MINDSET

Reporting on **Mental Health**

STIGMA AND MENTAL ILLNESS

By André Picard, Health Columnist, The Globe and Mail

There is no question that stigma has an impact on the lives of people living with mental illness. Negative stereotypes and prejudicial attitudes help create an environment that can dissuade people from getting help, impact their medical treatment, interfere with their ability to get work, undermine their human rights, destroy relationships with family and friends, and even push people to take their own lives.

The media influence, to a perverse degree, public opinion and public policies, both of which have the potential to improve the care and the lives of people with conditions like depression, schizophrenia, bipolar disorder, anorexia, addiction and other brain diseases.

So what is the role of journalists and editors in tackling the stigma that invariably comes along with these diagnoses?

Is our role to sit back, observe and report dispassionately on this sad state of affairs, or to proactively set out to bring about social change?

The short answer is: A bit of both.

The single most influential change that the media can (and should) make is to start treating mental illnesses the way they do physical illnesses: With curiosity, compassion and

a strong dose of righteous indignation when people are mistreated or wronged.

Journalists should be as willing to write about depression as breast cancer, as dogged and thorough in the reporting of advances and setbacks, and as determined to seek out patients to illustrate their stories. They should be no more forgiving of long waits for a child to see a psychiatrist than they are of long waits for grandmothers needing hip replacements. They should cover suicides the same way they cover murders, seeking to find answers about the causes, while mourning the dead, flaws and all.

Yet, all too often, we are too willing – subconsciously or otherwise – to accept this second-class status for mental health issues as the norm.

The media have also allowed certain quirks to shape coverage of mental health issues. We rarely write about people with severe mental illness unless they experience a psychotic episode and perpetuate some gruesome act like beheading a stranger on a bus. When we do features on patients who have overcome mental illness, we treat them as objects of pity, rather than beneficiaries of treatment. As for suicide, there are longstanding taboos that lead us to turn away in shameful silence.

Some of this can be explained. In the media, we cover the unusual, not the mundane; we tend toward the black-and-white rather than the grey; and we shy away from the inexplicable.

Yet, when it comes to mental health, these approaches serve to perpetuate stigma.

In recent years, mental health has come out of the shadows. Things are changing, in the media and elsewhere, but not quickly enough.

For real, meaningful change to occur, we need to be conscious of our failings, of the shortcomings in coverage of mental health issues, and address them systematically.

It starts with language. We have to be conscious about the impact of outdated, prejudicial turns of phrase – not saying, for example, that someone has "committed" suicide, which implies a crime has been committed. We need to do away with euphemisms like "died suddenly" and "he snapped" and use precise language like "took his own life" and "suffered a psychotic episode."

We also need to clean the slate of assumptions, like people with mental illness are less intelligent or more artistic. Instead of fueling the notion that people with mental illness are violent, we should provide context, that they are, in fact, many times more likely to be victims of violence.

Then comes the hard part: Equality – treating mental health like other health and social issues.

It's the process the media has followed, at varying speed, in writing about every major social change, from the abolition of slavery to the emancipation of women and beyond.

Writing about mental illness in all its richness, and with all its challenges, need not cause stigma. Rather, it provides us with a rare chance to bring about meaningful social change alongside a golden opportunity to better journalism.

This is a journalist-to-journalist guide researched, written and edited by an experienced team for the Canadian Journalism Forum on Violence and Trauma.

We have consulted widely about the content and recommendations over several years and we appreciate the input of many journalists and mental health professionals alike.

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The Forum is solely responsible for the content.

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WHAT'S IT ALL ABOUT?

Almost everyone in Canada is affected in some way by mental illness. Statistics Canada estimates that 20% of the population has some form of mental disorder each year.

Some suffer in silence, too afraid to seek help. Up to 30% of Canadians will receive a mental illness diagnosis in their lifetime. It's a surprising figure – and one that incidentally underlines the broad range of illness and disorder that falls under the heading of mental illness.

As some recover and others fall sick, and as family and friends become involved, there's no longer any 'them' and 'us'. Mental illness becomes an issue for all. Yet fear and negative feelings for people who are mentally ill are persistent and pervasive.

Stigma often flies in the face of facts, which should make it a natural concern for journalists. One in five journalists know this all too well, because they are currently experiencing mental illness themselves. Journalists are not immune.

Many who experience mental disorders lead useful and productive lives, either in full recovery or by managing their symptoms through medication, therapy and other means.

Very, very few of those affected by mental illness will pose any threat to others. People who are mentally ill, in general, are far more likely to become victims rather than perpetrators of violence. But that's not what our gut tells us.

This guide will explore why that is so, how the news media may unintentionally or otherwise contribute to such a false impression, and what we as journalists can do about it.

It's not about self-censorship, or changing the definition of news. It's about getting the facts right, exploding myths and placing stories in proper perspective.

It's also about alerting ourselves to stories we may be missing – stories that probe issues, successes and shortcomings in Canada's fractured and sometimes fractious mental health system.

After all, these are stories about us. All of us in time are likely to slide back and forth along the continuum between mental health and mental illness.

Public attitudes aren't determined by any means exclusively by the media, but the media has a very big impact on public attitudes and on the ability to change public attitudes for the better or for the worse. I think that journalists have a huge role to play in moving mental illness from kind of a concept to something at the real individual, personal level. And only journalists can do that because they have the reach.

The Hon. Michael Kirby
Former Senator
Founding Chair, Mental Health Commission of Canada

CHAPTER 1

UNDERSTANDING STIGMA

As many as two thirds of Canadians who suffer some form of mental disorder avoid seeking treatment, for fear of how they will be perceived and how their lives might be affected. Under-reporting leads to under-provision of mental health services, making the situation even worse.

With so many people going without help, we see less evidence of recovery, so that prejudices against people with mental illness are reinforced.

Discrimination feeds on misinformation. Way down at its root, when it comes to mental illness, lies our deep-seated fear of unpredictable, horrific violence. And it is those violent stories that take a great deal of our attention, because they are newsworthy.

But to blame journalism for creating this situation is both unfair and pointless. More useful questions to ask are:

- **To what extent does journalism compound the problem?**
- **What can we add to stories involving violence that puts them in perspective?**
- **What is journalism doing to throw light into the dark corners of mental illness and the mental health system, to help vanquish enduring myths?**

Much excellent journalism has been done in this area by Canadian newspapers, radio and television. Many journalists, we believe, entered the business with a desire to make a difference, not simply to reinforce or feed on society's prejudices.

We live with illnesses, but as people we are so much more and many of us are very productive people, who live next door to you. By recognizing this, I believe the media could go a long way to reducing the stigma attached to people who live with a mental health condition.

Rick Owen, Journalist,
Kirkland Lake, Ontario
(Diagnoses: Depression and Addiction)

This guide is based on three propositions which we found were widely supported by mental health professionals we consulted or interviewed:

- **The lion's share of stigma is generated and reinforced by very rare, highly shocking, well-publicized instances of violence by people affected by very serious untreated illness.**

- **Attempts to counter the emotional impact of such stories by generating more positive news about mental illness are commendable, but unlikely to succeed on their own.**

- **Censoring or playing down coverage of major incidents of psychotic behaviour leading to death or serious physical harm is not an option in an open society.**

So what can journalists who recognize the problem actually do to make a real difference? We arrived at two broad answers:

- **Journalists should train some of their investigative skills on mental heath issues with persistence, fearlessness and vigour. Ultimately, the best way to reduce the number of stories about horrific acts by people in psychotic episodes is to probe why these incidents continue to occur.**

- **In all their work, reporters and editors should be aware of the damage that can be done by reinforcement of stereotypes and strive to minimize it.**

The purpose of this guide is to give you some tools and ideas about how to do just that, and to do smarter, better stories.

For decades, people with mental illnesses were subjected to one of the most intense kinds of discrimination in Canadian history. They were shoved into institutions or attics or basements for years. We're still dealing with the echoes of all that. Stigma is not nearly as bad as it was, people are talking, but 50% of Canadians who have a mental illness or have it in the family will still not reveal it publicly. Journalists can help by bringing more understanding to the table.

Lloyd Robertson, CTV News

CHAPTER 2

ONE SIZE DOESN'T FIT ALL

Treating mental illness as a single category is a big part of the problem.

With physical health, we routinely differentiate, for example, between infections, heart problems and cancer. When it comes to mental health, however, much tends to become conflated. And so unreasonable fear produced by extreme cases of psychosis rubs off on a much larger range of people with anxiety disorders and the like.

It's worth repeating: With the exception of a tiny minority, most people diagnosed with a mental illness are significantly more likely to be the victims rather than the perpetrators of violence. But this is not always recognized by the public at large.

Vagueness only makes it worse. When dealing with stories involving mental illness and violence, it's important to be specific. You should always seek authoritative confirmation of a specific diagnosis. A police officer's word or a neighbour's vague assertion that someone in the news had 'mental problems' can be problematic and contribute to stigma. Besides, it's not accurate.

Even within schizophrenia – potentially the most severely challenging of mental illnesses – there is no uniformity. People may have mild, medium or severe forms of the disorder. They may or may not hear voices, and those voices may or may not present real dangers. Indeed, not everyone who hears voices fits the rest of the criteria for a diagnosis of schizophrenia. Nor does every person with schizophrenia become violent. Once again, journalists need to exercise professional caution.

While full recovery (meaning a return to their state before the illness struck) in people with schizophrenia is rare, as many as 65% do, with treatment, achieve a degree of control over their symptoms and some hold down jobs – even in at least one case as a neuroscientist. Thus the stigma generated by high-profile acts of violence by people in psychosis caused by untreated schizophrenia is a significant problem for others under treatment for the disorder, as well as those with less disabling diagnoses.

Consider adding some of these facts to provide context to your stories.

BEST PRACTICE CHECKLIST

- ✓ **Don't reinforce stereotypes (especially in headlines).**
- ✓ **If violence is involved, put it in context: Violence by people with mental illness is rare.**
- ✓ **Don't imply all people with schizophrenia are violent.**
- ✓ **Avoid referring to people with schizophrenia as "schizophrenics". Generally speaking, labeling someone by the name of their disease is not a good idea.**
- ✓ **Strive to include quotes from those affected or others like them.**
- ✓ **Be careful and specific about diagnoses.**
- ✓ **Include professional comment / seek professional advice when needed.**

Don't just associate mental illness with terrible crimes. Write about it in another way, not necessarily more positive, but in a framework that better represents reality. Ninety-seven percent of people with schizophrenia never commit crimes. You have to be very careful not to let mental illness become synonymous in the public mind with violence.

Katia Gagnon, La Presse

The first thing we have to do is talk about mental health challenges. We have to part the curtain. What we'll find is an illness, not a moral failure. Once we start sharing our stories, we will take the charge out of talking about it. If we all do this, it will be as easy as talking about any illness. It's important to know that we aren't alone in this. Not by a long shot.

Shelagh Rogers, OC
CBC Radio Host/Producer
(Diagnosis: Depression)

QUICK REFERENCE

Schizophrenia: A serious, chronic but treatable brain disease affecting about 1% of the population. Onset usually occurs in adolescence or young adulthood. Patients may hear command voices and lose touch with reality (psychosis). A small proportion of people with untreated schizophrenia may become violent during psychosis. Treatments include psychotherapy, awareness therapies and anti-psychotic drugs. Although schizophrenia is often seriously debilitating, treatments can deactivate symptoms and enable patients to work and relate well to others. Schizophrenia does NOT involve 'split-personality'.

Bipolar Disorder: Sometimes called manic depression. Patients cycle between depression and hyperactivity, sometimes accompanied by recklessness and unrealistic belief in their abilities and importance. A small minority of patients may become psychotic and violent. Treatable with therapy and drugs.

Depression: A debilitating disorder involving loss of motivation, lethargy, anxiety, feelings of worthlessness, insomnia and general hopelessness. Interferes with a person's ability to cope with daily life. Some may become suicidal. Treated with medication and therapy and may be managed by therapy and self-help techniques.

Post-Partum Depression: One of the most common complications following childbirth, characterized by an intense sense of inability to cope with the baby's needs. Accompanied by tiredness, irritation and loss of appetite. Untreated, it can lead to suicide and infanticide.

Anxiety Disorders: A range of conditions affecting about 12% of Canadians. These include Obsessive Compulsive Disorder and Post-Traumatic Stress Disorder. Generalized Anxiety Disorder is characterized by chronic worry, fear and panic interfering with ordinary living and social interaction. Treated by counseling, group therapy and medication.

Personality Disorders: These disorders involve inflexible behaviours outside social norms, persisting to the point of making ordinary life difficult. May be caused by trauma in childhood. Treated by psychotherapy.

Obsessive Compulsive Disorder: Characterized by repeated and ritualistic behaviours, such as repeatedly carrying out actions in a set order, repeated hand washing or counting.

Attention Deficit Hyperactivity Disorder: The most common behavioural disorder occurring in childhood. Children with ADHD have difficulty concentrating, and they become restless and distracted. Children with ADHD may be prone to impulsive outbursts of speech or behaviour.

Eating Disorders: Among all mental illnesses, these have the highest mortality rate. About 10-20 per cent of patients die from the disease or from complications. These disorders are more common among females than males and usually relate to issues of self-esteem.

Recovery: Professionals use this term in different ways. The important thing to stress in order to provide context and a complete picture is that many people with a mental illness who receive treatment can recover. There are two main ways professionals use the term recovery. They mean different things so it's important to check what they really mean:

Recovery in Mental Illness: When someone with a chronic mental illness can manage the symptoms and return to some quality of life, although not the same as before the onset.

Recovery from Mental Illness: Also referred to as clinical recovery. This means returning to the state one was in before the onset of the condition.

I think the key is to think of them as if they were from your family. Don't think of them as a label, a patient, or as someone with schizophrenia. Think of them as a person, talk to them like they are our people, as indeed they are.

John Kastner, Director of documentaries
NCR: Not Criminally Responsible
and *Out of Mind, Out of Sight*

CHAPTER 3

TREATMENT ISSUES

Even before psychiatry expanded the definitions of mental illness with the publication in 2013 of the DSM-5, a diagnostic classification tool, recorded incidence of mental illness had been on the rise worldwide. That may be because of improved detection and broader research, rather than increased occurrence. Rates of schizophrenia and bipolar disorder, two of the most serious mental illnesses, are generally steady.

Among those who believe mental illness to be broadly increasing, opinion is divided as to the relative roles of biological and social factors. Some argue that the pace and stress of 21st century life renders many more susceptible to disorders such as anxiety and depression.

Beginning in the 1960s, many countries adopted a policy of increased care in the community. The move followed the development of the first anti-psychotic and anti-depressant drugs. Many mental hospital beds were closed, usually without sufficient funding being transferred to community services. This resulted in spiking rates of homelessness, unemployment, self-medication with alcohol and street drugs, and petty crime.

MENTAL HEALTH ACTS

Every province in Canada has its own Mental Health Act. They lay down, among other things, the conditions under which a physician can prescribe treatment against the patient's will. For some patients with psychotic illnesses, symptoms can include a lack of insight into the fact of their own illness.

The patient has a right to a hearing, with legal representation, within seven days to dispute any doctor's treatment order. The appeal is heard by an independent three-person board, consisting of a psychiatrist, a lawyer and a member of the public.

SOURCES OF TREATMENT

A shortage of psychiatrists in Canada and their concentration in major urban areas means patients seeking voluntary treatment may have to wait a year to see one.

Some patients with minor disorders are treated by general practitioners. Some also pay for counseling, outside provincial health programs, by clinical psychologists.

A variety of self-help groups for various conditions is also available. Some of these groups style themselves "consumer/survivors" and may be opposed to standard psychiatric methods.

TREATMENT ISSUES

Some civil liberty groups oppose forced treatment in any circumstances, arguing that people have a right to be sick. A challenge to Ontario's Mental Health Act on that basis was rejected by the Ontario Supreme Court in September, 2013.

On the other hand, some psychiatrists believe mental health acts should give doctors more latitude, when making treatment orders, to consider what they are told by family members about a patient's behaviour. In British Columbia, the law now allows this in the case of a family member who is a care-giver.

A lack of forced treatment has been a factor in well-publicized criminal cases involving pleas of Not Criminally Responsible. (See Chapter 5.)

CHAPTER 4

INTERVIEWING

Stories about people with mental illness should include the voices of those people. Giving a voice to the people who are actually living the experience makes for better story telling, and better journalism. Including people with mental illness helps break the myth that they are "not like us" when in fact they are in the mainstream.

Psychotic behaviour – by someone who is out of touch with reality – is easily recognizable. No one should attempt an interview with a person in that state. People with personality disorders such as psychopathy, involving impulsive anti-social behaviour, may also be dangerous. Otherwise, there is no physical danger to the reporter.

The real danger lies in distorting news coverage by ignoring the voices of 20% of the Canadian population. Very often, news reports talk about people with mental illnesses as though they were outside normal social interactions – a throwback, perhaps, to times when mentally ill people were locked up and forgotten.

If you were writing a story about surviving a heart attack, you would almost certainly speak to people who had done so.

Ignoring the voices of mentally ill people also runs the risk of alienating one-fifth of your readers, listeners or viewers. Most journalists have learned to change their approach when they switch from interviewing powerful people to vulnerable ones: Being friendly, taking time, asking open-ended questions, taking care not to push too hard or to re-traumatize, but still seeking clarity and insight.

I report on mental illness – depression, schizophrenia – and I am aware that in these cases the journalist must use his power with a lot of discretion. It's understood that I will recognize the limits imposed by the person's illness and their fundamental right to respect.

Michel Rochon
Health & Science Journalist
Radio-Canada (2014)

Demonstrating empathetic interest helps. Assuming you know how the person feels or ought to feel doesn't.

Take care to ensure that the interviewee understands that his or her name and diagnosis will be made public, and that the person is in a proper emotional state to give informed consent.

If the person is not in such a state, ask if you can return at a later time to include their words in a follow-up story, if there will be one. Leave a phone number so that they can initiate contact when they are ready. For today's story, try talking to a mental health professional instead.

DEFINITIONS OF RECOVERY

Reporters should be aware that mental health professionals may hold differing views about aspects of mental illness. The matter of recovery, especially in connection with serious illness, is a case in point.

As with physical illness, many people with a mental illness who receive treatment can recover. Reporters and editors who bear this in mind can help reduce stigma.

Among those whose illness is chronic, some are able, with appropriate treatment, to manage their symptoms and substantially improve their quality of life. This is sometimes called 'recovery in mental illness', as opposed to 'recovery from mental illness', or clinical recovery, defined as returning to the state the person was in before the illness occurred.

When interviewing professionals who cite recovery rates, journalists should determine which definition is being used and report accordingly.

See them as a person, not a diagnosis. There's no reason to fear. Not only ask them about their experience of what it's like to have schizophrenia... you need to ask them what has helped or hindered you in your recovery? What has helped you to have some quality of life? So interview that person just like you would interview a person who has Parkinson's disease.

Chris Summerville
CEO, Schizophrenia Society of Canada

INTERVIEWING DOS AND DON'TS

- ✓ **Do** talk to people who have mental disorders and include what they say in your stories.
- ✓ **Do** remember these are people who naturally deserve respect.
- ✓ **Do** demonstrate empathy, ask open-ended questions.
- ✓ **Do** ensure the person understands the implications of being interviewed and gives informed consent.

- ✓ **Don't** re-traumatize by pushing too hard.
- ✓ **Don't** interview people when they are out of touch with reality or psychopathic.
- ✓ **Don't** be scared: Outside those rare conditions, people with mental disorders are harmless.
- ✓ **Don't** assume you know how the person feels or thinks.
- ✓ **Don't** imply their illness is incurable.

CHAPTER 5

MENTAL ILLNESS AND THE LAW

Very few of the seven million Canadians with mental disorders ever come into conflict with the law. Those most likely to do so are the ones whose illness leads to homelessness, addiction and petty crime or breaches of public order.

Until fairly recently, such people were generally dealt with in the regular court system, waiting for weeks or months for medical assessment, clogging courts and jails that were ill-equipped to deal with them, receiving little or no treatment during incarceration, having no follow-up treatment arranged after release, and consequently often repeating the cycle with depressing regularity. The cost to the legal and penal systems was substantial.

Most major cities now have diversion courts, sanctioned by the Criminal Code, many of which deal exclusively with low-risk cases in which the accused appears to have a mental illness. These courts are oriented towards treatment rather than punishment. Their repeat-offender rate is impressively lower than that in the regular court and penal system, and strain on the public purse is significantly reduced.

Cases are selected for diversion by the Crown. Both judge and Crown have special training and legal personnel are usually outnumbered by dedicated mental health and social workers.

Typically the accused is medically assessed – often on site the same day – acknowledges the offence, agrees to court-ordered treatment, and has his or her charges withdrawn when it is satisfactorily completed.

Treatment orders are issued by mental health courts with the patient's consent (albeit under circumstantial duress) and so do not have to conform to the restrictions of the provincial Mental Health Act for involuntary treatment. However, where the accused is 'unfit to stand trial' the court may impose involuntary treatment for up to 60 days. Court proceedings are open to the media, but few of the cases handled, by their nature, generate much news.

FITNESS TO STAND TRIAL

The Criminal Code provides that if a mental disorder makes an accused person unable to conduct his defence or instruct counsel, he is 'unfit to stand trial'. The prosecution is held in abeyance and a provincial or territorial Review Board assumes jurisdiction. It decides where the accused is to be housed, under what conditions, reviewing the matter not less than once a year.

(Covering a review hearing) is an opportunity to take some social responsibility, which I think most reporters feel. I think that's why they're reporters in the first place.

Heather Stuart, Ph.D.
Bell Mental Health and
Anti-Stigma Research Chair,
Queen's University

I always have a bit of a knot in my stomach when one of these (high profile) cases comes up, because I'm wondering how we're either going to be set back or advanced by how the media cover it.

Hon. Justice Richard D. Schneider
Chairman, Ontario Review Board

NOT CRIMINALLY RESPONSIBLE

When a trial proceeds, either in mental health court or in superior court in the case of serious offences requiring a jury, there is provision in the Criminal Code for pleading that an accused person is not criminally responsible for the act they committed. It involves showing, on a balance of probabilities, that the accused was 'suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.' In other words, the person was psychotic at the time of the offence. This is known as the NCR defence.

When such a defence is initiated, the judge will usually order a number of psychiatric evaluations to be carried out by experts he or she chooses. It's a common misconception that the prosecution and defence lawyers can 'shop around' for experts to

support their case, though they may ask the judge to commission extra evaluations if they aren't satisfied with the first results.

'GETTING AWAY WITH IT'

Another popular misperception is that those found not criminally responsible for murder are effectively let off. This view is often taken by members of a victim's family, and repeated in news reports. The reality is that most people found NCR and committed for treatment will lose their freedom for longer than they might if they had simply pleaded guilty. Furthermore, with treatment comes belated, life-long appreciation of the enormity of their acts.

REVIEW PROCESS

When a jury finds someone not criminally responsible, the case is referred to the provincial or territorial review board. Typically, the board will lock the person up in a secure mental hospital and order treatment, reviewing their progress at least once a year. Members of the victim's family usually attend each review, frequently generating further newsworthy outbursts of rage, once again reported alongside – or sometimes above – the medical evidence presented.

The federal government introduced legislation in 2013 called the Not Criminally Responsible Reform Act. It came into effect in July 2014. It formally enshrines public safety as the paramount consideration for Review Boards, builds into the Criminal Code a definition of 'significant threat to public safety' – the phrase which governs a Review Board's jurisdiction over a mentally disordered person – and allows judges, upon application by the Crown, to designate some mentally ill people found NCR as 'high risk'.

Such people cannot then be granted conditional or absolute discharges, and may be eligible for reviews only once in three years. The designation can be revoked only by a court after recommendation by a Review Board. Access to treatment is not affected.

Before it became law, some judges expressed doubt whether the legislation would have had any impact on high profile cases of recent years. It was also criticized by mental health professionals, especially the three-year period between reviews, irrespective of progress in treatment. It was widely seen as punitive – and thus in conflict with the principle that the person is not guilty of a crime. As well the provision forced the occupation of a hospital bed where it might not have been clinically necessary.

Beyond provisions that give victims notification rights when a previously-violent patient is released, by 2020 the reform act did not appear to have had significant impact in generating great numbers of accused receiving a high-risk designation. Review boards already had a history of treating potentially dangerous patients conservatively, while prosecutors and judges still appeared reluctant to apply a designation that would essentially pre-judge the success of any treatment.

What remains unknown is the number of accused who have, because of the potential for such a harsh designation, avoided availing themselves of the NCR defence. The effect of this would be to put greater numbers of people who could have mounted one successfully into the correctional system where it is known they do poorly, their prognoses worsen, and they become more likely to re-offend once released into the community, typically with little or no support.

REVIEW BOARD HEARING BEST PRACTICE CHECKLIST

- ✓ Be clear that the patient is not a criminal.
- ✓ A review hearing is not a re-trial: Focus your story on rehabilitation, not vengeance.
- ✓ Check the 'facts' contained in statements made outside the hearing.
- ✓ Carefully consider the fairness of relaying characterizations of the patient made outside the hearing.
- ✓ Don't reproduce offensive language that casts stigma on people who are mentally ill unless it is critical to the story.
- ✓ Consider doing a more in-depth follow-up story which may generate more light than heat.
- ✓ Editors should review this checklist before writing headlines.

CHAPTER 6

COVERING SUICIDE

TAKING RECOMMENDATIONS TO THE NEXT LEVEL

Much has changed since Mindset was first published in 2014. We now report more and in greater depth about suicide in Canada, and on the whole we do it better. Journalists are delving deeper into causes, population groups especially at risk and policy shortcomings, as well as reporting on measures to reduce loss of life.

In some respects, this deeper reporting has outstripped the development of best-practice recommendations, which have generally focused on the reporting of suicide deaths as they occur, trying to reduce any collateral damage. Experience has shown that applying all of them rigidly in other contexts can inhibit work aimed at advancing the greater public good. Up to now, journalists facing problems around suicide reporting have mostly had to find their own way, with help from whoever in the suicide prevention community they have chosen to consult.

While such consultation can help, there is a range of differing perspectives on suicide issues in the social science and medical communities. As reporters, we need a journalistic framework to help us evaluate any advice received. This chapter, together with related material on the Mindset website, offers starting points that can be referenced by journalists and suicide prevention professionals alike.

"I had looked at the Mindset guidelines, the other guidelines that existed out there, and I didn't find that they were sufficient for what we were trying to do. And so part of our early process was reaching out to many experts to talk about how we could do this in a responsible and sensitive way."

Renata D'Alisio, Lead Reporter on Globe and Mail team that tracked and exposed the high rate of suicide among Canadian Afghanistan veterans in the multiple-award-winning series *The Unremembered*

Suicide remains one of the most challenging topics to cover. When a suicide death has news value – occurring in a public place, involving a public figure or touching a public policy issue, for example – it must be reported factually, reliably and responsibly. It is equally in the public interest that we take steps to avoid unnecessary harm, paying particular attention to elements that may encourage others near the point of despair to take their own lives. Faced with a suicide, reporters should first take note of the basic do and don't recommendations in this chapter, recognizing that while they offer solid advice for most incident reporting, they can be varied, with care, when the public interest calls for it.

No advice can completely replace ethical journalistic judgement, independently exercised in light of the particular facts. This is why we call our offerings "recommendations" rather than "guidelines", a term which can imply they come from those in authority over a regulated profession. Journalism has no overseeing regulatory

body, for good reason. Independent judgement, responsibly applied, is essential to maintaining free media.

Here is an example of circumstances in which one of the **don't** recommendations was, we think, appropriately varied. In July 2019, CNN aired footage of a man, clinging to the outside of suicide barriers on a highway overpass, being persuaded by passers-by not to jump. The story dramatically showed the life-saving power of human contact and expressions of concern. Not using it because it also made clear the intended method of suicide would, in our judgement, have been perverse. Appropriately, the story did not explain exactly how the distressed man had circumvented the barriers.

WEIGHING POTENTIAL HARM AND BENEFITS

The possibility of unintended harm exists in many kinds of journalism. Often it can be diminished by dropping details that aren't essential to the purpose of the story. But the idea that details or entire stories should be dropped when there is any possibility of incidental harm cannot be supported.

In asserting this, journalists are not alone. The idea that doctors are required to "do no harm" is a fallacy. Chemotherapy treatment for cancer, for example, carries the risk of significant, even fatal, harm from the toxins used. Yet treatment is permitted because there is a net positive benefit. In reality, doctors weigh all the circumstances and strive to minimize potential harm, rather than freezing whenever it arises. That should be the case for journalists too.

And not just for journalists. The "do no harm" mantra has occasionally been used by authorities in an effort to deny journalists' requests for data under Freedom of Information (FOI) legislation. At least one such case relied on an absolutist interpretation of what it called "guidelines" which, it argued,

meant no information at all could be released if there was the slightest possibility of harm. The agency in question was being investigated for what seemed to be inadequate suicide prevention measures. Mindset holds that such blanket refusals are inconsistent with both the public interest and the basic purpose of FOI laws.

FLEXIBILITY CUTS BOTH WAYS

As much as journalists handling suicide incidents may, in the public interest, need the sort of flexibility we describe here, there will be times when those working on investigative or feature stories should also be ready to be flexible about normal journalistic practice. For example, circumstances may occur in which sharing a story with families before publication – a practice frowned upon in most news organizations – would be beneficial.

On the Mindset website, we deal with all of these matters in more detail, examining three types of feature stories in which some leeway on specific recommendations may be in order, taking into account the overall story arc, the relative risk of others taking their lives, the potential impact on families and the expected public benefit of the piece.

Go to the website as well for the latest assessments of how closely Canadian media are following Mindset's recommendations. A 2019 study of Canadian newspapers showed very high adherence to much of our core advice, but a far lower rate of inclusion of information on available helplines and messages of hope from mental health professionals.

SUICIDE CONTAGION

Contagion – in which learning of one person's death may prompt other desperate people to kill themselves as well – is a clinical concern supported by robust evidence, particularly when the initial death is that of a celebrity or a high-profile individual with whom others may identify and admire. Research shows that up to double-digit percentage increases in suicides can occur after a celebrity's death. Clearly these are circumstances in which journalists should try hard to minimize harm. That doesn't mean journalists should avoid covering a celebrity's death or fail to attribute it to suicide. But it does mean that extra care must be taken to provide context, make reference to help available and to remind the news consumer that there are alternatives to suicide, with positive outcomes. Most suicides arise from treatable mental illnesses and are therefore preventable.

Though the concept of suicide contagion is widely accepted, demonstrating links between specific news coverage and particular deaths has always been problematic. A study after the suicide of Robin Williams in 2014 showed that Canadian newspaper articles about it were twice as compliant with at least 70% of the Mindset recommendations as their US counterparts. Yet in the month that followed, Canadian suicides spiked by 7%. The researchers noted by way of a possible explanation that most Canadians are exposed to US media, a variety of online news sources and social media, as well as the Canadian newspapers whose coverage they had studied. Links to these and other resources are on the Mindset website.

Global suicide figures are stark. And, for some of us, confusing. About 800,000 people kill themselves every year, three times as many as are killed in military conflicts. According to contagion

theory, the amplifying effect of the communications revolution in the new millennium should have been making the world's suicide crisis very much worse. Yet between 2000 and 2018, global suicide dropped by 29%. Large reductions in India and China, linked to increased social and economic wellbeing and decreased availability of ready means, confirm that contagion is far from the most significant factor in the big picture. In fact contagion, though important, is only one of 14 broad factors identified as influencing suicide rates, according to a recent review in the New England Journal of Medicine. Reporting on the underlying contributors to depression and anxiety could help to save many more lives than just concentrating on reducing suicide contagion. In the public interest, we should be doing both.

Reporting appropriately about suicide gives journalists an important opportunity to help people understand the underlying social ills, to help prevent further tragedies and to raise awareness of the importance of mental wellness in the community.

Dr. Paul Yip, Director, Hong Kong Jockey Club Centre for Suicide Research and Prevention.

REPORTING DETAILS OF THE METHOD OF SUICIDE

Mindset has consistently recommended that reporters should not describe details of the method of death. In some cases, it is not necessary to mention method at all. But where that prevents proper understanding of the story, saying a person used a gun, took an overdose, hanged herself or jumped in front of a train doesn't reveal anything about methods that is not already common knowledge. Failure to be straightforward about key facts can undermine the integrity of any reporting. Mindset supports comprehensive and accurate reporting on suicides, but we do not licence the inclusion of harmful details not essential to the story.

Describing how a person reached the roof of a tall building, the number and type of pills taken, or the measures a person took to make their death more certain or painless are all examples of what ethical reporters should avoid doing. Such unnecessary details could encourage further deaths – even if such information is available elsewhere.

SUICIDE NOTES

Mindset recommends not publishing suicide notes, absent an exceptional public interest reason. Publishing a note that glorifies the act or presents suicide as a solution to problems, for example, may be seen as justifying similar action by others. Where a greater public interest to the contrary exists and details of the suicide note are included, account should also be taken of any potential traumatic impact on the dead person's loved ones. At a minimum, bereaved families should be prepared in advance of publication of such material.

In August 2019 the BBC allowed part of a suicide note to be read by the dead man's daughter on the Radio 4 program Today. The story involved draconian and sudden action by British tax authorities against people who had used a tax reduction

arrangement that had been deemed legal for some 20 years. Authorities denied reports that some people, facing very high demands for back taxes and penalties, had killed themselves. The story indicated that the man in question had an underlying mental illness, but his note made clear the tax demand was the final straw. BBC editors concluded the public interest was better served by broadcasting the note than by suppressing it. In most such cases a mention of the contents of the note might be sufficient to make the point.

AVOID PORTRAYING SUICIDE POSITIVELY

There is obvious danger in glorifying a suicide, making it seem almost heroic. This can be done by the reporter's approach to the story, by reported comments, even through coverage of memorials or vigils after a celebrity suicide, where inappropriate messages – on signs and banners in the crowd, for example – may be visible. Caution is required, but even such caution can be taken too far. Where a qualified person in appropriate context expresses an informed opinion that might appear to breach this recommendation, the default should be in favour of including it, if it seems likely there would be a net positive benefit.

THE IMPORTANCE OF THE STORY ARC

The overall story arc – its larger context and intent and the level of detail and facts beyond the loss of a life or lives – is critical to ensuring good reporting about suicide. If you have any doubt about that, remember the example of *The Unremembered*.

A Globe and Mail team spent three years painstakingly confirming and writing about 31 previously untracked suicides by Canadian veterans of the war in Afghanistan, but they also took the time to find and write about four veterans who had considered suicide but had obtained life-saving help. Because

the team got its initial leads by checking thousands of obituary notices, finding people who had not died wasn't easy. Including those survivors' stories demonstrated that the deaths might well have been reduced if systematic help had been in place. The overall story arc may also have played a part in checking further deaths. The series won many accolades, including the inaugural Mindset Award for Workplace Mental Health Reporting.

SUICIDE IN TIMES OF CRISIS

When a community or nation is struck by a crisis such as the COVID-19 pandemic, or any other disaster, there may be a tendency to attribute suicides solely to that cause. Statements to that effect by grieving relatives should be treated with proper journalistic caution. Suicide has many causes, biological, psychological, environmental and social. Speculation linking suicide deaths to the dominant story of the time, while many people are still struggling with it, may not be in the public interest. Covering the added difficulties a crisis creates for people with mental illnesses can be more helpful, if due attention is paid to the story arc. Consider delaying publication or broadcast of analysis of any links between suicides and the crisis until it can be done with the benefit of all the evidence, carefully considered, with reduced potential for harm.

WHO SHOULD DO THIS WORK?

It is sometimes suggested that suicide stories should be handled exclusively by health reporters, rather than generalists or 'crime' reporters. Mindset, written primarily for general-assignment journalists, does not endorse this point of view. Health reporters contribute significantly to our better understanding of issues around suicide. But they have complex beats to cover and may not be available when newsworthy suicides occur. And some investigative work around suicide can take longer than a busy beat reporter can afford.

Consider also that suicide is a field of concern not only for mental health professionals but also for social scientists, ethicists and policy experts to name only a few. Some discussions within the suicide prevention community turn on the relative importance of 'upstream' – that is broader and more general – social issues compared to immediate mental health ones. Putting suicide predominantly in the hands of health reporters could tend to align media coverage with one side of those discussions. Narrowing the diversity of reporters handling suicide stories is not, in our opinion, a direction in which journalism should travel.

SUICIDE REPORTING AND SOCIAL MEDIA

Reporters covering all kinds of incidents now frequently turn to social media for leads, contacts and reaction. It is vital to understand that posts by members of the public are generally produced without any journalistic discipline and may have more to do with drawing attention to the originator than with accuracy. This caution is especially important in cases of suicide. Even when time is short, simply repeating what has been posted without checking or evaluating it for potential harm is unacceptable. If a name is mentioned on social media, that does not provide licence for journalists to do the same. Also bear in mind that inaccurate reporting, speculation and commentary can increase trauma for family and friends of the person who has died.

DIFFERENTIATION OF TERMS

As we have discussed, "Suicide contagion" or "copy-cat suicide" is one of the main concerns driving guidance for media advanced by suicide prevention organizations. In this phenomenon, the suicide of someone of local, national or international stature can be followed by a temporary increase in suicides by predisposed people who identify strongly with that person.

"Suicide clusters" are a different phenomenon. The term is applied to simultaneous or serial suicides among people who were somehow connected before the first such death occurred. Often the group will share a common problem and may be in contact with each other, so that they may know about the death before reporters do. But remember that people can be connected through shared circumstances as much as by geography.

A significant danger can arise from the way in which reporters link a death with the shared problem – teen depression or eating disorders for example, or third-world conditions on some Indigenous reserves. When evidence points clearly to such underlying factors, it should not be suppressed, but nor should it be handled in a way that may make further suicides by similarly-affected people seem, to them, justified. There should be room within the story to add information about other available remedies, in addition to the usual "if you need help" contact numbers, typically provided at the end. It could, for example, take the form of a quote or a clip from a qualified person working to provide those alternatives.

Journalists are more accustomed now to treating vulnerable individuals differently than they might, for example, handle seasoned politicians. Remote communities can be vulnerable too. Local leaders may strive to preserve their community's image after a series of suicides, not as a cover-up but in an effort to limit general despondency. While reporting accurately on the issues behind the suicides, journalists can help by giving a more complete, nuanced picture. Including wider context, or mention of positive community responses such as setting up support services, treats the people involved with respect and makes for better journalism.

SUICIDE DOS AND DON'TS

- ✓ **Do** write about suicide, but do it responsibly.
- ✓ **Do** consider whether this particular death is newsworthy.
- ✓ **Do** look for links to broader social issues.
- ✓ **Do** respect the privacy and grief of family or other 'survivors'.
- ✓ **Do** include their suffering.
- ✓ **Do** tell others considering suicide how they can get help.
- ✓ **Do** present suicide as mainly arising from treatable mental illness, thus preventable.

- ✓ **Don't** romanticize the act or characterize it as a solution to problems.
- ✓ **Don't** go into details about the method used.
- ✓ **Don't** accept single-reason explanations uncritically. The reasons why people kill themselves are usually complex, with multiple factors interacting.
- ✓ **Don't** publish suicide notes without compelling public interest justification and due concern for families.
- ✓ **Don't** automatically mention suicide in every story you do about mental health.

➤ LANGUAGE BEST PRACTICE

- ✓ **Do** use plain words. Say the person 'died by suicide' or 'took their own life.' 'Completed suicide' is jargon, best avoided.
- ✓ **Don't** say a person 'committed suicide'. This outdated expression, linking suicide with illegality or moral failing, can make it harder for others to seek help, or for families to recover.
- ✓ **Don't** frame suicide as an achievement by calling it 'successful' or attempted suicide 'unsuccessful'.
- ✓ **Don't** use or quote pejorative expressions such as 'the coward's way out', which reinforce stigma.

"When you announce that people who have died by suicide are cowardly, you're sending a message to depressed people fighting suicidal thoughts. The message isn't one of perseverance. It's one of worthlessness."

Ken White,
Contributing Writer,
The Atlantic.

BACKGROUND FACTS

Suicide in Canada is three times more common among men than women. Men who are middle aged or elderly have the highest rates. Married people are less likely to die by suicide than those who are single, divorced or widowed. The proportion of deaths by suicide among adolescents is relatively stable, although it may appear to have increased relative to the number of total deaths in this age group. This is largely due to the fact that the number of accidental deaths has decreased.

Indigenous people in Canada, taken as a whole, are twice as likely to kill themselves as other Canadians, but that average hides enormous variations, from a stunning 30 times the national rate for young Inuit living in traditional homelands, to practically zero in some First Nations. Go to chapter 8 of this guide for more information.

About 90% of people who die by suicide have some mental or addictive disorder, or both. The most common association, in around 60% of cases, is with depression. It is important to recognize that depression and anxiety are often linked, in turn, to socio-economic issues, as well as personal ones such as relationship breakdowns. In several countries, these 'upstream' factors have been shown to influence suicide rates in both directions.

Suicide is most often attempted when a person reaches the point of being completely overwhelmed by cumulative feelings of despair, pain and hopelessness. At that stage, the ready availability of means is an important factor, since the final decision to end one's life is often impulsive. Evidence also shows that people with suicidal intent can change their minds

if human intervention at that late stage provides a spark of hope. Intervention can be as simple as asking someone, "Are you OK?"

Do not assume that United States statistics on suicide can be extrapolated to the Canadian experience. The U.S. has much higher rates of suicide than Canada, and is an outlier among developed nations in that those rates are increasing. Canada's are relatively stable. Many factors contribute to the U.S. problem, including the widespread availability of guns, which kill substantially more people by suicide than by homicide.

For the latest suicide statistics as they emerge, please see the Mindset website.

CHAPTER 7

THE ILLNESS OF ADDICTION

Some stories that don't appear at the outset to involve mental illness really do. Medicine considers addiction – to drugs, alcohol, nicotine or the like – to be a substance use disorder. This often clashes with popular perception.

Journalists whose stories tend to echo the view that addiction is a sign of personal weakness or choice are ignoring facts known to the medical profession for more than half a century. Addictions, including those involving self-medication, are illnesses like any others. Since journalists ourselves have a higher-than-average alcohol addiction rate, some at least should have personal insight into the problem.

Addiction changes the brain, altering the order in which it ranks priorities, regardless of consequences. Dependence is not addiction, but can be a step on the road to it. When substances are used for self-medication, dependence can bring on increasingly compulsive use and greater tolerance, becoming addiction, now clinically known as a substance use disorder. Such compulsive behaviour is also found in other mental disorders.

But reporters should be aware that dependence under medical prescription is not the same. Some patients depend on prescription drugs, for example, to deal with chronic pain. Their use is monitored and controlled. Failing to distinguish between these different circumstances, or using the word dependence loosely, can increase public prejudice.

The opioid crisis has drawn attention to the stigmatization of people with addictions. Careful and precise use of language is

important to convey an accurate picture, and to minimize stigma in this and in all cases of addiction. Be aware that stigmatizing people with addictions causes real harm and can adversely affect their prognosis.

As with any disease or disorder, putting the person ahead of the ailment should be routine. People are much more than their disease, and language that suggests otherwise can be very harmful. We don't call someone "cancerous"; we should not describe them as "schizophrenic"; and we should not label them alcoholics or addicts either. It assigns a crude and harmful caricature. Dehumanizing people has no valid place in ethical journalism. Nor does setting some apart by the language we use. It's more accurate as well as less stigmatizing to say that a person who has recovered is 'healthy', rather than 'clean'.

A person with a substance dependency or use disorder may use more colloquial terms to describe themselves, such as "junkie". That is their right, and journalists should not censor the term the person applies to themselves. But their saying it does not give us licence to do the same, or permit others to do so in our stories. Nor should it be used in headlines. When we show that we understand that addictions are much more complicated than life choices, we are on the way to better, more factual, more enquiring journalism.

Reporters should also know that the old assertion that the only way out of addiction is through a 12-step program is not supported by current research. There are, in fact, many ways out, just as there are many ways in, according to studies of those in recovery conducted in Canada and elsewhere. Many treatments emphasize dealing with upstream causes – the reasons why someone started self-medicating in the first place.

Bear in mind that in 2017 alcohol put 13 times as many Canadians in hospital as opioids did. There is also a growing body of evidence that drinking alcohol can not only exacerbate

social problems linked to mental illness, but also significantly increase susceptibility to physical illnesses, including cancer. Research published in June 2020 shows this can occur well below Canada's current maximum daily drinking guidelines. See the Mindset website for details and developments.

While psychiatry treats addiction as a mental disorder in its own right, it frequently co-exists with others. Up to 80% of people diagnosed with schizophrenia, bipolar disorder or antisocial personality also have an addiction problem. Across non-addiction mental disorders as a whole, the 'comorbidity' rate is around 20%. Journalists doing in-depth work about addictions will find useful resources and contacts on the Mindset website, including cautions about some questionable story lines they may encounter.

➤ ADDICTION CHECKLIST

- ✓ **Addiction results from physical changes in the brain, and is considered a mental disorder.**
- ✓ **Addiction may co-exist with other mental disorders.**
- ✓ **Addiction can also be associated with hereditary and social factors.**
- ✓ **People with addictions are ill: Respect the person, understand the behaviour, use person-first language.**
- ✓ **Stigmatizing people with addictions causes real harm and can adversely affect their prognosis.**

CHAPTER 8

MENTAL ILLNESS AMONG INDIGENOUS PEOPLES OF CANADA

Indigenous communities often have quite different collective experiences to the ones that are commonly portrayed in media.

By and large, mental illness affects Indigenous Peoples in Canada disproportionately. Suicide is a leading indicator of mental illness, and First Nations, Métis and Inuit are, on average, twice as likely to kill themselves as the rest of Canadians. Among young Inuit living in their traditional homelands, the suicide rate is as much as 30 times the national figure.

But these shocking statistics hide an important truth. The crisis is not universal. There are Indigenous communities in Canada in which suicide is almost unknown, indicating extraordinarily high levels of mental health and wellbeing.

Journalists covering Indigenous people and mental health must recognize this reality to avoid framing their work in ways that increase prejudice and reinforce unhelpful myths. The stereotype of the "drunken Indian", for example, belies the fact that abstinence from alcohol is higher among First Nations people than the rest of the Canadian population.

We all, often subconsciously, make assumptions based on stereotypes. It may surprise you to learn that there can be significant differences in the collective experience of communities we often lump together. Taking time to understand the particular experience of the community in which you are

> *"Many Canadians know Aboriginal people only as noble environmentalists, angry warriors or pitiful victims."*
>
> Royal Commission on Aboriginal Peoples (1996)

working will help you produce better journalism. But the guiding principles should be familiar enough: Don't generalize; don't stigmatize; look for systemic and underlying issues that provide illuminating context for the story; and don't let preconceived story frames make you overlook facts that don't fit.

Good journalism means going beyond the story you are telling and looking at the bigger picture and system that created it. If you are covering a rash of local suicides, provide context about the devastation that comes from detaching generation after generation from their roots. If other local communities are not similarly affected, ask why.

Appreciate the function of cultural identity as a promoter of mental wellbeing. Its loss can have devastating effects over successive generations. Its maintenance or restoration can generate extraordinary resilience.

Social devastation in the wake of such policies should not be surprising. Health Canada places 'knowing and taking pride in who you are' at the top of its list of universal indicators of good mental health. Evidence is growing that Indigenous communities with the lowest rates of mental illness and addiction are the ones in which people feel most in control of their own lives.

General assignment reporters who bear this background in mind when covering news stories involving mental illness or addiction in Indigenous contexts will likely take more care to look for case-specific facts and be less inclined to frame stories in stereotypical ways. In other words, they will do better journalism.

"The trouble with colonialism is that it deprives people of the ability to create their own futures and shape their own destinies. The mending of hearts and treaties that is so desperately needed is not easily matched by deeds. Crisis intervention is necessary, but we also must find a practical strategy that will give all Indigenous people a chance to make a livable present and a better future."

Bob Rae
Canadian politician
and diplomat.

Reporters may encounter a slogan sometimes adopted by people seeking to improve public perception of their group: *Nothing About Us Without Us*. This may be advanced in ways that run counter to journalistic principles, such as demanding the right to approve copy before publication. Journalists clearly cannot surrender editorial control in that manner, no matter who is asking. But it makes good sense, as well as good journalism, to include Indigenous sources to ensure that Indigenous perspectives are covered.

Here are some more steps journalists can take towards improving their knowledge of Indigenous communities and lifestyles, on or off reserves:

Get to know Indigenous people in various walks of life outside the context of news coverage. As with all reporting, the deeper the relationship, the more the trust, the greater the openness and the deeper the knowledge of cultural context.

Understand that Indigenous communities are not all the same. Take time to learn and appreciate the differences in approach and tradition between the ones you are most likely to encounter professionally.

Remember the importance of cultural nuance and sensitivity in dealing with people who feel they have lost control of who they are and who gets to define them.

When intergenerational trauma is a factor, treat interviewees with the care and consideration you would afford to any trauma victim.

Take time to listen carefully to what is said and avoid fitting what you think you are hearing into preconceived story frames.

Use cultural references to provide context that furthers understanding, not as stereotypical or gratuitous colour.

Bear in mind that safeguards you may believe to be universal may not apply on reserves. For example, Indigenous police forces are established under a federal program and are not subject to the provisions of provincial police acts, such as policing standards, complaints procedures and oversight mechanisms. And it is legally permissible to practice medicine on reserves without a licence.

Watch videos on the Mindset website (www.mindset-mediaguide.ca) for more nuances and insights from the extraordinary discussion at a town hall meeting in Edmonton in May, 2016.

Read Duncan McCue's excellent, informative, provocative and entertaining guide *Reporting in Indigenous Communities* available free online at http://riic.ca/the-guide/

"There is much to be fixed on reserves and beyond, from poor drinking water to child welfare, through to addiction and mental-health supports. Imagine if we took all the money that goes into crisis response and used it instead to facilitate Indigenous communities learning from each other, nation-to-nation. Imagine if we listened to young people's hopes and fears and helped them design solutions without there having to be an outburst of self-harm to get our attention."

André Picard, Health Columnist,
The Globe and Mail

QUICK REFERENCE

INDIGENOUS /ABORIGINAL Before colonization, there was no collective term for the many distinct groups of Indigenous inhabitants of the land that became Canada. The first broad classifications were introduced for the administrative convenience of colonial authorities. These terms have evolved in a process not yet concluded.

There is a growing preference for the term Indigenous Peoples. CP style requires capitalization of both Indigenous and Aboriginal. These terms include First Nations, Métis and Inuit. Avoid using terms such as Canada's Indigenous Peoples, Canada's Aboriginal Peoples or Canada's First Nations, which some see as carrying possessive colonial overtones. Indigenous Peoples of Canada, or equivalents, should be preferred.

Using current, best-accepted terms not only shows respect, but can help reporters seeking contacts and understanding of stories in Indigenous communities.

FIRST NATION / INDIAN Although some Indigenous people still call themselves Indians, or even Natives, these terms are not generally acceptable when used by others. An exception is when referring to the Indian Act and the legal terms following from it. Under the Act, ***status Indians*** qualify for certain rights; ***non-status Indians*** are those of Indian heritage who don't qualify for, have not registered for or have lost status under the Act; and ***treaty Indians*** are those descended from people who signed treaties with the Crown and are registered with a treaty band.

A band is a First Nation community for which lands are set aside and for whom the Crown holds money in trust. There are about 600 bands in Canada. First Nation can be used as a noun or a modifier. Where more than one band is involved, use First Nations. In the 2016 census Statistics Canada counted 977,230 people who identified as First Nations.There were 1,673,785 Indigenous people in all - 4.9% of the total population, compared with 4.3 % in 2011. Comparable statistics from the 2021 census will be posted on the Mindset website when they are available.

The term First Nation includes both status and non-status Indians. In a unanimous decision in April, 2016, the Supreme Court of Canada declared that non-status Indians and Métis are to be considered 'Indians' under the Indian Act. The court largely left the implications of the decision to be worked out on a case-by-case basis.

In 2019 the federal government removed the last provisions of the Indian Act that had discriminated against Indigenous women by restricting the transmission of status in some circumstances to the male line. All descendants born prior to April 17, 1985 to women who lost status or were removed from band lists

because of their marriage to a non-Indian man dating as far back as 1869, became entitled to registration, bringing them in line with the descendants of men who never lost status. It is estimated that between 270,000 and 450,000 more people are now eligible to register as a result, with far-reaching implications for First Nations funding, governance and trust agreements.

MÉTIS Originally, the term was applied to descendants of French traders and trappers in the northwest and First Nations women. It is currently used to mean anyone of mixed Indigenous and non-Indigenous race who chooses that identity. In 2003 the Supreme Court of Canada defined as Métis anyone who self-identifies as Métis, has an ancestral connection to the historic Métis community, and is accepted by the modern community with continuity to the historic Metis community. In the 2016 survey 587,545 people self-identified as Métis.

INUIT This (not Eskimo, which is considered derogatory) is the name of Indigenous people who are neither First Nation nor Métis, whose traditional homelands are in northern Canada. The area is collectively called the **Inuit Nunangat**, a vast territory of land and sea that includes **Nunavut**, where almost half of the Inuit live, **Inuvialuit** in the Northwest Territories and Yukon, **Nunavik** in Northern Quebec and **Nunatsiavut** along the northern coast of Labrador.

The Inuit Nunangat is home today to nearly three quarters of all Inuit in Canada. Be aware, however, that the term is sometimes used to include traditional Inuit areas of Alaska and Greenland, as well as Canada.

One person is an **Inuk**, two people are called **Inuuk**, and more than two are referred to by the collective **Inuit**. Their most common language is **Inuktitut**, but other local dialects are also spoken. Together they are called the **Inuit language**. There are

eight main ethnic groups among the Inuit of Canada, who in the 2016 survey numbered 65,030.

Because Inuit means "the people", it is considered redundant to write or talk about "the Inuit people". Inuit generally prefer to be called, simply, the Inuit.

Be careful not to confuse the Inuit with the Innu, an Algonkian-speaking First Nation living primarily in northeastern Quebec and southern Labrador.

POPULATION GROWTH The Indigenous population of Canada is rising four times faster than the non-Indigenous. This is due both to natural growth and to more people newly identifying themselves as Aboriginal on census forms. Children under 15 make up 26.8% of the Indigenous population, compared with 16.4% for non-Indigenous.

RESERVES Most Indigenous people in Canada do not live on reserves. A majority of First Nations people, regardless of their official status, live off-reserve and very few Métis and Inuit have ever lived on them. Reservation is an American term, not used in Canada.

Health care and social services on most reserves are provided by the federal government. (In British Columbia, they are now provided by the First Nations Health Authority, under a self-government agreement.) The provincial systems covering most Canadians do not apply. In January, 2016 the Canadian Human Rights Tribunal ruled that First Nations children were victims of willful and reckless discrimination, because federal programs on reserves receive significantly less funding than equivalent ones off-reserve. Mental health resources, already scarce in most parts of Canada, may be much more so under these circumstances. Many reserves have small populations, making privacy in medical matters – including mental health

– problematic. This can complicate stories themselves and sensitive reporting of them.

RESIDENTIAL SCHOOLS The residential school system in Canada was intended to convert First Nations, Métis and Inuit children to Christianity and aggressively assimilate them into Euro-Canadian culture. It was instituted in the late 19th century, and the last school did not close until 1996.

A total of about 130 schools were established, funded by the federal government and run by church authorities, in every jurisdiction except Newfoundland, Prince Edward Island and New Brunswick.

Some 150,000 Indigenous children were forced to leave their families and most attended for 10 months of the year or more. They were forced to speak only English or French and punished severely for speaking their own languages or practicing Indigenous traditions. There were also many cases of sexual abuse.

In 2007 the federal government created a $1.9 billion package to compensate victims of the system.

For more details, we recommend *"A history of residential schools in Canada"* on the CBC News website.

THE SIXTIES SCOOP Even as it began to close residential schools in the 1950s and '60s, official policy still held that assimilation through education was in the best interests of Indigenous children. Some 20,000 Indigenous children – including newborns – were taken away from their parents and placed in care. These children were then fostered or adopted by white families in Canada, the United States and Europe, and so generally educated in public school systems.

It was found that Indigenous children became 4.5 times more likely to be taken into care than the norm. The term "Sixties

Scoop" was coined by Patrick Johnson in a report in 1983 titled *Native Children and the Child Welfare System.*

INTERGENERATIONAL TRAUMA This refers to the impacts on later generations of aggressive assimilation policies, including the residential schools and the Sixties Scoop. These impacts can be both psychological and practical, affecting well-being and health and reinforcing social problems. One example of practical consequences would be the struggle faced by people raising children in communities with little or no experience of normal family life.

Be clear that the term does not imply any genetic predisposition to mental disorders among Indigenous people. There is no scientific evidence for any such predisposition.

➤ BEST PRACTICE CHECKLIST

- ✓ **Get to know Indigenous people.**
- ✓ **Appreciate diversity among Indigenous communities.**
- ✓ **Avoid stereotypical story frames and assumptions.**
- ✓ **Focus on underlying systemic problems.**
- ✓ **Appreciate the impact of intergenerational trauma.**
- ✓ **Recognize the importance of traditional culture to self-determination and emotional resilience.**

CHAPTER 9

YOUNG PEOPLE AND THEIR MENTAL HEALTH

Young people facing serious mental health issues are highly vulnerable, making this both an important field for journalistic attention and one that calls for thoughtful and flexible approaches.

Democratic societies come with a built-in duty of care towards their most vulnerable members. Journalism supports democracy by ensuring the free flow of information that sustains it, and by seeking out and shining light on things that go wrong, holding those responsible to public account. As journalists we cannot ethically play the democracy card to justify our work if we simultaneously ignore the needs of vulnerable people about whom we report. A basic principle of good journalism is to minimize harm. So in covering sensitive subjects like this one, we adjust our approach and practices to fulfill our duty responsibly.

Constructive, incisive and knowledgeable journalism can help. Our stories may at times be shocking, but shock has its value and a place in serious reporting that examines problems and their causes, teases out possible solutions and, where appropriate, seeks accountability. Without such added value, however, shock is little more than "trauma porn."

Canada has the third highest rate of youth suicide in the industrialized world, and suicide – while not an inevitable outcome of psychological distress – is a significant indicator of poor mental health. Stress and anxiety for young people has increased significantly over the past decade. By the age of 18,

"When we are talking about young people, we have to layer in the vulnerability that comes with the stage of development that they're at, where their brain development is at, all the really complex contexts within which they operate."

Dr. Joanna Henderson,
CAMH & University of Toronto;
Executive Director, Youth
Wellness Hubs Ontario

20% of Canada's young people have experienced significant mental health problems, with less than a third getting access to or making use of services.

General assignment reporters are increasingly likely to be called on at short notice to cover a wide variety of stories involving young people and mental health problems. A basic understanding of context will help them work more accurately and quickly, avoiding making things worse for the subject of the story or others like them. Better-informed work will also help to reduce misconceptions and false assumptions on the part of readers and audiences. First impressions do count.

Because this guide is written primarily for these "first-responder" journalists, we have concentrated on stories involving young people and mental health that are likely to be encountered in Canada. Journalists, however, should respect the rights and dignity of children, youth and young adults everywhere,

and in all circumstances. For health, feature and investigative journalists, or general assignment ones who want to dig deeper, more detailed information, discussion and resources can be found on the Mindset website.

Seventy per cent of diagnosed mental health disorders are first observed in childhood or adolescence - times when the still-developing brain leaves many young people vulnerable and confused by society's mixed messages. Social, financial and identity issues contribute to the increased mental turmoil with which today's adolescents contend. Growing up was never easy, but children now are learning to find their feet in a more bewildering world than ever before.

VOICES, AGENCY & CONSENT

Journalists should include the voices of children and youth in their stories but must adjust their approach and interviewing techniques appropriately. Hearing directly from young people makes for more powerful and compelling journalism. Knowing

"Youth do want to speak up. We just don't know when and we don't know how."

Loizza Aquino, mental health activist (at age 19).

they are being heard can help to relieve young people's frustration and emotional distress.

But vulnerability cannot be overlooked. When time permits, consider consulting with community mental health workers about potential interview choices. In any case, getting informed consent for an interview needs to be explicit, the more so as the possibility of negative consequences rises.

Judgement is required to determine whether circumstances warrant obtaining parental consent to interview a young person. In Canada, there is no legal requirement to do so. Some guidelines that follow academic research or medical practice specify that parental consent is required before interviewing any minor. That, however, takes no account of the realities of daily journalism or of journalism's primary focus on public interest. Journalists nevertheless should act ethically, minimizing harm as much as possible within their role.

The dilemma is well expressed in CBC Policy: "Children and youth do not necessarily have the experience to weigh the consequences of publication of their statements. They nevertheless enjoy freedom of expression and the right to information. Their realities and concerns cannot be fully reflected without being heard in our reporting."

Some parents could block an interview for reasons that are opposed to a child's best interests. It can also be very frustrating to a young person to be told that their voice cannot be heard without someone else's consent. In difficult cases, a solution could be to do the interview without parental consent, but withhold the young person's identity.

In obtaining consent from a minor who will be identified, make sure they understand that some of what they say may be

published or broadcast; that not everything they say will be; and that other people may be interviewed as well to corroborate or dispute what they say.

Remember that proper consent is based on a reasonable understanding of the potential consequences of one's actions. That requires, by definition, the ability to anticipate and weigh outcomes in the future. The undeveloped frontal lobe in children, adolescents and even early adults (particularly in males) makes it very difficult, if not impossible, for them to accurately foresee and adequately understand the impact of their actions. In a world in which what is reported is more universally accessible and durable than ever, reporters and editors have a moral duty to consider disguising the identity of minors whose admissions could come back later to ruin their lives.

A degree of power-sharing can build trust and lead to more insightful reporting in the public interest and the interest of the child. With appropriate editorial line agreement, it may also be acceptable to ease the general rule that interviewees are not permitted to vet stories before broadcast or publication. Where a young interviewee has been traumatized or upset, for example, a reporter might go over a draft of the story with them for the purpose of clarifying facts, making it clear this does not grant them a veto or control of how the story is presented. Such decisions should be made on a case-by-case basis. Go to the Mindset website for further exploration of these important issues.

INTERVIEWING TECHNIQUE

Best practice already calls for journalists to adjust their interviewing style when the person is traumatized or vulnerable. Doing so yields better results and also reduces potential harm.

"Go in with an open mind and authentic commitment to engaging and understanding what's going to be helpful in this context, given the potential risks but also the potential benefits."

Dr. Joanna Henderson, CAMH & University of Toronto; Executive Director, Youth Wellness Hubs Ontario

Remember that every story is unique to those involved, even if at first it seems similar to others you have covered. Avoiding stereotypical story framing starts with recognizing the individuality of the people you ask to help you understand and convey it, especially if they are children.

A young person being approached for an interview should never be made to feel pressure to comply. Reporters who explain why they think an interview would be helpful and then make it clear that it's the young person's right to decide whether to agree will have taken an important first step towards establishing trust. Once an interview is agreed, the reporter should offer to conduct it in a quiet place nearby if circumstances permit, and make clear that the subject can decline to answer any question that makes them uncomfortable.

The interview should not begin without either making it clear that the subject will not see the story before publication or broadcast, or being explicit about the terms of pre-publication access. Transparency here might derail the interview, but that risk is warranted because of the naïveté and vulnerability of young people in these circumstances. For further discussion and background, go to the Mindset website.

Questions generally should be "open-ended" – helping to move the narrative along without implying an expected answer or a binary choice. In TV and radio interviews in which brevity is necessary, it is sometimes best to allow the story to unfold in whatever order the interviewee feels comfortable with, after which they can be asked to summarize parts of it more succinctly

"It's not our story, it's their story. Maybe we need to listen more and ask fewer questions in a way, and be less directive, because these kids are thinking and they're powerful and they're insightful. And they don't always know what they need, but they need something and they're asking for help. And I think if we start thinking about us as a way of communicating what they need, and then demanding answers and services and accountability from other people, maybe that's how we can change our reporting a little bit."

Karen Pauls,
National Reporter, CBC News

if necessary, still in their own words. The old adage that the first telling is always the best may not hold when the interviewee is young and feels under pressure. Keep the length of the interview appropriate to the person's age. If circumstances require a longer interview with a young person, allow breaks.

In all of this, remember that you are a journalist and not a social worker. You should not become involved in trying to resolve an individual's situation directly. If you have concerns, contact social authorities and let them handle it.

BEWARE OF TRIVIALIZATION

Serious as some situations are for young people, it is unhelpful if media reports paint virtually all of them as having major mental health issues. When minor stresses are generalized and treated as dramatically as serious concerns, young people may find it harder to reach out for the help they need, feeling that if everyone is in the same boat, they should be able to handle their problems alone. Journalists should recognize that exaggeration can be as harmful as indifference. If in doubt, consult a mental health professional in the community to put the story in context.

BEWARE OF REPEATING WHAT 'EVERYONE KNOWS'

When reporting about young people and their mental health we need to be especially wary of echoing common assumptions. Social media use, for example, is widely assumed to contribute to young people's mental health problems. But scientific studies have been found it to have both positive and negative influences on them, with frequency and quality of use emerging as key factors, rather than total screen time. Similarly, playing online videogames – often popularly associated with antisocial outcomes – has been found to improve

concentration skills. Check the Mindset website for updates on the latest research findings.

PHOTOGRAPHS AND IDENTIFICATION

There are circumstances in which it is simply not practical to try to obtain consent before taking photographs of children and youth – an obvious example being a school shooting in which children stream out with their hands up. Young people taking part in a public march or demonstration would be another. It should nevertheless be normal practice to obtain consent in less dynamic situations when mental health is an issue.

Using photographs posted on social media sites by minors can have legal consequences, unless attribution is made and permission obtained. An exception to the latter may be using a photograph of themselves posted by a minor with public access, but it is always better to ask.

Using a photograph of a minor posted by someone else, even in a public setting, should not be done without careful consideration of any risk to the subject. Photographs posted in circumstances involving bullying should not normally be used, unless no more harm can be done to the victim and the picture has clear deterrence value.

There are also circumstances under which identification of minors is prohibited under provisions of the federal *Youth Criminal Justice Act* (YCJA), the *Criminal Code* or provincial/territorial legislation such as Ontario's *Provincial Offences Act*, *Mental Health Act* and *Child and Family Services Act*. Courts can also issue publication bans on identification in civil cases.

The YCJA prohibition on identification extends to young witnesses and victims of crimes alleged to have been committed

> *"Kids aren't born resilient. Resilience is something that we build up over time, by going through difficult circumstances, by coming through it and understanding who our people are, who's got my back, where can I turn for support?"*
>
> Ainsley Krone, Deputy Manitoba Advocate for Children and Youth

by a person under the age of 18, as well as to the alleged perpetrator. There are exceptions, including one that, in cases where a young victim or witness has died, allows parents to agree to the publication of their child's identity. Legal advice is recommended when any of these situations arises.

RESILIENCE AND HOPE

Stories about resilience and hope are important and are a helpful part of accurately covering the mental health of young people. News of steps towards alleviation of a problem is as important as reporting on the problem itself. Such developments and initiatives should be reported, and tested critically, remembering to include young people's perspectives. Many young people who find themselves in emotional difficulties do in fact find ways to make the moment pass, alone or with help. Journalists can help by mentioning this in their

stories, without implying fault of the part of those who have not yet done so. Adding information about where to turn if readers are feeling overwhelmed or suicidal is also good practice.

MULTIPLE SUICIDES

If suicide or potential suicide features in your story, please also refer to the suicide chapter in this guide. Be aware that suicide contagion and suicide clusters are not the same phenomenon. Clusters – which may be more likely to occur among young people – are differentiated by the fact that those involved were connected to one another before the first suicide or attempted suicide occurred. Such groups, whether gathered in person or through social media, often form around a shared vulnerability.

Contagion is a term properly applied to copy-cat suicides among people with no previous personal connection to the trigger or to one another. They are assumed to have learned about the initial death through news reports, social or entertainment media or by word of mouth. Much deeper consideration of this phenomenon and its varied implications for journalism is contained in the suicide chapter.

Members of a group within which a suicide cluster forms usually do not need the media to tell them that a death has occurred. Yet the possibility of contagion outside such groups must also be considered, with care also taken not to present the deaths as a solution to problems or to detail methods used.

INDIGENOUS YOUTH

If your story concerns young Indigenous people, be sure to read chapter 8, Mental Illness Among Indigenous Peoples of Canada, which debunks stereotypes and explores why

Indigenous Peoples suffer disproportionately (but not uniformly) from mental illness compared with the Canadian population as a whole.

INVESTIGATIVE WORK

There is an honourable place in every branch of journalism for investigative work that seeks to bring abuses or failings to light and to hold people, institutions or systems accountable. In investigative work involving the mental health of young people, the balance between public and private considerations may sometimes need adjustment. General guidelines intended to protect children should never be used to try to block or inhibit such enquiries. Equally, journalists should do all they can to minimize collateral damage, short of rendering the reporting ineffective.

CHECKLISTS

- ✓ **Do** act ethically, reducing potential harm as much as possible within journalism's legitimate role.
- ✓ **Do** include the voices of children, youth and young adults in stories about them.
- ✓ **Do** consult appropriate professionals to help establish the context and significance of the story.
- ✓ **Do** explain clearly why an interview is needed, how it will be used and that the young person has a right to decline.
- ✓ **Do** take into account the inherent vulnerability of children and youth due to stages of brain development.
- ✓ **Do** include discussion of possible consequences when obtaining consent for interviews from young people.
- ✓ **Do** obtain additional parental consent when appropriate and circumstances permit.
- ✓ **Do** adjust interviewing technique to the circumstances, avoiding leading questions.
- ✓ **Do** keep interview length age-appropriate, providing breaks if necessary.
- ✓ **Do** consider relaxing protocols to give a traumatized young person some share in editorial control.
- ✓ **Do** include appropriate mention of resilience and hope, action being taken to alleviate problems and local resources for young people in emotional difficulties.

➤ CHECKLISTS

- ✓ **Don't** pressure young people to give interviews.
- ✓ **Don't** focus stories on shocking aspects alone. 'Trauma porn' is lessened when reporters dig deeper.
- ✓ **Don't** frame stories stereotypically.
- ✓ **Don't** rely on common assumptions about the influence of social media, video games, social, financial or gender issues – seek facts.
- ✓ **Don't** exaggerate minor concerns, which can make some young people feel they must solve their problems without help because 'being in emotional trouble is normal'.
- ✓ **Don't** cross the line between journalism and social work by direct intervention.
- ✓ **Don't** concede editorial control to professionals or organizations consulted for advice.
- ✓ **Don't** breach legal requirements regarding identification of minors, including as witnesses, in certain circumstances.

IF YOU WANT TO...

Delve deeper into issues raised in this guide

Consider other journalists' thoughts and first-hand experience

Hear the views of suicide prevention and mental health specialists

Follow pertinent case studies

Start or join a discussion

Find useful contacts

GO TO OUR WEBSITE: www.mindset-mediaguide.ca

QUICK REFERENCE COMPENDIUM

BEST PRACTICE CHECKLIST

- ✓ Don't reinforce stereotypes (especially in headlines).
- ✓ If violence is involved, put it in context: Violence by people with mental illness is rare.
- ✓ Don't imply all people with schizophrenia are violent.
- ✓ Avoid referring to people with schizophrenia as "schizophrenics". Generally speaking, labeling someone by the name of their disease is not a good idea.
- ✓ Strive to include quotes from those affected or others like them.
- ✓ Be careful and specific about diagnoses.
- ✓ Include professional comment / seek professional advice when needed.

QUICK REFERENCE COMPENDIUM

INTERVIEWING DOS AND DON'TS

- ✓ **Do** talk to people who have mental disorders and include what they say in your stories.
- ✓ **Do** remember these are people who naturally deserve respect.
- ✓ **Do** demonstrate empathy, ask open-ended questions.
- ✓ **Do** ensure the person understands the implications of being interviewed and gives informed consent.

- ✓ **Don't** re-traumatize by pushing too hard.
- ✓ **Don't** interview people when they are out of touch with reality or psychopathic.
- ✓ **Don't** be scared: Outside those rare conditions, people with mental disorders are harmless.
- ✓ **Don't** assume you know how the person feels or thinks.
- ✓ **Don't** imply their illness is incurable.

QUICK REFERENCE COMPENDIUM

REVIEW BOARD HEARING BEST PRACTICE CHECKLIST

- ✓ Be clear that the patient is not a criminal.
- ✓ A review hearing is not a re-trial: Focus your story on rehabilitation, not vengeance.
- ✓ Check the 'facts' contained in statements made outside the hearing.
- ✓ Carefully consider the fairness of relaying characterizations of the patient made outside the hearing.
- ✓ Don't reproduce offensive language that casts stigma on people who are mentally ill unless it is critical to the story.
- ✓ Consider doing a more in-depth follow-up story which may generate more light than heat.
- ✓ Editors should review this checklist before writing headlines.

QUICK REFERENCE COMPENDIUM

SUICIDE DOS AND DON'TS

- ✓ **Do** write about suicide, but do it responsibly.
- ✓ **Do** consider whether this particular death is newsworthy.
- ✓ **Do** look for links to broader social issues.
- ✓ **Do** respect the privacy and grief of family or other 'survivors'.
- ✓ **Do** include their suffering.
- ✓ **Do** tell others considering suicide how they can get help.
- ✓ **Do** present suicide as mainly arising from treatable mental illness, thus preventable.

- ✓ **Don't** romanticize the act or characterize it as a solution to problems.
- ✓ **Don't** go into details about the method used.
- ✓ **Don't** accept single-reason explanations uncritically. The reasons why people kill themselves are usually complex, with multiple factors interacting.
- ✓ **Don't** publish suicide notes without compelling public interest justification and due concern for families..
- ✓ **Don't** automatically mention suicide in every story you do about mental health.

QUICK REFERENCE COMPENDIUM

SUICIDE LANGUAGE

- ✓ **Do** use plain words. Say the person 'died by suicide' or 'took their own life.' 'Completed suicide' is jargon, best avoided.

- ✓ **Don't** say a person 'committed suicide'. This outdated expression, linking suicide with illegality or moral failing, can make it harder for others to seek help, or for families to recover.
- ✓ **Don't** frame suicide as an achievement by calling it 'successful' or attempted suicide 'unsuccessful'.
- ✓ **Don't** use or quote pejorative expressions such as 'the coward's way out', which reinforce stigma.

ADDICTIONS CHECKLIST

- ✓ **Addiction results from physical changes in the brain, and is considered a mental disorder.**
- ✓ **Addiction may co-exist with other mental disorders.**
- ✓ **Addiction can also be associated with hereditary and social factors.**
- ✓ **People with addictions are ill: Respect the person, understand the behaviour, use person-first language.**
- ✓ **Stigmatizing people with addictions can adversely affect their prognosis.**

QUICK REFERENCE COMPENDIUM

MENTAL ILLNESS AMONG INDIGENOUS PEOPLES

- ✓ Get to know Indigenous people.
- ✓ Appreciate diversity among Indigenous communities.
- ✓ Avoid stereotypical story frames and assumptions.
- ✓ Focus on underlying systemic problems.
- ✓ Appreciate the impact of intergenerational trauma.
- ✓ Recognize the importance of traditional culture to self-determination and emotional resilience.

QUICK REFERENCE COMPENDIUM

YOUNG PEOPLE CHECKLISTS

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www.mindset-mediaguide.ca
More detail and discussion may be found on the same website.

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