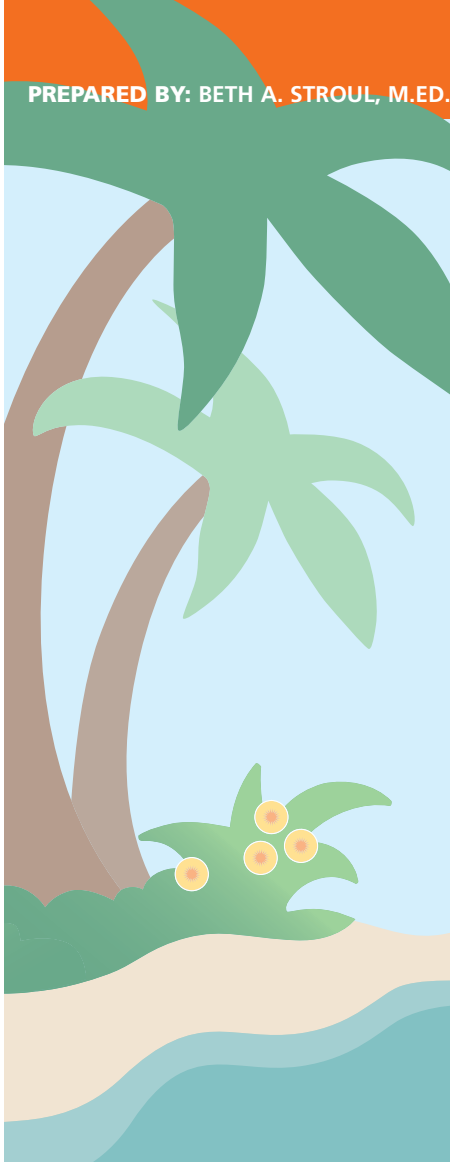


# Financing Children's Mental Health Services: Coping with a Changing Fiscal Environment

SUMMARY OF THE SPECIAL FORUM HELD AT THE  
2006 GEORGETOWN UNIVERSITY TRAINING INSTITUTES

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## Introduction

A series of Special Forums were held at the Georgetown University Training Institutes in July 2006 to provide opportunities for dialogue about critical issues in order to contribute to the development of future policy and technical assistance. The Special Forums were designed as interactive discussions about communities and populations with unique service needs, requiring specialized planning and service delivery approaches within systems of care. Specifically, the goals of the Special Forums were to:

- Summarize issues and challenges related to each topic
- Identify effective service delivery strategies for local systems of care\*
- Develop recommendations for policy and technical assistance that will support communities in implementing these effective service delivery strategies

Each Special Forum began with brief framing presentations summarizing issues and challenges related to the topic and offering examples of effective service delivery strategies. The remainder of the forum consisted of facilitated discussion among forum participants focusing on recommendations for services, financing, policy, advocacy, information development and dissemination, and training and technical assistance. The Special Forums were tape recorded and transcribed, and additional input was collected from participants through worksheets completed at the conclusion of each forum. These materials were used to prepare a paper summarizing the issues and recommendations resulting from each Special Forum.

This paper presents the issues and recommendations from the Special Forum on Financing Children's Mental Health Services: Coping with a Changing Fiscal Environment. Presenters included:

- Sheila Pires, M.P.A., *Partner, Human Service Collaborative, Washington, DC*
- Chris Koyanagi, *Policy Director, Bazelon Center for Mental Health Law, Washington, DC*

## Issues and Strategies

### A Strategic Approach to Financing

Sheila Pires characterized financing for systems of care as a strategic exercise. The Deficit Reduction Act is an environmental variable that has entered the scene, and there are many other environmental variables that affect financing, often depending on the state and community. Rising health and behavioral health care costs and concerns about the uninsured are other factors. Despite these factors, there are interesting developments in states and

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localities that are paying attention to mental health. For example, California passed Proposition 63, a taxpayer referendum that levies a 1% income tax on the salaries of millionaires and above. This has created a lot of new revenue for mental health services for both adults and children. Communities have implemented levies to fund mental health services as well. One locality has implemented a .1% levy on property taxes to create a new fund for mental health, and another uses a .1% levy on sales taxes to create new money for mental health services. Getting a taxpayer referendum passed takes time and depends on political will, but these strategies are being used more often. This may reflect, in part, breaking down barriers around mental health.

Pires pointed out that to talk about strategic financing for systems of care, you must begin not by talking about the money, but by answering the questions: "Financing for whom?" and "Financing for what?" In terms of financing for whom,

these are the populations of children and families for which you want to develop financing strategies. This can be a total population, that is, all children in a county or state, who have or are at risk for behavioral health problems including Medicaid-eligible children and SCHIP-eligible (State Children's Health Insurance Program) children and those not eligible for those programs. For example, New Jersey took a total population focus in its behavioral health reform. Alternatively, the focus can be on a subset of the population. For example, a state or community may be concerned about transition age youth or about children ages zero to five. Milwaukee Wraparound is an example of a county that focused on a subset of children—that is, children with serious and complex behavioral health challenges who are at risk for residential treatment. The more you know about the population—the size of the population, demographics (e.g., culture/race/ethnicity, gender, etc.), how they currently use services,

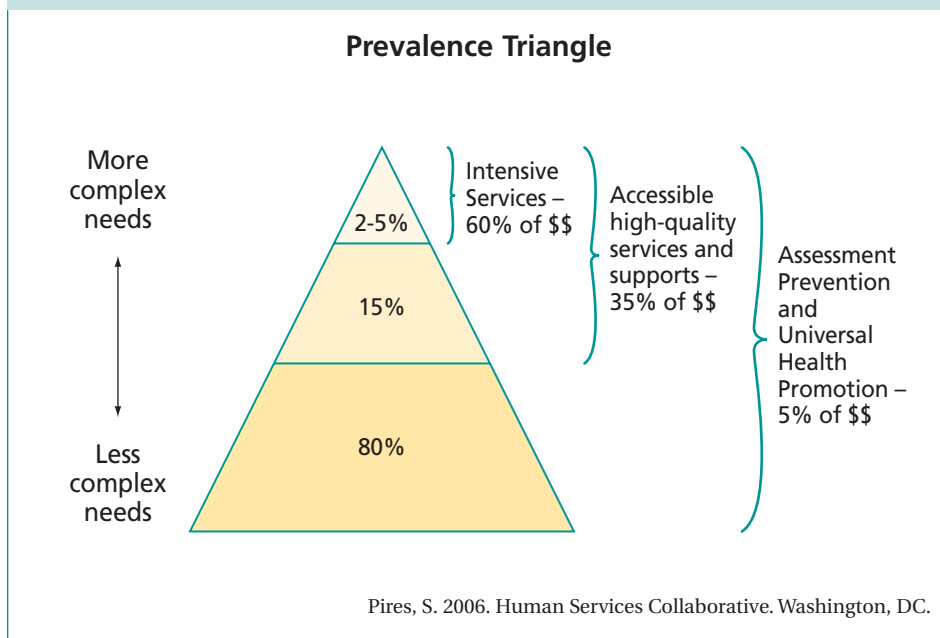
their strengths and needs, resources in the community—the more strategic you can be about financing.

Pires also noted that another aspect of identifying the population is strategically analyzing the prevalence and current service utilization of the population, as shown in Figure 1. For example, in a state in which 2-5% of your population of children, those with the most serious disorders, are utilizing 60% of the dollars, the state would have only about 35% for the 15% or so of children that are very high risk for having serious problems, and very little to spend on primary prevention or mental health promotion. In most states and communities today there are, unfortunately, few new dollars for behavioral health services. The dollars are finite, so in order to fund appropriate home and community-based services and supports, states are redirecting dollars from places where they are either buying high cost services or achieving poor outcomes.

Pires went on to explain that the next step in a strategic financing approach is focusing on the question of "Financing for what?"

- What are the outcomes you want to achieve with respect to the identified population? Desired outcomes are governed by values; it is important to reach consensus about values and outcomes across different stakeholder groups.
- What are the services and supports that will lead to effective outcomes for the identified target population?
- What is the "practice model" you want to promote? Service systems must be concerned not only with providing a range of different services and supports, but with creating a practice model. In systems of care, the practice model

FIGURE 1



involves providers, clinicians, and front-line staff adopting an individualized, family driven, youth guided, strength based, and culturally competent approach to service planning and provision, and providing effective home and community-based services. You cannot assume that people come into your system or are in your system with those kinds of skills. It takes specific skills to implement this type of approach, and systems must think about the requirements for changing the practice model.

Pires explained that the next concern is how values, principles, the desired practice model, and needed services and supports will be organized into a coherent service delivery system. "What is the system design? Can you draw a picture of your reformed system? Do all stakeholders agree on what the re-designed system should look like?" If you are focusing on a total

population, all children in a county for example, you must pay attention to early identification and access, as well as to creating a locus of accountability for those children who have multiple problems and are involved in multiple systems. Pires noted that, "When multiple entities are responsible, no one is really responsible. So you must create locus of accountability."

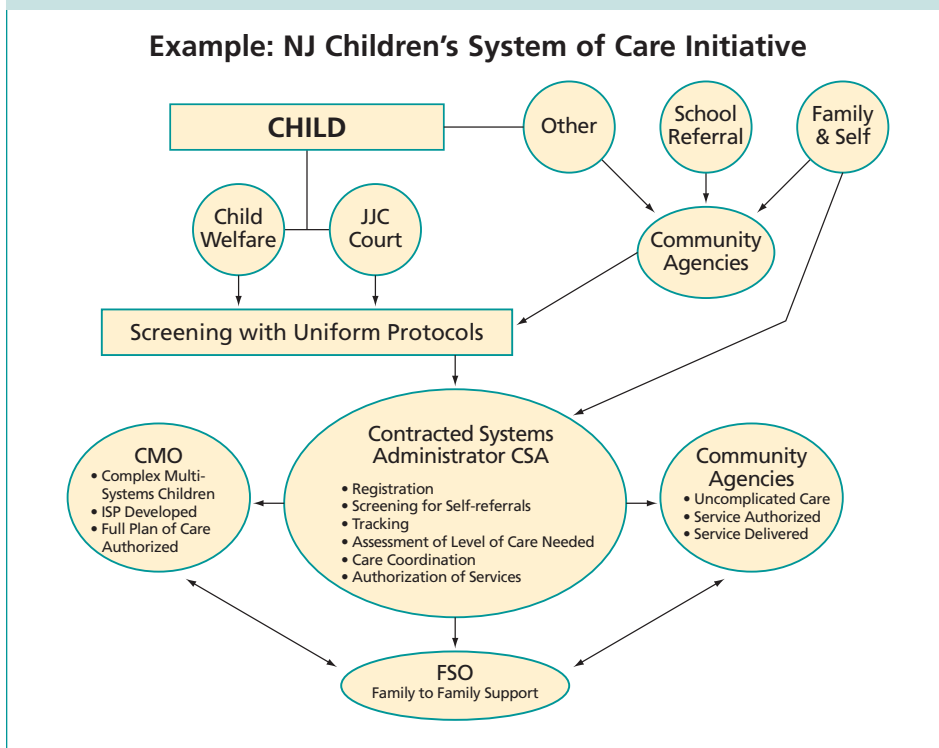
Shown on Figure 2, New Jersey provides an example of a system design graphic illustrating a reformed system of care. It depicts an organized pathway into services for all children and families in a state through a statewide "contracted systems administrator." The contracted systems administrator serves an administrative service organization function; it has a 1-800 number and it triages families to providers in the community. In addition, the system design graphic shows how New Jersey has created a

locus of care management accountability through their care management organizations for children who have serious and complex disorders and their families. These care management organizations have been partnered with family support organizations, which are family-run organizations that are funded with a combination of Medicaid dollars (administrative case management dollars) and general revenue dollars that have been redirected from child welfare and some mental health block grant dollars. This is an example of a design that has taken into account both early identification and a locus of accountability for children with serious disorders and their families.

Pires explained that strategic financing also must consider the system infrastructure that is needed to support the system design. System infrastructure elements include: training and capacity development, data systems, quality improvement structure, financial management, purchasing and contracting, and family and youth partnership capacity. For example, New Jersey set up, in effect, a single payer system through the state Medicaid agency for both Medicaid and non-Medicaid eligible children. From the provider standpoint, you do not really know what dollar is paying for your services, nor do you as a family. You receive a system of care card, and the Medicaid agency disentangles what needs to be billed back to Medicaid for Medicaid reimbursable services or what is billed to other financing sources.

Once the system design is in place, you must figure out how much it would cost before you can begin to look at financing. A system of care can be costed out based on target population numbers, expected utilization (given outcomes and

FIGURE 2



system redesign), types of services and supports, and required administrative/system infrastructure.

Figure 3 shows examples of sources of funding for children and youth with behavioral health and/or special needs in the public sector. Being strategic requires knowing how these various funding streams operate, what they are currently buying, and whether they buying the kinds of services and supports that you want, given what you want to achieve for your target population.

Pires noted that the financing strategies that you use should be based on the principle that it is the system design that drives the financing and not the other way around. The main financing strategies that are used include the following:

- *Redeployment/Redirection*—This involves taking existing dollars that are now buying services with high costs and/or poor outcomes and moving them to other services, such as shifting funds from deep-end treatment to home and community-based services. For example, if you are buying high-cost services or poor outcomes for children being served in residential treatment or group homes, these are potential resources for redirection to home and community-based services and supports. In many places, a great deal of money is spent buying psychiatric and psychological assessments for children, particularly for those involved in child welfare and juvenile justice, that tend to be “cookie cutter” evaluations that rarely lead to strength-based,

individualized, culturally competent services and supports. That is money for redirection into more strength-based assessments in the practice model that you want to achieve. Analyses of expenditures can be done to identify the potential for redirection by doing a better job of managing service utilization. When you redirect dollars, if you create savings, it will be savings per individual child served, which is an important distinction to make to legislatures and governors’ offices. You do not want to redirect resources on the basis that you will save dollars from the total budget. Typically, you will not save total dollars, because children’s services typically are under-funded, utilization is low compared to need, and if you build a better system, people will come and use it. But dollars will be saved per child served; you should ensure that those savings come back into the system of care to support enhanced service delivery—that is, to serve more children or build more service capacity.

- *Refinancing*—Refinancing is generating new money by increasing federal claims. There are challenges to doing that today in Medicaid, but also some opportunities which the Deficit Reduction Act created. A number of opportunities should be explored with respect to Medicaid. One is with respect to Medicaid enrollment rates; if you have an enrollment rate of 60%, there is an opportunity to draw down more federal dollars by increasing enrollment. Another has to do with the services covered by your state Medicaid plan. Do you cover a wide range of services and supports that you know produce good outcomes? Do you use the Rehabilitation Services Option? Can you add new

FIGURE 3

Examples of Sources of Funding for Children/Youth with BH/Special Needs in the Public Sector

<p><b>Medicaid</b></p> <ul style="list-style-type: none"> <li>• Medicaid In-Patient</li> <li>• Medicaid Outpatient</li> <li>• Medicaid Rehabilitation Services Option</li> <li>• Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT)</li> <li>• Targeted Case Management</li> <li>• Medicaid Waivers</li> <li>• TEFRA Option</li> </ul>	<p><b>Mental Health</b></p> <ul style="list-style-type: none"> <li>• MH General Revenue</li> <li>• MH Medicaid Match</li> <li>• MH Block Grant</li> </ul>	<p><b>Education</b></p> <ul style="list-style-type: none"> <li>• ED General Revenue</li> <li>• ED Medicaid Match</li> <li>• Student Services</li> </ul>
<p><b>Substance Abuse</b></p> <ul style="list-style-type: none"> <li>• SA General Revenue</li> <li>• SA Medicaid Match</li> <li>• SA Block Grant</li> </ul>	<p><b>Child Welfare</b></p> <ul style="list-style-type: none"> <li>• CW General Revenue</li> <li>• CW Medicaid Match</li> <li>• IV-E (Foster Care and Adoption Assistance)</li> <li>• IV-B (Child Welfare Services)</li> <li>• Family Preservation/ Family Support</li> </ul>	<p><b>Other</b></p> <ul style="list-style-type: none"> <li>• WAGES</li> <li>• Children’s Medical Services/Title V—Maternal and Child Health</li> <li>• Mental Retardation/ Developmental Disabilities</li> <li>• Title XXI—State Children’s Health Insurance Program (SCHIP)</li> <li>• Vocational Rehabilitation</li> <li>• Supplemental Security Income (SSI)</li> <li>• Local Funds</li> <li>• Tribal Funds</li> </ul>
	<p><b>Juvenile Justice</b></p> <ul style="list-style-type: none"> <li>• JJ General Revenue</li> <li>• JJ Medicaid Match</li> <li>• JJ Federal Grants</li> </ul>	

Pires, S. 2006. Human Services Collaborative. Washington, DC.

services and supports by changing service definitions or is a state plan amendment needed? Many of the service definitions under the Rehabilitation Option in states are written with adults in mind, but these often can be rewritten so that they make sense for children's services without requiring a state plan amendment.

- *Raising Other Revenue to Support Families and Children*—Raising new revenue is a third option and includes donations, special taxes and taxing districts for children, fees and third party collections including child support, and trust funds. It is more difficult and usually is a longer term strategy, but typically these are flexible dollars. For example, it probably took about 10 years to get a children's trust fund approved by the voters in Dade County, Florida (Miami). The children's trust fund generated about \$23 million in the first year, all going into early intervention. Today, after three or four years, the fund is close to \$40 million because social marketing was undertaken to educate the community about the benefits of the children's trust fund. This has generated a lot of flexible dollars.
- *Financing Structures that Support Goals*—It is also important to look at financing "structures" that support system of care goals. All of the siloed funding structures comprise a huge barrier to more integrated service delivery. There are a number of examples of financing structures that support systems of care, including financial claiming invisible to families (seamless services), as in New Jersey, blended funding pools that break the lock of agency ownership of funds, as in Milwaukee, flexible dollars that remove the barriers to meeting the unique needs of families, and incentives (such as

performance-based contracting) that reward good practice.

Pires provided several examples of these funding strategies. When New Jersey first started its system of care reform, the strategies included redirection, refinancing, pooled funding, and new funds. Funds were combined to create a pool, including child welfare general revenue dollars that were paying for behavioral health services, mental health dollars, Medicaid, and some new money from the legislature. The pool initially was \$114 million, but is now higher. This created a match pool in order to expand services under the Medicaid Rehabilitation Option and, therefore, draw down new federal revenue.

Wraparound Milwaukee is an example of pooled funding combining dollars from child welfare, juvenile justice, Medicaid, and mental health. In Milwaukee, as in many states and communities, mental health has fewer funds to contribute. When you do a strategic analysis and mapping of what other agencies are spending money on behavioral health services that are either very high cost or yielding poor outcomes, you typically are led to child welfare, then to juvenile justice. Today, Wraparound Milwaukee has a \$30 million fund. None of this is new money; it is all redirected money—primarily from child welfare and juvenile justice—being used to support a home and community-based delivery system. Among other outcomes, Milwaukee has succeeded in decreasing the average daily residential population from 375 children to 50 without changing their service population one bit. There are about 120 children with sex offenses in the population being served. This does not mean that residential treatment is never used. Rather, it is used very differently (primarily for

short-term stays), and it is highly integrated with the rest of the service continuum and very much wedded to the practice model of partnering with families and youth, individualized, strength based services. Psychiatric inpatient days declined from 5,000 days to fewer than 200 days a year. Both of those reductions represent enormous cost savings that then were plowed back into the system. New Jersey was a state with an over-reliance on both residential and hospital beds, with about 90% of their dollars tied up in beds of one form or another. This has been reduced to 60%, and while that still is too high, it is on the right trajectory.

Cuyahoga County, Ohio (Cleveland) is serving a combination of populations, as compared with all children in New Jersey and those with serious and complex disorders in Milwaukee. Each time a population is rolled in, funding streams are identified to attach to those populations. Cuyahoga is bringing together 11 neighborhood collaboratives with lead provider agencies in a partnership to serve the identified populations of children and to serve as the locus of accountability with flexible funding. At the county level, an administrative service organization is being created, called a system of care office, to oversee the different funding streams that are being combined. The county is creating "virtual pooled funds" whereby the dollars stay in their home agencies, but the plans of care developed at the neighborhood level dictate what is spent from those line items.

Maryland is implementing a major redirection. In this state, most psychiatric residential treatment beds are Medicaid reimbursable. That creates a perverse incentive for child welfare and juvenile justice to

place children in residential treatment, because these systems do not have to pay for the services once the youth are placed. The state is redirecting Medicaid dollars to care management entities at the local county level, beginning with the two localities that account for about 60% of the children that are in residential or at risk for residential treatment—Baltimore City and Montgomery County. They are combining Medicaid dollars, block grant funds, and some child welfare and juvenile justice dollars since two-thirds of the youth in residential treatment in Maryland are child welfare and/or juvenile justice-involved, which tends to be the case nationally.

Pires further explained that once you have identified your population, the services and supports, the practice model, the system design, the infrastructure that's needed, and you have made some attempt to cost it out, then you can undertake a strategic financing analysis. A strategic financing analysis involves the following steps:

1. Identify the state and local agencies that spend dollars on children's behavioral health services/supports, how much each agency is spending, and the types of dollars being spent (e.g., federal, state, local, tribal, nongovernmental).
2. Identify resources that are untapped or under-utilized (e.g., Medicaid).
3. Identify utilization patterns and expenditures associated with high costs/poor outcomes, and strategies for redirection.
4. Identify disparities and disproportionality in access to services/supports, and strategies to address.

5. Identify the funding structures that will best support the system design (e.g., blended or braided funding; risk-based financing; purchasing collaboratives).
6. Identify short and long term financing strategies (e.g., Federal revenue maximization; re-direction from restrictive levels of care; waiver; performance incentives; legislative proposal; taxpayer referendum, etc.).

A Self-Assessment and Planning Guide resulting from an ongoing study of effective financing strategies for systems of care provides a roadmap for strategic financing (<http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/AssessPlanGuide2006>).

### Implications of the Deficit Reduction Act

Chris Koyanagi described the provisions in the Deficit Reduction Act and the challenges that this legislation has created for financing systems of care. She emphasized that Medicaid is the crucial funding stream for child mental health services in a public system, and the Deficit Reduction Act (DRA) of 2006 has made some very significant changes to Medicaid. Many of the provisions are not mandates, but are state options:

- *Targeted case management*—The rules for targeted case management are going to change. Under the Deficit Reduction Act, there is language making it very difficult for child welfare systems to bill for the case management done by a child welfare caseworker. The Centers for Medicare and Medicaid Services (CMS) contends that nearly everything those caseworkers do is either a basic child welfare service or is a social service, not a health service.

Mental health case managers should still be able to bill Medicaid for case management. Children with serious emotional disorders comprise one of the populations that would benefit from targeted case management, because targeted case management is designed for people who need a high level of coordination across systems or across various needs. If a child fits into an appropriate category for targeted case management, that makes targeted case management “medically necessary.” If the service is then provided by a mental health worker, it should be reimbursable. Specific regulations from CMS are pending. A second provision in the targeted case management change, which also is a mandate, is that if there is another third party legally liable to pay for a service, Medicaid will be second payer. The best example of this is private insurance. If a child has insurance, the insurance must be billed first. There are allowances that, after a reasonable period of time and a reasonable amount of effort, Medicaid can be billed if insurance, for one reason or another, does not pay. Regulations for this provision also are pending.

- *Premiums and Co-payments*—States are going to be allowed more flexibility with respect to premiums and co-payments. This is not a federal mandate, but allows for state options. Medicaid has never required recipients to pay premiums, but now people can be charged a premium to be on Medicaid, and states have greater flexibility to charge children and families co-payments for services. These provisions are already in effect, and some states already are doing this. They can also charge families for non-emergency use of an emergency room.

- *Different Benefits*—States have the flexibility now to take certain populations in Medicaid and give them a different benefit instead of giving them the Medicaid benefit that all mental health systems rely upon. In many states there is a separate, privately based plan for SCHIP (the State Children's Health Insurance Program) children, which looks like more traditional insurance, that is, it covers inpatient psychiatric hospitals, outpatient office-based services, and physician services. It does not cover most of the things done through systems of care, such as in-home services, any evidence-based practices like wraparound or multi-systemic therapy, therapeutic foster care, and sometimes even residential treatment is not covered. This will create problems if children with serious emotional disorders are moved into these types of plans by the states, and there already are states picking up this option.
- *Proof of Citizenship*—Another requirement is that anybody on Medicaid must prove that they are a citizen. This issue has received a great deal of publicity recently, because CMS has just published its rules. The only group of children that has been exempted from this requirement is children on SSI. Children who qualify for Medicaid due to the family's low income will have to prove citizenship, as will children who come into Medicaid through the child welfare system. Citizenship has to be proved by a certain list of documents; CMS specifies levels of documents that must be produced. You have to start by trying to get a document out of level one, and then, if you cannot get that, you go to level two, and level three, and finally level four. People who are now on Medicaid and who come up, as they will, for a redetermination of their eligibility also must prove citizenship or they will lose Medicaid. People who are on Medicaid now and who have never had to prove citizenship before will stay in the program while they make good faith efforts to obtain their documents. This is going to be a challenge for many families, especially if they now live somewhere where the child was not born, and they have to go back to another state to get the birth certificate. Hopefully, case managers around the country are learning about this and are starting to help families be ready when the family comes up for recertification.
- *Family Opportunity Act*—The Family Opportunity Act enables families who have a child with a disability, but whose income does not qualify them for Medicaid, to buy into the program, by paying a premium. In this case, buying into Medicaid allows the child to obtain all needed services that are covered under Medicaid. This will be very helpful to a lot of families who have been giving up custody in order to get services. A compromise that was added to the DRA specifies that this is only for families with incomes up to 300% of poverty. Also, it is phased in by age so it will take three years to get everybody covered, but it is a start. Hopefully, we can move forward to increase the income level in the future. This is a state option.
- *Home and Community-Based Services as Alternatives to Residential Treatment*—Ten states will receive funds to provide home and community-based services through a waiver as an alternative to residential treatment center services. This has not previously been permitted. Previously, these services could only be provided in lieu of psychiatric hospital services. Additionally, home and community-based services can be provided as a state option without asking for a waiver. However, if the state does that, any of the home and community-based services it provides through that option must be available to anybody on the Medicaid program if they need them, not just to a targeted population. This creates some complications for states because they are used to providing home and community-based services for very specific populations—people with developmental disabilities, people with physical disabilities, and children with serious emotional disorders. Now, if they do this for one group, all those groups would be equally eligible for the services.

Koyanagi posed the question: "What action steps can be taken?" A key action will be for states to ensure that children with serious emotional disorders are clearly a covered targeted case management population and that, when the service is provided through the mental health system or by mental health professionals, that it is payable and separate from anything that child welfare caseworkers provide. It would be best to have a special provision that clearly pays for mental health case managers. Premiums and co-pays are decisions to be made by the state, and the first thing you need to know is who could be subjected to them. The first action would be to advocate that no child with serious emotional disturbance or their families as a group should be included in any premiums or co-pays or that amounts that those families would have to pay would be nominal. It may also be possible to exempt services from co-pays instead of

children. For example, a state may decide not to charge co-payments for services provided through the public mental health system. Advocacy efforts might oppose giving providers the choice of

denying services to people who do not pay their co-payments, might oppose the imposition of premiums, and might oppose the state option of denying Medicaid coverage if people do not pay their premiums. Support

for the opportunities in the DRA also is needed, for example, to encourage states to pick up the Family Opportunity Act or the statewide option of home and community-based services.

## Recommendations

### Financing

- Redeploy funds from deep-end services to home and community-based approaches.
- Ensure that state Medicaid plans utilize the Rehabilitation Option and other options to allow coverage of a broad service array and individualized, flexible services.
- Eliminate federal policy and regulatory barriers to blending funds across child-serving systems.
- Work with federal and state Medicaid agencies to cover evidence-based interventions, such as Multi-Systemic Therapy (MST), Multidimensional Treatment Foster Care, and others.
- Encourage state governments to choose to participate in the Family Opportunity Act which allows low-income families to buy into the Medicaid program.
- Advocate that dollars saved in moving to community-based services and avoiding costly deep-end placements be reinvested in local systems of care for expanded service capacity.
- Explore opportunities at state and local levels for collaboration among child-serving agencies to finance behavioral health services.

### Policy and Advocacy

- Move systems from hospital and residential care to more community-based services.
- Increase the participation of families and youth in policy making at local and state levels.
- Engage state agencies in system of care development in order to implement state policy and financing to support the development and sustainability of local systems of care.

### Information Development and Dissemination

- Engage in public education and social marketing activities to inform and educate the public about children's mental health needs and systems of care.

- Develop and disseminate outcome information, including cost effectiveness data, from systems of care that have blended or pooled funding.
- Develop "model" benefit plans for insurance companies that cover a broad array of home and community-based services.

### Training and Technical Assistance

- Provide a financing "template" or guide for states and communities to use for financing behavioral health services within systems of care.
- Provide technical assistance in how to blend funds across multiple child-serving systems at a community level.
- Provide guidance and technical assistance to states on how to maximize funds by coordinating resources. States need assistance with addressing different target populations, eligibility requirements, and reporting requirements of the different systems when dollars are pooled. For example, child welfare services have requirements related to safety and permanency and mental health has others.\*
- Work with the National Conference of State Legislators to provide technical assistance to state legislators around financing children's mental health services.
- Provide technical assistance to states to bring home and community-based systems to scale.
- Provide technical assistance to states and communities regarding implementation of changes in the Deficit Reduction Act of 2006.
- Provide technical assistance to states and communities on how to maximize the use of Medicaid to fund services and supports.
- Provide technical assistance to states and communities in developing and implementing strategic financing plans and understanding how to use the various funding streams.

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