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Webinar

An interdisciplinary panel discussion

**A Collaborative Approach to Supporting
People at Risk of Suicide**

Monday, 13th May 2013

“Working together. Working better.”

Supported by The Royal Australian College of General Practitioners, the Australian Psychological Society, the Australian College of Mental Health Nurses and The Royal Australian and New Zealand College of Psychiatrists

This webinar is presented by



Panel

- Dr Timothy Wand (Mental Health Nurse Practitioner)
- Dr David Webb (Suicide Survivor)
- Ms Susan Beaton (Psychologist)
- Dr Michael Dudley (Psychiatrist)

Facilitator

- Dr Mary Emeleus (General Practitioner)

Ground Rules

To help ensure everyone has the opportunity to gain the most from the live webinar, we ask that all participants consider the following ground rules:

- Be respectful of other participants and panellists. Behave as if this were a face-to-face professional development activity.
- Please post your comments and questions for panellists in the 'general chat' box. For help with your technical issues, please post in the 'technical help' chat box. Be mindful that comments posted in the chat boxes can be seen by all participants and panellists.
- Your feedback is important. Please provide your feedback by completing the short survey which will appear as a pop up when you exit the webinar.

Learning Objectives

At the end of the session participants will be better equipped to:

- Raise awareness of the indicators and stigma associated with suicidality
- Identify the key principles of the featured panellists' approach in assessing, treating and supporting people at risk of suicide
- Identify the merits, challenges and opportunities in providing collaborative care for people at risk of suicide

Mental Health Nurse Perspective



Issues to consider

- Challenging developmental background
- Family disruption
- One OD in the past
- Previous involuntary hospitalisation
- Anxiety and stress
- Sleep



Dr Timothy Wand

Mental Health Nurse Perspective



Positives

- Despite adversity Caitlin has managed to support herself and get into Uni. 3rd year!
- A seemingly significant period of wellness
- Caitlin looks after her health
- Self-efficacy and resilience
- No substance misuse issues evident
- Resources- mother, friends, Caitlin's motivation



Dr Timothy Wand

Mental Health Nurse Perspective



Assessment and assistance

- No evidence for the effectiveness of risk assessment in self-harm suicide reduction
- ‘Even more worried’
- Normalise not pathologise the situation
- ‘Crying for no reason’
- ‘Not her usual cheerful self’
- Assessment of strengths, assets and abilities
- Health education, symptom management
- Sleep



Dr Timothy Wand

Mental Health Nurse Perspective



Collaboration

- Competing risks - resentment, demoralisation, loss of income, missing University and falling behind.
- Mother and family
- Friends
- University - letters of support
- Colleagues and services - support, information sharing and differing perspectives



Dr Timothy Wand

Suicide Survivor Perspective

The socio-cultural context

- Prevailing response to suicide - PANIC - fear, ignorance and prejudice
- Stigma = discrimination - i.e. belongs with those who discriminate against us
- Likely pathway (for Caitlin?) - diagnosis, hospitalisation, coercion, forced/unwanted “treatment”
- The politics of suicide (prevention) - power hierarchy of suicide prevention industry



Dr David Webb

Suicide Survivor Perspective



What's missing, what's needed?

- Respect for (rather than judgement of) the suicidal person
- Whole person (holistic) approach - suicide as a “crisis of the self”
- Sanctuary, asylum, refuge (e.g. Maytree, UK)
- Spiritual dimensions of suicidality - causes and/or recovery
- Demedicalise and "decriminalise" suicide - human rights versus "duty of care"
- Move beyond "evidence based" paralysis
- Genuinely collaborative approach - doctors on tap, not on top (cf. mental health versus drug and alcohol)
- Include first-person knowledge - Nothing About Us Without Us



Dr David Webb

Suicide Survivor Perspective

Caitlin

- Risk assessment 1 - gold standard (Aeschi Group) is to ask her (all other "indicators" are secondary/clues)
- Risk assessment 2 - the danger she faces from mental health system
- Unhelpful language - assessment, diagnosis, illness/sickness/disorder, treatment, relapse etc
- Recognise your own fears, judgements, prejudices etc
- Capacity to "bear witness" - without judgment, resisting urge to advise/solve/fix (saviour complex)
- Do not feign false empathy
- Most of all, respect and honour her intensely important, meaningful (and sacred) crisis



Dr David Webb

Suicide Survivor Perspective



"I have never before read anything relating to suicide that speaks of suicidal feelings as being worthy of respect. The possibility that I may actually be able to honour these feelings is a totally new concept, one which has proven to be a catalyst for change and personal growth."

Josephine Williams, suicide attempt survivor
[from back cover of "Thinking About Suicide"]



Dr David Webb

Psychologist Perspective



Ms Susan Beaton

Psychologist Perspective



“If I am suicidal, I want a therapist who believes I’m going
to live, not die.

Even if I am chronically suicidal and have only a smidgen
of ambivalence between me and a lethal attempt, I don’t
think I need a healer who has already quit on me.”

- Dr Paul Quinnett



Ms Susan Beaton

Psychologist Perspective

Risk Factors

- Previous suicide attempt
- Relationship breakup – loss
- Low mood – potentially suffering from depressive symptoms
- Age – not fully developed PFC (could influence impulsivity and decision making)
- Loneliness, isolation from friends
- Lack of sleep
- Loss of appetite
- Ruminating
- Cognitive functioning impaired
- Panic attack



Ms Susan Beaton

Psychologist Perspective

Protective Factors

- Continued with education despite difficult times – perseverance
- Achieved well to get into Physiotherapy
- Improved relationship with Mo
- Problem identification
- Help-seeking
- Attending gym
- Keeping up with job
- Faced previous adversity and recovered



Ms Susan Beaton

Psychologist Perspective

AESCHI Working Group www.aeschiconference.unibe.ch/pdf/Guidelines.pdf

1. The clinician's task is to reach, together with the patient, a shared understanding of the patient's suicidality
2. The clinician should be aware that most suicidal patients suffer from a state of mental pain or anguish and a total loss of self-respect
3. The interviewer's attitude should be non-judgmental and supportive
4. The interview should start with the patient's self-narrative
5. The ultimate goal must be to engage the patient in a therapeutic relationship
6. We need new models to conceptualize suicidal behaviour that provide a frame for the patient and clinician to reach a shared understanding of the patient's suicidality

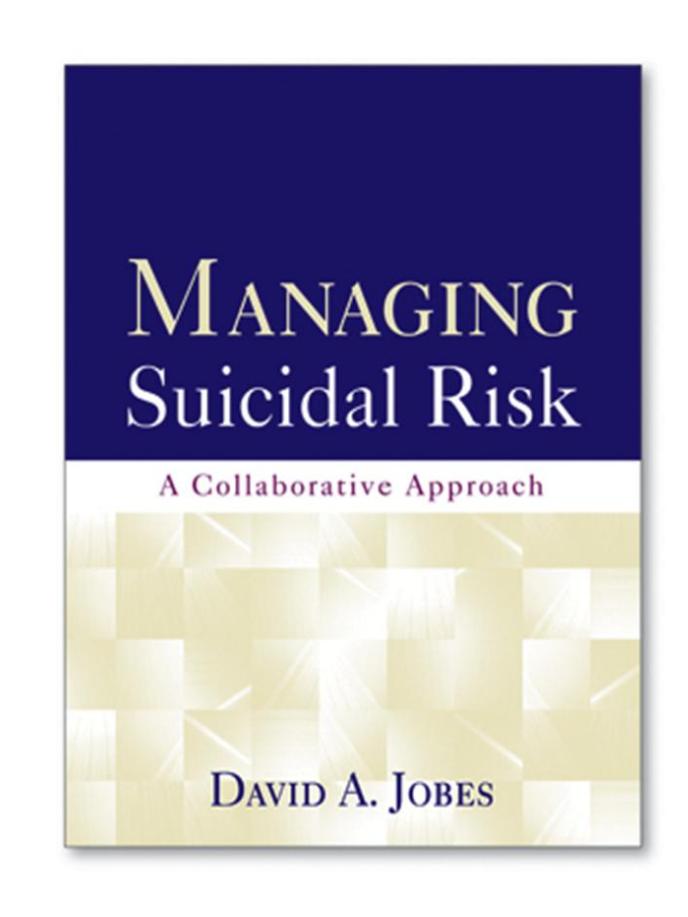


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Psychologist Perspective

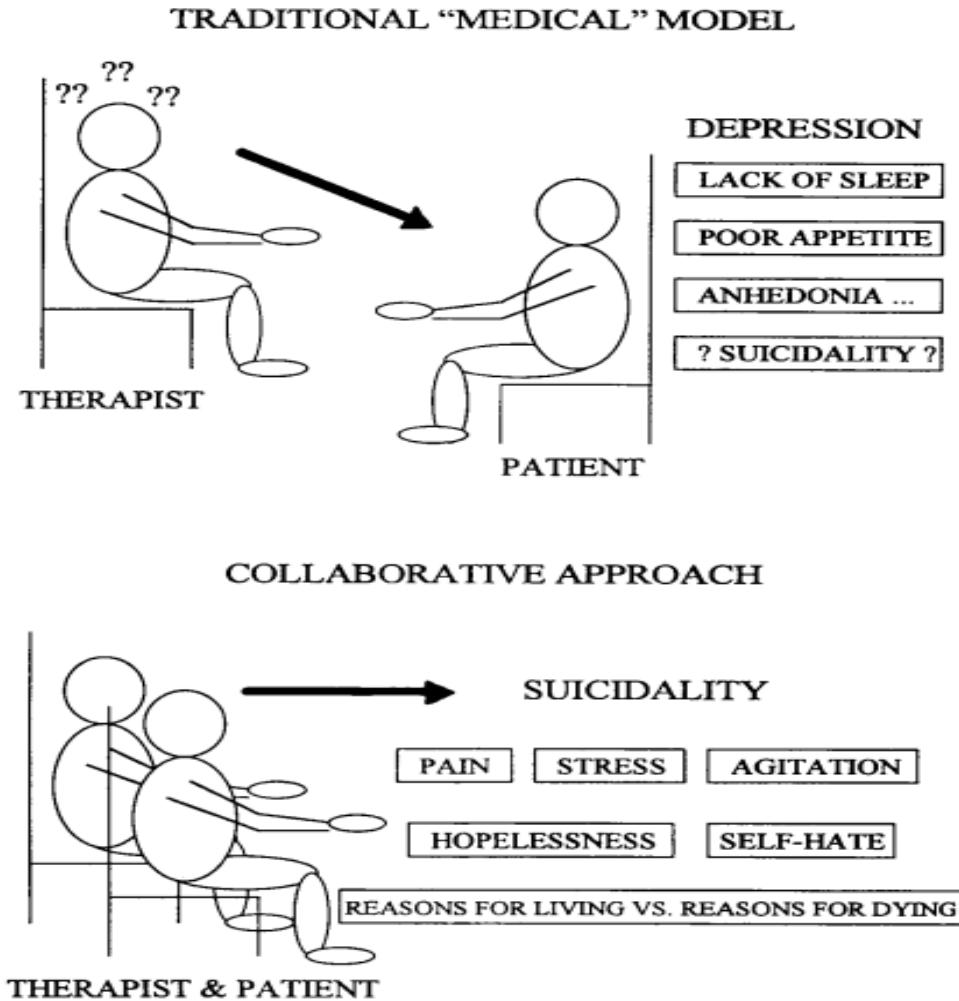


Collaborative Assessment and Management of Suicidality (CAMS)



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Psychologist Perspective

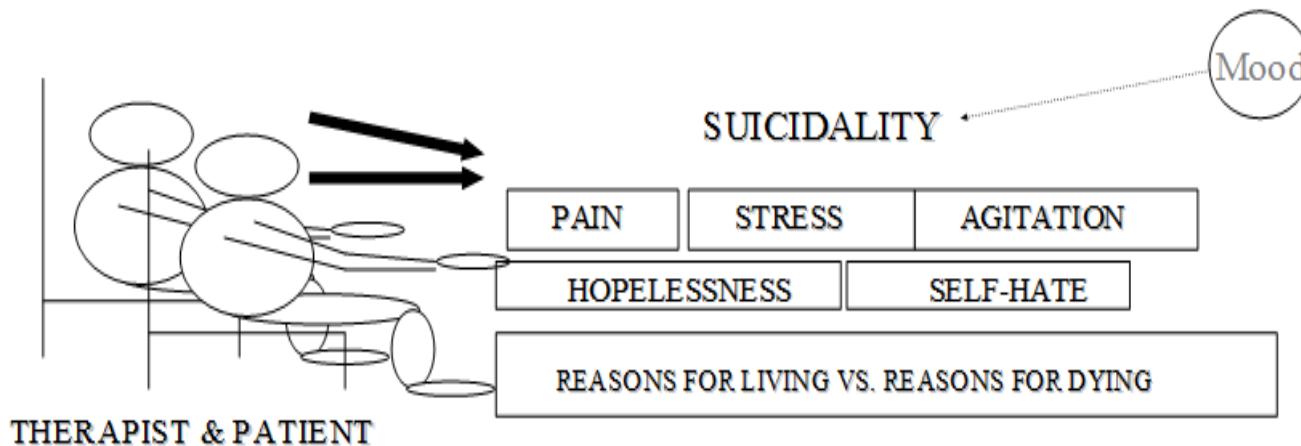


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Figure 1. Traditional (medical model) assessment of suicide risk versus Collaborative Assessment and Management of Suicidality (CAMS).

Psychologist Perspective

THE CAMS APPROACH



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Psychologist Perspective



Sample Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:
1. _____
2. _____
3. _____
Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):
1. _____
2. _____
3. _____
Step 3: People and social settings that provide distraction:
1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____ 4. Place _____
Step 4: People whom I can ask for help:
1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____
Step 5: Professionals or agencies I can contact during a crisis:
1. Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
2. Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services _____ Urgent Care Services Address _____ Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)
Step 6: Making the environment safe:
1. _____
2. _____

Safety Plan Template ©2008 Barbara Stanley and Gregory K. Brown, is reprinted with the express permission of the authors. No portion of the Safety Plan Template may be reproduced without their express, written permission. You can contact the authors at bhs2@columbia.edu or gregbrown@mail.med.upenn.edu.

The one thing that is most important to me and worth living for is:



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Psychologist Perspective

Suicide Mitigation, Alys Cole-King

“Risk assessment should be seen as a therapeutic intervention with the potential to save lives rather than an information gathering exercise. Instead of focusing on simply quantifying and characterizing risk, the emphasis should be on identifying patients’ needs and empowering them to accept help, reducing their distress and maximizing protective factors and reasons for living through co-creation of a risk mitigation plan and the instillation of hope.

Suicide mitigation, originally proposed by Cole-King and Lepping, promotes practitioners and carers to engage and collaborate with patients in a positive person-centred therapeutic relationship to diligently assess and mitigate risk (Cole-King and Lepping, 2010b). The concept of suicide mitigation is, as the authors suggest, a paradigm shift in the assessment of and response to suicidal individuals.”



Cole-King, Green, Peake-Jones, & Gask (2011)
InnovAiT: The RCGP Journal for Associates in Training

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Coping with Suicidal Thoughts

I'm seriously thinking about suicide. What should I do?

If you are thinking about suicide, you are not alone. Many people have thoughts of suicide, for a number of reasons. Thoughts of suicide can be very scary. You probably feel hurt, confused, overwhelmed and hopeless about your future. You may feel sadness, grief, anger, guilt, shame, or emptiness. You may think that nothing can be done to change your situation. Your feelings may seem like they are just too much to handle right now. It is important to know that thinking about suicide does not mean that you will lose control or act on these thoughts. Having thoughts of suicide does not mean you are weak, or 'crazy'. Many people think about suicide because they are looking for a way to escape the pain they are feeling.

Even though your situation seems hopeless and you wonder if you can stand another minute of feeling this bad, there are ways to get through this and feel better. You don't have to face this situation alone. Help is available. Here are a few ideas that you can use right now.

Connect with others: If you are worried that you may lose control or do something to hurt yourself, tell someone. Make sure you are around someone you trust. If you live alone, ask a friend or family member to stay with you. If you don't know anyone or can't reach friends or family members, call 1-800-SUICIDE (1 800-784-2433).

Keep your home safe by getting rid of ways to hurt yourself: It is important to get rid of things that could be used to hurt or kill yourself, such as pills, razor blades, or guns. If you are unable to do so, go to a place you can feel safe.

Develop a safety plan: It is very helpful to have a written safety plan when you have thoughts of hurting yourself. Have a trusted family member, friend, or professional help you to complete this safety plan. Keep this plan somewhere you can see or find easily. Write down the steps you will take to keep yourself safe (see the following example). Follow the steps. If you follow these steps and still do not feel safe, call a crisis line, get yourself to a hospital emergency room or call 911.

Dr. Joti Samra, R.Psych. and Dr. Dan Bilsker, R.Psych. (Lead Authors; 2007), Consortium for Organizational Mental Health (COMH; www.comh.ca), Faculty of Health Sciences, Simon Fraser University, Vancouver, BC. Inquiries may be directed to: info@comh.ca.

This document is not intended to replace professional care with a therapist or physician.



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Psychologist Perspective

Working with the Suicidal Patient

A Guide for Health Care Professionals

Summary

<ul style="list-style-type: none"> • Assess/Ensure Safety • Build Rapport – introduce yourself, your role, your goals • Assess Current Suicidal Ideation • Obtain Details on Current Attempt (if applicable) • Obtain History • Communicate with Family/Friends 	<ul style="list-style-type: none"> • Connect with Primary Healthcare Provider(s) • Advise Patient – instill hope, obtain information on existing supports, provide a safety plan • Provide Referrals at Time of Discharge • Follow-up Post-Discharge
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♦ Refer to Mental Health/Psychiatry if high risk ♦

Task One: ASSESS

1. Assess current suicidal ideation

Is suicidal ideation present now?
Have you gotten to the point where you did not want to go on? Have you had thoughts of not wanting to be alive? What about right now?

Passive Ideation: The patient would rather not be alive, but does not indicate a plan that involves an act of initiation
 = LOWER RISK (e.g., *I'd rather not wake up in the morning; I wouldn't mind if a car hit me when I was crossing the road*)

Active Ideation: The patient has acute thoughts of completing suicide = HIGHER RISK (e.g., *I do think about killing myself; I feel like throwing myself into traffic*)

Intense, continuous ideation = HIGHER RISK

Is there a plan?
Do you have a plan as to how you would end your life?

Detailed, carefully thought-out plan = HIGHER RISK

Is there intent?
You talk about wanting to die, and have even considered [taking pills] but are you intending to do this?

Low Intent: Suicidal thoughts and fantasies about plans, with absolutely no intent to put these plans into action. Fantasizing about suicide can provide some comfort to those in distress to know there is always a way out
 = LOWER RISK (e.g., *Oh no, I could never do that, I have children*)

High Intent: Expression of specific intent to end life
 = HIGHER RISK (e.g., *I intend to do this as soon as my daughter's graduation is over*)

Ambivalent or Unclear Intent: Ask about what has helped in past.
*What has stopped you from ending your life to this point?
 What has helped in the past when/if you've had these thoughts?*

2. Obtain details if there is a suicide plan

How lethal is the plan?
 How lethal does the patient believe the method(s) to be?

Is there access to means?
 Obtain specific details.
*What pills do you have or would you take to overdose?
 Exactly where would you get a gun from?*

Has patient chosen a time and/or place?
 How isolated is the patient? What preparations have been made (e.g., buying rope)?

Has patient made final arrangements?
 Has patient prepared a suicide note, settled their affairs or communicated to others?

Higher lethality, access to means, preparations and arrangements = HIGHER RISK

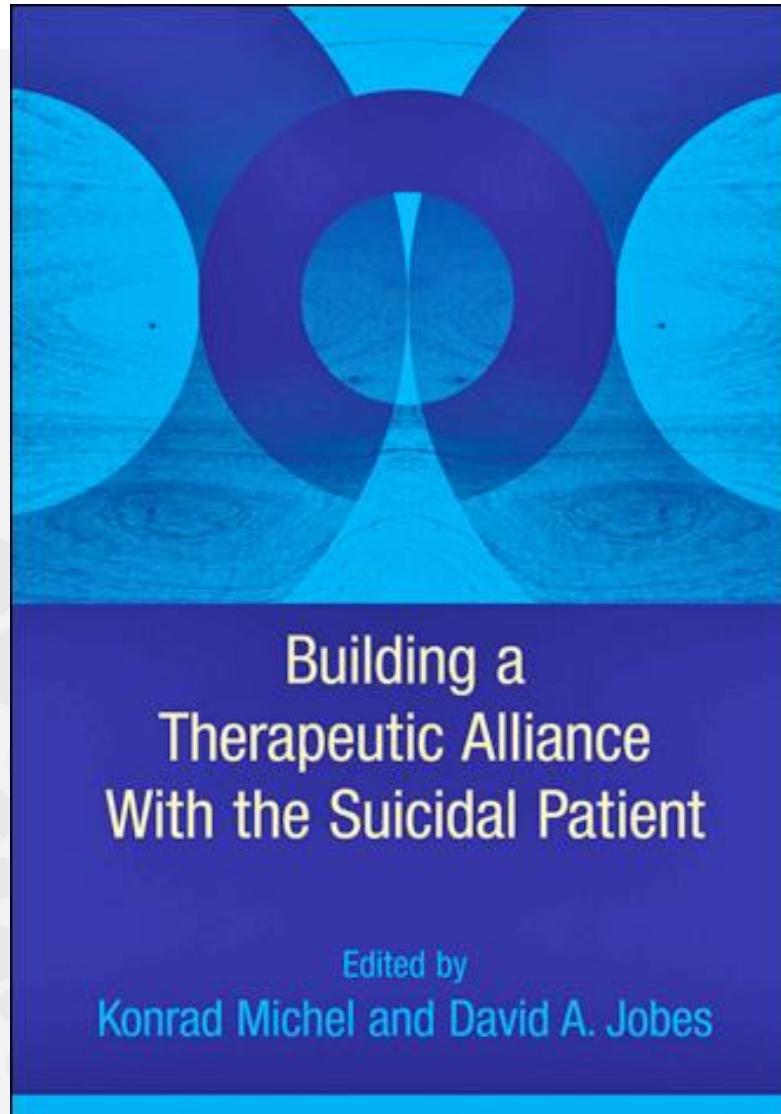
Note: This document is intended to be a guide to working with the suicidal adult, and should not replace a psychiatric consultation. When suicide risk exists, an expert opinion should be sought to determine the need for hospitalization and clarification of diagnosis.

Dr. Dan Bilsler, R.Psych., and Dr. Joti Samra, R.Psych. (Lead Authors; 2007), Consortium for Organizational Mental Health (COMH; www.comh.ca), Faculty of Health Sciences, Simon Fraser University, Vancouver, BC. Inquiries may be directed to: info@comh.ca.



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Suicide Care in Systems Framework

National Action Alliance; Clinical Care & Intervention Task Force

In 2011, we set out to identify the best practice toolkit for better suicide care. What we found most compelling were the cultural and system changes that were common in the most innovative suicide intervention programming. This thought paper lays out a logic map model for replication.



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Psychologist Perspective



Few voices of suicide attempt survivors have emerged in the public conversation about suicide, and few resources exist for us and for those who've wrestled with suicidal thoughts. We wanted to create a space that people and those who love them can stumble across while Googling answers to those lonely questions, "Has this ever happened to anyone else?" and "What do we do now?"



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“The Reasons to go on Living Project is designed to understand how people’s thinking changes after a suicide attempt. We do not understand the thinking processes that occur for people who choose to go on living after an attempt and there is very little research in this area. We believe that if we had a better understanding of how people found the strength to go on living after an attempt, we might be able to better help people who are thinking of ending their lives, before they make an attempt.”



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Acknowledgements

Susan Beaton, Bob Goldney, David Webb, Jagoda Pasic
and colleagues, at WPA Prague 2012, modified)



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Psychiatrist Perspective



Suicide: epidemiology

- A tragic, preventable global health issue
- In Australia, it leads causes of death by injury, and causes of death for 15-44 year olds
- Despite decreases since 1997, rates from 2002 to 2007 were 30-40% under-reported
- Suicide attempts and self-harm are not only a major public health and clinical problem, but a barometer of how well we care as a society



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What makes people suicidal?

- Unbearable psychological pain and cognitive constriction (Schneidman, 1993)
- The wish to die involves failed belongingness and perceived burdensomeness (the misperception one's death will relieve others), and acquiring the capacity to lethally self-injure (Joiner, 2005, 2009)
- What does stigma contribute?



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Public doubt about preventing suicide

- Public scepticism about suicide prevention (SP)— $\frac{1}{4}$ thought that suicide was not preventable, 1/10 were undecided (Lifeline Newspoll 2009)
- Scepticism about SP applies to intervening with non-clinical groups, as well as patients



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Doubt & disconnection among health professionals

- Health professionals sometimes doubt SP (e.g. Morgan and Evans (1994) – 20% thought SP was infeasible)
- One Australian study found treatment satisfaction for suicide attempt survivors as mixed for 1/3 and poor/very poor for 1/5; 28% reported attitudes of hospital health professionals as mixed and 33.5% as poor or very poor (De Leo et al., 2005)



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Stigma about suicide

- 'Those who talk about it don't do it'
- 'Don't talk about it: it'll give them ideas'
- 'There's no point intervening: people who are determined will just do it anyway'
- 'They're cowards', or 'they're selfish', or 'they're seeking revenge' etc etc (see Thomas Joiner's 'Myths about Suicide' (2010))
- Stigma comprises illiteracy, prejudice and practices
- Role of ambivalence



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Stigma and trauma constrain help-seeking for suicidality

- By young people and young men in particular but also various marginalised groups and suicide-bereaved people and suicide attempt survivors, who do not receive continuing treatment – and also those like Caitlin who have been 'burnt' by the psychiatric system



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Constraint of professionals

- Fear and organisational demands may elevate risk assessment (which cannot predict suicidal acts) above therapeutic relationships
- Organisations, doctors & psychiatrists (especially) may be blamed or sued for negligence, resulting in untold financial and emotional costs and defensive practice
- Accurate documentation of psychosocial and risk assessment is needed. Standards of care must be reasonable and prudent (Berman, 2006)
- However, pressure to fulfil (medico-legal) 'duty of care' can also be in tension with the patient's human rights



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What specific interventions are available/skills are required?

- No specific anti-suicide therapies exist (problem-solving therapy = same as usual care (Hatcher et al, BJP, 2011). Leading groups (e.g. NICE guidelines, Royal College of Psychiatrists and RANZCP) do not recommend any definitive intervention
- Trained communities and individuals who engage with the person's distress in pragmatic and timely ways and who offer hope and compassion can be as effective as paid helping professionals in sustaining life. Connection is critical.



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Starting and staying with the person

- Various gps and individuals are reclaiming the precept of listening to & learning from suicidal persons: building relationships through courtesy and respect, clear explanations of process and content, and delivering on what is promised.
- Avoid medicalising, as drug companies & sometimes psychiatry do - Use psychiatric language and diagnosis where needed but if possible sparingly; and avoid the pitfall of using taxonomies to classify people (trust in psychiatric taxonomies and 'evidence-based' psychiatry? – maybe a topic for discussion!)



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Psychosocial (including risk) assessment

- Clinical risk assessment and categorisation cannot predict suicidal actions
- But the practice of psychosocial (including risk) assessment underpins a comprehensive approach to care
- While routine A& E assessment can prevent self-harm – Level 3 (case-control) evidence – A&E's also can be unfriendly places: illiterate and censorious about self-harm, poorly informed about services, and poorly organised for follow-up – so that people can be alienated and lost without trace.



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Hence, improve staff knowledge and confidence

Because:

- Lack of staff knowledge about self-harm
- Poor communication between staff and with the patient
- Sub-optimal post-discharge follow-up
- And lack of knowledge of and access to services,
- Can also contribute to poor outcomes.



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Diagnosis = science, culture, marketing, exercise of power

- Clinical depression is not as common as drug companies and some national awareness programs would have us believe. But:
- Its melancholic form (= 'moderate-severe major depression' (DSM)?) has an ancient pedigree
- Clinical depression is qualitatively different to sadness or grief (a differential diagnosis for Caitlin), it is disabling, potentially dangerous, occurs with other conditions (e.g. eating disorders (Caitlin?)) and is often inadequately recognised and treated before and after suicide attempts. It needs to be detected



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Psychiatric hospitalisation

- Psychiatric – including compulsory – hospitalisation reportedly (in Level 3 (cohort & case-control) studies) reduces suicide risk but its hidden injuries are rarely examined or discussed
- To doctors: don't admit, treat, seclude or restrain people against their will unless there is absolutely no less restrictive alternative. Explain decisions, work with patient and staff to maintain her control and prevent hospital-induced trauma, explicitly inform the patient of her rights and promote these, actively support her decision-making wherever possible and ASAP. Don't hospitalise adolescents with adults



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Follow-up interventions

- Intensive follow-up and 'Green card'* improve adherence,
?Green Card reduces repeat DSH esp. for first time
attempters
- Brief intervention & contact reduces repetition (Motto &
Bostrom 2001; Carter et al, 2005; Fleischmann et al, 2008)
- Dialectical behaviour therapy for episodes in Borderline PD
- Brief Interpersonal Therapy, CBT for families?
- Research alternative approaches (safe places, peer
mentors)
- (*Wallet-size card with time and date of appointment with
a named mental health professional, 24 hour crisis
numbers, invitation to return to ED if in crisis)



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Psychiatrist Perspective



Implementation of mental health service recommendations

While et al, *Lancet*, Feb 2, 2012

- As more service recommendations implemented, suicide rates declined
- Those services which implemented 7 – 9 recommendations had significantly lower suicide rates than those who had only implemented 0 – 6 recommendations



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Drug treatments that work?

- Antidepressant, anti-anxiety and anti-psychotic medications may be required to treat symptoms or underlying disorders, but can be misused for overdose
- Lithium and clozapine may also be anti-suicidal



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Safety and effectiveness of antidepressants?

- The antidepressant story is confounded by drug company marketing and disease mongering
- Among young people SSRI antidepressants are rarely associated with suicide
- They seem more likely to be effective in moderate to severe depression and related conditions (such as anxiety and OCD disorders) but the placebo effect is also marked



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Interview in ED or office

- Offer privacy in ED or office
- Let the patient tell her story and encourage this
- (learn the assessment structure thoroughly, then listen and follow the patient carefully)
- What is the existential/spiritual issue?
- Social circumstances, problems, stressors
- Events around self-harm: focus on intent, safety - access to methods, opportunity and supports
- Past history of self-harm, MH problems, coping strategies and strengths
- Mental State Exam; and Management of specific conditions (e.g. psychosis, melancholia)



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Caitlin

- How does one establish a relationship in this situation? To acknowledge the fear and to repair and establish trust with MH services takes time. Caitlin must decide whether she can trust those with whom she deals, just as they must listen very carefully to her and seek her point of view
- Is there anyone whom she trusts, who can accompany her? Who will support her, help reduce her anxiety by assisting her to care for herself, solve problems and to protect her rights?
- How to respectfully obtain a history, including treating delicate information with sensitivity – e.g. re exposure to violence and abuse



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Caitlin

- Is this a crisis (existential + grief)? What is the role of illness (persistent biological symptoms) if any? What do insecure attachment and previous trauma in relationships/MH system contribute?
- What about Caitlin's strengths?
- Explaining very clearly what one is doing. Identifying and expressing hope, supporting Caitlin's safety, her decision-making and her rights at each step – preferably as an outpatient, possibly in relation to engaging in therapy, maybe medication



Dr Michael Dudley



A decorative graphic in the bottom left corner consists of a cluster of semi-transparent gray circles of various sizes, arranged in a roughly triangular shape that tapers towards the bottom left edge of the slide.

Q&A session

Thank you for your participation

- Please ensure you complete the *exit survey* before you log out (it will appear on your screen after the session closes). Certificates of attendance for this webinar will be issued in 4-5 weeks
- Each participant will be sent a link to online resources associated with this webinar within 1-2 days
- For more information about MHPN networks and online activities in 2013 visit www.mhpn.org.au



Are you interested in leading a face-to-face network in your local area with a focus on Suicide Prevention?

MHPN can support you to do so.

Please fill out the Expression of interest that you'll receive as a link in the webinar follow up email. MHPN will follow up with you directly.



Thank you for your contribution and participation

