



mosaic
GROUP

Behavioral Health Landscape Analysis

NEW HANOVER COMMUNITY ENDOWMENT
AUGUST 2026





About Mosaic Group

Who we are: Management consultants dedicated to achieving health equity by strengthening the capacity of systems and organizations to meet their community's most pressing needs.

Our Approach: We innovate sustainable, whole health solutions—tailored to the unique needs of each community we serve—to improve health and well-being.

Table of Contents

Section	Slide Number
Background & Methodology	<u>4</u>
Community Context & Place-Based Analysis	<u>8</u>
Behavioral Health Needs Assessment	<u>16</u>
Behavioral Health Assets & System Gaps	<u>32</u>
Stakeholder & Community Voices	<u>39</u>
Funder Landscape & Tested Models	<u>48</u>
Strategic Investment Considerations	<u>53</u>
Implementation Overview	<u>71</u>

Background & Methodology

Engagement scope, data sources, and analytical framework

Background and Context

ABOUT THE ENDOWMENT

The New Hanover Community Endowment (The Endowment) was established from the proceeds of the sale of the New Hanover Regional Medical Center to Novant Health.

The Endowment drives its mission of improving the health, education, safety and economic opportunity of every New Hanover County resident through its core pillars:

Social &
Health Equity

Education

Community
Safety

Community
Development

Behavioral health is cross-cutting across all four pillars intersecting in areas such as homelessness, education, criminal justice, workforce, and economic mobility.

PURPOSE OF THE LANDSCAPE ANALYSIS

New Hanover County has made intentional, sustained strategic investments in mental health and substance use care through its Mental Health and Substance Use Disorder Fund.

Building on that work, The Endowment conducted this analysis to strengthen understanding of behavioral health needs and system conditions countywide and to guide a strategic grantmaking approach.

- Assess the current mental health and substance use system of care
- Identify strengths, gaps, and structural barriers affecting access
- Incorporate perspectives from providers, community partners, and residents
- Examine behavioral health within the broader context of community wellbeing
- Provide analytical insight to guide future Board decision-making

Behavioral Health Landscape Analysis Components

Six integrated components structured to produce a comprehensive, equity-informed analysis of New Hanover County's behavioral health landscape

01

Quantitative Data Analysis

Comprehensive analysis of data from national, state, and local sources including ED and hospital utilization, Trillium claims, crime, homelessness, academic achievement, overdose rates, and demographics from the Census Bureau's American Community Survey (ACS)

02

Community Stakeholder Engagement

Interviews with 60+ stakeholders and 6 community listening sessions across community-based service organizations, providers, government, schools, and families to surface strengths, gaps, and structural barriers

03

Ecosystem & Service Mapping

Inventory of 95+ organizations mapped by service type, population, ZIP codes, and insurance — with NC Trillium Tailored Plan network and Medicaid taxonomy analysis

04

Strategic Plan Alignment

Alignment to The Endowment's Strategic Refresh and the County's Mental Health and Substance Use Disorder Strategic Plan, situating behavioral health across The Endowment's Social and Health Equity, Education, Community Safety, and Community Development pillars

05

Funder Landscape & Evidence Review

Comparative scan of national and NC funders (SAMHSA, HRSA, Trillium, Medicaid, philanthropy) and review of evidence-based social and behavioral health strategies

06

Analysis & Opportunities

Synthesis of findings into strategic investment opportunities, workforce and equity considerations, and alignment to The Endowment's grantmaking priorities building upon and leveraging the County's existing investments in behavioral health

Project Scope and Methodology

The methodology was composed of a multi-level, spatial, and equity-focused analysis (ZIP Code → County → State → National)

DATA SOURCES AND METHODS

- Assess the current mental health and substance use system of care
- Conduct 60+ stakeholder interviews across community-based service organizations, providers, government, schools, and families
- 6 community listening sessions: high school students, postpartum women, caregivers of young children, school staff, justice-involved individuals, and employers of behavioral health workers
- ED utilization analysis (NC DETECT), overdose data, Homeless Management Information System (HMIS) and Point-in-Time (PIT) counts, and housing gap data
- Census/ACS demographic analysis at ZIP code level
- Provider inventory: 95+ organizations mapped by service type, population, zip code, and insurance
- NC Trillium Tailored Plan network review and Medicaid service taxonomy analysis
- Post-acute psychiatric continuum gap analysis (NC Medicaid service definitions vs. local availability)
- Criminal justice / Iryna's Law impact assessment

ANALYTICAL FRAMEWORK

- **Institute of Medicine Continuum of Care**
Mapping of Promotion → Prevention → Treatment → Recovery Services
- **Post-Acute Continuum Analysis**
NC Medicaid taxonomy vs. New Hanover County asset map gaps
- **Evidence-Based Model Review**
e.g. street medicine, peer recovery supports, residential step-down programs
- **Funder Landscape Scan**
SAMHSA, HRSA, Trillium, Medicaid, County and state funding, and local philanthropy
- **Workforce Ecosystem**
Pipeline, training, supervision, burnout, retention, and administrative burden
- **Disparity Analysis**
Outcomes by race, ethnicity, age, and socioeconomic status
- **Criminal Justice Pathways**
Iryna's Law, re-entry continuity, forensic capacity

Community Context & Place-Based Analysis

Demographics, ZIP code disparities, housing, and access.

New Hanover County: One Community, Uneven Ground

Understanding who lives here — and where — is the essential starting point for any place-based investment strategy

~240K

2024 Estimated Total County Population
Fastest-growing North Carolina Coastal County

\$116K Gap

Median income **difference** within county
(range \$54K to \$172K)

31-Year Span

Median Household Age **varies by 31.1 years**
across ZIP codes.
(NHCo Median age = 41 years old)

12.3%

Average Poverty Rate
(vs. 13.4% North Carolina Average)

A COUNTY OF MANY COMMUNITIES

Age Structure	County skews older (22–24% age 65+), yet 28403 has a median age of 28.5 — a 30-year span within the same county
Racial Composition	Predominantly White non-Hispanic county-wide; Black, Hispanic, and other communities concentrate in urban core ZIPs, particularly 28401
Income Span	Median income ranges from under \$54K to over \$172K across ZIP codes — all within the same county boundary
Population	28412 is the largest ZIP (44,166 residents); coastal ZIPs 28449 and 28480 have fewer than 3,000 residents each
Rural Enclave	28429 (Castle Hayne): 9,662 residents, 18% poverty, limited transit — geographic isolation creates distinct structural conditions

WHY A PLACE-BASED LENS IS ESSENTIAL HERE

- When data is reported at the county level, high-need communities can be averaged in with lower-need ones, and the result may look more manageable than the underlying reality. A place-based lens helps disaggregate the data to suggest where conditions may be most acute.
- Structural conditions such as income, housing stability, insurance coverage, and social isolation tend not to distribute evenly. They often concentrate in specific communities and can compound one another.
- A community with high poverty, limited insurance, unstable housing, and low social connectedness may face a substantially different structural starting point than a more affluent coastal ZIP.
- Place-based investment can help reach people where structural risk concentrates, rather than only where services are most visible or easy to deliver.
- Data points in this analysis are best viewed through a geographic lens. Where someone lives typically shapes their access, their risk, and the conditions that precede health outcomes.

Key Finding: New Hanover County is not one community, it is multiple, with vastly different structural starting points. County-level averages mask the concentrated vulnerability that only a ZIP-level lens can reveal and that only a place-based strategy can address.

Ten ZIP Codes, Ten Structural Realities — and the Differences Between Them Are Not Marginal

A \$57,000+ income gap between the lowest- and highest-income urban ZIPs, a 30-year age span, and poverty rates ranging from 4% to nearly 25%

High Level of Vulnerability

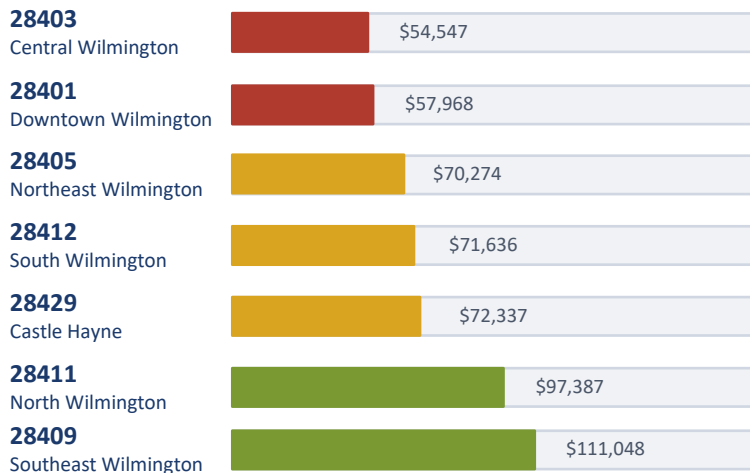
ZIP CODE	POPULATION AREA	POPULATION	MEDIAN AGE	MEDIAN INCOME	UNINSURED	COMMUNITY STRUCTURE
28401	Downtown Wilmington “Northside, Southside, Brooklyn Arts”	22,007	41.7	\$57,968	3.2%	Second-lowest median income; second-highest poverty; greatest racial diversity in the county
28403	Central/Midtown Wilmington “Forest Hills, Oleander, Winter Park”	40,319	28.5	\$54,547	7.0%	Lowest median income, youngest age; densest population; highest uninsured rate in urban area; highest poverty level
28405	Northeast Wilmington “Murrayville, Kings Grant”	35,467	38.0	\$70,274	4.7%	Mixed-income; embedded deprivation pockets in specific neighborhoods
28409	Southeast Wilmington “Masonboro, Bradley Creek”	36,163	43.2	\$111,048	1.8%	Highest-income ZIP in urban area; lowest structural vulnerability
28411	North Wilmington “Ogden, Porters Neck, Scotts Hill”	37,233	42.1	\$97,387	0.0%	Affluent suburban; moderate population; lowest uninsured rate among primary ZIPs
28412	South Wilmington “Monkey Junction, Myrtle Grove”	44,166	40.8	\$71,636	4.6%	Largest population in county; moderate income; moderate poverty
28428	Carolina Beach “Wilmington Beach, Pleasure Island”	7,136	53.2	\$93,241	12.0%	Third-highest income; small population; highest uninsured rate among ZIP codes
28429	Castle Hayne (Rural Community)	9,662	43.8	\$72,337	6.3%	Rural enclave; high poverty; geographic and transportation barriers; limited-service access
28449	Kure Beach (Beach Community)	2,131	57.2	\$107,563	4.7%	Second-oldest median age; third highest income in county
28480	Wrightsville Beach (Beach Community)	2,776	59.6	\$172,500	0.0%	Oldest median age; highest income in county; lowest uninsured

Key Finding: *The structural conditions that shape behavioral health risk such as income, poverty, age, insurance coverage, vary dramatically across ZIP codes that are minutes apart. These are not marginal differences; they represent fundamentally different environments in which residents live, work, and seek care.*

Economic Conditions and Insurance Gaps Do Not Distribute Evenly, They Cluster and Compound in the Same Communities

A community with low income, high housing costs, and low insurance, is not just economically constrained, it is structurally distanced from behavioral healthcare

MEDIAN HOUSEHOLD INCOME BY ZIP (SEE APPENDIX)



■ Highest structural vulnerability ■ Moderate ■ Lower vulnerability

INSURANCE COVERAGE & STRUCTURAL BARRIERS (SEE APPENDIX)

28403 — Uninsured rate	7.0%
Highest in county; compounds access barriers in youngest, densest ZIP	
28429 — Uninsured rate	6.3%
Uninsured pockets in rural areas face compounded barriers to accessing care	
28405 — Uninsured rate	4.7%
Many in a coverage gap—income too high for Medicaid and too low to afford coverage	
28412 — Uninsured rate	4.6%
Moderate coverage gap in county's largest population ZIP	
28401 — Uninsured rate	3.2%
High poverty amplifies the coverage gap in highest-need community	

POVERTY RATES (SEE APPENDIX)

28403 — Poverty rate	24.8%
High poverty and large population drive demand that outpaces available resources	
28401 — Poverty rate	18.6%
Moderate overall but concentrated deprivation in specific neighborhoods	
28429 — Poverty rate	17.9%
Rural ZIP; geographic and transportation barriers layer onto income constraints	

Key Finding: . The ZIP codes under the greatest economic pressure also face the largest coverage gaps. In rural 28429, lack of transit further limits access to care. These are not separate problems — they are compounding structural conditions that accumulate in the same communities.

Racial Composition Varies Significantly by ZIP — Variations Align with Structural Disadvantage, Not Demographics Alone

Where racial diversity concentrates in New Hanover County, so too do poverty, lower insurance rates, and reduced access to services

RACIAL COMPOSITION BY GEOGRAPHIC CLUSTER (SEE APPENDIX)

Urban Core — 28401

Poverty rate of 24.8% — among the highest in the county, 2nd lowest median income in the county. Also has the county's highest concentration of Black residents, a pattern that may reflect long-standing structural factors.

Central & NE — 28403, 28405

28403 is the most racially diverse of the denser ZIPs. 28405 contains specific neighborhood pockets (e.g., Creekwood area) with concentrated minority populations and poverty despite a moderate overall ZIP-level income.

Suburban ZIPs — 28409, 28411, 28412

Predominantly White non-Hispanic. Lower poverty rates and higher incomes. 28412, despite being the largest ZIP in the county, shows more homogeneous racial composition with moderate structural risk overall.

Rural & Coastal — 28429, 28428, 28449, 28480

28429 has somewhat higher racial diversity among rural ZIPs and the second-highest poverty rate in the county at 18%. Coastal ZIPs are predominantly White non-Hispanic with the lowest poverty and highest incomes in the county.

WHERE STRUCTURAL CONDITIONS CONCENTRATE (SEE APPENDIX)

Income & Poverty Align with Race by ZIP

The three ZIPs with the highest poverty rates — 28401 (24.8%), 28403 (21.1%), and 28429 (18%) — also have the highest proportions of residents of color. These patterns reflect longstanding differences in where economic opportunity, housing access, and community investment have concentrated.

Insurance Gaps Compound Racial Disparities

28403 (12% uninsured) and 28401 (7% uninsured) — the county's two most diverse ZIPs — carry the highest uninsured rates. Limited insurance coverage reduces access to services, creating structural barriers that fall disproportionately on communities of color.

Geographic Isolation Compounds Racial Access Gaps

28429 — 18% poverty, sparse transit, limited proximate services — face barriers driven by geography, not volume. 28401, the most racially diverse ZIP, combines the highest poverty rate with among the highest uninsured rates, layering multiple structural barriers in one community.

Key Finding: *Racial diversity in New Hanover County is not evenly distributed—communities of color are concentrated in specific ZIP codes where structural conditions also tend to cluster.*

When Kids Aren't in Class, They are at High Risk for Falling Behind

The schools carrying the most strain cluster in the same parts of the county, from elementary through high school

ELEMENTARY SCHOOLS — SCHOOL PERFORMANCE GRADE BY ZIP (Sorted: Lowest → Highest)					
SCHOOL (1–13)	ZIP	GRADE	SCHOOL (14–25)	ZIP	GRADE
Rachel Freeman Sch. of Eng.	28405	F	Eaton Elementary	28411	B
Sunset Park Elementary	28401	D	Murrayville Elementary	28411	B
Wrightsboro Elementary	28401	D	Porters Neck Elementary	28411	B
Alderman Elementary	28403	D	Anderson Elementary	28412	B
College Park Elementary	28403	D	Bellamy Elementary	28412	B
Forest Hills Global Elem.	28403	D	Codington Elementary	28412	B
Blair Elementary	28405	D	Pine Valley Elementary	28412	B
Snipes Academy Arts & Design	28405	D	Carolina Beach Elementary	28428	B
Holly Tree Elementary	28409	C	Castle Hayne Elementary	28429	B
Mary C. Williams Elementary	28412	C	Masonboro Elementary	28409	A
Intl. School at Gregory	28401	B	Ogden Elementary	28411	A
Winter Park Elementary	28403	B	Wrightsville Beach Elementary	28480	A
Bradley Creek Elementary	28409	B			

Key Finding: 8 of 25 elementary schools earned a D or F — all concentrated in ZIPs 28401, 28403 & 28405. Zero schools in these ZIPs earned an A, signaling a geographic achievement gap that closely mirrors the county's highest-need communities.

HIGH SCHOOLS — ABSENTEEISM, DROPOUT & GRADUATION					
New Hanover High			Emsley A. Laney		
ZIP 28401			ZIP 28405		
CHRONIC ABSENT	DROPOUT RATE	4-YR GRAD RATE	CHRONIC ABSENT	DROPOUT RATE	4-YR GRAD RATE
38.08%	7.04%	82.3%	38.27%	6.14%	89.4%
1 in 3 students			1 in 3 students		
J.T. Hoggard High			Eugene Ashley High		
ZIP 28403			ZIP 28412		
CHRONIC ABSENT	DROPOUT RATE	4-YR GRAD RATE	CHRONIC ABSENT	DROPOUT RATE	4-YR GRAD RATE
25.71%	5.51%	89.0%	38.03%	5.41%	89.6%
			1 in 3 students		

Source: NC School Report Cards, New Hanover County 2023

Key Finding: 3 of 4 high schools exceed 38% chronic absenteeism. New Hanover High stands apart with the highest dropout (7.04%) and lowest graduation rate (82.3%) — a 7-point gap below its peers, concentrated in ZIP 28401.

Housing Instability is Not a Downstream Consequence Of BH Need — It is an Upstream Structural Driver That Precedes It

With severe housing problems in the 85th percentile and social connectedness in the 26th percentile, structural conditions shape behavioral health risk countywide

85th

Housing Severity Percentile (Statewide)
with 17.2% having severe housing problems

26th

Social Connectedness Percentile (Statewide)
9.92 Associations per 10,000

593

Persons Experiencing Homelessness (County)
Up 85% from 2014 to 2025

\$1,580

Fair Market Rent per Month
Requires ~\$30/hour wage to avoid cost-burden

WHAT THE STRUCTURAL CONDITIONS MEAN

- Being in the 85th percentile for housing problems means New Hanover County has more severe housing instability than 85% of NC counties — despite being one of the wealthier counties by average income
- Social connectedness at the 26th percentile means protective community ties — neighbors who check in, informal support networks, organizational belonging — are weaker here than in three-quarters of NC counties
- 53% of homeless individuals are unsheltered. Few shelter resources exist — some requiring ID, have limited capacity or serve specific populations, and others are only open during the daytime or during certain weather conditions. Shelter capacity has not kept pace with an 85% growth in homelessness since 2014
- 28401 (Downtown Wilmington) is the most common last permanent address among HMIS-enrolled individuals — the same ZIP with the county's lowest median income and highest poverty rate. This is not coincidence.

HOUSING AS PRE-CONDITION: NOT PARALLEL – UPSTREAM

- Housing instability is not what happens when behavioral health systems fail — it is what causes them to fail. Investment strategies that treat housing as downstream may not be comprehensive.
- Cost burden (spending >30% of income on housing) leaves fewer resources for food, transportation, and medications — creating cascading structural stress
- Social isolation, measured by the 26th percentile connectedness score, may remove the protective relationships that buffer against crisis across all age groups
- Racial disparities in homelessness mirror racial disparities in poverty: Black residents are disproportionately represented among HMIS-enrolled individuals relative to their county population share

Key Finding: *Housing instability is not what happens when behavioral health systems fail — it is what causes them to fail. Investment strategies that treat housing as downstream will miss the point entirely.*

Where You Live in the County Shapes Your Structural Starting Point — and Structural Starting Points Predict Health Outcomes

Four conditions emerge from the community context that frame how to read the behavioral health data that follows

01

Place Concentrates Disadvantage

Income, poverty, uninsured status, racial diversity, and housing instability do not distribute randomly across New Hanover County. They cluster — in 28401, 28403, 28412, 28429, and specific neighborhoods within 28405. A place-based lens is not an analytical preference; it is a structural reality.

02

Economic Conditions Are Compounding, Not Isolated

Low income does not exist alongside high uninsured rates by coincidence. It exists alongside high poverty, high housing cost burden, and limited transit access — because these conditions reinforce each other. Communities facing all of them simultaneously face qualitatively different structural barriers than those facing any one alone.

03

Racial Disparities Are Embedded in Geography

The county's disparities in income, insurance coverage, and housing stability concentrate in the same ZIP codes. These are geographic patterns — the same communities that face the greatest economic barriers also tend to face barriers in accessing services.

04

Housing & Social Isolation Are Upstream Conditions

At the 85th percentile for housing problems and 26th for social connectedness, the county's challenges may extend beyond clinical capacity — structural conditions can shape outcomes before and alongside any clinical response.

The behavioral health outcome data that follows is not a separate story. It is the measurable consequence of the structural conditions described in this section — place, income, housing, insurance, and social isolation. The patterns of crisis utilization and unmet need in the next section trace directly back to what this community portrait reveals.

Behavioral Health Needs Assessment

Substance use, mental health, crisis demand, and co-occurrence

Behavioral Health Landscape in New Hanover County

Understanding the scale, distribution, and drivers of behavioral health need provides the foundation for targeted philanthropic investment

+51%

Anxiety
hospitalizations

+46%

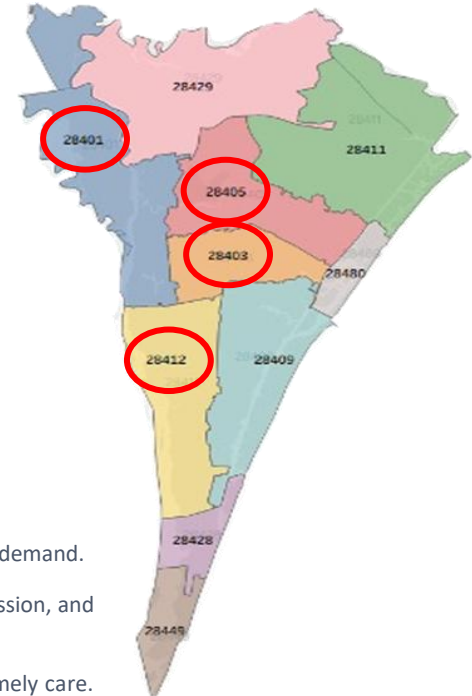
Depression
hospitalizations

+109%

Polysubstance
hospitalizations

4 ZIPs

Account for ~68%
of crisis demand



- Behavioral health need is geographically concentrated — four ZIP codes account for roughly two-thirds of crisis demand.
- Post-pandemic demand has accelerated, not stabilized — hospitalizations continue to rise across anxiety, depression, and substance use over this 5-year timespan.
- Crisis utilization reflects structural conditions: poverty, uninsurance, housing instability, and limited access to timely care.

Source: NC DETECT / NC State Center for Health Statistics / U.S. Census ACS, 2020–2024

Behavioral Health Need Has Increased Across Multiple Conditions

Sustained post-pandemic increases in hospitalizations — with direct implications for inpatient capacity, higher-level outpatient, and timely treatment access

51%

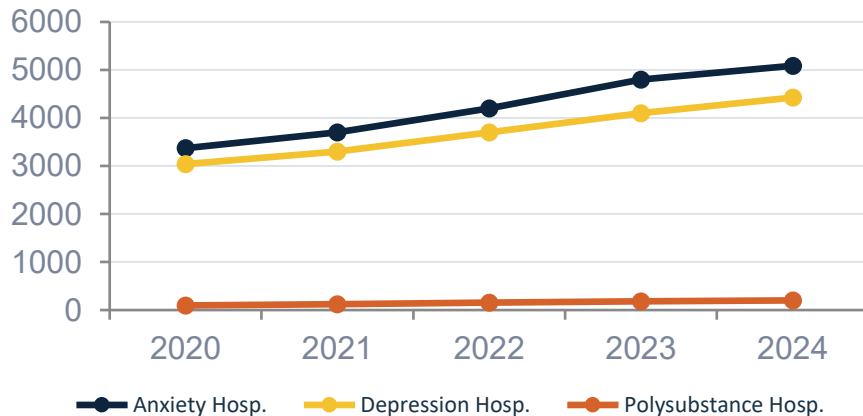
Anxiety Hospitalizations
3,371 → 5,088 (2020–2024)

46%

Depression Hospitalizations
3,040 → 4,426 (2020–2024)

109%

Polysubstance Use Hospitalizations
96 → 201 (2020–2024)



Source: NC DETECT / NC State Center for Health Statistics / U.S. Census ACS, 2020–2024

SYSTEM IMPLICATIONS

Pressures inpatient capacity

Rising anxiety and depression admissions are occupying acute psychiatric beds — tightening inpatient availability county-wide.

Signals need for rapid higher-level outpatient

Patients who cannot access inpatient residential treatment, PHP or intensive outpatient support quickly default to ED—avoidable with capacity in place.

Requires ready outpatient treatment

Sustained demand requires a higher-level outpatient infrastructure that can absorb step-downs and prevent re-admission cycles.

Key Finding: *Rising hospitalizations for anxiety, depression, and polysubstance use are not just an ED problem — they signal the need for an accessible, rapid-entry higher-level outpatient system that can intercept demand before it reaches inpatient level.*

Behavioral Health Crisis is Driven by Multiple Overlapping Conditions

Mental health and substance use disorders overlap to create complex behavioral health crises requiring hospitalization and coordinated response

Anxiety and Depression Dominate

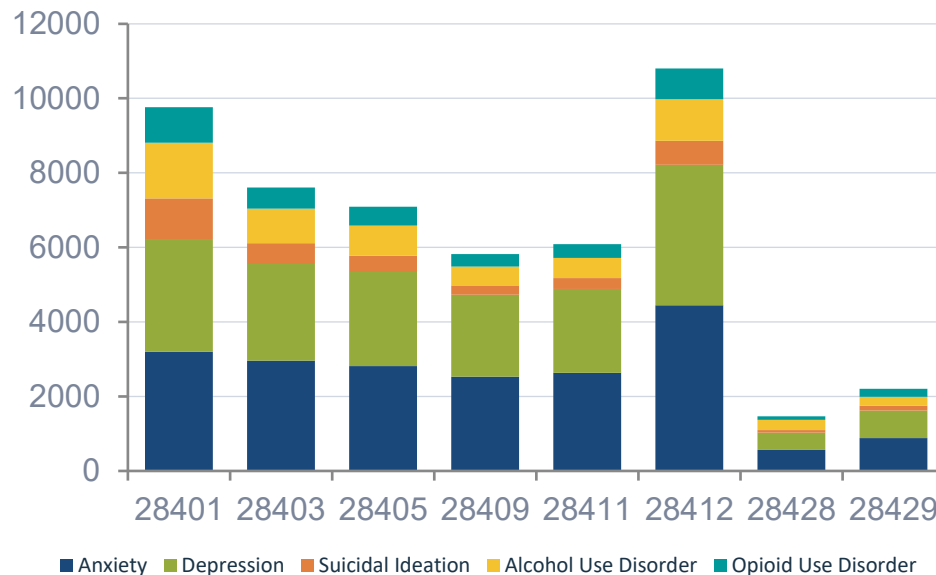
Anxiety and depression together account for the largest share of psychiatric hospitalizations in every ZIP code.

SUD Creates Parallel Demand

Alcohol and opioid use admissions run alongside mental health demand — with significant overlap in the same patient populations.

Co-Occurrence Drives Severity

Patients with co-occurring MH and SUD conditions have longer stays, higher readmission rates, and greater crisis acuity.

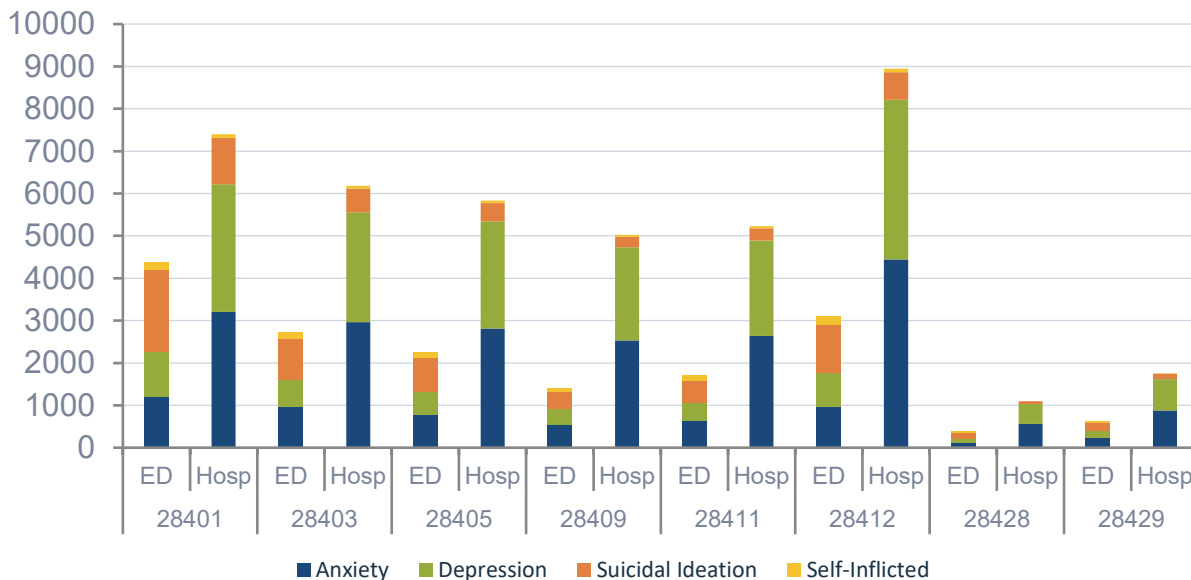


Source: NC DETECT / NC State Center for Health Statistics / U.S. Census ACS, 2020–2024

Key Finding: Anxiety and depression are associated with much of the inpatient volume; substance use creates parallel and intersecting demand. Recognizing the co-occurring nature of these conditions is key — investment opportunities should consider that many patients present with both.

Mental Health Crisis Demand Is Highly Concentrated

Four ZIP codes account for roughly two-thirds of all mental health ED visits and hospitalizations in the county



75%

of mental health
ED visits

68%

of hospitalizations

28401 • 28403 • 28405 • 28412

Source: NC DETECT 2020–2024

Source: NC DETECT / NC State Center for Health Statistics / U.S. Census ACS, 2020–2024

Key Finding: 28401, 28403, 28405, and 28412 are not just high-need — they function as crisis convergence zones where deprivation, access gaps, and co-occurring conditions intersect. Place-based investment in these four ZIPs reaches most of the crisis demand.

Severe Mental Illness (SMI) Also Produces High-Acuity Demand

Bipolar disorder and schizophrenia-related diagnoses are fewer in comparison, but high in acuity — and the gaps in post-acute care create dangerous cycling

SMI Typically Requires

- Inpatient hospitalization (acute stabilization)
- Crisis stabilization services
- Long-term care coordination

Post-Acute Gap — A Critical Missing Layer

Inpatient Residential Treatment / Housing Stabilization

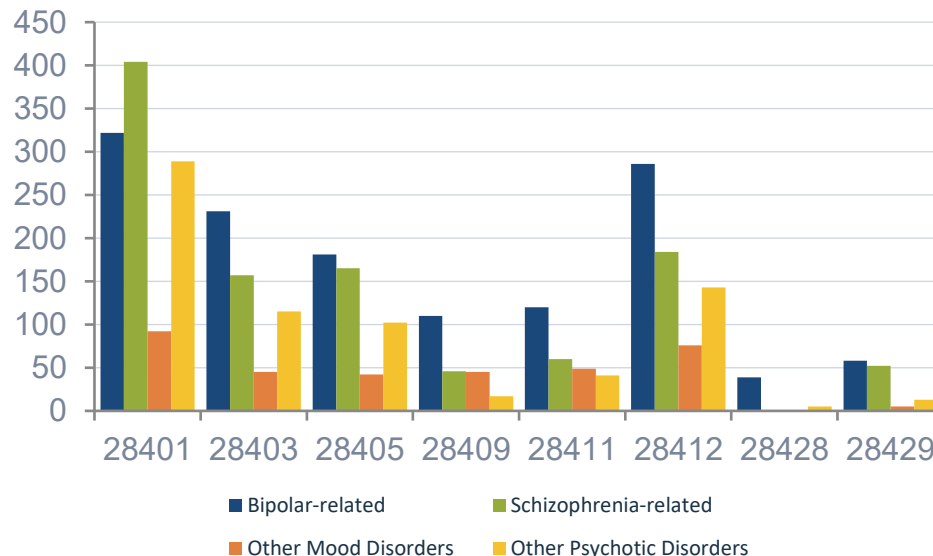
Step-down from inpatient is unavailable for most patients — leading to discharge back to crisis conditions.

Partial Hospitalization Program (PHP)

Structured day programming is the bridge between inpatient and outpatient care. Local capacity is limited, so few patients can step down at the intensity they need.

MH Intensive Outpatient (IOP)

MH IOP is mostly reachable via commercial insurance or a Medicaid In Lieu of Service (ILOS) through Wellcare. A billable or extended service would widen outpatient access.

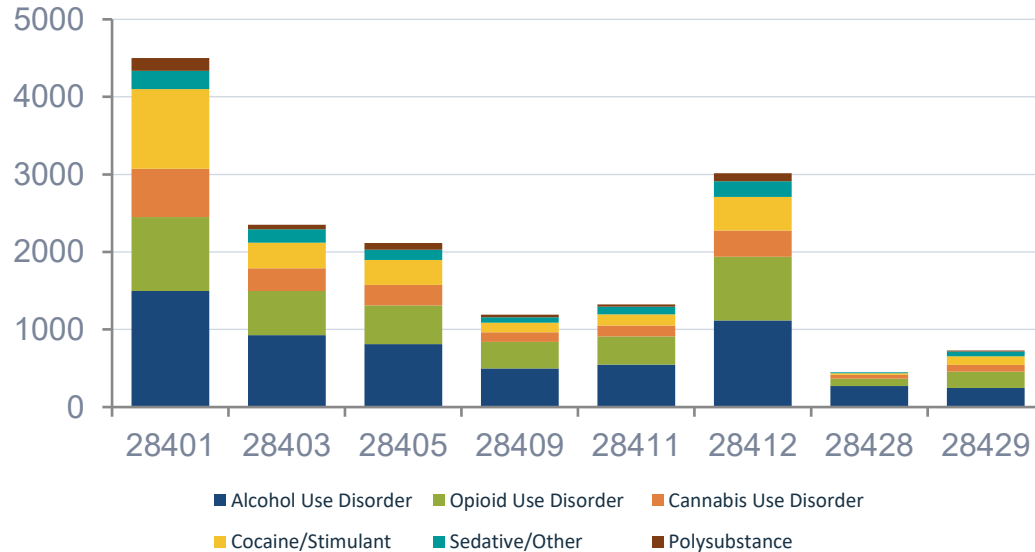


Source: NC State Center for Health Statistics, 2020–2024

Key Finding: *Bipolar disorder and schizophrenia drive high-acuity inpatient demand — but the critical gap is in what comes after: inpatient residential treatment, transitional housing, medical respite, permanent supportive housing, partial hospitalization, and MH intensive outpatient are limited or largely absent, leaving patients cycling back to crisis.*

Substance Use Disorders Create Parallel Crisis Demand

Substance use disorders represent a major parallel driver of behavioral health hospitalizations and emergency care



SUD AT A GLANCE

4,500

SUD hospitalizations from 28401 alone (5-year total)

2,515

Cocaine/Stimulant Use hospitalizations countywide (3rd largest SUD category)

48%

28401 and 28412 account for 48% of all county SUD admissions

Source: NC State Center for Health Statistics, Hospitalization Records 2020–2024

Key Finding: Alcohol and opioid use disorders account for the largest share of SUD hospitalizations across all ZIPs, with 28401 alone recording nearly 4,000 SUD-related admissions over five years. Polysubstance use is the fastest-growing category, signaling increasing complexity of crisis presentations.

Emergency Departments Carry Significant Crisis Burden

Emergency departments function as the primary entry point for behavioral health crises across the county

ED AS DEFAULT ENTRY POINT

Suicidal ideation — single largest crisis category

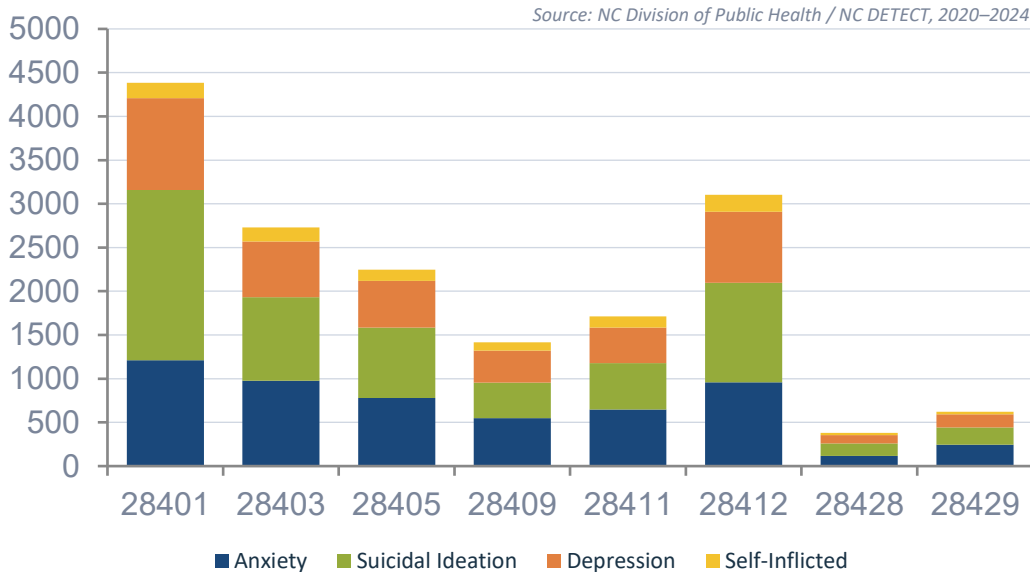
800+ visits in 28401 alone over 5 years.
Concentrated in 28401 and 28412.

Anxiety drives highest ED-to-admission rate

High acuity presentations funneled to ED,
potentially reflecting limited outpatient and higher-level care upstream.

28401 and 28412 carry majority of burden

Together account for over 38% of all county BH ED visits across all four categories.

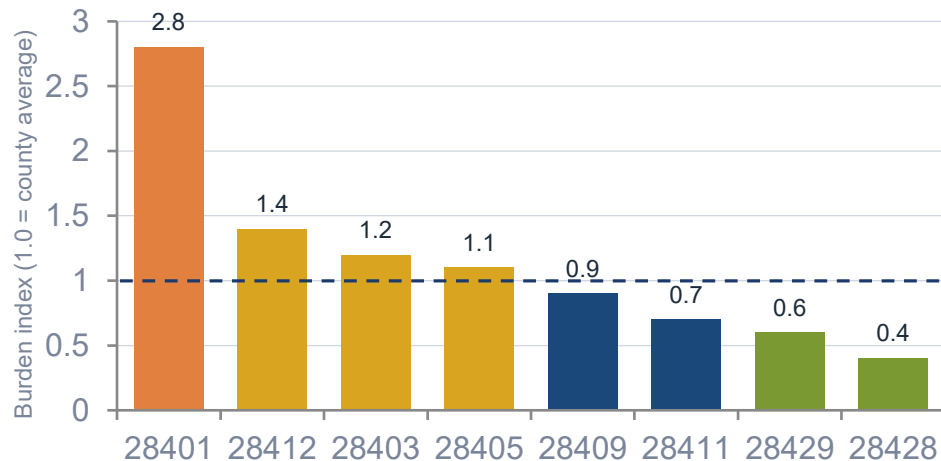


Key Finding: Anxiety, suicidal ideation, depression, and self-inflicted injury cluster disproportionately in 28401, 28412, and 28405. The ED is functioning as the system's default crisis stabilizer — a role that is both costly and clinically insufficient.

Downtown Wilmington Functions as a Crisis Convergence Zone

ZIP 28401 carries the highest behavioral health burden in the county — with nearly three times the average crisis rate.

Composite BH Burden Index by ZIP



Source: NC DETECT / NC State Center for Health Statistics / U.S. Census ACS, 2020–2024

How to read: The index compares each ZIP's population-adjusted BH service use to the county average. Above 1.0 = higher use; below 1.0 = lower use; 1.0 = parity

ZIP 28401 — STRUCTURAL DRIVERS

Second-Highest Poverty Rate (18.6%)

County average: 10.8%

Second-Lowest Median Income (\$57,968)

vs. \$172.5K in highest-income ZIP

Highest Racial Diversity

Greatest concentration of Black and Hispanic residents

Highest ED Utilization Volume

994 BH ED visits; 38% of county total with 28412

Multi-Diagnosis and Co-Occurrence

Highest overlap of MH, SUD, and suicidality in county

2.8× County Average Burden Index

Across both ED and inpatient metrics

Key Finding: 28401 is the county's crisis convergence zone — where poverty, diversity, and multi-diagnosis burden intersect at the highest levels. It requires the most intensive, integrated, and culturally responsive investment of any ZIP in the county.

High-Burden Communities Share Structural Characteristics

High behavioral health burden areas combine larger populations, higher poverty rates, and limited insurance access — conditions that compound crisis vulnerability

ZIP / AREA	POPULATION	POVERTY RATE	UNINSURED	BH BURDEN
28401 – Downtown Wilmington “Northside, Southside, Brooklyn Arts”	22,007	18.6%	3.2%	HIGH
28403 – Central Wilmington “Forest Hills, Oleander, Winter Park”	40,319	24.8%	7.0%	HIGH
28405 – Northeast Wilmington “Murrayville, Kings Grant”	35,467	13.8%	4.7%	MOD-HIGH
28412 – South Wilmington “Monkey Junction, Myrtle Grove”	44,166	11.2%	4.6%	MOD-HIGH
28409 – Southeast Wilmington “Masonboro, Bradley Creek”	36,163	4.3%	1.8%	MOD
28411 – North Wilmington “Ogden, Porters Neck, Scotts Hill”	37,233	4.3%	0.0%	LOW-MOD
28428 – Carolina Beach “Wilmington Beach, Pleasure Island”	7,136	6.1%	12.0%	LOW
28429 – Castle Hayne (Rural) “Wrightsboro”	9,662	17.9%	6.3%	ACCESS GAP

WHAT THE DATA SHOWS

Poverty amplifies crisis risk

28401 and 28403 — the two highest-poverty urban ZIPs — also carry the highest ED utilization and hospitalization rates. Deprivation is not a background variable; it is a direct driver.

Uninsurance compounds access barriers

Uninsurance—12% in 28403 and 7% in 28401—creates a key barrier to behavioral health and preventive care, funneling unmet need toward the ED as the default entry point.

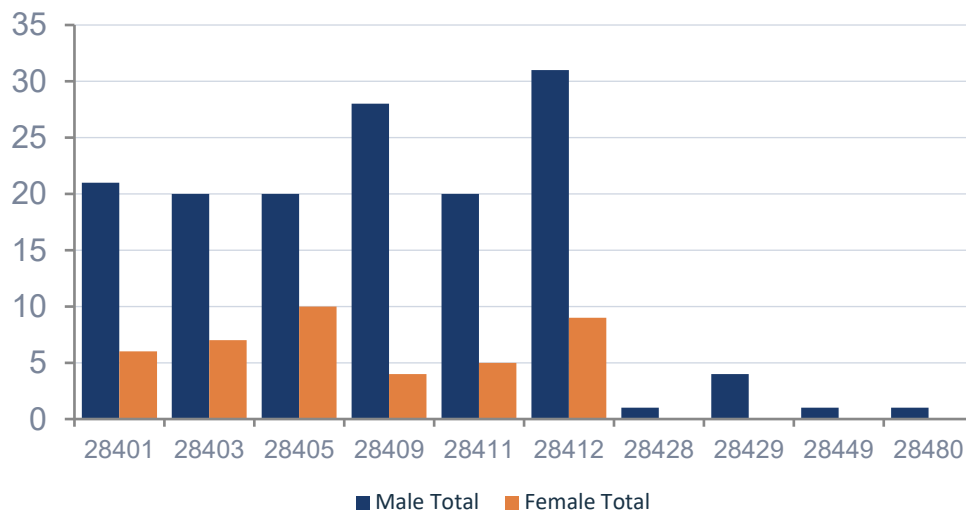
Rural poverty creates a different risk

28429 (18% poverty, limited transit) faces an access-gap risk profile — not high volume, but structural isolation. Targeted strategies are essential here.

Key Finding: *Many high BH burden ZIPs share similar conditions — poverty rates above 14%, elevated uninsured populations, and resources that may not fully meet local needs. These conditions are often measurable and can help guide targeted investment.*

Suicide Risk Is Concentrated Among Middle-Aged Adults

Suicide mortality disproportionately affects adults ages 45–64, particularly men — 2–7 times higher than female rates across ZIP codes



WHO IS MOST AT RISK

89 suicide deaths

New Hanover County, 2019–2023

Ages 45–64 most affected

Highest counts in 28412, 28401, 28409

Males 2–7× more likely

Greatest disparity in 28409; highest absolute burden in 28412

MOST COMMON CO-OCCURRING CIRCUMSTANCES

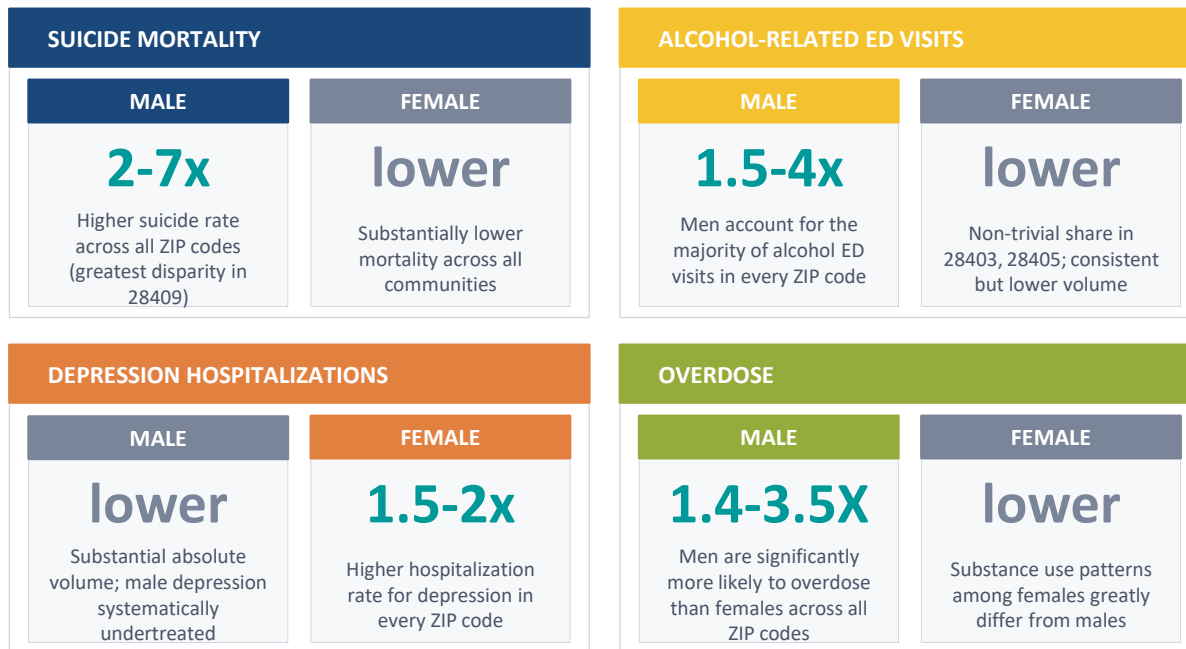
- Ever treated for mental health or SUD (~27 per yr)
- Currently diagnosed mental health problem (~26)
- Current treatment for MH or SUD problem (~18)
- Current depressed mood (~14)
- Alcohol problem present (~7)

Source: NC State Center for Health Statistics, 2020–2024

Key Finding: Males experience 2–7× higher suicide rates than females across all major ZIP codes. 28412 has the highest absolute burden; 28409 the largest gender disparity. Mental health diagnosis and SUD involvement are the most common co-occurring circumstances.

Behavioral Health Crisis Shows Clear Gender Disparities

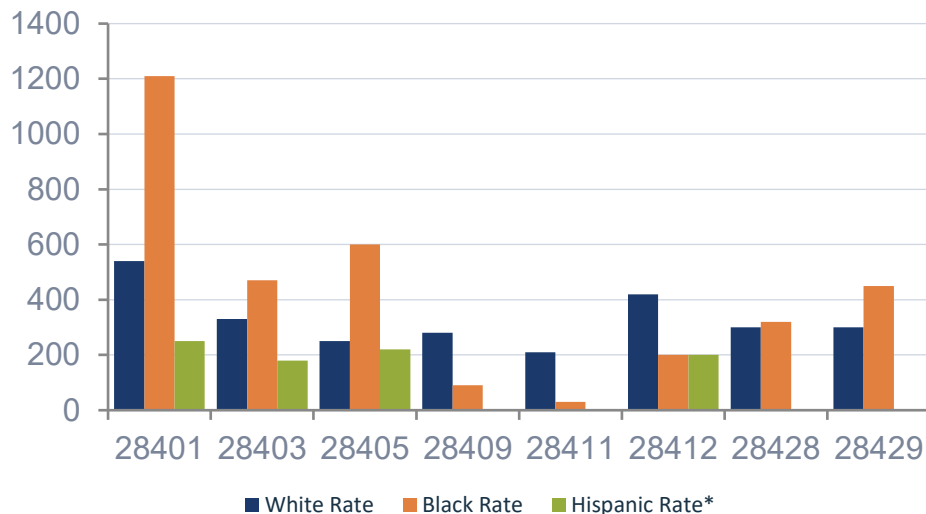
Men experience significantly higher overdose mortality and suicide risk; women show higher hospitalization rates for some mood disorders



Key Finding: Gender disparities in behavioral health are consistent and directional — men face far greater suicide and overdose mortality; women show higher mood disorder hospitalization rates. Gender-responsive programming is not optional; it is foundational to effective design.

Racial Disparities in Overdose Appear in Specific High-Burden Communities

Racial disparities in drug overdose outcomes are concentrated in specific communities — not distributed evenly across the county.



Crude rates per 100K ACS 5-year population | Source: NC DETECT / NC Division of Public Health, 2020–2024

*Hispanic rate suppressed where count <5

WHERE DISPARITIES CONCENTRATE

Higher overdose rate

2.2×

Black residents in 28401 vs. White residents — same ZIP, dramatically different burden.

Disparity epicenter

28401

Highest poverty and highest overdose rates among Black residents in the county.

Access, not biology

Equity

Disparities reflect structural barriers such as insurance gaps, housing and geographic access, not inherent risk.

Key Finding: Black residents in 28401 experience overdose ED rates 2.2× higher than White residents in the same ZIP. These disparities are driven by structural conditions including concentrated poverty, geographic access, and insurance gaps, and demand equity-centered investment.

Crisis Demand Splits Across Two Distinct Age Segments

Working-age adults 25–64 dominate acute crisis care, serious mental illness demand and SUD hospitalizations while older adults drive the majority of mood and anxiety disorder hospitalizations

TWO POPULATIONS, TWO PRIORITIES

3.3x

More acute crisis ED visits

Adults 25–64 generate 3.3x more acute crisis ED visits than all other age groups combined driven by overdose and suicide presentations in 28401 and 28412.

81%

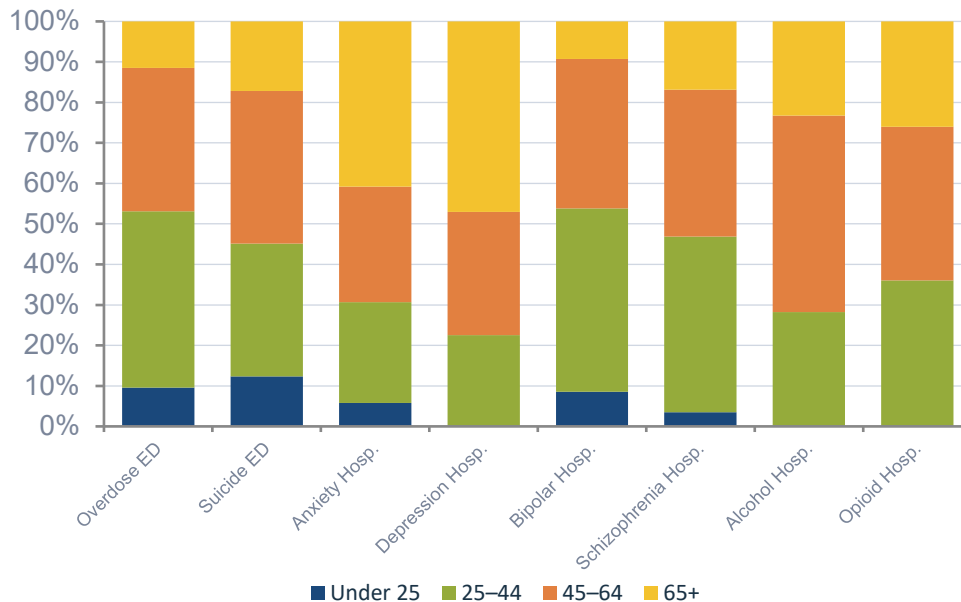
Share of hospitalizations

Bipolar and schizophrenia hospitalizations are 81% working-age adults — the highest 25–64 concentration of any category.

Aged
45-64

Leads across three categories

Ages 45–64 are the single highest-burden group for alcohol disorder, opioid hospitalizations, and suicide-related ED visits.



Source: NC DETECT — ED related overdose visits by age group 2020–2024, % share of county-wide burden by age group

Key Finding: Adults 25–64 dominate acute ED and serious mental illness demand, accounting for 79–81% of overdose, suicide, bipolar, and schizophrenia visits. Adults 65+ drive the majority of anxiety and depression hospitalizations (41–47%). Targeted strategies should span the lifespan to avoid missing half of the burden.

Key Insights from the Behavioral Health Landscape

Behavioral health need in New Hanover County is geographically concentrated, shaped by community conditions, and driven by multiple overlapping diagnoses

1

Crisis demand is geographically concentrated

Four ZIP codes — 28401, 28412, 28403, and 28405 — account for 75% of mental health ED visits and 68% of hospitalizations. 28401 carries 2.8× the county average BH burden.

→ Place-based investment in these four ZIPs reaches the majority of need.

3

Disparities are concentrated and structural

Males face 2–7× higher suicide rates. Black residents in 28401 face 2.2× higher overdose ED rates. Working-age adults 25–64 drive the majority of crisis demand across all conditions.

→ Equity-centered, gender-responsive, age-targeted programming is foundational.

2

Anxiety, Depression & SUD drive most hospitalizations

Anxiety (+51%), depression (+46%), and polysubstance use (+109%) are all rising. Alcohol and opioid disorders create parallel and intersecting demand — requiring integrated response.

→ Integrated MH+SUD services and rapid outpatient access are the critical gaps.

4

Structural conditions shape community risk

Poverty, uninsurance, and geographic isolation cluster in the same high-burden ZIPs. Few intensive mental health options exist between crisis/acute care and standard outpatient drive readmission cycles: inpatient residential, medical respite, PHP and MH-specific IOP, housing stabilization, and recovery supports.

→ Addressing structural conditions and post-acute capacity is essential for durable impact.

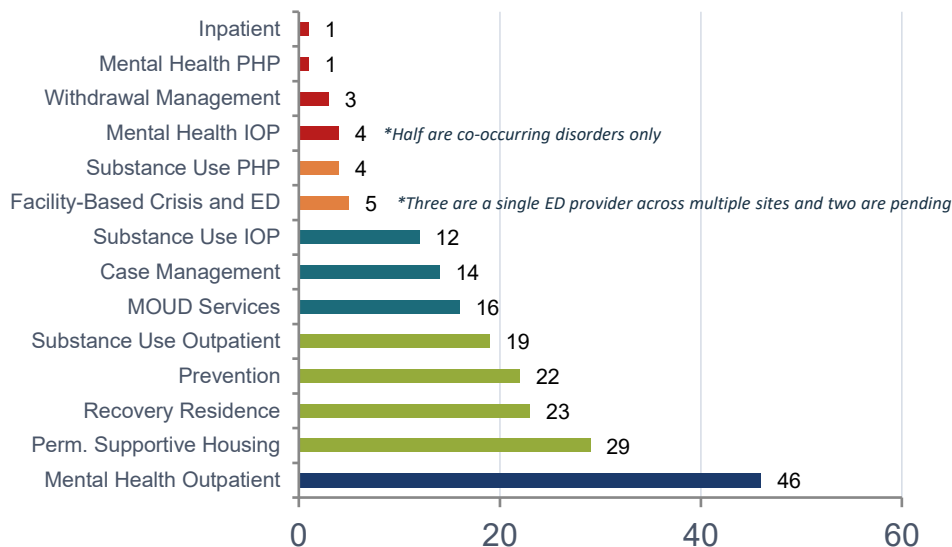
Key Finding: *The landscape data points to a clear investment thesis: concentrated place-based intervention, integrated, coordinated services, rapid higher-level outpatient access, recovery services and structural supports, including housing in four high-burden ZIP codes can address the majority of New Hanover County's behavioral health crisis demand.*

Behavioral Health Assets and System Gaps

Mapped providers, continuum analysis, workforce, and system fragmentation

Provider Counts Overstate What the System Can Actually Deliver

Most outpatient providers do not accept Medicaid or uninsured clients — the population carrying the greatest need



Source: New Hanover Behavioral Health Landscape Analysis Data Dashboard, Mosaic Group, March 2026

CONTINUUM AT A GLANCE

69

Unique service providers across 151 locations or program sites

46

Outpatient MH providers — the dominant tier, yet many do not accept or bill Medicaid, even if they are credentialed to do so.

1

Acute inpatient psychiatric provider serving the entire county

Key Finding: Provider count is not the same as access. Capacity concentrates in standard outpatient care, while the more intensive post-acute levels remain thin with a single acute inpatient provider, with few step-down options beyond it. That is where the continuum appears most underbuilt.

Low Claims Reflect Missing Providers, Not Missing Need

Trillium claims volume and NHC provider supply converge on the same service gaps. Low utilization is not evidence of low demand – it is evidence that limited billable supply exists

9 SERVICE CATEGORIES MATCH

0	Psychiatric Collaborative Care
0	Residential Step-Down (MH)
1	Partial Hospitalization Program (MH)
3	Withdrawal Management
5	Facility-Based Crisis & Stabilization (including pending sites)

Provider count in NHC — each corresponding to a red bar in the chart

TAILORED PLAN MECHANICS

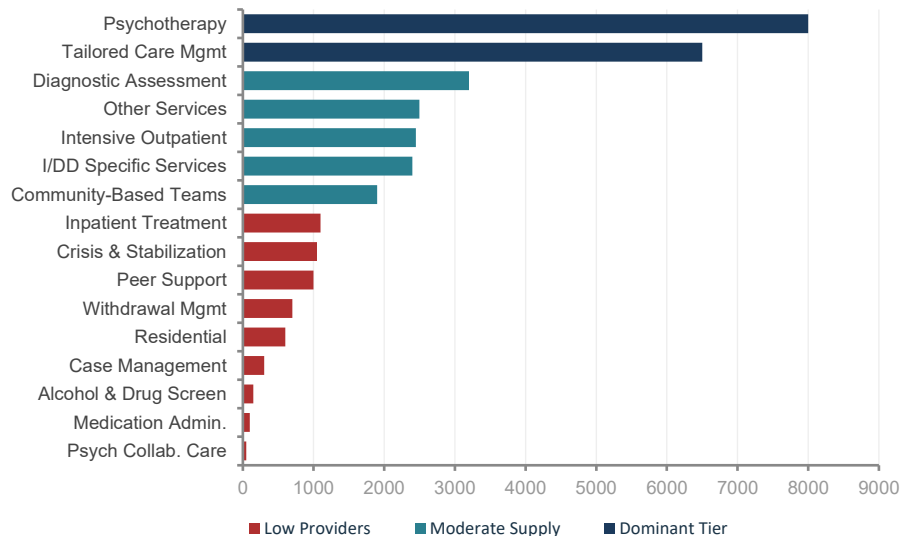
Automatic: Retrospective algorithm — slow, data-driven, not a referral.

Manual — Service-Associated Request (SAR): ~1 day, retroactive. Provider or member can submit, but no clear indicator of who is responsible for the submission

Manual — Non-Service Associated Request: 5–6 days avg, effective 1st of following month. Provider or member submits, but no clear indicator of who is responsible.

Network availability: Enrollment unlocks access to additional billable services, but lack of available services leads to un-enrollment from the tailored-plan for the medically complex.

Trillium Claims Volume by Service Category in New Hanover County



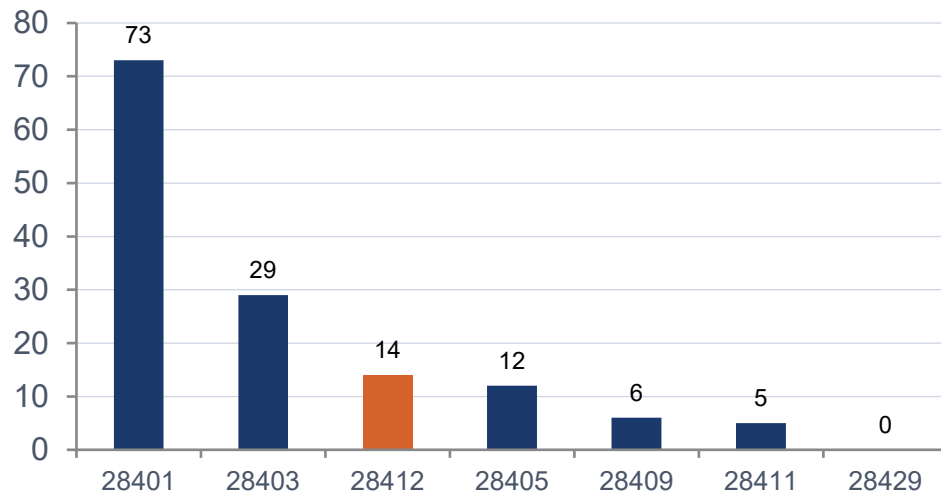
**Services categories include both MH and SUD services unless noted otherwise*

Key Finding: The nine service categories with lowest Trillium claim volume match the 9 categories with under three providers in NHC's continuum. Low claims are not a demand signal — they are a supply signal. Tailored Plan enrollment mechanics compound this: even correctly enrolled members cannot access services no provider delivers.

Half the County's Service Assets Cluster in One ZIP While Other High-Need Communities Go Without

48% of all service locations are in 28401, 28412 (ZIPs with significant need) has limited higher intensity clinical services while 28429 has limited-service assets

Provider Locations by ZIP Code



Source: New Hanover Behavioral Health Landscape Analysis Data Dashboard, Mosaic Group, March 2026

Distribution in Focus

48%

Of all service locations sit in a single ZIP — 28401

14

Locations in 28412 —but lack clinical services such as inpatient residential, MH PHP, and MH IOP

0

Providers located in 28429 — a rural ZIP with 18% poverty and geographic isolation

Key Finding: Provider geography does not follow need. Concentration in 28401 leaves high-need ZIPs like 28412 structurally underserved with critical services— and 28429 entirely without coverage. Even in provider-dense ZIPs, Medicaid and uninsured residents face a system that largely does not serve them.

The Continuum Falls Short at Both Ends: Prevention Is Underbuilt, Post-Acute Care Is Nearly Absent

Limited prevention providers serve the front end of the continuum. One acute inpatient provider serves the back end. In between, step-down pathways are limited, and care is rarely integrated across settings

1

Acute Care Rests on A Single Provider

One acute inpatient psychiatric provider serves the entire county with no backup. Iryna's Law mandates psychiatric evaluations for certain justice-involved individuals, but ED bottlenecks and scarce beds — locally and regionally — can leave people waiting in jail rather than receiving timely mental health care.

→ Single-provider tiers are structural fragility, not a resource shortfall.

2

Step-Down From Acute Inpatient Is Nearly Absent

The pathway down from acute hospitalization — through inpatient residential, PHP, psych rehab, and IOP — is nearly empty. Only 1 MH PHP and 4 MH IOP providers exist county-wide, each a separate system with minimal coordination connecting them.

→ People often leave hospital care with nowhere structured to land.

3

Prevention Is the Thinnest Tier in the Continuum

Only 22 promotion or prevention-focused providers, with youth and early childhood services especially scarce. Prevention largely sits apart from the treatment system, with few formal links between the two.

→ The continuum is weighted toward response. The upstream end is underbuilt.

4

Fragmentation Runs Across the Whole System

From prevention through acute care into recovery, providers operate in separate systems with little shared information or referral infrastructure. Clients with co-occurring MH and SUD needs face this most acutely. Navigation burden falls entirely on the individual.

→ No single gap explains the breakdown. The architecture itself creates it.

Key Finding: *The provider inventory reveals a continuum with structural failure at both ends. Prevention infrastructure is too thin to intercept emerging need. Post-acute capacity is limited to support recovery after crisis. Between those, transitions across settings are largely unmanaged. The system is built to respond to the middle and underserve everything else.*

Several High-Need Populations Are Served by a Fraction of the Provider System

The landscape reveals deep gaps in specialty care for populations such as perinatal women, young children and youth, non-English speakers, justice-involved individuals — populations the data identifies as high-burden

Coverage Gaps

4

Providers serve perinatal women — among the highest-consequence gaps in the system

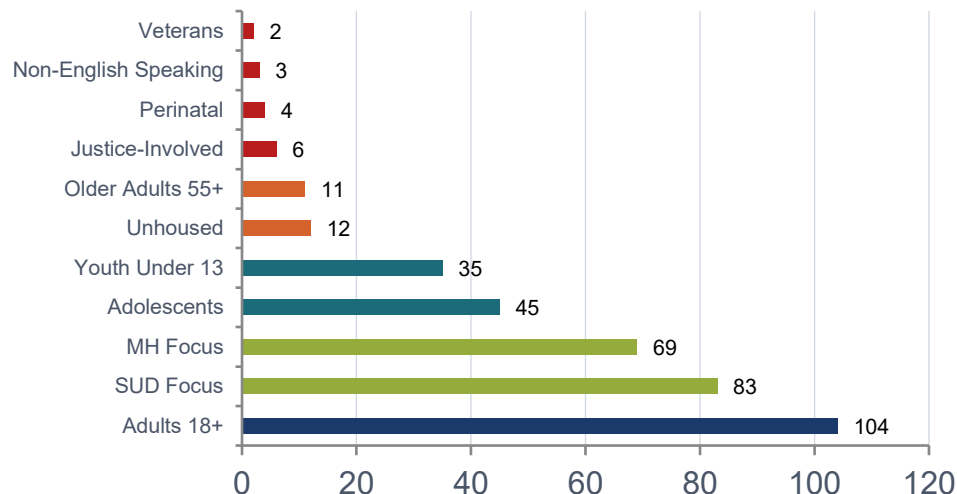
3

Providers serve non-English speaking residents

35

Providers serve youth under age 13 however, very few serve young children, and many do not accept Medicaid

Number of Providers by Specific-Population Served



Source: New Hanover Behavioral Health Landscape Analysis Data Dashboard, Mosaic Group, March 2026

Key Finding: *The populations with the fewest providers are not marginal. With so few providers, these vulnerable populations must piece together care across fragmented, uncoordinated settings — adding navigation burden to an already inaccessible system.*

Provider Mapping Defines the Gap; Community Voices will Reveal the Consequences

Do these structural gaps match what communities experience on the ground?

WHAT THE PROVIDER DATA SHOWS

- **Provider supply is concentrated and unequal**
48% of locations in one ZIP; rural communities unserved; Medicaid and uninsured residents face access barriers from the most common service tier.
- **Prevention infrastructure is the thinnest tier**
Limited prevention-focused providers — fewer than recovery residences or permanent supportive housing. Youth and early childhood services are especially scarce.
- **Post-acute care has single points of failure**
One acute inpatient provider, one MH-specific PHP, one high-level residential — with no coordinated step-down pathway between levels of care.
- **Specific populations have almost no coverage**
Young children, youth, perinatal, veterans, non-English speaking, justice-involved — all identified as high-need in the landscape data.

WHAT COMMUNITY PERSPECTIVE WILL EXAMINE →

- **Whether residents experience the access gap**
Do Medicaid and uninsured residents encounter the barriers the provider data implies — and how do they navigate around them?
- **Whether the upstream gap is recognized**
Do community members see prevention and early intervention as absent — and what do they identify as the entry points that are missing?
- **Whether the step-down gap is felt on the ground**
What happens after a crisis episode? Do residents describe cycling back through the ED for lack of alternatives?
- **Whether the population gaps match lived experience**
Do caregivers of young children, youth, individuals recently re-entered from the criminal justice system, student support team members and new mothers validate the gaps and what are their thoughts on solutions?

Key Finding: *What the data cannot show is what it feels like to move between these systems — and where people fall through the gaps*

Is the Provider System Aligned with Community Demand?

Understanding where behavioral health need is greatest raises this critical question

WHAT THE LANDSCAPE TELLS US

- Four ZIPs carry 75% of mental health ED crisis demand — concentrated, not distributed
- Anxiety, Depression and SUD drive most hospitalizations and ED visits
- Working-age adults 25–64 are the core crisis population
- Structural conditions — poverty, uninsurance, isolation — amplify risk
- Post-acute gaps (inpatient residential, MH-specific IOP and PHP mostly accessible through commercial plans, medical respite, housing stabilization and recovery support) are driving readmission cycles

NEXT: PROVIDER ASSET MAPPING

1

Behavioral health providers

Who is operating — and where?

2

Service distribution

Do services align with high-burden communities?

3

Treatment capacity

Are there enough beds, slots, and providers?

4

Geographic service gaps

Where does the system leave communities without care?

The data establishes the need. The asset map will show whether the current system can meet it — and where the gaps encourage philanthropic action.

Stakeholder & Community Voices

Cross-cutting themes from 50+ interviews and 6 listening sessions

The Community Spoke, and Mosaic Group Listened

Over 100 participants – spanning parents, providers, educators, young people, employers and members of the recovery community -shared their experience with the behavioral health system

Listening Sessions

High School Students

15+ participants

Public High School

Postpartum Women

10 participants

Community-Based Organization

Caregivers of Young Children

12+ participants

Early Childhood Non-Profit

School Staff Members

10 participants

Public School District

Justice-Involved Participants

10+ participants

Community-Based Organization

Behavioral Health Employers

30+ participants

Chamber of Commerce Convening

Key Stakeholder Interviews

~50+ participants

Clinical providers across preventative, treatment and crisis services, educational professionals, government officials, primary care & FQHC providers, law enforcement, first responders, faith and other community leaders, Medicaid MCO leadership, recovery community organizations.

Fragmentation, Not Demand, Is Driving System Strain

Challenges in navigation, care transitions, housing stability, and workforce capacity are limiting the system's ability to consistently support recovery; upstream conditions create vulnerability

System Navigation is Confusing and Overwhelming

- Lack of systems translators and connectors in trusted settings.

Post-acute continuum is broken

- No step-down from hospital or jail. People often discharged to nothing and cycle back.

Children/youth: Gaps at every stage

- Limited developmental screening and prevention intervention.
- At capacity school support and no high school day treatment.

Housing instability undermines everything

- Recovery with inadequate housing is a revolving door. Very limited BH in shelters.

Justice-involved: Failed Transitions

- Iryna's Law adds pressure.
- Fragmented housing, employment, or treatment continuity from incarceration.

Workforce retention is the lever

- System design pushes clinicians to private practice.
- Administrative burden is primary complaint.

Cultural Competency gaps

- Limited Black and bilingual providers, trusted messengers in communities untapped.

Crisis Response is inadequate

- Long wait times, multiple overlapping doors, limited to no low barrier options.
- Separate and uncoordinated crisis care.

Key Finding: *Stakeholders consistently describe a system where services exist but are not well connected. Strengthening coordination, transition supports, and culturally responsive workforce capacity presents a major opportunity to improve outcomes and reduce crisis-driven care.*

Trust is the Prerequisite: The Community's Trusted Organizations are the Front Door

Organizations with credentials often lack community trust; organizations with trust lack clinical capacity and sustainable funding

Community Leaders

Leaders of community-based programs noted that funding consistently flows to credentialed providers who lack community relationships — leaving organizations with the deepest trust chronically under-resourced.

Non-Traditional Service Providers

Some of the most connected community organizations described being consistently excluded from formal systems — trusted by residents but not recognized by the institutions meant to serve them.

Youth Advocates

Youth-serving organizations emphasized the need for sustained adult mentors with lived experience — people who show up consistently over time and model healing, not just in crisis moments.

Trauma Survivors

Trauma survivor advocates stressed that helpers must be well into their own healing — deploying individuals still in active struggle erodes trust and can replicate harm in vulnerable communities.

Persons in Recovery

Individuals with lived experience indicate lack of trust and fear among traditional providers based on historical experiences with over-medication and lack of compassionate listening.

Key Finding: *Trusted community-based organizations can serve as the first point of contact — bridging this gap without triggering resistance.*

Families and Young People Describe a System that is Invisible, Inaccessible, and Often Punitive

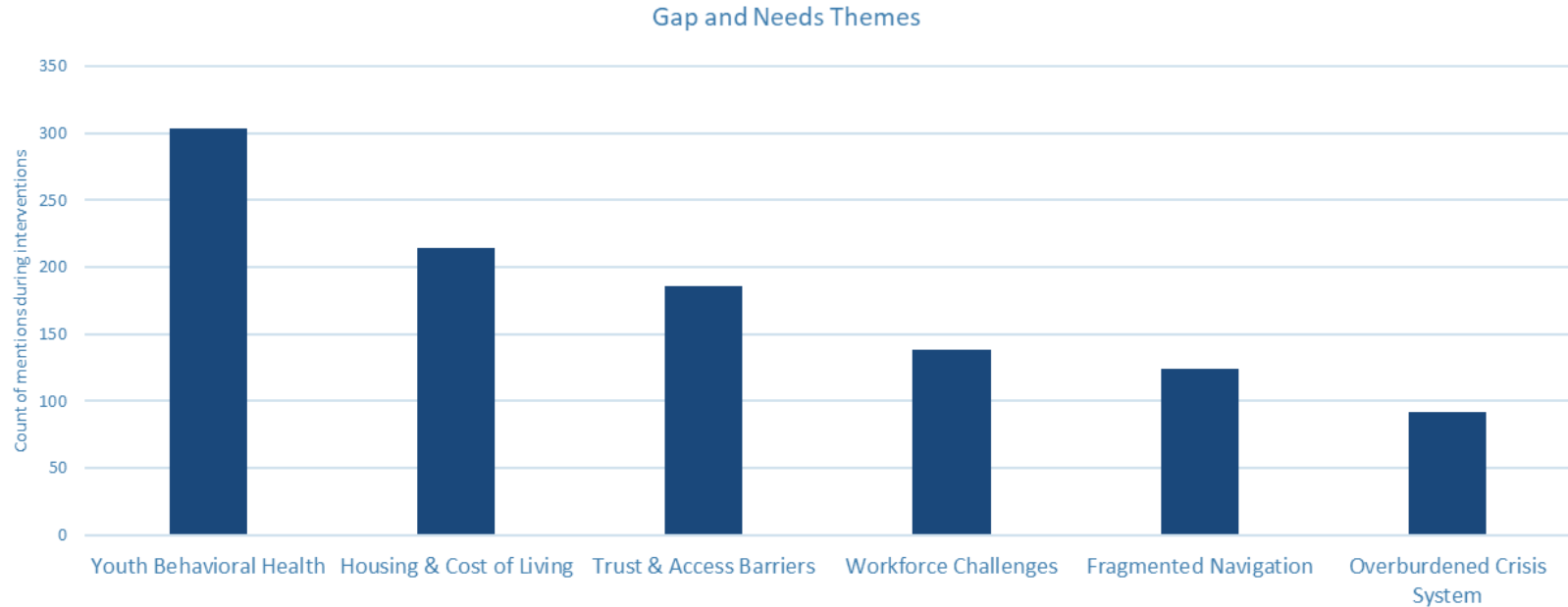
Stakeholder perspectives reveal a system hard to reach, hard to trust and often incomplete

	What They Said	Strategic Implication
High School Students	<i>Want mentors and trusted adults to talk to about their stress, drop-in spaces and recreation in their neighborhoods, confidential access without parental notification</i>	Non-clinical touchpoints: mentoring, trusted messengers, peer models, creative programming
Postpartum Women	<i>Women in recovery described word-of-mouth as the primary way people learn about services — highlighting that peer networks, not formal outreach, drive awareness. Peer support was identified as central to sustained recovery.</i>	Peer-to-peer models in trusted settings; expand provider and trusted messenger knowledge and proficiency with post-partum population
Public School Staff Members	<i>Public school staff members described students being discharged from EDs with no follow-up plan or medication education — returning to school without supports in place. Teams called for embedded navigators who bridge clinical and school systems.</i>	Embedded navigators in schools; HS day treatment; expanded mental health and student support team members
Caregivers of Young Children	<i>Transportation, childcare, stigma are barriers to addressing stress and needs of their young children. Want services where they already go.</i>	Co-located services in childcare, Head Start, churches; healing circles
Pediatric providers	<i>Identified significant delays in obtaining needed evaluations for developmental screening concerns resulting in young children never receiving early intervention services and supports.</i>	Additional resources for psychologic evaluations, early intervention supports and caregiver navigation in community health settings

Key Finding: *The system fails families and young people twice- through gaps in trusted pathways and gaps in the services those pathways should lead to.*

Gaps & Needs: Structural Strain Concentrated in Youth and Housing

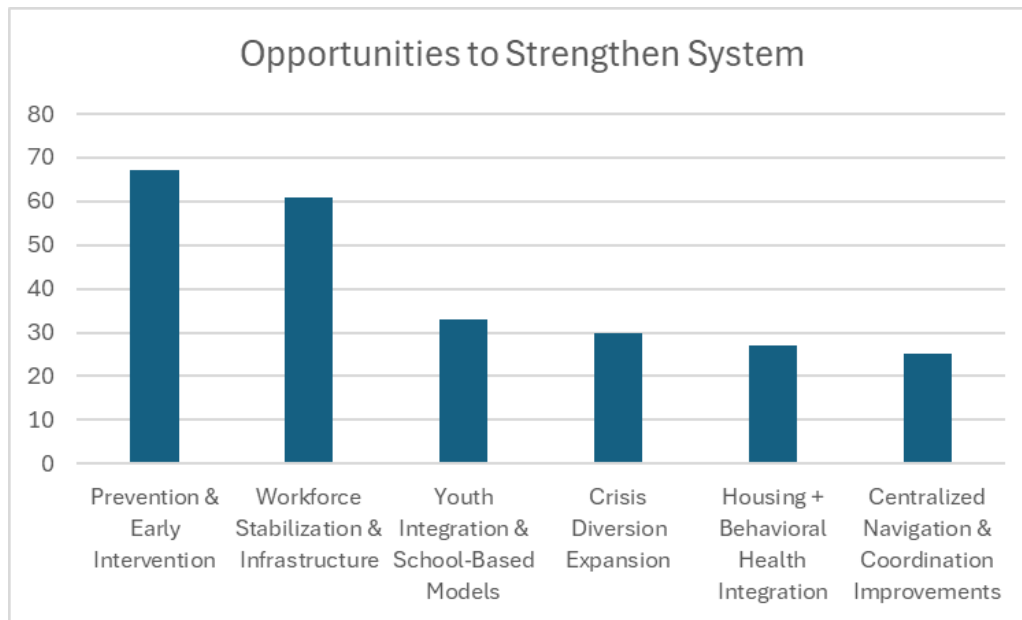
Stakeholder input indicates that pressure is concentrated in youth-serving systems and housing stability, with downstream impacts on access, workforce capacity, and crisis utilization



Key Finding: Stakeholders most frequently described youth system strain and housing instability as dominant gaps. Workforce shortages and navigation breakdowns follow closely, while crisis utilization appears as a downstream manifestation of these structural pressures.

Stakeholders Emphasize Prevention and Workforce Stabilization as Top Leverage Points

Stakeholder voices point to a clear signal; lack of prevention services and housing are under the greatest strain



Key Finding: Across interviews, stakeholders most frequently identified prevention, early intervention, and workforce stabilization as the most actionable strategies to reduce downstream crisis demand and strengthen system capacity.

Stakeholders Envision Structural Redesign When Resources Are Unconstrained

Community providers value moving upstream to address youth while stabilizing those with behavioral health needs with housing



Key Finding: *When asked to imagine unconstrained investment, stakeholders shifted to prioritizing supportive housing, youth system overhaul, crisis infrastructure enhancement workforce reinvestment, and improved system integration.*

Employers and Providers Identify Shared Infrastructure as the Missing Ingredient

Across employers, providers, and schools, stakeholders point to system fragmentation as the barrier to workforce stability and access.

BH Workforce Retention	Agencies compete for same small pool. Leadership often lack time, tools and funding to invest in retention.
Administrative Burden	Limited or no clerical staff means paperwork, pre-authorization, billing and other administrative tasks fall to the clinicians who are already taxed with high caseloads in busy, high-need practices.
Training Infrastructure	No shared training across agencies. Each reinvents orientation. Professional development opportunities contribute to retention.
Peer/CHW Workforce	Are capacity multipliers but standards vary by role with state-oversight for peers and association-monitored for CHWs. Additional supervision capacity is needed, leaving training uneven. Career ladders are also largely absent.
Community Mental Health	Supervisors are burned out. Clients are complex. Salaries are lower than private sector. Trainees not attracted to come, therapists who start leave after licensure.
Provider Sustainability	Small practices cannot absorb burden for Medicaid participation credentialing as is, and expertise to effectively participate in Medicaid.

Key Finding: *Lack of shared infrastructure is a core constraint on workforce stability, provider sustainability, and access to care.*

Five Strategic Postures

Taken together, these postures focus on long-term system capacity rather than short-term program funding.

1 Invest in multi-year timeframes

2 Fund the connective tissue, not just programs

3 Prioritize community voice in design

4 Build the workforce, not just programs

5 Support trusted orgs with operational funding

6 Embed technical assistance in every grant

Key Finding: System impact will require moving beyond program funding to sustained investment in infrastructure, workforce, and trusted community partners.

Strategic Investment Considerations

Five Strategic Investment Areas of Opportunity to Transform the Behavioral Health Landscape

Aligned to The Endowment's Theory of Change and the County's Mental Health and Substance Use Disorder Strategic Plan

1

Build a Coordinated Behavioral Health System of Care

2

Strengthen the Behavioral Health Crisis System

3

Advance Early Childhood Behavioral Health

4

Strengthen Youth Behavioral Health & School-Based Supports

5

Build and Sustain the Behavioral Health Workforce

Investment Opportunity 1: Build a Coordinated Behavioral Health System of Care

STRATEGY 1

Strengthen Infrastructure for an Integrated System of Care

APPROACHES

- Convene providers and partners to establish shared governance, data-sharing, closed-loop care transitions across various settings and sectors, and a shared accountability scorecard with equity indicators
- Invest in a community-wide technology platform enabling real-time provider availability, closed-loop referral tracking, and active care navigation
- Support local navigator and Medicaid ombudsman capacity and co-design accessible, culturally responsive consumer navigation materials with people with lived experience
- Join statewide philanthropy-led advocacy to protect Medicaid and ACA coverage and ensure New Hanover County's voice is represented as federal and state budget threats to the behavioral health safety net grow.

STRATEGY 2

Co-Invest to Address Gaps in the Post-Acute Care Continuum

APPROACHES

- Co-invest with key public and private partners in a residential treatment facility grounded in evidence-based model selection and fidelity
- Assess and expand intermediate levels of care — including Partial Hospital, Psychiatric Rehabilitation, and Intensive Outpatient programs — to reduce acute system reliance
- Explore and strengthen care pathways for medically complex individuals with co-occurring behavioral health needs — including medical respite, specialized home health, and residential care options

STRATEGY 3

Augment Recovery Support Through Community-Based Organizations

APPROACHES

- Expand WRAP-funded recovery support services including transportation, short-term housing stabilization, employment support, and peer recovery coaching
- Integrate recovery support organizations into the broader system of care — including the technology platform and closed-loop referral network — to ensure referrals are tracked and completed

Investment Opportunity 1: Build a Coordinated Behavioral Health System of Care

EVIDENCE & BEST PRACTICE FOUNDATION

- Discharge is where continuity of care breaks down: more than half of patients lose contact with care within 30 days of hospital discharge, making fragmentation at discharge the system's primary failure point. Evidence comes from a randomized controlled trial of the Eric Coleman Care Transitions Intervention (Archives of Internal Medicine, 2006), which found that assigning a transition coach at admission, with follow-up within 72 hours after discharge, reduced readmissions. That trial indicates effective transitions depend on a person accountable for the handoff, not a discharge plan alone.
- The SAMHSA System of Care framework identifies shared governance and population-level accountability as the key difference between communities with services and communities with systems. A convening body, such as a coalition, intermediary, or endowment-backed entity, is the common structural element in systems that close service gaps. Provider-level accountability alone cannot produce system outcomes.
- Technology-enabled, closed-loop referral platforms (Unite Us, NowPow, FindHelp) track social service referrals through to resolution, unlike untracked warm handoffs, which end at the point of referral. Evidence also shows digital tools alone widen equity gaps for high-barrier populations, meaning platforms must be paired with human navigation for individuals in crisis or with low connectivity and literacy. (Drewry, 2023; Gottlieb, 2016).
- Systems that include consumer and peer voice in governance and service design outperform those that do not across access, engagement, and treatment completion (Crawford et al., systematic review, BMJ, 2002). Co-design with people with lived experience is not an equity add-on but an evidence-based design principle for high-complexity populations.
- North Carolina involuntary commitment petitions rose 97% from 2011–2021. Iryna's Law (passed October 2025, phased through 2026) increases demand by requiring psychiatric evaluations in EDs for certain arrested individuals without adding resources. Structured reentry protocols with warm handoffs from jails to community providers are among the highest-yield, lowest-cost interventions and address the cycling pattern documented in New Hanover County ED data.

COMMUNITY MODELS

St. Louis Integrated Health Network (St. Louis, MO)

A healthcare intermediary that convenes and holds a cross-sector provider network accountable without delivering direct services. Its Care Transitions Initiative deploys CHWs for warm handoffs including pre-release jail connections, producing 5,304 client encounters and 1,217 completed referrals. Funded by NIH and Medicaid.

Broward Behavioral Health Coalition (Broward County, FL)

A county-level coalition managing funding oversight and quality accountability across 200+ behavioral health providers. Operates a shared EHR across partner clinics, co-located psychiatry, and a formal governance structure with defined quality metrics and outcome reporting across the network.

Camden Coalition (Camden, NJ)

A regional Health Information Exchange connecting nearly 50 health systems and CBOs as the data backbone for care management and cross-sector coordination. Their 'Pledge to Connect' initiative linked ED patients with BH needs to timely follow-up, achieving 100% appointment offer rates and receiving the SAMHSA Behavioral Health Equity Challenge award.

Pathways Community HUB (National) (AHRQ-Recognized)

This AHRQ-recognized, regional clearinghouse connecting at-risk individuals to community navigators via standardized 'Pathways' — step-by-step processes tracked to measurable completion, with payment tied to outcomes rather than activity. A Toledo/Lucas County implementation resolved over half of 3,515 identified health and behavioral risks for 651 adults within two years.

HopeWay: A Replicable Step-Down Continuum for New Hanover County

Charlotte, NC · Physician-led · Evidence-based · NC Medicaid accepted · Founded 2019

THE TREATMENT CONTINUUM



⇒ Clients can step back up at any level — no new ED visit required. Closed-loop navigation tracks every transition.

OUTCOMES — HOPEWAY 2023 DATA



KEY DIFFERENTIATORS

- Physician-led: 6 psychiatrists for ~150 clients across all programs — extraordinary access
- Unlocked, voluntary, home-like setting (not a locked inpatient unit)
- Cost comparable to a 2 to 3-week inpatient stay — with better outcomes and lower readmission
- Accepts NC Medicaid + most major commercial insurance

Investment Opportunity 2: Strengthen the Behavioral Health Crisis System

STRATEGY 1

Support Development of a Clearly Defined County Behavioral Health Crisis System

APPROACHES

- Convene all crisis response and stabilization partners to co-design the system with expert facilitation — including providers, 911 communications, and community members
- Develop key features of community and provider education around crisis system navigation, entry points, and appropriate use
- Identify gaps in services across the crisis continuum — including response times, geographic coverage, and population-specific needs
- Define metrics and standards for response times and other crisis framework elements, including a shared performance dashboard across all operators

STRATEGY 2

Co-Invest in Identified Gaps in the Crisis System

APPROACHES

- Develop a Behavioral Health Urgent Care / walk-in crisis stabilization center to serve as the system's front door — reducing emergency department reliance and providing a low-barrier access point
- Fund youth-specific mobile crisis response and stabilization services, including school-linked crisis teams and youth-appropriate crisis stabilization
- Enhance and expand existing co-responder and mobile crisis program including peer recovery specialists, community health workers, and clinical staff

Investment Opportunity 2: Strengthen the Behavioral Health Crisis System (cont.)

STRATEGY 3

Develop Community Education on How to Access the Crisis System of Care

APPROACHES

- Create accessible, culturally responsive, and multilingual consumer navigation materials co-designed with people with lived experience of crisis
- Build provider education on crisis system entry points, referral pathways, and response protocols — including for primary care, schools, and faith communities
- Partner with trusted community organizations to disseminate crisis access information and reduce barriers to help-seeking

STRATEGY 4

Strengthen Behavioral Health Supports and Expand Low-Barrier Access Points for High-Need Individuals in Trusted Community Settings

APPROACHES

- Expand behavioral health screening, care navigation, and connection to treatment within emergency shelters and transitional and supportive housing settings
- Integrate behavioral health services at safety-net health settings to ensure continuity of care for individuals experiencing homelessness or housing instability
- Engage trusted community messengers such as barbers and salon professionals, faith leaders, and other with deep community reach to de-stigmatize mental health and expand Mental Health First Aid training in informal community settings
- Partner with the County and homeless services providers to explore a Street Medicine program delivering evidenced-based integrated health and behavioral health care to unsheltered individuals

Investment Opportunity 2: Strengthen the Behavioral Health Crisis System

EVIDENCE & BEST PRACTICE FOUNDATION

- The Crisis Now framework, codified in SAMHSA's 2020 National Guidelines, defines an effective crisis system through three integrated elements: someone to call, someone to come, and somewhere to go. These elements function as a coordinated continuum rather than separate programs. Communities with system-level governance, including shared dispatch, clear referral pathways, and cross-provider performance dashboards, consistently outperform fragmented systems.
- Crisis Stabilization Units and behavioral health urgent care centers reduce inpatient psychiatric hospitalizations by about 25–30% and cost \$150–300 per encounter compared with \$1,200–2,200 for an emergency department visit. No-refusal walk-in standards, with no appointment, referral, or insurance required, are linked to higher utilization, better outcomes, and faster law enforcement drop-off times (SAMHSA Crisis Services review, 2014).
- Youth crisis care remains a major national gap. Emergency departments often serve as the default setting but are poorly designed for adolescent psychiatric and substance-related crises. Evidence supports dedicated youth crisis stabilization programs that incorporate developmentally appropriate protocols, school-linked referral pathways, and strong family engagement (SAMHSA Youth Crisis Guidelines, 2022).
- Community education about crisis resources is itself an evidence-supported intervention. Only about a quarter of U.S. adults report being at least somewhat familiar with 988, with lower familiarity among Black, Hispanic, and Asian adults and those with limited English. Materials co-designed with individuals with lived experience and distributed through trusted community partners consistently achieve greater reach, trust, and engagement than clinician-designed materials (KFF, 2024; NAMI/Ipsos, 2024).
- Street Medicine Pittsburgh, founded in 1992 and the basis of the Street Medicine Institute, showed that relationship based mobile clinical care can engage people who previously refused services and reduce emergency department visits. International replication, including Médecins du Monde and programs in Brazil and India, confirms reduced hospitalizations and improved trust leading to housing acceptance. The Institute now trains programs in 30+ countries.

COMMUNITY MODELS

Durham HEART – System Governance Model (Durham, NC)

A directly applicable, four-component NC model under one Community Safety Department with a shared 911 dispatch and RTI evaluation infrastructure. Governance structures, not just programs, produces accountable outcomes.

CCORS — Youth Crisis Stabilization (King County, WA)

Dedicated youth mobile crisis + short-term stabilization with defined school referral protocols, pediatrician linkage, and family engagement requirements built in. Demonstrates that youth crisis requires distinct protocols — not scaled-down adult programs.

GCAL — Statewide CSU Network (Georgia)

No-refusal CSUs with LE drop-off under 10 minutes and standardized intake protocols across all sites with 25–30% reduction in inpatient hospitalization; the national model for clear operating standards and consistent protocols.

988 Community Education (New York)

Co-designed with lived experience and community stakeholders. Multilingual materials distributed through trusted community partners — not clinical channels. Crisis awareness reaches highest-need populations only when community organizations own the distribution.

Street Medicine Pittsburgh / Street Medicine Institute

Foundational program (est. 1992); basis for the Street Medicine Institute (30+ countries). Sustained engagement with individuals who refused all prior services; significant ED reductions.

Investment Opportunity 3: Advance Early Childhood Behavioral Health

STRATEGY 1

Strengthen the Early Childhood Behavioral Health Workforce

APPROACHES

- Build on the work of early childhood non-profits and state training initiatives to expand and deepen professional development for early educators in childcare centers
- Develop practical implementation supports — including coaching, mentoring, and on-site technical assistance — to move workforce training into everyday practice
- Cross-train early childhood educators and pediatric health care providers to build shared understanding and warm referral pathways

STRATEGY 2

Establish Early Childhood Mental Health Screening, Consultation, and Supports

APPROACHES

- Embed early childhood mental health consultants (ECMHCs) in early childhood settings, prioritizing existing programs serving the most vulnerable young children
- Integrate evidence-based behavioral health screening, intervention, and consultation into home visiting programs
- Explore expansion of integrated behavioral health models in pediatric primary care settings serving young children

Investment Opportunity 3: Advance Early Childhood Behavioral Health

STRATEGY 3

Support Parent and Caregiver Social-Emotional Wellbeing

APPROACHES

- Work with early childhood non-profits and trusted community partners to expand evidence-based caregiver support models that are already in practice within New Hanover County
- Partner with trusted community-based organizations to introduce culturally relevant caregiver support groups for Black and low-income families — including peer support and other peer-led models
- Address mothers' social-emotional needs in the fourth trimester by building on a perinatal nurse champion program to integrate mental health screening and support in maternal and child health care settings

STRATEGY 4

Improve Developmental Screening and Early Intervention Access

APPROACHES

- Ensure pediatric primary care providers follow American Academy of Pediatrics (AAP) Bright Futures guidelines for developmental screening using validated tools consistently with follow-up navigation to evaluation and early intervention
- Explore alternative developmental evaluation models to address bottlenecks within the county, including existing models in partnership with key public and private organizations.
- Support family navigation to ensure young children are evaluated and receive early intervention services, and advocate for system-level fixes to structural bottlenecks
- Facilitate smooth handoff of developmental information from county early intervention to school system services when children turn five

Investment Opportunity 3: Advance Early Childhood Behavioral Health

EVIDENCE & BEST PRACTICE FOUNDATION

- A substantial body of evidence — including ratings by SAMHSA, Blueprints for Healthy Youth Development, and the California Evidence-Based Clearinghouse — supports the integration of behavioral health consultation and support into early childhood settings as the most effective model for reaching young children and caregivers who would not otherwise access clinical services.
- Caregiver mental health is the primary mechanism through which early childhood investment produces child outcomes. Research consistently shows that parenting stress, depression, and unresolved trauma must be addressed directly — not treated as background context — for child-focused interventions to work (National Academies, Depression in Parents, Parenting, and Children, 2009).
- Evidence across the field identifies five design principles that determine whether early childhood behavioral health approaches work for Black and low-income families: racial concordance; lived experience in the provider role; community settings over clinical settings; two-generation design; and naming racism-related stress as a legitimate health concern, not background noise.
- Home visiting, early childhood mental health consultation, pediatric integration, and peer support are not aspirational — they are mature practice areas with decades of rigorous evaluation, documented outcomes, and implementation guidance. The strategies in this investment area draw from that established evidence base (HHS HomVEE review; Georgetown Center of Excellence for IECMHC).
- Developmental screening and early intervention systems are well-established in policy and in law (IDEA Part C), but implementation quality and equity of access are highly variable. The evidence supports both strengthening existing infrastructure and closing the gap between identification and service receipt — particularly for children whose families face navigation barriers (IDEA Part C; AAP developmental screening policy, Pediatrics, 2020).

COMMUNITY MODELS

Pyramid Model (Maryland, Michigan, multiple states)

Statewide training framework for early educators in social-emotional support. Documented reductions in preschool suspension and expulsion; stronger teacher-child interaction quality across diverse program settings.

Infant & Early Childhood MH Consultation (Colorado)

Statewide IECMHC system embeds consultants in childcare, home visits, and Head Start. Evaluations show reduced child expulsion, improved teacher wellbeing, and stronger engagement for families unlikely to seek clinic-based services.

Healthy Steps (24 states + DC)

Embeds a developmental specialist in the pediatric well-child visit from birth through age three. Evidence of improved caregiver mental health, reduced stigma, and stronger developmental screening in a setting families already trust.

LAUNCH Family Partner Model (Massachusetts)

Pairs a clinician with a peer professional with lived experience raising a child with BH needs. Designated a Best Practice by AMCHP; reduces caregiver depression and stress alongside child behavioral gains.

SAAF – Strong African American Families

Community co-designed, RCT-tested. Racial socialization and discrimination recognition are core content — not add-ons. Demonstrates effects on psychological functioning, racial pride, and resilience.

Investment Opportunity 4: Strengthen Youth Behavioral Health and School-Based Supports

STRATEGY 1

Strengthen Public Schools' Capacity to Address the Full Spectrum of Social, Emotional, and Behavioral Health Needs

APPROACHES

- Leverage existing County mental health funding to expand school-based mental health therapists in high-need, high-volume schools
- Expand student support teams to include behavioral intervention specialists and care navigators in high-need schools; align with Communities in Schools and full-service community school programming
- Partner with the school district, Medicaid MCO and community-based organizations to develop targeted solutions for students with severe behavioral health needs, drawing on existing regional models
- Promote awareness of and access of existing health access resources for adolescents among students, families, and school staff, actively reducing barriers including trust and parental consent

STRATEGY 2

Engage Youth-Serving Organizations and Young People as Active Partners in Social and Emotional Wellness

APPROACHES

- Integrate social-emotional wellness training and supports into trusted youth-serving organizations including youth development organizations, recreation centers, and sports leagues
- Expand evidence-based youth mentoring programs through trusted community organizations
- Support development of peer-led youth wellness programming in schools and community settings

STRATEGY 3

Build Capacity of Pediatric and Adolescent Providers to Screen, Identify, and Treat Behavioral Health Needs

APPROACHES

- Support providers in implementing APP Bright Futures guidelines for evidence-based mental health and substance use screening with tools and training to intervene effectively
- Promote awareness and use of NC PAL (North Carolina Psychiatry Access Line) among pediatric and adolescent providers
- Facilitate structured communication between health care providers and student support teams to strengthen care coordination
- Partner with health care organizations and community partners to expand behavioral health integration in primary care settings and telehealth models to address gaps in pediatric psychiatry

Investment Opportunity 4: Strengthen Youth Behavioral Health and School-Based Supports

EVIDENCE & BEST PRACTICE FOUNDATION

- Schools are often the only realistic access point for youth behavioral health. Students complete treatment at substantially higher rates when services are delivered in school rather than through community referral. MTSS, codified through ESSA, frames school behavioral health from universal prevention through intensive intervention (Jaycox et al., 2010; Hoover & Bostic, Psychiatric Services, 2021).
- School discipline disparities are not explained by behavior differences. Black students are 4x more likely to receive out-of-school suspension and 2x more likely to be referred to law enforcement, even after controlling for poverty and behavior. They are also 40% more likely to be classified under emotional disturbance in special education. Strategies that do not address these structural patterns will reproduce disparities (U.S. GAO-18-258, 2018; U.S. Dept. of Education CRDC).
- Restorative practices are one of the few interventions effective across the full MTSS continuum. A study of 485 middle schools found increased restorative practice use linked to declines in misbehavior, gang involvement, depressive symptoms, victimization, and substance use, with the strongest effects after two or more years and in reducing racial suspension disparities (Darling-Hammond, LPI, 2023).
- Trusted adults in non-clinical settings such as coaches, youth development staff, and faith leaders serve as key mental health gatekeepers for Black youth and youth in low-income communities. Youth MHFA increases knowledge, confidence, and willingness to intervene. In Hope Squad schools, over 95% of mental health referrals come from students who are not squad members, suggesting norms spread beyond trained students (Wright-Berryman et al., Children & Schools, 2019; Hope Squad data).
- Pediatric providers are the most common access point for youth, yet consistent Bright Futures screening remains limited. NC PAL helps providers manage cases without specialist referral, while primary care integration and telehealth offer near-term responses to the pediatric psychiatry shortage (AAP Bright Futures; NC-PAL; Asarnow et al., JAMA Pediatrics, 2015).

COMMUNITY MODELS

Hope Squad (National)

2,500+ schools working as a peer-nominated gatekeeper program. Students elect non-conventional leaders. Referrals for suicide-related distress grew from 80 to 673 over four years across implementing districts.

Boys & Girls Club of San Marcos — Integrated Wellness

Housing-focused outreach built around a by-name list, shared HMIS, and structured case conferencing. Cited by NAEH as a national exemplar of integrated outreach-shelter-housing coordination.

The Ohio State University – Coach Beyond / LiFEsports Program

Most rigorously developed coach mental health training nationally. 25,000+ coaches trained; Ohio mandated mental health training for all school-based coaches in 2023. Includes 6-session athlete resilience curriculum and Coach Beyond Readiness Index.

Active Minds (National)

RAND 4-year longitudinal study found meaningful improvements in mental health attitudes and helping behaviors. Peer-to-peer contact-based approach reaches 8 million youth annually. K-12 expansion surpassed 2,564 schools in under 3 years.

Investment Opportunity 5: Build and Sustain the Behavioral Health Workforce

STRATEGY 1

Strengthen Pipelines into Community Behavioral Health Careers

APPROACHES

- Build on lessons learned from the Healthcare Career Partnership to develop school-to-career pathways in partnership with public schools, higher education, and behavioral health employers
- Explore career ladder development for the existing unlicensed behavioral health workforce — including Qualified Professionals (QPs), community health workers, and peer recovery specialists — to support advancement toward licensure
- Partner with schools of social work to strengthen community mental health as a career destination through dedicated tracks or certificate programs, loan repayment, and incentives to attract and retain graduates in New Hanover County
- Prioritize recruitment and retention of clinicians of color and bilingual providers — particularly Spanish-speaking clinicians — to better serve Black and Latino residents who face significant barriers to culturally and linguistically responsive care

STRATEGY 2

Invest in Retention and Sustainability of the Existing Behavioral Health Workforce

APPROACHES

- Explore development of a centralized Management Services Organization (MSO) to provide outsourced administrative, billing, human resources, and supervision support — alleviating burden on smaller providers and private practitioners and enabling greater Medicaid participation
- Equip supervisors with tools and training to prevent burnout, support their teams' wellbeing, and create structured pathways for staff pursuing licensure in community mental health settings
- Invest in shared infrastructure for professional development — including communities of practice, specialized training, and career advancement opportunities — that community mental health providers can access and offer to their staff

Investment Opportunity 5: Build and Sustain the Behavioral Health Workforce

EVIDENCE & BEST PRACTICE FOUNDATION

- Loan repayment is the highest-yield tool for placing and retaining clinicians in community behavioral health. NHSC data show recipients remain at placement sites 4+ years on average, beyond the two-year commitment, and are more likely to stay in shortage-area practice. North Carolina's State Loan Repayment Program targets behavioral health professionals in shortage areas and aligns with the existing pipeline strategies (HRSA NHSC retention data; NC Office of Rural Health SLRP).
- Provider–patient cultural concordance is linked to longer engagement, higher satisfaction, and better outcomes. Black patients with Black providers are more likely to complete treatment. MSW graduates from HBCUs and HSIs are also more likely to enter and remain in community settings, making diversity-focused workforce pipelines both an equity and retention strategy (Alsan et al., American Economic Review, 2019; Cabral & Smith, 2011).
- Replacing a community behavioral health clinician costs 150–200% of annual salary when recruitment, onboarding, caseload disruption, and lost Medicaid billing are included. Organizations investing in retention supports — supervision, career pathways, reduced administrative burden — often recover these costs within 1–2 years (National Council for Mental Wellbeing workforce survey, 2023).
- Documentation burden and administrative workload are the most cited modifiable drivers of clinician departure, ranking above compensation in qualitative studies. Clinicians spend 30–40% of their time on administrative tasks. Shared MSO-type infrastructure for billing, HR, and credentialing reduces this burden without each organization building its own capacity (National Council/Harris Poll, 2023).
- Supervisor relationship quality is the strongest predictor of clinician retention, exceeding compensation or caseload size. The ARC intervention (Glisson et al.), tested in randomized trials, showed that investing in supervisory culture and team climate reduces role conflict, improves job satisfaction, and increases organizational commitment. Supervisors receiving active support produce stronger retention across their teams.

COMMUNITY MODELS

Kaiser Permanente Mental Health Workforce Accelerator

Launched 2023 in Colorado and Georgia; expanding nationally. Provides stipends, placement, and supervised clinical hours for pre- and post-master's associates (MSW, MFT, LPC) in community settings. Targets the licensure completion gap — nearly half of master's graduates never reach licensure — with a pipeline explicitly built for community retention.

Behavioral Health IPA Model (New York)

NY State's 2018 BH Value-Based Payment Readiness Program seeded BH-specific IPAs, letting independent community clinicians pool billing, credentialing, and payer contracting under one entity while retaining clinical independence. Early results: reduced administrative burden, stronger payer contracts, and shared infrastructure across fragmented providers.

University of New Mexico – Project ECHO (National)

Hub-and-spoke tele-mentoring network connecting community BH providers to weekly specialist-facilitated case learning. Documented reductions in provider isolation and competency gains across 180+ countries — a direct model for the shared professional development infrastructure Strategy 2 calls for.

ARC Organizational Intervention

RCT across community-based BH programs: investment in organizational culture and supervisory climate reduced role conflict, improved job satisfaction, and increased commitment. Supervisor support, not training alone, produced measurable, sustained retention gains and improved client outcomes (Glisson et al.).

Relating Strategy to The Endowment Theory of Change

IA1 Build a Coordinated Behavioral Health System of Care

Strategy

Strengthen Infrastructure for an Integrated System of Care

Theory of Change Contribution

*Connect systems and data; improve access and coordination →
Expand access to appropriate levels of care*

IA2 Strengthen the Behavioral Health Crisis System

Strategy

Support Development of a Clearly Defined County Behavioral Health Crisis System

Theory of Change Contribution

*Improve crisis response, community safety, and access to care →
Reduce ED reliance and lower barriers for highest-need individuals, including people experiencing homelessness*

IA3 Advance Early Childhood Behavioral Health

Strategy

Support Parent and Caregiver Social-Emotional Wellbeing / Improve Developmental Screening and Early Intervention Access

Theory of Change Contribution

Prevention and family wellbeing → Early identification and intervention

IA4 Strengthen Youth Behavioral Health & School-Based Supports

Strategy

Strengthen Public Schools' Capacity to Close the K-12 Achievement Gap and Address the Full Spectrum of Social, Emotional, and Behavioral Health Needs

Theory of Change Contribution

Early intervention for youth → Community engagement and prevention

IA5 Build & Sustain the Behavioral Health Workforce

Strategy

Invest in Retention and Sustainability of the Existing Behavioral Health Workforce

Theory of Change Contribution

Grow workforce capacity → Sustain and diversify the behavioral health workforce pipeline

Theory of Change: **Build, Strengthen, and Invest**

IF we invest in building the missing post-acute continuum,



THEN people leaving crisis or the hospital have a pathway to stability instead of cycling back to the ED.

IF we invest in system navigation **AND** the services to navigate to,



THEN families access the right care, reducing crisis utilization and improving outcomes.

IF we support workforce retention through structural changes,



THEN community mental health providers maintain experienced, culturally responsive clinicians.

IF we fund-trusted community-based organizations as behavioral health entry points,



THEN underserved populations engage earlier through trusted community doors.

IF we build a children's continuum from trusted settings,



THEN the community shifts from reactive trauma-focused response to proactive support and wellness.

IF we rationalize crisis architecture and links recovery to housing,



THEN people in crisis have a clear pathway from street to stability.

Leveraging Together

Where Recommended Strategies Intersect with [New Hanover County's MH/SUD Strategic Plan](#)

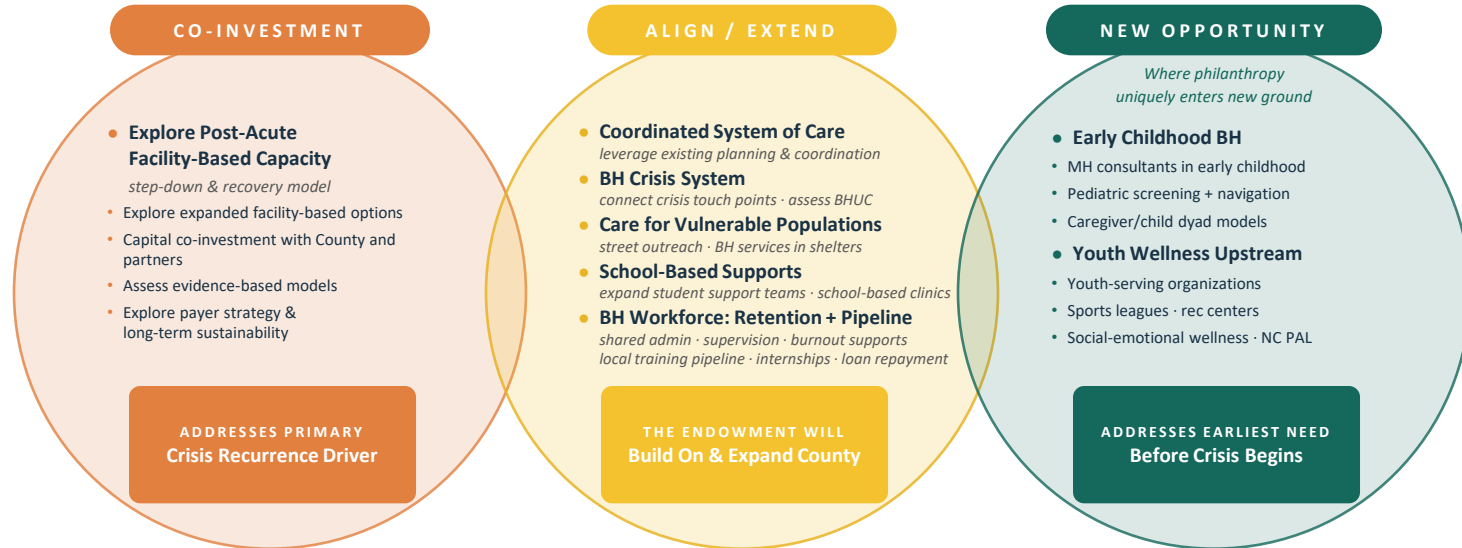
THE COUNTY'S
FUNDING
COMMITMENT

New Hanover County MH/SUD Strategic Plan (2022)

Education & Outreach | Access to Services & Treatment | Sustainable Recovery & Wellbeing

\$50M+
Committed

POTENTIAL DRAFT PARTNERSHIP ZONES



WHAT PHILANTHROPY UNIQUELY BRINGS

- 1 Bring partners together**
across sectors
- 2 Try new ideas**
before others will fund them
- 3 Fund for years**
not just one budget cycle
- 4 Prove what works**
test, then show results
- 5 Fill the gaps**
public funds can't reach

Implementation Considerations

Nine Implementation Principles to Help Guide Investment Decisions

Place-based	Target investments to serve residents in 28401, 28403, 28405, 28412 where data shows highest burden and deepest disparities.
Build the continuum and navigation	Both are needed. Build the missing services AND create the system to connect people to them.
Leverage co-investors	Co-invest with the County and other funders that can support the work.
Community voice	Advisory structures with lived experience; listening sessions become ongoing, not one-time.
Technical assistance for fidelity	Technical assistance can be embedded alongside grant funding, supporting evidence-based fidelity and practical measurement.
Build on what works	Strengthen existing strong organizations, especially Community Based Organization's and adapt promising and evidence-based models— don't duplicate. Fund the connective tissue.
Invest in design	Dedicate time and expertise to rigorous program planning before implementation, ensuring initiatives are set up for success from the outset.
Learning and impact evaluation	Build in evaluation from the start to measure impact, generate evidence, and support continuous learning.
Sustainability and systems change	Plan from the beginning for long-term sustainability and the deeper systems change needed for lasting impact.

The Role of Philanthropy

Catalytic Investor	Provide the startup and bridge capital that unlocks self-sustaining service delivery — funding what the market will not start and what government cannot move quickly enough to build.
Co-Investment Partner	Align and leverage resources alongside county government, state agencies, managed care organizations, and national philanthropy — multiplying impact and establishing shared accountability for outcomes.
Convener	Bring providers, government, payers, and community stakeholders to a shared table around problems that no single actor has the standing or mandate to solve alone.
System Architect	Design and fund the connective infrastructure — navigation, closed-loop referrals, shared data, and system governance — that transforms a fragmented set of programs into a coherent system of care.
Innovation Catalyst	Test emerging models, create structured space for promising approaches to be piloted and evaluated, and accelerate the adoption of what works across the broader system.
Quality and Learning Driver	Embed technical assistance and evidence-based fidelity in investments when applicable — ensuring that grantees improve continuously and that the field learns from both success and failure.
Community Voice Amplifier	Institutionalize lived experience in program design, implementation, and evaluation — making community voice a structural feature of governance, not a periodic input.
Accountability Steward	Maintain a public scorecard tracking outcomes, equity, and system performance — driving improvement through transparency and sustaining community trust over time.

A P A T H F O R W A R D

Strategic Opportunity

New Hanover County has strong community commitment and emerging initiatives addressing behavioral health challenges.

The strategies recommended in this report represent opportunities for The Endowment and its partners to accelerate progress by investing in approaches that:

Strengthen systems of care

Expand access to services

Support families and communities

Improve long-term behavioral health outcomes

This work builds on a strong local foundation, including New Hanover County's mental health and substance use disorder strategic plan and the efforts already underway across local providers and partners. Through strategic and coordinated investments, The Endowment, other funders and partners including health systems, payors, and providers can play a catalytic role in building a more responsive and equitable behavioral health system for the region.

From Findings to Focus

The landscape analysis surfaced five investment areas of opportunities. The Endowment assessed each through a decision and implementation lens — including the County’s mental health and substance use disorder strategic plan and funded projects — and selected three priorities, while also allowing for the possibility of flexible and timely investments and partnerships.

01	Five Investment Areas of Opportunities <i>What the analysis found</i>	System of care, crisis services, early childhood, youth and school-based supports, and workforce — each presented with strategies, evidence, and community models.
02	Decision & Implementation Lens <i>How the choices were made</i>	Landscape analysis, demonstrated need, impact, readiness, leverage, and sustainability, applied alongside alignment to The Endowment’s Theory of Change.
03	Three Strategic Priorities <i>Where we landed</i>	Early childhood behavioral health, youth behavioral health and school-based supports, and behavioral health workforce now set the direction for The Endowment’s behavioral health portfolio.



ALIGNED SYSTEM ARCHITECTURE & CRISIS OPPORTUNITIES: FLEXIBLE INVESTMENTS

Coordinated system of care and crisis response infrastructure remain in the portfolio as flexible investments. The Endowment will contribute strategically as opportunities arise while collaborating with partners to strengthen the broader behavioral health system.

Three Priorities, One Connected System

All New Hanover residents can get the right behavioral health care at the right time — support that begins early, is available where it is needed, and is backed by a workforce able to deliver it.



Early Childhood Behavioral Health

Strengthen supports for young children and families to promote healthy social and emotional development.

Help families early



Youth Behavioral Health & School-Based Supports

Expand school-based and community supports that address behavioral health needs and keep youth connected.

Meet young people where they are



Behavioral Health Workforce

Build and sustain a strong, diverse workforce to meet community needs now and into the future.

Make sure someone is there to help

WHAT HOLDS THE THREE PRIORITIES TOGETHER

Coordination and crisis capacity are not a fourth priority — all three depend on them. When services connect, gaps between levels of care close, and crisis options are dependable, each priority delivers more. The Endowment will support this work alongside County and community partners already leading it.

How the Work Proceeds and What Changes for Residents

How The Endowment Envisions the Work

- **Co-invest, not alone** — align funding with the County, State, MCOs, and other philanthropic partners under shared accountability.
- **Build on what works** — strengthen existing CBOs and providers rather than duplicating services already in place.
- **Focus where need is greatest** — prioritize the communities carrying the highest burden so access improves where it is thinnest.
- **Keep listening** — sustain community feedback so residents continue to shape the work as it progresses.

What Should Change for Residents

- **Help arrives earlier** — needs are met before they escalate, easing reliance on crisis and post-acute care.
- **Fewer gaps, clearer paths** — access improves across levels of care, with obvious routes to help.
- **Stronger family support** — children and adolescents thrive through settings they already use, such as schools.
- **Support that carries across life stages** — behavioral health care reinforces the maternal, infant, and preventive care families already rely on.

HOW WE WILL KNOW IT IS WORKING

Progress tracked through shared measures and public reporting, with community voice built in at every stage.



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