

Mental illness and suicide

D R A M A

SCENE 24

TAKE 4

a Mindframe resource for stage and screen



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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.

Developed by the Hunter Institute of Mental Health in partnership with the Australian Writers' Guild and SANE Australia for the Mental Health and Suicide Prevention Programs Branch, of the Australian Government Department of Health and Ageing.

Developed with the assistance of Australian scriptwriters and consumers, carers and service providers in mental health.

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The project website at www.mindframe-media.info contains the most up-to-date contacts and information on how to obtain additional copies of the resource.

Foreword

This resource forms part of the ***Mindframe Stage and Screen*** project funded by the Australian Government Department of Health and Ageing.

It has been developed with the support of the National Media and Mental Health Group, with representatives from all the peak media bodies in Australia, mental health and suicide prevention representatives and the Australian Writers' Guild.

Good writing comes from good research, when the writer knows the subject well and can build good characters and a strong narrative in circumstances which ring true. In an age when anything can be Googled it seems that research is easy. Some subjects, however, are easier to research than others. When it comes to mental illness and suicide, it's not hard to find facts and statistics – it's much harder to find what a writer really needs; first hand stories about what it is like to live with mental illness.

As someone who has written about a related area, dementia, I was interested when the Writers' Guild was asked by the Australian Government Department of Health and Ageing to take part in the preparation of this resource. Members of the Guild, working in partnership with mental health agencies and people directly affected by mental illness and suicide have assembled something invaluable for anyone contemplating a story in this subject area. There are nuggets in here, real gold. And not only is this booklet a wonderful resource for writers, it contains much useful information for producers, directors and anyone involved in putting these challenging stories onto the stage or screen.

Geoffrey Atherden





‘ I don’t want to be told
what to write about, but
I want to be informed
about what I write ’

About this resource

This resource provides practical advice and information for people involved in the development of Australian film, television and theatre. It is designed to help inform truthful and authentic portrayals of mental illness and suicide.

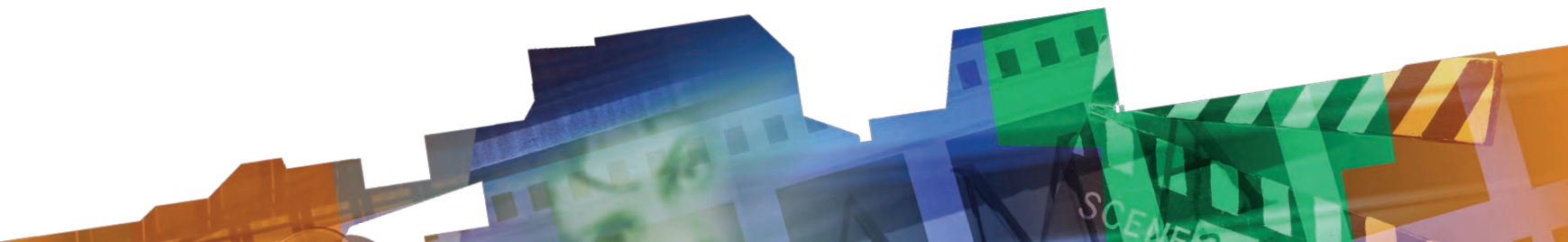
Mental Illness and Suicide: A Mindframe resource for stage and screen provides information about audience impact and key issues to consider when developing storylines that include either mental illness or suicide. The resource also provides contextual information about mental illness and suicide.

The resource has been developed in consultation with Australian scriptwriters and people with experience of mental illness.

It is also available online at www.mindframe-media.info

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SCENES

Introduction

In Australia, 45% of people¹ will directly experience a mental illness in their lifetime and around 1900² people per year take their own life. Many more people are affected by mental illness and suicide as a family member, friend or colleague.

Film, television and theatre exert a powerful influence on community attitudes towards mental illness and suicide. In March 2007, a workshop brought together Australian scriptwriters with people directly affected by mental illness and those working in mental health. This established the need for resources that would enhance the development of more truthful and authentic portrayals of mental health issues rather than portrayals that perpetuate current myths and stereotypes.

As one writer commented, “there are so many opportunities to make good drama out of reality rather than trying to make drama out of not very well informed fantasy.”

‘I think at times under the pressure of production [we] do resort to stereotypes. The problem is, not only do you perpetuate a stereotype but you miss out on a better story’



‘For me it’s about honesty. It doesn’t mean you have to portray everyone and everything as positive and wonderful, but I just think you need to have your facts right’

When developing a storyline that includes **mental illness, ask yourself...**

- Why am I introducing mental illness into the story?
- Will my portrayal be fresh and original?
- Am I perpetuating or challenging common stereotypes?
- Will my portrayal be truthful and show a range of experience?
- Can I improve the accuracy and authenticity of my portrayal?
- Can the storyline model or promote help-seeking behaviour?

When developing a storyline that includes **suicide, ask yourself...**

- Why am I introducing suicide into the story?
- Should the suicide act be portrayed?
- Might my portrayal of suicide be wrongly interpreted as a solution to a problem?
- How can I explore the issue with more depth?
- Have I checked the accuracy and authenticity of my portrayal?
- Can I encourage people who are distressed to seek help?

Audience Impact...

Because of their broad reach and appeal, film, television and theatre may exert a powerful influence on community attitudes towards mental illness³⁴⁵.

Handled well, storylines involving mental illness provide an opportunity for sensitive, engaging and powerful material. Handled poorly, storylines can have harmful effects, perpetuating the stigma associated with mental illness. Stigma can reduce the likelihood that people who experience mental illness will seek appropriate help.

People living with a mental illness and their families report that⁶:

- they experience stigma regularly and the effects of stigma are often more distressing than the symptoms of the illness;
- less stigma is the number one thing that would make their lives better;
- negative or stereotyped depictions of mental illness make life more difficult for them.

People with mental illness have also made suggestions about ways to improve portrayals of mental illness⁷:

- researching for accuracy;
- directing viewers how to get help;
- showing well rounded and factual portrayals;
- using appropriate language.

‘...makes me feel like I am crazy and that one day I will act like they are portraying. This makes me scared’

‘I had not really considered the whole concept that stigma could actually be worse than the symptoms of mental illness... I was aware they were affected by portrayals on film and television, but not to the extent that these portrayals may discourage people from seeking treatment and discourage people from being open about their illness..?’

Research⁸ has revealed that people living with a mental illness are often inaccurately portrayed as:

- having a violent or aggressive nature;
- being eccentric, seductive, self-obsessive;
- objects for scientific observation; or
- simpletons.

A skewed picture of mental health treatment is often presented, emphasising the more dramatic psychotherapy and electro convulsive therapy (ECT) rather than more common forms of treatment such as medication⁹. Alternatively, the impression can be given that all treatments are ineffective and instead love will conquer all.

Mental health professionals are variously portrayed as incompetent, sinister, unrealistically selfless or seductive (in the case of women), or only to be proved wrong as the plot unfolds.

For a full review of the research evidence, visit www.mindframe-media.info

Key Issues to Consider...

45% of Australian's will directly experience a mental illness in their lifetime¹⁰ with many more supporting a family member or friend through that experience. Your audience will include people directly affected by mental illness as well as people who have limited knowledge of mental illness.

When developing a storyline that might include mental illness, you may want to **ask yourself ...**

Why am I introducing mental illness into the story?

- Is it to explore the issue from a personal perspective or is it just an easy way to resolve a storyline?
- How will introducing a character with a mental illness impact the storyline? Will it be different for an ongoing character or a guest character?
- Will my character with mental illness be viewed as credible? Do I have sufficient grasp of the subject matter to do it justice?

‘Drama can play a role
in educating the public
and be entertaining...
that is the challenge
I think’

Humour is not taboo in storylines about mental illness.

People living with mental illness have emphasised the value of portrayals where the audience can “laugh with” rather than “laugh at” the characters.

Will my portrayal be fresh and original?

- Consider the value in talking to people directly affected by mental illness when developing storylines. First hand research will give the story/character both originality and authenticity. See the **Contacts** section of this resource.
- Consider the whole human context of the person living with a mental illness, their relationships, work, goals and ambitions.
- Exploring the impact on the carers, families, friends, colleagues and others in the community can be powerful.
- Consider exploring cultural, religious and age diversity in characters. Mental illness is conceptualised, accepted and managed in varied ways across cultures.

Am I perpetuating stereotypes?

- A person with mental illness does not need to be evil, nor does the evil character need to have a mental illness.
 - Someone with a mental illness is far more likely to be a victim of violence than a perpetrator.
 - Consider using one or more characters to challenge negative and stereotypical attitudes expressed by another character.
-

Will my portrayal of mental illness be truthful?

- Remember that people can manage and live with their mental illness; it is not ‘traumatic’ every day.
- Consider exploring a character’s recovery or ongoing management of mental illness. The ‘quick fix’ is not necessarily a reality, especially when the mental illness is given to a time-poor guest character.
- A resolution does not have to be the ‘cure’ or the ‘death’ of a character with mental illness.
- Consider balancing a more negative storyline with a more positive or counter-balancing storyline.

What language will my characters use?

- Terms such as “schizo”, “psycho”, “mad” and “emo” may reflect the language of a particular group (eg young people) but, unchallenged, may cause immediate distress to audience members.
- Incorrect use of psychiatric labels can misinform and confuse audiences. For example when the word *schizophrenia* is used to indicate split personality, or *psychotic* is used to refer to psychopathy.
- Refer to the website at www.mindframe-media.info for a list of psychiatric terms, and information about current treatments.

‘An interesting challenge would be to give a major character a mental illness, then you can actually carry the storyline through and deal with the long-term consequences and you don’t have to cure them immediately’

‘My first sort of moment when I realised I was coming back out of the drug-induced unconsciousness ... I’m walking up and down the hospital corridor with my mother next to me and I look down and I realise I’ve got a red sock tied around my ankle. I must have done it because I couldn’t work out how to put it on’

For first-hand stories of people living with mental illness, visit the Industry Area of the Stage and Screen website at www.mindframe-media.info

Can I improve the accuracy and authenticity of my portrayal?

- Take time to research the details of each mental illness that is portrayed to ensure representations are accurate.
- Some characteristics associated with mental illness (eg twitching) are side effects of treatments rather than the illness itself.
- Consider the range and type of services and service providers that are portrayed to ensure they are accurate and reflect current trends in treatment approaches.
- Check the portrayal of the physical environment of mental health care and treatment facilities is accurate.

Can the storyline have a positive effect on the audience?

- Consider whether there are opportunities to show how people can get effective help. Many people who are experiencing a mental illness do not access support because of the stigma associated with mental illness.
 - Including phone numbers and contact details for services at the end of a piece (or as part of the drama) provides immediate support for those who may be prompted to seek assistance.
-

Common Misconceptions about Mental Illness...

There are many myths and misconceptions about mental illness in the community. Some common myths are listed below.

Myth: people who are mentally ill are violent

- Most violent people have no history of mental disorder¹¹.
- Most people with mental illness have no history of violent behaviour¹².
- The use of drugs or alcohol has a stronger association with violence than does mental illness¹³.
- People living with a mental illness are more likely to be victims of violence, especially self-harm¹⁴.
- When it does occur, violent behaviour usually happens in the context of distressing hallucinations or treatment that has not been effective¹⁵.

Myth: mental illness is a life sentence

- Most people will recover fully from mental illness, especially if they receive help early¹⁶.
- Some people will only experience one episode of mental illness and recover fully, others may be well for long periods with occasional episodes, and a minority of people will experience ongoing disability¹⁷.
- Most people with mental illness will be treated in the community.

‘On a TV drama last night, a character with bipolar disorder was shown deliberately running someone over with a car. That sort of negative portrayal makes it hard for me to tell people that I have bipolar, and have to explain that I’m not a dangerous person’



‘Something I hadn’t thought about was how well adjusted people living with a mental illness could be and how they can have a regular life with bipolar disorder or schizophrenia’

Myth: mental illnesses are all the same

- There are many types of mental illness and many types of symptoms. Not everyone with the same diagnosis will experience the same symptoms¹⁸.
- A mental illness may also have physical as well as psychological features, such as insomnia, weight gain or loss, increase or loss of energy, chest pain and nausea¹⁹.

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

- People from any background can develop mental illness²⁰.
- Cultural background affects how people experience mental illness and how they understand and interpret the symptoms of mental illness²¹.
- Many Aboriginal and Torres Strait Islander people carry a significant burden of grief and loss from an early age, due in part to the high rates of mortality, illness, incarceration, and deaths in custody²².
- Pre-migration experiences and the process of resettlement in a foreign land can impact on the mental health of people from culturally and linguistically diverse backgrounds and their children²³.

Specific Mental Disorders...

Anxiety Disorders

Anxiety disorders occur when a person has an intense and paralysing sense of fear or a more sustained pattern of worrying when there is no real danger or threat. Anxiety can occur in almost all age groups and severe disorders left untreated can cause great distress and disruption to a person's life.

Some common anxiety disorders include generalised anxiety disorder, simple phobias, post-traumatic stress disorder, agoraphobia, panic disorder and obsessive compulsive disorder (OCD).

Symptoms may include:

- a persistent and excessive sense of worry or impending doom;
- feeling irritable or unable to relax;
- body sensations such as difficulty breathing, a pounding heart, dizziness, sweating, upset stomach;
- an overwhelming feeling of panic;
- difficulty concentrating;
- altered perceptions whereby the world may seem unreal.

Treatment for anxiety may include counselling, behavioural and cognitive therapies and/or medication. For most people experiencing an anxiety disorder, seeking professional help will result in recovery.

‘OCD is a disorder where you do include your loved ones because sometimes you make them do the rituals... and that enables you to stay unwell’



‘If you focus not just on the person with the illness but the drama it creates for people around them, then you’ve got all really interesting kinds of conflict to resolve. The key is looking at the complexity of it’

Depression

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

Depression is often accompanied by a range of physical and psychological symptoms, such as:

- sleep disturbance;
- loss of sexual interest;
- loss of energy and concentration;
- feeling extremely sad or tearful;
- feelings of worthlessness, hopelessness and guilt;
- inability to cope with decision making;
- physical aches and pains;
- weight loss or gain;
- thoughts of death.

Depression may be triggered by a major life event such as the loss of a loved one, separation, repeated stress, unrealistic expectations of oneself or ongoing abuse. However, depression may also occur without apparent cause and in people who have previously coped with life well.

Bipolar Disorder

Bipolar mood disorder (formerly called manic-depression) is defined by recurrent episodes of extreme mood variation from major depression (as outlined on page 12) to very elevated mood (known as mania).

The symptoms of mania tend to include:

- Feeling very high and full of energy;
- Increased levels of activity;
- Reduced need for sleep;
- Rapid speech and thought;
- Irritability and a tendency to get angry;
- Lack of inhibition;
- Engaging in risky behaviours;
- Grandiose plans and beliefs.

Bipolar disorder usually has its first onset in the early twenties and occurs equally among men and women. 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 in between.

‘My moods – whether they go up or down – change fairly rapidly. They influence my functioning from day to day and they influence my relationships and can make it very hard to live productively..’



Auditory hallucinations are a common symptom of schizophrenia

‘Every time I would be just about to go to sleep it was like someone clapping their hands right near my ear and that would be accompanied by a flash of pop art’

‘As well as derogatory voices some are friends. Voices become so important to some people that they would miss them if they left’

Schizophrenia

Schizophrenia is a type of psychotic disorder. The term schizophrenia covers several related disorders, all with overlapping symptoms. People with schizophrenia have one personality; they do not have a ‘split personality’.

Some symptoms experienced by people with schizophrenia include:

- **Thought disorder** – thought and speech may become jumbled and difficult to follow.
- **Delusions** – where the person holds false beliefs about being persecuted, being under outside control, or of being in some way ‘special’ or ‘powerful’.
- **Hallucinations** – although these can occur in any of the five senses, they most commonly involve hearing voices. The person may experience one or more voices, often threatening or pejorative, commenting on their behaviour or thoughts. Hallucinations are experienced as very real by the individual and can be relentless and disruptive.

Other symptoms can include: loss of initiative or motivation, reduced ability to express emotions or respond appropriately to people, withdrawal from contact with other people, and denial of the illness.

Onset of schizophrenia is usually in adolescence or early adulthood. Some people experience only one or two brief episodes and recover fully. Others may have to manage their illness throughout their lives.

Eating Disorders

Eating disorders are a group of illnesses characterised by disturbed eating patterns and a preoccupation with body image. Both men and women experience eating disorders, however far more women are affected.

There are two major types of eating disorders:

- **Anorexia nervosa** is characterised by a preoccupation with control over body weight, eating and food, with at least 15% weight loss. Symptoms include distorted beliefs about body shape and weight, self-induced weight loss, intense fear of becoming fat, and cessation of menstrual periods. Other symptoms can include depression, exercise rituals, laxative abuse, insomnia, low blood pressure and poor health.
- **Bulimia nervosa** is characterised by an intense fear of weight gain, controlled by restrictive eating patterns, binge eating of calorie-rich foods and attempts to compensate by self-induced vomiting, laxative abuse, or compulsive exercise.

While people with anorexia may lose weight to the degree that they endanger their lives, people with bulimia generally maintain a normal weight. Treatment may include nutritional treatment to recover physical health, cognitive-behavioural therapy around beliefs and distorted body image, psychotherapy and/or medication.

‘Teenage girls in particular can be affected by depictions of women who are unrealistically thin. They can feel less confident, more angry, and more dissatisfied with their appearance as a result’



The *Mindframe* website contains more detailed information about specific mental disorders, their symptoms, treatments and contacts.

Visit

www.mindframe-media.info

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. As a result, relationships are often fraught with difficulty. 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).

Substance Use Disorders

Substance use disorders are generally classified when a person has taken one or more drugs over an extended period, and are showing various behavioural, physical and psychological symptoms. Substance use disorders are classified as either substance dependence or substance abuse.

Features include: tolerance; withdrawal; lack of success in cutting down or controlling their use of the drug; spending a lot of time trying to get hold of the drug or recovering from its effects; and inability to meet obligations with work, family etc.

Audience Impact...


The portrayal of suicide in television drama, film and theatre internationally is widespread. It has increased over time, with depictions of the act of suicide becoming lengthier, more graphic and more sensationalised²⁴.

While the portrayal of suicide can be shocking and engaging, evidence suggests that the dramatic portrayal of suicide can have an impact on vulnerable audiences.

- Fictional on-screen suicide may impact on actual suicidal behaviour, increasing the possibility of “copycat” suicides. For example:

A study in the United States found a significant increase in the number of suicides immediately following soap opera stories in which there was a suicide theme²⁵.

- A succession of stories about suicide can normalise suicidal behaviour as an acceptable course of action.



‘No one would like to think that something they wrote or produced contributed to a person taking their life’

‘The problem is that a film is not going to turn a very well person into someone who suddenly starts thinking about suicide, but there will be unwell people watching and they may become distressed’

- In particular, there appears to be a relationship between the method of suicide portrayed in a fictional film or television program, and increased rates of suicide using that method. For example:

A study in Germany found that after the screening of a television series depicting the railway suicide of a 19-year old male there was an increase in suicides by the same method²⁶.

A study in the UK found that there was a significant increase in cases of self-harm with ingestion of a product in the month in which it was depicted in an episode of *Casualty*²⁷.

- Preferred portrayals of suicide do not glorify or romanticise it and do not provide visual details of or spoken references to the exact method. Rather more appropriate portrayals depict the consequences for others and provides sources of help for vulnerable viewers.

For a full review of the research evidence, go to the *Mindframe* website at www.mindframe-media.info


Key Issues to Consider...

Suicide is a prominent public health issue in Australia with over 2000 people taking their lives each year. While suicide used to be a taboo subject, many people are becoming more comfortable talking about the issue. However, dramatic portrayals of suicide can have an impact on vulnerable audiences, leading to increased rates of suicide attempts or deaths.

When developing a storyline that might include suicide, you may want to **ask yourself...**

Why am I introducing suicide into the story?

- Is it to resolve a storyline, or to explore the issue from a personal perspective?
- Consider that depictions of suicide may be harmful to vulnerable viewers.
- Consider that people who have lost someone to suicide are themselves vulnerable to mental health problems and suicidal thinking and may also be affected by the story.



‘As writers we are in a very powerful position. We shouldn’t abuse that power out of ignorance’

One boy tells his story...

‘I always find it interesting ... watching programs about people who suicide. In a way I look up to people who kill themselves. I think, well, so many other people do it. Maybe I’ll do it as well’

Should the suicide be portrayed?

- Detailed portrayal of particular methods of suicide have been linked to “copycat suicides” by that particular method.
- If portrayed, consider the length of the depiction and the impact this may have on vulnerable viewers or people affected by suicide.
- Might my portrayal of suicide be wrongly interpreted as a solution to a problem?
- Could less detail have a better dramatic effect than a graphic depiction?
- Does the music, lighting, or setting romanticise or glamorise suicide?

How can I explore the issue with more depth?

- Understanding causes or risk factors for suicide can enhance the portrayal. Many people who attempt or die by suicide have a mental disorder, a drug related illness or other risk factors such as relationship breakdown, financial distress or physical illness.
 - Showing the impact of suicide on other characters - such as family, friends, colleagues and the whole community - may place the death in a broader context of tragedy and loss, showing the wastefulness of the act.
 - Different communities, cultures and age groups (eg children) have different attitudes to suicide and ways of coping with loss that may provide new insights.
-

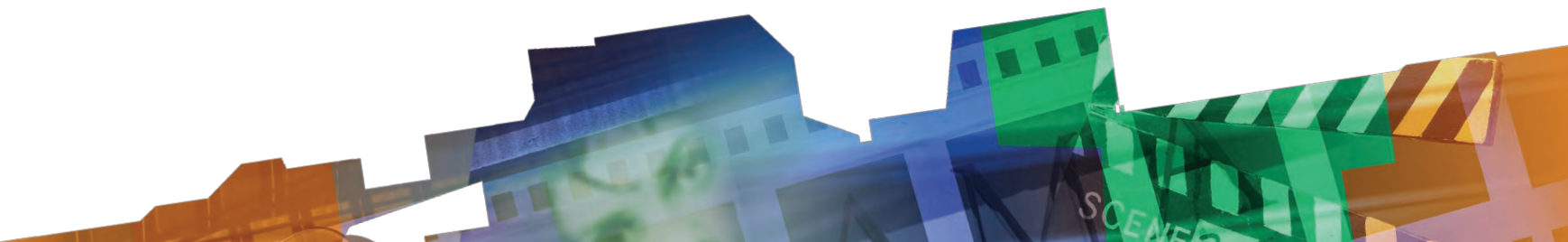
Have I checked the accuracy and authenticity of my portrayal?

- There are many myths and misconceptions about suicide and suicide risk. Accessing reliable information and expert opinion about suicide trends and risk factors is important.
- Consider the value in talking to people directly affected by suicide when developing storylines.
- For links to accurate information about suicide trends, risks and reflections from personal experience go to the *Mindframe* website at **www.mindframe-media.info**

What else can I do?

- Depictions that emphasise consequences for others and sources of support for vulnerable viewers may encourage people to seek help.
- Including phone numbers and contact details for support services at the end of a piece (or as part of the drama) provides immediate support for those who may have been distressed, or prompted to seek help.

‘Unfortunately, the message you are sometimes left with is that the suicide was inevitable, and there was nobody around who could have helped’



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Common Misconceptions about Suicide...

The community holds a number of myths and misconceptions about suicide and people at risk of, or affected by, suicide. Below are some common myths and some accurate information that may challenge these myths.

Myth: Most suicides occur without warning

- Although there may be some cases where suicide occurs without warning, many people that attempt or die by suicide give verbal or non-verbal clues before the incident.
- Often there has been a history of personal problems, mental health issues, suicide threats or prior attempts.
- Many people thinking about suicide will tell someone and some will seek professional help.

Myth: People who attempt suicide are just selfish or weak

- People who attempt suicide are often experiencing strong negative feelings (depression, guilt, fear, anxiety) and may believe there is no other solution.
- People in this situation need professional and personal support, not judgement.

Some warning signs:
Spending less time with family and friends;
Expressions of hopelessness;
Written or verbal notice of intention;
Self-harm;
Thinking or talking about death;
Irrational behaviour;
Feelings of guilt.

If a person is thinking about ending their life, there are some practical things people can do:

1. Let them know you are concerned;
2. Ask if they are thinking about harming themselves;
3. Help them to take action, by pointing out ways they can seek help – eg GP, counsellor, employee assistance program, the mental health service, or presenting to hospital.

Myth: People who talk about taking their own life are just seeking attention

- Any suggestion of suicidal thoughts or threats of suicide should always be taken seriously.
- A person who threatens or attempts to take their life is in need of support, whether or not they are serious about ending their life at that particular time.
- Addressing the underlying problems may reduce the risk of future attempts.

Myth: Talking about suicide with someone at risk will give them the idea and increase the chance they will take their own life

- Many troubled people may be relieved if the issue is raised in a caring and non-judgemental way, allowing them to talk one-on-one about their feelings and to seek help.
 - However, specifically raising the issue of suicide in a group setting (eg a school classroom), or in the media without providing an opportunity to talk about the issue one-on-one is not recommended.
-

Some Facts about Suicide...

When portraying suicide and suicide risk, it is important to be aware of trends, risk factors, groups at risk and impacts of suicide so that the portrayal will be both authentic and accurate.

How many people die by suicide in Australia?

- Over the past decade, around 1900 people have died by suicide each year, representing 1-2% of all deaths registered in Australia.
- Although suicide attempts are more common in women than men, generally men take their own lives at a rate four times that of women.

Is the problem getting worse?

- Suicide rates for both males and females have generally decreased since the mid-90s, with the overall suicide rate decreasing by 37% between 1998 and 2007.
 - Despite the common belief that there is a “youth suicide epidemic”, suicide rates among young males have fallen considerably over recent years (by over 50% since 1998), and suicide in children under the age of 15 is a rare event in Australia.
 - Although accurate suicide statistics are difficult to obtain for Aboriginal and Torres Strait Islander people, figures reveal that the percentage of all deaths attributable to suicide is generally much higher for these populations and may be increasing.
-

Self-harm means any behaviour that involves the deliberate injury to oneself. Self-harm may be an attempt at suicide although not necessarily so. It is usually a response to distress.

People at risk of suicide include:

- people who have previously attempted suicide;
- people with mental disorders;
- people with alcohol or drug abuse problems;
- males (particularly those aged 25-45 years);
- young Indigenous males;
- people who are in custody;
- people in remote communities;
- people bereaved by suicide.

What are some risk factors for suicide?

There is no single cause of suicidal behaviour and each person's situation is unique. However, research has revealed a number of common risk factors, that may increase the likelihood of someone taking their life:

- **Individual factors** - such as being male, being Indigenous, experiencing physical health problems and stressful life events such as bereavement or relationship breakdown;
 - **Mental illness** - such as depression, substance abuse, psychotic disorders and a history of previous suicide attempts;
 - **Family-related factors** - such as family breakdown, family conflict, abuse or family history of suicide;
 - **Social factors** - such as socio-economic disadvantage, unemployment, school disengagement, incarceration, cultural differences and social and geographical isolation (especially remote communities);
 - **Environmental factors** - such as access to methods of suicide and exposure to suicide methods via the media or peers.
-

Are there protective factors for suicide?

Similar to risk factors, there are no clear universal protective factors that may decrease the likelihood of a person taking their life. Some known factors include:

- being connected or belonging to a family, school or other community, such as a sporting or recreation group;
- having at least one significant person to relate to and bond with (whether that is a family member, a friend or other person);
- having personal skills and resilience to deal with difficult situations;
- spirituality and beliefs;
- economic security;
- good physical as well as mental health;
- receiving effective treatment for mental illness and emotional problems.

‘People can go right to the edge, to the rawest edge, and when they come back from it they have often developed enormous strength...’

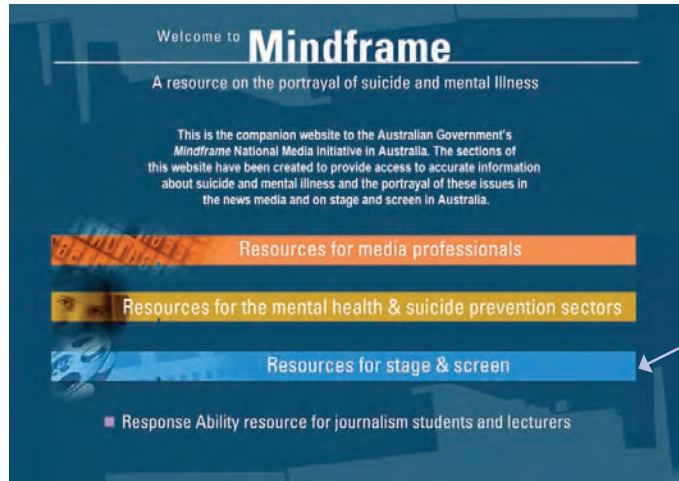
‘...the anger, guilt, sorrow and love expressed by each person makes you realise that those of us left behind are as much victims as the ones who died. I wish you’d just attempted suicide rather than completed it. We could have used the attempt as a warning and then helped you’²⁸

What are some of the impacts of suicide?

- A death by suicide can have devastating impacts on family, friends, colleagues, and potentially the whole community. People who have been directly affected by suicide may themselves experience mental health problems, and are at increased risk of taking their own lives.
- People who identify with the person who has taken their own life (as someone in similar life stage or circumstances to themselves) may be adversely affected by their death and consider suicide themselves as a result.

Mindframe Website

www.mindframe-media.info



Mindframe Stage & Screen website can be located at www.mindframe-media.info and by clicking on the "Stage & Screen" tab.

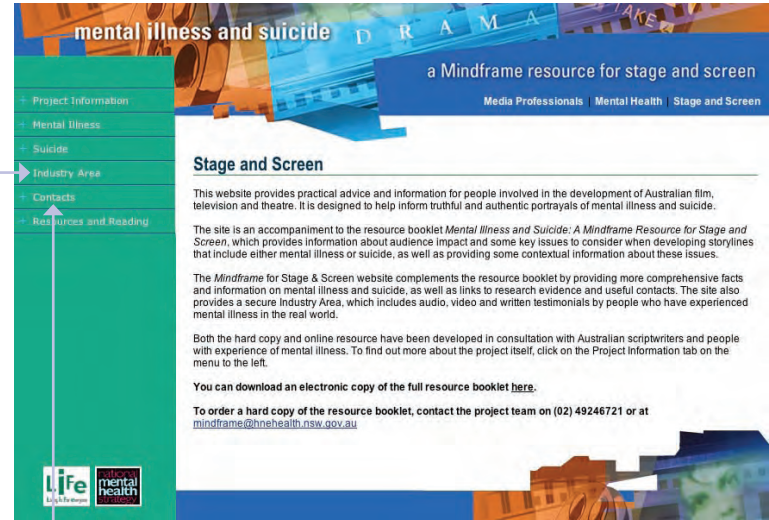
The website contains background information on the *Mindframe* Stage and Screen project, information about the impact of fictional portrayals of mental illness and suicide, as well as information about mental illness and suicide, including facts, statistics and descriptions of specific disorders.

‘To get access to a website and know who to call will make a difference to me as a storyteller’



‘The big problem we face is that drama is life with the boring bits taken out... audiences want colour, they want bizarre, it’s not exciting to watch everyday life... its about finding a way of doing that so it’s compelling. This resource is a good start’

The website is an excellent resource for scriptwriters who are interested in accessing first hand testimonials from people directly affected by mental illness and/or suicide. Video and written interviews are provided in the **Industry Area** of the site.



The website will assist you to find additional resources such as websites, video resources and lists or organisations who may be able to assist with enquiries in the **Contacts** section.

Contacts

SANE Australia

National charity helping people affected by mental illness

www.sane.org

(03) 9682 5933

Black Dog Institute

Educational, research, clinical and community-oriented facility offering specialist expertise in mood disorders

www.blackdoginstitute.org.au

(02) 9382 4523

beyondblue

Support, information and resources for people experiencing depression, their families and friends and the wider community

www.beyondblue.org.au

(03) 9810 6100

Suicide Prevention Australia

Prevention, education and training for suicide prevention

www.suicidepreventionaust.org.au

(02) 9568 3111

Office for Aboriginal and Torres Strait Islander Health (OATSIH)

Improving the access of Aboriginal and Torres Strait Islander peoples to comprehensive primary health care services

www.health.gov.au

(02) 6289 5027

Multicultural Mental Health Australia

National leadership in mental health and suicide prevention for Australians from culturally and linguistically diverse backgrounds

www.mmha.org.au

(02) 9840 3333

The SANE Media Centre can link writers with people living with specific mental illnesses and their carers.

Contact the SANE Media Centre on 03 9682 5933 or www.sane.org



Other useful links

Australian Government
Department of
Health & Ageing
www.mentalhealth.gov.au

LIFE: National Suicide
Prevention Strategy
www.livingisforeveryone.com.au

Australian Indigenous
Health Infonet
www.healthinfonet.ecu.edu.au

ORYGEN Youth Health
and Research Center
www.orygen.org.au

DepressioNet
www.depressionservices.org.au

Lifeline - 131114

National 24-hour telephone counselling service

Kids Helpline - 1800 551 800

National 24-hour telephone counselling service for children and young people

Mens Line Australia – 1300 78 99 78

National 24-hour counselling service for men

Just Ask - 1300 131 114

Mental health information line for rural communities

SANE Helpline – 1800 18 SANE (7263); helpline@sane.org

Free helpline – weekdays 9am-5pm.

ReachOut! - www.reachout.com.au

Interactive website for young people

A full list of Helpline numbers and other useful sites are provided in the **Contacts** section of the *Mindframe* website at **www.mindframe-media.info**

Project Team

This resource has been developed as part of the *Mindframe Stage and Screen* Project. The project is a partnership between the Hunter Institute of Mental Health, the Australian Writers' Guild and SANE Australia, with funding from the Australian Government Department of Health and Ageing as part of the *Mindframe* National Media Initiative. The project also identified and worked with eight Australian scriptwriters to develop the current resources.

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To obtain further copies of this resource, contact the Hunter Institute of Mental Health, phone: 02 4924 6721, email Mindframe@hnehealth.nsw.gov.au.

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The *Mindframe*
National Media
Initiative also includes
the following projects:

The *Response Ability*
Project for
Journalism and Public
Relations Education

Mindframe Media and
Mental Health Project

Mindframe for the
Mental Health Sector

The Media
Monitoring Project

SANE Australia's
Media Centre

Mindframe for
Police and Courts

More information at
www.mindframe-media.info

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