Welcome to the NASMHPD Special Meet-Me Call Webinar!

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Saving Holden Caulfield: Long and Short-term Strategies for Preventing Youth Suicide

National Association of State Mental Health Program Directors (NASMHPD) Meet-Me Call Webinar

February 16, 2017

David Brent, MD
Anyway, I keep picturing all these little kids playing some game in this big field of rye and all. Thousands of little kids, and nobody's around - nobody big, I mean - except me. And I'm standing on the edge of some crazy cliff. What I have to do, I have to catch everybody if they start to go over the cliff - I mean if they're running and they don't look where they're going I have to come out from somewhere and catch them. That's all I'd do all day. I'd just be the catcher in the rye and all. I know it's crazy, but that's the only thing I'd really like to be. I know it's crazy." (22.51-55)
Disclosure

- Funding from NIMH, AFSP
- On board of Klingenstein Foundation
- Royalties from Guilford Press, eRT, and UpToDate
- Reviewer for Healthwise
Holden’s Mistakes

• He is standing by the cliff, at which point it is almost too late. Someone should be leading kids away from the cliff.
• If kids are playing in a field with a cliff, shouldn’t there be a fence?
• He is alone
  • Need a team
  • Embedded in the field where the kids are
  • Change the culture of those who are in the field
Leading Kids Away From the Cliff

- Prevent common risk factors for adolescent suicidal behavior
- Maltreatment, disruptive disorder, alcohol/substance abuse → Depression and Suicidal behavior
- All of these risk factors lead to adverse outcomes through common processes, so it is possible and efficient to try to prevent multiple adverse outcomes
Maltreatment

- Population attributable risk (PAR) of sexual abuse with respect to suicide attempt = 19%. (Fergusson et al., 2000; Molnar et al., 2007; Enns et al., 2006)

- Sexual abuse increases risk for attempt even controlling for psychopathology

- Depressed patients have earlier onset, more persistent disorder, less responsive to treatment (Nanni et al., 2012)
Population Attributable Risk (%) of Maltreatment on Psychiatric Disorder Onset*

*Green et al. 2010
Reduction in Child Abuse Rates by Intervention (%)

- SEEK
- Durham F
- CPEC
- PPP
- PCIT
- NFP

SEEK=Safe Environment for Every Kid; Durham F=Durham Family Initiative; CPEC=Child Parent Educational Centers; PPP=Positive Parenting Program; NFP=Nurse Family Partnership

% abuse reduction

0 10 20 30 40 50 60
Potential Impact of Reduction in Abuse Rate on Suicide Rate

• Population attributable risk for suicide of abuse around 25%

• Programs impact on abuse range from 17-58%, median effect around 30% reduction

• $30\% \times 25\% = 7.5\%$ reduction in suicide and suicidal behavior
Other Forms of Child Adversity

- Poverty
- Parental criminality and incarceration
- Parental substance abuse, depression
- Parent loss, divorce, bereavement
The ACE Score and the Prevalence of Attempted Suicide

Robert F. Anda. Overview of the Adverse Childhood Experiences (ACE) Study Slides
SES Adversity

- Natural experiment with casino on Native American reservation
- Increased employment and income supplements to population
- Those who moved from below the poverty line to above it showed declines in child externalizing symptoms that persisted into adulthood (Costello et al., 2003, 2010)
Preventive Parenting Interventions

- Meta-analysis of 101 studies (Sanders et al., 2014)
  - Emotional/behavioral symptoms child $d=0.47$
  - Parenting behavior $d=0.58$
  - Observed parent-child behavior $d=0.50$
- Relatively few (3/22) studies with 3+ year outcomes have examined suicidal outcomes (Sandler et al., 2015)
<table>
<thead>
<tr>
<th>Intervention</th>
<th>Social Contextual Path</th>
<th>Individual Path</th>
<th>Suicide Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families Unidas, (Vidot et al., 2016)</td>
<td>Positive parenting, communication, monitoring</td>
<td>Reduced substance use, high risk sex, alcohol use</td>
<td>@30 months, decreased attempts in those with low parent-child connection</td>
</tr>
<tr>
<td>Family Check-Up, (Connell et al., 2016)</td>
<td>Increased parent child relationship quality, monitoring Reduced family conflict</td>
<td>Reduced antisocial behavior, depression, obesity</td>
<td>5-15 years, decreased ideation or attempt</td>
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<tr>
<td>Family Bereavement Program, (Sandler et al., 2016)</td>
<td>Positive Parenting, parent depression, alcoholism, grief disorder, coping efficacy</td>
<td>Coping, emotional expression, cortisol, internalizing, externalizing, self-esteem, grief</td>
<td>6-15 years, 3-6 fold decrease in ideation or attempt</td>
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Communities that Care (CTC)

- Assesses risk and protective factors in community
- Implements a collaborative strategic planning process with the community to match evidence-based prevention programs to strengths and needs of the community based on survey
- RTC randomized 24 communities to either CTC or usual care (Hawkins et al., 2014):
  - Drug use decreased 32%
  - Alcohol abuse- 31%
  - Delinquency-- 18%
Good Behavior Game

- Universal prevention program
- Classroom based in 1st grade
- Socialize participants to student role
- Teachers get 40 hours training/support in Cohort 1; subsequent cohorts got less training/support
- Post rules in classrooms
- Teams of students reinforced for prosocial behavior
- Follow-up ages 19-21, 30-32 years of age.
Overall Effects of GBG at Ages 20 and 30 (Effect Size=ES) (www.wsppi.gov)

- Smoking
- Alcohol
- Drug
- Conduct
- ASP

Legend:
- 20 yrs
- 30 yrs
GBG Effects on Suicidal Ideation and Attempts (%) (Wilcox et al., 2008)
Good Behavior Game

- Effects are stronger when teachers got more intensive supervision
- Effects are strongest in males who were aggressive by teacher rating in first grade
- Among aggressive males, impact on suicidal ideation and behavior mediated by positive peer ratings (Herman et al., 2015)
School-based Interventions

- QPR
- Screening and referral
- Signs of Suicide
- YAM
Gatekeeper Training (Wyman, 2008)

- QPR=Question, Persuade, Refer

- RCT of QPR vs. usual care in schools

- QPR associated with:
  - improved knowledge
  - Improved perceived self-efficacy about identifying and referring suicidal teens
  - but did NOT affect identification of suicidal youth

- Because only 1/5 of suicidal youth would seek out an adult, interventions needed that also target youth’s attitudes towards help-seeking.
Garrett Lee Smith Memorial Act

- Community suicide prevention programs
- Increase recognition of risk factors (gatekeeper training)
- Improved access and linkages to MH and SA treatment
- Surveillance of suicide-related outcomes
- Public awareness of suicide
- Reduction of stigma for treatment
Effect of GLSMA on Suicide Attempts

- 466 counties exposed to GLS (57,000)
- 1161 counties unexposed (84,000)
- Program delivered 2006-2009
- Adjust for pre-intervention suicide rate, socio-demographic factors
- Decline in suicide attempt rate in 16-23 year olds as assessed by the National Survey of Drug Use and Health but effect gone in 1 year
- Decline proportion to the number of gatekeepers trained
Impact of GLSMA on Suicide

- Limited to counties with 3000+ youth
- 466 exposed counties and 1161 unexposed
- Found decline in suicide in adolescents and young adults but not older adults
- Proportional to number of gatekeepers trained
- Like the effect on attempts, effect lasted one year and then faded
- More evident effects in rural counties
Mental Health Curricula to Reduce Stigma and Increase Help-seeking
Signs of Suicide (SOS)

- Curriculum-based intervention consisting of two components
  - Education about suicide as related to mental illness, not just “too much stress”
  - Teach students how to respond to depression in suicidal ideation in self and in others (ACT: Acknowledge, Care, Tell)
- Depression screener given to students to aid in self-recognition (information not given to school personnel)
SOS Results

- **Study 1**: 2100 students, SOS decrease in suicide attempts mediated by improvements in knowledge about depression and suicide (Aseltine & DeMartino, 2004)

- **Study 2**: in 4133 students found reduction in suicide attempt (3.0% vs. 4.5%) (Aseltine et al., 2007)

- In *neither* study was there an impact on help-seeking.

- **Pilot study** in middle schoolers shows an effect on attempts in those with baseline ideation (Schilling et al., 2014).
SELYE Study (Wasserman, 2014)

- EU Study of 168 schools, 11,100 students
- Randomized by school to one of 4 interventions
  - QPR- Gatekeeper training
  - Youth Aware of Mental Health (YAM)-interactive training on recognition and coping with depression and suicidal ideation
  - Screening and referral
  - Control
- Assessed for ideation and attempt at 3 and 12 months post intervention
Suicidal Ideation and Attempts at 3 and 12 Months Post-intervention (%)*

*SELYE study: Wasserman et al., 2014
Conclusions and Considerations

- YAM- most similar to Signs of Suicide (Aseltine et al., 2004, 2007), both efficacious in reducing attempts
- QPR, Screening and referral not effective in preventing ideation or attempts
- Limitations
  - Low consent rate
  - Focus only on ideation and attempt- what about other outcomes?
  - Don’t know how it worked
Go to Where the Kids Are: Improving Access to Care by Provision of On-site Services
Adolescent Depression: Prevalence of Depression and Rate of Treatment (%)*

- Lifetime
- Last year
- Dx Specific tx

*Avnevoli et al., 2015
School-based IPT for Depressed, Suicidal adolescents (Tang et al., 2009)

- 73 adolescents screened in a high school in Taiwan and identify as depressed and suicidal.

- RCT of IPT for Self Harm and depression vs. supportive care delivered at school.

![Graph showing comparison of BSS, BDI, BHS, and BAI scores between IPT, IPAT-FU, TAU, and TAU-FU conditions.]
Collaborative Care for Adolescent Depression (Richardson, 2014)

- Response and Remission

- Treatment Received
Collaborative Care: Embed Folks Who Can Help in the Field

- Better access with less stigma
- Better integration with physical health care
- Outcomes superior to usual care
- With training primary care physicians in specific regions can reduce suicide rates (Hungary, Sweden)
- Need to reverse trend of therapeutic nihilism for adolescent depression
Insomnia

- Insomnia increases risk for suicidal risk 2-5 fold (Pigeon et al. 2012; Goldstein et al., 2008)

- Cause and consequence of substance abuse (Pieters et al., 2015)

- Association of hypnotic use with suicide attempt (OR=3.4, Brower et al, 2011)

- Treatment of insomnia with CBT-I reduces suicidal ideation (Trockel et al., 2015)

- School-based interventions feasible and effective (Owens et al., 2010; Quach et al., 2014)
Build a Fence Around the Field: Role of Availability of Agents in Suicide

- More relevant in youth suicide because more impulsive
- Related to case-fatality of the method
- Evidence to support role for restriction of access
  - Case-control studies Tendency to use method most available
  - Ease of access of method related to likelihood of use
  - Changes in availability and access related to changes in rates of use
Build a Fence Around the Field

- Guns, storage and suicide
  - Loaded guns and impulsive suicide—especially in the young
  - People will respond to education for safe storage

- Acetaminophen
- Bridges
- Pesticides
Don’t Work Alone: Teamwork and System Change

- Suicidal patients too demanding to be managed by one person without support and teamwork
- Prevention of suicide in an organization involves systemic change and top-to-bottom organizational commitment and involvement
Systems Change: Henry Ford Hospital

- Consumer advisory group
- CBT training and in suicide risk
- Rapid access to care
- Assertive follow-up by phone of non-adherence
- Removal of lethal agents
- Support and education for families, patients, and staff

*Suicide Rates in HAP-HFMG Patients*

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Hampton, 2010
Zero Suicide at Henry Ford HMO

- Suicides declined in mental health patients
- Suicide did not decline in medical patients where there was no suicide intervention
Organization of Services in UK (While et al., 2012): Suicide in Care

- Suicide risk after contact with mental health care in past 12 months is high
- Implementation of these service system changes were associated with regional decreases in suicide rates within the past 12 months
  - Assertive outreach
  - 24-hour crisis line
  - Dual diagnosis treatment
  - Case review when suicide occurs
Implementation of Service Changes and Decline in Suicide Rates (per 100,000) (While et al., 2012)
Meta-analysis of “bridging interventions” after an attempt seen in ED (Inagaki et al., 2014)

- 24 trials (postcards, letters, calls, follow-up appointments)
- At 12 months, lower rate of attempt (N=5319; RR=0.83)
- At 24 months, no effect (N=925, RR=0.98)
Attempted Suicide Short Intervention Program (ASSIP; Gysin-Mallart, 2016)

- Randomized clinical trial of outpatients who had recently attempted suicide (N=120)
- Randomized to ASSIP + UC vs. UC
- ASSIP: 3 or 4 sessions + 6 letters over 24 months
  - Session 1: narrative review of events leading up and including the attempt
  - Session 2: watch videotape of review and discuss
  - Session 3: identify warning signs, develop safety plan and crisis card for emergencies
Risk of Reattempt in ASSIP vs. UC (8.3% vs. 26.7%)


http://journals.plos.org/plosmedicine/article?id=info:doi/10.1371/journal.pmed.1001968
Saving Holden Caulfield

- Prevention: lead children away from the cliff
- Improve access and quality of care: embed skilled professionals in the field
- Access to lethal agents: Build a fence between the cliff and the field
- Systems change: don’t work alone, but together as part of a team that changes cultures in health care systems.
How to Allocate Prevention and Intervention Dollars?

- Narrow or broad focus? A more broad focus like GBG or CTC may be more cost effective because it affects more outcomes.

- Early or late intervention? Earlier may be more cost effective but may need booster interventions for sustained effects.

- Screening and gatekeeper efforts alone do not appear to be sufficient unless paired with change in student attitudes, availability of effective services.
Return on Investment for Prevention Programs ($) (Washington State Public Policy Institute)

GBG = Good Behavior Game; PCIT = Parent-Child Interaction Therapy; CC-MDD = Collaborative Care for Depression; NFP = Nurse Family Partnership
Long-term strategies for prevention of suicidal behavior

- Early intervention to prevent or buffer effects of adversity such as maltreatment
- Universal programs to reduce burden of conduct disorder, substance abuse, and depression through augmenting family and child resources
Short-term strategies

- Bridging interventions
- Student education and coping training
- Access to lethal agents
- System change in care of suicidal patients
- Improve access and outcome for depression and other risk factors for suicide
Thank you for your attention!
NASMHPD Meet Me Call

Washington Update
February 16, 2017

Stuart Yael Gordon, J.D., NASMHPD Director of Policy & Communications
Christy Malik, M.S.W., Senior Policy Associate
Aaron J. Walker, M.P.A., Senior Policy Associate
MHLG Meets with Congressional Staff on ACA

- On January 24, Mental Health Liaison Group (MHLG) representatives (including NASMHPD) met with Laura Pence from the staff of the Health Education Labor and Pensions (HELP) Committee Chairman, Senator Lamar Alexander (R-TN), and Sarah Schmidt from the office of Senator Rob Portman (R-OH). Discussions focused on advocating for retention of mental health and substance use disorder services at parity with other medical services as repeal and replacement is being sought for the ACA.
  - HELP staff said there would be no committee markups of the ACA repair/repeal and replace bill in the Senate. Rather the Senate will take up the House-passed bill straight away, or develop a Senate alternative repeal package and take it straight to the Senate floor.

- MHLG met with staff of Energy and Commerce Chair Greg Walden (Kristen Shatynski) on February 8 to convey the same messaging and discuss the impact of Medicaid block grants on substance use and mental health services.
  - Shatynski volunteered interest in modifying statute underlying 42 CFR Part 2.

- Predictions seem to have Senate action on ACA repeal occurring in early March.

- Speaker Ryan has predicted Congress will be finished with ACA repair/repeal and replace by the end of 2017.
Repealing and Replacing the ACA

- President Trump signed an Executive Order on his first day in office, January 20, directing Federal agencies to “exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Affordable Care Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications.”

- House Energy and Commerce Health Subcommittee began considering health insurance market replacement measures at a hearing scheduled February 2, that include measures modifying the protection for pre-existing conditions, widening the age band for older insureds from 3-1 to 5-1, allowing states their own grace periods for nonpayment of premiums, and requiring enrollee documentation for Special Enrollment Periods. No vote yet.

- Sens. Bill Cassidy (R-LA) and Susan Collins (R-ME) and Rep. Pete Sessions (R-TX) have introduced replacement legislation, S. 191, the “Patient Freedom Act,” giving states the ability to choose to:
  1. continue to operate ACA-type exchanges with ACA-type plans;
  2. adopt a market-based health insurance system, administered by either the state or Federal government, that substitutes enrollee health savings accounts (HSAs) funded monthly through refundable tax credits for premium subsidies, and that may include coverage of Medicaid expansion enrollees; or
  3. implement a state system without Federal funding.

- Cassidy-Collins retains coverage for pre-existing conditions, coverage of young adults under their parents’ plans, prohibitions against discrimination, and prohibitions against annual or life-time caps on coverage, and coverage for serious mental illness and serious emotional disturbance as essential health benefits.
ACA Repeal/Repair Likely to Pick Up Under New HHS Secretary Price

- Full Senate approved nomination of Rep. Tom Price (R-GA) at 2 a.m. February 10, 52-47, along party lines.
  - GOP members have attributed slow pace of ACA repeal/repair to need for leadership from new HHS Secretary.
  - GOP members expect Price to take steps to roll back ACA administratively, even before legislation is drafted. Likely first up: changing the maximum age banding premium ratio for seniors from 5:1 to 3.9:1 to reduce premiums for non-seniors.
- CMS Administrator-designee Seema Verma scheduled for Senate Finance hearing on her nomination on February 16.
  - Hearing will not be webcast.
- Substance Abuse and Mental Health Services Administration (SAMHSA) Assistant Secretary yet to be nominated, but rumors abound, and include:
  - Rep. Tim Murphy (R-PA), a psychologist
  - Robert Heinssen, Director, Division of Services and Intervention Research at NIMH
  - Former Indiana Family and Social Services Administration Secretary (and psychiatrist) John Wernert, and
  - two former American Psychiatric Association presidents.
Trump spokesman Kelly Anne Conway told Sunday morning talk shows on January 22 that it would be part of the Trump policy agenda to convert the Medicaid Program to a block grant program.

Budget reconciliation will address whether enhanced funding remains for states that expanded Medicaid, whether it is reduced, or whether it disappears.

Full Medicaid reform unlikely to occur until next year, according to sources on the Hill. Republicans at GOP retreat in Philadelphia on January 26 began telling the press it wasn’t clear that Medicaid “reform” would be addressed this year. However, new rumors suggest Medicaid block granting could be included in ACA repair/repeal and replace.

Energy and Commerce Health Subcommittee Chair Michael Burgess (R-TX) said January 13 that Medicaid reform could include extending funding for the Children’s Health Insurance Program (CHIP), due to expire at end of F2017.

- Rep. Price told members of the Senate Finance Committee he would favor extending CHIP funding in accordance with a MACPAC recommendation of five years, or as long as eight years.
- GOP has CHIP funding extension on timeline for third quarter of 2017.
- GOP members in Congress reportedly considering only one-year extension while they hash out insurance/Medicaid changes.
Seema Verma’s Positions on Medicaid

- Positions of CMS Administrator-designate can be derived from June 12, 2013 Congressional testimony presented before Energy and Commerce, and written answers submitted later, in which she said:
  - Medicaid coverage alone does not guarantee improved care or outcomes.
  - Medicaid program is jointly funded, but not jointly managed.
    - States are largely dependent on Federal policy, regulation and permission to operate their programs, with administrative review and approval processes adding administrative bureaucracy that thwarts state innovation.
  - Reform efforts should center, at minimum, around encouraging consumer participation, holding states accountable based on quality outcomes instead of compliance with bureaucratic requirements, encouraging flexible managed care approaches, and allowing states to use flexible funding mechanisms.
    - Uncompromising cost-sharing policies disempower individuals from taking responsibility for their health, allow utilization of services without regard for public cost, and foster dependency.
  - § 1115 waiver approval process is so daunting that states often abandon promising ideas if a waiver is necessary. Evaluation guidelines and required timelines are absent; it is not unusual for waiver negotiations to take a year or more.
    - Approvals are capricious, as waivers do not transfer from state to state.
    - States often face shifting policy positions during the waiver approval process.
Seema Verma’s Positions on Premium-Assisted Medicaid Expansion

- Ms. Verma offered recommendations to help ameliorate some of the federal barriers to implementing Medicaid expansion premium assistance alternatives, in answers to questions submitted by Committee members after her testimony:
  - Allow states to mandate enrollment into a Medicaid State Plan premium assistance option for the individual market as they can for premium assistance in the group market.
  - Streamline and make more transparent the § 1115 application and approval process and the budget neutrality and cost-effectiveness requirements.
  - Allow states to review § 1115 premium assistance demonstrations for the full demonstration period of 5 years.
  - Allow for states to use monthly required contributions or premiums for individuals at all income levels, including those with incomes below 150% of FPL.
  - Allow states to use the qualified health plans standard cost-sharing limited to 5% of income maximum out of pocket as an alternative to CMS allowable cost-sharing under premium assistance demonstrations.
Seema Verma’s Positions on Premium-Assisted Medicaid Expansion (cont’d)

- More premium assistance alternative recommendations:
  - Clarify the provisions that may be waived and those that may not. The granting of waivers is inconsistent at best. One state may receive a waiver of a certain provision and another state may be denied a waiver on the same provision.
  - Allow states to be exempt from the requirement to provide wrap around services for EPSDT and non-emergency transportation (for individuals 19 and 20).
  - Clarify that wraparound payments to federally-qualified health centers are not required under a premium assistance option, as qualified health plans are already required to pay at least this rate.
  - Clarify reporting expectations for qualified health plans covering Medicaid participants under premium assistance options.
  - Clarify the policy around Risk Adjustment, Reinsurance, and Risk Corridors for qualified enrolling individuals through Medicaid premium assistance.
  - Provide detail on how cost-effectiveness will be determined through a Medicaid State Plan option and how states will be required to demonstrate ongoing cost-effectiveness under an § 1115 premium assistance demonstration.
Seema Verma’s Positions on Premium-Assisted Medicaid Expansion (cont’d)

- All states implementing Medicaid expansions, whether through premium assistance or other methods, are required to come up with a definition for “medically frail” individuals and assure these individuals are given a choice between Medicaid expansion coverage and coverage that offers all of the benefits available on the Medicaid State Plan.

- Individuals qualifying as medically frail may not be mandatorily enrolled into an alternative benefit plan that provides less than the Medicaid State Plan benefits states.

- The CMS requirements around how states must treat populations considered ‘medically frail’ make it more difficult for states to appropriately address the needs of these populations.
  - While not mentioned in the ACA, CMS defined medically frail by regulation to include individuals with: (1) a disabiling mental disorder, (2) a chronic substance use disorders, (3) serious and complex medical conditions, (4) a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, or (5) a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the Medicaid State Plan criteria.

- States have to develop processes to identify medically frail individuals at enrollment, and have to develop at least two alternative benefit plans, one indexed to the Medicaid State Plan for medically frail individuals and one indexed to the commercial market essential health benefits for individuals receiving premium assistance, creating additional complexity for states and enrollees but does not assure the provision of appropriate services to this population.
Seema Verma Positions on Medicaid Managed Care

- There are many examples of successful managed care programs, and there are key characteristics of an effective program:
  - reimbursement and payment structures that require adherence to quality and operational metrics and penalties for non-compliance;
  - contracts that include pay-for-performance, shared savings, or capitation withholds and bonuses to assure quality;
  - facilitating the use of home and community based services instead of reliance on institutional services; and
  - facilitating comprehensive and integrated care to reduce the fragmentation of service delivery with sufficient flexibility to respond to unique enrollee needs.

- The federal authority to operate a managed long-term services and supports (MLTSS) program is very complex and can require a combination of waivers and Medicaid State Plan amendments.
  - This creates a lengthy and cumbersome approval process. Reform efforts should include allowing maximum state flexibility with a streamlined federal approval process.
Rep. Tim Murphy (R-PA) participated by phone at the February 3 SAMHSA National Advisory Council meeting.

- Rep. Murphy emphasized need for states to look across silos. He said there is a need for data to evaluate mental health programs beyond how we traditionally evaluate them. The Federal government should not just evaluate mental health spending based on the community mental health budget, but also look and evaluate based on the whole system (Criminal Justice, Emergency Rooms’, etc.).

- Rep. Murphy also said the National Institute of Mental Health, the Center for Disease Control and Prevention, and SAMHSA need to collaborate more. To become more governmentally cost efficient, there is a need to treat the whole person, regardless of which government silo is in charge. This needs to be a guiding principle as Congress replaces the ACA, and behavioral health should not be in a dark recess, but should drive change.

- Murphy he is looking to SAMHSA to look the best they have ever been and feels they are the leaders in this.

- Murphy addressed concerns brought up by NAC members during the call.

  - He answered concerns regarding Medicaid block grants by stating he needs data to show how block grants would cause disaster on drive up state costs. He said there is a need to track costs across siloes, and it is specifically critical to get cost data from different state systems to show the effects of Medicaid block grants.

  - He said reform should not just be block grants or per capita cap, but also what to do with the money when it reaches the states. The States and the Federal government need to work back and forth to drive change.
The Associated Press reports that, as of February 10, over 12.2 million people had enrolled in the ACA for 2017, indicating a 4 percent decline in initial sign-ups from 2016.

- ACA proponents are attributing the enrollment drop to the Trump Administration’s withdrawal of $5 million worth of enrollment advertising in the last week of January, as enrollment closed.

- Nearly 64 percent of enrollees live in states that Trump won in November.

- HHS reports that 9.2 million enrolled in the 39 states served by the federal Marketplace, Healthcare.gov, which is about 400,000 fewer than last year’s enrollment.

- The 11 state-based Marketplaces, where an additional 3 million enrolled, saw an increase in five states—California, Colorado, Massachusetts, New York and Washington state.
  - Maryland saw a 3 percent decline in enrollment.

- Unclear what the potential impact will be to the Marketplace as Republicans move to repeal/repair and replace the ACA, but GOP Congressmen like Jason Chaffetz (UT), Diane Black (TN), James Sensenbrenner (WI), and Justin Amash (MI) discovered crowds of angry ACA enrollees at town hall meetings in their districts in the last few weeks.
Thank You!!

We invite you to complete a brief evaluation of this webinar event