Integrating Mental Health Services into Primary Care Settings

SUMMARY OF THE SPECIAL FORUM HELD AT THE 2006 GEORGETOWN UNIVERSITY TRAINING INSTITUTES
ORLANDO, FLORIDA • JULY 2006

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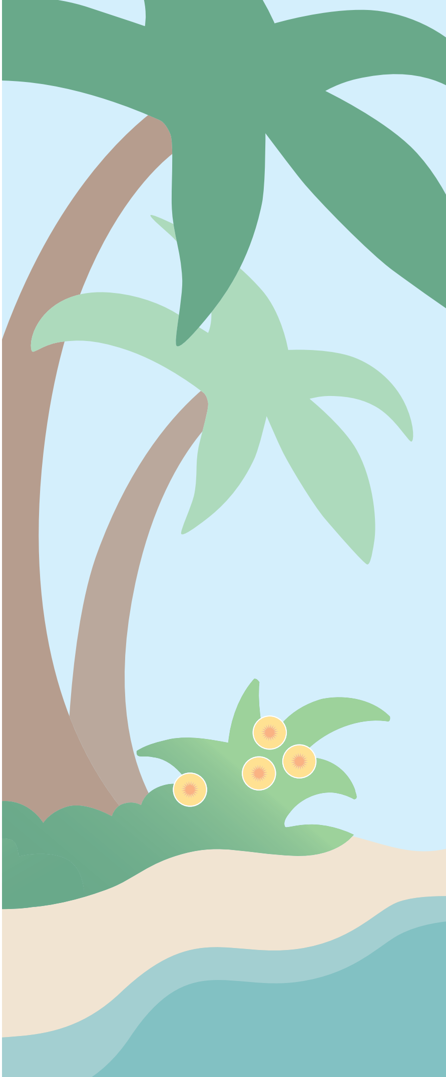


Introduction

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 Integrating Mental Health Services into Primary Care Settings. Presenters included:

- Bela Aradhana Sood, M.D., *Professor of Psychiatry and Pediatrics and Chair, Division of Child Psychiatry, Virginia Commonwealth University Health Systems, Richmond, VA*
- Katherine Grimes, M.D., *Assistant Professor, Department of Psychiatry, Psychiatric Research and Academic Center, Harvard Medical School, Cambridge, MA*
- Mary Tierney, M.D., *Senior Research Analyst, American Institutes for Research, Washington, DC*
- Jayne Wick, *Executive Vice President, Abri Health Plan, Inc., Grafton, WI*

Published by:

National Technical Assistance Center for Children's Mental Health
GEORGETOWN UNIVERSITY CENTER FOR CHILD AND HUMAN DEVELOPMENT

In Partnership with:

Center for Mental Health Services—Child, Adolescent and Family Branch
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Issues and Strategies

Overview of Issues

Bela Sood opened the forum noting that there is a huge unmet need of child mental health services in our nation. About 15 million children need services of some kind, and, unfortunately, only 20% of them receive any type of mental health intervention. Examining the group that does receive some mental health intervention, only 20% of them are treated by individuals who are actually trained in child mental health; 80% of the work is done by default by individuals who have little or no training in mental health, frequently in the primary health care sector. This is becoming a monumental problem.

Sood noted that the American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics have begun to struggle with this issue. Medical students receive little training in child psychiatry. As result, disparities in mental health care are growing, compounded by issues such as ethnicity, socio-demographic status, geographic locations, and insurance status. The time has come to integrate the training and practice of pediatricians and family practitioners with mental health professionals so that appropriate mental health care can be provided to the children of our nation.

Mary Tierney presented an overview of integrating mental health with primary care. In 2004, an iterative process was begun to address this area. Two working meetings were held in September, 2004 and December, 2005 that were funded by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services and Research Administration (HRSA). The meetings were attended by four states that had both strong medical home projects funded by MCHB (especially focusing on children with special needs) and systems of care funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The four participating states were Wisconsin, Massachusetts, South Carolina, and Colorado. Family organizations also participated, including Family Voices, the Federation of Families for Children's Mental Health, and other family and youth representatives. The outcomes of the meetings included a review of the literature, a consensus document, and strategic planning documents.

Tierney described the four major issues areas that were identified through this process:

- *Communication and Confidentiality*—Communication issues involve the need to communicate between providers, families, and youth and between mental health and primary care. A number of strategies were identified to improve communication between providers and families including cross-training; family friendly, youth friendly communication forums; and use of the media. Cross training; co-location; standing meetings, teleconferences, and webinars; and the development of protocols by national organizations were strategies suggested for improving communication between mental health and primary care practitioners. In addition, cross training in Health Insurance Portability and Accountability Act (HIPAA) and the development of protocols were recommended as strategies for addressing the privacy and confidentiality requirements of the HIPAA law.
- *Financing Models*—Issues included the complex and obtuse financing systems that support health and mental health services and the lack of ongoing communication between providers, families, and the financing establishment. Recommended strategies included identifying and training community-based individuals as "experts" on Early Periodic Screening, Diagnosis, and Treatment (EPSDT), Individuals with Disabilities Education Act (IDEA), Title V/Maternal and Child Health (MCH) and other financing streams. In addition, a recommended strategy involves facilitating cross training, regular meetings, and relationship development with Medicaid, mental health, MCHB, the American Academy of Pediatrics, systems of care, mental health advocacy organizations, etc. to foster communication between families, providers, and the financers of services.
- *Expanding Practitioner Skills for Both Primary Care and Mental Health*—Lack of knowledge and of a common language of each other's discipline and lack of evidence-based or best practices for each discipline (including screening tools and protocols) were issues identified. Strategies include developing tool kits and curricula for cross-system training to improve knowledge and understanding across disciplines. Utilizing practices that are recognized in the literature, implementing promising practices, and evaluating the efficacy of these practices were strategies recommended to improve practice and improve the evidence base.
- *Infrastructure Development*—Issues include time in that most providers don't feel that they have

the time to address additional issues. Strategies include changes in staff responsibilities, new protocols to guide discussions, use of care managers to handle some of the screening and referral, and the use of tools by parents and youth. Primary care and specialty referrals for mental and physical health is another issue identified. Recommended strategies include co-location of services, telemedicine, and scheduled telephone consultation to facilitate these referrals.

Strategies for linking and aligning primary care and mental health systems that emerged from this process are included at the end of this summary.

Service Delivery Strategies

Katherine Grimes described an approach used in the Massachusetts Mental Health Services Program for Youth (MHSPY) system of care. This initiative started officially in 1998, based on collaboration among the state child-serving agencies in Massachusetts to improve care for children with multiple needs who often are involved in multiple systems, but whose needs are not being adequately met. Some children were receiving insufficient services, and others were receiving a lot of services, but they were not necessarily receiving good care. A grant from the Robert Wood Johnson Foundation provided resources for planning this program which, from the start, integrated mental health and medical care. In addition to the standard Medicaid medical, mental health, and substance abuse service provision, the program added wraparound care and a variety of other nontraditional interventions to create a complete, expanded benefit package.

Grimes explained that the MHSPY program recognizes that youth are connected to a family or some type of caregiver and receive both formal and informal services and supports from a variety of sectors—mental health, substance abuse, education, juvenile justice, health, and social services. The program tries to make all of these agencies visible to each other and seeks to ensure that the child and family get the support they need to facilitate connections among those players. MHSPY is the only system of care in the country that offers built-in medical care. It has now expanded to five different towns in Massachusetts, with additional expansion in the planning phase.

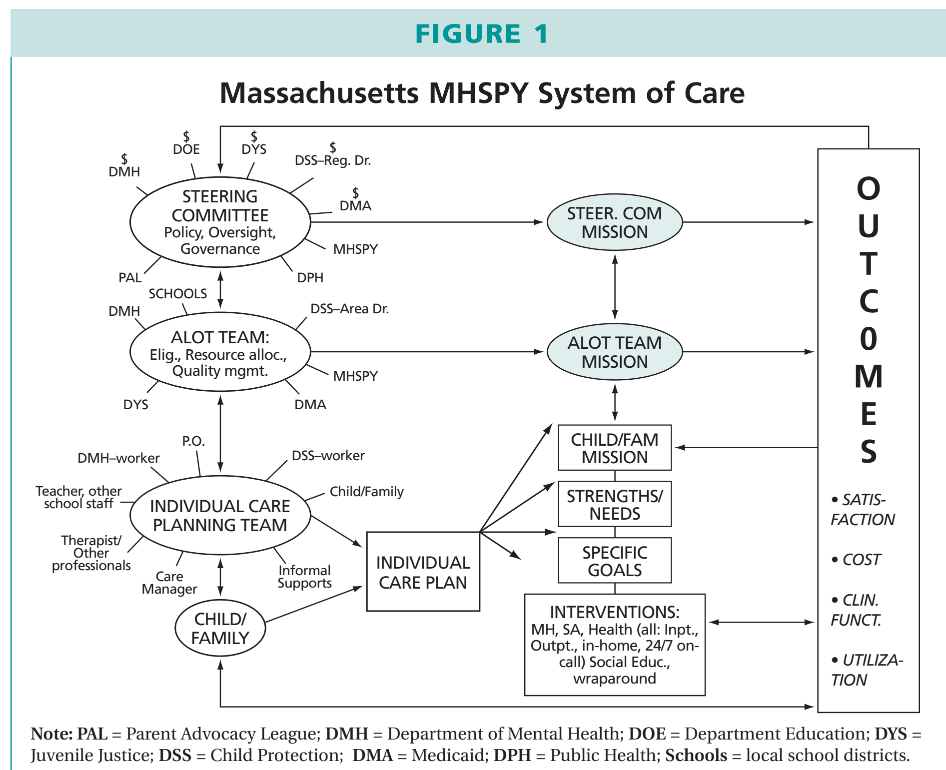
As shown on Figure 1, communication structures are incorporated at each level of the system's operation. A steering committee is the gathering place for policy decision makers in the state who invest their resources in this integrated system of care, and the next circle down is where the implementation at the regional and local level occurs. The third circle is the individual care planning team, which is where the real work happens—child protection workers, teachers, caregivers, and youth hammer out a set of expectations, the goals that drive the selection of services, the services to be provided, how those interventions are going to be measured, and a crisis safety plan.

Grimes reviews the key concepts involved in the program:

- *Comprehensive identification of needs and strengths (includes physical health)*—Since the focus is on children who are developing with an evolving set of needs, a comprehensive identification of needs and strengths must include physical health. It is a disservice to children, many of whom have multiple vulnerabilities to not to address the life domain of general

FIGURE 1

Massachusetts MHSPY System of Care



Note: PAL = Parent Advocacy League; **DMH** = Department of Mental Health; **DOE** = Department Education; **DYS** = Juvenile Justice; **DSS** = Child Protection; **DMA** = Medicaid; **DPH** = Public Health; **Schools** = local school districts.

health. Further, being in MHSPY has facilitated the recognition and diagnosis of chronic conditions, such as diabetes or asthma.

- *Intervention pathways should include health care providers*—In order to prevent fragmentation, intervention pathways must be integrated. All providers, including health care providers, are in the communication loop with the family to develop and implement an individualized care plan.
- *Family driven, individualized care in least restrictive setting*—Maintaining children in least restrictive settings can be better supported when there is a collaborative knowledge base among families, youth, and providers.
- *Interactive impact of physical and psychiatric diagnoses*—There may be an interactive aspect to physical and psychiatric diagnoses which is better understood when care is integrated. For example, a child with a very serious lung disease also was oxygen deprived and therefore exhausted and depressed, but the teacher thought she was just incredibly cranky and weepy and wanted her out of the school. What they did not understand is that she was without sufficient oxygen and that the expectations for her physical effort and classroom participation were unrealistic. When the school had better knowledge of her needs, including that her irritability and exhaustion were medically determined, they modified her schedule and allowed her to take breaks. This made a big difference.
- *Sustainability depends on community resources and natural supports*—Development of appropriate supports at the community level for both parents and youth facilitates transition from clinically intensive systems of care to sustainable participation in school and at home.

Grimes also described the key processes in the system of care:

- *Begin with comprehensive record collection (including medical records)*—It is important to get all the records when a child enters care and to be persistent in asking for medical records too, where key important information may reside. HIPAA is only a reminder about the need to be attentive to confidentiality; people can choose to share whatever they want to share with you by signing a consent form. Generally, people want to give this information to somebody so that someone can help them figure it out.
- *Family voice and choice and engagement*—Family voice and choice and engaging with families is critical in connecting on every level. It helps with engagement when the program cares about everything that affects the child.
- *Local system partnerships; accountability*—The accountability that is built into local system partnerships is another key process. Everything should be transparent, accessible, and people should be able to see what they are getting back. If people are asked to come to a meeting, they should be able to see what they get back for showing up. If they are making a resource available, they should see the resource being used.
- *Care manager builds Care Planning Team inclusively with primary care as a team member*—A care manager is the key person taking care of the child and guiding the individual care planning team. Care managers make sure that the primary care provider is part of the team.
- *Consensus-driven formulation and collaborative implementation*—There needs to be consensus regardless of specialty, so that the teacher has as good an understanding as the therapist, and the nurse understands what the probation officer understands, so that there will be collaborative implementation of the care plan.
- *Overall health status monitored in the context of mental health treatment*—Overall health status should be monitored in the context of mental health treatment not only because the medications that we give people can have adverse medical effects, but because medical conditions can influence mental health conditions as well.

Jayne Wick described the design of a program planned for Milwaukee County. She has worked with the health care industry, both in government and private sectors, with process reengineering focused on productivity and enabling technologies. Her work with Abri Health Plan, a Health Maintenance Organization (HMO) in southeast Wisconsin, has been to develop business processes for serving special populations within Medicaid. This program design is for children in out-of-home care. Milwaukee County is the largest county in Wisconsin and, historically, has had a poor record of providing health care to children in out-of-home care. A Request for Proposals (RFP) was issued to provide integrated health care services to the children who were getting their health care services through Medicaid fee for service, a system that was disjointed with no accountability and little

continuity for the child across dental, medical, physical health, mental health, and developmental services.

Wick noted that the program is under a 1915(b) waiver under Medicaid. The design includes four components:

- *Identification*—Screening of all children in out-of-home care for medical, behavioral health, and developmental needs.
- *Stratification*—Establish a "level of care" for each child.
- *Outreach*—Ongoing case managers and health care managers. Health care managers are a new role that integrates care and addresses the physical, medical, mental health, and dental domains of the child on behalf of the ongoing case manager. They do not replace the ongoing case manager, but comprise a new role that supplements that individual. Co-location of these two care managers is key to this program. The health care managers will have a strong focus on communications and will support the medical community and the family.
- *Intervention*—Medical home to enable each child to have a primary care provider, an integrated plan of care, and quality measures.

The system relies on Wraparound Milwaukee, an existing system of care for behavioral health, which will establish mental heath assessment teams and an expanded provider network to ensure greater access to mental health providers for needed services.

Wick outlined some of the challenges and issues related to integrating mental health and primary care, including:

- Lack of technology and/or data at the provider level
- Determining who to contact and when to make contact
- Establishing trust between physical medicine and mental health providers
- Privacy concerns
- Access including waiting lists and unavailability of services

Unfortunately, there have been some changes related to a modification and amendment to the federal waiver and the approach will not be implemented at this time.

Sood, a child psychiatrist, emphasized that when child mental health specialists are training, these specialists ought to train other professionals that interface with children and families, such as pediatricians, family practitioners, and psychiatrists. She described an approach in Virginia that involves providing consultation to pediatricians. There were long waiting lists to obtain specialty mental health services for children, and there were no formal consultation mechanisms in place within the pediatric community. Although no funding stream could be identified to support the provision of consultation to pediatricians, Sood started to provide assistance to pediatricians informally to see what kind of demands that put on her as an academic child psychiatrist, what the volume of requests would be, and whether it was manageable.

This approach has been in place for about three years and has worked exceedingly well. Sood began to tell the pediatric community that "curbside consults" were welcomed and that they could call and talk to her for 10 or 15 minutes for telephone consultation, guidance, or to refer the child. Through this process, she found three or four like-minded pediatricians who wanted to get this approach off the ground. Sood works with six or seven pediatric practices, providing telephone consultation, or seeing the child immediately in a crisis or within a week, or referring the child to another mental health professional. She may take over the care for a period of time and then transfer responsibility back to the pediatrician, or may provide longer-term follow up. The implicit assumption is that there is a lot of education involved in every interaction with the pediatrician. An example involves a child who had separation anxiety and did not want to stay in school. The approach involved pediatric attention for the physical aspects, mental health treatment, and involvement by the school guidance counselor. Conference calls were used to communicate. The situation created an opportunity for the pediatrician to see how mental health consultation could be used to respond to a complex situation.

Sood noted that efforts are underway to engage other child psychiatrists to adopt a similar approach in other areas of the state. Discussions have been initiated in Fairfax County where there is a child psychiatrist and a group of pediatricians who are willing to implement this strategy. A listserv also has been developed through which child psychiatrists can work as expert consultants. Pediatricians can email questions, which are non-specific (i.e., not related to a specific patient due to legal issues), thus creating an educational platform whereby pediatricians can learn from child psychiatrists.

Another strategy under consideration in Virginia is telemedicine to provide consultation

to pediatricians in rural Virginia. The concept is that by using telemedicine, the family and child can consult with child mental health professionals and the pediatrician, family practitioner, or adult psychiatrist can participate in the process to increase their knowledge and skills for responding to similar situations in the future. With this type of training, they may be more comfortable doing assessments and intervening.

These approaches have been implemented without any funding; it is hoped that funding sources for these activities will be identified to continue and expand them. A potential funding approach is to fund the child psychiatrist on a retainer model.

Recommendations

Service Delivery

- *Provide consultation to primary care providers on behavioral health*—Provide and fund telephone consultation from child behavioral health specialists to primary care providers.
- *Utilize universities to provide behavioral health consultation to primary care practitioners and others*—Oregon Health Science University has its grant from the state's Office of Mental Health and Addiction Services to provide a consultation line to primary care practitioners throughout the state. Child psychiatry faculty at the university provide the service.
- *Increase the role of primary care providers* in identifying and addressing behavioral health needs.
- *Use co-location of child behavioral health specialists in primary care settings as a strategy for increasing access to services and consultation to primary care providers*—Behavioral health providers, particularly early childhood mental health specialists, should be co-located with primary care providers to provide services and consultation. These clinicians can provide screening, assessment, treatment, referral, and care coordination.
- *Use case managers to improve coordination* between health care and behavioral health care.
- *Implement the medical home approach* to ensure that youth have access to physical health care, dental care, eye care, etc. in addition to behavioral health care.
- *Implement collaborative strategies between systems of care and federally qualified health centers to co-locate behavioral health services at the health centers*—In South Carolina, a graduated system of care grant community and the federally qualified health center in the state are going to co-locate services. In Westchester County, New York, a collaboration between a family support organization and a federally qualified health center has received funding from a private family foundation in the amount of $350,000 a year for three years with the possibility of another three after that. The effort will involve screening of all pediatric cases at the health center, providing an assessment for those indicating behavioral health issues on the screening, and operating a on-site family support resource center. This provides health center staff and families a chance to immediately access some services.
- *Provide health and mental health services through school-based clinics.*

Financing

- *Develop financing strategies to support mental health consultation to primary care practitioners*—Currently there are few viable funding sources for consultation to pediatricians. Retainers, payment for consultation through managed care systems, billing codes under Medicaid and private insurance, and other approaches to financing consultation should be explored and implemented. There are some service codes under Medicaid that provide reimbursement for consultation, for example, early childhood mental heath consultation to primary care, day care, Head Start, and other settings. This should be used to support increased consultation to primary care providers.
- *Provide funding to primary care providers to do extra screening and assessment related to behavioral health*—Payment is needed to incentivize primary care providers to undertake more thorough screening related to behavioral health and providing services in a more holistic manner.

Recommendations

Policy and Advocacy

- *Create state-level steering committee to address the provision of behavioral health services within primary care settings*—In Connecticut, a steering committee with all the key players has been established to consider how to enhance the provision of behavioral health services within primary care settings, including Medicaid. Through Medicaid, the state is creating "enhanced care clinics" where they're increasing the rate 25% to mental health clinics for children to provide a certain set of services that will increase access. Built into these clinics is the expectation that they have a relationship with at least two primary care practices in their community for children and one for adults. Guidelines have been drafted regarding the expectations for these relationships with primary care practices and memoranda of understanding between the mental health clinic and the primary care setting that addresses communication, co-management, training, and reimbursement issues.
- *Incorporate measures related to behavioral health in certification requirements for pediatricians through the American Board of Pediatrics*—If measures are incorporated that address behavioral health, there is likely to be greater attention to these issues.
- *Pass mental health parity laws* and improve monitoring of existing parity laws.
- *Approve DC: 0-3 as allowable diagnoses* for mental health services to young children.

Information Development and Dissemination

- *Compile information on best practices throughout the nation on incorporating behavioral health services into primary care settings*—Develop resource information on effective strategies for incorporating behavioral health screening, services, and consultation into primary care and disseminate widely.
- *Develop "tip sheets" on how to finance behavioral health consultation* to primary care providers.
- *Disseminate information on systems of care and children's mental health to pediatricians* through national organizations, conferences, written materials, and other strategies.
- *Develop protocols for primary care providers to use for screening, assessment, treatment, and referral of children's behavioral health problems*—Protocols should be widely disseminated through organizations such as the American Academy of Pediatrics.
- *Develop and disseminate screening tools appropriate for each age group* or developmental stage that can be easily used in primary care settings to screen for behavioral health problems.

Training and Technical Assistance

- *Develop a training curriculum for mental health professionals* to work in primary care settings.
- *Incorporate pre-service training in medical school curricula related to behavioral health care*—Most of these strategies involve in-service training with providers already practicing. However, pre-service training for physicians should incorporate training related to behavioral health, engaging families and children in discussions about behavioral health, screening, communicating with other professionals, and other related areas. If a family does not feel safe talking about mental health needs when they go into a doctor's office, it is not going to happen. Family members should be enlisted as teachers and experts to contribute to this training. Incorporate children's mental health as a part of training in all pediatric residencies.
- *Provide training on family-driven care to primary care and behavioral health professionals*—Currently, most medical care is based on the medical model, whereby professionals are the experts, have all the answers, and are paternalistic towards families. Training should be directed at shifting this mindset.
- *Implement workforce development strategies to increase the skills and competencies of primary care practitioners in identifying behavioral health needs and providing basic behavioral health services*—Consultation models are one strategy, but given the shortage of child mental health professionals, targeted workforce development strategies should be implemented to increase the skills and comfort of primary care providers in handling behavioral health problems. Both pre-service and in-service strategies are needed to increase their competencies in this area.

SUGGESTIONS FOR LINKING AND ALIGNING PRIMARY CARE AND MENTAL HEALTH SYSTEMS

COMMUNICATIONS AND CONFIDENTIALITY

I. Use Family-Driven Communication Strategy:
- Make information pervasive
- Obtain care coordinators' and trainers' input
- Contract with and support existing family organizations

II. Focus on Providers:
- Co-locate to promote formal and informal communication
- Host periodic meetings with mental health, primary care, and family representatives
- Provide co-training for mental health and primary care providers and families-training by and for all players
- Implement office systems changes to improve screening and referrals across mental health and medical home providers
- Include mental health practitioner (nurse practitioner, developmental pediatrician, social worker) in primary care/ pediatricians office

III. Engage Federal Support:
- Encourage Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA) to a) write a joint policy statement on ways to work together and share communication; b) build a shared communication strategy; and c) build integration requirements into grant programs

IV. Identify Indicators:
- Convene health policy-makers, practitioners, and family organizations to identify communication indicators for measuring the integration of primary and behavioral health care
- Use National Committee for Quality Assurance (NCQA) to assist systems change (http://www.ncqa.org)

V. Utilize Technology:
- Promote use of shared database across all health services areas
- Develop and disseminate existing online data and resource portals for providers and families

FINANCING

I. Involve Medicaid:
- Provide TA and education about Medical Home and System of Care (SOC) to Medicaid officials
- Obtain Medicaid financing for Medical Home and SOC and care coordination compensation
- Maximize use of the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, including case management
  - Increase the use of Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (D-C 0-3), used to designate mental health services; crosswalk with ICD-9 codes for Medicaid billing
  - Facilitate meetings and TA with Medicaid and Mental Health Directors, Early Intervention and Title V; focus on EPSDT and how to use existing models

II. Provide Education and Resources to Providers, State-Level Medicaid, Mental Health, and Medical Home officials:
- Disseminate information on financing streams/needs assessment
- Obtain data on cost-effectiveness of integrated systems

III. Braid Funding Streams:
- Medicaid, Supplemental Security Income (SSI), Title V, Mental Health, Temporary Assistance for Needy Families (TANF), State Children's Health Insurance Program (SCHIP), etc.
- Eligibility for these programs is affected by varying definitions/criteria for "special needs" and "disabilities" across Federal as well as State funding streams
- Be aware of managed care and Medicaid fee-for-service (FFS) differences within and across States regarding coverage
- Private Health Insurance
- Individuals with Disabilities Education Act (IDEA)

SYSTEMS STRUCTURE

I. Screen All Children and Families in Primary Care Settings for Behavioral Health Issues:

- Provide screening tools that are culturally competent and appropriate for varying literacy levels
- Ensure that screening takes place across entire spectrum of development
- Have adequate referral resources, systems in place: primary care providers cite lack of mental health resources as a barrier to screening and referrals.
- Incorporate behavioral health into quality improvement programs

II. Coordinate Across Systems:

- Provide care coordination and services that bridge systems and address families' needs
- Co-locate: at least one expert from each discipline available at entry point establishment (either Medical Home or mental health clinic)
- Conduct coordinated medical home/mental health visits and training with psychiatrist teaming with pediatrician

III. Integrate System at All Levels:

- Integrate at Federal, State, and practice levels

IV. Educate Practitioners:

- Educate physicians and mental health workers on strengths of both the primary care and mental health systems and their value to families
- Teach physicians how to determine the appropriate level of mental health practitioner to refer patients to, and how to navigate managed care carve-out referrals
- Educate physicians to be able to recognize and provide referrals for parent and family mental health needs (as well as the mental health needs of children and youth)

V. Combat Stigma by Re-Conceptualizing Comprehensive Health Care:

- Avoid separation of mental health from overall health

VI. Promote Measurement of Comprehensive Health Care

- Disseminate data on how medical home's comprehensive health care is affecting child health outcomes
- Disseminate data on how medical home's comprehensive health care is affecting parent satisfaction

SKILLS DEVELOPMENT

I. Develop Tool Kit:

- For Practitioners:
  - Must be expedient, easy, culturally appropriate
  - Should contain information and screening measures
  - During development, need input from both Mental Health and Primary Care practitioners
- For Families:
  - Must contain Family Assessment Tools; families should come to practitioner having already identified issues at home
  - Toolkit would include information on how to recognize needs for mental health, and existing developmental services (evidence indicates that needs are under-recognized and services underutilized)

II. Develop Curriculum:

- Provide specialized curricula for primary care and mental health specialists

III. Develop Community Resource Maps:

- Identify existing family organizations with which to partner

IV. Use National and Federal Resources:

- Create a Federal Action Agenda: 1-year plan and 5-year strategy for implementation

This document is funded by a cooperative agreement with the Child, Adolescent and Family Branch of the Center for Mental Health Services, Substance Abuse and Mental Health Administration with supplemental support from the Administration for Children and Families, U.S. Department of Health and Human Services. The views expressed do not necessarily reflect the views or policies of the funding agencies and should not be regarded as such.

Published by:
National Technical Assistance Center for Children's Mental Health
Georgetown University Center for Child and Human Development
3300 Whitehaven Street, NW, Suite 3300
Washington, DC 20007

Phone: 202-687-5000

Available from: www.gucchd.georgetown.edu

Suggested Citation:
Stroul, B. (2007). *Integrating Mental Health Services into Primary Care Settings—Summary of the Special Forum Held at the 2006 Georgetown University Training Institutes*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

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