

Public Behavioral Health Care Reform in North Carolina:

Will We Get It Right This Time Around?

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North Carolina seeks to provide affordable and high-quality care for people with mental health, developmental disabilities and substance abuse conditions by reforming its behavioral health care system. This article presents an overview of current efforts to achieve that goal and discusses the challenges that must be overcome if reform is to be effective.

The behavioral health system in North Carolina, as elsewhere in the United States, has historically faced many daunting challenges in the organization, delivery, and financing of care, leading to serious gaps in services and cycles of attempted reforms. Some of these challenges include the lack of capacity for community-based treatment, chronic shortages of behavioral health providers, and a shortage of state and local hospital capacity. As it faces these challenges, the state also has new opportunities. There is greater coordination and integration of care between primary care providers and behavioral health specialists; the state has expanded community hospital treatment capacity through 3-way contracts; there is greater capacity for crisis support; the number of Critical Access Behavioral Health Agencies has increased; and new models of delivery of services exist, such as telemedicine. In addition, the Affordable Care Act of 2010 and the Mental Health Parity and Addiction Equity Act of 2008 offer the potential to improve delivery and coordination of care while increasing the number of people eligible for insurance coverage. New behavioral health “carve-out” 1915(b)/(c) Medicaid waivers will give local communities greater flexibility to redesign behavioral health care, although such carve-outs may work at cross-purposes with the existing Enhanced Primary Care Case Management model offered under Community Care of North Carolina. The pace of these changes—particularly the rapidity of the statewide expansion of the Medicaid waivers—raises cautions about local capacity to build effective managed care organizations from the ground up. Will these new opportunities help the state transform its behavioral health system to address these persistent challenges?

Numerous reports, analyses, and commentaries have dissected and debated North Carolina’s troubled efforts to reform its public behavioral health system over the past

decade [1-8]. Despite legislative and fiscal uncertainties, new efforts are under way to overcome the shortfalls of the past and to get the public behavioral health system back on track to provide affordable and high-quality care to the many thousands of people with behavioral health conditions in North Carolina.

National Trends and Developments

Behavioral health care in the North Carolina and the nation is yet again at a crossroads. Dramatic changes in the treatment technologies, organization, and financing of behavioral health services and income supports since the deinstitutionalization of patients in state psychiatric hospitals in the early 1960s have substantially improved the well-being of persons with mental illnesses [9-13]; indeed, Frank and Glied describe the condition of people with such illnesses as “better, but not well” [12]. The passage of the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act of 2010 (ACA) offers unprecedented opportunities to rethink and integrate general and mental health care, to guarantee at least minimally adequate mental health coverage, and to dramatically expand insurance coverage [14-16]. States have a major role to play in defining the services that will be included in the essential health benefit that will be available to small businesses and individuals who purchase new coverage after 2014 and in the benchmark plan that must be offered to people who are newly eligible for Medicaid. These reforms come with great uncertainty at a time when demands for health care cost containment have become politically undeniable and states are straining to pay their share of the state-federal Medicaid partnership that pays for the bulk of public behavioral health care. Ironically, the strain to pay for Medicaid-funded services may widen the gap between what we know works and what services are available.

Electronically published June 7, 2012.

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0029-2559/2012/73304

Part of this gap has arisen from declines in financial support for mental health and substance abuse treatment in the private and public sectors [11-13]. In the 1980s, as the costs of general health care rose, employers increasingly sought to control them through managed care cost-containment strategies wherein mental health and substance abuse services were “carved out” and managed as a separate benefit. Typically this entailed applying separate benefit and dollar limits to mental health and substance abuse treatment, a strategy made possible by the absence of a consistent legal mandate for insurers to provide mental health and substance abuse coverage on a par with other health care benefits—a problem now addressed through the Mental Health Parity and Addiction Equity Act and the ACA. However, these managed behavioral health care efforts led to massive reductions in mental health spending in private insurance plans: Mental health spending as a share of total spending fell from slightly more than 6% in 1988 to roughly 3% a decade later [13]. As a result, many behavioral health providers and psychiatric hospital services simply went out of business, dramatically weakening the behavioral health workforce and shrinking the supply of available alternatives to state psychiatric beds and public behavioral health services [9]. Emergency departments and primary care providers with scant treatment resources themselves began seeing an increasing number of psychiatric patients [17]. These trends in private insurance coverage shifted a substantial burden of care to public behavioral health services, primary care providers, emergency departments, and the justice system.

North Carolina Trends and Developments

North Carolina mirrored these national trends; however, compared with many states, we were slow to shift from reliance on state hospital beds to the provision of local community services; we were also slow to leverage state hospital funding for Medicaid-fundable community services. Indeed, as the state’s supply of community psychiatric beds shrank dramatically, state hospital beds were left in place to fill the void. In the early 2000s, during the Easley administration, the ongoing performance problems of local mental health agencies and an overreliance on state hospital beds led the General Assembly to direct the Secretary of the North Carolina Department of Health and Human Services (DHHS) to overhaul North Carolina’s public system of mental health, developmental disabilities, and substance abuse services (MHDDSAS) [3-6]. The Secretary’s State Plan 2001: Blueprint for Change [18] called for the following changes: (1) The bed capacity of state psychiatric hospitals was to be reduced by 700 beds. (2) The previous 40 mental health area programs were to be converted into a smaller number of local management entities (LMEs) responsible for developing provider networks, assuring quality, and funding services at the local level. (3) The area program roles of administering and providing services were to be separated, creating a newly privatized system. LMEs would

not provide any direct treatment or rehabilitative services as long as qualified private providers were available to do so, thereby avoiding the conflict of interest that many stakeholders believed was present when area programs functioned as both provider and funder of services. (4) All state mental health, substance abuse, and developmental disability dollars were to be targeted for the care of severely ill or impaired adults and children.

Funding for this transition was to come from a newly designated state trust fund, new Medicaid-funded services, and downsizing of the state hospitals. Many viewed this reform agenda as overly ambitious and poorly operationalized [3-4]. Rash discusses the history of the state’s mental health system more fully in this issue [6].

Regrettably, subsequent downturns in the state economy made adequate funding for the mental health trust fund elusive, thwarting efforts to grow community treatment capacity; federal approval of new Medicaid services was significantly delayed; high demand for state hospital beds made bed reductions hard to accomplish, until the state mandated state hospital waiting lists; and reliance on poorly defined but generously reimbursed community support services led to ballooning Medicaid expenditures by the state, estimated at \$400 million [17]. In a welcome corrective effort to reduce demand for state hospital beds and to address the dramatic shortage of local psychiatric bed capacity, the state legislature later identified new funding for hospitalizations for uninsured patients in so-called 3-way contracts, provided support for mobile crisis teams, and providing funding for local psychiatrists [6, 19-20]. Trantham and Sherry [19] and Murphy [20] describe the roles of mobile crisis and crisis intervention teams in this issue. Despite the new support for crisis services, shortages of state psychiatric beds have continued to lead to boarding of the most challenging patients in local hospital emergency departments [17]. Vicario discusses this problem more fully in his commentary in this issue [17]. At the same time, collaborative care efforts designed to build primary care capacity to manage behavioral health problems were encouraged, with the intention of easing pressure on specialty behavioral health providers and better integrating general and behavioral health care [21-22]. Dickens, Lancaster and Crosbie describe North Carolina’s efforts to promote integrated care in primary care and behavioral health settings in their commentary [21], and Williams reviews the research literature about co-located and integrated care in his sidebar [22]. Despite some progress in building treatment capacity, mental health reform efforts during the Easley administration were largely viewed as inadequate in building effective community-based services.

Governor Beverly Perdue’s election in 2008, accompanied by the appointment of new DHHS leadership, led to hoped-for mid-course corrections to reform efforts. One of DHHS’s early major initiatives during the Perdue administration called for renewed clinical accountability and integration

through the formation of Critical Access Behavioral Health Agencies (CABHAs), which were designed to restore medical leadership to provider agencies and to require them to become comprehensive service providers, rather than allowing them “cherry-pick” profitable services [23]. Another initiative promoted judicious expansion of Piedmont Behavioral Health’s successful model program using the state’s first 1915(b)/(c) Medicaid waiver [24]. However, optimism was soon quashed by the downturn in the economy, combined with the shift of the legislature to tighter fiscal conservatism. The new legislative leadership called for deep Medicaid cuts and for the passage of House Bill 916, which mandated rapid statewide extension of Medicaid 1915(b)/(c) waivers, coupled with widespread mergers of 23 LMEs into 11 newly created managed care organizations (MCOs) designed to administer capitated behavioral health services [24]. Shipman describes the history of Piedmont Behavioral Health’s managed behavioral health care waiver [24], which was the precursor of the statewide waiver, and Terhune discusses the role that CABHAs will play within the new managed care system [23]. Savidge and Stein also explain the opportunities that may be available under the waiver to improve the system of services and supports for people with substance abuse disorders [16].

Amidst these contested policies and in this charged political climate, Disability Rights North Carolina filed a complaint based on the US Supreme Court’s *Olmstead* decision with the US Department of Justice, arguing that North Carolina is inappropriately institutionalizing people in adult care homes. Settlement of such cases in other states has required significant investments in community-based care [25-27]. Smith explains the underlying reasons for the *Olmstead* complaint in her commentary [25]; Melcher and Watson describe how the state hopes to respond to the concerns raised by the federal government [26]; and Farnham, in a sidebar, discusses how North Carolina can use some of the same strategies the state has employed in transitioning people out of other institutional settings to transition people with mental illness out of adult care homes [27].

This special issue of the NCMJ explores the countervailing challenges and opportunities at the intersection of federal and state health and mental health reforms, funding constraints, and litigation. Below, we focus on several key issues in this coming wave of behavioral health reform in North Carolina.

Key Issues for Consideration

Opportunities afforded by the ACA. Paradoxically, solutions to many of the current problems with public behavioral health care in North Carolina may come from national health care reform, not from further state-level reforms. The ACA and the Medicaid waiver expansion present multiple opportunities to redesign North Carolina’s public behavioral health system [14]. Various provisions of the ACA provide 5 such opportunities for redesign.

First, states and federal agencies can test and evaluate improved financing and organizational arrangements to overcome the fragmentation of services that has led to poor quality and high cost of care. Second, provisions that promote comprehensive and coordinated care—the ones that encourage the development of patient-centered medical homes, for instance—should encourage more responsiveness to chronic disease comorbidities, such as severe mental illness and other serious chronic diseases or risks. Third, providers are encouraged to coordinate Medicaid behavioral health services with social services and housing supports that seek to prevent homelessness among people with severe mental illness. Fourth, the ACA allows providers to use preventive services and encourages those treating persons with severe mental illness to focus more on conjoint substance abuse education and treatment. And fifth, the act encourages the wider use of evidence-based practices such as assertive community treatment and supported employment, as well as model programs that develop and validate coordinated approaches to care delivery and payment.

These provisions do not take effect automatically, and the forthcoming Supreme Court review could affect the fate of the ACA considerably. The ACA provisions will require active planning and collaboration by the state, which must work with federal authorities, seeking approval to implement innovative practices that respond to current limitations regarding the way in which the public behavioral health system addresses the needs of people with disabling behavioral health conditions.

Managing current and future complexity. One fact often noticed but rarely understood is that, although the public MHDDSAS system and the human services bureaucracies that manage it have shrunk over the past 50 years, providing services to people with these conditions has become much more complex and is difficult to manage well [11-12]. In the 1950s, the public MHDDSAS system in North Carolina consisted of 4 state psychiatric hospitals, along with a separate array of substance abuse and developmental disabilities facilities. Most people with MHDDSAS conditions eventually spent time in these state facilities, and virtually all public funds flowed through the centralized state facilities system.

Today, these state facilities have shrunk to less than a fraction of their size in the 1950s. Many people with MHDDSAS conditions are never admitted to state psychiatric hospitals or facilities; following decades of mainstreaming efforts, people with these conditions can be found all over the community map. Funding for their care and support now flows from, and through, a highly decentralized and complex array of federal, state, and local agencies, including the Centers for Medicaid and Medicare Services, the US Social Security Administration, the Division of Social Services of the North Carolina DHHS, the state and federal criminal justice systems, agencies that provide supported housing, and school systems, as well as agencies that provide state support for inpatient and outpatient mental health care. The result is

that the North Carolina Division of MHDDSAS no longer has exclusive jurisdiction over the main funding streams, policy levers, and direct services that affect the quality of life experienced by the large majority of people with MHDDSAS conditions. Indeed, no single agency is in charge anymore. Efforts to manage this array of providers, payers, and policy-makers have become exceedingly complex, requiring much more in the way of negotiation with oversight and peer agencies, rather than traditional top-down directives within a single chain of command. As discussed below, demands to manage this complexity will dramatically intensify as North Carolina implements a new, publicly controlled, locally managed, “carved out,” risk-based Medicaid managed care program.

Clinical services integration. One of the historic achievements of the community mental health center movement, represented in North Carolina by area programs, was the creation of comprehensive integrated service agencies—so-called “one-stop shops.” Controversially, the breakup of area programs became the hallmark of the mental health reform effort of 2001. Responsibility for service provision was divested from area programs to a growing network of private service providers, each of whom entered into contracts with newly created LMEs for a specific set of remunerative services, delivered in defined geographic areas. One of the unanticipated consequences of this privatization was the increasing fragmentation of services. Coordination and continuity of care suffered mightily as each provider focused on its own service array. No single provider agency was tasked with taking—nor were the LMEs fully empowered to take—a comprehensive and integrated view of consumer needs and how best to meet them. In this environment, the market became flooded with many small, limited-service providers.

One DHHS response to this fragmentation was to create a new category of provider agency: the CABHA, which was designed to ensure that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a more complete continuum of services [23]. The goal was to enhance the integration of clinical services while consolidating the provider marketplace by disqualifying small, single-service providers. By March 2012, more than 200 CABHAs had been certified across the state—far more than anticipated [28].

The state of the behavioral health workforce. Poor public and private funding, stigma, and marginalization of behavioral health services have all left the national behavioral health workforce in crisis; this largely low-status workforce is also poorly prepared to deliver empirically validated and culturally sensitive services [29]. Despite rapid population growth over the past 3 decades, large areas of North Carolina remain rural and lack an adequate supply of behavioral health professionals. Three-fourths of North Carolina counties have fewer than half the psychiatrists required to meet county needs [30]. On the other hand, 5 counties that are located adjacent to university medical centers in

the central Piedmont area of the state (Durham, Granville, Orange, Person, and Vance) have several times the number of prescribers needed to meet the needs of their local populations [30].

Overall, the supply of prescribers in North Carolina meets only about half of the state’s need. To make up the deficit under current national patterns of care, North Carolina would need nearly 1,000 additional prescribers. In contrast, North Carolina has 3 times the needed number of nonprescribers, albeit often inadequately trained ones. Although nonprescribers (psychologists, nurses, social workers, marriage and family therapists, and counselors) are often functionally substitutable for one another, they cannot function as prescribers due to scope of practice regulations and expertise constraints [30]. Several telemedicine initiatives and efforts to train advance practice professionals (eg, nurse practitioners, physician assistants) in behavioral health prescribing hold promise for partially addressing these shortfalls [31–32]. However, due to persistent state budget shortfalls and competing funding priorities, serious investment in the development of the behavioral health workforce has been sorely neglected.

Psychiatric hospital beds. One of the key conclusions of the State Auditor’s Report that led to passage of mental health reform legislation in 2001 was that North Carolina’s funding for public MHDDSAS services was out of balance [8]. The State Auditor concluded that too much money was being devoted to the operation of the 4 state psychiatric hospitals, whereas the vast majority of persons with behavioral health conditions were being served by grossly underfunded community programs. The report called for the downsizing of the state psychiatric hospitals and the transfer of dollars saved to expand community services. However, in the years immediately following 2001, admissions to the 4 state hospitals rose rapidly, so much so that by 2007 North Carolina had more 17,000 state hospital admissions [33]. Although many other states had converted their state psychiatric hospitals to long-stay facilities in the 1980s, in 2007 North Carolina was still using these hospitals for acute care.

That year, following a series of incidents involving allegations of patient neglect and premature deaths and the threatened loss of Medicaid and Medicare reimbursements, the North Carolina Division of MHDDSAS instituted waiting lists for admissions to the state psychiatric hospitals in order to reduce overcrowding and to protect both patient and staff safety. Within a year of being adopted, the waiting lists began to show dramatic reductions in the total number of admissions and sharp drops in short-stay patients. Bed capacity at the hospitals also began to be curtailed consistent with the State Auditor’s recommendations. By 2010, there were 60% fewer beds in the state hospitals than there had been at the start of reform in 2001 [1–2]. North Carolina was catching up with the rest of the country: Between 1970 and 2002, the deinstitutionalization movement nationally had eliminated 85% of the beds in public psychiatric hospitals [34].

Although waiting lists helped relieve the stress on state hospitals, the waits they imposed created major problems for emergency departments in local general hospitals, where in 2010 the average patient needing a state hospital bed was estimated to wait 2.6 days [2]. DHHS has attempted to address this problem by purchasing access to a few hundred psychiatric beds in general hospitals across the state, but the impact of that initiative is as yet unclear [17].

The larger problem underlying the growing shortage of psychiatric beds in North Carolina is the absence of a rational bed-need methodology for determining the required ratio of beds to population that would adequately serve diverse areas of the state. Current bed allocations are based largely on historical trends rather than on careful assessments of population needs and the varying availability of state, private, and general hospital psychiatric beds and crisis services that can help to meet needs for intensive care with fewer beds per capita. The state needs a comprehensive continuum-of-care model that defines the role of state hospitals (limiting their use to intermediate- and long-term treatment) and links them to community-based crisis housing and crisis intervention services that alleviate emergency department backlogs while promoting community-based crisis management.

The interface between the criminal justice and mental health care systems. Jails and prisons now serve as the default system of care for many difficult-to-manage persons with severe mental illness, in much the same way that the state psychiatric hospitals did prior to recent reductions in the number of hospital beds and the institution of controls on admission. Good data for North Carolina are lacking, but nationally, more than a million persons with severe mental illness are detained in local jails each year, and tens of thousands more are incarcerated in state prisons [35-37]. Because the system of community services is largely voluntary and there are waiting lists for the state hospitals, jails have become one of the few community settings able to provide 24-hour custody and control of difficult-to-manage individuals with severe mental illness, who often refuse treatment and engage in behaviors that lead to arrest and detention. Incarceration likely exacerbates psychiatric illness, because the justice system lacks adequate treatment resources, and even brief stays in correctional settings are associated with trauma [38].

A variety of interventions have been developed over the past 2 decades to deal with the large numbers of mentally ill persons in the criminal justice system [35-38]. Communities throughout North Carolina have adopted many of these strategies in limited forms, including police-based crisis intervention teams, jail-diversion programs, mental health courts, and specialized mental health probation and parole programs [37]. To date, evidence demonstrating the success of these efforts in North Carolina and nationally has been difficult to demonstrate. The interface between the criminal justice and mental health care systems remains one of

the most challenging areas impeding the development of a well-functioning community-based public behavioral health system.

Housing needs. A lack of stable housing is one of the major gaps in care facing many persons with behavioral health conditions, many of whom are poor and therefore need low-cost or subsidized housing. Indeed, the lack of such housing and the resulting overutilization of adult care homes largely precipitated the Olmstead-based US Department of Justice complaint [25-26].

The national loss of low-cost housing has meant that people with disabilities, who typically live on Supplemental Security Income or other disability income supports, cannot afford a 1-bedroom apartment in any housing market in the United States [39]. A continuum of subsidized housing is needed, from independent living situations to supported housing, where people with severe mental illness and other conditions can have assistance in meeting their daily needs. Such housing can help to keep people out of state hospitals as well as the criminal justice system.

Two things that are lacking in North Carolina are a range of housing options to help individuals who are unable to live independently and intensive community treatment teams that can engage consumers in active treatment and skills development. Dihoff and Weaver discuss the need for safe and affordable housing, along with other recovery supports, to help people with mental illness live successfully with their illness [40].

North Carolina's Embrace of Medicaid Behavioral Health Managed Care

Medicaid is now the largest payer of services for people with mental illness [11]. This fact alone places Medicaid policies and provisions front and center in any discussion about reorganizing North Carolina's public behavioral health system. In 2009, the North Carolina legislature authorized the phased conversion and consolidation of 23 LMEs into 11 MCOs under section 1915(b)/(c) of the Medicaid regulations, waiving federal requirements for fee-for-service payments and open choice of providers [24,41]. The new LME/MCOs will function as behavioral health carve-outs, whereby the behavioral health benefits for defined groups of Medicaid eligibles will be segregated from other Medicaid benefits and managed by the LME/MCOs under contract with the Division of Medical Assistance. Financial risk will remain with the state.

The promise of improvements in coordination of services, cost effectiveness, and quality of care is the impetus for shifting to Medicaid managed care. In principle, Medicaid waivers help to bridge 2 of the big problems that have plagued the public behavioral health system in North Carolina for years—namely, the fragmentation of financing and the lack of connection between funding and policymaking in the provision of MHDDSAS services.

With regard to the experiences that several states have

had with risk-based, carved-out Medicaid managed care programs, the reviews are mixed on whether behavioral health carve-outs have reduced costs, improved access, and improved quality of care, especially for patients with complex problems [42-44]. In addition, such carve-out plans potentially fragment medical and behavioral health care [44-45]. Indeed, the behavioral health carve-out approach to Medicaid managed care would seem to be at cross-purposes with North Carolina's other, longer-standing, Medicaid managed care initiative—primary care case management (PCCM), now represented in an enhanced form through Community Care of North Carolina (CCNC) [21]. The enhanced PCCM model attempts to further achieve clinical integration through implementing a medical home concept. Several states with behavioral health carve-outs are carving behavioral health back into their medical plans in the interest of similar efforts at integration [44].

States that operate Medicaid behavioral health carve-out plans are in the minority, and the managed care plans of most of those that do are typically contracted to established nonprofit or for-profit MCOs statewide or regionally [44]. Guided by the positive results from a single homegrown regional pilot program operated by Piedmont Behavioral Health, North Carolina is set to implement its Medicaid managed care carve-out plan statewide by 2013. North Carolina appears to be unique in having decided to implement 11 separate local public behavioral managed care plans, a decision reflecting the state's concerns about outside corporate management and profit-taking.

A host of concerns are raised by the rapid statewide expansion of Medicaid managed care in North Carolina. Not the least of these is the sheer rapidity of the transformation of single- and multi-county LMEs into MCOs. Competently building these new business entities *de novo* with the requisite workforce, managed care acumen, standard operating procedures, inter-local government agreements, and operational flexibility on a short timeline poses a substantial risk that multiple organizational failures will occur. Indeed, a recent report from consultants monitoring the readiness of regional managed care operations found worrisome problems with business operations and clinical capacities [46].

Because capitation creates financial incentives to limit treatment costs by providing services in the least volume and in the least costly setting, there is a heightened risk of undertreatment—especially given the complexity of the MHDDSAS disabilities and the diverse agencies involved in their care [42-43]. Although some short-term savings may be achievable with tighter utilization review, greater savings and clinical outcomes may be achieved over time by improving access, changing patterns of care, reducing hospital utilization, implementing chronic disease management programs, and improving care coordination, all of which are achievable in enhanced primary care case management programs.

A recent review by the Kaiser Commission on Medicaid

and the Uninsured identified several key concerns about Medicaid managed care [43]: payment concerns (eg, adequacy of payments and incentives to deliver high quality care, especially when providers are paid comparable fee-for-service Medicaid rates; promptness of claims payment and the multiplicity of claims payment processes across MCOs); provider network and delivery system concerns (eg, the depth, quality and accessibility of provider networks, especially in rural areas; coordination among providers, especially acute and longer-term care and integration with physical health care); and consumer protection and oversight (eg, engagement of consumers in informed choice of services; development, efficient collection and interpretation of meaningful quality and outcome measures; transparent grievance processes and accountability).

Conclusions

All of the opportunities for a new wave of public behavioral health reform will be seriously compromised without concurrent efforts to fundamentally improve the way behavioral health service utilization and outcome data are collected and evaluated in order to manage the public MHDDSAS system. State and county budget cuts over the past 2 decades have progressively eroded the program evaluation capacity of state agencies and local government. The complexities of emerging systems of care and financing far exceed the historic capabilities of the state, LMEs, and the network of provider agencies to manage in a coherent and integrated fashion. North Carolina must fully transition to an evidence-based management model in which proposed policies are empirically evaluated and vetted in advance of implementation.

One of the missing ingredients in North Carolina's behavioral health management and reform efforts is a neutral entity with the requisite technical and clinical skills to conduct rigorous ongoing policy analyses and program assessments to help guide legislative oversight, effective management of the public behavioral health system, and the growth of high-quality services for the people of North Carolina. North Carolina has engaged a series of outside consultants for these needs, leading to new learning curves with each engagement and, sometimes, conflicting conclusions. North Carolina universities are one of the major untapped resources in the state to address these information and implementation issues. North Carolina will soon have a new governor, new legislative leadership, and yet another chance at a new beginning with regard to behavioral health system development. Mobilizing university resources to meet pressing behavioral health policy and information needs could have a dramatic impact on getting the public behavioral health systems back on track in the years ahead. NCMJ

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Acknowledgment

Potential conflicts of interest. M.S. and J.M. have no relevant conflicts of interest.

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