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Development and evaluation of a leaflet for concerned family members and friends: *"It's safe to talk about suicide."*

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Abstract

Objectives: Significant others can play a key role in suicide prevention but little attention has been given to the resources they need in order to do so successfully. Based on previous qualitative research, and working in partnership with suicide prevention charities, we developed a simple educational leaflet to help family members and friends recognise and respond to a possible suicidal crisis. 15,000 copies were disseminated through a wide range of community agencies within one English local authority. This paper describes the development, distribution and evaluation of the leaflet. The aim of the evaluation was to assess: how the distribution strategy was working; whether the leaflet was regarded as useful and acceptable; how it was being used, and whether there were any concerns about its content.

Design: Interview study

Methods: We conducted two rounds of semi-structured telephone interviews with every agency on the distribution list, and in-depth qualitative interviews with a purposefully-selected sub-sample.

Results: The leaflet was seen as filling an important gap. It was eagerly embraced by staff in frontline agencies, who either passed it on to clients, used it for their own personal/professional development and to support clients or colleagues, or used it as a teaching aid. No concerns were raised about its content.

Conclusion: The findings reveal a deep-seated fear of talking about suicide among frontline staff. They were using the leaflet in ways we had not anticipated, demonstrating lateral thinking and a real commitment to suicide prevention in agencies that are not typically associated with it.

Keywords: suicide; suicide prevention; public education; leaflet; evaluation.

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Introduction

Suicide is a major public health problem. Globally, around 800,000 people take their own lives each year, equating to more than one every minute. It is one of the three leading causes of death among those aged 15-44 years, and ranks second after road traffic injury among 15-29 year olds (World Health Organization, 2016b). These are unnecessary deaths that represent a significant loss to society and have far-reaching consequences for the health of others. Those who are bereaved by suicide can experience a prolonged and complicated grief process, attended by feelings of intense guilt and shame, often developing mental health problems and suicidal thoughts of their own (Tal Young et al., 2012).

A significant proportion of those who take their own lives have had no contact with health services -- either primary or secondary -- in the month prior to death (Luoma et al., 2002). Young people especially are known to be reluctant to consult health practitioners when experiencing mental distress (Biddle et al., 2004). Non-users of services pose huge challenges for suicide prevention. In the absence of opportunity for clinical risk assessment and intervention, the burden of care lies entirely with family and social network members, whose capacity to recognise and respond to a possible suicidal crisis is vitally important.

In recent years, the focus of policy has increasingly turned to community (as opposed to clinical) settings and has begun to acknowledge that lay people (i.e. those with no clinical training) may have a role to play in suicide prevention. The slogan, "Suicide prevention is everybody's business", was first used as the strapline for World Suicide Prevention Day in 2005 and has since appeared in numerous national strategy documents and campaigns worldwide. The World Health Organization (WHO) recognises that the prevention of suicidal behaviours is "a task for all" and calls on national authorities and the public to come together to tackle the challenge, including in its action plan the provision of support not only to those who are suicidal, but also to their relatives and close friends (World Health Organization, 2016a). This is echoed in the national suicide prevention strategy for England (Department of Health, 2012).

Despite this prevailing rhetoric, little is known about the part lay people can play in suicide prevention or the resources they need in order to do so. In an effort to shed light on this neglected area, Owens et al conducted in-depth interviews with those who had lost a relative or friend through suicide, in order to understand what a suicidal crisis looked like from within the family and social network (Owens et al., 2009; Owens et al., 2011). The findings revealed that signs and communications of distress were often oblique and open to a variety of interpretations, and that relatives and friends tended to disregard warnings and focus instead on positive signs. Even when they did recognise that something was terribly wrong, they reported that there were significant personal risks involved in taking any action at all, chief among them the risk of damage to the relationship and ultimately loss. The authors concluded that proximity to the suicidal individual and emotional investment in the relationship can make it difficult for relatives and friends to see what is happening, say anything to the distressed individual or seek help either inside or outside the social network.

Most public health education campaigns are based on a simple See-Do model, insofar as messages typically take the form of "Spot these signs; take this action." A variant is See-Say-Do, or "Spot these signs; say something to the afflicted person, and persuade them to take this action." These models are based in turn on an assumption that people are always rational actors. They fail to take account of the real-world domestic and social contexts in which mental health crises unfold and the cognitive and emotional blocks that can operate within them. In

relation to suicide, an over-simplistic portrayal of warning signs is particularly dangerous as it can exacerbate already unbearable feelings of guilt in the bereaved, who can easily be led to believe that they 'failed' by *not* spotting the signs.

Building on the work of Owens et al (Owens et al., 2011; Owen et al., 2012), we worked in partnership with bereaved people, suicide prevention charities and a local authority public health team to develop, disseminate and evaluate a public education resource for concerned family members and friends that was informed by an understanding of the difficulties they face in acknowledging what is going on and taking action. The aim of the evaluation was to assess: how the dissemination strategy was working; whether the leaflet was regarded as useful and acceptable; how it was being used, and whether there were any concerns about its content.

Method

Product development

The resource took the form of a tri-fold leaflet of the sort that is widely available to pick up in the waiting rooms of GP practices. This medium was deliberately chosen over an online resource or app in order that we could focus on the content without the distraction of technology. Drawing on established principles of health communication (Abraham and Kools, 2012), the first author (CO) initially drafted the leaflet and then circulated it repeatedly to members of a virtual stakeholder panel (n=12) made up of bereaved family members and representatives of suicide prevention charities, inviting them to comment freely. The content, layout, language, tone of voice and overall 'look and feel' of the leaflet underwent numerous revisions in response to comments. The communications department at our local county council supplied the graphic design work, and the final product was circulated again for stakeholder approval.

The leaflet was arranged over eight panels, designed to be read sequentially when it was unfolded and re-folded (Appendix 1). It was structured around the See-Say-Do model but, drawing on the findings of the qualitative research, it explicitly addressed the misconceptions, cognitive biases and fears reported by study participants at each stage. Page 1 (front cover) was designed to introduce readers gently to an awful possibility that they may not consciously have considered, namely that a family member or friend may be contemplating suicide. Page 2 provided reasons why they may need to do so. The challenge here was to highlight flaws in lay epidemiology and give a vitally important wake-up call (e.g. "It can happen in any family") without arousing too much fear and thus causing any further information to be rejected (Abraham and Kools, 2012). The standard medicalised discourse of 'risk factors' was deliberately eschewed in favour of simple vernacular. Page 3 highlighted the possible absence of warning signs and the ambiguous presentation of the suicidal self that many study participants have reported. Pages 4-5 stressed the importance of asking directly about suicidal thoughts, reassuring the reader that any fears about doing so are normal but unfounded. These pages provided suggestions for how to start a conversation and highlighted some conversational pitfalls to avoid, illustrated by speech bubbles that were based on actual reported conversations from the earlier qualitative research (Owens et al., 2011). Pages 6-7 provided suggestions on what to do next and where to seek help, and the back cover (p.8) contained attributions and logos.

Dissemination strategy

The leaflet was intended for the lay person (i.e. someone not trained in mental healthcare) who is concerned about someone close to them. The typical target audience member was conceived as Mrs Smith, who is worried about her son, Joe.¹ Joe is distraught because, following the breakdown of their relationship, his girlfriend has denied him access to his children. Mrs Smith is anxious to help him but is not sure how to do so, and worries that anything she does may make things worse. The leaflet focused on the particular problems that are caused by kinship or emotional involvement with the person, particularly the fear of alienating them by saying or doing ‘the wrong thing.’ It was not intended for the person who is feeling suicidal, nor for health and social care professionals.

Two distribution strategies were considered. The first was to deliver a copy of the leaflet to every household in the county. The second was to make it available via the sort of frontline agencies and community organisations that families are likely to turn to at times of trouble, such as GP practices, Citizens Advice Bureaux (CABs), local authority housing departments and other statutory and voluntary settings. The second strategy was considered to be more feasible and less risky initially, and a list of organisations was drawn up by the local public health team in consultation with the university. It was considered important to place the leaflet in non-health settings because Mrs Smith may not interpret Joe’s distress as a medical problem and, rather than consulting the doctor, may be focusing on practical solutions, such as seeking advice about his parental rights (Owens et al., 2005).

An initial print-run of 15,000 copies was produced, paid for by the local public health directorate. The leaflet was launched on World Suicide Prevention Day, 10th September 2014, and attracted attention from local and regional newspapers and radio stations in the South West of England. Immediately following the launch, bundles of 25 or more leaflets were sent out to each identified organisation/agency, with a covering letter from the local Director of Public Health explaining its purpose and asking them to consider making it available to members of the public in any way they considered appropriate. We deliberately refrained from being prescriptive as to how they should use it, preferring to leave it to their discretion and observe what they did.

Evaluation design

Data collection

Round 1: In the first three months, we endeavoured to contact every organisation on the distribution list, including individual branches where applicable, and carry out a semi-structured telephone interview to ascertain their initial response to the leaflet, whether they planned to use it and if so how, and whether they had any concerns or questions.

Round 2: Approximately six months after the initial contact, we contacted each organisation/agency/branch again and conducted a second semi-structured telephone interview to ascertain whether they had been able to do what they had planned to do, whether they had noted any benefits from or adverse reactions to the leaflet, and whether they had any suggestions about how it might be improved.

¹ Throughout this paper, ‘Mrs Smith’ is used to represent the target audience member, i.e. the concerned relative or friend, and ‘Joe’ is used to represent the suicidal individual. The scenario depicted here is based on qualitative interviews with many parents of young men who have taken their own lives.

In-depth follow up of selected organisations: From these responses, we identified four main ways in which organisations were using the leaflet. We used this as the basis for purposive sampling, selecting a number of organisations from each category for further in-depth follow up. We approached key individuals in those organisations (n=12) and invited them to participate in a face-to-face qualitative interview.

Data analysis

Quantitative and qualitative data from Rounds 1 and 2 were recorded on *pro formas* and entered into an Excel database. Qualitative data were coded and sorted thematically within an Excel worksheet, using Framework analysis techniques (Ritchie and Lewis, 2003). In-depth interviews were audio-recorded and transcribed verbatim, and subjected to inductive thematic analysis (Braun and Clarke, 2006)

Results

How was the dissemination strategy working?

The organisations included fell into two broad types: frontline agencies, whose premises are visited by or whose staff interact directly with members of the public, and intermediary organisations, which support or co-ordinate the work of multiple agencies but do not have direct contact with the public. The latter were expected to act as centres for onward distribution, forwarding batches of leaflets to frontline agencies. Table 1 shows the range of organisations on the distribution list, together with the number of leaflets they received.

[INSERT TABLE 1 HERE]

From the outset we surprised by the demand. On receiving their initial allocation of 25 copies, several agencies responded immediately with requests for more. Some came back repeatedly, taking large quantities of leaflets. They included two district councils, two mental health drop-in centres and several emergency services. Their heavy consumption was largely due to the presence in these organisations of individual champions, who made it their mission to promote the leaflet and distribute it as widely as possible using their personal and professional networks in an effort to raise awareness of suicide.

Some organisations that were not on the initial mailing list approached us and requested copies, having heard about the leaflet through press reports or word of mouth. These included several that we had not identified as having a role to play in suicide prevention but that expressed a desire to be involved:

“Suicide is a subject that’s coming to prominence more, and yeah, I think we do have a role, perhaps a fringe involvement, if nothing else just in getting leaflets or literature out as far and wide as we can.” (Community Safety Partnership)²

² In England and Wales, Community Safety Partnerships (CSPs) are statutory partnerships of organisations that work together to protect their local communities from crime and disorder and to help people feel safer.

We also identified a number of distribution problems. Chief among these was that many of the original batches of leaflets had been addressed to an organisation, rather than to a named individual. In some cases, nobody in the organisation could tell us whether or not they had been received, let alone how they were being used. The findings underlined the importance of prior intelligence gathering and relationship building, in order to ascertain whether the leaflets can be used and to ensure that they are sent to the most appropriate person. This emerged as particularly important in relation to GP practices, some of which reported that they no longer displayed any leaflets because of the sheer volume they receive and the additional work created for staff:

“We’re bombarded with information and we simply can’t display all of it... We’d have taken more interest if we’d received advance warning.” (General practice manager)

The role and resourcing of intermediary organisations had also not been sufficiently thought out. The covering letter was written with frontline agencies in mind and did not give any instructions to intermediary organisations as to how they should move the leaflets on to individual branches or frontline agencies; nor were they offered any help with postage costs. Some intermediaries nonetheless managed to overcome these obstacles. For example, the county library service distributed bundles to all 50 local public libraries along with copies of the original covering letter, and also promoted the leaflet in its weekly bulletin.

We identified a number of agencies that still needed to be brought into the distribution network, including job centres, family solicitors, law courts, probation offices, food banks and pharmacies.

Perceived usefulness and acceptability

Initial responses to the leaflet were overwhelmingly positive. There were many comments about its overall clarity and accessibility:

“It presents a very complex issue in a very simple way, without dumbing it down.”
(Public health manager)

“I can’t see anything that could be improved on, because it’s very simple to read... very well thought out.” (Emergency service worker)

Many people commented that there was nothing else like it and that the leaflet filled a really important gap. In particular, they commented on its potential to break the taboo on talking about suicide, by addressing people’s fears about doing so:

“It’s the only leaflet about suicide that I’ve seen. It’s a subject that isn’t talked about, but it should be.” (Volunteer, Citizens Advice Bureau)

Several sections were singled out for special commendation, including the information about contradictory signs:

“The section on warning signs is really useful, especially the fact that people may be hiding their thoughts and feelings.” (Faith community leader)

While some organisations requested an electronic version to make available on their websites, it was clear that, even in a digital world, people valued the tactile nature of the paper leaflet:

“You can feel how warm this leaflet is, because I carry it around with me all the time.” (Public health practitioner)

No concerns were expressed about the content of the leaflet. Several informants reported that they were used to displaying information on sensitive issues, such as domestic violence or drug abuse, and that that is exactly what the people who use their services are seeking. Some wanted to know whether we considered it appropriate for use by children and young people.

How was it being used?

We identified four different ways in which the leaflet was being used by frontline agencies, sometimes in combination with one another

- i) placing it in a display rack for anyone to pick up
- ii) handing it to selected clients within the context of a consultation
- iii) equipping frontline staff and volunteers to have conversations with vulnerable members of the public
- iv) use within the organisation to support vulnerable members of the workforce.

Placing it in a display rack

Many organisations, including mental health drop-in centres, CABs, community centres and churches whose premises were used by community groups, reported that they were displaying it in a leaflet rack or on tables in reception areas. This simple universal (as opposed to targeted) strategy was what we had in mind when developing the leaflet. However, some drawbacks were highlighted. Whilst it ought to ensure that the leaflet is freely available to anyone who chooses to pick it up, it relies on members of the public identifying their own need for it and having the courage to do so. Several informants pointed out that people might be embarrassed to be seen picking up a leaflet on suicide and that this might deter them from doing so. For this reason, one youth service reported that they had placed copies in the toilets, and another agency had chosen to put copies on display in private interview rooms but not in public waiting areas. These findings highlight the need to balance the visibility of the leaflet with the privacy of potential end users.

Selective distribution within the context of a consultation

Some informants described a selective or targeted distribution strategy, in which a staff member identifies a client as someone who may benefit from the leaflet and proactively hands them a copy. This requires the staff member to recognise target audience members and to have the

confidence to raise the possibility of suicide. Perhaps unsurprisingly therefore, agencies that reported using the leaflet in this way were ones that had either a health or social care remit or a clear pastoral role. Examples included student health and welfare centres and a chaplaincy service:

“It’s happening more and more often, a student will come in and tell us they’re worried about one of their friends... In the last two weeks a young lady came in whose boyfriend had attempted suicide... and she wanted to know, ‘*How will I know if he’s going to do it again?*’ I talked to her... and I gave her the leaflet. I wouldn’t just give it to them. I talk through it and I read through it with them... The leaflet provides a framework for the conversation... and it’s something for them to take away to remind them. They can stick it in their bag and it’s there if they need it.” (Nurse, student health service)

This also points to a new role for the leaflet in helping professionals to structure the advice they routinely give out and in reinforcing it. An informant from a different educational establishment described a similar scenario:

“When someone is suicidal, it’s really easy just to focus on them... whereas all the other people around them can be really distressed and worried and not know what to do... So this is really useful for the friends and flatmates who’ve got drawn into the situation and need to know that they’re not alone and they’re not going to screw it up by trying to support their friend by asking how they’re feeling... In the last couple of days I’ve given it to two friends of a student who took an overdose... Both of them were really happy to receive it. Their faces lit up almost, to get that kind of permission... and because it’s on a leaflet it’s sort of official, it’s not just me telling you this.” (Staff member, student welfare service)

Whilst recognising that the leaflet was intended for “the supporting people”, one of the informants cited above reported having given some copies to a suicidal student and advising her to give them to her friends so that they would know how to support her. This is evidence of a service that is really embracing the resource and thinking creatively about how to incorporate it into its practice.

Equipping frontline staff to have conversations with vulnerable clients or members of the community

We did not envisage staff or volunteers working in frontline agencies as the audience for the leaflet, only as having a role to play in ensuring that it reached ‘Mrs Smith’, wherever she was. Nonetheless, staff in some agencies assumed that it was intended for them and welcomed it. Examples included staff in local authority housing and benefits departments, those answering personal alarm calls from elderly people living alone, and even ministers of religion, whose roles include supporting vulnerable people in the community but who receive no mental health training. One such informant reported:

“Often the clients we come across, they’re living on their own and there’s no-one else, so we don’t have a friend or a family to give this to, but we’re using it ourselves... I think the leaflet’s extremely useful for all of us. Our admin staff, for example, quite often take

telephone calls from people who mention suicide... and we're not qualified or trained to talk about this." (Environmental health officer)

At the same time, this same informant recognised that some people might question whether it was appropriate for non-health staff to be having these sort of conversations, which could be perceived by clients as intrusive and thus provoke complaints. This concern was echoed by one housing department manager, who had distributed the leaflet to staff but was not encouraging them to talk about suicide with their clients.

The lack of training and resources for frontline staff and volunteers in non-health agencies came up repeatedly. Several agencies, including a number of educational establishments and local council departments, reported that they were either incorporating the leaflet into the training they currently provide or were planning to build training around it. In one innovative departure, a local consultant psychiatrist reported having successfully piloted its use as the basis for a brief training session for lifeboat crews and others involved in the prevention of death by drowning and jumping from cliffs:

"The RNLI [Royal National Lifeboat Institution] and Coastguard Agency respond to about 4-500 possible suicides per year... We now have a Coastal Safety Programme which aims to try and stop people getting into the water in the first place... I was digging around to see if I could find a toolkit that I could use to train volunteers and people on the coastal paths to have a conversation whilst they waited for more specialist help... I came across the leaflet, I looked at it and I thought, I bet you I could train off the panels of this leaflet. It's evidence-based... and the structure and the layout of the leaflet is great. It was really easy to do... I took it along to a group of 9 or 10 people that turned up and I ran a session on it... and by the end of the 90 minutes every one of them said they would now no longer walk on by and that the leaflet would be a useful tool to have in their kit." (RNLI Medical Advisor)

Use within the organisation to support vulnerable members of the workforce

As stated earlier, we had only envisaged the organisations on our mailing list as vehicles to be used in the distribution process, helping to ensure that the leaflet reached Mrs Smith. However, people in some organisations recognised that Mrs Smith, or indeed Joe, could be one of their own employees. In one case, copies had been left with the human resources department for use when supporting members of staff through change, redundancy or other personal difficulties. In two others, both emergency services with a prevailing 'macho' culture, it was being used as part of a drive to reduce the stigma attached to mental health problems and encourage openness and peer support among colleagues. One informant described how the leaflet had helped her manage a conversation with a depressed colleague:

"I read through this leaflet beforehand and there was a few things in here which really helped me... When I did speak to him I was quite direct with him and I said, 'Are you suicidal right now?' ... I asked him that, and he was very open with me and he said, 'I have had suicidal thoughts' ... I know I was able to discuss it with him far more openly than I would've done had I not read this leaflet first." (Member of peer support network, emergency service)

Disappointingly, such strategies did not always meet with support from senior management. In one public sector organisation in which job cuts were imminent, a member of the workforce had distributed copies of the leaflet widely, leaving them in coffee areas, on staff notice boards and elsewhere within the building, only to find that they were all removed:

“The response from the upper management was very strange... It was like, ‘You can’t give these out, not at this time, people are vulnerable enough as it is.’ And I said, ‘Isn’t that the ideal time? People are going to be feeling extremely vulnerable and stressed and those are the times when people need to talk about how they’re feeling.’ ... But the attitude of senior management was very much, ‘We don’t talk about things like that.’” (District council employee)

Discussion

Based on previous qualitative research, and working in partnership with suicide prevention charities, we developed a simple educational leaflet to help family members and friends recognise and respond to a possible suicidal crisis. We distributed 15,000 copies via a wide range of frontline agencies and community groups within one English local authority. Results of the evaluation showed that it was filling a vital gap. It was eagerly embraced by staff in frontline agencies, satisfying a hunger that we did not know existed and revealing deep-seated fears and uncertainties about dealing with mental health crises. Staff were using the resource in a number of different ways, some of which we had not anticipated, demonstrating lateral thinking and a genuine commitment to suicide prevention in agencies that are not typically associated with it. We also observed a broadening of the audience for the leaflet and its message, which is very encouraging. Although developed for family members and friends, the content was viewed as being equally pertinent to the housing officer who has concerns about a client, the rambler who encounters a distressed person on a coastal footpath and the staff member in any organisation who is concerned about a colleague.

We deliberately did not set out to measure the effect of the leaflet in terms of bringing about changes in public knowledge, attitudes and behaviours or reductions in suicides, as others have attempted to do (Dumesnil and Verger, 2009; Matsubayashi et al., 2014). We recognised at the outset that there was no way to ascertain whether copies of the leaflet were reaching ‘Mrs Smith’ (the envisaged target audience member) and influencing her behaviour towards her troubled son. To our surprise, however, these early findings do in fact suggest that the leaflet may have given people confidence to initiate conversations about suicide and that in some cases it has led to specifiable changes in behaviour. Workers in community-based organisations have essentially acted as proxies for the target audience. In so doing, they demonstrate that suicide prevention really can become “everybody’s business.” There is clearly still some way to go with this agenda and no room for complacency. Some passionate individuals, who had been inspired by the leaflet to change their practice and were encouraging others to do likewise, found themselves up against reactionary and risk-averse attitudes and organisational cultures in which suicide talk was not condoned.

This study provides an example of how it is possible to mobilise a wide array of people and organisations at community level to disseminate intervention materials and extend the reach of public health messages (Mittelmark et al., 1993; Coffman, 2002). It also demonstrates the potential of qualitative evaluation methods to capture evidence of *effort* as opposed to

effect (Coffman, 2002) and uncover activities and impacts that were neither prescribed nor predicted (Vanclay, 2012).

Our study also points to an important role for qualitative research in re-framing public health messages, particularly in exposing any fears that need to be explicitly addressed, resulting in more emotionally-informed and nuanced messages. It also underlines the importance of involving people with lived experience when developing the messages and designing materials. The iterative consultation process we used to do this was time-consuming, but paid off in terms of the simple, candid language of our leaflet and its very direct appeal to the lay person.

For the future, there are practical challenges to be faced, including that of keeping up the supply chain and widening the reach to other geographical areas. Already some other English local authorities are seeking to replicate our dissemination strategy. There is also potential for further underpinning research to inform the development of additional resources that may be better suited to specific populations, such as children, or settings, such as public places.

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Table 1: Distribution of the leaflet within one English local authority

Type of agency	Number of agencies/ branches/establishments	Number of copies sent initially	Further copies sent on request	Total number of copies
GP practices	127	3,175 (25 each)	100	3,275
NHS walk-in centres	4	100 (25 each)	-	100
NHS mental health services, including drop-in centres	4	430	180	610
NHS general hospital	1	-	100	100
NHS ambulance services	4	200	e-copy	200
Other health: counselling services	2	50	50	100
Other emergency services: police; fire & rescue; RNLI; moorland rescue		400	1,400	1,800
Clinical Commissioning Group		10	25	35
Local authority frontline services: housing, benefits, environmental health, youth services	16	300	675	975
Local authority public health leads	3	1,225	100	1,325
Citizens' Advice Bureaux (CABs) and Welfare Rights units	16	400 (25 each)	25	425
Miscellaneous voluntary services/groups	10	500	200	700
Educational establishments (schools, further and higher education establishments)	5	50	1,275	1,325
Criminal justice settings	1	-	30	30
Councils for Voluntary Services (CVSs)	3, each supporting hundreds of local voluntary and community organisations	75 (25 each)	100	175
Community Safety Partnerships (CSPs)	3, each co-ordinating activity of numerous statutory & voluntary agencies	-	775	775
County library service	50 libraries across county	1,200	-	1,200
Church of England diocesan office	> 600 Anglican churches, plus links with other denominations	300	700	1,000
Regional Zero Suicide Collaborative		150	200	350
Local conference on death and dying		-	300	300
Totals		8,565	6,235	14,800

Appendix 1: Leaflet

What to do next

Here are some suggestions and sources of support. If at first you don't find the help you need, persist. Try all avenues and don't give up.

If someone tells you they're feeling suicidal...

- Make sure they're not left alone
- Remove anything they could use to take their own life, e.g. tablets, firearms, rope
- Get medical help immediately

Get medical help

- Phone your GP surgery (outside normal surgery hours, you'll be directed to an out-of-hours service)
- Call 999 or take them to A&E and **stay with them until they are seen by a member of the mental health team**

Even if it's only a hunch, share your concerns with others

- Don't be afraid to involve their family, friends or colleagues
- Share this leaflet with others and plan together how you are going to keep the person safe

Take care of yourself

- Talk to your own GP about your feelings
- Confide in a trusted friend
- Find a support group for carers of people with mental health problems
- If the person does take their own life, don't feel guilty. It is not always possible to prevent suicide.

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Contact confidential helplines and sources of support

Samaritans
116 123 (24 hours, free to call)
www.samaritans.org

PAPYRUS: Prevention of Young Suicide
0800 068 41 41
(Mon–Fri 10am–10pm; weekends 2pm–10pm; bank hols 2pm–5pm)
www.papyrus-uk.org

CALM: Campaign Against Living Miserably
0800 58 58 58
(7 days a week, 5pm–midnight)
www.thecalmzone.net

SANE
0845 767 8000
(7 days a week 6pm–11pm)
www.sane.org.uk

MIND
0300 123 3393
(Mon–Fri 9am–6pm)
www.mind.org.uk

Maytree: A sanctuary for the suicidal
020 7263 7070
www.maytree.org.uk/index.php

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This leaflet was developed at the University of Exeter Medical School in collaboration with The Alliance of Suicide Prevention Charities (TASC), and was originally produced by Devon County Council.

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Does someone close to you seem really down?

Might they be thinking about suicide? **The only way to know is to ask**

It's safe to talk about suicide

[Page 1]

Appendix 1: Leaflet contd.

Suicide is rare, but...

- it happens
- there are over 6,000 deaths by suicide in the UK every year – an average of 16 per day.

Don't think: "It couldn't happen to us."
It can happen in any family.

Intense emotional strain and mental exhaustion can cause people to behave in uncharacteristic and unpredictable ways.

Don't think: "He's not the suicidal type."
There isn't one.

Some things that drive people to think about suicide are:

- Personal catastrophes, such as being made redundant, the collapse of their own business, the break-up of a relationship or being refused access to children
- A persistent sense of worthlessness or failure; uncertainty about sexual identity or personal goals
- Good things happening to other people (e.g. friends getting married, going off to university or getting new jobs), and feeling left behind
- A combination of the above. A whole series of little setbacks can sometimes be more devastating than one big thing.

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What are the warning signs?

There may not be any. An emotional crisis is not like a heart attack or a stroke, where there are visible warning signs.

People who have reached rock bottom can be very skilled at hiding their thoughts and feelings.



They MAY be:

- Quiet
- Brooding
- Withdrawn or distant
- Not making eye contact
- Agitated
- Irritable or rude
- Drinking a lot
- Talking about suicide or saying it's all hopeless

They may ALSO be:

- Busy
- Chirpy
- Living life as normal
- Going to work
- Laughing and joking
- Talking about future plans
- Telling you not to worry about them

So how will you know if they're thinking about suicide?

The safest way is to ask them.

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Why it's important to ask

If someone is suicidal, they are likely to be feeling:

- cut off from everyone around them
- frightened and ashamed about wanting to die
- desperate for help but afraid to ask.

They need someone to start the conversation for them. This shows them that they have permission to talk about it and that they don't have to wrestle with their dark and terrible thoughts alone.

Some common fears:

"Won't talking about suicide put the idea in her head?"

No. If a person is suicidal, the idea is already there. If they aren't suicidal, it won't do any harm.

"What if I say the wrong thing? It could damage our relationship."

Showing a person you care about them won't damage your relationship. Saying nothing could result in losing them forever.

It's important to trust your gut instincts. If something about the person doesn't look or feel right, say something.

Saying something is safer than saying nothing.

Saying the word won't make it happen.

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What to say

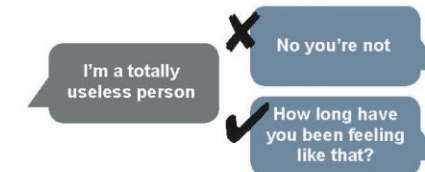
It can be really scary starting this kind of conversation.

Step 1: Explore how they're feeling

If something bad has happened to them, ask, "How has it made you feel?" They may shrug and say, "I'm OK." If they don't seem OK to you, keep trying, quietly and gently.

Listen attentively. Try to keep the dialogue open by asking questions like, "How bad is it?" or "What's that like?"

Don't deny what they're telling you, and don't pretend you know how they feel.



Step 2: Ask the 'S' question

If they give any indication that they're feeling hopeless or can't see the point in going on, ask clearly and calmly, "Are you having any thoughts of suicide?"

Don't be too quick to accept denials or joking responses.



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