Evaluation of the Choose Life North Lanarkshire Awareness Programme
Final Report
April 2012

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Acknowledgements

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Introduction

The Centre for Men's Health at Leeds Metropolitan University, with consultants from MRC Social and Public Health Sciences Unit, Glasgow, and Men's Health Forum, Scotland (MHFS), were appointed to conduct the Choose Life (North Lanarkshire) evaluation, beginning in March 2011. The key evaluation questions are:

1. How has the social marketing approach to increase awareness of crisis service numbers and de-stigmatise understandings and attitudes about suicide worked?
2. Has the programme as implemented been effective? Which aspects of the programme have been particularly effective?
3. Has this programme been of benefit to the community, in particular young men aged 16-35?
4. What contribution has the community made to the effectiveness of the programme?

The Choose Life public awareness raising programme in North Lanarkshire began in 2007 with the appointment of the programme Co-ordinator. The awareness raising campaign began the following year, in 2008. However, this campaign built on an earlier implementation Action Plan (2005) which also included training and media elements, and fits within the national Choose Life campaign which was first launched in December 2002. **Choose Life, the National Strategy and Action Plan to Prevent Suicide in Scotland**, launched in 2002 targeted a reduction in suicides of 20% by 2013. The national plan focuses on **seven objectives**.

- *Promoting Greater Public Awareness and Encouraging People to Seek Help Early*
- *Early Prevention and Intervention*
- *Responding to Immediate Crisis*
- *Longer Term Work to Provide Hope and Support Recovery*
- *Coping with Suicidal Behaviour and Completed Suicide*
- *Supporting the Media*
- *Knowing What Works*

The Choose Life priority groups include young people (especially young men) as well as children, people with mental health problems, people who have attempted suicide, people affected by the aftermath of suicidal behaviour and people in prison. The strategy also states the importance of focusing on people who are affected by unemployment, people in isolated or rural communities, recently bereaved, and people who are homeless.

In North Lanarkshire there has been particular focus on the Choose Life National Objective of 'Awareness raising and encouraging people to seek help early'. The North Lanarkshire Choose Life Plan (2005) outlines that the rationale for awareness raising work is to address myths surrounding suicide, reduce stigma associated with using services, and to encourage people to seek help early. The programme aims to help reduce the incidence of suicide, through increased awareness of crisis service numbers such as Samaritans and Breathing Space and the "de-stigmatisation" of understandings and attitudes about suicide. Desired outcomes include:
- Improved access to information on suicide and deliberate self-harm.
- Increased knowledge of suicide and self-harm.
- Reduced cultural stigma associated with suicide.

Social marketing, referred to in the first evaluation question above, has been defined for purposes of 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, 2006 p.1). The approach focuses on behaviour change and initially involves identifying relevant behaviours, both those which to be encouraged, and those which are aspects of the 'problem'. It has been further defined as a 'programme-planning process that applies commercial marketing (CM) concepts and techniques to promote voluntary behaviour change' that benefits society as well as the individual (Grier and Bryant, 2005; French and Blair-Stevens, 2006). The benchmarks that are featured within the UK National Social Marketing centre's guidance (DH 2008) as criteria for good social marketing practice include:

- o *Customer/consumer orientation, and insight* (understanding the target audience and seeing things from their perspective; consumer research informs the programme development);
- o *Audience segmentation* (segmenting the audience into distinct subsets that behave in a similar way or have similar needs). This can be done using demographics, geography, or behaviours, leading to developing an intervention to fit a specific rather than general audience;
- o *Defining clear behavioural change goals*; *using a theory* (of behavioural change). This involves having a clear vision of what the target audience is expected to do, and how they will change;
- o *Exchange.* This involves factoring in the perceived costs and benefits to the audience of changing behaviour;
- o *Competition.* This involves taking account of the factors and influences that 'compete' for the audiences' time, attention and inclination to behave in a particular way, and developing strategies to minimise the impact of competition;
- o *Solutions mix.* This involves having an appropriate range of activities and/or services in place to encourage people to achieve the desired action. It requires taking a strategic approach: including a full, long-term programme 'intervention mix' and not only a tactical, short-term 'marketing mix'.

This report presents findings from the Choose Life North Lanarkshire evaluation (see below). A brief literature review, setting the work in the context of evaluated campaigns which aim to reduce suicide and suicidal acts is included as Appendix 12.

Methods

The evaluation design is one of mixed quantitative and qualitative approaches to address the evaluation aims. Phase one involved a review of current datasets, including data held by Samaritans, Breathing Space, and North Lanarkshire A&E admissions. The aim of this was to ask whether the programme may have been effective (its impact) in relation to use of crisis numbers. Phase two included a. a survey of public awareness of the campaign in North Lanarkshire (including over 500 members of the general public with quotas for age, gender and location), and b. interviews with 20 stakeholders with particular involvement in the campaign. The aim of the survey was to further address question 2, concerning effectiveness of the programme, and question 3, concerning targeting. The aim of the qualitative stakeholder interviews was to provide formative insights to address question 1, concerning processes within the campaign, and question 4, concerning community contribution, as well as complementing the quantitative findings around programme effectiveness and targeting. Phase three of the evaluation included discussion group sessions with men and women. Six discussion events were held at four locations in Motherwell, Cumbernauld and Newarthill, to provide further insights into questions 1, concerning awareness of call numbers and de-stigmatising attitudes; 2, concerning the aspects of the programme which worked best; 3, concerning benefits to the community; and 4, concerning contribution the community makes to the effectiveness of the programme. During these sessions a total of 10 small groups were formed with the following age and gender composition: 3 x 16-25 male; 2 x 16-25 female; 1 x 26-35 male; 3 x 36+ male; 1 x 36+ female. Discussions during these sessions were recorded with digital voice recorders, and fully transcribed, and further session notes taken including plenary feedback on flipcharts. Quantitative analysis was conducted using PASW (SPSS). Descriptive analysis of survey data was

carried out at the outset to highlight actual responses, and a number of inferential tests performed to examine the relationships between variables. Results were analysed by demographic variables to examine the role of sex, age and local area on results within the target population. Qualitative data was analysed using NVivo through a process of descriptive and analytic coding with codes then clustering under theme headings. The following sections report on findings from the four components that made up the evaluation design in turn, beginning with the survey of the general public, then the stakeholder interviews, then the secondary data-sets, and lastly the discussion groups.

Key findings

Survey

The public survey (total sample size 521) assessed the extent to which the social marketing campaign has reached the community. The questionnaire considered changes in relation to community awareness of services, public attitudes, and behaviour. The areas with most awareness of the campaign among respondents are Motherwell and Wishaw, while much lower awareness levels were recorded in Cumbernauld and Airdrie. Campaign materials seen by respondents in Motherwell in/on taxis (as part of daily activities) and at Motherwell Football Club were recalled at higher levels than materials seen in other settings in other localities. The setting where most respondents recalled seeing campaign materials was taxi cabs. The campaign material recalled by most respondents was poster/billboard materials. Football-related materials were also recalled comparably well.

Of those respondents who had some awareness of the campaign, 39% said the campaign made them more aware of the services which would provide help or information on how to prevent a suicide, whilst 42% said they were already aware.
  o A higher percentage of male respondents than of female respondents said the campaign had made them more aware of services, whereas a slightly higher percentage of females were already aware.
  o More people among those with some awareness of the campaign thought their attitudes had been altered on some level than not at all.
  o Higher levels of campaign awareness are associated with greater change in attitudes.
While over 90% of respondents would talk to someone who might be thinking of suicide, over 20% said they would do so as a result of the campaign.
  o The most common activity following the campaign among men was getting information on suicide/mental health issues, whilst the most common activity amongst women was discussing these issues. Getting information was significantly associated with higher levels of campaign awareness.
  o Significantly more Motherwell respondents said they had discussed suicide and mental health issues following the campaign in comparison with those in other localities.

Stakeholders' views

Interviews were held by telephone or in person with 20 stakeholders with particular expertise and involvement in Choose Life North Lanarkshire. The stakeholders represented a range of voluntary and statutory services, and the campaign Co-ordinator's views were also sought.

The campaign *targeting* of deprived areas was considered appropriate, however, the geographical targeting had focused most effectively on Motherwell and southern parts of North Lanarkshire.
  o The combined campaign *focus* on whole population awareness and targeted segments e.g. young men was important for realising different levels of intervention.

o A holistic view of 'interdependent' campaign elements was taken by professionals. It is important to focus on organisations, networks and individuals to improve early intervention and increase community capacity.

The views of stakeholders about campaign *objectives* can be seen in terms of their fit with change processes for communities, organisations and individuals. Stages of the change 'journey' mentioned include a). general *awareness raising* e.g. of emergency call numbers; b). *attitude change* e.g. around stigma reduction and 'normalising' talking; c). *greater engagement* towards behaviour change e.g. greater investment in emotional health; d). developing greater *community/organisational ownership to maintain change*.

Campaign settings, activities and media are likely to be effective if associated with the *lifestyle choices* of particular community group 'segments'. Campaign events have been effectively sequenced and linked thematically - e.g. starting from Suicide prevention week.
o The campaign has had a considerable *impact* in raising the awareness of the general public, specifically about the Choose Life brand and strap-line challenging stigma and offering call numbers. In particular the football campaign at Motherwell had impacted on large numbers.

Reservations concern understanding longer term impact and whether public awareness was of sufficient strength to lead to people becoming engaged and changing behaviour. There were doubts about reach, particularly across geographical areas and to marginalised men. The main impacts on organisations concern culture change (e.g. professionals talking about suicide), awareness, and improvements in practice and service design (e.g. action plans, debriefs after a crisis).
o *Challenges* for the campaign include: more effective targeting, ensuring sustainability, overcoming organisational and community resistance, and measuring progress towards long term goals.
o *Factors leading to success* include: the working partnerships between statutory and voluntary sectors, involving the Co-ordinator post and the steering group; leadership (particularly the Co-ordinator); work with organisations, co-ordinating training and targeted social marketing campaigns (public awareness needs matching with capacity-building and reinforcing pathways for prevention e.g. from general to specialist services); integration of national and local messages.
o *Success of the awareness raising campaign* has been helped by integrating campaigning with support for people to engage in valued 'lifestyle' activities. Statements that promote taking action, not only information provision, could stimulate higher engagement. Ownership is encouraged where community champions and networks develop campaign messages further in community settings, though developing this takes time. Effective marketing has involved 'personalisation' e.g. combining media information and one-to-one conversation with taxi drivers. Campaign continuity requires planning for progression or reinvention.

Concerning *sustainability*, key enabling factors identified by stakeholders include retaining funding, mainstreaming work within services, and adopting community development to spread change, and renew the campaign. Hard-to-reach groups such as unemployed/disconnected young males are often best engaged through Choose Life having partnerships with third sector organisations. Priority groups for the future include children and young people, out-of-work men of different ages, those at risk of addiction, over-65s, and at-risk women. Campaign renewal requires further regional 'localisation' involving local organisations taking account of processes of community change, and further evidence of what works in relation to suicide prevention.

Secondary data
The data sets from Breathing Space, Samaritans and A&E attendance were collected for various purposes using different systems and are not closely comparable. Nevertheless, it is clear that

locality and gender are important factors in suicide related calls to help-lines and A&E attendances and admissions.

- o The majority of calls to Breathing Space from June 2010 to April 2011 were made from Motherwell. More females made calls than males.
- o Concerning Samaritans, data on dialogue contact calls, involving a volunteer providing emotional support lasting over 30 seconds, shows that between 2007-2009 the number of calls from females to Samaritans Hamilton reduced, while the number of calls involving males increased. However data from Samaritans, Scotland shows a less clear pattern.
- o Data on attendance at A&E departments in North Lanarkshire between 2005-2010 shows higher levels of attendance during the campaign period than pre-campaign where the diagnosis mentioned self-harm. Data on admissions to hospital following self-harm showed highest percentage reduction among males in the Motherwell locality of residence compared to other localities, with an increase among males from some other localities including Wishaw, North (Cumbernauld/Kilsyth) and Airdrie. Female admissions followed a different pattern.

Discussion groups

Six discussion events were held at four locations in Motherwell, Cumbernauld and Newarthill. During these sessions a total of 10 small groups were formed. The range of **campaign materials** that had been seen by participants included: the football club billboards, sponsorship shirts, cups, T-Shirts, posters in pubs, and panels on taxis and buses. These were seen mainly in Motherwell.

Places. Placing messages in 'surprising' locations (festivals, football stadia) attracted men's attention. Promoting suicide awareness in leisure-time activity settings made people more receptive. Widely visible public locations such as buses and taxis attracted attention, and further possibilities include bus shelters, and shopping centres. Higher risk people need to be reached, for example in job centres, health centres and venues where they might be. Settings-based approaches that worked in Motherwell could be used elsewhere.

Messages. The message 'Suicide. Don't hide it. Talk about it' was good for attracting people's attention due to its striking theme, positive tone, brevity and clarity. It evoked many emotions, including hope and pride. This challenges a dominant 'masculinity' which avoids communicating vulnerability, and normative cultural stigmatising of mental ill-health. Participants expressed some concerns about understanding who the message was mainly for, and providing a clear guide to action that can be taken by the general public. It was very important that the public should not only see the generic message, but also messages which explicitly address the general public to help others. For example the A2 Motherwell poster and postcard contained the message 'There's no Substitute for Life - Help a Friend Stay in the Game', and further guidance to action.

The campaign made a difference to people's awareness, attitudes and behaviour in the following ways.

- o The campaign contributed to *initial awareness*, and normalised the suicide prevention message, by setting it in trusted venues within people's lifestyles. It normalised awareness of depression, and communication over mental health. The message strapline is only a first step to challenging attitudes and overcoming the cultural and gender barriers to men talking about suicide.
- o The *attitudes* of at least a proportion of the public changed as they felt more open to talk about negative emotions. Non-professional men or women were supported as 'influencers' to talk to others.
- o Prevalent *cultural values* include the stigma around mental health (moral shame), the (gendered and cultural) embarrassment of talking about suicide, and the reluctance to admit to vulnerability or accept help. The campaign message mainly pointed people at risk to ring the helpline rather than talk to others in the community, or family members, so the culture

of secrecy might not be broken.

- o *Confusion* over campaign targeting raises questions over how far cultural attitudes were being shifted. The need for sustained message diversity was emphasised, appealing separately to influencers.
- o *In terms of engagement,* it was not clear whether the public could obtain advice from phone-lines, or should themselves talk with people at risk.

Main challenges include: the depth and complexity of cultural stigma, reinforced by gendered communication barriers; coherence between campaign aspects; message clarity, reaching different influencers, establishing a different culture through education, reaching different generations of at risk-groups, and geographical reach.

In response to concerns about cultural stigma and normative perceptions, themes around trust, influence and personalisation indicate the campaign strengths can be developed further. The wider public could be engaged through stories, and role models that people identify with. Groups of people with high potential influence should be targeted. These interact with the general public in spaces where health and social care professionals do not go. They may include barbers, taxi drivers, postal workers and shop workers. People in such roles should be given basic training. Face-to-face communication, central to trust, should always be increased.

Strengths of the social marketing campaign also included the appeal to individuals in their social and age groups (e.g. 'niche' festival goers, football fans), while recognising the environmental factors (e.g. unemployment) and cultural factors. Building on these strengths, suggestions for developing the campaign were made.

- o *Wide targeting* using more mass events and media could attract a still larger audience, drawing further on the TV potential of sport. TV advertising and soaps could present narratives about suicide prevention that families would identify with. Large music festivals such as T in the Park can reach an intergenerational public.
- o Younger people suggested forms of '*personalised*' messages which they would want. Durable items like festival wristbands marking personal identity can display and spread people's engagement.
- o *Varying* communication more whilst retaining brand recognition makes sense in terms a. of different lifestyle preferences (e.g. age, gender differences) and b. different positions along journeys of change (from initial awareness of the campaign through developing engagement to community ownership of change).
- o The campaign needs *narrative strategies* and *stories*, for different age and interest groups, using different media, trusted role models (speakers), and graphics.
- o Universal education in schools and colleges could help young people to develop skills and knowledge to pass on to others in their networks, and inter-generationally. Young people in *primary school* can be educated linking into alcohol education, bullying, and emotional literacy.
- o Trusted settings to target further include, for young people, festivals and gigs, for men of working age the bookmakers and pubs, for women the shopping centre, for people of different ages, particularly older people, cafes and community centres.
- o *Intergenerational family influence* is important, and family networks can be targeted more through school, mass media, and family friendly events in the community.
- o *Unemployed people* need to be targeted carefully, for example through job centres.

Middle aged men and women (35-50) can be influenced around parenting and family health. Young people may stay with parents longer during difficult economic times, so parent education is important. *Women* are influencers on male peers, children and husbands - more women can be reached by careful social marketing. The campaign can engage further with isolated older people post-retirement. Concerns around debt and care create further risk.

- o For *unemployed people* targeting job centres with leaflets, information about healthy activities, person to person support, and help finding volunteer activities was suggested. Training on suicide prevention could provide motivation and build capacity.
- o Individuals in *minority groups* (for example by ethnicity, or sexual orientation) may have experiences leading to them mistrusting services. They may be reached through outreach to trusted support groups and networks.
- o Distributing resources more effectively across the *entire region* needed to be a priority. Across the region, more use could be made of *existing trusted networks* of target groups. Work with diverse community forums can map a spectrum of leisure activities for different groups in their areas, so these can be targeted for campaign work.
- o The potential in informal/semi-formal community networks (including online) for *developing new initiatives and new advocates* for suicide prevention was highlighted.
- o Further *partnerships with consumer or regulatory organisations* particularly private sector businesses e.g. drinks manufacturers and retail brands and outlets could yield benefits.

Discussion

The final section highlights the contribution of Choose Life to preventing suicide, first, indicating impressive successes of the campaign in relation to targeted 'intermediate' outcomes; before reflecting on how these achieved objectives might support wider processes of change and longer-term goals.

Programme effectiveness. The campaign appears to have effectively raised the awareness of services of a substantial proportion of the population.
- o The awareness of the campaign varies by age (people of 55 and under relatively more aware), and locality (with for example far higher awareness in Motherwell and Wishaw than in Airdrie and Cumbernauld).
- o Survey findings showed only a *higher* awareness level was strongly predictive of altered attitudes.
- o Concerning influence on organisational attitudes, the training campaign may have contributed with the awareness campaign to impact on those organisations that were engaged in training.
- o Data on calls to Samaritans and Breathing Space supports the finding that the campaign has affected individual help-seeking behaviour of men and women, most strongly within Motherwell.
- o The finding that the campaign positively affected the behaviour of both men and women, but in somewhat different ways, has implications for targeting members of the public as 'influencers'. As these differences are relative, suicide prevention tactics should diverge subtly and in a considered way by gender. The regional variation in impact on behaviour is also very important for future targeting.

How has the social marketing approach worked? The combined use of settings appealing to targeted groups and settings with widespread appeal proved important for achieving campaign objectives. The messages need to vary in some respects between settings, and clarity about target audiences and goals is important. Different engagement strategies can be matched to stages along a community journey of cultural change, and varied approaches taken to different target groups, without changing the core brand and key messages.

Has this programme been of benefit to the community, in particular young men aged 16-35? The campaign has increased the confidence and capacity of people who are highly aware of the campaign, including young men, to talk to others in their community or to seek help. It has 'normalised' talk about suicide and about mental health and emotions, among those who have become highly aware. The campaign challenge now is to spread the great benefits further to the

relatively un-reached high-risk communities, and priority groupings, including older people, and continuing to reach peers and families of at-risk individuals.

What contribution has the community made to the effectiveness of the programme? The campaign's successes have been based on strong partnerships with businesses and community and voluntary organisations embedded in specific communities. A community development approach was advocated by stakeholders and the general public to spread change and renew the campaign.

Choose Life (North Lanarkshire), after 3.5 years with a full-time Co-ordinator, has maintained the intensity of the media campaign and is continuously seeking to develop. Renewal can be achieved by co-ordination of training and campaign aspects, taking diverse approaches across different localities and target groups, and using different materials to retain interest, offer personalisation, and deepen engagement.

Theory or model of change. To extend the campaign's reach and sustainability, it is important to understand mechanisms of change where the campaign is effective. In the discussion chapter of this report, campaign progress is considered in relation to an evidence-driven change model which looks at steps of campaign implementation. The model for change within the campaign needs to be systematic, and include pathways. Earlier steps lead to the intermediate campaign to date (see discussion points above), while later steps concern emerging considerations for campaign direction from the evaluation (see discussion points below).

Public awareness-raising campaign development. Evidence from other evaluations and this one suggests that campaigns require a variety of resources, for people at risk, and for the public who might influence them. This has already been achieved to some extent, for example through the Motherwell Postcard and A2 poster addressing the general public ('Help a Friend Stay in the Game'), which can be contrasted with the washroom panel appealing to the individual at risk ('It's OK to talk about feeling suicidal'). An interacting and coherent range of strategies and messages is needed, with tailored narrative and drama approaches developed further to extend the public campaign beyond the initial level of awareness-raising, to challenge public attitudes and support engagement. Presenting stories and using credible role models, with which people identify, can extend the campaign's reach.

Gendered and non-gendered targeting. Evidence suggests that non-gender specific targeting results in more women than men noticing and acting upon campaigns around mental health and suicide, whereas targeting settings matched to men's lifestyles can rebalance that effect. Men need to be targeted strategically and signposted to further information. Choose Life (North Lanarkshire) has targeted young men effectively in male settings, and further settings can be explored to reach more men. A good way to involve men may be to support them to combine practical action with communication, arranging or participating in events, and guiding others to services.
o The campaign has trained a high proportion of female professionals to engage in suicide prevention work. However, it has not prepared a high proportion of the public to play a supported role within circles of influence. In engaging with the public there is scope to reflect on gender and the possible roles of men and women within networks of influence and support.
o There is work to do reaching out to people who become unemployed, older people at risk, for example after retirement, people in rural areas, and people in sexual minorities (categories where male suicide rates are elevated).
o It is very important to maintain a separate focus on two groups: very young men and middle aged men, both with high suicide levels.
o The openness of very young people in terms of culture and identity supports further, earlier awareness-raising in schools.

Integration of training with public awareness campaign in a systemic approach*.* The additive/synergetic 'preventive' effect of media awareness, training public service (statutory and

voluntary sector) employees, and training other intermediaries with the public might be increased further if the level of training of intermediaries/gatekeepers who directly interact with targeted sections of the public was raised, as stakeholders suggested, and the media campaign focused still more clearly on targeted sections of the general public.

- o The national Impact evaluation of Choose Life training (Griesbach and Russell, 2011) and associated 'learning notes' and 'analysis and response' papers (Choose Life, NHS Scotland, 2011a, b) recommend broader targeting of training to a wider range of 'gatekeepers' beyond health and social care professions, taking account of the fact that the majority of those trained so far have been women, and the majority of interventions from those trained have been with women. Training may need to particularly include more men who have frequent contact with men in the community, especially those at high risk.
- o If, as suggested, more community/voluntary sector members of homelessness services, sports centres, football clubs, pubs and workplaces were trained, complementing the existing excellent training, then further consideration needs to be given to their support needs. The extent to which people are to be trained for a specific add-on 'role' or as a capacity building community 'resource' needs considering.

Networks and trust-building. Developing community capacity around suicide prevention, through awareness campaigning, training, and networking can contribute to developing trusting relations - 'social capital' - and resilience in communities. The issue of trust concerns normalising talk about emotions and mental health, so it becomes 'safe' to do so in terms of social identities. Community resilience can be increased in the area of suicide prevention, if the cultural stigma over suicide and gendered communication barriers are shifted, so that people talk within trusted networks about how they feel, and offer and seek help in a timely way.

- o Involving and training 'well-connected' people in the community, voluntary and business sectors, as well as 'gate-keepers' in public services, can help strengthen the positive, trusted networks of members of the general public who work towards suicide prevention. This would support the essential work already being done by trained professionals. There is potential for developing initiatives in tight cohesive networks of people with strong associational bonds (for example men at the football stadium), in cross-group networks which bridge age, class and occupation divisions (e.g. families and at cross-generational festive events), and in networks developing links between services and professionals and the general public.
- o Reaching unemployed, otherwise disengaged, and isolated people who may have lost trust in statutory services, and may currently rely on relatively weak community networks, is a major challenge. Both professional 'gatekeepers' (job centre, housing, court and other support and care workers) and trained and supported members of those networks (men in particular) can potentially contribute.

Long term change. Evaluating the likely long-term success of a campaign involves looking beyond and behind calls to services and current rates of suicide, at evidence of raised capacity and confidence of young people and other sections of the public to seek and give help across their networks of influence, and raised service capacity to respond to requests. In the Choose Life campaign, capacity is being raised, among the public (through the campaign) and in services (through training). If the successful approaches are still more effectively co-ordinated, the impact of the campaign in the future could be increased.

- o It is important to sustain and increase: vertical co-ordination of national and regional resources, horizontal integration of regional elements, and co-ordination with complementary wider anti-stigma and mental health awareness campaigns, and within overall mental health programmes. This complementarity should be clarified for the public.
- o On-going mainstreaming of campaign elements within services is also a key to sustaining impact.
- o These steps can be achieved if appropriate national and regional drivers and support are maintained.

Conclusions

Choose Life (North Lanarkshire) awareness-raising programme has made huge steps towards improved public access to information on suicide and deliberate self-harm; increased public knowledge of suicide and self-harm, and challenging cultural myths and stigma associated with suicide. Particular progress has been made with the young men through a targeted community settings approach. The outstanding campaign emphasis on public awareness and communication using social marketing approaches has been a pathfinder in suicide prevention work in Scotland. The approach aims to support a culture transformation to an attitude of enabling trust, that it is 'safe' to talk about suicide. This transformation requires on-going development of trustworthy organisations and services.

Cultural and service transformation takes time to accomplish. Further steps can be taken, in the public awareness campaign, taking a systems focus on the public, individuals and organisations, and developing, supporting and celebrating community-centred approaches that can lead to culture change. The direction of the public campaign and its system-wide integration with wider suicide prevention and mental health work needs to be sustained and resourced through the next stages of its development.

Section 1: Choose Life campaign survey analysis

This section of the report presents key analyses of the public survey, which was developed in order to assess the extent to which the social marketing campaign has reached the community. The questionnaire considered changes in relation to community awareness of services, public attitudes, and behaviour. Table 1 on the following page presents the variables which were assessed within the questionnaire in more detail, alongside an explanation of the items which were used to do this. Using these variables as a guide this analysis will be split into 4 sections modelled around the topics the evaluation was designed to assess, as follows:

- Section 1: Demographic data of respondents

- Section 2: Awareness of the Choose Life campaign & related materials

- Section 3: Awareness of suicide-related services

- Section 4: Impact on public attitudes & behaviour

Demographic data is presented alongside proposed quotas, where applicable. Within Sections 2 to 4, more complex questions are asked of the data, which are of interest in relation to the evaluation questions. Three key levels of analysis are employed within each section:

- Sex: male/female

- Age group: refers to the 5 age categories used = 16-25, 26-35, 36-45, 46-55, 56+

- Locality: refers to 5 localities (i.e. built up areas that are more identifiable as the traditional towns and cities of Scotland than administrative areas, such as Council areas) that the questionnaire was administered within = Airdrie, Cumbernauld, Kilsyth, Motherwell, Wishaw

Sex and age quotas were calculated to account for differentiated suicide rates within these categories. Quotas for the five localities were calculated using a proportional quota sampling strategy which took into account the total population of each locality, thus providing a spread of respondents aiming to be representative of localities included. Importantly, these North Lanarkshire localities were selected for inclusion in this evaluation as they have death rates from suicide that are significantly worse than the Scottish average (http://www.scotpho.org.uk/home/Comparative health/Profiles/2010CHPProfiles.asp). By employing these levels of analysis data is often split down into many categories. By spreading the data further the numbers of respondents within some categories are sometimes very low. In these cases caution should be exercised when interpreting results, and in drawing conclusions about the campaign's reach.

Notes about the way information is presented in this analysis:

- Analysis conducted within Sections 2 to 4 is presented in a systematic manner: descriptive data is presented first, and then key points are discussed followed by the use of inferential statistics to assess the statistical significance of findings, wherever possible. The details and results of any statistical tests performed are presented as footnotes.

- When graphs are presented they are done so in percentages, to allow easier comparison between groups. Each graph also displays the number of people within each group in *italic* type, making the results as transparent as possible.

- Whilst most of the points covered in this analysis will contain either a table or graph which displays the data being discussed, some of the tables have been presented at the end of this report as appendices to increase the readability of the report.

- Data highlighted in tables in shaded cells with **bold** type flag particularly interesting results.

- Missing data has been excluded from this analysis.

Table 1 below describes the different topics which were covered in the questionnaire, explaining how each of these was assessed.

Table 1: Variables covered in the questionnaire and how these were assessed

Variable	Method of assessment	Who responds?
1. Demographic data	Age, Sex, Ethnic origin and Occupation.	All respondents
2. Awareness of the Choose Life campaign	6 point likert-type response scale: higher score = more aware (1 = "Not aware", 6 = "Very aware")	All respondents
3. Recall of campaign materials	Respondents shown images of campaign materials developed by Choose Life North Lanarkshire then asked "settings" and "types" questions. **Settings**: this item corresponds with whereabouts respondents recall having seen Choose Life campaign materials. A list of 8 settings are given for which the respondent either answers "Yes" they have seen the material in that setting, "No" they have not, or that they "Don't go" to that setting. Respondents can select as many settings as applicable. **Types**: this item relates to what types of campaign materials respondents recall having seen from a list of 7. The respondent answers "Yes" or "No" to each material type. Respondents can select as many types as applicable.	All respondents
4. Campaign's impact on awareness of services	Respondents asked if campaign has made them aware of where someone could go for help or information to prevent a suicide-3 answer options: 1) Already aware of these services, 2) Campaign has made more aware, 3) Campaign has not made more aware. Respondents can select one option only.	Only respondents who answered above 1 on variable 1 **OR** "Yes" to at least one option within variable 2.
5. Suicide and mental health-related attitudes	**"If someone wants to commit suicide it is their business and we should not get involved"**: respondents asked to rate how much they agree or disagree with this statement on 6-point likert-type scale: higher score = stronger agreement (1 = "Strongly disagree", 6 = "Strongly agree"). **Altered attitude**: respondents asked on 6-point likert-type scale if the campaign has altered their attitudes about suicide and mental health: higher score = more altered (1 = "Not at all", 6 = "Very much")	Only respondents who answered above 1 on variable 1 **OR** "Yes" to at least one option within variable 2.
6. Campaign's impact on behaviour to support someone with suicide or mental health-related issues	**Predicted impact on behaviour in relation to talking to someone who might be thinking of suicide**: respondents given 3 options: 1) Would already have talked to someone, 2) Would now talk to someone following the campaign, 3) Would never talk to someone despite the campaign. Respondents can select one option only. **Actual effect on behaviour**: respondents asked what they have done as a result of the campaign in order to support other people who might have mental health problems. A list of 4 behaviours are provided: 1) Discussed suicide/mental health, 2) Got information on suicide/mental health, 3) Sought help for someone with suicide/mental health-related issues, 4) Nothing (2 sub-categories provided for "Nothing": 1) done nothing because of no opportunity **OR** 2) done nothing because did not want to). Respondents can tick as many as are applicable out of the first 3 options **OR** option 4.	Only respondents who answered above 1 on variable 1 **OR** "Yes" to at least one option within variable 2.

Demographic Data

Five hundred and twenty-one people responded over five localities (Airdrie, Cumbernauld, Kilsyth, Motherwell and Wishaw) within a one-week survey period. Of these respondents 75.4% (*n* = 393) were male and 24.6% (*n* = 128) were female.

Table 1.1 below shows the age and sex distributions over the entire sample, including targeted quotas.

Table 1.1: Age and sex

Sex	Age					Total	Original quota
	16-25	26-35	36-45	46-55	56+		
Male	116	55	76	53	93	393	*> 365*
% of males	29.5%	14.0%	19.3%	13.5%	23.7%	100.0%	
Original quota		*> 130*		*> 170*	*> 65*		
Female	32	14	24	21	37	128	*> 126*
% of females	25.0%	10.9%	18.8%	16.4%	28.9%	100.0%	
Total	148	69	100	74	130	521	*500*
% of Total	28.4%	13.2%	19.2%	14.2%	25.0%	100.0%	

As shown in the table above, stated quotas were exceeded in all categories aside from males aged 36 to 55 years (sample obtained = 129). This was due to difficulties survey staff found in locating men who fell into this category. Despite this the total sample of men exceeded the original quota by 28 respondents.

Table 1.2 below shows the number of respondents surveyed within each locality, as well as the original quotas for these.

Table 1.2: Locality of survey administration

Locality	Frequency	Percent	Original quota
Airdrie	114	21.9%	*> 110*
Cumbernauld	160	30.7%	*> 160*
Kilsyth	31	6.0%	*> 30*
Motherwell	103	19.8%	*> 100*
Wishaw	113	21.7%	*> 90*
Total	521	100%	*500*

All quotas in relation to how many questionnaires were administered within each locality were either met or exceeded.

- **Respondents' employment status**

The largest proportion of participants were unemployed (30.7%, *n* = 160) (N.B. the category "Unemployed" includes respondents who were simply unemployed, those who were unemployed and looking for work, mothers, and carers. Due to the variety of responses these categories were collapsed into one). Over one quarter of respondents were employed full time (26.3%, *n* = 137), 18.8% (*n* =98) were retired, 13.4% (*n* = 70) were students, whilst those employed part time made up the smallest group of respondents (9.0%, *n* = 47). Nine respondents (1.7%) refused to state their

employment status. Comparisons in relation to employment status are not presented within this report.

- **Respondents' ethnic group**

Only 26 (5%) of respondents identified as being in an ethnic group other than White British. As the groups' ethnicities were almost homogenous comparisons in relation to ethnic origin are not included. Please see Appendix 1 for the full breakdown of ethnic groups.

Awareness of the Choose Life campaign[1]

One hundred and forty-six respondents said they were aware of the campaign to some extent, equating to 28.2% of the total number of respondents who answered this question (n= 518).

- **Sex and Campaign awareness**

Whilst 25% (n=32) of female respondents were aware of the campaign, slightly more males were aware at 29.2% (n=96). However further analysis showed that this difference was not statistically significant[2].

Table 2.1 below shows campaign awareness by respondent age group.

Table 2.1: Awareness of Choose Life Campaign, by age

Age group	Not aware	Aware	Total
16-25	100	48	148
% in age group	67.6%	**32.4%**	100%
26-35	50	18	68
% in age group	73.5%	26.5%	100%
36-45	68	30	98
% in age group	69.4%	30.6%	100%
46-55	48	26	74
% in age group	64.9%	**35.1%**	100%
56+	106	24	130
% in age group	81.5%	**18.5%**	100%

Survey participants aged 46-55 years, followed by those aged 16-25 years were most aware of the campaign, at 35.1% (n=26) and 32.4% (n=48) respectively. The age group least aware of the campaign were those aged over 56 years , followed by those aged between 26 and 35 years, at 18.5% (n=24) and 26.5% (n=18) respectively. There was not a statistically significant relationship between campaign awareness and respondent age group[3].

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[1] Participants were asked to rate on a scale of 1 to 6, where 1 is "Not aware" and 6 is "Very aware", their awareness of the Choose Life campaign. Within section 2 this scale has been collapsed so that participants who rated their awareness as 1 are classed as "Not aware", whilst those who rated their awareness ≥ 2 are classed as "Aware", interpreted as respondents noting any awareness at all.

[2] A Mann-Whitney U Test revealed no significant difference in awareness of the Choose Life campaign between males (Md = 1, n = 390) and females (Md = 1, n= 128), U = 23732, z = -1.06, p = .29, r = .04.

[3] A Spearman's rho test did not reveal a significant relationship between campaign awareness and respondent age group, r_s = .08, p=.055

Table 2.2 below shows respondents' awareness of the Choose Life campaign by locality.

Table 2.2: Awareness of Choose Life Campaign, by locality

Locality	Airdrie	Cumbernauld	Kilsyth	Motherwell	Wishaw
Aware	20	27	11	47	41
% in locality	**17.5%**	**17.0%**	35.5%	**46.1%**	**36.6%**
Not aware	94	132	20	55	71
% in locality	82.5%	83.0%	64.5%	53.9%	63.4%

The areas with most awareness are Motherwell and Wishaw, at 46.1% (*n* = 47) and 36.6% (*n* = 41) of respondents who stated they were aware respectively. Kilsyth also had a comparatively high awareness level at 35.5% (*n* = 11). These results are in stark comparison to awareness levels in Cumbernauld and Airdrie, which were at 17% (*n* = 27) and 17.5% (*n* = 20) respectively. A statistically significant difference was found between locality and campaign awareness [4].

Recall of campaign materials: types and settings

- **Overall setting recall of campaign materials**

Table 3.1 below shows which settings respondents recalled seeing campaign materials within.

Table 3.1 Recall of campaign materials within given setting

Recall	Motherwell FC	Taxi	Bus advert	Washroom at work	Pub	Chemist/ Pharmacy	Library	Community Centre
No	266	416	441	415	431	463	407	385
% setting	51.5%	80.3%	85.0%	80.1%	83.2%	89.4%	78.4%	74.3%
Yes	**64**	**84**	**63**	21	40	**18**	26	**22**
% setting	**12.4%**	**16.2%**	**12.1%**	4.1%	7.7%	**3.5%**	5%	**4.2%**
Don't go	**187**	18	15	82	47	37	86	**111**
% setting	**36.2%**	3.5%	2.9%	15.8%	9.1%	7.1%	16.6%	**21.4%**

The setting where most respondents stated that they recalled seeing a campaign material was in/on taxi cabs. Campaign materials were also recalled by comparably more respondents in/on buses. Taxi cabs and bus adverts may be recalled by more respondents due to their mobility, often visible on a day-to-day basis, whether they are used by an individual or not. Displaying campaign messages on/in such vehicles may be important for reaching a wider population. Particularly high numbers of respondents said they do not go to Motherwell Football Club, yet of those who did go a comparably high percentage recalled campaign materials within the setting. Conversely, whilst a particularly high number of respondents did not visit community centres, there was also a very low level of recall within these settings. Least people recalled seeing materials at the chemist/pharmacy, followed closely by washrooms at work.

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[4] All six levels of awareness were used in this Kruskal-Wallis ANOVA, which revealed a statistically significant difference in campaign awareness across the five survey localities (Airdrie: *n* = 114, Cumbernauld: *n* = 159, Kilsyth: *n* = 31, Motherwell: *n* = 102, Wishaw: *n* = 112), $H = 40.71$, $df = 4$, $n = 518$, $p < 0.001$). Motherwell had a higher mean rank than the other localities (*Mean Rank* = 308.75), followed by Wishaw (*Mean Rank* = 283.14), Kilsyth (*Mean Rank* = 278.66), Airdrie (*Mean Rank* = 232.07), and with the lowest mean rank was Cumbernauld (*Mean Rank* = 227.18).

- **Recall of campaign materials within given settings by locality of survey administration**

The majority of respondents who recalled campaign materials in the listed settings were in the Motherwell area. Campaign materials seen by respondents in Motherwell in/on taxis (34.7%, *n* = 35) and at Motherwell Football Club (30%, *n* = 30) were higher than materials seen in other settings by respondents surveyed in other localities. Again Airdrie respondents in particular had low recall of seeing campaign materials in the listed settings, reporting the least recall of materials in/on taxis (4.4%, *n* = 5), in/on buses (4.4%, *n* = 5), at the pub (2.6%, *n* = 3), in the chemist/pharmacy (1.8%, *n* = 2), at the library (2.6%, *n* = 3) and at the community centre (0.9%, *n* = 1). Cumbernauld respondents also had some of the lowest recall of sightings, namely at Motherwell Football Club (5.0%, *n* = 8) and in washrooms at work (2.5%, *n* = 4). The setting that people had seen campaign materials in least across all localities was the chemist/pharmacy (3.5%, *n* = 18), whilst the setting they had been seen most in was in/on taxis (16.2%, *n* = 84). Please refer to Appendix 2 for the full table of results.

- **Settings of campaign materials recalled by age**

As shown previously in Table 3.1, though a high percentage of respondents said they did not go to Motherwell Football Club (Motherwell Football Club had the highest percentage of respondents who said they don't go across all age groups), when considering those who do go, campaign materials in Motherwell Football Club were the best recalled amongst those aged 16-25 (26.8%, *n* = 26), 36-45 (21.5%, *n* = 14), and 46-55 year olds (26.8%, *n* = 11). Those aged 26-35 and 56+ recalled materials in/on taxis the best out of all listed settings at 21.9% (*n* = 14) and 11.3% (*n* = 14) respectively. Bus adverts were also recalled well amongst all age groups aside from those aged 56+ (16-25: 15.6%, *n* = 22; 26-35: 10.9%, *n* = 7; 36-45: 12.2%, *n* = 12; 46-55: 20.5%, *n* = 15; 56+: 5.5%, *n* = 7), whilst materials in the pub were recalled by 13.6% (*n* = 18) of 16-25 year olds who went. Motherwell Football Club and the pub may therefore be two settings important in targeting 16-25 year olds, whilst taxi-related materials were recalled well amongst 26-35 year olds - both key target age groups for this campaign. Please see Appendix 3 for the full table of results.

- **Recall of campaign materials types**

Table 3.2 below shows how many respondents recalled seeing different types of campaign materials.

Table 3.2 Recall of given types of campaign materials

Recall	On poster/ Billboard	In a Video	In an advert in newspaper	On pocket sized card	On Radio	On TV	On football banner, etc.
No	408	512	475	498	466	455	452
	78.9%	98.8%	91.7%	96.1%	90.0%	88.0%	87.4%
Yes	**109**	**6**	43	20	52	62	**65**
	21.1%	**1.2%**	8.3%	3.9%	10.0%	12.0%	**12.6%**

The campaign material recalled by most respondents was poster/billboard materials. Football-related campaign materials and TV-based materials were also recalled comparably well. The campaign materials which respondents said they recalled least were those in video format and on pocket-sized cards.

- **Type recall of campaign materials respondents have seen by locality of survey administration**

Respondents in Motherwell had highest recall of seeing Choose Life materials in all type categories (Poster/billboard: *n* =41, 40.2%; Video: *n* =4, 3.9%; Newspaper advert: *n* =20, 19.6%; Pocket-sized card: *n* =10, 9.8%; On the radio: *n* =16, 15.7%; On the TV: *n* =26, 25.7%; Football-related products: *n* =31, 30.7%). This may suggest that campaign efforts have been particularly focussed within this locality. Compared to respondents surveyed in Airdrie and Cumbernauld, who had notably low recall of all campaign materials, those who responded in Wishaw and Kilsyth had better levels of recall of

poster/billboard materials (23.0% and 25.8% respectively), and on the TV (11.5% and 16.1% respectively). Please see Appendix 4 for the full table of results.

- **Type of campaign materials recalled by age group**

The type of campaign material recalled best by all age groups was Choose Life posters/billboards (16-25: 26.2%, *n* = 38; 26-35: 22.1%, *n* = 15; 36-45: 22.0%, *n* = 22; 46-55: 28.4%, *n* = 21; 56+: 10.0%, *n* = 13), suggesting that this material may be a key method in reaching the overall population. In descending order those aged 16-25 also recalled football-related products (17.9%, *n* = 26), and radio adverts (15.2%, *n* = 22) notably well. Those aged 56 years and over recalled all materials, except for pocket-sized cards and newspaper adverts, the least, which may be partly a result of the younger target age of the campaign. Video-based campaign materials and pocket-sized cards were recalled particularly poorly by all age groups. Please see Appendix 5 for the full table of results. Notably, the materials that were recalled best are those that were made visible as part of individuals' everyday life and activities - for example seeing a "poster" on a bus or on the side of a taxi, or noticing the Choose Life message on a football player's shirt during a game. Conversely, seeing the message in a video or on a pocket-sized card requires either asking for or being given the chance to see a related video, or being given/picking up a card. Those materials which respondents stated better recall for are those which can be engaged in with less diversion from everyday life.

Awareness of suicide-related services

Of those 170 respondents who were eligible to answer the question related to service awareness (see Table 1), 67 (39.4%) said the campaign made them more aware of the services which would provide help or information on how to prevent a suicide, whilst 71 (41.8%) respondents said they were already aware. Though the remaining 32 (18.8%) said the campaign had not made them more aware of services available to help prevent a suicide, the number of respondents who said the campaign made them more aware of services was more than double the number who said it did not make them more aware. The finding that over 40% of respondents were already aware of services is also positive.

- **Respondents' sex and how aware the campaign made them of where to go for help or information to prevent a suicide**

Interestingly a higher percentage of male respondents (40.4%, *n* = 55) said the campaign had made them more aware of services than did females (35.3%, *n* = 12), whilst a slightly higher percentage of female respondents said they were already of aware of the relevant services than males (females: 44.1%, *n* = 15, males: 41.2%, *n* = 56). A lesser percentage of males (18.4%, *n* = 25) said they were not more aware of services than females (20.6%, *n* = 7). Within both sexes the answer most frequently stated was that they were "already aware" of the services available for someone to go for help and information on how to prevent a suicide. Notably, the least stated answer amongst both sexes was that the campaign had "not made them more aware" of services. Over double the number of men said they were more aware of services due to the campaign compared to those men who said they were not more aware. No significant associations were found between sex and awareness of services[5].

- **Respondent's age and how aware the campaign made them of where to go for help or information to prevent a suicide**
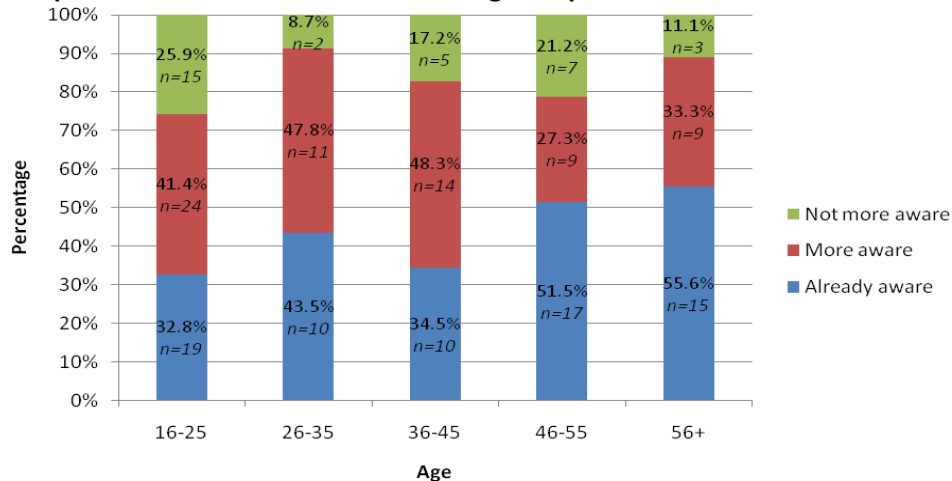The graph below shows the variations in the awareness of services by age.

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[5] A Pearson's chi-square test for independence revealed no significant association between awareness of services and sex, χ^2 (2, *n* = 170) = .31, *p* = .86

Graph 1.1: Awareness of services amongst respondents who were aware of the campaign, by age

Within each age group there was a higher frequency of those who became more aware when compared to those who did not become more aware. The highest percentage of those who said the campaign made them more aware of services was the 36 to 45 year age group (48.3%). This was followed closely by those aged 26 to 35 years and 16 to 25 years, at 47.8% and 41.4% of respondents respectively. Further analysis did not reveal a statistically significant difference between age and awareness of services following the campaign[6].

Impact on public attitudes & behaviour

As explained in Table 1 at the beginning of this analysis, questions on the campaign's impact on behaviour and attitude were only completed by respondents who answered above 1 on variable 1, or "Yes" to at least one option within variable 2.

- **Sex and level of agreement with the statement "If someone wants to commit suicide it is their business and we should not get involved"**

The majority of both males (59.7%, *n* = 83) and females (73.5%, *n* = 25) who were aware of the Choose Life campaign strongly disagreed with the statement "If someone wants to commit suicide it is their business and we should not get involved", compared to those who strongly agreed (males: 10.8%, *n* = 15, females: 2.9%, *n* = 1). Given the slight targeting of the campaign towards men it is interesting to note that men's stated agreement with this statement was significantly higher than females[7]. Underlying reasons for this need to be investigated further. For full results please see Appendix 7.

- **Respondents' altered attitudes about suicide and mental health**

Eighty-one (47.6%) respondents selected option 1, stating that the campaign had not altered their attitudes at all. Nevertheless there is a more complex pattern in the responses to this question: when those that selected between 2 and 6 "Very much" are summed (i.e. all those that thought the

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[6] A Kruskal-Wallis ANOVA indicated that there were no statistically significant differences between age groups and awareness of services following the campaign (Already aware: *Mean Rank* = 94.85, More aware: *Mean Rank* = 80.27, Not more aware: *Mean Rank* = 75.70), H = 4.873, df = 2, n = 170, p =.09.

[7] A Mann-Whitney *U* test indicated that males' level of agreement with the statement "If someone wants to commit suicide it is their business and we should not get involved" (*Mean Rank* = 90.22, n = 139) was significantly higher than female participants level of agreement (*Mean Rank* = 73.85, n = 34), U = 1916.00, z = -1.98 (corrected for ties), p = .05. This effect can be described as "small" (r = .15).

campaign had altered their attitudes to some extent) it is evident that more people thought their attitudes had been altered on some level (52.4%), than not at all (47.6%). Please see Appendix 8 for the full table of results.

- **Level of campaign awareness and level of altered attitude about suicide and mental health**

When looking at level of campaign awareness and altered attitudes about suicide and/or mental health a pattern emerges which suggests that the more aware individuals were of the campaign the more attitudes have been altered. Please see Appendix 9 for the table of results. Further analysis shows a significant positive correlation between level of campaign awareness and level of altered attitude[8].

- **Respondents' behaviours in relation to talking to someone who might be thinking of suicide**

Whilst 10 (5.8%) respondents said they would never talk to someone who might be thinking of suicide, 161 (94.2%) respondents said they would. Of those that said they would, 125 (73.1%) said they would have already spoken to someone before the Choose Life campaign, whilst 36 (21.1%) respondents said they would as a result of the campaign.

- **Behaviours in relation to talking to someone who might be thinking of suicide and sex**

Whilst a higher percentage of female respondents (31.3%, n = 10) than male respondents (18.7%, n = 26) said that following the campaign they would now speak to somebody that they thought might be thinking of suicide, there was a slightly higher percentage of men who said they would already have spoken to someone before the campaign (males: 74.1%, n = 103, females: 68.2%, n = 22). For the table of results please see Appendix 10. There is no statistically significant relationship between sex and the behaviour in relation to talking to someone who might be thinking of suicide[9].

- **Does behaviour following the campaign in order to support someone who might have mental health problems vary by sex?**

Interestingly, the most common action amongst men was getting information on suicide/mental health issues, whilst the most common activity amongst women was discussing suicide/mental health issues. Also, a notable point, whilst a higher percentage of females (28.6%, n = 10) than males (14.1%, n = 19) discussed suicide and/or mental health issues following the campaign, more males than females both got information (males: 18.5%, n = 25; females: 11.4%, n = 4) and sought help for someone (males: 10.4%, n = 14; females: 5.7%, n = 2). Of these three behaviours, the only statistically significant difference between the sexes was amongst those who had discussed suicide and/or mental health with someone[10].

- **Does respondents' behaviour following the campaign in order to support someone who might have mental health problems vary by locality?**

Whilst there was no association between locality and getting information or seeking help for suicide/mental health issues, tests showed that there was a statistical association between locality

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[8] A Kendall's tau test indicated a significant relationships between level of campaign awareness and level of altered attitude, τ = .19, p < 0.01.

[9] A Chi-square test for independence indicated no significant association between sex and behaviour in relation to talking to individuals who might be thinking of suicide, following the Choose Life campaign, χ^2 (2, n = 171) = 4.349, p = 0.114 .

[10] 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.

and discussion of suicide and mental health issues[11]: compared to the average across localities significantly more Motherwell (31.1%, *n* = 19) respondents said they had discussed these issues, whilst significantly fewer Wishaw (4.7%, *n* = 2) respondents had done so. Please see Appendix 11 for the full table of results.

- **Does level of campaign awareness affect behaviour in order to support someone who might have mental health problems following the campaign?**

Table 4 below displays what respondents said they had done in relation to their level of awareness of the Choose Life campaign.

Table 4: Behaviour to support other people who might have mental health problems, by level of campaign awareness

Awareness of campaign	Have discussed	Got information	Sought help
1 "Not aware"	3	4	2
	11.1%	14.8%	7.4%
2	3	3	0
	13.0%	13.0%	0.0%
3	7	4	4
	17.9%	10.3%	10.3%
4	5	3	3
	14.3%	8.6%	8.6%
5	4	3	2
	25.0%	**18.8%**	**12.5%**
6 "Very aware"	7	12	5
	25.0%	**42.9%**	**17.9%**

Table 4 above shows those who were "Very aware" of the Choose Life campaign appear to have discussed, got information and sought help to support other people who might have mental health problems more than those who were less aware of the campaign. Statistical tests show no significant differences between discussing or seeking help for someone and campaign awareness[12], yet the campaign awareness of those who got information to support someone was significantly higher than those who did not get information[13].

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[11] A Fisher's exact test revealed a significant association between locality of survey administration and discussing suicide/mental health issues following the Choose Life campaign, χ^2 (4, *n* = 170) = 13.543, *p* < 0.01 .

[12] A Mann-Whitney *U* test indicated that campaign awareness of respondents who had discussed (*Mean Rank* = 96.40, *n* = 29) was not significantly higher than those who had not discussed (*Mean Rank* = 82.02, *n* = 139), *U* = 1670.50, *z* = -1.47, *p* = .141, two-tailed.
A Mann-Whitney *U* test indicated that campaign awareness of respondents who had sought help (*Mean Rank* = 104.16, *n* = 16) was not significantly higher than those who had not sought help (*Mean Rank* = 82.43, *n* = 152), *U* = 901.50, *z* = -1.73, *p* = .084, two-tailed.

[13] A Mann-Whitney *U* test indicated that campaign awareness was significantly higher amongst respondents who had gotten information for someone (*Mean Rank* = 104.33, *n* = 29) than those who had not gotten information (*Mean Rank* = 80.36, *n* = 139), *U* = 1440.50, *z* = -2.46, *p* = .014, two-tailed. This effect can be described as "small" to "medium" (*r* = .19).

Section 2: Stakeholders' views

Contexts for delivery

Interviews were held by telephone or in person with 20 stakeholders with particular expertise and involvement in Choose Life North Lanarkshire. The stakeholders represented a range of services with knowledge of and interest in the Choose Life campaign. These included voluntary services such as Samaritans, Lanarkshire Links - a service user and carer led organisation, and Voluntary Action North Lanarkshire. Statutory services included mental health services (CAMHS), GPs, NHS Lanarkshire - Public Health, police, and the Lanarkshire alcohol and drug partnership. The campaign Co-ordinator's views were also sought. Organisations delivering campaign elements included United Taxis and Motherwell Football Club, and Reeltime Music were also interviewed. Appendix 12 shows the organisations from which stakeholders' views were considered.

The awareness raising campaign delivery began in 2007 with the appointment of the Co-ordinator, but implementation did not fully commence until 2008, so stakeholders were reflecting on 3.5 years of delivery. Involvement of campaign delivery partners varied, both in the type of participatory activity, and in the type and stage of health knowledge and behaviour change promoted. Motherwell Football Club harnessed substantial resources for branded media campaigns which stimulated initial *awareness* among a large targeted segment (the football fan public). Taxi companies and five a side football tournaments combined presentation of information and encouraging individuals to *engage* in further talk and networking in smaller scale participatory settings where everyday activities take place. Participation in the campaign was regarded as 'empowering' for some individuals who took *ownership* of development of materials. So a campaign partner like Reeltime Music mobilised young people in developing the campaign, on the basis of the brand: "creating a project of putting young people in the driving seat of putting on music gigs about mental health".

Champions of the campaign often confirmed that there was a strong personal driver for involvement, for example experience of suicide among friends or colleagues within the campaign organisation (as at the football club). There has been a strong engagement with those members of the general public who have lost a close friend or relative to suicide, evident with Motherwell Football Club, United taxis, and five-a-side tournament campaigns.

Policy drivers for the campaign at national level included a strong steer on targeting young men based on a. levels of suicide in this group and b. issues around young men and communication. Lanarkshire councils had chosen either to buy in a service for Choose Life or co-ordinate the campaign within their existing staff groups, and North Lanarkshire had significantly chosen the former from SAMH. This allowed the campaign to draw on the strength of "existing partnership structures" (e.g. bringing together public, private and voluntary sector partners) "to support the strategic delivery of the programme".

Social determinants for the high levels of suicide in North Lanarkshire include a cluster of interrelated long and short term issues. Longer term deprivation issues mentioned by stakeholders include: high population density, de-industrialisation (steel works and mining closures), intergenerational (family) poverty, substance misuse, and strands of "sectarian culture" in North Lanarkshire especially at "the industrialised southern end". Short-term issues include high unemployment, recession, cost of fuel and food, and unmanageable debt with reduction of support services. Socio-cultural and individual consequences have included loss of social cohesion and hope,

strains on relationships, rising substance issues, and increased suicidal ideation, self-harm and suicide, with young men felt to be at particular risk.

Focus of the campaign

The focus of the campaign was discussed in terms of geographical targeting, as well as targeting by age and gender among hard-to-reach groups. The campaign rightly aimed to target the areas of highest deprivation. However, questions were asked whether the geographical targeting had focused most effectively on Motherwell and southern parts of the region, areas where there was strong support which made sustainability most feasible, particularly with the Motherwell Football Club and United Taxis campaign elements, rather than on other areas. Messages had been taken to different areas (for example Cumbernauld), but finding a foothold has proved difficult, as these have specific cultures and histories which requires local engagement in delivery.

> "Lanarkshire is bigger than just Motherwell."
> "I wonder if we should have been looking for some kind of Motherwell Football Club equivalent in the northern part of our area".

The *combined* campaign 'target' focus on whole population awareness and targeted segments (i.e. young men) was understood to be important for realising different levels of intervention in communities. One level involves long term efforts to build resilience in whole population segments (e.g. of young people), strengthening supports in the environment, and building cultural capacity in relation to supportive attitudes towards mental health in communities. Stigma around suicide had been prevalent, and it was believed that the campaign would eventually change this, so that talking about suicide becomes culturally acceptable. This can be facilitated through a range of approaches building community capacity, including training public-facing providers of everyday services e.g. taxi drivers and hairdressers. This feeds into another level involving prevention and early intervention through supporting at-risk individuals to engage with services, and signposting to sources of help.

A holistic view of campaign elements was expressed by professionals, reflecting their view that community members live complex lives holistically. Different campaign dimensions highlight raising public awareness, developing skills and knowledge for prevention, networking to extend capacity, and promoting agency involvement through training 'champions'. Partnerships with statutory and voluntary services, strengthened through structural linkages (e.g. on the steering group) and through developing strong working relationships, are important to address inequalities at the cusp of the problems people face e.g. housing, debt, unemployment, so that underlying determinants can be tackled. While the campaign focused on at-risk communities, particularly including men, addressing inequalities means looking further into geographical disadvantage and at-risk groups not reached by current segmenting.

Disempowerment is prevalent among high-risk communities. The cultural focus of the campaign needed to keep sights on both men and the wider geo-social culture, as both dimensions influenced a reluctance to speak about issues. Young men are the highest risk group but other groups are also at risk, and community members who could look out for others are influenced by wider culture. For this reason campaign advertising on taxis and buses was not gender specific, while specific campaign settings (e.g. the football club) appealed to men, but not exclusively. The campaign needed to empower communities to action, rather than solely providing information. This was facilitated by targeting specific segments of communities around activities that are meaningful to them, e.g. groups of young people developing resources on suicide prevention for a gig within a 'Sound Minds' music festival. Communication around practical activity has proved more appealing to men than communication separated from daily activity.

The major focus of the campaign on men, particularly young men, was understood and supported by

stakeholders. Young men are at great risk of unemployment, and the coping strategies of the less resilient involved greater risks e.g. of addiction. Targeting the young was seen as a positive way of influencing the culture of future generations. However, a risk of too-exclusive targeting is that shifting demographic patterns lead to rising levels of suicide among older people. A related risk is of ignoring specific female groups e.g. young single mums. Settings-based campaigns were effective in reaching particular segments of men in leisure settings, at least gaining their attention. Men may not 'recognise' issues of depression in themselves and others, and may also have difficulties in communicating vulnerability: recognition and communication are necessary to suicide prevention. Once barriers to communication and recognition are crossed and relationships of trust established men may feel 'endorsed' to speak of feelings around mental health, hence the importance of the campaign strapline 'Suicide. Don't hide It. Talk about it.' This trusting relationship can be helped by working with the grain of men's existing loyalties to activities and brands e.g. the football club, and using trusted role models.

Taking a holistic view of suicide prevention meant that some stakeholders emphasised the importance of training front-line staff from statutory and voluntary agencies. Targets were set by Scottish government for NHS Scotland that 50% of all frontline staff should be trained in suicide prevention by 2010, and more than 1,300 had been trained in Lanarkshire. It was also important to train champions at the interface with the community in public service, consumer or leisure activity settings, and train population segments to do peer work. For example "young people are being trained how to approach other young people or to support other young people if they share concerns about their mental health with them".

It was important to focus on organisations and networks as well as individuals, to improve early intervention and to increase community capacity. For example, work in schools involved developing pathways, called 'lifelines', across tiers of service support, with directions about how to approach a young person at risk, and routes to layers of support. Network events such as those held by Volunteer Action North Lanarkshire can effectively increase awareness and engagement with the public. Volunteer networks in specific segments e.g. Reeltime Music networks of young people are a resource for developing and spreading capacity (i.e. campaigning skills and knowledge). One view is that there is a need to develop further networks and training with employers and commercial companies at the interface with general public.

Objectives for change

The observations of stakeholders about the campaign objectives for change could be fitted in a conceptual framework which distinguishes between different stages of change and highlights the community/individual dichotomy. This framework is developed later in this report in the Discussion and Conclusions section, which considers what has been achieved overall in the campaign and what steps can be taken. This evaluative approach seeks to develop a theory of change with constituent pathways (highlighting long-term goals, short term/intermediate outcomes, and influences on those outcomes). Stages of the change 'journey' for both individuals and communities, mentioned by stakeholders (not necessarily linear) include a. general awareness raising, influencing b. attitude change as a prelude to c. greater engagement towards behaviour change, and d. developing community ownership to maintain change. Campaign elements focused on *awareness* have the objectives of letting people know they can call for help or help others, providing information accessibly and acceptably, and developing 'coping strategies' or capacity. Objectives focused on *changing attitudes* involve 'normalising' talking about suicidal feelings and stigma/taboo reduction within a community - while considering the discomfort felt when 'knowing' one thing but feeling another ('cognitive dissonance'), threatening members of the public as 'men' and citizens in a specific culture when talking about suicide. Objectives focusing on *engagement* involve raising people's investment in their own emotional health and the health of others, and persuading services

and individuals to become champions of suicide prevention. Taking *ownership of behaviour change* around suicide prevention was discussed in terms of services and the public talking to each other and the relationship of the campaign to community empowerment. Within this ownership stage, generic services such as provided by teachers and taxi drivers, and also community networks, activities, and champions facilitate spread of capacity, relieving some of the preventive burden on statutory services. Where community organisations and champions deliver activities promoting mental health that they like to do anyway, (e.g. while talking to customers in a cab, or developing festival design logos) this potentially promotes self-esteem, confidence, and ownership to maintain change.

Components of the campaign

Among the Choose Life campaign components, activities and media associated with specific settings identified by community members in terms of lifestyle choice were seen as important. Leisure settings used in the campaign have included Motherwell football ground, five-a-side football events, library reading groups, and Sound Minds music festival. The football club campaign can be seen as initially more 'spectacle' than festival focused, as well as more 'regular' than the five-a-side tournament and Sound Minds. Stakeholders observed that it promotes awareness of a campaign brand through association with a trusted brand (the football team) in a very well-trusted setting (a match day football stadium). Its audience has been substantially male but intergenerational and family focused also, though not all deprived or at-risk individuals watch football. The Choose Life brand was promoted through 'flag-waving' billboards, and strap-lines and logos on branded items such as team shirts picked up on television broadcasts. Further potential exists, according to stakeholders, to develop the approach with training and other events outside of match days within the stadium.

Some settings offer an active focus around participating in an occasional festive big event (Five-a-side football is more community inclusive, Sound Minds focused on a specific segment). Stalls at the five-a-side football have offered information integrated with games and socialising for people participating in a festive event. The Reeltime Music festival model has involved a group of young people designing and up to three further groups testing and adapting materials to promote Choose Life. Media elements (projected behind performers) combined colours, sounds, images and a lifestyle choice context (music). This locally empowering model needs monitoring to ensure that message integrity is retained.

The 'Healthy Reading group' within library services has offered a regular activity format, engaging a different gender and age target group in suicide prevention work. Library staff were trained to work with service users. Another important setting has been public transport, where buses and taxis offer wide visibility to members of the public. With United Taxis, cards were given out to passengers, the vehicles themselves were emblazoned with the campaign message and contact numbers, and drivers *trained* to talk with the public.

There was said to be a strong case for considering further how different campaign elements fit together holistically. This makes sense in terms of a. how the public live their lives, and b. how professionals view suicide prevention. A series of campaign elements are pulled together around interconnected issues, to achieve a cumulative effect, for example by strengthening networks. An example of this holistic approach involved sequencing campaign activities starting from Suicide prevention week, through events like Mental Health Awareness Week, and the Mental Health Arts and Film festival.

Stakeholders' perceptions of Impact

Stakeholders reported anecdotes that provided insights into the impacts of the campaign on both the 'general public' and on organisations. Stakeholders asserted that the campaign has raised the awareness of the general public, specifically about the Choose Life brand and strap-line challenging stigma and offering call numbers. In particular, the football matches have the potential to reach large numbers (8,000). Awareness-raising came from mass media reports, not just direct public contact with the campaign. Direct measurements had been taken of the positive impact of talks and events on the day in terms of evaluation by participants.

There were reservations, concerning longer term impact, and whether awareness was of sufficient strength to lead to engagement and behaviour change. People might not recognise the information as relevant to themselves due to not seeing that they suffer depression, or being too 'busy' (it does not fit their view of themselves as men or as citizens within a particular culture – so there is cognitive dissonance). There were also doubts about campaign reach (across geographical areas and marginalised men beyond the main settings e.g. football), although the campaign had tried to reach different localities and segments. Impact was considered by stakeholders to be enhanced when local people were involved in design and delivery across communities segmented by age and specific interest. In terms of on-going engagement of the general public, definite but uneven progress had been made on challenging cultural stigma and taboo and people being open to talk about suicide and accepting feeling low.

There was some consideration of the challenge of measuring long term goals, for example preventing children from being future suicide victims, and doubt over resources for this. Rates of suicide cannot be the sole measure of success, there is a need to measure raised awareness, capacity to seek help, and service capacity to cope with increased demand. The use of qualitative as well as quantitative data was advocated - to get narratives of change. Follow up work with young people on intermediate outcomes around self-esteem and well-being was planned but not resourced.

The main impacts on organisations such as commercial services and public sector health and non-health services would be in terms of culture change, awareness, and improvements in practice and service design. Two examples of culture change around attitudes which mirrored wider cultural stigma and practice include professionals taking about suicide, and debriefs for professionals who encountered a situation. In the taxi company, the first drivers to get Choose Life branding were teased initially but there was soon sympathy towards the cause - dialogue came first then approval. It was important to organisational impact that the campaign would be embedded in organisations. For example, staff signing the 'see me' anti stigma pledge means that the campaign gets translated into Action Plans and 50% of staff going for suicide prevention training. The 'see me' campaign is a separate mental health campaign supported by the Scottish Government that is concurrently influencing staff and organisations. This creates a fluid, multi-message, multi-faceted context within which local Choose Life activities are implemented. To date there has been little cross-over at a national level between Choose Life and 'see me'. The delivery of SafeTALK and ASIST (which targeted professionals) was spread across a diversity of organisation types, including health organisations, frontline services such as police, fire, education, community planning partners, and voluntary organisations.

Challenges for the campaign

The challenges for the campaign that were mentioned include: more effective targeting, ensuring sustainability of the awareness-raising process, and overcoming organisational and community resistance. Targeting young people was viewed as a challenge, within a 'whole community approach'

campaigning through such outlets as the football club, five-a-side tournaments, pubs and taxis. The challenge of targeting disadvantaged groups across the geography of North Lanarkshire was also highlighted. Concerning sustainability, networking had to lead to organisations taking responsibility for making suicide prevention 'everybody's business'. An important challenge was to move responsibility further up the 'tiers' of intervention, so community champions, volunteers, and professionals (e.g. in local shops) dealing with the general public as part of their daily lifestyle (shopping, getting fit, relaxing at the pub) took more initiative of a preventative kind, talking with people 'earlier' in their mental health journey.

'Normalised' organisational and community views on not talking about mental health and suicide were often considered strong or deep-seated, even impeding buy-in to the campaign within parts of statutory services (for example resistance arose in one organisation over using the Choose Life message as wallpaper on organisational computer desktops). Thus the task of *sustaining engagement*, rather than only stimulating moderate levels of awareness starting from an initial chasm, should not be underestimated. However, most stakeholders mentioned only a few challenges, which raises the question whether there is some dissonance between stakeholders' views and the levels of campaign awareness evidenced among the general public. Certainly the stakeholders described a *process* of implementation that had been invigorating and worked well.

Factors contributing to success

Holistic, multi-layered and partnership approaches were said to be important to the success of the programme. The collaborative working model involves the *structure* of the partnership including the Co-ordinator post and the steering group, and the functioning partnerships *in delivery*, e.g. establishing pathways for prevention in schools (although this is not fully realised yet). Creating a full-time ring-fenced Co-ordinator post was important (although funding is not protected), as was being able to mark clear achievements over time, and also including wide-ranging representation of appropriate agencies on the steering group. The integration of a multi-layered approach, including a mass media campaign, levels of training, and the social marketing campaign was key to successful delivery, in that, for example, raised public awareness needs to be matched by capacity-building and availability of pathways for prevention.

Leadership factors contributing to success included a clear 'vision' of goals, and means to achieve them, setting and meeting realistic targets, approachability of the Co-ordinator, and management skills, including planning phases and feeding back appropriately to the steering group. Within individual services, having a named person, a champion for Choose Life, enables service partnerships to be strong.

'Vertical' integration of national and local messages was important. National branded materials are important as evidence-based social marketing product development is most feasible on a national scale, but locally responsive variations were thought to be effective, targeting local impact factors, e.g. taxis, and local festivals and bands for young people. 'Horizontal' integration meant ensuring that services work in effective partnerships tying together different strands. The voluntary sector (e.g. housing associations) can reach certain at risk groups before they require a response from statutory services. Generic consumer services (e.g. taxis and shops) reach the general public during their daily activities. The Co-ordinator post is local authority funded, managed by the voluntary sector, and co-located with local authority services, which supports strong co-ordination. Consistency of message (across different media) needs to coincide with consistent practice, e.g. in models of routes to information and support across services. Underpinning this, elements of health promotion campaigns (such as 'see me' and Healthy Working Lives awards) need to be integrated with a clear model of how they are going to join together to bring about change. Professionals held a holistic model of local Choose Life activity, and emphasised the power of creating new

communication pathways between stakeholders, building up skills and capacity of professionals, and building social capacity in communities: "bringing different species together - that's what makes the campaign strong for reducing the suicide rate". The public awareness campaign, triggering off many activities that should later bear fruit, needed to be linked to the other components. Related to the issue of consistency of message and practice, there was some discussion of integrating the 'sharp end' of suicide prevention within a wider intervention model of promoting well-being.

A number of factors were discussed contributing to the 'success' of the social marketing campaign. Among these is the integration of campaign elements with support for people to engage in valued 'lifestyle' activities which 'embody' cultural messages or learning. The five-a-side football tournament campaign was activity-focused and messages integrated with festive activities at the stalls. A 'call to action' was important rather than only information provision. High level action with 'ownership' is exemplified where volunteer champions design messages behind bands at a festival, or develop plays around well-being.

Market understanding and 'mapping' of lifestyles and normative/cultural preferences of each community 'segment' was regarded as important. On this basis, for example the taxi campaign could be directed to young people coming from pubs at night, a potential trigger moment. The importance of working with rather than against the grain of lifestyles was also emphasised, for example telling people not to bet was said to be a bad idea. Further mapping across stages of awareness, readiness and engagement might also be important, as one stakeholder commented that marketing Choose Life on the Motherwell football shirt may raise awareness 'in a subliminal way', as an initial attention catching process. Further fine-grained segmenting and market understanding - insight work - was needed around sub-cultures within age groups and geographies.

Effective social marketing in the campaign often also involved 'personalisation' – through combining media 'information' and personalised interaction, for example through talking with taxi drivers, (as well as the above information and action). This could engage people, rather than merely prompting low level initial awareness.

Success was also influenced by quality of materials in various ways, including: durability, accessibility, conciseness and clarity of information, design and message being integrated rather than one overwhelming the other. The design strengths of the materials needed to complement and be complemented by the social environment they are embedded in. This context includes mainstream or niche activities people engage in, elements of personalisation such as discreteness (e.g. an in-your-pocket card), and potential to relay messages on to others. The branding has been important, for example football-branded cards with call numbers for Samaritans and Breathing Space challenge cultural stigma in a way the Samaritans brand alone does not. The message tone was most effective if concise and direct, grounded in everyday contexts, positive and good-humoured, and with a call to action: 'it's real get on board' for public transport. There was some discussion of language and its conceptual underpinning. The 'mental health' aspect of campaigns needs to be modelled in an inclusive way, highlighting *wellbeing*. However, the focus on *suicide* can be explicit, because this helps remove the stigma from talking about it, and because people at risk of suicide will respond to the call.

Key factors supporting people in communities to move to higher levels of awareness and engagement were said to be developing community ownership through using community settings and networks (e.g. community arts), and getting community notables (e.g. pub landlords) to be champions willing to promote the suicide prevention messages. Role models respected in the community helped to engage hard-to-reach groups. These could be sporting figures, people who had survived similar problems and thrived, or local bands for young people. Success in engaging with and supporting people to take ownership of their communities' health was encouraged through working

with peer support groups, with the aim of building support networks. For example a peer support group member took on a champion role and wrote and presented plays in pubs promoting the ASIST training.

Continuity or recurrence of campaign elements - for example holding the five a side tournament with Choose Life campaigning every year - was important to culturally embed people's engagement within a community setting. The football club also saw the brand as integrated with wider cultural messaging around community health, and promoted with 'continual support through the year'. However, it was also important to plan for progression and reinvention, as social marketing needs to be cutting edge to hold attention, and "for something to be news it also has to be NEW". It is also very important to continue to identify gaps in the 'market' and renew the campaign to fill the gaps, both in terms of hard-to-reach groups, and in terms of stages and levels of community change.

Meeting community needs

Stakeholders were asked what has been learned from the project about meeting particular community needs and translating campaign messages into real community change. To engage community members, and "build mental health capacity into communities" it was necessary to embed messages in community settings and events which are part of community life, get community activists involved and develop and use capacity building networks - this builds confidence, empowering people to make decisions, generate ideas and be active - "a call to action" clarifying what people can do, not just what they should know. Beyond promotion of community engagement and ownership, there is a need to *spread* change and *renew* the campaign within the community. A community development model was advocated, using informal networks and community teams and forums, so the networks generate their own ideas for what they think their communities of interest will find engaging and continue to use, within and as part of their cultural activities. Existing community leaders and activists can champion this, and future leaders can be engaged through "training folks who have access to the wider general public", recognising that "expertise lies equally with people with that life experience as with people with academic expertise". Within these approaches some advocated involvement of survivor groups.

> "if there is an awareness, getting community activists involved, if there isn't an awareness in the community then thinking about how you can allow that to be more prominent, and that's where there is a big role for public health improvement with the process of community engagement and using community development approaches"

Within a community development approach there were ideas about building capacity and confidence as well as commitment to organisational and community system change. This means giving people the confidence to communicate, to ask someone if they want help, and empowering community groups to take some decisions around progression and diffusion, and deciding what is best for that community, e.g. "involving young people through music and giving them the opportunity to speak and make decisions and empowering them" "not assuming what is best for other people". Finally it was important to respond to the diversity of hard-to-reach communities through social marketing, by geography, gender, age, risk (e.g. addiction) and interest.

Sustainability and future priorities

Stakeholders were asked finally about securing the sustainability of the campaign, and where their priorities lay for the future. Dedicated funding was important to sustain the full time co-ordination role, and maintain national as well as regional commitment, and the loss of ring-fencing in money provided to local authorities over the last three years was a risk factor. Mainstreaming campaign elements within services (suicide being interlinked to many public health and social agendas) is a key way of sustaining the main project goals of suicide prevention. A vital element could be to develop

collaborative approaches which tie together interrelated themes, particularly through a public health approach, embedding the work in people's roles and responsibilities. As the networking to organisations has progressed, the priority becomes working with organisations to persuade them to embed the agenda in their strategic and service action plans (for example pledging to 'see me' www.**seeme**scotland.org.uk/). One aspect of mainstreaming is persuading organisations to train individuals as trainers. Making training a core requirement for staff was important.

As detailed earlier, a community development approach to sustainability includes developing partnerships with organisations and champions who interface with the public (e.g. hairdressers, taxi drivers as well as housing and employment offices) building on community networks, and embedding empowering activities in community friendly environments. 'Natural' networking drawing on communication through existing service interactions matched to people's lifestyles has been proved effective through the taxi campaign. With young people, a cohort-cascading approach (envisaged by Reeltime Music) involved empowering groups to develop campaign materials around gigs and then "letting them grow up", as they pass the mantle to new recruits.

Hard-to-reach groups, such as unemployed and disconnected young people who miss out on campaigns through mainstream settings such as schools or football grounds, are best reached through existing or emerging third sector partnership networks or 'hubs', drawing on peer support, and obtaining further feedback from hard-to-reach themselves about routes. This approach might also require joint campaigning, as people experience issues in relation to underlying pressures. It is important, while doing this, to maintain a whole community approach as well. To strengthen the interface between campaign and community activities, it might be advantageous to shift the balance between single big events towards smaller scale events recurring over the year. However, community development approaches should not be expected to bear fruit for a few years, since capacity building, confidence raising and culture change at community levels take time, "as the generations grow up and as people become more confident in managing this".

Among the priorities for the future mentioned by stakeholders, it was considered important to target carefully, building on an emerging understanding of how change 'spreads' through the campaign, and refining messages for specific target groups: "If you get the processes right first of all you can build in a lot of other things from there". Particular 'candidate' groups for closer targeting were suggested, including the future generations (school years, mother-child groups), at-risk women, older people aged 65+, and people from specific deprived communities. This could be done through holding more frequent events, and using smaller activity or interest group networks (local participatory sports clubs). The targeting should continue to be based on an increasingly precise understanding of inequalities agendas. This involves considering demographic inequalities by region, and particular groups, for example men who don't work anymore, those at risk of addiction, and people who are not a captive audience, for example the 35-55 out-of-work group.

> "in North Lanarkshire people are five times more likely to complete a suicide if they live in the 20% most deprived area in Lanarkshire than if they live in the 20% most affluent area."

It was considered important to renew the campaign inventively to sustain involvement. However, this needs calibrating with a model taking account of stages of community change. Greater localisation was considered important to promote the engagement of specific communities. This could involve more community consultation about directions, focusing on very local settings (e.g. primary schools), building partnerships with local companies and networks, and establishing local contact numbers (not remote call centres).

Finally, a stronger focus on understanding what works was urged, for example more attention to understanding the evidence concerning the relationship between self-harm and suicide prevention.

Box 1: Sustaining and extending the campaign – summary of suggestions from stakeholders

- o Further fine-grained segmenting and market understanding is needed around sub-cultures within age groups and geographies.
- o It is important to target campaign elements building on an emerging understanding of how change 'spreads' through the campaign, and refining messages for specific target groups.
- o It is important to plan for progression and reinvention, to hold attention.
- o This progression needs planning with a model taking account of stages of community change.
- o Dedicated funding is important to sustain the full time co-ordination role, and maintain national as well as regional commitment.
- o Mainstreaming campaign elements within services is key to sustaining main project goals.
- o A call to action rather than only information provision could stimulate higher engagement, although men are initially more likely to seek information.
- o Ownership is encouraged where community champions and networks develop campaign messages further in community settings.
- o Hard-to-reach groups, such as unemployed and disconnected young people are best reached through existing or emerging third sector partnership networks.
- o Greater localisation is important to promote the engagement of specific communities.

Section 3: Secondary data analysis

NHS 24: Breathing Space

The data available from Breathing Space provided a limited insight into interactive calls (i.e. where the caller conversed with the Breathing Space worker) made by those who have Lanarkshire as their Health Board between June 2010 and April 2011. The data presented in this section refers to calls where self-harm and/or suicide was an issue identified during the call.

A total of 89 calls were made to Breathing space between June 2010 and April 2011. Fifty-one of these calls (57.3%) were made by females, 35 (39.3%) by males and the sex of 3 (3.4%) callers was unknown. It is interesting to note the lesser number of calls from males.

Table 5 below shows the division of calls made by locality and month.

Table 5: Self-harm and/or suicide-related calls to Breathing Space from June 2010 to April 2011, by locality

Month	Airdrie	Cumbernauld	Kilsyth	Motherwell	Wishaw	Total
Jun-10	0	0	0	0	0	0
Jul-10	0	0	0	4	1	5
Aug-10	0	0	0	3	0	3
Sep-10	0	0	0	9	0	9
Oct-10	0	1	0	6	0	7
Nov-10	0	0	0	0	0	0
Dec-10	0	0	0	1	0	1
Jan-11	0	0	0	3	1	4
Feb-11	1	0	0	2	0	3
Mar-11	0	0	0	2	0	2
Apr-11	0	0	0	11	0	11
Total	1	1	0	41	2	45
Percentage	2.2%	2.2%	0.0%	91.1%	4.4%	100%

It is very clear that the majority of calls to Breathing Space during this period came from Motherwell, despite the fact that Airdrie's urban centre (pop. 35,500) and Cumbernauld's urban centre (pop. 50,480) have larger populations than Motherwell's urban centre (pop. 31,280). This may therefore suggest a stronger awareness of the Breathing Space service within Motherwell.

Samaritans

The data provided by Samaritans facilitates consideration of dialogue contacts (i.e. where a volunteer is able to provide emotional support, lasting more than 30 seconds) answered by Samaritans in the Hamilton branch, and those answered in Scottish branches overall. It is vital to bear in mind that calls to the local Hamilton branch can be diverted to other branches, and calls outside of the local areas can be diverted to the Hamilton branch, depending on volunteer availability. It is therefore not possible to state that variations in call numbers are due to variations in calls placed in the local area, which makes it difficult to identify obvious trends. Figure 1.1 below gives an indication of Hamilton's proximity to North Lanarkshire.

Figure 1.1: Hamilton in relation to North Lanarkshire

Graph 2.1 below shows the division between calls received from identified males and females to Samaritans Hamilton between 2000 and 2010.

Graph 2.1: Dialogue contacts with Samaritans Hamilton branch by sex of caller*
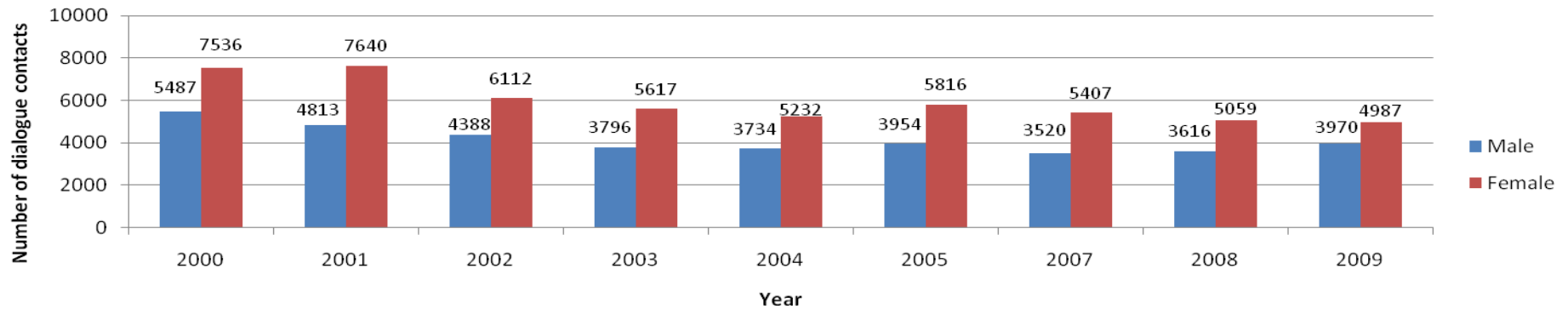
*Please note 2006 data was not available, and also that the sum of dialogue contacts from males and females does not equate to total contacts as gender is sometimes undetermined.

It is evident that for each year a higher proportion of callers to Samaritans Hamilton were identified as female. It is interesting to note that as the number of females callers reduced between 2007 and 2009 (during campaign) the number of calls received by the Hamilton branch from males increased. Graph 2.2 below shows quite a different pattern when considering dialogue to Samaritans branches throughout Scotland by sex.

Graph 2.2: Dialogue contacts with Samaritans Scotland by sex of caller*
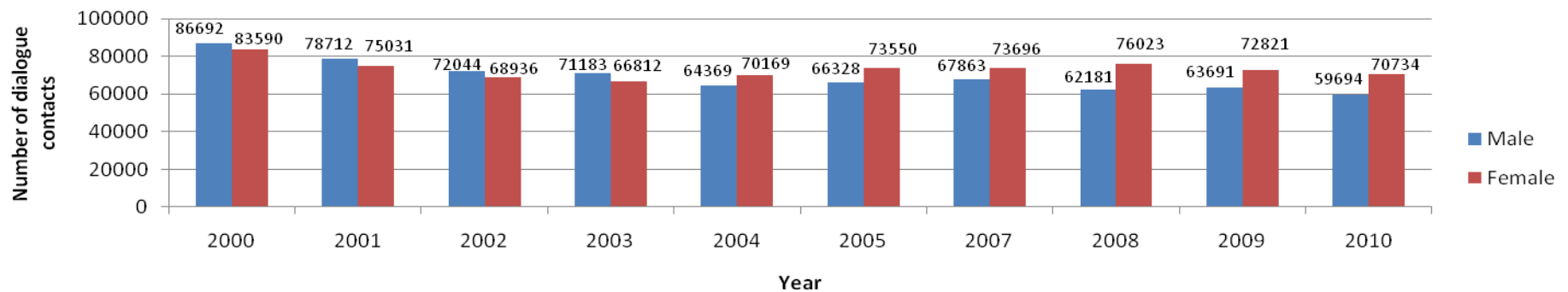
*Please note 2006 data was not available, and also that the sum of dialogue contacts from males and females does not equate to total contacts as gender is sometimes undetermined.

Between 2000 and 2003 more males were recorded as having dialogue contact than females, yet as of 2004 females had more contacts than males. It is also interesting to note that whilst in Hamilton dialogue contacts from males increased year on year between 2007 and 2009, Samaritans Scotland saw a fall in calls from 2007 to 2008, followed by a slight increase in 2009 and another steeper fall in 2010. Unfortunately 2010 data for Samaritans Hamilton was not available for this comparison.

Accident & Emergency

The data provided in relation to A&E attendances was our most detailed dataset, and facilitates analysis of attendance to A&E departments in North Lanarkshire in relation to a number of factors including age, sex, and place of residence (i.e. locality).

Graphs 3.1 and 3.2 below show the number of male and female residents of North Lanarkshire who attended A&E between 2005 and 2010, where the diagnosis mentioned self-harm (including poisoning/overdose and those who have a personal history of self-harm) by age group.

Graph 3.1: Male residents of North Lanarkshire number of attendances at Lanarkshire A&E departments where the diagnosis mentioned self-harm, by age group
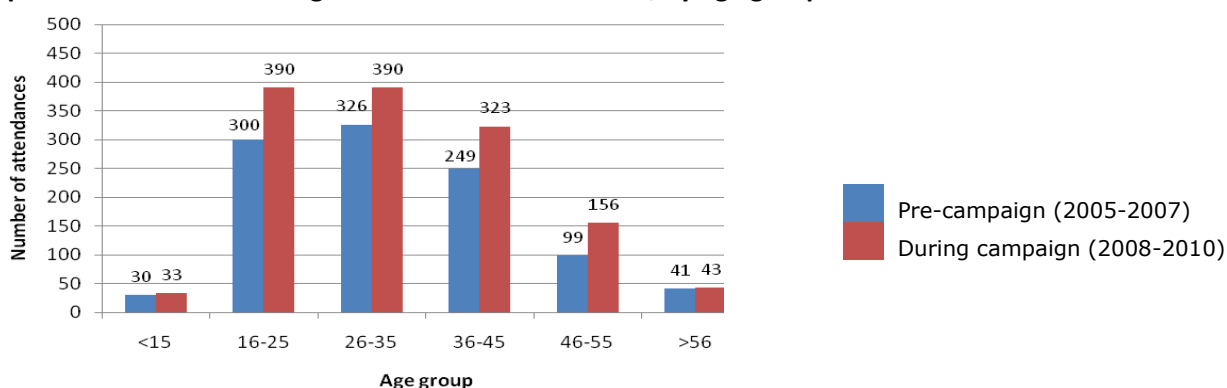
Graph 3.2: Female residents of North Lanarkshire number of attendances at Lanarkshire A&E departments where the diagnosis mentioned self-harm, by age group
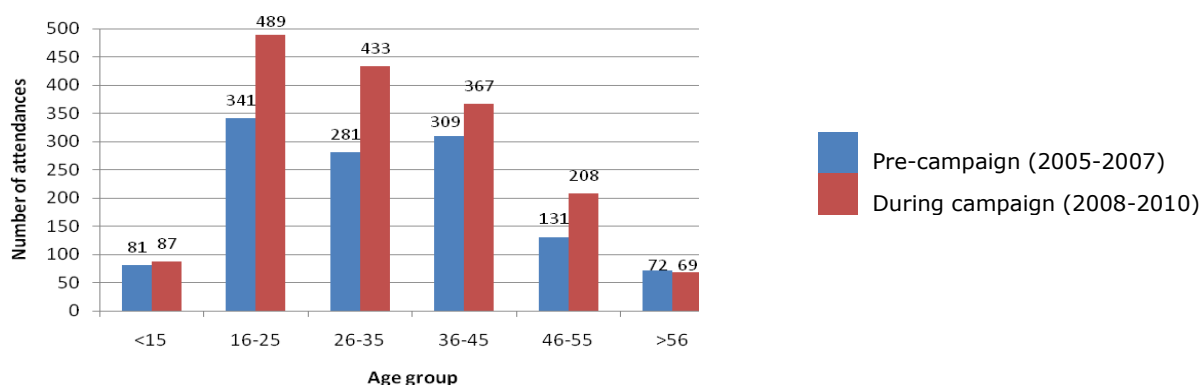
Graphs 3.1 and 3.2 above show that the mean number of male A&E attendances was higher amongst all age groups during the campaign when compared to pre-campaign. This was also true for female A&E attendances, except for those aged over 56 years who had a 4.2% decrease in attendances. A similar trend is evident during both time periods and for both sexes, with the highest number of attendances amongst those aged between 16 and 35 years. It is unclear whether these results should be interpreted positively or negatively. On the one hand increases in attendance during campaign compared to pre-campaign may suggest a positive campaign impact, i.e. that more people are, in a fashion, seeking help for their issues through A&E attendance. Conversely it could also suggest a negative result, i.e. that relatively fewer people are using the services available (such

as Breathing Space and Samaritans) to help prevent self-harm/suicide-related activities, and therefore more people are ending up in need of medical treatment.

Graphs 3.3 and 3.4 below show male and female admissions to hospital following self-harm (i.e. emergency admissions to acute hospitals in Scotland as the result of self-inflicted injury or poisoning) by locality of residence.

Graph 3.3: Male North Lanarkshire residents' number of emergency admissions at acute hospitals in Scotland as the result of self-inflicted injury or poisoning, by locality of residence
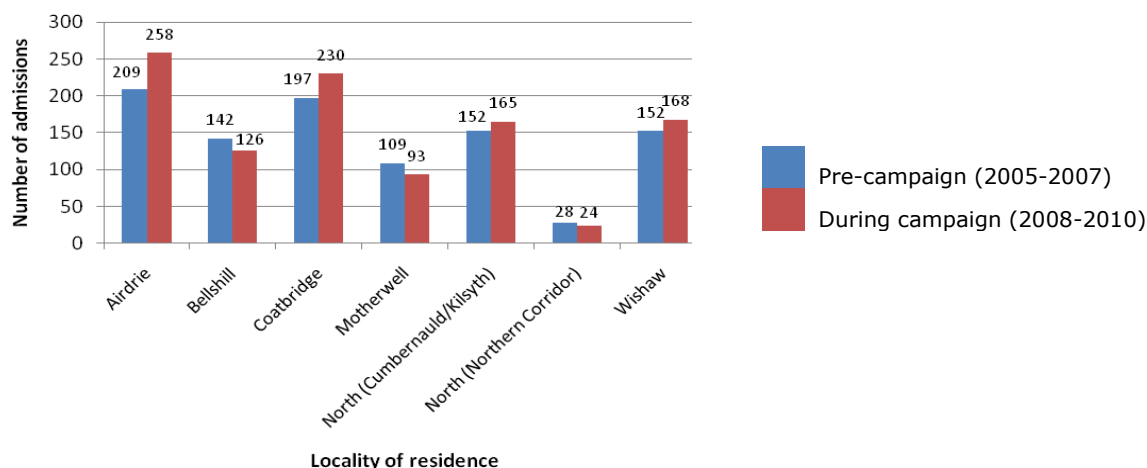
Graph 3.4: Female North Lanarkshire residents' number of emergency admissions at acute hospitals in Scotland as the result of self-inflicted injury or poisoning, by locality of residence
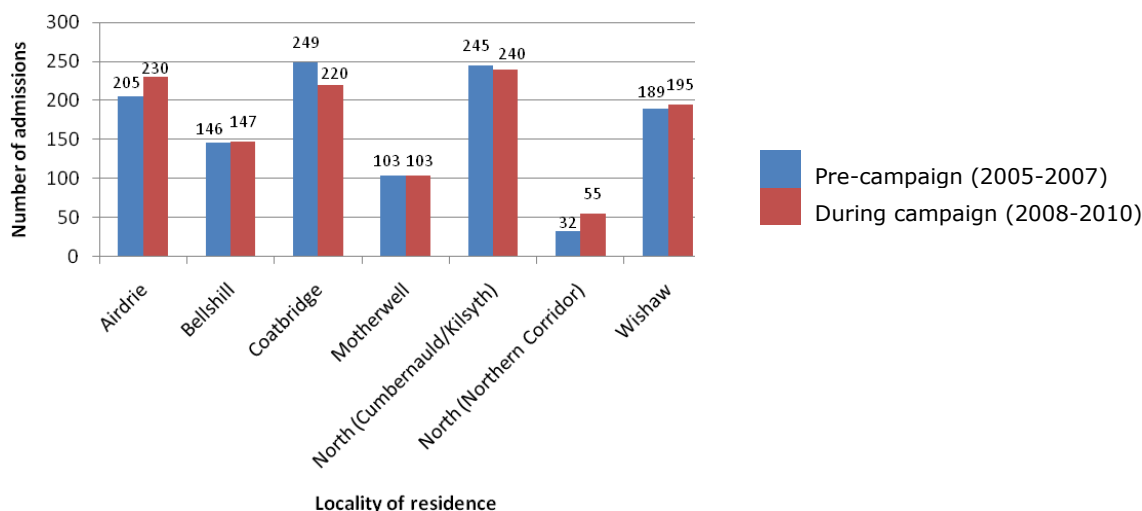
Graph 3.3 above shows that admissions amongst males residing in Motherwell following self-inflicted injury or poisoning were 14.7% lower during the campaign period compared to the pre-campaign period. This was the highest percentage reduction amongst males, though other decreases were seen amongst male residents of Bellshill and the North (Northern Corridor) (decreases of 11.3% and 14.3% respectively). Interestingly, in comparison, Graph 3.4 shows that North (Northern Corridor) saw by far the largest percentage increase in female emergency admission with a 71.9% increase. The highest increase in emergency admissions for males was amongst residents of Airdrie (23.4% increase). Amongst females a lower number of emergency admissions was seen during the campaign period amongst residents of Coatbridge and North (Cumbernauld/Kilsyth), with decreases of 11.6% and 2.0% respectively.

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Although it has been difficult to draw any solid conclusions from the secondary data it remains clear that locality and gender are important factors in suicide-related calls to help-lines and A&E attendances and admissions.

Section 4: Discussion groups

Introduction

Phase three of the evaluation includes discussion group sessions with men and women. Six discussion events were held at four locations in Motherwell, Cumbernauld and Newarthill, to provide further insights into questions 1, concerning awareness of call numbers and de-stigmatising attitudes; 2, concerning the aspects of the programme which worked best; 3, concerning benefits to the community; and 4, concerning contribution the community makes to the effectiveness of the programme. During these sessions a total of 10 small groups were formed with the following age and gender group composition: 3 x 16-25 male; 2 x 16-25 female; 1 x 26-35 male; 3 x 36+ male; 1 x 36+ female. Discussions during these sessions were recorded with digital voice recorders, and fully transcribed, and further session notes taken including plenary feedback on flipcharts. Qualitative data from these groups was analysed using NVivo software through a process of descriptive and analytic coding with codes then clustering under theme headings.

Experience of the campaign

Materials seen
Participants discussed their experiences of the campaign in terms of materials they had seen, places where they were seen, and messages. The materials noticed in Motherwell included: the football club billboards, sponsorship shirts, cups, and T-Shirts, posters and beermats in pubs, posters above workplace and pub urinals, and panels on taxis and buses.

> "We've got posters and stickers saying 'Choose Life', the shirts, posters above urinals, taxis, Motherwell sponsorship shirts, advertising signs, handing out information, give-aways like the T shirts, cups." over 36 m

Places
Surprising placement in places where people unwind
Social marketing campaigns use techniques of product placement and demographic targeting associated with marketing of consumer products around lifestyle preferences of particular groups of men and women. Among 'trusted' places where people could relax and escape, targeted by Choose Life, more men than women attend football stadia and town centre pubs, while more young people attend local music and arts festivals such as Sound Minds. Participants reflected on the placement of promotional materials. Where a suicide prevention message was noticed in an unexpected leisure location, such as a football stadium, a pub or a washroom, this 'incongruent' placement attracted men's attention.

> "Motherwell were playing in Europe at that time, I was quite surprised the campaign had used such a big occasion to market the campaign in particular a European football match." 26-35 m
> "I did like the fact it was in quite incongruent places as you don't normally see the word 'suicide' at a football match. I thought it was good to see." over 36 m

There was a strong consensus that promoting suicide awareness in leisure activity contexts where people escape the chaos and pressure of their daily lives has been a positive step. In 'trusted' leisure contexts, men particularly may be less psychologically 'defended' from acknowledging the campaign's relevance to them, and subconsciously more receptive. This would be the case whether the setting involved spectatorship (Motherwell FC) or participation (Five a side football), and whether it was focused around competitive sport (football) or other activities e.g. fitness (Gym) or arts (drama).

"Life can be chaotic and problematic but if you go to football you generally don't give that [football] up, because for that ninety minutes of football it's an escape so it really is a great place to advertise that type of thing, to people who are genuinely needing some help or some support." 26-35 m

Universal places

Some materials were placed in 'universally' visible public locations which are relatively age and gender neutral, for example on panels on the side of buses. Messages on passing taxis and buses were noticed and might be recalled later, but details (call numbers) were not always fully registered, as the message is 'fleeting'. More adverts could be placed in such fixed locations as bus shelters, where there is time to absorb the information.

"It's brilliant because you're seeing taxis all the time passing by." over 36 f

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

Some settings would particularly attract women, and so placing more posters in shopping centres, in supermarkets, bakers (e.g. Greggs) and clothes shops, for example, would attract attention.

"Putting a poster up at Greggs [would be] an ideal opportunity, while people are standing there for five to ten minutes. People stand in queues in Tesco's and Asda. Marks and Spencer." over 36 f

"We think put adverts like places where we're going to be, places like clothing shops." 16-25 f

Focusing on different age groups in message placement was important. Men and women over 50 might notice television adverts, while younger people (16-25) were more likely to notice messages in social settings, for example around fashion (shops), and music (festivals and gigs).

"I think our age group are more likely to be sitting watching TV in the evening. Television advertising's expensive but ok I think most people in their 50s, 60s are watching TV." over 36 m

Higher risk people and their spaces

Whereas participants had certainly noticed the materials in places where the general public go they were unsure materials were being seen where people at high risk go. Alcohol consumption being a high risk factor, placing posters in pubs was appropriate, but more posters might be located in job centres, health centres and venues where people at risk might come together e.g. in alcohol support groups.

"I've seen it about the pubs a good way to get it across because if folk have got suicidal thoughts they're going down the pub and drinking." 26-35 m

"Places like AA groups. The campaign should go in there because the amount of people I know that have committed suicide through alcohol abuse." 26-35 m

Region and place

The high visibility of materials in locations around Motherwell was strongly valued, but not matched elsewhere. Cumbernauld participants had not seen the materials, and rural locations saw little of the campaign. Approaches that worked in Motherwell might be used elsewhere, for example approaching leisure settings with untapped potential such as Broadwood stadium in Cumbernauld. Some Cumbernauld residents might prefer to use Glasgow facilities, rather than go to Motherwell.

"I haven't seen any posters or leaflets or anything in this area at all." over 36 m

"Two of the biggest teams in Scotland, in Glasgow, that is where you should put it. Many people from here go there." over 36 m "Also Clyde football stadium, just here." over 36 f

Messages

Tone, brevity and clarity

The message '*Suicide. Don't hide it. Talk about it*' attracted people's attention due to its striking theme, positive tone, brevity and clarity, framed in most cases by bold colours and design. The topicality of the message attracts attention - high profile individuals had attempted or carried out suicides recently. The message that suicide should not be hidden but spoken about challenges both a dominant strand of masculine identity where men avoid communicating vulnerability, and normative stigmatising of mental ill-health as shameful. However the blunt message might put some people off.

> "Good for everyone." "Short and snappy." "Breaks the stigma." "Gives people confidence to talk about it rather than hide it away." 16-25 m
>
> "Some people liked the bluntness of it, others thought that if you were in that frame of mind it might be a bit too harsh, a bit upsetting." 16-25 m
>
> "The girls…very emotional. It does need to approach us more gently." 16-25 f

The brevity of the message makes it suitable for leisure settings and lifestyle activities where people will focus quickly on the information, and absorb it consciously or subconsciously for later recall.

> "It'll probably surprise you what you take in without realising." over 36 m
>
> "It's one of those things that you take in and you suddenly remember when you actually need it…subconsciously." over 36 f

Participants expressed some concerns about who the message was mainly for. It was very important that the public should not only see the striking and effective generic message '*Suicide. Don't hide it. Talk about it*' (such as on the Motherwell shirt and billboard) but also messages which explicitly address the general public, and call on them to help others. An example of this is the message '*Help a Friend Stay in the Game*' on the A2 Motherwell poster and postcard. Clarity is absolutely needed given the social norm among the general public of silence and attribution of mental health issues to others. Second, to engage with men and women at a deeper level around attitudes and engagement requires more varied forms of communication, including use of narrative strategies (stories about people who the viewer identifies with).

Address

The main ambiguities around the 'message' concerned how it would be interpreted by people at risk and by members of the public who might influence them, and how far it provides a guide to action ('next steps') for each of these audiences. The strapline and the call numbers as presented in various media often left participants in doubt how appropriate the message was to the general public. It was vital to challenge the taboo of silence, but people with potential influence on those at risk (for example family and friends) might feel uncertain if the message to 'Talk' applied to them, and might not know if they should use the call numbers. On the other hand, the A2 Motherwell poster and postcard addresses the public explicitly and contains further guidance to action, which was very useful. However, this message does not mention suicide explicitly in the strapline, and therefore it might not have had the same initial impact.

> "'Choose Life' is a good title but when it comes to 'what does this mean for me?' that's a big thing. There needs to be something that says 'how do I identify with this? What am I meant to do?' " over 36 m
>
> "It was targeting everybody but what should you do, and it seemed to me there's two types of folk. There's the 'you might be talking to somebody who's thinking about killing themselves' or 'you might be the person' and the instruction would be different depending on who you are." over 36 m

The second area of concern touches on the use of narratives or stories. The prevalent message and settings made for an effective 'first step', but a 'next step' was needed to engage community members more deeply, through stories or narratives and also music, with which people identify in order to challenge cultural barriers, and to provide cues to action. This is discussed further in *Challenges* below.

> "With that message 'Don't hide it. Talk about it' that's simple and good but I'm thinking 'what would I do? If I felt like that, what would I do?' That's the next step and I think it needs some drama or something." over 36 m

Overall participants expressed mixed emotions about the messages, including surprise at the placement, sombre recognition of the topicality, anger and sadness at tragic problems, hope at the positive tone, and uncertainty about who was addressed and what they could do. There were feelings of stress and worry knowing the prevalence of the problem, of anxiety and anger that the campaign reach was limited. Finally there was a sense of achievement and pride that people are starting to talk about this now.

Impact on awareness

Stages of change

The participants considered how far the campaign was impacting on the *awareness* of members of the general public. Stages of the change 'journey' may include a. general awareness raising, b. attitude change as a prelude to c. greater engagement towards behaviour change, and d. developing community ownership to maintain change. This section considers participants' views of awareness-raising, the following section considers attitude change and engagement towards behaviour change, and the sections on challenges and developing the campaign, and subsequent discussion, include reflections on community ownership.

Campaign elements focused on *awareness* have the objectives of letting people know they can help others or call for help, and need first to provide information accessibly and acceptably, and support people to develop 'coping strategies' or capacity. The public nature of the campaign contributed significantly to raising *initial awareness* by simply putting the issue in front of people in family or community settings.

> "Previously it was a closed doors thing, you didn't talk about it. The fact it was on the TV [national TV advert] and it was out there, that's the thing that changed people." 26-35 m

Normalisation

Awareness is increased when people see the message routinely within trusted settings where they *normally go* as a lifestyle activity: beyond the surprise lies a normalisation of the message that suicide is something to talk about, through repetition. This removes some of the shame factor. However, it was felt that the awareness may sit within individuals and, due to group norms and preferences, not be commented on socially during or right after spectator events where the primary focus lies elsewhere (e.g. a football match). The campaign focus on 'lifestyle' needs to be appropriate for this 'normalisation' of a message to be possible. Campaign linkage to events considered 'inappropriate' by age groups or sections of the target audience, in terms of lifestyle, might mean the message is ignored.

> "Lots will get that message at the football. Nobody's ever come back to me and said 'I was at the game on Saturday and I saw this'. Nothing like that." 26-35 m

Beside the normalisation of 'suicide' as topic, it was felt the campaign has led to greater awareness that it is *normal to feel depressed*, and that to express or *communicate concern* over mental health and wellbeing is normal. The campaign also made many people aware that they could be *watchful* in

the community, and watchful not to react to another's distress with a stigmatising response: all of this was normalised.

> "We all agreed with that campaign we'd be more alert, more likely to talk to somebody." over 36 m
>
> "You wouldn't say 'pull yourself up by the boot straps' or 'get your act together'." over 36 m
>
> "My personal view is quite often is that person must start off feeling a bit down, that turns into depression, it gets worse and they don't catch it or there's no intervention, they don't speak to a doctor or anybody at that stage, it builds. I would hope that people are saying you can discuss suicide then people will also feel more happy to even not say 'I'm suicidal' because they might not be but to say 'I really feel shit just now and whatever I do it's not getting any better'." over 36 m

The extent to which the campaign message raises awareness depends partly on how far it resonates with people's direct community experience. It was also crucial that the campaign continued over time (repeat exposure), with variation in the messaging. As in any marketing campaign, brand consistency and innovation in messaging and placement keep people's attention in the face of competing consumer messages.

Limited content
Awareness might be constrained by the limited message content of some materials, it was felt, (see *Address* and *Narratives* above) - not clarifying if call numbers are meant for the community or only people needing help for themselves, what happens when someone rings Samaritans or Breathing Space, and how suicide can be talked about to a person in need. The Motherwell postcard and A2 poster, which contains further guidance to the public, still does not really clarify whether the public should call the phone-lines to help a friend. It was felt that a single message cannot easily achieve these things. The surprise can fade if not supplemented by further awareness raising strategies that engage people's sense of identity.

The main message strap-line, '*Suicide. Don't hide it. Talk about it*', raising awareness greatly, was felt to provide a necessary but insufficient resource. Overcoming the cultural and gender barriers to men talking about suicide requires an interacting and coherent range of strategies using a range of messages, with other support empowering men to talk and find help. Otherwise people easily let the message slip from the threshold of low level awareness, forgotten as 'for someone else', and irrelevant.

> "It makes you aware that Choose Life is there and Samaritans and Breathing Space but we don't think it makes it clear what they're exactly there for and can actually do for you. We don't quite know what's going to happen when you phone them up." 16-25 m
>
> "When you see poster and have a chat about it, you become aware but it does not last any more than two minutes. Think it is someone else's problem." 16-25 m

Impact on attitudes and behaviour change

Openness and legitimisation
The attitudes of at least a proportion of the public, aware of the campaign, were changed as they felt more open to talk about negative emotions. The topic of suicide, indeed mental health, was previously rarely talked about in the West of Scotland, and among men particularly, and the campaign 'allowed' men in the pub to mention feelings of being low or depressed. Very positively, the campaign was normalising the possibility that men who were not suicidal would talk about their own emotional health.

> "Definitely helped me do something because myself, I was a wee bit depressed about a year and a half ago like and through Choose Life getting over my problem I managed to help a couple of my friends with their own." 26-35 m

On the other hand the campaign message '*Suicide. Don't hide it. Talk about it*' mainly pointed people at risk to ring the helpline rather than talk to others in the community, or family members, so that the culture of secrecy would largely continue. The '*Help a Friend Stay in the Game'* materials went beyond this, but did not attract attention through the use of 'Suicide' in the strapline, and might have been missed by many members of the public. Positively, these campaign messages together legitimised men or women as 'influencers' to talk to others without having been trained or having a badge of expertise. They could point a person at risk in the right direction. This presented a problem, however, that they might not know what to say, not being trained.

> "It's definitely helped to raise some awareness and change some attitudes because if you compare what attitudes are now compared to ten years ago before the campaign started, we're definitely better off now." 16-25 m
>
> "People as individuals may be phoning up Samaritans but not talking to others about it. That is still being kept a secret as well. It may be working but we don't know it is working because nobody is talking about it." 16-25 m

Persistence of cultural values and stigma
It was identified that it takes time and consistency to change attitudes. In particular, older generations are more culturally embedded in prevailing cultural values, and it is very difficult indeed to reach a whole adult generation. The prevalent cultural values that are hard to shift include the stigma around mental health (moral shame), the (gendered and cultural) embarrassment of talking about suicide, and the reluctance to admit to vulnerability or accept help ('pride'). The 'attribution' that people who want to commit suicide are doing it for 'attention' was discussed as exemplifying 'normative' cultural attitudes. Gendered identity and communication issues were not consistently separated from cultural taboos over mental health by participants.

> "That's a case, accepting help. It's kind of like pride engrained into the Scottish people…" 16-25 m
>
> "Because of stigma around mental health it's difficult to change, not that it can't be done." 16-25 m
>
> "Certainly attitudes, I certainly think there's a slight change, or certainly working towards a change but attitudes are generally so deep rooted aren't they that it's not an easy thing to change. It's a long term thing, changing attitudes." 26-35 m

Clarity of campaign approach to culture change and engagement
Given the challenge of changing embedded attitudes, public confusion over campaign targeting raises questions over the extent to which attitudes were being shifted. This confusion could lead people to think that the campaign's purpose is to direct people in need to contact services, without affecting the cultural issues among the public or normalising suicide talk. The need for increased prominence of '*Help a Friend*' type material content, and message diversity (dual focus) was emphasised, appealing with a separate message to influencers as distinct from people with suicidal thoughts.

> "Instead of saying "are you thinking about suicide" say "do you know someone who's thinking about suicide. If you think they are, don't be afraid to talk to them" something like that." 16-25 m
>
> "People see the poster and think "that is good there is somewhere for people who have a problem to go"." 16-25 m

Clarity, discussed above concerning awareness-raising, was a central issue in how the campaign helped people to *engage in behaviour* - mainly information-seeking and discussion - that might help themselves or others. The lead message '*Suicide. Don't hide it. Talk about it*' was good in influencing help-seeking for people with suicidal thoughts who did not want to talk to friends, family and acquaintances. However, the general public were not told what to *do*.

45

>"You could say "if there's somebody you're worried about, phone the Samaritans" ."" over 36
>f

"Too specific, instead of saying like "if you feel suicidal, call this" rather be like "if you know anyone you're worried about, then call this number and we'll give you advice on what to do." 16-25

Influence and action
When considering influence, participants discussed how the general public could act on the message, focusing on calls for advice, and on training. Questions arose whether it would be best to directly talk to a friend who shows signs of suicidal thoughts, take them to a setting where information is displayed, or call a helpline for advice. The discussion groups were unsure if Samaritans or Breathing Space would provide the advice to them. Knowledge empowers, it was felt, providing confidence, and skills to talk to people. Yet the campaign lead 'message' was not providing those ingredients to the general public. An offer of training or of guidance and advice to the public would be welcomed, further to the initial call. Interested individuals could then recognise signs, and have a repertoire of communication strategies.

>"If you saw the information you could discuss it to help somebody…interaction… discuss how you're going to help somebody if you've heard that somebody's contemplating it." over 36
>m

>"I'm not personally aware if there is like anything like Samaritans where you're free to phone up and then talk to them about how to talk to someone if they are feeling suicidal."
>16-25 m

Education
Considering the challenge of engaging the general public in sustained community-level behaviour change, participants considered how universal education in schools and colleges could help young people to develop skills and knowledge that they would then pass on to others in their social networks, and later pass on with their own children, inter-generationally. Work in schools (already undertaken for Choose Life through Samaritans) should be mainstreamed and far-reaching. Children would influence their parents, so *inter-generational* influence would work in two directions. This approach would develop social and cultural resources and resilience in the next generations by using peer networks and bonds, peer-teacher networks and ties, and family inter-generational bonds.

>"Give schools that knowledge and they themselves will pass it on to their kids in school. Doing it in relation to the things they already do there. The big thing in school is bullying. It's bullying in schools that leads to kids attempting suicide. Then they take it back to the parents. Kids will take the leaflets home." over 36 m

There are also areas where young people's emotional moods and cultural beliefs are shaped, for example music and marketing. Education should also focus on helping people to understand how these influences can affect mental health. Young people were already being reached through settings like festivals and youth clubs.

Addressing the challenges and developing the campaign

The challenges for the campaign were viewed as complex and systemic, as risk factors surrounding suicidal behaviour are multi-faceted and interacting. The main challenges were seen to include: the depth and complexity of cultural stigma, reinforced by gendered communication barriers; coherence between different campaign aspects; clarity of message; reaching different influencers; establishing a different culture through education; reaching different generations of at-risk groups, and geographical reach. Underlying these, culture change requires systematic interventions at individual, community, organisational and political levels. Participants discussed what aspects of the campaign work well, and what was needed within the campaign and also in wider strategy, to sustain the campaign and develop it further.

Stigma and gender

The challenge of cultural stigma around mental health interacts, as mentioned above, with gendered inhibitions around a. acknowledging and b. communicating vulnerability. These social norms inhibit flexible interaction. Suicide is stigmatised (shameful, immoral), so that, particularly for young men - whose life is said to 'lie before them' - to feel lonely or depressed, and to have suicidal thoughts, is felt weak and inappropriate. A masculine 'ideal' of emotional contained-ness, resilience and 'hardness' is transmitted inter-generationally and reinforced in male peer groups, it was said, closing off avenues of help-seeking or emotion talk.

> "Even a group where several people might feel depressed, if one person speaks up about it another one sniggers. The rest of them follow that. No-one really wants to speak about it." 16-25 m

> "Young guys if they're feeling depressed or suicidal, then they probably feel that they shouldn't be feeling like that. Like 'I'm young, I'm eighteen, my life ahead of me, what have I got to be depressed about, I shouldn't be depressed, I'm not going to tell anybody I'm depressed." 26-35 m

> "Peer pressure will stop young people getting involved" "They might feel like that too. People defend themselves. Think I am not like that. Probably affected more people we don't know about." 16-25 m

> "Until you get old and more confident you always want to be a part of what is the norm." 26-35 m

Relevance

'Normative' perceptions among the public that the campaign is not relevant to them, the second major barrier, may be reinforced by the campaign message. The campaign needs to challenge the pattern of sectors of the public attributing mental health issues to 'others'.

> "If people don't see it as relevant to them they don't want to talk about it." 16-25 m

In response to concerns about cultural stigma and normative perceptions about campaign relevance, a number of themes were explored that focused on how the campaign works well and can be developed further to make it sustainable and effective.

Universalise the issues

It was vital to keep working to ensure the campaign messages appear relevant to all, not only people with suicidal thoughts. Working with young people in schools and places like youth drop-in centres or sports centres would promote a necessary culture shift. The campaign should clarify further its focus on the general public, with wider distribution of a version of campaign messages directly addressed to those who might influence others at risk. The wider public could be engaged with the campaign *empathetically* through stories, and role models, that people identify with. Celebrity endorsements in music would engage young people, while advertising through television, DVD or live drama stories would also involve people. The use of arts is discussed below, as an aspect of social marketing.

> "Get people thinking about it. It's my problem, it's your problem, it's everybody's problem. It's everybody's problem because everybody's started to think about it." over 36 m

Target and train gatekeepers as 'champions'

Particular groups of people with great potential influence are not health or social care professionals, but potential 'intermediaries' who may interact with the general public, including people with suicidal thoughts, in spaces where professionals do not go. These groups, it was said, include *barbers, hairdressers, taxi drivers, postal workers and shop workers*. Taxi drivers are trained in the campaign to talk with people who have seen the advertising on the taxis. Other groups dealing with

the public include community and voluntary sector workers in areas like *sport, physical and leisure activities, arts, and music*.

> "I think people like human contact so you don't want to just sit and read about it. If you can talk to your hairdresser, taxi driver, maybe that's going to help you as well rather than just feeling as if it's you and nobody else will understand. How do you train people, how do you give them confidence to even approach a relative or a neighbour, just to break the mould? There are posties as well. I was a postie and we were always taught if the mail's building up and milk bottles and you're thinking 'something's not right' … they're not as engaged as maybe they'd normally be so…. " 26-35 m

People in such roles should be given basic training to support their engagement with the public on mental health and suicide issues, it was felt. Choose Life has provided training mainly to public service professionals and voluntary sector workers, rather than to potential intermediaries or 'champions' in trusted community roles or retail services. This theme is expanded in the discussion below.

> "Basic level training. There is the anxiety that everybody feels about talking. Talk and listen, so people feel a little bit more confident to do it." over 36 m
> "Your business, for example, you've got staff. Something like this SafeTALK just to give you a bit of convincing, then they've got ASIST, to equip people at different levels so that they don't feel quite as exposed in a situation." over 36 m

Face to face communication

Targeting the general public and community gatekeepers as 'champions' recognises the centrality of face-to-face communication to build trust. Valued talks in schools, colleges and workplaces should be increased, it was felt, especially where these occasions included role models or people with credibility.

> "Make sure that there's a personal element because information's great but you need to speak to people as well so that there's human contact there." 26-35 m

Social marketing

The Choose Life Campaign used a number of social marketing methods in its segmenting of the target audiences and adopting a settings-based approach designed to appeal to different demographic groups in different trusted settings associated with their lifestyle choices. Three elements are often used to describe social marketing:

1. Its primary aim is to achieve a particular 'social good' (rather than commercial benefit) with clearly-defined behavioural goals.

2. It is a systematic process phased to address short, medium and long-term issues.

3. It uses a range of marketing techniques and approaches (a 'marketing mix') to address these issues.

A social marketing approach places individuals at the centre: considering environmental, rational and emotional factors in their world that make people adopt or resist certain behaviours - and uses these as the basis for designing interventions to engage, and to encourage and sustain positive behaviour change. Audience segmentation is one of the key features that differentiates social marketing from traditional health promotion as it focuses on highly-targeted groupings. Other features of social marketing, described in the Introduction to this report, include *insight* work with targeted sections of the public, which the discussion groups in this evaluation provide, as a possible basis for further campaign development.

The discussion groups identified strengths of the social marketing campaign, and areas where planned changes might sustain it and spread its reach. The Choose Life campaign settings-based

approach appealed resonantly to individuals in their social groups (e.g. 'niche' festival goers, football fans), while recognising the environmental factors (e.g. unemployment) and cultural factors (e.g. stigma, masculine identities) underpinning individual behaviour. The messages did not necessarily vary greatly from one setting to another, and as identified above, there was a perceived lack of clarity about target audiences and behavioural goals. The integration of marketing and training elements was not well understood by the general public, and they were not very clear about how long term issues were being addressed strategically through the campaign.

Renewal
A suicide awareness social marketing campaign needs to renew itself, to prevent campaign fatigue. Renewal was discussed concerning integration of training and campaign aspects (above), diverse approaches to different target groups, different strategies encompassing stages of change, and different materials for the same group and stage, to retain interest, offer personalisation, and deepen engagement (below).

> "I think Choose Life at Motherwell is a great foundation. There's no point doing the same thing over and over at the same venue. You've got to move the message round the area." 26-35 m

> "Keep going the way they are going. Maybe rethink that [washroom] poster, make it stand out more, use brighter colours." 16-25 m

> "More variety in advertising and more advertising in places where we're all going to be." 16-25 m

Mass media events
'Wide targeting' was felt to be a good strategy for reaching large population segments, using mass events and mass media. The groups most strongly targeted in the campaign (young to middle aged men and those who influence them), form a broad swathe of Scotland's population, many (not all) sharing TV and football interests. A still larger audience could be attracted through media coverage of SPL football and other high profile sport (including Glasgow clubs, Scotland's team, the Commonwealth Games 2014). Television advertising, and elements within trusted TV soaps/dramas could introduce narratives about suicide and prevention that people in families would identify with. Large, trusted music festivals such as T in the Park also reach an inclusive intergenerational public.

> "Put it into a TV programme. People are involved in the soaps." 16-25 m

> "If you look at T in the Park, Music Venue, they should be going to things like that particularly with the t-shirts. Music's fantastic because it works on so many different levels and age groups." over 36 m

> "Everyone in Scotland goes to T in the Park at some point, you've got that wider variety of people." 16-25 m

Personalisation
'Personalisation', an approach described by the UK Department of Health as meaning that "every person who receives support...will have choice and control over the shape of that support", fits with a social marketing approach to the extent that targeted demographic groups prefer personalised communication and support. Two aspects of personalisation include some control over interaction and communication with other people (this could mean choice over who to talk to) and some control over information flow and management. The message of the campaign promotes two telephone call lines and a national website - hugely valuable, but limited options. The younger people in discussion groups suggested examples of personalised media they would want. Durable items that mark personal identity can effectively display and spread engagement. Festival wristbands were valued as they could be worn as a mark of pride and identity for the year. Tickets for gigs are kept for similar reasons. In the same vein, for a different segment, Motherwell Football Club t-shirts and other personal merchandise e.g. mugs are already marketed.

> "Good idea is Festival wristbands so you keep them on all year. So again there's a variety of people that you are targeting. Everyone likes a wrist band, everyone's going to wear their wristband." 16-25 m

Journey of awareness, attitude change and engagement
A further social marketing axiom is that communication needs to be targeted carefully to people at different *stages* of their health journey. For people with suicidal thoughts the message to 'Talk', with call numbers, is very functional and powerful. For the highly targeted demographic sections of the public, varying communication more, whilst retaining brand recognition makes sense in terms of a. different lifestyle preferences of different sections (e.g. age, gender differences) and b. different positions along journeys of awareness, cultural attitude change, and sustained positive activity or behaviour. While the initial message grabs attention, varied strategies are then needed to sustain engagement, including integration with training and use of narrative strategies (above). These narrative strategies which invite empathetic engagement can include use of community arts.

Culture change and engagement – music, television, comedy and drama
The campaign needs more stories, which could be developed for different age and interest groups, using different media, role models, and graphics, it was said. School dramas, film, and cartoon productions can work for children, while comedy in pubs can appeal to working age men. For example, Samaritans (partnering Choose Life) had visited schools in North Lanarkshire and presented a character scenario involving a man writing his suicide note, which was thought effective. Drama productions in community centres and pubs may be seen by people who do not attend football.

> "Community arts. That might mean drama groups and they could put a sketch and either show how it has affected people or 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 has reached out to them and got them some help." 16-25 m
>
> "The campaign needs stories that folk can identify with. Maybe arrange the stories across the age groups. Ideally they give you an idea of how to behave if somebody talks to you, if you're feeling like that you need stories and images - the statistics should be few and powerful. I mean if you say 24 young men in North Lanarkshire will kill themselves this year unless you do something about it. But stories, whether it's cartoon-like stories, something on the TV or a poster." over 36 m
>
> "We worked through comedy in pubs and clubs and making people aware of suicide, and at the same time how to act and react if someone is suicidal. At schools and sports centres, with drama, they're laughing and you are getting this message across." over 36 m

The empathetic identification and engagement of the public which stories encourage can also be influenced, it was felt, by including the voice of speakers who faced mental health issues, especially local community figures or those with 'lifestyle' credibility (e.g. actors, musicians, footballers).

Outreach to different settings for different groups
Further challenges for a social marketing approach concerned targeting different social groups within the wider community. Building on the great success of the campaign in targeting at-risk males, it was important to diversify campaign settings, extending outreach to different social groups.

> "It's working well because predominantly you've got a large group of people who all go to the pub, go to the football, get a taxi home of a weekend, so you're targeting the age group that are potentially vulnerable." 26-35 m

Young people still in primary school can be educated in the final year, at age 11-12, before they perhaps disassociate themselves more from networks of educational influence and wider support. This can be linked into resonant thematic areas like alcohol education, bullying and emotional literacy, and through campaign 'days' across the region.

"If they're aware of Choose Life, Samaritans, Breathing Space at an early enough age then it becomes part of their culture. Once they've passed a certain age it's hard to influence them. I would say at primary school, the last year of primary school." over 36 m

"Focussing on the schools more, doing workshops, working with people more directly instead of just letting them see the information." 16-25 m

'Trusted' settings to target further, it was said, include, for young people, festivals and gigs, for men of working age the bookmakers and pubs, for women the shopping centre, for people of different ages and particularly middle age and older people, cafes and community centres.

Varying the message and design for different groups
The campaign media, formats, and content should contain the same basic message appropriate to each phase of the health journey, but tailored differently to different lifestyle preferences of age and gender groups. Blunt messages for community groups of young adult males at football or in the pub might be softened slightly for post-retirement men and women. While the social marketing *brand* should stay the same, material design could be tailored more to lifestyle preferences of groups. However, colour schemes and fonts on taxis, buses, posters, and football billboards were different, in a way which could hinder brand recognition, it was noted.

"It's kind of easier to sell stuff to younger people if it's bright and loud and interesting." 16-25 m

"Adverts designed to target individual groups even though the message is the same. An advert that is going to attract a young person, won't attract someone maybe in the middle, thirties forties. Something to take each group and make them focus on it." 16-25 m

Targeting influencers across generations
The range of sections of the public who might influence people with suicidal thoughts is diverse, and the campaign faces a challenge reaching significant influencers. Family networks remain a strong but very problematic area of potential positive and negative influence. Middle-aged 'family provider' men and women (35-50) can be influenced more easily around health in two main areas, parenting and family health, and conditions associated with the onset of middle age. However, mental health remains strongly stigmatised, particularly among older men, so it was felt that addressing them specifically around parenting concerns might be resonant. Young people stay with parents longer, it was said, so parent education is important.

"Males between eighteen and twenty five are staying with their parents now because they can't get onto the property ladder. Why not educate the parents to maybe recognise some of the signs and symptoms." 26-35 m

"But again that's a generation thing, because your dad never cried, your grandpa never – so that's a problem, how do break that? Having the confidence and trust to go and talk to that person and know you'd get a positive response rather than getting a 'don't be so silly'. " 26-35 m

Age diversity and influence
It was also felt the campaign is not engaging enough with isolated older people post-retirement, for whom concerns around debt and care create further risk, and with young mums. Community or health service gatekeepers who might offer support to people with depression or suicidal thoughts would vary according to the age and context of the person. With training, volunteers at community groups and also home carers could provide support for older people. Mother and toddler group workers could work with young mums.

Gender diversity and influence
Survey findings show that women are proportionately more likely to communicate as a result of the campaign (men being more likely to seek information). Women therefore have a potentially

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important role as influencers on male and female peers, and family members including children and husbands. Young women who felt they could make a difference believed more women could be reached through targeting shopping venues.

> "There needs to be adverts in places where we're going to meet. Like clothing shops." 16-25 f

Reaching disadvantaged communities

A major challenge is that poor, troubled, stigmatised, in-crisis or suicidal people are not being reached directly through mainstream venues like football clubs or fitness centres. It was important to access where people in crisis might go. Targeting job centres with information about healthy activities, person-to-person support, and assistance with finding volunteer activities was suggested. Training for unemployed people on suicide prevention could provide motivation and build confidence, and spread skills within relevant networks. Other places where people in crisis find themselves like hospitals, undertakers, and courts could be considered.

> "That's one of the places where you are going to get people who are really, really depressed. There is nothing in the job centre saying suicide, depression, anything like that." 16-25 m
> "If you can give them a training course that's something to keep on their CV so that people would look better to an employer, and they might want to get involved because of that." 16-25 m

Reaching victims of perceived prejudice and discrimination

Particular individuals within minority groups (for example by ethnicity, or sexual orientation) have experiences leading to them mistrusting services. As individuals may mistrust the call process, fearing what will be done with information about them, outreach was perhaps needed to trusted 'intermediary' support networks.

> "There are plenty of suicides about that. [Among LGT 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

Outreach – regional

The challenge was particularly highlighted of reaching the Northern part of North Lanarkshire, and including more deprived areas. People in Cumbernauld, Airdrie and Kilsyth, for example, might not visit Motherwell for shopping or football, but many visit Coatbridge or Glasgow. Charity football tournaments could be held in these areas, and local football clubs involved. Distributing resources more effectively across the entire region needs to be a priority, (perhaps exploring more co-ordinated west of Scotland campaigning, making use of the enormous coverage of Glasgow teams and media).

> "Many people from Airdrie and Cumbernauld do a lot of their shopping at maybe Coatbridge and Glasgow. So you'd try and get Airdrie Football Club involved. Clyde in Cumbernauld. So have a charity football tournament or a similar advertising campaign with other local football teams, spread it through local shopping centres." 26-35 m

Networking

To reach groups in rural areas or towns such as Kilsyth, Cumbernauld and Airdrie, and to reach the most disadvantaged groups, further use could be made of trusted community networks. The campaign could consolidate work with community forums to map leisure activities for different groups in their areas, so that these can be targeted for campaign work, as local community based activity networks have peer support in place. A specific product of this could be a pocket sized booklet of 'healthy' activities, networked to the campaign, which could also be made available at job shop and health centres.

> "Cumbernauld Community Forum I think's a great opportunity for all the organisations to come together and do something like mapping of the whole area of these groups that young women can go to, there's groups that older women can go to, there's different activities and

people have the awareness of all of that, you know they're really isolated, there's a peer support in places, I think it's a really good tool that would benefit the whole community." over 36 f

Regional community networks could reach people that a campaign driven from Motherwell misses. Networks can be strengthened further with voluntary and community organisations (for example Citizens Advice) which organise events, raising the campaign profile.

"But the figures [awareness of campaign] for Airdrie are so low and it's a problem across Scotland, surely the government should give money to the clubs at local level where the government can't reach out because they're not close enough." over 36 m

Network with powerful organisations
As campaign' success has been based on partnerships (for example with Breathing Space and Motherwell Football Club), strengthening partnerships further with consumer organisations, particularly drinks manufacturers and retail brands and outlets would yield benefits. This approach could lead to marketing products with logos and a web-link.

Networks that generate cultural knowledge and action
The potential for spreading social activation was highlighted - developing new initiatives and new champions for suicide prevention within networked groups or communities of shared interest with socially diverse membership. This approach had been used at Reeltime Music where young people made plans towards the Sound Minds festival. Campaign materials and actions were planned within groups, and they communicated with wider social networks. Young people participate in a range of organised and networked activities, where co-ordinating bodies could provide partners for Choose Life.

"Spreading the message through different groups. Youth groups and community sports. Organising tournaments. Especially to get to the younger group. Even if it is not sponsored by Choose Life, but to have that as part of it." 16-25 m
"One way to keep it going is to get the young ones involved in it. Then they can take it out and discuss it with other groups." over 36 m

Among young people the potential and reach of online social networking was also emphasised, although considered approaches are needed to sustain trust since viral marketing is not always considered trustworthy.

"we're all on Facebook and You Tube - and on Twitter as well and we think that people will get involved if you can give them something." 16-25 f

Evidence
The challenge of providing evidence to support sustainable extension and resourcing of the campaign was discussed. Two types of evidence were needed - evidence of the scope of the problem in the region, and evidence of campaign effectiveness. Statistics about prevalence would make it 'everybody's issue', while comparative evidence about campaign effectiveness would support funding arguments.

Box 2: Sustaining and extending the campaign – summary of suggestions from the public

- The campaign should clarify further its focus on the *general public*, directly addressing those who might influence others at risk.
- People in roles with great potential influence who are not health or social service professionals, but potential '*intermediaries*' (barbers, taxi drivers, shop workers) who may interact with the general public should be given basic training on mental health and suicide issues.
- *Wider targeting* using more mass events and media could attract a still larger audience, drawing further on TV potential; large festivals.
- Younger people suggested '*personalised*' messages. Durable items like festival wristbands marking personal identity can spread people's engagement.
- *Varying* communication more whilst retaining the brand makes sense in terms a. age-related and gendered lifestyle preferences and b. different positions along journeys of change.
- *Face-to-face communication* is needed as well as printed information to build trust.
- The campaign needs *narrative strategies and stories*, for different age and interest groups.
- Education linking into alcohol education, bullying, and emotional literacy could help young people to develop knowledge to pass on to others in their networks.
- Trusted settings to target further include, for young people, festivals and gigs, for men of working age the bookmakers and pubs, for women the shopping centre, for people of different ages, particularly older people, cafes and community centres.
- *Intergenerational family influence* is important and family networks can targeted more.
- *Unemployed people* need to be targeted carefully, for example through job centres.
- *Women* are influencers of male peers, children and husbands, and can be reached through considered marketing.
- Individuals in *minority groups* (for example by ethnicity, or sexual orientation) may be reached through outreach to trusted support groups and networks.
- Across the region, more use could be made of *existing trusted networks* of target groups.
- Work with community forums can map leisure activities for different groups, to target for campaign work.
- Further *partnerships with consumer or regulatory organisations*, particularly drinks manufacturers and retail brands and outlets could yield benefits.
- The campaign can be sustained through developing *new initiatives* and new champions for suicide prevention within networked groups or communities of shared interest.

Section 5: Discussion and conclusions

Introduction

Choose Life, the National Strategy and Action Plan to Prevent Suicide in Scotland, targeted a reduction in suicides of 20% by 2013, as mentioned in the introduction to this report. The national plan focuses on **seven objectives**.

- o *Promoting Greater Public Awareness and Encouraging People to Seek Help Early*
- o *Early Prevention and Intervention*
- o *Responding to Immediate Crisis*
- o *Longer Term Work to Provide Hope and Support Recovery*
- o *Coping with Suicidal Behaviour and Completed Suicide*
- o *Supporting the Media*
- o *Knowing What Works*

In North Lanarkshire there has been particular focus on the Choose Life National Objective of 'Awareness raising and encouraging people to seek help early'. The Choose Life awareness raising programme aims to help reduce the incidence of suicide, through increased awareness of crisis service numbers such as Samaritans and Breathing Space and the "de-stigmatisation" of understandings and attitudes about suicide. Desired outcomes include:

- o Improved access to information on suicide and deliberate self-harm.
- o Increased knowledge of suicide and self-harm.
- o Reduced cultural stigma associated with suicide.

The objectives of this evaluation have been to improve the understandings of the effectiveness of the awareness raising programme. Effectiveness was considered in relation to:

- o Improving knowledge of available services to help those who may be thinking of suicide or for advice if supporting someone at risk of suicide.
- o Encouraging people to seek help.
- o Positively influencing public and/or organisational attitudes towards suicide and people with thoughts of suicide.
- o Reducing the stigma associated with thoughts of suicide and the local communities' opinion of suicide.

The aimed-for campaign outcomes, and the related evaluation objectives, therefore concern two broad areas of impact: a. public/community awareness, knowledge, and cultural attitudes, and b. behaviour of individuals who may seek help or wish to provide support to others. The dual focus creates challenges, at all levels of campaign development and evaluation, since individuals are social actors, and mental health is everyone's concern.

The evaluation in this report is intended to be formative, contributing to future development of suicide prevention programme work. However, the evaluation was commissioned at a relatively late stage of the national ten year Choose Life programme. Any insights from an evidence-based evaluation can best be applied to middle and long term programme development. Future development in North Lanarkshire, drawing on Choose Life evaluations and other evidence, depends on maintaining adequate funding, sustaining a strong Co-ordinator role, and retaining both national and regional commitment to systematic development of suicide prevention work. The evaluation pointed to the success of Choose Life in achieving a range of outcomes such as raised awareness of call numbers and altered attitudes to talking about suicide, which can be considered *intermediate*,

on the route to longer term goals around suicide reduction and improved well-being in healthier self-protecting communities. This final section highlights major themes concerning the contribution of Choose Life to preventing suicide, particularly concentrating on linkages between current achievements around intermediate objectives, and implications for achieving longer term goals. This involves, first, highlighting impressive successes of the campaign in relation to targeted outcomes (as well noting any limits and their implications); before reflecting on how these achieved objectives might support wider and deeper processes of change. This entails considering underlying assumptions within the suggested conceptual framework or theory of change which has emerged through the course of the evaluation, and how these assumptions may be supported by the evidence.

Extent to which objectives are being met

Campaign effectiveness in achieving intermediate outcomes was assessed during the evaluation in relation to a number of key evaluation questions, which are set out below.

Has the programme as implemented been effective?
The campaign appears to have effectively raised the awareness of services of a substantial proportion of the general population (28% of survey respondents were aware of the campaign to some extent). Among those with some awareness of the campaign, 39% said this made them more aware of services to provide information or help prevent a suicide, while 40% were already aware, again a positive outcome. The awareness of the campaign appears to vary by age (people of 55 and under being relatively more aware), and by locality (with, for example, far higher awareness in Motherwell and Wishaw than in Airdrie and Cumbernauld). The age effect persists concerning the extent to which the campaign made people aware of services: people of 45 and below had been made more aware than those above that age, with a fairly even distribution across age bands 16-25, 26-35, and 36-45. The strongly positive impact of targeted campaigning on younger men's (and women's) awareness in specific regions leaves other age groups and regions - including northern and rural regions, at greater risk of remaining marginalised.

The awareness raising campaign has also had evident success in de-stigmatising public attitudes. There was a positive correlation between levels of campaign awareness and levels of altered attitude in survey results. At the same time, the challenge of reducing stigma, of 'normalising' talk about mental health and suicide in the community, and of influencing and supporting men in particular to disclose vulnerability remains formidable. The survey findings showed only a *higher* awareness level was strongly predictive of altered attitudes. Almost half of the respondents from the public who were aware of the campaign did not feel their attitudes had been altered. To develop higher levels of awareness among the public, the campaign may need to consider various issues raised in discussion groups and by stakeholders. These include clarity and inclusiveness of address, a call to action, co-ordination of information and support/discussion, integrating initial awareness with subsequent narrative approaches, and the place of community and community-professional networks in raising awareness further.

When considering the direct influence of the awareness raising campaign on organisational attitudes, the evidence is less clear. The effects of a multi-component campaign may, taken together, have additive or synergistic effects: the training campaign may have contributed with the awareness campaign to generate impact on those organisations that were engaged in training. The impact of SafeTALK and ASIST training (which targeted professionals) was spread across a diversity of organisation types, including NHS, local authority, frontline services such as police, fire, education, community planning partners, and some voluntary organisations.

If the range of organisations included within training was still wider, and perhaps if more organisations were drawn into the media campaign, the organisational impact might be greater. Issues around campaign complexity and co-ordination are considered further below. The main impacts on organisations would be in terms of culture change, and improvements in practice and service design. The campaign needs to be increasingly systematically embedded in organisations, as diverse stakeholders stated. Certainly, companies signing the distinct 'see me' anti-stigma pledge has meant that a commitment to eliminate the stigma and discrimination of mental ill-health gets translated into Action Plans, which may include suicide prevention training, running workshops in the workplace, and media displays.

High levels of campaign awareness also appear to be affecting public behaviour, since those very aware of the campaign were more likely to have discussed, got information or sought help to support other people by comparison with those less aware. These effects on behaviour vary by gender and place. Significantly more women than men among those surveyed had discussed issues, and significantly more Motherwell residents had done so, while there was no significant difference by gender between those seeking information or help.

Specifically concerning individual help-seeking behaviour, data from NHS 24: Breathing Space on interactive calls where self-harm or suicide was an issue between June 2010 and April 2011 indicates that the majority of calls during this period from North Lanarkshire came from Motherwell despite the comparable size of Airdrie and Cumbernauld's urban centres. Data on dialogue contacts with Samaritans Hamilton (Lanarkshire) branch by sex of caller between 2000-2010 shows that for each year a higher proportion of callers were identified as female. However, as the number of female calls received by Hamilton branch reduced between 2007-2009 the number of male calls increased. This contrasts with the pattern when considering dialogue to Samaritans branches throughout Scotland. The data on calls to Samaritans and Breathing Space provides only limited insights, due to issues with data compatibility, but offers some support for the finding that the campaign has affected individual help-seeking behaviour of men and women, particularly within Motherwell.

The finding that the campaign positively affected the behaviour of both men and women, but in somewhat different ways, also has implications for targeting members of the public as 'influencers'. As these differences are relative, the implication is that suicide prevention tactics should diverge subtly and in a considered way by gender. The regional variation in impact on behaviour is also very important for future targeting.

How has the social marketing approach worked? Which aspects of the programme have been particularly effective?
The Choose Life Campaign used some social marketing methods in its segmenting of the target audiences and use of a settings-based approach designed to appeal to different demographic groups in different *trusted* settings associated with their lifestyle choices. The settings-based approach engaged individuals in their targeted social groups (e.g. young 'niche' festival goers, football fans). The use of Motherwell football ground to reach men and families was highly effective, and five-a-side tournament, pub and festival settings also supported young men in particular, providing an environment where public awareness could be initiated. The combined use of settings appealing to targeted groups and settings with more widespread appeal was considered by stakeholders and the public to be important for achieving campaign objectives. The use of public transport (taxis and buses) and of television was effective in reaching a wider public. Poster/billboard materials and football related materials, TV and radio adverts were relatively well recalled.

The messages evidently need to vary in some respects from one setting to another, while retaining clear brand identity, and clarity about target audiences and behavioural goals is important. Different communication and engagement strategies should perhaps be matched to stages along a

community journey of cultural change, and a variety of approaches taken to different target groups. The coherence of the campaign and integration of different campaign elements could perhaps be promoted more widely among the public. Evidence from this evaluation can be used as a basis for development of further strategic elements of a social marketing campaign, perhaps including further detailed insight work with 'segmented' sub-groups (see Theory of Change below in Table 6 and summary of evidence in the model in Appendix 14, and illustration of insights from this evaluation positioned within a model of campaign development in Appendix 13).

Has this programme been of benefit to the community, in particular young men aged 16-35?
The evidence suggests that the campaign has definitely and powerfully increased the confidence and capacity of people who are highly aware of the campaign, including young men, to talk to others in their community or to seek help. It has 'normalised' talk about suicide and about mental health and emotions more generally, among those who have become highly aware. It remains the case that the proportion of the adult population who are aware of the campaign is still perhaps less than one-third (according to survey findings: 25% of female respondents, 29% of male respondents). As a geographical area, North Lanarkshire can be considered to be inhabited by numerous overlapping communities. There are communities of geography, people who have ties of neighbourhood, like Cumbernauld residents, and communities of interest, for example people who have a leisure activity in common that brings them together. The challenge for the campaign in this area, as stakeholders and members of the public confirmed, is now to spread the great benefits further to the relatively unreached disadvantaged and high-risk communities, taking particular account of high area deprivation, and priority groupings (see Introduction above). This evaluation has also highlighted, with evidence from stakeholders and the general public, the importance of reaching vulnerable older people, and isolated young mothers. Tactical diversification of campaign communication and settings might also ensure that the campaign continues to reach peers and families of at-risk groups and individuals.

What contribution has the community made to the effectiveness of the programme?
The campaign's successes have been based on strong partnerships with businesses and community and voluntary organisations embedded in specific communities, such as Motherwell Football Club, Reeltime Music, and United Taxis. The embedding of campaigning in community-based settings has helped to normalise talking about suicide and de-stigmatise mental health. Within those community settings, trained participants such as taxi drivers and community librarians involved in the 'Healthy Reading group' have played a role in support of the campaign message, talking with the public and signposting them. In some cases, community members' networks have been used to develop and extend the campaign, as in the case of young people who actively develop and cascade messages across peer networks through their contributions to music festivals (e.g. Sound Minds). Building on these successes, a community development approach was advocated both by stakeholders and members of the public, to spread change and renew the campaign.

Sustaining, extending and renewing the campaign
A key theme of this evaluation has been the importance of sustaining and renewing the campaign, given the length of time required to achieve impact at the level of culture change. Earlier evaluations of the Nuremberg Alliance against Depression (NAD) and the Regensburg Alliance against Depression (RAD) (see Appendix 15 below) found a reduction in awareness and/or an increase in suicidal acts during the second year of campaigns, partly attributed to lower media activity in the second year (Dietrich et al., 2012, Hegerl et al., 2006). It has been suggested that a continuous and intensive programme of suicide prevention activity may be required to sustain positive results (Hubner-Liebermann et al., 2010). This evaluation found Choose Life (North Lanarkshire), after 3.5 years of sustained delivery with a full-time Co-ordinator, has maintained the intensity of the media campaign and is continuously seeking to renew itself, to prevent campaign fatigue. It has been suggested from our evidence that renewal can be achieved systemically by integration of training and campaign

aspects, diverse approaches to different target groups, across different localities (including where the campaign has not reached), and across different stages of community change, and by using different materials for the same stage, to retain interest, offer personalisation, and deepen engagement. The remaining sections focus primarily on sustaining, extending and renewing the campaign.

Theory or model of change

Challenges concerning extending the campaign's reach to diverse unreached communities, and its sustainability, make it particularly important to understand the mechanisms of change where the campaign is proving highly effective, and to understand how best to apply learning from the campaign to extend its reach to other communities in a sustainable way. To do this a model is offered in Table 6 below, drawing on understandings concerning how the campaign expects change to occur. The model is grounded in primary evidence from the evaluation, and is also supported from a wider research and evidence base that we refer to below. Campaign progress against objectives, discussed above, can be considered in relation to a change model which distinguishes steps of campaign implementation. The model for change within the campaign needs to be systematic, and include pathways (including intermediate goals and mechanisms, and assumptions or conditions of success at each stage). Steps 1-3 leading to the intermediate outcomes concern the campaign to date, what the different steps have been, and how the steps are expected to work. At each step, questions can be posed, in order to check the robustness of the assumptions that appear to underlie the mechanisms. The questions around steps 1-2 have largely been considered throughout this evaluation, and earlier in this section (see Appendix 14 for a brief summary of evidence within the model). Concerning step 3 it has not been possible to establish the views of trained people within this evaluation remit. However, the positive views among the public about engaging with trained gatekeepers were confirmed. Steps 4-6 largely relate to considerations for the emerging campaign direction, supported from the evidence within the evaluation, which have not yet had time to reach maturity. These aspects have been introduced earlier in the evaluation, and are discussed further through the rest of this section.

Issues for consideration

The remainder of this chapter discusses the issues that have emerged from the evaluation and highlights areas to be considered as the programme evolves. The discussion focuses on exploring emerging steps and approaches which are supported through the evaluation and set out in Table 6 below. The first area discussed, in the next section (under step 4) is that of *further development of media campaign and materials*. The same section also examines the wider evidence to consider gender issues in the targeting of men and women. The discussion then considers *the integration of the public awareness campaign and training* with a focus on training community 'intermediaries' (step 4). The development of *organisational and community networks* of 'trust' (through steps 5-6) is then explored, as a means of extending the wider cultural transformation.

Table 6

Model of change in Choose Life Awareness Raising campaign

Steps 1-3 lead to intermediate outcomes	Mechanisms	Assumptions	Key questions
Step 1	Media campaign and materials developed. Training programme.	Media campaign will raise public awareness and contribute to normalising talk about suicide among general public. This will contribute to increased engagement manifested in greater number of calls to helplines. Training programme will result in professionals and gatekeepers able to intervene with people with suicidal thoughts.	Are campaign messages, materials and settings sufficiently developed and varied to engage with people with different lifestyles and attitudes? Has awareness of call numbers increased among public? Has campaign normalised talk about suicide among public (help-giving or seeking)? Who do public feel able to talk to? Is training resulting in desired provision of help to targeted sections of community, in particular young men? Has training been taken up by men/people from disadvantaged communities or organisations in those communities?
Step 2	Media campaign implemented in preferred settings. Partner organisations cultivated to extend reach of campaign.	Campaign will reach and engage desired groups in desired settings. Reach into organisations and communities with networks to population groups with high suicide risk.	Has campaign as delivered in settings achieved reach? Has campaign in different settings led to gender-specific, age-specific or similar behaviours among public? What actions do public engage in? Are partnerships and networks achieving reach in terms of geographical communities, communities by age, gender, risk factors?
Step 3	Trained gatekeepers and members of the public engage with/support the public who have become aware of the campaign.	Training will motivate, develop awareness/skills and prepare people (taxi drivers, housing officers, for example) for role. Participants will be able and ready to do role following training Training is reaching the appropriate range of people.	How do trained people feel about their role with the public? Are they supported? Are the public aware of these intermediaries, and how do they feel about engaging?
Intermediate outcomes	Improved public access to information, awareness of services. Increased knowledge of suicide and self-harm. Reduction in stigma. Engagement in behaviour leading to early help where needed.		

Steps 4-6 lead to long term goals	Mechanisms Aimed at extended reach, and sustainability, towards long term goals	Assumptions	Key questions
Step 4	Media strategies renewed and diversified. Public empowered in communities to influence and support individuals to talk about mental health or suicide. Public supported through this by professionals providing guidance, and by community intermediaries. Trained intermediaries supported to work through community/organisations' networks and link these up to service networks. Staff & trained volunteers use knowledge and skills to influence individuals and families.	Campaign reach extended by using diverse media strategies. Targeting can be refined further by gender, age, interest. Public have confidence, skills and knowledge to discuss or seek information and support. Trained people in voluntary sector (e.g. housing) and community able to share knowledge, offer support, use and develop networks, and signpost to professional support and services. Media work and training makes a difference to the extent to which community capacity is built, and makes a difference through community members talking to a person with suicidal thoughts.	Do people in different communities, and at different stages of engagement identify with and respond to media strategies? Is targeting more effective by age, gender, geography, and reaching areas of disadvantage? Do people in voluntary sector and community act on training to raise awareness of health issues? With whom? Do they intervene with people in crisis? With whom? Are they signposting people to other services? With whom? Do they act through community networks to strengthen trusting lines of communication? What barriers exist to integrating the training with the media campaign, supporting those trained to work with the public?
Step 5	Local organisations (voluntary and community, and businesses) embed systems and support into their work to support media campaign and trained intermediaries.	Local organisations will offer the right type of support and encouragement to enable media outreach campaign, and also to enable advocates or intermediaries from the public or on their staff to work effectively. Suicide prevention message is relevant for their core work.	Is organisational capacity and system change for suicide prevention built (mainstreaming)? To what extent is there a strategic approach being developed?
Step 6	A wider cultural transformation is spread in communities, embedding change. Localisation of activities, closer targeting of resources, deeper outreach.	The programme achieves synergy and scale through integration of elements. Networks and partnerships of 'trust' are strengthened both within and between current lines of communication and influence, including local communities and local organisations. Integration of elements, partnerships, networks contributes to greater reach and sustainability.	Is synergy and scale being achieved? Are community led events happening? Are networks developing and strengthening, is there evidence of organisational mainstreaming? Is outreach to diverse communities occurring? Is culture shift being evidenced by practice in priority sections of the community? Are more people seeking help early as a result of a shift to cultural 'trust'?
Long term Goals	Suicide reduction and improved well-being. (Health inequalities addressed. Healthier self-protecting communities, organisations)		

Media campaign development

Language and address

An emerging theme from the campaign is that the media campaign can be developed further to increase the reach and improve the involvement of targeted groups along their journey of awareness and engagement. Some suggestive themes arise from comparing previous media campaign evaluations (reported in the literature review) with the current evaluation. The literature review conducted for this evaluation (see Appendix 15) identified two main approaches in media campaigns *aiming to reduce suicidal acts*; type a: those using language with a focus on mental health, and type b: those using language with a sense of urgency and clear focus on intense distress and imminent action. Campaigns within type b. using *direct explicit reference* to suicide and suicidal acts were not found in the literature. The review concludes that both approaches may be needed, type a. being aimed at improving knowledge, help-seeking behaviour and long term outcomes for people who become distressed and may consider suicide in the future, type b. being aimed at catching individuals before they commit a suicidal act. Choose Life (North Lanarkshire) media campaign belongs to type b, and includes direct reference to suicide. There is therefore particular interest in understanding how this approach works. Key elements identified within the Nuremberg Alliance against Depression (NAD) type a. approach were that the language of the media elements in three key messages ('depression can affect anybody', 'depression takes many forms' and 'depression is treatable') avoids using the concept of "suicidality" and also avoids personalisation with messages about behaviour change or words such as 'you'. By contrast, in Choose Life, (type b.) the message personalises the issue through a direct form of address and urging behaviour change ("Suicide. Don't Hide it. Talk about it."). The message attracted attention, evoked emotions, including hope and pride, and challenged gendered and cultural barriers over communication of vulnerability on a stigmatised topic. But there was some public uncertainty about who the message was for, and concern whether the campaign was providing a clear guide to action to the general public. The 'Help a Friend Stay in the Game' football materials did this to a greater extent, while, however, not using 'suicide' in the strapline. This public uncertainty was earlier reflected to some extent in the broadly positive national Choose Life media campaign evaluation - a survey of public awareness of national materials (NHS Health Scotland, 2008). The personalisation within type b. approaches was considered appropriate by the public, as urgent action is required. Building on this, it seems that, within type b. campaigns, appealing to the public requires a targeted variety of resources, including those for people themselves at risk, and those for the general public who might influence them. An example of targeted resources for people at risk consists of specific online, radio and television presentations for young men who may be socially withdrawn while still consuming media by themselves (NHS Health Scotland, 2010).

Further, an interacting and coherent range of strategies and message*s* is needed, with carefully tailored narrative and drama approaches, as recommended by participants from the public and stakeholders. These can be developed further to extend the public campaign beyond the initial level of awareness-raising, to challenge public attitudes and support public engagement. While messages alert and instruct, stories with characters engage people at a cultural level, since the storyline can develop and also question cultural scripts, and the characterisations invite identification and empathy, which can be used to explore the place of peer influencers, and to 'normalise' people who have suicidal thoughts. The NAD campaign includes a cinema spot, for example. Positive Mental Attitudes in Glasgow makes use of film and community theatre workshops to discuss suicide prevention within communities and increase confidence http://www.positivementalattitudes.org.uk/ . Time to Change campaign http://time-to-change.org.uk/ funded by the UK Department of Health, includes on its website personal stories,

forums, cartoons, and narrative videos. A five frame cartoon advert 'By the Water Cooler' (shown in Metro newspaper, 31-01-2012) provides a good example. This campaign advert is clearly targeted at the public, focused on comparing different possible ways of talking to a colleague who returns to work after time off with 'mental illness' . It invites engagement with the 'peer'/influencer character who asks 'Should I say anything?' and offers different interaction scripts for what might happen if he does, comparing the response he fears ('unlikely') to the far more 'likely' positive response from the colleague. Features of this cartoon are its interactionality, its appeal to public identification with the peer, its humour, and its narrative element. A similar approach could form part of a repertoire of communication tactics in a type b. suicide prevention campaign.

The use of narrative, drama and visuals to present stories with which the public can identify can also help to extend the reach of the campaign. For example, television drama and advertising has very broad reach to individuals and families, internet videos and song lyrics reach young adults, while drama at primary and secondary school engages young people during formative years. 'Case study' stories of people who become champions within organisations, creative writing and photography competitions around the theme of 'support' have been developed within the 'see me' campaign (http://www.seemescotland.org/getinvolved/). Use of role models with credibility, telling their stories, can have a big impact on community members who are otherwise disengaged.

Gendered and non-gendered targeting
Evidence suggests that non-gender specific targeting results in more women than men noticing and acting upon campaigns around mental health and suicide, whereas targeting settings matched to men's lifestyles can rebalance that effect. The type a. NAD campaign has resulted in more females becoming aware of the campaign than males. In another type a. campaign, 'Minding your Head' phase one which targeted the general public through television, print and radio and press adverts, was more likely to have been noticed by females than males. However, phase two, which targeted young men aged 16-24 through male-oriented media and settings like washrooms increased the proportion of young males exposed to the campaign, and increased the likelihood that they would think about discuss or act upon the messages to improve their mental health.

The findings of the Choose Life (North Lanarkshire) evaluation survey show a slightly, but not *significantly*, higher proportion of males than females being aware of the campaign. The campaign had an orientation to targeting male settings (football stadium) and also more gender neutral or perhaps female friendly settings (transport). Survey findings suggest that the most frequent forms of engagement following from noticing the campaign may differ by gender: the most common activity among men was getting information on suicide/mental health issues, while the most common activity among females was discussing suicide/mental issues. These findings, with prior evidence, raise two considerations for targeting the public. Men need to be targeted very specifically and strategically to become more aware of the campaign, and perhaps clearly signposted to further information. Choose Life (North Lanarkshire) has targeted men effectively in male settings, and there may be further settings to explore to reach more men. Communication around practical activity has previously proved attractive to men, which would indicate that a good direction for involving men from the general public is to support them towards *combining practical action with communication*, for example arranging or participating in events, and guiding others to services. Women are perhaps as responsive to the campaign as men in terms of discussing issues with others and possibly exerting influence (particularly within families, for example), as well as signposting to services or providing support. Therefore the potential for women to influence culture change in the community should be noted. Regarding influence, and gender, the campaign has also trained a high proportion of female professionals to engage in suicide prevention work. However, it has not trained a very high proportion of the public to play a supported role within circles of influence. In engaging with the public, there is scope to reflect on gender issues and the possible roles of men and women within networks/circles of influence and support.

Evidence from the campaign suggests that while it has succeeded in targeting young and early middle aged men in specific sports and leisure settings, there is still work to do in reaching out to older people at risk, for example after retirement or unemployment, and to men and women in rural areas, and men and women in sexual minorities (all categories where male suicide rates are elevated) (Canetto and Clearly, 2012). It is also very important to maintain a separate focus on targeting two groups: very young men and middle aged men. Statistics show that in Scotland by 2009 the highest suicide rate per 100,000 for all males was in 30-39 age range, followed by 40-49 age range: the risk of suicide is highest in the early middle age groups (Samaritans, 2011). There is also every reason to target boys and girls in schools more widely during their formative years: indeed, a substantial proportion of lifetime mental health concerns begin to emerge before adulthood (Scottish Government, 2011; HM Government, 2011). Supportive school environments are a very important protective factor against the risk of suicide among young people (McLean et al.; 2008). The 'see me' campaign has worked within secondary schools, and its new campaign for 2012 'What's on your mind' (http://www.seemescotland.org/getinvolved/childrenyoungpeople) is aimed at 13-15 year olds. This will provide all secondary schools in Scotland with resources for teachers, and be made available to youth workers and organisations and anyone working with this age group. The openness of young people in terms of culture and identity formation perhaps lends itself to further, earlier intervention, for example during final years of primary school. This openness has been has been interpreted in terms of research into masculinity and health to suggest that during boyhood, 'gendered identities are negotiated outside of conventional [i.e. adult-based] models of masculinity…this is crucial in terms of identifying how emotional distress is interpreted and discussed' (Mac an Ghaill and Haywood, 2012). Specifically, pre-adolescent boys are both influenced by other people's expectations and assumptions and actively engaged in the formation of their own developing identities (Chu, 2004). Young people, on the one hand, are influenced by a wider cultural stigma on mental illness and suicide, and 'masculine' concerns over revealing vulnerability, and subject to powerful institutional influences, for example the *language* and *attitudes* of adults and peers at school and at home around masculinity. However, on the other hand, they are also engaged in an active developmental 'reflexivity', a formative exploration of their attitudes, specific to their age and process of identity formation and learning. Interventions at this level, which might focus on relevant issues like bullying and its emotional effects, and young people's particular experience of friendships and isolation, need to be tailored with the understanding that boys and girls are still forming their gendered selves, in complex ways (Mac an Ghaill and Haywood, 2012).

Place of public awareness campaign within the broader suicide prevention campaign

Integration of training with media campaign in a systemic approach
A further theme from the evaluation evidence is that there is potential to explore and strengthen links between the media campaign and training. The literature review also highlighted that in the NAD campaign, overall reduced suicidality was believed to be largely attributable to additive as well as synergetic effects of the four level structure of the programme (Hegerl et al., 2006). These levels are, briefly, 1. Training for primary care physicians; 2. A public media campaign; 3. Gatekeeper training community members whose role might make them pivotal in help-seeking amongst people who are suicidal/depressed; 4. Self-help groups for suicide attempters and their relatives.

Choose Life (North Lanarkshire) campaigned vigorously for suicide prevention through extensive training of primary care health providers and also of other service providers in local authority education and voluntary sector (at level 1), although GPs were not easily included; and a substantial public media campaign (level 2). Level 3 (gatekeeper training) was initially a feature of the national campaign. However, as we discuss below, few members of local communities participated in a non-

professional capacity (only 2% of those trained between April 2007-March 2010) (Griesbach and Russell, 2011). The relatively low training of the general public within the national training programme was reflected in North Lanarkshire (see below). The additive/synergetic 'preventive' effect of media awareness, training public service employees, and training gatekeepers could perhaps be increased further if more integration was achieved. This might be possible if the level of training of gatekeepers who directly interact with targeted sections of the public was raised, as stakeholders and discussion group participants suggested, and the media campaign focused more clearly on targeted sections of the general public, as discussion group participants suggested. This theme is developed further below.

Targeting gatekeepers as champions
It was felt by discussion group participants that people who have high potential influence, and who may interact with the general public in spaces where professionals do not go, should be given basic training to support their engagement with the public on mental health and suicide issues. The groups might include *barbers, hairdressers, taxi drivers, postal workers and shop workers*, and perhaps community and voluntary sector *workers* in areas like *sport, physical and leisure activities, arts, and music*. A further theme was the importance of education work in schools and with young school-age people. There is complementary evidence in the national impact evaluation of Choose Life training (Griesbach and Russell, 2011) and associated Impact Evaluation learning notes (Choose Life, NHS Scotland, 2011a) and Choose Life team Impact Evaluation analysis and response (Choose Life, NHS Scotland, 2011b) to support some redirection of training along these lines.

National training evaluation.
The national Impact Evaluation learning notes (Choose Life, NHS Scotland, 2011a) highlighted that training has been most effective where it is an integral part of a multi-pronged approach. Increases in skills and confidence of those trained need matching with organisational and cultural change to support sustained changes in practice. It was noted however in the Analysis and Response (Choose Life, NHS Scotland, 2011b) that by the second phase of the Choose Life strategy, training was being delivered as a distinct area of work with little cross over between training and communication teams, although since that time there had been some examples of more joined-up working with awareness raising campaigns (including North Lanarkshire). Training should enable interventions, rather than becoming a barrier, which could occur for example if frontline and lay people are not intervening because they feel they have not been trained. There is therefore a need for a *coherent approach* raising skills knowledge and attitudes through both information resources and training (Choose Life, NHS Scotland, 2011b). Effective behaviour change only occurs when increase of skills and reduction of stigma (through training individuals) are combined with the changes in structures and culture of environments in which participants will be in following training. Individual training needs to be part of a coherent *larger strategy*. This means the development of knowledge, skills and attitudes of gatekeepers has occurred alongside awareness-raising campaigns, local engagement work, and increases of knowledge about risk and protective factors and effective interventions (Choose Life, NHS Scotland, 2011b).

While the training has resulted in changes in skills, confidence, and attitudes among those trained, it is far less clear nationally that as a result there are more interventions with people at risk of suicide (Griesbach and Russell, 2011; Choose Life, NHS Scotland, 2011a, 2011b). The Learning Notes and Analysis and Response highlight two main factors surrounding this challenge: the need to target a wider range of gatekeepers and the need to secure better organisational support for people once trained.

Broader targeting of training to a wider range of 'gatekeepers' beyond health and social care professions is indicated (Choose Life, NHS Scotland, 2011b). As a result of the NHS Scotland HEAT target, since 2008, training has become increasingly focused on professionals in health and social

care and services providers in the community and voluntary sector, with few members of local communities participating in a non-professional capacity (only 2% of those trained between April 2007-March 2010) (Griesbach and Russell, 2011). Yet a majority of ASIST training participants when asked who they would approach if they had suicidal thoughts said "friends and family" not "GP" or "A&E" (Choose Life, NHS Scotland, 2011b).

Gender is a key consideration for redirecting the balance of training to build community capacity (Choose Life, NHS Scotland, 2011b). A large majority (80%) of those attending suicide awareness courses nationally are women. This high proportion reflects the composition of the public sector workforce (64% women) most represented on courses. Survey results suggest that the majority of interventions (60% among those surveyed nationally) are being performed with women. Yet the majority of suicides are carried out by men, the primary targets of the campaign. Since lower proportions of men are believed to attend social and health care settings, the policy of prime-targeting gatekeepers within these settings is called into question. It is argued that training needs recalibrating to particularly include more men who have frequent contact with men in the community especially those at high risk. Targeting services which are used by men, such as "homelessness services, sports centres, pubs and workplaces, especially male dominated workplaces such as construction and manufacturing, may be more appropriate in order to increase the numbers of interventions performed with men" (Choose Life, NHS Scotland, 2011b, p.17). This targeting of settings used by men has been a key feature of Choose Life awareness raising in North Lanarkshire (Choose Life, NHS Scotland, 2011b) but the direction of training in North Lanarkshire has broadly followed the national pattern (see below).

A further consideration is using training of teachers, school staff and young people to build capacity in schools. Whereas only 3% of those attending ASIST nationally during 2008-2011 were teachers and school staff, there is a broad emphasis within the campaign on developing schools' capacity, and some evidence supporting the view that training young people, along with staff training, increases peer support provided to young people at risk of suicide (Kalafat, 2000; Choose Life, NHS Scotland, 2011b). Some areas have delivered SafeTALK and Suicide Talk to schools, and, in view of the strong support for such an approach from stakeholders and the general public in North Lanarkshire, this approach could perhaps be explored further.

In the light of this recommendation to adjust the national balance of training, careful consideration would need to be given to the type of training most suitable for the purpose of training untrained sections of the community (whether SafeTALK or Suicide Talk are most appropriate for example), and how this training is to be supported, while also maintaining the training and support of trainers. The advocated national training strategy (Choose Life, NHS Scotland, 2011b) would have to integrate training within the wider strategic approach.

North Lanarkshire training
Training in North Lanarkshire broadly reflects the national picture summarized above, while the awareness campaign has vigorously engaged with wider segments of the community in gendered and age-specific settings. Registration data from North Lanarkshire ASIST and SafeTALK training (2010-2011) shows a pattern of extensive and successful training of NHS and Council statutory service workers, including those providing general services such as library and leisure service staff, with other sectors represented at a lower level. In the period February 2010 - October 2011 the proportion of those trained in ASIST from the general public was apparently less than 1% of those receiving training, while those from the business sector was less than 2%. Around 15% of those receiving training were from the voluntary sector, and a similar proportion from the education sector, while the highest proportion were from North Lanarkshire Council (40%) and the NHS (24%). Of those within the voluntary sector receiving this training, the majority were professional volunteers delivering welfare/caregiving rather than leisure or other community services.

SafeTALK statistics indicate that the use of a shorter course than ASIST has not so far resulted in training a substantially different category of 'gatekeepers'. During the period January 2010 - September 2011 the proportion of those trained in SafeTALK from the general public was apparently less than 0.5% of those receiving training (including 'Other' as members of the public), while those from the business sector was less than 1%. Around 8% of those receiving training were from the voluntary sector, and 7% from the education sector, while the highest proportion were from North Lanarkshire Council (47%) and the NHS (32%). Of those within the voluntary sector receiving this training, the majority again were delivering welfare / professional caregiving rather than leisure or other community services.

The overall national picture in terms of *gender* (80% of those attending courses are women) is confirmed by the local datasets for 2010-2011 (ASIST and SafeTALK). For the 2 years February 2010-October 2011, 22% of those people trained in ASIST were male. For the equivalent 2 years January 2010-September 2011, of those attendees for whom a register was taken and whose gender is known, 15% were male. So SafeTALK was apparently delivered to a lower proportion of males, and a lower proportion of members of the public, and of voluntary and business sectors, than ASIST.

Trained community participants' role and follow-up support
Highlighting the need for systematic integration of individual and organisational elements within a multi-pronged suicide approach, the national evaluation and associated reports also identified the need to secure better organisational support for people once trained. "Culture change within services is only likely to happen when managers and systems (e.g. client assessment and review documentation, inter-agency referral and client support arrangements, staff support following interventions) also support culture change" (Griesbach and Russell, 2011, p.61). The importance of organisational system development would also apply beyond the statutory services which have been the primary target of national training. Trained people, working as intermediaries between public and professional services around their circles of influence, would need to be networked with each other and with other supportive professionals.

If more members of homelessness services, sports centres, football clubs, pubs and workplaces were provided with training, as is suggested, complementing the excellent existing training, then questions would arise about the nature and location of support (within an organisation or from other services in a tiered model), and whether organisational change is also planned for and feasible. The 'gatekeeper' terminology may need reconsidering, for example a term like 'champion' may have greater resonance in terms of trust-building in community and business as opposed to statutory service settings. The extent to which people are to be trained for a specific add-on 'role' or to act as a capacity building community 'resource' needs considering, given the degree of dissonance that may exist between the 'role' and current occupational roles. Training of community members would need to clarify the purpose of training, and this needs to be aligned with the wider campaign goals. The training delivery and follow-up support required would vary, for example, according to how the training aims describe a mix and balance between the following:
  o   Capacity to talk to individuals 'at risk' (brief engagement and signpost individuals to services and support)
  o   Capacity to engage with wider community, general public, work peers, family (culture champion) in circles of influence
  o   Capacity to work within specific organisation (system change)

Networks and trust-building

As the previous section suggested, more use in the campaign should perhaps be made of *existing*

networks associated with the lifestyles of target groups - for example mapping established leisure activities and settings for different groups in their areas, so that these can be targeted for campaign work. This forms part of the community development approach advocated by some stakeholders. The potential for using *developing*, and *new networks* for spreading social engagement - *developing new initiatives and new champions* for suicide prevention within groups – was also highlighted. If training community participants is viewed partly as a means of increasing the strength of *trusted community resources* for capacity building, the part the trained people can play in engaging with a wider community might involve their relationships to community networks. It should perhaps be considered how far training of gatekeepers or champions can prepare them for potential roles in relation to fostering and supporting such networks.

Developing community capacity around suicide prevention, through awareness campaigning, training, and networking can be seen as an aspect of developing trusting relations -'social capital'- and resilience in communities. This fits closely with the intermediate outcomes of increased social connectedness, relationships and trust that are modelled in the national strategy for improving mental health improvement (Scottish Government, 2009, p.11). It also dovetails with the recommended focus on developing family and community connectedness in a recent systematic evidence review of risk and protective factors around suicide (McLean et al., 2008). The issue of trust concerns, for example, normalising talk about emotions and mental health, so it becomes 'safe' to do so in terms of social identities. This is particularly important for males, whose socialisation around communication of vulnerability can constitute a *risk factor.* 'Social capital' concerns the quality and quantity of positive, trusting, empowering relationships between members of a society. Its definition, much debated, has been understood in terms of the nature and extent of social networks and associated cultural norms of reciprocity (Putnam, 2000). This understanding of social capital as a capacity of a 'group or network' (not just of individuals) can be considered in terms of resources (e.g. supporting information exchanges, providing access to knowledge and resources significant for staying healthy) flowing through networks, and the social infrastructure of networks, and the power structures ('gradients') of society around the networks to which they may or may not have links (Szreter and Woolcock, 2004).

In a contribution which seems very relevant to Choose Life, three forms of social capital have been distinguished, "*bonding* capital refers to trusting and co-operative relations between members of a network who see themselves as similar in terms of shared social identity" (Szreter and Woolcock, 2004 p. 654), for example friends, family and neighbours, neighbourhood football fans; "*bridging* social capital comprises relations of respect and mutuality between people who know that they are not alike in some socio-demographic (or social identity) sense (differing by age, ethnic group, and class)" and "*linking* social capital" is defined as "norms of respect and networks of trusting relationships between people who are interacting across explicit, formal or institutionalized power or authority gradients in society" (Szreter and Woolcock, 2004 p. 655). Although these forms of capital can be put to unhealthy purposes, strengthening all three can improve health outcomes, especially around delivery of resources through on-going interaction (Szreter and Woolcock, 2004 p. 655). Developing and maintaining networks depends on developing trust around shared social norms, which therefore implies shared or at least mutually respected cultural values and beliefs.

The Choose Life awareness raising campaign has targeted specific groups of people where strong associational bonds and networks exist - for example at the football stadium and the pub. The great strength of such networks for information flow and mutual support drawing on relations of community solidarity and trust might potentially be offset if group members, particularly in marginalised communities, a. lack the knowledge (around mental health) to assist each other and b. share a 'defensive' culture which inhibits communication on mental health. Indeed cohesive networks, particularly combined with 'traditional' norms of masculinity, can constrain behaviour, communication, and information flow due to strong social norms (Poortinga, 2011) as, for example,

if men at a football match see Choose Life billboards but do not discuss them with peers. Choose Life, at a national level, also targets people across age, class and occupation divisions through 'universal' media approaches e.g. use of television with multi-generational appeal to families, and mass events e.g. T in the Park and community events with cross-generational appeal such as some comedy and arts events. The potential for wide outreach, capacity building, overcoming culturally restrictive norms and developing empathy through cross-group 'bridging networks' can be weighed alongside particular questions about where cross-group networks are strong enough to support trusting communication about mental health. These networks may grow stronger through shared activities and inclusive routines, e.g. organising or participating in interesting community events. The campaign has been co-ordinated by organisations including North Lanarkshire Council, SAMH, Samaritans, and Breathing Space, with help from enterprises such as Motherwell Football Club. Here the challenge is to build and maintain norms of respect and trusting relationships 'vertically' through links between formal services and professionals and the general public. Trust will be lower among some groups, according to factors such as region, gender, age, social class, depending on wider perceptions of fairness or equity in how resources have been distributed.

The campaign has aimed, with substantial evidence of success, to develop trusting communication with the public by promoting the message through trusted community settings, and through training public employees to develop better understanding and communication. Challenges around trust building that have been identified concern the integration of the training and the campaign, (the campaign message does not, for everyone, normalise public trust of the services, it may seem aimed at 'others', while the training of professionals does not inevitably increase direct interventions in areas where services are being avoided); the depth and complexity of cultural stigma and 'mistrust' of mental illness, reinforced by gendered mistrust of communicating vulnerability; and reaching different sections of the public where trust is low, due to perceptions and experiences of inequity.

There is a connection between increasing community resilience and building trusting communication and support for health. Resilience has been defined as the "capability of individuals, or systems (such as families, groups and communities) to cope significantly in the face of significant adversity and risk" (Lyons et al., 1998). Access to community assets, including economic resources, skills, amenities, and social networks, underpins collective resilience. Where economic disadvantage is worse, social networks can play a vital role (Poortinga, 2011). Community resilience can then be increased, in the area of suicide prevention within disadvantaged regions, if the cultural stigma over suicide and gendered barriers to communication of vulnerability are shifted, so that people talk within trusted networks about how they feel, and offer and seek help in a timely way.

It seems likely that involving and training 'well-connected' champions in the community and voluntary and business sectors, as well as 'gate-keepers' in public services, can help strengthen the positive, trusted networks of members of the general public who work towards suicide prevention. This would supplement and support the essential work already being done by trained professionals. But clarity is then needed about the part trained community and voluntary or business sector intermediaries would play, limits of their capacity, and the support they would need. There may be a need to distinguish between 'trusted intermediary' roles and 'professional gatekeeper' roles (e.g. housing workers). For example, as recommended in discussion groups, trained people in settings and networks where people may have strong common bonds can include five-a-side football co-ordinators/volunteers, young people in schools, men's barbers, bar staff, even unemployed people contacted through job centres. 'Trusted intermediaries' (particularly including males) could then promote and discuss the message through community networks, and a community member aware of the message and concerned about the health of others would be able to speak to trusted intermediaries.

Trained people in 'cross-group network' settings, which might include festivals bringing diverse

social groups together (organisers, volunteer activists, community arts workers), as well as formal consumer service and workplace settings, e.g. construction work, (company and business champions, shop workers) can also provide a first point for communication, a focus for information flow (a link between networks) and a champion for organisational approaches. A proportion of the public spend many hours in the workplace, where co-ordinated approaches are needed, mapping training onto wider organisational mental health and wellbeing developments. At the other end of the spectrum, health service and other professionals like teachers, and homelessness workers can link services to social networks, linked in through intermediaries, who they support.

Unemployment, especially prevalent among young males, poses a substantial threat to the wellbeing and resilience of people within affected communities, and is a major risk factor for suicide (McLean et al., 2008). Unemployment specifically increases risks of social isolation, stress and anxiety (Institute of Public health in Ireland, 2011), and increases in unemployment across EU countries have been directly correlated with increases in suicide over 25 years (Stuckler et al; 2009). Labour market statistics show 11.2% unemployment levels among men (July 2010-June 2011) in North Lanarkshire (https://www.nomisweb.co.uk/reports/lmp/la/2038432142/report.aspx). Suicide prevention work is therefore inseparable from wider work addressing inequalities and social exclusion. As suicide rates in Scotland rise with increased deprivation, a key for long term effectiveness is whether the campaign is targeting most deprived and at-risk communities and groups. Specifically, reaching unemployed, otherwise disengaged, and isolated people who may have lost trust in statutory services, and may currently rely on relatively weak community networks, is a major challenge and a priority for suicide prevention. Both professional 'gatekeepers' (e.g. job centre, finance advice, housing, court and other support and care workers) and trained members of those networks (e.g. unemployed young people, older volunteers at community centre) can potentially contribute, bearing in mind that in some cases combining an activity with dialogue, information and support can be effective in engaging men.

Ways forward/sustainability

Long term change
In the long term, the Choose Life programme goal is sustained suicide reduction. To achieve the long term goal, the public awareness campaign aims to achieve healthier more self-protecting and resilient communities and organisations, where 'healthy' systems and services help to prevent suicide and people in communities look out for each other. This approach dovetails with the social model of health and well-being underpinning government strategy on mental health improvement (Scottish Government, 2009), and with systematic evidence on multi-faceted, interactive risk and protective factors for suicide, where key protective factors include social support (McLean et al., 2008).

In order to gain robust evidence that the programme is working towards 'intermediate outcomes' which can support achievement of the long term goal, it is necessary to take account of processes of change, as discussed earlier, and therefore different forms of evidence need to be considered together. It would be very desirable to identify whether the media aspect of the programme is having an impact on calls to helplines. However, interpreting calls data to evaluate a media campaign remains problematic for three reasons: to date, data systems and measures have not been closely integrated across services and partners to allow robust comparative analysis; the interaction of different programme elements, (and indeed different programmes), may have synergetic and additive effects so that analysing the separate effect of a media campaign is problematic; and in any measures of change over time, context factors, such as an economic down-turn in particular, may affect the outcomes.

The recurring theme in this evaluation that culture change can be achieved by working with young people and future generations implies that evaluating the likely long-term success of a campaign involves looking beyond and behind calls to services and current rates of suicide. This requires analysing evidence of raised capacity and confidence of young people and other sections of the public to seek and give help across their networks of influence, and raised service capacity to respond to requests. The evaluation has found that capacity is being raised, among the public (through the campaign) and in services (through training). It has also been suggested that if the successful approaches of the multi-component programme are still more effectively co-ordinated and targeted, the impact of the campaign in the future could be increased.

Co-ordination of approaches
The importance of vertical co-ordination of national and regional drivers and resources, and horizontal integration of regional elements has been emphasised through this evaluation, in considering evidence from stakeholders and the general public. Illustrating the interdependency of the national and regional campaign, the national campaign strapline has been adopted regionally, along with regionally developed communication resources. Prominent *national* campaign materials (for example the black-and-white 'drawer' 'washroom' and 'sofa' posters) have addressed at-risk individuals, while other resources ('the art of conversation' booklet) guide the general public. The North Lanarkshire campaign engaged with local groups (e.g. North Lanarkshire Licensing Forum and members of Sound Minds) to design fresh materials. These local groups recommended that black-and-white images might deter the public from engaging. The innovative adaption of the brand and '*Suicide. Don't hide it. Talk about it*' strapline to highly public-focused, boldly designed, colourful, settings-based messages and materials in North Lanarkshire (e.g. the bright-coloured Motherwell FC 'shirt' billboard, poster and postcards, and the taxi and bus panels) has made it possible to reach out and engage very positively with a wider public. Yet there is still more work to do in co-ordinating national and regional campaigning, for example in materials design, development and placement. This means, in part, making sure the learning from North Lanarkshire is reflected on and applied nationally. To build on the mutually beneficial national and regional interdependency, resources (online, television, radio and print) need to be developed and targeted in a more systematically co-ordinated and segmented way, with greater brand consistency in material design, to ensure strong recognition, to reach sections of the general public, and to reach at-risk individuals. The at-risk individuals include isolated and marginalised people, who can be approached through both national media and particular local networks and settings.

There is also the importance, on a national scale, of the co-ordination of the suicide prevention programme with complementary wider anti-stigma and mental health awareness campaigns such as 'see me', and within overall mental health and wellbeing programmes. For example, 'see me' functions as a separate voluntary organisation whereas Choose Life is part of NHS Health Scotland nationally. Partner organisations support a range of campaigns - as exemplified in football stadium and website promotion of Choose Life, see me, Breathing Space, and Samaritans messages. It seems important, since there is a complementary relationship between different campaigns, resources, brands and messages, that this complementarity should be clarified and reinforced for the public. This requires improved horizontal communication, to provide clear coherent messages about mental health and wellbeing to the population of Scotland, without diluting the specific focus and strengths of campaigns. Choose Life (North Lanarkshire) is exceptional in its focus on targeted sections of the public including young males. It is evident that a huge strength of the campaign has been its partnerships, and that the integrating role of the campaign Co-ordinator has been vital. These assets could be built on in future, for example strengthening and extending cross-sectoral partnerships to reach the most disengaged groups such as some young unemployed males, which include people at high risk. Existing and new partnerships can be used to extend organisational outreach, to mainstream work structurally in services, and to reach out to existing and emerging networks to

develop the campaign in communities that have been excluded. Closer harmonisation of the awareness raising and training programmes would perhaps support the desired social, cultural transformation. All these steps can only be achieved if appropriate national and regional drivers and support are maintained.

Conclusions

This evaluation has identified that the Choose Life (North Lanarkshire) awareness-raising programme has made huge steps towards improved public access to information on suicide and deliberate self-harm, increased public knowledge of suicide and self-harm, and challenging cultural myths and stigma associated with suicide. Particular progress has been made with the young male priority group through adopting a targeted community settings approach. The outstanding campaign emphasis on public awareness and communication using some social marketing approaches has been a pathfinder in suicide prevention work in Scotland. The approach towards developing public awareness and communication aims at encouraging and supporting a culture transformation to an attitude of enabling *trust*, that it is 'safe' to talk about suicide. This transformation requires, at another level, on-going development of trustworthy organisations and services, especially in terms of communication and delivery of resources to marginalised groups and individuals.

The complex process of cultural and service transformation evidently requires time to accomplish. Further steps can be taken, in the public awareness campaign, drawing on what has been learned from the campaign so far, towards the goal of suicide reduction. Considerations for the emerging campaign direction, supported from the evidence, have been presented here for discussion. The evaluation also confirms the importance of a systems focus on the public, individuals and organisations, and developing, supporting and celebrating community-centred approaches that can lead to culture change. It is paramount that the direction of the public campaign and its system-wide integration with wider suicide prevention and mental health work continues to be sustained and resourced through the next stages of its development.

Appendices 1-11: Survey Tables

Appendix 1: Ethnic group

Ethnic Group	Frequency	Percent
White British	495	95.0%
Irish	1	0.2%
Any other White background	8	1.5%
Caribbean	1	0.2%
African	3	0.6%
Chinese	1	0.2%
Pakistani	2	0.4%
Bangladeshi	1	0.2%
Any other Asian background	1	0.2%
Refused	8	1.5%
Total	521	100%

Appendix 2: Settings respondents have seen campaign materials within, by locality

Setting of campaign material		Locality					Total
		Airdrie	Cumbernauld	Kilsyth	Motherwell	Wishaw	
Motherwell FC	No	71	65	9	45	76	266
	% in locality	62.3%	40.9%	29.0%	45.0%	67.3%	51.5%
	Yes	8	8	3	30	15	64
	% in locality	7.0%	5.0%	9.7%	30.0%	13.3%	12.4%
	Don't go	35	86	19	25	22	187
	% in locality	30.7%	54.1%	61.3%	25.0%	19.5%	36.2%
Taxi	No	109	136	24	63	84	416
	% in locality	95.6%	85.5%	77.4%	62.4%	74.3%	80.3%
	Yes	5	15	4	35	25	84
	% in locality	4.4%	9.4%	12.9%	34.7%	22.1%	16.2%
	Don't go	0	8	3	3	4	18
	% in locality	.0%	5.0%	9.7%	3.0%	3.5%	3.5%
Bus advert	No	109	143	25	72	92	441
	% in locality	95.6%	89.9%	80.6%	70.6%	81.4%	85.0%
	Yes	5	9	5	26	18	63
	% in locality	4.4%	5.7%	16.1%	25.5%	15.9%	12.1%
	Don't go	0	7	1	4	3	15
	% in locality	.0%	4.4%	3.2%	3.9%	2.7%	2.9%
Washroom at work	No	103	126	12	81	93	415
	% in locality	90.4%	79.2%	40.0%	79.4%	82.3%	80.1%
	Yes	3	4	3	5	6	21
	% in locality	2.6%	2.5%	10.0%	4.9%	5.3%	4.1%
	Don't go	8	29	15	16	14	82
	% in locality	7.0%	18.2%	50.0%	15.7%	12.4%	15.8%
Pub	No	107	135	20	71	98	431
	% in locality	93.9%	84.9%	64.5%	69.6%	87.5%	83.2%
	Yes	3	9	3	19	6	40
	% in locality	2.6%	5.7%	9.7%	18.6%	5.4%	7.7%
	Don't go	4	15	8	12	8	47
	% in locality	3.5%	9.4%	25.8%	11.8%	7.1%	9.1%
Chemist/ Pharmacy	No	108	139	28	83	105	463
	% in locality	94.7%	87.4%	90.3%	82.2%	92.9%	89.4%
	Yes	2	3	3	8	2	18
	% in locality	1.8%	1.9%	9.7%	7.9%	1.8%	3.5%
	Don't go	4	17	0	10	6	37
	% in locality	3.5%	10.7%	.0%	9.9%	5.3%	7.1%

Setting of campaign material		Locality					Total
		Airdrie	Cumbernauld	Kilsyth	Motherwell	Wishaw	
Library	No	106	119	16	69	97	407
	% in locality	93.0%	74.8%	51.6%	67.6%	85.8%	78.4%
	Yes	3	5	1	12	5	26
	% in locality	2.6%	3.1%	3.2%	11.8%	4.4%	5.0%
	Don't go	5	35	14	21	11	86
	% in locality	4.4%	22.0%	45.2%	20.6%	9.7%	16.6%
Community Centre	No	107	107	17	62	92	385
	% in locality	93.9%	67.3%	56.7%	60.8%	81.4%	74.3%
	Yes	1	5	4	8	4	22
	% in locality	.9%	3.1%	13.3%	7.8%	3.5%	4.2%
	Don't go	6	47	9	32	17	111
	% in locality	5.3%	29.6%	30.0%	31.4%	15.0%	21.4%

Appendix 3: Recall of campaign materials in different settings, by age

Age	Motherwell FC	Taxi	Bus ad	Washroom at work	Pub	Chemist/Pharmacy	Library	Community Centre
16-25	26	31	22	7	18	4	8	10
% in 16-25	26.8	20.7	15.6	5.3	13.6	3.0	6.9	9.3
26-35	8	14	7	1	4	2	2	2
% in 26-35	16.7	21.9	10.9	1.7	6.3	3.2	3.6	3.9
36-45	14	13	12	7	8	4	8	3
% in 36-45	21.5	13.5	12.2	7.8	8.4	4.3	9.8	3.8
46-55	11	12	15	4	7	5	3	3
% in 46-55	26.8	16.7	20.5	6.9	10.8	7.2	5.3	5.4
56+	5	14	7	2	3	3	5	4
% in 56+	6.3	11.3	5.5	2.0	2.6	2.4	4.1	3.5
Total	64	84	63	21	40	18	26	22
% in Total	19.4	16.8	12.5	4.8	8.5	3.7	6.0	5.4

Appendix 4: Types of campaign materials that respondents recall, by locality

Type of campaign material	Locality					Total
	Airdrie	Cumbernauld	Kilsyth	Motherwell	Wishaw	% of total
Poster/billboard	13	21	8	41	26	109
% within Locality	11.4%	13.4%	25.8%	40.2%	23.0%	21.1%
Video	0	1	0	4	1	6
% within Locality	0.0%	0.6%	0.0%	3.9%	0.9%	1.2%
Newspaper advert	6	5	4	20	8	43
% within Locality	5.3%	3.2%	12.9%	19.6%	7.1%	8.3%
Pocket –sized card	3	3	2	10	2	20
% within Locality	2.6%	1.9%	6.5%	9.8%	1.8%	3.9%
On the radio	4	16	4	16	12	52
% within Locality	3.5%	10.1%	12.9%	15.7%	10.6%	10.0%
On TV	6	12	5	26	13	62
% within Locality	5.3%	7.6%	16.1%	25.7%	11.5%	12.0%
On football-related product	8	9	3	31	14	65
% within Locality	7.0%	5.7%	9.7%	30.7%	12.4%	12.6%

Appendix 5: Recall of different types of campaign materials, by age

Age	On poster/ Billboard	In a Video	In an advert in newspaper	On pocket sized card	On Radio	On TV	On football-related products
16-25	38	2	20	6	22	18	26
% in 16-25	26.2	1.4	13.8	4.1	15.2	12.4	17.9
26-35	15	0	1	2	3	9	7
% in 26-35	22.1	0.0	1.4	2.9	4.3	13.0	10.1
36-45	22	2	7	3	11	14	15
% in 36-45	22.0	2.0	7.0	3.0	11.0	14.0	15.0
46-55	21	2	8	5	12	12	10
% in 46-55	28.4	2.7	10.8	6.8	16.2	16.2	13.7
56+	13	0	7	4	4	9	7
% in 56+	10.0	0.0	5.4	3.1	3.1	7.0	5.4
Total	109	6	43	20	52	62	65
% in total	21.1	1.2	8.3	3.9	10.0	12.0	12.6

Appendix 6: Respondents level of agreement with the statement "If someone wants to commit suicide it is their business and we should not get involved"

Level of agreement	Frequency	Percent
1 "Strongly disagree"	108	62.4
2	20	11.6
3	15	8.7
4	9	5.2
5	5	2.9
6 "Strongly agree"	16	9.2
Total	173	100

Appendix 7: Respondents level of agreement with the statement "If someone wants to commit suicide it is their business and we should not get involved", by sex

Sex	Level of agreement with "If someone wants to commit suicide it is their business and we should not get involved"					
	1 "Strongly disagree"	2	3	4	5	6 "Strongly agree"
Male	83	14	13	9	5	15
	59.7%	10.1%	9.4%	6.5%	3.6%	10.8%
Female	25	6	2	0	0	1
	73.5%	17.6%	5.9%	.0%	.0%	2.9%
Total	108	20	15	9	5	16
% of Total	62.4%	11.6%	8.7%	5.2%	2.9%	9.2%

Appendix 8: Respondents' level of altered attitude following the Choose Life campaign

	Level of altered attitude					Total
1 "Not at all"	2	3	4	5	6 "Very much"	Total
81	11	12	27	18	21	170
47.6%	6.5%	7.1%	15.9%	10.6%	12.4%	100%

Appendix 9: Altered attitudes, by level of awareness of campaign

Level of campaign awareness	Level of altered attitude due to campaign						Total
	1 "Not at all"	2	3	4	5	6 "Very much"	Total
1 "Not aware"	19	0	0	5	1	1	26
% within altered attitude	**23.5%**	.0%	.0%	19.2%	5.9%	4.8%	15.5%
2	12	4	2	3	2	1	24
% within altered attitude	14.8%	**36.4%**	16.7%	11.5%	11.8%	4.8%	14.3%
3	16	3	5	8	4	3	39
% within altered attitude	19.8%	23.7%	**41.7%**	**30.8%**	23.5%	14.3%	23.2%
4	13	2	4	5	7	3	34
% within altered attitude	16.0%	18.2%	33.3%	19.2%	**41.2%**	14.3%	20.2%
5	9	1	0	2	2	2	16
% within altered attitude	11.1%	9.1%	.0%	7.7%	11.8%	9.5%	9.5%
6 "Very aware"	12	1	1	3	1	11	29
% within altered attitude	14.8%	9.1%	8.3%	11.5%	5.9%	**52.4%**	17.3%
Total	81	11	12	26	17	21	168
% within altered attitude	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Appendix 10: Behaviour in relation to talking to someone who might be thinking of suicide, by sex

	Would already	Would now	Would never	Total
Male	103	26	10	139
	74.1%	18.7%	7.2%	100%
Female	22	10	0	32
	68.8%	31.3%	0.0%	100%

Appendix 11: Behaviour to support other people who might have mental health problems, by locality

Locality	Have discussed	Got information	Sought help
Airdrie	2	2	2
	10.0%	10.0%	10.0%
Cumbernauld	5	4	3
	14.3%	11.4%	8.6%
Kilsyth	1	4	0
	9.1%	**36.4%**	0.0%
Motherwell	19	13	8
	31.1%	21.3%	**13.1%**
Wishaw	2	6	3
	4.7%	14.0%	7.0%
Total	29	29	16
	17.1%	17.1%	9.4%

Appendix 12: Stakeholder participants

Campaign organisations
United Taxi service
Reeltime Music
Peer support group
Motherwell Football Club
North Lanarkshire Leisure (five-a-side football tournament)
Service delivery
Voluntary Action North Lanarkshire
Alcohol Drug Partnership
Lanarkshire Links service
Mental health services
Samaritans
Libraries
NHS Occupational Therapy
NHS Public Health
GP – Chair Drug related review group
Hospital Chaplain
Social work team manager
Addictions service manager
Police x 2
Health Improvement Senior
Campaign Co-ordinator (Choose Life)

Appendix 13: Building suicide prevention capacity – model of change

LONG TERM GOALS

SUICIDE REDUCTION and WELL-BEING, INEQUALITIES ADDRESSED | *HEALTHIER, SELF - PROTECTING COMMUNITIES, ORGANISATIONS*

INSIGHTS – CONSIDERATIONS FOR RENEWED INPUTS (FURTHER STEPS)

Maintain campaign. Coordinator and partnership facilitation, support. Renew, diversify media strategies. Trained community + voluntary sector intermediaries work through networks. Community-organised, maintained events. Organisational mainstreaming. Localisation, and closer targeting of resources. Wider cultural transformation through campaign synergy, improved co-ordination, networks of trust.

INSIGHTS - IDENTIFIED DEVELOPING CAPACITY AND SUPPORTIVE ENVIRONMENTS TO MAINTAIN AND SPREAD CHANGE

INDIVIDUALS
Knowledge, confidence, choices to talk, or seek information, support

+

COMMUNITIES
Support networks, activities, champions/intermediaries (social capital)

+

ORGANISATIONS
Trainers/trained. Action plans. System changes. Champions.

INSIGHTS - IDENTIFIED SUCCESS FACTORS

Integrating campaign with lifestyles for community groups. Inter-sectoral partnerships. Calls to action.

INSIGHTS - IDENTIFIED IMPLEMENTATION CHALLENGES

Geographical reach. Targeting unreached/excluded groups. Sustaining change. Building trust (organisations, communities). Co-ordinating campaign elements (training and media, national and local) → New steering group/co-ordinator inputs.

INTERMEDIATE OUTCOMES

High public awareness – services Knowledge of suicide | Stigma reduction. Talk about suicide, mental wellbeing, etc. | Help-seeking/ providing events. Calls to services. | Embedding capacity in supportive community and organisations. Action plans. Networks made and recurring and linked events established.

ACTION PLAN – INPUTS (STEPS)

Public awareness campaign. Media work (settings-based). Training (for capacity). Organisational work (for system change). Community networking (for capacity and confidence). Partnerships (interconnected issues, delivery)

IDENTIFIED COMMUNITY CHANGE PROCESS

Awareness raising → Attitude change → Increased engagement → Maintain and spread change through community/organisation ownership

IDENTIFIED PROBLEMS

High suicide levels. Young males. Stigma. Community deprivation.

Appendix 14: Model of Change and Formative Evidence in Campaign

Steps 1-3	Mechanisms	Assumptions	Evidence of change
Step 1	Media campaign and materials developed. Training programme.	Media campaign will raise public awareness and contribute to normalising talk about suicide among general public. This will contribute to increased engagement manifested in greater number of calls to helplines. Training programme will result in professionals and gatekeepers able to intervene with people with suicidal thoughts.	**Qualitative evidence** 1. Stakeholder interviews and discussion groups with general public showed that the campaign raised *awareness* of suicide and mental health issues by setting it in trusted venues within people's lifestyles. 2. The *attitudes* of a good proportion of the public changed as they felt more open to talk about negative emotions. *Concerning engagement,* it was not clear to all the public whether the message 'spoke' to them, and whether they could obtain advice from phone-lines, or should themselves talk with people at risk. 3. The combined use of settings/media appealing to targeted groups and settings/media with widespread appeal proved important for achieving campaign objectives. The messages need to vary in subtle respects between settings, and according to the intended audience. **Quantitative evidence** 1. Survey findings show the campaign raised public awareness of services. People with high awareness of the campaign were far more likely to have altered attitudes. High levels of campaign awareness also affected public behaviour, those very aware of the campaign were more likely to have discussed, got information or sought help to support other people. 2. Data on calls to Samaritans and Breathing Space provides some support for the finding that the campaign has affected individual help-seeking behaviour, especially in Motherwell. 3. National training data shows extensive training of public sector health and social care service providers, but fewer front-line volunteers, non-professionals, and other gatekeepers. Training has not been targeted at men who talk with other men in community settings.
Step 2	Media campaign implemented in preferred settings. Partner organisations cultivated to extend reach of campaign.	Campaign will reach and engage desired groups in desired settings. Reach into organisations and communities with networks to population groups with high suicide risk.	**Qualitative evidence** 1. The campaign has reached targeted groups, particularly young and early middle-aged men in and around Motherwell, in settings such as football stadium, five-a-side tournaments, and music festivals, encouraging them talk to others or to seek help. **Quantitative evidence** 1. The areas with most awareness of the campaign among respondents were Motherwell and Wishaw, with much lower levels in Cumbernauld and Airdrie. Campaign materials seen by respondents in Motherwell in/on taxis (as part of daily activities) and at Motherwell Football Club were recalled at higher levels than materials in other settings in other localities. 2. The campaign challenge is to spread the great benefits still further making use of statutory-voluntary partnerships and (informal/formal) community networks to engage with the relatively un-reached high-risk communities, and priority groupings, including older people, marginalised, out-of-work, and those in towns like Cumbernauld and rural areas which had lower awareness of the campaign. 3. The awareness of the campaign varies by age (people of 55 and under being relatively more aware). The most frequent forms of engagement following from noticing the campaign may differ by gender: the most common activity among men was getting information on suicide/mental health issues, while the most common activity among females was discussing suicide/mental issues.
Step 3	Members of the public and gatekeepers are trained, and engage with/support the public.	Training will motivate, develop awareness/skills and prepare for role. Participants able and ready to do role following training. Training is reaching the appropriate range of people.	**Qualitative evidence** 1. Discussion group findings suggest the public would feel very positive if more community intermediaries or gatekeepers such as barbers, taxi drivers, job centre workers were trained. 2. Public are generally not very aware of training elements or of community members who may have been trained. 3. Stakeholder interviews highlight the need to 'join up' the training and the public awareness campaign still more.
Intermediate outcomes	Improved public access to information, awareness of services. Increased knowledge of suicide and self-harm. Reduction in stigma. Engagement in behaviour leading to early help where needed.		

Appendix 15: Literature Review for Choose Life Evaluation

This literature review focuses on campaigns, or programmes with a campaign element, which aim to reduce suicide and suicidal acts. The following search strategy was undertaken.

- *Four major databases were chosen for the literature search: Psycharticles, Psychinfo,Academic Search Complete, CINAHL and The Cochrane Library.*
- *Searches of these databases were performed using combinations of the following terms:*
  (suicid*) AND (awareness campaign OR prevention campaign OR stigma campaign OR anti-stigma campaign OR health campaign OR health information programme OR social marketing OR health communication) AND (evaluation OR review)
- *Screening was undertaken to identify the papers most relevant to the Choose Life North Lanarkshire Suicide Awareness project. Inclusion and exclusion criteria, as below, used to identify studies to be included:*
  1. *Types of studies: only evaluations or literature reviews will be considered for inclusion.*
  2. *Types of participants: studies aimed at the general adult population or specific groups within the general public (particularly men) will be included.*
  3. *Types of setting: For inclusion, media campaigns must be delivered within a community setting, rather than within specific institutional boundaries (e.g. school, workplace, hospital, etc.) There is no restriction in terms of the geographical location of intervention delivery.*
  4. *Types of interventions: media campaigns with a focus on suicide prevention will be included. Those focusing solely on depression/mental health and related stigma to such will be excluded.*
  5. *Types of outcome measures: studies that reported at least one of the following outcomes will be included:*
     -Incidence of suicide/suicidal acts
     -Awareness/recollection of media campaign
     -Awareness/Knowledge of mental health issues pertinent to suicide
     -Attitude to media campaigns message
- *Review of major papers and other significant texts written into the evaluation report.*

Suicide is unquestionably a worldwide public health issue, with a 60% rise seen in the past 45 years (WHO, undated). As a result a number of media campaigns have been used to raise suicide awareness and encourage help-seeking behaviour with the ultimate aim of achieving reductions in suicide rates. Unfortunately, the evaluation of such campaigns is limited, as revealed by the literature search, and confirmed in other recent reviews (Wood et al., 2010, Dumesnil and Verger, 2009). Despite this, the following review utilises the available information to form a structured review of previous campaigns, the approaches taken, the evaluation methods used, and the effects attributed to the campaign.

The approaches taken by media campaigns aiming to reduce suicidal acts need to be carefully considered in the light of the sensitivity of the subject. On searching the literature it became apparent that two main approaches are currently in use:
1) media campaigns with an aim to reduce suicidal acts, using language with a focus on mental health
2) media campaigns with an aim to reduce suicidal acts, using language with a sense of urgency and a clear focus on intense distress and imminent action.

Category 1: Media campaigns with an aim to reduce suicidal acts, using language with a focus on mental health issues
Six main campaigns were found for inclusion in this category: the *Nuremburg Alliance against Depression* (NAD), the *Regensburg Alliance against Depression* (RAD), the *European Alliance Against Depression* (EAAD),

OPSI-Europe, the *Minding Your Head (MYH)* campaign, and the West Sussex project, entitled *Reducing the Risk of Suicide in Men aged over 40 years who are not in contact with Mental Health Services (RSMHS)*.

The NAD was a multiple approach, community-based intervention launched in 2001 in Germany (Dietrich *et al*, 2009), whose methods were later employed in the 2003 Regensburg program (RAD) (Hübner-Liebermann et al., 2010), in more than 40 regions and communities as part of the German Alliance Against Depression (GAD) (Hegerl et al., 2008), throughout 18 countries across Europe (European Alliance against Depression (EAAD)) (Hegerl et al., 2008) and within OPSI-Europe, which was funded to provide EU members with an evidence-based prevention concept for suicidality (Hegerl and Schmidt, 2009). The model being used in these projects consists of four levels of work: 1) training for primary care physicians; 2) a public media campaign; 3) gatekeeper training for community members whose role might make them pivotal in help-seeking amongst people who are suicidal/depressed; 4) self-help groups for suicide attempters and their relatives. The public media campaign messages highlights 'depression' in three key messages: 'depression can affect everybody', 'depression takes many forms' and 'depression is treatable', (Dietrich et al., 2010). Notably, an earlier article published on the NAD clearly states that "'suicidality' was of central importance in (their) cooperation with health professionals, but it was not actively addressed in (the) public relations campaign" (Hegerl et al., 2006). The messages also take on a blanket educational approach, avoiding personalisation through targeting people with behavior change messages or words such as "you".

The NAD public media campaign utilised posters, leaflets, information brochures, a 'cinema spot', a website and local media (i.e. radio, TV and print media). Materials provided details of services where people could find help, including a crisis telephone number. RAD used similar media (Hübner-Liebermann et al., 2010). Clear details of the materials used within EAAD and OPSI-Europe are not currently available, but it seems they would be similar to those mentioned above given that they have been modelled on the NAD (Hegerl and Schmidt, 2009).

Evaluation of the NAD media campaign involved baseline (2 months before the campaign began in 2000), and two follow-up evaluations (10 and 22 months after the campaign began). A control region was also employed. Telephone interviews covered the following topics: awareness of increased discussion of depression in the public; noticing the campaign; attitudes toward depression (severity and stigma); beliefs about causes, symptoms and treatments; and personal experience with depression. Overall effects of the entire NAD (that is, all four components) on suicidal acts (i.e. suicide attempts and completed suicides) at baseline, and during the first and second years of the campaign were also reviewed (Hegerl et al., 2006). Evaluation of the RAD differed from that of the NAD, as it did not include specific evaluation of the campaign element, but instead considered the overall programme effect on suicide rates, covering 5 years pre-campaign and 5 years post-campaign (i.e. 1998 to 2007). Notably it didn't cover all suicidal acts, but only completed suicides (Hübner-Liebermann et al., 2010).

In terms of the EAAD, though local evaluation may have taken place, this was not monitored stringently and no report could be located in the literature search. Following on from the EAAD, OPSI-Europe was funded to provide EU members with an evidence-based prevention concept for suicidality, including information and materials for implementation and evaluation (Hegerl and Schmidt, 2009). The evidence base is being drawn from interventions using the original 4-level NAD model in four European countries. As with evaluation methods used for the NAD and RAD, control regions have been assigned to each of the intervention regions (Hegerl et al., 2009). The primary outcome, as used to evaluate NAD, is suicidal acts at baseline, during the intervention and six months after the intervention ceases to run. Secondary outcomes are again similar to those assessed in the NAD, and cover areas such as knowledge awareness and attitude change (Hegerl et al., 2009). This program of work is currently ongoing.

Fortunately results of the NAD and the Regensburg intervention are already available. NAD media campaign analysis showed that within the intervention region the public noticed an increased amount of discussion about depression over the course of the campaign (Dietrich et al., 2010), which may be associated with the strong links NAD made with local media. The NAD campaign appears to have changed some attitudes and beliefs when comparing baseline to the first year follow-up, yet by the second year this effect declined amongst the overall surveyed population. One reason for this may be the lower levels of media activity during the second year of the campaign. Results also showed that more females were aware of the NAD campaign than males. Looking at those who were aware of the NAD campaign (baseline: 29.4%, second follow-up:

45.9%) there was a significant reduction of people who thought "just pulling yourself together" was a valid solution/treatment for depression at second follow-up (baseline: 17.9%, second follow-up 8.5%). Such a decrease was not visible amongst the control group- (baseline: 13.3%, second follow-up: 15.6%) (Dietrich et al., 2010).

As mentioned, suicidal acts were also considered in the NAD evaluation, though it is important to highlight that changes in suicidal acts/attempts cannot be solely attributed to the public campaign component of a four-level community-based intervention. Indeed, the community based nature of the campaign- with many potential influencing factors-means that the changes in numbers of suicidal acts cannot be wholly attributed to the NAD (Hegerl et al., 2006). Bearing this in mind, results showed a statistically significant reduction in suicidal acts in the intervention region: 620 at baseline, 500 during the first year of NAD, and 471 during the second year. These results are largely attributable to a fall in suicide attempts rather than completed suicides. In comparison the control region had 183 suicidal acts at baseline, 182 in the first year of NAD and 196 in the second year (Hegerl et al., 2006).

The year after the RAD began a significantly lower than average rate of suicide was recorded at 7 suicides per 100,000 population in Regensburg (deviation from average 10 year rate = -2.4, p<0.5). Decreases in rates of completed suicides had diminished considerably by the second year of the campaign (deviation from average 10 year rate = -0.2, ns). These findings are similar to those of the NAD, where completed suicides decreased from 100 to 75 during the first year of the campaign, but increased to 89 during the second year. No significant deviations from this pattern were found in the control regions or Germany overall. One notable point is that changes in male suicide rates accounted for overall significant deviations from the pattern in Regensburg, with the female rate remaining unchanged (Hübner-Liebermann et al., 2010). Hübner-Liebermann *et al*. believe this may be resultant of a couple of specific campaign events which inadvertently targeted males.

One campaign which has taken place independently of the NAD is Minding Your Head (MYH), a two-phase public information campaign that took place in Northern Ireland over 2007 and 2008. Phase one had two strands, one targeting the general public and one targeting young males (aged 16-24), whilst phase two was specifically focused on young males. Though one of the two main objectives of the campaign was to contribute to preventing suicide and self-harm (N.B. the other main objective was to promote, protect and enhance mental health and wellbeing) it was decided that the campaign would avoid focussing on suicide as the topic, and would take a more indirect approach to tackle suicide rates through raising awareness and reducing the stigma of mental and emotional health issues (HPANI, 2007), as informed via research commissioned to uncover the public's understanding of mental health (HPANI, 2006).

MYH utilised television, print materials, and radio and press advertisements to share the campaign messages over each phase, and both phases of the MYH campaign were evaluated via surveys. Results of the phase one campaign showed that 83% of the survey population was exposed to some element of the campaign, whilst women were more likely to have been exposed than men (HPANI, 2008). Highest prompted recall was for the television advertisements. When carrying out media campaigns it is also important to consider which mediums are most effective. Phase one leaflets were most successful at initiating activities to promote mental health, yet they were also the least viewed of all the campaign media. The TV and radio advertisements, and the poster caused between 34% and 44% of those who saw them to take action to promote mental health, whilst 'thinking about mental health' and 'discussing mental health issues with anyone' were the most common activities undertaken.

Phase two of the campaign proved to be more successful overall than phase one at encouraging those exposed to initiate an activity to promote mental health (HPANI, 2009). Young males were just as motivated as others to think about their mental health after exposure to the Phase two TV and radio adverts. The target groups' exposure to phase two was found to be no different to that of other respondents, which was an improvement over phase one, during which young males aged 16-24 were found to be significantly less likely to be exposed. This may have been due to the heavier targeting of key media/places, e.g. radio stations with predominantly male audiences, and male washrooms. Lastly, following phase two, young males aged 16-24 years old were significantly more likely to think about, discuss and do something to improve their mental health than they were following phase one (HPANI, 2009). Notably, the campaign evaluation presented no data on reduction of suicide and self-harm.

Lastly in West Sussex, RSMHS was a multi-component project which ran from 2006 to 2008 (Potter, undated). The intervention included joint working with GP surgeries to encourage men to attend routine health checks (including mental health screening), provision of ASIST suicide awareness training to key gatekeepers (statutory and voluntary health and social care providers, and community services), and the implementation and evaluation of a media campaign (NIMHE, 2007), which is the focus in this review.

The media campaign involved development and placement of beer mats, credit card-sized resources and posters in nine pubs. The beer mats, used for a maximum of one week, displayed the message "Are you trying to carry more than you can handle", whilst all resources detailed sources of help (including the Samaritans telephone number). Following the distribution of these resources, semi-structured interviews were carried out with seven of the nine pub managers and key points were written down by the interviewer (Potter, undated). With 100 being distributed at the beginning of the intervention period, a count was also performed to sum the total number of credit-card sized resources remaining in each establishment at the time of the interview, giving a crude indication of interest (Potter, undated). Though one pub was unable to count at the time of interview, of the remaining six pubs, four reported that no cards remained, whilst the other two pubs had more than half left. Brief anecdotal evidence was received, but managers were unsure of the extent to which resources were actually used by customers, therefore felt unsure of their impact. The limited insight offered by interviewing only pub managers is clear. Notably, whilst reduction in suicide risk was central to this project, suicide rates, or any other indication of the effect of the campaign on the target groups' mental health were not included in this analysis, making it hard to assess efficacy.

Category 2: Media campaigns with an aim to reduce suicidal acts, using language/links which imply suicide
As mentioned earlier, media campaigns using language with a sense of urgency and a clear focus on intense distress and imminent action are less prevalent in the literature. The Brighton and Hove Suicide Prevention Project for Men over Forty and the New Forest Suicide Prevention Initiative were the two projects identified for inclusion in this category.

Brighton and Hove's Suicide Prevention Project for Men over Forty (SPMF) was a multi-component project modeled on the RSMHS (Walker et al., unpublished). The intervention focused on delivering a media campaign, and setting up a suicide prevention support group for men over forty who were experiencing suicidal distress (Walker et al., unpublished). The key campaign message was "You are not alone. If you or someone you know is struggling with life, talking can help", and campaign materials displayed key contact information including the Samaritans and NHS Direct telephone numbers. Despite the RSMHS media campaign being listed with the category 1 campaigns, this message fits within category 2 due to the use of language suggestive of suicide (i.e. "struggling with life"), linked to inclusion of the Samaritans telephone number. The campaign ran for 4 weeks and included distribution of campaign materials to GP surgeries, posters displayed on the inside of 300 local buses, beers mats, business cards, and media engagement.

The evaluation focused on campaign awareness. Methods included a convenience sample survey of 135 members of the general public, and interviews with the pub landlords and a betting shop manager who displayed campaign materials within their establishments (Walker et al., unpublished). Four weeks after the campaign materials had been distributed 21% of the 135 members of the general public surveyed (n=29) had encountered campaign material. 31% (n=42) of those surveyed were part of the target group for the SPMF campaign (men aged over 40 years). Overall 72% (n=98) of all respondents either agreed or strongly agreed that the campaign was appropriate. Concerning men, 73% (n=30) of men aged over forty and 70% (n=26) of men under forty agreed that the campaign was appropriate. There was no significant difference between men and women, or men over forty and men under forty concerning how appropriate they believed the campaign to be. Further qualitative analysis of interviews with pub landlords revealed a positive response to the campaign message, however logistical problems such as beer mats being discarded after two days reduced campaign visibility. Some managers also highlighted that questions in relation to customers' response to campaign materials would be better directed at those working in closer proximity to customers (e.g. bar staff, etc.) (Walker et al., unpublished).

The New Forest Suicide Prevention Initiative (NFSPI) was a single-component intervention aimed at reducing the excess of car exhaust suicides in the area through campaign signage, and involved the placement of A4 signs at the entrance to 26 car parks located in New Forest, Hampshire, in which 50% of car park suicides had occurred, for a three year period (Oct 1998-Sep 2001) (King and Frost, 2005). The sign displayed the following

text: "24 hours. 1 phone number.", showed the Samaritans phone number and details of the nearest pay phone, and ended with the message "The Samaritans. We'll go through it with you" (King and Frost, 2005). The blunt language and the provision of the Samaritans telephone number indicate applicability to those in serious distress.

The evaluation of the NFSPI compared the number of suicides for the ten years preceding the initiative to the data collected during the three-year initiative, taking into account the national reductions seen in car exhaust suicides since 1992 (due to the requirement for catalytic converters to be fitted to all new cars). Results showed that numbers fell significantly from 10 per year in the years preceding the intervention to 3 per year during the intervention (King and Frost, 2005). No significant changes were found in comparable forest districts and the number of suicides remained low two years after the evaluation.

Conclusions

Media campaigns using vocabulary focusing on help-seeking for mental health/depression seem more common from the literature search, and appear to be aimed at improving knowledge, help-seeking behaviour and longer term outcomes for those who become depressed and may in turn consider suicide in the future. Those campaigns using urgent language which refers to extreme distress and/or a life-or-death situation may be aimed at catching individuals just before they commit a suicidal act. It seems plausible that there is a need for both approaches in the public health arena. Here it should be noted that despite a paucity of evidence, suicide awareness campaigns taking a more general mental health awareness approach are often considered more favourable (Chambers et al., 2005, HPANI, 2008, Beautrais, 1998, Gordon and Angus, 2007). Campaigns using language with direct, explicit reference to suicide/suicidal acts (i.e. using the word "suicide") were not found within the literature.

The studies found in our literature search presented quite an array of approaches, thus the indicators used to measure the effects and visibility of suicide awareness campaigns vary widely (Dumesnil and Verger, 2009). This often makes direct comparison of campaign effectiveness difficult. Nevertheless one of the common features of these campaigns as that they were often part of a multi-level programme, with the campaign only acting as one contributing element to suicide reduction (Dietrich et al., 2010, Hübner-Liebermann et al., 2010, Potter, undated, Walker et al., unpublished). For example within the NAD, overall reduced suicidality amongst people in the region was believed to be largely attributable to additive as well as synergistic effects of the four-level structure of the programme (Hegerl et al., 2006). Unfortunately Potter *et al.* (undated) and Walker *et al.* (unpublished) failed to conduct/report on robust evaluations, therefore the benefits of these evaluations were often lessons learnt about issues with evaluating media campaigns.

Another notable point is that a couple of the campaigns within this review observed a reduction in awareness and/or an increase in suicidal acts during the second year of a campaign, which has been partly attributed to lower media activity within the second year (Dietrich et al., 2010, Hegerl et al., 2006). It is therefore suggested that a continuous and intense programme of suicide prevention activity may be required to sustain positive results (Hübner-Liebermann et al., 2010).

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