NWX-SAMHSA CMHS (US)

Moderator: Chelsea Booth
June 20, 2014
2:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. During today's Q&A session if you'd like to ask a question, you may press Star then 1. Today's call is also being recorded. If you have any objections, you may disconnect at this time. Now I'd like to turn today's meeting over to Dr. Richard McKeon. Sir, you may begin.

Richard McKeon: Thank you. So I'm very pleased to be able to talk with you today regarding this new grant opportunity, the cooperative agreements to implement the National Strategy for Suicide Prevention.

Many of you have participated in our youth suicide prevention grant program, the Garrett Lee Smith grant program in which, to date, 49 of the 50 states have received one of those youth suicide prevention grants as well as many tribes at several territories in the District of Columbia.

So we're really glad to be able to have this additional suicide prevention opportunity, which I will describe to you the reason for it and the things that we are looking for. As you know SAMHSA's mission is reduce the impact of

substance abuse and mental illness on America's communities. And those things, of course, are very much linked to death by suicide.

Many of you are also familiar with SAMHSA's strategic initiative. So I will not go into detail around them. Suicide prevention is part of the prevention of substance abuse and mental illness and implementation of the National Strategy for Suicide Prevention is a key component of that as part of that strategic initiative.

But suicide also involves trauma. And we know there are many issues regarding military families and many issues relevant for health and, of course, a critical need for data quality and outcome. So for almost all of these strategic initiatives you can identify a suicide prevention piece that would be important.

So, again, this is a new program. The form of it is that these will be cooperative agreements. And, as I'm sure most of you are familiar, a cooperative agreement is a specific kind of grant where it is anticipated that the federal government and the states that receive the grants will work closely. I think that's particularly important for this grant opportunity because we have so much to learn about preventing suicide in this age group.

Now the amount of money that is available is just under $1.9 million, which will be enough for us to make four estimated awards of up to $470,000 per year to up to three years. We know that that's not a tremendous amount of money, but it at least is a starting point. And it's very comparable to where the Garrett Lee Smith Youth Suicide Prevention Grants started. Some of you may know we were able to increase the dollars in those grants just this past year.

So, again, the grants will be for up to three years, and the applications are due on July 16th. So you do have time to be working on this, and we certainly encourage you to do so. We would love to get a strong response to this application.

So regarding eligibility, this is one thing that is different than the Garrett Lee Smith Youth Suicide Prevention Grants. For this, eligibility is limited to the mental health authority in states, territories, and the District of Columbia.

So there are a couple of things there. So tribes are not eligible for this particular grant opportunity. We do have a separate Tribal behavioral health opportunity that is just for tribes as well as the youth suicide that both states and tribes can apply for.

The other thing is that in our Garrett Lee Smith Youth Suicide Prevention Grants the wording is very open and comes directly from the Garrett Lee Smith statute, the Garrett Lee Smith Memorial Act, in identifying who the applicant can be. For this we are identifying specifically the Mental Health Authority but with an expectation that the Mental Health Authority will work actively and closely with other parts of state government.

For example, the Department of Health is a critical partner. And in places where health and mental health may not be in the same structure, that will be an extremely important collaboration because the Department of Health is typically obtaining surveillance information about deaths by suicide and sometimes to suicide attempts as well.

So there are two key things to be aware of in terms of a program overview in addition to the fact that this is a new opportunity. So one is that the goal of these is to implement the 2012 National Strategy for Suicide Prevention,

particularly those sections that are most applicable to state systems and communities to implementing. There are parts of the National Strategy that are more focused on making recommendations on a national level. And so we try in the RFA to specify the areas that we think are most relevant.

But the thing I want to particularly call in mind is that the focus is on using the National Strategy to prevent suicide attempts among working age adults age 25 to 64. So, again, those of you who are familiar with the Garrett Lee Smith youth grants are aware that that grant opportunity by statute is focused on ages 10 to 24. This is trying to allow for activities to be done in the broad range of midlife between 25 and 64 years of age to be able to build on work that's been done by states in the youth suicide prevention work.

So why do we need this particular program? Well, the important thing is that adults in midlife have the highest number of deaths by suicide nationwide. So, for example, suicide is the second leading cause of death among all causes of death among adults age 25 to 64.

In a study released by the CDC, between 1999 and 2010, suicide among adults age 35 to 64 increased by a full 28 percent. And there were increases among both men and women although a significant majority of the deaths do occur in men. In 2010, more than 70% of the suicides in the U.S. took place among adults between the ages of 25 and 64. Now the 2011 data just came out, and we've not crunched those numbers, but it would be very comparable to the 70% in 2010.

So let me just take a moment to kind of reiterate that. So what we see here is that when you look at suicide prevention nationally, a significant majority of the deaths are taking place in this age range. And over the last decade, this has

been the area in which suicides have been increasing the most. And so it's part of where we think it's most important for us to be doing additional work.

Just some additional information regarding the National Strategy for Suicide Prevention is as many of you know it was released in 2012 by the US Surgeon General and by the National Action Alliance for Suicide Prevention. And a link in the resources page at the end of this presentation is provided.

The National Strategy is a comprehensive strategy for suicide prevention that includes four strategic directions including creating supportive environments that promote health and empowered individuals, families, and communities, enhancing clinical and community preventive services, promoting the availability of timely treatment and support services, as well as improving suicide prevention surveillance, collection, research, and evaluation.

So let me do an overview regarding this particular program and some of its goals. There is a particular focus within this RFA on advancing Goal 8 and Goal 9 of the National Strategy. Goal 8 is to promote suicide prevention as a core component of health care services.

So that means that the hope is for this grant application that suicide prevention in health care services including within behavioral health care services would be a central component. And Goal 9 is promoting and implementing effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behavior.

So this is part of the reason that we chose mental health authorities to be the eligible applicants, even though we strongly believe that there's a need to work across state departments and systems in order to implement comprehensive suicide prevention.

But much of the community work in suicide prevention is focused on getting people to health care systems for treatment. And so it's important that there also be a focus regarding people being able to get the kinds of help they need when they arrive in those treatment settings.

So when we talk about working across state departments and systems, some of the groups that we think should be important, obviously mental health who has to be the applicant, certainly substance abuse. So particularly where mental health and substance abuse are in different components of state governments, substance abuse needs to be an active part. We've already talked about the Department of Health.

Medicaid is a very important partner as really one of the, if not the leading, payer for mental health services currently. But we know there are also important suicide prevention issues for justice, corrections, labor, state, Veterans office, the National Guard, et cetera.

So let me talk about some of the required activities including activities focused on improving and implementing services on infrastructure development, on evidence-based practices, on data collection and performance measurement, as well as on local performance assessment.

So regarding services. So one of the requirements is to develop and implement a plan for rapid follow-up of adults who have attempted suicide or experienced suicidal crisis after discharge from emergency departments and in patient units. And this should care transition and care coordination services.

So one thing that we know that's extremely important is that we know that if you look at state - if you look at the data, the data suggests that somewhere

between 15 and 30% of those who died by suicide have had contact with mental health services during the past year.

Now, we don't have a lot of information regarding exactly what those patterns of contact have been with this exception. There is a lot of information that shows that the time after discharge from in-patient care, as well as the time from discharge from emergency departments, is a time of very high risk.

For example, a mammoth study done by the Department of Veterans Affairs showed that of almost a million veterans treated for depression over a period of years the time they were most likely to die by suicide was in the 30 days following discharge from an in-patient unit.

We also have data that up to 10% of deaths and suicide in some states may have occurred within 60 days of discharge of an emergency department. Yet in many places there are not organized systems to promote proactive outreach and care transition for these individuals.

We know that the rate of follow-up mental health services is low in these groups. At the same time, this is the area where we have the strongest data, the strongest evidence that there are things that can be done that can help prevent suicide and suicide attempts. So regard this as a particularly important area in the RFA.

Related, the second the bullet is on establishing follow-up and care transition protocols to help insure patient safety including among high risk adults who have serious mental illness.

And we would like information on how you would work with medical professionals including but not limited to primary care, emergency

department, and trying to ensure the transfer of relevant information between medical providers and behavioral health entities because we know that can be a critical place where information and people, unfortunately, can fall between the cracks. And people may not get the services they need. So the transmittal of information is a very important piece of that.

They're also asked to provide suicide prevention training to both community and clinical service providers and systems serving adults at risk. Providing suicide prevention training to communities has been a very central part of youth suicide prevention efforts and an important piece. But we also think that training for clinical service providers is very important.

The data that's been collected through the National Action Alliance for Suicide Prevention indicates that significant numbers of mental health providers report that they don't feel that they have the training, the supervision, and the support to treat people who are suicidal, which is why we think it is very important for there to be a systems-based approach and that clinical service providers be incorporated as well as community members.

To incorporate efforts to reduce access to lethal means among individuals with identified suicide risk done within all appropriate federal, state, and local laws. So, again, this is really focusing on those people who are suicidal. And we do know that there have been some important efforts that have gone on that have made sure that they have had a focus on this when working with people who are suicidal. And this can include a number of different kinds of efforts.

The developing a plan to ensure coordination and collaboration across settings and sectors will be something we'll be looking for as well as screening and assessing clients for the presence of co-occurring mental and substance use

disorders because we know that occurring singly risk for suicide and suicide attempts goes up in terms of mental health disorders and substance use disorders. But when they are both present, the rate of risk for suicide goes up significantly.

Regarding infrastructure development, there are a number of areas there that can be important. Certainly from my previous comments the importance of developing partnerships to implement activities is one obvious piece. Opportunities to adopt or enhance computer systems and electronic health records to incorporate suicide prevention and to enhance with the issues of care transition and care coordination is important.

And incorporation of input both from people who have made suicide attempts and/or experienced a suicidal crisis and there has been effort into the field to try to more clearly incorporate the voice of those who have experienced suicidal crisis and have gone through that and have recovered to basically learn from them about what helped and what didn't help, and of course the input of suicide loss survivors.

As many of you know that much of the impetus for our national suicide prevention work has come from family members who lost a loved one to suicide who advocated in Congress and the Executive Branch to try to insist that this nation could do better. We likely would not have had at least for many more years—a National Strategy for Suicide Prevention—if it was not for those who, from those tragic losses and from that pain, have worked to try to see that we all do better.

Training and workforce development to help your staff or other providers in the community identify mental and substance abuse issues or provide effective services. There's a requirement to measure the competence, confidence of

health and behavioral health clinical staff in some of these areas. And there are, you know, there are tools available for this.

Some of the folks who have participated in what's referred to as the Zero Suicide Initiative which really focuses on the implementation of Goal 8 of the National Strategy have had behavioral health workforces about 30,000 strong fill out a measure looking at their confidence and (unintelligible) experience of confidence in this area and then given it again after receiving suicide prevention trainings. For infrastructure development per se, the limit is 30% of the total grant award.

On data collection, ultimately what we're looking to do - we recognize obviously it's ambitious - but it's critical that we look to try to demonstrate the impact of grant activities on adult suicide deaths and attempts within key sectors by utilizing timely surveillance data and during the beginning and during the end of the grant.

Now we know that the national level data from CDC is a number of years behind. The 2011 data just came out. The 2012 data we're hoping will be available within a few months. But we know that states frequently have access to this data earlier than the national data. And we would look toward working closely with you, as well as with the CDC and other partners, to help us all learn how to best utilize the data that is available as early as possibly to plan the activities and the grants to be able to make kind of midcourse corrections during the grant and ultimately to see if we can measure outcomes.

Recording performance measurement, many of these you will be familiar with if you have other SAMHSA grants through SAMHSA's track system. I won't go in detail through each of these that are reported quarterly through the current track system.

Then regarding local performance assessment, certainly part of that is whether you've achieved your goals, objectives, and outcomes as you've stated them in a successful application but what you need to adjust and meet your goals and see if you're having the impact you think that you're having.

But in particular what we want to call your attention to - we think it's extremely important and something we would like to work closely with you around - within your state to see how grant activities impacted suicide, deaths, and nonfatal suicide attempts including within key sectors such as suicide, deaths, and attempts within key sectors such as health and behavioral health because if we don't have this information, in essence we're flying blind.

And having that information we can at least begin to ask the right questions that can help inform us because we think the approach we need to take for suicide prevention generally, certainly for this population where much less has been done, is a mindset of continuous quality improvement, you know. We know there's no quick and simple formula. We know this is challenging. So it's essential that we all learn together for this. The limit is 20% of the total award for the data collection performance measurement performance assessment.

The next, as the basic structure of the grant application you will have access to this. I'm not going to go into any detail on the 10 that are listed here. Let me just check with my colleague, (Lora Fleetwood). So everyone will have access to this PowerPoint, correct?

(Lora Fleetwood): The PowerPoint will be posted to the SPRC Web site.

Richard McKeon: So the whole PowerPoint will be posted to the SPRC Web site. So it will have the full listing of the basic structure of the grant application, which, of course, is also available on the SAMHSA Web site at http://beta.samhsa.gov/grants/grant-announcements/sm-14-016

Couple of things, tips for managing the grant writing process. So as you begin organizing and preparing an outline to try to match required information in each section, it's really important that you answer questions in the section that it's requested. You run the risk if you refer to information that's given in other sections that the reviewers may not give you points for that. In fact, they typically have instructions to not give points for that.

So do try to avoid saying, you know, in a section where a response is required saying please see appendix whatever, you know, for it. Do try to answer within it rather than solely relying on reference to another part of the application or to an appendix.

And for that reason don't hesitate to repeat information in different sections if it's asked. If you think you're saying something really good and really important, it's okay to say it in more than one place, you know, if it appears very relevant to what the RFA is asking for. Pay close attention to the points given to each section of the review criteria.

Okay we're going to move onto just going over Section A, which really is based around the question why do you need the support in your state. Identify the target population and rationale, the pattern of working age adult suicide locally including service gaps that you may have identified, comparison data that might add contrast and depth to your needs statement. Utilize visuals, tables, graphs, et cetera, and narrative text. Try to explain everything and provide citations for data.

Section B is on proposed evidence-based services and practices. So here is what are you going to do including describing your plans to draw from evidence-based practices or Best Practices or other interventions and explain.

You should look at SAMHSA's NREPP (http://www.nrepp.samhsa.gov/Index.aspx) and the SPRC's Best Practices Registry. Evidence-based practices may not exist for your program and that's okay. You can still submit it. But it's very important then that you explain and justify what you plan to implement and what evidence you may have or that you may have identified regarding these particular practices.

You will want to explain how the practices dress your needs, provide evidence and support for it. If you're needing to modify proposed practices, we would want you to explain what the modification is and why you're doing it. So, for example, if a practice was developed with one population and you think it may really have applicability to another so you're going to modify it, then you would want to say that.

We will definitely want to make sure you explain how you will promote suicide prevention as a core component of health care services, how you will follow-up after discharge from emergency departments and in-patient units, and how you will promote and implement practices for assessing and treating those at risk for suicidal behaviors.

Propose C, the propose implementation approach. So one way to summarize this is how will you do what you propose to do, the purpose, the rationale, the time line, milestones, responsibility of staff, who the responsible staff is, rather.

The number of people you think will be reached by the program, how you will reach them, how you think you will be able to impact state systems level change, how you will build on your state suicide prevention plan, how you involve consumers, survivors of attempts and suicide loss, how you might partner with other SAMHSA funded projects in your state, et cetera, how you will screen and assess for mental and substance abuse disorders, how you will assure emergency care but then also how you will also implement care transition protocols for after the emergency care, how you'll train providers.

Who are you're partners? And then how you will sustain your efforts. And that's certainly something that we want to continue to speak to successful applicants about as well to everyone who is working in adult suicide prevention is that to try to figure out how to best embed suicide prevention in states across the country, what is really needed, and how can SAMHSA best help with that.

Section D is staff and organizational experience. Why are the people involved best suited to do the suicide prevention, their capabilities and experience, the staff positions, and what other resources are available in your state to help you do this work. Again, we know $470,000 some odd dollars is not a huge amount of money. So other resources being able to be partnered with could certainly be very beneficial.

Section E is data collection and performance measurement, documenting your ability to collect the required data, how you use it to improve your program over time because we all have to have this continuous quality improvement mindset, and how you'll conduct local performance assessment and try to measure your impact on suicide deaths and non-fatal suicide attempts.

Now, again, we know that not every state has this infrastructure right at the start. So if you're not able to do this from day one, then we would urge you to tell us how you think you can do it moving forward during the course of the grant.

There is a section, Section F, on electronic health records. Some of you may have seen this in previous SAMHSA grants. The difference between this is that we want to know how the electronic health record will be used to enhance suicide prevention efforts.

So we'll want to see suicide prevention components embedded and utilized within the electronic health record in terms of awarded these points. We do think that electronic health records and specifically incorporating suicide prevention is a very important part of successful suicide prevention efforts moving forward. And we know some individual organizations that have, you know, that have done this. The Veterans Administration has done this and others have as well.

Okay. So here are some additional SAMHSA resources. There are resources for grant writing and for developing competitive SAMHSA grant applications that we would call your attention to. Again, many of you are familiar with SAMHSA's NREPP and the URL, the link for that is incorporated here. We have also incorporated - we also have a link for the Best Practices Registry for suicide prevention through the SPRC Web site.

Every state has on the SPRC Web site a state page that includes data pages. We hope that you're all familiar with that, but if not, please look at it. It is possible in a state where a suicide prevention coordinator be in the Department of Health that the mental health authority may not be as familiar

with it. So we would definitely suggest that you check that out, the SPRC library in general, a comprehensive listing of resources.

There is also on resources from the SPRC on taking action on a data-driven planning model, on assessing and managing suicide risk as one particular training tool for training clinical staff. Although I would give the caveat you're not required to use assessing and managing suicide risk as opposed to there may be other trainings that you would want to use that is accessible that is certainly very acceptable.

There is also on the SPRC Web site a link around continuity of care in the role of emergency departments. That would be highly relevant. Then the National Action Alliance for Suicide Prevention has through their Zero Suicide in health and behavior health care a section of their Web site materials. And, of course, the 2012 National Strategy for Suicide Prevention.

Important tip - please don't put off submitting your electronic submission until July 16th. I have unfortunately have had the experience on several difficult occasions over the years of folks contacting me or a member of our staff as to say that they got it in just late. And I had one state suicide coordinator several years back call me in tears because she had gotten it in five minutes late. It's a very unforgiving system in terms of the timing.

So please allow yourself extra time. Anticipate it's going to take you more time than you think. And allow yourself some extra time to you don't get caught in that bind. We would hate to lose any applications in this vitally important area, you know, because of that.

We suggest that you submit to grants.gov at least three days prior in order to troubleshoot and resolve any technical issues that may come up. If you are

having issues, please communicate with the IT help desk. You're also welcome to let us know. We certainly want to make this as trouble free as possible and that everybody who wants to apply does apply.

Okay. So with that we're going to move to answering questions about the application and about submissions. The final slide indicates our traditional questions for program-related issues. You're welcome to contact me. You see my telephone number there as well as my email address. And then for grants management and budget issues, Gwen Simpson from our Division of Grants Management is the contact.

There may be times that if, including on the call today, if you ask a question that I am unable to answer, I will ask you to send an email so that I can get that information, particularly things that might be much more technical than programmatic that could happen. So if that happens, I will encourage you to send that email.

Okay. So with that, why don't we end? And we can open it up for questions.

Coordinator: Sure. At this time if you'd like to ask a question, you may press Star then 1. Remember to unmute your phone and record your name clearly when prompted. If you'd like to withdraw your question, you may press Star 2. Once again, if you'd like to ask a question, please press Star then 1. One moment for our first question.

Richard McKeon: And one thing that I would just ask is that when you ask a question you identify yourself and your state.

Coordinator: Showing no questions in queue at this time.

Richard McKeon: Okay. Let's wait a couple of minutes for people to be able to give it some more thought because I don't want to short change anyone's...

Woman: We do have a question that came in...

((Crosstalk))

Richard McKeon: Okay, there. Looks like we do have one that came in electronically. So the question says is there a specific suicide prevention training that needs to be used in the community and for clinical service providers or can that be determined by the project?

Okay. That's a great question. And that can be determined by the project. So there is no single training that we are recommending. For community suicide prevention there are a number of trainings that have been utilized in the Garrett Lee Smith grant programs, for example, as well as others have. We are not in a position to recommend one over another. You are certainly welcome to check in (NRP) and in the Best Practices Registry, you know, regarding different trainings.

The SPRC also has a document that does a side-by-side comparison of different gatekeeper trainings focused on the community. But you are free to utilize them. So you would just need to give the rationale for whatever one that you were planning on using.

Okay. So there's a question that says there are limits for the budget, 20% for evaluation and data collection and 30% for - and the other limitation -

Woman: Was that infrastructure?

Richard McKeon: I believe it was 30% for infrastructure. Let me just double check. Yes. So the 30% for infrastructure.

So for some of you who may be familiar with the youth suicide prevention grants, there are also some requirements that basically said 85% of the grant needs to go for services, with services defined broadly as incorporating prevention services. That's language from the Garrett Lee Smith Memorial Act and that doesn't apply to this grant. So there is no similar requirement here for that.

Woman: Are there any calls on the phone?

Coordinator: Still showing no questions in queue at this time.

Richard McKeon: Okay, we have another - okay. So the next question that's come online says follow-up care from hospital care - does this include bereavement support for families that have lost a loved one to suicide. And the patient died while at the hospital.

Follow-up would be with the family. Would this count for the continuity of care requirement? Looking to set up active postvention systems with hospitals knowing that people who are bereaved by suicide are at heightened risk for suicide themselves.

So let me say two things about that. One would be that I think that that would be a very appropriate and allowable intervention to be supported through this grant. What would be less clear would be if the application focused on only that and did not include any other attention to those who have made suicide attempts being discharged from in-patient units and emergency departments, whether that might not score well.

So taken in two steps - the one question is, is that an allowable activity under these grants? And for that the answer is yes. That would definitely be an allowable activity under this grant.

The other question would be how might it score. And I think there you have to look at the language of the RFA itself. There's a lot of language in the RFA that talks about people making suicide attempts or being in suicidal crisis and the need for their care transition. So that's important to be aware of.

Woman: Are there any other questions on the phone? And please let people know how they can ask questions on the phone.

Coordinator: Yes. As a reminder, if you'd like to ask a question, you may press Star then 1.

Richard McKeon: Okay. So one question says this grant seems largely focused on the treatment services of suicidal clients, having trouble finding money and time left over for environmental protection for 35 to 64 year olds. And just a reminder that the 25 to 64 is the allowable age range for the grants.

So let me say a couple of things. One is that we do include - there is language in the RFA regarding working with the community around this. Now it says - let me make this point. So the question said (unintelligible) focused on the treatment services of suicidal clients. And I would not frame it that way in the sense that this is really focused more broadly on systems, being able to focus in a systematic way on those with needs who are suicidal.

So if you think of the Veterans Administration as an example of that. The Veterans Administration has implemented a comprehensive kind of care package for suicidal clients, you know.

These are not grants where their focus is on, okay, use these grants to do cognitive behavioral therapy or dialectical behavior therapy. We think it's important for systems to have the availability of those kinds of treatment services, but there's a lot of emphasis on care transitions. And, you know, unless you interpret treatment very broadly, it's really about those broader system's effects within health and behavioral health.

We do recognize that, you know, that 470 thousand some-odd dollars is not a lot of money and that you can't do everything. And that's a limitation. We would love it if we had more money for these. But we're hoping people will do the best that they can.

The President in this year's budget, the FY2014 - the FY2015 budget, rather, has recommended an increase in this program from $2 million to $4 million. Of course, we have no idea yet how that will work out. But I would certainly agree that there are so many important things that could be done that it would be a challenge to fit all of it into a grant of this size. So I sympathize with that and just urge you to do the best that you can.

And it was in part for that reason that we put the emphasis on care transitions there because we felt like the evidence would seem to suggest if there was one thing folks could do that would save lives that that was probably the best bet. And so that's why the language there is so strong. We would love to see people doing a range of activities, building strong partners with others to allow for a range of activities to be done. But I totally get it that that's a challenge.

You mentioned tools to measure clinician confidence and competence with suicidal prevention and intervention. What are they and where can they be found?

The Zero Suicide Web site has some of those - in terms of that has what has been used by folks who have been part of this what's called Zero Suicide Initiative. There are other measures though that are out there.

We don't have a specific tool that we are mandating, you know, that you use. But basically what we're saying is that we think training is really important. But it's important that we don't, for example, do a training once and assume that everything is fine. And so that's the reason for that language because we would want you to be thinking about and thinking through with us ultimately how to best do that. But, again, there's not one specific tool. There is a tool that Zero Suicide group has on that Web site. And there are some other relevant tools that others have developed.

Okay. Asked to just repeat what the name of the grant is. And these are cooperative agreements to implement the National Strategy for Suicide Prevention. And they're called National Strategy Grants.

The area that's mostly likely to be confused with is the Garrett Lee Smith Youth Suicide Prevention Grants. We are glad that these are not out on the street at the same time because then there would be more confusion regarding the two of them.

But the major difference is not so much in the content because there's a fair amount of overlap with the youth grant, not exact, but a fair amount of overlap. But the major difference is that while the Garrett Lee Smith grants by statute focus on 10 to 24, this is asking you to focus on 25 to 64, those in

midlife. And let me just say because I've already been asked, well, what about the elderly.

And, you know, we think that that's also, without doubt, a vital area for suicide prevention that certainly warrants attention. But given the question that was asked earlier, which is trying to find the money in these grant to do all of the things that we're recommending and hoping to be done, we just thought that to extend it to include older Americans as well would just make it too difficult to be able to do something meaningful.

Let me check to see - any other phone calls coming in?

Coordinator: Still showing no questions in queue at this time.

Richard McKeon: Okay. So I think that this is showing that folks are becoming much more comfortable with online stuff than the telephone per se, unless you're texting on the telephone. But that's fine.

So we don't have any other questions in the queue at the moment. So let's just wait another couple of minutes in case anyone has any additional thoughts or questions or comments.

Woman: Working - so they press Star 1 several times.

Richard McKeon: Okay. So we're getting some indication that some folks are having some problems with the phone system. So I'm guessing that they're having difficulty getting their phone question into the queue...

Woman: Right, exactly.

Richard McKeon: ...but that people are able to hear what I'm saying.

Coordinator: Dr. McKeon?

Richard McKeon: Yes?

Coordinator: What I'll do is actually just open up the phone lines.

Richard McKeon: Okay. Why don't you do that?

Coordinator: All right. And as a quick reminder, if you are not speaking, please utilize your mute feature. All lines are currently open.

Richard McKeon: Okay. So if somebody else would like to ask a question, all the lines are open. And you're welcome to ask your questions.

(Amana Bade): Sorry. My name is (Amana Bade), and I'm from Illinois, Du Page County Health Department. And I'm actually on the SAMHSA Web site right now trying to locate those PowerPoint slides. Is that where I would be able to obtain it?

Women: Well, those are the things that...

Richard McKeon: Yes. Those slides, the slides that we just went through...

(Amana Bade): Yes.

Richard McKeon: ...will be posted to the SPRC Web site, the Suicide Prevention Resource Center Web site that SAMSHA funds. That's www.sprc.org. And, (Laurel), when do you think we'll be able to have those posted?

(Laurel): Probably Monday or Tuesday.

Richard McKeon: Okay. So will hope that those will be available hopefully on Monday but Tuesday at the latest.

Any other questions on the phone?

((Crosstalk))

Richard McKeon: There are two folks. So we can just go one at a time. And I'll make sure to get to both of you.

Woman: Please go ahead.

Richard McKeon: Okay. So, well, one of you can go ahead at any rate.

Woman: Well, I have a very basic question. And that is around the age limits. A lot of SAMSHA applications have had very strict page limits. I don't see that in this application. And I wanted to clarify, obviously to (sync) this best with effective information communicated. But if you could clarify that, that would be very helpful. And then I have another question, but I'll let the other person go.

(Theresa Lee): Hi, thanks. This is (Theresa Lee) calling from the California Mental Health Services Authority. I just had a really basic question. I might be just reading this incorrectly.

But on Page 8 it says that grantees must utilize third party and other revenue (unintelligible) from provision of services to the extent possible and use

SAMSHA's grant funds only for services to individuals who are ineligible for public or commercial health and (unintelligible) programs, individuals for whom coverage has been formally determined to be unaffordable or services that aren't sufficiently covered by their health insurance plan.

Could you expand on that a little bit more regarding the - I mean, this kind of indicates the population that needs to be served by this grant?

Richard McKeon: Yes. So that is standard SAMSHA language. So that is not specific for this suicide prevention. And so let me tell you my interpretation of what that would mean.

One is that in general in all our suicide prevention grants one of the issues that comes up is basically is this for mental health services per se. So, in other words, you know, could a state, for example, say, you know, as they may be able to do for other grants they should - could a state say, okay, you know, we think our mental health services are really important for suicide prevention. So we're going to use these funds to provide direct treatment services for them.

Now, for other SAMSHA grants that language is basically saying, you know, this shouldn't duplicate people who have other means of funding of support for their receiving services. For the Suicide Prevention grant, you know, the notion is that these really shouldn't be focused on general mental health services. There is not a prohibition against the use of the grants for direct mental health services for, you know, direct treatment services - individual psychotherapy, et cetera.

But people really need to show how this fits into a broader suicide prevention program. Now, part of it is a question of how you define things like treatment, you know. So if care coordination and screening are part of treatment, you

know, then within that definition some of the things that are being urged in here would fall into that. If you have a more narrow interpretation, then they would not.

So the bottom is I think that that is there to make sure that there is not shifting from one payer to another potential payer for health services but that things get to the people who need them the most. But for this grant opportunity you particularly should be focusing on those at risk for suicide in mid-life and the kind of care that they need including things like care transitions. So it's more of a caution and a caveat I think within the context of this particular grant.

(Theresa Lee): Thank you very much.

Richard McKeon: Okay.

Eileen Zeller: This is Eileen Zeller. I just wanted to let you know that there are page limits on the RFA. And if you look at Page 21 in the RFA, Sections A through F together may not be longer than 30 pages. And it gives some more details. And, again, that's standard for SAMSHA RFAs.

Richard McKeon: Thank you very much, Eileen. And that was our oversight in not including that in this particular presentation. So we'll make sure we add that before this goes up on the Web site. So thank you for asking that question and identifying that issue.

Okay. We have another question on the line that says can you repeat what you said about the Zero Suicide...

Woman: What I see is that the...

((Crosstalk))

Richard McKeon: ...toolkit making sure that training isn't just a one-time effort. All right. So, again, the idea of trying to measure in some way. Again, we don't specify how we need to measure that - is based on the idea that a mental health system can't do a training once and expect that it will continue to have an impact three, five years, you know, down the road. It needs to be embedded ultimately in some way.

So that is what we want, we think you should give attention to. When you look at some of the suicide prevention work that's out there, for the Air Force model, which was essentially researched...

((Crosstalk))

Richard McKeon: ...one of the things that they showed was that the Air Force did their model. They reduced suicide by a third. Then the rates went up again. When they looked into it, they found that many of the things they had done folks had stopped doing. They redoubled their efforts and the rates went down again. So it was clearly that effective suicide prevention requires sustained attention. So that's the large point and the larger context.

We've also recently seen in our youth suicide grants we've been able to show an effect on counties who have implemented activities in the year following the activities but not two years after the activities. So, again, you know, the broader point is that what we are ultimately hoping for and the language around sustainability here is we're hoping that states can do things, that they can find ways to embed in their systems moving forward and where we at SAMSHA can identify ways that we can help you in doing that.

Any other questions on the phone? Okay. I don't see any further...

Woman: Yes. Dr. McKeon, I'm interested in knowing more about how you see primary care fitting into this. Obviously different state systems are in different places with integrated care. But if you could speak to that a little bit in terms of those known with mental health or substance abuse diagnoses and primary care.

Richard McKeon: Yes. Let me say a couple of things. And let me also give you the caveat that remember that for any SAMSHA grant that basically what happens is that independent reviewers will be taking the language of the RFA and looking at what you propose and then scoring it accordingly.

((Crosstalk))

Richard McKeon: So remember that what's most important is what we wrote - not necessarily what we were thinking when we wrote it - because the reviewers will not have access to me or members of our staff to basically say, well, what were you thinking when you wrote this. The reviewers will have to go, just as you will have to do, based on what's in the RFA.

That being said, we do have language about primary care. We do have language about health plans. We don't specify, you know, that you need to give, you know, X percent attention to behavioral health care systems per se or X percent of attention to emergency rooms, you know, or Y percent to primary care.

So the applicant has some flexibility there. And that writing in that flexibility was deliberate. And it was also with a recognition that things like care transitions, while we've certainly talked about the importance of care transitions with people leaving emergency departments, in-patient units, et

cetera, there's also a very important care transition when people are trying to leave primary care to be connected to behavioral health. That's also a care transition.

Okay. But what I would say is that, you know, that kind of work is certainly encouraged. You know, when you look at the mortality data and you look at the number of deaths within the past year and what proportion of people have had behavioral health care services versus those who have had primary health care services, what you see is that the number of received primary health care services is much greater than those who received behavioral health care services.

So there's certainly an important, you know, role for that. And under the evaluation criteria of the RFA when you see that, and you see that language, that means you have an opportunity to focus on that if you wish. But, again, the decision to not specify that it needs to be X percent for, you know, for emergency department, X percent for mental health facilities, X percent for primary care, et cetera, was deliberate to give you some flexibility.

((Crosstalk))

Richard McKeon: Any other questions on the phone?

Coordinator: As a reminder, all lines are currently open.

Richard McKeon: Okay. So if there are no further questions, and we don't see any on the Chat, and there's no more on the line, we will end. Again, let me remind you that for program related issues you are welcome to contact me. And for grant management and budget issues to contact Gwen Simpson.

And I'll just make one final comment which, in general, I think has been the been advice I've been able to give potential applicants over the years, you know, which is I think you're typically best served when you propose to do what you think is going to have the greatest impact and is of the greatest importance.

Obviously, you look at the RFA and see what we're saying, and you try to match that to the extent possible. But I think we all do better when potential applicants feel they have strong reason to believe they've got an approach that is going to save lives, that they put that in their application and try to justify it within the language of the RFA rather than giving up on it and doing something that they think is not nearly as good.

This is an area that we all simply must learn. We all need to learn from each other. We all need our best efforts. We need SAMSHA's best efforts. We need each state's best efforts. And, you know, we know this is a challenging RFA. We are hoping that we will be able to get four strong applications. So that's the other thing to remember. You know, you need to be in the top four is the key issue in terms of the competition.

Although we would love to find ways to provide assistance and work with folks even who are not awarded the grants, to work with them and to help them through the National Suicide Prevention Lifeline or the Suicide Prevention Resource Center or the Zero Suicide Initiative, you know, in order to better prevent suicide for those in midlife.

So, with that, thank you for your time and attention. Again, feel free to contact me. If you have a question in five minutes, feel free to contact me. If you have a question in five days, feel free to contact me. I would say if you have a question in five weeks, but that might put us over the limit. I haven't crunched

the math on that one. But right up until the deadline, you know, if you have questions you're certainly welcome to get in contact with me.

So thanks again, and good luck to all of you in this important effort. Bye-bye.

Coordinator: Thank you. And that concludes today's conference. All parties may disconnect at this time.

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