

# LIFE

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## A framework for prevention of suicide in Australia



Australian Government  
Department of Health and Ageing

*Living Is For Everyone (LIFE) Framework (2007)*

ISBN: 1-74186-296-5

Online ISBN: 1-74186-297-3

Publications Number: P3 -2060

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*The Australian Government Department of Health and Ageing has financially supported the production of this review/publication. While every effort has been made to ensure that the information contained in the review/publication is accurate and up-to-date at the time of publication, the department does not accept responsibility for any errors, omissions or inaccuracies.*

# Using the Living Is For Everyone (LIFE) resources

## Which LIFE (2007) resource is most useful to you?

### What do you want to know?

You want to know about the latest understanding of suicide and suicide prevention.

You want to know that your suicide prevention activities are well founded and well informed.

You want to know about the overall purpose, structure, principles and priorities for suicide prevention in Australia.

You want something that explains more about suicide, why people suicide, and tells you what you can do or say to help prevent suicide, or to help people bereaved by suicide.

### Who are you?

You may be an academic, researcher, policy maker, member of parliament, health or community services professional, service provider or community organisation.

You may be a community member, professional carer, service provider, employer, friend, family, work colleague or associate of someone you think is suicidal, or of people affected by a suicide – or you yourself may be at risk of suicide.

### Which document matches your needs?

*Living Is For Everyone: Research and Evidence in Suicide Prevention* sets the context for suicide prevention activity, summarising current theories, research, evidence and statistics relating to suicide and suicide prevention in Australia.



*Living Is For Everyone: A Framework for Prevention of Suicide in Australia* provides a summary of current understandings of suicide and outlines the vision, purpose, principles, Action Areas, planned outcomes and strategies for suicide prevention in Australia.



*Living Is For Everyone: Practical Resources for Suicide Prevention* is a set of plain language **fact sheets** arranged around topic areas that summarise the key issues in suicide prevention and suggest further sources of information and help.



The Living Is For Everyone website: [livingisforeveryone.com.au](http://livingisforeveryone.com.au) has up-to-date information on suicide prevention activities in Australia and links to a wide range of resources, guidelines and fact sheets.

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living is for everyone

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# Living Is For Everyone (LIFE) materials



*Living Is For Everyone (LIFE) Framework (2007)* is the latest in a series of national suicide prevention initiatives in Australia that began in the early 1990s. It provides national policy for action based on the best available evidence to guide activities aimed at reducing the rate at which people take their own lives. The materials aim to support population health approaches and prevention activities that will assist in reducing the loss of life through suicide in Australia.

The LIFE (2007) package of materials includes:

This document, *Living Is For Everyone: A Framework for Prevention of Suicide in Australia (2007)*, outlines the vision, purpose, principles, action areas, and proposed outcomes for suicide prevention in Australia. It replaces the *Living Is For Everyone (LIFE) Framework (2000)*.

The LIFE Framework is based on the understanding that:

- suicide prevention activities will do no harm
- there will be community ownership and responsibility for action to prevent suicide; and
- service delivery will be client-centred.

*Living Is For Everyone: Research and Evidence in Suicide Prevention* sets the context for suicide prevention activity, summarising current theories, research, evidence and statistics relating to suicide and suicide prevention in Australia.

*Living Is For Everyone: Practical Resources for Suicide Prevention* is a set of fact sheets, arranged by topic areas, providing practical information about suicide prevention.

The LIFE (2007) package of materials is located at [livingisforeveryone.com.au](http://livingisforeveryone.com.au)

# Australia was one of the first countries to develop a national strategic approach to suicide prevention.

## Audience for the LIFE (2007) materials

The LIFE (2007) materials have been produced for use by people across the Australian community who are involved in suicide prevention activities. The materials aim to improve understanding about suicide, of appropriate ways of responding to people considering taking their own life or who have been affected by suicide, and of the role that people can play in reducing the tragic loss of life to suicide in Australia.

The two documents, *Living Is For Everyone: Research and Evidence in Suicide Prevention* and *Living Is For Everyone: A Framework for Prevention of Suicide in Australia* are particularly aimed at academics, researchers, policy makers, health or community services professionals, service providers and community organisations.

*Living Is For Everyone: Practical Resources for Suicide Prevention* is primarily aimed at community members, carers, service providers, employers, friends, family, work colleagues or associates of someone who may be suicidal, or who has been affected by a suicide.

## How the LIFE (2007) materials were developed

In 2000, the *Living Is For Everyone: A Framework for Prevention of Suicide and Self-harm in Australia* (the LIFE Framework) was released. That framework provided a strategic plan for national action to address the tragedy of suicide, to prevent suicide, and promote mental health and resilience across the Australian population. It has played an important role in providing research, evidence and information about suicide and suicide prevention internationally and within Australia, and it remains an important source document.

In early 2006, an independent review and consultation with key stakeholders on the LIFE Framework was commissioned. It became apparent that a set of more practical documents and resources was needed to assist the wider community in suicide prevention. As a result of that review a redevelopment of the LIFE Framework was commissioned in 2007.

The new framework was developed after extensive consultations from November 2006 to June 2007. These consultations involved the wider Australian community and included representatives from national and state government departments, academics and researchers; health and community service professionals; peak bodies and service providers in the public and non government sectors; local communities, services and recreation clubs; special interest groups; people bereaved by suicide; and families, friends and individuals. The consultations were supplemented by a wider canvassing of the most recent international and national research.

The new LIFE Framework suite of resources was developed in 2007 from these consultations and is a revision and replacement of the earlier LIFE Framework.

# Suicide Prevention in Australia

## Background

Australian governments, communities and organisations have supported suicide prevention efforts for more than ten years, and these efforts have contributed to a decrease in the age standardised rate of suicide from a peak of 14.7 suicides per 100,000 people in 1997 to 10.3 per 100,000 people in 2005. The LIFE Framework (2007) is the latest in a series of national suicide prevention initiatives in Australia that began in the mid 1990s.

Australia was one of the first countries to develop a national strategic approach to suicide prevention. The initial focus was primarily on youth suicide. In the 1995-1996 Federal Budget, \$13 million was allocated over four years to develop and implement a national plan for youth in distress. In the following year, a further \$18 million was allocated to expand the National Youth Suicide Prevention Strategy, with a total of \$31 million allocated between 1995 and 1999.

In 2000, *Living Is For Everyone: A Framework for Prevention of Suicide and Self-harm in Australia* provided a strategic framework for national action to prevent suicide and promote mental health and resilience across the Australian population.

In 2006-07, a redevelopment of the LIFE Framework was commissioned, and these resources are designed to replace the original LIFE Framework.

### The Council of Australian Governments (COAG)<sup>i</sup> Agreement July 2006

In July 2006, COAG agreed to a National Action Plan on Mental Health 2006-2011 involving a joint package of measures and significant new investment by all governments over five years to promote better mental health and provide additional support to people with mental illness, their families and their carers.

The National Action Plan on Mental Health 2006-2011 focuses on promotion, prevention and early intervention; improving mental health services; providing opportunities for increased recovery and participation in the community through employment and stable accommodation; better-coordinated care; and building workforce capacity.

This National Action Plan sets out agreed funding commitments, outcomes, and most importantly, specific policy directions for action that emphasise coordination and collaboration between government, private and non-government providers. The COAG statement emphasised the need for a more seamless and connected care system.

A key element of the National Action Plan is the commitment from the Australian Government to double funding for the National Suicide Prevention Strategy (from \$61 million to \$123 million) to enable the expansion of suicide prevention programs, particularly those targeting groups at high risk in the community.

A COAG Mental Health Group in each State and Territory has been established. These groups involve the Commonwealth and the States and Territories working together to coordinate implementation. In some cases, such as Queensland, it includes community sector and other non-government representatives.

The Plan will also be monitored against nationally agreed progress measures over a five-year period and will be subject to an independent review at the end of this period.

### Government and non-government suicide prevention and related activities

Contact details for further information on these initiatives can be found at Appendix A.

<sup>i</sup>COAG is the peak intergovernmental forum in Australia, comprising the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association (ALGA).

More than two thousand  
Australians take their  
own lives every year.



# What is known about suicide and suicide prevention?

Around two thousand Australians take their own lives every year with impacts on families, friends, workplaces and communities.

People of all ages and from all walks of life in Australia take their own life and the causes often appear to be a complex mix of adverse life events, social and geographical isolation, cultural and family background, socio-economic disadvantage, genetic makeup, mental and physical health, the extent of support of family and friends, and the ability of a person to manage life events and bounce back from adversity.

In 2005, 2,101 deaths by suicide were registered in Australia (Australian Bureau of Statistics, 2007):

- This is an age-standardised rate of 10.3 per 100,000 people<sup>ii</sup>. This rate has been dropping steadily since a peak of 14.7 suicides per 100,000 people in 1997.
- Males accounted for nearly 80% of these deaths.
- This compares with 1,638 deaths by motor vehicle accidents in the same period.
- Suicide accounted for almost a quarter of all deaths amongst young men aged 20 to 34.
- Suicide rates are fairly similar for females of all ages with the highest age-specific rate in the 35-39 years age group (6.9 per 100,000) and the lowest in the 15-19 years age group (3.6 per 100,000).
- The age-specific suicide death rates for males shows significant variations between age groups, with the highest being in the 30-34 years age group (27.5 per 100,000) and the lowest in the 15-19 years age group (9.5 per 100,000), and in men aged over 75 the rate was 21.6 per 100,000.

Reducing the rate at which people take their own lives is the responsibility of all Australians and this is best achieved by a coordinated response across the community.

## Risk and protective factors for suicide

The many factors that influence whether someone is likely to be suicidal are known as:

- *risk factors*, sometimes called vulnerability factors because they increase the likelihood of suicidal behaviour; and
- *protective factors*, which reduce the likelihood of suicidal behaviour and work to improve a person's ability to cope with difficult circumstances.

Risk and protective factors are often at opposite ends of the same continuum. For example, social isolation (risk factor) and social connectedness (protective factor) are both extremes of social support.

Risk and protective factors can exist at three levels:

- the *individual or personal level* which includes mental and physical health, self-esteem, and ability to deal with difficult circumstances, manage emotions, or cope with stress;
- the *social level*, which includes relationships and involvement with others such as family, friends, workmates, the wider community and the person's sense of belonging; and
- the *contextual level or the broader life environment* which includes the social, political, environmental, cultural and economic factors that contribute to available options and quality of life.

Risk and protective factors may be:

- *modifiable* - things we can change; and
- *non-modifiable* - things we cannot change.

For example, in some areas of Australia isolated older men may be more likely, according to statistics, to take their own life. Nothing can be done about their age or gender (non-modifiable factors that increase risk), but it is possible to change their social isolation (modifiable factors).

<sup>ii</sup> The age-standardised rate accounts for the changing age structure of the Australian population over time.

## Influencing risk and protective factors

Suicidal behaviours, both fatal and non-fatal, result from interactions between risk factors across a person's life span. Risk factors for people taking their own life – that is, the characteristics that increase the likelihood that a person will become suicidal can be divided into two broad groups (Moscicki, 1999). These are:

- *distal risk factors* (further away in time from becoming suicidal) are those that expose a person to the risk of taking their own life or are likely to increase the person's vulnerability. They include, for example, genetic factors and psychopathology; and
- *proximal risk factors* (closer to the time of becoming suicidal) can be viewed as triggers for a person to take their own life. However, they are not sufficient in themselves, nor are they a necessary precursor for a person to take their own life. Proximal risk factors include negative recent life events, or a crisis.

In each person, it is the action of distal and proximal risk factors together that might result in suicidal behaviours.

In assessing the risk of someone taking their own life, it is important not to assume that an individual in a particular group or population necessarily shares the characteristics and risks of that group or population (Platt & Hawton, 2000). For example, based on research, it might be assumed - incorrectly - that every male or every elderly person is automatically at increased risk. Similarly, because suicide and mental illness are linked, it may be assumed - again, wrongly - that everyone who engages in suicidal behaviour is mentally ill. This is one of the common myths about suicide (De Leo & Krysinska, 2008).

Equally, it cannot be assumed that low risk means no risk. Risk factors are indicators only and it is incorrect to assume that suicide in a person with one risk factor is less likely than suicide in another person with several risk factors.

People who attempt to take their own life usually have many risk factors and few protective factors. But risk and protective factors don't explain everything about suicide. Most people with multiple risk factors do not attempt to take their own life, and some who do take their lives have few risk factors and many protective factors.

Particular risk factors are more important for some groups than others. For example, the factors that may put a young man at risk are generally quite different to those that increase the risk for a retired, older man. Applying an understanding of risk factors to prevent suicide involves identifying:

- the risk factors (individual, social, contextual) that are present for a particular person or group of people;
- individuals who are most likely to be badly affected by these risk factors, and those who are most likely to be resilient; and
- which of the risk factors can be changed (modifiable) to reduce the level of risk.

There is not a straight one-to-one relationship between reduced risk and the presence of protective and/or risk factors, which may be for a number of reasons:

- The same life event can have very different impacts on individuals, depending on what else is happening in a person's life at the time, and their ability to grow and learn from life's challenges. To assist someone who is feeling suicidal it is critical to understand their sense of self, their ability to cope and their personal competence.
- People vary widely in their beliefs about what makes life worth living, and these views may also change over time. Despite many years of research, researchers have not yet been able to explain how and why these differences occur.

## What assists in protecting people against suicide?

A further challenge lies in the strong relationship between socio-economic factors and health. At present in Australia, there is a strong link between geographic location (regional, rural and remote), socio-economic disadvantage (low socio-economic status) and ill health. This relationship also exists for suicide - suicide rates tend to be much higher in regional, rural and remote locations and in areas of higher socio-economic disadvantage.

## Applying our knowledge of risk and protective factors in suicide prevention

The most recent research suggests that an understanding of risk factors in suicide is best used to identify populations or specific socio-economic groups that might be at risk, rather than attempting to identify individuals at risk. The main reason is that the majority of people who can be categorised as at risk do not and will not ever take their own life. It is extremely difficult to determine from risk factors alone which individuals within an at risk group are more or less likely to become suicidal.

Most researchers recommend that suicide prevention initiatives should focus on constellations of risk and protective factors. Activities may include:

- reducing exposure to social and contextual risk through structural changes that target specific at risk groups such as remote Indigenous communities, socially or geographically isolated older men or people with a mental illness. For example, developing social support networks, improved employment prospects or access to affordable housing.
- increasing individual protective factors through activities that help to build self-esteem, psychological strength and personal competence. For example, teaching young people social and emotional skills, fostering positive peer relationships and relationships with teachers and other adults, and encouraging help-seeking behaviours.
- providing easier access to appropriate care and support that is in the right place, at the right time, using the right approach. For example, non-judgemental assistance for people bereaved by suicide, provided by their peers, in the places they frequent and where they feel most comfortable.
- reducing risk and increasing protection for people who are in current crisis. Such groups might include those who have attempted to take their own life, or who have been recently discharged from mental health care.

Everyone experiences stress and difficult circumstances during their life. Most people can handle these tough times and may even be able to make something good from a difficult situation. There are others however who may respond negatively when faced with difficult or traumatic events and may become discouraged or defeated and become more vulnerable. One of the main aims of suicide prevention activities is to build resilience in individuals, their families and in whole communities, to increase their capacity to respond to life's events, whatever they may be.

Many factors shape how each person develops self-image, life skills and the ability to manage and survive under pressure or when faced with life changing events. Some of these factors are genetic, some are linked to current and past physical or mental health, some are the result of previous life or family experiences, some are cultural or gender-related, and some relate to the person's social support systems.

## What is resilience?

Resilience is the ability to bounce back after experiencing trauma or stress, to adapt to changing circumstances and respond positively to difficult situations. It is the ability to learn and grow through the positive and the negative experiences of life, turning potentially traumatic experiences into constructive ones. Being resilient involves engaging with friends and family for support, and using coping strategies and problem-solving skills effectively to work through difficulties.

The same circumstance may contribute either to vulnerability or to resilience. For instance a family environment that is supportive and caring will enhance resilience, while lack of family support or exposure to abuse or trauma in a family may make a person more vulnerable and less able to cope in the future with potentially traumatic incidents.

**FIGURE 1:** Factors that contribute to individual health and wellbeing.

<b>Individual health and wellbeing</b>	
<b>Self-image</b>	Sense of self includes: Self-esteem; secure identity; ability to cope; and mental health and wellbeing.
<b>Behaviour</b>	Social skills include: Life skills; communication; flexibility; and caring.
<b>Spirit</b>	Sense of purpose includes: Motivation; purpose in life; spirituality; beliefs; and meaning.
<b>Heart</b>	Emotional stability includes: Emotional skills; humour; and empathy.
<b>Mind</b>	Problem solving skills includes: Planning; problem solving; help-seeking; and critical and creative thinking.
<b>Body</b>	Physical health includes: Health; physical energy; and physical capacity.

(Adapted from Beautrais, 1998; Kumpfer, 1999; Maslow, 1943; Rudd, 2000)

There have been many theories about how individuals develop and how they build their resilience, wellbeing and attitude to life. **Figure 1** summarises the main internal building blocks of individual health and wellbeing that are regarded as contributing to resilience and building strengths and capacities to prepare individuals for their life's events and stresses, and support them through those experiences.

However, individual health and wellbeing described in **Figure 1** is just one of the four main factors that work together to build individual resilience and increase the capacity to manage when placed in difficult or anxiety-provoking situations. Other external factors that impact on the individual's ability to manage the range of events that can occur throughout their life include family life, social interactions and accumulated experiences from the past (cultural, social, family), and anticipation of the future (expectations, hopes, dreams and fears).

**Figure 2** summarises these factors that together work to influence a person's reaction to life events (Commonwealth of Australia, 2007).

**FIGURE 2:** The four main groups of factors that influence a person's ability to respond positively to adverse life events.

<b>Individual health and wellbeing</b>	Sense of self; social skills; sense of purpose; emotional stability; problem solving skills; and physical health.
<b>Predisposing or individual factors</b>	Genes; gender and gender identity; personality; ethnicity/culture; socio-economic background; and social/geographic inclusion or isolation.
<b>Life history and experience</b>	Family history and context; previous physical and mental health; exposure to trauma; past social and cultural experiences; and history of coping.
<b>Social and community support</b>	Support and understanding from family, friends, local doctor, local community, school; level of connectedness; safe and secure support environments; and availability of sensitive professionals/carers and mental health practitioners.

## Vulnerability and suicide risk

Despite many years of research into suicide and suicide prevention in Australia and overseas, it is still not possible to predict reliably whether a person is likely to take their own life; or to be sure which interventions are the most effective to prevent people from taking their own life. For some, suicide may be an impulsive and irrational act. For others it may be a carefully considered choice - particularly where the person believes that his or her death will benefit others. Some people take their own life or harm themselves apparently without warning. Some give an indication of suicidal intent, especially to friends and loved ones and to professionals. The most recent theories about the different motivations for people to take their own life suggest that it may be any one or combination of:

- a direct result of a mental illness, such as clinical depression or schizophrenia. However, many people with a mental illness are not affected by suicidal thoughts or behaviour, and not everyone who takes their own life is mentally disturbed or mentally ill.
- an outcome of reckless behaviour. Suicide is, for example, often associated with alcohol or other drugs, or it may result from dangerous or life threatening activities. Such behaviour is sometimes referred to as a death wish.
- an attempt to end unmanageable pain. This may be psychological pain and despair, stemming from humiliation, guilt, shame, or loss; or it may be chronic physical pain or debilitating illness.
- an attempt to send a message or gain a particular outcome such as notoriety, vengeance, defiance, or to leave a particular legacy or impact.
- an altruistic or heroic act, relieving others of a burden, dying to save another, or dying for a cause; or
- an expression of the person's right to choose the manner of their death. In some circumstances, the specific means or place of taking their own life has particular symbolic significance to the person.

## Tipping points

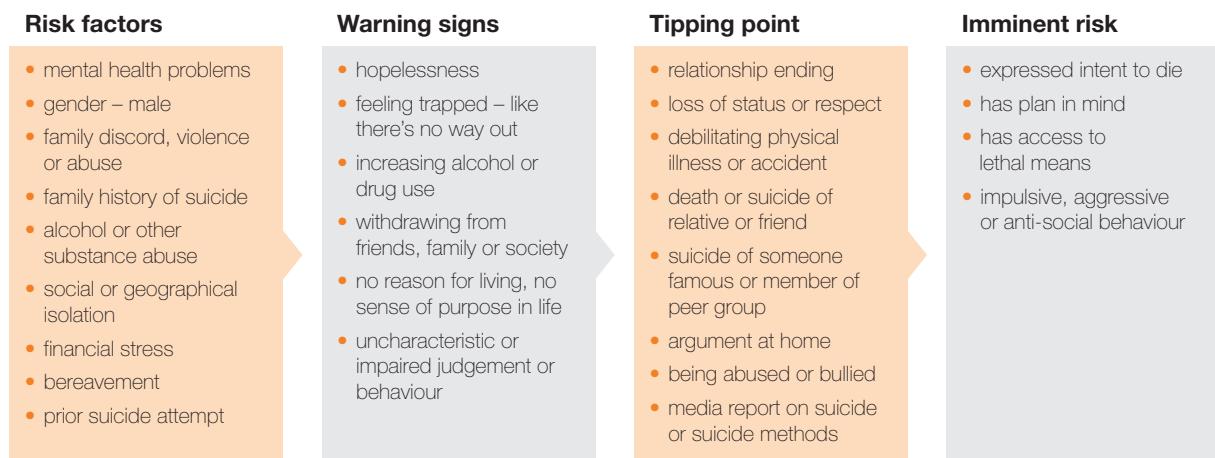
Many people who are thinking of taking their own life do not want to die, but can't see any other way out of their situation. They are likely to be deeply ambivalent or confused about their suicidal thoughts or intentions. Their state of mind may change rapidly in a short period of time. People take their own life usually as the result of a complex range of factors, but it is often just one or two things that can trigger actions such as making a plan or finding a means to take their own life.

The point at which a person's risk of taking their own life increases due to the occurrence of some precipitating event may be called a tipping point. Tipping points vary for every individual, but there are some indicators of times at which people may be under particular stress. The warning signs and tipping points can be likened to signposts that give early warning of the potential for someone to take their own life. Sometimes referred to as triggers or precipitating events, they include mental disorders or physical illnesses, alcohol and/or other substance abuse, feelings of interpersonal loss or rejection, or the experience of potentially traumatic life events (unexpected changes in life circumstances).





**FIGURE 3:** Examples of typical triggers and precipitating events to suicide.



## Warning signs

For families, friends and work colleagues, knowing the main warning signs and responding to them quickly and effectively may save a person's life. This is the main component of indicated interventions that are outlined in the following section. However, it should be noted that in many cases of someone taking their own life, there appear to be no warning signals that are obvious and even the most skilled professionals may miss them.

A warning sign indicates that a person might be at a heightened risk, is having serious thoughts about taking their own life, and may be planning or taking actions towards this. Warning signs may be a cry for help, and they can provide a chance for family, friends, associates and professionals to intervene and potentially prevent the person from dying or injuring themselves. The following behaviours are more common among people who are feeling like taking their own life, although many people show some of these signs at some point in their lives, especially when they are tired, stressed or upset:

- threatening to hurt themselves or take their own life;
- looking for ways to take their own life, or talking about their plan to do so;
- talking or writing about death, dying or taking their life (especially when this is out of character or unusual for the person);

- expressing feelings of hopelessness;
- using expressions of rage, anger or seeking revenge;
- engaging in reckless or risky behaviours, seemingly without thinking;
- expressing feelings of being trapped, like there's no way out;
- increased use of alcohol or other drugs;
- withdrawing from friends, family or the community;
- anxiety or agitation;
- abnormal sleep patterns - not sleeping or sleeping all the time;
- dramatic changes in mood, such as sudden feelings of happiness after a long period of sadness or depression;
- giving away possessions or saying goodbye to family and/or friends; and/or
- saying they have no reason for living or no sense of purpose in life.

For families, friends  
and work colleagues,  
Knowing the main  
warning signs  
may save a  
person's life



# The Living Is For Everyone (LIFE) Framework for Suicide Prevention

## Context

Traditionally, approaches to care in the health sector were based on the concepts of primary, secondary and tertiary prevention. Primary prevention aims to prevent the onset of a particular disorder. Secondary prevention aims to identify and treat persons who have no symptoms, but have developed risk factors or preclinical disease. Tertiary prevention aims to minimise the effects of an established disorder, and prevent complications (U.S. Preventative Services Task Force, 1996).

In the 1980s, with increasing awareness of the complexity of the factors (risk, protective, contextual, personal) that influence any illness, the traditional model was replaced by the universal, selective and indicated prevention model, introduced by Gordon (1983).

This model focussed on different groups of clients rather than on the treatment mechanisms. Universal measures can be applied to everybody, a whole population or a whole community; selective preventative measures can be applied to a sub-group at known increased risk; and indicated measures target individuals who are at high risk. This approach is now the basis of suicide prevention in the United States.

Mrazek and Haggerty (1994) adapted Gordon's model to include the whole spectrum of interventions<sup>iii</sup> (prevention, treatment, maintenance, recovery).

This model has been widely used, and has been adapted for use in the Australian National Mental Health Strategy (Raphael, 2000) and the 2000 version of the Australian National Suicide Prevention Strategy (Commonwealth of Australia, 2005).

## The LIFE (2007) model

In light of recent research and consultations, the Mrazek and Haggerty (1994) model was adapted further in 2007 for the LIFE Framework to focus on the following key features:

- The individual's health, wellbeing and responses to life events are at the centre of the model, recognising that people respond and cope differently, and vary in their vulnerability and resilience;
- The new model uses more everyday language, to make it accessible to a wider audience;
- Community-based safety nets to support people as they move from one treatment setting to another, or are discharged back into the community. There is strong evidence - both from health systems generally, and in relation to suicide in particular - that people are most exposed to risk at these handover points between interventions. This is when things are most likely to go wrong and when support is most critical; and
- The model recognises that individuals respond differently when faced with adverse events. They do not always follow a logical or linear decline in health – from risk, to warning sign, to tipping points, to the need for specialised care. A person may move, with no apparent warning, from apparent good health directly into distress and despair and a need for immediate specialised care.

<sup>iii</sup> Intervention - To take action or provide a service so as to produce an outcome or modify a situation. Any action taken to improve health or change the course of, or treat a disease or dysfunctional behaviour.

## LIFE Framework continuum of suicide prevention activities

The LIFE (2007) model is based on the premise that:

- the responsibility for suicide prevention rests with individuals, professional groups and services across the community and that interventions should be provided in a coordinated and integrated way according to the needs of the individual and community;
- in order to reduce the loss of life through suicide, activities will occur across eight overlapping domains of care and support (see Figure 4); and
- safety nets should be provided to support people moving between treatment options, and back into the community through:
  - community-based services to support and foster recovery after discharge from clinical care;
  - effective client hand-over practices between services and back into the community; and
  - cooperation and communication between health professionals, community support services, families, workplaces, and community groups.

The eight domains are:

1. *Universal interventions* aim to engage the whole of a population or populations to reduce access to means of suicide, reduce inappropriate media coverage of suicide, and to create stronger and more supportive families, schools and communities.
2. *Selective interventions* entail working with groups and communities who are identified as at risk to build resilience, strength and capacity and an environment that promotes self-help and support. This might include, for instance, working with families of those who have taken their own life to respond to their grief and loss and their elevated risk of suicide; or working with children who are survivors of child abuse to build strength and resilience.

3. *Indicated interventions* target people who are showing signs of suicide risk or present symptoms of an illness known to heighten the risk of suicide (eg severe depression). These people can be helped to manage their current situation by solving some of the problems that have caused the illness. Alternatively, referral can be given to doctors or psychologists, or family and community members can be educated to recognise warning signs and take appropriate action to support people at-risk.
4. *Symptom identification* - knowing and being alert to signs of high or imminent risk, adverse circumstances and potential tipping points by providing support and care when vulnerability and exposure to risk are high.
5. *Finding and accessing early care and support* when treatment and specialised care is needed. This is the first point of professional contact that provides targeted and integrated support and care, and monitors interventions to ensure client's access to further information and care as needed.
6. *Standard treatment* when specialised care is needed. Integrated, professional care to manage suicidal behaviours and comprehensively treat and manage any underlying conditions, improve wellbeing and assist recovery.
7. *Longer-term treatment and support* to assist in preparing for a positive future. This entails continuing integrated care to consolidate recovery and reduce the risk of adverse health effects. In particular, this may be a time to directly focus on distal or background risks for suicide to remove them or to reduce their impact in the future. Alongside this, efforts can be made to improve protective factors for the individual, their immediate family and their local community.

8. *Ongoing care and support* involving professionals, workplaces, community organisations, friends and family to support people to adapt, cope, and build strength and resilience within an environment of self-help. This may be the opportunity to increase broader community education about the issues and build awareness of the strategies that may be needed to prevent recurrences.

Suicide prevention interventions that are represented across these domains include:

- assisting people to help themselves and creating an environment that supports self-help (promoting self-help);
- recognising early warning signs and providing early intervention to assist people to resolve issues and/or access appropriate help (responding to help-seeking behaviours);
- increasing understanding of suicide and suicide prevention and the capacity for individuals and local communities to recognise and respond to early warning signs and to take appropriate steps to make people safe (promoting local understanding and support);
- building the capacity for meeting the needs of individuals who might be feeling suicidal (targeted support and care);
- providing access to specialist care and integrated local support for those who are feeling chronically suicidal or are exposed to greater risk of suicide (specialised care); and
- maintaining an environment where individuals, families and communities can build resilience and improve their general health and wellbeing during times of adversity (individual, family and community growth and development).

**Figure 4** provides a summary of the range of types of suicide prevention activities and interventions that are essential for a whole of community response to reducing the rate of suicide in Australia, and the risk of suicide, of suicide attempts and of suicidal behaviours in individuals. For each activity/intervention the following is defined: the target group; the proposed outcomes; and who might be involved in the activity/intervention.



**FIGURE 4:** LIFE Framework continuum of suicide prevention activities.

	<b>Target groups</b>	<b>Outcomes</b>	<b>Who is involved?</b>
<b>Universal intervention</b>	Activities that apply to everyone (whole populations)	Reducing access to means of suicide, altering media coverage of suicide, providing community education about suicide prevention and creating stronger and more supportive families, schools and communities.	Involving: individuals, families, consumer and carer organisations, multicultural organisations, local councils, sporting and recreational clubs, workplaces, media, educational organisations, providers of education and information on mental health and suicide prevention, service clubs and pubs.
<b>Selective intervention</b>	For communities and groups potentially at risk	Building resilience, strength and capacity and an environment that promotes self-help and help-seeking and provides support.	Involving: individuals, families, consumer and carer organisations, multicultural organisations, local councils, sporting and recreational clubs, workplaces, media, educational organisations, Divisions of GP, service clubs and pubs.
<b>Indicated intervention</b>	For individuals at high risk	Building strength, resilience, local understanding, capacity and support; being alert to early signs of risk; and taking action to reduce problems and symptoms.	Involving: individuals, families, consumer and carer organisations, multicultural organisations, GPs, police, gerontologists, rehabilitation providers, emergency workers, specialist physicians, sporting and recreational clubs, workplaces, educational organisations, service clubs and pubs.
<b>Symptom identification</b>	When vulnerability and exposure to risk are high	Being alert to signs of high risk, adverse health effects and potential tipping points; and providing support and care.	Involving: GPs, help lines, police, gerontologists, rehabilitation providers, emergency workers, specialist physicians, teachers, pharmacists, workplaces family and friends and other gatekeepers.
<b>Early treatment</b>	Finding and accessing early care and support	Providing first point of professional contact; targeted and integrated support and care; and monitoring and ensuring access to further information and care.	Involving: GPs, psychologists, allied mental health professionals, Aboriginal Health Workers, emergency departments, police, gerontologists, emergency workers, specialist physicians, community health services, help lines, crisis teams, school counsellors.
<b>Standard treatment</b>	When specialised care is needed	Providing integrated professional care to manage suicidal behaviours and improve wellbeing as a step in recovery.	Involving: psychiatrists, psychologists, GPs, allied mental health professionals, Aboriginal Health Workers.
<b>Longer-term treatment and support</b>	Preparing for a positive future	Providing ongoing integrated care to consolidate recovery and reduce the risk of adverse health effects.	Involving: psychiatrists, psychologists, GPs, allied mental health professionals, families, workplaces, local community organisations and clubs, rehabilitation services, Aboriginal Health Workers, help lines.
<b>Ongoing care and support</b>	Getting back into life	Building strength, resilience, and adaptation and coping skills, and an environment that supports self-help and help-seeking.	Involving: GPs, allied mental health professionals, Aboriginal Health Workers, community service providers, families, local community organisations, workplaces and clubs.

**Safety Nets** for people moving between treatment options, and back into the community. These include:

- community-based services to support and foster recovery after discharge from clinical care
- effective client hand-over practices between services and back into the community; and
- effective cooperation and communication between health professionals, community support services, schools, families, workplaces and community groups.

# The LIFE Framework for Action

## Strategic directions

The LIFE Framework reflects a vision that suicide prevention activities will reduce suicide attempts and the loss of life through suicide by providing individuals, families and communities with access to support so that no-one in crisis or experiencing personal adversity sees suicide as their only option.

The purpose of the LIFE (2007) materials is to provide information, resource materials and strategies that will support population health approaches and suicide prevention activities undertaken across the Australian community and thereby contribute to a reduction in suicide and suicide attempts.

The central goal of the LIFE Framework is to reduce suicide attempts, the loss of life through suicide and the impact of suicidal behaviour in Australia. This requires a number of interlinked and coordinated strategies that reflect universal, selective and indicated approaches.

Suicide prevention activities, programs and interventions will aim to build:

- stronger individuals, families and communities
- individual and group resilience to traumatic events
- community capacity to identify need and respond
- the capability for communities and individuals to respond quickly and appropriately; and
- a coordinated response, and provide smooth transitions to and between care.

## Principles underpinning the LIFE Framework for Action

There are a set of binding principles underpinning the LIFE Framework. They are:

1. Suicide prevention activities should first do no harm. Some activities that aim to protect against suicide have the potential to increase suicide risk amongst vulnerable groups. Activities need to respect the context, health, receptivity and needs of the person who is feeling suicidal.
2. Suicide prevention is a shared responsibility across the community, families and friends, professional groups, and non-government and government agencies.
3. Activities should be designed and implemented to target and involve:
  - the whole population
  - specific communities and groups who are known to be at risk of suicide; and
  - individuals at risk.
4. Activities need to include access to clinical or professional treatment for those in crisis and support for people who are recovering and getting back into life.
5. Activities must be appropriate to the social and cultural needs of the groups or populations being served.
6. Information, service and support need to be provided at the right time, when it can best be received, understood and applied.
7. Activities need to be located at places and in environments where the target groups are comfortable, and where the activities will reach and be accessible to those who most need them.
8. Local suicide prevention activities must be sustainable to ensure continuity and consistency of service.
9. Suicide prevention activities should either be, or aim to become, evidence-based, outcome focused and independently evaluated.

10. Activities need to be sensitive to the broader factors that may influence suicide risk – the many social, environmental, cultural and economic factors that contribute to quality of life and the opportunities life offers – and how these vary across different cultures, interest groups, individuals, families and communities.
11. Services for people who are recognised as suicidal should reflect a multi-disciplinary approach and aim to provide a safe, secure and caring environment.

## Considerations in implementing the LIFE Framework for Action

In designing activities, actions and programs, the following must be taken into account:

- Care and support must match people's different needs. In particular, whether the path towards suicide is gradual and visible, or rapid with no outward sign of distress, specialised care needs to be readily and rapidly available when it is needed.
- There should be a focus on:
  - reducing exposure to risk of suicide;
  - reducing access to the means of suicide;
  - improving protective factors;
  - providing individuals who are feeling suicidal with access to a range of support - from the family and community, in the workplace, from professional carers and health services;
  - identifying the individual's particular needs and providing the right support, in the right place, at the right time;
  - improving community understanding of the needs of those who are mentally ill, grieving, profoundly distressed or traumatised; and
  - education for the immediate family, friends, social networks, the local doctor and work colleagues of people at risk.



## Summary of Action Areas

### Action Area 1

*Improving the evidence base and understanding of suicide prevention.*

Improving the quality of the evidence for suicide and suicide prevention is fundamental to the development, implementation and review of effective suicide prevention policies and practices. A sound evidence base will assist in:

- improving understanding about the prevalence and causes of suicide;
- increasing understanding about interventions that are likely to be the most effective;
- determining what services and interventions are needed, for which specific groups;
- evaluating interventions and services provided; and
- providing reliable information to the community about suicide and suicide prevention.

### Action Area 2

*Building individual resilience and the capacity for self-help.*

Protecting against suicidal behaviour includes implementing preventative measures such as providing environments where appropriate support is accessible as well as implementing programs that promote and support wellbeing, optimism and social connectedness.

### Action Area 3

*Improving community strength, resilience and capacity in suicide prevention.*

Improving individual, family and community awareness and understanding of suicide and suicide prevention will increase the capacity of communities to prevent and respond to suicide.

### Action Area 4

*Taking a coordinated approach to suicide prevention.*

Effective suicide prevention relies on communities, organisations and all levels of government working together using sound evidence, with a careful assessment of outcomes.

### Action Area 5

*Providing targeted suicide prevention activities.*

To address the needs of individuals and prevent suicide, there are a number of key elements:

- early identification and intervention;
- building individual resilience and the capacity for self-help;
- creating environments that encourage and support help-seeking;
- creating environments where it is acceptable to express emotions and suicidal thoughts without a fear of acrimony, personal weakness or stigmatisation; and
- ensuring access to the range of required support and care for people feeling suicidal.

### Action Area 6

*Implementing standards and quality in suicide prevention.*

Suicide prevention programs need to reflect evidence of what works and does not work, and to communicate it effectively to the point of need.

## The importance of evaluating suicide prevention activities

Systematic evaluation of all suicide prevention projects, activities and programs is essential for the continued development of best practice. It will ensure that interventions are based on a solid foundation of evidence, that resources and effort are allocated appropriately and that the required outcomes and impacts can be achieved.

For an evaluation to be effective it must be planned, built into all activities and measure the significant outputs and outcomes that will show how well a program is working. Measures relevant to suicide prevention may include:

- reductions in suicide attempts and/or suicidal thinking;
- reductions in risk factors and vulnerabilities to suicidal behaviours (eg mental illness, feelings of hopelessness);
- increase in individual and/or community awareness of appropriate suicide prevention;
- changes in behaviours and response to suicide prevention strategies;
- improvements in individual protective or resiliency factors (eg improved coping skills, more help-seeking behaviours, better social connectedness, better understanding of mental illness); and

- improvements in service models or practices to reduce the adverse impact of the system on individuals.

The type(s) of evaluation used will depend on the size, scope and intent of each project. For instance, evaluation of a prototype or an innovative idea will focus largely on what can be learnt from its development and implementation (process evaluation). In projects of this type, evaluation is often fed back into the project as it unfolds, to improve and refine the development of the project (practice or process improvement).

On the other hand, where a project that is known to work, has been funded or sponsored by an outside agency, the evaluation will usually focus on whether the project has made a difference or achieved its stated objectives (impact) or delivered on its contractual obligations (accountability).

It is assumed that all suicide prevention activities arising from the action areas defined on the following pages will be systematically evaluated.

Evaluations of suicide prevention activities may focus on indicators of:

- effectiveness
- program quality
- efficiency; and
- quantity.

**Figure 5** sets out eleven categories of measures that may be useful in evaluating and reporting suicide prevention activities against these indicators.

**FIGURE 5:** Indicators for evaluation of suicide prevention activities.

<b>Effectiveness indicators</b>	<b>Program quality indicators</b>	<b>Efficiency indicators</b>	<b>Quantity indicators</b>
<p>1. Policy and program objectives outcomes met</p> <ul style="list-style-type: none"> <li>policy objectives</li> <li>program objectives</li> <li>project/service objectives</li> </ul>	<p>4. Quality of process</p> <ul style="list-style-type: none"> <li>conforms to requirements</li> <li>quality of activities and methodologies</li> <li>engagement of key stakeholders</li> </ul>	<p>7. Allocative efficiency</p> <ul style="list-style-type: none"> <li>best use of available resources in addressing the issue of suicide prevention</li> <li>best return on investment for this outcome</li> </ul>	<p>11. Quantity delivered in terms of:</p> <ul style="list-style-type: none"> <li>policy</li> <li>need</li> <li>agreed targets</li> <li>inputs to project</li> </ul>
<p>2. Stakeholder satisfaction</p> <ul style="list-style-type: none"> <li>sponsoring agency</li> <li>key stakeholders</li> <li>project partners</li> <li>customers/consumers</li> </ul>	<p>5. Quality of products</p> <ul style="list-style-type: none"> <li>adequacy</li> <li>right type, mix, range</li> <li>appropriate to need</li> <li>target market covered</li> </ul>	<p>8. Resource efficiency</p> <ul style="list-style-type: none"> <li>staffing</li> <li>infrastructure</li> <li>consumables</li> </ul>	
<p>3. Sustainability</p> <ul style="list-style-type: none"> <li>outcome is relevant and applicable</li> <li>outcome is easily understood and adopted</li> <li>outcome is sustainable</li> </ul>	<p>6. Quality of service</p> <ul style="list-style-type: none"> <li>accessible</li> <li>equitable</li> <li>professional</li> <li>competence/knowledge and understanding</li> </ul>	<p>9. Cost efficiency</p> <ul style="list-style-type: none"> <li>absolute cost</li> <li>recurrent cost</li> <li>value for money</li> </ul>	<p>10. Time efficiency</p> <ul style="list-style-type: none"> <li>responsiveness</li> <li>meets agreed timelines</li> </ul>

# The Living Is For Everyone (LIFE) Action Areas

## Action Area 1

### *Improving the evidence base and understanding of suicide prevention*

Improving the quality of the evidence for suicide and suicide prevention is fundamental to the development, implementation and review of effective suicide prevention policies and practices. A sound evidence base will assist in:

- improving understanding about the prevalence and causes of suicide;
- increasing understanding about interventions that are likely to be the most effective;
- determining what services and interventions are needed, for which specific groups;
- evaluating interventions and services provided; and
- providing reliable information to the community about suicide and suicide prevention.



## Action Area 1

Outcomes	Strategies
<b>Outcome 1.1.</b> Understanding of imminent risk and how best to intervene	<ul style="list-style-type: none"><li>i. Identify and clarify the link between suicide prevention activities and interventions and their impact on, and relevance to, the incidence of suicidal behaviours.</li><li>ii. Improve the evidence base for the identification and differentiation of warning signs, tipping points and imminent risk factors.</li></ul>
<b>Outcome 1.2.</b> Understanding of whole of community risk and protective factors, and how best to build resilience of communities and individuals	<ul style="list-style-type: none"><li>i. Develop a better understanding of the positive and negative impacts of economic, social and environmental influences on suicide and suicidal behaviours.</li><li>ii. Improve the evidence base for the impact of community capacity and resilience building in the long-term prevention of suicide, including in rural and remote communities and/or those adversely affected by climate change or natural disasters.</li><li>iii. Research the influence and impact on suicidal behaviours of new technologies/multi-media communication (eg media, internet, MySpace, YouTube, chat rooms, instant messaging).</li><li>iv. Improve understanding of the cultural significance of suicide and how suicide can be prevented across different cultural and at-risk groups</li><li>v. Synthesise and strengthen understanding of suicide through incorporation in relevant systematic, longitudinal, multi-disciplinary, multi-site studies.</li></ul>
<b>Outcome 1.3.</b> Application and continued development of the evidence base for suicide prevention among high risk populations	<ul style="list-style-type: none"><li>i. Apply and develop the research and evidence of interventions that work for Aboriginal and Torres Strait Islander communities.</li><li>ii. Apply and develop the evidence base to identify and address the needs of people bereaved by suicide.</li><li>iii. Apply and develop the evidence base of interventions to encourage men's help-seeking behaviour and emotional openness.</li><li>iv. Measure the effectiveness of management and care options for people who have previously attempted suicide or engage in self-harming behaviours.</li></ul>
<b>Outcome 1.4.</b> Improved access to suicide prevention resources and information	<ul style="list-style-type: none"><li>i. Contribute to a centre for the collection and dissemination of quality information and resources in suicide prevention.</li><li>ii. Progress a national standardised recording system relating to deaths through suicide.</li></ul>

## Action Area 2

### *Building individual resilience and the capacity for self-help*

Protecting against suicidal behaviour includes implementing preventative measures such as providing environments where appropriate support is accessible as well as implementing programs that promote and support wellbeing, optimism and social connectedness.

#### Action Area 2

Outcomes	Strategies
<b>Outcome 2.1.</b> Improved individual resilience and wellbeing	<ul style="list-style-type: none"><li>i. Develop and promote universal programs to support the acquisition of life skills that enhance individual and community resilience (eg social competence, communication, problem-solving, community development skills).</li><li>ii. Develop and promote mental health and wellbeing programs for the whole community, including those designed to support particular high risk groups or populations (eg culturally appropriate programs for diverse communities, initiatives for children whose parents have a mental illness, etc).</li><li>iii. Provide support to professions that have a key role in suicide prevention or trauma response, to safeguard mental health and wellbeing, enhance service delivery, improve staff retention and minimise the likelihood of suicide (eg health professionals, law enforcement officers, emergency services personnel, education and social service professionals).</li><li>iv. Foster environments (eg families, schools, workplaces) where it is acceptable to express emotions (anxiety, stress, sadness, grief) without a fear of stigmatisation.</li></ul>
<b>Outcome 2.2.</b> An environment that encourages and supports help-seeking	<ul style="list-style-type: none"><li>i. Develop and promote programs that raise awareness of the importance of social and emotional wellbeing, mental disorders and suicide prevention (eg via the media, schools and workplaces).</li><li>ii. Develop and promote programs to enhance help-seeking behaviour among high-risk groups and in people that are known to be least likely to seek help including young people, men, Aboriginal and Torres Strait Islander communities and people from some culturally and linguistically diverse communities.</li><li>iii. Work to destigmatise conditions that contribute to suicide risk (eg mental illness, homelessness, financial hardship) with a view to encouraging help-seeking behaviour.</li></ul>

Protecting against  
suicidal behaviour includes  
implementing programs  
that promote wellbeing,  
optimism and support  
social connectedness.



## Action Area 3

### *Improving community strength, resilience and capacity in suicide prevention*

Improving individual, family and community awareness and understanding of suicide and suicide prevention will increase the capacity of communities to prevent and respond to suicide.

#### Action Area 3

Outcomes	Strategies
<b>Outcome 3.1.</b> Improved community strength and resilience	<ul style="list-style-type: none"><li>i. Raise awareness of the characteristics of healthy and resilient communities, and support their development.</li><li>ii. Use mentoring and leadership development programs to promote the development and sharing of good practice in local communities.</li><li>iii. Develop and promote strategies that enable and support groups within local communities to work together on suicide prevention.</li></ul>
<b>Outcome 3.2.</b> Increased community awareness of what is needed to prevent suicide	<ul style="list-style-type: none"><li>i. Educate communities to identify and respond to warning signs, tipping points and imminent risk factors associated with suicide.</li><li>ii. Work with the mainstream and multilingual media to improve community knowledge and understanding of suicide and suicide prevention and encourage responsible coverage of these issues.</li><li>iii. Reduce the stigma and myths surrounding suicide by actively communicating the range and complexity of factors that contribute to suicidal behaviours.</li><li>iv. Develop and promote strategies that enable organisations to work together to reduce risk factors and strengthen protective factors in individuals and communities.</li></ul>
<b>Outcome 3.3.</b> Improved capability to respond at potential tipping points and points of imminent risk	<ul style="list-style-type: none"><li>i. Enable locally based networks and cooperative partnerships to respond effectively to traumatic incidents or significant changes in local circumstances (eg drought, industry closures).</li><li>ii. Develop materials and provide locally based support to assist staff and volunteers in organisations such as pubs, clubs, cultural and religious centres and recreational and sporting groups, to identify potential suicidal behaviour and to respond effectively.</li><li>iii. Expand and resource the capacity of schools, workplaces and other relevant settings, to identify and provide support to those at risk.</li><li>iv. Use the media and other strategies to raise awareness of the risk factors, warning signs and tipping points for suicide.</li><li>v. Develop and disseminate resources that recognise and support the important role of and impact on family, friends, colleagues and peers in suicide prevention.</li></ul>

## Action Area 4

### *Taking a coordinated approach to suicide prevention*

Effective suicide prevention relies on communities, organisations and all levels of government working together using sound evidence, with a careful assessment of outcomes.

#### Action Area 4

Outcomes	Strategies
<b>Outcome 4.1.</b> Local services linking effectively so that people experience a seamless service	<ul style="list-style-type: none"><li>i. Encourage and resource integrated, cross-functional, cross-agency solutions to locally based suicide prevention activities.</li><li>ii. Develop an understanding of people's journeys to find services in order to inform and improve service responses.</li><li>iii. Develop and promote client-centred, shared case-management approaches to suicide prevention in local communities.</li><li>iv. Strengthen the capacity for families, schools, workplaces, pubs, clubs and sports, recreational and social groups to identify quickly and respond effectively to indicators of potential suicidal behaviour.</li><li>v. Develop practical tools for information sharing, including shared service agreements, dealing with privacy and confidentiality requirements and barriers, developing local data and outcome measures, and joint service/client protocols.</li><li>vi. Promote and support linkages between community based and clinical initiatives in suicide prevention.</li></ul>
<b>Outcome 4.2.</b> Program and policy coordination and cooperation, through partnerships between governments, peak and professional bodies and non-government organisations	<ul style="list-style-type: none"><li>i. Develop cross-government mechanisms to improve the integration of health, housing, community, justice, employment and other policy and programs, for better suicide prevention.</li><li>ii. Support and improve linkages and cooperation between governments, academic institutions, non-government organisations (NGOs), peak and professional bodies, to support information sharing and reduce duplication of effort.</li><li>iii. Design and implement resources and tools (eg shared care guidelines, protocols and evaluation tools for professionals, multidisciplinary teams and service providers) to support coordinated community service provision.</li><li>iv. Address the information needs of different professional and community groups concerned with suicide prevention.</li></ul>
<b>Outcome 4.3.</b> Regionally integrated approaches	<ul style="list-style-type: none"><li>i. Promote natural catchment approaches, including reducing jurisdictional barriers, to support better regional cooperation in suicide prevention activities.</li><li>ii. Increase cooperation within regions to improve suicide prevention activities.</li><li>iii. Actively engage local government in suicide prevention.</li><li>iv. Strengthen local capacity by supporting sharing of practice and experience across agencies involved in community and emergency services.</li><li>v. Develop shared service agreements, local data and service metrics, joint service protocols and joint client assessments.</li></ul>

## Action Area 5

### *Providing targeted suicide prevention activities*

To address the needs of individuals and prevent suicide, there are a number of key elements:

- early identification and intervention;
- building individual resilience and the capacity for self-help;
- creating environments that encourage and support help-seeking;

- creating environments where it is acceptable to express emotions and suicidal thoughts without a fear of acrimony, personal weakness or stigmatisation; and
- ensuring access to the range of required support and care for people feeling suicidal.

### Action Area 5

Outcomes	Strategies
<b>Outcome 5.1.</b> Improved access to a range of support and care for people feeling suicidal	i. Develop and promote innovative programs to reach those in high-risk populations who traditionally do not access health services. ii. Make services highly visible and approachable. iii. Develop support systems for individuals who have attempted suicide and their families. iv. Support people with mental illness and related problems who are at risk of suicide.
<b>Outcome 5.2.</b> Systemic, long-term, structural interventions in areas of greatest need	i. Identify communities in which suicide and suicidal behaviour is prevalent, and proactively develop strategies and services that address the underlying causes and contributing factors. ii. Provide and resource mentoring and support for high risk groups and communities, to enable them to undertake effective suicide prevention activities.
<b>Outcome 5.3.</b> Reduced incidence of suicide and suicidal behaviour in the groups at highest risk	i. Support interventions for groups identified as high risk. This includes men aged 20-54 and over 75, men in Aboriginal and Torres Strait Islander communities, people with a mental illness, people with substance use problems, people in contact with the justice system, people who attempt suicide, people in rural and remote communities, gay and lesbian communities, and people bereaved by suicide. ii. Develop effective and sustainable interventions for groups and communities where suicidal behaviours are prevalent, by encouraging ownership and active involvement. iii. Develop and promote mental health and wellbeing programs in occupational groups whose members are subject to frequent traumatic events (eg Police, Emergency Services). iv. Provide support to the caring professions to minimise the likelihood of suicide amongst carers and clinical professionals.
<b>Outcome 5.4.</b> Improved understanding, skills and capacity of front-line workers, families and carers	i. Implement guidelines and support tools to improve the understanding and skills of front-line workers who routinely interact with high risk groups, to identify and respond rapidly to suicide warning signs, tipping points and imminent risk factors. ii. Provide education and information for consumers and carers involved with at-risk individuals and groups to enable them to identify and respond rapidly to suicidal behaviour. iii. Develop and resource discharge planning, clinical handover and transition to community care and support that recognises the increased risk to individuals at and after discharge. iv. Educate and inform professionals, service providers, families and community organisations in the provision of safe and secure care environments for people at risk. v. Provide access to training programs at undergraduate, post-graduate and vocational levels. Wherever possible, these should be multidisciplinary and cross-agency.

## Action Area 6

### *Implementing standards and quality in suicide prevention*

Suicide prevention programs need to reflect evidence of what works and does not work, and to communicate it effectively to the point of need.

#### Action Area 6

<b>Outcomes</b>	<b>Strategies</b>
<b>Outcome 6.1.</b> Improved practice, national standards and shared learning	i. Develop and promote national standards specific to suicide prevention. ii. Disseminate evidence to underpin practice. iii. Identify the skills and training required to work effectively in suicide prevention.
<b>Outcome 6.2.</b> Improved capabilities and promotion of sound practice in evaluation	i. Promote systematic evaluation of suicide prevention initiatives. ii. Promote the role of evaluation and research in expanding the evidence base of suicide prevention and assist in continuously improving practices. iii. Develop and promote robust and accountable evaluation models and processes. iv. Improve the capacity to undertake sound evaluations.
<b>Outcome 6.3.</b> Systemic improvements in the quality, quantity, access and response to information about suicide prevention programs and services	i. Develop and maintain timely, robust and transparent reporting systems to ensure that information on suicide programs is available. ii. Enable access to information about suicide prevention programs, so that new programs can build on past experience. iii. Encourage and support shared learnings to reduce duplication and promote good practice. iv. Promote and provide funding arrangements to enable and facilitate flexible community responses to emerging practice and identified and demonstrable needs.

# Appendix A: Relevant government and non-government policies, programs and activities

## Australian Government

National Suicide Prevention Strategy  
[livingisforeveryone.com.au](http://livingisforeveryone.com.au)

Department of Health and Ageing  
[www.health.gov.au](http://www.health.gov.au) and [www.mentalhealth.gov.au](http://www.mentalhealth.gov.au)

National Drug Strategy 2004-2009  
[www.nationaldrugstrategy.gov.au](http://www.nationaldrugstrategy.gov.au)

National Alcohol Strategy 2006-2009  
[www.alcohol.gov.au](http://www.alcohol.gov.au)

National Policy Framework for Indigenous people  
[www.indigenous.gov.au](http://www.indigenous.gov.au)

Department of Families, Housing, Community Services and Indigenous Affairs' Community Mental Health Programs  
[www.facsia.gov.au](http://www.facsia.gov.au)

Family Court of Australia Mental Health Support Program  
[www.familycourt.gov.au](http://www.familycourt.gov.au)

Department of Veterans' Affairs  
[www.dva.gov.au](http://www.dva.gov.au)

### New South Wales

NSW Health  
[www.health.nsw.gov.au](http://www.health.nsw.gov.au)

Centre for Mental Health  
[www.health.nsw.gov.au/policy/cmh](http://www.health.nsw.gov.au/policy/cmh)

### Victoria

Victoria Health  
[www.health.vic.gov.au](http://www.health.vic.gov.au)

Mental Health  
[www.health.vic.gov.au/mentalhealth](http://www.health.vic.gov.au/mentalhealth)

### Tasmania

Department of Health and Human Services  
Tasmanian Suicide Prevention Steering Committee (TSPSC)  
[www.dhhs.tas.gov.au](http://www.dhhs.tas.gov.au)

Mental Health  
[www.dhhs.tas.gov.au/health\\_and\\_wellbeing/mental\\_health](http://www.dhhs.tas.gov.au/health_and_wellbeing/mental_health)

### Queensland

Department of Communities  
[www.communities.qld.gov.au](http://www.communities.qld.gov.au)

Suicide Prevention  
[www.communities.qld.gov.au/community/suicide\\_prevention](http://www.communities.qld.gov.au/community/suicide_prevention)

## State and Territory Government

### Western Australia

WA Ministerial Council on Suicide Prevention  
[www.mcsp.org.au](http://www.mcsp.org.au)

WA Suicide Prevention Plan  
[www.mcsp.org.au/prevention/prevention\\_plan](http://www.mcsp.org.au/prevention/prevention_plan)

### South Australia

Government of South Australia Department of Health  
[www.health.sa.gov.au](http://www.health.sa.gov.au)

Mental Health  
[www.health.sa.gov.au/mentalhealth](http://www.health.sa.gov.au/mentalhealth)



### Northern Territory

Department of Health and Families  
[www.health.nt.gov.au](http://www.health.nt.gov.au)

Mental Health  
[www.health.nt.gov.au/Mental\\_Health](http://www.health.nt.gov.au/Mental_Health)

### Australian Capital Territory

ACT Health  
[www.health.act.gov.au](http://www.health.act.gov.au)

Mental Health  
[www.health.act.gov.au/mentalhealth](http://www.health.act.gov.au/mentalhealth)

# Glossary of terms

**Aboriginal and/or Torres Strait Islander:** A person who is of Aboriginal or Torres Strait Islander descent; and identifies as an Australian Aboriginal or Torres Strait Islander person; and is accepted as such by the community in which s/he lives or has lived.

**Adverse life event:** An incident within one's life that has the potential to cause emotional upset, disruption, or negative health outcomes.

**Bereavement:** The period after a loss (usually through death) during which grief is experienced and mourning occurs (Raphael, 1984).

**Best practice:** The use of methods (often evidence-based) that achieve improvements and/or optimal outcomes.

**Capacity building:**

Individual - Enhancing and/or developing personal aptitude, strength, coping and/or independence.

Community - The ability of a community's organisations, groups and individuals (collectively) to build their structures, systems, people and skills, so they are better able to define, implement, manage and achieve their shared objectives.

**Client-centred:** Client-centred therapy or the person-centred approach is a movement associated with humanistic psychology that emphasises 'the capacity of each individual to arrive at a personal understanding of his or her destiny, using feelings and intuition rather than being guided by doctrine and reason. Rather than focusing on the origins of client problems in childhood events (psychodynamic) or the achievement of new patterns of behaviour in the future (behavioural)... concentrate on the here and now experiencing of the client' (McLeod, 2003, p. 157).

**Clinical paradigm:** This paradigm focuses on repairing damage within a disease or medical model of human functioning.

**Cognitive:** Mental processes and conscious intellectual activities such as planning, reasoning, problem solving, thinking, remembering, reasoning, learning new words or imagining.

**Common factors (therapy):** Features of therapy that are common to success, despite the differing theoretical position of each therapist and the specific techniques used.

**Community ownership:** A community takes responsibility for an issue, such as suicide, and agrees to work together to develop effective and sustainable solutions.

**Connectedness:** Enquiry into protective factors for suicide has focused on the capacities within people (resilience factors) and on external protective factors (Seifer *et al.* 1992), including a person's sense of belonging and connectedness with others. There is evidence that connections with family, school or a significant adult can reduce risk of suicide for young people. Feelings of connectedness to a partner or parent or responsibility for care of children appear to be protective factors, and connectedness within a community has been linked to health and wellbeing.

**Content:** The quality and the proportion or quantity of information adequately matched to the need.

**Continuing care:** Engagement with longer-term treatment, support and care where needed.

**Data:** Statistics that inform on specific aspects of suicide, such as rates and trends of suicide and suicide attempts. Data collection can also be a means of monitoring service arrangements, such as post-discharge follow-up or outcomes.

## Glossary of terms (continued)

**Deliberate self-harm:** Any behaviours causing destruction or alteration of body tissues, with or without the intent to die, including self-injury.

**Distal factors:** see risk factors.

**Effectiveness:** Whether there is the capacity to bring about an effect or outcome.

**Efficacy:** The capacity of a service to deliver a desired result or outcome.

**Efficiency:** The production of an agreed output with a minimum of waste and the minimum consumption of resources (time, cost, labour).

**Evaluation:** 'The continuous process of asking questions, reflecting on the answers to these questions and reviewing ongoing strategy and action' (Commonwealth of Australia, 2001, p.4).

**Evidence-based:** Approaches that use and are based on clear evidence from existing literature.

**Gatekeeper:** A person who holds an influential position in either an organisation or a community who coordinates or oversees the actions of others. This could be an informal local opinion leader or a specifically designated person, such as a primary-care provider, who coordinates patient care and provides referrals to specialists, hospitals, laboratories, and other medical services.

**Help-seeking:** The process of an individual asking for help or support in order to cope with adverse life events or other difficult circumstances.

**Holding environment:** Refers to a therapeutic setting that permits the client to experience safety, and thus enhances therapeutic work.

**Imminent risk:** The point at which suicide is extremely likely in the near future; intervention may be necessary.

**Indicated Intervention:** Work with individuals who are showing early signs of risk for health problems, with the aim of preventing a condition from arising.

**Indigenous Australians:** A person who is of Aboriginal or Torres Strait Islander descent; and identifies as an Australian Aboriginal or Torres Strait Islander person; and is accepted as such by the community in which s/he lives or has lived.

**Integrated response:** Interventions that respond to a range of issues using a multi-faceted approach.

**Intervention:** To take action or provide a service so as to produce an outcome or modify a situation. Any action taken to improve health or change the course of or treat a disease or dysfunctional behaviour (Moore, 2004).

**Jurisdiction:** The area for which a particular government (Commonwealth, State or Territory) is responsible.

**Loss:** Loss is produced by an incident which is perceived to be negative by those involved and results in long-term change.

**Medium:** The mode, means or carrier (person or resource) through which information or support is provided.

**Mental disorder:** A recognised, medically diagnosable illness or disorder that results in significant impairment of an individual's thinking and emotional abilities and may require intervention. There are many different mental disorders.

**Mental health problem:** A situation in which a person experiences some disturbance or impairment of normal emotions and/or thinking.

## Glossary of terms (continued)

**Mental health promotion:** Action to maximise mental health and wellbeing among populations and individuals.

**Multi-faceted:** Having many aspects or facets.

**Multi-sector, multi-disciplinary approach:** Approaches that involve a combination of expertise from a range of disciplines and professions, involving agencies, organisations, and persons from a range of distinct parts or branches of enterprise and/or society.

**Peer education:** The use of identified and trained peers to provide information aimed at increasing awareness or influencing behaviour change.

**Population-based interventions:** Interventions targeting populations rather than individuals. They include activities targeting the whole population as well as activities targeting population subgroups such as rural or Aboriginal and Torres Strait Islander peoples.

**Post Traumatic Stress Disorder (PTSD):**

A psychological disorder affecting individuals who have experienced or witnessed profoundly traumatic events, such as torture, murder, rape, or wartime combat, characterised by recurrent flashbacks of the traumatic event, nightmares, irritability, anxiety, fatigue, forgetfulness, and social withdrawal (Edgerton, 1994).

**Postvention:** Interventions to support and assist the bereaved after a suicide has occurred.

**Predisposing factors:** Non-modifiable factors that may increase a person's susceptibility to suicidal behaviours, such as genetic and neurobiological factors, gender, personality, culture, socio-economic background and level of isolation.

**Prevention:** Preventing conditions of ill health from arising.

**Primary care:** The care system that forms the first point of contact for those in the community seeking assistance. It includes community-based care from generalist services such as general practitioners, Aboriginal medical services, school counsellors and community-based health and welfare services.

**Protective factors:** Capacities, qualities, environmental and personal resources that drive individuals towards growth, stability, and health.

**Proximal factors:** see risk factors.

**Receptivity of client:** The capacity and willingness of the person to receive and absorb information and support.

**Recovery:** Recovery is the process of a gradual restoration of a satisfying, hopeful and meaningful way of life.

**Resilience:** Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and provide protection from factors that might otherwise place that person at risk of suicide. Resilience is often described as the ability to bounce back from adversity. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem-solving, cognitive and emotional skills, communication skills and help-seeking behaviours.

**Risk factors:** Factors such as biological, psychological, social and cultural agents that are associated with suicide/suicide ideation and increase their probability. Risk factors can be defined as either distal factors, such as genetic or neurochemical factors, or proximal factors, such as life events or the availability of lethal means - factors which can 'trigger' a suicide or suicidal behaviour.

**Selective intervention:** Activities that target population or community groups at higher risk for a particular problem, rather than the whole population or particular individuals. This might include working with the families of those bereaved through suicide or, for instance children who have been traumatised or abused over time.

**Self-injury:** Deliberate damage of body tissue, often in response to psychosocial distress, without the intent to die. Sometimes called non-suicidal self-injury, self-inflicted injuries or self-harm.

**Suicide:** The act of purposely ending one's life.

**Suicidal behaviour:** Includes the spectrum of activities related to suicide and self-harm including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts. Some writers also include deliberate recklessness and risk-taking behaviours as suicidal behaviours.

**Suicidal ideation:** Thoughts about attempting or completing suicide.

**Suicide prevention:** Actions or initiatives to reduce the risk of suicide among populations or specific target groups.

**Support:** To assist with the burden or the weight of an issue, problem or adversity. Support can take many forms, including information provision, services and face-to-face counselling.

## Glossary of terms (continued)

**Sustainability:** The ability of a program to function over the long-term.

**Timeliness of service:** Provision of information, service or support at the most appropriate or opportune moment for it to be received, understood and meaningfully applied.

**Tipping point:** The point at which a person's risk of suicide increases due to the occurrence of some precipitating event, such as a negative life event or an increase in symptoms of a mental disorder.

**Universal intervention:** Interventions that target the whole of a population or populations. In suicide prevention, these include activities to reduce access to means of suicide, or to create stronger and more supportive families, schools and communities.

**Warning signs:** Behaviours that indicate a possible increased risk of suicide, such as giving away possessions, talking about suicide or the withdrawal from family, friends and normal activities.

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# Acknowledgements

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The LIFE (2007) suite of documents have been prepared for the Australian Government Department of Health and Ageing by a consortium of organisations supported by a wide network of specialist consultants, advisers and community consultations.

The lead consultants were Corporate Diagnostics Pty Ltd, United Synergies Ltd, Professor Graham Martin and Dr. Judith Murray (University of Queensland) and Greengage Research and Communications. Additional editing and review was provided by NOVA Public Policy Pty Ltd.

The main sub-consultants were Professor John Mendoza, Associate Professor Nicholas Procter, Sunrise Solutions, GKY Internet, Auseinet, the Australian Institute for Suicide Research and Prevention (AISRAP, Griffith University), Oxygen Kiosk, DDSN Interactive and the Four Design Group.

Specialist advisers who commented on and assisted with various drafts during the project included Professor Beverley Raphael, Professor Diego De Leo, Professor Ian Webster, Trevor Hazell, Professor Don Zoellner, Professor Edward White, Professor Ernest Hunter, Dr. Karolina Krysinska, Lorraine Wheeler, Dr. Angela Kirsner, Susan Beaton, Dr. Michael Dudley, Dr. Don Spencer and John Arms (NSW Central Coast Coroner).

The diversity reference group to the project were Jill Fisher (Chair), Mick Adams, Melba Townsend, Travis Shorey, Nooria Mehraby, Julian Krieg, Gerald Wyatt, Hilary Knack and Samantha Harrison.

The following three Australian Government advisory committees contributed to the development of the LIFE (2007) resources:

The National Advisory Council on Suicide Prevention; The Community and Expert Advisory Forum; and The Indigenous Strategies Working Group.

There were many hundreds of people who attended the community consultations.





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