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Influencing public awareness to prevent male suicide.

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Introduction

This paper reports key findings from a formative evaluation of a suicide prevention public awareness campaign - Choose Life, North Lanarkshire (hereafter NL). The prime focus here is on preventing male suicide, although the evaluation focus was broader. The paper explores how **far** the public campaign supports a co-ordinated, community based direction for suicide prevention work, and examines how good practice can be identified, spread, and sustained.

Across Europe, suicide rates are 3 times higher for men than women (European Commission, 2011). Suicide remains the leading cause of death in men in the 30-39 age range in the EU27 countries, and accounts for over two-thirds of all fatal injuries among young people (15-24 years) (European Commission, 2011). In the UK, while suicide rates per 100,000 have tended to be highest among young men aged 15–44, rates for men aged 45–74 have been increasing and in 2010 this age group had the highest rates (Office of National Statistics, 2012). In Scotland, where around three-quarters of suicides are men (General Register Office for Scotland, 2012), by 2009 the highest suicide rate for all males was in the 30-39 age range, followed by 40-49 (Samaritans, 2011).

Suicide prevention work is inseparable from addressing inequalities and social exclusion (Scottish Government, 2010). Socio-economic inequalities in suicide are pervasive across Europe (Lorant et al., 2005). In Scotland, suicide rates in the most deprived 30% of areas are significantly higher than the national average (The Scottish Public Health Observatory, 2012). Prolonged unemployment is a major risk factor (Stuckler et al., 2009; McLean et al., 2008; Kinderman and Tai, 2008), increasing risks of social isolation and anxiety (Institute of Public Health in Ireland, 2011), with correlations

between male suicide rates and rising unemployment in European and in Asian countries (Cooper, 2011; Pritchard, 1992; Chang et al., 2009).

The region in which the Choose Life NL campaign has been conducted is characterised by the relatively young population, high poverty, low income levels, and high unemployment in more deprived localities (especially among males – at 11.2% in NL, July 2010-June 2011) (Nomis, 2012). Patterns of suicide may be expected to change, responding to demographic trends, ideas and practices of masculinity, and socio-economic conditions. This fluidity raises concerns about rising levels among middle-aged, and unemployed men (Samaritans, 2012), as well as persistent high levels among young men.

A systematic review for the Scottish Government identified socio-economic risk factors, along with substance misuse, previous mental illness, previous self-harm, and other individual factors. Protective factors include employment, family connectedness, and social support (McLean et al; 2008). This model, however, leaves high male rates unexplained. The review found 'gaps in evidence' around possible risk including isolation and non-help seeking, and possible protective values of help-seeking, neighbourhood quality and social connection. These 'missing' factors will intersect with gender, influencing suicide and suicide prevention. There are indications, explored below, that aspects of *social connectedness* supporting men to communicate about vulnerability may help protect those at risk from suicide. This focus on communication and gender underpins a campaign which emphasises talk about suicide among men.

The ways men are socialised to communicate vulnerability and the ways others communicate can constitute a *risk factor* for suicide according to a recent evidence review of men's mental health (Wilkins, 2010). Qualitative evidence indicates that some men concur with a version of masculine self-belief that sees emotional help-seeking as an indicator of weakness (O'Brien et al., 2005), and

quantitative evidence suggests many young men at heightened risk of suicide may be more likely to act out rather than talk about feelings: a third of the depressed and potentially suicidal groups in a survey of 1344 young male respondents would "smash something" if they were worried or upset (Samaritans, 1999). Evidence suggests fewer men than women would talk to friends about feeling unhappy (Mind, 2009), and that male levels of social support and contact with friends can be lower (Pevalin and Rose, 2003). With lower support and trust, people are more likely to report feelings of poor health and well-being (Boreham et al., 2000).

A further issue concerns stigma and mental health (Goffman, 1963). Assigned a label of *mental illness*, a person may take on a stigmatised identity (Corrigan and Wassel, 2008). This stigma can interact with concerns around men communicating vulnerability, reinforcing perceptions among men that talk about suicide is highly 'risky'. When men are positioned further as 'marginalised' (for example by long-term unemployment, or sexuality), this presents complex *disincentives* to communicating a need for help. Particular groups of men such as the homeless or long-term unemployed may mistrust some services, associating them with previous negative experiences around resources, organisational/administrative flexibility or attitudes (European Commission, 2010). Non-recognition or non-communication of emotional vulnerability can contribute to under-diagnosis of male mental health concerns (Kilmartin, 2005). Understanding the interaction of gender and other risk and protective factors is therefore vital to suicide prevention. A premise of the Choose Life campaign, with its strapline "Suicide, don't hide it. Talk about it", and focus on reaching out to men in leisure settings, is that in some socially 'trustworthy' settings men may be supported to talk about vulnerability and mental health. Previous media campaigns, which sought to raise suicide awareness and encourage help-seeking, have not consistently targeted particular groups of men in preferred lifestyle settings, and unfortunately, the evaluation of such campaigns has been limited (Robinson et al., 2012, Wood et al., 2010, Dumesnil and Verger, 2009).

The campaign

Choose Life campaign in NL began in 2007 building on the national Choose Life campaign, launched in 2002, which aimed for a reduction in suicides of 20% by 2013. The strategy highlights people affected by unemployment, in isolated or rural communities, recently bereaved, or homeless. In NL a particular focus was on the Choose Life National Objective of 'Awareness raising and encouraging people to seek help early', and on young males. The programme aims to help reduce suicide levels, through increased awareness of crisis service numbers such as Samaritans and Breathing Space and challenging the stigma around suicide.

The campaign was developed using aspects of a social marketing approach. Social marketing, defined for health promotion as 'the systematic application of *marketing concepts and techniques* to achieve specific behavioural goals, to improve health and reduce health inequalities' (French and Blair-Stevens, 2010, p.1), initially involves identifying problematic and desirable behaviours, and then focusing on effective communication with specific targeted groups. It is a 'programme-planning process' to 'promote voluntary behaviour change' (French and Blair-Stevens, 2010; Grier and Bryant, 2005). The campaign was selectively promoted to different age groups in targeted settings including Motherwell Football club, public transport, pubs, pharmacies, libraries, workplace washrooms, five-a-side football tournaments, music festivals, and community centres, and through national media, using support materials such as billboards, panels, posters, cards, DVDs, branded football products, newspaper, TV and radio. Desired 'intermediate' outcomes intended to contribute to long-term outcomes of suicide reduction include: improved public access to information; increased public knowledge; and reduced cultural stigma.

The evaluation team were appointed to conduct the Choose Life (NL) evaluation, from March 2011. The key evaluation questions were:

1. Has the programme been effective? Which aspects have been particularly effective?

2. How has the social marketing approach worked?

3. Has the programme benefitted the community, in particular young men aged 16-35?

4. What contribution has the community made to the programme's effectiveness?

Methods

Considering the complexity of the programme, (with multiple aims and outcomes, context-sensitive delivery, and some social marketing approaches) the evaluators adopted mixed quantitative and qualitative methods. It is especially important to focus on change processes in evaluating public awareness programmes engaging with the complexity of suicide prevention. A key campaign dimension is to foster culture change in public attitudes to male suicide, most likely a complex, on-going process, confronting stigma around mental ill-health, and masculinity. Change processes were explored through qualitative interviews with stakeholders and discussion groups with men, alongside the examination of campaign impact through a survey.

Phase one reviewed current datasets held by Samaritans, Breathing Space, and NL A&E admissions, examining whether the programme led to increased use of crisis numbers. Since service data systems did not permit robust comparisons, this phase is excluded here. Phase two included a survey of public awareness of the campaign in NL, approximately 3.5 years after the campaign had started, (including over 500 members of the general public with quotas for age (16-25, 26-35, 36-45, 46-55, 56+), gender, and location (Airdrie, Cumbernauld, Kilsyth, Motherwell, Wishaw). Sex and age quotas were calculated to account for differentiated suicide rates. Quotas for the five localities were proportional to the locality population. Localities were selected as they have suicide rates significantly worse than the Scottish average. The survey examined the effectiveness of the programme and its targeting, investigating any changes in public awareness of services, attitudes, and behaviour.

During phase two also, the same month as the survey, interviews with 20 key stakeholders were held to examine campaign processes and targeting. At Phase three, three months later, 10 discussion group events with men and women were held, each lasting 1.5-2 hours, at different geographical locations to provide insights concerning how, to what extent and for whom changes might have occurred; aspects of the social marketing programme which worked best; benefits to the community; and contributions the community were making to the programme. The age and gender composition of the groups (reflecting the priority targeting of the campaign to males) were: 3 x 16-25 male; 2 x 16-25 female; 1 x 26-35 male; 3 x 36+ male; 1 x 36+ female. Recruitment of members of the public was facilitated by 'champions' of community networks such as football supporters, community sports and arts, and youth music festival volunteers, identified through earlier stakeholder interviews. Discussions were recorded with digital voice recorders, and transcribed, and further session notes taken.

Descriptive analysis of survey data was carried out using PASW (SPSS), and inferential tests applied to examine the relationships between variables. Results were analysed by demographic variables to explore the role of sex, age and local area on results within the target population. Qualitative data was analysed using NVivo through descriptive and analytic coding, with codes then clustering under theme headings.

Ethics approval was granted through the appropriate University research ethics committee. Interview and discussion group participants received an explanatory information sheet in advance and were free to withdraw at any time. Digital-recording only occurred after written consent had been obtained. Individuals were assured that their anonymity would be protected during the reporting of findings.

Results

This section highlights the contribution of Choose Life to preventing suicide, indicating achievements of the campaign in relation to targeted 'intermediate' outcomes. The first sub-section on programme effectiveness draws on the quantitative survey, and subsequent sub-sections on how the social marketing programme worked and on community involvement draw on qualitative data. The article then reflects on how the achieved objectives and lessons learned might support wider change processes and longer-term goals.

Programme effectiveness.

The campaign raised the awareness of services of a substantial proportion of the general population. Among those with some awareness of the campaign (28% of all survey respondents), 39% (40% of male respondents) said this made them more aware of services which could provide information or help prevent a suicide, while 40% of respondents were already aware. The awareness of the campaign varied by age (people of 55 and under being relatively more aware), and by locality (with far higher awareness in Motherwell than other northern and rural regions of NL). The campaign may also have had some success in de-stigmatising public attitudes. There was a positive correlation between levels of campaign awareness and altered attitude in survey results (a Kendall's tau test indicated a significant relationships between level of campaign awareness and level of altered attitude, $\tau = .19$, $p < 0.01$). This correlation might also be influenced by those people with less stigmatising attitudes being more receptive, so attitude change was explored further in qualitative discussion groups.

Insert Table I: Altered attitudes, by level of awareness of campaign

Only a *higher* awareness level was strongly correlated with altered attitudes (Table 1). Almost half the campaign-aware survey respondents did not feel their attitudes had been altered. High campaign awareness also appears to be associated with changes in public behaviour. Those very

campaign-aware were more likely to have discussed, got information or sought help to support other people compared with those less aware as Table 2 below shows.

Insert Table II: Behaviour to support other people who might have mental health problems, by level of campaign awareness

The effects on behaviour vary by *gender*. Regarding behavioural intentions, as a result of the campaign more women (31%) than men (19%) who recognised the campaign stated they 'would now talk to someone' thinking about suicide (whereas 74% of men and 68% of women stated they would already have talked to someone). On the other hand, there was no significant difference by gender between those who would seek information or seek help. The only statistically significant difference between the sexes concerning actual behaviours was amongst those (women 29%; men 14%) who *had discussed* suicide and/or mental health with someone. Chi-square tests for independence indicated no significant associations between sex and getting information or seeking help in order to support others who might have mental health problems following the Choose Life campaign, yet a significant association was found between sex and discussing these issues, χ^2 (*n*=170) = 4.129, *p* = .042). An important consideration in the comparatively low levels of behaviour change overall is regional variation. Compared to the average across localities, significantly higher proportions of Motherwell (31%) respondents said they had discussed these issues, whilst significantly lower proportions of Wishaw (4.7%) respondents had done so. Since the campaign was concentrated most intensively in Motherwell, (e.g. at Motherwell football club), this helps to explain lower region-wide levels of impact to this time.

How has the social marketing approach worked*?*

The campaign's social marketing approach used only some social marketing methods. Benchmarks within the UK National Social Marketing centre's guidance for good social marketing practice are shown in Box 1 (Department Of Health, 2008).

Insert Box I: Social Marketing Benchmarks

The campaign targeted demographic groups (younger men and families) in *trusted* settings (for example football stadia) supposedly reflecting lifestyle choices. The campaign's behavioural goals include the public discussing suicide and men calling for help, while the composite national programme included training and awareness-raising. However, the campaign was not initially built on extensive 'consultation' with the public. The evaluation discussion groups offer insights, 3.5 years into the local campaign, that could improve sustainability.

Discussion groups of men expressed the view that 'trusted' leisure contexts, for example Motherwell football ground, five-a-side tournaments, pubs and festivals, provided male-friendly environments where men particularly are subconsciously more receptive to health messages.

> "Life can be chaotic and problematic but if you go to football you generally don't give that [football] up, it's an escape so it really is a great place to advertise that" 26-35 m

Discussion groups highlighted the importance of focusing on different age groups. People over 50 might notice television adverts, while younger people (16-25) favoured messages in preferred lifestyle settings, such as retail outlets (fashion/food), and festivals (music). However, participants were unsure materials were reaching marginalised groups, commenting that more materials might be placed in job centres, and other social support settings. It was suggested the campaign might work further with neighbourhood community groups, to map leisure activities for targeted campaign work. This approach, mapping community activities and tapping on existing social networks, was described by stakeholders as 'asset-based'.

A mix of settings appealing to targeted groups and 'universal' settings was considered appropriate. Use of public transport (including taxis where drivers were trained to talk about suicide with men),

television and radio was reaching a wider public. However, messages (with call numbers) on passing

transport in busy spaces can make a fleeting impression.

> "It would be good seeing it on bus shelters where there's no moving." 16-25 m

Discussion groups highlighted the importance of clarity about target audiences and behavioural

goals. The message attracted attention, evoked hope, and challenged gendered and cultural

barriers. Yet, the lead strapline ("*Suicide. Don't Hide it . Talk about it.*") left some male participants

expressing uncertainty if the message to 'Talk' applied to them, the 'public', rather than only 'at-risk'

individuals, or if they should use the call numbers.

> "'Choose Life' is a good title but there needs to be something that says 'how do I identify
>
> with this? What am I meant to do?' " over 36 m

Journey of awareness, attitude change and engagement

The social marketing benchmark around a *theory* of behaviour change implies targeting varied

communications to people at different *stages*, along journeys of awareness, attitude change, and

sustained engagement. Discussion groups suggested that community arts could convey engaging

narratives of male survivors.

> "Drama groups could show how somebody might come to thinking in a suicidal way, but
>
> then end up not committing suicide because somebody's seen the campaign and reached
>
> out to them." 16-25 m

Has this programme been of benefit to the community, in particular young men aged 16-35?

The confidence and capacity of highly campaign-aware people, including young men, to talk to

others in their community or to seek help, was likely to have powerfully increased, discussion groups

suggested. Among highly aware men, it 'normalised' talk about suicide, and led to greater awareness

that it is *normal to feel 'low'* and to *communicate concern* about emotional well-being. More people could be *watchful* in the community, and less likely to stigmatise another's distress.

"We all agreed with that campaign we'd be more alert, more likely to talk to somebody."

over 36 m

However, the proportion of the adult population who were aware of the campaign may still be less than one-third (according to survey findings: 25% of female respondents, 29% of male respondents). Discussion groups confirmed survey findings that this awareness was greatest in geographical areas where campaign resources were concentrated. The campaign had some way to go in encouraging men to *discuss suicide*. Diversification might also ensure the campaign reached more peers and families of at-risk men. Men within minority groups (for example by ethnicity, or sexual orientation) may have been led by experience to mistrust what services will do with information.

"There are plenty of suicides about that. [Among Lesbian Gay Bisexual and Transgender people] 30% don't want to phone up and admit they have got a problem. Don't want to be a statistic." 16-25 m

What contribution has the community made to the effectiveness of the programme?
The campaign's successes were based on strong partnerships with community organisations and local businesses, such as Motherwell FC, and United Taxis. Embedding campaigning in community settings helped to normalise men talking about suicide and de-stigmatise mental health. Here, trained community members such as taxi drivers supported the campaign message, talking with men and signposting them to services. More such training should occur, men in discussion groups suggested. Community members' informal networks have extended the campaign, for example young people contributing to music festivals (e.g. 'Sound Minds') cascaded messages to peers. Building on these successes, a community development approach was advocated by stakeholders and members of the public, to spread and sustain the campaign.

Discussion

It is a challenging process to interpret evaluation findings from a complex programme. Nationally the programme has multiple strands and priority groups, organisational complexity around partnerships and funding, and local area flexibilities in scope and delivery (Mackenzie et al., 2007). In NL, the multiple aims, relations between intermediate and long-term goals, and overlap of local and national communications makes attribution more difficult.

Public awareness-raising campaign development.

The literature suggests two main approaches in public awareness campaigns *aiming to reduce suicidal acts*; type a: those using language with a focus on mental health, (e.g. Hübner-Liebermann et al., 2010; Hegerl et al., 2006) and type b: those using language with a sense of urgency and clear focus on intense distress and imminent action (e.g. King and Frost, 2005). Choose Life (NL) campaign belongs to type b, interestingly and unusually including direct reference to suicide. Within type b. campaigns, appealing to the public requires a targeted variety of resources, for the people at risk, e.g. specific online, radio and television presentations for young men who may be socially withdrawn (NHS Health Scotland, 2010), and for the general public who might influence them.

An interacting, coherent range of strategies and message*s* is needed to extend the public campaign beyond initial awareness-raising levels and support public engagement. Messages alert, but stories engage people, and can be used to explore the place of peer influencers, and to 'normalise' people who have suicidal thoughts. Positive Mental Attitudes in Glasgow makes use of film and community theatre workshops to discuss suicide prevention in communities and increase confidence (Quinn and Knifton, 2012); http://www.positivementalattitudes.org.uk/ . Story-based approaches could be adopted extensively in suicide prevention campaigns.

Gendered and non-gendered targeting.

Communication around practical activity has proved attractive to men (Robertson, 2007), so a good way to involve men who feel difficulty in discussing mental health issues can be to support them towards combining practical action with communication, for example arranging or participating in events, volunteering, and guiding others to services. To help men with this, training, already provided to taxi drivers, may need extending to include more men such as barbers, postal workers, and pub staff, and more community/voluntary sector workers in housing, sport, physical and leisure activities, music and arts, and clubs, who have frequent contact with men in the community, especially those at high risk. As women are responsive in discussing issues about suicide, their potential as cultural change agents (particularly within families) (O'Brien et al., 2007) should be carefully considered.

While the campaign succeeded in targeting young and early middle-aged men, there was work to do in reaching out to older people at risk, for example after retirement or unemployment, and to people in rural areas, and in sexual minorities (categories where male suicide rates are elevated) (Canetto and Clearly, 2012). It is particularly important to focus on middle aged men. In Scotland, by 2009, the male suicide rate highest in the early middle-age groups (30-49) (Samaritans, 2011), was accelerating most among middle-aged, unemployed white males who drink heavily (Samaritans 2012).

There is every reason to target boys and girls in schools more widely, as a substantial proportion of lifetime mental health concerns begin to emerge before adulthood (Scottish Government, 2011; HM Government, 2011). Supportive school environments are protective against the risk of suicide among young people (McLean et al., 2008). The openness of young people in terms of culture and identity perhaps lends itself to intervention during final years of primary school. Interventions might

focus on bullying, and young people's experience of friendships and isolation (Mac an Ghaill et al., 2012).

Conclusions

This paper has reported on key findings from the evaluation of a suicide prevention campaign targeting particular groups of the general public (predominantly, but not only, younger men) in specific settings. It has highlighted progress towards intermediate outcomes and offered considerations for future planning. The evaluation found some evidence of raised capacity and confidence of targeted sections of the public to seek and give help across networks of influence. However evidence of attitude transformation and behaviour change is more limited. This can partly be explained by cross-regional resource disparities, complexities of cultural change processes and protracted time required to support change. Because the campaign with its limited social marketing approach and resources, was not, initially, deeply embedded in community processes region-wide, it had so far achieved uneven geographical reach to disadvantaged areas (e.g. Cumbernauld), and limited access to 'hard-to-reach' groups, such as unemployed men away from football stadia. It is important for suicide awareness campaigns to target priority groups precisely, and strengthen community-centred partnerships to reach existing/emerging high risk groups.

Asset-based approaches to sustainable programme development are recommended which 'value the capacity, skills and knowledge and connections in individuals and communities. They focus on the positive capacity of individuals and communities rather than solely on needs, deficits and problems' (Mclean, 2011, p.4). Participatory processes should be undertaken early in programme planning to offset opportunity costs of limited asset mapping. It is also important for suicide prevention programmes to sustain and increase co-ordination of national and regional resources for example in materials development (including 'branded' design features); and improved co-ordination with wider mental health programmes.

Evaluation remains challenging, as changes under scrutiny are influenced by interacting programme elements (including, for example, training professionals) and other 'secular trends' (Mackenzie et al., 2007) (for example, austerity , economic recession and rising inequalities). Among the limitations of this paper, as the evaluation was commissioned mid-campaign, it was not possible to use longitudinal methods, nor to include evidence of interesting initiatives emerging from the evaluation. The findings rely on triangulation of a public survey, discussion groups and stakeholder 'accounts', without evidence of calls to diverse help-lines.

Nevertheless, this paper has reflected on insights from a complex suicide awareness-raising programme, exceptional and timely in its focus on targeted (male) sections of the public. The paper has indicated the importance of understanding the *intersection* of factors concerning male identity, stigma and mental health, and other risk and protective factors, including community engagement, which can inform campaigns highlighting male talk about suicide within a health inequalities framework.

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