ID # (assigned by CSG): 12-W-01-AZ

Please provide the following information, adding space as necessary:

State: Arizona; Assign Program Category (applicant): Health & Human Services, Human Services

Program Name: Central Arizona Programmatic Suicide Deterrent System
Administering Agency: Arizona Department of Health Services/Division of Behavioral Health Services

Contact (Name and Title): Dr. Laura Nelson, Chief Medical Officer, Arizona Department of Health Services, Deputy Director, Division of Behavioral Health Services

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Telephone Number: (602) 364-4566; E-mail Address: laura.nelson@azdhs.gov
Web Address: www.azdhs.gov and www.magellanofaz.com/suicide

1. How long has this program operated (month/year)? Note: must be between 9 months and 5 years old as of April 5, 2012 to be eligible for this year’s award.
   The Programmatic Suicide Deterrent System launched in November 2009 and has evolved from a training initiative for behavioral health professionals to a comprehensive national model for addressing a growing, but previously overlooked, challenge facing our most vulnerable population – individuals diagnosed with mental illness at risk of suicide.

2. Describe the program:
   • Why was it created?
     We created the Central Arizona Programmatic Suicide Deterrent System with the ultimate objective to render suicide a “never event” for individuals receiving mental health and addiction services funded through the Arizona Department of Health Services/Division of Behavioral Health Services. Nationally, most public sector behavioral healthcare systems have relegated suicide prevention to secondary or tertiary status as the responsibility of a niche group of crisis interventionist specialists, and concluded that many suicides are simply inevitable (see Forbes 2010, “The Forgotten Patients”). We have rejected that view and concluded that as a preventable cause of death, suicide represents a gross failure to provide safe, effective, patient-centered, timely, efficient, and equitable care. We believe suicide takes place in desperate isolation, and historic approaches have been wholly inadequate. A giant leap was needed – thus, we developed the system as a revolutionary approach that would bring the core business of state funded behavioral healthcare to tackle the challenge, including a systematic “do whatever it takes” approach, top leadership commitment, measurement and reporting and robust performance improvement. The innovation includes a clinical approach that does not consider suicide as a secondary symptom of mental illness but as a stand alone challenge that can be prevented if addressed directly.

   Arizona has the ninth highest rate of suicide in the U.S. according to the American Association of Suicidology. In 2009 (the most recent year for which state data is available), 1,060 people died by suicide in Arizona (twice the number of homicides). However, we know that 52 individuals died by suicide in Maricopa County between July 2010 and June 2011 who were actively served by the state-funded ADHS/DBHS Regional Behavioral Health Authority contractor and its network of 150 behavioral healthcare agencies.

   This initiative directly addresses the population at highest risk for suicide — individuals with serious mental illness (SMI). They are six to 12 times more likely to die by suicide than the
general population and are at greater risk than other “high-risk” groups (e.g., white males over 65, veterans/military, Native Americans and LGBT individuals).

Statistics show that the life expectancy for those with SMI in Arizona tends to be cut short by 25 to 32 years as compared to those without such an illness. The Central Arizona Programmatic Suicide Deterrent System was created to help combat these disturbing trends.

The initiative aims to eliminate suicide among the 110,000 individuals actively receiving services from the public mental health system —particularly the 21,000 individuals with serious mental illness—who sometimes fall through the cracks in getting help from suicide prevention agencies designed for the broader extended community and general public.

Since 2009, the initiative has made tremendous strides in training behavioral health professionals to recognize the signs and symptoms of suicide in those with mental illness, and to help these individuals stay safe and seek help, as needed. Since that time, the program has become even more far-reaching to include partnership with the National Action Alliance for Suicide Prevention and the Substance Abuse and Mental Health Services Administration (SAMHSA) in developing an innovative clinical care and intervention framework, and enhanced engagement programs increase the lifespan of those most at risk.

• **Why is it a new and creative approach or method?**

What distinguishes our program from other national initiatives is our comprehensive systems-based approach to suicide care and intervention. Similar high reliability performance improvement initiatives have been used to reduce/eliminate wrong patient and wrong site surgeries as well as improve commercial aviation safety. Our program makes behavioral health recipients at risk of suicide the focal point and assures that care is:

i. **Safe:** the entire behavioral healthcare workforce is properly trained and equipped to engage individuals at risk and every client gets screened

ii. **Effective:** we publically account for reductions in deaths for those enrolled, improvements in workforce staff confidence and the impact upon cost of care

iii. **Timely:** immediate accessibility to support staff and frequency of contacts/interventions based on need

iv. **Efficient:** screening and assessment drives the type of intervention and a standardized program is baked into daily practice, with clinical decision support tools and tracking by electronic health medical records

Our program has been developed with the intensive involvement of the entire mental health community—from provider agencies and other caregivers to police officers and public officials—as this underscores the importance of building greater exposure and ongoing support for all mental health issues. This initiative is a key component of the ADHS/DBHS agenda to transform central Arizona’s decades-old mental health system. The Central Arizona Programmatic Suicide Deterrent System is one more positive step in this process.

Historically, mental health providers in the United States have not made suicide prevention and intervention a primary area of focus, largely because they have viewed the issue as already addressed by national, regional and local agencies and prevention programs. Suicide has not been considered core business for three key reasons:

• Fear around the subject experienced by professionals who believe they lack appropriate training, skills and/or supports

• Myths that continue to perpetuate that many suicides are not always preventable
• The tendency to treat suicide care as a specialty referral service

The shift in perspective can be summarized as follows:

<table>
<thead>
<tr>
<th>Shift in Perspective from:</th>
<th>To:</th>
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<tbody>
<tr>
<td>Accepting suicide as inevitable</td>
<td>Suicide is preventable</td>
</tr>
<tr>
<td>Stand alone training and Tools</td>
<td>Overall Systems and Culture Change</td>
</tr>
<tr>
<td>Specialty referral to niche staff</td>
<td>Part of everyone’s job</td>
</tr>
<tr>
<td>Individual Clinician Judgment &amp; Actions</td>
<td>Standardized screening, assessment, risk stratification and interventions</td>
</tr>
<tr>
<td>Hospitalization during Episodes of Crisis</td>
<td>Productive interactions throughout ongoing continuity of care</td>
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</table>

“If we can save one life…” “How many deaths are acceptable?”

This initiative has changed the mindset about suicide prevention, which traditionally has seen it as a peripheral, niche activity of specialty providers. By providing knowledge, skills, tools and management support, this project has made suicide intervention a core responsibility of all behavioral health staff. This initiative recognizes the complexities of suicide and addresses multiple issues:

- Behavioral health workers’ lack of skills and confidence to intervene (Applied Suicide Intervention Skills Training – ASIST)
- Lack of connectedness for those contemplating suicide (attempt survivor support groups, family engagement, community integration)
- Need for risk identification and stratification (clinical care and intervention).

Many behavioral healthcare professionals continue to subscribe to the pernicious myth that a person intent on suicide cannot be stopped. This misunderstanding stems from the difference in US demographics between those who attempt and those who die. One of the most important foundations of the Arizona system is that these are not two separate and distinct groups. Intense ambivalence (what European experts term “personal indecision”) is a core attribute for both those who make attempts and those who die by suicide.

We hold two core beliefs: suicides are preventable and future deaths are avoidable. The young woman pictured above right was physically wrestled off the Golden Gate Bridge in 2004. Separate research studies from the 1970s by David Rosen and Richard Seiden would suggest that nearly 95% of individuals who have made such attempts and been rescued would live the rest of their lives without dying by suicide. A core innovation of our system is uprooting the fatalism that permeates much of the nation’s public sector approach to suicide.

This initiative has captured international attention.
Awarded the International Association of Suicide Prevention (IASP) Peter Lee Award for Good Practices of Suicide Prevention presented at the 2011 World Congress in Beijing, China (nearly 50 countries participated)

Featured in lead story in May/June 2011 Behavioral Healthcare magazine, one of the top rated articles of the year

Recognized by the National Council of Community Behavioral Healthcare at their 2012 Awards of Excellence as the winner in the Service Innovation category

Highlighted by the National Action Alliance on Suicide Prevention in one of only four 2012 top priorities, “Zero Suicide in Healthcare” (includes the Secretary of the Army, the US Surgeon General, the Directors of the National Institute for Mental Health and the Substance Abuse and Mental Health Service Administration, and the original list of potential ideas totaled nearly 150)

Featured in a special webinar presented by Dr. Laura Nelson to the National Association of State Mental Health Program Directors

- **What are the specific activities/operations of the program in chronological order?**

  **Step 1: Identifying the problem**

  According to a 2009 survey conducted by SAMHSA, slightly more than 1 million Americans attempted suicide and more than 8 million citizens had serious thoughts of suicide. Despite these facts, mental health providers in the United States have not had comprehensive programs to address suicide. Instead, they have a few niche staff that provides crisis intervention. These resources have received secondary attention, and suicide intervention is not part of their core mission. Many times, their workforce has not received any training in suicide intervention, including social workers or counselors with professional licensure. Accreditation bodies, national trade associations and professional groups have avoided the topic. In September 2010, Forbes magazine indicted the field with an article entitled “The Forgotten Patients,” (see picture above) and the National Strategy for Suicide Prevention Decade Progress Report also published in 2010 corroborated this assessment.

  The ADHS/DBHS has historically dedicated resources to suicide prevention for the general population. However, this initiative took on an innovative new angle in 2009, when, as part of a routine review of service recipient case reports, we made a startling discovery—the incidence of suicide deaths among those with serious mental illness was unexpectedly high.

  To probe further into the issue, nearly 1,700 case managers, clinicians, nurses and physicians in the central Arizona workforce were surveyed to assess their confidence and skills in engaging in suicide with individuals most at risk. The result: a staggering 40 percent reported that an individual in their care had died by suicide, and nearly half of this group reported two or more died by suicide. Moreover, nearly half of the respondents said they did not have the skills, knowledge and supports to adequately address suicide.

  **Step 2: Establishing the Suicide Deterrent System Framework**

  With research findings in hand, ADHS/DBHS worked closely to engage a community collaborative to tackle this problem and place suicide prevention and intervention at the core of the community mental health delivery system. Together, ADHS/DBHS and these partners charted a course to eliminate suicide deaths among mental health service recipients, an approach that has come to be known as “Zero Suicide in Healthcare.”

  The collaborative decided to create a complete suicide barrier by empowering teams and igniting a culture to open dialog with those struggling with intense psychiatric pain. An integral component of the program was bringing together the mental health community—Magellan Health Services of Arizona, the counties’ dozen largest behavioral health
providers, and key service recipients and family members—with mental health advocates, law enforcement officials and even public policymakers to form a steering committee. The chief executives from the dozen largest community mental health service providers committed their agency resources to the mission. Leaders from all these organizations formed a steering committee to provide support and guidance. It was the first time these diverse leaders had come together to proactively tackle a major public mental health issue.

The group created a task force and six workgroups, each with an area of focus, including comprehensive staff suicide intervention training, attempt survivor and peer supports, family engagement, clinical care and intervention, community integration and race and equity. We quickly identified Living Works’ two day Applied Suicide Intervention Skills Training (ASIST) as the primary training vehicle because it is universal, evidence-based and has a proven track record of producing lasting outcomes (increased confidence in engaging those with suicidal thoughts), and is recognized by SAMHSA as a best practice.

**Step 3: Developing Program Essential Tenets**
The steering committee developed six essential tenets that would form the backbone of the Programmatic Suicide Deterrent System. These include:

1. Providing training for ALL agency staff in suicide intervention and prevention using a national best-practice modality—ASIST
2. Ensuring the availability of attempt survivor/loss survivor support groups to supplement the care plan for those at risk of suicide
3. Developing and implementing standardized approaches to clinical care and intervention, including risk stratification, accessibility and follow-up
4. Engaging/integrating family and natural supports as primary intervention at the outset
5. Engaging and integrating community supports and resources
6. Ensuring culturally appropriate approaches (40% of the central Arizona population is composed of Hispanic, African American, Asian and Native American populations).

**Step 4: Initiating ASIST Training**
In the fall of 2009, a dozen of the largest behavioral health service agencies in central Arizona began training their entire workforce in ASIST. The steering committee established a goal to train 2,000 behavioral health professionals. To date, the group has achieved 120 percent of this goal — nearly 2,400 direct care provider staff members have taken part in a two-day ASIST session. Not only has the training equipped participants with the skills and knowledge to identify and intervene with those at most risk of attempting suicide, it also has given participants self-confidence in managing through these situations.

**Step 5: Reaching Beyond Training**
Training staff was only the first objective in the program’s multi-year change process. As part of the program’s next stage of development, its leaders worked to develop support groups for those who have survived a suicide attempt or have persistent suicidal thoughts. The attempt survivor support groups provide participants with the resources to help them manage situations when suicidal thoughts occur and to support them in their ongoing recovery. The groups are peer facilitated with clinical support from a licensed clinician.

In addition, a task team helped develop Family Engagement training in partnership with the National Alliance on Mental Illness. The training was conducted for providers and is now a part of new employee orientation. The task team also created a Family Engagement packet to help the recipient’s “family of choice” better understand the system and provide support.
In 2011, program leaders began developing the most pioneering aspect of the program—a clinical care and intervention model that is being created in partnership with the National Action Alliance for Suicide Prevention. The model features four areas of focus:

- Risk stratification
- Best-practice regimens for intervention
- Accessibility and follow-up
- Engagement/education of professionals and recipients

The task group reviewed best practices, evidence-based research, existing tools in the community and elsewhere, and every day operations. From this, brief screening tools were developed for adults, adolescents, and children. These tools were mainly adapted from the Harvard Medical School Guide to Suicide Assessment and Intervention. Guidelines for administering and scoring the tool were developed. The screen is given at an appointment with the behavioral health medical practitioner or therapist. If an individual has a positive screen, a suicide risk assessment is completed by a clinician.

The assessments were adapted primarily from Henry Ford Health System and consist of a checklist and stratification into a low, moderate, or acute risk level. Once the risk strata is established, the clinical team follows recommendations on an intervention process map designed for SMI clinics, general mental health/substance abuse clinics, or children’s clinics.

The emphasis is on increased frequency of and more timely contact with individuals by providers, family and friends, peers, community resources in order to provide safety planning, follow-up, and weapons removal. This progressive model, including tools and processes, is being test piloted in spring 2012 with system-wide dissemination this summer. It provides the full safety net for those at risk and will help the program leaders reduce to zero the number of suicides among those in the central Arizona behavioral health system.

- Is it effective? Provide tangible results and examples.

Suicide intervention is now a priority and viewed as a “core mission” for the dozen largest mental health service providers in central Arizona. All dedicated themselves to training their entire clinical staff with ASIST and nearly 2,400 have been trained. In addition to these fundamental changes in culture and mission, three additional core areas are monitored:

1. Revolutionary cultural shifts in the view of helping individuals at risk of suicide shifting them from the periphery to the center of focus
2. Reduction in death rates for individuals receiving state-funded behavioral healthcare
3. Improvements in all behavioral healthcare workforce training, knowledge/skills and supports to effectively engage those at risk of suicide
4. Reduced healthcare costs as a result of the improvements in therapeutic relationships that minimize unnecessary hospital admissions and readmissions

1. Revolutionary cultural shifts
Many groups across the country are dedicated to supporting family members and friends who have been bereaved of those who have died by suicide, but the launch in 2011 of the nation’s first formalized peer support groups for individuals with a history of surviving suicide attempts is another significant milestone.

2. Suicide death rates for individuals served
Since FY2007, the suicide death rate (number per 100,000) has decreased:
• 42% for those with Serious Mental Illness (SMI)
• 67% for all behavioral health populations (including SMI)

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<td>52.8</td>
<td>35.8</td>
<td>47.5</td>
<td>47.8</td>
<td>25.7</td>
<td>67%</td>
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3. **Workforce training, skills and supports**
Surveys completed before and after ASIST showed an increase in the workers who “felt strongly” they could engage and assist those with suicidal desire and/or intent because they now have:
- Proper training - ↑187%
- Engagement & intervention skills - ↑131%
- Support & supervision –↑97%.

Prior to ASIST, approximately 50% of those surveyed in the workforce indicated that they lacked either the skills, training or supports to effectively engage those at risk, but this group plummets to fewer than 2% after the two day ASIST training.

4. **Reduced costs**
The initiative’s commitment to ending suicide also yielded a notable reduction in high cost inpatient treatment admissions for individuals by establishing a safety net of well-trained service providers within these self-contained service-delivery teams (Assertive Community Treatment Team, or ACT). The financial plan that follows is built upon a foundation of cost-of-care reductions realized by these efforts – one which demonstrates a high degree of sustainability. The creation of a safety net of providers prepared to offer outpatient support in lieu of costly inpatient treatment, in conjunction with a workforce development plan, will achieve and sustain those cost-of-care reductions; extending the impact realized by 1,299 individuals to larger populations which include 110,447 Arizonans.

Prior to 2010, the mean monthly rate of ACT team psychiatric hospital admissions was 7.2 admissions per 100 ACT service recipients. Throughout 2010, the mean rate of inpatient admissions declined as staff completed ASIST training. During 2011, that mean rate was reduced to 3.5; a reduction of 3.7 admissions or 51 percent per 100 ACT service recipients monthly. With an average cost per inpatient day in FY2011 of $539, an average length of stay of 9.8 days, and an average ACT census of 1,299 in 2011, the average monthly reduction in hospital cost was $254,990 or $3.1 million annually for these Medicaid-funded individuals. The projected savings of this initiative for only the population being served by ACT (approximately 1-2% of total) is $15 million over the next five-year contract cycle.

**Other key developments**
Clinical care/intervention tools and strategies were developed, including screenings and risk assessments. These are being piloted in early 2012 and disseminated throughout the entire network of behavioral healthcare clinical homes in the coming months. Family Engagement training was implemented in 2011 and is now included in employee orientation. Family Engagement packets are being finalized for distribution in 2012.
In 2012, 100 past suicide cases are being reviewed extensively, focusing on demographic information (e.g., sex, age, diagnosis), support characteristics (e.g., family supports, community supports) and other characteristics (e.g., family history of suicide, medication adherence, substance abuse). This information will be analyzed and used to inform the suicide intervention model, specifically assessment, targeted intervention and follow-up.

3. Did this program originate in your state? If YES, please indicate the innovator’s name, present address, telephone number, and e-mail address.

Yes, this innovative program originated in Maricopa County, Arizona. Dr. Laura Nelson is the deputy director of ADHS/DBHS, and she serves on the suicide steering committee, which has primary responsibility for developing the tenets of this project (contact information in the beginning of this application). David Covington chairs the steering committee as vice president of adult and child/youth services for ADHS’ RBHA contractor Magellan Health Services of Arizona. David's contact information is 4801 E. Washington, Suite 100, Phoenix, Arizona 85034, 602-572-5959 and dwcovington@magellanhealth.com.

4. Similar programs in other states? If YES, which and how does this program differ?

Dr. Laura Nelson is the current president of the National Association of State Mental Health Program Directors (NASMHPD) and has been involved in presentations to the group’s membership. No other state has such a program although several are working to replicate the Arizona model. In January 2012, the National Council for Behavioral Health and Suicide Prevention Resource Center applied for a CMS Healthcare Innovations Grant that would seek to replicate the Arizona model in New York, Kentucky and Texas (proposal includes the Office of Mental Health leadership in a partnership of all four states).

In addition, the Arizona collaboration is highlighted in the four key priorities for the National Action Alliance for Suicide Prevention in 2012, namely the “Zero Suicide in Healthcare.” The executive committee that selected this initiative from more than 150 ideas included the Secretary of the Army, the U.S. Surgeon General and the directors of NIMH and SAMHSA. The ADHS/DBHS RBHA contractor in Maricopa County, Magellan Health Services, has begun replicating the project in Pennsylvania (five counties) and New York (central region).

The “Zero Suicide in Healthcare” report from the National Action Alliance also points to work from the US Air Force, Henry Ford Health System and the National Suicide Prevention Lifeline, but while there are some similarities, these programs all lack the comprehensive and collaborative approaches of the Arizona model, which is expanding to include nearly 100 partners in a network of provider agencies under ADHS/DBHS leadership.

In 2012, Washington State has attempted to create one of the essential components of the Arizona initiative with mandatory suicide risk management training for all behavioral health staff through new legislation. SHB2366 passed the House and Senate in February and March and awaits signature from Governor Gregoire. It would require training of certain health professionals, including mental health counselors, to complete education in assessment, treatment and management at least every six years. Our Arizona program was included as a reference model in the Washington State dialogue.

5. What limitations or obstacles might other states expect to encounter?

Other states may face two significant barriers. The first is the resources required to transition suicide intervention to the core of the workforce. The agencies that committed themselves to this investment of time and energy believed that the increased self-assessment of skills, knowledge and supports would lead to reduced turnover, increased job satisfaction and better outcomes, but this was a major dialog in the beginning phases. By year-end 2011,
more than 4,500 work days were committed to ASIST training alone. The second major barrier has been the entrenched cultural beliefs held by many in the behavioral workforce that suicide is an inevitable component of our work. Webinars by national experts like Dr. Thomas Joiner of Florida State University (and author of *Why People Die by Suicide* and *Myths about Suicide*) have helped us conquer these perceptions.
Use these as guidelines to determine the appropriate *Program Category* for your state’s submission and list that program category on page one of this application. Choose only one.

**Infrastructure and Economic Development**
- Business/Commerce
- Economic Development
- Transportation

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- Elections
- Information Systems
- Public Information
- Revenue
- Telecommunications

**Health & Human Services**
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- Children & Families
- Health Services
- Housing
- Human Services

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- Management
- Personnel
- Training and Development
- Workforce Development

**Natural Resources**
- Agriculture
- Energy
- Environment
- Environmental Protection
- Natural Resources
- Parks & Recreation
- Water Resources

**Public Safety/Corrections**
- Corrections
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