



ZERO SUICIDE:
An International Declaration for
Better Healthcare

Atlanta 2016

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• Hong Kong • Japan • Malaysia • Netherlands • New
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Keywords

Mental Health
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Robust Performance Improvement
Patient Safety

Acknowledgements

International Initiative for Mental Health Leadership (IIMHL)

This declaration was developed by participants in the September 2015 IIMHL match event in Atlanta, which was planned by a group who convened in Oxford, United Kingdom in June 2014 for the first ever international gathering of Zero Suicide pioneers.

IIMHL is a unique international collaborative that focuses on improving mental health and addictions services. IIMHL is a collaboration of eight countries: Australia, England, Canada, New Zealand, Republic of Ireland, Scotland, USA and Sweden.

International Association of Suicide Prevention (IASP)

The 2015 match event was also sponsored by IASP, a group of professionals and volunteers from more than fifty different countries dedicated to preventing suicidal behavior, alleviating its effects, and providing a forum for academics, mental health professionals, crisis workers, volunteers and suicide survivors. IASP is a Non-Governmental Organization in official relationship with the World Health Organization (WHO) concerned with suicide prevention.

Pictured Page 4, 13 & 15:

A diverse group of healthcare administrators, peer leaders, and policy makers from 13 countries convened for *Atlanta 2015: An International Declaration and Social Movement*.

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Introduction

Every 40 seconds a person dies by suicide somewhere in the world. Over 800 000 people die due to suicide every year and it is the second leading cause of death in 15-29-year-olds. There are indications that for each adult who died of suicide there may have been more than 20 others attempting suicide.

*Suicides are preventable... **Health-care services need to incorporate suicide prevention as a core component** (World Health Organization, [Preventing suicide: A global imperative, 2014](#))*

Suicide is a complex, multifaceted biological, sociological, psychological, and societal problem with few resources for prevention.

As a major international health problem, it is estimated that it will contribute more than 2% to the global burden of disease by 2020. Suicide deaths impose a huge unrecognized and unmeasured economic global hardship in terms of potential years of life lost (YPLL), medical costs incurred, and work time lost by mourners.

The stigma associated with mental illness works against prevention by keeping persons at risk from seeking lifesaving help while the stigma associated with suicide deaths seriously inhibits surviving family members from regaining meaningful lives.

In the UK, twice as many people die from suicide than from road accidents every year. Whilst in the US, suicide is the tenth leading cause of all deaths and the second such cause for young people aged 15-24 years, and claims 40,000 lives annually, more than from homicide.

While many lives are saved in healthcare by clinicians and other staff, many lives are also lost by individuals receiving mental health services. Until now, a central focus on suicide prevention in healthcare settings has been largely missing. Yet many people experiencing suicidal ideation are in healthcare or in contact with healthcare: recent mental health contacts by about 30% of those who die, recent primary care contacts by about 45% (70% among older men), emergency department contacts by about 10%. Furthermore, there is great risk among people treated in/discharged from psychiatric inpatient and/or crisis facilities after a prior attempt.

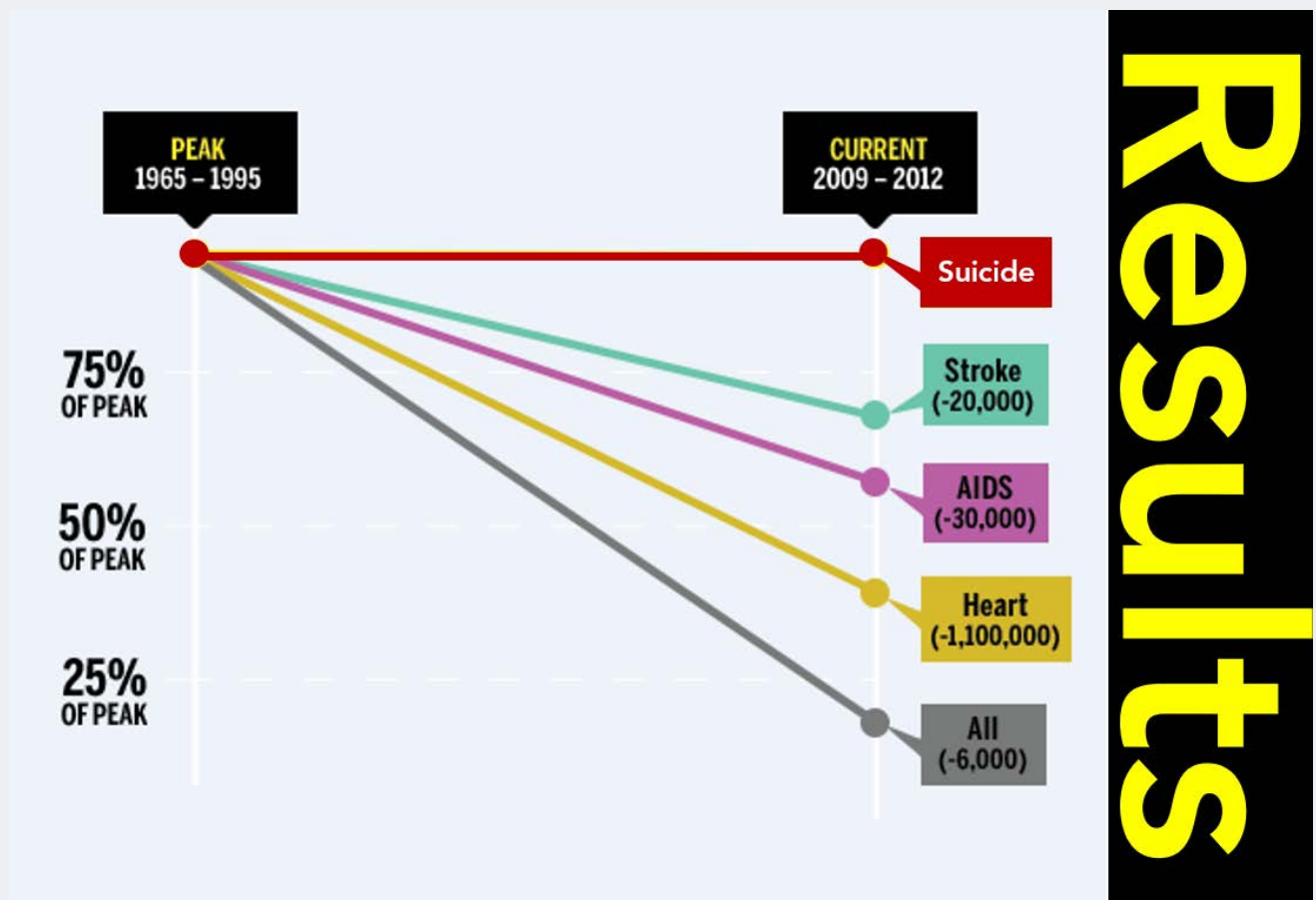
We can do something to change all of this.

Imagine a World Where...

We can talk about suicide openly, honestly, empathically and directly.

- Not one patient in healthcare dies by suicide
- Leaders, administrators, professionals, patients, families, and communities line up around the central goal of suicide prevention in high quality mental health and addiction care
- Augmentation of hope, safety, recovery and perspective is core to all interventions within healthcare systems
- And, as a consequence, population suicide rates drop dramatically

History has shown that action by organizations can, eventually, make a large and life-saving difference, even for issues that at first seem intractable. Stroke, AIDS and heart disease have dropped dramatically. However: not for suicide. Yet.



Thomas Insel, National Institute of Mental Health, April 2, 2015

Other Healthcare Mortality Reductions

In the last 60 years, tremendous strides have been made in the fight against cancer, polio, smallpox, and other wicked diseases. The healthcare workers, scientists, and policy makers engaged in those fights transformed their angst and set for themselves a Big Hairy Audacious Goal (BHAG) to reduce or eliminate deaths caused by those diseases.

And they were successful. Consider the following achievements:

- Smallpox was eradicated in 1980.
- The five-year survival rates in 1975 of certain forms of cancer, such as breast, prostate, and colorectal, were 75%, 69%, and 51%, respectively. In 2007, survival rates increased to 90%, 100%, and 67%, respectively.
- And the incidence of polio has gone down dramatically since 1988, when over 350,000 cases were reported. In 2014, that number plummeted to only 359 reported cases, a 99% decrease.

So what is a BHAG? The term BHAG, coined by *Good to Great* author Jim Collins, represents a long-term goal that changes the very nature of an organization's existence.

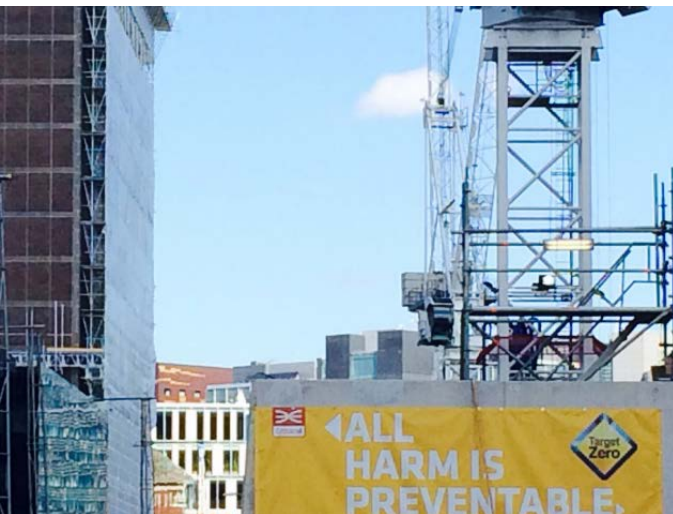
In the case of polio and smallpox, it meant a global effort to immunize every human being.

In the case of cancer, it meant more research, better screening, and aggressive therapies.

And in the case of suicide, it means setting a goal of ZERO DEATHS.



Figure 1: Is Your BHAG as Humbling as El Capitan? [Read the Blog](#)



Targeting zero is neither innovative nor controversial, but simply a technique other industries utilize daily. A London construction site says, "All Harm is Preventable... Target Zero," fostering a mindset that presses beyond incrementalism.

Zero defect and perfect process approaches are common in aviation, automobile, manufacturing, and other industries. Who would consider flying on an airline that can only guarantee a safe landing for 98 out of 100 flights? Who would want to give birth in a hospital that is proud of the fact that last year, only two infants were sent home with the wrong mother?

Yet zero defect initiatives are commonplace in healthcare. Zero medication errors. Zero inpatient falls. Zero surgical mistakes. Zero infections.

So why not zero suicides?

Perhaps because suicide is on the fringes, off the radar of most healthcare administrators and pressed to the periphery of the healthcare system. Too many clinicians believe that suicide is a personal choice, a choice they cannot often influence, and if they intend to act to influence this choice, they will be blamed if the person dies by suicide. Suicide scares and mystifies many of us. "The reality of healthcare is fear, logistics, low research funding and more risk than reward all conspire to make suicide the neglected disease." (Forbes Magazine, 2010)

In fact, many US pharmaceutical companies refuse to perform clinical trials of antidepressants on individuals with elevated risks of suicide, even though the US Food and Drug Administration (FDA) has approved such trials.

The impact of this pervasive fear and misunderstanding of the patient's experience of his/her suicidality is that these patients typically receive less compassionate, supportive attention than those in the current care system's "bullseye." Many patients don't feel heard, understood, or taken seriously. They experience mental healthcare as superficial, beating around the bush, condescending, and sometimes disrespectful.

The Zero Suicide Initiative

On 20-21 September 2015 in Atlanta, US, experts from 13 countries met under the aegis of IIMHL and IASP to craft a declaration of Zero Suicide in Healthcare. Experts included leaders with lived experience of suicide loss and suicidality, international healthcare management, health policy, and suicide prevention experts in public and private health care systems. This call to action for healthcare organizations that deliver mental health and/or addiction services includes key implementation recommendations and targets to be promoted in all countries throughout the world.

Consensus experts attending the Atlanta event believe achieving this result will be significantly enhanced if we first focus on reducing suicides through delivering "perfect care" through our healthcare systems.

Those individuals who enter the healthcare system are known to us, we understand the pathways of care provided to them and they should leave the healthcare system stronger. They should have a follow-up plan that has been designed in partnership with the individual; their clinicians, family or support network; and the community-based services which will help support their ongoing recovery.

All countries working to reduce suicides use, to varying degrees, existing systems to improve access, quality, and follow through. With around 20% of all deaths occurring in people who have exited our healthcare systems, this Declaration focuses on the opportunity that Zero Suicide in Healthcare affords all countries as they design and deliver national suicide prevention strategies, programmes, and services. These efforts will help ensure the WHO can achieve its global target of reducing the suicide rate in countries by 10% by 2020.

What Does "Zero Suicide" Mean?

Stated quite simply, Zero Suicide reflects a commitment by healthcare leaders to strive to make suicide a "never event" so that not one person dies alone and in despair.

To achieve this ambitious goal, there is a just culture where caring, competent, and confident staff are supported to continuously improve and learn together.

Patients are actively engaged and supported to talk about suicide and despair. They are also supported to rediscover hope and find ways to survive, with a continuous eye to re-engagement with and contribution to the communities in which they may live, work, and play for a lifetime.

What It Does Not Mean

Zero Suicide is not a zero tolerance approach, as there is already a significant burden felt by many clinical professionals related to suicide. Furthermore, it doesn't mean that people that die by suicide are "bad" or that healthcare providers should be ashamed when one of their patients dies by suicide.

In sum, it means that together we will do everything we can to bring the number of deaths by suicide to zero.



Not one of our patients should die alone
and in despair.



Core Recommendations

The core recommendations of Zero Suicide in Healthcare initiatives fall into three categories: Leadership, Continual Improvement, and Patient Support. They are built on a foundation of core values: that not one of our patients dies by suicide and that our work should be modified to accomplish the goal, not the other way around.

Leadership

- Foster a safety-oriented culture committed to dramatically reducing suicide among people under care;
- A just culture that avoids blame, ensures professionals perform at their best and *everyone* learns from adverse incidents and near misses;
- Develop an effective strategy and action plan revolving around clinical leadership, with clear targets, and firm dates for their attainment;
- Monitor progress using standardized data collection linked to these goals, keep the helm straight and stick to the target of zero; and
- Connect to and exchange with other leaders and organizations to learn, to help and to accelerate change and improvement in healthcare.



Figure 2: Dr. Mike Hogan at Zero Suicide Academy

Continual Improvement

- Apply a data-driven quality improvement approach in regards to routine care to suggest system changes that will lead to improved patient outcomes and better care for those at risk;
- Invest in training for healthcare teams and non-specialized health workers/caregivers, which focuses on identification, assessment, and collaborative management of suicidal behavior, and early identification of people with mental health and alcohol/substance misuse difficulties, chronic pain, and acute emotional distress.
- Learn from every fatal outcome and near-miss. Perform adverse incident reviews following patient suicides within 72 hours, summarizing the “root cause” contextual issues, and ensure fact-finding investigations are completed within two months. Every death by suicide should be regarded as a systems failure. Identify the problem, disseminate lessons learned to the entire organization and improve the system as soon as possible.

Patient Support

- Ensure every person has a timely and adequate pathway to care and supports;
- Systematically identify, assess and monitor suicidality in the entire patient population, and along the entire treatment pathway, for purposes of triage and indication to appropriate levels of acuity and intensity of care;
- Use effective, evidence-based care, including collaborative safety planning, restriction of lethal means, and effective treatment of suicidality;
- Respond to people at risk for suicide and people who have attempted suicide with follow up care and provision of community support to them and their family, especially after acute care;
- Overcome patient confidentiality concerns to engage families in suicide prevention planning; and
- Provide post-event support for families bereaved by suicide and for family and friends of attempt survivors, as well as health care providers.

Leaders in both the US Airforce and Henry Ford Health System initiatives reported that they believed the elements above were interdependent and synergistic, with none alone providing the critical component that made the difference in dramatically reducing rates.

And, today we have a series of specific practices available to healthcare that were relatively unknown even a decade ago. These include a focus on follow-up, continuity of care, and collaborative safety planning including the engagement of family and friends.

Clinical Staff Support Zero Suicide



Beyond the tragedy for individuals and family, healthcare systems have given scant attention to the impact of suicide upon their employed professionals. About one-third have an acute emotional reaction to a suicide death (like friends or family) and some depart the workforce as a result.

Since 2009, Zero Suicide leaders have surveyed more than 30,000 in the mental health workforce across nine US states, asking clinicians, case managers, peer specialists, and other community mental health center staff to rate their own skills, training, and supports to effectively engage those at risk of suicide.

The results of the survey indicate about 50% of respondents at least “agree” that they have what is needed (skills, training and supports/supervision). About one in four report that someone under their care and responsibility has died by suicide (and for almost half that group, this tragedy has occurred more than once).

Attaining This Goal is Possible

Setting ambitious goals and reaching them is well within our grasp. Consider the reduction of coercion and compulsion. Ten years ago, isolating patients was the norm in psychiatry in most of the world. Now, it’s considered a highly exceptional, last-resort measure in many countries, and the approach continues to spread. Who would have thought that patients in a closed ward would come to be separated as rarely and briefly as they do now? This goal is being achieved by proclaiming that isolation should no longer exist and by striving towards bringing an end to isolating patients completely.

Some may argue that setting a goal of zero suicides is unrealistic. Unattainable. Irresponsible. Against a backdrop of fear for “shaming and blaming,” it is understandable that mental health providers want to manage expectations concerning the possibility of preventing suicides. It is a reason why some healthcare professional have avoided committing to a concrete goal or target to reduce the number of suicides. *After all, not having tried is not having failed.*

Yet there are pioneers in the Zero Suicide approach. The Henry Ford Health System (HFHS) in the US is one such example. The cornerstone of their program is a Perfect Depression Care program, which has one objective: do everything that can help against depression and avoid doing things that could stand in the way of that.



The HFHS results are impressive. Within the system:

- The number of suicides decreased by 75% in the mental health system in 8 years' time (from 89 suicides per 100,000 to 22 per 100,000 a year);
- There were 25-75% less falls;
- They saw 33-40% less mistakes made with medication; and
- Financial results increased eightfold due to lower costs and higher returns.

Gains were also made at Centerstone America, based in Nashville, TN. Twenty months after implementing Zero Suicide, suicides rates decreased from 31 per 100,000 people to 11 per 100,000.

But the US isn't the only place Zero Suicide has taken a foothold.

Several pilot programs have begun in the UK, including:

- [Project Zero](#) in southwest England. This program includes individuals with lived experience in its steering committee and partners mental health and social service organizations with local emergency services to identify and support individuals at risk, including utilization of Jeffrey Brenner's "hot spotting" techniques.
- [Mersey Care](#). An NHS trust in Liverpool, this program has established a goal to eliminate suicides in its area by April 2018, with training for staff in the skills to support those at risk, such as safety planning. They have also engaged a tiger team for monitoring individuals at highest risk.
- [Stop Suicide Campaign](#). This program in Eastern England's Cambridgeshire and Peterborough is providing ASIST (Applied Suicide Intervention Skills Training), and using social media and community events with public pledges.

Zero Suicide also has a foothold in the Netherlands, where SUPRANET is a 113Online program aimed at the development and empowerment of suicide prevention action networks in healthcare, communities and in mass and social media. Fourteen Dutch large mental health care organizations are exchanging best practices and benchmark data to improve their quality of care and reduce suicides drastically. Four of these organizations have already adopted Zero Suicide explicitly in their policies.

What You Can Do

The purpose of this document – indeed, this challenge of Zero Suicide – is to kick-start healthcare organizations into action by addressing issues in an orderly and effective way across and within countries. It is intended to offer hope by reducing the risk from and potentially life-threatening impact of suicide, giving large numbers of people the opportunity to receive life-saving care.

There is no room for doubt regarding the shortcomings in current international suicide prevention efforts. People continue to needlessly die from suicide. Families and communities suffer. Lives continue to be marred by stigma and discrimination relating to suicide.

Evidence from published data suggests that suicide prevention efforts and the provision of healthcare for people who are suicidal remains far from ideal. Yet organizations like the Henry Ford Health System and Centerstone America show us that suicide can be prevented. However, prompt and effective action within all healthcare organizations is required in order to improve health outcomes.

In the US, the new edition DSM-5 brings a stronger recognition of suicide related to diagnoses like Schizophrenia, Bipolar Disorder, and Major Depression. It also proposes for consideration Suicide Behavior Disorder, which would indicate an attempt within the past 24 months, and be applicable to those who may not have another mental health diagnosis.

In years past “you would hear people saying, ‘Well, [suicide is] the natural course of the illness,’” says Mary Cesare-Murphy, leader of the mental health program at the Joint Commission. Now, she says, workers are much more inclined to believe “interventions can reduce people’s drive to kill themselves.” (Forbes, 2010)

Sixty years ago, healthcare workers, scientists, and policy makers took on smallpox, cancer, and polio. They set audacious goals and have conquered them, or are well on their way.

Scientists and policy makers have joined the Zero Suicide movement. Now it’s time for healthcare leaders to do the same.

While many lives are currently saved by good mental health care, many more lives could be saved. Until now a focus on suicide prevention has largely been missing in mental health care. By gearing the organization towards suicide prevention, mental health organizations can defy pessimistic expectations commonly encountered in society and health care. Contrary to popular belief, suicide is preventable indeed.

Saving more lives is not easy. It requires leadership, management of systems and processes, excellent clinical performance, courage and heart. And finally it requires a joint commitment to a BHAG. This goal is Zero Suicide in healthcare.

It’s time to set a Big Hairy Audacious Goal: that no one dies alone and in pain by suicide.

Let us pursue this goal, invest in it, and stick with it. We can save many more lives than we are currently doing. Let us prove that suicide in healthcare really is preventable.

In December 2015, the National Institute of Mental Health in the US released RFA-MH-16-800 seeking Applied Research toward Zero Suicide Healthcare Systems (R01). In February 2016, Public Health England convened a forum of UK Zero Suicide initiatives to discuss evaluation and outcomes. These are critical next steps in the advancement and long-term success of these efforts.

Ten Steps to Start

There are a myriad of ways you can begin championing Zero Suicide within your organization. Here are 10 to get you started:

1. Create a steering committee and draft an implementation plan with a focus on 90, 180, and 360-day targets. Then make Zero Suicide a multi-year commitment, drafting 3- and 5-year targets, as well. Ensure inclusion of persons with lived experience.
2. Recognize that the guidance from those who have advance-pioneered the route map propose some fundamental leadership prerequisites. Dr. Ed Coffey and the Henry Ford Health System initiated their “Perfect Depression Care” initiative 15 years ago.
3. Create a social movement. Talk about the importance of perfect care and Zero Suicide everywhere you go and commence every meeting with a patient story of hope and recovery.
4. Add personalities to the effort. Bring responsible celebrities into your confidence and promote their curiosity and investment. Build alliances that develop a feel-good about all things related to suicide prevention.
5. When you’ve achieved success, replicate it in other venues. Monitor, evaluate, and get hungry to expand the successes of Zero Suicide throughout all of your organizations.
6. Stay informed about Zero Suicide developments.
7. Make a sustained personal commitment. A trusted Zero Suicide leadership team requires a trusted workforce. People cannot perform at their best if they are watching over their shoulder for the next wave of change.
8. Create leadership champions at every level within your organization. Aim for at least 20% of the workforce onboard from the beginning, with another 60% primed and willing to follow suit. Ever growing, ever nuanced, ever relevant!
9. Learn from every fatal outcome and near-miss. Perform adverse incident reviews following patient suicides within 72 hours, summarizing the “root cause” contextual issues, and ensure fact-finding investigations are completed within two months. Every death by suicide should be regarded as a systems failure. Identify the problem and improve the system as soon as possible.
10. Create a just culture. Ensure a 100% no-blame culture, but accompany that with 100% accountability culture. You may do this by having the CEO communicate directly with every family who loses a loved one under care to suicide. Or perhaps you guarantee each family can be part of the coroner’s inquiry and the healthcare organization’s internal review process.



For more ideas or strategies to incorporate into your organization, visit www.zerosuicide.org.

Appendices

Timeline of Zero Suicide in Healthcare

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2015

[US Air Force](#) – “[At the start] there was a lot of debate about whether or not it was even possible to reduce suicide through this type of an effort,” according to David Litts. “A lot of people, including mental health practitioners, were skeptical. But over a six-year period, the suicide rate dropped by one-third.”

[DSM IV-TR](#) – Prominent suicidologists, argue successfully, albeit erroneously, that suicide is not a healthcare issue. They kept suicide out of the mental health Bible, the DSM, stating, “Suicide is, by definition, not a disease, but a death that is caused by [choice] a self-inflicted intentional action or behavior.”

[Henry Ford Health System](#) – After becoming a finalist for a Robert Wood Johnson Foundation grant, Don Berwick challenges the HFHS team to pursue perfection. A nurse staff member suggests that would mean zero suicide deaths. Within eight years, their death rate had decreased by 75 percent.

[Programmatic Suicide Deterrent](#) – Arizona DHS and Magellan Health challenge the mental health provider network to eliminate health plan suicides. In 2011, *Behavioral Healthcare* cites a 38% reduction in deaths, decreased hospitalizations and dramatic increases in staff confidence.

[Suicide Care in Systems Framework](#) – A task force of the National Action Alliance sets out to identify the best practice toolkit for clinical care staff. The group is captivated by the cultural and system changes of earlier pioneers, and designs and publishes a framework for replication.

[Lancet While et al Research](#) – England & Wales mental health services implement recommendations, associated with lower suicide rates, and 24 hour crisis care is correlated with the biggest reduction.

An estimated **200 to 300** fewer suicides a year linked to national recommendations for improved patient safety
Implementation of Recommendations Study (2012)

[Revised US National Strategy](#) – The US Surgeon General and the National Action Alliance publish a revised national strategy with new goals 8 and 9, calling for suicide prevention to become a “core component” of health care, and for improved professional and clinical practices, respectively.

[1st International Zero Suicide Summit](#) – Leaders from New Zealand, the UK, the US and the Netherlands meet at IIMHL in Oxford, UK. Dutch psychiatrist Jan Mokkenstorm: “We are at the beginning of this journey and start out from the core value that not one of our patients should die alone and in despair.”

[Zero Suicide Toolkit Website](#) – The Suicide Prevention Resource Center launches a Zero Suicide model with seven fundamental elements, including leadership, training, risk assessment, engagement, treatment, care coordination and quality improvement. The site becomes a repository for resources and a learning community of providers.

[UK Country-wide Initiative](#) – In January, UK Deputy PM Nick Clegg promises a “Zero Suicide” campaign of charities, voluntary organizations, and the NHS in “every part of England.” He references pilots in Merseyside, the east of England, and the southwest that have employed the Henry Ford model.

[Suicide Clinical Pathway](#) – In June, US News & World Report describes the systematic transformation of the largest non-profit Community Mental Health Center in the country, Centerstone, and its ambitious Zero Suicide protocols which reduced its suicide death rate 65% in less than two years.



Tool Kit
 IRIS
 Leadership
 Intellectual Capital
 Social Movement
 From WITHIN the Orthodoxy
 Spiritual Capital
 Cadbury's
 The Newcastle Declaration
 PROVED
 WRONG



HFHS
 Timely
 Efficient
 Equitable
 Pursuing Perfect
 (in 2 years)
 The EXAMPLE
 Perfect Depression Care
 and the Henry Ford
 Health System
 Accuracy
 Health only 80%

Community Makes
 us whole!
 Before "Civil Rights"
 the Freedom Riders
 Movement: the
 Catalyst? An openly
 Gay Man: the
 MARCH ON
 WASHINGTON
 Justice Blueprint
 BE VISIBLE
 and VOCAL
 CREATE
 NARRATIVES
 WE ARE HUMAN BEINGS



Background and the Atlanta Summit

The impetus for this document arose from an international suicide prevention leadership meeting held in Oxford, United Kingdom as part of the 2014 International Initiative for Mental Health Leadership (IIMHL) exchange program in Manchester, UK.

What ultimately resulted was a conference in Atlanta in September 2015 with an international group consisting of leaders, clinicians, consumers, family members, Non-Governmental Organizations (NGOs), and researchers from around the world who worked together to produce the final International Declaration for Zero Suicide in Healthcare.

Contributors to this vision include:

- 50 leaders, clinicians, consumers, family members, NGO organizations and researchers from 13 countries who attended the IIMHL Exchange meeting in Atlanta (September 2015)
- Members of the IIMHL Atlanta Exchange organizing group: David Covington (USA), Dr. Jerry Reed (USA), Fergus Cumiskey (NI), Dr. Jan Mokkenstorm (Netherlands) and Professor Jo Smith (UK).
- IIMHL and IASP for their support in organizing and hosting the exchange meetings in Oxford (2014) and Atlanta (2015)

UK Professor Jo Smith facilitated the meeting alongside host David Covington. The purpose was to complete a document that might influence all nation states with a comprehensive suicide prevention plan to adopt the principles that make suicide care a central focus for mental health and integrated healthcare systems.

It was also designed to fan the flames of an emerging social movement related to Zero Suicide in Healthcare, and to address misconceptions about what it is, what it is not, and how it began.



Summit Participants

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Lead

Train

Identify

Engage

Treat

Transition

Improve



Welcome to the Zero Suicide Toolkit

Watch Mike Hogan, co-lead of the Zero Suicide Advisory Group, describe Zero Suicide. And read the Quick Guide, in the Tools below, for 10 steps to beginning a Zero Suicide initiative.

Need implementation
support?
zerosuicide.sprc.org/toolkit



Zero Suicide in Healthcare



Sydney 2017: From International Declaration to Local Action



“From International Declaration to Local Action”

SYDNEY 2017

Co-facilitated by Dr. Mike Hogan
& David Covington with array of
expert speakers

WELCOME!

We are pleased to invite you to participate in the 3rd International Summit of Zero Suicide which will be held in Sydney, Australia Monday and Tuesday, February 27 – 28, 2017, in conjunction with the **International Initiative for Mental Health Leadership (IIMHL) Exchange.**

For any inquiry, please contact any of the following:

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- Sue Murray, suem@suicidepreventionaust.org



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Adopt the mindset.
Change the world.
**Zero is the only goal
we can live with.**

