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6 Strategic frameworks for preventing and reducing suicide by young people

6.1 Introduction

The research literature recognises that, because there is no simple explanation and no single solution for suicide, suicide prevention ‘requires concerted action on many fronts and a strategic framework to integrate these efforts’.¹⁴² This chapter provides an overview of the major strategic frameworks for suicide prevention that are in operation in Western Australia. These are the strategic frameworks that have been promoted at a national level by the Australian Government¹⁴³ and at a state level by the Western Australian Government.¹⁴⁴

These strategies aim to provide an overarching framework for the suicide prevention activities that are occurring at all levels in the community, to integrate existing activities into the framework, to identify where gaps exist and to stimulate additional activities by public, private and not-for-profit organisations to fill these gaps. The Office also analysed the extent to which the existing strategic frameworks correspond to the patterns in the factors associated with suicide identified during the investigation and discussed in Chapter 5.

6.2 Suicide prevention models

The research literature refers to a model of interventions for mental health problems developed by Mrazek and Haggerty in 1994 entitled *The spectrum of interventions for mental health problems and mental disorders (the Mrazek and Haggerty model)*.¹⁴⁵ This model continues to underpin current thinking about suicide prevention strategies. The Mrazek and Haggerty model divides interventions for mental health problems into three categories - Prevention, Treatment and Continuing Care – and further into eight domains associated with each of these categories (Figure 31).

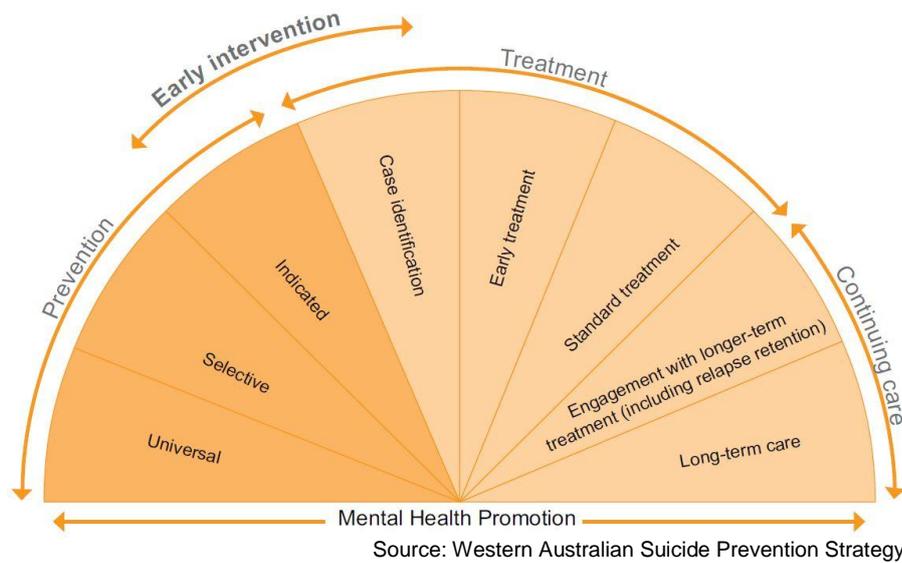
¹⁴² Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 30; Australian Government, Department of Health and Ageing, *National Suicide Prevention Strategy*, Australian Government Publishing Services, Canberra, 2012, p. 10.

¹⁴³ Australian Government, Department of Health and Ageing, *National Suicide Prevention Strategy*, Australian Government Publishing Services, Canberra, 2012; Australian Government, Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, Government Publishing Services, Canberra, 2013.

¹⁴⁴ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009.

¹⁴⁵ P Mrazek & R Haggerty (eds), *Reducing risks for mental disorders: frontiers for preventative intervention research*, National Academy Press, Washington, 1994.

Figure 31: Spectrum of interventions for mental health problems and mental disorders



More recent research recognises that ‘failures in complex systems tend to occur primarily at the points of handover of responsibilities’¹⁴⁶ and identifies the need to modify the Mrazek and Haggerty model to:

...respond to the need for support and care in the gaps between the model’s segments. Community-based safety nets are needed to bridge these gaps which focus on providing the support needed by people who are feeling suicidal and are in transition between stages of professional care and support.¹⁴⁷

Studies of suicide among Aboriginal young people have taken a slightly different approach, stating that preventing suicide by Aboriginal young people ‘should be the business of all agencies that deal with child and youth development and wellbeing.’¹⁴⁸ The complexity of the causes of suicide ‘requires a sustained, strategic and transparent program of investment in multiple service interventions, service coordination and ongoing research to build the evidence based on effective and practical ways to prevent the loss of life.’¹⁴⁹

Within each category of suicide prevention strategies, a range of State government departments and authorities, health professionals, private sector and non-government organisations are currently providing information, services and support to prevent or reduce the risk of young people taking their own life. As part of these efforts, Aboriginal and non-Aboriginal organisations are working with Aboriginal communities to prevent or reduce the risk of suicide among Aboriginal young people in particular.

¹⁴⁶ Australian Government, Department of Health, *Living Is For Everyone: Research and Evidence in Suicide Prevention*, Australian Government Publishing Services, Canberra, 2007, p. 26.

¹⁴⁷ Australian Government, Department of Health, *Living Is For Everyone: Research and Evidence in Suicide Prevention*, Australian Government Publishing Services, Canberra, 2007, p. 26.

¹⁴⁸ Menzies School of Health Research, *Suicide of Children and Youth in the NT 2006-2010*, Darwin, 2011, p. 41.

¹⁴⁹ J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 14.

6.3 National level strategic frameworks

6.3.1 The *National Suicide Prevention Strategy*

The *National Suicide Prevention Strategy (the National Strategy)* states that it provides 'the platform for Australia's national policy on suicide prevention with an emphasis on promotion, prevention and early intervention.'¹⁵⁰

A key component of the National Strategy is the Living Is For Everyone (LIFE) Framework (**the LIFE Framework**). The LIFE Framework's *Continuum of Suicide Prevention Activities* '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.'¹⁵¹ In recognition of the recent research literature that identifies that community-based safety nets are needed to bridge the gaps between the segments of the Mrazek and Haggerty model, as discussed above, the LIFE Framework's *Continuum of Suicide Prevention Activities* now also includes the following specific features:

- recognition that people respond to, and cope with, life events differently and vary in their vulnerability and resilience. A person may move with no apparent warning from apparent good health directly into distress and a need for immediate specialised care; and
- community-based safety nets to support people as they move from one treatment setting to another.¹⁵²

Further, 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.'¹⁵³ The LIFE Framework identifies the following six Action Areas:

- Action Area 1 - Improving the evidence base and understanding of suicide prevention;
- Action Area 2 - Building individual resilience and the capacity for self-help;
- Action Area 3 - Improving community strength, resilience and capacity in suicide prevention;
- Action Area 4 - Taking a coordinated approach to suicide prevention;
- Action Area 5 - Providing targeted suicide prevention activities; and
- Action Area 6 - Implementing standards and quality in suicide prevention.

¹⁵⁰ Australian Government, Department of Health, *National suicide prevention strategy*, October 2012, viewed 14 March 2014, <<https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-nsps#com>>.

¹⁵¹ Australian Government, Department of Health and Ageing, *A Framework for Prevention of Suicide in Australia*, Australian Government Publishing Services, Canberra, 2008, p. 21.

¹⁵² Australian Government, Department of Health, *Living is for everyone, A Framework for Prevention of Suicide in Australia*, Australian Government Publishing Services, Canberra, 2007, p. 18.

¹⁵³ Australian Government, Department of Health and Ageing, *A Framework for Prevention of Suicide in Australia*, Australian Government Publishing Services, Canberra, 2008, p. 6.

6.3.2 The *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*

In May 2013, the Australian Government Department of Health and Ageing released the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (the ATSI Strategy)*. This responds to the recommendation of the Senate Community Affairs References Committee in 2011 that ‘...the Commonwealth Government develop a separate suicide prevention strategy for indigenous communities within the *National Suicide Prevention Strategy*.’¹⁵⁴

The Foreword to the ATSI Strategy recognises that ‘suicide is a complex and multidimensional issue...This is even more so for Aboriginal and Torres Strait Islander peoples who are experiencing suicide within their communities at approximately twice the rate of the rest of the population.’

In common with the National Strategy, ‘the overarching objective of the [ATSI] Strategy is to reduce the cause, prevalence and impact of suicide on individuals, their families and communities.’

The ATSI Strategy identifies six Action Areas that align with the Action Areas in the National Strategy but are in a different order ‘to reflect the logic of engagement of Aboriginal and Torres Strait Islander communities and the priority that needs to be given to supporting community leadership and community action in suicide prevention.’¹⁵⁵

A critical factor for suicide prevention identified by the ATSI Strategy is that Indigenous communities that have strong cultural continuity have significantly lower rates of suicide among their young people:

...the association between Indigenous communities that have a strong ‘cultural continuity’ with significantly lower rates of suicide among their young people, in comparison to communities under cultural stress. In broad terms, cultural continuity refers to self-determination and cultural maintenance. It is thought that young people from a strong cultural background have a sense of their past and their traditions and are able to draw pride and identity from them.¹⁵⁶

The ATSI Strategy identifies the need for culturally competent services that provide culturally safe management and treatment based on Aboriginal peoples’ understanding of culture, family and connection to the land. An example of quality indicators for such services can be found in the *Operational Guidelines for Aboriginal and Torres Strait Islander Suicide Prevention Services*, as follows:

- provide culturally safe, non-triggering management, treatment and support to Aboriginal and Torres Strait Islander peoples at high risk of suicide or self-harm at a critical point in their lives and to mitigate the reverberations from suicide in the client’s community;

¹⁵⁴ The Senate Community Affairs Reference Committee, *The Hidden Toll: Suicide in Australia*, The Senate Printing Unit, Canberra, 2010.

¹⁵⁵ Australian Government, Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, Australian Government Publishing Service, Canberra, 2013, pp. 26-45.

¹⁵⁶ Australian Government, National Mental Health Commission, *A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention*, NMHC, Sydney, 2013.

- be staffed by administrators and clinicians that are trained and understand mental health and suicide prevention cultural safety;
- establish management protocols that reflect the multiple levels of diversity found in modern Aboriginal and Torres Strait Islander populations; and
- be based on Aboriginal and Torres Strait Islander peoples' definitions of health, incorporating spirituality, culture, family, connection to the land and wellbeing and grounded in community engagement.¹⁵⁷

6.4 State level strategic framework – the *Western Australian Suicide Prevention Strategy 2009-2013: Everybody's Business*

The *Western Australian Suicide Prevention Strategy 2009-2013: Everybody's Business (the State Strategy)*, also known as the *One Life Strategy*,¹⁵⁸ is based on the National Strategy and is designed to 'provide the foundational framework for the State government to coordinate and invest in suicide prevention strategies at all levels in the community.'¹⁵⁹ The State Strategy is designed to 'implement a comprehensive strategy with a particular emphasis on young people, young men, Aboriginal people and people who live in rural and regional Western Australia.'¹⁶⁰

The State Strategy identifies that the 'National Suicide Prevention Strategy: *Living Is For Everyone* (LIFE) offers a framework from which new suicide prevention initiatives will be developed and delivered in Western Australia.'¹⁶¹ It identifies six Action Areas that mirror those in the National Strategy.

The State government has committed \$13 million over the four years 2009-2013 to implement the State Strategy.¹⁶² On 7 August 2013, the Minister for Mental Health, Disability Services and Child Protection, the Honourable Helen Morton (**the Minister**), advised that funding for suicide prevention under the State Strategy would be available until December 2013.¹⁶³

The Minister is responsible for leading the State Strategy and 'has been mandated by Cabinet to ensure that all State government departments prioritise suicide prevention and participate in a coordinated response to the issue.'¹⁶⁴ The Minister has given responsibility

¹⁵⁷ Australian Government, National Mental Health Commission, *Targeted prevention in Aboriginal and Torres Strait Islander communities*, viewed 14 March 2014, <<http://www.mentalhealthcommission.gov.au/our-report-card/preventing-suicide/in-focus.aspx>>.

¹⁵⁸ Ministerial Council for Suicide Prevention, '*One Life Strategy*', Perth, 2008, viewed 26 November 2013, <www.onelifewa.com.au/one-life-strategy/>.

¹⁵⁹ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 8.

¹⁶⁰ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 4.

¹⁶¹ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 31.

¹⁶² Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 3.

¹⁶³ Western Australia, Legislative Council, Debates, pp. 2858d-2859a.

¹⁶⁴ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy, Everybody's business, 2009-2013*, Department of Health, Perth, 2009, p 3.

for the implementation of the State Strategy to the Ministerial Council for Suicide Prevention (**the Ministerial Council**) which comprises 'suicide prevention experts, community, corporate and government organisations and people who have been impacted by suicide.'¹⁶⁵

The government funding associated with the State Strategy is the responsibility of the Mental Health Commission and the Commissioner for Mental Health is accountable through the Minister to Parliament for this funding. The Commissioner is also a member of the Ministerial Council.¹⁶⁶ In addition, the Mental Health Commission has responsibility for strategic policy, planning, purchasing and monitoring of mental health services generally in Western Australia.¹⁶⁷

On 16 June 2010, the (then) Minister, Dr Graham Jacobs, announced that Centrecare had been appointed as the preferred non-government organisation to implement the State Strategy.¹⁶⁸ Centrecare has responsibility for the day to day work of the Ministerial Council, the development of community awareness initiatives and the coordination of training, research and evaluation of suicide prevention strategies across Western Australia.

As a part of the implementation of the State Strategy, Centrecare has engaged Local Community Coordinators to support local communities in mapping existing suicide prevention activities and determine the need for future initiatives that will be documented in Community Action Plans.¹⁶⁹ As at 7 August 2013, there were 45 Community Action Plans in 255 locations across the state.¹⁷⁰

Centrecare has entered into a partnership arrangement with Edith Cowan University to conduct the research and evaluation components of the State Strategy as an independent entity.¹⁷¹ The Minister, stated on 7 August 2013: '[T]he evaluation results [by Edith Cowan University] will inform the direction of the strategy past 2013...the government made a clear statement that the suicide prevention strategy will continue...'¹⁷²

In addition, the Office of the Auditor General is undertaking a performance audit focusing on whether the State Strategy has been successful in delivering effective, sustainable action to reduce suicide.¹⁷³

¹⁶⁵ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy, Everybody's business*, 2009-2013, Department of Health, Perth, 2009, p. 3.

¹⁶⁶ Ministerial Council for Suicide Prevention, *One Life Strategy: The Western Australian Suicide Prevention Strategy is a call to action*, Perth, viewed 26 November 2013, < www.onelifewa.com.au/one-life-strategy/ >.

¹⁶⁷ Government of Western Australia, Mental Health Commission, *Mental Health 2020: Making it personal and everybody's business. Reforming Western Australia's mental health system*, Mental Health Commission Perth, 2010, p. 5.

¹⁶⁸ Western Australia, Legislative Assembly, Debates, pp. 3895b-3895b.

¹⁶⁹ Centrecare, *Suicide Prevention*, Perth, 2014, viewed 26 September 2013, <<http://www.centrecare.com.au/counselling-support-services-2/metropolitan-services/suicide-prevention/>>.

¹⁷⁰ Western Australia, Legislative Council, Debates, 7 August 2013, p2858d-2859a; Western Australia, Legislative Assembly, Estimates Debates, 21 August 2013, pp. 395b-407a.

¹⁷¹ Centrecare, *Suicide Prevention*, Perth, 2014, viewed 26 September 2013, <<http://www.centrecare.com.au/counselling-support-services-2/metropolitan-services/suicide-prevention/>>.

¹⁷² Western Australia, Legislative Council, Debates, pp. 2858d-2859a.

¹⁷³ Office of the Auditor General, *Current Audits 2013, Perth, 2013*, viewed 17 March 2014, <<https://audit.wa.gov.au/work-in-progress/current-audits/#PASSSP>>.

6.5 Implications of the patterns identified by the investigation

6.5.1 Different suicide prevention activities may be relevant to each of the four groups of young people

The State Strategy recognises Mrazek and Haggerty's model as providing 'a useful way to conceptualise suicide prevention'.¹⁷⁴ The State Strategy contains a simplified version of the Mrazek and Haggerty model, including its three categories of suicide prevention - Prevention, Treatment and Continuing Care – and its eight domains. The State Strategy also discusses the types of actions that would be taken in each domain.¹⁷⁵ This way of understanding suicide prevention is shown in Figure 32 below.

¹⁷⁴ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy, Everybody's business, 2009-2013*, Department of Health, Perth, 2009, p. 29.

¹⁷⁵ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy, Everybody's business, 2009-2013*, Department of Health, Perth, 2009, p. 30.

Figure 32: Categories and domains of suicide prevention activities

Domain	Activities associated with this domain
<i>Prevention Category</i>	
1.Universal Intervention	Activities that apply to everyone (whole populations) and result in 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.
2.Selective Intervention	For communities and groups potentially at risk and result in building resilience, strength and capacity and an environment that promotes self-help and help-seeking and provides support.
3.Indicated Intervention	For individuals at high risk and result in building strength, resilience, local understanding, capacity and support; being alert to early signs of risk; and taking action to reduce problems and symptoms.
<i>Treatment Category</i>	
4.Symptom Identification	Activities that are appropriate when vulnerability and exposure to risk are high, which result in being alert to signs of high risk, adverse health effects and potential tipping points; and providing support and care.
5.Early Treatment	Activities for finding and accessing early care and support, which result in providing first point of professional contact; targeted and integrated support and care; and monitoring and ensuring access to further information and care.
6.Standard Treatment	Activities that are appropriate when specialised care is needed and result in providing integrated professional care to manage suicidal behaviours and improve wellbeing as a step in recovery.
<i>Continuing Care Category</i>	
7.Longer-term Treatment and Support	Activities for preparing for a positive future, providing ongoing integrated care to consolidate recovery and reduce the risk of adverse health effects.
8.Ongoing Care and Support	Activities for 'getting back into life'...building strength, resilience, and adaptation and coping skills, and an environment that supports self-help and help-seeking.

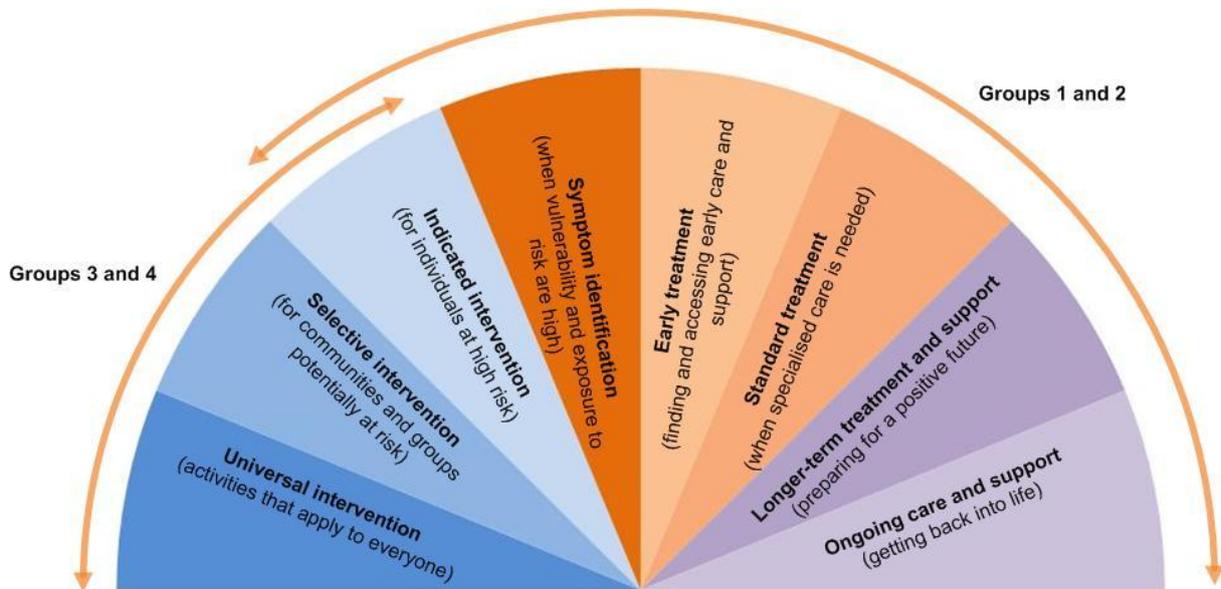
Source: LIFE Framework¹⁷⁶ and Ombudsman Western Australia

The Office's analysis in Chapter 5 indicates that the four groups of young people experienced different factors associated with suicide. The Office analysed how the patterns in the factors associated with suicide experienced by the 36 young people,

¹⁷⁶ Australian Government, Department of Health, *Living is for everyone, A Framework for Prevention of Suicide in Australia*, Australian Government Publishing Services, Canberra, 2007.

aligned with the categories and domains of suicide prevention activities. The Office's analysis found that each of the four groups may be aligned with different, albeit overlapping, domains of suicide prevention activities. This alignment is illustrated below.

Figure 33: Alignment between the patterns identified by the investigation and the domains for suicide prevention, as discussed in the LIFE framework



Source: LIFE Framework and Ombudsman Western Australia

Accordingly, different suicide prevention activities may be relevant to each of the four groups of young people, as follows:

- **Group 1** comprised 20 young people who all were recorded as having allegedly experienced one or more forms of child maltreatment, with most also recorded as experiencing mental health problems and suicidal ideation and behaviour. Suicide prevention activities that may be aligned with the characteristics of the young people in Group 1 involve recognising and addressing the impacts of child maltreatment and other mental health problems through: symptom identification; providing early, standard and/or longer term treatment; and providing ongoing care and support.
- **Group 2** comprised five young people who were recorded as either having been diagnosed with one or more mental illnesses, having a parent who had been diagnosed with a mental illness and/or demonstrating significant planning of their suicide. Suicide prevention activities that involve symptom identification and early, standard and longer term treatment of mental health problems may be aligned with the characteristics of the young people in Group 2, along with activities to provide ongoing care and support.
- **Group 3** comprised six young people who were recorded as having experienced few factors associated with suicide except for two young people who were recorded as having experienced suicidal ideation. These young people were recorded as being highly engaged in school and highly involved in sport. Universal, selective and indicated interventions, such as those already provided for under the State Strategy,

may be aligned with the characteristics of the young people in Group 3. However, it may also be important to consider whether research into suicide by young people who did not experience the currently identified factors associated with suicide, such as those young people in Group 3, should be conducted to develop a greater understanding of this group and inform future suicide prevention activities.

- **Group 4** comprised five young people who were recorded as having experienced few factors associated with suicide, except for four young people who were recorded as having demonstrated suicidal ideation and behaviour and/or engaged in substance use. However, the Office observed that all five young people were recorded as having demonstrated impulsive or risk taking behaviour. Universal interventions may be aligned with the characteristics of the young people in Group 4. In addition, three young people in Group 4 were Aboriginal, and three young people resided in a regional, remote or very remote area. Chapter 3 identified that Aboriginal young people are at significantly elevated risk of suicide, as are young people residing in a rural area. Accordingly, selective and indicated interventions, which target communities and individuals at risk, may also be aligned with the characteristics of the young people in Group 4.

Recommendation 1: As part of the development of the State Strategy past 2013, the Mental Health Commission considers developing differentiated strategies relevant to each of the four groups of young people, taking into account the findings of the investigation regarding the demographic characteristics of the 36 young people who died by suicide, the factors associated with suicide they experienced, and their contact with State government departments and authorities.

Recommendation 2: The Mental Health Commission, in collaboration with relevant stakeholders, considers whether it may be appropriate to undertake, or facilitate the undertaking of, mental health literacy and suicide prevention activities for those young people who demonstrate few factors associated with suicide, as identified by the investigation.

6.5.2 Preventing and reducing suicide by young people may involve symptom identification, treatment and continuing care for young people who have experienced child maltreatment and mental health problems

The State Strategy identifies that it is focused on the Prevention category of the Mrazek and Haggerty model, which comprises activities that ‘... can be targeted universally at the general population, they can focus on selective at-risk groups or they can be directed to those at risk as required.’¹⁷⁷ As shown in Figure 33 and discussed above, the Office’s analysis also indicates that suicide prevention activities in the Prevention category may be important and should continue. In addition, the Office’s analysis indicates that the factors

¹⁷⁷ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy, Everybody’s business, 2009-2013*, Department of Health, Perth, 2009, p. 6.

associated with suicide experienced by 25 (69 per cent) of the 36 young people may align with the Treatment and Continuing Care categories of the Mrazek and Haggerty model.

6.5.3 State government departments and authorities potentially have an important role to play in preventing and reducing suicide by young people, including the Department of Health, the Department for Child Protection and Family Support and the Department of Education

The State Strategy identifies that State government departments and authorities have an important role to play in suicide prevention. The State Strategy recognises that:

Effective suicide prevention in Western Australia requires a coordinated approach across all levels of government and the whole of the community. It is important for all government agencies to deliver integrated policies, programs and responses to improve suicide prevention.¹⁷⁸

The Office's analysis, discussed in Chapter 5, is consistent with this. Records indicate that all of the 36 young people had contact with State government departments and authorities at some point in their lives. Thirty-one of the 36 young people (86 per cent) were recorded to have had contact with multiple State government departments and authorities. These 31 young people were across Groups 1 to 4.

Chapters 7 to 9 of this report contain detailed analysis of the contact by the 36 young people with three State government departments and authorities who potentially have an important role to play in addressing the factors associated with suicide identified by the Office's analysis. These are the Department of Health's Child and Adolescent Mental Health Service (**CAMHS**), the Department for Child Protection and Family Support (**DCPFS**) and the Department of Education. The recommendations in these sections are largely concerned with activities that align with the Treatment and Continuing Care categories of the Mrazek and Haggerty model. The recommendations complement the State Strategy's existing focus on the Prevention category of the Mrazek and Haggerty model. The recommendations could be considered as part of the development of the State Strategy past 2013.

Although Chapters 7 to 9 discuss three of these departments separately it is not intended that these chapters are separable or that the departments work in isolation of each other. This point is discussed further in Chapter 10.

Recommendation 3: As part of the development of the State Strategy past 2013, the Mental Health Commission gives consideration to whether the scope of the State Strategy should be expanded to encompass the Treatment and Continuing Care categories of suicide prevention, by incorporating the investigation's recommendations about ways that State government departments can prevent or reduce suicide by young people.

¹⁷⁸ Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy, Everybody's business, 2009-2013*, Department of Health, Perth, 2009, p. 6.

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