

RESPONSIBLE REPORTING ON MENTAL HEALTH, MENTAL ILLNESS & DEATH BY SUICIDE

A practical guide for Journalists by the National Union of Journalists



NEW EDITION FEATURING:

SOCIAL MEDIA GUIDE. REPORTING ON THE STATE HOSPITAL, CARSTAIRS. INTERVIEWING PEOPLE WHO HAVE BEEN BEREAVED BY SUICIDE



Dos and Don'ts when reporting issues or news about mental health, mental ill health and deaths by suicide

Do

- Report mental health, mental ill health and death by suicide sensitively
- Ensure you use correct diagnosis where appropriate
- Use medical terms correctly
- Focus on help, support and treatments
- Offer contact details such as helplines

Don't

- Use derogatory language
- Stigmatise mental health and mental illness
- Assume link between mental illness and violence
- Dismiss mental illness as a fad
- Discriminate against those with mental illnesses
- Glamourise or sensationalise
- Use colloquialisms such as:-
 - ‘happy pills’ for anti-depressants
 - ‘cocktail’ of drugs for overdose
 - ‘shrink’ for psychiatrist

When reporting deaths by suicide, don't

- Provide details of method or location, including photos
- Sensationalise
- Glorify or romanticise
- Speculate
- Distort
- Invent

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Standfirst...

We in the media carry an enormous responsibility to deal with certain issues in a sensitive and thoughtful way. With support from the Scottish Government this guide to reporting mental health, mental illness and death by suicide is the latest to be produced to help with that responsibility and to make you think about your own mental health. Since the first guide was produced, there has been a vast improvement in how journalists report mental health and deaths by suicide. However there are still lessons to be learned as certain recent events have shown. Public attitudes to mental illness have also improved vastly and nowadays the public are not slow to protest when mental health issues are presented inappropriately in the media or elsewhere.

The link between violence and mental health still tends to be exaggerated on occasion and the use of derogatory language, while reducing, can still be problematic. Terms as derogatory as 'nutter', 'maniac' or 'schizo' would be unthinkable in relation to race or physical disability. This type of media reporting often has a negative effect on people with mental health problems. Similarly, journalists reporting on patients of the State Hospital at Carstairs should remember it is a hospital, not a prison, and those being assessed or treated are patients, not prisoners.

Well-respected NUJ member Derek Masterton's powerful and eloquent first-person account of the toll depression can take, and how indiscriminate it can be, is a lesson we should take on board. You can read Derek's account on page 20 and 21.

There is no excuse for ignorance in reporting mental health issues or suicide when the information in this guide is before you. It is the nature of the environment in which we work that we can sometimes be numbed to the desperate circumstances people find themselves in and the impact that the language we use can have on those affected.

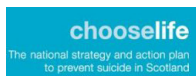
The NUJ is committed to the highest professional and ethical reporting standards, particularly in regard to the most vulnerable and exposed members of society. Indeed, it is at the core of our Code of Conduct. It is not political correctness or censorship; it is about maintaining journalistic standards but also a matter of basic humanity.

Media workers in their presentation of events can make a difference. We hope this guide will make it for the better.

The NUJ Scotland would like to thank the **Scottish Government, Choose Life** national programme at NHS Health Scotland, **see me** and **Samaritans** for supporting the development and production of this guide.

PAUL HOLLERAN NUJ Scottish organiser

With grateful thanks to Claire Walker, Fiona Davidson and Sallyanne Duncan for their contributions to this guide



Intro...

These guidelines have been written to assist you in your pursuit of fair and accurate reporting. They are not intended to hector or constrain you as a journalist. They concern those things writers and broadcasters hold dear: language and imagery. These guidelines should be read in conjunction with Samaritans' Media Guidelines for Reporting Suicide and supplementary factsheets. These can be found at: www.samaritans.org



Mental health problems can affect anyone – and that includes you and your colleagues. Your mental health is precious, so look after it as assiduously as you would your physical health. If you are putting together a piece on any aspect of mental health (it is a rich source of feature material), before you even begin your research, stop for a minute and think. Think about your own mental health; think about people you know who have experienced mental health difficulties. Think about your readers, viewers or listeners who have mental health issues. One in four adults experience mental health problems at some stage in their lives: that's a sizeable chunk of your audience. It is also a quarter of your colleagues.

The reporting of suicide requires extremely sensitive handling. There is an extensive section on the subject in this guide. It is not only the use of language in this context, but the content too. Evidence suggests that when method or means are depicted this can motivate further copycat suicides.

If you consider all of these things before you begin your story then the likelihood of you inadvertently offending people – and worse, far worse, deepening their distress and hampering their recovery – will be reduced.

This resource has been put together to help you extend your knowledge of mental health issues and provide a comprehensive selection of contacts that can help you with your story. Or if you are feeling emotionally vulnerable, or know someone who is, they will help you too.

All comment on this guide is welcomed. Or if you would like the NUJ to come to your place of work to discuss its contents, then contact:

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The role of the media:

There is an established link between mental illness and suicide, and between media reporting and suicide. More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of vulnerable individuals dying by suicide. The magnitude of the increase is related to the amount, duration and prominence of coverage. Covering mental health, mental illness and death by suicide positively, even briefly, can change public misperceptions and correct myths, which can encourage those who are vulnerable or at risk to seek help. Research has also shown that young people often get their information on suicide from the media, and high profile cases of suicide can sometimes lead to copycat effects. The World Health Organisation has recommended toning down media reports as one of its six broad approaches to suicide prevention.

Understanding terminology

Mental health difficulties arise when a problem, life event or situation, disrupts the way we think and feel. This can either be temporary – for example, following bereavement – or be more enduring. Mental health issues can come about because someone is suffering stress, constant worrying, deep-seated or chronic unhappiness, loneliness, lack of self-esteem, an inability or lack of resilience in dealing confidently with adverse life events or circumstances, or an inability to build and maintain healthy relationships.

The term mental illness is generally used to describe the medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning. The changes need to be bad enough to affect how the person operates or to cause distress to them or to other people. 'Mental health problem' is often used to describe conditions seen as less serious and as distinct from severe and enduring mental illness. Mental health problems (e.g. mild depression or mild anxiety) are more common, are usually less severe and of a shorter duration than mental illnesses but may develop into a mental illness.

Mental illness refers to a diagnosable illness that significantly interferes with a person's cognitive, emotional or behavioural functioning, and may affect the way they interact with others. The more common mental illnesses are depression, postnatal depression, severe anxiety, schizophrenia, bi-polar affective disorder, obsessive compulsive disorder, eating disorders, drug and alcohol addiction and dementia (organic illness). Personality disorders typically emerge in adolescence and can continue into adulthood. They can be associated with genetic and family factors. Experiences of distress or fear during childhood, such as neglect or abuse, are

common. When severe, personality disorders can impact upon relationships and day to day functioning. Various types are described by psychiatrists, for example dissociative, emotionally unstable, and dependent personality disorders.

If a person has always had a problem in their thinking, feeling or behaviour, then this is not usually called mental illness. It may then be called a developmental problem.

Mental illnesses are usually defined medically by using internationally recognised classifications such as the World Health Organisation's International Classification of Diseases version 10 (ICD-10). However, terminology can still vary across professions and cultures. More definitions can be found on the wellscotland website at www.wellscotland.info/about

The jury is still out regarding the nature versus nurture debate on whether we are born with a genetic disposition towards mental health problems or that our environment causes them. Equally, depression is not about feeling down or having an 'off' day. It is a living torture to those experiencing it and it can be fatal – in the form of suicide risk. It is impossible for a person experiencing depression to 'pull themselves together'. If you have never experienced it yourself, talk to someone who has. Besides medication, behavioural and talking treatments (such as counselling and psychotherapy), the response of family, friends, colleagues and society at large is a crucial factor in how, if and when someone with a mental health problem makes a recovery.

Many people who have experienced mental distress say the discrimination and stigma they faced was worse than the mental health problem itself. How damning is that? You, as a journalist, are well aware of the role the print and broadcast media has in shaping people's attitudes – and of the responsibility you carry because of that.

Responsible reporting of mental health

Reporting mental illness and mental health issues presents many challenges for journalists such as limited time to research complex issues, difficulties in finding people with mental health issues or their families who are willing to be interviewed or trying to distil intricate information into the constraints of a news story by deadline.

As well as being aware of guidance in codes of conduct like the NUJ code and making sure you have access to the most reliable information by consulting mental health experts, you might find some of the following points helpful.

Language

As writers we place accuracy pretty high on our priority list, if not at the top. Selecting just the right word to convey meaning is always at the forefront of the journalistic mind, even when the deadline is pressing. Language is all – as you know. So here are some signposts on the use of terminology when reporting on mental health matters. Obviously, no intelligent, responsible journalist would use words like ‘psycho’, ‘loony’, ‘nutter’, ‘madman’, ‘schizo’ or ‘bonkers’ to describe someone with mental health problems. But there are a few more traps for the unwary.

For example, people are discharged from psychiatric hospitals, not ‘released’. They have not been in jail. They are sent to hospital for treatment not punishment.

In the rare instances where someone with a mental health problem or mental illness commits a crime, it is important to recognise that the mental health problem or mental illness may have played a major role in their offence. A civilised society should not punish people for being mentally ill.

Bear in mind that many people experiencing mental distress delay seeking help because they are frightened of what they are experiencing and fear stigma and discrimination. You can help to reduce the stigma through the careful choice of words and encourage people to seek help early. For example, try to avoid writing ‘the mentally-ill’. It is better to use mental health patients or people with mental health problems.

Avoid defining people by their mental health problem as in ‘he’s a depressive’ or ‘she’s a schizophrenic’. The mental health problem is only an element of that person’s life and this kind of reductionism is regarded as narrow and stigmatising. It would be better to say ‘she has schizophrenia’ or ‘he has depression’, or ‘a person with’ which is clear, accurate and preferable to ‘a person suffering from’. Also, referring to someone with a mental illness as a ‘victim’ or ‘afflicted by’ a mental illness is outdated and should be avoided.

There is still a great deal of confusion between the terms ‘psychosis’ and ‘psychopath’. Psychosis means a severe mental disorder typified by radical changes in personality in which thoughts and emotions are so impaired at times that the person can lose contact with reality. Psychosis is triggered by other mental or physical conditions, or as a result of alcohol or drug misuse. Psychosis is an acute, short-term condition that, if treated, can often lead to a full recovery. A psychopath is considered to have a severe form of personality disorder, who can pose a threat to others as he/she can be violent. However most people with psychosis are usually only a threat to themselves. Care should be taken when using these terms. In the mind of the general public, the term ‘psychopath’ is frequently associated with violence. Only a sub-group of individuals who meet the ICD-10 based diagnosis of severe dissocial

personality disorder would also meet criteria for psychopathy. Psychopath is not a term in frequent use by mental health professionals, so best just to avoid it.

Australian media guidelines, *Reporting suicide and mental illness, a Mindframe resource for media professionals* (2011), state that the term mental illness covers a wide range of symptoms, conditions, and effects on people’s lives. They suggest journalists should be careful not to imply that all mental illnesses are the same and that they should make sure medical terms are used correctly. For example, a person who is down or unhappy is not the same as someone experiencing clinical depression.

They also advise avoiding the use of colloquialisms in place of accurate terminology for treatments of mental illness, such as ‘happy pills’ for antidepressants and ‘shrinks’ to refer to psychiatrists or psychologists.

If in doubt, contact the ‘see me’ anti-stigma mental health programme at www.seemescotland.org

The logo for 'see me' features the words 'see me' in a bold, orange, sans-serif font. To the right of the text are three small orange circles of varying sizes, arranged in a slightly descending line from left to right.

Violence and negative portrayals

There is a popular misconception that links mental health problems or mental illness with violence in the minds of the general public. Think Jack Nicholson in *The Shining*. The facts, however, do not bear out these lurid imaginings. People with mental health problems are overwhelmingly more likely to harm themselves than others. For instance, people diagnosed with schizophrenia are 100 times more dangerous to themselves than to others.

Also, fear of mental illness is often based on the notion that those with mental health problems will attack people at random when in actual fact you are thirteen times more likely to be killed by a stranger without mental health problems than by someone who has a mental health problem. Research has shown that the majority of people (63%) believed that mental illness was associated with violence. More worryingly, two thirds of them quoted the media as the source of their beliefs. Even the interviewees who knew people with mental health problems and knew them

not to be violent believed the negative media portrayals rather than the evidence of their own eyes. The 'see me' programme says it is important that journalists contextualise the facts when their stories highlight mental illness as being a factor in a violent crime.

Reporting on The State Hospital, Carstairs

When reporting on The State Hospital at Carstairs we would like to remind you that:

- The State Hospital provides assessment, treatment and care in conditions of special security for individuals with mental disorder who, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting.
- The hospital should be referred to as The State Hospital at Carstairs and not just Carstairs.
- This State Hospital is a Special Health Board as part of the NHS in Scotland, and as such shares the same values, aims and challenges as the rest of NHS Scotland.
- The State Hospital is unique because it has the dual responsibility of caring for very ill, detained patients as well as protecting them, the public and staff from harm.
- The State Hospital is not a prison and has no prisoners. It is a high security hospital for NHS patients detained under mental health law.
- Not all patients have been convicted of an offence, but those without formal convictions will have displayed seriously aggressive behaviours, including physical and sexual aggression.
- Patients are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 and have the same entitlements under The Patient Rights (Scotland) Act 2011 as anyone else.
- You should refrain from using language such as 'inmates', 'jail', 'cell', 'caged', 'monsters', 'axe-men', 'nutters', 'basket cases', 'schizo' etc. These terms not only provoke negative reactions but mistakenly lead the public into believing that The

State Hospital is like a prison thus implying that patients are so dangerous that they have to be kept locked up.

- Sensationalist reporting also reinforces the myth that all people with mental illness are violent or a risk to the general public, when in reality people with mental illness are more likely to be victims of crime than perpetrators. This type of reporting can cause distress to patients and their families by interfering detrimentally with their care and treatment, while simultaneously creating a climate of public fear, stigmatisation and rejection.
- Images that might reinforce negative myths about the hospital and/or its patients should not be used.

Focus on treatable causes

Some mental illnesses are treatable and it is important that you make this clear when you're reporting because it can enable you to take a more positive angle on your story. For example depression is treatable, but in about 50% of cases, major depressions still go untreated. Media reporting can help by providing accurate information and advice about recovery.

Focussing on treatable causes can help you contextualise the facts of the story and provide important background for vulnerable people who are worried about their own mental health or the health of a loved one. However, you need to be sure you've got your facts right so try to consult an expert on mental illness and mental health care to include their advice in your reporting. There's a list of experts and organisations at the end of this resource that might be able to help.

It is also useful if you can add information about support organisations including helplines' contact details, local services and websites. However, these need to be relevant to the story, for example if the story is about depression try Action on Depression.

Reporting on self-harm

Self-harm is misunderstood by many people and those who self-harm are often portrayed as weak, attention-seekers. It is important, therefore, that you don't perpetuate myths and avoid suggesting that those who self-harm do so to manipulate people, to feign suicide or because they are part of a subculture. Also, you should avoid glamourising or sensationalising self-harming behaviour or

referring to it as a 'fad' as this can prevent people from seeking help. It can also encourage copycat behaviour.

Self-harm can be described as a physical symptom of internal distress. That is, the majority of people who self-harm do so as a way of coping with their distress. The underlying causes of this distress are complicated and may range from experiences of child sexual abuse to financial worries. The focus for any professional - journalist or otherwise – should be on the person and the underlying causes of the self-harm rather than the behaviour. However, describing any self-harm acts, such as 'cutting to relieve internal pain' or to 'feel in control' can influence others to see self-harm as a suitable means of managing emotional stress if not set within a proper context. Any discussion about these types of 'coping strategies' should only be mentioned in the context of seeking help and harm-minimisation.

Using judgemental terms such as 'cutters' or 'self-harmers' can also lead to their alienation and could lead to people avoiding seeking help. As discussed above the correct terminology should focus on the person, such as 'a person who self-harms' or 'a person with lived-experience of self-harm'.

It is also important to avoid using sensational imagery regarding self-harm as this, too, can encourage vulnerable people to see self-harm as a way of managing emotional stress.

Contact an expert for the best information and advice or research the websites of organisations like Breathing Space or Penumbra, the charity that provides support for young people and adults who self-harm.

Responsible reporting of suicide

"For the journalist, a death by suicide presents a difficult dilemma. As suicide is an issue of concern to the public, it is clearly the responsibility of the reporter to present the facts as they happen, without glamourising the story or imposing on the grief of those affected." - Simon Armson, former chief executive, in his introduction to the first edition of Samaritans' guidelines on reporting of suicide. Indeed there can be a positive aspect to reporting suicide, as debate may help to de-stigmatise the subject. However, some research shows that inappropriate reporting or depiction can lead to 'copycat suicides'.

The chances are that at some time in your career you will have to report on a death by suicide. Sadly, the chances in your lifetime of someone you know dying by suicide – or trying to – are frighteningly high. Reporting suicide requires sensitivity and compassion. It is therefore important you are aware that how you report suicide can have a direct effect on vulnerable people. Irresponsible reporting can

potentially cause copycat suicides: the words used can be damaging; referring to the method and location is dangerous; providing excessive detail of the method used goes against media guidelines; and romanticising the story or ill-thought out use of pictures can also cause huge problems.

Reports about suicide can be in the public interest, for example they can provide vital information that can help educate the public, so they should be based on the most reliable information. Gathering the views of health experts, researchers into suicide and self-harm and relevant community leaders can assist with this.

The following sections provide you with information that you might find helpful in reporting suicide responsibly.

Copycat suicides/contagion

Numerous research studies worldwide conclude that media reporting of suicide can lead to copycat behaviour and that certain newspaper coverage is associated with a significant increase in the rate of suicide. This risk is increased "if the coverage is extensive, prominent, sensational, or explicitly describes the method". (Source – World Health Organization Preventing Suicide – A Resource for Media Professionals (2008)) The effect on the suicide rate depends on the amount, duration, and prominence of media coverage. For example, there tends to be an increase in deaths following the appearance of suicide stories, but a decrease when the media stop reporting or are prevented from reporting because of factors like newspaper strikes.

Reporting suicide can create a ripple effect that can lead to suicide 'contagion' or 'clustering'. This is where more completed or attempted suicides than would be expected statistically, occur close together in time and location. Untreated people who identify with someone who completes a suicide, for example, if they are being bullied, are more likely to imitate the act. Vulnerable, young people can be particularly affected by this. Contagion as a result of media reporting can also have a more powerful impact and affect more people than direct person-to-person contact so it is important that journalists exercise caution and sensitivity with particularly vulnerable groups. For example, an increase in suicides can occur when the number of stories about individual suicides increases and when a particular death is reported at length or in many stories.

There is strong evidence to suggest that the positioning/prominence of stories in the newspaper can have a direct effect on the scale of the increase in suicidal behaviour. Copycat incidents are more likely when the story appears on the front page, has a large headline, and is heavily publicised. However, it is less clear what types of content can have a detrimental effect. Some evidence suggests that celebrity suicides,

particularly when they are on the front page, can lead to copycat incidents. Other research indicates that non-celebrity stories also have a significant impact, although to a lesser extent, if they receive enough publicity.

Language

How you use words can have great effect on the people who read your stories. Therefore, it is important that you choose your words carefully. Here are some pointers.

Don't describe a suicide as 'successful' if someone dies, or 'unsuccessful', 'failed' or 'suicide bid' if it doesn't result in death. It is better to use the phrases 'died by suicide' when someone dies and 'attempted' or 'non-fatal attempt' when someone survives. You can also use phrases like 'completed suicide', 'took their own life', 'ended their own life', and 'a person at risk of suicide'.

Remember suicide is not a crime so it is inaccurate to use the word 'committed'. Describing someone as having 'committed suicide' reduces the person to the type of death or implies criminal or sinful behaviour. An alternative term is "died by suicide".

Also avoid these phrases: 'suicide victim', 'just a cry for help', 'suicide-prone person', or 'suicide tourist'.

Try not to use 'stop the spread' or 'epidemic of suicide' when reporting several suicides as this is alarmist and implies that suicide can spread like a disease. It also suggests a more dramatic, sudden increase than is generally the case. Referring to a rise in suicide rates is more accurate, if that is indeed the case. In the period 2000-02 to 2010-2012, the suicide rate in Scotland reduced by 18%.

Also, try not to use 'suicide' in a gratuitous manner such as in phrases like 'suicide mission' or 'political suicide' when you can use a more appropriate term.

Putting the word 'suicide' in the headline or referring to the cause of death as 'self-inflicted' increases the likelihood of copycat suicides and contagion so this should be avoided. It is better to place the cause of the death in the story rather than in the headline. Also, including it in the headline can make the story more attractive to vulnerable people by glamourising and normalising suicide.

When reporting deaths that are likely to have a great impact on readers, such as celebrity deaths or a death by suicide in a small community, think about using straightforward headlines such as 'Joe Bloggs dead at 46' which avoid sensationalism. Research shows that suicides increase when headlines about specific suicide deaths are dramatic such as 'Girl, 9 kills herself over cyber-bullying'. Deaths by suicide are

complicated and it is very unlikely that there is one single reason why someone has chosen to take their own life.

Method and location

Most media guidelines state that the method and location of suicide should not be described, displayed or photographed. This is because evidence shows that copycat suicides can result from detailed descriptions or depictions of the method. Where possible avoid disclosing the method of suicide – and there should generally be a public interest justification for doing so. Therefore, both journalists and editors face a twin test: they must both publish with sensitivity and avoid excessive detail. If it is important to the story try to use general terms only such as an overdose 'of drugs' rather than the specific medications, which should not be named. Be wary. No journalist wants to be responsible for a death – or deaths.

You should also be very cautious when reporting an unusual method as research indicates that other people may try it to take their own life after reading the story. It is safer not to state the method at all.

There are now sites on the internet that detail methods and means for people who wish to take their own lives. You would assume no paper would print the addresses of these. You would be wrong. Don't do it. Care should be taken not to inadvertently promote these websites and drive vulnerable people to the internet to research suicide methods by mentioning the detailed instructions they provide.

Reporting the location of suicides may lead to them becoming popular places for suicide attempts so you should be very careful not to portray these locations as 'suicide spots' and don't refer to them in your reporting as 'suicide hotspots'.

If it is necessary to refer to the location then try to do this in general terms instead of giving the exact location. For example, refer to the location as the Erskine Bridge and avoid using details such as its height or the actual place of the suicide, and do not use a photograph of the exact spot.

Sensationalism/romanticising suicide

While journalists want their audience to identify with the people in their stories, glorifying or romanticising suicide by including exaggerated community expressions of grief, regret or other comments that suggest the local community are honouring the act rather than mourning the person's death are best avoided. Reports that

idealise a person who has died by suicide might encourage others to identify with them and emulate their behaviour. **It is important to balance statements that praise the deceased with a more accurate picture of their situation by acknowledging that they may have been experiencing difficulties in their life.** If this is left out of the story then suicidal behaviour may seem attractive to others who are at risk, especially if they rarely receive positive reinforcement.

Special situations –

Youth suicide

The reporting of the death by suicide of a child or young person needs especially careful handling. Bear in mind that people bereaved by suicide are themselves at higher risk.

People who have suffered a death by suicide of a family member are vulnerable and working through grief and related issues – imagine if that family member was a child or young person. Also remember that the impact of a pupil's suicide will have a powerful effect on the staff and other pupils at the school. The risk of copycat suicide is very high at times like these. Evidence shows that media sensationalism or idealised obituaries of the deceased may contribute to this phenomenon. Try not to glorify the individual or present the suicidal behaviour as a legitimate strategy for coping with difficult situations.

It is probably best to wait for statements from the school or local authority. Approaching fellow pupils on their way to and from school is not only distasteful – it could be dangerous and contrary to codes of conduct. Again, avoid describing the method of suicide and avoid interrupting school as you may exacerbate what will inevitably be an already painful time.

The NUJ Code of Conduct states a journalist: 'does nothing to intrude into anybody's private life, grief or distress unless justified by overriding consideration of the public interest'. As with everything in journalism, there is a judgement call to be made here. For instance, in the North of Scotland a young boy took his own life. He hanged himself from a tree. Afterwards, the local community split: on one hand there were people who wanted to put a plaque on the tree in memory of the boy. On the other were members of the community who wanted the tree cut down, believing that young people would congregate around it and maybe copycat

suicides would result. That's a story. But what if your editor wanted to run a picture of the tree? It might encourage others to see it as a suitable place/method of suicide. Think about the consequences of running the story.

Celebrity cases

Care needs to be taken when reporting the death by suicide of a celebrity. Such deaths are newsworthy and reporting them can often be considered to be in the public interest. However, research suggests that because celebrities are admired their suicide can influence the behaviour of vulnerable people and can encourage copycat incidents. The possibility of identification with a celebrity is much greater. Glorifying their death may suggest that this is acceptable behaviour. It is also important to avoid portraying a celebrity's suicide as the tragic last act of an anti-hero which glorifies the act of suicide. Avoid describing the method of suicide. Instead, where possible, focus on the impact on those left behind and seek a comment on the wastefulness of the act. Speculation about the reason for them taking their own life can also be harmful. Also, including a helpline number in the story can encourage vulnerable people who may be affected by the death to seek help.

Murder-suicide

Although there is growing media interest in murder-suicide where a parent kills their children and/or their partner and then themselves, instances are rare in the UK and the number of cases has remained fairly constant for several years. For example, there are around five incidents a year in England and Wales, and just under half that number of deaths in Scotland. However, murder-suicide can have a pervasive effect on the family and community and insensitive media reporting may cause unnecessary harm to those left behind.

The parent/perpetrators are often described as devoted to their families, may be involved in a custody battle after a family break up and may be described as feeling a sense of powerlessness or despair. According to Samaritans, the reasons why someone chooses to murder others and to then take their own life are extremely complex. The academic literature available suggests that risk factors can include serious mental health problems and substance misuse.

When covering this type of story it is best to follow the general guidelines on suicide

reporting. There is evidence that poor media reporting can lead to copycat incidents so it is important to take a balanced approach and avoid speculation, distortion and invention. Watch the language you use too. Phrases like 'family wipeout' should definitely be avoided. Equally, sensational headlines can cause considerable harm to relatives and to the wider community.

Murder-suicide where the perpetrator is not related and might be unknown to the victims, such as school shootings, also attract media interest, and again care should be taken in reporting these stories particularly in the early stages of a breaking news story. Using information from social media without verification can result in inaccuracies and speculation which can be harmful to relatives and the community.

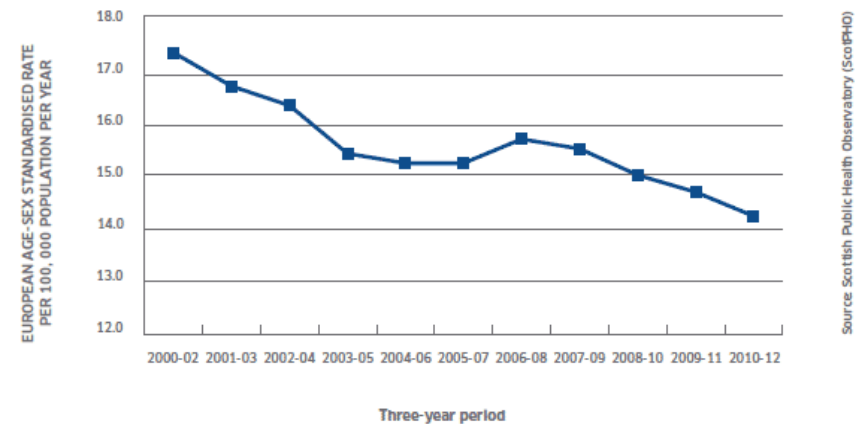
Suicide pacts

Suicide pacts – another rare type – are also covered extensively by the media. A suicide pact is a mutual agreement between two or more people to die at the same time and usually in the same place. They account for less than 1% of suicides in the Western world. Intensive media reporting can lead to contagion, particularly amongst adolescents, which could potentially result in clusters of suicides. However, not all incidents of contagion are suicide pacts because there may not have been a mutual agreement to complete suicide. Journalists should avoid simplifying the reason as being, for example, the act of loving individuals who do not wish to be separated and see no other way to be together. Research has shown that most pacts involve a coercive person and one who is particularly dependent.

Using pictures

As noted previously, do not use pictures of the location or site of a death by suicide as research shows that this can encourage imitation by people who are vulnerable, even though there might be a public interest reason. Using pictures of grieving relatives, school friends or teachers, local people expressing their grief, or a funeral or memorial can also encourage vulnerable individuals to consider suicide as a means of, for example, making bullies regret the hurt they caused. Additionally, placing pictures in a prominent position, such as the front page of a newspaper, can exaggerate the act of suicide. Always seek permission from relatives if you intend to use a picture of the deceased, including those from social media. (See section on Digital media reporting).

Scottish Suicide Rate



Reporting suicide rates and statistical information

Statistical information can be a key factor in reporting suicide stories - therefore it is important that you are aware of how these are calculated. Annual changes are based on relatively small numbers, so may not be statistically significant. It is conventional to pool rates over a three-year period, and develop three year rolling averages to account for yearly fluctuations. Annual data on suicide in Scotland are published by the General Register Office for Scotland at www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/suicides/index.html

Further analysis is published (also annually) by the Scottish Public Health Observatory http://www.scotpho.org.uk/home/Healthwell-beinganddisease/suicide/suicides_keypoints.asp

Suicide statistics usually combine two causes of death: those by intentional self-harm where it appears that someone intended to kill themselves and those by undetermined intent where there is insufficient evidence to indicate whether the deceased actually intended to kill themselves.

The Scottish Suicide Information Database (ScotSID) is a useful resource. It contains demographic information, including information on past contact with health services by people who have died by suicide, related health data, and will eventually (through inclusion of information from other data sources) provide details relating to the suicide incident

and individuals' wider social circumstances. It is intended that the information flowing from ScotSID will help inform future action on suicide prevention. The ScotSID reports are available at <http://www.isdscotland.org/Health-Topics/Public-Health/Publications/>

NB it is important to know which statistics release relates to your particular part of the UK. Statistics covering deaths by suicide in England and Wales are released at a different time of year than those in Scotland. Whilst there may be a rise in suicides in one part of the UK there may be a fall in another.

Social/digital media reporting

Journalists using content from social media and online sites should handle with care, particularly when dealing with mental health, mental illness and death by suicide. As a journalist you might be expected to take such material from publicly accessible online sites without the knowledge of bereaved relatives and friends, and although this may be legal (assuming there are no privacy, intellectual property e.g. copyright or other limitations), some people, particularly those at the centre of sensitive stories, might believe this is intrusive and wrong.

Journalists don't just take comments and pictures from these sites as a matter of course. Instead, they tend to use them to find sources who knew the deceased or to read tributes for research, with the aim of gaining access to the family.

That said, relatives are concerned about unauthorised use of social media material and worry that reporters could fail to check the accuracy of information if they don't contact the family. Other relatives and friends who decide to tell the story themselves through tribute sites would like to be warned if publications are going to use it in their stories.

Just because a profile is open to the public doesn't diminish the intrusion that bereaved relatives and friends might experience, giving rise to feelings of personal hurt, invasion, anger and disgust. Remember that those who are bereaved are themselves vulnerable and potentially at risk of suicide.

Use of pictures from social media sites is a common dilemma for journalists. One senior editor said there were three key issues: the privacy settings on the site, the appropriateness of any picture likely to be used, and the consent of the family. Journalists should always try to gain consent from the family for the use of such pictures to comply with media guidelines, he said. The very act of contacting the family gave some warning that a story with a picture was likely to appear.

So the bottom line is:-

1. seek the family's consent by involving them;
2. give them some control over the story by interviewing them; and
3. use the information they give you in the context that you have said you would use it.

Digital media reporting probably calls for greater vigilance because it is instantaneous. As a result, an explicit and insensitive suicide story could increase the risk of copycat suicides.

To reduce this risk and inform readers you should think about including hyperlinks to helpful websites that can offer support for those who may be affected by mental health issues and suicide. You can also build in key phrases, such as risk factors or depression, as links in your story to provide more information.

You should take particular care over user-generated comments. Some publications prefer not to allow readers to make comments on sensitive stories like suicide. Others have procedures to encourage safe comments and monitor these closely. Samaritans offer the following tips in their Media Guidelines for Reporting Suicide, available at www.samaritans.org



- Apply extra vigilance when using online sources for a story about a death by suicide. Speculation about a death or the circumstances surrounding a person dying can easily be misreported or wrongly repeated as fact. The instantaneous and 'viral' nature of information online makes it all the more important to double check the reliability and trustworthiness of online sources of information.
- Consider the impact on bereaved families and friends before using images from social networking sites to illustrate a story. Do the same before linking to an online video of, or about, the person who has died.

First person by journalist Derek Masterton



“I have experienced a mental illness”

It's not something to boast about. It's not something to wear like a badge of honour. But it's certainly NOT something to be ashamed of.

Even in these allegedly enlightened times, mental illness carries a stigma.

Too often it's regarded as a character defect, a weakness to be despised. Or the person is written off as a hopeless case, incapable of coherent thought or of leading a normal, useful life.

Well, forget the stereotypical picture of a dribbling idiot who should be banged up in a rubber-walled room in some dark, Victorian institution.

I was a 50-year-old national newspaper journalist with more than 30 years' experience, happily married with three healthy grown-up children and living in a very comfortable home in a West of Scotland seaside town when I became mentally ill.

That's not the typical profile of someone who experiences mental illness – because there is no typical profile. The simple fact is that mental illness can visit anyone. Government figures show that one in four people will experience mental illness at some time in their lives.

Who knows where, who knows when? And above all, who knows WHO?

The first time I visited a psychiatrist, I told her: 'I never thought of myself as the type of person this would happen to.'

She replied: 'And what sort of person do you think it should happen to?' My face was shut.

My problem was a depressive illness – I shan't go into the causes. I visited all the dark places that most people don't even realise exist. I contemplated suicide. But with the love and support of my family and close friends I survived and grew stronger. The proper medication and psychiatric and psychological treatment were vital for the next stage – the long climb back to feeling good again.

The hardest thing was admitting to myself that I had a mental illness. Telling others was out of the question. It was all about stigma – what other people would think of me. I suppose I was a victim of my own prejudice. Until that point, I had probably been as liable as anyone to pigeonhole and stereotype people as loonies or wimps who probably shouldn't be in the job in the first place.

So I lied. People I met while out walking found it odd that I wasn't at work. Was I alright? Of course, I just had a few days off. But as time wore on, the lie became unsustainable. So I withdrew. I didn't want to meet people. I didn't want to have to admit I was ill. Mentally.

Prejudice is born of ignorance or fear of something we don't understand. I doubt if anyone who hasn't experienced mental illness can really understand it. The causes are many and varied. We all have our triggers which, when pulled hard enough or often enough, can cause mental devastation.

Psychiatrists, psychologists, GPs, nurses, social workers, counsellors and medication all have vital roles to play in helping those who experience mental illness to recover. But every one of us can make a contribution. The only qualifications required are concern, humanity and compassion. Do not judge others. Don't write off colleagues as lost causes just because they are going through a bad patch that you can't understand. Offer support. A few kind words can be really helpful.

I'm lucky. My friends and colleagues and the National Union of Journalists were wonderfully supportive throughout my 15-month ordeal. I no longer feel stigmatised.

Will you be as lucky? I just pray you don't have to learn the lesson the hard way.



**1 in 4 of us will experience
mental ill-health**
**It's time for the stigma
to stop**

see me
LET'S STOP THE STIGMA OF MENTAL ILL-HEALTH
www.seemescotland.org

The facts, the myths and the law

Mental health facts

- Just over one in four (28%) people will experience a mental health problem at some point in their lives.
- Nearly two thirds (61%) of the population know someone close to them who has experience of mental ill-health.
- Up to two thirds of people will recover from long term mental health problems.
- The most commonly experienced mental health problems are depression, panic attacks, severe stress and anxiety disorder.
- Risk factors that can lead to mental health problems include negative life events such as relationship breakdown, disability, long-term illness, social isolation and exclusion, deprivation and inequality.
- Those diagnoses most likely to attract stigma are personality disorder, eating disorder, schizophrenia and obsessive-compulsive disorder (OCD). Self-harming behaviour can also attract stigma.
- Recovery from mental ill-health is helped by support from family members and friends.
- The percentage of the public who think that 'people with mental health problems are often dangerous' fell from 32% in 2002 to 19% in 2009 (Source "Well? What Do You Think" surveys (Scottish Government)). There are still public concerns about links between mental ill-health and public protection. 'see me' believe that these concerns are strongly related to negative media coverage.

Suicide facts

- Around one million people throughout the world die by suicide every year. That's one suicide every 40 seconds (Samaritans: Suicide: Facts and figures - Statistics Report 2013).
- More people die by suicide each year than by murder and war combined (Source: Samaritans Suicide: Facts and figures – Statistics Report 2013).
- In Scotland around two people die from suicide every day and those in the nation's most deprived areas have a suicide risk that is double the Scottish average (Source: chooselife.net).

- There were 762 deaths by suicide in Scotland in 2012 (Source: General Register Office (Scotland) www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/suicides/index.html).
- The suicide rate in Scotland reduced by 18% from the period 2000-2002 to the period 2010-12.

For more facts about suicide and its prevention in Scotland go to: <http://www.chooselife.net/Evidence/statisticssuicideinScotland.aspx>

In Scotland suicide is three times more common amongst men than for women. In 2012 this was 20 per 100,000 of the population for men compared to 7 per 100,000 for women. (Source: Scottish Public Health Observatory).

In Scotland, suicide is a leading cause of death among people under the age of 35 (Source ScotPHO August 2013).

In December 2013 the Scottish Government published a new Suicide Prevention Strategy 2013-2016 setting out five key themes – responding to people in distress, talking about suicide, improving the NHS response to suicide, developing the evidence base and supporting change and improvement – as part of its commitment to continue the downward trend in suicides (the suicide rate in Scotland reduced by 18% from the period 2000-2002 to the period 2010-12). The Strategy echoes key messages learned from practice and research that suicide is preventable, that it is everyone's business and that collaborative working is key to successful suicide prevention.



Myths about mental health

Myth: People with mental health problems are different from normal people. Their problems are not real illnesses in the same way that physical illnesses are.

FACT: We all have mental health, just like we all have physical health. Mental illnesses are impairments of cognitive, emotional or behavioural function which have been shown to be influenced by genetic and biological risk factors, in exactly the same way that diabetes and cancer are.

Myth: There is no effective treatment for mental illness and people with mental illness never recover.

FACT: People with mental illness can and do recover. As with most physical conditions, such as diabetes, most mental illness can be successfully treated, allowing people to lead normal and productive lives.

Myth: Mental health and physical health are totally separate.

FACT: Mental health is just as important as physical health. The two are inter-connected, not separate. In fact, mental ill health can cause physical symptoms and physical conditions can affect mental wellbeing.

Myth: People experiencing depression are weak and they could snap themselves out of their bad mood if they just concentrated on being positive. It's a phase they are going through. Also, if they did nothing they would probably start to feel better naturally.

FACT: A mental illness is not caused by personal weakness, nor can it be 'cured' by personal strength, although some depressions do spontaneously improve. Proper treatment is needed. Psychotherapy and/or medication have been shown to help. Many people who have gone through this actually feel stronger. Depression is quite a common condition - about 15% of people will have a bout of severe depression at some point in their lives (Source – www.nhsinform.co.uk – Health Library – Depression). However, the exact number of people with depression is hard to estimate because many people do not get help, or are not formally diagnosed. Women are twice as likely to suffer from depression as men, although men are far more likely to take their own lives. This may be because men are more reluctant to seek help for depression. Depression can resolve spontaneously without treatment but this can take some time.

Myth: People who have a mental illness are threatening, violent and unpredictable. People with schizophrenia are often dangerous and aggressive and it is common for them to kill people.

FACT: Most people who have a mental illness are no more violent than someone suffering from cancer, diabetes or any other serious illness. In fact, people with a mental illness are much more likely to be victims of violence than its cause. People with schizophrenia are actually more likely to harm themselves than they are to harm other people. The incidence of violence in people with schizophrenia is not much higher than in the general population.

Myth: Addicts are weak people. They aren't sick and money shouldn't be wasted on helping them get 'well'.

FACT: More than half of all people who misuse alcohol and drugs have a mental health problem. The most common are depression and anxiety disorders. Drugs and alcohol can be used as a way of dealing with emotional problems – treating the underlying issue can tackle the addiction.

Myth: People with mental illnesses cannot work or contribute to society.

FACT: Often people with mental illness find effective treatment through medication, therapy or both. Treatment that works allows people with mental illness to contribute to society and being enabled to work can be beneficial for people experiencing mental health problems. It is the stigma of mental illness that prevents people from seeking treatment.

Myth: Mental illness does not affect young children. They are generally happy and if they have problems it's just part of growing up. Children are too young to get depressed, it must be something else.

FACT: One in 10 children between the ages of five and 16 have a mental health disorder, according to research by Green, Meltzer et al for the Office for National Statistics in 2004. The study also found that mental disorder is more common in boys - and that rates of mental health problems among children increase as they reach adolescence. Among five to 10-year-olds, 10 per cent of boys and 5 per cent of girls had a mental disorder. In the older age group (11 to 16-year olds), the proportions were 13 per cent for boys and 10 per cent for girls. Nearly 80,000 children and young people, over 8,000 aged under 10, suffer from severe depression (Source: Green, H., McGinnity, A., Meltzer, H., et al. (2005) Mental health of children and young people in Great Britain 2004 - The Office for National Statistics). See www.mentalhealth.org.uk and www.youngminds.org.uk for more facts and statistics.

Myth: Troubled youth just need more discipline.

FACT: A report by the Prison Reform Trust estimates that nine out of ten people in prison have mental health problems. More than 90% of imprisoned young offenders have at least one, or a combination of, the following: personality disorder, psychosis, depression and anxiety disorders or problems with substance misuse. In addition, more than 30% will have spent time in the care system. Nearly 30% of young women in prison report that they have been sexually abused. These troubled young people have a complicated range of needs and require a combination of services to help with their problems. Increasing discipline is not likely to help.

Myths about suicide

Myth: People have to be mentally ill to think about suicide.

FACT: Many people have thought of suicide at some time or another. People who take their own life don't fit into a 'type' for suicide, and while there may be warning signs, they aren't always noticed. Also, not all people who die by suicide have mental health problems at the time of death. Many people who kill themselves do have such problems, usually to a serious degree and often undiagnosed. However, feelings of desperation and hopelessness are more accurate predictors of suicide.

Myth: Some people are always suicidal.

FACT: Suicide affects all ages, both men and women and across cultures. In Scotland in 2012, the 45-49 age group had the largest number of probable suicides with 13%, followed

He had a way of hiding behind a laugh but when I asked him to be honest with me he said he'd thought about suicide.

Jim realised his mate was hiding how he felt, so he asked him about it. Because he did, his mate's still alive.

If you can read between the lines, you can save lives.

For help and advice for you or the person you're worried about, call **Breathing Space** on 0800 83 85 87 or Samaritans on 08457 90 90 90.

chooselife
www.chooselife.scot.nhs.uk

healthier scotland
www.healthier-scotland.scot.nhs.uk

by 40-44 year olds (also 13%) then the 50-54 age group with 12%. These numbers fluctuate from year to year. In the late 1990s, the 25-29, 30-34 and 35-39 age groups had the highest numbers (Source: General Register Office for Scotland Statistics August 2013).

Myth: People who talk about suicide aren't really serious and are not likely to actually kill themselves.

FACT: People who take their own lives have often told someone that they do not feel life is worth living or that they have no future. They may have said they want to die. All people who say they feel suicidal should be treated seriously. Many people who complete suicide have told someone about their suicidal feelings in the weeks prior to their death. Listening to and supporting people in these circumstances can save lives.

Myth: People who threaten suicide are just seeking attention and shouldn't be taken seriously.

FACT: People may talk about their suicidal feelings because they want support in dealing with them. The response of loved ones can be important to their recovery and giving them the attention they need may save their life. An attempted suicide should always be taken seriously.

Myth: Once a person has made a previous suicide attempt, they are unlikely to make another.

FACT: Those who have attempted suicide once are 100 times more likely than the general population to do so again. According to various studies, about 30-60% of people who attempt suicide have tried it before. About 15-25% of them would try again within a year, and about 40% of those who die by suicide have attempted suicide in the past.

Myth: If someone wants to end their life then there is nothing you can do.

FACT: Most people contemplating suicide do not want to die: they want to end the pain they are suffering in the life they are leading. Feeling suicidal is often a temporary and relatively short term state of mind. Although sometimes a suicide cannot be predicted, in many cases a tragic outcome may be averted if appropriate and timely help is offered to a person and they are willing to accept this help.

Myth: Talking about suicide is a bad idea as it might encourage someone to try it.

FACT: When someone feels suicidal they often do not want to worry or frighten others and so do not talk about the way they feel. However, serious talk about suicide does not create or increase risk and it can help to reduce it. By asking directly about suicide you give them permission to tell you how they feel. Openly listening to and discussing someone's thoughts of suicide can be a huge source of relief for them and can be key to preventing the immediate danger of suicide.

Myth: Most suicides happen in the winter months.

FACT: While suicide has historically been more common in the spring and summer months, recent data suggests that there is no significant association between the occurrence of suicide and the month of the year.

Myth: Women are more likely to kill themselves.

FACT: More women say they have considered suicide but far more men than women die by suicide every year.

Myth: The danger is over when a person shows signs of feeling better.

FACT: Often the risk of suicide can be greatest as depression lifts, or when a person appears calm after a period of turmoil. This may be because once they have made the decision to attempt suicide they may feel that they have found a solution, however desperate it may be.

The law: mental health

In Scotland the law relating to mental health comes under the Mental Health (Care and Treatment) (Scotland) Act 2003, which came into effect in April 2005. For an easy read guide to the Act see <http://www.scotland.gov.uk/Publications/2007/09/03145057/0>. For more detail on this legislation and its use, see the website of the Mental Welfare Commission for Scotland <http://www.mwscot.org.uk>.

The law relating to mental health in England and Wales comes under the Mental Health Act 2007. It amends the Mental Health Act 1983, the Mental Capacity Act 2005 (MCA) and the Domestic Violence, Crime and Victims Act 2004. See [mind.org.uk](http://www.mind.org.uk) for further information at <http://www.mind.org.uk/information-support/legal-rights/mental-health-act-the-mind-guide/about-the-mental-health-act/#.U3OMsXbW5K8>

The law: suicide

Suicide is not a crime in the UK. It was decriminalised in England and Wales with the passing of the Suicide Act 1961. Previously, anyone who attempted suicide in England or Wales could be prosecuted and imprisoned because they were considered to have committed a crime. The family of those who took their own lives also faced prosecution.

The Act does not apply to Scotland because suicide is not a crime under Scots law and has not been for many centuries. Therefore, anyone who attempts suicide and survives does not commit an offence. It is therefore not appropriate to use the term 'commit suicide'. An alternative is 'die by suicide'. However, if the attempt is carried out in a way to cause alarm to the public, and not as a private act, it may be prosecuted as breach of the peace.

Educating the public

Try to encourage public understanding of the complexity of suicide. People do not decide to take their own life in response to a single event, however painful that event might be. There are often several inter-related reasons, so suicide should not be

portrayed as the inevitable outcome of serious personal or social problems. You can inform the public by providing a detailed analysis of the types of reasons why people take their own lives. There is seldom only one cause for a suicide. Instead there are almost always multiple complex reasons so don't over simplify.

Suicide prevention training

NHS Health Scotland's Choose Life programme offers suicide prevention training programmes covering awareness and exploration to suicide first aid skills. Courses are organised and delivered at a local level by qualified trainers. More detailed information, including on how to attend a training course, is available at <http://www.chooselife.net/Training/index.aspx>

Since 2004, some 55,000 people in various sectors have received training in suicide prevention.

Stories to consider covering

Here are some suggestions of stories you could cover that focus on the wider issues relating to suicide, rather than the incident itself.

- Trends in suicide rates (paying close attention to official published data)
- Recent treatment advances
- Individual stories of how treatment was life-saving
- Stories of people who overcame despair without attempting suicide
- Myths about suicide
- Warning signs of increased risk of suicide
- Actions which people can take to prevent suicide by others
- Feature pieces on local support organisations.



Suicide Prevention Week happens each year in Scotland. A week of activities is centred around World Suicide Prevention Day on 10 September, including awareness-raising events and initiatives across the country. Choose Life on 07500 854 574 can give story ideas and contacts.

There is also an annual Scottish Mental Health Arts and Film Festival which aims to support the arts and to challenge preconceived ideas about mental health as well as promoting positive mental health and well-being. The festival takes place across Scotland throughout October. Contact their director Lee Knifton (leeknifton@gmail.com) or <http://www.mhfestival.com/index.php>



Interviewing a person with a past or current mental illness

Interviewing vulnerable people can be a harrowing experience for both the interviewee and the journalist. However, if you follow sensible, good practice, adhere to codes of conduct like the NUJ's code, plan your interview with care, ask thoughtful questions, are honest with your interviewee and behave sensitively and with discretion then it should be a successful experience for both you and your interviewee.

Remember that although many people with a past or current mental illness may be willing to speak to the media, talking publicly about a deeply personal issue can be difficult and distressing.

Planning the interview is important and you are likely to get a better interview if you are able to help your interviewee be more at ease. Be sure that the person is genuinely prepared to be interviewed and negotiate the location where the interview will take place. It might also be helpful to ask them if they want to have a friend present during the interview as this may help them to be more comfortable. An advocacy organisation may also be able to help to source and support the person through the interview process.

Only identify the person by name in the story if they have given you permission to do so. They may be prepared to discuss their condition but do not want people to know their identity so to name them could be detrimental. Also, seek agreement beforehand on the use of photos and video, and whether the person will be identified.

Providing your interviewee with the questions you want to ask prior to the interview might help them relax and will give them time to consider what they want to say about their personal experience. Most people are anxious before an interview with the media.

Wherever possible, use the person's own words to represent their experiences. If the person has a different view of their illness to family or doctors, try to include the person's understanding of their experience.

Take care when using comments not to include details of a suicide method or details of acts of self-harm.

Be honest with your interviewee. Let them know if material is likely to be shared with other media outlets, so they are not taken by surprise when their story appears in other contexts. Also, tell them if you plan to take a particular angle and inform them about likely editing processes your story will go through before it is published or broadcast.

The 'see me' programme has a pool of trained media volunteers who can provide lived experience testimony of mental ill-health. If you would like to interview a volunteer please contact 'see me'.

Working with people who have been bereaved by suicide

Interviewing a bereaved family is never easy. You're asking them to express raw and intimate thoughts about the loss of their loved one and in that situation both you and the bereaved people can feel bruised by the process. The burden of responsibility on you to get it right is immense because the grieving family and friends need to feel that the emotional cost of them speaking to you at this tragic time is worthwhile and productive. This also applies if you're writing a story about the death of their loved one without interviewing them. It's their story – not yours or your publication's – and it needs to be told in the right way. Reporting suicide provides us with the facts of a person's death but it also enables you to report as a matter of record the emotions of those left behind and so it helps us to understand their personal loss. Therefore, the way their story is told and the way their grief is portrayed takes on a special significance.

Although suicide stories can be a testing part of the job they can also be memorable. Research shows that journalists tend to focus on their identification with those who take their own life, on how it relates to their own circumstances and on their increased awareness of suicide.

Every day, at least two families in Scotland learn of the death of their loved one by suicide. Immediately afterwards, grieving relatives and friends may have difficulty understanding what has happened and in their first shocked reaction they may find the suicide inexplicable or may deny there were warning signs. It is therefore important for you to be aware of what they are going through and to understand that they are also at increased risk of suicide.

What it's like for the bereaved person

Nothing really prepares a person for the news that someone they love or care about has taken their own life. The relative or friend you interview may have been told about the death or they might have had the traumatic experience of discovering the body. Everyone grieves differently: there is no correct response. Some people feel low and unable to cope, others find it very difficult to sleep, eat or feel motivated to do anything. The bereaved person you plan to interview may have had suicidal thoughts themselves.

Some people might feel angry, confused, helpless and isolated. They might find it helps to talk about their feelings, including to a journalist. Others may prefer not to talk about things and feel that what they need is to 'put it behind them and get on with life'. This may lead to disagreements within a family or among friends, and you could find yourself in the middle of this. It is worth recognising that although some

people may not want to talk about their loss initially, this may change as time goes on. Everyone grieves in different ways and at different times.

The emotions that they experience can be powerful, frightening and overwhelming. The death might have come out of the blue. Even where someone had said they were feeling depressed, or had self-harmed or made suicide attempts, their death may still come as a shock.

Some relatives and friends might have 'seen it coming' but been powerless to prevent it. Or a loved one might have gone missing. Whatever the circumstances, finding out about a suicide is a deeply painful experience.

They will probably ask themselves, "Why did they do it?" Even if the person left a note, it might not provide all the answers. Notes are generally written at a time when the person was extremely distressed and they may not properly express how the person was feeling at the time. The bereaved family and friends will probably never know for sure.

Before you arrive to interview bereaved people it is likely the police have already spoken to relatives, friends and colleagues as potential witnesses. Also, next-of-kin or someone close to the deceased person may have been asked to formally identify the person. The police might appoint a family liaison officer to assist relatives with media enquiries.

Later the Fiscal in Scotland or the Coroner in England will investigate to decide whether there is a need for criminal proceedings or if a Fatal Accident Inquiry or inquest should be held. In Scotland FAls are rare in suicide cases, especially if an expert report has raised no cause for concern. In England and Wales inquests are more common. However, for bereaved people these public enquiries where journalists are often in attendance can be traumatic.

Interviewing bereaved people: tips and angles to pursue

General tips

- Make it clear at the interview how you and your publication intend to use the information your interviewees give you. Don't say you will do a tribute unless you mean it.
- Be honest with your interviewee. Outline what you want to ask them, tell them how much time you have with them or what your deadline is and explain that you don't make all editorial decisions about the story.
- Be aware that bereaved people often find it difficult to understand what has happened and that they might be anxious about that.
- There is seldom only one cause for a suicide. Instead there are almost always multiple, complex reasons so don't over simplify.

- Relatives and friends can be distressed to see their loved one's pictures or online profile material in a publication without their knowledge or consent. Although this material may be in the public domain it still upsets them.
- If you are doing the story without interviewing bereaved relatives and friends, think about how they might feel when they read your story. Have you said anything that could intrude into their grief and shock?
- Using depictions of grieving relatives, friends, mourners at funerals or memorials, or community expressions of grief, to show the impact of suicide may encourage copycat behaviour among vulnerable people.

During the interview

- It is best not to suggest that you understand a bereaved person's situation because you have experienced the death of a relative or friend.
- Avoid trying to empathise with your interviewee by using clichéd phrases like 'time is a great healer'.
- Avoid asking your interviewees, 'How do you feel?' when you want to get their reaction to the death.
- Everyone reacts to grief differently so try not to anticipate your interviewee's emotional state based on the length of time since the bereavement.
- People bereaved by suicide generally have feelings of acute guilt and regret. Therefore, you should avoid asking questions that could suggest that family or friends may have contributed to the death in some way.
- Bereaved people need time to tell their story so where possible don't rush them. They may also appear forgetful or distracted. Changing subjects too quickly or not giving them the chance to say what they want can leave people feeling 'used'.
- Be a good listener and react to their answers rather than only focussing on asking your own questions.
- Use silence or pauses to give them time to gather their thoughts and emotions.
- Check the information you get before you leave, particularly personal details. Inaccuracies in the written story can cause considerable distress to bereaved relatives and friends.
- Your interviewee might become emotional during your interview. If this happens you should ask them if they want to stop the interview.

After the interview

- If you have any doubt about the notes you have taken during the interview you should check them with the family or friends rather than publish what you think they said.
- If possible, put the story in the broader context of mental health issues or social problems to try to explain the death. Speak to experts and include their advice. This could potentially help other vulnerable people.
- When you write your story include details of helplines and contact information of suicide prevention or bereavement organisations where vulnerable people can seek help.
- Samaritans ask you to remember the effect on survivors of suicide, either

those who attempt it or those who are bereaved. They suggest it might be helpful to offer your interviewees some support such as information about their organisation, or bereavement groups like The Compassionate Friends, Cruse Bereavement Care Scotland or Touched by Suicide Scotland.

Look after yourself

Look after yourself. Reporting mental illness and suicide can be very distressing in itself, even for the most hardened news reporter, especially if the subject touches something in your own experience. Talk it over with someone you trust such as colleagues, friends, family or Samaritans. You can also speak in confidence to someone at the NUJ, if you would prefer. See the Dart Centre for Journalism and Trauma for more advice and resources at www.dartcenter.org/topic/suicide.

This guide is intended to add to your knowledge of mental illness, suicide and the reporting of issues surrounding these topics. Equally, we hope it will encourage you to look after your own mental health.

If you work in a newsroom, are up against tight deadlines, have to report on death and disaster, you will be no stranger to stress. Worse, if there is also a culture of bullying at your workplace then your mental health is in jeopardy.

The NUJ has carried out various workplace surveys and discovered that the major causes of stress are:- bullying and victimisation, working long hours, high workloads, lack of appreciation and only negative criticism shown by bosses. Personal experience of members has also suggested workplace issues appear to have contributed to mental illness and suicide among journalists.

In response, the NUJ is encouraging management to take steps to recognise sources of stress and act accordingly. Stress counselling is also available. If you are having difficulty at work, contact your union representative. Now. You can also find support information at Breathing Space www.breathingspacescotland.co.uk, Steps for Stress at www.stepsforstress.org or contact your GP.

Conclusions

We've come a long way since newspaper articles such as one which gratuitously presented a list of Britain's most common locations for suicide. Or those that make textbook errors of revealing enough detail of a suicide method to effectively spell out how it could be copied. Apart from the odd exception, it would appear that overall the UK press is reporting more responsibly and sensitively than ever before.

As well as mitigating against the risk of copycat suicides, we also know from conversations with people who have been bereaved by suicide that sensitive and responsible

media reporting can impact positively on them coming to terms with the sudden loss. This in itself can prevent further deaths, as people recently bereaved by suicide are at greater risk themselves.

We know that the media can – and do – report suicide-related news that is in the public's interest in a way that doesn't provide excessive detail about the method and that doesn't present suicide as an appealing option through glamourising the events that led to the death. These simple, clear guidelines are a must for anyone acting as a mouthpiece on suicide. Even the busiest of us will benefit from checking to ensure we're making the right decisions about what we communicate.

Contacts

National organisations

These national organisations can provide you with information and statistics and put you on to other contacts.

Choose Life

is NHS Health Scotland's national suicide prevention programme. Contact NHS Health Scotland's communications team on 07500 854 574
Email: info@chooselife.net
www.chooselife.net

Samaritans

The Upper Mill, Ewell, Kingston Road, Surrey KT17 2AF. T: 020 8394 8300
Out of hours: 07943 809 162
Email: press@samaritans.org
www.samaritans.org

Samaritans Scotland

Spectrum House, 2 Powderhall Road, Edinburgh, EH7 4GB
Scottish office: 0131 556 7058
Email: scotland@samaritans.org
National telephone helpline: 08457 90 90 90

'see me'

is Scotland's national anti-stigma programme that aims to challenge the stigma and discrimination associated with mental ill-health. 'see me' has a pool of trained media volunteers who can provide lived experience testimony of mental ill-health. 5th Floor, 23 Lauriston Street,

Edinburgh, EH3 9DQ. T: 0131 516 6819
Email: info@seemescotland.org
www.seemescotland.org

Penumbra

(works to promote mental health and wellbeing for all, prevent mental health for those 'at risk' and support people with mental health problems)
Norton Park, 57 Albion Road, Edinburgh EH7 5QY. T: 0131 475 2380
Email: enquiries@penumbra.org.uk
www.penumbra.org.uk

The Scottish Association for Mental Health

Brunswick House, 51 Wilson Street, Glasgow, G1 1UZ. T: 0141 530 1054 or 1000
Email: rebecca.sibbett@samh.org.uk, or enquire@samh.org.uk
Out of hours: call 07971 892817.
www.samh.org.uk

The Scottish Centre for Healthy

Working Lives (SCHWL) leads on national work on improving mental health and wellbeing in employment and working life. It is delivered nationally by NHS Health Scotland. Contact NHS Health Scotland's communications team on 07500 854 574
www.healthyworkinglives.com

Bipolar Scotland

Studio 1015, Mile End Mill, Abbey Mill Business Centre, Seedhill Road, Paisley PA1 1TJ. T: 0141 560 2050
Email: info@bipolarscotland.org.uk
www.bipolarscotland.org.uk

Support in Mind (formerly the National Schizophrenia Fellowship Scotland)

6 Newington Business Centre, Dalkeith Road Mews, Edinburgh EH16 5GA. T: 0131 662 4359
Email: info@supportinmindscotland.org.uk
<http://www.supportinmindscotland.org.uk>

Royal College of Psychiatrists

12 Queen Street, Edinburgh EH12 1JE
T: 0131 220 2910. www.rcpsych.ac.uk

Action on Depression Scotland

5, Rose Street, Edinburgh EH2 2PR
T: 0131 243 2786. Helpline: 0808 802 2020
Email: info@actionondepression.org
<http://www.actionondepression.org/>

Saneline

(national telephone helpline)
T: 0845 767 8000
<http://www.sane.org.uk/home>

Association for Post Natal Illness

145 Dawes Road, Fulham, London SW6 7EB. T: 020 7386 0868
Email: info@apni.org. www.apni.org

Alzheimer Scotland

22 Drumsheugh Gardens, Edinburgh EH3 7RN.
T: 0131 243 1453. Email: alzheimer@alzscot.org. www.alzscot.org
Dementia helpline: 0808 808 3000 (24 hr freephone)

The Compassionate Friends

14 New King Street, Deptford, London SE8 3HS. T: 0845 120 3785
Email: info@tcf.org.uk or media@tcf.org.uk
www.tcf.org.uk. Helpline: 0845 123 2304

ChildLine Scotland

T: 0844 892 0200 - Aberdeen
0844 892 0210 - Glasgow
0844 892 0280 - Edinburgh

www.childline.org.uk

Helpline: 0800 11 11
Bullying Line: 0800 44 11 11

Cruse Bereavement Care Scotland

Email: info@crusescotland.org.uk
Helpline: 0845 600 2227
www.crusescotland.org.uk

Scottish Recovery Network (SRN)

aims to help promote and support the process of recovery for individuals and to gain a wider understanding and awareness of what helps people recover. Simon Bradstreet, Director
T: 0141 240 7790
Email: info@scottishrecovery.net
www.scottishrecovery.net

Touched by Suicide Scotland

102 Kingsway, Scotstoun Glasgow G14 9YS. T: 0141 584 3211
Email: touchedbysuicidescotland@hotmail.co.uk.
Touchedbysuicidescotland.org
Helpline number 01294 273274

Academic contacts

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psychology/staff/rasmussensusandr/
s.a.rasmussen@strath.ac.uk](http://www.strath.ac.uk/humanities/courses/psychology/staff/rasmussensusandr/s.a.rasmussen@strath.ac.uk)

Scottish Mental Health Research Network

<http://www.smhrn.org.uk/>
<http://www.smhrn.org.uk/staff/staff.asp>

Some helpful websites

www.wellscotland.info

The national mental health improvement
website for Scotland.

www.livinglifetothefull.com

This is a powerful free life skills resource.
The course has been written by a
psychiatrist who has many years of
experience using a Cognitive Behaviour
Therapy (CBT) approach and also in
helping people use these skills in
everyday life.

www.mhfestival.com

The annual Scottish Mental Health Arts and
Film Festival aims to support the arts and
challenge preconceived ideas about mental
health as well as promoting positive mental
health and well-being. The festival takes place
across Scotland throughout October. Contact
Director Lee Knifton at leeknifton@gmail.com

www.allmediascotland.com

Scottish media news and contacts database.

www.openuptoolkit.net

Launched by Mental Health Media, it
includes facts about mental health
discrimination, legal rights, ideas and
resources such as tools like diet and
exercise. They provide information on
staying healthy, as well as assistance for
dealing with illness of a friend or loved one

www.mentalhealth.org.uk

The website of the Mental Health
Foundation, a charity that improves the lives
of those with mental health problems or
learning disabilities.

[www.bbc.co.uk/health/emotional health/mental_health/](http://www.bbc.co.uk/health/emotional_health/mental_health/)

Good starting point for background
research and links.

www.youngminds.org.uk

Children's and adolescents' mental health
charity, information on young people and
related mental health issues.

www.healthscotland.com

NHS Health Scotland is Scotland's national
health improvement agency for improving
the health of our country and reducing health
inequalities. NHS Health Scotland's mental
health improvement work includes: the
development and distribution of a range
of mental health related resources and
publications; the development of a set of
national mental health indicators; work to gather
and disseminate the evidence base for mental
health improvement and support the evaluation
of practice; work on improving mental health
and well-being in employment and working life;

the Choose Life programme; and the provision
of a range of learning and development oppor-
tunities including Scotland's Mental Health First
Aid training course.

www.scotpho.org.uk

Scottish Public Health Observatory
(ScotPHO) ScotPHO brings together key
national organisations involved in public
health intelligence in Scotland, led by ISD
Scotland and NHS Health Scotland. Along
with summary data and statistics, the Scot-
PHO website aims to provide background,
interpretation, policy notes, commentaries on
data sources, references and links to further
information on a variety of key health areas
including mental health.

www.breathingspacescotland.co.uk

Breathing Space is a free, confidential phone
line with skilled and experienced staff to listen
to callers who present with issues of low mood
and depression and if necessary signpost
callers to appropriate services.
Helpline: 0800 83 85 87 Breathing Space
Communications & Marketing: 0777 645 7115

www.mediawise.org.uk

MediaWise promotes ethical standards within
the media for the benefit of the public and
has produced guidance on reporting suicide
and health at [http://www.mediawise.org.uk/
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Suicide-.pdf](http://www.mediawise.org.uk/wp-content/uploads/2011/03/The-Media-and-Suicide-.pdf) See also [http://www.mediawise.org.uk/wp-content/
uploads/2011/03/Sensitive-Coverage-Saves-Lives.pdf](http://www.mediawise.org.uk/wp-content/uploads/2011/03/Sensitive-Coverage-Saves-Lives.pdf) and
[http://www.mediawise.org.uk/wp-content/
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NUJ code of conduct

A journalist:

- 1.** At all times upholds and defends the principle of media freedom, the right of freedom of expression and the right of the public to be informed.
- 2.** Strives to ensure that information disseminated is honestly conveyed, accurate and fair.
- 3.** Does her/his utmost to correct harmful inaccuracies.
- 4.** Differentiates between fact and opinion.
- 5.** Obtains material by honest, straightforward and open means, with the exception of investigations that are both overwhelmingly in the public interest and which involve evidence that cannot be obtained by straightforward means.
- 6.** Does nothing to intrude into anybody's private life, grief or distress unless justified by overriding consideration of the public interest.
- 7.** Protects the identity of sources who supply information in confidence and material gathered in the course of her/his work.
- 8.** Resists threats or any other inducements to influence, distort or suppress information and takes no unfair personal advantage of information gained in the course of her/his duties before the information is public knowledge.
- 9.** Produces no material likely to lead to hatred or discrimination on the grounds of a person's age, gender, race, colour, creed, legal status, disability, marital status, or sexual orientation.
- 10.** Does not by way of statement, voice or appearance endorse by advertisement any commercial product or service save for the promotion of her/his own work or of the medium by which she/he is employed.
- 11.** A journalist shall normally seek the consent of an appropriate adult when interviewing or photographing a child for a story about her/his welfare.
- 12.** Avoids plagiarism.

The NUJ believes a journalist has the right to refuse an assignment or be identified as the author of editorial that would break the letter or spirit of the NUJ code of code.

The NUJ will support journalists who act according to the code.

“As patron of a mental health charity I have witnessed at first hand the distress irresponsible reporting of mental health issues can have on service users. Inaccurate or sensationalist reporting, in part through use of insensitive language, not only stigmatises and trivialises mental illness but also reinforces discrimination among sections of the general public. Any initiative that improves journalists’ understanding and awareness of mental health issues is to be welcomed. At STV we will continue to impress upon our editorial team the importance of responsible reporting in helping change public attitudes and eradicate some of the stigma and prejudice. I cannot guarantee that we will always get it right but we will certainly try.”

Donald John MacDonald

Editor News Programmes STV

“I welcome anything that helps destigmatise mental health problems. Tired old clichés, especially in the headlines, dehumanise our readers and bury the real story. Scottish newspapers have moved on in the last ten years. And while I can’t endorse every dot and comma in this guide, I would urge every journalist to read it, debate it and think again”

Allan Rennie - Managing Director and Editor in Chief of Media Scotland, publishers of the Daily Record, Sunday Mail, Scotland Now and S&UN titles.