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.

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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 battling 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
President, Partners for Mental Health

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 seldom 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 dealing with a broken leg, the first thing you would do would be to speak to people in that situation.

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

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.

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.

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

'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 to designate some mentally ill people found NCR as 'high risk'.

Such people can not then be granted conditional or absolute discharges, and are 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. The provision is widely seen as punitive – and thus in conflict with the principle that the person is not guilty of a crime.

It's 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

➤ 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.

COVERING SUICIDE

RECONSIDERING THE TABOO

Some news organizations still have policies against covering suicide – policies that are often broken when newsworthy suicides occur. This traditional taboo is now out of step with recommended practice.

Suicide is the ninth leading cause of death for Canadians of all ages and the second biggest killer of adolescents between the ages of 15 and 19. The suicide rate among teens, however, is static. There is a strong, but not universal, connection between suicide and mental illness.

Studies have suggested that adolescents in particular may be susceptible to 'suicide contagion'. Yet suicide prevention experts now advocate open discussion and do not oppose sensitive reporting of newsworthy deaths by suicide. This is especially important in the age of social media, when false information and rumour may be rampant.

How we report newsworthy suicides matters. Here is a brief guide to what reporters and editors need to know to cover suicide deaths 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 reference to their suffering.

Do tell others considering suicide how they can get help.

Don't shy away from writing about suicide.The more taboo, the more the myth.

Don't romanticize the act.

Don't jump to conclusions. The reasons why people kill themselves are usually complex.

Don't suggest nothing can be done because we usually never know why people kill themselves.

Don't go into details about the method used.

LANGUAGE BEST PRACTICE

Do use plain words. Say the person 'died by suicide', 'killed herself', or 'took his own life.'

Don't say the person 'committed suicide'. It's an outdated phrase implying illegality or moral failing.

Don't call suicide 'successful' or attempted suicide 'unsuccessful.' Death is not a matter of success.

Don't use or repeat pejorative phrases such as 'the coward's way out' which reinforce myths and stigma.

Media attention to the issue of bullying – linking it to suicide – is one example of how suicide has been oversimplified.

Tim Wall
Executive Director
Canadian Association for Suicide Prevention

BACKGROUND FACTS

Although much attention is focused on suicide by the young, killing oneself intentionally is more common among men who are elderly or middle-aged. Canadian men are three times more likely to die by suicide than Canadian women. This has been a long-term trend. Married people are the least likely to die by suicide compared with those who are single, divorced or widowed.

About 90% of people who die by suicide in Canada have some mental or addictive disorder. The most common of these is depression (around 60% of cases).

Tim Wall, executive director of the Canadian Association for Suicide Prevention, says: "Suicide is a very complex issue and there are many things that will contribute to someone getting to the point in their life where their sense of hope is completely overwhelmed by feelings of despair and pain and hopelessness." Stigma is thought to be among the contributory causes.

The overall suicide rate in Canada peaked in 1983 at 15.1 per 100,000 deaths. By 2009, the rate had declined by 29% to 10.7.

Suicide today represents an increasing proportion of deaths among adolescents, but only because the other most significant cause of death – accidents – has been steadily declining, while adolescent suicide rates have been essentially flat.

The most common means of suicide is by hanging (44%) but this declines with age. Poisoning, including overdoses, is the second most common at 25%. Suicide by gunshot (16%) increases with age.

CHAPTER 7

MENTAL ILLNESS AND ADDICTION

Some stories that don't appear at the outset to involve mental illness, really do. Medicine considers addiction – to drugs, alcohol, cigarettes, gambling or anything else – to be a mental disorder. This often contrasts sharply with popular perception.

Journalists whose stories tend to echo the view that addiction is a sign of personal weakness are ignoring facts known to the medical profession for more than half a century. Since journalists themselves 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 involves compulsive use, increasing tolerance and leading in turn to further increased use. Such compulsive behaviour is also found in other mental disorders.

The brain changes involved in addiction are difficult or impossible to reverse. Consequently an alcoholic, for example, may – through treatment or willpower – stop drinking. But recovery in the sense of returning to 'normal' or 'acceptable' drinking patterns is extremely rare.

The underlying reasons why some people appear to be more prone than others to substance abuse disorder are subjects of debate. Some research suggests a genetic component may be at play. Some psychologists observe that addiction often arises in response to stress, and shape treatments accordingly.

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%.

➤ 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.**
- ✓ **Medical science says people with addictions are ill. Respect the person, understand the behaviour.**
- ✓ **Stigmatizing people with addictions 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 working will help you produce better journalism. But the guiding

"Many Canadians know Aboriginal people only as noble environmentalists, angry warriors or pitiful victims."

Royal Commission on Aboriginal Peoples (1996)

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

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. House style may differ, but current CP style (2016) is to use a lower-case letter when indigenous or aboriginal is used as a common adjective, (as in 'an indigenous person' – stylistically similar to 'a white person') but upper case when using the proper name for the Indigenous (or Aboriginal) Peoples of Canada.

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 2011 Statistics Canada's National Household Survey enumerated 851,560 people who identified as First Nations. There were 1.4 million indigenous people in all – 4.3% of the total population. (Updated numbers will be posted on the Mindset website as they become 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.

Meanwhile, the federal government introduced changes to the Act after dropping an appeal against a Quebec Superior Court ruling in 2015 that sections dealing with recognizing Indian status were discriminatory. Members of the Senate aboriginal peoples committee found the government's proposed fix to be inadequate. In January 2017 Ottawa requested and received extra time to improve its proposals, with a court-imposed deadline of July 3, 2017. For further developments, check the Mindset website.

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 2011 survey 451,792 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 2011 survey numbered 59,445.

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 much faster than the non-indigenous. Between 2006 and 2011 the indigenous growth rate was 20.1%, compared with 5.2% among non-indigenous people. Children under 14 make up 28% of the indigenous population, compared with 16.5% 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.**

I can absolutely guarantee that in most of the crimes that are committed by addicted and mentally-ill offenders, there's no element of wanting to do that. There's no joy from it.

Chris Curry, former addict and journalist, turned alcohol & drug counsellor

➤ 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.

➤ 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.

SUICIDE DOS AND DON'TS

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 reference to their suffering.

Do tell others considering suicide how they can get help.

Don't shy away from writing about suicide.The more taboo, the more the myth.

Don't romanticize the act.

Don't jump to conclusions. The reasons why people kill themselves are usually complex.

Don't suggest nothing can be done because we usually never know why people kill themselves.

Don't go into details about the method used.

SUICIDE LANGUAGE

Do use plain words. Say the person 'died by suicide', 'killed herself', or 'took his own life.'

Don't say the person 'committed suicide'. It's an outdated phrase implying illegality or moral failing.

Don't call suicide 'successful' or attempted suicide 'unsuccessful.' Death is not a matter of success.

Don't use or repeat pejorative phrases such as 'the coward's way out' which reinforce myths and 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.**
- ✓ **Medical science says people with addictions are ill. Respect the person, understand the behaviour.**
- ✓ **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.

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This field guide is made freely available to news organizations
and journalism schools. It may also be downloaded as a .pdf file from:
www.mindset-mediaguide.ca
More detail and discussion may be found on the same website.

The Canadian Journalism Forum on Violence and Trauma is a federally-registered charity primarily concerned with the physical and mental wellbeing of journalists, their families and those they influence.

More information about the Forum is available through:
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