had the highest rate per population with 599 LCMHCSs serving residents at a rate of 1.65 per 10,000 population. Vaya had 245 LCMHCSs with a rate of 1.32 per 10,000. Partners had 260 LCMHCSs at 1.14 per 10,000, and Trillium reported the lowest rate per

10,000, but not the lowest number of LCMHCSs, with 362 LCMHCSs at 1.13 per 10,000. There was also a difference in LCMHCS rates per 10,000 between metro (1.46) and nonmetro (0.86) areas, suggesting there are only half as many LCMCHS per the population in nonmetro counties as metro counties.

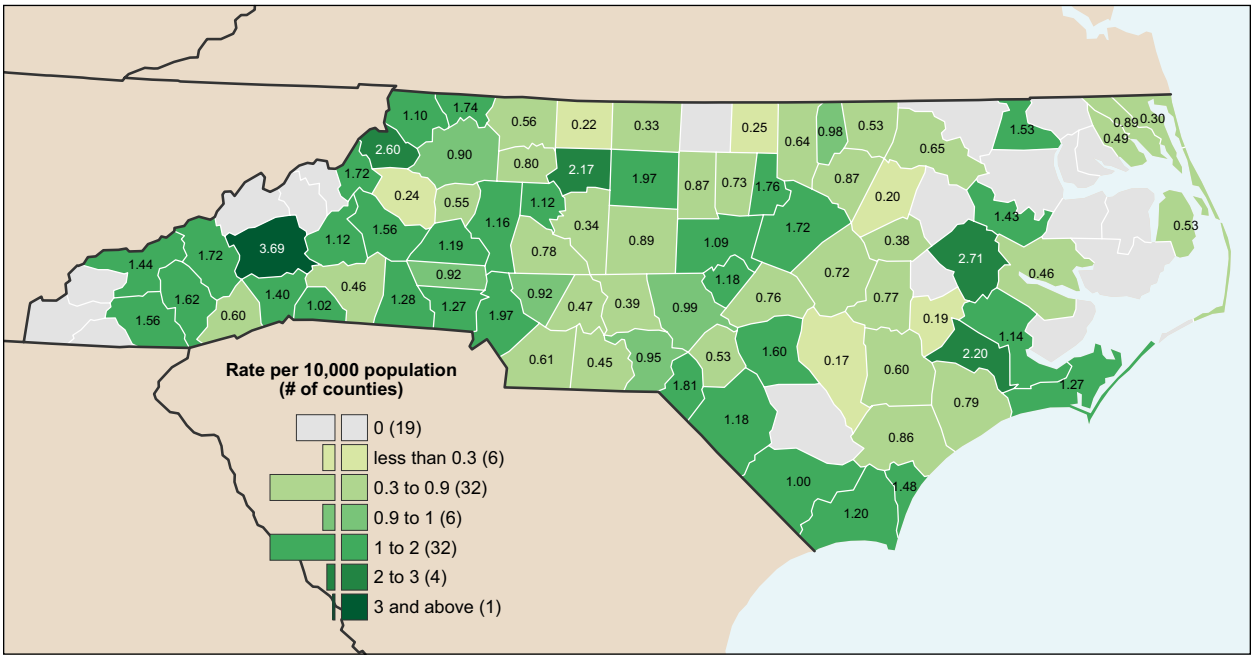
Table 67. Licensed Clinical Mental Health Counselor Supervisors Workforce in North Carolina by Geographic Region, North Carolina, 2024

LCMHCSs	N[a]	Population[b]	Rate per 10,000 population
Statewide	1,470	10,984,106	1.34
By AHEC Region			
Area L	8	285,994	0.28
Charlotte	331	2,231,872	1.48
Eastern	112	1,060,329	1.06
Greensboro	162	1,256,677	1.29
Mountain	158	827,070	1.91
Northwest	208	1,691,002	1.23
South East	70	578,697	1.21
Southern Regional	105	939,130	1.12
Wake AHEC	312	2,113,335	1.48
By Tailored Plan County Catchment Area			
Alliance	599	3,635,141	1.65
Partners	260	2,277,684	1.14
Trillium	362	3,208,448	1.13
Vaya	245	1,862,833	1.32
By County Urbanicity			
Metro	1,275	8,761,216	1.46
Nonmetro	191	2,222,890	0.86

Note. AHEC=Area Health Education Center.
[a] N=4 missing county data.
[b] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data. Urbanicity population based on 2023 data.
Source. NCBLCMHC Licensure Data.

Almost one-fifth (n=19) of North Carolina counties had no LCMHCS reporting a licensure address. A little more than half of the counties (n=57) had an LCMHCS rate per 10,000 lower than 0.9, and thirty-eight counties (n=38) had a rate of 0.9-2.0 per 10,000. Five counties had a rate higher than 2.0 per 10,000 population, with Buncombe the highest at 3.69 per 10,000. Notably, Buncombe had the highest county rate per 10,000 for all licensed mental health counselors (LCMHC, LCMHCA, LCMHCS). (Figure 15)

Figure 15. Licensed Clinical Mental Health Counselor Supervisors per 10,000 Population by County, North Carolina, 2024



Source. NCBLCMHC Licensure Data.

All Graduate-Level Licensed Clinical Mental Health Counselors

North Carolina had 12,280 graduate-level licensed clinical mental health counselors in total, representing a statewide rate of 11.18 counselors per 10,000 residents.

Geographic Distribution of All Graduate-Level Licensed Mental Health Counselors

The distribution of graduate-level licensed clinical mental health counselors across North Carolina's AHEC regions varied. The Mountain AHEC region had the highest rate at 18.50 counselors per 10,000 population, followed by Wake AHEC at 12.44 per 10,000 and Charlotte AHEC at 12.40 per 10,000. The Greensboro AHEC rate was 10.88 per 10,000, closely approximating the state average of 11.18. Five AHEC regions had rates below the state average. Area L had the lowest rate at 3.99 counselors per 10,000 people. The South East region had 10.13 per 10,000, Northwest had 9.80 per 10,000, Southern Regional had 7.96 per 10,000, and Eastern had 7.91 per 10,000.

Among the four Tailored Plan catchment areas, Alliance had the highest rate per population with 5,030 graduate-level licensed clinical mental health counselors serving residents at a rate of 13.84 per 10,000 population. Vaya had 2,207 counselors with a rate of 11.85 per 10,000. Partners had 2,150 counselors at 9.44 per 10,000, and Trillium reported the lowest count with 2,851 counselors serving residents at a rate of 8.89 per 10,000. There was also a difference in counselor rates between metro (10,703 counselors, 12.22 per 10,000) and nonmetro (1,535 counselors, 6.91 per 10,000 population) areas.

Mental health counselor distribution showed metro-nonmetro county differences, with metropolitan counties reporting 10,703 counselors (12.22 per 10,000 population) compared to 1,535 counselors in nonmetropolitan counties (6.91 per 10,000 population), representing a nearly two-fold difference in workforce density between metro and nonmetro areas in NC.

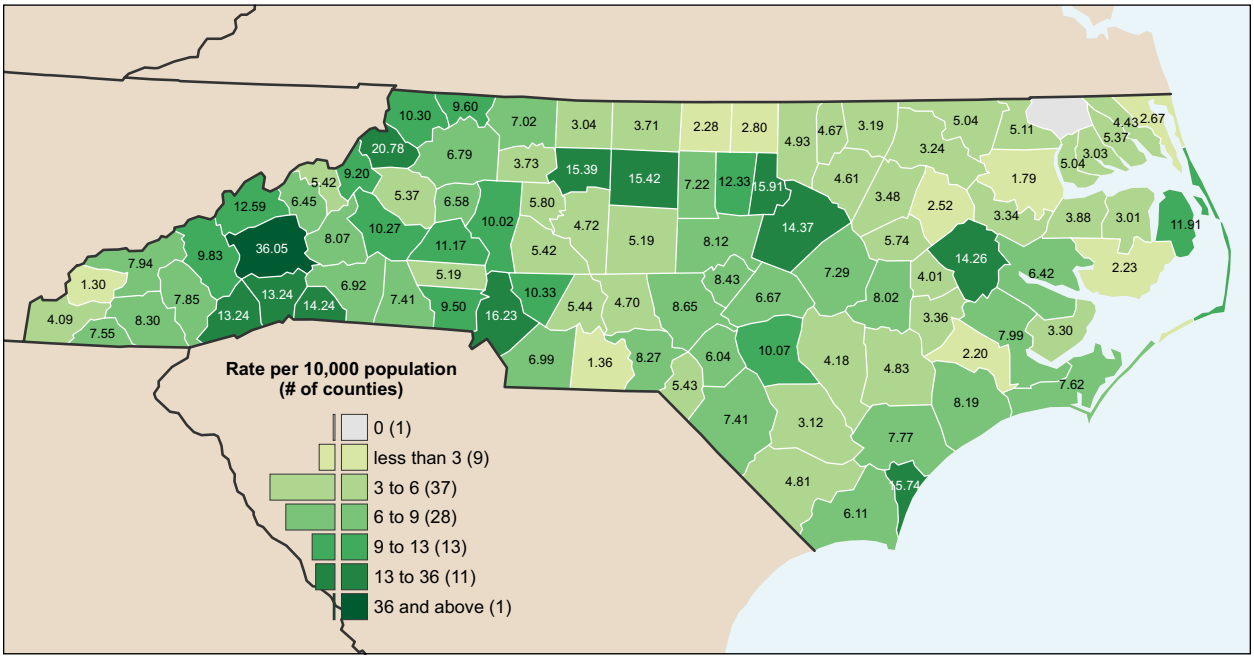
Table 68. Licensed Clinical Mental Health Counselor Workforce Distribution by Geographic Region, North Carolina, 2024

All Master's-Level Licensed Clinical Mental Health Counselors			
	N[a]	Population[b]	Rate per 10,000 population
Statewide	12,280	10,984,106	11.18
By AHEC Region			
Area L	114	285,994	3.99
Charlotte	2,768	2,231,872	12.40
Eastern	839	1,060,329	7.91
Greensboro	1,367	1,256,677	10.88
Mountain	1,530	827,070	18.50
Northwest	1,657	1,691,002	9.80
South East	586	578,697	10.13
Southern Regional	748	939,130	7.96
Wake AHEC	2,629	2,113,335	12.44
By Tailored Plan County Catchment Area			
Alliance	5,030	3,635,141	13.84
Partners	2,150	2,277,684	9.44
Trillium	2,851	3,208,448	8.89
Vaya	2,207	1,862,833	11.85
By County Urbanicity			
Metro	10,703	8,761,216	12.22
Nonmetro	1,535	2,222,890	6.91

Note. AHEC=Area Health Education Center.
[a] N=42 missing county data.
[b] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCBLCMHC Licensure Data.

North Carolina counties ranged from 0 to 36.05 graduate-level licensed mental health counselors per 10,000 population. One county had no graduate-level mental health counselors. Ten counties had less than 3 MHCs per 10,000 population. The most counties (n=37) had between 3 and 64 MHCs per 10,000 population working as their reported practice address. Twenty-eight counties had between 6 and 9 MHCs per 10,000 population, and 13 counties had between 9 and 13 MHCs per 10,000 population. Eleven counties had between 13 and 36 MHCs per 10,000 population, and 1 county, Buncombe (36.05), had more than 36 MHCs per 10,000 population. (Figure 16)

Figure 16. All Graduate-Level Licensed Clinical Mental Health Counselors per 10,000 Population by County, North Carolina, 2024



Source. NCBLCMHC Licensure Data.

Demographic Characteristics of Mental Health Counselors

Data used to identify demographic characteristics of the mental health counselor workforce were drawn from NPPES. As such, the numbers of mental health counselors are different than the licensure data and the difference between LCMHCs and LCMHCAs is not indicated.

The mental health counselor workforce was 83.7% female (n=5,438) as of 2024. There were small regional differences in the proportion of the mental health counselor workforce that were female. The proportion of the mental health counselor workforce that was female ranged from 77.3% in the Mountain AHEC region to 86.0% in the Eastern, Wake, and Southern Regional AHEC regions. Female representation across the Tailored Plan areas ranged from 77.4% in Vaya to 85.5% in Alliance. Female representation was 83.8% (n=4,822) in metropolitan counties and 82.7% (n=616) in nonmetropolitan counties.

Table 69. Clinical Mental Health Counselor Workforce Demographics by Geographic Region, North Carolina, 2024

Clinical Mental Health Counselors	
	N (%) Female
Statewide	5,438 (83.69)
By AHEC Region	
Area L	55 (78.57)
Charlotte	1,231 (84.66)
Eastern	404 (85.96)
Greensboro	611 (84.74)
Mountain	579 (77.30)
Northwest	603 (81.27)
South East	244 (84.14)
Southern Regional	384 (85.52)
Wake AHEC	1,327 (85.45)
By Tailored Plan County Catchment Area	
Alliance	2,407 (85.51)
Partners	919 (82.64)
Trillium	1,297 (85.44)
Vaya	815 (77.40)
By County Urbanicity	
Metro	4,822 (83.82)
Nonmetro	616 (82.68)

Note. AHEC=Area Health Education Center.
Source. NPPES.

All Graduate-Level Licensed Clinical Mental Health Counselors Credentialed to Provide Services to North Carolina Medicaid Beneficiaries

While North Carolina licenses 9,205 LCMHCs and 3,075 LCMHCAs, not all licensed professionals are credentialed to serve Medicaid beneficiaries. Using the North Carolina Medicaid provider enrollment file, we examined the proportion of all graduate-level licensed clinical mental health counselors enrolled to provide services to Medicaid beneficiaries and their enrollment patterns across the state's four Tailored Plans.

The Medicaid provider enrollment file does not distinguish between LCMHCs and LCMHCAs, reporting both professions under two possible classifications — Counselor, Mental Health (Taxonomy code: 101YM0800X) or Counselor, Professional (Taxonomy code 101YP2500X). Of the 12,280 LCMHCs and LCMHCAs in North Carolina in 2024, 3,956 were enrolled as Medicaid providers or 32.2% of all LCMHCs/LCMHCAs.

All four Tailored Plans credentialed more than 1,500 LCMCH/LCMHCAs. Vaya Health Tailored Plan credentialed the most LCMHC/As (n=1,835), followed closely by Partners (n=1,769). There were 1,700 LCMHC/LCMHCAs enrolled to deliver services to Medicaid beneficiaries but were not credentialed to one of the four Tailored Plans. Most LCMCH/LCMHCAs were credentialed with all four Tailored Plans (n=982; 24.8%).

Table 70. Licensed Clinical Mental Health Counselors Credentialed to Deliver Services to Medicaid, North Carolina, 2024

Mental Health & Professional Counselors	N	%
LCMHC, LCMHCA, LCMHC Supervisor In Active Practice in NC in 2024	12,280	
Unique Identifiers with an address in NC in 2024	3,956	32.21%
Credentialed with a Tailored Plan, by Type of Tailored Plan		
Alliance Health	1,516	38.32%
Partners Health Management	1,769	44.72%
Trillium Health Resources	1,576	39.84%
Vaya Health	1,835	46.39%
Number of Tailored Plans a Unique ID is Credentialed with		
4 Tailored Plans	982	24.82%
3 Tailored Plans	572	14.46%
2 Tailored Plans	350	8.85%
1 Tailored Plans	352	8.90%
No Tailored Plans	1,700	42.97%

Note. LCMHC=Licensed Clinical Mental Health Counselor; LCMHCA=Licensed Clinical Mental Health Counselor Associate; LCMCHS=Licensed Clinical Mental Health Counselor Supervisor. NC=North Carolina.
Source. Provider Enrollment File, 2024.

Comparisons of Data Sources to Estimate the Size of the Mental Health Counselor Workforce

Estimating the size of the mental health counselor workforce is difficult because the definition of mental health counselors using national data sources has changed over the years. In 2014, the BLS standard occupation code (SOC) system was changed, moving from two separate SOC codes one for mental health counselors and one for substance abuse and behavioral disorder counselors to a combined code of "substance abuse, behavioral disorder, and mental health counselors."

In 2024, BLS data reported there were close to 9,000 substance abuse, behavioral disorder, and mental health counselors, at the same time there were 13,970 mental health counselor licenses (inclusive of independent and provisional licenses) reported to the NC General Assembly Oversight Committee and 6,498 reported in NPPES. This could mean that there were more licensed mental health counselors in the state than BLS and NPPES. North Carolina licensure data indicated that there are 12,280 mental health counselors in the state as of 2024. (Table 71)

Table 71. Mental Health Counselor Workforce Estimates by Data Source, North Carolina, 2014–2024

	Licensure (N)	BLS (N)				NC Commerce (N)	ACS[a] (N)		NCGA Oversight Committee Licensing Annual Report (N)				NPPES (N)
		2014	2022	2023	2024	2022	2018	2023	2015	2022	2023	2024	2024
LCMHCs	7,735												
LCMHCAs	3,075												
Supervisors	1,470												
Mental Health Counselors	12,280	3,540	N/A	N/A	N/A	9,728	3,908	6,011	7,153	10,465	12,293	13,970	6,498
Substance Abuse and Behavioral Disorder Counselors (BLS 2014)[b]		1,620	N/A	N/A	N/A	--	2,696	3,509	--	--	--	--	--
Substance Abuse, Behavioral Disorder, and Mental Health Counselors[b]			8,950	9,980	8,930	9,728	--	--	--	--	--	--	--

Note. BLS=Bureau of Labor Statistics; ACS=American Community Survey; NCGA=North Carolina General Assembly; NPPES= National Plan and Provider Enumeration System; N/A=Not Applicable.
[a] ACS 5-Year Estimates Public Use Microdata Sample (2018=2014-2018; 2023=2019-2023)
[b] The SOC code used for mental health counselors was updated from 21-1014 (Mental Health Counselors) to 21-1018 (Substance Abuse, Behavioral Disorder, and Mental Health Counselors).
Source. NCBLCMHC Licensure data, BLS, NC Commerce, ACS, NCGA, and NPPES.

SOCIAL WORKERS

Licensed Clinical Social Workers (LCSWs) in North Carolina are trained to provide mental health therapy, clinical assessments, and treatment planning for individuals, families, and groups facing emotional, behavioral, and psychological challenges. Licensed Clinical Social Worker Associates (LCSWAs) hold a provisional license and are not allowed to practice independently but fill important roles in mental health and substance use services settings. To become a LCSW, licensed by the North Carolina Social Work Certification and Licensure Board, an individual must complete a Master's of Social Work (MSW) degree, 3,000 hours of supervised clinical experience, and pass a national exam to practice independently.

The current report includes licensure data drawn from the North Carolina Social Work Certification and Licensure Board. As of 2024, there were 13,945 licensed Master's-level social workers in active practice in North Carolina, of which 9,830 were LCSWs and 4,115 were LCSWAs, resulting in a statewide rate of 12.70 per 10,000 population.

Licensed Clinical Social Workers

Statewide there were 8.95 LCSWs per 10,000 population in 2024. However, there were significant regional and county-level variations in the supply of LCSWs to the population. Mountain AHEC (13.37) and Wake AHEC (12.86) regions reported the highest rates of LCSWs per 10,000 population, while Area L (3.78) and Northwest (5.37) had the lowest. Among the four Tailored Plan areas, Alliance had the highest LCSW workforce rate to the population (12.29) and the largest number of LCSWs (4,4,67), followed by Vaya (9.01), Trillium (7.59), and Partners (5.46). Metro counties had almost two times as many social workers per the population than nonmetro counties 9.95 LCSWs per 10,000 in metro counties compared to 4.98 LCSWs in nonmetro counties. (Table 72)

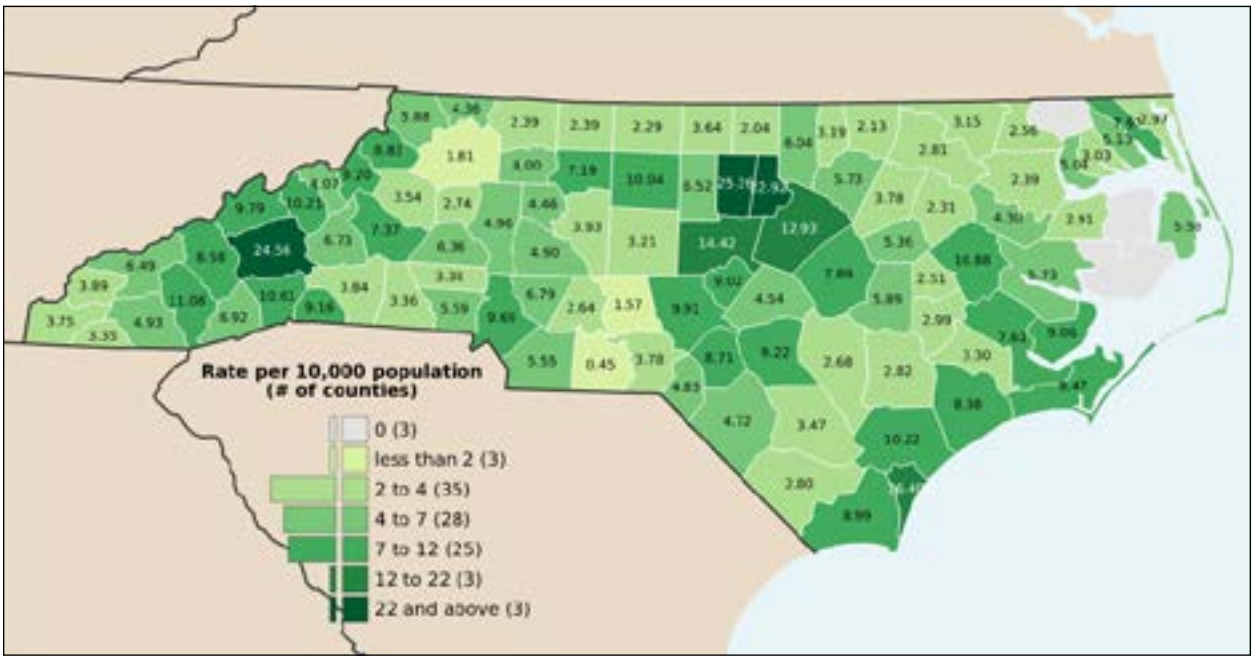
Table 72. Licensed Clinical Social Worker Workforce Distribution by Geographic Region, North Carolina, 2024

Licensed Clinical Social Workers	N	Population[a]	Rate per 10,000 population
Statewide	9,830	10,984,106	8.95
By AHEC Region			
Area L	108	285,994	3.78
Charlotte	1,690	2,231,872	7.57
Eastern	735	1,060,329	6.93
Greensboro	1,257	1,256,677	10.00
Mountain	1,106	827,070	13.37
Northwest	908	1,691,002	5.37
South East	647	578,697	11.18
Southern Regional	656	939,130	6.99
Wake AHEC	2,717	2,113,335	12.86
By Tailored Plan County Catchment Area			
Alliance	4,467	3,635,141	12.29
Partners	1,243	2,277,684	5.46
Trillium	2,435	3,208,448	7.59
Vaya	1,679	1,862,833	9.01
By County Urbanicity			
Metro	8,716	8,761,216	9.95
Nonmetro	1,108	2,222,890	4.98

Note. AHEC=Area Health Education Center; N=6 missing region information.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCSWCLB Licensure Data

North Carolina counties ranged from 0 to 25.26 LCSWs per 10,000 population. Three counties had no LCSWs working as their reported practice address. Six counties had fewer than two LCSWs per 10,000 population. The most counties (n=35) had between 2 and 4 LCSWs per 10,000 population. 28 counties had between 4 and 7 LCSWs, and 25 counties had between 7 and 12 LCSWs per 10,000 population. Three counties had more than 22 LCSWs per 10,000 population, including Buncombe, Orange, and Durham. (Figure 17)

Figure 17. Licensed Clinical Social Workers per 10,000 Population by County, North Carolina, 2024



Source. NCSWCLB Licensure Data.

Licensed Clinical Social Worker Associates

As an individual works to become an independently licensed LCSW, they must maintain a provisional license called a licensed clinical social work associate (LCSWA). LCSWAs are allowed to directly bill Medicaid, but are unable to practice independently.

There were 4,115 LCSWAs practicing in North Carolina in 2024, with a rate of 3.75 LCSWA per 10,000. While LCSWAs had regional variation, the distribution of this workforce is different than LCSWs. For example, Southern Regional (4.89) and Wake (4.90) AHEC regions reported the highest rates of LCSWAs per 10,000 population, while Northwest (2.21) and Area L (2.94) had the lowest. Among the four Tailored Plan areas, Alliance had the highest LCSWA rate to the population (5.20) and the largest number of total LCSWAs (1,890), followed by Trillium (3.48), Vaya (2.79), and Partners (2.58). Metro counties had a higher supply of LCSWAs (4.05 per 10,000) compared to nonmetro counties (2.55 per 10,000). (Table 73)

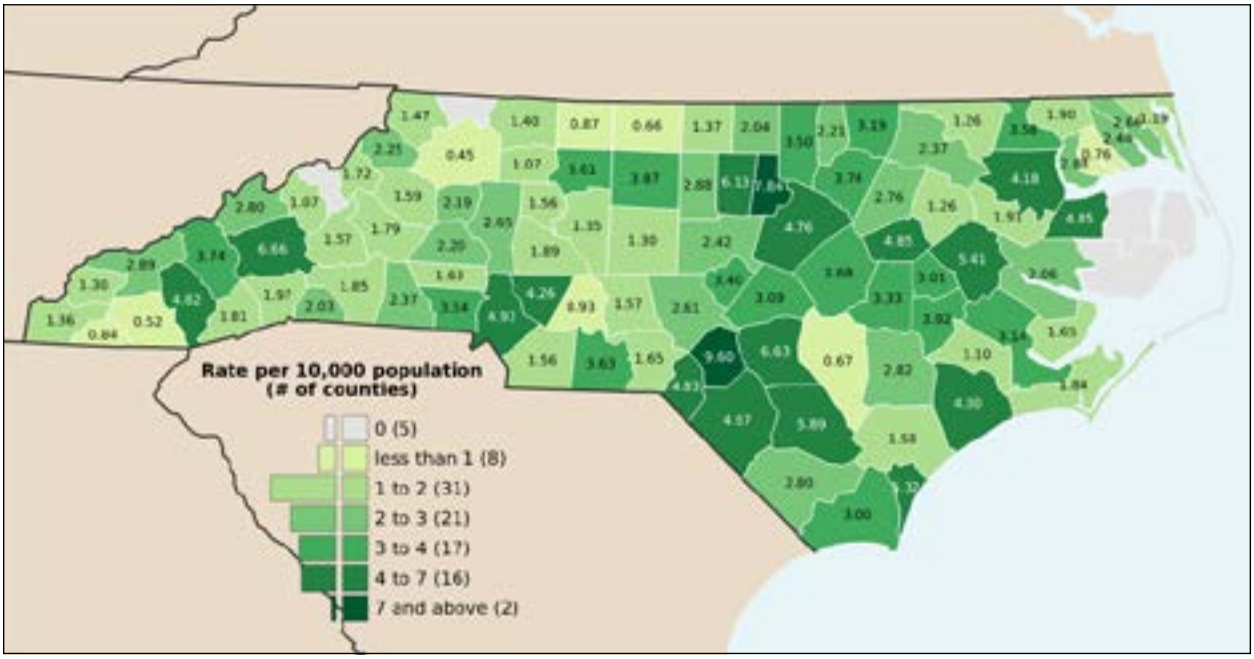
Table 73. Licensed Clinical Social Worker Associates Workforce Distribution by Geographic Region, North Carolina, 2024

Licensed Clinical Social Worker Associates	N[a]	Population[b]	Rate per 10,000 population
Statewide	4,115	10,984,106	3.75
By AHEC Region			
Area L	84	285,994	2.94
Charlotte	874	2,231,872	3.92
Eastern	353	1,060,329	3.33
Greensboro	412	1,256,677	3.28
Mountain	303	827,070	3.66
Northwest	373	1,691,002	2.21
South East	218	578,697	3.77
Southern Regional	459	939,130	4.89
Wake AHEC	1,035	2,113,335	4.90
By Tailored Plan County Catchment Area			
Alliance	1,890	3,635,141	5.20
Partners	587	2,277,684	2.58
Trillium	1,115	3,208,448	3.48
Vaya	519	1,862,833	2.79
By County Urbanicity			
Metro	3,544	8,761,216	4.05
Nonmetro	567	2,222,890	2.55

Note. AHEC=Area Health Education Center
[a] N=455 missing region information
[b] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source: NCSWCLB Licensure Data.

North Carolina counties ranged from 0 to more than 7 LCSWAs per 10,000 population. Five counties had no LCSWAs working as their reported practice address. Thirteen counties had fewer than one LCSWA per 10,000 population. The most counties (n=31) had between 1 and 2 LCSWAs per 10,000 population. 22 counties had between 2 and 3 LCSWAs per 10,000 population, 17 counties had between 3 and 4 LCSWAs per 10,000 population, and 16 counties had between 4 and 7 LCSWAs. Two counties had more than 7 LCSWAs per 10,000 population, including Durham and Hoke. (Figure 18)

Figure 18. Licensed Clinical Social Worker Associates per 10,000 Population by County, North Carolina, 2024



Source. NCSWCLB Licensure Data.

All Graduate-Level Licensed Clinical Licensed Social Workers

As of 2024, there were 13,945 licensed Master's-level social workers (LCSWs and LCSWAs) in active practice in North Carolina with a statewide rate of 12.70 per 10,000 population.

Geographic Distribution of All Graduate-Level Licensed Clinical Social Workers

When combining all graduate-level licensed social workers in North Carolina, Wake AHEC (17.75) and Mountain (17.04) AHEC regions reported the highest rates of social workers per 10,000 population, while Area L (6.71) and Northwest (7.58) had the lowest. Among the four Tailored Plan areas, Alliance had the highest social worker rate per 10,000 population (17.49), followed by Vaya (11.80) and Trillium (11.06). Partners reported the lowest rate with 8.03 social workers per 10,000 population. Metro counties had a higher supply of social workers (13.99) compared to nonmetro counties (7.54).

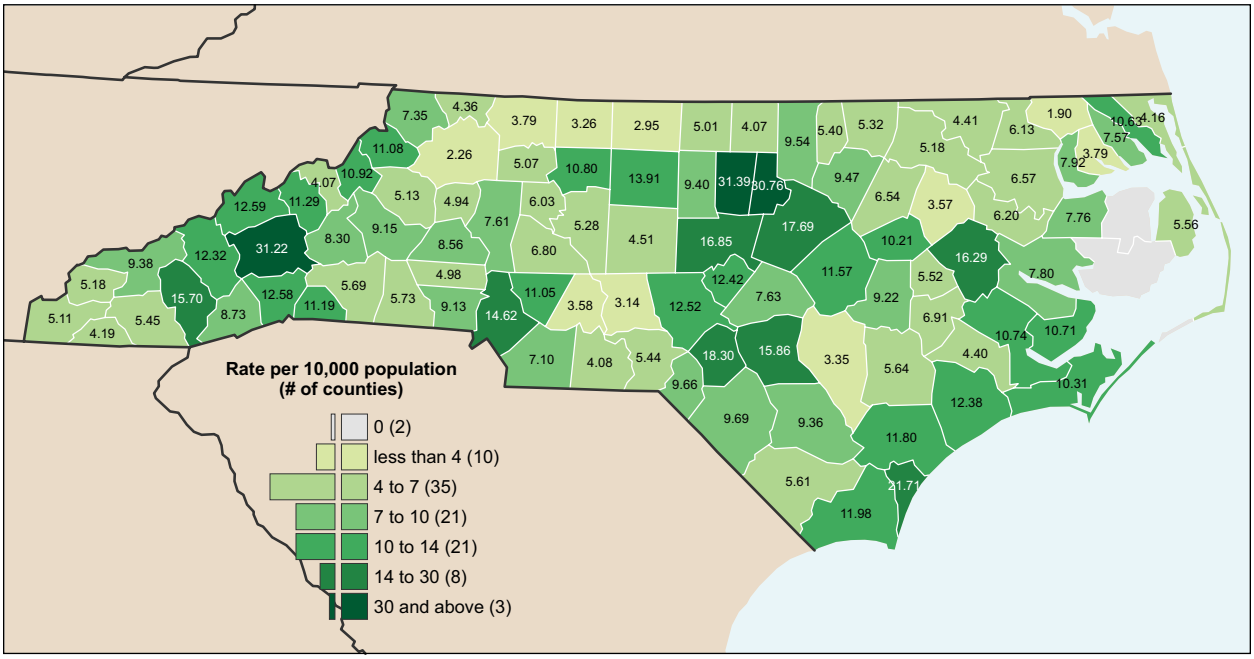
Table 74. All Graduate-Level Licensed Clinical Social Workers Workforce Distribution by Geographic Region, North Carolina, 2024

All Licensed Clinical Social Workers (LCSW & LCSWA)	N[a]	Population[b]	Rate per 10,000 population
Statewide	13,945	10,984,106	12.70
By AHEC Region			
Area L	192	285,994	6.71
Charlotte	2,564	2,231,872	11.49
Eastern	1,088	1,060,329	10.26
Greensboro	1,669	1,256,677	13.28
Mountain	1,409	827,070	17.04
Northwest	1,281	1,691,002	7.58
South East	865	578,697	14.95
Southern Regional	1,115	939,130	11.87
Wake AHEC	3,752	2,113,335	17.75
By Tailored Plan County Catchment Area			
Alliance	6,357	3,635,141	17.49
Partners	1,830	2,277,684	8.03
Trillium	3,550	3,208,448	11.06
Vaya	2,198	1,862,833	11.80
By County Urbanicity			
Metro	12,260	8,761,216	13.99
Nonmetro	1,675	2,222,890	7.54

Note. AHEC=Area Health Education Center.
[a] N=10 missing region information.
[b] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCSWCLB Licensure Data.

North Carolina counties ranged from 0 to 31.39 Master's-level Licensed Social Workers (LCSWs and LCSWAs) per 10,000 population. Two of the state's 100 counties had no LCSWs and LCSWAs working as their reported practice address. Twelve counties (12%) reported fewer than 4 per 10,000 population. Thirty-five counties (35%), the highest, had 4 to 7 LCSWs per 10,000 population, and 21 counties reported between 7 to 10 LCSWs per 10,000 population. Another 21 counties had 10 to 14 LCSWs per 10,000 population. Only 12 counties (12%) reported more than the state average rate of 12.70 per 10,000 population. Of these 12, 8 counties had 14 to 30 LCSWs per 10,000 population, and 3 counties had 30 or more LCSWs per 10,000 population. Orange (31.39), Buncombe (31.22), and Durham (30.76) Counties had the highest rates for Masters-level LCSWs per 10,000 population.

Figure 19. All Graduate-Level Licensed Clinical Social Workers Workforce Distribution by County, North Carolina, 2024



Source. NCSWCLB Licensure Data

Comparison of the Distribution of the Graduate-Level Licensed Social Work Workforce by Type

There were differences in rates per 10,000 population among LCSWs, LCSWAs, and all graduate-level licensed social workers in metro and nonmetro areas. Rates for all groups were higher in metro counties than nonmetro counties, though this rate was more than doubled for LCSWs compared to LCSWAs whereas there were 1.6 times as many LCSWAs in metro than nonmetro areas.

Among AHEC regions, Area L, Eastern, and Northwest regions all had both LCSW and LCSWA rates per 10,000 population lower than the state average. Conversely, South East and Wake AHEC regions had both LCSW and LCSWA rates per 10,000 that were higher than the state average. Within Charlotte and Southern Regional, the LCSW rate per 10,000 was lower than the state average, yet the LCSWA rate per 10,000 was above the state average, indicating areas of potential future growth among LCSWs. However, the combined LCSW/LCSWA rates per 10,000 for both Charlotte and Southern Regional were still below the state average,

despite LCSWA rates per 10,000 being above the state average. Greensboro and Mountain AHEC regions had the opposite pattern, with LCSW rates per 10,000 being higher than the state average and LCSWA rates per 10,000 being lower. Likewise, both regions had a combined LCSW/LCSWA rate per 10,000 above the state average despite the LCSWA rate per 10,000 being below the state average.

With LCSWAs requiring supervision from LCSWs, the discrepancy in rates of licensed social workers per 10,000 seen in Charlotte and Southern Regional, and the overall lower rates in Area L, Eastern, and Northwest AHEC regions suggests these are areas that require more supervision responsibility among their LCSW workforce or reliance on remote supervision.

Table 75. Social Work Workforce Distribution by Geographic Region, North Carolina, 2024

	LCSW		LCSWA		LCSW/LCSWA Combined	
	N[a]	Rate per 10,000 population	N[a]	Rate per 10,000 population	N[a]	Rate per 10,000 population
Statewide	9,830	8.95	4,115	3.75	13,945	12.70
By County Urbanicity						
Metro	8,716	9.95	3,544	4.05	12,260	13.99
Nonmetro	1,108	4.98	567	2.55	1,675	7.54

Note. LCSW=Licensed Clinical Social Worker; LCSWA=Licensed Clinical Social Worker Associate.
[a] The sum of metro and nonmetro numbers does not equal the statewide total due to missing geographic information.
Source. NCSWCLB Licensure Data.

Demographic Characteristics of Social Workers

Data used to identify demographic characteristics of the workforce for social workers were drawn from NPPES. As such, the total numbers of social workers are different than the licensure data and the breakdown between LCSWs and LCSWAs is not indicated. The total number of licensed social workers in the state reported by NPPES is 13,488. The social work workforce was 85.6% female (n=11,678). Female representation in the social work workforce was consistently high across all regions, ranging from 80.4% in Mountain AHEC to 91.1% in Area L. There were similar proportions of females in the social work workforce in the Tailored Plan catchment areas with Trillium having the highest (88.2%) and Vaya having the fewest females in the workforce (82.3%). The proportion of females in the workforce was the same between metro and nonmetro counties, with 86.8% female in metro areas and 85.7% in nonmetro areas. (Table 76)

Table 76. Social Workers Workforce Demographics by Geographic Region, North Carolina, 2024

Licensed Social Workers	N (%) Female
Statewide	11,678 (85.59)
By AHEC Region	
Area L	163 (91.06)
Charlotte	2,255 (89.27)
Eastern	922 (88.23)
Greensboro	1,229 (86.55)
Mountain	1,201 (80.44)
Northwest	1,065 (85.60)
South East	730 (89.46)
Southern Regional	1,013 (87.63)
Wake AHEC	3,057 (86.02)
By Tailored Plan County Catchment Area	
Alliance	5,334 (87.09)
Partners	1,533 (87.15)
Trillium	2,852 (88.24)
Vaya	1,916 (82.34)
By County Urbanicity	
Metro	10,028 (86.77)
Nonmetro	1,607 (85.66)

Note. AHEC=Area Health Education Center.
Source. NPPES.

All Graduate-Level Licensed Clinical Social Workers Credentialed to Provide Services to North Carolina Medicaid Beneficiaries

While North Carolina licenses 9,830 LCSWs and 4,115 LCSWAs, not all licensed professionals are credentialed to serve Medicaid beneficiaries. Using the North Carolina Medicaid provider enrollment file, we examined the proportion of all graduate-level licensed clinical social workers enrolled to provide services to Medicaid beneficiaries and their enrollment patterns across the state's four Tailored Plans.

The Medicaid provider enrollment file does not distinguish between LCSWs and LCSWAs, reporting both professions under one classification — Social Worker, Clinical (Taxonomy code:1041C0700X). Of the 13,945 LCSWs and LCSWAs in North Carolina in 2024, 5,983 (49.2% of all LCSW/LCSWAs) were enrolled as Medicaid providers.

All four Tailored Plans credentialed more than 2,700 LCSW/LCSWAs. Vaya Health Tailored Plan credentialed the most LCSW/LCSWAs (n=3,010), followed closely by Partners (n=2,988). There were 2,383 LCSW/LCSWAs enrolled to deliver services to Medicaid beneficiaries but were not credentialed to one of the four Tailored Plans. Most LCSW/LCSWAs were credentialed with all four Tailored Plans (n=2,019; 33.8%).

Table 77. Licensed Clinical Social Workers Credentialed to Deliver Services to Medicaid, North Carolina, 2024

Social Workers	N	Proportion
LCSW & LCSWA in NC in 2024	13,945	
Unique LCSW/LCSWAs with an address in NC in the Provider Enrollment File	5,983	42.90%
Credentialed with a Tailored Plan, by Type of Tailored Plan		
Alliance Health	2,738	45.76%
Partners Health Management	2,988	49.94%
Trillium Health Resources	2,850	47.63%
Vaya Health	3,010	50.31%
Number of Tailored Plans a Unique ID is Credentialed with		
4 Tailored Plans	2,019	33.75%
3 Tailored Plans	736	12.30%
2 Tailored Plans	457	7.64%
1 Tailored Plans	388	6.49%
No Tailored Plans	2,383	39.83%

Note. LCSW=Licensed Clinical Social Worker; LCSWA=Licensed Clinical Social Worker Associate; NC=North Carolina.
Source. Provider Enrollment File, 2024.

Comparisons of Data Sources to Estimate the Size of the Social Work Workforce

This section compares the supply of social workers across several available data sources. Limitations exist in the BLS, NC Commerce, and ACS data as it is unclear what proportion of the workforce has a master's degree or above (as is required to become a licensed clinical social worker). Similarly, the social work licensure board is required to report the number of total licenses supervised which likely includes inactive license or social workers who maintain a North Carolina license but practice out-of-state.

The most recent licensure data indicates the total social worker count as 13,945, with 9,830 (70%) of these registered as LCSWs and 4,115 LCSWAs (30%). The NPPES and North Carolina General Assembly (NCGA) Oversight Committee report had the closet estimates of the size of the social work workforce in North Carolina in 2024 with the NCGA report identifying 17,101 social workers and NPPES reporting 13,488 social workers. BLS, ACS, and NC Commerce data report significantly higher numbers of social workers practicing in North Carolina. Estimates in the size of the social work workforce ranged from 17,101 (NCGA) to 32,524 (ACS, 2023). The workforce sizes of health care social workers and mental health and substance abuse social workers were more comparable across the BLS, NC Commerce, and ACS than for other types of social workers. Yet health care social workers had a growth in the workforce and mental health and substance abuse social workers had a noted decline. BLS data indicate growth of

health care social workers from 3,660 in 2014 to 4,650 in 2024 (27% increase). NC Commerce reported 3,504 in 2022, while ACS shows higher estimates of 4,159 in 2018 and 4,210 in 2023. BLS data showed mental health and substance abuse social workers dropping from 3,530 in 2014 to 2,700 in 2024, with a particularly sharp decline to 1,410 in 2022.

Child, Family, and School Social Workers represented the largest social worker specialty across BLS, ACS, and NC Commerce data and time periods. BLS data showed steady growth of child, family, and school social workers from 9,680 in 2014 to 13,960 in 2024, representing approximately 61% of social workers in 2024. NC Commerce data indicated 12,908 child, family, and school social workers in 2022, while ACS shows 4,469 in 2018 declining to 3,448 in 2023, demonstrating significant measurement discrepancies across data sources for this specialty.

Table 78. Social Work Workforce Estimates by Data Source and Specialty, North Carolina, 2014–2024

	Licensure	BLS (N)				NC Commerce (N)	ACS[a] (N)		NCGA Oversight Committee Licensing Annual Report (N)				NPPES (N)
	2024	2014	2022	2023	2024	2022	2018	2023	2017	2022	2023	2024	April 2024
Social Workers (total)	13,945	17,950	18,840	21,930	23,000	19,334	33,404	32,524	10,303	14,252	15,592	17,101	13,488
LCSWs	9,830												
LCSWAs	4.115								--	--	--	--	--
Child, family, & school social workers		9,680	12,860	14,350	13,960	12,908	4,469	3,448	--	--	--	--	--
Healthcare social workers		3,660	3,420	4,210	4,650	3,504	4,159	4,210	--	--	--	--	--
Mental health & substance abuse social workers		3,530	1,410	1,820	2,700	1,459	1,233	1,380	--	--	--	--	--
Social workers, all other		1,080	1,150	1,550	1,690	1,463	23,543	23,486	--	--	--	--	--
Social Workers (all)		--	--	--	--	--	--		10,303	14,252	15,592	17,101	13,488

Note. BLS=Bureau of Labor Statistics; ACS=American Community Survey; NCGA=North Carolina General Assembly; NPPES= National Plan and Provider Enumeration System.
[a] ACS 5-Year Estimates Public Use Microdata Sample (2018=2014–2018; 2023=2019–2023).
Source. NCSWCLB Licensure data, BLS, NC Commerce, ACS, NCGA, and NPPES.

Fee-based Pastoral Counselors

Fee-based pastoral counselors in North Carolina are certified through the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors, established in 1991, to oversee and administer certification of practicing pastoral counselors who charge fees for their services. Fee-based pastoral counselors are distinct from clergy providing pastoral counseling, requiring board certification to practice on fee-for-service basis while integrating spiritual and therapeutic approaches in their counseling practice.

Two data sources were available to estimate the size of the fee-based pastoral counselor workforce: Licensure data (available from the North Carolina Board of Examiners of Fee-Based Practicing Counselors website) and NPPES. NPPES data captured more than twice the number of pastoral counselors compared to licensure data (101 vs. 45). The statewide rate difference was substantial, with NPPES showing 0.09 pastoral counselors per 10,000 population compared to licensure data's 0.04 per 10,000. This difference suggests that NPPES captures both certified fee-based pastoral counselors and other practitioners who identify as pastoral counselors but may not be licensed. (Table 79)

Table 79. Pastoral Counselor Workforce Estimates by Data Source and Specialty, North Carolina, 2014–2024

	Licensure Data (N, active, statewide)	NCGA Oversight Committee Licensing Annual Report (N)				NPPES (N)
	2024	2015	2022	2023	2024	April 2024
Pastoral Counselors[a]	45	58	N/A	54	N/A	101

Note. NCGA=North Carolina General Assembly; NPPES=National Plan and Provider Enumeration System; N/A=Not Applicable.
[a] No SOC Code for pastoral counselors - could fall within clergy, counselors, or religious workers SOC codes dependent on core functions.
Source. NC Pastoral Counseling Board Licensure Data, NCGA Oversight Committee Annual Reports, and NPPES.

Geographic Practice Characteristics of Pastoral Counselors

Both licensure data and NPPES show similar geographic patterns in practicing pastoral counselors, with Wake AHEC and Charlotte AHEC containing the largest absolute numbers of pastoral counselors. Wake AHEC had the highest rates of pastoral counselors in both datasets (0.06 per 10,000 in licensure data; 0.14 per 10,000 in NPPES), closely followed by Charlotte AHEC (0.06 licensure, 0.13 NPPES per 10,000). Several regions including Area L, Eastern, South East, and Southern Regional AHEC had minimal pastoral counselor presence in both datasets. There were also significant differences in the size of the pastoral counselor workforce in metro and nonmetro counties in both data sets. Using licensure data, there were only two pastoral counselors practicing in nonmetro counties, compared to 43 in metro counties with a rate of 0.05 per 10,000 population in metro counties. Using NPPES data, there were less than 10% of the total pastoral counselor workforce practicing in nonmetro counties, with 0.04 pastoral counselors per 10,000 population in nonmetro counties compared to 0.10 pastoral counselors per 10,000 population in metro counties.

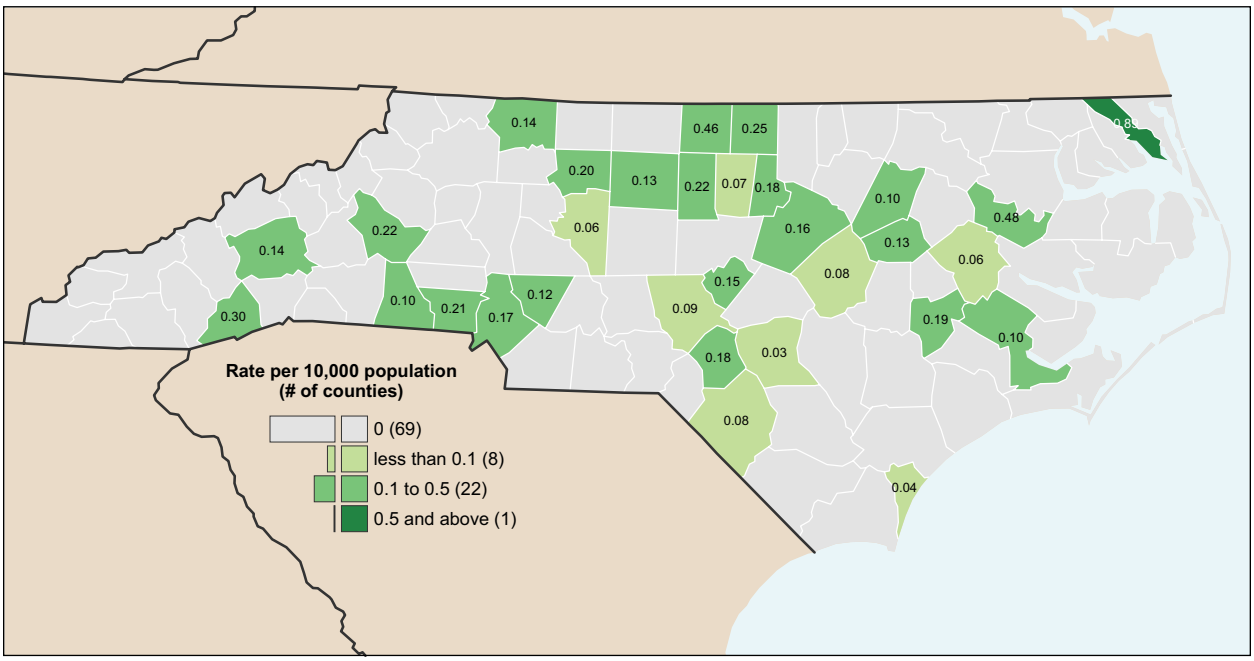
Table 80. Pastoral Counseling Workforce Estimates by Data Source and Region, North Carolina, 2024

Pastoral Counselors	Licensure Data		NPPES Data		
	N	Rate per 10,000 population	N	Rate per 10,000 population	N (%) Female
Statewide	45	0.04	101	0.09	51 (50.50)
By AHEC Region					
Area L	^	0.03	^	0.07	^
Charlotte	13	0.06	29	0.13	17 (58.62)
Eastern	^	0.01	5	0.05	^
Greensboro	7	0.06	13	0.10	8 (61.54)
Mountain	5	0.06	5	0.06	^
Northwest	^	0.02	12	0.07	6 (50.00)
South East	^	0.02	^	0.02	--
Southern Regional	^	0.01	^	0.04	^
Wake AHEC	13	0.06	30	0.14	15 (50.00)
By Tailored Plan County Catchment Area					
Alliance	25	0.07	50	0.14	26 (52.00)
Partners	7	0.03	21	0.09	11 (52.38)
Trillium	6	0.02	19	0.06	9 (47.37)
Vaya	7	0.04	11	0.06	5 (45.45)
By County Urbanicity					
Metro	43	0.05	91	0.10	47 (51.65)
Nonmetro	2	0.01	10	0.04	^

Note. AHEC=Area Health Education Center; NPPES=National Plan and Provider Enumeration System.
^Data suppressed with any n<5.
Source. NC Pastoral Counseling Board Licensure Data and NPPES.

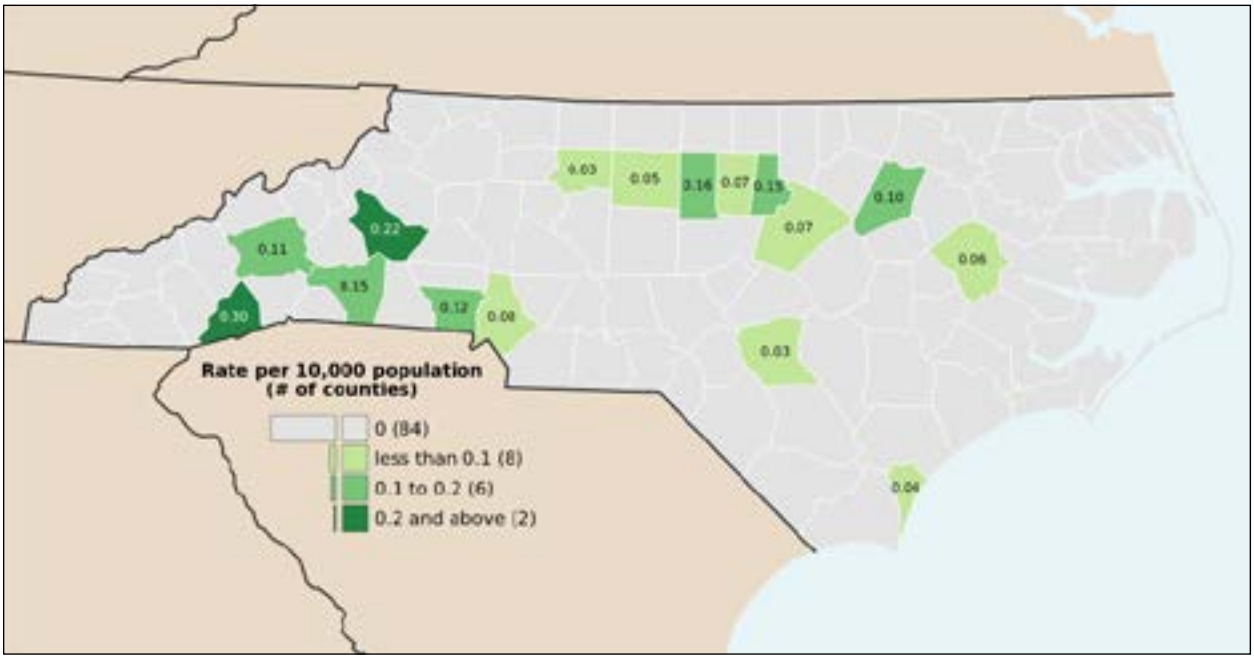
The two data sources also reveal differences in the number of counties in North Carolina that have at least one practicing pastoral counselor. Using NPPES data, 69 counties had no pastoral counselors present, whereas in licensure data 84 counties had no pastoral counselors present (Figure 20, Figure 21).

Figure 20. Pastoral Counselors per 10,000 Population in the National Plan and Provider Enumeration System by County, North Carolina, 2024



Source. NPPES.

Figure 21. Pastoral Counselors per 10,000 Population in the State Licensure Data by County, North Carolina, 2024



Source. NC Pastoral Counseling Board Licensure Data.

Demographic Characteristics of Pastoral Counselors

NPPES data include information on the gender of the workforce. Half of NC Pastoral Counselors in NPPES were female (50.5%). There were some regional differences in the proportion of the pastoral counselor workforce that were female. Eastern AHEC and Mountain AHEC had 20% of their pastoral counselor workforce identify as female, while Greensboro AHEC included 61.5% identifying as female. (Table 80)

ADDICTION COUNSELORS

Addiction counselors in North Carolina provide specialized treatment for individuals experiencing substance use disorders, including alcohol and drug misuse. North Carolina Addictions Specialist Professional Practice Board (NCASPPB) is the licensing and certifying body for substance use disorder professionals in North Carolina. The NCASPPB maintains the licenses and certifications for six roles: Licensed Clinical Addiction Specialists (LCAS), Licensed Clinical Addiction Specialist Associates (LCASA), Certified Alcohol and Drug Counselors (CADC), Certified Prevention Specialist, Certified Criminal Justice Addictions Professional, Certified Clinical Supervisor (CCS).

Table 81. Number and Percentages of Credentials among Addiction Counselors, North Carolina, 2024

Credential	2024 N (%)
Certified Alcohol and Drug Counselors (CADC)	2,407 (26.40)
Certified Criminal Justice Addictions Professional (CCJP)	85 (0.93)
Certified Clinical Supervisor (CCS)	1,177 (12.91)
Certified Prevention Specialist (CPS)	86 (0.94)
Licensed Clinical Addiction Specialists (LCAS)	3,640 (39.92)
Licensed Clinical Addiction Specialists Associate (LCASA)	1,724 (18.91)
Total	9,119 (100.00)

Note. An individual can have more than one credential.
Source. NCASPPB Licensure Data.

CERTIFIED ALCOHOL AND DRUG COUNSELORS

Certified Alcohol and Drug Counselors (CADC) in North Carolina provide addiction treatment services under the supervision of licensed clinicians and perform screening, intake, assessment, treatment planning, individual and group counseling, case management, crisis intervention, and client education for individuals with substance use disorders. CADC practitioners require ongoing supervision throughout their careers and serve as essential frontline providers. CADC entry-level requirements in North Carolina include a high school diploma or equivalent, completion of relevant substance use disorder counseling training, 300 hours of a supervised practicum, and 2,000-6,000 hours of additional supervised practice.

North Carolina's CADC workforce totaled 2,407 active, in-state clinicians in 2024, representing a rate of 2.19 per 10,000 population.

Demographic Characteristics of Certified Alcohol and Drug Counselors

The CADC workforce was predominantly female (71.0%), and 44.7% identified as underrepresented minorities (URM). (Table 82)

There were significant differences in the proportion of the CADC workforce that were from an URM background across AHEC and Tailored Plan areas. Southern Regional (69.9%), Area L (62.7%), and Wake AHEC (61.1%) had the highest proportion of CADCs from URM backgrounds. Mountain AHEC region had significantly lower URM representation at just 11.6%. Alliance and Trillium regions had relatively high URM representation (61.9% and 55.3%, respectively), while Vaya had the lowest at 20.0%. There were relatively small differences between the proportion of the CADC workforce that were URM between metro and nonmetro counties: nonmetro counties at 46.9% and metro counties at 44.0%.

There were modest differences across the regions in the proportion of the CADC workforce that were female. Female representation was highest in Area L (80.3%), followed by Eastern (75.0%) and Greensboro (73.0%). The Mountain AHEC region had the lowest female representation at 66.3%. Female participation in the CADC workforce was similar across Tailored Plan catchment areas, ranging from 68.0% to 73.4%, with Partners showing the highest proportion of women in the CADC workforce (73.4%). Female representation among CADCs was slightly higher in nonmetro counties (73.1%) compared to metro counties (70.3%)

Table 82. Demographics of Certified Alcohol and Drug Counselors by Region, North Carolina, 2024

CADC	N	% Female	% Underrepresented Minority[a]
Statewide	2,407	70.96	44.69
By AHEC Region			
Area L	76	80.26	62.67
Charlotte	392	70.77	53.87
Eastern	309	75.00	52.10
Greensboro	186	72.97	57.38
Mountain	384	66.32	11.58
Northwest	368	72.25	29.20
South East	180	66.67	33.52
Southern Regional	274	72.10	69.85
Wake AHEC	238	68.94	61.11
By Tailored Plan County Catchment Area			
Alliance	563	69.17	61.87
Partners	432	73.43	31.85
Trillium	871	72.70	55.26
Vaya	541	68.04	20.00
By County Urbanicity			
Metro	1,831	70.28	43.99
Nonmetro	576	73.12	46.92

Note. AHEC=Area Health Education Center; CADC=Certified Alcohol and Drug Counselors. Missing values are excluded from percentage calculations.
[a] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
Source. NCASPPB Licensure Data.

Geographic Practice Characteristics of Certified Alcohol and Drug Counselors

CADC workforce distribution showed variation across regions. Mountain AHEC had the highest concentration of CADCs at 4.64 per 10,000 population (n=384), followed by Eastern AHEC at 2.91 per 10,000 (n=309), Southern Regional AHEC at 2.92 per 10,000 (n=274), and South East AHEC at 3.11 per 10,000 (n=180s). Wake AHEC, Charlotte AHEC, and Greensboro AHEC had the fewest CADCs to the population. (Table 83)

Vaya catchment area had the highest rate of CADCs per the population at 2.90 per 10,000 (n=541), while Alliance had the lowest rate of 1.55 CADCs per 10,000 (n=536).

Nonmetro counties had more CADCs per the population compared to metro counties, with nonmetro counties having 576 CADCs at 2.59 per 10,000 population versus metro counties' 1,831 CADCs at 2.09 per 10,000.

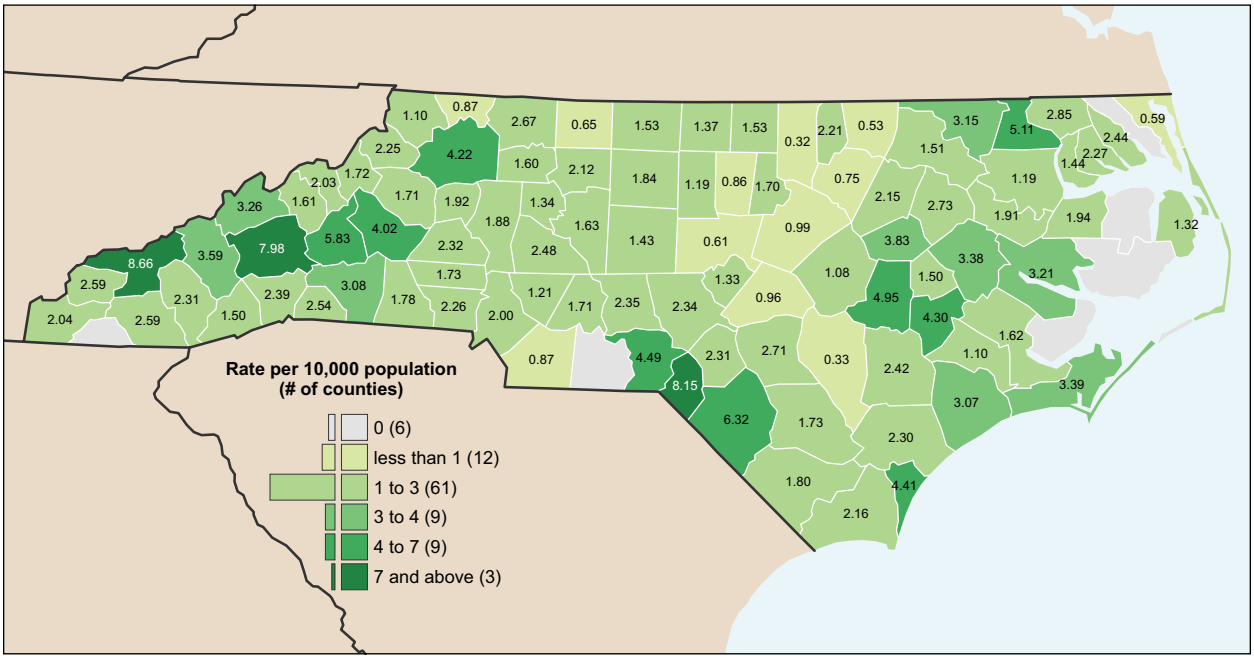
Table 83. Supply of Certified Alcohol and Drug Counselors by Region, North Carolina, 2024

CADC	N	Population[a]	Rate per 10,000 population
Statewide	2,407	10,984,106	2.19
By AHEC Region			
Area L	76	285,994	2.66
Charlotte	392	2,231,872	1.76
Eastern	309	1,060,329	2.91
Greensboro	186	1,256,677	1.48
Mountain	384	827,070	4.64
Northwest	368	1,691,002	2.18
South East	180	578,697	3.11
Southern Regional	274	939,130	2.92
Wake AHEC	238	2,113,335	1.13
By Tailored Plan County Catchment Area			
Alliance	563	3,635,141	1.55
Partners	432	2,277,684	1.90
Trillium	871	3,208,448	2.71
Vaya	541	1,862,833	2.90
By County Urbanicity			
Metro	1,831	8,761,216	2.09
Nonmetro	576	2,222,890	2.59

Note. AHEC=Area Health Education Center; CADC=Certified Alcohol and Drug Counselors.
[b] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCASPPB Licensure Data.

Six counties (6%) had no CADCs, while 18 counties (18%) had CADC per the population rates below 1.0 per 10,000 population. The majority of counties (61; 61%) had CADC rates between 1.0 to 3.0 per 10,000 population. Nine counties (9%) demonstrated rates of 3.0 to 4.0 per 10,000 and another nine counties (9%) showed rates of 4.0 to 7.0 per 10,000. Three counties (3%; Buncombe, Swain, Scotland) had the highest rates of CADCs at 7.0 or more per 10,000 population. (Figure 22)

Figure 22. Certified Alcohol and Drug Counselors (CADCs) per 10,000 Population by County, North Carolina, 2024



Source. NCASPPB Licensure Data.

CERTIFIED CRIMINAL JUSTICE ADDICTIONS PROFESSIONAL

A Certified Criminal Justice Addictions Professional (CCJP) in North Carolina provides addiction-related support to individuals within the criminal justice system, including law enforcement and correctional settings. Their role involves applying their knowledge of addiction and criminal justice processes to help prevent or reduce addiction by screening, assessment, support counseling, and case management.

As of 2024, there were 85 certified CCJP in North Carolina with a rate of 0.08 CCJPs per 10,000 people in the population. The majority of CCJPs were female (68.2%) and close to 39.8% were from an underrepresented minority background.

Demographic Characteristics of Certified Criminal Justice Addictions Professional

Many AHEC regions had small numbers of CCJPs, with any number under 5 being suppressed. The Northwest AHEC region held more than a third of all CCJPs in the state, with 31 CCJPs. Four AHEC regions had six CCJPs and two regions (Area L and Eastern) had less than 5 CCJPs. The remaining two AHEC regions (Charlotte and Mountain) had 13 and 10 CCJPs, respectively. (Table 84)

Due to the small number of CCJPs across AHEC regions and data suppression, identified trends in demographics characteristics across AHEC regions are limited. Female representation in the CCJP workforce across Tailored Plan areas ranged from 54.6% in Alliance to 92.3% in Vaya. Trillium had 71.4% female representation, while Partners demonstrated 62.5%. The variation spans nearly 40 percentage point differences between the highest and lowest tailored plan regions. Nonmetro counties had higher female representation at 77.8% compared to metropolitan counties at 65.7%, representing a 12 percentage point difference.

Alliance led in underrepresented minority representation within the CCJP workforce at 63.6%, followed by Trillium at 47.6% and Vaya at 38.5%. The Partners catchment area had the lowest minority representation at 29.0%, creating more than a two-fold difference between the highest and lowest areas. Metropolitan counties had higher minority representation in the CCJP workforce at 41.5% compared to nonmetropolitan counties at 33.3%, an eight percentage point difference.

Geographic Distribution of Certified Criminal Justice Addictions Professional

The CCJP workforce distribution showed significant regional concentration, with Northwest AHEC and Partners Tailored Plan areas each having the highest rates at 0.18 per 10,000 population. Northwest AHEC contained 31 CCJPs (36% of the statewide workforce), while Partners had 40 CCJPs (47% of the workforce), indicating substantial geographic clustering. Wake AHEC demonstrated the lowest concentration at 0.03 per 10,000, followed by Eastern AHEC (0.04 per 10,000) and Greensboro AHEC (0.05 per 10,000).

There was also variation by Tailored Plan catchment area. The Alliance Tailored Plan area had the lowest rate at 0.03 CCJP per 10,000 with only 11 CCJPs working in that area, while Partners had the highest at 0.18 CCJPs per 10,000 population with 40 CCJPs working. This is nearly a six-fold difference between the two regions. Vaya and Trillium both had 0.07 CCJPs per the population.

CCJP distribution demonstrated equal rates between metropolitan and nonmetropolitan counties (both 0.08 per 10,000).

Table 84. Certified Criminal Justice Addictions Professional by Region, North Carolina, 2024

CCJP	N	Population[a]	Rate per 10,000 population	% Female	% Underrepresented Minority[b]
Statewide	85	10,984,106	0.08	68.23	39.76
By AHEC Region					
Area L	^	285,994	0.10	^	^
Charlotte	13	2,231,872	0.06	69.23	^
Eastern	^	1,060,329	0.04	^	^
Greensboro	6	1,256,677	0.05	83.33	^
Mountain	10	827,070	0.12	80.00	^
Northwest	31	1,691,002	0.18	67.74	36.67
South East	6	578,697	0.10	^	^
Southern Regional	6	939,130	0.06	^	83.33
Wake AHEC	6	2,113,335	0.03	^	^
By Tailored Plan County Catchment Area					
Alliance	11	3,635,141	0.03	54.55	63.64
Partners	40	2,277,684	0.18	62.50	28.95
Trillium	21	3,208,448	0.07	71.43	47.62
Vaya	13	1,862,833	0.07	92.31	38.46
By County Urbanicity					
Metro	67	8,761,216	0.08	65.67	41.54
Nonmetro	18	2,222,890	0.08	77.78	33.33

Note. AHEC=Area Health Education Center; CCJP=Criminal Justice Addictions Professional. Missing values are excluded from percentage calculations.
^Data are suppressed <5.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
[b] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
Source. NCASPPB Licensure Data.

CERTIFIED PREVENTION SPECIALIST

Certified Prevention Specialists (CPS) in North Carolina (formerly known as Certified Substance Abuse Prevention Consultants) are credentialed professionals who focus on preventing substance use disorders and promoting mental health and wellness before problems develop. These specialists work proactively in communities, schools, workplaces, and health care settings to reduce risk factors and strengthen protective factors that influence substance use initiation and progression. Unlike counselors who provide one-to-one or group treatment for individuals with existing substance use disorders, Prevention Specialists work proactively with people in high-risk categories and alcohol and drug education settings.

There were 86 Certified Prevention Specialists (CPS) in North Carolina with an average rate of 0.08 CPS per 10,000 population in 2024. More than three-quarters of CPS workforce were female statewide (78.8%) and close to half of CPS were from an underrepresented minority background (44.7%).

Demographic Characteristics of Certified Prevention Specialists

Due to the small number of CCJPs across AHEC regions and data suppression, identifying trends in demographics characteristics across AHEC regions is limited. Among unsuppressed regions, female representation was the lowest in Eastern AHEC (69.2%) and highest in Mountain AHEC (90.9%). Across Tailored Plan catchment areas, female representation ranged modestly from 74.2% in Trillium to 82.1% in Alliance. The variation between the highest and lowest Tailored Plan areas spans almost eight percentage points. Nonmetro counties had higher female representation at 83.3% compared to metropolitan counties at 77.6%. (Table 85)

Alliance led in URM representation within the CPS workforce among those catchment areas that are not suppressed, at 58.6%. Trillium, by comparison had 48.4% minority representation. Metropolitan counties had lower minority representation in the CPS workforce at 42.7% compared to nonmetropolitan counties at 52.9%, another 10-point percentage point difference.

Geographic Distribution of Certified Prevention Specialists

Because there are few credentialed CPS in North Carolina, it is difficult to assess the geographic distribution of this workforce. Four AHEC regions had higher than the state average of CPS to the population: Area L (0.10 CPS per 10,000), Charlotte (0.10 per 10,000), Eastern (0.12 per 10,000) and Mountain AHEC (0.13 per 10,000). Alliance and Vaya Tailored Plan catchment areas had the average state rate of CPS per the population (0.08 per 10,000), while Trillium had the highest rate of CPS per the population (0.10 per 10,000) and Partners area had the lowest rate of CPS (0.05 per 10,000). Metropolitan and nonmetropolitan counties showed equal CPS rates at 0.08 per 10,000.

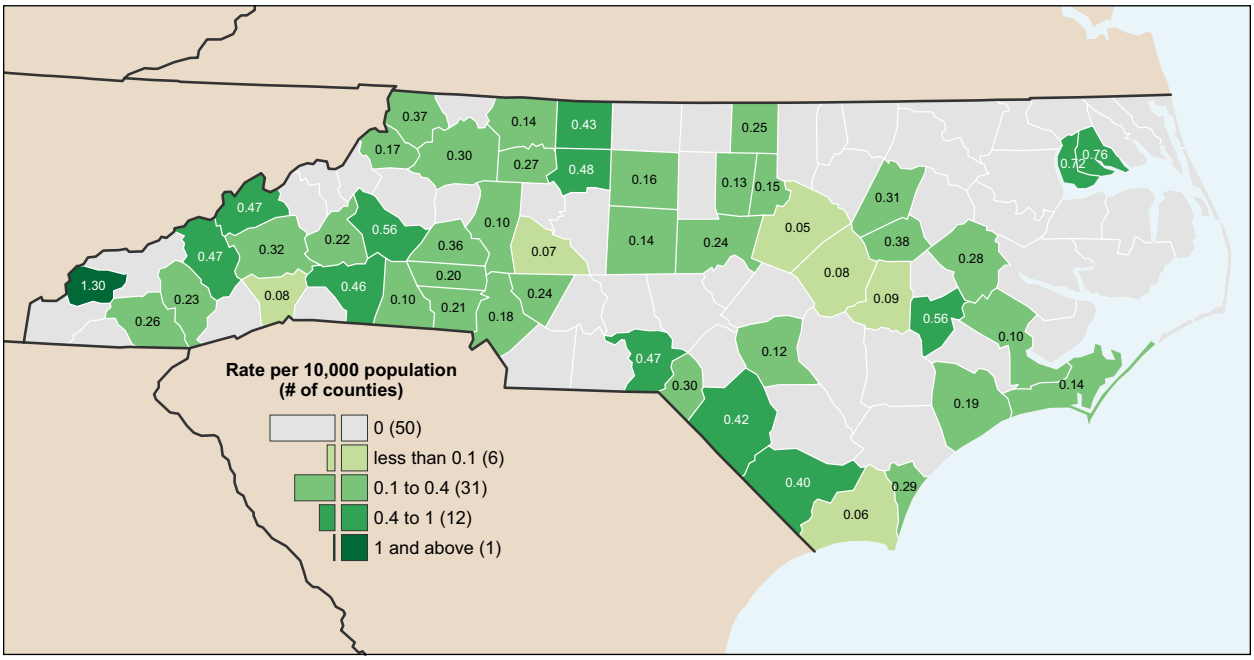
Table 85. Certified Prevention Specialist by Region, North Carolina, 2024

CPS	N	Population[a]	Rate per 10,000 population	% Female	% Underrepresented Minority[b]
Statewide	86	10,984,106	0.08	78.82	44.70
By AHEC Region					
Area L	^	285,994	0.10	^	^
Charlotte	22	2,231,872	0.10	76.19	81.82
Eastern	13	1,060,329	0.12	69.23	46.15
Greensboro	9	1,256,677	0.07	77.77	55.56
Mountain	11	827,070	0.13	90.90	^
Northwest	10	1,691,002	0.06	80.00	^
South East	^	578,697	0.07	^	^
Southern Regional	6	939,130	0.06	^	^
Wake AHEC	8	2,113,335	0.04	87.50	^
By Tailored Plan County Catchment Area					
Alliance	29	3,635,141	0.08	82.14	58.62
Partners	11	2,277,684	0.05	81.82	^
Trillium	31	3,208,448	0.10	74.19	48.39
Vaya	15	1,862,833	0.08	80.00	^
By County Urbanicity					
Metro	68	8,761,216	0.08	77.61	42.65
Nonmetro	18	2,222,890	0.08	83.33	52.94

Note. AHEC=Area Health Education Center; CPS=Certified Prevention Specialists. Missing values are excluded from percentage calculations.
^Data are suppressed <5.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
[b] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
Source. NCASPPB licensure data, NPPES.

Half of North Carolina counties had no CCJP or CPS working (50%). Most counties (n=31) had between 0.1 and 0.4 CCJPs and CPSs per 10,000 population. One county (Graham) had more than 1 CCJP and CPS per 10,000. (Figure 23)

Figure 23. Certified Criminal Justice Addictions Professionals and Certified Prevention Specialists per 10,000 Population by County, North Carolina, 2024



Source. NCASPPB Licensure Data.

LICENSED CLINICAL ADDICTION SPECIALISTS AND LICENSED CLINICAL ADDICTION SPECIALISTS ASSOCIATES

Licensed Clinical Addiction Specialists (LCAS) and LCAS Associates (LCASA) in North Carolina are credentialed professionals who specialize in assessing, diagnosing, and treating individuals with substance use disorders and co-occurring mental health conditions. LCAS professionals provide comprehensive addiction treatment services including individual and group counseling, treatment planning, case management, and crisis interventions. LCASA are professionals who have met educational and examination requirements but are completing supervised clinical experience hours required for full LCAS licensure, working under the supervision of fully licensed professionals.

North Carolina had 3,640 LCAS as of 2024, representing a rate of 3.31 LCAS per 10,000 population. The LCAS workforce was predominantly female at 76.5% and demonstrates considerable diversity with 30.8% from underrepresented minority backgrounds.

Licensed Clinical Addiction Specialists

Demographic Characteristics of Licensed Clinical Addiction Specialists

Female representation in the LCAS workforce varied modestly across AHEC regions, ranging from 71.2% of LCAS in Mountain AHEC to 83.6% of LCAS in Area L AHEC. Metro-nonmetro comparisons revealed slightly higher female representation of the LCAS workforce in metropolitan counties (77.1%) compared to nonmetropolitan counties (73.6%). (Table 86)

Underrepresented minority representation in the LCAS workforce showed significant variation across the AHEC regions, with Southern Regional AHEC demonstrating the highest diversity at 56.8% within the LCAS workforce, followed by Charlotte AHEC at 45.8% and Area L AHEC at 41.7%. In stark contrast, Mountain AHEC showed 6.0% minority representation in the LCAS workforce, representing nearly a 10-fold difference between the proportion of URMs in the LCAS workforce in highest and lowest regions. Underrepresented minority participation varied substantially, with Alliance leading at 44.1%, followed by Trillium at 33.6% and Partners at 24.7%, while Vaya showed the lowest diversity at 11.6%. Differences between metro and nonmetro area indicate there was greater diversity in metro counties (31.7% URM) compared to nonmetro counties (26.5%).

Geographic Distribution of Licensed Clinical Addiction Specialists

LCAS distribution across North Carolina revealed significant regional variation in workforce supply. Mountain AHEC demonstrated the highest rate of LCAS per the population at 7.17 per 10,000 population — more than double the state average — followed by South East AHEC at 4.68 and Eastern AHEC at 3.90 per 10,000. Wake AHEC maintained a rate of 3.12 LCAS per 10,000, slightly below the state average. Area L AHEC had the lowest supply of LCAS to the population at 2.17 per 10,000, followed by Charlotte AHEC (2.54), Northwest AHEC (2.62), and Greensboro AHEC (2.71), all falling below the state average.

Among Tailored Plan catchment areas, Vaya demonstrated the highest LCAS supply to the population at 4.41 per 10,000, followed by Trillium at 3.52 per 10,000. Alliance maintained a near-average rate of 3.24 LCAS per 10,000. Partners catchment area showed the lowest concentration of LCAS per the population at 2.25 per 10,000.

The metro-nonmetro distribution revealed a modest but notable difference in LCAS supply, with metropolitan counties maintaining higher LCAS concentration to the population at 3.43 per 10,000 compared to 2.84 per 10,000 in nonmetropolitan counties.

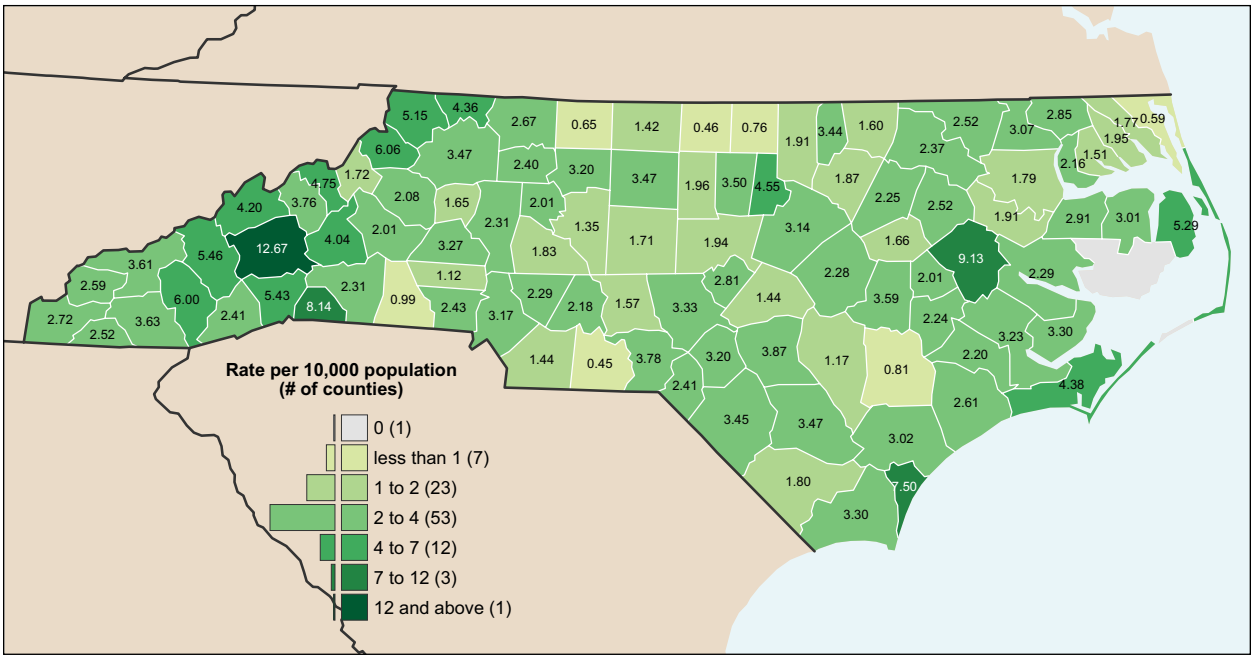
Table 86. Licensed Clinical Addiction Specialists by Region, North Carolina, 2024

LCAS	N	Population[a]	Rate per 10,000 population	% Female	% Underrepresented Minority[b]
Statewide	3,640	10,984,106	3.31	76.49 (2,762)	30.78 (1,109)
By AHEC Region					
Area L	62	285,994	2.17	83.61	41.67
Charlotte	567	2,231,872	2.54	80.00	45.83
Eastern	414	1,060,329	3.90	78.69	33.01
Greensboro	340	1,256,677	2.71	71.68	36.28
Mountain	593	827,070	7.17	71.18	5.99
Northwest	443	1,691,002	2.62	73.55	18.08
South East	271	578,697	4.68	80.00	13.70
Southern Regional	291	939,130	3.10	77.08	56.79
Wake AHEC	659	2,113,335	3.12	78.90	38.84
By Tailored Plan County Catchment Area					
Alliance	1,177	3,635,141	3.24	79.33	44.05
Partners	513	2,277,684	2.25	76.41	24.70
Trillium	1,128	3,208,448	3.52	77.16	33.57
Vaya	822	1,862,833	4.41	71.27	11.59
By County Urbanicity					
Metro	3,009	8,761,216	3.43	77.09	31.68
Nonmetro	631	2,222,890	2.84	73.59	26.45

Note. AHEC=Area Health Education Center; LCAS=Licensed Clinical Addiction Specialist. Missing values are excluded from percentage calculations.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
[b] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
Source. NCASPPB licensure data, NPPES.

Only one county (1%) within North Carolina did not have any LCAS. Eight (8%) had LCAS rates below 1.0 per 10,000 population and 23 counties (23%) had LCAS rates between 1.0 to 2.0 per 10,000 population. The majority of counties (53%) included rates from 2.0 to 4.0 per 10,000 population. Twelve counties (12%) demonstrated rates of 4.0 to 7.0 per 10,000 and another three counties (3%) showed rates of 7.0 to 12.0 per 10,000. Buncombe County achieved the highest concentrations of LCAS at 12.63 per 10,000 population. (Figure 24)

Figure 24. Licensed Clinical Addiction Specialist per 10,000 Population by County, North Carolina, 2024



Source. NCASPPB Licensure Data.

LICENSED CLINICAL ADDICTION SPECIALIST ASSOCIATE WORKFORCE

North Carolina had 1,724 Licensed Clinical Addiction Specialist Associates, representing a rate of 1.57 per 10,000 population. There were approximately two LCAS for every one LCASA (2.1:1) which suggests a growing workforce of LCAS will be practicing within two years.

Demographic Characteristsics of Licensed Clinical Addiction Specialist Associates

The LCASA workforce showed even higher female representation than fully licensed clinical addiction specialists at 81.3%. The LCASA workforce also demonstrates high diversity with 56.0% of LCASA from underrepresented minority background, nearly double the proportion of those from unrepresentative backgrounds compared to the LCAS workforce. (Table 87)

Female representation in the LCASA workforce varied considerably across AHEC regions, ranging from 71.0% in Mountain AHEC to 100% in Area L AHEC, with most regions showing higher female participation than the fully licensed LCAS workforce. Among Tailored Plan catchment areas, female representation showed small differences and ranged from 74.3% in Vaya to 84.1% in Alliance, with Alliance, Trillium, and Partners all exceeding the state average at 78%. Metro-nonmetro comparisons revealed slightly higher female representation of the LCASA workforce in nonmetropolitan counties (83.1%) compared to metropolitan counties (81.0%), reversing the typical geographic trends.

Underrepresented minority representation in the LCAS workforce showed even more substantial variation across AHEC regions than the licensed LCAS workforce, with Southern Regional AHEC demonstrating the highest diversity at 79.7% of LCASA, followed by Area L AHEC at 74.1% and Charlotte AHEC and Wake AHEC both exceeding 66%. Mountain AHEC again showed the lowest minority representation at 12.0% of LCAS workforce, representing more than a six-fold difference between the highest and lowest regions in diversity of the LCASA workforce. Underrepresented minority participation varied considerably across Tailored Plan county catchment areas, with Alliance having the highest LCASA workforce diversity at 69.1%, followed by Trillium at 59.3% and Partners at 54.6%. Vaya showed significantly lower diversity of the LCASA workforce at 24.4%, less than half the rate of other catchment areas. The proportion of the LCASA workforce that was from an underrepresented minority background is nearly equivalent between metro (56.3%) and nonmetro counties (54.7%).

Demographic Characteristsics of Licensed Clinical Addiction Specialist Associates

LCASA distribution across North Carolina showed significant regional variation, though less dramatic than the LCAS workforce. Mountain AHEC demonstrated the highest rate of LCASA to the population at 2.62 per 10,000, followed by Southern Regional AHEC at 2.51 and Eastern AHEC at 2.03 per 10,000. South East AHEC had a rate of 1.73 LCASA per 10,000, while Wake AHEC supply rate was 1.53 per 10,000, slightly below the state average. Charlotte AHEC (1.28), Greensboro AHEC (1.12), Northwest AHEC (1.06), and Area L AHEC (0.94) all fell below the state average.

Among Tailored Plan catchment areas, Alliance had the highest LCASA supply to the population at 1.78 per 10,000, followed closely by Trillium at 1.70 and Vaya at 1.69 per 10,000. Partners catchment area had the lowest supply of LCASA to the population at 0.95 per 10,000, representing nearly a two-fold difference between the highest and lowest catchment area.

The metro-nonmetro distribution revealed a modest difference in the supply of LCASA to the population with metropolitan counties having a slightly higher LCASA supply at 1.60 per 10,000 compared to 1.44 per 10,000 in nonmetropolitan counties.

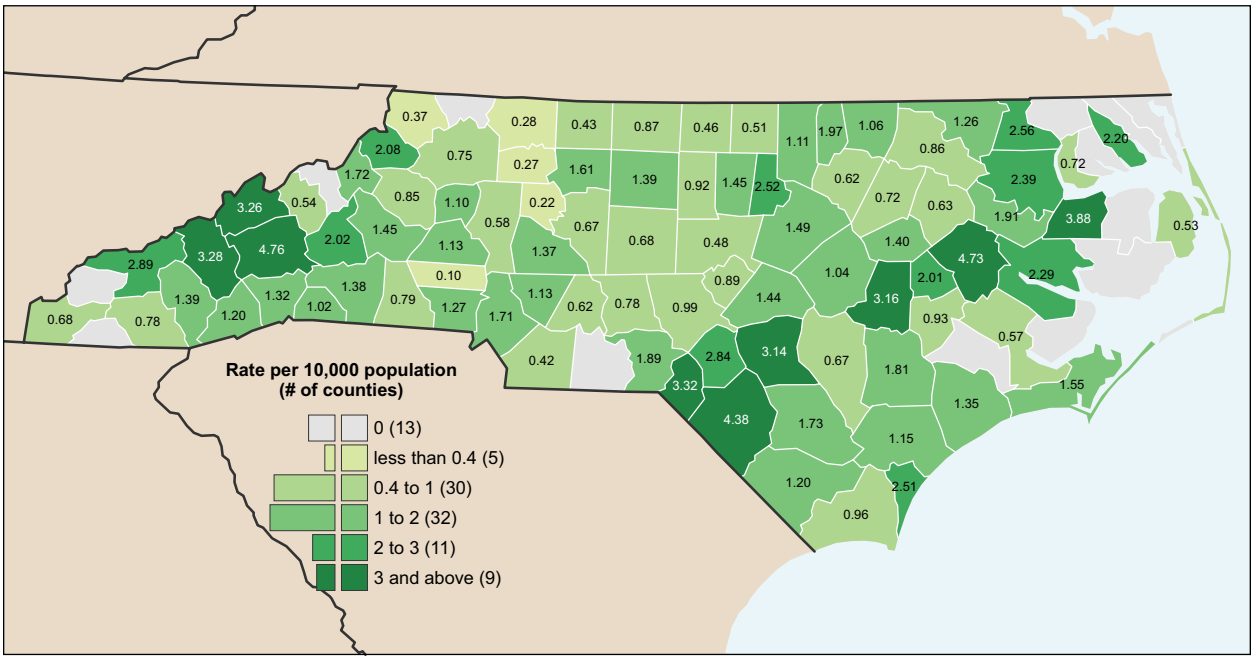
Table 87. Licensed Clinical Addiction Specialist Associates by Region, North Carolina, 2024

LCASA	N	Population[a]	Rate per 10,000 population	% Female	% Underrepresented Minority[b]
Statewide	1,724	10,984,106	1.57	81.32 (1,402)	56.03 (966)
By AHEC Region					
Area L	27	285,994	0.94	100.00	74.07
Charlotte	286	2,231,872	1.28	83.51	66.43
Eastern	215	1,060,329	2.03	81.86	58.14
Greensboro	141	1,256,677	1.12	80.14	59.57
Mountain	217	827,070	2.62	70.97	11.98
Northwest	179	1,691,002	1.06	76.53	47.49
South East	100	578,697	1.73	84.84	33.00
Southern Regional	236	939,130	2.51	86.86	79.66
Wake AHEC	323	2,113,335	1.53	82.97	66.56
By Tailored Plan County Catchment Area					
Alliance	647	3,635,141	1.78	84.08	69.09
Partners	216	2,277,684	0.95	78.14	54.63
Trillium	546	3,208,448	1.70	83.52	59.34
Vaya	315	1,862,833	1.69	74.29	24.44
By County Urbanicity					
Metro	1,404	8,761,216	1.60	80.97	56.34
Nonmetro	320	2,222,890	1.44	83.13	54.69

Note. AHEC=Area Health Education Center; LCASA=Licensed Clinical Addiction Specialist Associate. Missing values are excluded from percentage calculations.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
[b] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
Source. NCASPPB Licensure Data.

There are 13 counties (13%) in North Carolina that did not have any LCASA. Eighteen (18%) counties had LCASA rates below 0.4 per 10,000 population, and 30 counties (30%) had LCASA rates between 0.4 and 1.0 per 10,000 population. The majority of counties (32%) had rates from 1.0 to 2.0 per 10,000 population. Eleven counties (11%) reported rates between 2.0 to 3.0 per 10,000, and nine counties (9%) showed rates of 3.0 and above per 10,000. Buncombe, Pitt, and Robeson counties held the highest concentrations of LCASA at 4.76, 4.73, and 4.38 per 10,000 population, respectively. (Figure 25)

Figure 25. Licensed Clinical Addiction Specialist Associates per 10,000 Population by County, North Carolina, 2024



Source. NCASPPB Licensure Data.

CERTIFIED CLINICAL SUPERVISORS

Certified Clinical Supervisors (CCS) supervise, mentor, and evaluate substance use disorder professionals to ensure appropriate and effective service delivery of substance use disorder services in North Carolina. CCS supervise LCASA working toward independent licensure (i.e., LCAS). To become a CCS, an individual must already be an LCAS in North Carolina, complete 30 hours of clinical supervisor-specific education, gain 4,000 hours (about two years) of supervised clinical supervisory experience, and pass the IC&RC Clinical Supervisor Examination. CCS are critical to expanding the size of the addiction counselor workforce, as LCASA require being supervised by CCS to meet licensing requirements.

North Carolina had 1,177 certified clinical supervisors as of 2024, representing a rate of 1.07 per 10,000 population. (Table 88)

Demographic Characteristics of Certified Clinical Supervisors

Female representation in the CCS workforce varied modestly across AHEC regions, ranging from 68.2% of CCS in Northwest AHEC to 83.3% in Area L AHEC. Female representation remained relatively consistent across Tailored Plan areas, ranging from 70.9% of CCS in Partners to 77.3% in Alliance. Female representation in the CCS workforce was slightly higher in metropolitan counties at 74.8% compared to 70.2% in nonmetro counties.

Underrepresented minority participation in the CCS workforce showed striking regional variation, with Southern Regional AHEC reporting the highest proportion of the workforce from an underrepresented minority background at 62.2%, followed by Charlotte AHEC at 53.7%, while Mountain AHEC region had the lowest diversity at 7.4%. Underrepresented minority representation varied substantially across the Tailored Plan catchment areas, with Alliance demonstrating the highest diversity at 49.9%, followed by Trillium at 35.8%. Partners catchment area had 25.9% minority representation, and Vaya exhibited the lowest proportion at 11.3%, representing more than a four-fold difference between the highest and lowest areas. Metro counties also had greater CCS diversity, with 34.2% underrepresented minority representation compared to 27.9% in nonmetro counties, though this disparity was less pronounced than the metro-nonmetro differences observed in other health professions.

Geographic Distribution of Certified Clinical Supervisors

Certified clinical supervisor distribution across AHEC regions revealed significant geographic variation, with rates ranging from 0.45 to 2.33 CCS per 10,000 population, a more than five-fold difference between the lowest and highest AHEC region. Mountain AHEC demonstrated the highest concentration at 2.33 per 10,000, followed by South East AHEC at 1.59 and Eastern AHEC at 1.44 per 10,000. In contrast, Area L AHEC showed the lowest rate at 0.45 per 10,000, with Northwest, Charlotte, Greensboro, and Wake AHEC all clustered near or below the state average (0.82 to 0.96 per 10,000).

The four Tailored Plan catchment areas demonstrated more moderate variation in certified clinical supervisor distribution than AHEC regions. Vaya catchment area had the highest rate of CCS per the population at 1.45 per 10,000, followed by Trillium at 1.17 per 10,000, both exceeding the state average. Alliance maintained a near state average rate of 0.99 CCS per 10,000, while Partners showed the lowest supply of CCS to the population at 0.74 per 10,000. Metropolitan counties had a modestly higher supply of certified clinical supervisors to the population compared to nonmetropolitan areas (1.10 versus 0.96 per 10,000).

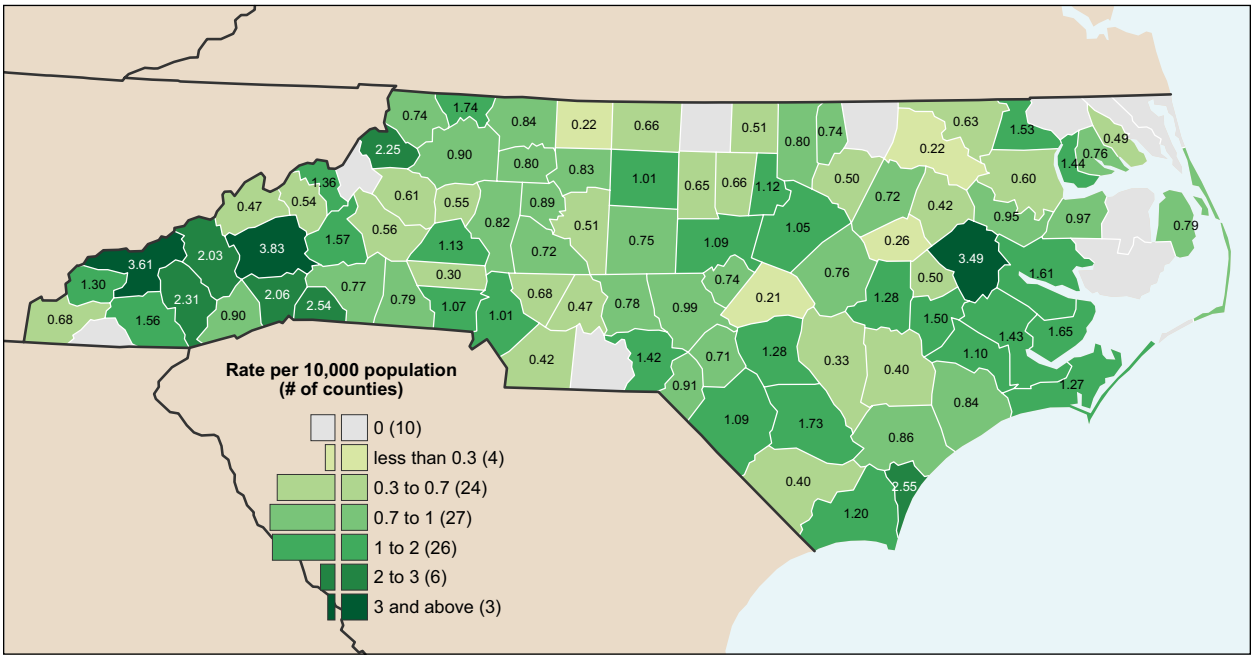
Table 88. Certified Clinical Supervisors by Region, North Carolina, 2024

CCS	N	Population[a]	Rate per 10,000 population	% Female	% Underrepresented Minority[b]
Statewide	1,177	10,984,106	1.07	74.01 (860)	33.10 (384)
By AHEC Region					
Area L	13	285,994	0.45	83.33	41.67
Charlotte	188	2,231,872	0.84	75.81	53.72
Eastern	153	1,060,329	1.44	80.39	40.40
Greensboro	106	1,256,677	0.84	68.87	31.43
Mountain	193	827,070	2.33	70.49	7.41
Northwest	138	1,691,002	0.82	68.15	14.93
South East	92	578,697	1.59	73.91	13.04
Southern Regional	91	939,130	0.97	69.66	62.22
Wake AHEC	203	2,113,335	0.96	77.00	41.21
By Tailored Plan County Catchment Area					
Alliance	361	3,635,141	0.99	77.25	49.86
Partners	169	2,277,684	0.74	70.91	25.90
Trillium	376	3,208,448	1.17	73.80	35.75
Vaya	271	1,862,833	1.45	71.91	11.32
By County Urbanicity					
Metro	964	8,761,216	1.10	74.84	34.24
Nonmetro	213	2,222,890	0.96	70.19	27.88

Note. AHEC=Area Health Education Center; CCS= Certified Clinical Supervisors. Missing values are excluded from percentage calculations.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
[b] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
Source. NCASPPB licensure data, NPPES.

There were 10 counties (10%) in North Carolina that did not have any CCS. Fourteen (14%) counties held CCS rates below 0.3 per 10,000 population. The counties were evenly split between the next three categories; 24 counties (24%) between 0.3 to 0.7; 27 counties (27%) between 0.7 to 1; 26 counties (26%) between 1.0 to 2.0 per 10,000 population. Six counties (6%) report rates of 2.0 to 3.0 per 10,000 population. Buncombe, Swain, and Pitt counties held the highest concentrations of CCS at 3.0 and above (3.83, 3.61, and 3.49, respectively). (Figure 26)

Figure 26. Certified Clinical Supervisors per 10,000 Population by County, North Carolina, 2024



Source. NCASPPB Licensure Data.

HEALTH AND ALLIED HEALTH OCCUPATIONS SUMMARY

North Carolina's MH/SU services system relies on a diverse workforce of health and allied health professionals who provide specialized services. These professionals address the comprehensive needs of individuals experiencing mental health and substance use disorders through rehabilitation, communication support, therapeutic activities, and specialized nursing care. (Table 89)

The MH/SU services health/allied health workforce includes 3,743 MH/SU Registered Nurses (3.41 per 10,000), 570 MH/SU Licensed Practical Nurses (0.52 per 10,000), 7,648 Speech Language Pathologists (6.96 per 10,000), 118 Occupational Therapists in MH settings (0.11 per 10,000), 44 Occupational Therapy Assistants in MH (0.04 per 10,000), 853 Licensed Recreational Therapists (0.78 per 10,000), 1,362 Behavioral Analysts (1.24 per 10,000), and 95 Assistant Behavior Analysts (0.09 per 10,000).

Table 89. Health and Allied Health Workforce Summary of Findings, North Carolina

Occupation	Supply (2024)	Rate per 10,000 Population	% Over Age 65	% Female	% Underrepresented Minority[a]
MH/SU Registered Nurses (RNs)	3,743	3.41	10.07	83.89	34.57
MH/SU Licensed Practical Nurses (LPNs)	570	0.52	7.72	90.00	47.57
Speech Language Pathologists (SLPs) & Speech Language Pathology Assistants	7,648	6.96	NA	NA	NA
Occupational Therapists (OTs)	4,928	4.49	3.3	91.0	9.5
OTs in Mental Health Settings	118	0.11	5.93	89.74	16.67
Occupational Therapy Assistants (OTAs)	2,107	1.92	2.7	88.5	13.9
OTAs in Mental Health Settings	44	0.04	^	86.36	11.36
Licensed Recreational Therapists (RTs)	853	0.78	NA	88.39	18.86
Behavior Analysts (BAs)	1,362	1.24	NA	NA	NA
Assistant Behavior Analysts (ABAs)	95	0.09	NA	NA	NA

Note. MH/SU=Mental Health/Substance Use Services. NA=Not available. Missing values are excluded from percentage calculations.
[a] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
Source. NCBON, NCBOESLPA, NCBOT, NCBRTL, and NCBALB Licensure Data.

Demographics and Training Location

- The health and allied health workforce is a relatively young workforce, with MH/SU services RNs being the older cohort (10.1%) over 65 and OTAs in mental health the youngest with less than 2.3% over 65.
- The MH/SU services health/allied health workforce is overwhelmingly female with more than 80% of each credential's workforce identifying as female.
- The health/allied health workforce had a higher proportion of the workforce coming from an underrepresented minority background than other MH/SU services workforce occupation categories. Close to half of MH/SU services LPNs are from an underrepresented background (47.6%), while OTs have the lowest proportion of the workforce from an underrepresented background (9.5%) in this category.

Geographic Distribution

Table 90 describes the distribution between AHEC region, Tailored Plan area, and metro-nonmetro county for eight MH/SU services health and allied health types. All health and allied health occupations showed regional differences; however, the regional trends were different than other MH/SU services credentials included in this report. Cells shaded orange represent lower than the state average while cells shaded blue represent higher than the state average.

- Wake AHEC had workforce rates above state average for all but two occupations (OTAs and ABAs). Charlotte AHEC had workforce rates below state average for all but one occupation (BAs).
- Tailored Plans varied in distribution patterns for the health/allied health credentials in MH/SU services. Partners Tailored Plan was below the state average across all roles. Trillium was below in most credentials except for MH/SU LPNs at 0.59 and OTAs at 0.04, which were the only two MH/SU credentials Alliance was lower than (MH/SU LPNs at 0.43 and MH/SU OTAs at 0.02).
- Metro counties had higher rates for seven of the eight credentials than nonmetro county rates. Only MH/SU LPNs had a higher nonmetro rate (0.63) per 10,000 population than metro (0.49).

Table 90. Supply of Health and Allied Health Workforce by Geographic Region, North Carolina, 2024

	MH/SU RNs per 10,000	MH/SU LPNs per 10,000	SLPs Rate per 10,000	OTs in MH Settings Rate per 10,000	OTAs in MH Settings per 10,000	LRT/ LRTA per 10,000	BAs per 10,000	ABAs per 10,000
Statewide	3.41	0.52	6.96	0.11	0.04	0.78	1.24	0.09
By AHEC Region								
Area L	1.99	0.80	3.74	0.03	^	0.45	0.17	^
Charlotte	2.29	0.32	6.92	0.09	^	0.48	1.75	0.05
Eastern	4.29	0.77	5.39	0.15	0.12	0.88	0.92	0.05
Greensboro	2.45	0.33	7.37	0.15	-	0.71	0.74	^
Mountain	4.64	0.59	7.21	0.16	0.06	0.65	0.68	--
Northwest	4.08	0.55	6.48	0.07	0.05	0.92	0.92	^
South East	2.80	0.45	7.31	--	^	1.04	1.71	0.09
Southern Regional	2.51	0.46	6.22	0.04	^	0.40	1.61	0.63
Wake AHEC	4.45	0.66	8.48	0.16	0.03	0.77	1.48	0.03
By Tailored Plan County Catchment Area								
Alliance	3.49	0.43	8.38	0.13	0.02	0.60	1.88	0.17
Partners	3.14	0.48	6.26	0.07	0.03	0.78	1.08	0.03
Trillium	2.84	0.59	6.28	0.07	0.06	0.77	0.99	0.08
Vaya	4.54	0.62	6.18	0.18	0.05	0.71	0.61	^
By County Urbanicity								
Metro	3.49	0.49	7.42	0.11	0.04	0.76	1.44	0.10
Nonmetro	3.07	0.63	5.14	0.11	0.04	0.48	0.45	0.04

Note. AHEC=Area Health Education Center; MH/SU-Mental Health and Substance Use Services; RN=Registered Nurses; LPN=Licensed Practical Nurses; SLP=Speech-Language Pathology; OT=Occupational Therapists; OTA=Occupational Therapy Assistant; MH=Mental Health; LRT=Licensed Registered Therapists; BA=Behavior Analyst; ABA=Assistant Behavior Analyst.
^Data suppressed with any n<5.
Pale orange = lower than state average, Light blue = higher than state average
Source. NCBON, NCBOESLPA, NCBOT, NCBRTL, and NCBALB Licensure Data.

HEALTH AND ALLIED HEALTH OCCUPATIONS

A wide range of health and allied health professionals provide essential services within North Carolina's mental and MH/SU services system. This section examines seven health and allied health disciplines practicing in mental health settings or specializing in psychiatry or MH/SU services: Registered Nurses (RNs), Licensed Practical Nurses (LPN), Clinical Nurse Specialists (CNS), Speech Language Pathologists (SLPs), Occupational Therapists (OTs), Occupational Therapy Assistants (OTAs), and Licensed Recreational Therapists (LRTs; including Licensed Recreational Therapist Assistants [LRTAs]). These professionals bring unique expertise to address the comprehensive needs of individuals experiencing mental health and substance use disorders through rehabilitation, communication support, therapeutic interventions and programs, and specialized nursing care.

MENTAL HEALTH AND SUBSTANCE USE SERVICES REGISTERED NURSES

Registered nurses (RN) working in mental health settings provide specialized nursing care for individuals with psychiatric, mental health, and substance abuse conditions. RNs in mental health and substance use service settings provide comprehensive psychiatric nursing care including medication administration, patient assessment, and coordination of multidisciplinary treatment plans for individuals experiencing mental health and substance use disorders. This report defines MH/SU services RNs as those whose employment setting is reported to be mental health or whose practice specialty is psychiatric/mental health/substance use.

In 2024, North Carolina had 3,743 RNs practicing in mental health and substance use services settings, representing a statewide rate of 3.41 MH/SU services RNs per 10,000 population. This is 3.1% of the total RN workforce practicing in the state in 2024 (n=120,267).

Demographic Characteristics of Mental Health and Substance Use Services Registered Nurses

MH/SU services RNs had a mean age of 48.8 years (SD=12.1) with approximately 10.1% over age 65. The workforce in 2024 was predominantly female at 83.9% (n=3,140). Underrepresented minority (URM) representation in the MH/SU services RN workforce was substantial, with 34.6% of RNs working in mental and MH/SU services identifying as a URM. (Table 91)

While the average age of RNs working in MH/SU settings did not widely vary across regions of the state, there were regional differences in the proportion of the workforce over the age of 65. The Charlotte AHEC region had the lowest proportion of RNs over the age of 65 (7.6%), and the South East AHEC region had the highest proportion of RNs over the age of 65 (15.4%). Overall, the MH/SU services registered nurse workforce was a relatively young workforce.There was geographic variation across regions in the proportion of the MH/SU services RN workforce from a URM background. Southern Regional AHEC demonstrated the highest minority representation at 56.2%, followed by Wake AHEC at 54.5%, while Mountain AHEC shows the lowest at 7.7%. Among Tailored Plan areas, Alliance demonstrated the highest minority representation at 51.1%, while Partners showed the lowest at 17.8%. Nonmetro counties had a higher minority representation (37.8%) compared to metro counties (33.9%).

There were modest differences in the proportion of MH/SU services RN workforce that were female across regions. Among AHEC regions, female representation ranged from 81.3% in Wake AHEC to 92.0% in South East AHEC. Tailored Plan areas showed similarly modest variation, with female representation ranging from 79.9% in Vaya to 87.3% in Trillium. Metro and nonmetro counties had no difference in female participation rates in the RN workforce at 83.9% and 83.9% respectively.

Table 91. Demographic Characteristics of Mental Health and Substance Use Services Registered Nurses by Region, North Carolina, 2024

RN	N	Mean Age (SD)	Age Range	% (N) ≥65 years	% (N) Female	% (N) Underrepresented Minority[a]
Statewide	3,743	48.79 (12.1)	21–84	10.07 (377)	83.89 (3,140)	34.57 (1,222)
By AHEC Region						
Area L	57	49.74 (10.0)	23–70	^	85.96 (49)	42.59 (23)
Charlotte	511	46.92 (11.8)	21–79	7.63 (39)	88.06 (450)	33.95 (166)
Eastern	455	49.31 (12.0)	22–78	9.89 (45)	86.15 (392)	27.52 (120)
Greensboro	308	47.83 (12.2)	22–76	8.47 (26)	82.74 (254)	43.55 (125)
Mountain	384	47.84 (12.7)	23–82	10.42 (40)	82.55 (317)	7.69 (28)
Northwest	690	49.72 (12.0)	21–84	10.87 (75)	81.88 (565)	20.81 (138)
South East	162	49.05 (14.2)	23–83	15.43 (25)	91.98 (149)	16.77 (26)
Southern Regional	236	48.08 (12.1)	22–81	10.17 (24)	84.32 (199)	56.16 (123)
Wake AHEC	941	49.64 (11.9)	21–82	10.63 (100)	81.30 (765)	54.49 (473)
By Tailored Plan County Catchment Area						
Alliance	1,270	48.06 (12.0)	21–82	9.61 (122)	84.25 (1,070)	51.05 (607)
Partners	716	48.89 (11.8)	21–79	9.64 (69)	83.66 (599)	17.83 (123)
Trillium	911	48.93 (12.5)	22–83	10.21 (93)	87.27 (795)	30.44 (263)
Vaya	846	49.64 (12.2)	23–84	10.99 (93)	79.91 (676)	28.91 (229)
By County Urbanicity						
Metro	3,061	48.57 (12.1)	21–83	9.90 (303)	83.89 (2,568)	33.85 (980)
Nonmetro	682	49.78 (12.2)	23–84	10.85 (74)	83.87 (572)	37.81 (242)

Note. AHEC=Area Health Education Center; SD=Standard Deviation; RN=Registered Nurses; Missing values are excluded from percentage calculations.
[a] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
^Data suppressed with any n<5.
Source. NCBON licensure data, NPPES.

Geographic Distribution of Mental Health and Substance Use Services Registered Nurses

The MH/SU services RN workforce demonstrated significant geographic variation across AHEC regions in 2024. Rates ranged from 1.99 RNs per 10,000 population in Area L to 4.64 per 10,000 in Mountain AHEC, representing more than a two-fold difference between the two regions. Wake AHEC had both the largest absolute number of MH/SU services RNs (941) and a high rate of 4.45 per 10,000 population. (Table 92)

Among the four Tailored Plan catchment areas, Alliance maintained the largest MH/SU services RN workforce with 1,270 RNs, a rate of 3.49 per 10,000 population. Vaya had the highest workforce distribution at 4.54 per 10,000 population, while Trillium was the lowest at 2.84 per 10,000. Metro counties had a slightly higher concentration of MH/SU services RNs to the population (3.49 per 10,000 population) compared to nonmetro areas (3.07 per 10,000 population).

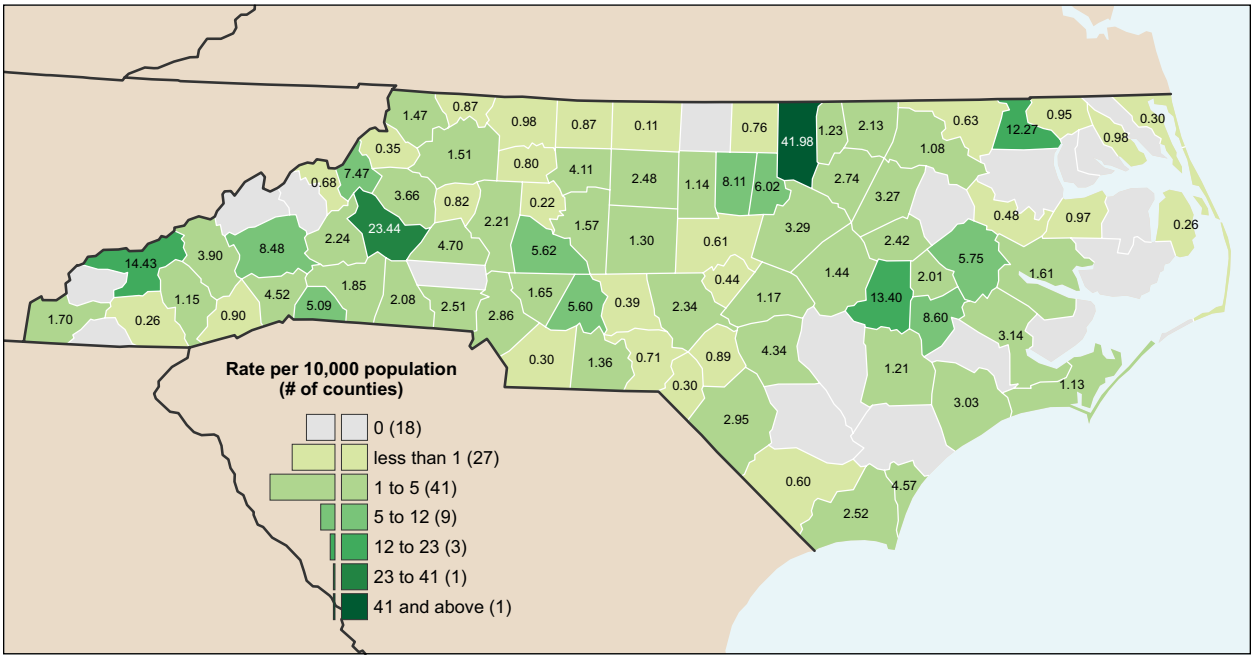
Table 92. Mental Health and Substance Use Services Registered Nurses by Region, North Carolina, 2024

MH/SU Services RN	N	Population[a]	Rate per 10,000 population
Statewide	3,743	10,984,106	3.41
By AHEC Region			
Area L	57	285,994	1.99
Charlotte	511	2,231,872	2.29
Eastern	455	1,060,329	4.29
Greensboro	308	1,256,677	2.45
Mountain	384	827,070	4.64
Northwest	690	1,691,002	4.08
South East	162	578,697	2.80
Southern Regional	236	939,130	2.51
Wake AHEC	941	2,113,335	4.45
By Tailored Plan County Catchment Area			
Alliance	1,270	3,635,141	3.49
Partners	716	2,277,684	3.14
Trillium	911	3,208,448	2.84
Vaya	846	1,862,833	4.54
By County Urbanicity			
Metro	3,061	8,761,216	3.49
Nonmetro	682	2,222,890	3.07

Note. AHEC=Area Health Education Center; RN=Registered Nurses. MH/SU=Mental Health/Substance Use.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCBON Licensure Data.

The rate of MH/SU services RNs per population varied across counties in North Carolina. Eighteen counties had no RNs who report working in MH/SU services. Forty-five counties had less than 1 RN per 10,000 population. Forty-one counties had 1 to 5 RNs per 10,000 population, and nine counties had 5 to 12 RNs per 10,000 population. Five counties had the highest rate of RNs per 10,000 population including three counties (Swain, Wayne, Hertford) with 12 to 23 RNs per 10,000 population, one county (Burke) with 23 to 41 RNs per 10,000 population, and one county (Granville) with more than 41 RNs per 10,000 population. (Figure 27)

Figure 27. Mental Health and Substance Use Services Registered Nurses per 10,000 Population by County, North Carolina, 2024



Source. NCBON Licensure Data.

Practice Settings of Mental Health and Substance Use Services Registered Nurses

Most MH/SU services RNs worked in mental health facilities (n=1,711; 45.7%), followed by hospitals (n=1,334; 35.6%). Other significant employment settings of mental and MH/SU services RNs included ambulatory care (n=128; 3.4%), community health (n=116; 3.1%), and correctional facilities (n=54; 1.4%). (Table 93)

Table 93. Primary Employment Settings of Mental Health and Substance Use Services Registered Nurses, North Carolina, 2024

Setting	N	% of MH/SU RNs
Mental Health	1,711	45.71
Hospital	1,334	35.64
Other	224	5.98
Ambulatory Care Setting	128	3.42
Community Health	116	3.10
Correctional Facility	54	1.44
Insurance Claims/Benefits	41	1.10
Nursing Home / Extended Care	32	0.85
Academic Setting	30	0.80
Public Health	28	0.75
All other settings	45	1.21

Source. NCBON Licensure Data.

Location of Educational Training of RNs Working in Mental Health and Substance Use Services

The majority of RNs working in MH/SU services that were active and in-practice in 2024 were trained in-state (71.0%). The educational patterns among RNs shifted between 2014 and 2024, showing a slightly decreased reliance on out-of-state training programs. In-state educated RNs increased from 69.2% of the workforce in 2014 to 71.0% in 2024, while out-of-state educated RNs decreased from 30.8% to 29.0% over the same period. (Table 94)

Table 94. Training Location of Mental Health and Substance Use Services Registered Nurses, North Carolina, 2014 and 2024

	2014 MH/SU RN (N = 2,085)		2024 MH/SU RN (N= 3,743)	
	N	%	N	%
Education				
In-state	1,413	69.16	2,542	70.97
Out-of-state	630	30.84	1,040	29.03
Not Available	42	--	161	--

Note. MH/SU=Mental Health and Substance Use Services; RN=Registered Nurses. Missing values are excluded from percentage calculations.
Source. NCBON Licensure Data.

MENTAL HEALTH AND SUBSTANCE USE SERVICES LICENSED PRACTICAL NURSES

Licensed Practical Nurses (LPNs) in MH/SU services provide direct patient care, administer medications, monitor patient behavior and symptoms, and document patient progress under the supervision of registered nurses and physicians. Their role includes offering support, ensuring patient safety, assisting with daily living activities, and communicating crucial information to the treatment team. This report defines MH/SU services LPNs as those working in psychiatric, mental health, or substance use settings, or those in who designated they work in a mental health specialty area.

As of 2024, North Carolina had 570 LPNs working in MH/SU services settings, representing a rate of 0.52 per 10,000 population. MH/SU services LPNs constituted 3.2% of North Carolina's total LPN workforce and experienced substantial growth, nearly doubling from 293 in 2014 to 570 in 2024. MH/SU services LPNs per 10,000 population increased in the same period from 0.30 to 0.52. In contrast, the total LPN workforce contracted between 2014 and 2024, declining from 18,085 to 17,618 nurses (2.6% decrease), with the overall rate per 10,000 population dropping from 18.30 to 16.04. (Table 95)

Table 95. Comparison of the Total Licensed Practical Nurse Workforce to Mental Health and Substance Use Services Licensed Practical Nurses in North Carolina, 2014 and 2024

Year	MH/SU Services LPN N	MH/SU Services LPN Rate Per 10k	All NC LPNs N	All NC LPN Rate per 10k
2014	293	0.30	18,085	18.30
2024	570	0.52	17,618	16.04

Note. MH/SU=Mental Health and Substance Use; LPN=Licensed Practical Nurses.
Source. NCBON Licensure Data.

Demographic Characteristics of Mental Health and Substance Use Services Licensed Practical Nurses

LPNs working in mental health settings in 2024 had a mean age of 47.5 years (SD=11.9) with 7.7% over age 65. The workforce was predominantly female at 90.0% (n=513). The proportion of LPNs from underrepresented minority background was substantial at 47.6% (n=254) of the workforce. (Table 96)

Age across AHEC regions showed modest variation. Wake AHEC had the oldest mental health LPN workforce at a mean age of 50.3 years, followed by South East AHEC at 50.0 years. The youngest workforce was found in Area L AHEC with a mean age of 44.1 years, followed by Southern Regional AHEC at 45.1 years. Age distribution among Tailored Plan areas shows Vaya with the oldest workforce at a mean age of 50.2 years, while Partners had the youngest at 44.7 years. Alliance and Trillium show similar ages at 47.3 and 47.7 years respectively. Nonmetro counties have a slightly older workforce with a mean age of 49.0 years compared to 47.0 years in metropolitan counties. The proportion over 65 is also higher in nonmetropolitan counties (9.9%) compared to metropolitan counties (7.0%).

Female representation of the LPN workforce was consistently high across all regions. Charlotte AHEC had the highest proportion of the workforce identifying as female at 95.8% and South East AHEC had the lowest

female representation at 84.6% of the LPN workforce. Female representation varied modestly across tailored plan areas, ranging from 88.7% in Vaya to 91.5% in Trillium. Alliance (89.1%) and Partners (90.0%) fell between these extremes, showing consistent female representation across all catchment areas. Female representation was slightly higher in nonmetro counties at 92.2% compared to 89.3% in metro areas.

Underrepresented minority representation in the LPN workforce showed significant regional variation. Wake AHEC had the highest at 72.2% minority representation, followed closely by Greensboro AHEC at 71.9% and Charlotte AHEC at 58.8%. In contrast, South East AHEC (20.8%) and Mountain AHEC (21.3%) demonstrated the lowest minority representation, representing more than a three-fold difference between the highest and lowest regions. Underrepresented minority representation also varied substantially among tailored plan areas. Alliance had the highest minority representation at 69.4%, followed by Trillium at 49.2%. Partners had the lowest at 28.7%, while Vaya showed 34.6%, representing more than a two-fold difference between Alliance and Partners. However, there were minimal differences in underrepresented minority representation between metro-nonmetro counties, with metropolitan counties at 48.1% and nonmetropolitan counties at 45.9%.

Table 96. Demographic Characteristics of Mental Health and Substance Use Services Licensed Practical Nurses by Region, North Carolina, 2024

LPN in Mental Health	N	Mean Age (SD)	% ≥65 years	% Female	% Underrepresented Minority[a]
Statewide	570	47.52 (11.9)	7.72	90.00	47.57
By AHEC Region					
Area L	23	44.13 (13.2)	^	95.65	52.38
Charlotte	72	46.42 (9.4)	^	95.83	58.82
Eastern	82	46.98 (13.3)	10.98	91.46	49.37
Greensboro	42	48.07 (11.9)	11.90	88.10	71.88
Mountain	49	47.31 (11.5)	^	91.84	21.28
Northwest	93	45.74 (11.8)	^	88.17	25.30
South East	26	50.04 (13.0)	^	84.62	20.83
Southern Regional	43	45.07 (12.6)	^	95.35	47.37
Wake AHEC	140	50.34 (13.8)	10.71	85.71	72.18
By Tailored Plan County Catchment Area					
Alliance	156	47.31 (10.9)	7.05	89.10	69.39
Partners	110	44.73 (11.2)	^	90.00	28.71
Trillium	189	47.68 (12.9)	10.05	91.53	49.16
Vaya	115	50.21 (11.6)	8.70	88.70	34.58
By County Urbanicity					
Metro	429	47.03 (11.7)	6.99	89.28	48.12
Nonmetro	141	49.00 (12.3)	9.93	92.20	45.93

Note. AHEC=Area Health Education Center; LPN=Licensed Practical Nurse; SD=Standard Deviation. Missing values are excluded from percentage calculations.
a Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
Source. NCBON licensure data, NPPES.

A slight majority of mental health LPNs were white at 50.8% of the workforce (n=271), followed closely by Black or African American LPNs at 43.1% (n=230). Other racial and ethnic groups represented smaller proportions of the workforce: Hispanic or Latino LPNs comprised 1.7% (n=9), Asian LPNs represented 1.5% (n=8), American Indian LPNs accounted for 1.1% (n=6), and practitioners identifying as "Other" represented 1.7% (n=9). Hawaiian Pacific Islander LPNs comprised less than 0.5% of the workforce. (Table 97)

Table 97. Race/ethnicity of Mental Health and Substance Use Services Licensed Practical Nurses, North Carolina, 2024

MH/SU LPN (N=570)	N	%
Race/Ethnicity		
American Indian	6	1.12
Asian	8	1.50
Black or African American	230	43.07
White	271	50.75
Hispanic or Latino	9	1.69
Other	9	1.69
Hawaiian Pacific Islander	^	^
Missing	36	--

Note. LPN=Licensed Practical Nurse. MH/SU=Mental Health/Substance Use Services. Missing values are excluded from percentage calculations.
^Data suppressed with any n<5.
Source. NCBON Licensure Data.

Geographic Distribution of Mental Health and Substance Use Services Licensed Practical Nurses

MH/SU services LPN distribution across North Carolina's nine AHEC regions varied significantly in supply and rate per the population. Area L AHEC had the highest rate at 0.80 per 10,000 population with 23 LPNs, followed by Eastern AHEC at 0.77 per 10,000 with 82 LPNs. Wake AHEC had a rate of 0.66 per 10,000 with the largest absolute workforce of 140 LPNs. Mountain AHEC (0.59 per 10,000) and Northwest AHEC (0.55 per 10,000) exceeded the state average, while Charlotte AHEC and Greensboro AHEC had the lowest concentrations at 0.32 and 0.33 per 10,000, respectively, representing more than a two-fold difference between the highest and lowest regions. (Table 98)

Among the four Tailored Plan catchment areas, Vaya had the highest mental health LPN rate per the population at 0.62 per 10,000 with 115 LPNs working. Trillium had the largest workforce with 189 LPNs at a rate of 0.59 per 10,000. Partners had a rate of 0.48 per 10,000 with 110 LPNs, while Alliance had the lowest rate of the catchment areas at 0.43 per 10,000 with 156 mental health LPNs.

The metro-nonmetro distribution revealed an atypical pattern where nonmetropolitan counties had higher mental health LPN supply per the population at 0.63 per 10,000 compared to metropolitan counties at 0.49 per 10,000. Nonmetro counties had 141 mental health LPNs while metro counties had 429 LPNs working.

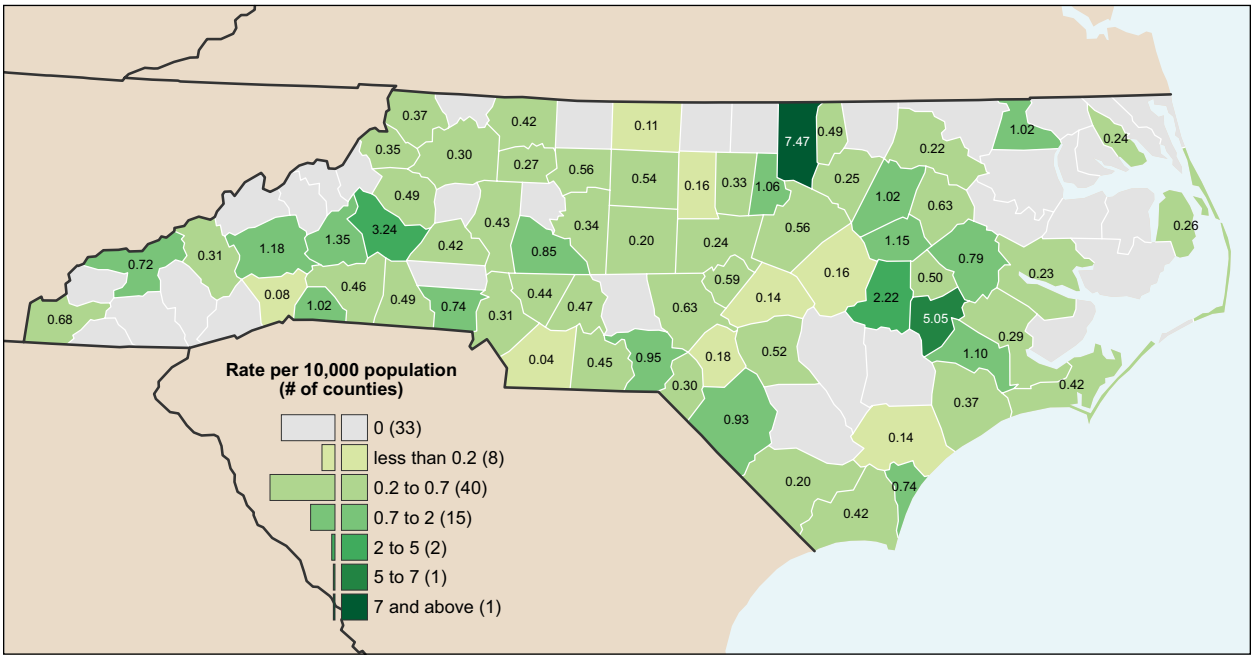
Table 98. Supply of Mental Health and Substance Use Services Licensed Practical Nurses by Region, North Carolina, 2024

LPN in Mental Health Settings	N	Population[a]	Rate per 10,000 population
Statewide	570	10,984,106	0.52
By AHEC Region			
Area L	23	285,994	0.80
Charlotte	72	2,231,872	0.32
Eastern	82	1,060,329	0.77
Greensboro	42	1,256,677	0.33
Mountain	49	827,070	0.59
Northwest	93	1,691,002	0.55
South East	26	578,697	0.45
Southern Regional	43	939,130	0.46
Wake AHEC	140	2,113,335	0.66
By Tailored Plan County Catchment Area			
Alliance	156	3,635,141	0.43
Partners	110	2,277,684	0.48
Trillium	189	3,208,448	0.59
Vaya	115	1,862,833	0.62
By County Urbanicity			
Metro	429	8,761,216	0.49
Nonmetro	141	2,222,890	0.63

Note. AHEC=Area Health Education Center; LPN=Licensed Practical Nurse.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCBON Licensure Data.

Thirty-three counties (33%) had no mental health LPNs. Forty-one counties had less than 0.2 mental health LPNs per 10,000 population. The largest group consisted of 40 counties (40%) with rates between 0.2 to 0.7. Fifteen counties (15%) fall within the 0.7 to 2 range. Four counties have two or more mental health LPNs working: Burke and Wayne counties with between two to five LPNs per 10,000 (3.24, 2.22, respectively), Lenoir County with 5 to 7 LPNs working per 10,000 population (5.05), and Granville County with more than seven LPNs working per 10,000 population (7.47).

Figure 28. Mental Health and Substance Use Services Licensed Practical Nurses per 10,000 Population by County, North Carolina, 2024



Source. NCBON Licensure Data.

Location of Educational Training of Mental Health and Substance Use Services Licensed Practical Nurses

The majority of MH/SU services LPNs that were active and in-practice in 2024 were trained in-state (66.6%). The educational patterns among MH/SU services LPNs shifted between 2014 and 2024, however, showing an increased reliance on out-of-state training programs. The proportion of in-state educated LPNs decreased more than six percentage points from 2014 to 2024.

Table 99. Training Location of Mental Health and Substance Use Services Licensed Practical Nurses, North Carolina, 2014 and 2024

	2014 MH/SU LPN (N=293)		2024 MH/SU LPN (N=570)	
	N	%	N	%
Education				
In-state	213	73.20	376	66.55
Out-of-state	78	26.80	189	33.45
Missing	2	--	5	--

Note. MH/SU=Mental Health and Substance Use Services; LPN=Licensed Practical Nurse. Missing values are excluded from percentage calculations.
Source. NCBON licensure data, NPPES.

SPEECH LANGUAGE PATHOLOGISTS

Speech Language Pathologists (SLPs) working in mental health settings assess and treat communication disorders, cognitive-linguistic impairments, and social communication difficulties that frequently accompany psychiatric conditions, developmental disabilities, and neurological disorders, helping individuals improve their ability to express needs, participate in therapy, and engage meaningfully in social interactions.

The SLP workforce in North Carolina includes both permanent and temporary SLPs, as well as SLP assistants. The number of licensed SLPs regulated by the North Caralina Board of Examiners of Speech Language Pathologists and Audiologists reached 9,053 practitioners in 2024, representing substantial growth from 4,583 in 2014. This is inclusive of SLPs working across any setting, not just those in mental health settings. These licenses consist primarily of SLPs (n=8,396) and SLP Assistants (SLPAs) (n=572), with a small portion of temporary licenses (temporary SLPs=78, temporary SLPAs=7). Data used for this report henceforth include SLPs and SLPAs when describing the SLP workforce and exclude temporary licenses.

When examining licenses that are active and in-state, the overall SLP workforce in North Carolina was reduced to 7,648 at a rate of 6.96 per 10,000 population.

Geographic Distribution of Speech Language Pathologists

The geographic distribution of SLPs (SLPs and SLPAs) varied across AHEC regions. Wake AHEC had the highest rate at 8.48 per 10,000 and Area L had the lowest at 3.74 per 10,000. Mountain AHEC (7.21 per 10,000) and South East AHEC (7.31 per 10,000) exceeded the state average, while Southern Regional AHEC (6.22) and Eastern AHEC (5.39 per 10,000) were lower than the state average.

Alliance Tailored Plan area had the highest SLP workforce to the population at 8.38 per 10,000, followed by Trillium (6.28 per 10,000), Partners (6.26 per 10,000), and Vaya (6.18 per 10,000). Metro counties maintained a larger SLP workforce to the population (7.42 per 10,000) compared to nonmetro counties (5.14 per 10,000).

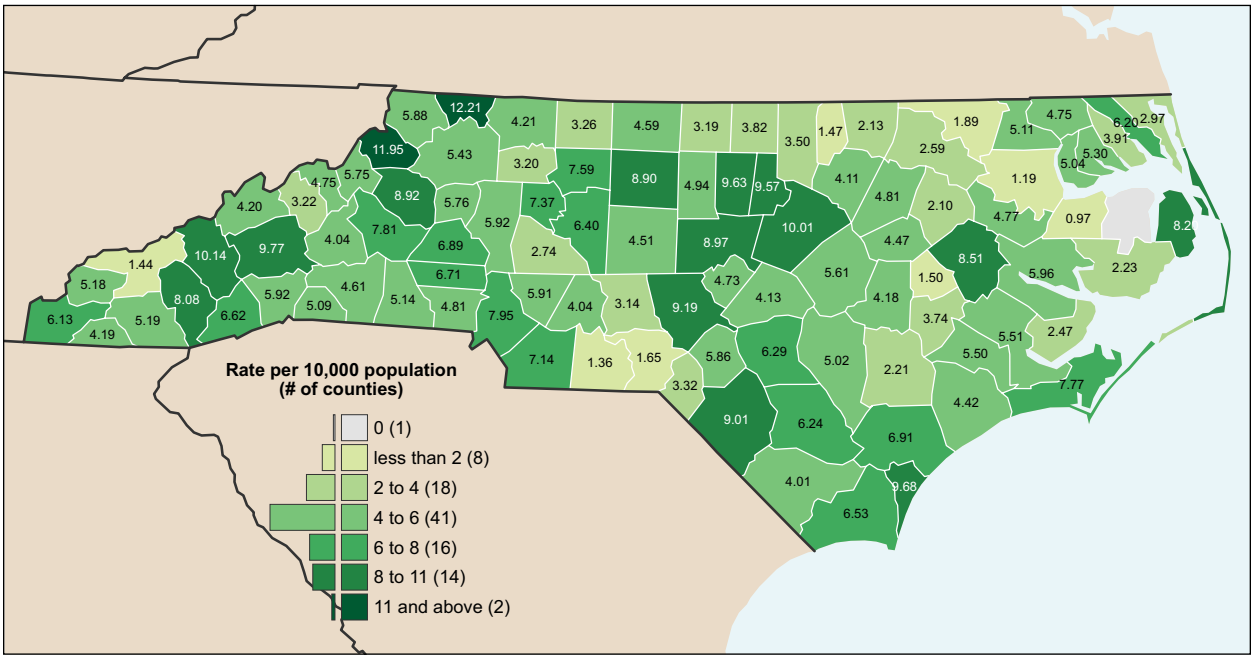
Table 100. Speech Language Pathologists[a] by Region, North Carolina, 2024

	N[b]	Population[c]	Rate per 10,000 population
Statewide	7,648	10,984,106	6.96
By AHEC Region			
Area L	107	285,994	3.74
Charlotte	1,545	2,231,872	6.92
Eastern	572	1,060,329	5.39
Greensboro	926	1,256,677	7.37
Mountain	596	827,070	7.21
Northwest	1,095	1,691,002	6.48
South East	423	578,697	7.31
Southern Regional	584	939,130	6.22
Wake AHEC	1,792	2,113,335	8.48
By Tailored Plan County Catchment Area			
Alliance	3,048	3,635,141	8.38
Partners	1,425	2,277,684	6.26
Trillium	2,015	3,208,448	6.28
Vaya	1,152	1,862,833	6.18
By County Urbanicity			
Metro	6,497	8,761,216	7.42
Nonmetro	1,143	2,222,890	5.14

Note. AHEC=Area Health Education Center.
[a] SLP workforce licensure numbers are inclusive of SLPs and SLPAs working across any setting, not just those in MH/SU services.
[b] Eight SLPs reported an address in NC but no identifying county.
[c] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCBOESLPA Licensure Data.

County rates ranged from having no SLPs to over 11 SLPs per 10,000 population. One county (Tyrrell) had no SLPs. Nine counties had fewer than two SLPs per 10,000 population. The majority of counties (n=41) had 4 to 6 SLPs per 10,000 population. Only two (Allegheny, Watauga) counties exceeded 11 SLPs per 10,000.

Figure 29. Speech Language Pathologists per 10,000 Population by County, North Carolina, 2024



Source. NCBOESLPA Licensure Data.

Comparisons of Data Sources to Estimate the Speech Language Pathology Workforce

Data sources varied in estimating the size of the SLP workforce in North Carolina. In 2024, total SLP counts (excluding SLPAs) ranged from 5,160 (BLS) to 9,151 (NCGA Oversight Committee). It is difficult to compare the size of the workforce across different data sources because the data is available for different years. For example, licensure data is available in 2024 for SLPs (8,474), while ACS data are available for five-year period of 2018-2023 (6,697) and NC Commerce reported on 2022 data (5,017). (Table 101)

The rates of growth for the SLP workforce also differed significantly across sources. Licensure data showed substantial growth from 4,405 SLPs in 2014 to 8,396 in 2024 (91% increase), while BLS data indicated more modest growth from 4,030 to 5,160 over the same period (28% increase). ACS five-year estimates data grew from 5,757 in 2018 (2014-2018) to 6,697 in 2023 (2018-2023).

Differences in estimates of the SLP workforce may also be due to how SLPs are defined in each source. BLS, ACS, and NC Commerce do not specify the rates of the SLP workforce by type, while licensing data reported by the NCBOESLPA and annual reports to the NC Oversight Committee included SLPAs. However, even when comparing SLPs across the data sources, licensure and NCGA Oversight Committee data had between 2,500 and 4,000 more SLPs working in North Carolina.

Table 101. Speech Language Workforce Estimates in North Carolina by Data Source, North Carolina, 2014–2024

	BLS (N)				NC Commerce (N)	ACS (N)		Licensure Data (N, active, residing in- and out-of-state)[c]				NCGA Oversight Committee Licensing Annual Report (N)			
	2014	2022	2023	2024	2022	2018[a]	2023[b]	2014	2022	2023	2024	2021	2022	2023	2024
SLPs	4,030	4,880	4,810	5,160	5,017	5,757	6,697	4,405	8,080	8,764	8,396	8,531	9,364	8,809	9,151
SLPs- Assistants	--	--	--	--	--	--	--	178	530	612	572	397	525	478	507

Note. BLS=Bureau of Labor Statistics; ACS=American Community Survey; NCGA=North Carolina General Assembly.
[c] NCBOESLPA Licensure Data presented does not include temporary SLPs and temporary SLPAs.
[a] ACS 5-Year Estimates Public Use Microdata Sample (2018; 2014-2018)
[b] ACS 5-Year Estimates Public Use Microdata Sample (2023; 2019-2023)
Source. BLS, NC Commerce, ACS, *Source.* NCBOESLPA licensure Data, and NCGA Oversight Committee Annual Reports.

OCCUPATIONAL THERAPISTS

In North Carolina, occupational therapists (OTs) help people of all ages perform daily tasks, or "occupations," they need and want to do by addressing challenges from illness, injury, disability, or developmental impairment. They evaluate client needs, develop treatment plans, and provide tools, adaptive equipment, and strategies to promote independence in self-care, work, leisure, and community participation. This work aims to help clients overcome limitations, achieve meaningful lives, and participate more fully in their homes, communities, and workplaces. (Table 102)

There were 4,928 licensed occupational therapists (inclusive of all settings, not just MH/SU services) practicing in North Carolina in 2024, which results in a rate of 4.49 OTs per 10,000 population. The OT workforce was young, with less than 4% age 65 or older. Most of the OT workforce was female (91.1%) and 9.5% of the workforce was from an underrepresented minority group.

There were some regional AHEC differences in the supply of the OT workforce to the population, but in general the workforce was more equally distributed than other occupations included in this report. Area L had the lowest supply of OTs to the population with 2.20 per 10,000 population, while Wake AHEC region had the highest supply per the population with 5.30 per 10,000. The proportion of the OT workforce over the age of 65 varied across AHEC regions. The Area L region had the fewest OTs over the age of 65 (1.6%), and Mountain AHEC had the most OTs over the age of 65 (6.2%). There was no minimal regional variation in female participation in the OT workforce. There were significant regional variations in the proportion of the OT workforce that were from an underrepresented racial or ethnic background. For example, Area L had more than 20% of their OT workforce from an underrepresented background while South East AHEC had the lowest at 0.8% of the workforce.

Table 102. All Active, Statewide Occupational Therapists in North Carolina by Region, North Carolina, 2024

OT	N	Population[a]	Rate per 10,000 population	% ≥65 years	% Female	% Underrepresented Minority[b]
Statewide	4,928	10,984,106	4.49	3.3	91.1	9.5
By AHEC Region						
Area L	63	285,994	2.20	1.59	87.30	20.97
Charlotte	1,141	2,231,872	5.11	1.75	94.21	12.33
Eastern	396	1,060,329	3.73	5.81	91.67	5.13
Greensboro	524	1,256,677	4.17	3.82	89.29	10.92
Mountain	433	827,070	5.24	6.24	85.15	3.56
Northwest	695	1,691,002	4.11	2.88	89.19	8.32
South East	252	578,697	4.35	3.17	90.48	0.82
Southern Regional	303	939,130	3.23	3.63	93.73	14.63
Wake AHEC	1,121	2,113,335	5.30	2.85	91.70	10.30

Note. AHEC=Area Health Education Center; OT=Occupational Therapists, inclusive of all settings, not just MH/SU services. Missing values are excluded from percentage calculations.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
[b] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
Source. NCBOT licensure data, NPPES.

Occupational Therapists Working in Mental Health Settings

Occupational Therapists working in mental health settings are identified as those whose employment setting is mental health or whose specialty includes developmental disabilities, disabilities, or mental health. This specialized OT workforce totals 118 practitioners statewide, resulting in a rate of 0.11 per 10,000 population.

The OT mental health workforce had significant geographic variation, with rates ranging from 0.03 per 10,000 in Area L to 0.16 per 10,000 in Mountain and Wake AHEC regions. Alliance had the largest workforce with 48 OTs at a rate of 0.13 per 10,000, while Partners and Trillium showed the lowest density at 0.07 per 10,000.

Demographic Characteristics of Occupational Therapists Working in Mental Health Settings

Mental health OTs had a mean age of 42.3 years (SD=11.4) with 5.9% over age 65 in 2024, suggesting that the mental health OT workforce may be older than the total OT workforce.

Female representation in the mental health OT workforce was high at 89.7% (n=105), which is comparable to the total OT workforce. There was substantial regional variation in the proportion of the mental health OT workforce that were female, from 75.0% in Northwest AHEC to 100.0% in Southern Regional AHEC. Tailored Plan areas showed female representation ranging from 80.0% in Partners to 93.8% in Alliance. Metro counties had slightly lower female participation representation (89.3%) compared to nonmetro counties (91.7%). Underrepresented minority representation was 16.7% statewide, suggesting that the OT mental health workforce may be more diverse than the total OT workforce. (Table 103)

Table 103. Demographic Characteristics of Occupational Therapists in Mental Health Settings by Region, North Carolina, 2024

OT in Mental Health Settings	N	Mean (SD)	% Female
Statewide	118	42.33 (11.4)	89.74
By AHEC Region			
Area L	^	--	^
Charlotte	20	44.15 (13.0)	95.00
Eastern	16	51.81 (13.0)	87.50
Greensboro	19	40.11 (9.5)	89.47
Mountain	13	43.77 (10.9)	92.31
Northwest	12	39.42 (7.5)	75.00
South East	0	--	^
Southern Regional	^	47.0 (17.2)	100.00
Wake AHEC	33	38.27 (8.8)	90.63
By Tailored Plan County Catchment Area			
Alliance	48	39.15 (8.5)	93.75
Partners	15	43.60 (13.2)	80.00
Trillium	22	50.77 (14.2)	90.91
Vaya	33	40.76 (9.8)	87.50
By County Urbanicity			
Metro	93	41.66 (11.0)	89.25
Nonmetro	25	44.84 (12.7)	91.67

Note. AHEC=Area Health Education Center; OT=Occupational Therapists. Missing values are excluded from percentage calculations.
[a] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
^Data are suppressed if <5.
Source. NCBOT licensure data.

Geographic Distribution of Occupational Therapists in Mental Health Settings

The distribution of OTs working in mental health settings showed significant geographic variation across North Carolina. Wake AHEC had the most OTs working with 33 OTs present at a rate of 0.16 per 10,000, followed by Charlotte AHEC (20 OTs, 0.09 per 10,000) and Greensboro AHEC (19 OTs, 0.15 per 10,000). Several regions had minimal OT presence and South East AHEC did not have any OTs in mental health settings. (Table 104)

Among Tailored Plan areas, Alliance had the largest OT mental health workforce with 48 practitioners at a rate of 0.13 per 10,000, while Vaya followed with 33 OTs (0.18 per 10,000). Partners and Trillium had lower concentrations of mental health OTs at 0.07 per 10,000.

While metropolitan counties had a majority of OTs with 93 mental health OTs (0.11 per 10,000) compared to 25 OTs in nonmetropolitan counties, both metro and nonmetro counties had the same rate (0.11) per 10,000 population.

Table 104. Occupational Therapists in Mental Health Settings by Region, North Carolina, 2024

OT	N	Population[a]	Rate per 10,000 population
Statewide	118	10,984,106	0.11
By AHEC Region			
Area L	^	285,994	^
Charlotte	20	2,231,872	0.09
Eastern	16	1,060,329	0.15
Greensboro	19	1,256,677	0.15
Mountain	13	827,070	0.16
Northwest	12	1,691,002	0.07
South East	0	578,697	--
Southern Regional	^	939,130	^
Wake AHEC	33	2,113,335	0.16
By Tailored Plan County Catchment Area			
Alliance	48	3,635,141	0.13
Partners	15	2,277,684	0.07
Trillium	22	3,208,448	0.07
Vaya	33	1,862,833	0.18
By County Urbanicity			
Metro	93	8,761,216	0.11
Nonmetro	25	2,222,890	0.11

Note. AHEC=Area Health Education Center; OT=Occupational Therapists.
^Data are suppressed if <5.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCBOT Licensure Data.

OCCUPATIONAL THERAPY ASSISTANTS

In North Carolina, occupational therapy assistants (OTAs) work under the supervision of an occupational therapist (OT) to help clients of all ages participate in daily activities. They implement treatment plans, teach clients how to use adaptive equipment, lead therapeutic exercises and activities, and document progress. OTA's role is focused on implementing interventions and providing direct client care to improve functional independence and participation in desired occupations.

There were 2,107 licensed occupational therapy assistants (inclusive of all settings, not just MH/SU services) practicing in North Carolina in 2024, resulting in a rate of 1.92 OTAs per 10,000 population. The OTA workforce was young, with less than 3% age 65 or older. Most of the OTA workforce were women (88.5%) and 13.9% of the workforce were from an underrepresented minority group. (Table 105)

There are some regional AHEC differences in the supply of the OTA workforce to the population, but in general the workforce is more equally distributed than other credentials included in this report. Greensboro AHEC area had the lowest supply of OTAs to the population with 1.15 per 10,000 while Mountain AHEC region had the highest supply per the population with 3.18 per 10,000. The proportion of the OTA workforce over the age of 65 varied across AHEC regions where the Area L and South East AHEC regions had the most OTAs over the age of 65 (both at 3.9%, and Southern Regional AHEC region had the least OTAs over the age of 65 (1.2%). There was minimal regional variation in female participation in the OTA workforce. There were significant regional variations in the proportion of the OT workforce that were from an underrepresented racial or ethnic background. For example, Wake AHEC had more than 21% of their OTA workforce from an underrepresented background while Mountain AHEC had the lowest at 2.7% of the workforce.

Table 105. All Active, Statewide Occupational Therapy Assistants in North Carolina by Region, North Carolina, 2024

OTA	N	Population[a]	Rate per 10,000 population	% ≥65 years	% Female	% Underrepresented Minority[b]
Statewide	2,107	10,984,106	1.92	2.7	88.5	13.9
By AHEC Region						
Area L	51	285,994	1.78	3.92	90.20	20.00
Charlotte	451	2,231,872	2.02	1.77	89.80	20.09
Eastern	246	1,060,329	2.32	2.44	91.87	12.40
Greensboro	144	1,256,677	1.15	2.78	82.64	18.44
Mountain	263	827,070	3.18	2.28	88.93	2.71
Northwest	365	1,691,002	2.16	3.56	87.40	11.45
South East	156	578,697	2.70	3.85	85.26	3.21
Southern Regional	161	939,130	1.71	1.24	87.58	15.00
Wake AHEC	270	2,113,335	1.28	3.70	89.26	21.35

Note. AHEC=Area Health Education Center; OTA=Occupational Therapy Assistants, inclusive of all settings. Missing values are excluded from percentage calculations.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
[b] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
Source. NCBOT licensure data,

Occupational Therapy Assistants in Mental Health Settings

Occupational Therapy Assistants working in mental health settings represented a small but specialized workforce of 44 individuals statewide, resulting in a rate of 0.04 per 10,000 population. (Table 106)

Demographic Characteristics of Mental Health Occupational Therapy Assistants

Mental health OTAs had a mean age of 45.8 years (SD=12.6) with only 2.3% over age 65 in 2024. The workforce was 86.4% female with 11.4% of the OTAs in mental health settings having an underrepresented minority background. No regional variation was available due to small count sizes of OTAs working in mental health settings in North Carolina.

Table 106. Demographic Characteristics of Occupational Therapy Assistants in Mental Health Settings, North Carolina, 2024

OTAs In Mental Settings	N	Population[a]	Rate per 10,000 population	Mean (SD)	% ≥65 years	% Female	% Underrepresented Minority[b]
Statewide	44	10,984,106	0.04	45.77 (12.6)	2.27	86.36	11.36

Note. AHEC=Area Health Education Center; OTA=Occupational Therapy Assistants. Missing values are excluded from percentage calculations.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
[b] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
Source. NCBOT licensure data.

Geographic Distribution of Occupational Therapy Assistants in Mental Health Settings

OTA distribution in mental health settings revealed concentrated geographic patterns across North Carolina. Eastern AHEC led with 13 OTAs at a rate of 0.12 per 10,000, followed by Northwest AHEC (9 OTAs, 0.05 per 10,000) and Mountain AHEC (5 OTAs, 0.06 per 10,000). Several regions showed minimal or no OTA presence, with Greensboro AHEC reporting no OTAs in mental health settings. (Table 107)

Trillium Tailored Plan catchment area had the highest mental health OTA concentration with 19 OTAs and a rate of 0.06 per 10,000 population. Alliance and Vaya catchment areas each had nine mental health OTAs (0.02 and 0.05 per 10,000 respectively), while Partners had seven mental OTAs (0.03 per 10,000).

The rate per 10,000 population was equal between metropolitan (35 OTAs, 0.04 per 10,000) and nonmetropolitan counties (9 OTAs, 0.04 per 10,000).

Table 107. Occupational Therapy Assistants in Mental Health Settings by Region, North Carolina, 2024

OTA in Mental Health Settings	N	Population[a]	Rate per 10,000 population
Statewide	44	10,984,106	0.04
By AHEC Region			
Area L	^	285,994	^
Charlotte	^	2,231,872	^
Eastern	13	1,060,329	0.12
Greensboro	0	1,256,677	0
Mountain	5	827,070	0.06
Northwest	9	1,691,002	0.05
South East	^	578,697	^
Southern Regional	^	939,130	^
Wake AHEC	6	2,113,335	0.03
By Tailored Plan Catchment Area			
Alliance	9	3,635,141	0.02
Partners	7	2,277,684	0.03
Trillium	19	3,208,448	0.06
Vaya	9	1,862,833	0.05
By County Urbanicity			
Metro	35	8,761,216	0.04
Nonmetro	9	2,222,890	0.04

Note. AHEC=Area Health Education Center; OTA=Occupational Therapy Assistants.
^Data are suppressed if <5.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCBOT Licensure Data.

LICENSED RECREATIONAL THERAPISTS AND LICENSED RECREATIONAL THERAPIST ASSISTANTS

Licensed Recreational Therapists (LRTs) in North Carolina assess, plan, implement, and evaluate evidence-based, individualized treatment that promotes function and holistic well-being through structured recreational interventions and programs. Licensed Recreational Therapy Assistants (LRTAs) work under the supervision of LRTs to help implement individualized treatment plans using therapeutic recreational interventions.

North Carolina had 827 LRTs and 26 LRTAs with active licenses practicing with 853 Recreational Therapists (RT) in 2024. This is inclusive of all settings, not just MH/SU services. Results presented in this report describe the LRT and LRTA workforce combined. There were 0.78 LRTs per 10,000 population in 2024.

Demographic Characteristics of Licensed Recreational Therapists

Licensed RTs had strong female representation in the 2024 workforce with 88.4% (n=731) of RTs identifying as female. Nearly 20% of the RT workforce came from an underrepresented minority background (18.9%).

There were modest differences in the proportion of the RT workforce that were female across geographic regions. Female participation in the RT workforce ranged from 83.3% in Mountain AHEC to 94.6% in Southern Regional AHEC regions. Area L had particularly high female representation at 91.7%, while several regions including Charlotte AHEC (92.4%), Eastern AHEC (85.7%), and Greensboro AHEC (90.6%) showed consistently high female participation. Among Tailored Plan catchment areas, female representation ranged from 86.7% in Vaya to 91.5% in Alliance. Metro and nonmetro counties showed similar female participation rates at 88.9% and 86.4% respectively. (Table 108)

There was substantial geographic variation in the proportion of the RT workforce that was from an underrepresented minority background. Charlotte AHEC had the highest minority representation at 32.4% of the RT workforce, followed by Area L AHEC at 33.3%, while South East AHEC had the lowest proportion at 3.4%. Among Tailored Plan catchment areas, Alliance had the highest proportion of the RT workforce from an underrepresented minority group at 25.5%. Trillium and Vaya had the two lowest proportions at 13.9% and 14.1%, respectively. Metropolitan counties on average had higher minority representation in the RT workforce (19.6%) compared to nonmetropolitan counties (12.6%).

Table 108. Demographic Characteristics of Licensed Recreational Therapists and Licensed Recreational Therapist Assistants by Region, North Carolina, 2024

LRT and LRTA	N[a]	% (N) Female	% (N) Underrepresented Minority[b]
Active License	853	88.39 (731)	18.86 (156)
By AHEC Region			
Area L	13	91.67 (11)	^
Charlotte	107	92.38 (97)	32.38 (34)
Eastern	93	85.71 (78)	16.48 (15)
Greensboro	89	90.59 (77)	14.12 (12)
Mountain	54	83.33 (45)	9.26 (5)
Northwest	156	86.84 (132)	18.30 (28)
South East	60	88.14 (52)	^
Southern Regional	38	94.59 (35)	18.92 (7)
Wake AHEC	163	88.39 (137)	21.29 (33)
By Tailored Plan County Catchment Area			
Alliance	217	91.51 (194)	25.47(54)
Partners	178	87.28 (151)	20.23 (35)
Trillium	246	87.82 (209)	13.87 (33)
Vaya	132	86.72 (111)	14.06 (18)
By County Urbanicity			
Metro	667	88.89 (576)	19.60 (127)
Nonmetro	106	86.41 (89)	12.62 (13)

Note. AHEC=Area Health Education Center; LRT and LRTA= Licensed Recreational Therapists and Licensed Recreational Therapist Assistants. Missing values are excluded from percentage calculations.
[a] Totals by Region/Catchment Area/Urbanicity will not add up to total. 853 with active license in NC, 773 with work address in NC.
[b] Underrepresented minorities include health professionals that self-identify as African-American/Black, American Indian or Alaskan Native, Asian, and/or Hispanic.
Source. NCBRTL Licensure Data.

Geographic Distribution of Licensed Recreational Therapists

The workforce concentration of LRTs varied across North Carolina. South East AHEC had the highest rate at 1.04 per 10,000 population (60 RTs), followed by Northwest AHEC at 0.92 per 10,000 population (156 RTs), and Eastern AHEC at 0.88 per 10,000 (93 RTs). Wake AHEC had a substantial workforce with 163 RTs at a rate of 0.77 per 10,000, while Southern Regional AHEC had the lowest concentration with 38 RTs at a rate of 0.40 per 10,000 population.

Alliance Tailored Plan catchment area had the lowest LRT density at 0.60 per 10,000 population despite having 217 practitioners, reflecting the region's large population base. Partners (0.78 per 10,000), Trillium (0.77 per 10,000), and Vaya (0.71 per 10,000) had comparable workforce supply.

Metro-nonmetro distribution revealed higher RT concentration in metropolitan counties with 667 RTs at a rate of 0.76 per 10,000 compared to 106 RTs in nonmetropolitan counties at 0.48 per 10,000, indicating geographic access disparities. (Table 109)

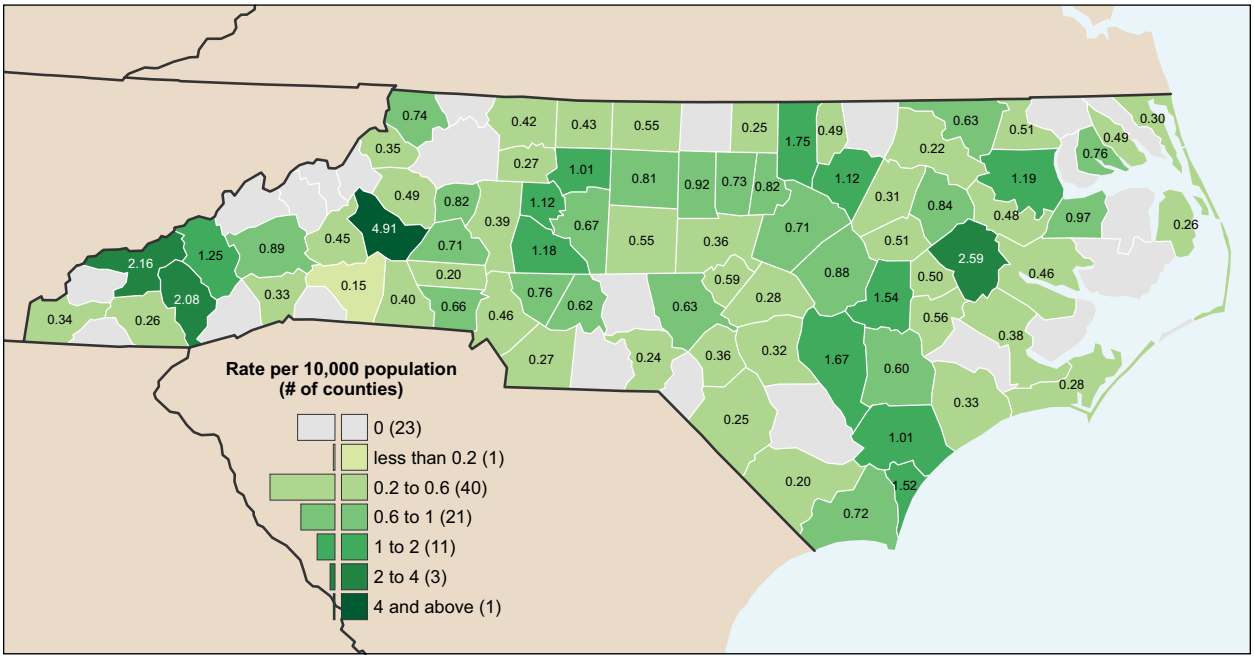
Table 109. Licensed Recreational Therapists by Region, North Carolina, 2024

LRT	N[a]	Population[b]	Rate per 10,000 population
Active License	853	10,984,106	0.78
By AHEC Region			
Area L	13	285,994	0.45
Charlotte	107	2,231,872	0.48
Eastern	93	1,060,329	0.88
Greensboro	89	1,256,677	0.71
Mountain	54	827,070	0.65
Northwest	156	1,691,002	0.92
South East	60	578,697	1.04
Southern Regional	38	939,130	0.40
Wake AHEC	163	2,113,335	0.77
By Tailored Plan County Catchment Area			
Alliance	217	3,635,141	0.60
Partners	178	2,277,684	0.78
Trillium	246	3,208,448	0.77
Vaya	132	1,862,833	0.71
By County Urbanicity			
Metro	667	8,761,216	0.76
Nonmetro	106	2,222,890	0.48

Note. AHEC=Area Health Education Center; LRT and LRTA=Licensed Recreational Therapists and Licensed Recreational Therapist Assistants.
[a] Totals by Region/Catchment Area/Urbanicity will not add up to total. 853 with active license in NC, 773 with work address in NC.
[b] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCBRTL Licensure Data.

Twenty-three counties (23%) in the state had no LRT in active practice. Jointly, 24 counties had fewer than 0.2 RTs per 10,000 population. Sixty-one (61%) counties had between 0.2 to 1 RTs per 10,000 population, and 11 counties 1 to 2 RTs per 10,000 population. Only four counties (4%) had more than 2 RTs per 10,000 population. Pitt, Swain, and Jackson had between 2 to 4 RTs per 10,000 (2.59, 2.16, and 2.08 respectively), and only Burke County (4.91) had more than 4 per 10,000 population.

Figure 30. Licensed Recreational Therapists per 10,000 Population by County, North Carolina, 2024



Source. NCBRTL Licensure Data.

Specialization Areas of Licensed Recreational Therapists

LRT specialization varied across practice areas, with psychiatry representing the largest specialty at 26.6% (n=220), followed by geriatrics at 21.0% (n=174). Other significant specialties included developmental disabilities (12.7%), pediatrics (9.6%), and rehabilitation (8.3%). (Table 110)

Table 110. Licensed Recreational Therapists by Primary Specialty Area, Employment Setting, and Work Status, North Carolina, 2024

Licensed Recreational Therapists	N = 853	
	N	%
Specialty		
Psychiatry	220	26.60
Geriatrics	174	21.04
Other	171	20.68
IDD (Developmentally Disabled)	105	12.70
Pediatrics	79	9.55
Rehabilitation	69	8.34
Burns	6	0.73
Medical/Surgical	3	0.36
Missing	26	--
Employment Setting		
Hospital	294	35.55
Other	158	19.11
Community Setting Program	144	17.41
Nursing Home/Assisted Living	107	12.94
Rehabilitation Program	42	5.08
College/University	37	4.47
Group Home	11	1.33
Public Health Program	10	1.21
School System	10	1.21
Corrections	7	0.85
Military Facility	6	0.73
Hospice	1	0.12
Missing	26	--
Work Status		
Full Time	706	85.37
Part Time	61	7.38
Not Actively Practicing	60	7.26
Missing	26	--

Note: Missing values are excluded from percentage calculations.
Source. NCBRTL licensure data.

Practice Settings of Licensed Recreational Therapists

Hospital settings employed the largest proportion of LRTs at 35.6% (n=294), followed by community setting programs (17.4%) and nursing homes/assisted living facilities (12.9%). The workforce was distributed between private practice locations (62.1%) and public settings (37.9%).

BEHAVIOR ANALYSTS

Behavior Analysts (BAs) working in MH/SU services settings provide modifications to improve personal and interpersonal behaviors. BA services may include positive reinforcement, consequences, or other methods for adopting modifications.[26] Beginning of 2023, licensed BAs in North Carolina were allowed to act independently as a Licensed Qualified Autism Service Provider through the Research Based-Behavioral Health Treatment State Plan Amendment. The BAs included in this analysis are identified as those whose employment setting is reported in mental health and substance use services.

In 2024, North Carolina had 1,362 licensed BAs in active practice, representing a statewide rate of 1.24 BAs per 10,000 population.

Geographic Distribution of Licensed Behavior Analysts

The supply of the licensed BA workforce varied significantly across the nine AHEC regions. Across North Carolina, Charlotte (1.75) and South East (1.71) AHEC regions had the highest rates of BAs per 10,000 population, while Area L (0.17) and Mountain (0.68) had the lowest. Among the four Tailored Plan catchment areas, Alliance reported the highest BA workforce rate to the population (1.88), followed by Partners (1.08), Trillium (0.99), and Vaya (0.61). Metro counties had a higher supply of BAs (1.44 per 10,000) compared to nonmetro counties (0.45 per 10,000).

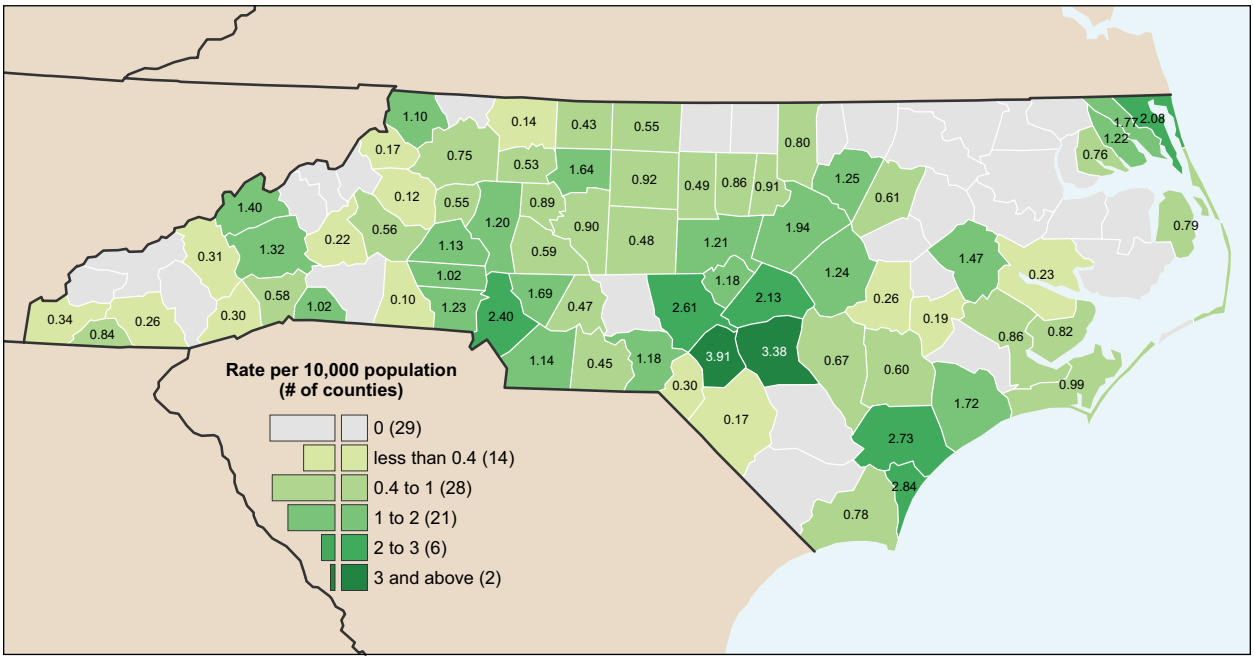
Table 111. Active, In-state Licensed Behavior Analysts by Geographic Region, North Carolina, 2024

Behavior Analysts	N	Population[a]	Rate per 10,000 Population
Statewide	1,362	10,984,106	1.24
By AHEC Region			
Area L	5	285,994	0.17
Charlotte	391	2,231,872	1.75
Eastern	98	1,060,329	0.92
Greensboro	93	1,256,677	0.74
Mountain	56	827,070	0.68
Northwest	156	1,691,002	0.92
South East	99	578,697	1.71
Southern Regional	151	939,130	1.61
Wake AHEC	313	2,113,335	1.48
By Tailored Plan County Catchment Area			
Alliance	683	3,635,141	1.88
Partners	247	2,277,684	1.08
Trillium	318	3,208,448	0.99
Vaya	114	1,862,833	0.61
By County Urbanicity			
Metro	1,261	8,761,216	1.44
Nonmetro	101	2,222,890	0.45

Note. AHEC=Area Health Education Center.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCBALB Licensure Data.

Almost a third of counties in North Carolina (n=29) had no BAs in active practice. Forty-three counties had a rate lower than 0.4 per 10,000, 28 counties had between 0.4–1.0 BAs per 10,000, 21 counties had between 1.0–2.0 per 10,000, and six counties had between 2.0–3.0 BAs per 10,000 population. Two counties, Hoke (3.91) and Cumberland (3.38), reported the highest rates at more than 3.0 BAs per 10,000 population.

Figure 31. Licensed Behavior Analysts per 10,000 Population by County, North Carolina, 2024



Source. NCBALB Licensure Data.

Assistant Behavior Analysts

Assistant Behavior Analysts (ABAs) working in mental health and substance use services settings provide modifications to improve personal and interpersonal behaviors. ABA services may include positive reinforcement, consequences, or other methods for adopting modifications. The ABAs included in this analysis are identified as those whose employment setting is reported in mental health and substance use services.

In 2024, North Carolina had 95 ABAs practicing in mental health settings, representing a statewide rate of 0.09 ABAs per 10,000 population.

Geographic Distribution of Assistant Behavior Analysts

The supply of the ABA workforce varied significantly across the nine AHEC regions. Throughout North Carolina, Southern Regional (0.63) had the highest rate of ABAs per 10,000 population, followed by South East (0.09), Charlotte (0.05), Eastern (0.05), and Wake (0.03). Northwest, Area L, Greensboro, and Mountain AHEC regions each had counts that were too low for analysis. Among the four Tailored Plan areas, Alliance had the highest BA workforce rate to the population (0.17), followed by Trillium (0.08) and Partners (0.03). Metro counties had a higher supply of ABAs (0.10 per 10,000) compared to nonmetro counties (0.04 per 10,000).

Table 112. Active, In-state Licensed Assistant Behavior Analysts by Region, North Carolina, 2024

Assistant Behavior Analysts	N	Population[a]	Rate per 10,000 Population
Statewide	95	10,984,106	0.09
By AHEC Region			
Area L	^	285,994	^
Charlotte	12	2,231,872	0.05
Eastern	5	1,060,329	0.05
Greensboro	^	1,256,677	^
Mountain	^	827,070	^
Northwest	^	1,691,002	^
South East	5	578,697	0.09
Southern Regional	59	939,130	0.63
Wake AHEC	7	2,113,335	0.03
By Tailored Plan County Catchment Area			
Alliance	60	3,635,141	0.17
Partners	6	2,277,684	0.03
Trillium	25	3,208,448	0.08
Vaya	^	1,862,833	^
By County Urbanicity			
Metro	86	8,761,216	0.10
Nonmetro	9	2,222,890	0.04

Note. AHEC = Area Health Education Center. ^ = Data suppressed with any n<5.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCBALB licensure data.

CERTIFIED PARAPROFESSIONALS AND MENTAL HEALTH AND SUBSTANCE USE SERVICES SUPPORT SPECIALISTS

Certified paraprofessionals play a vital role in expanding access to mental health and substance use services in North Carolina. Certified paraprofessional roles like Community Health Workers and Certified Peer Support Specialists bridge gaps in care and enhance the capacity of the MH/SU workforce. Community Health Workers (CHW) serve as trusted liaisons between health care systems and communities, providing education, navigation assistance, and culturally responsive support to individuals seeking MH/SU services. Certified Peer Support Specialists (CPSS) bring lived experience with mental health conditions or substance use disorders to their work, offering recovery-oriented support to individuals on their own recovery journeys.

While workforce data are available for CHWs and CPSS, comparable statewide data for other MH/SU support specialists is limited. The following sections present findings on the distribution and characteristics of CHWs and CPSS across North Carolina.

COMMUNITY HEALTH WORKERS

Community Health Workers (CHWs) play a critical role in MH/SU service settings by serving as trusted liaisons between individuals, communities, and care systems. CHWs help community members navigate MH/SU services, address social determinants of health, and reduce stigma through education and advocacy. CHWs are increasingly integrated into care management teams under Medicaid Tailored Plans and receive standardized training and certification to support their work in culturally responsive, community-based MH/SU services. The NC Community Health Worker Association (NCCHWA), launched in 2021, certifies CHWs at four levels based on CHW training and experience.

In 2024, 811 CHWs were actively certified by NCCHWA and located in North Carolina, a rate of 0.74 CHWs per 10,000 population. The majority (86.1%) of CHWs were certified through the Standardized Core Competency Training (SCCT), while a smaller portion qualified through the Legacy track (n=10.0%). Advanced certifications — Levels II through IV — were less common, with only 32 CHWs statewide holding these higher-level credentials. From 2024 to October 1, 2025, the CHW certified workforce in North Carolina grew from 811 to 1,076, a growth of 32.7% in less than a year.

Geographic Distribution of Community Health Workers

There were regional differences in the supply and distribution of certified CHWs. Within the AHEC regions, Mountain and South East AHEC had the highest rate to the population of certified CHWs, at 1.66 and 1.05 per 10,000 people, respectively. Following these two regions was Area L, with 0.98 CHWs per 10,000. Greensboro AHEC (0.38) and Northwest AHEC (0.40) had the lowest rates of CHWs.

Among the Tailored Plan catchment areas, Vaya (n=198) had the highest rate of CHWs per 10,000 at 1.06. Alliance (n=274) and Trillium (n=236) followed with CHW rates per 10,000 at 0.75 and 0.74 respectively. Partners had the lowest CHW count (n=103) and rate (0.45 per 10,000). The CHW rate per 10,000 was slightly higher in nonmetro areas (0.86) than metro areas (0.71).

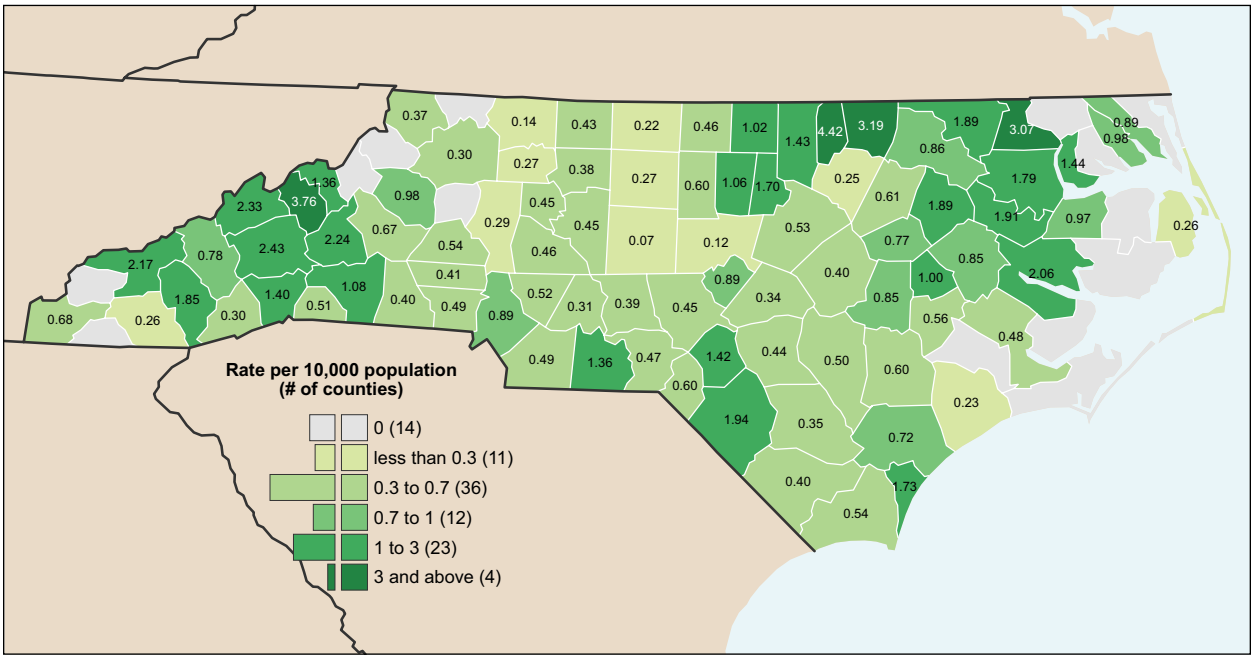
Table 113. Certified Community Health Workers in North Carolina by Region and Level, North Carolina, 2024

CHWs	N	Population[a]	Rate per 10,000	Certification Type				
				CHW I - Legacy	CHW I - SCCT	CHW II	CHW III	CHW IV
				N	N	N	N	N
Statewide	811	10,984,106	0.74	81	698	15	6	11
By AHEC Region								
Area L	28	285,994	0.98	1	26	1	0	0
Charlotte	157	2,231,872	0.70	12	137	4	1	3
Easten	71	1,060,329	0.67	7	63	0	1	0
Greensboro	48	1,256,677	0.38	6	40	0	0	2
Mountain	137	827,070	1.66	15	112	5	3	2
Northwest	68	1,691,002	0.40	12	54	1	1	0
South East	61	578,697	1.05	5	54	1	0	1
Southern Regional	64	939,130	0.68	1	60	3	0	0
Wake AHEC	177	2,113,335	0.84	22	152	0	0	3
By Tailored Plan County Catchment Area								
Alliance	274	3,635,141	0.75	25	242	3	0	4
Partners	103	2,277,684	0.45	12	86	2	2	1
Trillium	236	3,208,448	0.74	18	211	5	1	1
Vaya	198	1,862,833	1.06	26	159	5	1	5
By County Urbanicity								
Metro	619	8,761,216	0.71	65	531	9	5	9
Nonmetro	192	2,222,890	0.86	16	167	6	1	2

Note. AHEC=Area Health Education Center. CHW=Community Health Worker
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCCHWA certification data.

Throughout North Carolina, 14 counties did not have a CHW. A quarter of counties (25%) had rates below 0.3 CHWs per 10,000 population. The largest group of counties (n=36) had between 0.3 and 0.7 CHWs, and 12 counties had between 0.7 and 1 CHWs per 10,000 population. Twenty-three counties had rates between 1 and 3, while only four counties (4%) exceeded 3 CHW per 10,000 residents, with the highest rates observed in Vance (4.47), Yancey (3.76), Warren (3.19), and Hertford (3.07).

Figure 32. Certified Community Health Workers per 10,000 Population in North Carolina by County, North Carolina, 2024



Source. NCCHWA Certification Data.

Comparison of Data Sources to Estimate the Size of the Community Health Worker Workforce

Estimates of the CHW workforce in North Carolina varied substantially across data sources. Bureau of Labor Statistics (BLS) data showed growth from 780 CHWs in 2014 to 1,600 in 2024, a doubling of the workforce. NC Department of Commerce data reported 1,381 CHWs in 2022. NCCHWA active certifications through 2024 totaled 811, lower than the BLS estimates for 2024.[27] NPPES included 136 CHWs as of April 2024, likely reflecting that this source only includes individuals who bill Medicare and Medicaid and excludes many CHWs who do not directly bill for their work. ACS does not provide data on CHWs, as CHW standard occupation code is combined with "other community and social service specialists".

Table 114. Comparison of Data Sources to Estimate the Size of the Community Health Worker Workforce in North Carolina

	BLS (N)				NC Commerce (N)	ACS (N)		Certification Data (N)	NPPES (N)
	2014	2022	2023	2024	2022	2018	2023	2024	April 2024
Community Health Workers	780	1,350	1,220	1,600	1,381	N/A	N/A	811	136

Note. BLS=Bureau of Labor Statistics; ACS=American Community Survey; NCGA=North Carolina General Assembly; NPPES= National Plan and Provider Enumeration System ; N/A=Not Applicable.
Source. NCCHWA Certification Data.

PEER SUPPORT SPECIALISTS

Certified Peer Support Specialists (CPSS) are integral to the MH/SU services workforce, offering support grounded in lived experience with mental health and/or substance use recovery. CPSS, or Peers, provide person-centered services that include emotional support, advocacy, and system navigation. Peers work in a variety of settings, such as inpatient units, outpatient treatment, and community-based programs, and help individuals build coping strategies, set recovery goals, and access essential resources like housing and employment.

As of December 9, 2025, there were 6,772 CPSSs in North Carolina. Of those 6,772 CPSSs, 2,222 (32.8%) were actively employed as Certified Peer Support Specialists, a rate of 2.02 CPSS per 10,000 population.

Demographic Characteristics of Certified Peer Support Specialists and Those in North Carolina Employed as Certified Peer Support Specialists

Table 115 highlights the demographic characteristics of all CPSSs compared to CPSSs who are actively employed as a peer in North Carolina. In both groups, the reported CPSS workforce is racially and ethnically diverse, with a greater proportion of females in the workforce, and consistently split across type of recovery experience in mental health, substance use, or both. In both groups, between 7% to 8% reported having a military status of active duty or as a veteran.

Racially/ethnically, the largest proportion of employed CPSSs (40.0%) identified as African American or Black, followed by 30.3% as white. A smaller percentage of employed CPSS identified as Two or More Races (2.5%), American Indian/Alaska Native (1.9%), or Hispanic/Latinx (1.8.%). A notable portion (22.7%) of employed CPSS did not specify their race or ethnicity. Comparatively for all CPSSs, the largest proportion of CPSSs (47.0%) identified as African American or Black, followed by 31.3% as white. The next largest percentage (13.6%) did not specify their race or ethnicity, as the question was recently added to the certification process and is optional. Other race/ethnicity groups comprised a much smaller proportion of the CPSS workforce at 3.9% Two or More Races, 1.8% Hispanic/Latinx, 1.6% American Indian/Alaska Native, 0.8% Other, 0.2% Asian, and 0.1% Native Hawaiian/OPI.

There were more females in both groups of CPSS. The majority of employed CPSSs identified as female (63.0%) and the majority of all CPSSs identified as female (62.2%).

Employed CPSSs bring a range of lived experiences to their roles: 34.4% reported recovery from mental health conditions, 35.2% from substance use disorders, and 30.4% co-occurring conditions. The lived experiences of all CPSS was similar, as 37.7% of all CPSSs reported mental health recovery, 32.3% substance use disorder, and 30.0% co-occurring disorders recovery.

Educational attainment of employed CPSSs ranged from high school diploma to doctorate degree. The largest proportion of employed CPSSs had some college education (30.9%), followed by those with a high school diploma and a bachelor's degree (both 18.9%). Smaller proportions of employed CPSSs held an associate's degree (13.2%), GED (9.9%), or master's degree (7.9%). Similar to the distribution among currently employed CPSSs, the largest percentage of all CPSSs reported some college education (27.1%), followed by high school (22.1%), then Bachelor's (18.9%) and Associate's (12.3). GED followed (10.5%), then Master's (8.4%), with PhD (0.8%) comprising the lowest percentage of all educational backgrounds for CPSSs.

Table 115. Demographic Characteristics of All Certified Peer Support Specialists and Employed as Certified Peer Support Specialists, North Carolina, 2025

	2025 All CPSS Certified by NCCPSS[a]	2025 Employed as CPSS in NC[b]
	N (%)	N (%)
Certifications	6,847	2,222
Race/Ethnicity		
African American or Black	3,213 (46.93)	889 (40.01)
American Indian/Alaska Native	107 (1.56)	43 (1.94)
Asian	14 (0.20)	^
White	2,142 (31.28)	674 (30.33)
Hispanic/Latinx	120 (1.75)	40 (1.80)
Two or More Races	265 (3.87)	56 (2.52)
Native Hawaiian/OPI	5 (0.07)	^
Other, not listed	52 (0.76)	11 (0.50)
Not specified	929 (13.57)	505 (22.73)
Sex		
Male	2,200 (32.13)	781 (35.15)
Female	4,256 (62.16)	1,399 (62.96)
Non-Binary	24 (0.35)	11 (0.50)
Other	17 (0.25)	^
Not specified	350 (5.11)	28 (1.26)
Military Status		
Civilian/non-military	6,364 (92.95)	2,048 (92.17)
Active Duty/Veterans	483 (7.05)	174 (7.83)
Recovery Experience		
Co-Occurring	2,055 (30.01)	676 (30.42)
Mental Health	2,578 (37.65)	765 (34.43)
Substance Use Disorder	2,214 (32.34)	781 (35.15)
Current level of education		
Less than high School	^	^
GED	720 (10.52)	219 (9.86)
High School	1,510 (22.05)	419 (18.86)
Associate's	843 (12.31)	293 (13.19)
Some College	1,852 (27.05)	686 (30.87)
Bachelor's	1,294 (18.90)	420 (18.90)
Master's	574 (8.38)	175 (7.88)
PhD	53 (0.77)	10 (0.45)

Note. NCCPSS=North Carolina Certified Peer Support Specialist; CPSS=Certified Peer Support Specialist; OPI=Other Pacific Islander.
[a] N of 6,847 represents all those certified by NCCPSS Program, regardless of residence.
[b] N of 2,222 represents all those certified by NCCPSS Program, residing in NC, and employed as CPSS.
^Data are suppressed with any n<5.
Source. NCCPSS Program Certification Data.

Geographic Practice Characteristics of Certified Peer Support Specialists Employed as Peer Support Specialists

The rates for Certified Peer Support Specialists (CPSS) employed as such varied across the nine AHEC regions, with a statewide rate of 2.02 per 10,000 population. The Mountain AHEC region had the highest rate at 3.48 per 10,000, followed by Area L (3.36) and Eastern (2.09) AHEC regions. Wake (1.93), Northwest (1.92), Greensboro (1.81), and South East (1.69) AHEC areas all had rates lower than the state average. Charlotte AHEC region had the lowest rate, 1.65 per 10,000 population. Among the four Medicaid Tailored Plan areas, Vaya had the highest rate at 2.94 per 10,000, followed by Trillium (1.99) and Alliance (1.80). Partners had the lowest rate at 1.68 CPSSs per 10,000 people. Employed as CPSS rates were higher in nonmetro counties (2.59 per 10,000) compared to metro counties (1.88 per 10,000). (Table 116)

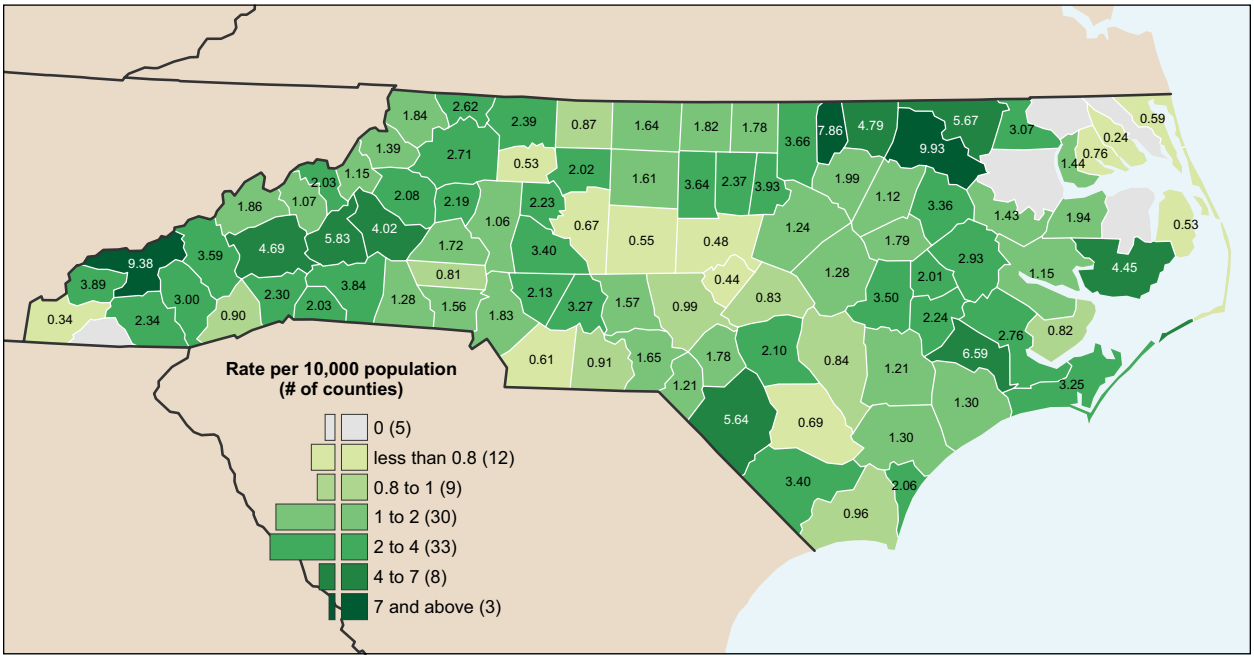
Table 116. Supply of Certified Peer Support Specialists Employed as Peer Support Specialists by Region, North Carolina, 2025

Employed CPSS	N	Population[a]	Rate per 10,000 population
Statewide	2,222	10,984,106	2.02
By AHEC Region			
Area L	96	285,994	3.36
Charlotte	369	2,231,872	1.65
Eastern	222	1,060,329	2.09
Greensboro	227	1,256,677	1.81
Mountain	288	827,070	3.48
Northwest	325	1,691,002	1.92
South East	98	578,697	1.69
Southern Regional	190	939,130	2.02
Wake AHEC	407	2,113,335	1.93
By Tailored Plan County Catchment Area			
Alliance	655	3,635,141	1.80
Partners	382	2,277,684	1.68
Trillium	637	3,208,448	1.99
Vaya	548	1,862,833	2.94
By County Urbanicity			
Metro	1,647	8,761,216	1.88
Nonmetro	575	2,222,890	2.59

Note. AHEC=Area Health Education Center. CPSS=Certified Peer Support Specialist.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCCPSS Program Certification Data.

There were five counties with no CPSSs employed as a CPSS. Twenty-six counties (a little over a quarter) had an employed-as-CPSS rate less than 1.0 per 10,000 and 30 counties had a rate between 1.0 to 2.0 per 10,000. The largest group of counties (n=33) had a rate of 2.0 to 4.0 per 10,000. Eleven counties had a rate greater than 4.0 per 10,000, with the highest rates reported in Swain (9.38), Vance (7.86), and Halifax (9.93) Counties.

Figure 33. Certified Peer Support Specialists Employed as Peer Support Specialists per 10,000 Population by County, North Carolina, 2024



Source. NCCPSS Program Certification Data.

Geographic Practice Characteristics of North Carolina Certified Peer Support Specialists, Regardless of Employment Status

Table 117, as compared to Table 116, presents the supply of all CPSSs residing in North Carolina, rather than just those employed as CPSSs. The overall total (n=6,772) is lower than the total in Table 115 (n=6,847) due to removing 75 individuals who did not report residing in North Carolina. The rates of all CPSSs residing in North Carolina varied across the nine AHEC regions, with a statewide rate of 6.17 CPSSs per 10,000 population. The Area L region had the highest rate of CPSS to the population at 9.86 per 10,000, followed by Mountain (8.77), Southern Regional (6.44), Eastern (6.20), and Wake (6.18). Greensboro (6.17), Charlotte (5.82), South East (5.79), and Northwest (4.65) all had rates of CPSSs per 10,000 lower than the state average. Among the four Medicaid Tailored Plan areas, Vaya had the highest CPSS rate at 7.84 per 10,000, followed by Trillium (6.42) and Alliance (5.98). Partners had the lowest rate at 4.74 CPSSs per 10,000 people. CPSS rates were higher in nonmetro counties (7.58 per 10,000) compared to metro counties (5.81 per 10,000). (Table 117)

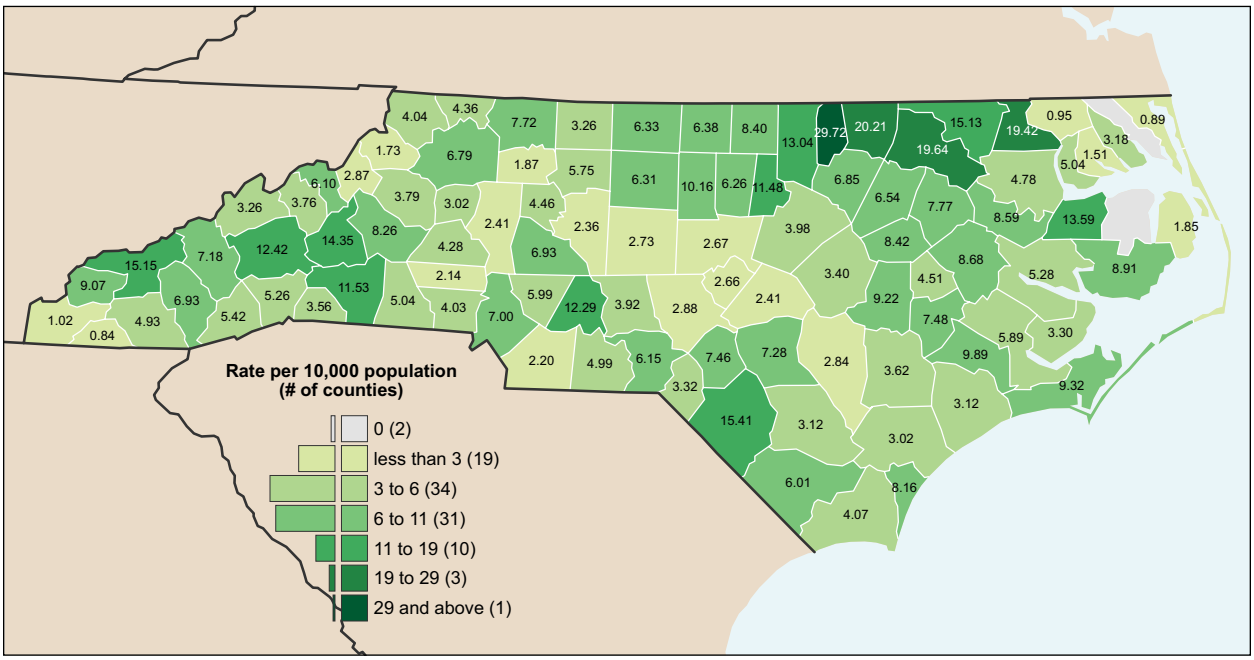
Table 117. Supply of North Carolina Certified Peer Support Specialists Regardless of Employment Status, by Region, 2025

All Certified Peer Support Specialists	N	Population[a]	Rate per 10,000 population
Statewide	6,772	10,984,106	6.17
By AHEC Region			
Area L	282	285,994	9.86
Charlotte	1,300	2,231,872	5.82
Eastern	657	1,060,329	6.20
Greensboro	775	1,256,677	6.17
Mountain	725	827,070	8.77
Northwest	787	1,691,002	4.65
South East	335	578,697	5.79
Southern Regional	605	939,130	6.44
Wake AHEC	1,306	2,113,335	6.18
By Tailored Plan County Catchment Area			
Alliance	2,172	3,635,141	5.98
Partners	1,079	2,277,684	4.74
Trillium	2,060	3,208,448	6.42
Vaya	1,461	1,862,833	7.84
By County Urbanicity			
Metro	5,087	8,761,216	5.81
Nonmetro	1,685	2,222,890	7.58

Note. AHEC=Area Health Education Center.
[a] Population census data and estimates downloaded from the NC Office of State Budget and Management via NC LINC, based on 2024 US Census data.
Source. NCCPSS Program Certification Data.

Of all North Carolina counties, two did not have any CPSSs, and 21 counties had fewer than 3.0 CPSSs per 10,000. The largest group of counties (n=34) had between 3.0-6.0 CPSSs per 10,000, and 31 counties had between 6.0-11.0 CPSSs per 10,000. Fourteen counties had a rate higher than 11.0. Of those fourteen counties, four counties close to each other bordering Virginia had the highest rates: Hartford (19.42), Halifax (19.64), Warren (20.21), and Vance (29.72).

Figure 34. Certified Peer Support Specialists per 10,000 Population by County, North Carolina, 2024



Source. NCCPSS Program Certification Data.

Employment Characteristics of Certified Peer Support Specialists

It can be useful to understand how and if CPSSs are employed as it affects the CPSS workforce and can inform potential growth in the field. Nearly one-third of CPSS were directly employed as CPSSs (32.5%) with an additional 9.9% employed in a related field. A little more than a quarter of CPSS were employed in another field (26.6%) with an additional quarter (25.6%) actively seeking employment. Notably, CPSSs could select more than one employment response. (Table 118)

Table 118. Employment Characteristics of All Certified Peer Support Specialists, North Carolina, 2025

Certified Peer Support Specialists (All)	N (%)
Employment	
Employed as CPSS	2,223 (32.47)
Employed in Other Field	1,819 (26.57)
Seeking Employment	1,755 (25.63)
Employed in Related Field	678 (9.90)
Student	437 (6.38)
Volunteer	119 (1.47)

Note. Multiple entries allowed.
Source. NCCPSS Program Certification Data.

COMPARING MENTAL HEALTH AND SUBSTANCE USE SERVICE NEED TO SUPPLY

Examining the need for mental health and substance use (MH/SU) services alongside the supply of the workforce available to meet those needs provides a way to identify potential challenges individuals and families face in accessing care. This section presents a comparative analysis that overlays four key indicators of MH/SU service need with the geographic distribution of the MH/SU services workforce supply by Area Health Education Center (AHEC) regions and Tailored Plan catchment areas.

Four indicators were selected to represent the need for MH/SU services, including Emergency Department (ED) Visits for Depression, Suicide Deaths, ED Visits for Drug Overdose, and Overdose Deaths from Medications or Drugs. Emergency department visits for depression and drug overdose represent acute service utilization, while suicide deaths and overdose deaths from medication or drugs represent adverse outcomes that may have been avoidable if care had been available. Each geographic area is compared to the state average for the four MH/SU services need indicators and MH/SU service workforce supply in the same region.

The following figures illuminate patterns of alignment and misalignment between the need for MH/SU services and the distribution of the MH/SU workforce across the state. These figures provide an overview of patterns in MH/SU services workforce distribution relative to need. The figures are not intended to provide a definitive measure of the adequacy of the supply of the workforce relative to the need for MH/SU services by geographic area. For example, areas that have MH/SU workforce supply above the state average may still experience substantial unmet need for services and areas with lower MH/SU need for services may also experience shortfalls in access to care. In some geographic areas, there is clear misalignment with high indicators of need alongside lower workforce supply.

Interpreting the Figures

Six types of MH/SU services workforce credentials were compared to regional supply by AHEC and Tailored Plan Catchment Areas:

1. Graduate-level MH/SU services clinicians;
2. Addiction counselors;
3. MH/SU services physicians;
4. MH/SU services physician assistants;
5. MH/SU services nurse practitioners;
6. All MH/SU services prescriber clinicians.

Each figure summarizes how well the need for MH/SU services matches workforce supply. One challenge in assessing the alignment between need and supply is that there is no fixed benchmark for how many mental health professionals are required to adequately meet demand. Therefore, we compare the supply of six different credential types per 10,000 population in the region to the state average. Further complicating the assessment of need and supply is that different types of credentials have overlapping scopes of practice and therefore, a lower supply of one type of credential in a region could be offset by a higher supply of another type of credential. For this reason, we've shown the six credential types for each region.

In the figures, the **orange circle** represents the indicator of need (i.e., ED Visits for Depression, Suicide Deaths, ED Visits for Drug Overdose, and Overdose Deaths from Medications or Drugs) in that region. The **blue diamond** represents MH/SU services workforce supply in the region. The **gray line** is the benchmark of the state average. The placement of supply (the blue diamond) and the need (the orange circle) visually shows how much each region's need and supply vary from the state mean. When the indicator of supply or need is to the right of the gray line, that region is above the state average; indicators to the left of the gray line are below the state average. The greater the distance between the two markers, the greater the mismatch between a region's relative need and its relative supply.

The coloring of the cell summarizes need and supply indicators data for each region.

Cells shaded orange reflect a geographic region in which the MH/SU indicator of need (i.e., ED Visits for Depression, Suicide Deaths, ED Visits for Drug Overdose, and Overdose Deaths from Medications or Drugs) is proportionally greater than the regional workforce supply of the column's credential type relative to their respective state averages.

Cells shaded blue reflect the opposite pattern: the regional workforce supply of the column's credential type is proportionally greater than the regional MH/SU indicator of need (i.e., ED Visits for Depression, Suicide Deaths, ED Visits for Drug Overdose, and Overdose Deaths from Medications or Drugs) relative to their respective state averages. The gradient of the colors indicates if supply and need are closely aligned or not. Those geographic regions with the greatest difference between need and supply are shaded either darker orange or darker blue. Cells shaded in darker orange have a greater difference between their need indicator and supply of the workforce than those in lighter orange. A darker orange shading indicates regions with the greatest difference among those whose rates of need are higher than the workforce supply. Cells shaded in darker blue have more of a difference between supply and need, highlighting the regions in the state with higher workforce supply and lower need.

Note: Cells in lighter shading versus darker shading do not mean sufficient supply or insufficient supply. A dark blue cell, with lower than state average need indicator and greater that state-average supply, cannot determine if the needs for MH/SU services are being met in these areas. Instead, it shows us the comparison of each of these to the state average and allows for comparisons across different areas of North Carolina.

Mental Health Indicators of Need Compared to MH/SU Services Workforce Supply

Emergency Department Visits for Depression Compared to MH/SU Services Workforce Supply

The 2024 rate of emergency department (ED) visits for depression per the regional population compared to the supply of six MH/SU services workforce groups is presented in Figure 35.

Three AHEC regions, Northwest, Mountain, and Greensboro, had higher rates of depression ED visits to the population; yet the supply of the MH/SU services workforce varied across these regions. Northwest AHEC had a lower workforce supply to the regional population across all six MH/SU services occupation groups. The Mountain AHEC region had higher supply to the regional population than the state average for all MH/SU workforce types. Greensboro AHEC region's supply of the MH/SU services workforce varied by type: the MH/SU services physician workforce was higher compared to the statewide rate, yet the Greensboro region had a lower supply of addiction counselors and MH/SU services PAs compared to the statewide average.

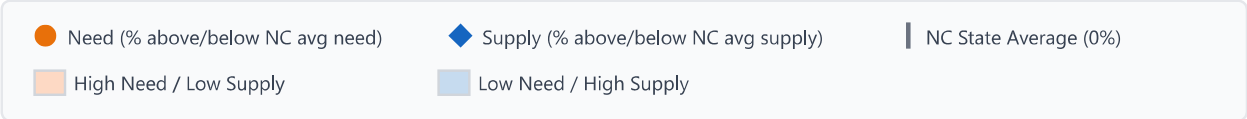
The rate of ED visits for depression per the population in Area L, Charlotte, and Eastern AHEC regions were all slightly below the state average. All MH/SU services workforce types in Area L were below the state average except for MH/SU services NPs, with a rate of supply to the regional population slightly above the state average. Charlotte AHEC region has a higher supply of MH/SU services PAs and NPs and just below the state average for supply of the other MH/SU services workforce groups. The Eastern AHEC region workforce supply typically also fell close to the state average, except for addiction counselors (higher supply to the regional population) and MH/SU services PAs (lower supply to the regional population).

South East, Southern Regional, and Wake AHEC all had below average rates of depression ED visits, but varying rates of the workforce supply. South East AHEC had higher than average rates for most workforce supply, with only the MH/SU services physicians supply lower than the statewide average. Similarly, Wake AHEC had a higher than the statewide average for all occupations except for one, with the supply of addiction counselors just below the statewide rate. Southern Regional AHEC had a higher supply of addiction counselors than the state average, but lower supply of all other workforce types compared to the state average.

Alliance Tailored Plan catchment area was the only tailored plan area with below average rates of depression ED visits and high workforce supply across all MH/SU services occupation groups. The addiction counselor supply within the Alliance area was the only occupation with a rate close to the statewide average. Partners rate of depression ED visits were considerably higher than the state average, paired with supply rates lower than statewide average across all MH/SU services occupation groups. Trillium was close to the state average of depression ED visits and had a lower supply of all workforce types to the state average, except for addiction counselors which the supply was just above the state average. Vaya had a higher than statewide average for depression ED visits. Like Trillium, the Vaya Tailored Plan catchment area had lower than average supply of all workforce types except for addiction counselors. Notably, the Vaya area had the highest rate of addiction counselors to the regional population among all Tailored Plans.

Figure 35. Rates of Emergency Department Visits for Depression Compared to the Mental Health and Substance Use Services Workforce Supply, North Carolina, 2024

NEED NC DETECT Depression ED Visits	SUPPLY Grad-Level Clinicians	Addiction Counselors	MH/SU Physicians	MH/SU PAs	MH/SU NPs	Prescriber-Level Clinicians
Statewide	28.04	4.88	1.43	0.52	1.33	3.28
By AHEC Region						
Northwest						
Area L						
Charlotte						
Eastern						
Greensboro						
Mountain						
South East						
Southern Regional						
Wake AHEC						
By Tailored Plan Catchment Area						
Alliance						
Partners						
Trillium						
Vaya						



Note. MH/SU=Mental Health and Substance Use Services; AHEC=Area Health Education Center; PA=Physician Assistant; NP=Nurse Practitioner; Low Need=The regional need is less than state average need; High Need=The regional need is greater than state average need; High Supply=The regional supply is greater than state average supply.; Low Supply=The regional supply is less than state average supply.
Source. NCMB, NCBON, NCPB, NCMFTLB, NCBLCMHC, NCSWCLB, NC Pastoral Counseling Board, NCASPPB Licensure Data, and NC DETECT, 2024.

Deaths by Suicide Compared to MH/SU Services Workforce Supply

The 2023 rate of suicide deaths per population compared to the supply of six MH/SU services workforce groups is presented in Figure 36.

The Northwest AHEC region had a higher suicide rate to the population and lower workforce supply to the regional population for all six MH/SU services occupation groups. Area L, Eastern, and Southern Regional AHEC regions all had a higher suicide rate and lower than the state average for five of the six occupation groups. Area L had higher than the state average for MH/SU NPs, while both the Eastern and Southern Regional AHEC had a higher supply of addiction counselors. Mountain AHEC had a higher suicide rate to the population, yet also a higher supply of all MH/SU services occupation groups, particularly among addiction counselors.

Charlotte, Greensboro, and South East AHEC regions all had suicide rates slightly lower than the state average and differences in their MH/SU services workforce supply. South East AHEC had slightly higher than average supply across five of the six occupation groups. Though South East AHEC had slightly lower than average MH/SU physicians supply, they had higher than average supply of prescriber level clinicians, indicating PAs and NPs drive their prescriber level workforce supply. In contrast to South East AHEC's low physician supply rate, Greensboro AHEC region had the highest rate of MH/SU physicians to the regional population. Greensboro AHEC region also had higher than average workforce supply for prescriber level clinicians and graduate-level clinicians. Charlotte AHEC generally had a lower than statewide average workforce supply, except for MH/SU PAs and NPs that were either just at or slightly above the state average. Wake AHEC had the lowest suicide rate compared to the state rate and had a higher rate for five of the six MH/SU services workforce, with the rate of addiction counselors just below the state average.

Partners Tailored Plan catchment area had a higher suicide rate to the population and lower workforce supply to the regional population for all six MH/SU services occupation groups, though the supply of MH/SU services PAs was just below the state average. Trillium and Vaya catchment areas both had higher suicide rates to the population and lower workforce supply for graduate-level clinicians, MH/SU physicians, PAs, NPs, and prescriber level clinicians, but had a higher supply of addiction counselors than the state average. The Alliance catchment area had lower suicide rates to the population and higher workforce supply of all MH/SU services occupation groups (graduate-level MH/SU services clinicians, addiction counselors, physicians, PAs, NPs, and prescriber-level clinicians), though the supply of addiction counselors was close to the state average.

Figure 36. Rates of Suicide Deaths Compared to the Mental Health and Substance Use Services Workforce Supply, North Carolina, 2023

NEED NC-VDRS Suicide Counts	SUPPLY Grad-Level Clinicians	Addiction Counselors	MH/SU Physicians	MH/SU PAs	MH/SU NPs	Prescriber-Level Clinicians
Statewide	28.04	4.88	1.43	0.52	1.33	3.28
By AHEC Region						
Northwest						
Area L						
Charlotte						
Eastern						
Greensboro						
Mountain						
South East						
Southern Regional						
Wake AHEC						
By Tailored Plan Catchment Area						
Alliance						
Partners						
Trillium						
Vaya						

Note. MH/SU=Mental Health and Substance Use Services; AHEC=Area Health Education Center; PA=Physician Assistant; NP=Nurse Practitioner; Low Need=The regional need is less than state average need; High Need=The regional need is greater than state average need; High Supply=The regional supply is greater than state average supply.; Low Supply=The regional supply is less than state average supply.
Source. NCMB, NCBON, NCPB, NCMFTLB, NCBLCMHC, NCSWCLB, NC Pastoral Counseling Board, NCASPPB Licensure Data, and NC-VDRS, 2023.

Substance Use Indicators of Need Compared to MH/SU Services Workforce Supply

Emergency Department Visits for Overdose Compared to MH/SU Services Workforce Supply

The 2023 rate of medication and drug overdose ED visits per the population compared to the supply of six MH/SU workforce groups is presented in Figure 37.

The Area L AHEC region had the highest rate of unintentional medication and drug overdose ED visits and the greatest difference between need and supply among all AHEC regions. Area L had a lower workforce supply for all MH/SU services occupation groups except for MH/SU services NPs. The Northwest AHEC region had higher rates of drug overdose ED visits to the population and lower workforce supply to the population for all occupation groups, though not to the same degree of distance seen in Area L. The MH/SU PA supply in the Northwest AHEC region was the closest of all occupation groups to the state average. Eastern and Southern Regional AHEC regions had similar patterns: higher rates of medication and drug overdose ED visits and an overall lower workforce supply, except for addiction counselors. Mountain AHEC has a similar pattern to earlier figures. The Mountain AHEC regional need (unintentional medication and drug overdose ED visits in this case) is higher than the statewide average, yet this region also had a supply of all MH/SU services occupation groups, particularly among addiction counselors.

Greensboro and Charlotte AHEC regions both had a rate of unintentional medication and drug overdose ED visits close to the state rate, though the rate was slightly above the average in Greensboro AHEC and slightly below the average in Charlotte AHEC. In Greensboro AHEC, addiction counselors, MH/SU PAs, and NPs were lower than the statewide average. Charlotte AHEC, on average, was close to the state average across all six MH/SU services occupation groups with addiction counselors being the occupation group below the state average in the region and MH/SU PAs the group most above the state average.

The South East AHEC region had a lower rate of unintentional medication and drug overdose ED visits and a higher supply of five of the six MH/SU services workforce groups but a lower supply of MH/SU services physicians than the state average. Like the South East Region, Wake AHEC also had a lower rate of unintentional medication and drug overdose ED visits and a higher supply of five of the six MH/SU services occupation groups. The supply of addiction counselors in Wake AHEC was slightly lower than the state average.

Alliance Tailored Plan area was the only tailored plan area with ED visits for unintentional medication and drug overdose to the population lower than the statewide average and high workforce supply for all six MH/SU services occupation groups. The Partners area showed the opposite pattern, where the rate of unintentional medication and drug overdose ED visits was higher than the state average and the workforce supply was lower than the state average across all six MH/SU services occupation groups. Trillium and Vaya both had higher rates of unintentional medication and drug overdose ED visits when compared to the state average. In both Trillium and Vaya areas, the workforce supply was lower than the state average except for addiction counselors, which had a supply higher than the state average.

Figure 37. Rates of Emergency Department Visits for Overdose Compared to the Mental Health and Substance Use Services Workforce Supply, North Carolina, 2023

Note. MH/SU=Mental Health and Substance Use Services; AHEC=Area Health Education Center; PA=Physician Assistant; NP=Nurse Practitioner; Low Need=The regional need is less than state average need; High Need=The regional need is greater than state average need; High Supply=The regional supply is greater than state average supply.; Low Supply=The regional supply is less than state average supply.
Source. NCMB, NCBON, NCPB, NCMFTLB, NCBLCMHC, NCSWCLB, NC Pastoral Counseling Board, NCASPPB Licensure Data, and 2025 NCDPH analysis of NC State Center for Health Statistics, Vital Statistics Death Certificate Data, 2023.

Overdose Deaths Compared to MH/SU Services Workforce Supply

The 2023 rate of drug overdose deaths per the population compared to the supply of six MH/SU workforce groups is presented in Figure 38.

The Northwest AHEC region had a higher rate of overdose deaths to the population and lower workforce supply to the regional population for all six MH/SU services workforce groups. Though the Southern Regional AHEC region had the highest rate of medication overdose deaths to the population among all AHEC regions, the region had a higher supply of addiction counselors than the state average yet lower supply of the five other MH/SU services occupations. Eastern AHEC had a similar pattern with higher medication overdose death rates (though just slightly above average) and lower supply across all MH/SU occupation groups except for addiction counselors. Area L and Mountain AHEC regions also had higher rates of medication overdose deaths to the population; while Mountain AHEC had a higher supply of all MH/SU services occupation groups, particularly among addiction counselors and Area L had a lower supply of all MH/SU services occupation groups except for MH/SU NPs. The South East AHEC region had higher rates of overdose deaths to the population and higher workforce supply to the regional population for almost all MH/SU services occupation groups, except for MH/SU physicians. Greensboro AHEC region had a higher rate of overdose deaths and a lower supply of addiction counselors, MH/SU PAs, and MH/SU NPs.

Charlotte and Wake AHEC regions both had lower rates of overdose deaths to the population than the state average. In the Charlotte AHEC region, the workforce supply varied across MH/SU services occupation groups, with higher supply of MH/SU PAs and NPs. Wake AHEC was the only region that had lower rates of overdose deaths to the population and higher workforce supply for most MH/SU services occupation groups, with the exception of addiction counselors.

Partners Tailored Plan catchment area had higher medication overdose deaths to the population and lower workforce supply to the regional population for all six MH/SU services occupation groups, with the supply of MH/SU services PAs being just below the state average. Trillium and Vaya both had higher medication overdose deaths to the population and lower overall workforce supply, though a higher supply of addiction counselors than the state average in both regions. Alliance Tailored Plan catchment areas had lower average rates of overdose deaths to the population and a higher workforce supply for all MH/SU services occupation groups.

Figure 38. Rates of Overdose Deaths Compared to the Mental Health and Substance Use Services Workforce Supply, North Carolina, 2023

Note. MH/SU=Mental Health and Substance Use Services; AHEC=Area Health Education Center; PA=Physician Assistant; NP=Nurse Practitioner; Low Need= The regional need is less than state average need; High Need= The regional need is greater than state average need; High Supply=The regional supply is greater than state average supply.; Low Supply= The regional supply is less than state average supply.
Source. NCMB, NCBON, NCPB, NCMFTLB, NCBLCMHC, NCSWCLB, NC Pastoral Counseling Board, NCASPPB Licensure Data, and 2025 NCDPH analysis of NC State Center for Health Statistics, Vital Statistics Death Certificate Data, 2023.

APPENDIX I: WORKFORCE APPENDIX

Mental Health and Substance Use Services Workforce Occupation Appendix

For each occupation, the appendix below provides a brief description of the occupation and settings, along with the following areas, detailing requirements for:

1. Education,
2. Supervised Practice Hours,
3. Exams,
4. Supervision,
5. Scope of Practice, and
6. Continuing Education.

The occupations are listed in the order presented in the report, grouped by the categories of prescribers, graduate-level clinicians, addiction counselors, health/allied health, and certified paraprofessionals and mental health support specialists. Typically, laws and codes pertaining to each occupation are cited (when available), along with supporting materials.

Psychiatrist

A psychiatrist is a medical doctor who specializes in the diagnosis and treatment of mental illnesses through a combination of personal counseling (psychotherapy), psychoanalysis, hospitalization, and medication.[28,29] Psychiatrists typically attend 8-12 years of medical school and training where they gain expertise in the diagnosis and treatment of mental health problems.[29] Training occurs in office, hospital, and emergency room settings, and community sites such as primary care.[30]

- *Education:* Doctoral degree (MD or DO) from an accredited medical school.[31]
- *Supervised Practice Hour Requirements for Licensure/Certification:* Residency training program accredited by the Accreditation Council for Graduate Medical Education (ACGME).[32] Typically this lasts four years, with the first year in a hospital working with patients with a wide range of medical illnesses, and the remaining three years spent learning the diagnosis and treatment of mental health, including various forms of psychotherapy and the use of psychiatric medications and other treatments.[30]
- *Exams:* American Board of Psychiatry and Neurology, Inc. (ABPN) psychiatry certification examination, in addition to the national exam required for a medical license.[31]
- *Supervision:* Once licensed, psychiatrists may practice independently.

- *Scope of Practice:* Psychiatrists are licensed to practice medicine and may diagnose physical or mental conditions, prescribe and administer medications, and provide treatment, including psychiatric evaluations, managing psychiatric emergencies, and providing therapeutic interventions.[33]
- *Continuing Education:* With ABPN, 90 Category 1 CME credits and 1 PIP activity must be completed every three years. Psychiatrists may choose instead to take a Continuing Certification Exam every 10 years to stay certified.[34] The North Carolina Medical Board required physicians in North Carolina to complete 60 hours of CME relevant to their specialty every three years.[35]

Addiction Psychiatrist

Addiction psychiatrists are psychiatrists who are Board-certified in the subspecialty of addiction psychiatry after becoming Board-certified in general psychiatry.[36] Addiction psychiatry involves focusing on evaluation and treatment of individuals with alcohol, drug, or other substance-related disorders, and of individuals with dual diagnosis of substance-related and other psychiatric disorders.[36]

- *Education:* Doctoral degree (MD or DO) from an accredited medical school.[31]
- *Supervised Practice Hour Requirements for Licensure/Certification:* Psychiatry residency program (typically four years) and one year of Accreditation Council for Graduate Medical Education (ACGME)-accredited fellowship training in addiction psychiatry.[36]
- *Exams:* Addiction Psychiatry subspecialty certification exam and Psychiatry specialty certification examination, in addition to the national exam required for a medical license.[31]
- *Supervision:* Once licensed, psychiatrists may practice independently.
- *Scope of Practice:* Psychiatrists are licensed to practice medicine and may diagnose physical or mental conditions, prescribe and administer medications, and provide treatment, including psychiatric evaluations, managing psychiatric emergencies, and providing therapeutic interventions.[33]
- *Continuing Education:* With the American Board of Psychiatry and Neurology, 90 Category 1 CME credits and 1 PIP activity must be completed every three years. Psychiatrists may choose instead to take a Continuing Certification Exam every 10 years to stay certified.[34] The North Carolina Medical Board required physicians in North Carolina to complete 60 hours of CME relevant to their specialty every three years.[35]

Child and Adolescent Psychiatrist

Child and adolescent psychiatrists have additional skills and training in the diagnosis and treatment of developmental, behavioral, emotional, and mental disorders of childhood and adolescence.[37] They are Board-certified in the subspecialty of child and adolescent psychiatry after becoming Board-certified in general psychiatry.[37]

- *Education:* Doctoral degree (MD or DO) from an accredited medical school.[31]
- *Supervised Practice Hour Requirements for Licensure/Certification:* Two years of subspecialty training in child and adolescent psychiatry, which may be completed on a part-time basis, in addition to psychiatry residency training.[37]
- *Exams:* Child and Adolescent Psychiatry subspecialty certification exam and Psychiatry specialty certification examination, in addition to the national exam required for a medical license.

- *Supervision:* Once licensed, psychiatrists may practice independently.
- *Scope of Practice:* Psychiatrists are licensed to practice medicine and may diagnose physical or mental conditions, prescribe and administer medications, and provide treatment, including psychiatric evaluations, managing psychiatric emergencies, and providing therapeutic interventions.[33]
- *Continuing Education:* With the American Board of Psychiatry and Neurology, 90 Category 1 CME credits and 1 PIP activity must be completed every three years. Psychiatrists may choose instead to take a Continuing Certification Exam every 10 years to stay certified.[34] The North Carolina Medical Board required physicians in North Carolina to complete 60 hours of CME relevant to their specialty every three years.[35]

Addiction Medicine Physician

An addition medicine physician specializes in the prevention, evaluation, diagnosis, and treatment of people with the disease of addiction, those with substance-related health conditions, and those who show unhealthy use of substances including nicotine, alcohol, prescription medications and other licit and illicit drugs.[31,39,40] They also help family members whose health and functioning are affected by a loved one's substance use or addiction.[39]

Addiction medicine physicians work in clinical medicine, public health, educational, and research settings.[41]

- *Education:* Doctoral degree (MD or DO) from an accredited medical school.[42]
- *Supervised Practice Hour Requirements for Licensure/Certification:* Before beginning a subspecialty fellowship for addiction medicine, physicians must complete a residency program (3 to 7 years, depending on specialty) and possess a specialty certification.[43] Most addiction medicine fellows choose Family Medicine or Internal Medicine residencies.[44]
    - Beginning on January 1, 2026, applicants must complete a 12-month fellowship program accredited by the Accreditation Council for Graduate Medical Education (ACGME).[43] Previously, an alternative option of a practice pathway required individuals to complete 1,920 practice hours over at least 24 months in the five-year period preceding June 30 of the application year (including at least 480 hours in direct practice care and 1,440 hours in addiction-specific practice activities).[45]
- Exams: Addiction Medicine subspecialty certification exam, in addition to the national exam required for a medical license.[46]
- *Supervision:* Once licensed, addiction medicine physicians may practice independently.
- *Scope of Practice:* Addiction medicine physicians are licensed to practice medicine and may diagnose physical or mental conditions, prescribe and administer medications, and provide treatment, including psychiatric evaluations, managing psychiatric emergencies, and providing therapeutic interventions.[33] Some addiction medicine physicians limit their practice to patients with addiction or unhealthy substance use while others focus on patients within their initial medical specialty who have substance-related health conditions.[41]
- *Continuing Education:* With the American Board of Psychiatry and Neurology, 90 Category 1 CME credits and 1 PIP activity must be completed every three years. Psychiatrists may choose instead to take a Continuing Certification Exam every 10 years to stay certified.[34] The North Carolina Medical Board required physicians in North Carolina to complete 60 hours of CME relevant to their specialty every three years.[35]

Psychiatric-Mental Health Nurse Practitioner

- A Psychiatric-Mental Health Nurse Practitioner (PMH-NP) is a type of Advanced Practice Registered Nurse (APRN) who can assess, diagnose, and treat individuals, families or groups with complex psychiatric-mental health problems or with the potential for such disorders.[47] PMH-NPs work in multiple settings, such as hospitals, primary care, community health centers, schools, substance use treatment programs, nursing homes, private practices, and academia.[47] They can prescribe medication, provide psychotherapy, and provide clinical supervision.[47] PMHNPs are licensed as RNs by the North Carolina Board of Nursing (NCBON) and granted approval to practice as nurse practitioners by the NCBON in conjunction with the NCMB.
- *Education:* Master's, Post-graduate certificate, or Doctor of Nursing Practice (DNP) from an institution with a program accredited by the Commission on Collegiate Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN), or the National League for Nursing (NLN) Commission for Nursing Education Accreditation (CNEA).[48] Applicants must also have an active permanent North Carolina Registered Nurse (RN) license or Registered Nurse (RN) license with multistate privileges from another compact state.[48]
- *Supervised Practice Hour Requirements for Licensure/Certification:* The PMH-NP degree program must include a minimum of 500 faculty-supervised clinical hours and clinical training in at least two psychotherapeutic treatment modalities.[48]
- *Exams:* Psychiatric-Mental Health Nurse Practitioner (PMH-NP) (Across the Lifespan) board certification examination from the American Nurses Credentialing Center (ANCC).[48]
- *Supervision:* In NC, all NPs (including PMH-NPs) must enter into a Collaborative Practice Agreement (CPA) with a supervising physician licensed by the North Carolina Medical Board.[49] Quality Improvement (QI) meetings are also required monthly for the first 6 months of a new CPA and then every 6 months thereafter.[49] Onsite physical presence is not required for supervision, but the supervising physician must be continuously available to the NP for consultation.[49]
- *Scope of Practice:* The agreement between the NP and the supervising physician outlines what an NP can do at their practice site, which may be more restrictive than their actual scope of practice.[49] NPs have prescriptive authority, including controlled substances (consistent with controlled substance laws and rules).[49 50] As defined under 21 NCAC 36, an NP's scope of practice includes a broad range of personal health services:
    - promotion and maintenance of health;
    - prevention of illness and disability;
    - diagnosing, treating, and managing acute and chronic illnesses;
    - guidance and counseling for both individuals and families;
    - prescribing, administering, and dispensing therapeutic measures, tests, procedures, and drugs;
    - planning for situations beyond the nurse practitioner's scope of practice and expertise by consulting with and referring to other health care providers as appropriate; and
    - evaluating health outcomes.[51]

- *Continuing Education*: With the North Carolina Board of Nursing, NPs must maintain national certification or complete 50 contact hours of CE every two years.[52,53] With the American Academy of Nurse Practitioners Certification Board, NPs may recertify with completion of 1,000 practice hours and 100 contact hours of advanced continued education, or choose instead to complete a National Certification Examination.[54]

Psychiatric Mental Health Clinical Nurse Specialist

A Psychiatric-Mental Health Clinical Nurse Specialist (PMH-CNS) is a type of Advanced Practice Registered Nurse (APRN) with a Clinical Nurse Specialist certification.[55]

CNSs may provide preventive care, client and family education and counseling, psychotherapy, and/or supervision and mentoring of physical and mental health needs over time.[56] The CNS is responsible and accountable for treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities. The CNS role began in hospitals but CNSs increasingly practice in most health care settings.[56] To practice as a CNS in NC, an individual must receive recognition from the North Carolina Board of Nursing (NCBON) and a national CNS Certification.[56] A National CNS Certification is offered through two organizations: the American Association of Critical-Care Nurses Certification Corporation (AACN Cert Corp)'s three certification programs for Clinical Nurse Specialists: ACCNS-Neonatal, ACCNS-Pediatric, ACCNS-Adult-Gerontology; and the American Nurses Credentialing Center (ANCC)'s Adult-Gerontology Clinical Nurse Specialist board certification (AGCNS-BC).[57,58]

- *Education:* Master's or higher in nursing with clinical specialization and preparation for an expanded role with national certification in adult/gerontology, pediatrics, or neonatal clinical nursing. Applicants must also have an active permanent North Carolina Registered Nurse (RN) license or Registered Nurse (RN) license with multistate privileges from another compact state.[59]
- *Supervised Practice Hour Requirements for Licensure/Certification:* 500 faculty-supervised clinical hours.[60]
- *Exams:* Clinical Nurse Specialist exam (corresponding to the certification program: Adult-Gerontology, Pediatric, or Neonatal).[60,61]
- *Supervision:* Once licensed, as a type of APRN, PMH-CNSs practice autonomously. Unlike NPs they do not have prescriptive authority and they are not required to have a supervising physician for medication orders.
- *Scope of Practice:* According to the American Psychiatric Nurses Association, psychiatric advanced practice nurses, whether they practice under the title of CNS or NP, share the same core competencies of clinical and professional practice.[62] As defined in 21 NCAC 36, the scope of practice of a CNS includes the basic components of nursing practice as well as the understanding and application of nursing principles at an APRN level in the area of clinical nursing specialization, including:
    - assessing clients' health status, synthesizing and analyzing multiple sources of data, and identifying alternative possibilities as to the nature of a health care problem;
    - diagnosing and managing clients' acute and chronic health problems within the essential core competencies for professional nursing education;
    - assessing for and monitoring the usage and effect of pharmacologic agents within the essential core competencies for professional nursing education;

- formulating strategies to promote wellness and prevent illness;
- prescribing and implementing therapeutic and corrective non-pharmacologic nursing interventions;
- planning for situations beyond the clinical nurse specialist's expertise and consulting with or referring clients to other health care providers as appropriate;
- promoting and practicing in collegial and collaborative relationships with clients, families, other health care professionals, and individuals whose decisions influence the health of individual clients, families, and communities;
- initiating, establishing, and using measures to evaluate health care outcomes and modify nursing practice decisions;
- assuming leadership for the application of research findings for the improvement of health care outcomes; and
- integrating education, consultation, management, leadership, and research into the clinical nurse specialist role.

Unlike NPs, CNSs do not currently hold prescriptive authority in NC.

- *Continuing Education:* With the North Carolina Board of Nursing, APRNs must maintain national certification or complete 50 contact hours of CE every two years.[52,53]

Psychiatric-Mental Health Registered Nurse / Psychiatric Mental Health Nurse - Board Certified

A psychiatric–mental health registered nurse (PMH-RN) cares for patients with mental health issues, mental health problems, psychiatric disorders, and co-occurring psychiatric and substance use disorders. They work with individuals, families, groups, and communities, selecting and implementing evidence-based interventions to promote positive outcomes and recovery. PMH-RNs help people gain, re-gain, or improve coping abilities, living skills, and managing symptoms; maximize their strengths; and prevent further disability.

- *Education:* Nursing degree program options include two-year programs leading to an associate's degree in nursing, four-year college or university programs leading to a bachelor's degree in nursing (BSN), accelerated BSN programs (for those who already have a bachelor's in another discipline), and Direct Master's Entry (DME).[47,64] In the past, NC had a diploma in nursing (hospital-based) option, as well.
- *Supervised Practice Hour Requirements for Licensure/Certification:* PMH-BCs must hold a current, active RN license and have practiced the equivalent of two years full-time as an RN.[65] They must have a minimum of 2,000 hours of clinical practice in psychiatric–mental health nursing within the last three years, and completed 30 hours of continuing education in psychiatric–mental health nursing within the last three years.[65]
- *Exams:* The National nursing exam (NCLEX-RN), which is needed to become an RN, and the Psychiatric–Mental Health Nursing board certification examination.[65]
- *Supervision:* RN practice does not require assignment or supervision by a higher level health care provider for nursing functions.[65]

- *Scope of Practice:* According to the North Carolina Board of Nursing, the RN scope of practice in all steps of the nursing process is independent and comprehensive.[50] As defined in N.C.G.S. 90-171.20, an RN's scope of practice includes:
    - Assessing the patient's physical and mental health.
    - Recording and reporting the results of the nursing assessment.
    - Planning, initiating, delivering, and evaluating appropriate nursing acts.
    - Teaching, assigning, delegating to or supervising other personnel in implementing the treatment.
    - Collaborating with other health care providers in determining the appropriate health care for a patient but not prescribing a medical treatment regimen or making a medical diagnosis, except under supervision of a licensed physician.
    - Implementing the treatment and pharmaceutical regimen prescribed by any person authorized by State law to prescribe the regimen.
    - Providing teaching and counseling about the patient's health.
    - Reporting and recording the plan for care, nursing care given, and the patient's response to that care.
    - Supervising, teaching, and evaluating those who perform or are preparing to perform nursing functions and administering nursing programs and nursing services.
    - Providing for the maintenance of safe and effective nursing care, whether rendered directly or indirectly.[66]
- *Continuing Education:* The North Carolina Board of Nursing requires RNs to complete 30 contact hours of continued education. 15 hours may be substituted for 640 hours of active practice within previous 2 years, completion of a nursing project as Principal Investigator or Co-Investigator, authoring a nursing-related article, or conducting a nursing continuing education presentation totaling at least five contact hours. All 30 hours may be substituted for National Certification by a National Credentialing Body recognized by the Board.[67]

Licensed Practical Nurse

A Licensed Practical Nurse (LPN) is a health care professional responsible for basic patient care and comfort, monitoring a patient's status, managing basic care, and keeping up-to-date medical records.[68] LPNs typically work under an RN's direct supervision.[68]

- *Education:* Diploma in Practical Nursing from a community college, which generally lasts one year.[64]
- *Supervised Practice Hour Requirements for Licensure/Certification:* LPN programs include mandatory supervised clinical hours, with varying hours required by state or program. The NCBON stipulates that practical nursing curriculum must include a minimum of 90 hours in the final semester in a focused client care experience (FCCE).[69]
- *Exams:* National Council Licensure Examination (NCLEX®) prepared by the National Council of State Boards of Nursing (NCSBN) for graduates of Board-approved nursing education programs.[70]

- *Supervision:* LPNs' work requires assignment or delegation by and performance under the supervision, orders, or directions of a registered nurse (RN), physician, dentist, or other person authorized by State law to provide the supervision.[71] LPNs implement health care plans developed by the RN and/or by any person authorized by State law to prescribe such a plan.[71]
- *Scope of Practice:* LPNs are not allowed to practice independently; their scope is dependent and directed.[71] As defined under N.C.G.S. 90-171, the practice of nursing by an LPN consists of:
    - Participating in the assessment of the patient's physical and mental health, including the patient's reaction to illnesses and treatment regimens;
    - Recording and reporting the results of the nursing assessment;
    - Participating in implementing the health care plan developed by the registered nurse and/or prescribed by any person authorized by State law to prescribe such a plan, by performing tasks assigned or delegated by and performed under the supervision or under orders or directions of a registered nurse, physician licensed to practice medicine, dentist, or other person authorized by State law to provide the supervision;
    - Assigning or delegating nursing interventions to other qualified personnel under the supervision of the registered nurse;
    - Participating in the teaching and counseling of patients as assigned by a registered nurse, physician, or other qualified professional licensed to practice in North Carolina;
    - Reporting and recording the nursing care rendered and the patient's response to that care; and
    - Maintaining safe and effective nursing care, whether rendered directly or indirectly.[72]
- *Continuing Education:* The North Carolina Board of Nursing requires LPNs to complete 30 contact hours of continued education. Fifteen hours may be substituted for 640 hours of active practice within previous two years, completion of a nursing project as Principal Investigator or Co-Investigator, authoring a nursing-related article, or conducting a nursing continuing education presentation totaling at least five contact hours. All 30 hours may be substituted for National Certification by a National Credentialing Body recognized by the Board.[67]

Psychiatric Physician Assistant

Physician Assistants (PAs) examine, diagnose, and treat patients under the supervision of a physician.[73] PAs must be nationally certified and receive a license from the North Carolina Medical Board.[74] They practice on health care teams with physicians and other health care workers.[73] PAs practice in physician offices, hospitals, outpatient care centers, and in educational services (state, local, private) and government.[73] Psychiatric PAs most frequently report seeing patients with depressive disorders, bipolar and related disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma-related and stressor-related disorders, and substance-related and addictive disorders.[75] PAs can obtain a Psychiatry Certificate of Added Qualifications (CAQ), though the certification is not required in North Carolina to practice psychiatry.[76]

- *Education*: Program for PAs or surgeon assistants (nearly all are Master's degrees), accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).[77]

- *Supervised Practice Hour Requirements for Licensure/Certification:* PA programs include more than 2,000 hours of clinical rotations with an emphasis on primary care in ambulatory clinics, physicians' offices and acute/long-term care facilities.[77]
- *Exams*: Certification from the National Commission on Certification of Physician Assistants, after a passing score on the National Exam.[77]
    - *Optional:* A Psychiatry Specialty Exam may be taken to receive a Psychiatry CAQ.[76] This CAQ requires 150 hours of psychiatry Continuing Medical Education (CME), 2,000 hours of practice experience in psychiatry, and patient care requirements in the form of an attestation from the supervising physician describing psychiatrist-observed patient case management across a broad range of psychopathology and appropriate treatments.[76]
- *Supervision:* PAs must enter into a supervisory arrangement with a supervising physician to perform medical acts, tasks, or functions.[78] Supervision must be continuous but does not require the physical presence of the supervising physician.[78]
- *Scope of Practice:* 21 NCAC 32S outlines requirements for PAs but not Psychiatric PAs.[78] It is the responsibility of the supervisory physician and PA to identify the PA's scope of practice in the supervisory arrangement.[78] PAs may prescribe but must consult the supervising physician prior to prescribing a targeted controlled substance when certain conditions apply.[78]
- *Continuing Education:* With the NCMB, 50 hours of National Commission on Certification of Physician Assistants (NCCPA) Category I continuing medical education (CME) are required every two years. With NCCPA, 100 CME credits, including at least 50 Category 1 CME credits, must be completed in a 2-year period. A physician assistant who prescribes controlled substances shall complete at least two hours of CME, from the required 50 hours, designed specifically to address controlled substance prescribing practices.[79] To maintain a psychiatry CAQ, a PA must earn a minimum of 75 credits of Category I CME focused on psychiatric practice, including 25 credits earned within the last two years.[59]

Psychologists

Psychologists assess, diagnose, and treat mental, emotional, and behavioral disorders ranging from everyday issues to severe, chronic conditions.[80] While several states allow psychologists to prescribe, North Carolina does not.[81] Psychologists work in a variety of settings, such as schools, hospitals, and private practice.[80] In North Carolina, Licensed Psychologists (LPs), Provisional Licensed Psychologists, and Licensed Psychological Associates (LPAs), whether in Independent Practice or not, may represent themselves as Psychologists, as well as individuals who hold graduate degrees in psychology and are exempt from licensure (e.g., professors, researchers), and school psychologists employed by boards of education.[82] The North Carolina Psychology Board (NCPB) issues licenses to psychologists and health services provider certifications to psychologists who provide health services; the Board does not license any specialty area.[83] This certification is mandatory for an LP who provides or offers health services, but it is optional for an LP holding a provisional license or for an LPA.[83] All health services are encompassed within the practice of psychology, but not all psychology activities are health services.[82]

Licensed Psychologist

- *Education:* Doctoral degree in psychology from a program accredited by the American Psychological Association (APA) or the Canadian Psychological Association.[25]
- *Supervised Practice Hour Requirements for Licensure/Certification*: Two years (3,000 hours) of supervised experience in the intended area of practice.[25] At least 1,500 of these hours and a minimum of 1 calendar year must occur at the post-doctoral level.[25] The post-doctoral experience may begin any time after the doctoral degree is awarded or, for applicants who have met all requirements for their doctorate, it may begin any time after the "met all requirements" date.[84] A provisional license is in-process of obtaining supervisions requirements for full, permanent licensure.[25]
- *Exams*: National Examination (the passing score for LP is 500) and State Examination.[25]
- *Supervision*: Once permanently licensed, licensed psychologists may practice independently. Any provisional license must continue to meet supervision requirements until fully licensed.[24]
- *Scope of Practice:* As defined under N.C.G.S. 90-270, the practice of psychology is the observation, description, evaluation, interpretation, or modification of human behavior by the application of psychological principles, methods, and procedures for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior or of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health, or mental health.[85] The practice of psychology includes, but is not limited to:

    - psychological testing and the assessment of personal characteristics;
    - counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy;
    - diagnosis and treatment of mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct, as well as of the psychological and neuropsychological aspects of physical illness, accident, injury, or disability; and
    - psychoeducational evaluation, therapy, remediation, and consultation.[85]

      For any patient conditions that fall outside the boundaries of the psychologist's competence, including diagnosis and treatment of relevant medical problems, the psychologist should assist the patient in obtaining outside professional help.[85]

- *Continuing Education:* With the North Carolina Medical Board, a psychologist must complete a minimum of 24 continuing education hours, a minimum of 15 of which must be completed under a Category A program sponsor.[86]

Licensed Psychological Associate

The level of education, a limited scope of practice, and supervision requirements are the primary differences between an LP and an LPA. An LPA may apply for Independent Practice after meeting certain requirements.

- *Education*: Master's degree in psychology or a specialist degree in psychology.[25]
- *Supervised Practice Hour Requirements for Licensure/Certification*: 500 hours (12 weeks) of supervised training during the degree, which must include an internship, externship, practicum, or other

supervised field experience related to the area of specialty and the practice of psychology.[25] Four hundred hours of the training shall be in the practice of psychology.[25]

- *Exams*: National Examination (the passing score for LPA is 440) and State Examination.[25] An LP applicant who has met all requirements for licensure except passing the examination may receive a license as an LPA without having a master's degree or specialist degree in psychology if the applicant passes the examination at the LPA level.[25]
- *Supervision*:
  - *Independent Practice LPA*: As of October 1, 2025, LPAs were able to apply for and become Independent Practice LPAs. Requirements for Board-approval are: 4,000 hours of psychological services (post-licensure, within 2–5 years) and having at least an average performance rating. Additionally a qualified Independent LPA can supervise other LPAs requiring supervision.[21]
  - *Supervised LPA*: Must be supervised by an LP or other qualified professionals if engaging in assessment of personality functioning; neuropsychological evaluation; psychotherapy, counseling, and other interventions with clinical populations for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior; and, the use of intrusive, punitive, or experimental procedures, techniques, or measures. May perform psychoeducational assessments independently.[25]
- *Scope of Practice:* As defined under N.C.G.S. 90-270, the practice of psychology is the observation, description, evaluation, interpretation, or modification of human behavior by the application of psychological principles, methods, and procedures for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior or of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health, or mental health.[85] It includes, but is not limited to:
  - psychological testing and the assessment of personal characteristics;
  - counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy;
  - diagnosis and treatment of mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct, as well as of the psychological and neuropsychological aspects of physical illness, accident, injury, or disability; and
  - psychoeducational evaluation, therapy, remediation, and consultation.[85]

  For any patient conditions that fall outside the boundaries of the licensed psychological associate's competence, including diagnosis and treatment of relevant medical problems, the psychologist should assist the patient in obtaining outside professional help.[85]

  Once enacted, NC Session Law 2025-37 stipulates that an LPA may also practice neuropsychology and forensic psychology once specialized education and training is demonstrated to the Board.[21]
- *Continuing Education:* With the NCPB, a psychologist must complete a minimum of 24 continuing education hours each biennial renewal period. A minimum of 15 hours must be completed under a Category A program sponsor.[86]

School Psychologist

School psychologists provide comprehensive school psychological services for students from pre-kindergarten through twelfth grade, helping students succeed academically, behaviorally, socially, and emotionally.[87] They have training and expertise in mental health, learning, behavior, and school systems.[87] School psychologists may be directly hired or contract with NC DPI and schools. If the contract is between a school system or charter school and an individual psychologist, the licensure may be with either NC Department of Public Instruction (NC DPI) licensure as a school psychologist or the NCPB.[88] However, employment within public schools with a title of "school psychologist" requires a license with NC DPI.[88] If the contract is between a school system/charter school and a contracting agency, provision of psychological services requires NCPB licensure.[88] Requirements for licensure with NC DPI include:

- *Education*:
    - *Graduate*: Approved program in school psychology at the level of sixth-year, specialist, or masters plus 30 credits. A minimum 60 graduate semester hours required.[88,89]
    - *Doctoral*: Approved program, typically four years of full-time coursework.
- *Supervised Practice Hour Requirements for Licensure/Certification:* The degree must include an internship (specialist minimum 1,200 hours; doctoral minimum 1,500 hours) with at least 600 of the hours in a school setting.[89] At the doctoral level, no supervised hours are required post-program. Specialists' degree vary if supervised hours are during or after the program.
- *Exams*: School Psychology Praxis test.[88]
- *Supervision:* If a regular employee of NC DPI with professional activities limited to their employment activities, supervision is not required. Contracted providers under an NC DPI license are not required to be supervised. Contracted providers licensed through the NCPB must follow NCPB supervision requirements. If a school psychologist is also an LPA, supervision may be required.[25]
- *Scope of Practice:* School psychologists deliver comprehensive school psychological services for students in pre-kindergarten through their senior year. This may include conducting psychoeducational evaluations, providing individual and group counseling, serving on threat assessment teams, and collaborating with school or district teams.[90]
- *Continuing Education:* A DPI-licensed school psychologist must complete a minimum of eight continuing education units (60 hours) over the five-year licensure cycle.[91]

Licensed Clinical Mental Health Counselor

Within the United States, several different titles are used to identify professional counselors.[92] In North Carolina, a Licensed Clinical Mental Health Counselor (LCMHC) is a person engaged in the practice of counseling and licensed by the North Carolina Board of Licensed Clinical Mental Health Counselors.[93] An LCMHC provides counseling and therapy services to individuals, couples, families, and groups to assist clients with mental health issues such as depression, anxiety, and trauma.[94] LCMHCs work with clients to develop coping mechanisms for stressors, and develop goals and treatment plans.[94] They may work in a variety of settings such as private practice, hospitals, schools, or community mental health centers.[94]

- *Education*: Master's degree (minimum of 60 semester hours or 90 quarter hours) in counseling or related field from an institution of higher education that is accredited by the Council for Accreditation of Counseling and Related Educational Programs.[95]

- *Supervised Practice Hour Requirements for Licensure/Certification:* 3,000 hours of supervised professional practice, including 2,000 hours of direct counseling and 100 hours of clinical supervision.[96]
- *Exams*: National Exam (either the National Counselor Examination, the National Clinical Mental Health Counselor Examination, or the Certified Rehabilitation Counselor Examination) and the Jurisprudence Exam.[95]
- *Supervision:* This is an independent licensure (non-restricted).[96]
- *Scope of Practice:* As defined under N.C.G.S. 90-330, the practice of counseling is holding oneself out to the public as a clinical mental health counselor offering counseling services that include, but are not limited to:
    - Counseling – Assisting individuals, groups, and families through the counseling relationship by evaluating and treating mental disorders and other conditions through the use of a combination of clinical mental health and human development principles, methods, diagnostic procedures, treatment plans, and other psychotherapeutic techniques, to develop an understanding of personal problems, to define goals, and to plan action reflecting the client's interests, abilities, aptitudes, and mental health needs as these are related to personal-social-emotional concerns, educational progress, and occupations and careers.
    - Appraisal Activities – Administering and interpreting tests for assessment of personal characteristics.
    - Consulting – Interpreting scientific data and providing guidance and personnel services to individuals, groups, or organizations.
    - Referral Activities – Identifying problems requiring referral to other specialists.
    - Research Activities – Designing, conducting, and interpreting research with human subjects.[93]
- *Continuing Education:* With the NCBLCMHC, 40 contact hours of continuing counselor education are required for renewal. In the case of newly issued licenses in which the initial renewal period is less than two full years, 30 contact hours is required with 3 of these hours related to ethics.[97]

Licensed Clinical Mental Health Counselor Supervisor

An LCMHC (who thus already obtained 3,000 hours of supervised practice) may become an Licensed Clinical Mental Health Counselor Supervisor (LCMHCS) if they have at least 2,500 hours of direct client content (over five years of full-time, eight years of part-time, or a combination of part-time and full-time experience) and three semester graduate credits in clinical supervision.[93,98]

Licensed Clinical Mental Health Counselor Associate

Licensure as a Licensed Clinical Mental Health Counselor Associate (LCMHCA) is a pre-requisite for new graduates and/or new counseling professionals to become a LCMHC.[96] It allows a person to engage in supervised practice of counseling in the state of North Carolina.

- *Education*: Master's degree (minimum of 60 semester hours or 90 quarter hours) in counseling or related field from an institution of higher education that is accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP).[99]

- *Supervised Practice Hour Requirements for Licensure/Certification:* LCMHCA applicants must complete both a supervised counseling practicum experience (100 hours over a full academic term that is a minimum of 10 weeks) and an internship (600 hours of supervised counseling internship in roles and settings with clients relevant to their specialty area, with at least 240 clock hours of direct service).[99] As of July 1, 2025, LCMHCA applicants in NC must complete all internship experiences in a clinical mental health setting that provides substantial opportunities to assess, appraise, diagnose, and treat mental health disorders and shall consist of direct counseling experience.[99]
- *Exams*: National Exam (either the National Counselor Examination, the National Clinical Mental Health Counselor Examination, or the Certified Rehabilitation Counselor Examination) and the Jurisprudence Exam.
- *Supervision:* The LCMHCA license is a restricted license, allowing individuals to gain clinical mental health counseling experience while practicing under the supervision of a qualified mental health professional.[96]
- *Scope of Practice:* As defined under N.C.G.S. 90-330, the practice of counseling is holding oneself out to the public as a clinical mental health counselor offering counseling services that include, but are not limited to:
    - Counseling – Assisting individuals, groups, and families through the counseling relationship by evaluating and treating mental disorders and other conditions through the use of a combination of clinical mental health and human development principles, methods, diagnostic procedures, treatment plans, and other psychotherapeutic techniques, to develop an understanding of personal problems, to define goals, and to plan action reflecting the client's interests, abilities, aptitudes, and mental health needs as these are related to personal-social-emotional concerns, educational progress, and occupations and careers.
    - Appraisal Activities – Administering and interpreting tests for assessment of personal characteristics.
    - Consulting – Interpreting scientific data and providing guidance and personnel services to individuals, groups, or organizations.
    - Referral Activities – Identifying problems requiring referral to other specialists.
    - Research Activities – Designing, conducting, and interpreting research with human subjects.[93]
- *Continuing Education:* With the NCBLCMHC, 40 contact hours of continuing counselor education are required for renewal. In the case of newly issued licenses in which the initial renewal period is less than two full years, 30 contact hours is required with three of these hours related to ethics.[97]

Licensed Clinical Social Worker

Licensed Clinical Social Workers (LCSWs) practice clinical social work, a specialty practice area of social work focusing on the assessment, diagnosis, treatment, and prevention of mental illness, emotional, and other behavioral disturbances.[100] They commonly use individual, group and family therapy treatment modalities and work in a variety of settings including private practice, hospitals, community mental health, primary care, and agencies.[100]

- *Education*: Master's (MSW), Doctoral (DSW), or PhD degree in social work from a Council on Social Work Education accredited school.[101]

- *Supervised Practice Hour Requirements for Licensure/Certification:* 3,000 hours of post MSW paid clinical employment appropriately supervised clinical practice) accumulated in no less than two (2) years, nor more than six (6) years.[101]
- *Exams*: Association of Social Work Boards Clinical level exam.[101]
- *Supervision:* 100 hours of supervision from an LCSW, MSW with an additional 2 years post LCSW clinical social work practice, on a regular basis: at least one (1) hour of supervision for every thirty (30) hours of clinical practice. A maximum of twenty-five (25) hours may be group supervision.[101]
- *Scope of Practice:* As defined under N.C.G.S. 90B-3, clinical social work practice is the professional application of social work theory and methods to the biopsychosocial diagnosis, treatment, or prevention, of emotional and mental disorders.[102] Practice includes, by whatever means of communications, the treatment of individuals, couples, families, and groups, including the use of psychotherapy and referrals to and collaboration with other health professionals when appropriate.[102] Clinical social work practice shall not include the provision of supportive daily living services to persons with severe and persistent mental illness as defined in N.C.G.S. 122C-3(33a).[102]
- *Continued Education:* With the North Carolina Social Work Certification and Licensure Board, 40 contact hours of Board-approved continuing education credits are required within each two-year renewal cycle.[103]

Licensed Clinical Social Worker Associate

Licensed Clinical Social Worker Associates (LCSWAs) practice clinical social work under supervision of an LCSW. Clinical social work is a specialty practice area of social work focusing on the assessment, diagnosis, treatment, and prevention of mental illness, emotional, and other behavioral disturbances.[100] Like LCSWs, LCSWAs commonly use individual, group and family therapy treatment modalities and work in a variety of settings including private practice, hospitals, community mental health, primary care, and agencies.[100]

- *Education*: Master's (MSW), Doctoral (DSW), or PhD degree in social work from a Council on Social Work Education accredited school.[101]
- *Supervised Practice Hour Requirements for Licensure/Certification:* No previous experience is required but LCSWAs working toward their LCSW requirements must document their supervision and practice to the Board every 6 months.[101,104]
- *Exams*: None required for initial LCSWA licensure.[101]
- *Supervision:* 100 hours of supervision from a LCSW, MSW with an additional 2 years post LCSW clinical social work practice, on a regular basis: at least one (1) hour of supervision for every thirty (30) hours of clinical practice.[101] A maximum of twenty-five (25) hours may be group supervision.[101]
- *Scope of Practice:* As defined under N.C.G.S. 90B-3, clinical social work practice is the professional application of social work theory and methods to the biopsychosocial diagnosis, treatment, or prevention, of emotional and mental disorders.[102] Practice includes, by whatever means of communications, the treatment of individuals, couples, families, and groups, including the use of psychotherapy and referrals to and collaboration with other health professionals when appropriate.[102] Clinical social work practice shall not include the provision of supportive daily living services to persons with severe and persistent mental illness.[102]
- *Continuing Education:* With the North Carolina Social Work Certification and Licensure Board, 40 contact hours of Board-approved continuing education credits are required within each two-year renewal cycle.[103,105]

Licensed Marriage and Family Therapist

Licensed Marriage and Family Therapists (LMFTs) use psychotherapeutic and family systems theories and techniques in the delivery of services to families, couples, and individuals for the purpose of treating diagnosed mental and emotional disorders.[106] LMFTs provide referrals to and collaborate with health care and other professionals when appropriate.[106] The North Carolina Marriage and Family Therapy Licensure Board issues licenses for LMFTs and LMFTAs.

- *Education:* Master's degree from a recognized educational institution in the field of marriage and family therapy, or a related degree (a Master's or doctoral degree in clinical social work, psychiatric nursing, or counseling; a Doctor of medicine or osteopathy and a residency in psychiatry; or any equivalent mental health field that has an equivalent course of study to marriage and family therapy).[106]
- *Supervised Practice Hour Requirements for Licensure/Certification:* 1,500 clinical hours with 200 approved supervision hours. Up to 500 of the clinical hours and any amount of approved supervision hours may be earned during the degree program. The remaining 1,000 hours must be acquired, under approved supervision or post licensure (LMFTA). A minimum of 25 supervision hours must be acquired post degree, regardless of the number of hours earned prior to completion of the degree.[106,107]
- *Exams:* National Marriage and Family Therapy Examination.
- *Supervision:* Once licensed, LMFTs do not require supervision.
- *Scope of Practice:* As defined under N.C.G.S. 90-270.47, the practice of marriage and family therapy means the rendering of professional marriage and family therapy services to individuals, couples, or families, singly or in groups, whether the services are offered directly to the general public or through organizations, either public or private, for a fee, monetary or otherwise.[106]
- *Continuing Education:* The North Carolina MFT Licensure Board requires 20 hours of continuing education credits in marriage and family therapy per year, to be submitted with license renewal forms.[108]

Licensed Marriage & Family Therapist Associate

Licensed Marriage & Family Therapist Associate (LMFTAs) practice marriage and family therapy under supervision. The LMFTA license is good for three years and is not renewable.[106] They use psychotherapeutic and family systems theories and techniques in the delivery of services to families, couples, and individuals for the purpose of treating diagnosed mental and emotional disorders.[106] The North Carolina Marriage and Family Therapy Licensure Board issues licenses for LMFTs and LMFTAs.

- *Education:* Master's degree from a recognized educational institution in the field of marriage and family therapy, or a related degree (a Master's or doctoral degree in clinical social work, psychiatric nursing, or counseling; a Doctor of medicine or osteopathy and a residency in psychiatry; or any equivalent mental health field that has an equivalent course of study to marriage and family therapy).[106]
- *Supervised Practice Hour Requirements for Licensure/Certification:* Must show evidence of intent to accrue the required supervised clinical experience for LMFT licensure.[106]
- *Exams:* National Marriage and Family Therapy Examination.[107]
- *Supervision:* LMFTAs practice under an AAMFT certified supervisor and must submit a supervision agreement as part of their LMFTA application.[109] LMFTAs have up to three years (a maximum of a one-year extension may be granted) from the date of initial licensing to acquire the clinical and approved supervision hours required for conversion to an LMFT.[109]

- *Scope of Practice:* As defined under N.C.G.S. 90-270.47, the practice of marriage and family therapy means the rendering of professional marriage and family therapy services to individuals, couples, or families, singly or in groups, whether the services are offered directly to the general public or through organizations, either public or private, for a fee, monetary or otherwise.[106]
- *Continuing Education:* The North Carolina MFT Licensure Board requires 20 hours of continuing education credits in marriage and family therapy per year, to be submitted with license renewal forms.

Fee-Based Practicing Pastoral Counselor

Pastoral Counselors provide counseling services integrating spiritual and psychological aspects, where insights and principles derived from theological disciplines and behavioral sciences are applied to help people across the lifespan achieve wholeness and health.[110] The goal of the professional relationship is to help a person modify "feelings, attitudes, and behavior that are intellectually, socially, emotionally, or spiritually maladjusted, ineffectual, or that otherwise contribute to difficulties in living."[110] Pastoral counseling services can be provided to the general public, to organizations, to individuals, groups, couples, or families. Individuals who charge fees for pastoral counseling must be certified as a Fee-Based Practicing Pastoral Counselor by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors.

- *Education:* At least two master's are required: a master's of divinity or higher (or its equivalent), and a master's or doctoral degree in pastoral counseling (or its equivalent). Both degrees must be from an accredited institution. Additionally, one unit of full-time clinical pastoral education is required, in a program accredited by the Association of Clinical Pastoral Education.[110]
- *Supervised Practice Hour Requirements for Licensure/Certification:* Applicants must have completed at least 1,375 hours of pastoral counseling, with at least 250 of those hours supervised. Supervision can be provided by a North Carolina Certified Fee-Based Practicing Pastoral Counselor, or other mental health professionals licensed or certified to practice in North Carolina (e.g., LCMHC, LMFT, LCSW, LP, Psych NP, etc....)[110,111]
- *Additional Requirements:* Applicants need to have been ordained (or equivalent) and completed three years of full-time work as a rabbi, priest, minister, or religious leader. They also need to be a recognized member of a denomination or faith group recognizing the applicant's status as a rabbi, priest, minister, or religious leader.
- *Exams:* Must pass a written and oral board examination in pastoral counseling. Exams are annual. Qualified applicants may receive a temporary certificate until the next annual exam is given. Temporary certificates are automatically terminated after the next exam and within one year's time.[110,111]
- *Supervision:* Once licensed, fee-based practicing pastoral counselors do not require supervision.
- *Scope of Practice:* Pastoral counseling and pastoral psychotherapy are used interchangeably. They include "sustaining, healing, shepherding, nurturing, guiding, and reconciling; interviewing, counseling, and using psychotherapy, diagnosing, preventing, and ameliorating difficulties in living; and resolving interpersonal and social conflict."[110] The general statute excludes teaching, writing, speaking, and research from the scope of professional pastoral counseling services as it related to the regulations.[110]
- *Continuing Education:* North Carolina requires 50 hours of continuing education each year.[153]

Fee-Based Practicing Pastoral Counseling Associate

- *Education:* A master's of divinity or higher (or its equivalent) from an accredited institution. Additionally, one unit of full-time clinical pastoral education is required, in a program accredited by the Association of Clinical Pastoral Education.[110]
- *Supervised Practice Hour Requirements for Licensure/Certification:* Applicants must have completed at least 375 hours of pastoral counseling, with at least 125 of those hours supervised. Supervision can be provided by a North Carolina Certified Fee-Based Practicing Pastoral Counselor, or other mental health professionals licensed or certified to practice in North Carolina (e.g., LCMHC, LMFT, LCSW, LP, Psych NP, etc.)[110,111]
- *Additional Requirements:* Applicants need to have been ordained (or equivalent) and completed three years of full-time work as a rabbi, priest, minister, or religious leader. They also need to be a recognized member of a denomination or faith group recognizing the applicant's status as a rabbi, priest, minister, or religious leader.
- *Exams:* Must pass a written and oral board examination in pastoral counseling. Exams are annual. Qualified applicants may receive a temporary certificate until the next annual exam is given. Temporary certificates are automatically terminated after the next exam and within one year's time.[110,111]
- *Supervision:* A fee-based pastoral counseling associate can only offer professional services under qualified supervision, whether a Fee-Based Practicing Pastoral Counselor or other licensed or certified mental health professional (e.g., LCMHC, LMFT, LCSW, LP, Psych NP, etc.)[110]
- *Scope of Practice:* Pastoral counseling and pastoral psychotherapy are used interchangeably. They include "sustaining, healing, shepherding, nurturing, guiding, and reconciling; interviewing, counseling, and using psychotherapy, diagnosing, preventing, and ameliorating difficulties in living; and resolving interpersonal and social conflict."[110] The general statute excludes teaching, writing, speaking, and research from the scope of professional pastoral counseling services as it related to the regulations.[110]
- *Continuing Education:* North Carolina requires 50 hours of continuing education each year.[111]

Substance Use Disorder Professionals

The North Carolina Addictions Specialist Professional Practice Board (NCASPPB) is the board for licensing and certifying substance use disorder professionals in North Carolina. It administers the exams for the International Certification and Reciprocity Consortium (IC&RC), a nonprofit organization that develops internationally recognized credentials, examinations, and reciprocity for prevention, substance use disorder and recovery professionals.[113]

Licensed Clinical Addiction Specialist

In NC, a Licensed Clinical Addiction Specialist (LCAS) is the equivalent to the IC&RC's Advanced Alcohol & Drug Counselor (AADC).[114] These individuals provide screening and assessment, counseling, case management, and treatment for those with addictive disorder or disease.[104] There are multiple pathways to apply to become an LCAS in NC through the North Carolina Addictions Specialist Professional Practice Board (NCASPPB) listed below. Most applicants are Criteria A.[115]

- Criteria A is the standard application procedure for all qualifying Master's Degrees.[104]
- Criteria B is the application procedure for persons who already hold a CADC from NCASPPB.[104]
- Criteria C is an accelerated path for pre-approved degree programs in substance use disorder and addictions treatment.[104]
- Criteria D is also known as Deemed Status, and applicants for this path have received a national addictions certification from one of IC&RC's Deemed Status entities.[104] According to the NCASPPB, applicants for Deemed Status must hold the addiction credential associated with one of the professional organizations below.
    - NAADAC Master Addiction Counselor (MAC);
    - National Association of Social Workers' Alcohol, Tobacco and Other Drugs Proficiency (NASW ATOD) (Not accepting new applications for this certification);
    - National Board of Certified Counselors (NBCC MAC) (Not accepting new applications for this certification);
    - Certified Rehabilitation Counselor (CRC MAC);
    - Addiction Nursing Certification Board (ANCB Master's-Level CARN or CARN-AP); or
    - American Psychological Association (APA).[116]
- *Education*: The requirements for practice hours vary depending on the applicant's pathway.
    - Criteria A & B - Master's degree with a clinical application in a human services field from a regionally accredited college or university.[117]
    - Criteria C - Master's degree in a human services field with both a clinical application and a substance use disorder specialty from a regionally accredited college or university that includes 180 hours of substance use disorder specific education and training pursuant to N.C.G.S. 90-113.41A.[117]
    - Criteria D - Master's Degree in a human services field with a clinical internship.[116]
- *Supervised Practice Hour Requirements for Licensure/Certification:* The requirements for practice hours vary depending on the applicant's pathway.
    - Criteria A - Two years postgraduate supervised substance use disorder counseling experience.[117]
    - Criteria B - Has been certified as a substance abuse counselor.[117]
    - Criteria C - One year of postgraduate supervised substance use disorder counseling experience.[117]

  Additionally, all LCAS applicants shall complete a 300-hour practicum supervised by an applicant supervisor that covers all core functions of addictions counseling as required by the IC&RC.[118] For Criteria A LCAS applicants, this practicum must be part of the required two years postgraduate supervised clinical addictions counseling and does not include the clinical application or practical training completed as a part of the master's degree used to apply for the LCAS.[118] The 300-hour practicum may be completed as part of an academic course of study in a regionally accredited college or university or may be developed in a work setting when supervised by an applicant supervisor.[118]

- *Exams:* IC&RC Advanced Alcohol & Drug Counselor Exam.[104]
- *Supervision:* G.S. 90-113.31B states that an LCAS may practice independently.[117,119]
- *Scope of Practice:* As defined under N.C.G.S. 90-113.31B, the LCAS scope of practice consists of: screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education, report and record keeping, consultation with other professionals in regard to client treatment and services, referral to reduce the conditions that place individuals at risk of developing addictive disorder or disease with co-occurring disorders, and treatment for addictive disorder or disease.[120] The NC Addictions Specialist Professional Practice Board states that the LCAS shall not conduct treatment counseling when a patient has a mental health diagnosis only, nor shall an LCAS conduct assessments on clients where substance use disorder is not the presenting disorder.[104]
- *Continuing Education:* Every two years, the North Carolina Addictions Specialist Professional Practice Board requires 40 clock hours of training for license renewal.[121]

Licensed Clinical Addiction Specialist Associate

The Associate status (Licensed Clinical Addiction Specialist Associate, LCASA) is a part of registration with the NC Addictions Specialist Professional Practice Board on the pathway to becoming a Licensed Clinical Addictions Specialist.[115] LCASA may bill third party payers.[115] Associate status is limited to five years.[115] The associate status allows individuals with the required advanced degree to legally work in the substance use disorder profession while gaining the required supervised experience from a CCS or CSI to become an LCAS.

There are multiple pathways to apply to earning LCASA status in NC:

  - Criteria A (most applicants): Associate status is earned after completing 300 post-master's experience hours.[115]
  - Criteria B: Upon Registration.[115]
  - Criteria C: Upon Registration.[115]

- *Education*: While the educational criteria mirror those of an LCAS, most applicants applying for associate status earn it through Criteria A (Master's degree with a clinical application in a human services field from a regionally accredited college or university).[104,116]
- *Supervised Practice Hour Requirements for Licensure/Certification:* For those with earning associate status through Criteria A, they must work to complete 300 hours post-masters practicum supervised by a CCS or CSI.[104,120]
- *Exams:* For those earning associate status through Criteria A, they must work to complete and pass the IC&RC AADC exam.[66]
- *Supervision:* The LCASA requires direct, on-going supervision by a CCS or CSI, whether through Criteria A, B, or C. The supervision must be completed with a ratio of one hour of supervision for every 10 hours worked.[119]
- *Scope of Practice:* An LCASA works under direct supervision to gain clinical experience in substance abuse treatment. The scope of the clinical experience can mirror that of an LCAS, though without any practicing independence.[104]

Certified Alcohol and Drug Counselor

The Certified Alcohol and Drug Counselor (CADC) is designed for applicants with a high school diploma or equivalent, associate degree, bachelor's degree, or graduate degree that does not meet the requirements for the Licensed Clinical Addiction Specialist (LCAS).[122] In NC, a CADC is the equivalent to the IC&RC's Alcohol & Drug Counselor (ADC).[114]

- *Education*: Board approved education and training of at least 270 hours, consisting of Substance Use Disorder Specific education and training in the amount of at least 190 hours of substance use disorder specific core competencies.[118]
- *Supervised Practice Hour Requirements for Licensure/Certification:* 6,000 hours of paid or volunteer supervised experience (4,000 hours if at least a bachelor's degree). If the work setting is not exclusively substance use disorder focused, the applicant may accumulate experience proportional to the substance use disorder services performed or as determined and verified by the applicant supervisor.[118,123]

  Additionally, all CADC applicants shall complete a 300-hour practicum supervised by an applicant supervisor that covers all core functions of addictions counseling as required by the IC&RC. [118] The 300-hour practicum may be completed as part of an academic course of study in a regionally accredited college or university or may be developed in a work setting when supervised by an applicant supervisor.[118] The 300-hour practicum may be completed as part of the three years (or 6,000 hours) of alcohol and drug counseling experience required for certification.[118]
- *Exams:* International Certification & Reciprocity Consortium (IC&RC) Alcohol and Drug Counselor exam.[124]
- *Supervision:* The CADC requires on-going supervision after credentialing. This supervision can be done by an LCAS. The Board stipulates the ration of supervision hours, based on years certified, ranging from one hour of supervision for every 40 hours provided (for those certified for less than two years) to one hour of supervision for every 160 hours provided (for those certified at least three years).[119]
- *Scope of Practice:* As defined under N.C.G.S. 90-113.31B, the CADC scope of practice consists of: screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education, report and record keeping, consultation with other professionals in regard to client treatment and services, and referral to treat addictive disorder or disease and help prevent relapse.[120]
- *Continuing Education:* Every 2 years, the North Carolina Addictions Specialist Professional Practice Board requires 60 clock hours of training for license renewal, and at least 30 of these hours must be SUD specific.[121]

Alcohol and Drug Counselor Intern

To be designated as an Alcohol and Drug Counselor Intern, a counselor shall: (1) Submit the requirements for Registration status as described in Rule .0202 of this Chapter, if not submitted previously; (2) (3) Provide documentation to the Board verifying the completion of 300 hours of supervised practice by a Certified Clinical Supervisor or Clinical Supervisor Intern; and Achieve a passing score on the Alcohol and Drug Counselor examination developed by the International Certification & Reciprocity Consortium (IC&RC) or its successor organization. Once an individual has been designated as an Alcohol and Drug Counselor Intern, they may function as a counselor intern under an approved supervisor at a ratio of one hour of supervision for every 40 hours of practice.[118]

Certified Prevention Specialist

Formerly known as Certified Substance Abuse Prevention Consultant (CSAPC)

A Certified Prevention Specialist (CPS) provides substance use disorder information and education, environmental approaches, alternative activities, community organization, networking, and referral to promote personal health and well-being to individuals, families, and communities who may not otherwise be clients receiving substance use disorder treatment.[118] This certification is offered for individuals working with people in high risk categories and/or in alcohol and drug education settings (e.g., human service agencies, drug and alcohol educators, high school guidance counselors).[125] It is not for individuals frequently involved in one-to-one and group counseling with persons who have substance abuse problems.[125]

- *Education:* High school diploma or a high school equivalency certificate.117
  - 270 hours of academic and didactic training, including 170 hours of primary and secondary prevention and in the prevention performance domains, and 100 hours in substance use disorder specific studies.[126]
- Supervised Practice Hour Requirements for Licensure/Certification:
  - 6,000 hours of supervised experience in the field (paid or volunteer) or 4,000 hours if the applicant has at least a bachelor's degree in a human services field from a regionally accredited college or university. If the work setting is not exclusively substance use disorder focused, the applicant may accumulate experience proportional to the substance use disorder services performed or as determined and verified by the applicant supervisor.[118,123,126]
  - 300 hours of supervised practical training practice hours documented by a certified clinical supervisor, clinical supervisor intern, or certified prevention specialist who has been certified more than three years.[118]
- *Exams:* International Certification & Reciprocity Consortium (IC&RC) Prevention Specialist (PS) Exam.[126]
- *Supervision:* Once certified, a CPS does not require additional supervision.[118]
- *Scope of Practice:* As defined under N.C.G.S. 90-113.31B, the CPS scope of practice is based on knowledge in the performance domains to prevent or reduce the conditions that place individuals at increased risk of developing addictive disorder or disease and help prevent relapse.[120]
- *Continuing Education:* The North Carolina Addictions Specialist Professional Practice Board credentials are valid for 2 years. To renew a CPS credential, 60 clock hours are required.[123]

Certified Criminal Justice Addictions Professional

A Certified Criminal Justice Addictions Professional (CCJP) is certified to provide direct services to clients or offenders exhibiting substance use disorders and works in a program determined by the Board to be involved in a criminal justice setting, such as law enforcement, the judiciary, and/or corrections.[120] CCJPs need addiction counseling skills and theoretical understanding, as well as an understanding of the criminal justice system and criminal thought patterns.[127] The CCJP credential, unlike the other clinical credentials of the Board, does not require an active caseload of clients.[128] After October 1, 2017, all CCJP applicants must first complete the LCAS or CADC (formally CSAC) credential.[128]

- *Education:* High school diploma or high school equivalency certificate.[117]
  - 270 hours of Board-approved education or training, or
  - 180 hours of Board-approved education or training if the applicant has at least a Master's degree with a clinical application and a substance use disorder specialty from a regionally accredited college or university.[117]
- Supervised Practice Hour Requirements for Licensure/Certification:
  - 300 hours of Board-approved supervised practical training. This supervision shall mean the administrative, clinical, and evaluative process of monitoring, assessing, and enhancing professional performance.[118]
  - Supervised work experience providing direct service to clients or offenders involved in law enforcement, the judiciary, or corrections meeting one of the following criteria:
    - Criteria A: High school diploma or an adult high school equivalency diploma AND 6,000 hours of documented work experience in direct services in criminal justice or addictions services or any combination of these services that have been obtained during the past 10 years.
    - Criteria B: Associate degree AND 5,000 hours of documented work experience in direct services in criminal justice or addictions services or any combination of these services obtained during the past 10 years.
    - Criteria C: Bachelor's degree AND 4,000 hours of documented work experience in direct services in criminal justice or addictions services, or any combination of these services, and this experience has been obtained during the past 10 years.
    - Criteria D: Master's degree in a human services field AND 2,000 hours of documented work experience in direct services in criminal justice or addictions services or any combination of these services that has been obtained during the past 10 years.
    - Criteria E: Master's degree in a human services field with a specialty from a regionally accredited college or university that includes 180 hours of substance use disorder specific education or training AND 2,000 hours of postgraduate supervised substance use disorder counseling experience.
    - Criteria F: Credential of a certified clinical addictions specialist or other advanced credential in a human services field from an organization that has obtained deemed status with the Board AND 1,000 hours of documented work experience in direct services in criminal justice or addictions services that has been obtained during the past 10 years.
- *Exams:* International Certification & Reciprocity Consortium (IC&RC) Certified Criminal Justice Addictions Professional (CCJP) Exam.[127]
- *Supervision:* The CCJP requires on-going supervision after credentialing. This supervision can be done by an LCAS. The Board stipulates the ration of supervision hours, based on years certified, ranging from one hour of supervision for every 40 hours provided (for those certified for less than two years) to one hour of supervision for every 160 hours provided (for those certified at least three years).[119]
- Scope of Practice: As defined under N.C.G.S. 90-113.31B, the CCJP scope of practice is based on knowledge in the performance domains of dynamics of addiction in criminal behavior; legal, ethical,

and professional responsibility; criminal justice system and processes; screening, intake, and assessment; case management; monitoring; and client supervision and counseling to prevent or reduce the conditions that place individuals at increased risk of developing addictive disorder or disease, treat addictive disorder or disease, and help prevent relapse.[120]

- *Continuing Education:* If you have a high school diploma or bachelor's degree, the North Carolina Addictions Specialist Professional Practice Board requires 270 hours of Board-approved education or training. If you have a master's degree with a SUD/addiction clinical internship/practicum, 180 hours of Board-certified education or training is required.[114]

Speech-Language Pathologist

Speech-Language Pathologists (SLPs) are experts in communication, working across the lifespan to treat communication and swallowing disorders, collaborating with other health care or school professionals.[129,130] Their objective broadly is to optimize individuals' abilities to communicate and swallow, in turn improving their quality of life.[130] SLPs work in a variety of settings, including schools, acute care, rehabilitation, psychiatric hospitals, long-term care facilities, and private practices.[131] They screen, evaluate, identify, diagnose, counsel, and treat those suffering from conditions or disorders affecting speech and language or swallowing.[132] Compliance and licensing is provided by the North Caroling Board of Examiners for Speech-Language Pathologists and Audiologist (NCBOESLPA). Under the Audiology & Speech-Language Pathology Interstate Compact (ASLP-IC), SLPs licensed in good standing in a compact member state are eligible to practice in North Carolina via "compact privilege". North Carolina enacted this ASLP-IC legislation, but as of September 2025, it is not yet operationalized.[133,134]

- *Education:* At least a master's degree in speech and language pathology from an accredited institution or qualifications deemed equivalent by the Board.[132,135]
- *Supervised Practice Hour Requirements for Licensure/Certification:* A minimum of 400 clock hours during the graduate program of supervised clinical experience with individuals presenting a variety of communication disorders. After graduation, supervised professional experience is required prior to licensing equivalent to nine months of full-time professional experience. Supervised professional experience can be full time (at least nine months in one calendar year at a minimum of 30 hours per week) or half time (at least 18 months in two calendar years at a minimum of 20 hours per week).[132]
    - A ***temporary license*** is required if an applicant has not completed their supervised experience and passed the required examinations. An applicant is eligible for a temporary license once the academic and clinical practicum requirements are met, along with a plan for supervised experience.[132]
- *Exams:* National written exam as approved by the Board. An examination is not required if the applicant holds a certificate of clinical competence issues by the American Speech-Hearing Language Association (ASHA) in the specialized area they seek licensure, or if they met requirements of another state or jurisdiction with equivalent or higher requirements.[132]
- *Supervision:* SLPs operate autonomously and are the primary care providers of speech-language pathology services, though in various settings, they work collaboratively with other professionals (e.g., health care, school) in making decisions to benefit the individual.[130]
- *Scope of Practice:* As defined under N.C.G.S. 90-293, the practice of speech and language pathology is the application of "principles, methods, and procedures for the measurement, testing, evaluation, prediction, counseling, treating, instruction, habilitation, or rehabilitation related to the development

and disorders of speech, voice, language, communication, cognitive-communication, and swallowing for the purpose of identifying, preventing, ameliorating, or modifying such disorders."[132] Their scope of practice includes five professional practice domains: advocacy and outreach, supervision, education, administration/leadership, and research. Service delivery domains include: collaboration, counseling, prevention and wellness, screening, assessment, treatment, modalities/technology/instrumentation, and population systems.[130]

- *Continuing Education:* The North Carolina Board of Examiners for SLPA requires 30 hours of continuing professional education in 3 years for license renewal.[136]

Speech-Language Pathology Assistant

A Speech-Language Pathology Assistant (SLPA) works under supervision, registered with the Board by a Primary Supervising Licensee.[132,135] Examples of authorized tasks for SLPAs are obtaining case histories, completing observation checklists, administering screening protocols as directed by Licensee, tabulating screening results, documenting communication. Direct patient evaluation is not part of the approved scope for assistants.[135] Compliance and licensing is provided by the NCBOESLPA.

- *Education:* Completion of an Associate's Degree in Speech-Language Pathology Assisting from an accredited institution or equivalent program or a Bachelor's Degree from an accredited institution with evidence of successful completion of Speech-Language Assisting curriculum courses outlined in the administrative code.[135]
- *Supervised Practice Hour Requirements for Licensure/Certification:* A temporary registration with NCBOESLPA is required to accrue clinical fieldwork hours. The **temporary SLPA** registration is available for 120 days and may not be extended. Within that time, the temporary SLPA needs to complete 100 hours of clinical field work (exclusive of observation), with at least 80 of those hours being in direct patient/client services.[137] The supervising SLP must meet all ASHA certification and state credentialing requirements.[132,135,138]
- Applicants with a bachelor's degree in Communication Science Disorders need 100 hours of supervised clinical fieldwork if they do not have at least one year of experience as an SLPA in another state within the past five years.[135]
- *Exams:* Competency test approved by the Board.[135]
- *Supervision:* An SLPA operates under the supervision of a Supervising Licensee who bears full responsibility for all patient services provided by an SLPA. SLPA tasks and level of supervision are determined by the Supervising Licensee to ensure quality of care.[135]
- *Scope of Practice:* The level of training and experience of an SLPA determines the amount of supervision and the ratio of indirect/direct supervision, as determined by their SLP supervisor. When an SLPA provides services, certain documentation is required, including a knowledge demonstration checklist completed by the SLP supervisor, informing the family/patient in writing of services being provided by an SLPA, a general treatment plan written by SLP, an evaluation completed by SLP in advance, and a completed Target Behavior form completed by the primary supervisor. A supervising SLP retains full legal and ethical responsibility for practice. If appropriate, the SLPA may provide service delivery, culturally responsive practices, administration and support, and prevention and advocacy.'[138,139]
- *Continuing Education:* The North Carolina Board of Examiners for SLPA requires 30 hours of continuing professional education in 3 years for license renewal.[136]

Occupational Therapist

Occupational Therapists (OTs) help people of all ages participate in their lives and the things they want, or need, to do. They provide evaluation, treatment, and consultation to individuals across the lifespan to help them achieve maximum level of independence through developing skills and abilities. Their clients' skills may be affected by disease, physical injury, developmental delays, mental health conditions, or impairment. They work in a variety of settings, including hospitals, schools, rehabilitation centers, nursing facilities, and private clinics. OTs are regulated by the North Carolina Board of Occupational Therapy (NCBOT). Temporary licenses are not offered.[140,141,142,143,144]

- *Education:* At least a master's degree in an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE), which is an eligibility requirement to take the National Board for Certification in Occupational Therapy (NBCOT) exam.[145]
- *Supervised Practice Hour Requirements for Licensure/Certification:* Completion of both Level I and Level II fieldwork as part of the graduate program. The number of hours is determined by the curriculum, though a minimum of the equivalent to 24 weeks' full-time Level II fieldwork is required according to the 2023 ACOTE Standard. The ACOTE Standard also recommends students be exposed in Level II fieldwork to a variety of clients across the lifespan and to a variety of settings.[141,142,146]
- *Exams:* NBCOT examination and a jurisprudence exam administered by NCBOT. Successful completion of the NBCOT certification examination is accepted as proof of graduation from an accredited curriculum and successful completion of fieldwork.[142] OT professionals certified with NBCOT are credentialed as Occupational Therapist Registered, OTR.[147]
- *Supervision:* A licensed OT can practice without supervision.[141,142]
- *Scope of Practice:* OTs conduct evaluations, determine needs, develop and implement intervention plans, treat, and consult to help individuals achieve a maximum level of independence. Occupational therapists use purposeful activities and specially designed orthotic and prosthetic devices to reduce specific impairments and to help individuals achieve independence at home and in the workplace.[142,148]
- *Continuing Education:* The North Carolina Board of Occupational Therapy uses a points system for OTs to maintain licensure. Up to 15 of the required points can be completed with continued education, as well as other activities (academic coursework, fieldwork supervision, etc.).[149]

Occupational Therapist Assistant

- *Education:* At least an associate's degree from a program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE).[145]
- *Supervised Practice Hour Requirements for Licensure/Certification:* Completion of both Level I and Level II fieldwork as part of the program. The number of hours is determined by the curriculum, though a minimum of the equivalent to 16 weeks' full-time Level II fieldwork is required according to the 2023 ACOTE Standard. The ACOTE Standard also recommends students be exposed in Level II fieldwork to a variety of clients across the lifespan and to a variety of settings.[142,146]
- *Exams:* NBCOT examination and a jurisprudence exam administered by NCBOT. Successful completion of the NBCOT certification examination is accepted as proof of graduation from an accredited curriculum and successful completion of fieldwork.[142] OT professionals certified with NBCOT are credentialed as Certified Occupational Therapy Assistant, COTA.[147]
- *Supervision:* An Occupational Therapist Assistant (OTA) must always have an OT supervisor and the OT

is ultimately responsible for all delegated services.[142]

- *Scope of Practice:* An OTA may contribute to the evaluation process by implementing assessments, provide input into an intervention plan, implement delegated aspects of the intervention, and contribute to reviewing the intervention. OTAs use purposeful activities and specially designed orthotic and prosthetic devices to reduce specific impairments and to help individuals achieve independence at home and in the workplace.[142,148]
- *Continuing Education:* The North Carolina Board of Occupational Therapy uses a points system for OTAs to maintain licensure. Up to 15 of the required points can be completed with continued education, as well as other activities (academic coursework, fieldwork supervision, etc.).[149]

Behavior Analysts

In North Carolina, behavior analysts work to improve personal and interpersonal human behaviors through systematic environmental and instructional modifications. The practice identifies functional relationships between behavior and environmental factors. Interventions are based on direct observation and measurement of behavior and the environment. Behavior analysts use contextual factors, motivating operations, antecedent stimuli, positive reinforcement, and other consequences to help people develop new behaviors, increase or decrease existing behaviors, and emit behaviors. Psychological testing, therapy, and long-term counseling are expressly excluded from the practice of behavior analysis.[150] According to the national Behavior Analyst Certification Board, Applied Behavior Analysis (ABA) is best known for treating individuals with autism spectrum disorder (ASD) and other developmental disabilities (e.g., Down syndrome, intellectual disabilities).[151] Behavior analysts are regulated by the North Carolina Behavior Analyst Licensure Board (NCBALB).

Licensed Behavior Analyst

Licensed Behavior Analysts (LBAs) must be certified as a Board Certified Behavior Analyst (BCBA) by the Behavior Analyst Certification Board or certified as a Qualified Behavior Analyst (QBA) by the Qualified Applied Behavior Analysis Credentialing Board (QABA).[150,152]

- *Supervision:* Once licensed, LBAs operate independently. If a Behavior Analyst does not hold a license with the NCBALB, they must be supervised by a Licensed Psychologist.[152]
- *Scope of Practice:* LBAs independently assess, design, and oversee behavior analytic services.

Requirements for education, supervised practice, and examinations vary slightly based on the credentialing entity:

- Board Certified Behavior Analyst (BCBA):
  - *Education*: Master's degree (or higher) in a behavior analysis program accredited by the Association of Professional Behavior Analysts or the Association for Behavior Analysis International (ABAI); or satisfying course requirements verified by ABAI.[153]
  - *Supervised Practice Hour Requirements for Licensure/Certification:* Fieldwork in applied behavior analysis (either 2,000 supervised fieldwork hours or 1,500 concentrated supervised fieldwork hours)[153]
- *Exams*: BCBA certification examination.[153]

- Qualified Behavior Analyst (QBA):
    - *Education*: At least a master's degree from an accredited university in a related field with 270 hours of approved coursework (18 semester credits), including 20 hours of supervision coursework (Master's degree in ABA, Psychology, Special education, or a related field). 20 hours of coursework must be in ethics and 20 hours must be in autism core knowledge.[154]
    - *Supervised Practice Hour Requirements for Licensure/Certification:* 1,500 hours of supervised fieldwork with a minimum of 900 indirect hours in the role of oversight or supervision (Functional behavioral assessment, reviewing data, training staff or parents, etc.) and a maximum of 600 direct hours.[154]
    - *Exams:* QBA exam.
- *Continuing Education:* BCBA and QABA each require 32 continuing education units within each 2-year recertification cycle, 3 units in supervision (for supervisors).[153,155]

BCBAs with doctoral or postdoctoral training in behavior analysis may apply for the designation of Board Certified Behavior Analyst-Doctoral.[153] The BCBA-D designation is not a separate certification and does not grant any privileges beyond BCBA certification.

Licensed Assistant Behavior Analyst

License Assistant Behavior Analysts (LABAs) are skilled direct care workers. They must be certified as a Board Certified Assistant Behavior Analyst (BCaBA) from the Behavior Analyst Certification Board or certified as a Qualified Autism Services Practitioner Supervisor (QASP-S) by the QABA.[152]

- *Supervision:* LABAs practice under the supervision of an LBA. If an Assistant Behavior Analyst does not hold a license with the NCBALB, then they must be supervised by a Licensed Psychologist.[150,156]
- *Scope of Practice:* LABAs cannot independently conduct assessments or develop treatment plans. They implement behavior analysis services under supervision.

Requirements for education, supervised practice, and examinations vary slightly based on the credentialing entity:

- Board Certified Assistant Behavior Analyst (BCaBA):
    - *Education*: Bachelor's degree in a behavior-analytic program accredited by Association for Behavior Analysis International (ABAI); or satisfying course requirements verified by ABAI.
    - *Supervised Practice Hour Requirements for Licensure/Certification:* Practical fieldwork in applied behavior analysis (either 1,300 Supervised Fieldwork hours or 1,000 Concentrated Supervised Fieldwork hours).
    - *Exams*: BCaBA certification examination.
- Qualified Autism Service Practitioner-Supervisor (QASP-S):
    - *Education*: Bachelor's degree from an accredited university for higher education with 180 hours of approved assessment-based ABA coursework or 12 semester credit units (including a minimum of 20 hours in ethics and a minimum of 15 hours in autism core knowledge)

- *Supervised Practice Hour Requirements for Licensure/Certification:* 1,000 hours of supervised fieldwork with a minimum of 600 hours in the role of a supervisor or program development
- *Exams*: QASP-S examination.

- *Continuing Education*: BCBA and QABA each require 20 continuing education units within each 2-year recertification cycle, including 3 units in supervision (for supervisors).[153,155]

Recreational Therapy Aide

Any unlicensed person who aids in the provision of recreational therapy services under the provisions of this Chapter, and who acts under the direction and on-site supervision of a licensed recreational therapist or licensed recreational therapy assistant. A Recreational Therapy Aide may perform recreational therapy related duties and functions which are assigned and are commensurate with an aide's training and competency. An aide's work shall not include responding to a physician's orders; designing, conducting, or interpreting individualized recreational therapy patient assessment; determining or modifying recreational therapy treatment plans or interventions; or any independent practice or performance of recreational therapy services.[157]

Community Health Worker

A community health worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.[158] This enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.[158] A CHW builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.[158] CHWs have lived experience that is shared with the community they serve.[159] The North Carolina Community Health Worker Association (NCCHWA) defines lived experience as personal knowledge about the world gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people.[159] It is also defined as the experiences of people on whom a social issue or combination of issues has had a direct impact.[159]

NCCHWA offers CHWs multiple pathways to professional certification through the Standardized Core Competency Training (SCCT) at several community colleges, a Legacy Track and Advanced Levels.[159] CHWs can apply for any level for which they may meet the criteria and do not have to go through the levels in order.[159] Eligibility for each track is determined by a combination of skills, training, and actual lived experience, which specifically requires experience and knowledge of population groups (e.g., geographic areas, communities of color, persons with substance use disorder, homeless persons, persons with disabilities, immigrant/refugees, LGBTQ+ persons, formerly incarcerated individuals, domestic and sexual violence survivors, persons with mental illness).[159]

- *Education:* Standardized Core Competency Training (SCCT) at a participating community college or professional experience (see below)
- *Supervised Practice Hour Requirements for Licensure/Certification:* (see below)
- Exams: The CHW I SCCT track offered through the North Carolina Community College system, including

an exam, requires passing the SCCT course with a score of 80 or higher. Legacy track and CHW II and III do not require the SCCT course and exam.[160]

- *Supervision:* As CHWs do not provide direct clinical services, they do not require clinical oversight from a licensed provider. However, CHWs are often embedded within care teams alongside other health professionals.
- *Scope of Practice:* A CHW acts as a liaison between health and social services and the communities they serve. Their core competencies include serving as a cultural liaison, a health navigator, a health and wellness promoter, an advocate, and providing outreach, social support, and collecting data or implementing assessments.[161]
- *Continuing Education:* The North Carolina Community Health Workers Association requires 24 hours of Contact Hours every 3 years for recertification.[159]

CHW I SCCT Track

- *Professional Experience:* Completion of SCCT coursework with 80 or higher
- *Lived Experience:* Experience and knowledge of at least 1 population group

CHW I Legacy Track

- *Professional Experience:* 2,000 hours of experience that demonstrates 9 competencies
- *Lived Experience:* Experience and knowledge of at least 1 population group

CHW II

- *Professional Experience:* 2,000–4,000 hours of experience that demonstrates 9 competencies
- *Lived Experience:* Experience and knowledge of at least 3–5 population groups

CHW III

- *Professional Experience:* 2,000–4,000 hours of experience that demonstrates 9 competencies
- *Lived Experience:* Experience and knowledge of 5 or more population groups

CHW IV

- *Professional Experience:* 4,000 hours of experience that demonstrates 9 competencies
- *Lived Experience:* Experience and knowledge of 5 or more population groups

Certified Peer Support Specialist

The North Carolina Certified Peer Support Specialist (NCCPSS) Program certifies Peer Support Specialists — people living in recovery from Serious Mental Illness (SMI) and/or Substance Use Disorders (SUD) who support others who can benefit from their experiences.[162] Certified Peer Support Specialists (CPSSs) must have lived experiences and be in recovery from a serious mental illness (SMI) and/or substance use disorder (SUD) for at least 18 months from all SMI and/or SUD; they cannot complete training or process certification before the 18 months).[163] The NCCPSS Program implements the certification, courses, partner engagement, and evaluation of the Program.[64] The NCCPSS Program currently provides two certification tracks (A and B). Applicants must complete all required steps within one track for certification. All approved courses in Certification Track B will expire by December 2029 and Certification Track A will be the only certification pathway.[164]

- *Education:* High school diploma or equivalent.[63]
- *Supervised Practice Hour Requirements for Licensure/Certification:*[164]
  - Track A: 60 hours (40-hour in-person training, 20-hour online course).
  - Track B: 50 hours of an NCCPS Approved Course Training (40 hours face-to-face, 10 hours pre-work)
- Both Tracks: 20 hours of additional training that includes approved Ethics and Peer Support Boundaries training.
- *Exams:* [164]
  - Track A: NCCPSS Program Certification Exam.
  - Track B: None.
- *Supervision:* According to NC Medicaid Clinical Coverage Policy No.: 8G, a Peer Support Services program must be under the direction of a full-time Qualified Professional (QP).[165] The PSS program must have designated competent mental health or substance use professionals to provide supervision to CPSS during the times of service provision.[164]
- *Scope of Practice:* CPSSs provide services one-on-one or in a group setting; they must only provide services to a beneficiary with similar lived experiences.[165] The services focus on the person, rather than the disorder, and emphasize the acquisition, development, and expansion of rehabilitative skills needed for recovery.[165] Services include peer mentoring or coaching (one-on-one), recovery resource connecting, skill building recovery groups, and building community.[165]
- *Continuing Education:* The North Carolina Department of Health and Human Services requires 20 hours of additional training during a two-year period https://pss.unc.edu/20-hours-additional-training-resources.[166]

Qualified Professional

Qualified Professionals (QPs), a designation defined and regulated by the North Carolina Department of Health and Human Services (NCDHHS), are clinical professionals working within North Carolina's Mental Health, Developmental Disabilities, and Substance Use Services (MH/DD/SUS) system providing direct care and clinical oversight. They work across the lifespan providing services for those with mental health or substance use treatment needs, developmental disorders, or substance use disorders. As part of the MH/DD/SUS system, they work in a variety of settings, from community- or state-run facilities, clinics, and

programs, whether inpatient or outpatient.[167] While some QPs may hold licenses or certificates, the role is not a credentialed, but a classification based on a person's education and professional experience. Someone licensed or certified in another field may be a QP, such as physicians, psychologists, psychological associates, social workers, registered nurses, fee-based practicing pastoral counselors, and certified counselors.[168]

- *Education & Supervised Practice Hour Required:* A QP must meet a combination of education plus supervised practice time that varies based on the individual's licensing and certification and/or educational level. A recent North Carolina General Assembly legislative rule change passed to update educational requirements to an associate degree in human services with two years of experience. This rule change will become enacted once officially active by the Mental Health Commisssion.[23] The current four categories of requirements to qualify as a QP are:
  - A license (provisional or full) or certificate in a human service profession, issued by a board
  - A registered nurse with an active NCBON license must have four years of full-time accumulated MH/DD/SU experience with the population served
  - A master's degree in a human service field plus one year full-time accumulated supervised MH/DD/SU experience OR a substance use professional with one year full-time accumulated supervised experience in alcoholism and drug abuse counseling
  - A bachelor's degree in a human service field plus two years full-time accumulated supervised MH/DD/SU experience OR a substance use professional with two years full-time accumulated supervised experience in alcoholism and drug abuse counseling
  - A bachelor's degree not in a human service field plus four years full-time accumulated supervised MH/DD/SU experience OR a substance use professional with four years full-time accumulated supervised experience in alcoholism and drug abuse counseling[167]
- *Exams:* None
- *Supervision:* Can provide direct care and services without supervision.
- Scope of Practice: There are no privileging requirements for QPs, or authorization to provide specific treatment services to clients.[167] Governing bodies of state facilities are required to develop policies specifying the clinical and administrative responsibilities of a QP. QPs are required to demonstrate knowledge, skills and abilities based on the population services and exhibit core skills such as technical knowledge, cultural awareness, and clinical skills. Qualified QPs may supervise and provide oversight to associate professionals, paraprofessionals, and other clinical staff.[167]

Associate Professional

Associate Professionals (APs), a designation defined and regulated by the North Carolina Department of Health and Human Services (NCDHHS), are professionals working within North Carolina's Mental Health, Developmental Disabilities, and Substance Use Services (MH/DD/SUS) system providing direct care and therapeutic services. They work across the lifespan providing supervised services for those with mental health or substance use treatment needs, developmental disorders, or substance use disorders. As part of the MH/DD/SUS system, they work in a variety of settings, from community- or state-run facilities, clinics, and programs, whether inpatient or outpatient.[167] While some APs may hold licenses or certificates, the role is not a credentialed, but a classification based on a person's education and professional experience. Someone licensed or certified in another field may be an AP, such as physicians, psychologists,

psychological associates, social workers, registered nurses, fee-based practicing pastoral counselors, and certified counselors.[168]

- *Education & Supervised Practice Hour Required:* An AP must meet a combination of education plus supervised practice time that varies based on the individual's educational level. The four categories of requirements to qualify as an AP are:
    - A master's degree in a human service field with less than one year of full-time, post-graduate degree accumulated MH/DD/SU experience OR a substance use professional with less than one year of full-time, post-degree accumulated supervised experience in alcoholism and drug abuse counseling.
    - A bachelor's degree in a human service field with less than two years full-time, post-degree accumulated MH/DD/SU experience OR a substance use professional with less than two years full-time accumulated supervised experience in alcoholism and drug abuse counseling.
    - A bachelor's degree not in a human service field with less than four years full-time, post-degree accumulated MH/DD/SU experience OR a substance use professional with less than four years full-time accumulated supervised experience in alcoholism and drug abuse counseling.
    - A registered nurse with an active NCBON license with less than four years of full-time accumulated MH/DD/SU experience with the population served.[167]
- *Exams:* None
- *Supervision:* APs are supervised by a QP with the population served until the AP meets the required years of experience. Individualized supervision plans are created and reviewed annually.[167]
- *Scope of Practice:* There are no privileging requirements for APs, or authorization to provide specific treatment services to clients.[167] Governing bodies of state facilities are required to develop policies specifying the individualized supervision plans initiated upon hiring an AP. APs are required to demonstrate knowledge, skills and abilities based on the population services and exhibit core skills such as technical knowledge, cultural awareness, and clinical skills. Qualified APs may supervise paraprofessionals and participate in service planning and treatment implementation.[167]

Certified Mental Health Technician

Certified Mental Health Technicians (CMHTs) are also known by other titles, including psychiatric aides, psychiatric technicians, mental health assistants, and mental health aides. CMHTs work within a team, providing direct care and support to individuals across the lifespan with mental illness or developmental disabilities. CMHTs are supervised by licensed professionals and employed in a variety of setting: psychiatric hospitals, residential treatment centers, and community mental health facilities.[169] The National Career Certification Board (NCCB) provides national-level certification, which is not mandatory to work as a CMHT.

- *Education:* A high school diploma or GED is required, though a certificate or associate's degree in human services may be required by certain employers.[170]
- *Supervised Practice Hour Requirements for Licensure/Certification:* None specified.
- *Exams:* Certification through NCCB requires passing a NCCB-certification exam.
- *Supervision:* Direct supervision is required, provided by licensed professionals, such as psychologists, psychiatrists, and counselors.[171]

- *Scope of Practice:* There is no defined scope of practice in North Carolina for CMHTs. They may monitor patient progress and vitals, help with implementing care strategies, assist with daily living activities, and track patient documentation.[171,172]
- *Continued Education:* None required.

Nationally Certified Psychiatric Technician

Nationally Certified Psychiatric Technicians (NCPTs) provide direct care and support to individuals across the lifespan in need. Multiple job titles are used for the role, such as psychiatric aide, psychiatric worker, behavioral health technician, mental health assistant, and wellness coach. NCPTs are employed in settings such as hospitals, psychiatric hospitals, group homes.[169,172,173] The American Association of Psychiatric Technicians (AAPT) administers a voluntary national-level certification.

- *Education:* Minimum educational requirements vary based on the certificate level (1-4). Level 1 certification requires a high school diploma or GED. Level 2 certification requires at least 480 college hours. Level 3 certification requires at least 960 college hours. Level 4 certification requires a bachelor's degree in mental health or developmental disabilities.[174]
- *Supervised Practice Hour Requirements:* If certified, no practice hours are required for Level 1. Those with higher levels of certification must have worked: at least one year in the mental health or developmental disability field (level 2), at least two years (level 3), or at least three years (level 4).[174]
- *Exams:* If certified, all candidates must pass a Level 1 certification exam administered by AAPT. Certification levels 2, 3, and 4 require an additional essay test.
- *Supervision:* Direct supervision by licensed professionals typically required.[171,172]
- *Scope of Practice:* There is no defined scope of practice in North Carolina for NCPTs. They typically provide supportive services and direct care.[172]
- *Continuing Education:* The American Association of Psychiatric Technicians requires 12 hours of study in the field, in a class, home-study course or in-service training. NCPTs must also read one book in the same time frame of four years.[175]

Licensed Recreational Therapist

Recreational therapists plan, direct, and coordinate recreation-based medical treatment programs to help patients of all ages maintain or improve their physical, social, and emotional well-being.[176] They help people reduce depression, stress, and anxiety; recover basic physical and mental abilities; build confidence; and socialize effectively.[176] Licensed Recreational Therapists (LRTs) practice recreational therapy, also known as therapeutic recreation, in accordance with the most recent version of the American Therapeutic Recreation Association, Standards for the Practice (the ATRA SOP).[177]

- *Education:* Bachelor's degree or higher and with a major or specialization in recreational therapy or therapeutic recreation from an accredited college or university.[178]
- *Supervised Practice Hour Requirements for Licensure/Certification:* 560-hour, 14- week internship under an LRT (in NC) and/or CTRS (out of NC).[178]
- Rates at an Achieves Expectations or higher for the Average Overall Performance Rating on the NCBRTL Clinical Performance Appraisal Summary & Reference Form

- *Exams: successful passage of the* National Council of Therapeutic Recreation Certification (NCTRC) Exam.[178]
- *Supervision:* Once licensed, LRTs do not require supervision.
- *Scope of Practice:* As defined in N.C.G.S. 90C, the practice of recreational therapy includes all direct patient or client services of assessment, planning, design, implementation, evaluation, and documentation of specific interventions, management, consultation, research, and education for either individuals or groups that require specific therapeutic recreation or recreational therapy intervention representing the process and knowledge base delineated in the most recent National Council for Therapeutic Recreation Certification (NCTRC) Job Analysis Study and professional standards of practice.[157] Scope is inclusive of professional and preprofessional education and training in recreational therapy, therapeutic recreation, and related research.[157]
- *Continuing Education:* The North Carolina Board of Recreation Therapy Licensure requires 20 hours of continuing education in a two-year period.[167]

Licensed Recreational Therapy Assistant

A Licensed Recreational Therapy Assistant (LRTA) may assist in the practice of recreational therapy in clinical, residential, and community settings under the supervision of a licensed recreational therapist and in accordance with a recreational therapy assistant's training, education, and scope of practice.[157]

- *Education:* Associate of Applied Science Degree in therapeutic recreation or recreational therapy from a community college.[178]
- *Supervised Practice Hour Requirements for Licensure/Certification:* 380-hour field placement experience in a clinical, residential, or community-based agency under the supervision of an LRT or LRTA. The field placement must be a minimum of 10 consecutive weeks with each week including a minimum of 20 hours.[178]
- Rates at an Achieves Expectations or higher for the Average Overall Performance Rating on the NCBRTL Clinical Performance Appraisal Summary & Reference Form.
- *Exams:* None.
- Supervision: LRTAs perform duties and functions under the clinical supervision of an LRT.[177]
- *Scope of Practice:* Once the LRT determines the LRTA has demonstrated competence to provide interventions, client documentation, and to make recommendations for program modification, the LRTA shall practice in accordance with ATRA SOP.[177]
- *Continuing Education:* The North Carolina Board of Recreation Therapy Licensure requires 20 hours of continuing education in a two-year period.[167]

Registered Behavior Technician

Registered Behavior technicians are paraprofessionals exempt from licensure who deliver applied behavior analysis services under direct supervision. Certification is administered by the Behavior Analyst Certification Board (BACB) to become a registered behavior technician (RBT). They perform non-client-related tasks and client-related tasks that do not constitute behavior analysis practice.[150,156]

- *Education*: High school diploma.
- *Supervised Practice Hour Requirements for Certification:* While not practice hours, a 40-hour training is required based on the RBT Task List. Starting January 1, 2026, applicants must meet requirements for an updated RBT 2026 40-hour training.[180]
- *Exams*: RBT Initial Competency Assessment, given by a qualified Behavior Analyst or Assistant Behavior Analyst. Beginning in 2026, applicants must meet requirements of completing the updated RBT Initial Competency Assessment, and Assistant Assessors much hold an RBT certification or higher.[180,180]
- *Supervision:* Works under the supervision of a qualified LBA or an LABA.
- *Scope of Practice:* Registered Behavior Technicians deliver services as assigned and do not design assessment or intervention plans. They perform both non-client and client-related tasks. Non-client tasks include clerical tasks, maintenance activities, and the preparation of the work area and equipment. Client-related tasks are those that are not within the scope of behavior analysis, and those that their supervisor identifies as having no potential to adversely impact the client.[150,156]
- *Continuing Education:* The Behavior Analyst Certification Board requires 12 hours of professional development units during the two-year recertification cycle.[153]

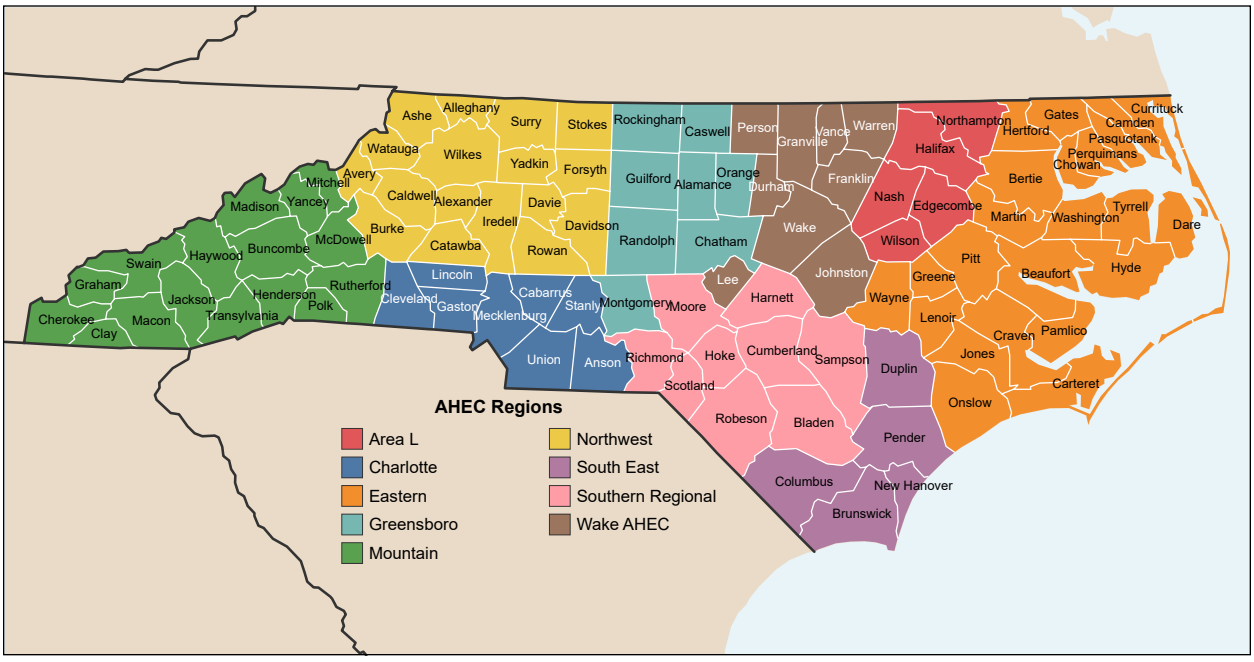
APPENDIX II: GEOGRAPHIC DISTRIBUTION METHODS NOTE

Throughout the report, geographic distribution of each MH/SU services credential is shown across four levels: statewide, AHEC regions, Tailored Plan catchment areas, and by county urbanicity. Each level provides a different perspective to approaching the question of MH/SU services workforce supply. We provide more information below on what the three sub-state levels are and methodological notes for how each is defined.

Area Health Education Center (AHEC) Regions

North Carolina's Area Health Education Center Program is a statewide program that provides and supports educational activities and services to those with less access to resources to recruit, train, and retain the workforce needed to create a healthy North Carolina. Each region has its own AHEC center focused on the unique workforce needs of the region. (Figure 39)

Figure 39. AHEC Regions by County, North Carolina, 2024

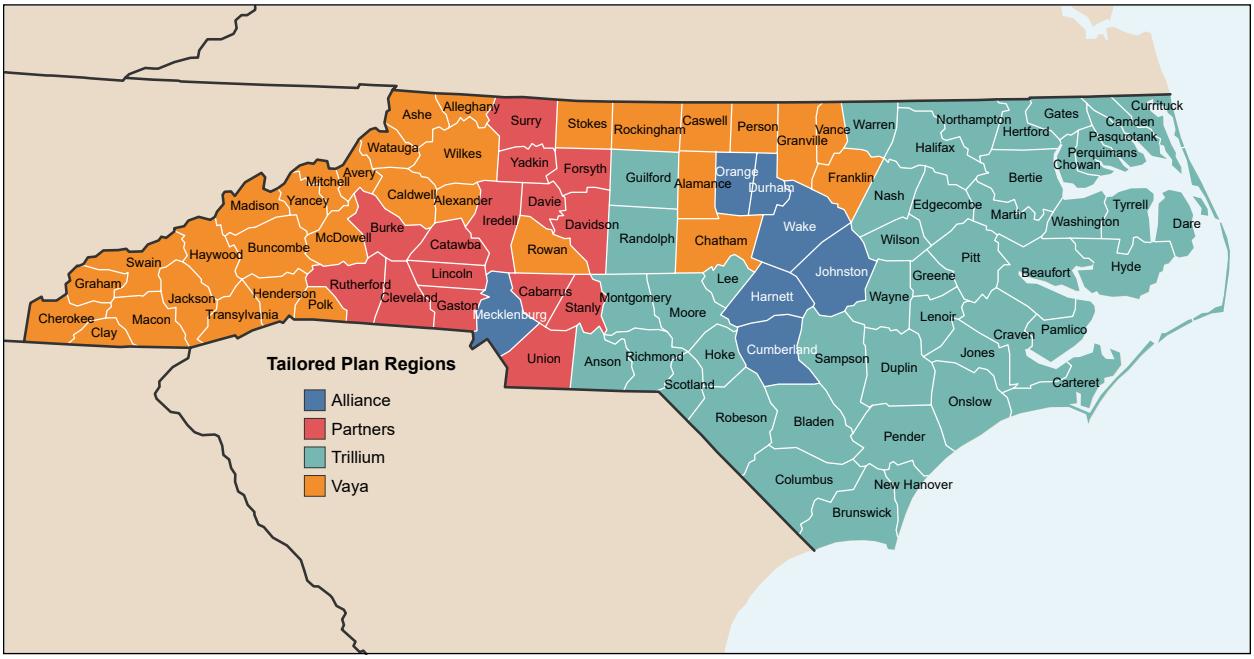


Source. NC AHEC, https://www.ncahec.net.

North Carolina Medicaid Tailored Plans

Tailored Plans are North Carolina Medicaid Managed Care health plans covering mental health, substance use, intellectual/developmental disabilities (I/DD), and traumatic brain injury (TBI) services. North Carolina's current arrangement of Tailored Plans started July 1, 2024. Tailored plans offer comprehensive coverage, including pharmacy, and behavioral health services in one plan. There are four tailored plans – Alliance Health, Partners Health Management, Trillium Health Resources, and Vaya Total Care. Counties are assigned to a Tailored Plan based on the Local Management Entity/Managed Care Organization (LME/MCO), creating a catchment area for each Tailored Plan (Figure 40). Alliance Health covers mainly metropolitan counties. Trillium Health Resources covers a majority of eastern North Carolina, including all counties in the Eastern AHEC, South East AHEC, and Area L AHEC regions and almost all counties with Southern Regional AHEC. Vaya Total Care covers most of western North Carolina as well as north-central counties. Partners Health Management Tailored Plan catchment areas cover a mix of central and western counties.

Figure 40. Tailored Plans catchment areas by County, North Carolina, 2024



Source. NCDHHS Fact Sheet: NC Medicaid Managed Care: Contracting with Tailored Plans.

By County Urbanicity: Metropolitan and Nonmetropolitan

Metropolitan and nonmetropolitan counties are identified in Figure 41. Green-colored counties are those included as a metropolitan in the report's analysis. Gray-colored counties are those counties identified as nonmetropolitan.

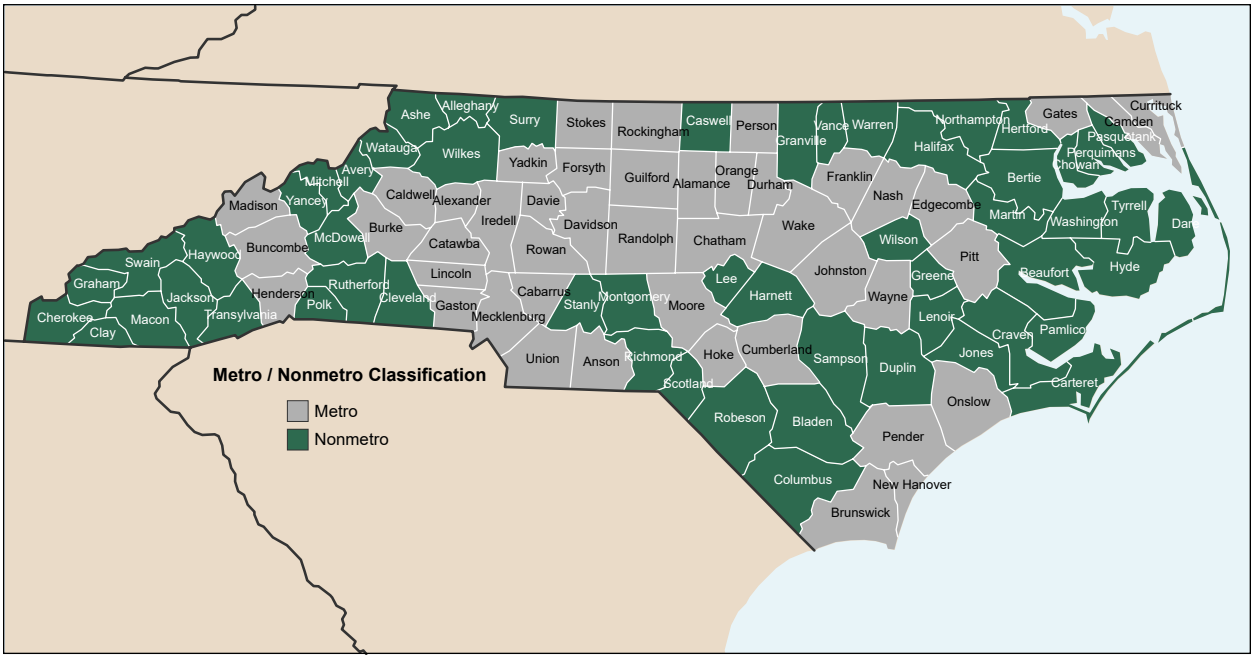
Metropolitan

Throughout the report, metropolitan counties are those associated with at least one core urbanized area (50,000 or more people) as defined by the United States Census Bureau and the Office of Management and Budget. It also includes adjacent counties with a high degree of commuting patterns to the metropolitan core. We applied the most recent delineation from 2023.

Nonmetropolitan

A county that does not contain a core urban area of 50,000 or more people, as defined by the United States Census Bureau and the Office of Management and Budget. Typically, this designation is used to describe rural counties. Similar to metropolitan, we applied the definition which was current at the time of the data.

Figure 41. County Urbanicity (metropolitan and nonmetropolitan), North Carolina, 2024



Source. US Census Bureau Delineation Files.

APPENDIX III: LIST OF TABLES

APPENDIX IV: LIST OF FIGURES

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