Chapter Three: Improving Prevention, Treatment, and Recovery Services

The North Carolina Institute of Medicine's Task Force on Mental Health and Substance Use focused on improving access to effective treatments and services that are easy to navigate and have adequate funding. The Task Force's vision is that we build upon current infrastructure to create an accessible, community-based, flexible system of mental health and substance use treatment services that produces positive outcomes for North Carolinians though a full range of services that are provided in a timely manner and at the most appropriate level of care. The Task Force focused heavily on the community-based mental health and substance use treatment services because these services are essential to keeping people healthy in their home and communities and assisting people transitioning back into the community after a crisis or in-patient treatment. In this chapter, the Task Force recommends actions for improving access to and coordination of mental health and substance use services for all populations. Subsequent chapters include recommendations for improving services for adolescents and older adults.

Navigating the Complex Web of Systems and Payers

Although the same variety of payers exists on the physical health side of health care, the pathways to accessing treatment and the various systems—primary care, specialty treatment, emergency care, and hospitals—are much better understood and coordinated. On the mental health and substance use treatment side of health care, the barriers to understanding and accessing treatment are significant and the various systems are more fragmented, as discussed in Chapter 2.

When someone has a physical ailment, the first step is fairly simple—they go to the doctor. While where someone seeks out care for a physical ailment does vary and is often limited by ability to pay, a trip to the doctor for a lingering cough or cold, broken arm, or persistent pain is well understood. However, there is no commonly understood path to treatment for someone who has been feeling depressed, is too anxious to sleep, has been drinking excessively, or is addicted to prescription drugs. Not only are such health problems stigmatized and hard to talk about with friends and family, the average person does not know where to begin to get treatment, who provides such treatment, and how their health insurance plan—if they have one—covers such treatment.

On the physical health side, North Carolina has well developed systems designed to address the full-spectrum of health needs from mild to urgent for those with insurance and without. In contrast, the mental health and substance use treatment service "system" in North Carolina, as in many other states, is less of a system and more of a fragmented set of financing mechanisms and service providers. The set of covered services varies greatly by payer, with Medicaid covering a robust array of services, private insurance covering a more limited array, and the state cpvering very limited services for some residents without insurance coverage. For consumers trying to access services, this fragmentation creates significant systemic barriers to needed prevention, treatment, and recovery services.

Further complicating access to mental health and substance use services for consumers is the lack of uniformly offered services, even by providers within the same specialty. In the physical health arena, the services an individual podiatrist, dermatologist, or other specialist offers are the same as others of the same medical specialty. In contrast, the services offered by mental health and substance use treatment providers, including psychiatrists, psychologists, professional counselors, marriage and family therapists, clinical social workers, clinical addiction specialists, substance abuse counselors, and others, vary greatly by provider.[1]

Most, but not all, mental health professionals can make a diagnosis and provide individual and group counseling; psychiatrists can also prescribe medication; social workers often provide case management, placement services, and other supports; and peer specialists have lived experience. Additionally, mental health professionals often specialize in working with certain populations and providing specific forms of therapy. Unfortunately, most people are not aware of the differences among the many types of mental health professionals and it is often impossible to know what population someone serves or the types of treatment they provide without contacting them first.

Improving Understanding of How to Access Mental Health and Substance Use Services

For any system to work, the intended beneficiaries must understand it; however, North Carolina's complex mental health system is not well understood. National data show that among those with mental health and substance use disorders reporting unmet treatment needs, cost was the primary reason, followed by not

knowing where to go.[2] This lack of understanding is commonly held by consumers, service providers outside of the mental health and substance use system, and others who interact with individuals with mental health and substance use needs.[3]

Today, the route by which consumers enter the system varies by mental health and substance use need severity, insurance type, and health literacy level, among other factors. A single point of entry for accessing mental health and substance use treatment is needed, similar to 911 for emergencies. "No wrong door" systems remove the burden on individuals and families having to figure out how to access services.

The Task Force goal is that consumers, health professionals, service providers, and others working in communities will understand how to access mental health and substance use services and how to assist others who may be in need of services. Ongoing education of consumers, providers, and other stakeholders is needed to improve understanding and access. Therefore, the Task Force recommends:

Recommendation 3.1: Educate communities on available mental health and substance use services.

1) The Division of Medical Assistance (DMA), in partnership with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), local management entities/managed care organizations (LME/MCOs), private insurance providers, provider organizations, the National Alliance on Mental Illness (NAMI), Care Share Health Alliance, Area Health Education Center (AHEC), and other partners should develop and disseminate model curricula and tools to educate and train patients and family members about the public mental health system including:
    a) Who is eligible for services
    b) What types of services are available
    c) How to access services and navigate the system
    d) Alternatives to the emergency department for crisis treatment

    Trainings should be targeted to local departments of public health and social services, community and faith-based organizations, social workers, agencies serving youth and older adults, and others working in communities.

2) DMH/DD/SAS, LME/MCOs, DMA, AHEC, and private insurers should develop trainings for providers who interact with individuals with mental health and substance use needs in their communities (e.g., health providers, pharmacists, public health, emergency medical personnel, local law enforcement, judges, social workers, and the Department of Justice) understand how the mental health and substance use system works, what services are available, who is eligible for services, and how different populations can access services. Specifically these trainings should:
    a) Work with professional associations, continuing education programs, and local communities to disseminate these training materials.
    b) Integrate this information into Mental Health First Aid training.

Recommendation 3.2: Develop a common access point for the mental health and substance use prevention, treatment, and recovery system.

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), Division of Medical Assistance (DMA), local management entities/managed care organizations (LME/MCOs), private insurers, first responder systems, and other stakeholders should work together to develop a common access point for the mental health and substance use system, particularly for those in crisis.

Engaging Communities around the Mental Health and Substance Use Needs of Residents

Mental health and substance use play an important role in an individual's overall well-being. For those who are living with mental health and/or substance use disorders, receiving appropriate supports that go above and beyond services and treatment can help improve their health outcomes. However, supports at the community level can be hampered by negative attitudes and beliefs associated with people with

mental illness and substance use disorders. People's underlying attitudes and beliefs about mental illness and substance use disorders can inform how they interact with and support community members managing these conditions. If community members have positive attitudes, they tend to engage in more supportive and inclusive behaviors, whereas, if they have negative attitudes, they are more likely to engage in avoidance, exclusionary, and discriminatory behaviors towards people with mental health and substance use disorders.[4] Therefore, shifting the attitudes of community members towards more positive engagement with and understanding of the needs of people with mental health and substance use disorders is paramount for the success of improving the quality of life for those with mental health and substance use disorders.

Mental Health First Aid (MHFA) is an evidence-based, population-level training that increases the capacity of community members to recognize, understand, and respond to signs of mental health and substance use disorders in individuals. Community members who are trained in Mental Health First Aid are more likely to provide help to others and are more likely to advise people to seek professional help.[5] As of 2016, North Carolina had over 18,000 Mental Health First Aid trainees.[6] Mental Health First Aid is an 8-12 hour course that can be delivered by trainers in a variety of community settings. There are multiple versions of the course, including Youth Mental Health First Aid, Mental Health First Aid, and Mental Health First Aid for Older Adults. Increasing the number of individuals trained in Mental Health First Aid is a goal of the North Carolina Department of Health and Human Services. In 2016, North Carolina was showcased as a best practice program for statewide implementation of Mental Health First Aid.[6]

To ensure those working with vulnerable populations, including adolescents and older adults, receive Mental Health First Aid training, the DMH/DD/SAS needs partners. Therefore the Task Force recommends:

Recommendation 3.3: Increase the number of North Carolinians trained in Mental Health First Aid.

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) should work with LME/MCOs, providers, and others to increase the number of individuals across the state trained in Mental Health First Aid.

1) Local Boards of Education, the North Carolina Center for Afterschool Programs, the YMCA, and other organizations serving youth, should encourage school staff and others who work with youth to receive the Youth Mental Health First Aid training.

2) The Mental Health, Substance Use, and Aging Coalition should work with DMH/DD/SAS to:

    a) Encourage existing Mental Health First Aid trainers to become certified as trainers for the Mental Health First Aid for Older Adults program.

    b) Promote the Mental Health First Aid for Older Adults program among those providing various services to older adults including caregivers, continuing care retirement communities, senior housing, senior centers, senior support programs, local law enforcement, emergency medical services, older adults, and others.

Ensuring Communities Provide Input to their LME/MCO

Currently there is a federally mandated process to assess adequacy of services provided through public mental health and substance use treatment systems. DMH/DD/SAS, in partnership with DMA, performs an annual LME/MCO service gaps analysis to assess the ability of the public mental health system to meet consumer needs. Results from the service gaps analysis are used to continue progress towards developing an accessible community-based system of care that provides a full range of services to meet the range of age, gender, and cultural needs of the community, as well as other conditions, as outlined by the Centers for Medicare and Medicaid Services (CMS). (See Recommendation 2.4.)

As part of the service gaps analysis, LME/MCOs are required to involve consumers, families, providers, and other stakeholders. Every LME/MCO has a process for gathering input, and some have worked hard to ensure that consumers and families participate. However, given the size and scope of the seven LME/MCOs, the process for gathering stakeholder input varies widely across the LME/MCOs. Efforts to involve stakeholders in the service gaps analysis need to be increased and standardized across LME/MCOs. In addition to ensuring consumers and other stakeholders have a voice, involving stakeholders in the service gaps analysis provides an opportunity to inform them about the work of the LME/MCO. Some communities are concerned that LME/MCOs are not providing the full array of services (as defined by CMS) and/or

that LME/MCOs are not fully aware of community needs; involving more community members in the gaps analysis could increase this awareness. Additionally, there is a lack of awareness in communities about the types of services being funded with LME/MCO funds. A rigorous method for collecting stakeholder input could benefit both the LME/MCOs and local communities. Therefore, the Task Force recommends:

Recommendation 3.4: Involve consumers and local communities in the LME/MCO service gaps improvement process.

DMH/DD/SAS should work in partnership with local LME/MCOs to establish best practices for how to involve local communities in the service gaps improvement process. Best practices should include ensuring that special populations are part of the process.

Improving Communities' Crisis Response

North Carolina has developed a range of services to meet the needs of individuals experiencing a mental health or substance use crisis. Those services include mobile crisis teams, Crisis Intervention Teams, emergency departments, and psychiatric facilities, both during and after the crisis. Although not all services are available in all communities, the goal is for all communities to have prevention, early intervention, crisis response, and stabilization services. In many communities, services are available, but there are not strong collaborative relationships between the key stakeholders in the crisis response system.[7] Poor working relationships cannot be fixed by any one stakeholder, but instead require all the stakeholders involved in crisis response and treatment to work together. Recognizing this, some communities in North Carolina are developing better processes for addressing the needs of individuals in crisis by pulling stakeholders together to develop new solutions.

Almost 13% of emergency room visits are due to mental health and substance use problems.[8] In many cases, the needs of these individuals can be met in other settings at a lower cost and with more appropriate treatment.[8] Currently, the emergency department is the default delivery point for all emergency medicine calls; however many mental health crises are not medical emergencies. To address these concerns, 13 counties in North Carolina are currently piloting community paramedicine programs, which use trained paramedics to divert individuals in mental health or substance use crises from unnecessary emergency department visits. Under these programs, supported with start-up funds from the state, emergency medical services can deliver individuals in crisis to specialty mental health and substance use crisis centers, or other outpatient resources when available, rather than to emergency departments.[9]

Mental health and substance use crisis services must be fully integrated into the full continuum of services and tailored to individual need. Finding ways to improve the funding and provision of crisis services can help ensure that people have timely access to appropriate services, without over-burdening providers at the highest levels of care.[10] Therefore, the Task Force recommends:

Recommendation 3.5: Support and encourage crisis response stakeholders to collaborate.

1) Hospitals and health care systems, local law enforcement, emergency medical services (EMS), LME/MCOs, community leaders, primary care and specialty providers, patients and families, and others involved in the crisis system in communities should collaborate to improve the response to mental health crises in communities, particularly for adolescents and older adults. These collaboratives should also work together to address other impediments to accessible, timely, quality mental health and substance use services, as well as prevention.

2) Community foundations and other philanthropic organizations should support the development of local stakeholder collaboratives to improve collaboration and coordination between all organizations involved in crisis response, or other aspects of the mental health and substance use system, within their community.

Recommendation 3.6 Develop new payment models to support community paramedicine programs with mental health and substance use crisis response.

The North Carolina Department of Health and Human Services should convene a working group including representatives from the Department of Insurance, health care systems, facilities, and public and private payers, including accountable care organizations, managed care organizations, and provider-led entities to develop new payment models to support community paramedicine programs implementing mental health and substance use crisis response.

Increasing North Carolina's Capacity to Provide Mental Health and Substance Use Treatment Services

Increasing understanding regarding how to access mental health and substance use treatment services is one step toward ensuring individuals and families are able to receive effective treatment. Equally important is making sure that North Carolina's health professional workforce is ready to meet the needs of the population with mental health and substance use needs. Doing this will require not only addressing the adequacy of the mental health and substance use professional workforces, but also expanding where and when individual's mental health and substance use needs are addressed.

Mental Health and Substance Use Treatment Providers

A robust, diverse workforce is necessary to meet the mental health and substance use needs of North Carolinians. In North Carolina, a wide range of providers including psychiatrists, psychologists, professional counselors, marriage and family therapists, clinical social workers, clinical addiction specialists, substance abuse counselors, and others provide mental health and substance use services. A study of the workforce in 2013 found that 13 counties in North Carolina did not have any active psychiatrists, psychologists, or psychiatric nurse practitioners.[11] Furthermore, 29 do not have any practicing psychiatrists and 22 do not have any active psychologists. Only 30 counties have at least one child psychiatrist and six counties have a geriatric psychiatrist.[12] Unfortunately, data is not available on the distribution of all mental health and substance use professionals. An analysis of the distribution of advanced practice psychiatric nurses, licensed professional counselors, marriage and family therapists, psychologists, and social workers found that, in theory, almost all counties have an adequate workforce to meet the mental health therapy needs of the population.[13] However, other factors, such as whether providers accept both public and private insurance, see children or older adults, and provide outpatient treatment could not be assessed, so there are likely shortages for certain groups, even where there are theoretically enough professionals available to meet the needs of the community.[13] For example, data show shortages of mental health and substance use professionals that specialize in treating children and older adults in most counties.[11]

Aside from psychiatrists, the path through education and training varies significantly across mental health and substance use providers. The licensing boards for each type of professional determine the education and training requirements for that field. Having a diverse field of mental health and substance use professionals is important, but the widely varying requirements contributes to inconsistencies among the workforce. There is a need for an infrastructure to support and improve the consistency and quality of mental health and substance abuse services statewide, to retain qualified staff, and to sustain evidence-informed practices. Therefore, the Task Force recommends:

Recommendation 3.7: Strengthen training and workforce development.

The North Carolina professional associations for the mental health and substance use workforce should work together with LME/MCOs, North Carolina's community colleges, colleges, universities, and AHEC to ensure there are courses and continuing education opportunities for the mental health and substance use workforce to develop:

1) Foundational skill training (core competencies) that encompasses a variety of evidence-based models and ranges across disciplines, (e.g., patient-guided practice, cultural and linguistic competence, screening, assessment and referral, treatment planning, systems knowledge, quality improvement).

2) Expertise in providing context-specific services to consumers (e.g., brief intervention, crisis).

3) The knowledge and skills to provide services in both specialty mental health settings (e.g., mental

health clinics, psychiatric hospitals, rehabilitation/reintegration, crisis centers) and non-specialty mental health settings (e.g., schools, social service agencies, integrated care).

4) Expertise and skills needed to work with adolescents, older adults, and/or those with co-occurring mental health and substance use needs.

Recommendation 3.8: Develop a more robust transition to practice system for mental health and substance use professionals.

The North Carolina professional associations for the mental health and substance use workforce should work with the state Medicaid agency, DMH/DD/SAS, Division of Social Services, University of North Carolina System, AHECs, and LME/MCOs to:

1) Address barriers to developing an effective workforce to meet the clinical needs of North Carolinians with mental health and substance use needs.

2) Develop a plan to create more clinical training sites, with appropriate supervision, in both specialty mental health settings and non-specialty mental health settings and with populations of all ages. Training and supervision are particularly needed for professionals seeing individuals with dual diagnoses, adolescents, older adults, and individuals of all ages with substance abuse concerns.

3) Strengthen and improve licensing requirements.

Integrated Care

Mental health and substance use and physical health are not separate. An individual's physical health is impacted by their mental health and substance use; likewise, an individual's physical health impacts their mental health and substance use. The opioid epidemic is a glaring example of how physical health and substance use are related. In our current health systems, physical health and mental health and substance use have been largely separated, even though evidence shows that doing so leads to worse health outcomes and higher spending.[14] National data show that 18% of adults have comorbid chronic physical diseases and mental health disorders, and 68% of adults with a mental disorder have a least one chronic condition.[15] Integrated care, which uses multidisciplinary teams to address a patient's physical and mental health and substance use concerns, is one way to increase individual's access to mental health and substance use services.

What is Integrated Care?

Integrated care is a model that utilizes a practice team of medical care and mental health and substance use clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address physical health, mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Integrated care as a term covers a wide range of working relationships that aim to better coordinate and address patients physical and mental health and substance use concerns, rather than referring to a single model.

Source: Peek CJ, National Integration Academy Council. *Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus*. Rockville, MD: Agency for Healthcare Research and Quality; 2013. http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf. Accessed September 19, 2016.

Over the past 20 years, integrated care has gained prominence across the country and in North Carolina as a health care delivery model that addresses both individuals' physical and mental health and substance use needs. Integrated care can successfully address many of the barriers to receiving mental health and substance use treatment services including limited knowledge about how to access care, not recognizing the need for treatment, and stigma.[2,16] Integrated care is one way to provide the prevention, early detection, and timely referral to mental health and substance use treatment services that are needed to reduce cost and improve outcomes.[10] Many health systems and practices in North Carolina have moved towards providing integrated care.

Moving traditional systems of health care toward a more integrated care delivery system is challenging. Integrated care requires the delivery of physical and mental health and substance use care in new ways, which often requires health providers to work in new ways and new roles, using new health information technology systems, all while trying to figure out how to get paid while providing care that does not fit the traditional fee-for-service model.

Transforming practices from traditional medical/mental health and substance use practices into integrated care practices is difficult work. To successfully transition to a practice/system providing integrated care requires a lot of technical assistance. Technical assistance may take many forms, but is often required to help identify ways to support integrated care through billing, implementing necessary modifications to workflow, and providing training on new tools.

There are a number of organizations in North Carolina that currently provide, or who may provide, technical assistance to practices/systems moving toward integrated care. In most cases in North Carolina, technical assistance is funded by philanthropic organizations. Technical assistance should support integrated care through training and the application of best- and evidence-based practices. The core concepts of this standard of care include team-based care, practice culture change, population management, screening and intervention protocols, motivational interviewing, comorbidities, billing, and workflow.

Within the Medicaid reform legislation passed by the North Carolina General Assembly, a new center, the Medicaid and NC Health Choice Transformation Innovations Center is to be created within the new Division of Health Benefits. Its purpose is "to assist Medicaid and NC Health Choice providers in achieving the ultimate goals of better health, better care, and lower costs for North Carolinians. The center should be designed to support providers through technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices."[a]

In light of the benefits of integrated care and the challenges faced by health care practices and systems transitioning towards more integrated care models, the Task Force recommends:

Recommendation 3.9: Support practice and system transformation towards integrated care.

1) Organizations including the Center of Excellence for Integrated Care, Community Care of North Carolina, AHEC, and others that work directly with providers should provide technical assistance to practices and health systems aiming to provide more integrated care. Technical assistance should be available to both primary care and mental health and substance use providers who are interested in providing integrated care. Technical assistance should include help in identifying ways to support integrated care through billing, implementing necessary modifications to workflow and culture change, training on new tools, and mentoring.

2) The North Carolina Department of Health and Human Services should include supporting integrated care as a core goal of the future Medicaid and NC Health Choice Transformation Innovations Center.

3) Under Medicaid reform, contracts with future Medicaid managed care organizations and provider-led entities should include a requirement to provide funding for technical assistance to practices providing, or moving toward providing, integrated care.

4) North Carolina foundations and philanthropic organizations should provide funding for technical assistance for practices moving toward providing integrated care.

Improving Access through Technology

As discussed, there is shortage of mental health and substance use professionals in many parts of North Carolina, which restricts consumer access to services in many parts of the state. One way to mitigate the shortage of mental health and substance abuse professionals in rural areas is to provide services for individuals with mental health and substance use disorders remotely using technology. Telepsychiatry is the term used to define the exchange of medical information from a provider to a consumer via electronic means with the aim of improving the consumer's health status. Telepsychiatry focuses on mental health and substance use outcomes and studies have shown its success in improving consumer well-being, in part because it improves the availability and accessibility of mental health and substance use professionals for consumers and their providers. Telepsychiatry is also cost-effective, as it reduces costs associated with poor disease management, low staff coordination, travel time, and hospital stays. Challenges to implementing telemedicine models across North Carolina include the need to provide reliable internet connectivity, videoconferencing equipment to providers, and health insurance integration. Despite these challenges, studies have shown that telepsychiatry can help redistribute mental health and substance use resources and ultimately improve quality of life.

a Session Law 2015-245.

Currently, language in the North Carolina Division of Medical Assistance telepsychiatry policy is vague about the appropriate use of telepsychiatry as a modality of delivering services and exactly when and for what purposes telepsychiatry is billable. The North Carolina Medicaid policy allows for the following providers to bill Medicaid or North Carolina Health Choice (the state children's health insurance program): physicians, advanced practice psychiatric nurse practitioners, advanced practice psychiatric clinical nurse specialists, doctorate level licensed psychologists, licensed clinical social workers, and community diagnostic assessment agencies.[b] The current policy is also restricted to Medicaid-enrolled sites, which limits the use of telepsychiatry in community-based settings.

Recommendation 3.10: Update DMA's telepsychiatry policy.

The Division of Medical Assistance should revise Clinical Coverage Policy 1H Section 6.2 to:

1) Explicitly state that the policy covers the use of telepsychiatry for the provision of ongoing direct services.

2) Expand the list of providers eligible to bill for telepsychiatry professional services to include all providers eligible to bill for outpatient mental health and substance use services under Clinical Coverage Policy 8C.

The Division of Medical Assistance should also explore the implications of certifying alternative telepsychiatry sites and credentialing programs rather than individual providers.

In recent years North Carolina has seen high emergency department admissions related to mental health and substance use issues and extended lengths of stays. The majority of emergency departments across the state do not have access to a full-time psychiatrist. The North Carolina Statewide Telepsychiatry Program (NC-STeP) connects hospital emergency departments across the state to provide psychiatric assessments and consultations to patients linked using telemedicine technology. This has resulted in reducing the length of stay for patients needing psychiatric care. Therefore, the Task Force recommends:

Recommendation 3.11: Maintain adequate funding for the NC-STeP Program.

The North Carolina Department of Health and Human Services should continue to provide adequate funding to support the NC-STeP Program.

Health professionals who provide telepsychiatry services to individuals in hospitals around the state are currently required to be independently credentialed by every hospital where they provide services. This creates an administrative burden that could potentially be avoided or significantly reduced. Additionally, providers must be credentialed to bill an LME/MCO for services. For providers who serve clientele in multiple catchment areas, this creates an administrative burden. While LME/MCOs all want quality control over who can provide services in their area, this may restrict the number of providers available to clients, particularly those living and working around the edges of the LME/MCO. To alleviate this burden and increase the number of potential providers, the Task Force recommends:

Recommendation 3.12: **Standardize credentialing across systems.**

Hospitals and health systems, the North Carolina Hospital Association, and LME/MCOs should explore strategies to make the process of credentialing in multiple systems less burdensome for providers, including standardizing the requirements for credentialing across systems, and explore opportunities for reciprocal and delegated credentialing.

b NC Division of Medical Assistance, Medicaid and Health Choice Clinical Coverage Policy 1H Section 6.2

REFERENCES

1. Swartz M, Morrissey J. Public behavioral health care reform in North Carolina: will we get it right this time around? *NC Med J.* 2012;73(3):177-184.

2. Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Mental Health Find*ings. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014. http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.htm. Accessed August 30, 2016.

3. Coates J. Navigating the cyclone: 21st century NC mental health policy. Carolina Public Press website. http://carolinapublicpress.org/25478/navigating-cyclone-nc-mental-health/. Published July 18, 2016. Accessed August 30, 2016.

4. Substance Abuse and Mental Health Services Administration. *Community Conversations About Mental Health: Information Brief*. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2013. https://www.mentalhealth.gov/talk/community-conversation/Information%20Brief%20remediated%20(2)-1.pdf. Accessed September 16, 2016.

5. North Carolina Department of Health and Human Services. Mental Health First Aid. North Carolina Department of Health and Human Services website. http://www.ncdhhs.gov/mental-health-first-aid. Accessed August 30, 2016.

6. North Carolina Department of Health and Human Services. NC showcased at national Mental Health First Aid Instructor Summit. North Carolina Department of Health and Human Services Blog. Published May 12, 2016. Accessed September 16, 2016.

7. Brodar B. St. Luke's Hospital. Law enforcement-BH providers Task Force of Polk County. Presented to: NCIOM Mental Health and Substance Abuse Task Force; Feburary 5, 2016; Morrisville, NC. http://www.nciom.org/wp-content/uploads/2015/05/Broder_2-5-16.pdf. Accessed August 30, 2016.

8. Center for Medicare and Medicaid Services. CMCS Informational Bulletin. Reducing nonurgent use of emergency departments and improving appropriate care in appropriate settings. Centers for Medicare and Medicaid Services website. https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-16-14.pdf. Published January 16, 2014. Accessed August 30, 2016.

9. North Carolina Department of Health and Human Services. Progress Report on the Community Paramedic Mobile Crisis Management Pilot Program. Raleigh, NC: North Carolina Department of Health and Human Services; 2016. https://ncdhhs.s3.amazonaws.com/s3fs-public/SL2015-241%2C%20Sec12F.8.%28c%29%20-%20Community%20Paramedic%20Mobile%20Crisis%20Rpt%20FINA%20DRAFT.pdf. Accessed August 30, 2016.

10. North Carolina Division of Health Service Regulation. Report to Joint Legislative Oversight Committee on Health and Human Services and Fiscal Research Division on Strategies for Improving Mental Health, Developmental Disabilities, and Substance Abuse Services. Presented to: Joint Legislative Oversight Committee; November 1, 2014; Raleigh, NC: North Carolina Department of Health and Human Services; 2014. http://www.ncleg.net/documentsites/committees/JLOCHHS/Handouts%20and%20Minutes%20by%20Interim/2014-15%20Interim%20HHS%20Handouts/November%2018,%202014/Reports/SL%202014-100%20Sect.%2012F.3%28a%29%20Final%20Report.pdf. Accessed August 4, 2016.

11. Richman E, Fraher E, Gaul K. The North Carolina mental health and substance abuse workforce. Presented to: NCIOM Task Force on Mental Health and Substance Abuse; June 5, 2015; Morrisville, NC. http://www.shepscenter.unc.edu/wp-content/uploads/2015/07/NCIOM-SHEPS-MHSA-revMap1.pdf. Accessed August 30, 2016.

12. Saeed S. Using telepyschiatry to improve access to evidence-based care. Presented to: NCIOM Task Force on Mental Health and Substance Abuse; September 18, 2015; Morrisville, NC. http://www.nciom.org/wp-content/uploads/2015/05/MHSA_Saeed_9-18-15.pdf. Accessed August 30, 2016.

13. Thomas KC, Ellis AR, Konrad TR, Morrissey JP. North Carolina's mental health workforce: unmet need, maldistribution, and no quick fixes. *NC Med J.* 2012;73(3):161-168.

14. Green LA, Cifuentes M. Advancing care together by integrating primary care and behavioral health. *J Am Board Fam Med.* 2015;28(suppl 1):S1-S6.

15. Druss BG, Walker ER. *Mental Disorders and Medical Comorbidity*. Princeton, NJ: Robert Wood Johnson Foundation; 2011. http://www.integration.samhsa.gov/workforce/mental_disorders_and_medical_comorbidity.pdf. Accessed August 30, 2016.

16. Mental health policy, planning and service development. World Health Organization website. Integrating mental health services into primary health care. http://www.who.int/mental_health/policy/services/en/index.html. Accessed August 30, 2016.