**Submission to Community Affairs References Committee Inquiry into Suicide in Australia** by Professor Peter Bycroft

## ABOUT MYSELF

I am the Managing Director of Corporate Diagnostics, an Environmental Psychologist and an Adjunct Professor in the Faculty of Arts and Social Sciences at the University of the Sunshine Coast (brief resume attached – Attachment 1). In 2006, I led a consortium of organisations that developed the National Suicide Bereavement Strategy for the Australian federal Government and in the following year (2007) I led a similar consortium which reviewed and updated the Australian National Strategy/policy on suicide prevention – entitled the Living is for Everyone (LiFE) Framework. Both projects were based on extensive consultations across all sectors and across all States and Territories in Australia as well as New Zealand over a period of many months.

The first of these, the National Suicide Bereavement Strategy has never been released by the Department of Health and Ageing whilst the second (the revised LiFE Framework) was substantially edited, significantly changed with critical components removed prior to its release. The eventual release contained substantial inaccuracies, errors in fact and showed little regard for the wide-ranging consultations with the community, researchers, service providers and people bereaved by suicide whose input and ideas were largely removed despite their being critical to the original document.

Parts of the current submission are edited from the original text of the strategies mentioned above.

## ABOUT THIS SUBMISSION

I contend that the major problems with suicide prevention in Australia relate to three inter-related issues:

1. The **control over research** by a small and comparatively self-interested sector which is regularly funded, heavily based in the "***medical/mental illness paradigm***" (see later definition and discussion) and supported by often unquestioning senior managers in the Department of Health and Ageing (see "*Adequacy of current research*");
2. The **ineffectiveness of the National Suicide Prevention Strategy** and many of the continuously funded programs under its auspice (see *"Effectiveness of the National Suicide Prevention Strategy"*), and
3. The generally **token and largely unwilling attitude** of some leading researchers, the medical profession generally, many academic researchers and the Department of Health and Ageing **to accept the critical role played by three factors** (1) the collective knowledge and experience of the community (including those bereaved/affected by suicide); (2) the impact of known life events and (3) the importance of individual resilience in predicting the likelihood of suicide (see *"Life events and suicide"*).

**These three interrelated issues have interacted and influenced outcomes to such an extent that despite the past twenty years of their domination of Australian suicide prevention research and funding, they have delivered no demonstrable difference in the incidence of or the understanding of suicide in Australia**.

**WHAT TYPE OF PEOPLE CHOOSE TO TAKE THEIR OWN LIVE?**

The following case studies are fictitious. They have been compiled from a combination of evidence and actual examples to illustrate the range of different circumstances in which a person can take their own life.

1. *Kelvin had recently separated from his wife of thirty years. Their three teenage daughters remained living with his wife and he had a shared custody arrangement brokered by the Family Court. He was a senior public servant, recognised by his colleagues as one of the brightest senior managers in his office. By all accounts he was a mild-mannered man, with no history of mental illness, who often joined his colleagues for after-work drinks. One morning he wrote a farewell letter to his family, leaving it on his bed. He drove one hundred kilometres to a major national park and leapt to his death.*

2. *John played guitar and was an accomplished cartoonist. He worked as a financial consultant and occasionally performed in the local amateur theatre company. He had a young family and was a local volunteer in the State Emergency Services. He and his wife decided to have a trial separation. He had seen his local doctor and, as a result, had been receiving regular counselling from a visiting psychologist. However, because they lived in a regional town, there were limited community-based support services. One evening, he took his own life.*

3. *Rosemary was a career hospitality worker in her late thirties. The "fun of the party", she seemed to be enjoying her life as a single woman. A very close girlfriend had taken her own life and Rosemary was emotionally upset for several months. She moved overseas and worked in a variety of hospitality jobs until, motivated by her sad correspondence, a close friend flew to meet her and brought her back home to Australia. She appeared to settle down amongst her friends again. Two months later, she was found dead by her own hand, hanging from a tree in front of her new boyfriend's home.*

4. *Nicholas was a fourteen year old Indigenous Australian living in a remote Indigenous community. Like many of his friends, he rarely attended school. He had witnessed many aspects of remote community life including alcoholism, domestic violence, chronic unemployment and poverty. One evening, at a social gathering involving card playing and drinking, Nicholas demanded that he be given alcohol or else he would take his own life. He was denied the alcohol and was taunted by some of the adults to "go on then, go and do it". That afternoon, Nicholas took his own life.*

5. *Sarah was 20 years old and studying nursing at university. She moved from her small, coastal town to the city to pursue her studies. She achieved consistently good results in her academic studies and had high expectations of herself. She had good relationships with her parents, siblings and friends, but had yet to meet the right partner. After a disappointing result in a mid-semester assignment, she became increasingly concerned that she may not pass her final exams. She was prescribed anti-depressants by her GP. A few days later, Sarah texted a cryptic message to a friend about not wanting to be a failure. She was found dead the next day in her apartment.*

6. *Walter worked the land and had lived on the outskirts of a small rural town for all of his life. He retired at 65 years of age and moved with his wife to a small coastal town for a happy retirement. Within two years, Walter was feeling restless and had survived two relatively minor health scares. His wife had joined several local clubs and had been encouraging him to get out and mix more. He often complained to his wife that he missed the old days when he could talk to people who shared the same memories and had the same background as he did. One evening, home alone and working in the garage, Walter improvised a noose and hung himself.*

Each of these people appears to be comparatively normal in comparatively normal life situations. The common thread in these and in many suicides is the shock, the surprise and often the ill-preparedness of family and friends for the aftermath (emotionally and practically) of the tragedy....and the struggle to understand what happened, what each person was going through, what was the trigger or tipping point and why they chose to end their life.

**WHY DO PEOPLE TAKE THEIR OWN LIVES?**

These case studies highlight the diversity of people and situations that can lead to someone taking their own life. It is a complex issue. Edwin Schneidman, the internationally acclaimed suicide researcher, has suggested that suicide is "*chiefly a drama in the mind*" - that people become suicidal when their vital needs (such as their need for achievement and nurturing) are frustrated. Their common goal is to escape the intolerable pain or the sense of hopelessness they feel. As a result, they become increasingly focussed on their problem and consequently lack the ability to see any other option than to take their own life. When a person is in this state, the positive and negative aspects of the environment in which they are placed become critical to their survival.

There are a wide range of attitudes towards people who choose to take their own life - varying from confusion, through guilt, to anger and condemnation. Those who are left behind after a suicide often struggle to understand the motivation for an act of suicide - be it altruism, despair or vindictiveness.

The main difficulty in understanding arises because information about why someone ends their life usually comes from those left behind or by retracing of what may have happened or what may have been the motivation of the deceased. There has been very little research to clearly identify and articulate the meaning that the act of suicide has for the victims themselves. Several researchers have attempted to develop a classification for suicide, with concepts such as escapist suicides, aggressive suicides, revenge suicides, self-destructive suicides, and suicides to "prove oneself".

Despite the legacy and the impact that suicide has on those who are left behind, it is essentially a very private act, which has a specific meaning to the person involved. This meaning revolves around a certain ambivalence about living; it can involve a desire to convey a message and may include symbolic gestures linked to the chosen method and/or to the location of the suicide.

## THE EIGHT MOTIVATIONS FOR SUICIDE

The most recent theories about the different types and different motivations around suicide suggest that suicides can be categorised into eight identifiably different, but often overlapping motivations/reasons for someone taking their own life, namely:

1. the result of mental health problems (e.g. dysfunctional behaviour, clinical depression, schizophrenia)
2. the result of reckless behaviour (e.g. alcohol and other drug or substance abuse, dangerous or life threatening activities)
3. to end physical and/or emotional pain (e.g. inability to cope, situational or episodic despair, relief from suffering, guilt, shame or loss, physical pain or debilitating illness)
4. to send a message or obtain an outcome (defiance, notoriety, vengeance, leave a legacy or aftermath)
5. altruistic or heroic act (relieving others of burden, to save another, to die for a cause)
6. as a rite of passage (to express manhood/maturity, to make a religious journey)
7. to express one's right to choose (creative expression, considered choice)
8. symbolic interest in the means/location (jumping, hanging, shooting; in the garage, in the forest, from a well known bridge or escarpment).

In each of these circumstances the motivation of the deceased is different and the actions that could have been taken to prevent the suicide would vary. For some suicides, the motivating factors involve a combination of these eight.

## THE CONTROL OVER RESEARCH – THE "MEDICAL/MENTAL ILLNESS PARADIGM"

Unfortunately, suicide prevention in Australia is predominated by one particular viewpoint. It pivots primarily around the notion that a person who is considering or who has taken their own life is most likely "mentally ill" (i.e. Motivation 1, above). There are three main reasons for this situation in Australia – one is definitional, one appears to be for simplicity sake and the other is about power and control over funding and resourcing.

In terms of definitions, the definition of mental illness which is most often cited is from the Diagnostic and Statistical Manual of Mental Disorders (DSM - IV) published in 1994. The definition is so broad as to be scientifically suspect – a mental illness can be as simple as anxiety, gambling, alcoholism, sexual fetishes through depression and personality disorders to chronic mental illness or psychosis. Critics of the definition, rightly state that it often makes unjustified categorical classifications of behaviours that could be better described and understood as normal human reactions. The predominance of this definition in the Australian suicide prevention sector has significantly restricted the development of a broader understanding of suicide and the breadth of situations in which it occurs (the remaining seven Motivations listed above).

Most attempts to develop a comprehensive theory of suicide to include modelling of all eight of the above motivations have been strongly resisted by the Australian suicide prevention establishment. Too many researchers and policy makers choose to turn a blind eye to the

evidence that individuals do take their own lives to end physical or emotional pain (e.g. euthanasia), for altruistic reasons (e.g. to relieve others of a burden), as a rite of passage (e.g. in some indigenous communities), for important religious reasons (e.g. suicide bombing) or as a right of choice (e.g. some poets/artists). There are many motivations for suicide and excluding the evidence, frequency, the context and motivation for all suicides because they do not seem to fit a particular paradigm is essentially very poor science. Suicide has a continuum of causes and they should be understood and studied if a comprehensive understanding is to be developed – the alternative approach of focussing on mental illness has significantly retarded suicide prevention, scientific research and the development of soundly-based theory of suicide prevention for many years.

The second reason for the predominance of the medical/mental illness paradigm is that it makes explanation so much more simple. Our consortium's extensive consultations with families of those who have taken their own lives have impressed upon me how unacceptable this explanation is for them. Their beloved was not mentally ill – they were struggling with life events, some of which were within their control and others were experienced as unfair, intolerable and out of their control. Nevertheless, the media, religious leaders, medical professionals, depression support organisations and researchers still maintain that mental illness is the strongest link to understanding suicide. This is despite the obvious, objective scientific fact that, even if they were right they are essentially "*medicating the symptom*" (prescribing medication for anxiety, sadness, unsocial behaviour) rather than dealing directly with the cause – the known sequence of life events and each individual's inner strength, ability and resilience when facing these potentially traumatic life events.

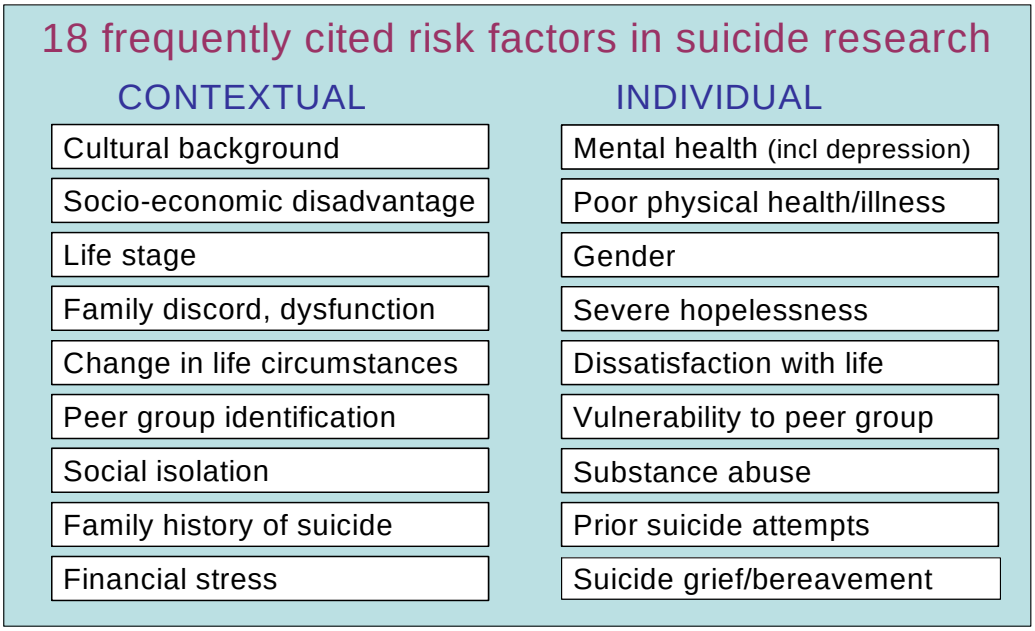
The third reason that the medical/mental illness paradigm predominates Australian suicide prevention activities is to maintain control (consciously or not) over policy advice, research, government funding and the distribution of resources that is held by the medical profession and the medical/scientific establishment. Federal government advisory bodies and favoured recipients for funding tend to overlap substantially and are predominated by medically or clinically trained practitioners, "*anointed"* researchers and/or favoured service providers – many of whom sit on the government advisory bodies. The general community, independent researchers, skilled non-medical or clinical scientists are insufficiently supported or adequately represented in the current system. As a result, there are ample examples of continuously funded research activities that have yet to contribute significantly to the growth of knowledge and understanding around suicide prevention – apart from the often quoted "*need for longitudinal randomised control trials*", "*more research needs to be done/funded*" or "*it is complex and no generalisations can be made*"!

More importantly, the control of the suicide prevention agenda by vested interests largely drawn from the medical/mental illness paradigm has seen most publicly funded communications about suicide prevention falling into the category of "*the cult talking to itself*". By this I mean that most of the federal government suicide prevention communications and, in particular the most recent LiFE Framework communications reflect a conversation amongst adherents within the paradigm rather than the development of effective communications for consumption by the general public (see discussion under "*Effectiveness of the National Suicide Prevention Strategy"*)

## ADEQUACY OF CURRENT RESEARCH

Current research is predominated by the medical/mental illness paradigm. This is despite a significant amount of research which indicates that it is but one of at least eighteen risk factors impacting on the likelihood of someone wanting to take their own life. The likelihood of a person having suicidal thoughts is closely linked to contextual and individual risk/protective factors (see Figure 1).

**Figure 1: The eighteen factors that interact to create the possibility of an individual being at risk of suicide**

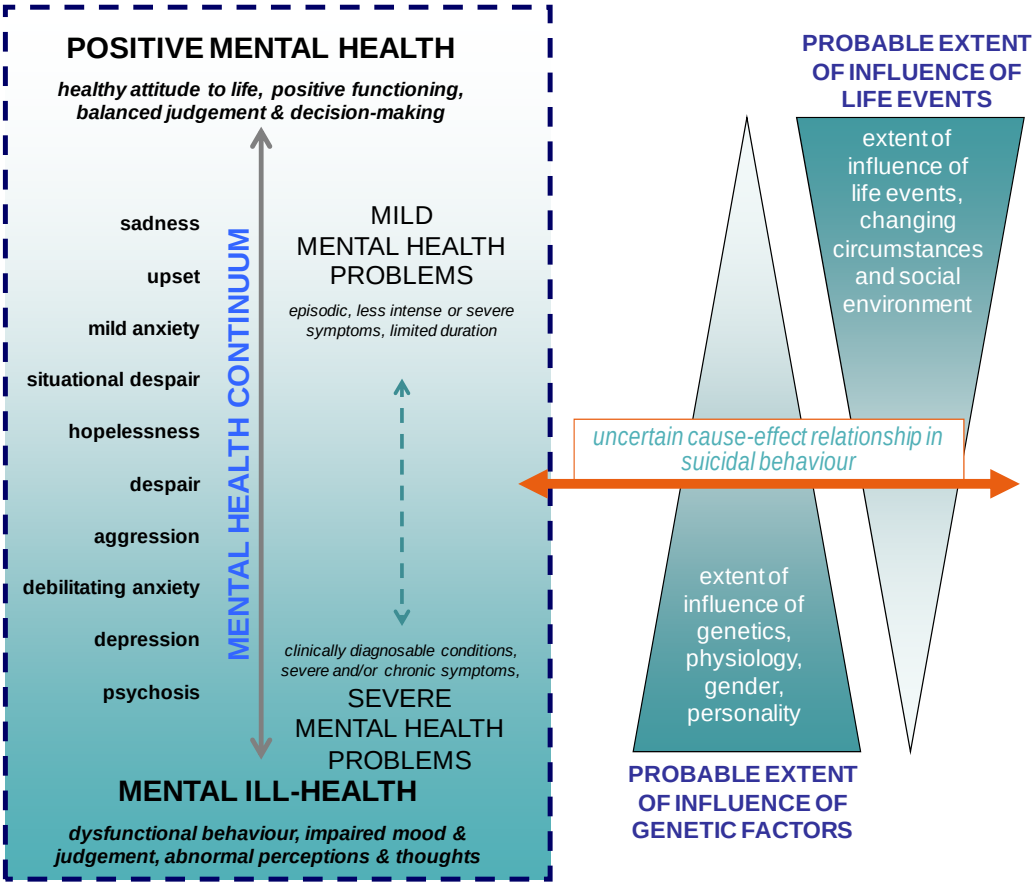



Many of these factors are outside of the control of an individual. For example, their cultural background, family history, social isolation, socio-economic disadvantages, physical health and gender. Nevertheless, suicide prevention activities in Australia continue to focus primarily on the mental health/mental illness risk/protective factor and funding continues to be channelled to people and organisations with medical, clinical, psychological or psychiatric credentials. This often occurs at the expense of the overwhelming evidence that contextual and life event factors are of equal importance and, indeed, often the cause of the mental health problems themselves.

To date the extent of funding and resourcing to better understand the impact of life events over and above genetics, gender, physiology and personality characteristics on the incidence of suicide is manifestly inadequate. Figure 2 brings together the broad continuum of mental health problems (behind which current mainstream theories in suicide hide) with a diagrammatic representation of the likely balance of influence between life events and genetic factors.

What Figure 2 highlights is that we can only be confident that there is a high correlation between suicide and mental illness where the mental illness is severe. Life events contribute far more significantly to suicidal thoughts and to the development of mental health problems than proponents of the current paradigm are prepared to admit.

**Figure 2: The influence of mental health problems and life events on disruptions to normal functioning following adverse life events (diagrammatic summary only)**

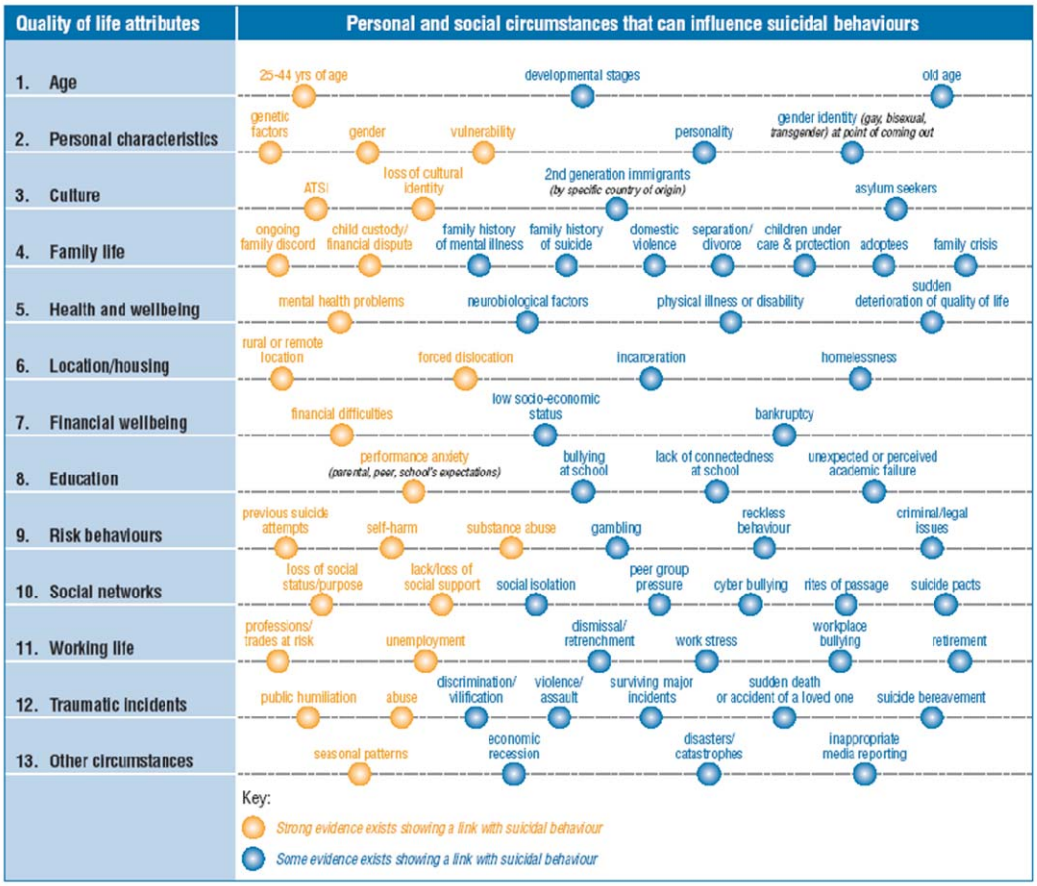



Currently there is an international body of literature that provides sufficient evidence for understanding which life events are most likely to impact on the likelihood of an individual feeling suicidal. Fortunately, in several of their recent annual rounds of funding through the National Suicide Prevention Strategy, the Department of Health and Ageing has given some recognition to this fact. In particular, they have funded programs to support the Child Support Agency and the Family Court of Australia to develop more sensitive process when dealing with people experiencing complications in their marital separation and child support arrangements. They have also funded several organisations nationally to support individuals bereaved by suicide with a view to minimising the likelihood of contagion/repeat suicides.

But these initiatives are the exception rather than the rule. It is clear that there needs to be a re-focussing of the suicide prevention research and intervention efforts in Australia to move away from the concept of mental illness towards a better understanding of which life events and under what circumstances they trigger suicidal thoughts.

Figure 3 summarises the extent of current knowledge about the impact of life events on suicidal thoughts.

**Figure 3: The range of life events that have been linked to suicide**




*(Note: This diagram is illustrative only. Life events shown are not of equal weighting in their potential contribution to suicidal behaviour)*

In the preparation of the revised LiFE Framework in 2007, the consortium of researchers I led provided much of this input to the Department of Health and Ageing and to the National Advisory Council on Suicide Prevention. All of this work was removed or significantly watered down in the final National Suicide Prevention Strategy despite it being based on the feedback from many hundreds of community members, government advocates, service providers and people bereaved by suicide from across Australia.

## EFFECTIVENESS OF THE NATIONAL SUICIDE PREVENTION STRATEGY

The statistics covering the incidence of suicide in Australia speak for themselves. Despite significant government funding, innumerable funded research studies and the predominance of the mental health paradigm, suicide rates in Australia have only been marginally impacted. In any other field of scientific endeavour, this would lead to an open admission of failure. In the suicide prevention sector it is largely used as an excuse to seek additional funding!

Apart from the sector operating under a false premise (mental illness as the primary cause of suicide) there is one other major cause of this failure to make a noticeable difference in Australia's suicide statistics. It is the fact that most research, most publications, most government studies and most communications about suicide prevention are within the sector itself and do not communicate effectively with the community generally.

On the available evidence to date, attempts to produce and deliver communications about identification and the prevention of suicide to the general media and the lay community have comprehensively failed. There is no better demonstration of this than the singular failure of the sector to change the expression that someone "*committed suicide*" to a phrase much less judgemental or accusatory. This phrase remains the most common phrase to describe a person's death by their own hands in the media, in the community, in religious circles and even in publications from the suicide sector itself. People bereaved by suicide see this as an offensive phrase that often aggravates their grief and hurt.

In 2007, the consortium of national specialists I led produced a report to the Department of Health and Ageing in which we delivered a comprehensive analysis of the way forward if the National Suicide Prevention Strategy was to make a meaningful impact in the Australian community. Our final report contained a lengthy discussion on how to communicate the National Suicide Prevention Strategy more effectively ("Dissemination, Advocacy and utilisation Strategy", pages 36 to 58 of our final report – see Attachment 2).

Our communications recommendations have been largely ignored in the commissioning of the current National Suicide Prevention Strategy communications contract which is held by Melbourne-based organisation Crisis Support Services Inc (see http://www.livingisforeveryone.com.au/About-LIFE.html). This website continues the tradition of communicating essentially with those already "*in the know*" and being a clearinghouse for information for the *already converted*.

**RECOMMENDATIONS**

There needs to be radical action if we are to significantly reduce the incidence of suicide in Australia. There are too many vested interests in control of the decision making process, in key positions of policy advice and in co-dependency relationships with the Department of Health and Ageing.

**Recommendation 1:** The advisory body/ies who are instrumental in decisions relating to priorities for policy, service provision and funding should be arms length from the Department and should not be dominated by either the medical/clinical professions or academics/researchers who are major beneficiaries of those funding decisions.

**Recommendation 2:** Funding strategies should focus on two major changes: (1) moving away from the predominance of the medical/mental illness paradigm to a more comprehensive and inclusive model of understanding suicide and implementing suicide prevention strategies that accord with the wealth of evidence supporting this move; (2) increasing the levels of support for understanding and implementing actions that support people experiencing the traumatic life events that are known to trigger suicidal thoughts.

**Recommendation 3**: Focus communication strategies on educating the general public on the risk and protective factors, the contextual and individual risk factors, the trigger and tipping points that most often lead to suicidal thoughts and/or completed suicides.

**ATTACHMENT 1:** Brief Resume: Professor Peter Bycroft

## About Professor Peter Bycroft

*Managing Director*
Corporate Diagnostics Pty Ltd

email: *peter.bycroft@cordia.com.au*

Peter Bycroft, the Managing Director of Corporate Diagnostics, is a recognised expert in market research, quality management and improving organisational performance. He is an Environmental Psychologist and an Adjunct Professor in the Faculty of Arts and Social Sciences at the University of the Sunshine Coast. Peter was formerly Visiting Professor in Quality Management at the University of New South Wales, Associate Professor at the University of Canberra, and has held Head of Department positions at three of Australia's top Universities.

Peter is widely recognised as one of Australia's leading authorities in strategic planning and evaluation having developed customised strategies and evaluation protocols for many State and Federal Government organisations and for major private sector organisations. In 1996, 1998 and again in 1999 his company was awarded international recognition by the Australasian Evaluation Society (AES) as the "best public sector evaluators in Australasia".

In 1999, one of his major clients, the Child Support Agency (CSA) was awarded the Federal Special Minister of State's Platinum Award for their significant work on integrating their business direction, client charter, market research and performance framework. In 2000, 2002 and 2004, the CSA was also awarded the Silver Award in the prestigious Prime Minister's Awards for Excellence in Public Sector Management– all of these awards were for work completed in partnership with Corporate Diagnostics.

Peter has played an instrumental role in the review and redevelopment of national policies in suicide prevention in Australia. In 2006 he led a consortium of organisations that developed the National Suicide Bereavement Strategy for the Australian federal Government and in the following year (2007) he lead a similar consortium which reviewed and updated the Australian National Strategy/policy on suicide prevention – entitled the Living is for Everyone (LIFE) Framework. Both strategies set the scene in Australia for suicide prevention and postvention policy and service provision for the next five years.

Peter has been a member of the Australasian Evaluation Society's International Awards Committee since 2000 and was appointed Chair of that Committee in 2005.

Peter's portfolio of clients includes the Department of Prime Minister and Cabinet, Federal Department of Finance, the Australian Taxation Office, the Department of Defence, the Department of Health and Ageing, the Department of Education, Science and Training, the Family Court of Australia, the Child Support Agency, the Department of Family and Community Services, the Department of Transport and Regional Services, the Department of Communications, Information Technology and the Arts and many smaller Federal, State, Local Government and not-for-profit agencies.

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Peter has also partnered with many leading international consulting companies including Ernst and Young, Price Waterhouse Coopers and IBM Consulting and has repositioned many public, private and not-for-profit sector organisations to better respond to the competitive pressures of their industries. He has developed uniquely tailored evaluation and organisational change methodologies that are widely sought after by both public and private sector clients.

Peter was a Noosa Shire Councillor from 1982 to 1986 and was responsible for many of the environmentally and community-sensitive policies for which that Shire is renowned. He was a founding member of the Noosa Economic Advisory Board from 2001 to 2005 and was appointed as Chair of the Noosa Iconic Places Panel from 2008 to the present. As a result, Peter is regarded as one of the key strategists involved in developing the national reputation of Noosa Shire for sensitive environmental, community and economic management and is regularly an invited keynote speaker at major national conferences on regional economic and community development.

## Brief Employment History

**1972-1973** – Tutor, School of Environmental Design, Tasmanian College of Advanced Education, Hobart.

**1973-1974** – Research Fellow, Department of Psychology, University of Surrey, England.

**1975-1982** – Lecturer in Behaviour Environment Studies, University of Queensland (including 2 years as Acting Head of Department).

**1980-1986** – Consultant to the Federal Schools Commission.

**1982-1986** – Councillor, Noosa Shire Council.

**1986-1988** – National Program Coordinator, Post-Occupancy Evaluation Program, Federal Department of Housing and Construction.

**1988-1989** – Visiting Professor in Quality Management, University of New South Wales.

**1989-1991** – Associate Professor, Head of Department/Course Co-ordinator in Behaviour-Environment Studies, University of Canberra.

**2001-2005** – Member of Noosa Council Community Economic Sector Board.

**1991-present** – Managing Director Corporate Diagnostics Pty Ltd.

**2004–present** – Adjunct Professor, Faculty of Arts and Social Sciences, the University of the Sunshine Coast.

**2005–2009** – Chairperson, Australasian Evaluation Society's (AES) International Awards for Excellence in Evaluation Committee.

**2006-present** – Member, University of the Sunshine Coast, Arts and Social Sciences Advisory Committee: Planning.

**2008-present** – Chairperson, Noosa Iconic Places Panel.

**ATTACHMENT 2:** The Dissemination, Advocacy and Utilisation Strategy for the National Suicide Prevention Strategy recommended by the Corporate Diagnostics consortium in 2007

# Dissemination, Advocacy and Utilisation Strategy

*"Dissemination and its outcomes are virtually impossible to micro-manage from the policy level. Dissemination is so dependent on the ability of those at lower levels to create the appropriate environment for competent communication that its outcomes cannot be directed easily from above. Even in highly centralised systems, complete control over knowledge dissemination and use among a broad population is an ephemeral goal"* (Louis and Jones, p 31).[ii]

## The Context

The redevelopment of the Living is for Everyone (LiFE) Framework was undertaken in response to an independent review and consultation with key stakeholders in 2006. Five of the nine outcomes from that review impact directly on improvements to dissemination and communication of the framework. These are:

- clarify the purpose of a revised LiFE Framework;
- ensure the revised LiFE Framework is reflective of a diverse Australia;
- add practical content with an implementation focus;
- present the information in a more visual and concise manner; and
- ensure greater integration of information.

During the redevelopment of the LiFE Framework, extensive consultations were held with the suicide prevention sector. These consultations involved representatives of governments, academics, researchers, medical professionals, mental health professionals, the suicide prevention sector, service providers, local communities, special interest groups, people bereaved by suicide, families, friends and individuals.

A major concern raised in these consultations related to the apparent failure of the LiFE Resources to achieve significant market penetration where it was most needed. This was a common theme across many of the consultations undertaken in the LiFE Framework redevelopment project. For example, the very first project policy consultation in Canberra on 13 December 2006 was attended by thirteen representatives of the following organisations: Aids Action Council of the ACT, Australian General Practice Network, Australian Medical Association, Australian Nursing Federation, Australian Rural Nurses and Midwives, Australian Sports Commission, Country Women's Association of Australia, Health Consumers of Rural and Remote Australia, National Rural Health Alliance, the OzHELP Foundation (on behalf of Construction and Building Industry Superannuation) and Rural Doctors Association of Australia. Of the thirteen representatives at that consultation, two had seen the LiFE Framework Resources and only one had ever referred to them!

In one, Think-Tank consultation, which included senior academics, national not-for-profit organisations and leading State and Territory Health Department representatives, one participant stated: *"I hope the new document reaches more people than the one hundred and forty people who actually used the LiFE Framework!"* (Sydney, Think Tank participant, 19 March 2007).

# Dissemination, Advocacy and Utilisation Strategy

The Department of Health and Ageing's contract for the redevelopment of the LiFE Framework specifically requested the development of "*a detailed strategy for the dissemination of the Research and Evidence document, the LiFE Framework Strategic Policy and the Practical ToolKit*" (p29).

## Improving market acceptability and take-up rates for products and services

The market research and client satisfaction industry has developed several key acronyms for how to improve market acceptability and take-up rate of products and services. Amongst these is the often used acronym A.I.D.A. – Awareness, Interest, Decision and Action.

**AIDA** describes a common list of events that are very often undertaken when promoting a product or service:

**A - Awareness**: attract the attention or raise the awareness of the customer/consumer that a certain product or service exists.

**I - Interest**: raise customer/consumer interest by demonstrating features, advantages, and benefits of the product or service.

**D - Decision:** convince the potential customers/consumers that they should engage with/purchase the product or service and that it will satisfy their needs.

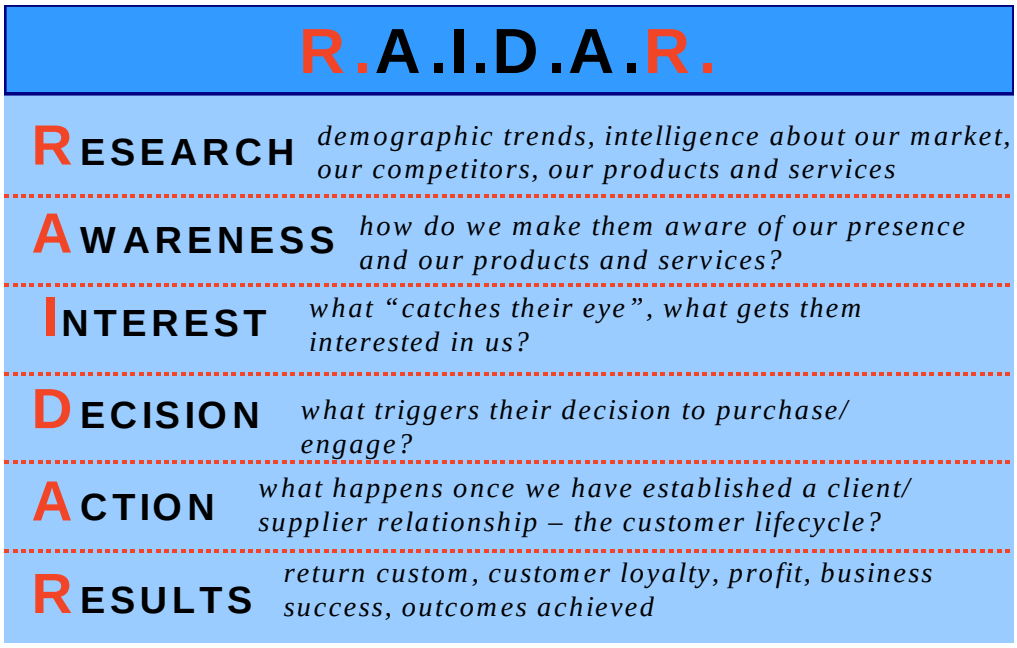
**A - Action:** customers/consumers engage with or purchase, use and experience the benefits of the product or service.

Corporate Diagnostics has modified this approach to establish a robust methodology for developing strategies to improve market acceptability and product take-up rates. Two steps have been added to "bookend" the **A.I.D.A**. approach.

In the front end, 'Research' is applied to identify demographic trends, to gather market intelligence and to map the most appropriate range of products and services for each market segment. The back end of the **A.I.D.A**. approach focuses on 'Results' – levels of customer loyalty or repeat use, achievement of outcomes, delivery of results. The revised model is referred to as the 'R.A.I.D.A.R.' approach (see Figure 19). The R.A.I.D.A.R. concept guides the development of successful targeted strategies to improve the market penetration and coverage of selected products or services. All organisations need to use their 'RAIDAR' efficiently and effectively if they wish to learn from their customers, improve their services, expand their business, improve coverage and take-up rates and gain and maintain a position and a market advantage.

# Dissemination, Advocacy and Utilisation Strategy

**Figure 19: The RAIDAR Model for improving market acceptability and product take-up rates**




## Developing a dissemination, advocacy and utilisation strategy

In communications terminology, **dissemination** is a planned approach to informing a wider audience about the results of a project; **advocacy** is the active/proactive support of a cause, course of action or a policy and **utilisation** is to put to use, make practical use of or to use effectively (adapted from Harmsworth et al, 2001[iii]; Hughes et al, 1997[iv]; Treffry et al, 2000[v]; Macquarie Library, 1981[vi]).

Traditionally, dissemination strategies have focussed on the delivery of messages from an "information provider" to "information receiver/s" (Duggan and Banwell, 2004)[vii]. However, Louis and Jones (2001, p 3)[viii] suggest that one of the most important recent developments in defining the theory of dissemination is the ***increased focus on the social processes related to dissemination***. In particular, they suggest that ***dissemination and utilisation are so closely linked that it is not possible to have one without the other***. They contend that effective dissemination depends on ***sustained interaction between researchers and practitioners*** (see also Brown, 1995 [ix]) and propose that effective dissemination has the following characteristics:

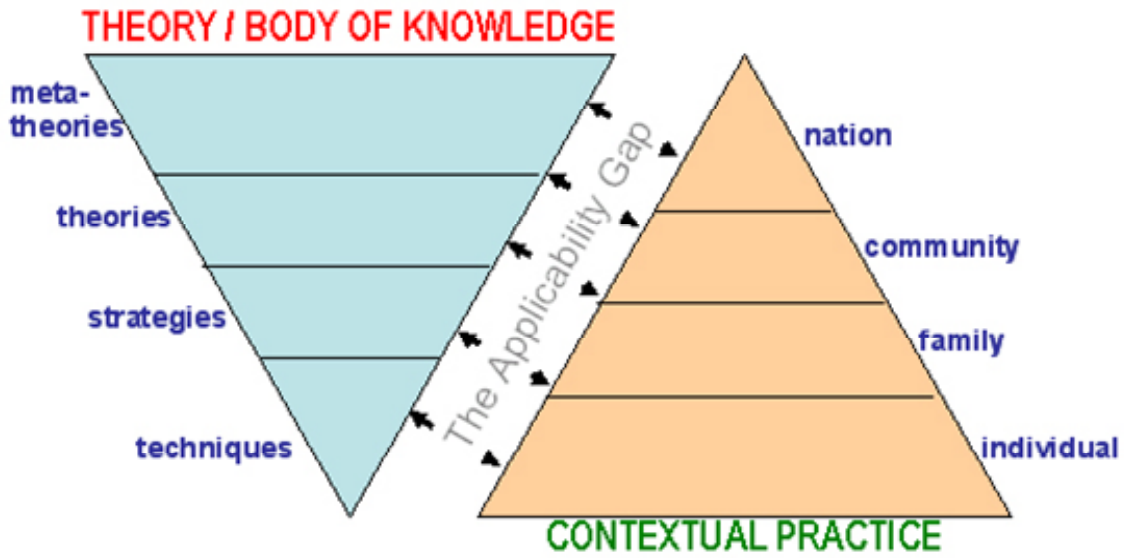
- a socially shared understanding of the field;
- sustained interaction between researchers and practitioners;
- increased meaning on the part of the creators and the users;
- learning and growth developed from peer interaction – challenging each other's assumptions and encouraging one another to rethink their ideas;

# Dissemination, Advocacy and Utilisation Strategy

- development of new ideas in relation to an existing core of shared knowledge;
- a level of familiarity that permits communication of challenges in ways that are not excessively threatening; and
- an emphasis on the way in which individual researchers and practitioners enter into relationships with one another.

Early on in the current project, it became obvious from the consultations and the review of previous research, literature and current practice that the suicide prevention sector contained a significant gap between the development of knowledge and the contextual experiences of practitioners (referred to as the "applicability gap" – see Figure 20). In some ways, this gap contributed to the comparatively low market penetration of the LiFE Framework Resources. The LiFE Framework documents communicated largely to the research, academic and policy audience and less so to the practitioner audience.

**Figure 20: The applicability gap - between research and practice in suicide prevention**

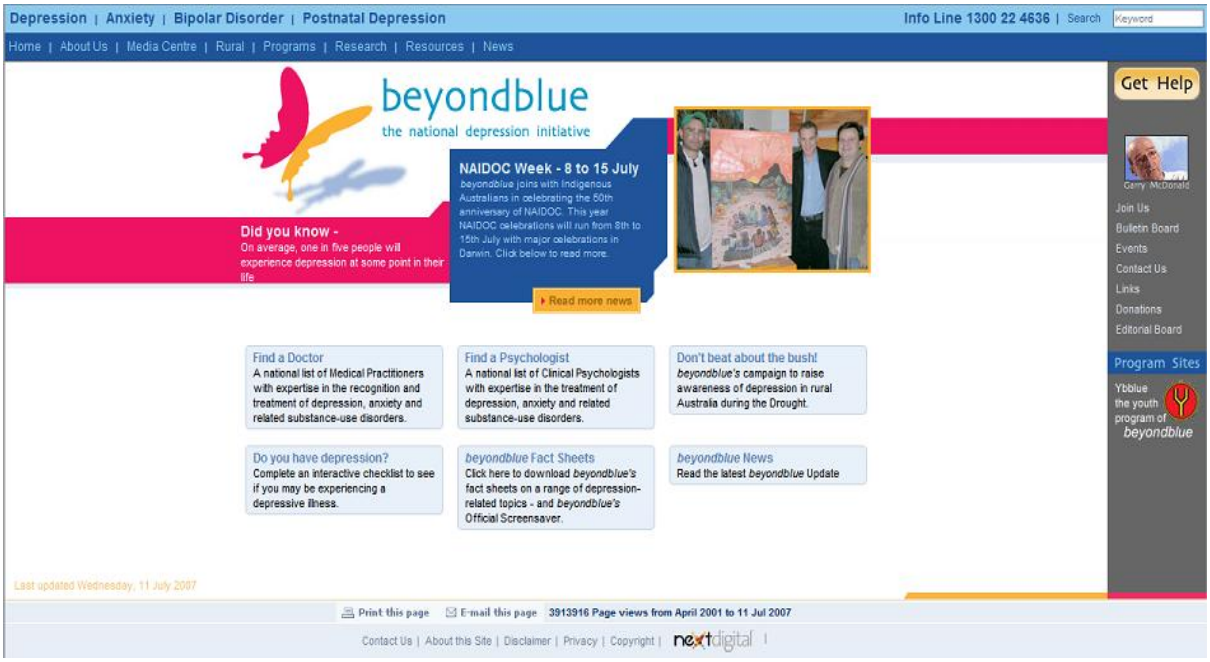


# Dissemination, Advocacy and Utilisation Strategy

Within the suicide prevention sector in Australia, there are also some excellent examples of successful dissemination strategies that bridge this gap. They achieve this by a coordinated involvement in advocacy, dissemination, a proactive involvement in facilitating communication and interaction and the capture and transfer of up-to-date knowledge. Probably the most often cited example during the project consultations was the work of the national depression initiative ***beyond blue*** (see Figure 21).

The evidence from consultations in the *Life is for Living* project, from the independent review and consultation on the LiFE Framework and from the recent literature on dissemination strategies suggests that the dissemination strategy for the *Life is for Living* Framework needs to adopt a broader and more proactive approach than has occurred to date. There is an identifiable need for the dissemination strategy to follow more closely the principles of advocacy, facilitation of knowledge transfer, dissemination and two-way communication, and unification of the suicide prevention sector if this initiative is to be effective in reducing the incidence of suicide in Australia.

**Figure 21: The beyondblue website**



# Dissemination, Advocacy and Utilisation Strategy

## The objectives of the *Life is for Living* Dissemination, Advocacy and Utilisation Strategy

The previous discussion highlights the importance of the dissemination strategy for the *Life is for Living* Framework in playing an integrative role in suicide prevention nationally. To achieve this, the notion of a national clearinghouse or website that collects, classifies and distributes information and/or assistance needs to be significantly expanded.

In addition to soliciting the systematic collection, assessment and distribution of information, the dissemination strategy needs to raise awareness, advocate, encourage, challenge and foster collaboration and coherence within the sector. Feedback from the suicide prevention sector identified the existence of an applicability gap that impacted on the adoption of the LiFE Framework. In response to this feedback, combined with the most recent literature on contemporary approaches to dissemination, the *Life is for Living* dissemination strategy has a focus on practical application, feedback and evaluation of activities from research and contextual practice and the development, promotion and adoption of best practice in suicide prevention.

For the *Life is for Living* Dissemination Advocacy and Utilisation Strategy to be effective it will need to achieve the following five major objectives:

1. **Advocacy** of the *Life is for Living* Resources
   **the objective: –** to ensure that the *Life is for Living* Resources continue and improve upon the Living is for Everyone (LiFE) "brand" by achieving a wider market penetration and broader adoption of these resources in the prevention of suicide;
2. **Knowledge capture and transfer**
   **the objective: –** to develop effective mechanisms for quality control, integration, revision, maintenance , evaluation and updating of information and resources on suicide prevention;
3. **Communication**
   **the objective: –** to facilitate the exchange and cross-fertilisation of information and ongoing communication between interested and specific target audiences for suicide prevention;
4. **Dissemination**
   **the objective: –** to interactively monitor and manage sectoral and cross-sectoral engagement, awareness, interest, understanding and the appropriate and sustainable application of information and resources in support of suicide prevention;
5. **Utilisation**
   **the objective: –** to ensure that the suicide prevention initiatives and information outlined and promoted in the *Life is for Living* Resources increase knowledge, positively influence attitudes and behaviours, improve the effectiveness and implementation of policy, programs, projects, practices and service delivery in suicide prevention and reduce the incidence of suicide in Australia.

# Dissemination, Advocacy and Utilisation Strategy

## Identifying the target audience and target markets

Because suicide is the result of many and varied, often complex factors, information on suicide prevention will, by definition, have a diverse and wide ranging audience. The *Life is for Living* project identified the following potential target markets and audiences for up-to-date information on suicide prevention:

- **Target markets for the *Life is for Living* resources:** the academic/research sector, patients/public, community clubs and societies, church/religious organisations, not-for-profit organisations, the health sector, the education sector, government and the media.
- **Target audiences for the *Life is for Living* resources:** individuals, families, friends and colleagues, opinion leaders, communities, health and mental health professionals/practitioners, emergency services and front line staff, coroners, funeral directors, social, not-for-profit and community organisations, service providers, clubs and societies, journalists and the media, educational institutions, all levels of government, government agencies, policy-makers, politicians, academics and researchers nationally and internationally.

In response to the wide range of potential target markets and of target audiences, the *Life is for Living* resources have been structured in a way that reflects and attempts to match the information needs of these differing audiences (see Figure 22).

## The *Life is for Living* Dissemination, Advocacy and Utilisation Strategy

The *Life is for Living* resources are the initiating and primary source of information for a broader range of resources and a broader national dissemination strategy. The *Life is for Living* resources will need to be continually updated and used as the source for a range of different communication and information products, via selected media or communications channels and customised to suit the needs of different target audiences. This will require an approach that reflects the industry-standard practices of communication and dissemination (see Figure 23).

The recommended strategy (Figure 23) requires a level of proactive, integrated and professional communications management that has yet to be achieved in the suicide prevention sector. It will require centralised coordination that extends beyond program and project funding regimes and the competitive nature of the government funding environment. It will also require a dedicated national resource (clearinghouse – see following discussion), which does not compete as a service provider within the sector and has a uniquely defined and ongoing role.

# Dissemination, Advocacy and Utilisation Strategy

**Figure 22: The structure of the *Life is for Living* Resources - targeting different audiences**

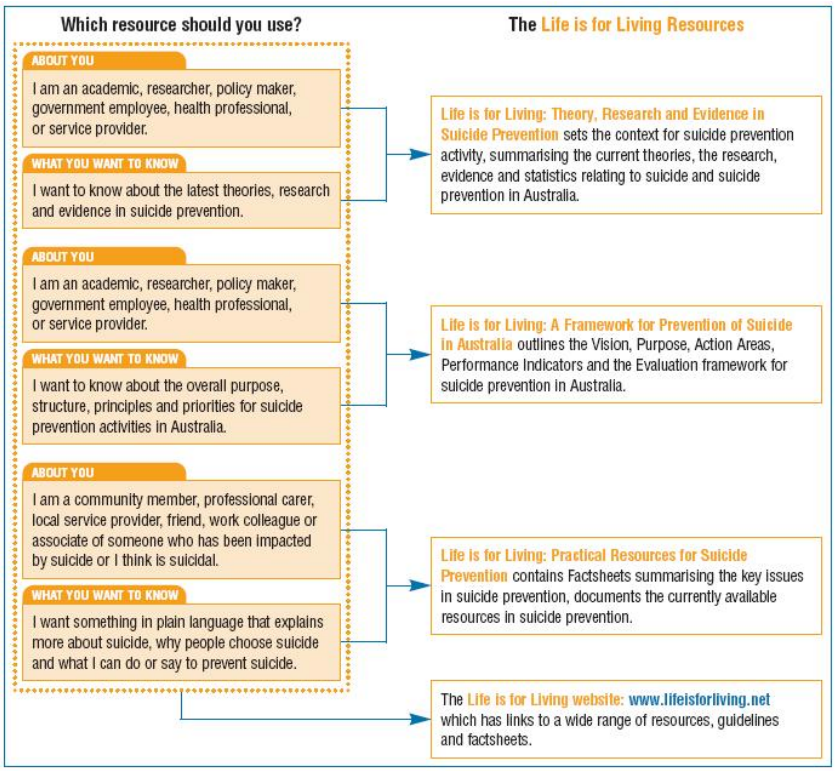
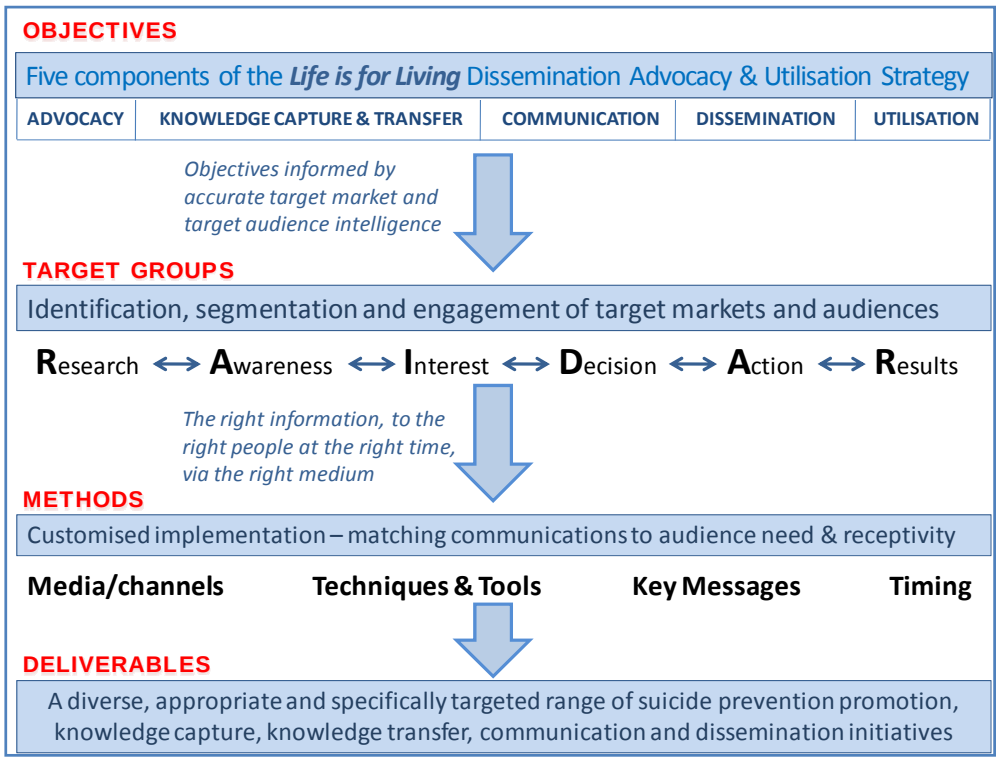



**Figure 23: The *Life is for Living* Dissemination, Advocacy and Utilisation Strategy**



# Dissemination, Advocacy and Utilisation Strategy

## A central clearinghouse for the *Life is for Living* Dissemination, Advocacy and Utilisation Strategy

The level of professionalism required in managing the ***Life is for Living*** dissemination, advocacy and utilisation strategy necessitates the creation of a single national clearinghouse. The single national clearinghouse must fulfil a broader role than has occurred in the past and must develop a sensible strategy and framework for the integration of the range of suicide prevention initiatives currently being undertaken and funded across Australia.

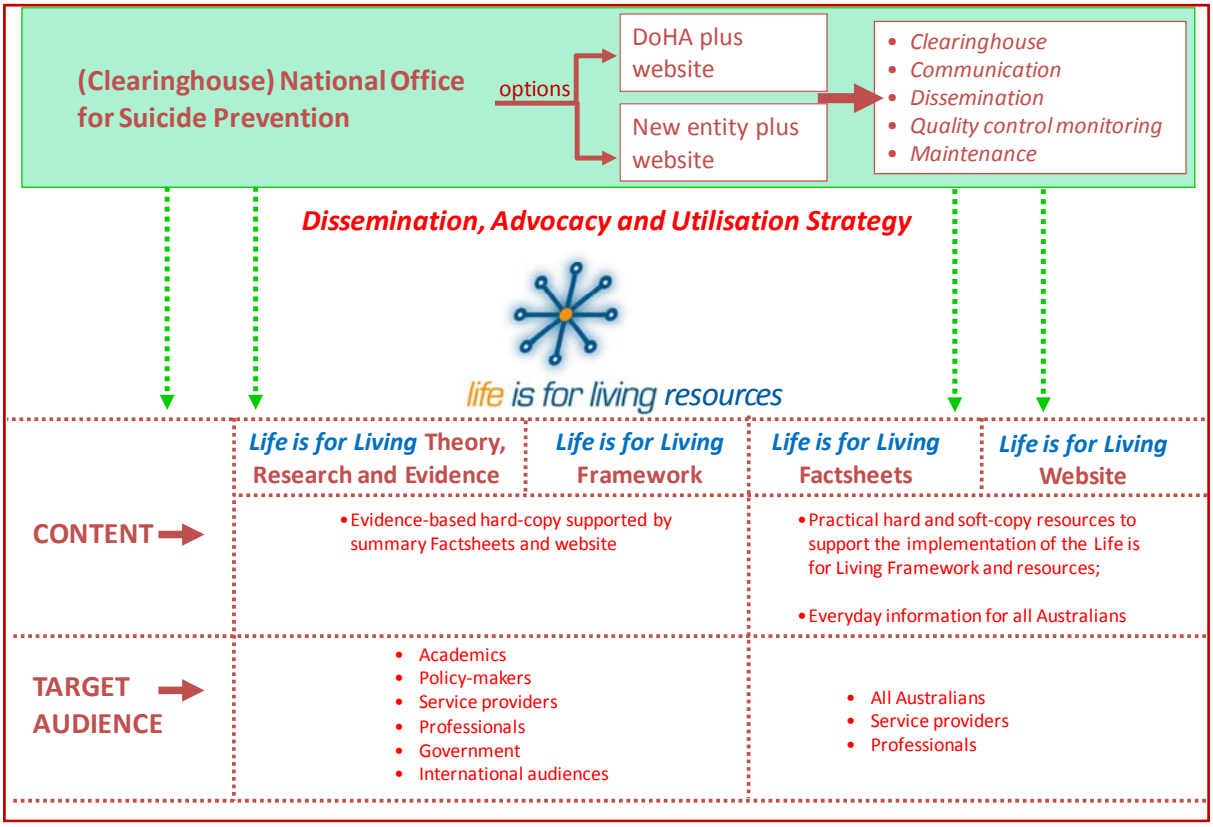
The national clearinghouse would need to have continuity of funding (as a new entity separate from government) or be located within the Department of Health and Ageing as an "Office of Suicide Prevention". To deliver better integration of suicide prevention activities across Australia, it would need to fulfil the following roles:

1. administer, communicate, promote and maintain the ***Life is for Living*** Resource in accordance with the Dissemination, Advocacy and Utilisation Strategy;
2. provide the principle focus (portal, interface) for consultation between the health, mental health, social and community sectors and government on matters relating to suicide and suicide prevention;
3. coordinate national communication strategies for suicide prevention activities;
4. provide high level, independent advice (policy and other) to the Minister for Health and Ageing and government;
5. provide secretariat support to the National Advisory Council for Suicide Prevention and its associated committees;
6. liaise across departments for the achievement of whole of government approaches to suicide prevention;
7. liaise across governments (State and Territory) in the achievement of a whole of community approach to the prevention of suicide in Australia;
8. advise on policy and other program issues as they relate to and impact on prevention of suicide activities in Australia and across governments;
9. represent the suicide prevention sector at state, national and international forums on suicide and suicide prevention; and
10. not compete as a service provider in the suicide prevention sector but maintain an exclusive role as clearinghouse, advocate and facilitator of sectoral knowledge and resources.

A priority function of the national clearinghouse will be to ensure that the ***Life is for Living*** resources reach their primary target audiences as outlined in Figure 24.

# Dissemination, Advocacy and Utilisation Strategy

**Figure 24: The initial function of an effective national suicide prevention clearinghouse**



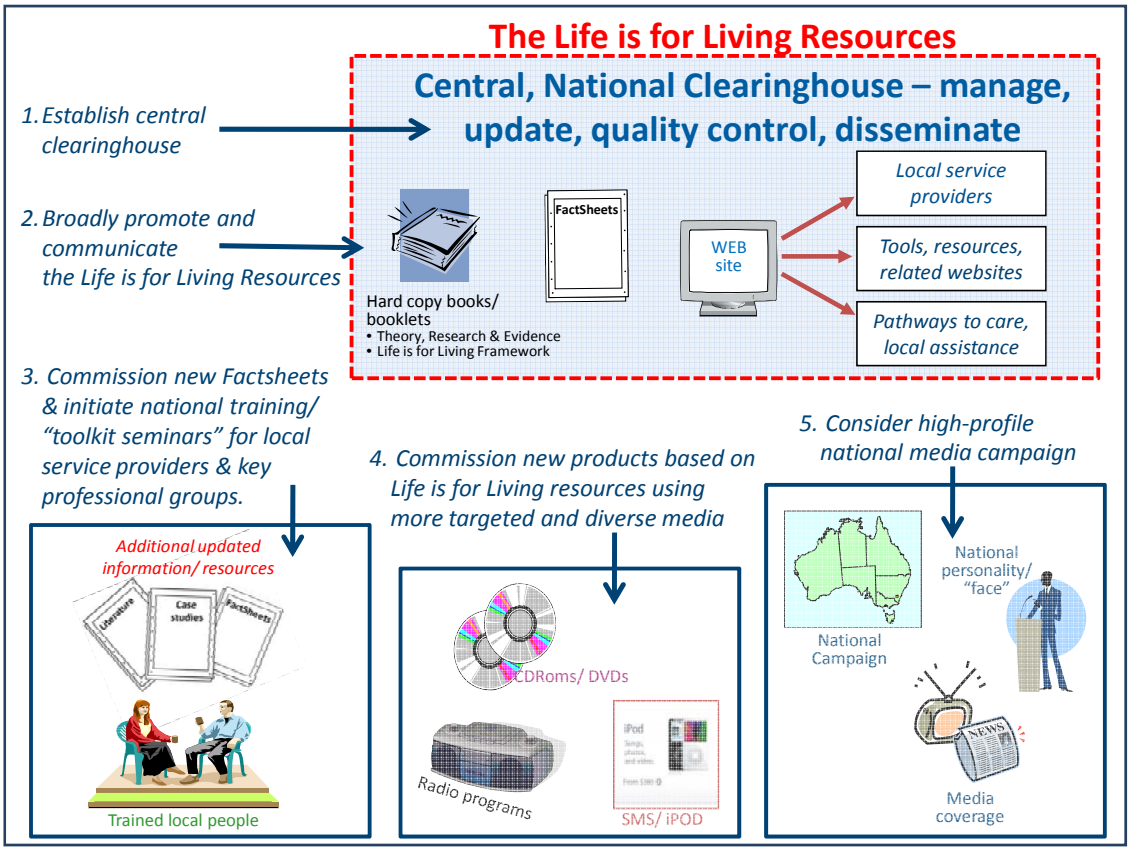
# Dissemination, Advocacy and Utilisation Strategy

A national clearinghouse will also play a key and ongoing advocacy role in suicide prevention. A major function of the national clearinghouse will be to use the *Life is for Living* Resources as source documents to commission the production of new and targeted materials and resources on suicide prevention. Project consultations identified a need to develop a range of resources and promotional initiatives relevant to the needs of selected high risk groups and communities (see Figure 25).

For instance, the consultations identified the need for the first wave of activity in disseminating the *Life is for Living* resources to include:-

- A national campaign to raise community awareness of suicide prevention;
- A national "roadshow" of explanatory seminars including the training of local "champions" and service providers in the use of the *Life is for Living* resources;
- Development of new resources using a variety of media – new Factsheets, CDRoms, DVDs, radio, the internet, SMS and iPod.

**Figure 25: The first wave of dissemination activities for the national clearinghouse**



# Dissemination, Advocacy and Utilisation Strategy

## Managing updates, upgrades and revisions

The *Life is for Living* resources have been designed as a dynamic set of resources. They will be updated, upgraded and revised over their planned five year duration (2008 to 2013). In developing the resources, the components have been segmented into:

- components that are unlikely to need supplementation during the five year life of the resources (namely the Theory, Research and Evidence and the *Life is for Living* Framework); and
- components that will need to be changed, revised and expanded during the life of the resources (the FactSheets and the website).

To assist in this process, the factsheets have been designed as a suite of separate, practically focussed resources covering an initial twenty-five topics. The twenty-five topics were chosen following consultation with the suicide prevention sector and will need to be supplemented by additional, specifically targeted factsheets developed in accordance with the strategy outlined in Figure 23 and Figure 25.

In addition, the prototype website/s (see following section) have been developed as the basis for an ongoing dynamic and up-to-date application of the internet with ample opportunity and provision for ease of updating.

A key role of the central clearinghouse will be to develop a proactive campaign to ensure that the new factsheets and the updating of the website occurs in response to the emerging needs of the suicide prevention sector.

## Evaluating the *Life is for Living* Dissemination, Advocacy and Utilisation Strategy

The *Life is for Living* resources have been prepared for the period 2008 onwards with an expectation that they will be reviewed in 2013. However, they are not a static set of resources. The integrated dissemination strategy discussed above highlights the need for the *Life is for Living* resources to grow and develop over time and as part of a better integration of research and practice in suicide prevention.

The centrally managed clearinghouse must achieve multiple objectives including advocacy, knowledge capture and transfer, communication, dissemination and utilisation if the *Life is for Living* initiative is to be successful (see Figure 23). It is essential, therefore that an independent system for monitoring performance, reviewing progress and evaluating the impact of the resources is in place from project commencement.

# Dissemination, Advocacy and Utilisation Strategy

The evaluation strategy should include:

- **a process evaluation** (from project inception) – of how the Dissemination, Advocacy and Utilisation Strategy has been developed and delivered, how it has been implemented, what lessons have been learnt and are being learned and how these lessons have been used to improve the strategy as it develops;
- **impact evaluations** (in the medium term)– initially focussing on the market penetration and acceptance of the ***Life is for Living*** resources, but developed over time into a standardised impact evaluation protocol for new resources as they emerge;
- **outcome evaluation** (periodically after the first twelve months of dissemination) – sector wide and segmented/targeted evaluations of the effectiveness of the ***Life is for Living*** resources and of the Dissemination, Advocacy and Utilisation Strategy. The effectiveness measures should include user satisfaction measures as well as selected indicators of effectiveness in achieving the objectives of ***Life is for Living*** Framework and ultimately in reducing the incidence of suicide.

The specific indicators of success for the ***Life is for Living*** Dissemination, Advocacy and Utilisation Strategy include, but should not be limited to:

- increased awareness and interest in the ***Life is for Living*** resources;
- increased market penetration/coverage by the ***Life is for Living*** resources;
- increased demand for the ***Life is for Living*** resources;
- less duplication of effort and better coordination and agreement on national priorities in suicide prevention;
- improved cooperation and collaboration between researchers and practitioners in suicide prevention;
- increased application of the principles, models and theoretical foundations of the ***Life is for Living*** resources;
- national recognition and use of the ***Life is for Living*** brand and logo;
- increased sectoral ownership and engagement with the ***Life is for Living*** initiative and with the national clearinghouse for suicide prevention.

The specific indicators of success for the ***Life is for Living*** resources include, but should not be limited to:

- *increased awareness and interest in the issues that impact on suicide and suicide prevention;*
- *improved understanding of the key issues in suicide prevention;*
- *increased understanding and application of what works, when and with whom in suicide prevention;*
- *improved family and community capacity to respond to people in need;*
- *increased individual resilience and well-being in high risk groups;*
- *a reduction in the incidence of suicide in the areas of greatest need (geographically and by high risk group)*

# Web-based Integration of the Life is for Living Framework

## The Context

The contract from the Australian Government Department of Health and Ageing for the Redevelopment of the Living is for Everyone (LiFE) Framework project specified the development of a Practical Toolkit as

"*a consolidated resource....in a format that allows individual pages or topic areas to be easily updated and must be created in both hard copy and in a format suitable for web-based publication*" (page 27).

The contract further specified that "*the Practical Toolkit..includes a prototype for the web-based dissemination of the Practical Toolkit that is consistent with the design of the* www.livingisforeveryone.com.au" (page 30).

The consultations with academics, service providers, researchers, governments, community leaders, health professionals and special interest groups confirmed that a website was the most appropriate medium to use to provide access to the wide range of existing resources and information available. However, due to the wide range of existing websites, resources and information already available in the suicide prevention sector, consultation participants also stressed the importance of not "reinventing the wheel", that is, not duplicating effort without adding any real value. It was suggested that the revised LiFE Framework website should act not only as a clearinghouse, providing information and access to other relevant resources, but should also direct people to the information most appropriate to their needs.

The consultations also suggested that a variety of other materials in a range of mediums (e.g. radio, DVD, CD, print, internet-based tools) need to be produced in order to effectively disseminate the information to the different target audiences using the most appropriate communication channels (media) for each audience.

As part of the website review process, a technical review of the capability and sustainability of the *Living is for Everyone* website was undertaken by independent consultants, *GKY Internet*. Due to the breadth of existing web-based information and resources available across the sector, many of which address some of the same key themes and topics that could be included in the practical toolkit, the scope of the technical review was broadened. A selection of websites was monitored, in addition to the *Living is for Everyone* website. This broad assessment assisted the Project in determining the performance of the *Living is for Everyone* website against industry standards of performance and benchmark its capacity against others in this sector. This review was achieved within the current budget allocation for this task and was based on continuous monitoring for one month, (from 15 February to 15 March 2007,) of the performance of each of the following websites which were identified in the consultations:

- Living is for Everyone (LiFE) website: www.livingisforeveryone.com.au
- Auseinet website: www.auseinet.com

# Web-based Integration of the Life is for Living Framework

- Lifeline Australia website: www.lifeline.org.au
- Our Community website: www.ourcommunity.com.au
- MindMatters website: http://cms.curriculum.edu.au/mindmatters/
- HealthInsite (DoHA) website:www.healthinsite.gov.au
- Read The Signs (Lifeline and MTAA) website: www.readthesigns.com.au
- Beyond Blue website: www.beyondblue.org.au
- Reach Out website (site for youth and kids): www.reachout.com.au
- Suicide Prevention Help: www.suicidepreventionhelp.com

## The methodology and results from monitoring website performance

The web site monitoring was based on technical performance and did not include measures of user acceptability or user friendliness. The ten websites were monitored using a dedicated 2M E1 link into Telstra's Tier 1 backbone. Each website monitored had one page loaded at a time every 15 minutes 24 x 7 for over 28 days. Only one page is loaded at a time so that the link is not simultaneously used. The link is capable of greater than 200k/s transfer rates.

The monitoring system simulates the end user visiting the website for the first time. The page load process involves a DNS lookup to get the IP address and then an http request to load the page in question. Time taken for the DNS response, start of page load and end of page load is measured and recorded.

A failure is recorded if:

- any form of DNS error occurs or the DNS request takes longer than a certain time (in this monitoring case that timeout was set at 60 seconds);
- any form of http error occurs or the total page load time takes longer than a certain time (in this monitoring case that timeout was set at 60 seconds).

Once a failure occurs, the system attempts to reload the page every 60 seconds to get a more accurate indication of failure duration.

Failure of the monitoring link itself will not result in a 'failure' being recorded. Connectivity to the greater internet is tested whenever a failure is monitored to ensure that false entries are not recorded.

Hourly transfer rates can often be higher than those averaged over a 24 hour period. Internet usage (both total traffic and number of users) varies over the course of the day. This affects congestion over networks and/or server delivery rates. Availability (over a certain period) is the total time that the web page could not be successfully loaded divided by the total time over which availability was measured. This is a standard method for quantifying system availability.

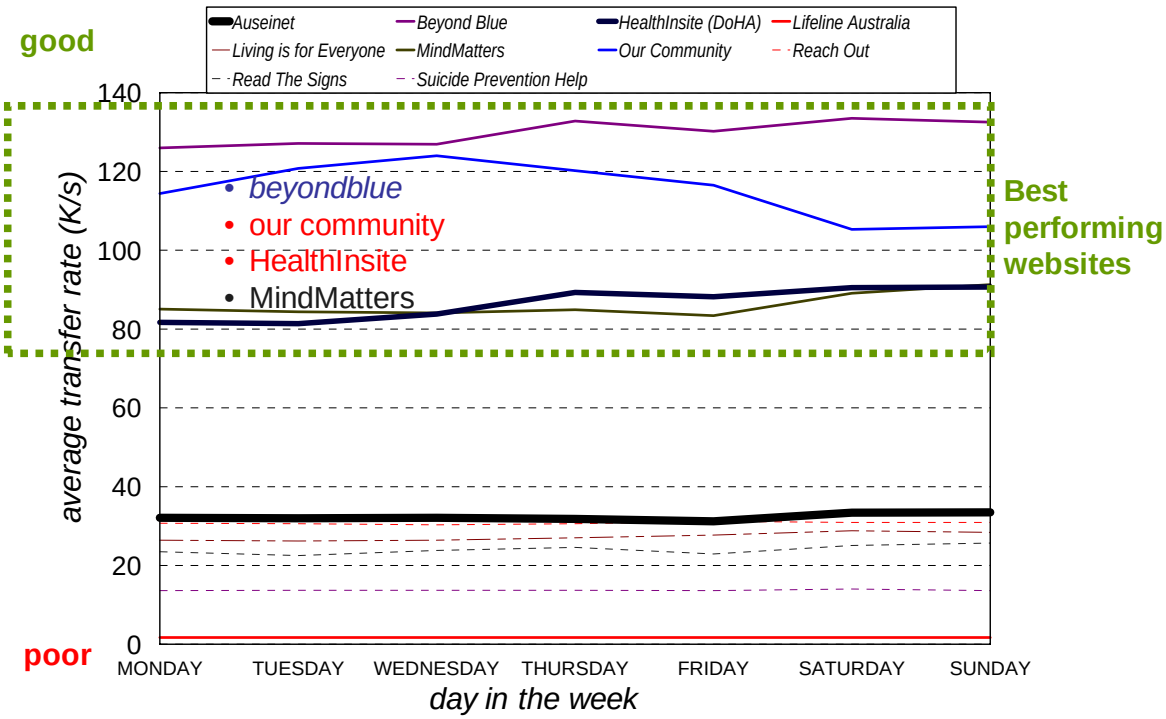
# Web-based Integration of the Life is for Living Framework

For this monitoring only the html was downloaded and not the images. Only transfer rate information (not total page load time) is presented in the analysis (see Figure 26 and Figure 28). If a website has a very small html page (e.g. less than 1k) then the transfer rate calculation can be skewed by latency – for example, there is not enough data being sent to get an accurate measurement of transfer rate. However, this does not appear to have occurred with any of the pages monitored.

The monitoring involved at least 2,688 loads of each web page in question. Each page was loaded at least once every 15 minutes for over 28 days.

The comparative performance of all ten web sites on the technical performance criteria (performance, failure rate and availability) is summarised in Figure 26, Figure 27 and Figure 28.

**Figure 26: Comparative performance over time of ten web sites**



# Web-based Integration of the Life is for Living Framework

**Figure 27: Comparative failure rates of ten web sites**

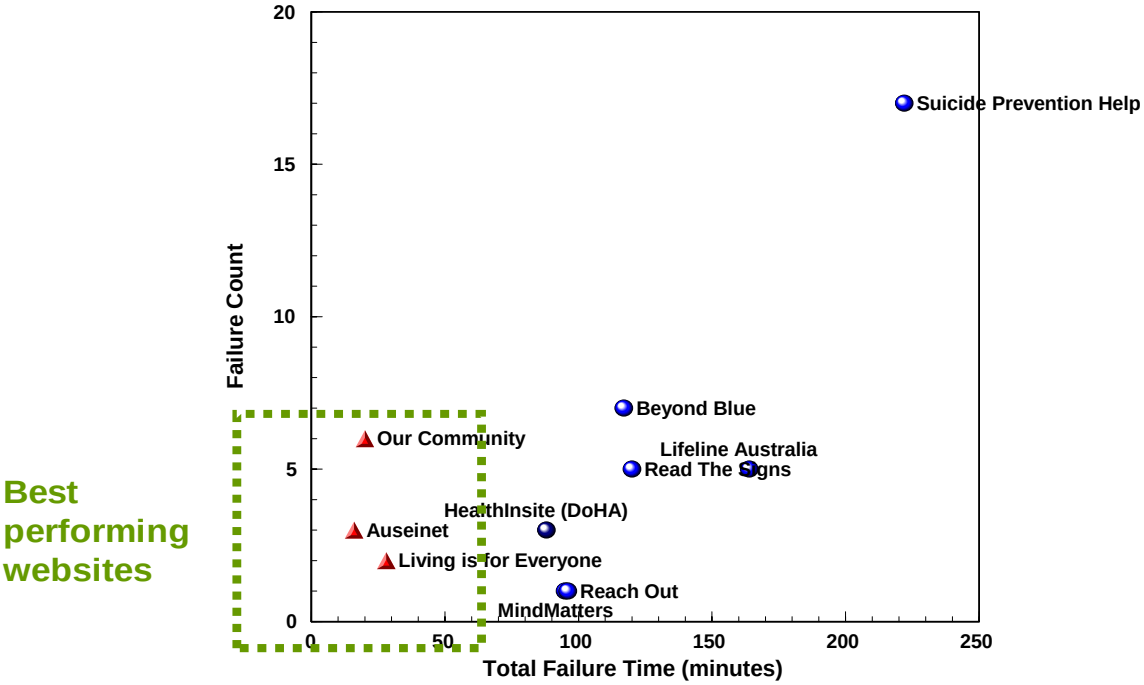
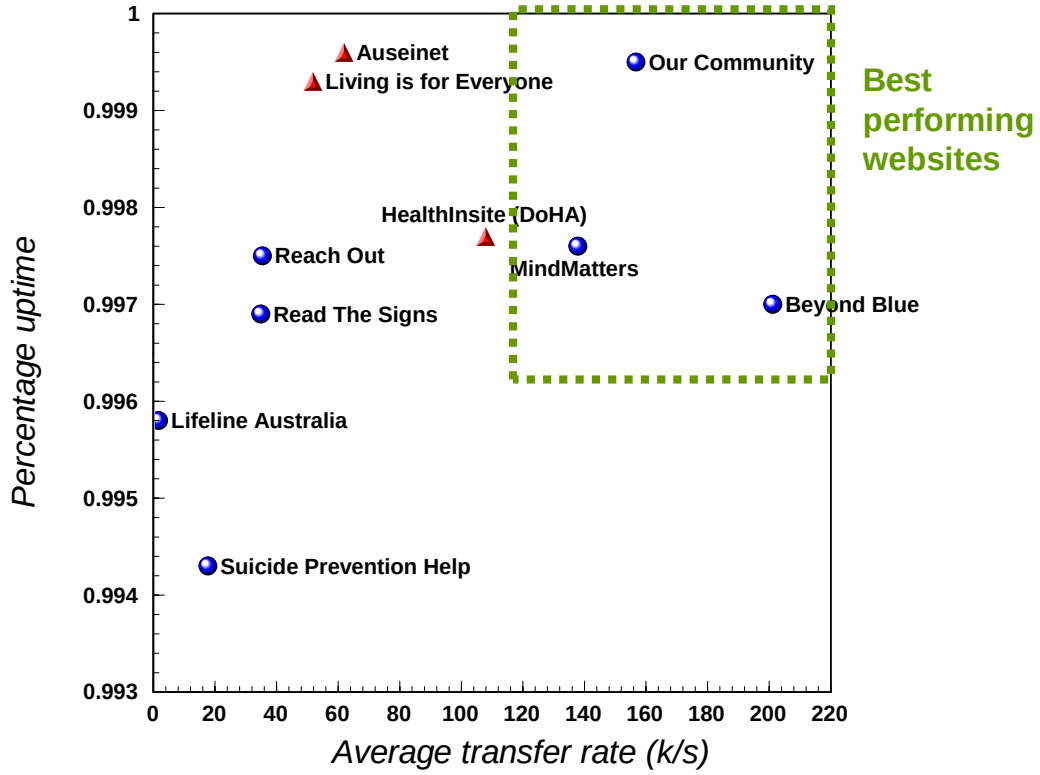



**Figure 28: Comparative availability of ten web sites**



# Web-based Integration of the Life is for Living Framework

## Implications of the web site monitoring

Results from this assessment demonstrated that there are three websites of the ten selected for this analysis that are performing better than the remaining seven on key performance criteria. These are beyond blue, our community and Mind Matters (see Figure 29). The Living is for Everyone website and its sister web site Auseinet have good comparative results for availability in terms of "up time", but score comparatively lower on general performance (transfer rates).

During the course of this project, approaches were made to the organisations responsible for hosting the leading websites but, in the light of the project timeline none were available or able to contribute to the development of a prototype for the *Life is for Living* prototype. As a result, the project team opted to investigate the development of a stand-alone prototype website.

**Figure 29: Best performing websites on technical monitoring criteria**

# Web-based Integration of the Life is for Living Framework

## The proposal – two different approaches to developing the website prototype

The suite of practically focussed resources that was required by the contract includes a series of factsheets (easily updated and expanded over time) linked to a website prototype. The website prototype was proposed as the major portal for the factsheets, but would also contain, promote and disseminate the overall ***Life is for Living*** suite of documents and links to other related resources and information.

The ***Life is for Living*** Resources have a wide range of potential audiences, each of which has different needs and different expectations. During the consultations, it became clear that there was one audience (mainly academics, researchers, policy-makers and government agencies) who wanted access to scientific information in a standardised and professional format. Another audience (mainly individuals, the general community, local service, recreation and social clubs and local service providers) wanted information in lay language and communicated through more accessible mediums.

In response to this feedback, two website prototypes have been developed by two quite different website development companies. This approach was adopted to demonstrate how the ***Life is for Living*** Practical Resources for Suicide Prevention can be displayed, accessed and updated in two very different ways. Each website development company had its own approach, process and style and, consequently, each resulted in different outcomes and functionality.

1. The more traditional website prototype was commissioned from DDSN Interactive. Their approach involved extensive consultation with experienced and naive users and focussed more on developing the logic and structure for the site. DDSN has a tried and proven systematic methodology for website development and they followed this in the creation of their prototype (see later discussion).

2. The more "intuitive" website prototype was commissioned from the Oxygen Kiosk – a younger company owned and managed by younger people (mid to late twenties). The Oxygen Kiosk prototype was commissioned to provide a more accessible and more contemporary approach for a potentially younger and lay-persons audience (see later discussion).

Both websites provide an easy-to-use format for accessing the ***Life is for Living*** suite of documents and the wide range of other resources, information and services relating to suicide prevention that are currently available. They are also both able to be used effectively by the wide range of stakeholders in the suicide prevention field, including people with disabilities, such as people with vision impairments.

# Web-based Integration of the Life is for Living Framework

Both sites allow for future upgrades and additions, such as discussion boards, forums, subscriptions and memberships, newsletters, multi-cultural content, etc. These functions would make the ***Life is for Living*** Practical Resources dynamic and interactive, allowing users from all backgrounds and interests to truly get involved in suicide prevention and contribute their own knowledge and experience. For example, an organisation managing a local suicide prevention project could update the ir project outcomes onto the website, enhancing knowledge in the field and encouraging partnerships and networking.

### How the two website prototypes differ from each other

Although both prototypes have much in common, they also differ in a number of ways, each with their own advantages as a result of their differing styles and approach to website design and development. For the purposes of accessing and refining the alternative prototype websites, a "gateway" website www.lifeisforliving.net has been developed from which access can be gained to both prototypes.

The advantages of each of the prototype websites are highlighted below.

## DDSN Interactive–

http://life.staging.ddsn.com

DDSN Interactive is a Melbourne-based website development company which creates functional, adaptable websites using a systematic methodology.

- **Where am I?** – each webpage shows exactly where a user is on the site, making it easy to navigate the site or return to previous pages.
- **Traditional style and consistent design** – the site employs a more traditional style that is familiar, uncluttered and simple. This ensures that all users, regardless of their computer and internet literacy, can easily navigate the site. The design also utilises images from the hard-copy documents, ensuring consistency throughout the ***Life is for Living*** package.
- **Drop-down boxes and hierarchical menus** – drop-down boxes from each menu item on the home page allow users to see what topics are covered under each broad heading, making finding the most relevant information faster. Once a topic has been chosen, sub-headings are shown in the menu on the left-hand side, shown in a logical order.
- **Extensive user-testing** – DDSN Interactive conducted extensive consultation with a range of potential users of the site. This allowed them to test the efficacy of the website structure and design, ensuring that the website prototype is based on real people's needs and capabilities.

# Web-based Integration of the Life is for Living Framework

## The Oxygen Kiosk –

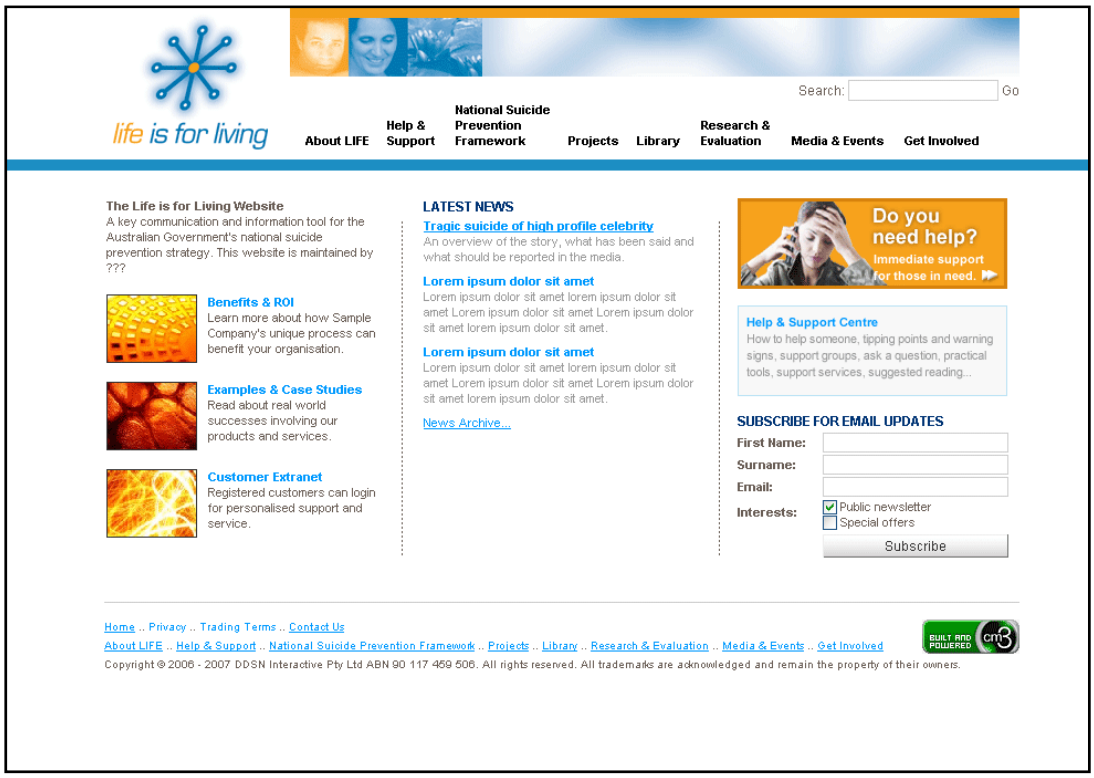
http://lifeisforliving2.net

The Oxygen Kiosk are a small, Brisbane-based website development and design agency that focuses on creating functional, intuitive and modern websites that are interactive and very easy to update.

- **Interactive search function** – the search function of this website automatically lists the related articles and pages as you search. For example, if a user searched for "evaluation", a list of the most related articles would appear under the search box as the word was typed. This allows for quick and easy accessing of the most related information, without waiting for a full search of the site. However, once the search is complete (i.e. the "search" button has been clicked), a full list of all related articles, links and pages appears, providing access to all available information related to the topic of interest.
- **Simple content management** – each piece of information on the website (such as a link to another website) is entered into the website as a single entity and can be linked to any area of the website. This means that when a change is made once, it is propagated throughout the site, without having to change the information on every page where it is shown. Similarly, new content need only be added once and it can be attached to all appropriate areas of the site with the simple click of a button.
- **Linked content** – all the information shown on the site is intricately linked using keywords. As a result, a list of related content and links are shown at the bottom of every page, making it easy for users to find and access other content which interests them.
- **Modern design and style** – the developers have created a modern, stylish and edgy design that would appeal to a wide range of audiences, from young, internet-savvy users to academics and service providers in the suicide prevention field.
- **Content driven** – the structure of the lifeisforliving2.net site is driven by the content, linking information in the most intuitive way and structuring the site around the most relevant content.

# Web-based Integration of the Life is for Living Framework

## DDSN Interactive Website




## The Oxygen Kiosk Website

# Web-based Integration of the Life is for Living Framework

## Summary and Recommendations relating to web site prototypes

The provision of two prototype websites is over and above the contractual requirements. The two prototypes have been provided to give the Australian Government Department of Health and Ageing and the sector two different perspectives on how the ***Life is for Living*** Resources might best be organised and accessed.

It is recommended that the best aspects of each of the website prototypes be combined to produce the final ***Life is for Living*** website. The resultant website will guide the implementation of the ***Life is for Living*** Framework by providing access to the ***Life is for Living*** documents and the wide range of other resources relevant to suicide prevention in an easy-to-use, easily updatable format. The project consultations with the sector suggest that the final website should be intuitive to use, have a design and style that appeals to a broad range of target audiences and be consistent with the hard-copy ***Life is for Living*** documents, while still being modern and eye-catching.

The ***Life is for Living*** website prototypes should be extensively tested with a range of users to ensure that the structure and layout of the sites are instinctive and practical. It may also be appropriate to create a number of related websites, each targeting a different interest group, using different designs and layouts and containing relevant content for each group, supporting the overall dissemination, advocacy and utilisation strategy for the ***Life is for Living*** Resources.

The ***Life is for Living*** website will also require a system for maintenance and management, including regular monitoring, quality control and updating of the content displayed on the site. It is suggested that this be done by a central office, with combined experience and expertise in website and multimedia management as well as in suicide prevention.

Please note that these website prototypes are intended to demonstrate how the ***Life is for Living*** documents and the range of other resources and information could be displayed and accessed. The content shown on the prototype websites has been included as a demonstration and will need to be updated.