

940575

SUICIDE:

A
MEDIA
RESOURCE
BOOK

Produced by the Ottawa-Carleton Health Department
and the Canadian Mental Health Association
Ottawa-Carleton District



SUICIDE

A
MEDIA
RESOURCE
BOOK

Produced by

Ottawa-Carleton Health Department

495 Richmond Road
Ottawa, Ontario
CANADA K2A 4A4

A SERVICE OF REGIONAL GOVERNMENT



December 1992 Disponible en français

Canadian Mental Health Association
Ottawa-Carleton Branch

1355 Bank Street, Suite 402
Ottawa, Ontario
CANADA K1H 8K7



**S U I C I D E : A M E D I A
R E S O U R C E B O O K**

Contents	Page
Suicide prevention and the media	5
Suicide is a growing problem	6
□ Suicide in Ottawa-Carleton	
General facts about suicide	9
□ Suicide in Canada	
□ When does suicide occur?	
□ Who commits suicide?	
□ Why do people commit suicide?	
Terms and definitions	11
Suggestions for reporting on suicide	12
Suggested materials for reprint/broadcast	14
□ Warning signs of suicide	
□ How to help	
□ Who to call	
□ Myths and facts about suicide	
Further reading	19
Media contacts	20

A COORDINATED EFFORT: RISP

The Ottawa-Carleton Regional Interagency Suicide Prevention (RISP) Committee was formed in early 1990 to manage efforts to prevent the occurrence of suicide in all age groups in Ottawa-Carleton.

RISP is made up of key community leaders from such organizations as crisis lines, hospitals, boards of education and health centres, and is sponsored by the Ottawa-Carleton Health Department.

RISP's main goal is to prevent suicide in Ottawa-Carleton by increasing public awareness of suicide through media activities, caregiver training and community-wide information programs.

The activities of RISP are facilitated, organized and reviewed by Janet Harris-Campbell, the Regional Suicide Prevention Coordinator. For further information, please contact the Coordinator through the Communications Office of the Ottawa-Carleton Health Department at 722-2328 (ext. 3706) or 724-4190.

SUICIDE PREVENTION AND THE MEDIA

Each year, community social service agencies receive hundreds of calls from journalists about a troubling subject: suicide. As mental and community health specialists, we are asked about trends, statistics and possible explanations for suicide deaths.

This resource book is intended to provide this and other commonly requested information to help journalists report on or research the issue of suicide.

It is not our intent to dictate to the media on how to report on suicide. However, there is evidence to suggest that sensitive reporting may have a positive influence on those people at risk of suicide.

There is also some concern about "copycat suicides" or imitative suicides. Several studies show that the rate of suicidal behaviour increased after news stories about suicide were published, particularly among teenagers and in the immediate geographical area (Goldney, 1989; Biblarz, 1987; Gold & Shaffer, 1986; Phillips, 1979). These studies showed that the more publicity there was, the more imitative suicides resulted.

Our primary concern is suicide prevention. We feel that by providing the public with information — about the warning signs of suicide, how to help, who to call, and where to get help — the media could help prevent potential suicides by providing a positive and preventive message to balance the story.

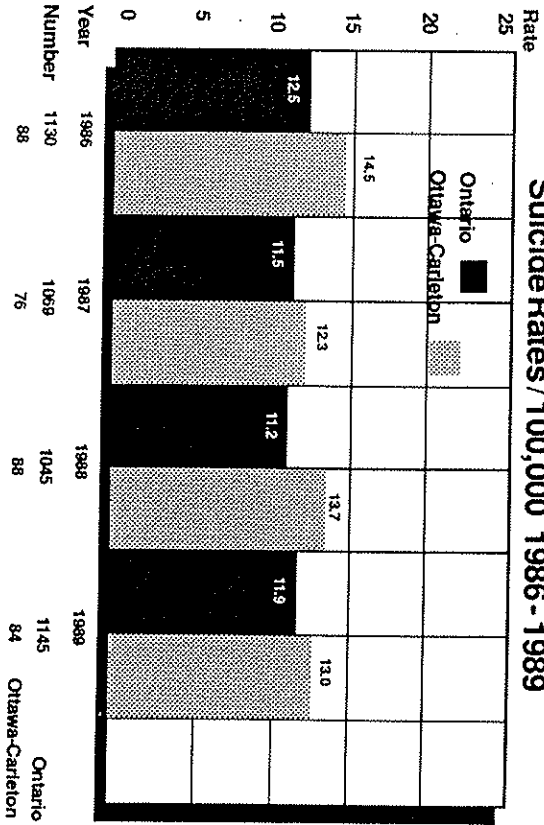
If your media organization does not already have a policy or set of criteria for reporting on suicide, it is hoped that this resource book will help you to formulate one. We ask for your support in this endeavour, and hope you will find the information contained within this resource book useful.

SUICIDE IS A GROWING PROBLEM

Suicide in Ottawa-Carleton

Suicide is becoming an increasing concern in Ottawa-Carleton. In 1989, Ottawa-Carleton's suicide rate was 13 deaths per 100,000 people — higher than the provincial average of 11.9 per 100,000 (see chart below) and the U.S. rate of 12.2.

Ottawa-Carleton and Ontario Suicide Rates / 100,000 1986 - 1989

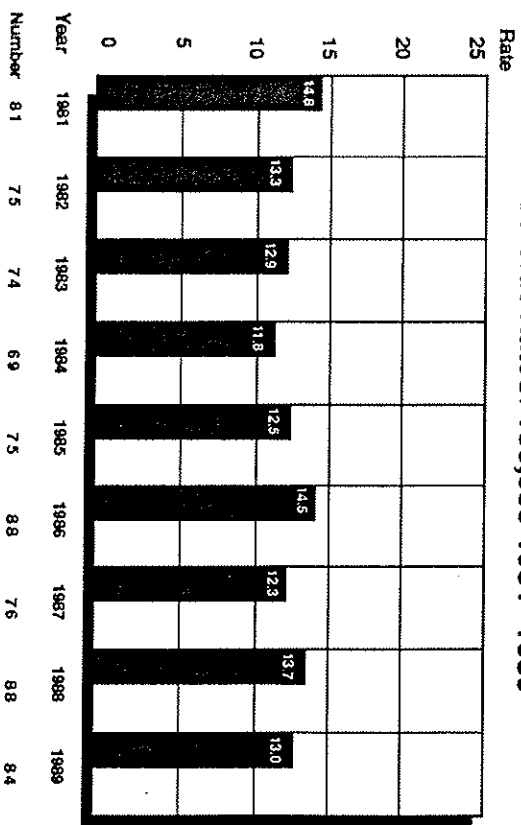


In each year of the 1980s, there were 74 to 88 suicide deaths in the Region. During this period, suicide was the second or third leading cause of potential years of life lost to age 75.

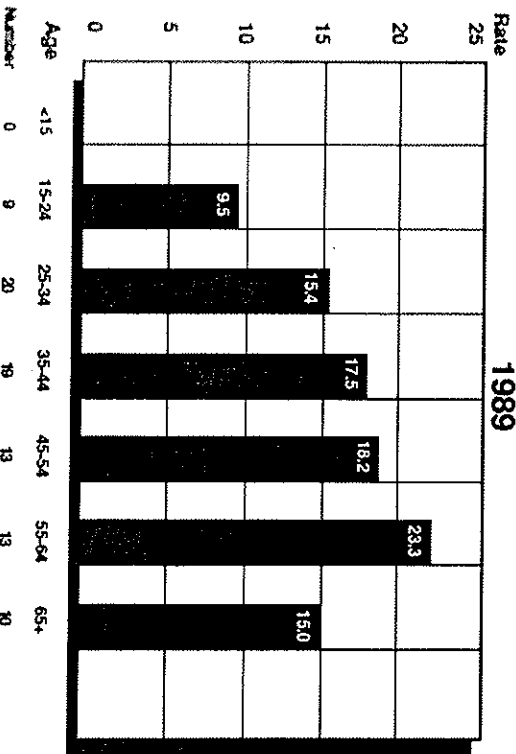
In 1984, Ottawa-Carleton's suicide rate was 11.8 per 100,000. In subsequent years, the rate has never returned to that level (see charts next page). No one knows for sure why people commit suicide, so we can't know exactly why it happens more often in some communities than in others. Possible explanations for this vary and

can include a variety of social, psychological or even biological factors. (See "Why do people commit suicide?", page 10.)

Ottawa-Carleton Suicide Rates / 100,000 1981 - 1989



Ottawa-Carleton Suicide Rates by Age / 100,000 1989



GENERAL FACTS ABOUT SUICIDE

Suicide in Canada

In total, more than 3,500 Canadians kill themselves each year. Canada's national suicide rate is 14 per 100,000 people.

Suicide was first recognized as a major public health problem in 1974 when a study ranked suicide as the fifth leading cause of early death. Today, suicide consistently ranks within the top ten causes of death in Canada, and the second leading cause of death for 15- to 24-year-olds.

It is estimated that for every completed suicide, there are up to 100 attempts.

When does suicide occur?

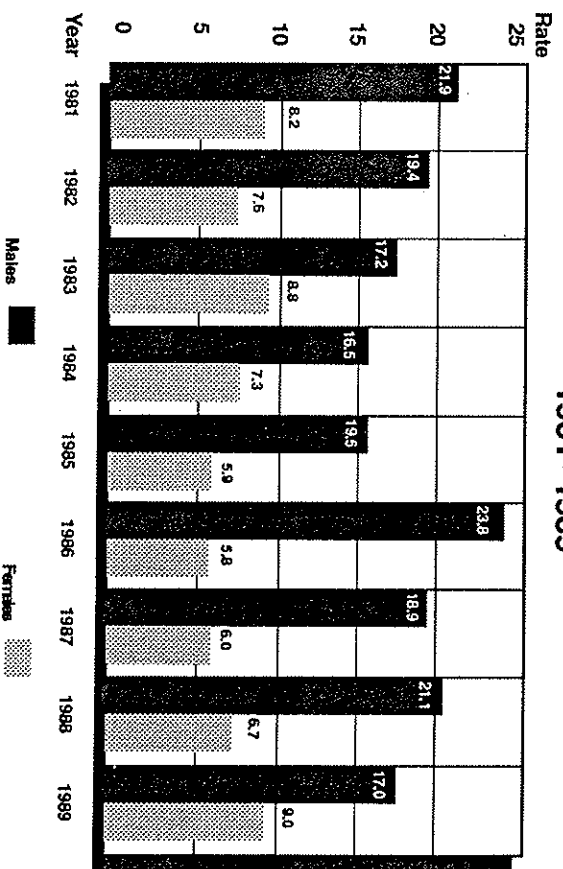
- suicide rates are higher in the spring and fall;
- suicide can occur in clusters within a local area. An imitative or 'copycat' effect is possible for persons who have similar stresses and are the same age, sex and race;
- people planning to commit suicide often communicate their plans to others.

Who commits suicide?

- people with a previous episode of suicidal behaviour have a 35 to 50 times greater risk of completing suicide than the overall population;
- mental disorders are a factor in more than half of the suicides in North America. These people typically suffer from some form of depression;
- substance abusers have a 7 times greater risk of completing suicide;
- persons bereaved by suicide, especially family members, are 8 times more likely to complete suicide themselves;
- males complete suicide more than 3 times as often as females;

In Ottawa-Carleton, as in all North American communities, the suicide rate for males is consistently higher than for females (see chart below). This is partly because men tend to use more lethal means of committing suicide than women, including the use of guns and hanging. Women most often turn to overdoses of drugs and poisons.

Ottawa-Carleton Male & Female Suicide Rates / 100,000 1981 - 1989



- Native Canadians and, in particular, young Native males are generally considered to be at high risk. However, some traditional native communities have had no suicides in the past 50 years;
- people in custody in jails or prisons have a suicide rate 3 times higher than the general population.

Why do people commit suicide?

Nobody knows why some people commit suicide and others don't. Possible explanations vary and include a variety of social, psychological or even biological factors.

- Research does, however, suggest that certain social and physical/medical factors are linked with higher suicide rates, including:
- marital status: more divorced people than married people commit suicide;
 - job pressures: a significant number of males experienced considerable career difficulties immediately prior to their suicide;
 - employment status: people who are unemployed are more likely to commit suicide than those who are employed. For every 1 per cent increase in the jobless rate, there was a 4 to 5 per cent increase in suicides;
 - social factors: stressful conditions, social mobility and social isolation are linked to suicide, including undesirable social conditions, crowded living arrangements, low-quality housing, involvement in crime, drug and alcohol abuse, solitary living and transient habits;
 - physical illness: a strong link exists between physical illness and suicide;
 - mental disorders: people who commit suicide are more likely to have had a major mental disorder than people who die a natural death;
 - stress: suicide attempters have been found to experience stressful events at four times the rate of the rest of the population.

TERMS AND DEFINITIONS

When you're talking to suicide prevention professionals, here are some of the terms they use and what is meant by them:

SUICIDE:

Intentional, self-inflicted death; often referred to as completed suicide.

SUICIDAL BEHAVIOURS:

A broader term that describes many types of non-accidental self-harm activities including suicide. Suicidal behaviours include:

- **SUICIDE ATTEMPTS:** Where there is a clear death intent.
- **PARASUICIDES:** Where there is an attempt with little or no intent to die.
- **SUICIDE PLANS:** Where there is a specific plan developed but not implemented.
- **SUICIDE IDEATION:** Where there is a pattern of thoughts about suicide.

SUGGESTIONS FOR REPORTING ON SUICIDE

As suicide prevention professionals, we suggest that media coverage of suicidal behaviour project an objective yet preventive message, as well as educate and inform the public about the subject. Many local media organizations agree that suicide should only be reported if:

- it occurred in a public place;
- victim was prominent;
- other people were somehow affected by the event;
- it was a symbolic protest of some perceived wrong.

It is best to avoid reporting the specific details about the method of death, or give simplistic cause-effect reasons for suicide, such as "Teen kills himself to avoid jail sentence", or "Boy kills himself because of braces". Although we feel that "downplaying" the suicide story would be desirable, we realize that this is not always possible because of the news value of some suicide stories.

Instead, suicide prevention experts recommend that the media balance the possible negative effect a suicide story may have by publishing or broadcasting helpful information the reader/viewer/listener may use if they feel at risk or if they know of someone at risk.

We also recommend that the media use terminology that projects a positive and preventive message about suicide whenever possible.

As the following examples will illustrate, choice of wording can have a positive or negative effect on your audience.

AVOID PHRASES LIKE ...

USE PHRASES LIKE ...

"a successful suicide attempt"	"a suicide"
"an unsuccessful attempt"	"a suicide attempt"
"suicide victim"	"a suicide completer" or "a completed suicide"
"suicide-prone person"	"person at risk (of suicide)"
"stop the spread/ epidemic of suicide"	"help prevent suicide"

"Suicide survivor" is the term commonly used by bereaved families associations to denote a friend or family member of a person who died of suicide. It does not refer to a suicide attempter who did not die as a result of his/her attempt.

**SUGGESTED MATERIAL
FOR REPRINT/BROADCAST**

Suicide prevention experts believe it is important to provide counter suggestions and information on suicide prevention whenever the media depicts or makes reference to suicide.

On the following pages, we have included information on the warning signs of suicide, how to help, who to call, and myths/facts about suicide. Whenever possible, we recommend that some of this information be printed or broadcast as part of, or simultaneously with, a suicide story to offset the possible negative effects of the suicide, most notably the imitation effect.

In the case of electronic media, we feel that even a brief mention of a distress line phone number may have a beneficial effect.

**SUGGESTED MATERIAL
FOR REPRINT/BROADCAST**

WARNING SIGNS OF SUICIDE

Most people who commit suicide have given warning signs beforehand. But unless you know what to look for, these signs can be easily missed.

If someone you know does any of the following, they may be exhibiting suicidal behaviour:

- threatens suicide
- talks about wanting to die
- shows sudden changes in behaviour, appearance, mood
- appears depressed and sad
- has previously attempted suicide
- uses drugs or alcohol excessively

HOW TO HELP

If someone you know exhibits any signs of suicidal behaviour, you can help them by doing the following:

- Listen openly and calmly. Don't expect to solve the problems, just listen. Don't be afraid to talk about suicide or the problems that have caused the suicidal behaviour. Problems don't get worse by talking about them.
- Show you care. If they confide in you that they have been thinking about suicide, tell them and show them how much you care.
- Don't agree to keep their suicidal thoughts a secret. Get a professional to do a suicide risk assessment and don't leave the person alone.
- Get professional help. Tell them you know their life is difficult right now, but there are people who can help. Help them to find professional help and support them in doing so.
- Don't ignore threats. Don't try to change the subject or ignore threats because you're scared. This may look like you don't care.
- Don't offer simple advice. To a person thinking about suicide, the problems look major and unsolvable right now.
- Don't tell them they're selfish to consider suicide when their life is so good. You will make them feel guilty as well as depressed.
- Don't say "suicide is the easy way out". There is nothing easy about suicide.

WHO TO CALL

If someone you know exhibits any signs of suicidal behaviour, suggest that they call one of the following 24-hour crisis lines:

- 238-3311
 - 741-6433
 - 239-2088
 - 1-800-668-6868
- KIDS HELP PHONE
HOSPITAL EMERGENCY DEPARTMENTS

MYTHS AND FACTS ABOUT SUICIDE

Here are some of the common myths that we encounter in our work in suicide prevention along with our understanding of the facts and assumptions behind these misconceptions.

Myth 1

"Only a certain type of troubled person tries suicide."

False. All types of people have committed suicide. We've all heard stories about people with "everything going for them" who committed suicide. However, by and large, people who have had previous attempts, mental illness or major life problems are at a higher risk.

Myth 2

"People who say they are going to kill themselves are faking to get attention — therefore ignore them."

False. Do not ignore threats. Every depressed person **requires** attention and their threats are their attempt to get what they need. When you feel their depressed, you're entitled to help.

Myth 3

"When people think about suicide, they are fully intent on dying — why stop them? It's their decision."

False. People usually have mixed feelings about dying, and few commit suicide without letting others know how they are feeling. They give clues which are really cries for help.

Myth 4

"Once the depression lifts, the risk of suicide is over".

False. Sometimes people actually seem unusually cheerful before their suicide, as if they feel relieved that they have finally made a decision. To us, it looks like the depression is over, but the danger is still there.

Myth 5

"By mentioning suicide to a depressed person, you risk putting that idea into their heads".

False. Many people contemplate suicide at one time or another. The suicidal person usually feels very alone with their problem. Your willingness to talk openly will come as a great relief. However, if you guessed wrong and they weren't contemplating suicide, they'll simply tell you so.

Myth 6

"Suicide happens without warning".

False. At least 80% of people who die from suicide have given clues.

FURTHER READING

The following resource materials may be useful should you wish to learn more:

Andruszka, B. *Helping Each Other After Suicide*. Ontario Funeral Service Association Toronto, Ontario, 1989.

Armstrong, S. Reason to Live: A Special Report on Youth Suicide. *Canadian Living*, 12 (3) (1987), p. 39-51.

Boldt, M. Towards the Development of A Systematic Approach to Suicide Prevention: The Alberta Model. *Canada's Mental Health*, 33 (2) (1985), p. 2-4

Langman, S.K. *Suicide Epidemiology and Newspaper Policies and Suicide Stories*. *Canada's Mental Health*, 30 (4) (1985), p. 8-9.

National Task Force on Suicide in Canada. *Suicide in Canada*, Ottawa: Ottawa Health & Welfare Canada, 1987.

Fell, Brian and Warner, Derek. Newspaper Policies and Suicide Stories. *Canada's Mental Health*, 30 (4) (1982), p. 8-9.

Wolton, S.L. and Ternery, B.L. (Eds) *Suicide in Older Adults: Selected Readings*. Suicide Information and Education Centre: Calgary, Alberta 1991.

MEDIA CONTACTS

Resource material is also available from:

Local:

Regional Suicide Prevention Coordinator
Janet Harris-Campbell
c/o Ottawa-Carleton Health Department
Communications
495 Richmond Rd.
Ottawa, Ontario
(613) 722-2328 (ext. 3706) or 724-4190

National/International:

The Suicide Prevention and Education Centre (SIEC)
c/o Karen Kiddey, Library Coordinator
201-1615 10th Avenue SW
Calgary, Alberta
T3C 0J7
(403) 245-3900

SIEC is a computer-assisted resource library housing over 15,000 print and audiovisual materials on suicide. It is the largest data base in North America.

N.B. If you have comments/suggestions or you would like additional copies of this resource book, please call the Ottawa-Carleton Health Department — Communications.