



reporting suicide and mental illness

a Mindframe resource for media professionals

[www.mindframe-media.info](http://www.mindframe-media.info)



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The opinions expressed in this document are those of the authors and are not necessarily those of the Commonwealth. This document is designed to provide information to assist policy and program development in government and non-government organisations.

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Developed with the assistance of media professionals, suicide and mental health experts, and consumer organisations for the Mental Health and Suicide Prevention Branch, of the Australian Government Department of Health and Ageing.

Contact details were correct at time of publication, although they are subject to change. The project website at [www.mindframe-media.info](http://www.mindframe-media.info) contains the most up-to-date contacts and information on how to obtain additional copies of the resource.



## Foreword

### Organisations represented on the National Media and Mental Health Group include:

*Free TV Australia;*  
*Commercial Radio Australia;*  
*Australian Press Council;*  
*Australian Broadcasting Corporation;*  
*Australian Indigenous Communications Association;*  
*Australian Writers' Guild;*  
*Special Broadcasting Service;*  
*Australian Communications and Media Authority;*  
*The National Advisory Council for Suicide Prevention;*  
*The National Mental Health Promotion and Prevention Working Party;*  
*SANE Australia;*  
*beyondblue – The National Depression Initiative;*  
*Australian Mental Health Consumer Network;*  
*Mental Health Council of Australia;*  
*Mental Health and Suicide Prevention Branch, Australian Government Department of Health and Ageing.*

A list of members of the National Media and Mental Health Group is at Appendix 3

The media has an important role to play in influencing social attitudes towards and perceptions of suicide and mental illness.

This resource provides practical advice and information to support the work of media professionals. It is designed to inform responsible and appropriate reporting of suicide and mental illness in order to reduce harm and copycat behaviour, reduce the stigma experienced by people who live with a mental illness, and increase community understanding of these issues.

*Reporting suicide and mental illness* is one of a suite of projects and resources funded as part of the Australian Government's National Mindframe Media Initiative.

Other projects under the initiative have focussed on:

- ▶ providing a baseline account of Australian media reporting on suicide and mental illness;
- ▶ contributing to the evidence base regarding portrayal of mental illness and suicide in the news media, film and drama;
- ▶ promoting resources and education opportunities for media professionals;
- ▶ supporting a community action site to encourage accurate and respectful portrayal of the issues;
- ▶ developing and disseminating curriculum resources for journalism students; and
- ▶ developing resources for the mental health sector to support their work with the media.

*Reporting suicide and mental illness* provides current contacts, research sources, facts and statistics, and suggestions about issues to consider when reporting suicide and mental illness.

As representatives of peak media bodies, suicide and mental health organisations, and the Australian Government we commend this resource to you.

*National Media and Mental Health Group*  
*March 2006*

## About this resource

This is a revised second edition of a resource for media professionals on reporting suicide and mental illness. The first edition, *Achieving the Balance*<sup>1</sup>, was produced in 1999.

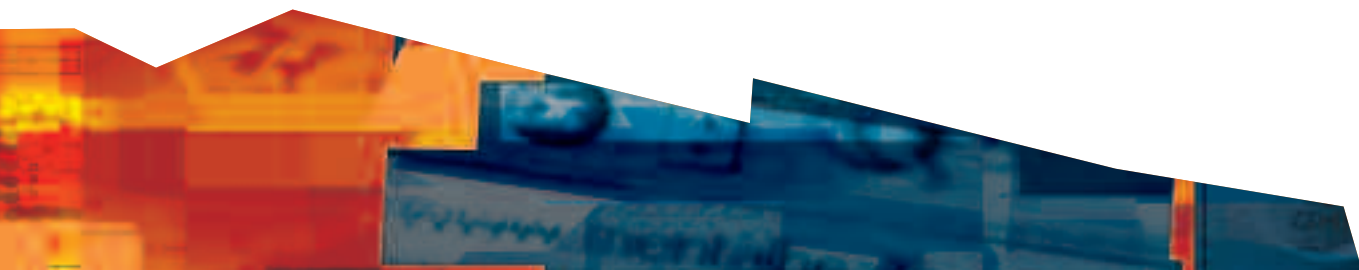
The current edition was developed following consultation with peak media organisations, mental health organisations and consumers, and testing with media professionals.

Drafts of the resource were also reviewed by members of the National Media and Mental Health Group.

*Reporting suicide and mental illness* was initially produced in 2002 by Quay Connection and Urbis Keys Young for the Mental Health and Suicide Prevention Branch of the Australian Government Department of Health and Ageing. It was revised in 2004 and again in 2006 under the Mindframe Media and Mental Health Project managed by the Hunter Institute of Mental Health in partnership with the Australian Network for Promotion Prevention and Early Intervention for Mental Health (Auseinet) and SANE Australia.

The resource is also available in electronic form at [www.mindframe-media.info](http://www.mindframe-media.info)

New statistics and research, updated contacts and information on how to obtain additional copies of the resource are also available on the website.





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## Introduction

Most members of the media report suicide and mental illness responsibly, and the media industry has been actively involved in helping to reduce suicide rates and addressing stigma and discrimination associated with mental illness.

- ▶ Generally suicides are not reported in the Australian media. Reports, when made, are usually presented with care to minimise the pain for relatives and friends. Most media try to ensure that suicide is not portrayed as a way to solve personal problems or glamorised in any way.
- ▶ In general, the media takes a sensitive attitude to reporting mental illness, and to interviewing people who have, or have had, a mental disorder.

However, research in 2001 on media reporting of suicide and mental illness, discussed overleaf, shows there is still progress to be made.

This resource is designed to help media professionals continue to report suicide and mental illness responsibly and accurately and to ensure that:

- ▶ when suicide is reported, coverage reinforces the attitude that there are alternatives to suicide and that help is available;
- ▶ reporting of mental illness is based on accurate information, challenges stereotypes and myths about mental illness and encourages people with mental health concerns to seek help;
- ▶ members of the media understand the potential impact of reporting on suicide and mental illness, based on the evidence from up-to-date research;
- ▶ research on suicide and mental illness, and information on reliable sources of data and expert comment, is available to media professionals when preparing a story; and
- ▶ appropriate contact details are provided for services to help people distressed or prompted to act by a story.

*'The media is a principal source of information for the community, and has a major role in influencing community attitudes towards mental illness.'*

Barbara Hocking, SANE Australia

*'Most journalists don't want to think someone could kill themselves from reading their story.'*

Radio Producer, Triple J

# 1. Australian media reporting of suicide and mental illness – a snapshot<sup>2</sup>

## Method of suicide

- ▶ In 50% of cases, the method of self-harm was described *in detail*. This is despite formal and informal industry codes that recommend that the method of suicide not be described.

## Language

- ▶ 41.7% of items on suicide used inappropriate language which suggested that completed suicide was a desirable outcome, eg 'failed suicide attempt', 'successful suicide bid'.
- ▶ One fifth of items on mental illness used language that was negative or outdated, eg 'cracked up', 'crazy lunatics', 'nutcase', 'a psycho', 'mental hospital' etc.
- ▶ Medical language was used inappropriately or out of context in only a handful of items on mental illness.

## Stigmatising mental illness

- ▶ The majority of items on mental illness did not stereotype people with mental illness as violent, unpredictable, unable to work, weak or unlikely to get better. However, 14.4% of items did stigmatise mental illness – eg suggesting that people with mental illnesses 'should not be let loose in the community', or that mental illness is a 'life sentence'.
- ▶ One fifth of items labelled the person by his or her diagnosis – eg 'anorexics', 'manic depressive', 'schizophrenic' – rather than focusing on the person first.
- ▶ The majority of items did not suggest that all mental illnesses are the same. 16.6% of stories suggested that all people with mental illness are alike or share the same experiences.

## Headlines and story placement

- ▶ 16.9% of items on suicide were placed on the front page or as the leading item. 29.5% of items used the word suicide in the headline. 13.5% included a photograph, diagram or footage related to the suicide.
- ▶ Only 4.2% of stories on mental illness had headlines that were inaccurate or inconsistent with the story.
- ▶ However, 29.3% of headlines were found to be unnecessarily dramatic or sensationalised, eg 'evil, gun-toting sadist', 'a threat to society', 'trapped in alcoholic despair'.

Many media professionals interviewed during the development of this resource said that they believe most media report suicide and mental illness appropriately.

However, research in 2001 showed that there are still some significant issues about the way Australian media report suicide and mental illness.

International studies have considered the *impact* of media reporting of suicide and mental illness. Little research has been done on the *extent* and *nature* of media reporting.

The *Media Monitoring Project*<sup>3</sup> found that reporting in Australia is extensive – a total of 17 151 items of reporting on mental health/illness and suicide was recorded within a 12 month period.

The *Media Monitoring Project* tracked reporting of suicide and mental illness in the Australian media over a 12 month period, from March 2000 to March 2001.

The research found that reporting of mental illness during this period was of a higher quality, and more appropriate than reporting of suicide.

Studies have found that any instances of negative reporting of mental illness impact significantly on people experiencing mental illness.

See Section 2 for more on the impact of media reporting on mental illness.

### Celebrity suicide

- ▶ During the study period, there were relatively few stories about celebrity suicide. In 91.2% of stories about celebrity suicide, reference was actively made to the person's status as a celebrity.

### Placing suicide in context

- ▶ Around half of items recorded reinforced that suicide is related to mental disorder and not merely a social phenomenon.

### Privacy

- ▶ In most cases, suicide stories did not include interviews with the bereaved – in only 18% of items were the bereaved interviewed.
- ▶ Nearly one third of stories on mental illness disclosed that a particular person had a mental illness and identified the person by name.

### Help services

- ▶ Only 6.5% of suicide and 6.6% of mental illness stories provided information on help services available. Often this was only a brief mention.

### About the study

- ▶ 3762 items recorded were on suicide, 12 338 on mental health/illness, and 1051 on suicide and mental health/illness in combination. Radio items far outnumbered television and newspaper items – 28.7% newspaper, 10.4% television, and 60.9% radio items were recorded.
- ▶ The *extent* of reporting varied by month across all media. High levels of reporting occurred in months when specific events (such as the suicide of a prominent politician or Mental Health Week) took place.
- ▶ Suicide items tended to be about completed suicide, an individual's experiences, policy/program initiatives, and/or statistical overviews of suicide risk in the Australian population.
- ▶ Mental health/illness items tended to be about policy/program initiatives, causes, symptoms and/or treatment of mental illness, mental health care and/or services, research initiatives, and/or an individual's experiences.



## 2. Impact of media reporting – the evidence : Suicide

- ▶ Reliable Australian research shows that reporting of suicide can have an impact on vulnerable people.
- ▶ The way in which suicide is reported appears to be particularly significant.
- ▶ In some cases, reporting of suicide has been linked to increased rates of actual suicide.
- ▶ A major 1995 study of coverage in Australian newspapers found that rates of male suicide increased following reports of suicide, with actual male suicides peaking on the third day after the story appeared.<sup>5</sup>
- ▶ There is also evidence that the way suicide is reported can *reduce* suicide rates. Reporting that positions suicide as a tragic waste and an avoidable loss, and focuses on the devastating impact of the act on others, has been linked to *reduced* rates of suicide.
- ▶ For example, a 1997 Australian study of reporting of Kurt Cobain's suicide in a range of media found that rates of suicide among 15 - 24 year olds *fell* during the month following reporting of Cobain's death. Significantly, media coverage of Cobain's death was highly critical of his decision to suicide.<sup>6</sup>

### Newspapers

- ▶ Higher rates of suicide have been reported during periods when suicide stories are run in newspapers. As noted above, in Australia, male suicide rates have been found to increase following reporting of suicide.<sup>7</sup>
- ▶ Higher rates of suicide have sometimes been recorded after *celebrity* suicides receive front page coverage. A 1984 US study found a significant increase in the suicide rate in months in which front-page articles were published on celebrity suicides.<sup>8</sup>
- ▶ Higher rates of suicide by a particular *method* such as burning or anti-freeze poisoning, have been found to follow the appearance of newspaper stories on a suicide by these methods.<sup>9</sup>
- ▶ The number of subway suicides and suicide attempts in Vienna dropped after the introduction of media guidelines led to less frequent reporting of suicides in these locations.<sup>10</sup>

### The relationship between media reporting and portrayal of suicide, and actual suicidal thoughts and actions continues to be debated.

The media generally takes a responsible approach to reporting suicide. However journalists interviewed in research for the development of this resource expressed some scepticism about the actual impact of reporting and portrayal.

There are enough examples in the literature to suggest media need to be cautious when reporting suicide.

Warwick Blood and Jane Pirkis (2001)<sup>4</sup> conducted a review of studies on a variety of media, and both fictional and non-fictional portrayals of suicide.

They found that recent, reliable Australian research does demonstrate a link between reporting and suicide.

Studies have also shown that the way suicide is reported can *reduce* suicide rates.

Findings of key studies are summarised here. However, for a comprehensive discussion of the evidence of the impact of media reporting, it is recommended that the Blood and Pirkis report, together with relevant key studies, be read in full.

The report is available at:  
[www.mindframe-media.info](http://www.mindframe-media.info)

A literature review conducted in 2005 (Pirkis, Blood, Francis & McCallum) indicated that the portrayal of suicide in films is widespread, and that it has increased over time with depictions of the act becoming lengthier, more extensively modelled, and more likely to involve firearms.

The findings also suggest it has become more romanticised, glorified and condoned, with young people being disproportionately represented in films with a suicide theme

The report is available at:  
[www.mindframe-media.info](http://www.mindframe-media.info)

## Film and television

- ▶ Some studies have found that rates of suicide increase following television news reporting of suicide. For example, a 1982 American study found that the national suicide rate increased for a period of 10 days following a news story on suicide.<sup>11</sup>
- ▶ Increases in the number of teenage suicides have also been recorded following news stories on suicide in international studies.<sup>12</sup> Coverage of suicide of elderly people has also been linked to higher levels of suicide by older people.<sup>13</sup>
- ▶ Several studies have found that the number of attempted suicides increased following the broadcast of a television movie or episode of a popular soap opera depicting suicide.<sup>14</sup>
- ▶ Studies have also found a relationship between the method of suicide portrayed in a fictional film or television program, and increased rates of suicide using this method.<sup>15</sup>
- ▶ On the other hand, appropriate portrayal may have a beneficial effect, according to a study which showed rates of suicide and suicide attempts by young people fell following the broadcast of telemovies showing the *impact* of suicide.<sup>16</sup>

## Music

The association between music preference and suicide risk is not conclusive. However some studies have shown a link between fans of certain music genres and suicide rates.

- ▶ A study on the relationship between heavy metal magazine subscriptions and youth suicide rates in America found that the stronger the heavy metal subculture, the higher the youth suicide rate.<sup>17</sup> A survey of high school students showed that those who identified themselves as heavy metal fans had less strong reasons for living and more thoughts of suicide than their counterparts.<sup>18</sup>
- ▶ Some studies also showed a link between being a fan of country music and suicide rates though this has been contested.<sup>19</sup>
- ▶ A 1993 Australian study found that a preference for rock or heavy metal music was associated with suicidal thoughts, acts of deliberate self-harm, and depression, particularly for girls.<sup>20</sup>

## Books

- ▶ Several studies found an increase in suicide and attempted suicide by asphyxiation, following the publication of a non-fiction book, *Final Exit*, which advocates euthanasia by poisoning or suffocation.<sup>21</sup>

## Mixed media

- ▶ Several Australian studies have looked at the relationship between reporting of suicide across media and suicide rates. A Queensland study found a peak in suicide rates following extensive negative publicity about suicides in the psychiatric wards of a local general hospital.<sup>22</sup>
- ▶ Suicide rates among young Australians aged 15-24 were significantly lower in the month following Kurt Cobain's death than for corresponding months in previous years.<sup>23</sup>
- ▶ In some instances, reporting of suicides in certain locations has led to safeguards being introduced in these places to prevent suicide.

### 3. Impact of media reporting – the evidence: Mental illness

#### Australian research shows that the media generally do a better job of reporting mental health and illness appropriately than reporting suicide.

Research on media coverage of mental health and illness has tended to focus on the *nature* and *extent* of media portrayal, with fewer studies investigating the *impact* of media coverage of mental illness on community attitudes.

Francis, C. et al (2001)<sup>24</sup> investigated literature on the portrayal of mental health and illness in the media, the impact of portrayal on community attitudes towards mental illness, and the impact of mental health promotion in the media.

Instances of negative reporting of mental illness impact significantly on people experiencing mental illness.

Studies have found that negative portrayal influences community attitudes, which in turn may lead to stigma and discrimination.

- ▶ According to international research, mental illness tends to be portrayed negatively in the mass media in both news and entertainment media. This is supported by Australian studies. However recent Australian research suggests reporting may be improving.
- ▶ Negative reporting of mental illness appears to influence community attitudes. Participants in many of the studies surveyed considered the media to have an impact on their attitudes towards mental health and illness. Those who cited the media as the most important source of their information and beliefs tended to have more negative attitudes towards mental illness.
- ▶ The presentation of negative images of mental illness in both fiction and non-fiction media results in the development of more negative beliefs about mental illness.
- ▶ The presentation of positive images does not appear to balance negative media portrayals.
- ▶ There is some evidence that mental health promotional campaigns impact positively on community attitudes.

#### Attitudes

- ▶ A recent Australian study shows that while 90% of respondents believe mental health is a significant issue in Australia, Australians do not have a clear understanding of mental illness.<sup>25</sup>
- ▶ 51% of respondents in a national study in the US felt that depictions of people with mental illness in the entertainment industry were negative, and 43% believed coverage of mental illness in the news media was mostly negative.<sup>26</sup>
- ▶ 75% of consumers of mental health services in a UK study felt that media coverage was 'unfair, unbalanced or very negative', while 50% believed media portrayal of mental health issues had 'a negative effect on their mental health'.<sup>27</sup>
- ▶ Several studies show that greater use of electronic media is associated with less tolerant attitudes towards people with a mental illness.<sup>28</sup>
- ▶ A major German survey showed that the media were the most important source of information about mental illness, and that negative media reports were more commonly recalled than positive reports.<sup>29</sup>
- ▶ Studies showed that when participants were exposed to fictional or news items which portrayed mental illness negatively, they developed less positive attitudes towards mental illness. Positive items did not alter attitudes.<sup>30</sup>

## 4. Issues to consider when reporting suicide

### ISSUES FOR EDITORS AND SUB-EDITORS

#### *Why should I run the story?*

Most media interviewed during the review of this resource said that they would not report a suicide story, unless it was a celebrity suicide. Yet recent research<sup>31</sup> shows that suicide is still widely reported – of a total of 3762 items on suicide recorded between March 2000 and March 2001, 1675 were on individual suicide. However, only 34 of these were on celebrity suicide.

Consider:

- ▶ whether the story needs to be run at all;
- ▶ how many suicide stories you have run in the last month;
- ▶ the potential impact of the story.

A succession of stories can promote a dose-response factor and normalise suicidal behaviour as an acceptable option.

#### *If you do decide to run the story:*

##### Headlines

Use of the word 'suicide' in the headline can contribute to glamorising and normalising suicide.

Replace 'suicide' with 'took own life', 'a fatal decision', or 'the last decision'.

##### Language

Check the language you use does not glamorise or sensationalise suicide, or present suicide as a solution to problems. For example:

- ▶ use 'non-fatal' not 'unsuccessful', 'cluster of deaths' or 'increasing rates' rather than 'suicide epidemic';
- ▶ use 'died by suicide' or 'experienced depression' rather than describing the person as a 'suicide' or a 'depressive';
- ▶ use the term 'suicide' sparingly. Avoid gratuitous use of 'suicide', eg 'suicide mission', 'suicide bomber' or 'political suicide' when other terms are more appropriate.

*'Take every single opportunity we can to avoid racking up a debate which may lead to young people suiciding.'*

*Professor Graham Martin, Auseinet*

### Media professionals can help prevent suicide by:

- ▶ providing referral and helpline contacts such as Lifeline and Kids Helpline at the end of articles, TV programs and broadcasts;
- ▶ highlighting the negative outcomes of suicidal behaviour, including the risk of long-term disability and the impact on loved ones;
- ▶ providing accurate information about suicide and its relationship to mental illness and social issues.

Media industry codes of practice provide guidance on appropriate reporting (see Appendix 1).

In their survey of reporting on suicide in the Australian media between March 2000 and 2001, Blood and Pirkis<sup>32</sup> found that:

- ▶ 50% of items reported the method of suicide in detail;
- ▶ 30% of media items included 'suicide' in the headline;
- ▶ only 6.5% of stories included helpline numbers or referral information; and
- ▶ 13.5% of items included a photograph, diagram or footage.

See Section 1 for more detail.

### **Handling celebrity suicide**

Celebrity suicide is often reported where it is considered to be in the public interest. Coverage of celebrity suicide can glamorise and normalise suicide, and can prompt imitation suicide. Avoid descriptions of the method of suicide and seek comment on the wastefulness of the act.

### **Where the story goes**

Some evidence suggests a link between prominent placement of suicide stories and copycat suicide. Locate the story on the inside pages of a paper, magazine or journal, in the second or third break of TV news, or further down the order of radio reports.

## **ISSUES FOR NEWS AND FEATURES JOURNALISTS**

### **Interviewing the bereaved**

The bereaved are often at risk of suicide themselves. Follow media codes of practice on privacy, grief and trauma when reporting personal tragedy. For example, interviewing the bereaved on the anniversary of a suicide death can be very distressing for them.

### **Language**

See suggestions under 'Issues for Editors and Sub-editors', on page 9.

## Place the story in context

Many people who suicide have a mental disorder or a drug-related illness. Where this is the case, reporting the underlying causes of suicide can help dispel myths that suicide is not related to a person's mental state.

Discussing the risk factors also promotes a better understanding of suicide as part of a wider issue and a challenge for society.

## Avoid depicting the method

Research shows that reporting of method is directly linked to copycat suicides. A step-by-step description can prompt some vulnerable people to emulate the act.

## Exercise caution in reporting location of suicide

In some instances reporting locations used for suicide may result in these places becoming 'popular' for suicide attempts.

## Include helpline numbers

Including helpline numbers, and information about the options for seeking help – such as visiting a GP or health professional – provides immediate support for those who may be distressed, or prompted to act, by your story.

## Seek expert advice

Where reporting suicide is thought to be in the public interest, reports should be based on the most reliable information about suicide from recommended experts (see the contacts section or refer to the website at [www.mindframe-media.info](http://www.mindframe-media.info) for more details).

## The impact of media reporting

- ▶ Reporting suicide may influence people who are already vulnerable to suicidal behaviour.
- ▶ Celebrity suicide usually makes headline news. These reports may lead to copycat suicides by people who identify with the celebrity.
- ▶ Reporting the method of suicide may influence vulnerable people to use the same method of suicide.

For more on the evidence on the impact of media reporting, see Section 2.

Examples of media codes of practice are included in Appendix 1.

## ISSUES FOR PHOTO EDITORS

### Photo selection and placement

Photographs and footage of the scene, location and method of suicide can lead to imitative action by people who are vulnerable and should not be used.

Avoid using photographs of the dead person unless given permission by family members.

Where used, photographs should not be placed on the front page as this over-dramatises the act of suicide.



## 5. Where to find suicide statistics and research

### MAJOR DATA SOURCES AND OR PROVIDERS OF STATISTICAL INFORMATION ON SUICIDE

#### Data analysis and research reports

- ▶ Australian Institute of Health and Welfare  
[www.aihw.gov.au](http://www.aihw.gov.au)  
(02) 6244 1000 (general)  
(02) 6244 1025 (media)
- ▶ Australian Institute of Criminology  
[www.aic.gov.au](http://www.aic.gov.au)  
(02) 6260 9200 (general)  
(02) 6260 9239 (media)
- ▶ Australian Institute for Suicide Research and Prevention  
[www.gu.edu.au/aisrap](http://www.gu.edu.au/aisrap)  
(07) 3875 3377 (general)  
(07) 3735 6782 (media)
- ▶ Research Centre for Injury Studies  
[www.nisu.flinders.edu.au](http://www.nisu.flinders.edu.au)  
(08) 8201 7602
- ▶ Suicide Prevention Australia  
[www.suicidepreventionaust.org](http://www.suicidepreventionaust.org)  
(02) 9568 3111

#### Causes of death and mortality rate data

- ▶ Australian Bureau of Statistics  
[www.abs.gov.au](http://www.abs.gov.au)  
1300 135 070

This section contains information on suicide, including facts and statistics, as well as information on key research sources.

For the most up-to-date information contact the agencies listed below, and in the contacts section of this resource. They will be able to provide reliable data which has been properly examined by statisticians and epidemiologists.

- ▶ Official suicide data and deaths in custody reports to Parliament are available from State Coroners Offices. Local and State Coroners Offices also keep police death reports of suspected *not* confirmed suicides.
- ▶ Area/district health administration population data is available from Area Health Services.
- ▶ Deaths in Custody Review Committees provide data on deaths in custody.
- ▶ The NSW Child Death Review Committee keeps data on child deaths including suicide or self-harm.

## Health department contacts for State-based data

- ▶ ACT Health and Community Care  
[www.health.act.gov.au](http://www.health.act.gov.au)  
Mental Health Services: (02) 6205 5142  
Media enquiries: (02) 6205 0837
- ▶ NSW Health  
[www.health.nsw.gov.au](http://www.health.nsw.gov.au)  
Centre for Mental Health: (02) 9391 9309  
Media enquiries: (02) 9391 9121
- ▶ NT Department of Health and Community Services  
[www.health.nt.gov.au](http://www.health.nt.gov.au)  
General enquiries: (08) 8999 2553  
Media enquiries: (08) 8999 2753
- ▶ Qld Health  
[www.health.qld.gov.au](http://www.health.qld.gov.au)  
General enquiries: (07) 3234 0111  
Media enquiries: (07) 3234 1135
- ▶ SA Department of Health  
[www.health.sa.gov.au](http://www.health.sa.gov.au)  
Mental Health Unit: (08) 8226 0777  
Media enquiries: (08) 8226 6488
- ▶ Tas Health and Human Services  
[www.dhhs.tas.gov.au](http://www.dhhs.tas.gov.au)  
Mental Health Branch: (03) 6230 7549  
Media enquiries: (03) 6233 4890
- ▶ Vic Department of Human Services  
[www.dhs.vic.gov.au](http://www.dhs.vic.gov.au)  
Mental Health Branch: (03) 9616 8592  
Media enquiries: (03) 9616 7296
- ▶ WA Department of Health  
[www.health.wa.gov.au](http://www.health.wa.gov.au)  
Office of Mental Health: (08) 9222 4099  
Media enquiries: (08) 9222 4333

## 6. Suicide facts and statistics<sup>33,34</sup>

- ▶ Suicide is a prominent public health problem in Australia. Over the past decade, more than 2000 people have died by suicide each year.
- ▶ Rates of suicide vary from year to year. In 2004, 2098 people died from suicide in Australia, a rate of 10.4 per 100,000. This represented 1.6% of all deaths registered in that year.
- ▶ Since at least the 1920s, more males than females die by suicide each year. In 2004, 1661 males (16.8 per 100,000) and 437 females (4.3 per 100,000) died by suicide. Thus, in 2004, males were almost 4 times more likely than females to die by suicide.
- ▶ An examination of Australian suicide rates over the past 40 years suggests a peak in 1963 (17.5 per 100,000), with rates declining to 11.3 per 100,000 in 1984. After that, suicide rates climbed back up and in 1997 they reached the level of 14.6 per 100,000. Suicide rates have tended to decline since that time with 10.4 Australians per 100,000 dying by suicide in 2004.
- ▶ Between 1997 and 2004, the suicide rate fell by 29%, with this rate of change similar for males (29%) and females (31%).
- ▶ The age-standardised suicide rate for total males (16.8 per 100,000) in 2004 was lower than in any year in the previous decade (1994-2004).
- ▶ The age standardised suicide rate for total females (4.3 per 100,000) in 2004 was also lower than in any year in the previous decade (1994-2004).
- ▶ Despite these decreases, suicide remains a major external cause of death, accounting for more deaths than transport accidents between 1994 and 2004.
- ▶ Suicide used to be rare among traditional Aboriginal and Torres Strait Islander peoples but has become more common in recent years, with 2004 data suggesting that deaths by suicide account for a much higher proportion of all deaths among Aboriginal and Torres Strait Islander people than other Australians.
- ▶ First generation migrants in Australia show similar suicide rates to those in their country of origin.
- ▶ People in any form of custody have a suicide rates three times higher than the general population.

### A note about using statistics

Caution should be exercised in reporting and interpreting suicide and self-harm information.

- ▶ The reliability of suicide statistics are affected by a number of factors including under-reporting, differences in reporting methods across Australia, and delays in the processing of possible suicides by coroners.
- ▶ Due to the relatively small numbers of suicides in some States and Territories, even one or two deaths can have a significant impact on suicide rates. Thus comparisons across Australia must be done cautiously.
- ▶ Data on suicides can be reported in different ways, including: as the number of people who died by suicide; as an age-standardised suicide rate such as 7 per 100,000 people (which allows for the comparison of groups with different age structures and sizes); and as a percentage of deaths from all causes which were due to suicide.
- ▶ The comparison of international suicide statistics can be very difficult due to differences in procedures in reporting and classifying deaths, definitions, time periods, and the level of undercounting.

## Key suicide contacts

National Suicide  
Prevention Strategy  
[www.livingisforeveryone.com.au](http://www.livingisforeveryone.com.au)

Australian Institute for Suicide  
Research and Prevention  
[www.gu.edu.au/aisrap](http://www.gu.edu.au/aisrap)  
(07) 3875 3377 (general)  
(07) 3835 6782 (media)

Auseinet (Australian Network for  
Promotion, Prevention and Early  
Intervention for Mental Health)  
[www.auseinet.com](http://www.auseinet.com)  
(08) 8201 7670

ReachOut! Website  
[www.reachout.com.au](http://www.reachout.com.au)

SANE Australia  
[www.sane.org](http://www.sane.org)  
(03) 9682 5933

National Association for Loss and  
Grief (NALAG)  
SA: (08) 8342 4005  
NSW: (02) 6882 9222  
VIC (03) 9650 3000

Suicide Prevention Australia  
[www.suicidepreventionaust.org](http://www.suicidepreventionaust.org)  
(02) 9568 3111

## Suicide and age

- ▶ From 1990 until 1997, 20 to 24 year old men were consistently the most likely of all age groups to die by suicide, with rates reaching 42.8 per 100,000 in 1997.
- ▶ However, in recent years the highest rates have been observed for males aged 30 to 34 years. In 2004, 221 men in this age group (29.2 per 100,000) died by suicide.
- ▶ From 1990 onwards, there has not been any one age group of females that has consistently had a higher rate of suicide than other age groups. In 2004, those women aged 45 to 49 years were most likely of all the age groups to die by suicide (51 suicide deaths or 7.1 per 100,000).
- ▶ The largest drop in suicide rates between 1997 and 2004 is observed for 20 to 24 year olds, with a fall of 51% in suicide rates for this group. This is followed closely by those aged 15 to 19 years, for which the suicide rate has fallen by 48%.
- ▶ In contrast, the smallest reduction in rates between 1997 and 2004 is seen for those aged 40 to 44 years, with a reduction of 16% between 1997 and 2004.
- ▶ Child suicide (under age 15 years) is a rare event in Australia.

The table below provides a comparison of trends in suicide between 1997 (the most recent peak) and 2004.

Age groups	Numbers and standardised rates of deaths by suicide, 1997*		Number and standardised rates of deaths by suicide, 2004*	
	Number	Rate	Number	Rate
15-24	416 males 93 females	Rate = 31.0 Rate = 7.2	196 males 69 females	Rate = 13.8 Rate = 5.1
25-34	540 males 115 females	Rate = 37.6 Rate = 8.0	393 males 78 females	Rate = 27.3 Rate = 5.4
35-44	431 males 122 females	Rate = 30.3 Rate = 8.5	382 males 91 females	Rate = 25.6 Rate = 6.0
45-54	294 males 96 females	Rate = 24.3 Rate = 8.1	257 males 89 females	Rate = 18.8 Rate = 6.4
55-64	177 males 56 females	Rate = 22.2 Rate = 7.1	167 males 41 females	Rate = 15.7 Rate = 3.9
65-74	146 males 47 females	Rate = 23.6 Rate = 6.9	135 males 29 females	Rate = 20.2 Rate = 4.1
75+	131 males 41 females	Rate = 36.1 Rate = 7.0	123 males 39 females	Rate = 24.8 Rate = 5.3
<b>Total #</b>	<b>2143 males 577 females</b>	<b>Rate = 23.6 Rate = 6.2</b>	<b>1661 males 437 females</b>	<b>Rate = 16.8 Rate = 4.3</b>

\* Rates are standardised by age and expressed as the number of deaths per 100,000 of the estimated population. Source: ABS (2006) catalogue number 3309.0.

# Includes deaths by suicide of those aged under 15 years and age not stated.

## Suicide and gender

- ▶ Suicide is much more common among males than females in every State and Territory. This is in line with trends in other Western countries.
- ▶ In contrast, more females than males intentionally harm themselves.<sup>35</sup>
- ▶ The ratio of male to female suicides rose from 2:1 in the 1960s to over 4:1 in the mid 1990s. Throughout the early 2000s, the ratio of male to female suicides has been slightly below 4:1, and stood at 3.8:1 in 2004.
- ▶ The ratio of male to female suicides is fairly similar across Australia with two exceptions. Using combined suicide rate data for 2000 to 2004, 6.2 males for every one female died by suicide in the Northern Territory. On the other end of the scale, in Victoria 3.2 males died for each female during 2000 to 2004.
- ▶ Almost half (49%) of male suicide deaths in 2004 were by hanging, followed by 28% due to poisoning (including drugs, gases, etc.). In contrast, hanging and poison accounted for the same percentage (40% each) of female suicide deaths.
- ▶ The ratio of deaths by suicide to the total number of deaths from all causes differs greatly among age groups.<sup>36</sup> In 2004, suicide represented:
  - ▶ 15% of all deaths for males aged 15 to 19 years and 17% of all female deaths in the same age group;
  - ▶ 24% of total male deaths and 17% of total female deaths for 20 to 24 year olds;
  - ▶ 26% of all male deaths and 14% of female deaths for 25 to 34 year olds;
  - ▶ 18% of total male deaths and 8% of total female deaths for 35 to 44 year olds;
  - ▶ 6% of all male deaths and 4% of all female deaths for 45 to 54 year olds;
  - ▶ 2% of deaths for males and 1% of deaths for females aged 55 to 64 years; and
  - ▶ less than 1% of total male and female deaths for those aged 65 years and over.
- ▶ Suicide rates for men born outside Australia are slightly lower than for Australian born men, whereas corresponding rates for women are very similar.

Suicide sometimes occurs in 'clusters' within a local area. This may happen when people have experienced a suicide and identify with the distress of the person who died.

They may have had similar experiences of stresses and may be in the same general age group or ethnic origin as the person who died.

This is where media reporting of suicide may have its greatest impact as an influence on suicide.

A range of factors appear to have the capacity to protect people from risk of suicide. These include:

- ▶ a range of personal coping skills and moral values;
- ▶ feelings of self-esteem and belonging;
- ▶ connections to family or school, responsibility for children; and
- ▶ social support.

Other risk factors for suicide include:

- ▶ relationship breakup, serious conflict and bereavement;
- ▶ social isolation;
- ▶ terminal illness;
- ▶ stressful life events (abuse or trauma);
- ▶ being from Eastern European descent, or an older male;
- ▶ legal problems.

### Suicide by State and Territory

- ▶ Combining suicide data over a 5-year period provides a more reliable picture of differences across the States and Territories due to the relatively small number of suicides in some States and Territories in any one year.
- ▶ When data for 2000 to 2004 were combined, the highest rate of suicide is evident in the Northern Territory (23.6 per 100,000), followed by Tasmania (14.7 per 100,000) and Queensland (13.5 per 100,000). In contrast, the ACT, New South Wales and Victoria all had rates lower than the national average of 10.4 per 100,000.
- ▶ Rates of male suicide fell in most States and Territories between 1997 and 2004. Rates for Tasmania and the Northern Territory have generally increased since 1997, with some years of decreased rates.

### When does suicide occur?

- ▶ Sometimes people may suicide after signalling their suicidal intentions to others, including loved ones and/or strangers. In other cases, there may be no warning.
- ▶ Incarceration is a risk factor for suicide. People in any form of custody have a suicide rate three times higher than the general population.
- ▶ People experiencing a mental disorder, such as major depression, or a psychotic disorder, are at increased risk of suicide. Psychological autopsy studies show consistently that up to 90% of people who suicide may have been experiencing a mental disorder at the time of their death.
- ▶ People are at higher risk of suicide while in hospital for treatment of a mental disorder and in the weeks following discharge from mental health in-patient hospital care.

### Attempted suicide

- ▶ According to hospitals data, females are more likely to deliberately injure themselves than are males. In the 1997-98 financial year, 57% of those who were hospitalised due to self-harm were female.
- ▶ For both males and females, the highest rate of deliberate self-harm occurs for those aged in their teens to middle age. In 1997-98, 78% of those who were hospitalised due to self-harm were aged between 15 and 44 years and the highest rates were for females aged 15 to 29 years.
- ▶ In 1997-98, there were 25,120 episodes of hospital care due to self-harm, which equates to a rate of 137.5 per 100,000. However not all people who are hospitalised due to self harm may have intended to die by suicide.
- ▶ Rates of hospitalised self-harm were much lower among both older men and women than other age groups in 1997-98. Furthermore, rates for men aged 85 years and over were higher than for women of the same age.

- ▶ Self-report studies of self-harming behaviour suggest that 5-10% of teenagers may have deliberately harmed themselves in some way.<sup>37</sup>

### Groups at risk of suicide

- ▶ People with a previous history of attempted suicide are at greatest risk of suicide.
- ▶ Mental disorders such as major depression and psychotic illness are associated with an increased risk of suicide, especially after discharge from hospital or when treatment has been reduced.
- ▶ People with alcohol or drug abuse problems have a higher risk of dying by suicide than the general population.
- ▶ Males die by suicide about four times more often than do females.
- ▶ Young Aboriginal males and Torres Strait Islander males are more likely to die by suicide than are other young Australians.
- ▶ People who are incarcerated - both Indigenous and non-Indigenous - are more likely to die by suicide than are other Australians.

### Youth suicide

- ▶ In 2004, 53 males aged 15 to 19 years and 143 males aged 20 to 24 years died by suicide. In the same year, 32 females aged 15 to 19 years died by suicide, as did 37 females aged 20 to 24 years.
- ▶ Considering all causes of death, suicide accounted for 15% of deaths among 15 to 19 year old males and 24% of deaths among 20 to 24 year old males in 2004. The corresponding percentage for females in both of these age groups is 17%.
- ▶ During the mid 1980s, suicide rates for 15 to 19 year old males rose rapidly and peaked at 21 per 100,000 in 1988. Over the following decade, rates fluctuated from around 17 to 19 per 100,000 for this group and stood at 18.4 per 100,000 in 1997.
- ▶ Since 1997, suicide rates among 15 to 19 year old males have decreased fairly consistently and in 2004, the rate was 7.5 per 100,000 – this is the lowest rate seen in this age group for at least 20 years.
- ▶ In contrast, for 15 to 19 year old females, the suicide rate has been relatively stable over the past 20 years at around 3 to 5 suicide deaths per 100,000. In 2004, 4.8 per 100,000 15 to 19 year old females had died by suicide.
- ▶ Similar to that seen for their younger counterparts, rates for 20 to 24 year old males also fell substantially between 1997 and 2004. In 1997, the suicide rate for this group was 42.8 per 100,000, compared with 20.0 per 100,000 in 2004.
- ▶ Although the change is not nearly as dramatic, there was also a decrease in suicide rates for women aged 20 to 24 years between 1997 and 2004, with rates at 9.0 and 5.5 per 100,000 respectively.

## Media coverage of suicide has tended to focus on young Australians, in particular young men.

Australian research found that some groups were more often associated with suicide in media coverage than others. Males, young people, and people living in rural areas commonly featured in suicide stories.

This report is available at:  
[www.mindframe-media.info](http://www.mindframe-media.info)

## Reports of a youth suicide 'epidemic' are inaccurate.

While rates of suicide among young people continue to be of concern, the group with the highest suicide rate has shifted upwards in recent years. Data for 2004 indicate that males aged 30 to 34 years had the highest rate of suicide.

## Suicide among Aboriginal peoples and Torres Strait Islanders was uncommon until 20-25 years ago and appears to be a problem in younger Aboriginal males.

Generally, Aboriginal peoples and Torres Strait Islanders have a shorter life expectancy than other Australians. This contributes to lower frequencies of suicide among their older members.

However, suicide rates in older Aboriginal and Torres Strait Islander Australians may be genuinely lower than other Australians, probably because suicide was traditionally uncommon.

Reliable data on suicide rates in Aboriginal and Torres Strait Islander communities is not readily available for some States and Territories, due to problems with identifying Indigenous status.

As numbers of suicides in Aboriginal and Torres Strait Islander communities are often small, rates are only indicative.

## Suicide among Aboriginal peoples and Torres Strait Islanders

- ▶ Suicide used to be rare among traditional Aboriginal peoples and Torres Strait Islanders but has become more common in recent years.
- ▶ Due to both the relatively small numbers and low coverage in some areas of Australia, the ABS only publishes data on suicide deaths among Aboriginal and Torres Strait Islander people for New South Wales, Queensland, South Australia, Western Australia and the Northern Territory. In 2004, there were 83 deaths by suicide of Aboriginal and Torres Strait Islander people in the five states and territories considered, compared with 76 suicide deaths in 2003.
- ▶ The percentage of all deaths attributable to suicide is much higher among Aboriginal and Torres Strait Islander people (4.2% in 2004) than other Australians (1.5% in 2004) in the specified states and territories.
- ▶ Suicide is more concentrated in the earlier adult years for Aboriginal and Torres Strait Islander Australians than for the general Australian population with 2003 data indicating the highest rates for both males and females being in the 15 to 24 year age group.
- ▶ As for other Australians, Aboriginal and Torres Strait Islander males are more likely to die by suicide than are Aboriginal and Torres Strait Islander females. Using combined data for 1998 to 2002, 6.7% of all males deaths were due to suicide compared with 1.9% of all deaths for females.
- ▶ Rates of suicide vary between Aboriginal and Torres Strait Islander communities and over time.



## 7. Issues to consider when reporting mental illness

Australian research shows that for the most part, media reporting on mental illness tends to be more appropriate than reporting of suicide. However of 12 338 items on mental illness surveyed between March 2000 and March 2001, 30% had sensational or exaggerated headlines, and 20% used negative or outdated language.<sup>38</sup>

### ISSUES FOR EDITORS AND SUB-EDITORS

*Should I run the story?*

**If you decide to run a story on mental illness:**

- ▶ check for consistency with codes of practice – eg those relating to discrimination, privacy, grief and trauma (see Appendix 1);
- ▶ consult experts on mental illness (see contacts section or refer to the website at [www.mindfame-media.info](http://www.mindfame-media.info));
- ▶ encourage people to seek help;
- ▶ include telephone helplines in the story;
- ▶ try to let the helpline know when the story is run in case they get an increase in calls.

### Headlines

- ▶ Is the person's mental illness really relevant to the story? Should it be mentioned in the headline?
- ▶ If the headline states or implies that someone has a mental illness, is this known to be true?
- ▶ Media guidelines and codes of ethics stress the right to privacy. What is the possible impact of disclosure on the person's life?
- ▶ Does the heading exaggerate the person's illness or the impact mental illness has on their behaviour?

*'If inaccurate or unbalanced information is presented [by the media], people in the community don't understand the warning signs, or seek help.'*

Barbara Hocking, SANE Australia

**Media professionals can help improve understanding and community attitudes towards mental illness by:**

- ▶ providing accurate information about mental illness and specific mental disorders;
- ▶ encouraging people in distress to seek help, for instance by providing helpline numbers;
- ▶ breaking down myths about mental illness and allowing people who have experienced mental illness to tell their own stories.

In their survey of reporting on mental illness in the Australian media between March 2000 and 2001, Blood and Pirkis<sup>39</sup> found that:

- ▶ 19.9% of items on mental illness used language that was negative or outdated;
- ▶ 14.4% of items stigmatised mental illness;
- ▶ 19.9% of items labelled the person by his or her diagnosis rather than focusing on the person first;
- ▶ 29.3% of headlines were highly dramatic or sensationalised;
- ▶ nearly one third of stories disclosed that a particular person had a mental illness and identified the person by name;
- ▶ only 6.6% of stories provided information on help services available.

See Section 2 for more detail.

## Language

- ▶ Most people working in the media are conscious about using appropriate language. However recent research shows that terms such as 'cracked up', 'nutcase', 'psycho' and 'lunatic asylum' are still in use. This language stigmatises mental illness and perpetuates discrimination.
- ▶ Avoid suggesting that people with a mental illness are inherently violent, unable to work, unpredictable, untrustworthy, weak or unable to get well.
- ▶ Referring to someone with a mental illness as a victim, suffering with or afflicted by a mental illness is outdated. Avoid language that implies mental illness is a life sentence – eg a person is not 'a schizophrenic', they are currently experiencing or being treated for schizophrenia.
- ▶ The term mental illness covers a wide range of symptoms, conditions, and effects on people's lives. Be careful not to imply that all mental illnesses are the same.
- ▶ Make sure medical terms are used correctly – eg being down or unhappy is not the same as experiencing clinical depression. Using psychiatric and medical terminology out of context is inaccurate – eg 'psychotic dog' or 'schizophrenic city'.

## ISSUES FOR NEWS AND FEATURES JOURNALISTS

### Interviewing a person with a past or current mental illness

Interviewing a person with a past or current mental illness requires particular sensitivity. While many people who have or have had a mental illness are happy to speak to the media, talking publicly can be a difficult and distressing experience. Making them more at ease will help you to tell the person's story.

- ▶ It is particularly important to check that the person is genuinely prepared to be interviewed. Negotiating the location where the interview takes place and whether the person wants to have a friend or associate present may help them to be more comfortable. An advocacy organisation may also be able to help.
- ▶ Do not identify the person by name in the story unless they have given permission. Identifying the individual and their mental disorder could be detrimental if they do not wish to disclose their illness.
- ▶ Seek agreement beforehand on the use of photos and video, and whether the person will be identified.
- ▶ It may help the person to speak about their personal experience if they have had a chance to consider the questions before the interview.
- ▶ 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.
- ▶ If material is likely to be shared with other outlets, let the interviewees know so they are not taken by surprise when their story appears in other contexts.
- ▶ Also let the person know about likely editing and interview outcomes. If you intend to emphasise a particular angle, tell the person.

## The impact of media reporting

- ▶ Negative reporting of mental illness appears to influence community attitudes.
- ▶ The presentation of negative images of mental illness in both fiction and non-fiction media results in the development of more negative beliefs about mental illness.
- ▶ The presentation of positive images does not appear to balance negative media portrayals.

For more on the evidence on the impact of media reporting, see Section 1.

## **Language**

See suggestions under 'Issues for editors and subeditors', page 21.

## **Include helpline numbers**

Including helpline numbers, and information about the options for seeking help – such as visiting a GP or health professional – provides immediate support for those who may be distressed by your story.

## **Seek expert advice**

New information about mental disorders, symptoms, and treatments is becoming available all the time. Reporting on mental illness should be based on the most reliable information from recommended experts (see the contacts section).

## **ISSUES FACED BY PHOTO EDITORS**

### **Photo selection and placement**

Seek the person's agreement on the use of photos (or video). Check whether the person has agreed to be identified.

## 8. Where to find mental illness statistics and research

### Key research sources

The Australian Bureau of Statistics *National Survey of Mental Health and Well-being* (1997)<sup>40</sup> provides the first national data on prevalence of mental illness in the adult population in Australia. This data is described and analysed in *The Mental Health of Australians* (1999)<sup>41</sup>

The child and adolescent component surveyed 4-17 year olds, and is reported in *The Mental Health of Young People in Australia* (2000).<sup>42</sup>

Other key sources of data on mental health and illness include:

### Clearinghouses

*Reports on health and welfare, burden of disease and injury*

- ▶ Australian Institute of Health and Welfare  
[www.aihw.gov.au](http://www.aihw.gov.au)  
(02) 6244 1000 (general)  
(02) 6244 1025 (media)
- ▶ Australian Institute of Family Studies  
[www.aifs.gov.au](http://www.aifs.gov.au)  
(03) 9214 7888 (general)  
(03) 9214 7804 (media)
- ▶ Australian Indigenous Health Infonet  
[www.healthinfonet.ecu.edu.au](http://www.healthinfonet.ecu.edu.au)  
(08) 9370 6109

### Mental illness data

- ▶ Australian Bureau of Statistics  
[www.abs.gov.au](http://www.abs.gov.au)  
1300 135 070

This section includes general information on mental illness, facts and statistics on occurrence of mental illness in the Australian population, and information about some of the main types of mental illness. A list of further reading and a glossary of common terms are included at the end of this resource.

The information included in this section is intended to provide an overview, but will not capture the reality of living with a mental illness.

## Independent research centres

*Research on nature, origins and causes of mental illness, diagnosis and treatment*

- ▶ Australasian Society for Psychiatric Research  
[www.aspr.org.au](http://www.aspr.org.au)  
(08) 9224 0235
- ▶ The Mental Health Research Institute of Victoria  
[www.mhri.edu.au](http://www.mhri.edu.au)  
(08) 9388 1633
- ▶ Queensland Centre for Schizophrenia Research  
[www.qcsr.uq.edu.au](http://www.qcsr.uq.edu.au)  
(07) 3271 8660
- ▶ Clinical Research Unit for Anxiety Disorders  
[www.crufad.com](http://www.crufad.com)  
(02) 8382 1720
- ▶ Centre for Mental Health Research  
[www.anu.edu.au/cmhr/index.php](http://www.anu.edu.au/cmhr/index.php)  
(02) 6125 2741

## Research and policy on mental illness

- ▶ State Health Departments (see contacts section for details)
- ▶ Australian Government Department of Health and Ageing  
[www.mentalhealth.gov.au](http://www.mentalhealth.gov.au)  
(02) 6989 1555
- ▶ Mental Health Council of Australia  
[www.mhca.org.au](http://www.mhca.org.au)  
(02) 6285 3100

## 9. Mental illness – definitions

- ▶ **Mental health** – is a state of emotional and social wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively or fruitfully, and is able to make a contribution to his or her community (WHO 1999).
- ▶ Mental health problems and mental disorders refer to the spectrum of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people.
- ▶ A **mental disorder** – is a diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities. Mental disorders are of different types and degrees of severity and some of the major mental disorders perceived to be public health issues are depression, anxiety, substance use disorders, psychosis and dementia. The term *mental illness* is sometimes used instead of mental disorder.
- ▶ A **mental health problem** – also interferes with a person's cognitive, emotional or social abilities, but to a lesser extent than a mental disorder. Mental health problems are more common mental complaints and include the mental ill health temporarily experienced as a reaction to life stressors. Mental health problems are less severe and of shorter duration than mental disorders, but may develop into mental disorders. The distinction between mental health problems and mental disorders is not well defined and is made on the basis of the severity and duration of the symptoms.<sup>43</sup>

### Mental illness: a snapshot

- ▶ About 20% of adult Australians, or one in five people, will experience a mental illness at some stage in their lives – including an alcohol or substance abuse disorder. Many will experience more than one mental illness at the one time, such as depression and anxiety, which commonly occur together.
- ▶ Each year a further 20 000 Australians are found to have a mental illness.
- ▶ Three million Australians will experience a major depressive illness during their lifetime.
- ▶ 5% of Australians experience anxiety so crippling that it affects every aspect of their lives.
- ▶ Almost one in 100 Australians will experience schizophrenia during their lifetime.
- ▶ 3 in 100 Australians will experience a psychotic illness such as schizophrenia, bipolar disorder and, increasingly, drug-induced psychosis.

In 1997 the Australian Bureau of Statistics (ABS) conducted the adult component of the National Survey of Mental Health and Well-being.

The survey, funded under the National Mental Health Strategy, involved 10 600 people aged over 18 and living in private dwellings in all States and Territories of Australia.<sup>44</sup>

Findings of the survey are described and analysed in *The Mental Health of Australians*.<sup>45</sup>

## Facts and statistics

### Mental illness in the adult Australian population

- ▶ Almost one in five Australians (17.7%) had experienced a mental disorder at some time during the 12 months before the survey.
- ▶ Younger people were more likely to experience a mental illness. Prevalence of mental disorders declines with age. 27% of 18-24 year olds had experienced a mental disorder, while only 6.1% of 65 year olds and over had experienced a mental disorder.
- ▶ Men and women experience similar rates of mental illness, but rates are highest for men and women living alone. Similarly, rates of mental disorder were higher among people who were separated or divorced (24% for men and 27% for women).
- ▶ Women are more likely than men to experience anxiety disorders (12% compared with 7.1%) and affective disorders (7.4% compared with 4.2%).
- ▶ Men were more than twice as likely as women to have substance abuse disorders (11% compared with 4.5%), with alcohol use disorders being more common than drug use disorders.
- ▶ Women were more likely to have anxiety and affective disorders in combination and men were more likely to have substance use disorders in combination with either affective or anxiety disorders.
- ▶ People unemployed or not in the paid workforce had the highest rates of mental disorder, a prevalence rate of 26.9% for unemployed men and 26% for unemployed women, compared with prevalence rates of 15.1% for men and 14.7% for women in full-time paid employment.
- ▶ Anxiety disorders were most common, and affected one in ten adults, followed by affective disorders 5.8% (of which depression is 5.1%), and substance use disorders – 7.7% (of which 6.5% is alcohol related).
- ▶ Those with a mental disorder averaged three days out of role (ie not undertaking normal activity because of health problems) over a four week period. This compared with one day out of role for people with no physical or mental condition.
- ▶ Only 38% of people with a mental disorder had used a health service and 29% had consulted a GP during the survey period.
- ▶ Hospital admissions for mental health problems were rare – less than 1% over the 12 month period.
- ▶ Women were more likely than men to use services for mental health problems.



## Young people and mental illness

- ▶ The greatest number of people with a mental illness are in the 18-24 year age group.
- ▶ Many people with schizophrenia first experience symptoms in their mid to late teen years.
- ▶ One third of people with a mental illness who are admitted to public hospitals are less than 30 years old.
- ▶ Depression is one of the commonest conditions in young people and increases during adolescence.
- ▶ Drug use can complicate diagnosis and exacerbate or trigger illness in vulnerable young people.

## Mental health of young people in Australia

- ▶ 14% of Australian children and adolescents aged 4-17 have mental health problems.
- ▶ This rate of mental health problems is found in all age and gender groups. Boys were slightly more likely to experience mental health problems than girls.
- ▶ There is a higher prevalence of child and adolescent mental health problems among those living in low-income, step/blended and sole-parent families.
- ▶ 21.1% of males and 22.1% of females with weekly household incomes of less than \$580 experienced mental health problems, compared to 8.9% of males and 9.1% of females living in households with a weekly income of more than \$1030.
- ▶ 25% of males and 19.7% of females living in step/blended families, and 22.2% of males and 26.7% of females living in sole-parent families experienced mental health problems, compared to 11.3% of males and 10.7% of females living with their original parents.
- ▶ Only one out of every four young persons with mental health problems had received professional health care.
- ▶ Family doctors, school-based counsellors and paediatricians provide the services that are most frequently used by young people with mental health problems. Younger children (4-12) were more likely to visit paediatricians and family doctors, while older children were more likely to visit school-based counselling services.
- ▶ Even among young people with the most severe mental health problems, only 50% receive professional help. Parents reported that help was too expensive or they didn't know where to get it, and that they thought they could manage on their own.

The Child and Adolescent Component of the National Survey of Mental Health and Well-being<sup>46</sup> is the first survey to investigate the mental health and well-being of children and adolescents in Australia.

4500 children aged 4-17 years were surveyed using interviews with parents and adolescents.

Adolescents with mental health problems report a high rate of suicidal thoughts and other health-risk behaviour, including smoking, drinking and drug use.

- ▶ 12% of 13-17 year olds reported having thought about suicide, while 4.2% had actually made a suicide attempt. Females had higher rates of suicide ideation than males.
- ▶ 23.1% reported smoking, 36.7% reported drinking, and 11% said they had used marijuana.

## Gender and mental illness

- ▶ Women are more likely than men to experience depression and anxiety disorders, while men are more likely to experience substance abuse.
- ▶ One in five recent mothers will experience a mild, moderate or severe form of post-natal depression.
- ▶ Though men and women are affected by schizophrenia in approximately equal numbers, women tend to experience later onset, fewer periods of illness, and better recovery.
- ▶ Obsessive-compulsive disorder is equally common in males and females.
- ▶ Up to 90% of eating disorders (anorexia nervosa and bulimia nervosa) occur in women.
- ▶ Sexual disorders, especially exhibitionism and fetishism, are much more common in men.
- ▶ Gender differences in different types of mental illness are influenced by cultural backgrounds.

## Myths about mental illness

*Myth: mental illness is a life sentence*

- ▶ Mental illness is not a life sentence. Most people will recover fully, especially if they receive help early. Some people may require ongoing treatment to manage their illness.
- ▶ Some people have only one episode of mental illness and recover fully. For others, mental illness occurs only occasionally with years of wellness between episodes. For a minority of those with a more severe illness, periods of acute illness will occur regularly and, without medication and effective management, leave little room for recovery.
- ▶ Many kinds of treatment are available. Not all involve medication.
- ▶ Though some people experience significant disability as a result of a chronic mental illness, many others live full and productive lives while receiving ongoing treatment and medication.
- ▶ Many people experiencing mental illness delay seeking help because they are frightened by the illness and fear stigma and discrimination. Reducing the stigma will encourage more people to seek help early.
- ▶ Most people with a mental illness are treated in the community, and most consult GPs.

*Myth: mental illnesses are all the same*

- ▶ There are many types of mental illnesses and many kinds of symptoms or effects.
- ▶ Though a particular mental illness will tend to show a certain range of symptoms, not everyone will experience the same symptoms – for example many people with schizophrenia may hear voices, while others may not.
- ▶ Simply knowing a person has a mental illness will not tell you how well or ill they are, what symptoms they are experiencing, or whether they may recover or manage the illness effectively.
- ▶ Mental illnesses are not purely ‘psychological’ and can have many physical features. While a mental illness may affect a person’s thinking and emotions, it can also have strong physical effects such as insomnia, weight gain or loss, increase or loss of energy, chest pain and nausea.

*Myth: people who are mentally ill are violent*

- ▶ Research indicates that people receiving treatment for a mental illness are no more violent or dangerous than the general population.
- ▶ People living with a mental illness are more likely to be victims of violence, especially self-harm. It has been calculated that the lifetime risk of someone with an illness such as schizophrenia seriously harming or killing another person is just .005%, while the risk of that person killing themselves is nearly 10%.<sup>47</sup>
- ▶ There appears to be a weak statistical association between mental illness and violence. This seems to be concentrated in certain sub-groups, for example – people not receiving treatment who have a history of violence, and those who abuse drugs or alcohol. However, the association between mental illness and violence is still weaker than the association between violence and alcohol abuse in general and between violence and being a young male between the ages of 15 and 25.<sup>48</sup>

*Myth: some cultural groups are more likely than others to experience mental illness*

- ▶ Anyone can develop a mental illness and no one is immune to mental health problems.
- ▶ People born in Australia have slightly higher rates of mental illness than those born outside Australia in either English-speaking or non English-speaking countries.
- ▶ Many people from culturally and linguistically diverse and refugee backgrounds have experienced torture, trauma and enormous loss before coming to Australia. These experiences can cause significant psychological distress and vulnerability to mental illness.
- ▶ Cultural background affects how people experience mental illness and how they understand and interpret the symptoms of mental illness.

Anxiety can occur in almost all age groups. One in five people will develop an anxiety disorder at some point in their lives.

The main types of anxiety disorder include:

- ▶ generalised anxiety disorder;
- ▶ simple phobia;
- ▶ social phobia;
- ▶ post-traumatic stress disorder;
- ▶ agoraphobia;
- ▶ panic disorder;
- ▶ obsessive compulsive disorder.

## Mental disorders

### Anxiety disorders

Anxiety disorders have in common an extreme sense of fear and worry and physical sensations that cover all systems of the body. Anxiety disorders occur when an individual has an intense and paralysing sense of fear or a more sustained pattern of worrying when there is no real danger or threat.

The symptoms of anxiety may include:

- ▶ a sense of worry or impending doom;
- ▶ feeling irritable, uneasy and unable to relax;
- ▶ body sensations such as breathlessness, palpitations, dizziness, sweating;
- ▶ overwhelming feeling of panic;
- ▶ sleep disturbances;
- ▶ difficulty concentrating;
- ▶ changed perceptions whereby, in a panic attack, the world may seem unreal.

Because of the strong physical symptoms associated with many anxiety disorders, people often seek help for what they believe is a physical illness. For example, the extreme sensations of a panic attack may be interpreted as a heart attack.

Untreated, moderate and severe anxiety disorders can cause great distress and disruption to a person's life and to those closest to them, and may lead to severe disability.

For most people, seeking professional help will result in recovery. Treatment may include counselling, behavioural and cognitive therapies such as systematic exposure therapy, and medication, depending on the form of anxiety and its severity.

Many factors influence the development of an anxiety disorder, including genetic makeup, previous life experiences, developmental stage, family history, and factors such as stress levels and physical condition. In some cases anxiety may be the result of a highly traumatic experience, such as torture or abuse. Many people with anxiety disorders also experience depression.

## Bipolar mood disorder

People with bipolar disorder experience recurrent episodes of extreme mood variation from major depression to very elevated mood (mania). The extent of mood range varies between people. Some experience both mania and depressed mood, others only the 'highs' without depression and episodes can range from mild to severe.

Symptoms of depression are outlined on the following pages.

Symptoms of mania tend to include:

- ▶ Feeling very high, happy and full of energy.
- ▶ Increased levels of energy and activity. People experiencing mania tend to have many activities and work very fast.
- ▶ Reduced need for sleep. This can be extreme, with people going for days without feeling any need for sleep.
- ▶ Rapid speech and thought.
- ▶ Irritability and a tendency to get angry with those who do not support or understand their ideas.
- ▶ Lack of inhibitions and a tendency to do things they would not normally do (eg spend large amounts of money; have brief, rapidly formed sexual relationships).
- ▶ Grandiose plans and beliefs where the individual feels particularly special or powerful and able to solve complex problems easily.
- ▶ Lack of insight that these behaviours or beliefs are unusual.

These symptoms and the behaviours produced can be damaging to people's lives and relationships. People with bipolar illness often have to contend with large debt, broken relationships and damaged reputations as a result of out-of-character behaviour during a manic episode.

Bipolar disorder is likely to be caused by several factors, including biochemistry, genetic inheritance, stress and sometimes seasonal effects. Between episodes of low or high mood, people experience normal mood variation and are able to live full and productive lives. For some people, extreme mood swings occur regularly; for others, the highs or lows may be occasional with years of stable moods between.

Treatment for bipolar illness, which may include medication, psychotherapy and lifestyle changes, tends to be effective. Maintenance treatment between episodes may greatly reduce or even prevent further episodes.

## Bipolar disorder was previously known as manic depression.

The onset of bipolar disorder is most common in peoples' twenties, though it may sometimes start in adolescence. Bipolar disorder occurs in about 1% of the population and tends to occur equally among men and women.

Depression refers to feelings of sadness and grief which most of us experience during our lives, as well as to a clinical form of mental illness.

Clinical depression is more than just temporary unhappiness or feeling down. It is a mood disorder that may be felt as a sadness that does not go away and/or an ongoing loss of pleasure and enjoyment in most activities. Depression may impair a person's ability to function or fulfil their usual social roles.

## Depression

- ▶ Major depression will be experienced by one in five adults at some point in their lives and accounts for more days lost to illness than almost any other disorder, physical or mental. Up to two fifths of Australia's young people suffer from depressed moods in any six monthly period.
- ▶ Some of the symptoms that often occur with major depression include sleep disturbance, loss of energy and concentration, feelings of worthlessness, hopelessness and guilt, inability to cope with decisions, weight loss or gain, and thoughts of death.
- ▶ Sometimes a depression develops after a major event, such as a loss of a loved one or a separation. Depression may also occur after repeated stress or ongoing abuse.
- ▶ Depression can also occur without apparent cause and in people who have coped well with life previously.
- ▶ Sometimes depression will lift after only a few weeks. In other cases the depression will continue for months or years, perhaps requiring hospitalisation, and affecting the person's life and relationships.
- ▶ Depression may run in some families. People who tend to be perfectionists and expect a great deal of themselves are also prone to depression, as are people who have experienced prolonged abuse or neglect.
- ▶ In its most serious form, a person with depression may lose touch with reality, experience hallucinations, or develop delusions. This is called psychotic depression and it can take months or years for full recovery to occur.
- ▶ Postnatal depression occurs soon after the birth of a baby and affects about 10% of all new mothers. This is a serious disorder in which mothers may feel sad and guilty for a prolonged period of time and feel unable to cope with daily life.
- ▶ Postnatal depression is not just 'the normal ups and downs' that come with having a baby. Symptoms may include mood changes, sleep and appetite disturbance, anxiety, loss of concentration and memory, feelings of guilt and inadequacy, and social withdrawal.
- ▶ There are a number of treatments for depression including professional counselling and psychotherapy (many varieties), anti-depressant medication and rarely, for some very severe prolonged depression, electro-convulsive shock therapy (ECT).
- ▶ The vast majority of people experiencing a major depression will recover fully, sometimes without treatment. However, effective treatment can greatly assist people to recover much faster and can lessen the pain and the cost that may be associated with the illness. It can also help people to develop strategies to better protect themselves against future bouts of illness.

## Eating disorders

### *Anorexia nervosa*

- ▶ Self-induced weight loss (through starvation, exercise and purging)
- ▶ Intense fear of becoming fat
- ▶ Cessation of menstrual periods in women

Individuals with anorexia report feeling fat even when severely underweight and hold distorted beliefs about body shape and weight. Other symptoms include odd eating habits, depression, exercise rituals, laxative abuse, insomnia, low blood pressure and poor physical health.

### *Bulimia nervosa*

- ▶ Repeated bouts of uncontrolled over-eating (bingeing)
- ▶ Intense fear of gaining weight
- ▶ Attempts to limit weight gain through intensive exercise, self-induced vomiting and use of laxatives and fluid tablets

While people with anorexia may lose weight to the degree that they endanger their lives, people with bulimia generally maintain a normal weight.

Causes of eating disorders are likely to involve a combination of genetic factors, family matters, unhappiness, stress level and societal preoccupation with dieting and weight control.

Treatment for eating disorders may include:

- ▶ nutritional treatment to recover physical health;
- ▶ cognitive-behavioural therapy around beliefs and distorted body image;
- ▶ psychotherapy;
- ▶ medication.

About half of people with eating disorders will recover, one quarter will continue to experience difficulty with symptoms, and the remaining quarter will not respond to treatment. It is likely that recovery rates will increase as the conditions are better understood and treatments become more targeted and effective.

The main characteristic of eating disorders is a preoccupation with control over eating, body weight, and food. Both men and women experience eating disorders, but far more women are affected.

## Personality disorders have been divided into three main groups:

- ▶ odd or eccentric behaviour (eg paranoid personality disorder);
- ▶ highly emotional, dramatic and erratic behaviour with particularly intense and problematic relationships (eg borderline personality disorder); and
- ▶ predominant anxiety, avoidance of social situations and a need for considerable support (eg dependent personality disorder).

Many individuals with personality disorders display features of more than one of these groups.

Personality disorders may range from mild to severe.

The person's behaviour or the disruption caused to others around the person may make it obvious that a problem exists. On the other hand, a person with a personality disorder may keep their distress well-disguised and hidden.

## Personality disorders

A person with a personality disorder has longstanding and persistent difficulties resulting from the way they feel about and view themselves, others and the world in general. They often experience themselves as unworthy or different, experience others as uncaring or even hostile and may view the world as a dangerous place devoid of any real meaning or sense of purpose.

As a result of these ways of viewing themselves and the world, relationships – whether intimate or in the work setting – are often fraught with difficulty. These difficulties are often so great that education, work and day-to-day living are disrupted to the point that significant social disadvantage may occur.

- ▶ People with personality disorders experience an inner fragility and lack the resilience to cope with many of life's difficulties. Not only can stressful or adverse life events have a devastating impact on their well-being, but so too can the responses of others towards them.
- ▶ Responses or actions of others which seem to confirm their sense of unworthiness or their expectation that others will treat them badly, for example, may lead to emotional responses of depression, anxiety, or even rage. These painful emotional experiences frequently lead to self-harm or suicide attempts.
- ▶ Individuals usually develop characteristic strategies to protect themselves from such painful experiences. These might include, on the one hand, either an intense need for relatedness, acknowledgement and support, or, on the other hand, avoidance of contact with others at all costs.
- ▶ Substance abuse, compulsive behaviour or idiosyncratic preoccupations are other ways that people with personality disorders attempt to deal with their internal distress.

There is a significant association between personality disorders and dysfunctional or abusive childhood experiences. As with other types of mental illness, it is likely that a number of other factors may also contribute to these disorders, including genetic inheritance and physical damage (eg to parts of the brain that influence personality).

- ▶ Treatment of personality disorders has generally been viewed as more difficult compared to other disorders, however, there is now strong evidence for the benefit of certain types of therapies.
- ▶ These are generally long-term and involve the development of a relationship with a therapist in which difficulties and their origins can be explored and understood, or in which new strategies, coping skills and alternative behaviours can be learnt.



## Schizophrenia

- ▶ The first onset of schizophrenia is usually in adolescence or early adulthood, particularly in males, although it can develop later, especially in females. The onset may be rapid, developing over several weeks, or it may be slow, over months or years.
- ▶ Some people experience only one or more brief episodes and recover fully. Others may have to deal with the illness throughout their lives.
- ▶ Early diagnosis and treatment can improve the course of the illness and reduce the short and longer term impact on the person's life.

Major symptoms may include:

- ▶ Thought disorder – thought and speech may become jumbled and difficult to follow. Conversation may jump from one subject to another without apparent logical connections, and reasoning processes make little sense to other people.
- ▶ Delusions – where the person holds false beliefs about being persecuted, being under outside control, or of being in some way 'special' or 'powerful'. These beliefs may seem bizarre to others and may continue to be held despite contradictory evidence.
- ▶ Hallucinations – though these can occur in any of the five senses (sight, sound, smell, taste and touch) they most commonly involve hearing voices. The person may experience one or more voices, often threatening or pejorative, conversing or commenting on their behaviour or thoughts. Hallucinations are experienced as very real by the individual and can be very disruptive.

Other symptoms can include:

- ▶ loss of drive, initiative or motivation;
- ▶ reduced ability to express emotions or respond appropriately to people;
- ▶ withdrawal from contact with other people;
- ▶ lack of insight into own behaviour and thinking, and denial of the illness;
- ▶ side effects of medication. While medication is improving, many side effects may be unpleasant and disruptive.

Schizophrenia is a potentially serious mental illness which affects almost one person in 100. The term covers several related disorders, all with overlapping symptoms.

Schizophrenia is not 'split' personality or intellectual disability.

#### Treatment:

- ▶ No cure is known for schizophrenia, but great advances have been made in early management as well as longer term control of the illness. Early detection of the initial symptoms (early psychosis) and their management with medication, psychotherapy, social support and family programs can help to return the person to optimal functioning in work, education, and personal life.
- ▶ Care is primarily in the community through community mental health services. However, the person may require a period of time in hospital if they are having an acute attack or are potentially suicidal.
- ▶ If the illness is recurrent or chronic, some people may require assistance with finances, accommodation, employment and social support. Rehabilitation and support programs may also play an ongoing role.

# 10. Contacts

For the most current and extensive list of contacts refer to the Contacts section of the Mindframe website at [www.mindframe-media.info](http://www.mindframe-media.info)

## NATIONAL HELPLINES

Lifeline 24 hour counselling and referral service	13 11 14
Kids Helpline 24 hour counselling service for people under 18 years	1800 55 1800
Just Ask Mental health information line for rural communities	1300 13 11 14
Mental Illness Fellowship Mental health information and referral	1800 98 59 44
Mensline Australia 24 hour counselling service for men	1300 78 99 78
SANE Helpline Mental illness information, support and referral	1800 18 SANE (7263)

## STATE CRISIS AND REFERRAL LINES

ACT	Crisis	(02) 6205 1065 or 1800 629 354
NSW	Referral	(02) 9816 5688 (metro) or 1800 674 200 (country)
NT	Crisis	(08) 8999 4911 (Darwin) or (08) 8951 7710 (Alice Springs)
QLD	Referral	(07) 3271 5544 or 1300 729 686
SA	Crisis	13 14 65 (metro) or 1800 182 232 (country)
TAS	Crisis	(03) 6233 2388 or 1800 332 388
VIC	Crisis	13 61 69
WA	Crisis	(08) 9227 6822 or 1800 676 822

## Helplines

- ▶ Include contact details for crisis and referral services in your story.
- ▶ Before publishing any of the contacts below, check the details – they may have changed.
- ▶ Inform the agency so that it can deal with possible increased demand following media exposure.

For local stories, check the availability of local services and phone lines. The general practitioner, community health centre, local Lifeline or local mental health services may be able to assist with support and referral.

## EXPERT COMMENT

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Australian Institute for Suicide Research and Prevention

*Suicide and self harm research, suicide prevention, training*

[www.griffith.edu.au/aisrap/](http://www.griffith.edu.au/aisrap/)

(07) 5552 9089 or 0408 727 706

beyondblue – the national depression initiative  
*Depression and suicide, anxiety, bipolar disorder, postnatal depression, mental health policy*

[www.beyondblue.org.au](http://www.beyondblue.org.au)

[www.ybblue.com.au](http://www.ybblue.com.au) (youth website)

(03) 9810 6100 or 0408 810 242

Black Dog Institute

*Depression, Bipolar Disorder, stigma and discrimination*

[www.blackdoginstitute.org.au](http://www.blackdoginstitute.org.au)

(02) 9382 4368

depressioNet

*depression and online support, mental illness, suicide and self harm, stigma*

[www.depressionnet.com.au](http://www.depressionnet.com.au)

(02) 9331 7222 or email

[team@depressioNet.com.au](mailto:team@depressioNet.com.au)

Lifeline

*Mental health and wellbeing, help seeking, suicide and self harm, stigma*

[www.lifelineaustralia.org.au](http://www.lifelineaustralia.org.au)

(02) 6295 8088 or 0410 442 236

Mental Health Council of Australia

*Delivery and funding of mental health services, mental health policy, suicide, stigma*

[www.mhca.org.au](http://www.mhca.org.au)

(02) 6285 3100 or 0417 289 111

ORYGEN Youth Health and ORYGEN Research Centre

*Youth mental illness (mood, anxiety, eating, substances), suicide, self harm, early intervention*

[www.orygen.org.au](http://www.orygen.org.au)

(03) 9342 3775 or 0401 825 772

SANE Australia

*Mental illness, suicide and self-harm, stigma and discrimination, media reporting*

[www.sane.org](http://www.sane.org)

[www.itsallright.org](http://www.itsallright.org) (young relatives and friends)

(03) 9682 5933 or 0414 427 291

Suicide Prevention Australia

*Suicide and self harm, suicide prevention, suicide postvention, stigma*

[www.suicidepreventionaust.org](http://www.suicidepreventionaust.org)

(02) 9568 3111 or 0425 382 800

National Drug and Alcohol Research Centre

*Drugs and alcohol, co-morbidity, amphetamine psychosis, cannabis and psychosis*

<http://ndarc.med.unsw.edu.au>

(02) 9385 0226 or 0419 402 099

## HEALTH DEPARTMENTS

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	<b>mental health</b>	<b>media unit</b>
ACT Health and Community Care	(02) 6205 5142	(02) 6205 0837
NSW Health	(02) 9391 9309	(02) 9391 9121
NT Health and Community Services	(08) 8999 2553	(08) 8999 2753
QLD Health	(07) 3234 0111	(07) 3234 1135
SA Department of Health	(08) 8226 0777	(08) 8226 6488
TAS Health and Human Services	(03) 6230 7549	(03) 6233 4890
VIC Human Services	(03) 9616 8592	(03) 9616 7296
WA Department of Health	(08) 9222 4099	(08) 9222 4333

## STATISTICS AND RESEARCH

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Australian Bureau of Statistics  
[www.abs.gov.au](http://www.abs.gov.au)  
1300 135 070

Australian Institute of Health and Welfare  
[www.aihw.gov.au](http://www.aihw.gov.au)  
(02) 6244 1000

Australian Institute of Family Studies  
[www.aifs.gov.au](http://www.aifs.gov.au)  
(03) 9241 7888

Australian Institute of Criminology  
[www.aic.gov.au](http://www.aic.gov.au)  
(02) 6260 9200

Australian Institute for Suicide Research and Prevention  
[www.gu.edu.au/aisrap](http://www.gu.edu.au/aisrap)  
(07)3875 3377

Centre for Mental Health Research  
[www.anu.edu.au/cmhr](http://www.anu.edu.au/cmhr)  
(02) 6125 2741

Clinical Research Unit for Anxiety Disorders  
[www.crufad.com](http://www.crufad.com)  
Phone: (02) 8382 1720

Queensland Centre for Schizophrenia Research  
[www.qcsr.uq.edu.au](http://www.qcsr.uq.edu.au)  
Phone: (07) 3271 8660

Research Centre for Injury Studies  
[www.nisu.flinders.edu.au](http://www.nisu.flinders.edu.au)  
(08) 8201 7602

ORYGEN Research Centre  
[www.orygen.org.au](http://www.orygen.org.au)  
(03) 9342 2800

World Health Organisation - Mental Health  
[www.who.int/mental\\_health](http://www.who.int/mental_health)

## ABORIGINAL AND TORRES STRAIT ISLANDER

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Auseinet  
Aboriginal and Torres Strait Islander Section  
[www.auseinet.com](http://www.auseinet.com)  
Phone: (08) 8201 7670

Australian Indigenous Health Infonet  
[www.healthinfonet.ecu.edu.au](http://www.healthinfonet.ecu.edu.au)  
Email: [healthinfonet@ecu.edu.au](mailto:healthinfonet@ecu.edu.au)  
Phone: (08) 9370 6109

LIFE: National Suicide Prevention website  
Aboriginal and Torres Strait Islander Section  
[www.livingisforeveryone.com.au](http://www.livingisforeveryone.com.au)  
Phone: (08) 8201 7670 (Auseinet)

Office for Aboriginal and Torres Strait Islander  
Health (OATSIH)  
[www.health.gov.au](http://www.health.gov.au)  
Email: [oatsih.enquiries@health.gov.au](mailto:oatsih.enquiries@health.gov.au)  
Phone: (02) 6289 5027

Vibe Australia  
For Aboriginal Medical Services:  
[www.vibe.com.au](http://www.vibe.com.au)  
Email: [admin@vibe.com.au](mailto:admin@vibe.com.au)

## MULTICULTURAL

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ACT Transcultural Mental Health Network  
[www.mmha.org.au/ServicesDatabase/acttmhn/view](http://www.mmha.org.au/ServicesDatabase/acttmhn/view)  
Phone: (02) 6205 1178

NSW Transcultural Mental Health Centre  
[www.dhi.gov.au/tmhc](http://www.dhi.gov.au/tmhc)  
Phone: (02) 9840 3800

Queensland Transcultural Mental Health Centre  
[www.health.qld.gov.au/pahospital/qtmhc/default.asp](http://www.health.qld.gov.au/pahospital/qtmhc/default.asp)  
Phone: (07) 3240 2833

Migrant Health Service, Adelaide  
[www.mmha.org.au/ServicesDatabase/MigrantHealthService/view](http://www.mmha.org.au/ServicesDatabase/MigrantHealthService/view)  
Phone: (08) 8237 3900

Multicultural Mental Health Australia (MMHA)  
[www.mmha.org.au](http://www.mmha.org.au)  
Phone: (02) 9840 3333

Tasmanian Transcultural Mental Health Network  
Phone: (03) 6332 2200

Victorian Transcultural Psychiatry Unit  
[www.vtpu.org.au](http://www.vtpu.org.au)  
Phone: 03 9417 4300

West Australian Transcultural Mental  
Health Centre  
[www.mmha.org.au/watmhc](http://www.mmha.org.au/watmhc)  
Phone: 08 9224 1760

## HEALTH PROFESSIONALS

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Royal Australian College of General Practitioners  
Professional association providing support and education for general practitioners.  
[www.racgp.org.au](http://www.racgp.org.au)  
(03) 8699 0414

Royal Australian and New Zealand College of Psychiatrists  
Professional association of psychiatrists providing support and professional development  
[www.ranzcp.org/](http://www.ranzcp.org/)  
(03) 9640 0646

Australian Medical Association  
Professional body for Australian doctors  
[www.ama.com.au](http://www.ama.com.au)  
(02) 6270 5400

Australian Psychological Society  
Professional association representing the interests of psychology and psychologists  
[www.psychsociety.com.au](http://www.psychsociety.com.au)  
(03) 8662 3300 or 1800 333 497

## OTHER CONTACTS

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Auseinet  
Australian Network for Promotion, Prevention and Early Intervention for Mental Health  
[www.auseinet.com](http://www.auseinet.com)  
(08) 8201 7670

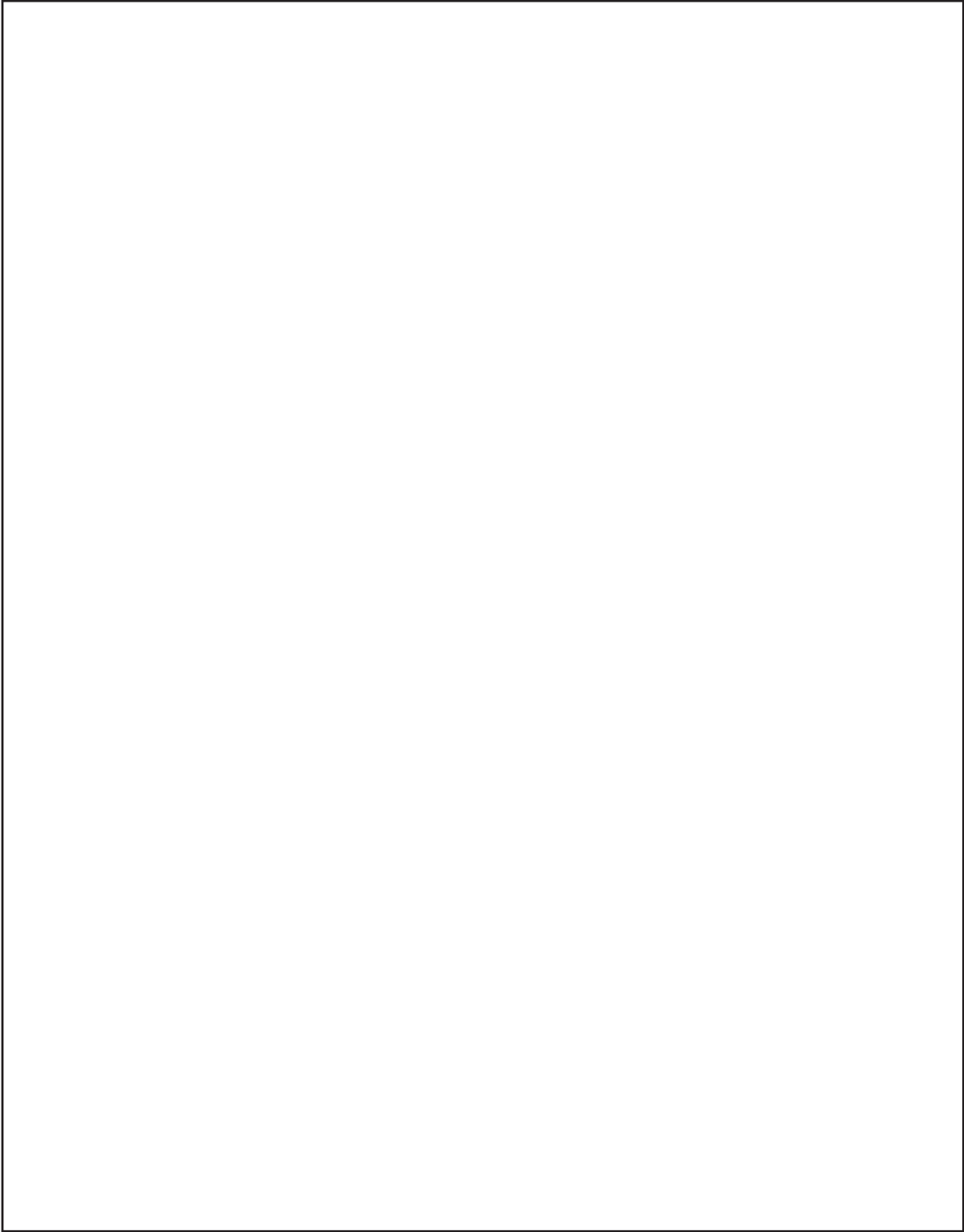
Australian Government Department of Health and Ageing  
[www.mentalhealth.gov.au](http://www.mentalhealth.gov.au)  
Phone: (02) 6289 1555 or 1800 020 103

Life: Living is for Everyone  
National Suicide Prevention Strategy  
[www.livingisforeveryone.com.au](http://www.livingisforeveryone.com.au)  
Phone: (08) 8201 7670 (Auseinet)

National Association for Loss and Grief  
Association involved in research, advocacy, referral, information, and training for grief and loss counsellors  
SA: (08) 8342 4005  
NSW: (02) 6882 9222  
VIC:(03) 9650 3000

ReachOut!  
Interactive website to 'help young people get through tough times'.  
[www.reachout.com.au](http://www.reachout.com.au)

LOCAL CONTACTS *Add your local contacts here*

A large, empty rectangular box with a thin black border, intended for users to add their local contacts. The box is currently blank.



# Codes of practice on reporting and portraying suicide and mental illness

## AUSTRALIA

### Print

*Australian Press Council  
www.presscouncil.org.au/*

The APC released revised reporting guidelines on suicide in July 2001.

The guidelines state that findings on the link between reporting and actual suicide are inconclusive. However the APC calls on the press to continue exercising care and responsibility in reporting suicide and mental illness.

The Council believes that papers are already aware of the desirability of avoiding:

- ▶ *adding to the pain of relatives and friends of the deceased;*
- ▶ *any reporting which might encourage copy-cat suicide or self-harm;*
- ▶ *unnecessary reference to details of method or place of a suicide;*
- ▶ *language or presentation which trivialises, romanticises, or glorifies suicide, particularly in papers which target a youth readership;*
- ▶ *loose or slang use of terms to describe various forms of mental illness, and the risk of stigmatising vulnerable people that may accompany such labels.*

The Council also recommends that articles dealing with suicide include reference to counselling services available to people in distress and their families, with contact details.

Since the Council takes the view that some suicides will be reported, as a matter of public interest, it does not advocate precise rules or guidelines.

*Instead, the Press Council prefers to encourage responsible approaches to the reporting of suicide and mental illness, and consultation with reputable associations, research centres, counselling services and health authorities when seeking comment for articles on these issues.*

## Appendix 1

Most media sectors have codes on reporting and portrayal of suicide.

While some also mention reporting and portrayal of mental or intellectual disability, mental illness is not specified, except by Australian Press Council reporting guidelines.

News Limited and John Fairfax do not issue codes of conduct to journalists. However both companies belong to the Australian Press Council. Some Fairfax papers, such as The Age and the Sydney Morning Herald, have their own code of ethics. These are consistent with the Press Council's guidelines.

The Australian Broadcasting Authority helps the television, radio and internet industries to develop codes of practice relating to content and complaints handling and investigates complaints about inappropriate content on broadcasting services and the internet.

Industry codes and standards are registered with the ABA.

[www.aba.gov.au/](http://www.aba.gov.au/)

## Broadcast

### *Commercial Television Australia*

The 1999 code of practice provides that:

For Children's (G) Hours (6am to 8.30am and 4pm to 7.30pm weekdays and 6am to 7.30pm at weekends):

- ▶ Only limited and careful verbal reference to suicide is acceptable, when absolutely justified by the story-line or program context, and provided that it is not presented as heroic, alluring or normal.

For late night (MA–AV) timeslots (9.30pm to 5am):

- ▶ Methods of suicide should not be shown in realistic detail. The program must not promote or encourage suicide.

### *Commercial Radio Australia Ltd*

In its 1999 code of practice the commercial radio industry provides that:

- ▶ 'a licensee must not broadcast a program which depicts suicide favourably or as a means of achieving a desired result, or which
- ▶ is likely to incite or perpetuate hatred against or vilify any person or group on the basis of ... mental disability.'

### *Internet Industry Association*

The 1999 internet content code of practice requires internet service providers to assist parents to regulate internet use by children under 18.

### *Australian Record Industry Association Limited*

The ARIA code of practice for labelling products with explicit or potentially offensive lyrics provides that albums which give instructions on how to commit suicide shall be refused classification and are not permitted to be sold.

### *Australian Association of National Advertisers*

The ANAA code of ethics does not specifically address suicide and mental illness.

### *Community Broadcasting Association of Australia*

The CBAA code of practice for television is similar to the commercial industry code. The radio code of practice does not specifically address suicide or mental illness.

### *Australian Subscription Television and Radio Association*

The ASTRA code of practice does not deal specifically with suicide and mental illness.

### *Media, Entertainment and Arts Alliance*

The AJA code of ethics says that journalists should respect private grief and personal privacy and never exploit a person's vulnerability or ignorance of media practice. Interviews should only be conducted after the informed consent of the interviewee.

### *The Australian Broadcasting Corporation (ABC)*

In its Code of Conduct, the ABC says that:

- ▶ If reported at all, suicides will be reported in moderate terms and will usually avoid details of method.
- ▶ Sensitivity will be exercised in broadcasting images of or interviews with bereaved relatives.

ABC Editorial Policy states that:

- ▶ The depiction of suicide in drama should be handled with extreme sensitivity; responsibility should be exercised to ensure that events or methods depicted do not encourage others to copy these actions.
- ▶ If reported at all, suicides should be reported in moderate terms. Reports should usually avoid details of method, with descriptions in general terms only, unless there is a good reason to go into detail. When the method used is unusual, reports should continue to be circumspect.
- ▶ Great care and sensitivity should be exercised in interviewing bereaved relatives.

*The Special Broadcasting Service (SBS)* code of practice (1999) states that SBS 'recognises that any portrayal of suicide requires a high degree of sensitivity. SBS will not broadcast material which is likely to incite or encourage self-harm or suicidal behaviour.'

## International

A number of international agencies – including media, suicide prevention and mental health bodies - have developed guidelines for media reporting.

A list of some examples, with website details for further information, is included here.

- ▶ Reporting on Suicide:  
Recommendations for the Media  
The American Foundation for Suicide Prevention recently released new guidelines for reporting on suicide. Available at <http://www.asc.upenn.edu/test/suicide/web/3.html>
- ▶ The UK Broadcasting Standards Commission's guidelines outline recommendations for reporting suicide and mental illness in the UK. Available from <http://www.bsc.org.uk> (look for 'codes of guidance fairness and standards and privacy' under 'about the commission')
- ▶ The Samaritans have developed media guidelines for appropriate reporting of suicide. These are available at <http://www.ias.ie/media/>

## Media organisations consulted in the redevelopment of this resource

### **MEDIA INDUSTRY AND REGULATORY BODIES**

- ▶ Australian Association of National Advertisers (AANA)
- ▶ Australian Broadcasting Authority (ABA)
- ▶ Australian Broadcasting Corporation (ABC)
- ▶ Australian Press Council
- ▶ Community Broadcasting Association of Australia (CBAA)
- ▶ Australian Subscription Television and Radio Association (ASTRA)
- ▶ Commercial Radio Australia (CRA) – formerly Federation of Australian Radio Broadcasters
- ▶ Commercial Television Australia (CTVA) – formerly Federation of Commercial Television Stations
- ▶ Media, Entertainment and Arts Alliance (MEAA)
- ▶ Office of Film and Literature Classification (OFLC)

In-depth interviews were conducted with media professionals from all States and Territories.

# Members of the National Media and Mental Health Group

Members are:

Ms Alina Lieurance  
FreeTV Australia

Mr Moses Kakaire  
Commercial Radio Australia

Mr Warwick Costin  
Australian Press Council

Mr Rex Jory  
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Ms Heather Forbes  
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Ms Barbara Hocking  
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Ms Julie Foster  
beyondblue – the National Depression Initiative

Ms Janet Meagher  
Australian Mental Health Consumer Network

## Appendix 3

The National Media and Mental Health Group was established in 2000 to provide advice about appropriate initiatives and methods to encourage the media to report and portray suicide and mental illnesses in a way that is least likely to cause harm, induce copycat behaviour, or contribute to the stigma experienced by people who have a mental illness.

Ms Joy Said AM  
Mental Health Council of Australia

Mr Michael Winter  
Australian Writers' Guild

Ms Georgina McClean  
Special Broadcasting Service

Chair & Secretariat  
Mental Health and Suicide Prevention Branch  
Australian Government Department of Health and Ageing

## Glossary

**Advocates:** people given the power by consumers to speak on their behalf.

**Aetiology:** all the factors that contribute to the development of an illness or disorder.

**Anxiety:** an unpleasant feeling of fear or apprehension accompanied by increased level of psychological arousal (eg heart rate, breathing).

**Anxiety disorder:** a disorder characterised by extreme sense of fear and worry with intense psychological sensations in situations where there is no real danger or threat. The sensations and intense fear are such that the individual is unable to function effectively in the feared situation.

**Agoraphobia:** fear about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available if a panic attack occurs. Fears can include situations such as being outside the home alone; being in a crowd or standing in a line; being on a bridge; and travelling in a bus, train, or car.

**Anorexia nervosa:** a serious eating disorder whose core feature is self-induced weight loss by starvation, exercise and purging. Individuals experience a distorted body image and an intense fear of becoming fat even when severely underweight.

**Assessment:** the systematic and ongoing evaluation of information about a consumer to determine his or her diagnosis, needs and the desired outcome of care.

**Bipolar disorder:** the more recent name for the mood disorder manic depressive illness. It is characterised by the presence of history of manic (or hypomanic) episodes usually alternated with depressive episodes although some individuals do not experience the depressed mood.

**Bulimia nervosa:** an eating disorder characterised by eating binges during which the person feels a loss of control and self disgust. To compensate for the binges and to avoid weight gain, individuals use self-induced vomiting and/or the abuse of laxatives and fluid tablets.

**Carer:** a person whose life is affected by a close relationship with a consumer, or who has chosen and contracted a caring role.

**Chronic:** of long duration or recurring frequently, often with progressive seriousness.

**Consumer/client:** a person who has experienced mental illness and has received services or has been significantly affected by a mental health service.

**Depressed mood:** feelings of sadness and unhappiness that most of us experience at times throughout our lives.

**Depressive disorder:** clinical term for a number of mood disorders characterised by deep and ongoing sadness and loss of pleasure; a collection of disturbances in emotional, behavioural and cognitive functioning that is defined by standard psychiatric diagnostic criteria.

**Diagnosis:** a decision based on the recognition of clinically relevant symptomatology, the consideration of causes that may exclude a diagnosis of another condition, and the application of clinical judgement.

**Discharge:** refers to the time when a person who has attempted suicide leaves the hospital or mental health facility. Research shows that there is increased risk of suicide up to four weeks after discharge from a mental health facility.

**Hallucinations:** most common form is hearing imaginary voices. Less common is seeing, tasting or smelling imaginary things that are very real to the person.

**Hypomania:** an episode of illness that resembles mania but is less intense and less disabling. The state is characterised by an euphoric mood, an unrealistic optimism, increased speech and activity, and a decreased need for sleep. For some, there is increased creativity, while others experience reduced judgement and functioning.

**Incidence:** The number of cases identified in a given period, usually a year, ie the number of people who die by suicide. Incident rate is usually expressed per 100 000 population.

**Maintenance treatment:** treatment designed to prevent a recurrence of illness or maintain maximum health.

**Mania/manic episode:** an episode of illness characterised by extreme mood swing where a person feels extremely high, energetic, and agitated, has less need for sleep and experiences rapid speech and thought. Some people also experience hallucinations and delusions.

**Mental disorder:** a diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities. Often used interchangeably with the term mental illness.

**Mental health:** holistic sense of well being and the capacity of people within groups and an environment to interact in a way that promotes subjective well-being and optimal development to achieve individual and collective goals.

**Mental health literacy:** 'The ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments and of professional help available, and attitudes that promote recognition and appropriate help-seeking.' (Jorm et al 1997, 182)

**Mental health problem:** reduced emotional, social, cognitive ability or well-being but not to the extent that the criteria for a mental disorder are met; disruption in the interactions between the individual, the group and the environment producing a reduced state of mental health.

**Mental health professional:** professionally trained person working specifically in mental health such as a social worker, psychologist, psychiatrist, psychiatric nurse and occupational therapist.

**Mental health promotion:** activity to maximise mental health and well-being among populations and individuals.

**Mental health service:** public or private service in which the primary role is to provide treatment, rehabilitation or community support for people affected by mental disorder or psychiatric disability.

**Mental illness/disorder:** a recognised, medically diagnosable illness which results in a significant impairment of an individual's thinking and emotional abilities and may require intervention.

**National Mental Health Strategy:** comprises the National Mental Health Policy and Plan adopted by Commonwealth, State and Territory Health Ministers in 1992 and the Statement of Rights and Responsibilities. The strategy commits all governments to improve the lives of people with a mental illness.



**National Suicide Prevention Strategy:**

a \$48 million whole-of-government and whole-of-community approach to suicide prevention, building on the National Youth Suicide Prevention Strategy. The NSPS supports national suicide prevention activities across the lifespan, with a continuing focus on young people. Activities include education and training within communities, building networks between primary care providers such as general practitioners and community organisations, and initiatives that aim to address risk and protective factors for suicide, including media activities and community development.

**National Youth Suicide Prevention Strategy:**

a \$31 million coordinated approach to youth suicide prevention (which ended in June 1999) that involved all Australian governments, health professionals, carers, researchers and others. Funding was provided for rural youth counselling, enhanced telephone counselling, programs for parents, the education and training of professionals and for research activities.

**Obsessive/compulsive disorder:** mental health disorder characterised by constant unwanted thoughts; often results in the performance of elaborate rituals in an attempt to control or banish the persistent thoughts. For example, the person may continually return home to check that the oven is turned off.

**Panic attacks:** episodes of overwhelming physical symptoms of anxiety and a fear of death or total loss of control; extreme panic attacks can occur in situations that would not scare most people.

**Phobia:** intense fear of specific objects/situations where there is no real danger. Phobias interfere significantly with the individual's ability to function effectively in the feared situation.

**Postnatal depression:** a serious depressive disorder that affects about one in eight women after the birth of a baby and involves mood changes, appetite and sleep disturbance, feelings of inadequacy, anxiety and guilt, and loss of concentration and memory.

**Prevalence:** the proportion of the population with the disease/disorder.

**Protective factors:** refers to a range of factors that appear to have the capacity to protect individuals who might otherwise be at risk of suicide.

**Psychiatric disability:** loss or deficit in a person's day-to-day functioning which is the result of having or having had a mental disorder. The level of psychiatric disability may be minimal or nonexistent if the disorder is well managed or if the individual has fully recovered.

**Psychiatrist:** medical practitioner with specialist training in psychiatry.

**Psychologist:** allied health professional with specialist training in psychology.

**Psychosis/psychotic episode:** a period of mental illness when the person loses contact with reality. The ability to make sense of thoughts, feelings and external information is seriously affected.

**Post-traumatic stress disorder:** many people who have experienced major trauma such as war, torture, motor accidents, fires or violence continue to feel terror long after the event. They may experience nightmares or flashbacks for years.

**Risk factors:** 'Those characteristics, variables, or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random from the general population, will develop a disorder.' (Mrazek and Haggerty 1994, 127)

**Schizophrenia:** a mental illness that affects one in 100. It interferes with a person's mental functioning and, over the long term, may cause personality changes. The first onset is usually in adolescence or early adulthood.

**Self-harm:** this includes the various methods by which individuals harm themselves, such as self-laceration, self-battering, taking overdoses, or deliberate recklessness. Recent research suggests that self-harm is more common than attempted suicide and is a serious youth health problem.

**Social phobia/ social anxiety:** fear that others will judge everything you do or say in a negative way. People may believe they are permanently flawed and worthless if any sign of poor performance is detected.

**Stigma:** a mark of shame or disapproval, of being shunned. It emerges when people feel uneasy or too embarrassed to talk about behaviour they perceive as different. Some degree of stigma is associated with all mental illness but is particularly strong when the illness results in unusual behaviour. Stigma can create a wall of silence that is damaging to the person, the community, his or her family and friends.

**Suicidal behaviours:** a broad term that describes the many types of non-accidental self-harm including suicide attempt.

**Suicide:** a conscious and deliberate act to end one's life. By conscious act, it is meant that the act was done to end the person's life.

**Suicide ideation:** a pattern of thoughts about suicide.

**Support:** support may refer to ongoing care by professionals as part of a therapeutic process or it may refer to support provided by anyone in the community.

**Substance use disorders:** disorders in which drugs are used to an extent that behaviour becomes maladaptive; social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug may be psychological, as in substance misuse, or psychological, as in substance dependence.

**Symptom:** an observable physiological or psychological manifestation of a disorder or disease, often occurring in a group to constitute a syndrome.

**Treatment:** an intervention (either medication or therapy) by a recognised health professional such as a psychiatrist, general practitioner or other doctor, nurse, psychologist, occupational therapist, social worker or other professional mental health worker.

**Werther effect:** a term drawn from literature to describe the copycat effect after media reporting of suicide. Relates to the story 'The Trials of Young Werther' by Johan Wolfgang von Goethe.

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