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SUMMER 2026

MENTAL HEALTH IN THE WORKPLACE

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A MESSAGE FROM GOVERNOR JOSH STEIN

Too many North Carolina families know the heartbreak of watching a loved one struggle with substance misuse or mental illness and fall through the cracks. We must do better.

A safer, healthier North Carolina relies on a strong behavioral health response. That's why I recently signed an Executive Order to equip behavioral health professionals, law enforcement, and judicial officers with the tools to connect those in crisis with care.

Our communities are strengthened when we look after one another. Together, we can build a North Carolina that is safer, stronger, and healthier.

A MESSAGE FROM NCDHHS SECRETARY DEV SANGVAI

There is no health without mental health, and I encourage organizations across the state to put employee wellbeing at the center of their mission. From simple acts of caring – like checking in with a colleague or encouraging employees to take a mental health day – to robust wellness programs, fostering a health-focused environment is the foundation for a happier workforce; improved brain health; and a stronger bottom-line. NCDHHS is committed to expanding access and ensuring everyone knows where to turn to for help when they need it.

Please visit our website at ncdhhs.gov/MentalHealth for a list of resources for support and crisis services.

A MESSAGE FROM MENTAL HEALTH DIRECTOR KELLY CROSBIE

I'm pleased to welcome you to this edition of the Triangle Business Journal, which highlights the challenges so many North Carolinians face today—from rural mental health provider shortages to the impacts of housing insecurity, financial pressure, and grief in the workplace. These stories reflect the daily experiences of our communities and reinforce why strengthening mental health care remains at the core of our mission.

At DHHS, we are working to meet these needs with solutions that build healthier and safer communities. Our new loan forgiveness programs for mental health clinicians are helping expand the workforce in areas that have lacked access for far too long. And through partnerships with UNC, the NC Social Work Education Consortium, and the Public Leadership Service Program (PLSP), we are creating strong pathways for students and early career professionals who want to serve in rural and underserved communities.

Executive Order 33 deepens this commitment by strengthening collaboration across mental health services, law enforcement, and corrections. Together, we are focused on supporting people earlier, improving access to care, and helping communities stay healthy and safe.

These challenges remind us why this work matters. By investing in people, supporting providers, and removing barriers to care, we are building a stronger North Carolina for everyone.

MENTAL ILLNESS AND VIOLENCE:

What Research Shows and Why It Matters for North Carolina's Workforce

BY CAROLINE BARNHILL

In recent months, two violent deaths in North Carolina have reopened a difficult public conversation. Iryna Zarutska was killed on a Charlotte light rail. In Raleigh, Ravenscroft School teacher Zoe Welsh was murdered inside her home. Afterward, public discussion quickly turned to familiar questions about mental illness, public safety and whether warning signs were missed.

For employers, policymakers and community leaders across the state, those questions carry real consequences. Whether North Carolina's response is effective – in workplaces, public safety systems and access to care – depends on whether decisions are grounded in evidence rather than fear.

The challenge is that high-profile cases tend to distort the picture. Violent acts associated with mental illness draw intense media attention, shaping public perception in ways that research does not support. Decades of research suggest something much more complicated – and far less alarming.

"Mental illness and violence do have a relationship," said Dr. Marvin Swartz, a professor of psychiatry and behavioral sciences at Duke University School of Medicine. "But it's a complex relationship. And it's rare."

A STUBBORN MISCONCEPTION

One of the most persistent myths is that mental illness is a primary driver of violent crime. In reality, its contribution is small. A population-level study published in Annals of Epidemiology found that even if serious mental illness were completely eliminated, overall rates of violence would decline by only about 4%.

"These incidents feel common because they're dramatic and highly visible," Swartz said. "But they're not representative. Most everyday violence doesn't make the news."

Dr. Robert Cochrane, statewide director of forensic services for the North Carolina Department of Health and Human Services, sees how that imbalance shapes public understanding.

"People with serious mental illness are much more likely to be victims than perpetrators," Cochrane said. "But when rare tragedies dominate headlines, that reality gets lost."

That misperception carries real consequences. When mental illness is equated with danger, policy responses often focus on control rather than care – approaches that neither prevent violence nor improve outcomes, and that can deepen stigma and discourage people from seeking help.

WHAT ACTUALLY RAISES RISK

When researchers look closely at violence risk among people with mental illness, the strongest predictors look strikingly similar to those in the general population.

Substance use – especially alcohol – consistently ranks near the top. Alcohol and certain drugs lower inhibition and increase impulsivity, while illicit drug use can place people in environments where violence is more likely.

Environmental stress plays a role as well. Living in a community with chronic violence changes how people respond to the world – heightening fear and reactivity, Swartz explains.

Other well-established risk factors, including a prior history of violence, exposure to domestic violence, age and gender, have little to do with mental illness itself.

"Mental illness on its own is a relatively weak predictor," Cochrane said. "Risk increases when illness goes untreated and is combined with other destabilizing factors."

WHEN SYSTEMS FAIL

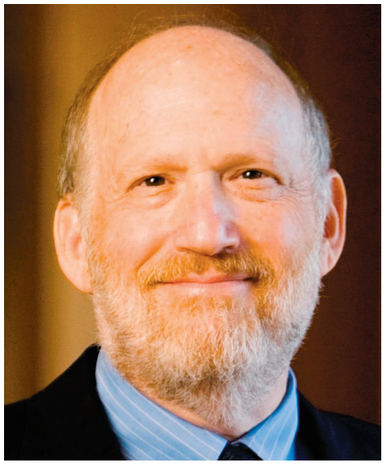
From Cochrane's statewide perspective, the most serious breakdowns occur not because people with mental illness are inherently dangerous, but because systems fail to engage them early or consistently.

One growing pressure point is the capacity-to-proceed crisis – cases in which defendants are found unable to understand or participate in their legal proceedings due to mental illness.

"In 2024, North Carolina courts referred roughly 2,400 individuals for capacity evaluations," Cochrane said. "About 60 percent were found incapable and required treatment to restore them."

Many of those individuals spend months in jail waiting for services, often without adequate care. North Carolina

Source: Dr. Marvin Swartz, a professor of psychiatry and behavioral sciences at Duke University School of Medicine.



Pictured above is Dr. Marvin Swartz, Professor of Psychiatry and Behavioral Sciences, Duke University School of Medicine. Photo Credit: Duke Health.

Pictured above is Dr. Robert Cochrane, Statewide Director of Forensic Services, North Carolina Department of Health and Human Services.

Share of Violent Crime Linked to Mental Illness

4%

Estimated share of violent crimes in the United States involving individuals with serious mental illness.

Source: National Academies of Sciences summarized by the Council of State Governments Justice Center

23%

Percentage of U.S. adult population who live with a mental illness.

Source: National Institute of Mental Health research summaries

5.2%

Population level estimate of violent crimes linked to severe mental illness in a large registry study.

Source: Fazel and Grann, American Journal of Psychiatry

is not alone; similar delays have triggered litigation in multiple states.

In response, the state has begun piloting community-based and detention-based restoration programs that divert people who do not require hospitalization into faster, lower-cost treatment settings.

"These programs get people care sooner, resolve cases more efficiently and preserve hospital beds for those who truly need them," Cochrane said.

THE OVERLOOKED RISK: VICTIMIZATION

Far less attention is paid to how often people with serious mental illness are harmed by others. Research consistently shows that these individuals are far more likely to be victimized than to be perpetrators of violence.

"The public narrative tends to fixate on the rare perpetrator," Swartz said. "But from a safety standpoint, the bigger issue is victimization."

That imbalance matters. It reinforces stigma while diverting attention from prevention strategies that could reduce harm for individuals and communities alike.

RESPONDING TO CRISES WITHOUT CRIMINALIZATION

In recent years, North Carolina has expanded its crisis response infrastructure, investing in 988 call centers, mobile crisis teams and law enforcement co-responder models. The goal is early intervention – before a mental health crisis turns into a criminal justice issue.

Evidence suggests these approaches reduce arrests, injuries and use-of-force incidents. According to Swartz, effective triage is key – directing low-risk crises away from police entirely and reserving law enforcement involvement for situations involving clear and immediate danger.

The state is also piloting non–law enforcement transportation for people in crisis, relying on trained clinicians or peer-support specialists rather than police officers to bring individuals to appropriate care settings.

"These models reduce trauma and escalation," Cochrane said. "They're better for the individual and for the system."

Other states have adopted additional tools, including Extreme Risk Protection Orders (ERPOs), which allow for the temporary removal of firearms during periods of acute crisis based on demonstrated risk, not diagnosis.

North Carolina has not enacted an ERPO law, despite multiple legislative attempts. As a result, clinicians and law enforcement have fewer options to temporarily separate individuals in crisis from lethal means – a gap public health researchers note is especially consequential given the role firearms play in impulsive acts of violence and suicide.

REENTRY, RECIDIVISM AND THE WORKFORCE

For people who do become involved in the justice system, evidence consistently supports a set of interventions that reduce recidivism and instability: mental health courts, supportive housing, substance use treatment and intensive community-based care.

North Carolina has expanded Forensic Assertive Community Treatment (FACT) teams, which provide wraparound services – psychiatric care, peer support, housing assistance and help accessing benefits – for individuals returning from incarceration.

"These teams require significant investment," Cochrane said. "But the evidence shows they reduce rearrests, hospitalizations and long-term instability."

The effects aren't limited to public safety. Untreated mental illness contributes to absenteeism, turnover and rising healthcare costs – challenges employers across North Carolina increasingly confront.

"We have services we're unable to deliver because we don't have enough providers," Cochrane said. "The workforce shortage is one of the biggest constraints we face."

WHAT THE EVIDENCE POINTS TO

Even after rare but devastating events, both experts emphasize the same point: treatment works.

"People get better," Swartz said. "Especially when care is continuous and supported."

Cochrane urges leaders to resist simplified narratives.

"We're talking about a relatively small number of people whose needs exceed what our systems can currently handle," he said. "The answer isn't fear. It's sustained investment in care, housing, workforce and early intervention."

Reducing violence while supporting mental health requires aligning public understanding with evidence. For North Carolina's workforce, communities and economy, the evidence is consistent: prevention begins with care – not criminalization. ■

Risk Factors that Influence Violence

4x higher risk

Violence risk rises sharply when mental illness occurs alongside substance use disorder.

Source: National Library of Medicine clinical review

under 5%

Share of people with most psychiatric disorders who commit violent offenses in long term studies.

Source: Lancet Psychiatry systematic review

HIDDEN HOMELESSNESS IN THE TRIANGLE WORKFORCE

BY CAROLINE BARNHILL

Public perception of homelessness often conflicts with reality. Many residents without stable housing work across the Triangle each day. One boards an express bus into downtown Raleigh. Another pours coffee on Fayetteville Street. A preschool teacher in Durham guides children through their ABCs. Conversation about the weather or last night's game passes easily.

Pictured above is David Ellis, County Manager, Wake County.

Few people suspect a car serves as a bedroom after work.

"Someone who is housing insecure looks just like us," said Dr. Latonya Agard, executive director of the North Carolina Coalition to End Homelessness. "Despite the myths, most people who are unhoused are working – and working hard."

In January 2025, the HUD Point-in-Time Count identified 1,788 people experiencing homelessness across Wake, Durham and Orange counties, a 15% increase from the year before. Wake County alone saw a 27% rise. Of the 1,258 people counted in Wake, 971 were staying in shelters and 287 were living unsheltered – more than double the unsheltered count recorded the prior year. One in four individuals counted was chronically homeless.

Sixty-one veterans were counted. Black residents made up 63% of those identified in Wake County, far exceeding their share of the overall population. Families and older adults account for a growing portion of the increase.

"Over the last few years, North Carolina – much like the rest of the United States – has seen an increase in elderly and family homelessness," Agard said. Rental costs have outpaced cost-of-living increases for people on fixed incomes and hourly workers. "Families who were able to make ends meet a few years ago are struggling more than ever."

Mental health and housing instability regularly reinforce one another. Serious mental health conditions raise the risk of housing loss, while housing instability worsens depression and anxiety.

"I cannot imagine what it would be like to have to figure out where I am going to sleep every night," she said. "I would imagine that would cause me to be really depressed, extremely anxious and paranoid."

Loss of housing often intensifies existing anxiety. As Agard explains, people aren't just "between places" – they're in survival mode. Parents try to sleep in cars but never fully rest because they're watching over their kids. Some families are split up when a shelter won't allow a 17-year-old son to stay with his mom and younger siblings. Families spend each day deciding where to shower and how children get to school. Sustained stress and exposure to danger increase mental health risk over time.

"If someone is experiencing homelessness and that experience goes beyond 30, 60, 90 days, that continual exposure to trauma exacerbates whatever mental health challenge someone may have, or simply causes it," Agard said.

Agard also cautioned against framing homelessness primarily as a mental health issue. The root problem of the housing crisis remains structural – there is simply not enough clean, affordable housing available for people, she explained. People lacking stable housing experience additional barriers to mental health treatment. Substance use often follows. Alcohol and other illicit substances are easier, and often cheaper, to obtain than consistent mental health care.

WHAT EMPLOYERS NEED TO UNDERSTAND

Agard also challenged the assumption that people without housing avoid work. "You can't budget your way out of the reality that you don't make enough money to pay the rent," she said.

Housing instability impacts a significant share of workers in the United States. A study from researchers at the University of Chicago showed 53% of people living in homeless shelters and 40% of unsheltered people were employed, either full-time or part-time, during the year they were observed homeless.

Employers are often unaware that an employee lacks stable housing, as the resulting instability often presents as fatigue, irritability, withdrawal or increased absenteeism. "A lack of having that stable foundation is going to lead to more adverse effects for that person," Agard said.

Research on homelessness repeatedly points to Housing First models, which place individuals into permanent housing before requiring treatment compliance or sobriety, as the most effective approach. "The nervous system can calm down enough for a person to get those other services," Agard said. Once stable, people engage more effectively with therapy, case management and substance use treatment.

Prevention plays a central role in reducing homelessness. Short-term rental assistance during illness, job transitions or other disruptions often prevents homelessness altogether.

"If I could wave a magic wand, I'd start with increased funding for

homelessness prevention. For so many families, just two months of support could keep them from eviction and ever having to enter the homelessness system at all," she explained. "We also need stronger protections for renters – things like letting evictions roll off rental histories faster and putting caps on rent hikes and application fees. Right now, one eviction can follow a family for years and shut them out of safe housing."

WAKE COUNTY'S RESPONSE TO THE AFFORDABILITY CRISIS

For Wake County Manager David Ellis, the county's 27% increase in homelessness stems from layoffs, increased housing costs and even health or behavioral health issues that make it difficult to hold a job.

"Housing instability is a traumatic experience," Ellis said. "You're having to make a decision: Do you pay your rent? Do you pay for your medicine? Do you buy groceries? You're trying to balance all that, and then there's a lot of stress on a person going through that."

To respond, Wake County has reframed housing as a component of a wider community health system. Under one umbrella, the county is coordinating social services, behavioral health, housing and workforce development so people aren't left to manage disconnected programs.

Ellis describes the strategy as a continuum "from homelessness to homeownership." On one side, the county partners with nonprofits that operate emergency shelters. On the other, it is investing in long-term stability through rental assistance and homeownership programs and close collaboration with the local housing authorities.

Under Housing Director Morgan Mansa, Wake County has added about 5,600 units of affordable housing in roughly eight years by working with nonprofits and municipalities. The county has also moved to preserve existing affordable units where tax credits were set to expire and rents were likely to jump.

"You want to make sure there's that short-term shelter to help people immediately," Ellis said, "but you've really got to also spend time on the permanent side, making sure we have permanent housing options, whether they're rental or homeownership."

Pictured above is Dr. Latonya Agard, Executive Director, North Carolina Coalition to End Homelessness.

WHY IT MATTERS TO EMPLOYERS

Ellis is blunt about the stakes for the business community: housing stability is a workforce issue.

"Employers want highly productive individuals to come to work and do well," he said. "When you're worried about losing your housing or you're worried about making ends meet, that will have a direct impact on how well someone can do their job, because they're not fully mentally there."

Many long-time residents still hold relatively affordable leases. But if they're forced to move – because a property is sold or they're evicted – they reenter a rental market that looks very different from a decade ago.

"Suddenly, someone who is fairly comfortable in a good position is going to be struggling, and maybe they have to pick up a second job," Ellis said. "Well, if they're picking up a second job, it means sometimes that may impact the first job."

He urges employers to look closely at today's local rents and to recognize that employees earning $30,000 to $35,000 a year and below are often one missed paycheck away from crisis.

"In the end, housing insecurity impacts their bottom line," Ellis said.

Source: www.hudexchange.info.

WATCHING FOR PROGRESS

The county is trying to make its work more visible through ImpactTracker, a public data platform that shows affordable housing created and preserved, as well as unsheltered homelessness trends through Wake's Continuum of Care.

"You'll start to see the numbers," Ellis said. "You'll start to see progress being made. I think that's helpful, because people feel like their tax dollars are making a difference."

He also points to eviction filings as an important warning sign. In Wake County, eviction numbers have climbed back to pre-COVID levels, and the county is seeing more first-time homelessness tied to job loss and sudden income disruptions.

Ellis stresses that housing instability is not only an urban issue.

"Sometimes we get focused on Raleigh being the only place where homelessness is," he said. "If you drive around and look out in your Knightdales, your Garners, and even a little further out, you're starting to see where people are really struggling."

For Ellis, progress will signify fewer families hitting that breaking point – and a business community that understands the connectivity between stable housing and workforce stability. ■

HAVE YOU OR ANYONE YOU KNOW EVER SERVED IN THE MILITARY?

ASK ME NC

Have you or a family member ever served in the military?

NORTH CAROLINA GOVERNOR'S CHALLENGE TO PREVENT SUICIDE

CHALLENGE ACCEPTED

Military service isn't always obvious. The person you're speaking with could be eligible for important services and benefits they don't know exist. Service Members, Veterans and their Families (SMVF) represent a distinct group of individuals with unique needs.

ASK ME NC focuses on asking the question at places where SMVF are receiving services in the community including healthcare, human services, libraries, the justice system and more.

Addressing needs among Service Members, Veterans and their Families related to the social determinants of health can play a role in in preventing suicide.

1 ASK

Ask "Have you or anyone you know served in the military?" Identifying and connecting them to the benefits and resources they have earned could improve health and wellbeing.

2 CONNECT

This simple question allows professionals to connect people with resources they've earned— and follow up with, "How are you feeling?" ensures we're also supporting their mental health and wellbeing.

3 PROTECT

Being connected to healthcare and resources is a protective factor against suicide. By normalizing both questions, we create safer, more supportive environments where the SMVF community can be heard, understood, and guided toward the right care.

4 CALL TO ACTION

Educated and Empowered Veterans thrive in our communities. Let's ensure that every North Carolinian who has served, and their families are recognized and supported. By simply asking, we open doors to stories, resources, and healing.

SCAN HERE

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Veterans Crisis Line

DIAL 988 then PRESS 1

CALL 1-855-962-8387

HOLDING SPACE FOR GRIEF IN THE WORKPLACE

BY CAROLINE BARNHILL

On March 14, 2020 – the earliest days of COVID – Rebecca Feinglos's father, a decorated physician at Duke University Medical Center, passed away suddenly. At the time, she was leading North Carolina's early childhood policy work at the North Carolina Department of Health and Human Services under then-Secretary Mandy Cohen.

Pictured above is Rebecca Feinglos, a certified grief support specialist, founder of Grieve Leave, and host of the podcast Grief'd Up.

"As a child, I had already lost my mother to an extremely aggressive form of brain cancer, so having lost both parents by age 30 and being in the middle of a pandemic lockdown, I felt trapped," Feinglos remembered. "Soon after, I was going through a divorce, which brings a different kind of grief, so everything came to a head for me."

She decided to leave the work she deeply enjoyed with the state government in order to more fully explore grief and loss – and soon after founded Grieve Leave as an organization to help individuals find better grief supports for all kinds of loss.

Most organizations offer three days of bereavement leave, a policy Feinglos says is designed to accommodate funeral travel rather than address the longer-term impact grief has on focus, judgment and day-to-day performance. That disconnect means employees often return to work without meaningful support and with the expectation to resume normal productivity.

"We want it to be true that a quick leave policy is the antidote and cure for grief. We've been conditioned to see grief as something inappropriate to talk about at work – as something personal that you overcome. It's the culture of the American workplace to pick yourself up by your bootstraps. You are supposed to be done with your grief when you come back to work, making sure that your grief doesn't come to work with you," she says.

The numbers say otherwise. According to the Centers for Disease Control and Prevention, unsupported grief in the workplace costs U.S. employers up to $225.8 billion annually. Grief often presents itself as fatigue, distraction, irritability or forgetfulness.

Feinglos felt it herself. "I wanted to get back to work as soon as I possibly could to regain some normalcy, but I was just not ready for how much weight my grief put on me while I was trying to do the work I had always done and be the leader I had always been," she remembered. "And I hear that all the time now in my work as I try to help companies create better grief-related policies. People share that they experienced loss, and their boss or colleagues never acknowledged what they were going through and just expected them to go back to how they were before."

That disconnect could be a reason why Feinglos said more than half of employees leave their jobs within a year of a significant loss. Formal national data are limited because bereavement policies vary widely, making figures difficult to track. But employees who feel unsupported often disengage gradually. Resignations frequently happen months later, after managers believe things have settled.

UNDERSTANDING GRIEF

Dr. Justin Yopp, a clinical psychologist and associate professor of psychiatry at the University of North Carolina at Chapel Hill, sees the long-term effects of grief firsthand. He works closely with widowed parents, including fathers raising children after the death of a spouse. In 2010, while working at the UNC Lineberger Comprehensive Cancer Center, he saw three young mothers with cancer pass away within several weeks of each other. Along with his boss, Dr. Don Rosenstein, they looked for a support group for grieving fathers to offer as a resource. None existed.

"It's not hard to imagine that if you were a father with children at home and you just lost your spouse, how that would be overwhelming in all kinds of ways – and having some kind of support group where you could meet with other people in the same boat might be a good idea. And we figured if no one else is doing it, how bad can we mess it up?" Yopp said.

So they started a group with a small handful of men and spread the word. What they thought would be six sessions, half psychoeducational and half discussion-based, quickly turned into something more.

"It became very clear early on that

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these men had a lot more to gain from each other than they would from either Don or me," Yopp continued. "We never would have thought it would turn into what it's become. We've probably had 150 men go through this group. We started a website, wrote a book and have done a number of research studies looking at widowed parents."

Rosenstein and Yopp co-authored The Group: Seven Widowed Fathers Reimagine Life, which chronicles men navigating loss while maintaining careers and parenting responsibilities. Yopp said the idea for the book emerged in part from the fathers' desire to help others through their experiences.

One harmful myth Yopp wants to debunk? The five stages of grief theory.

"There are absolutely no research studies that show people move through five stages of grief. That work was developed in 1969 by Elisabeth Kübler-Ross and was specific to individuals who were dying of leukemia, not people grieving the loss of someone else," Yopp explained. "However, it filled a void because no one was talking about grief back then. It kind of made intuitive sense and sounded nice to move through five steps, which ends in acceptance."

The reality is much different.

"There's a model called the dual process model of coping with bereavement, which says that after a significant loss, people face two kinds of stressors – loss-oriented and restoration-oriented – and it's healthy to oscillate between looking back on what was lost and looking forward to what has to change," Yopp explained. "And when you explain this to people actually working through grief, it almost always makes sense because they can overlay their own experience with this model and it checks out."

EMBRACING GRIEF AT WORK

When it comes to creating a grief-informed workplace, Feinglos says acknowledgment is a simple first step.

"Just recognizing that grief exists shifts leadership behavior," explains Feinglos. "Instead of avoiding the topic, managers initiate check-ins. They ask about workload adjustments – without assuming reduced capacity or a full recovery. They recognize that grief ebbs and flows over time."

Unfortunately, however, employers often handle grief in the workplace in one of two ways. They say nothing and hope privacy demonstrates respect, or they overcorrect and draw unwanted attention to the employee. Another pattern Feinglos often sees played out is when a manager quietly trims responsibilities, assuming less pressure on the employee will be a blessing. Instead, the employee views the reassignment as another thing taken away at a time when little feels stable.

"In your mind, you are giving me an alleviated schedule. You are taking pressure off of me. But that can actually end up hurting me more, because I might want to be anchored in routine and structure. Maybe the only thing that was making me feel successful right now, feel whole, was this one big project that I was looking forward to doing at work," she explained.

This is why Feinglos advises managers to ask employees what support they need rather than deciding for them. Then, they can clarify expectations by revisiting the conversation as circumstances change and time passes.

Some companies choose to formalize the approach. Feinglos has worked with employers that standardize condolence practices, train managers on grief conversations and expand leave language to allow flexible use over time, not solely in the immediate aftermath of death. Allowing employees to use leave later, such as for an anniversary or memorial, reflects how loss can resurface months later.

Grief-informed workplaces incorporate grief support as an essential part of their teams' well-being, allowing employees to bring their whole selves to work.

"We can teach how to talk to each other about grief. We know that any kind of loss we go through is going to feel painful. That part of grief is given," Feinglos said. "But the part of grief that is avoidable is the societal stigma that is layered on top of grief. That is the part that I want to see change in my lifetime. We can change that, but that comes with training and becoming comfortable with hard conversations." ■

Grief in the Workplace

20 MILLION
The number of working-age adults in the U.S. who grieve a death each year

$125 BILLION
Estimated amount grieving employees cost U.S. companies annually

~50%
The number of grieving employees who quit their job within a year of their loss

Source: www.grieveleave.com

Getty Images

INSIDE THE RURAL MENTAL HEALTH WORKFORCE GAP

BY CAROLINE BARNHILL

In many rural North Carolina communities, the mental health system doesn't resemble a system at all. There may be no psychiatrist practicing within the county. Families may be told to drive an hour or longer for specialty care. And when someone reaches a breaking point, the emergency department can become the default safety net – even when it isn't the right setting for treatment.

Brianna Lombardi, a clinical social worker and director of the Behavioral Health Workforce Research at UNC Cecil G. Sheps Center for Health Services Research. Photo credit: UNC School of Medicine.

But one of the most important realities of rural mental health shortages is also one of the least understood.

"When people mention mental health professional shortage areas, it sounds like we're talking about a shortage of all mental health professionals," said Brianna Lombardi, a clinical social worker and director of the Behavioral Health Workforce Research at UNC Cecil G. Sheps Center for Health Services Research. "But that indicator is specific to psychiatrists."

That distinction matters for rural residents, employers and policymakers trying to build a workforce that matches the need. It also helps explain why shortages can feel worse even in communities that have therapists, counselors or social workers: the prescriber pipeline is thin, supervision is hard to come by, and access is shaped by far more than raw headcounts.

A SHORTAGE THAT RESHAPES CARE DELIVERY

Even when a county has practicing clinicians, rural mental health care is often routed through settings never designed to carry the load.

"In rural communities, a lot of mental health care is delivered by primary care clinicians – by your family medicine provider," Lombardi said. "Mental health care looks very different from what it might look like in urban or suburban areas, where we have specialized mental health treatment settings."

Federally qualified health centers and rural health centers are also a critical access point, particularly as more clinics integrate behavioral health into primary care. Lombardi described that integration as one of the most encouraging shifts she has seen over the last decade. But there are limits to what primary care can absorb – especially when the most acute gaps are in prescribing capacity.

THE MOST ACUTE GAPS: PRESCRIBERS – AND KIDS

When the Sheps Center tracks the workforce by occupation and geography, Lombardi said the largest gaps are among prescribers – psychiatrists, psychiatric nurse practitioners and physician assistants.

"That's where we see the most counties in North Carolina without a prescriber," she said.

The most concerning shortage involves children.

"Most acutely, it's child and adolescent psychiatrists," Lombardi said. "We actually have fewer child psychiatrists today than we did 10 years ago – and more than 60 North Carolina counties do not have a child psychiatrist reporting their primary active practice location."

For employers, this is not an abstract concern. When children can't access care, the effects show up in absenteeism, unpredictable schedules, caregiving strain and turnover – particularly in rural communities where families have fewer options and longer travel times.

MENTAL HEALTH CARE IS A "TEAM SPORT" – WITH STRUCTURAL CONSTRAINTS

Lombardi emphasized that mental health care functions as a team sport, and that focusing on a single occupation can obscure how care actually works on the ground. In many communities, residents may not have access to a psychologist, but they do have licensed clinical social workers or licensed clinical mental health counselors – two workforces that have grown significantly in recent years.

Rural practice, however, is shaped by hierarchy: who can practice independently, who requires supervision and who can bill for which services. In smaller communities, supervisors can be scarce and expensive, making it harder for provisionally licensed clinicians to become fully independent.

Lombardi noted that even when rural areas have psychiatric mental health nurse practitioners, they must maintain collaborative practice agreements with physicians – another example of how regulatory requirements can restrict access even

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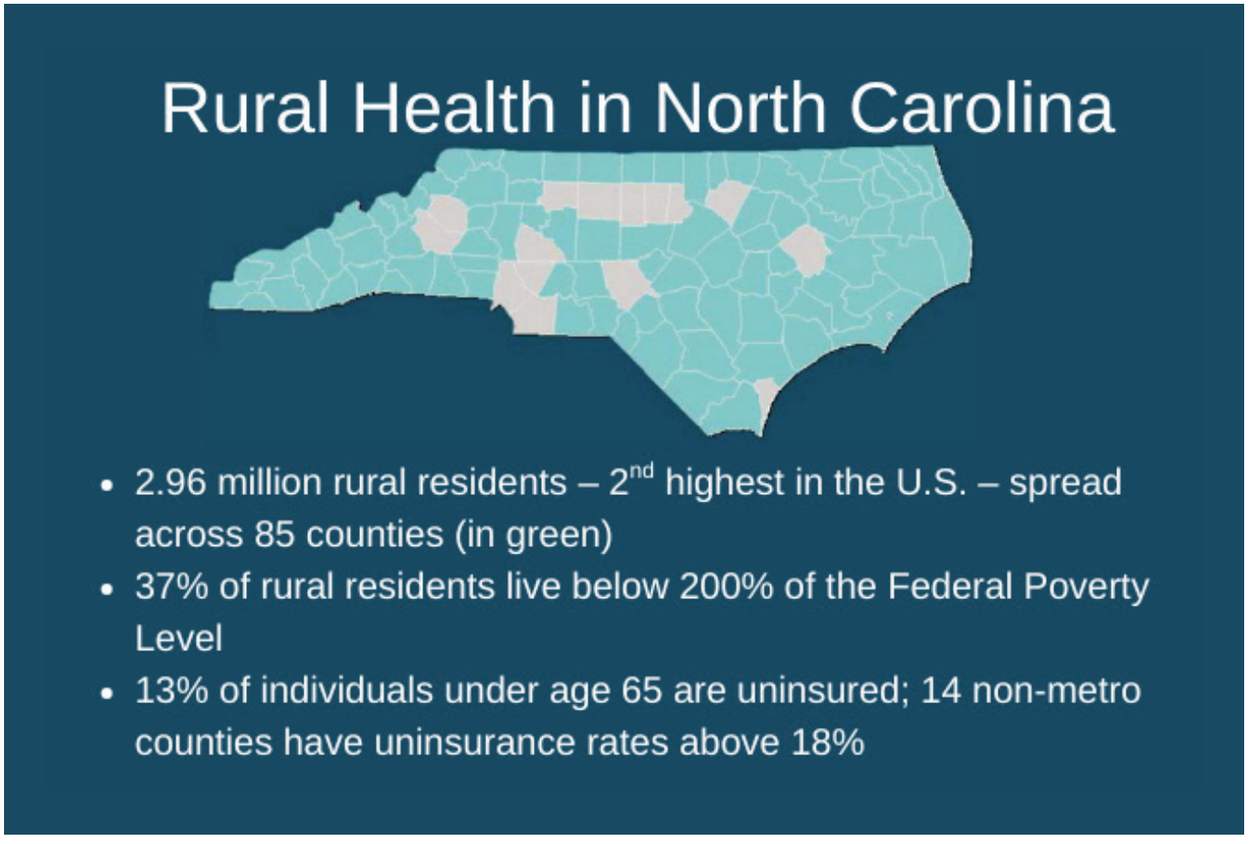
when clinicians are present.

There is also a data blind spot with real access implications. Licensure counts alone don't reveal which providers accept Medicaid (or any insurance), how much time they spend in clinical care, or whether they are accepting new patients.

Recently published statewide workforce data underscores how deeply the shortage affects access. Roughly one in four North Carolinians with a mental illness reports an unmet need for care, meaning they recognized they needed help but could not obtain it. The gap is even wider for substance use treatment: more than three-quarters of adults who need treatment do not receive it.

In rural communities, those gaps are especially visible. When outpatient care isn't available, the emergency department often becomes the only place left to turn during a mental health crisis. At the same time, the need for care continues to grow. Nearly one in three young adults reports living with a mental illness, and overall rates of mental distress have climbed steadily over the past decade.



Source: www.ncdhhs.gov.

TELEHEALTH HELPS – BUT DOESN'T ANSWER "HOW DO I GET IN?"

Telehealth has been one of the most visible changes since COVID, and for rural communities, it has clearly expanded reach.

"You don't have to have a provider physically located in your county to receive care," Lombardi said.

But she cautioned that access is about more than supply. Even when telehealth removes distance, people still need to know how to find care, evaluate quality, confirm insurance coverage and identify clinicians who are accepting new patients – what she described as the "accommodation" side of access.

Telehealth has also enabled practical improvements: easier engagement for parents, school-based partnerships and, critically, more responsive crisis assessment. Lombardi pointed to models in which emergency departments use telepsychiatry so patients in crisis are not left waiting 24 hours for an in-person psychiatric evaluation.

A NEW POLICY LEVER IN NORTH CAROLINA: LOAN REPAYMENT

As North Carolina expands its behavioral health strategy, workforce incentives are taking on greater importance. In December 2025, NCDHHS launched a $20 million loan repayment program aimed at addressing shortages – and Lombardi is watching closely.

The program targets licensed, master's-level professionals – counselors, social workers, psychologists and therapists – who are essential to service delivery but often face financial barriers to working in high-need rural areas.

"I've heard they've already received hundreds of applications, which reflects how much demand there is for programs like this," she said.

Loan repayment may help retain clinicians who might otherwise leave community-based settings for private

Source: Cecil G. Sheps Center for Health Services Research.

practice – a shift often driven by autonomy and flexibility as much as reimbursement.

"With that said, I don't think programs like this alone are going to pull people back from private practice into the public mental health system," Lombardi said, arguing that the state may need to focus on the next generation of providers rather than expecting the workforce to revert to pre-COVID patterns.

BUILDING THE RURAL PIPELINE AT SCALE

North Carolina's broader rural health strategy is increasingly focused on system design – strengthening how care is organized, staffed and sustained across rural regions.

In its North Carolina Rural Health Transformation Program (NCRHTP) plan, NCDHHS outlines a major workforce priority: "Build a Robust & Resilient Workforce & Innovative Care Team Models for Rural Communities." The plan points to persistent shortages driven by fragmented programming, limited training sites, faculty constraints, and ongoing placement and retention challenges.

The proposed future state centers on a modernized rural workforce supported by integrated training hubs, expanded residencies and fellowships, and upskilling pipelines – paired with incentives such as paid internships, tuition-free certification and placement services tied to a five-year rural service commitment.

One cornerstone is the creation of regional rural training hubs coordinated through NC ROOTS (North Carolina Rural Organizations Orchestrating Transformation for Sustainability) infrastructure and built with partners ranging from rural hospitals and universities to community colleges and career and technical education programs.

These hubs are designed for rural realities: interprofessional care teams, simulation for high-acuity/low-frequency events, stronger preceptor capacity and clearer pipelines from education to credentialing to rural practice.

> "Mental health care looks very different from what it might look like in urban or suburban areas, where we have specialized mental health treatment settings."
>
> **BRIANNA LOMBARDI**
> UNC Cecil G. Sheps Center for Health Services Research

EXPANDING – AND INTEGRATING – BEHAVIORAL HEALTH CAPACITY

Workforce growth is only one part of the rural access challenge. The NCRHTP plan also outlines a behavioral health strategy focused on expanding and integrating services across rural regions. That includes growing Certified Community Behavioral Health Clinics in rural counties, strengthening 24/7 crisis response through rural community crisis centers, expanding mobile response programs, and increasing youth access through rural school-based health centers.

The plan also highlights a school-based telehealth partnership. In March 2025, NCDHHS partnered with Hazel Health to provide virtual mental health care for nearly 400,000 K-12 students – a move explicitly designed to address provider shortages and cost barriers.

For employers, efforts like these shape whether a workforce remains stable – and whether families can stay in, return to or relocate to rural communities.

WHAT RURAL EMPLOYERS CAN DO NOW

Even as state-level strategies take shape, employers have tools available today – particularly in rural areas where the private sector may be the most consistent organizing force outside government and healthcare systems.

Based on Lombardi's observations, three practical steps stand out:

24.6% of adults with mental illness report an unmet need for care

78.5% of adults needing substance use treatment do not receive it

22.8% of adults received mental health treatment in the past year

16.7% of adults report frequent mental distress

Source: State of North Carolina's Mental Health and Substance Use Services Workforce: Need, Supply, and Distribution Landscape Assessment | March 2026

Treat mental health access as workforce infrastructure, not a perk. If roughly 20% of people are experiencing a mental health condition at any given time – and "half of us in our lifetime will experience one" – the issue isn't whether your workforce needs access. It's whether access is realistically available.

Make EAPs and tele-mental health usable in practice. Normalize use, protect privacy and ensure employees can engage outside work hours – especially caregivers navigating children's needs.

Partner locally where the pipeline is forming. Rural training hubs, community colleges and health centers need placement sites, preceptors and wraparound support. Employers can help by offering flexible schedules for trainees, supporting spousal employment and co-investing in community initiatives that make rural practice sustainable.

North Carolina's rural mental health challenge is real – but so is its opportunity. The state's emerging strategy reflects a move away from one-off fixes and toward a more durable approach: training where people live, building teams that share the load and designing systems that work across distance, workforce constraints and everyday family realities.

As Lombardi put it, "We have a lot of hands" – and the future depends on how effectively those hands are organized to meet the need.

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CAREGIVER MENTAL HEALTH AND THE CAREGIVING WORKFORCE

BY CAROLINE BARNHILL

Getty Images

At Central Regional Hospital in Butner, N.C., the constraint is not space. It is staffing. Hospital beds sit ready. Equipment is in place. Patients are waiting. But without enough nurses, nursing assistants and other caregivers, many of those beds remain empty.

"It is a crisis," said Dr. Bryan Smith, clinical director of the hospital's Geriatric Services Unit. "Even when there are beds, the rate-limiting factor is always staff. And that's not just at Central Regional – this is something impacting virtually all hospitals, nursing homes and assisted living facilities."

Medical facilities across the state are confronting similar constraints – forcing them to reduce admissions, consolidate units or adjust operations based on staffing levels rather than patient volume.

And the crisis isn't getting better any time soon. North Carolina is projected to see more than 186,000 openings for direct care workers over the next decade. Much of that reflects turnover – workers leaving faster than they can be replaced. So while the work itself has not changed, the workforce supporting it has become harder to sustain.

"It's a difficult job," Smith said. "There's emotional burnout, and it's physically demanding."

Caregivers assist with daily tasks such as bathing, eating, repositioning and mobility, while also monitoring behavior, managing agitation and helping patients through periods of confusion or decline. Over time, patients recognize them and become more comfortable in their care. Families rely on them. So when those caregivers leave, the absence is quickly felt. Remaining staff may need to adjust their assignments while new hires get up to speed.

Pictured above is Courtney Van Houtven, PhD, Professor, Duke University School of Medicine Department of Population Science | Photo Credit: Duke Health.

"Stable staff is better for patients and families," Smith said. "Now there's much more turnover, and it's harder on everyone."

Outside institutional settings, the same pressures are unfolding in private homes across the state – and nation.

THE IMPACT ON INFORMAL CAREGIVERS

More than one million North Carolinians provide unpaid care to adult relatives or loved ones. Many are also employed, leaving caregiving tasks to be handled early in the morning, late at night or in between work obligations.

Because of that pressure, caregivers are at risk for depression, adjustment disorders and substance misuse, explains Smith. Taking care of a parent or grandparent carries unique emotions.

"It's one thing to brush your child's teeth," he said. "It's another thing to brush your mother or father's teeth."

Dr. Courtney Van Houtven, a Duke University professor who studies caregiving and employment, has interviewed caregivers for years. While the details vary, the underlying

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sentiment remains the same.

"There's strong evidence that caregivers experience higher levels of depression, anxiety and strain," she said.

Caregiving introduces uncertainty into work and personal routines that previously felt stable. A single phone call can change the day, since medical needs do not align neatly with work schedules. From her research, Van Houtven said caregivers often describe the mental burden as constant rather than episodic.

"They're managing clinical calls, crises and interruptions," she said. "And that's not something that pauses just because the workday starts."

Many informal caregivers choose not to discuss these pressures at work.

"Some workers don't want their employer to know they're a caregiver," she continued. "They don't want to be viewed differently."

The concern is often less about a specific policy and more about uncertainty: How will disclosure be perceived, and could it influence opportunities for advancement?

THE COST – FOR BOTH EMPLOYEE AND EMPLOYER

These disruptions come at a cost. While not all caregivers change their jobs, many end up reducing their hours, turning down promotions or leaving the workforce altogether. Yet when researchers look at large national datasets, the average impact of caregiving on work over time appears more modest than the anecdotes suggest.

"For many women, there's a sharp initial hit to earnings that can partially recover over about a decade. Still, that disruption is very real, and it's much harder to bounce back if you lack good benefits or flexibility at work," Van Houtven explains. "Men, on average, don't see the same effects, but women caregivers often face lasting wage penalties even when they stay employed, likely due to missed promotions, unpaid leave or other hidden tradeoffs that aren't well captured in the data."

For employers, the stakes are high. When employees reduce hours, step out of leadership tracks or leave jobs entirely because of caregiving, companies bear the high cost of retraining and replacing them. At the same time, caregiving responsibilities are becoming more common as the population ages.

According to the AARP and National Alliance for Caregiving, nearly one in four Americans now serves as a caregiver – a number that has climbed steadily in recent years as the population ages and more older adults require assistance with daily living. In their report, Caregiving in the US 2025, caregivers spend an average of 27 hours per week providing care, with 24% reporting they provide 40 or more hours of care. And nearly half of all working caregivers experience impacts on their employment.

Van Houtven said workplace flexibility can determine whether caregivers remain employed.

Flexible scheduling, remote work options and leave policies can provide margin during periods when demands intensify. Even a few weeks of paid leave can make a huge difference, she explains.

"TWO KIDS IN EVERY CLASSROOM": *North Carolina Confronts Youth Substance Use*

BY CAROLINE BARNHILL

Getty Images

In a typical North Carolina middle or high school classroom of 25 students, roughly two meet the criteria for substance use disorder.

In a typical North Carolina middle or high school classroom of 25 students, roughly two meet the criteria for substance use disorder.

That's the implication of recent data Jeremy Croom, program director at the Governor's Institute, shared during a recent conversation about adolescent substance use. State estimates show one in 13 North Carolinians ages 12 to 17 qualifies for an adolescent substance use disorder diagnosis. Yet, most do not receive treatment.

"It's tough to think about," Croom says. "They're trying to go to school and live life while carrying something most adults would struggle to manage."

On June 3, Croom and his colleagues at the Governor's Institute will host the third annual Adolescent Substance Use Disorder Conference, a full-day virtual event for professionals who work with youth and families: social workers, counselors, school personnel, medical professionals and community partners.

The conference grew, in part, from concerns raised during child fatality reviews across North Carolina. Several years ago, Croom explains, county-level teams reviewing youth deaths in North Carolina – social workers, counselors and others – began identifying cases where agencies felt they were unable to provide the supports needed for young people dealing with substance use.

"We started hearing from people who had been engaging with young people for quite some time," Croom recalls. "They felt like they had essentially failed them or at least couldn't get them what they needed."

Those calls reached the Division of Mental Health, Developmental Disabilities and Substance Use Services (DMHDDSUS) at the N.C. Department of Health and Human Services (NCDHHS), and through that, the Governor's Institute. The institute focuses on training professionals in evidence-based treatment and research-based care.

Early efforts focused on Gaston County, where the institute helped support motivational interviewing training – a behavioral therapy approach that aims to address resistance to change and increase a person's internal motivation to make desired changes – and a series of related webinars. Requests for training soon arrived from counties across the state.

"We already knew the need existed," Croom says. "But it was fast-forwarded by what we were hearing in communities: 'We want anything related to adolescent substance use disorder and co-occurring disorders. Give us education we can actually use.'"

So, in 2024, in collaboration with DMHDDSUS, the institute launched its first Adolescent Substance Use Disorder Conference. Year one offered about five hours of education and attracted more than 700 registrants. Year two grew to seven hours and 1,100 registrants. Importantly, Croom notes that roughly 90% of participants are based in North Carolina – meaning what they learn will be used to serve youth across the state.

A STATEWIDE TRAINING EFFORT

The conference has quickly become one of the state's largest gatherings focused specifically on adolescent substance use disorder.

"On paper, you'd say our core audience is social workers and counselors,"

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Croom says. "In reality, any professional who might cross paths with an adolescent or family shows up – teachers, school administrators, nurses, nurse practitioners, physicians, first responders and more."

While the conference has been free of charge so far, the Governor's Institute is piloting a small fee this year to support attendance fidelity and the conference's long-term sustainability.

"It's not a money-making venture for us," Croom says. "We're a nonprofit. But when people pay even a small amount, they're more likely to attend, and it further solidifies our position to offer expert-level practical education for providers and continue hosting this conference for years to come."

WHY YOUTH SUBSTANCE USE IS DIFFERENT – AND MORE COMPLEX

This year's conference will be held on June 3 and will explore how substance use affects adolescents differently than adults. One of the anchor sessions each year focuses on the neurobiology of addiction and what substance use does to the still-developing adolescent brain, which continues developing into the mid-20s.

"We're trying to reframe how people think about adolescence," Croom says. "It doesn't end at 17 or 18. The brain is still developing, and that makes the impact of substance use in youth fundamentally different than use in a 30- or 40-year-old."

In response, the state has identified two priorities: delaying first use and increasing access to evidence-based treatment. From a harm-reduction standpoint, delaying the age of first use dramatically reduces the risk and severity of substance use disorder across the lifespan. "Early use – say, at age 14 – has a far greater impact on brain development and long-term addiction risk than first use in someone's mid-20s," Croom says.

Additionally, many adolescents with substance use disorder, Croom notes, have co-occurring mental health conditions – PTSD, anxiety, depression or ADHD – or significant trauma histories. For many, substance use is a way of coping with underlying pain, not just a "bad choice."

"The myth that we have to treat one thing at a time – mental illness first, or SUD first – is something we want to actively dismantle," Croom says. "The evidence tells us that these conditions are often intertwined, and they can and should be treated together, when possible. This year's conference will feature a psychiatrist who specializes in co-occurring disorders and youth, and will share some real-world cases and best practices."

THE SUBSTANCES SHAPING TODAY'S YOUTH LANDSCAPE

The conference will also address the substances most relevant to North Carolina's adolescents – alcohol, cannabis, opioids, and nicotine and tobacco. There will be a dedicated session this year on the latter, reflecting rising use among youth, even as some other substances plateau or decline.

Past programming has included a session on "North Carolina substance use landscape and emerging use patterns." This year will build on that with updated data and trends, based on reports from clinicians and school personnel.

On the treatment side, the conference will explore medications for substance use disorders, behavioral therapies, including trauma-focused cognitive behavioral therapy (TF-CBT), family-based therapies and individual and group therapy models, as well as integrated care approaches that combine medication, therapy, family support and community engagement.

"If you did a quick search for 'best practices for adolescent SUD,' you'd see integrated care and parallel care models," Croom says. "Medication when appropriate to stabilize and save lives, plus therapy, plus supportive activities like school, sports, church or other community connections. When these things go together, the evidence shows the best outcomes."

THE QUIET POWER OF "ONE CARING ADULT"

Beyond clinical interventions, Croom emphasizes something simple yet impactful: the presence of a genuinely caring adult in a young person's life.

Pictured above is Jeremy Croom, Program Director, The Governor's Institute.

"Across the research, you see this again and again," he explains. "If there's at least one legitimately caring adult in a child's life, the chances that they'll avoid misuse – or, if they are struggling, actually receive and stick with treatment – go up significantly."

While in many cases that adult is a parent or guardian, it could also be a grandparent, extended family member, social worker, coach, teacher, counselor, healthcare provider, faith leader or community mentor. And it's one reason why this conference is attended by individuals across that spectrum, Croom explains. "These are the people who are most likely to recognize those early signs of substance use disorder."

When it comes to early identification that a young person is struggling with substance use, Croom says to look for sudden changes in behavior, elevated irritability or anger, withdrawal or secrecy, or noticeable drops in school performance or engagement.

"Everybody has bad days," Croom says. "What we're talking about is a discernible, sustained shift from a young person's baseline. When you see that, it's okay – and important – to check in."

However, the way the question is presented matters.

"Stating 'I've noticed some changes in you and I care about you. Is everything okay?' is better than 'What's wrong with you? Why are you doing this?' That difference in tone can make or break whether a young person opens up," Croom notes.

STIGMA AND OTHER BARRIERS TO CARE

If adolescent SUD is prevalent, why don't more youth and families receive care?

Croom points first to stigma.

"Addiction is a disease," he stresses. "We say that, but we don't always treat it that way. People with diabetes or heart disease can usually talk more openly and access care more readily. Substance use disorder is often criminalized or moralized, especially for youth. Families feel ashamed. Young people feel ashamed. And they don't seek help."

That stigma doesn't just affect adolescents – it shapes family behavior, too. Caregivers may hesitate to tell schools, churches or community networks what's going on, out of fear of judgment.

Beyond stigma, families can face transportation problems, insurance gaps or financial hardship, lack of providers trained in adolescent addiction, and even a simple unawareness of what treatment and support options exist.

The state is leaning into these gaps and is actively leading efforts to increase supports in North Carolina for youth with substance use disorder. One new initiative, Unshame North Carolina, is an NCDHHS-supported platform sharing resources and education designed to reduce stigma and improve understanding of substance use and mental health. In turn, and building on its three annual addiction medicine conferences, the Governor's Institute is expanding training for behavioral health professionals, offering scholarships and support for counselors to become addiction specialists, social workers to pursue advanced addiction training and behavioral health providers to access motivational interviewing training and other evidence-based skills.

"It's complex work," Croom says. "Adolescent SUD, co-occurring mental illness, trauma, brain development, family dynamics – it's a lot. Although most adolescent SUD goes untreated, awareness is increasing and we see data on effective treatments. We know there is real hope." ■

WHEN SUBSTANCE USE BECOMES A WORKFORCE ISSUE

Inside Wilson County's Community-Led Model

BY CAROLINE BARNHILL

For many employers in North Carolina, substance use disorder shows up long before it ever becomes a policy conversation. It is felt when a shift goes uncovered, when a workplace accident raises safety questions, or when a trusted employee starts missing work to care for a family member who is struggling.

Barton College holds a "Welcome Back Barton" day during their first week of school; It is a community vending fair to expose students to community resources. WCSPC provides medication lock boxes and medication disposal kits, and also holds Narcan training for the campus resident advisors, in collaboration with the college's health department and EMS. Photo courtesy of Anna Godwin.

In Wilson County, a mid-sized, semi-rural community east of Raleigh, local leaders decided early on that substance use could not be addressed piecemeal or in isolation. Instead of treating it as an individual failure, they built a coordinated, community-wide response that brings prevention, treatment access, harm reduction and recovery supports under one roof through the Wilson County Substance Prevention Coalition (WCSPC).

"There is no one-size-fits-all solution to addiction, and we can't fix the problem in silos either," said Anna Godwin, director of WCSPC. "Employers, schools, healthcare, law enforcement and local government all see different pieces of the same issue. Our job is to help those pieces work together."

A COORDINATED RESPONSE, BUILT LOCALLY

Wilson County has faced many of the same substance use pressures seen across North Carolina – from alcohol and tobacco misuse to prescription opioids and illicit drugs. The effects

Pictured above is Anna Godwin, Executive Director, Wilson County Substance Prevention Coalition.

reach far beyond individual users, shaping outcomes for families, schools, employers, healthcare systems and public safety.

The coalition's roots date back to 2007, when a local nonprofit brought together leaders from law enforcement, county management, education and the faith community to address substance misuse collectively. Within a year, the group formalized its governance, hired staff and adopted bylaws – laying the foundation for what has since grown into a full-continuum, community-based model.

What sets Wilson's approach apart, Godwin said, is not a single program but sustained coordination. Prevention, treatment navigation, harm reduction and recovery supports are intentionally linked, reducing the risk that people fall through gaps when they are ready for help.

"People don't experience life in categories," Godwin said. "So the response shouldn't be fragmented either."

PREVENTION AS CULTURE – NOT A CAMPAIGN

In Wilson County, prevention efforts are embedded in places where people already spend time: schools, community events, faith spaces and workplaces. Youth coalitions conduct environmental scans to assess exposure to tobacco and vaping marketing and track underage sales. Educational materials focus on safe medication storage and practical risk reduction rather than fear-based messaging.

The emphasis, Godwin said, is consistency across the lifespan – from adolescents learning about vaping risks to older adults reconsidering how medications are stored at home.

"When the message is reinforced by trusted adults, youth leaders and community partners all saying the same thing, prevention stops feeling like a program and starts functioning as a norm," she said.

MAKING IT EASIER TO ASK FOR HELP

One of the coalition's most visible initiatives is Hope Alliance, a partnership with the Wilson Police Department that allows people to seek help for substance use without fear of

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arrest or judgment. Individuals can walk in or reach out to request assistance, and coalition staff help connect them directly to treatment providers – often making initial calls alongside them.

Whenever possible, financial barriers are addressed through grant funding and community support, allowing many participants to access treatment at little or no cost. Over time, Hope Alliance has served people across a wide range of professions, reinforcing a central point: substance use disorder does not follow job titles.

More recently, WCSPC added a certified peer support specialist to its staff – someone with lived experience who can walk alongside individuals throughout treatment and recovery, including continued support after they return to the community.

"Sometimes it's easier to talk to someone who's been there," Godwin said. "That relationship can make the difference between staying engaged and dropping off."

WHY EMPLOYERS MATTER

Engaging local businesses has become an increasingly important part of Wilson County's strategy. Godwin is quick to note that this work is not about labeling certain workplaces or customer bases as "at risk."

"It could be anyone – an employee, a customer, a family member," she said. "This is about preparedness, safety and recognizing substance use as a health issue."

One early step has been naloxone (Narcan) training for bar owners and staff in Wilson's downtown social district. In partnership with the county health department and EMS, the coalition provides training on recognizing overdoses and administering naloxone, encouraging businesses to store it alongside AEDs and other emergency equipment.

Rhyan Breen, chief financial officer and chief legal officer for Wilson-based Brewmasters, Inc., participated in the training.

"Some may feel that participating in this training somehow invites or signals to the community-at-large that we sanction drug use. That is incorrect – like believing you invite your car battery to die because you have jumper cables in your trunk," he said. "It is my hope to curb that stigmatization and help provide our local industry members with the tools they need if they are put in the position where they need to help a patron, employee or someone who just happens by."

The Wilson County Substance Prevention Coalition team and members of the North Carolina Department of Health and Human Services meet with members of the Wilson Warbirds to discuss partnership opportunities. Back Row (L to R): Lori Winstead (Wilson Deputy County Manager), Jeremy Clardy (Vice President of Ticket Sales, Wilson Warbirds), Ann Marie Webb (NCDHHS), David Lawrence (General Manager and Vice President of Business Development, Wilson Warbirds), Anna Godwin (WCSPC), Kelly Crosbie (NCDHHS), Don Mrdjenovic (NCDHHS), Anna Harris (WCSPC), and Adam Barnard (NCDHHS) Front Row (L to R): Melissa Hayes (Wilson County Health Department), Olivia Mudd (NCDHHS), & Liz King (Vice President of Food & Beverage, Wilson Warbirds). Photo courtesy of Anna Godwin.

After the training, Breen ensured purple Narcan boxes were positioned in all his group's restaurants and met with his managers to explain what the kits contain, what to look out for to recognize opioid overdose and how to use them.

"It is my sincere hope that the kits gather dust and are only opened when we need to replace expired doses. But I am glad that we are prepared just in case," Breen said.

The coalition is also building relationships with the Wilson Warbirds, the city's new minor league baseball team, aligning substance use prevention with the organization's broader health and wellness efforts.

"We were deeply moved hearing about the great work that Anna and her team do each and every day," said David Lawrence, general manager and vice president of business development and operations. "The Wilson Warbirds look forward to potential opportunities to partner with the Wilson County Substance Prevention Coalition and help advance their vision and mission."

These community partnerships are key, explained Godwin.

"It's about finding common ground," Godwin said. "When you frame the issue of substance use and prevention around safety and wellness, people are much more open."

WHAT EMPLOYERS CAN DO – WITHOUT BEING EXPERTS

For business leaders unsure where to begin, Godwin's guidance is practical: you don't need to be a substance use expert to be supportive.

"What matters is knowing who to call and being willing to connect employees to resources," she said.

WCSPC and its partners offer employer trainings on recognizing signs of substance use, understanding legal and disability considerations, and developing workplace policies that support treatment access – including flexible scheduling for medication-assisted treatment appointments.

Smaller actions matter too: posting resource flyers in break rooms, sharing information about local recovery centers, or rethinking workplace norms around alcohol-centered events.

"Not everyone drinks, and for some people those settings are isolating," Godwin said. "Offering inclusive options signals that recovery is respected."

MEASURING IMPACT – NUMBERS AND STORIES

The coalition's work is guided by data, including regular needs assessments, school-based surveys and analysis of county and state health indicators. Wilson County's overdose rates remain lower than many comparable rural areas, and the distribution of prevention and harm reduction materials continues to grow.

Still, Godwin said the impact is often most visible in individual stories – such as a former Hope Alliance participant who later became a certified peer support specialist.

Another defining feature of Wilson County's approach is strong local government support, including strategic use of opioid settlement dollars to fund recovery housing, treatment access, naloxone distribution and coalition infrastructure. "The county didn't just endorse the work – they invested in it," Godwin said. "That level of buy-in gives us room to adapt as needs change."

Godwin is careful not to present Wilson County's model as a one-size-fits-all solution. Every community, she said, must respond to its own assets and challenges. But several lessons translate well: sustained collaboration, willingness to innovate, engagement across the full continuum of care and intentional inclusion of employers. ■

Tarang at the Chinese American Friendship Association's Lunar New Year Gala. Photo courtesy of Pooja Mehta.

BUILDING ASIAN AMERICAN MENTAL HEALTH SUPPORTS ACROSS NORTH CAROLINA

A Q&A with Pooja Mehta, Founder and Director of Tarang

BY CAROLINE BARNHILL

Across North Carolina, conversations about mental health are becoming more visible – but many Asian American communities remain underserved by systems that were never designed with their languages, cultures or lived experiences in mind. Tarang, a new initiative supported by the North Carolina Department of Health and Human Services (NCDHHS), is working to change that by meeting communities where they already gather and by tackling the culture of silence that has long surrounded mental health, substance use and suicide in Asian American communities. We spoke with Tarang's founder and director, Pooja Mehta, about her personal path to this work, why culture change must come before clinical care, and how community-led approaches can reshape North Carolina's mental health landscape.

Pooja Mehta, Founder and Director, Tarang.

Share a bit about your background and how you came to this work.

I've been working in mental health advocacy and policy for about a decade, and for me this work is deeply personal. I was diagnosed with anxiety and auditory hallucinations when I was 15, growing up in the Triangle as part of a tight-knit South Asian community. My parents were incredibly supportive and helped me get care early, but once I received my diagnosis, one of the first things I was told was not to tell anyone.

My parents knew that most of our social, cultural and religious connections were through the temple, and that if people knew I was dealing with mental health challenges, I could lose relationships that were foundational to my life. That reinforced a message that stuck with me for years: as an Indian American, I couldn't have mental health challenges. I disengaged

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from care for the first several years after my diagnosis.

I often think about how different my experience could have been if my community had been a safe place to process what I was going through. More recently, I lost my brother to suicide in March 2020, and navigating that loss within my community was another powerful reminder of how damaging silence and stigma can be. People gossiped about what happened instead of recognizing that this was someone's real life, someone's family.

When I later worked in policy and political strategy in Washington, D.C., I noticed that Asian Americans were almost entirely absent from conversations about building better mental health systems. It became clear to me that if our communities aren't speaking up about our struggles, decision-makers won't assume we need help. All of those experiences came together and pushed me to focus on changing culture within our communities so that people feel safe asking for support – and so that systems are finally designed with us in mind.

What is your educational background, and how does it shape your approach?

My background is in public health. I did my undergraduate work at Duke and earned my master's in public health at Columbia – I actually started that program in fall 2019, right before COVID. Watching the mental health crisis unfold during the pandemic from a public health lens was eye-opening.

I remember seeing a video of a woman who had been prescribed anxiety medication after losing her job and facing homelessness. She held up the pill bottle and said, "This isn't going to fix what's actually wrong." That moment stuck with me. We talk a lot about investing in mental health services, but suicide and overdose rates continue to rise. We're building better nets to pull people out of the water while ignoring the broken bridge that's causing people to fall in.

That perspective drives my work. Mental illness and substance use disorders are clinical diagnoses that affect some people, but the stressors that lead people there – isolation, financial strain, identity conflict – are incredibly common. Until we address those upstream factors in culturally meaningful ways, we're not going to see real change.

Tarang had an activity at Hum Sub's Holi celebration that assessed community sentiments towards mental health while leaning into the fun of the festival. Photo courtesy of Pooja Mehta.

What is Tarang, and what led to its creation?

Tarang is an initiative supported by NCDHHS. Our mission is to address the culture of silence and shame around mental health, substance use and suicide in Asian American communities across the state.

A lot of mental health work focuses on connecting people directly to care – listing therapists, clinics or hotlines. That's important, but people won't engage with services if the topic itself doesn't resonate with them. Tarang focuses first on culture change. We partner with trusted community leaders – not clinicians – from specific communities, like Chinese, Indian, Nepali and Cambodian communities. These are people who see the harm silence causes and want to do something about it. We hope to expand to other Asian American communities as we grow.

Together, we find ways to integrate mental health conversations into existing cultural spaces – festivals, religious gatherings, heritage celebrations – and to deliver information in ways that feel familiar, accessible and respectful. Once people feel safe engaging with the topic, then we connect them to resources and services that already exist, and pathways to provide services that don't.

What does the name "Tarang" mean?

It means "ripple effect." The idea is that if you empower individuals to become safe spaces – giving them language and tools to talk about mental health – that impact ripples outward to families, social networks and entire communities. Over time, culture shifts.

What gap is Tarang designed to fill in North Carolina's mental health landscape?

Asian Americans, for instance, are the least likely demographic to receive mental health services and the least likely to be diagnosed, even though research suggests we experience distress at rates similar to other populations. Symptoms often present differently – people might talk about stomach pain instead of anxiety, for example – so even outreach efforts can miss us entirely.

Tarang fills the gap by bringing communities to the table and letting them define what support should look like. In the Indian community, we're seeing conversations around domestic labor, caregiving and relationship dynamics. In the Cambodian community, identity and belonging are central themes. Those differences matter, and systems need to respond to them.

Why is it important not to treat the Asian American community as a single group?

The term "Asian American" itself covers people with roots in a third of the globe and nearly half the world's population. Within that are different languages, religions, histories and migration stories. Even within one country, there can be enormous diversity.

When we flatten all of that into a single checkbox, we erase identities – and that erasure contributes to mental health challenges. Being intentional

about which communities we're serving and how we serve them allows us to design approaches that actually work.

How does Tarang help elevate community voices to statewide decision-making bodies?

A big part of my role is helping people navigate systems they've never been invited into. Many community members don't even know that things like the state's Lived Experience Advisory Council exist, much less how to apply.

When I meet people who have lived experience and want to make a change, I can help them put their names forward, connect them with decision-makers and ensure Asian American perspectives are represented. Right now, Asian American voices are largely missing from these spaces – not because we don't care, but because we've never been asked.

Why focus on hosting mental health conversations in existing community spaces?

Most Asian Americans who are already interested in mental health are engaged – that's maybe 20% of the population. The other 80% aren't going to attend a webinar labeled "mental health." But they will attend a cultural festival, a religious gathering or a heritage event.

So we meet people there. For example, at a Chinese American gala around Lunar New Year, we used traditional red envelopes filled with affirmations and self-care practices rooted in cultural traditions like tai chi or tea ceremonies. It reframes mental health as something familiar, not foreign or clinical.

How is Tarang expanding access to mental health resources across the state?

Right now, we maintain a growing digital directory of resources available to Asian American communities, including services that aren't culturally specific but are immediately accessible. We're very clear: don't let perfect be the enemy of the good. If someone needs help today, getting care – even if it's not perfectly tailored – matters.

At the same time, we're educating communities about how systems work and pushing systems to adapt. That pressure from both sides is how change happens.

How will what you're learning be shared back with the state?

We're tracking themes from community engagement, surveys and conversations and sharing those insights with the NCDHHS and partners. Some needs are big and systemic, like language access to providers. Others are very actionable, like making 988 materials available in Mandarin.

By consistently feeding this information back, we can chip away at barriers rather than feeling paralyzed by how big the challenges are.

What themes are you expecting to hear most often as this work continues?

Identity and belonging come up again and again – especially intergenerationally. Talking about mental health can feel like an "American" concept that threatens cultural identity. A lot of this work is about reframing: showing that caring for mental health doesn't mean giving up who you are.

Many of these challenges aren't solved solely through clinical care. They require education, community dialogue and mutual support – things that public systems don't always know how to address but desperately need to understand.

Looking ahead, what gives you the most hope?

Asian American cultures are deeply collectivist. We already rely on community for so much – weddings, caregiving, daily life – and it's a huge protective factor for us. If we can also rely on community for mental health support, especially preventive support, that's transformative.

Success for me looks like communities where people can share what they're going through and be met with care – and where others step up as peer supporters before crises escalate. That kind of culture change takes time, but once the seed is planted, it grows in ways systems alone never could. ■

Tarang's founder Pooja Mehta with members of the Cambodian Legacy Project following a roundtable discussion on mental health and Cambodian culture. Photo courtesy of Pooja Mehta.

Tarang's Partnering Organizations

Asian American Foundation for the Carolinas
CACEN Colorado Asian Culture & Education Network
CAFA
CLP Cambodian Legacy Project
Carolinas Asian American Chamber of Commerce
El Futuro
Governor's Institute – NC Department of Health and Human Services
Indian American Impact
my change AGENT
HUM SUB Bringing Communities Together
NAAPIMHA National Asian American Pacific Islander Mental Health Association
North Carolina Asian Americans Together
the bean flower
The Farm at Penny Lane – hope grows here
UCA WAVES Wellness Advocacy Voices Education Support 美国华人联盟心理健康组织

No matter your struggle, you are not alone.

The 988 Suicide and Crisis Lifeline is free, private and here to help. Whether feeling lonely, depressed, anxious or thinking about hurting yourself, you'll get support that can make a difference.

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Call, text or chat 988 — anytime.

988lifeline.org

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