Mind the Story
Mental health matters for all.

Media & Mental Health

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Health, Housing & Human Services
CLACKAMAS COUNTY

With generous support from:
PROVIDENCE Health & Services Oregon

Fair & Safe Communicating on Mental Illness & Suicide To Support Wellness & Recovery

~ A Behavioral Health Perspective ~

Clackamas County Health, Housing & Human Services
Behavioral Health Division
Mary Rumbaugh, Director

2017

Mind the Story: Media & Mental Health Toolkit:

Acknowledgements

The ***"Mind the Story: Media and Mental Health Toolkit"*** was authored and compiled by Kathy Turner, Regional Prevention Coordinator, on behalf of the Behavioral Health Division of the Clackamas County Health, Housing & Human Services Department.

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There have been many contributions by local media toward shifting the public narrative about mental health and suicide which deserve recognition and appreciation. Sheila Hamilton with KINK FM, Alpha Media and I Heart Radio's Campaign with Trillium to "Keep Oregon Well" and KGW's "Speak Up for Mental Health" are just a few notable examples to raise awareness and champion this cause.

We are grateful for the leadership from these community and media partners and want to encourage and support this momentum.

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Much of the content of the *Toolkit* builds on the work of experts and organizations that have pioneered this work. Examples of other, more comprehensive guides and resources are cited for your convenience; we applaud their work and impact.

The content, policies, views, recommendations, and opinions expressed in the *Toolkit* are those of the author and the Department and do not necessarily reflect those of Providence Health and Services or others who are quoted or cited.

If you share or post content from this *Toolkit*, please acknowledge and credit Clackamas County. Please do not sell the *Toolkit*, in whole or in part, for any reason.

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Mind the Story: Media & Mental Health Toolkit:

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Compiled and Authored by Kathy Turner for Clackamas County Behavioral Health

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CLACKAMAS COUNTY

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Introduction

We have created the *"Mind the Story Mental Health Matters for All: Media & Mental Health Toolkit"* to support communicating fairly and safely about mental illness and suicide. We have written the *Toolkit* from a behavioral health perspective to ***emphasize hope, treatment and recovery.***

The American Foundation for Suicide Prevention (AFSP) states that *"suicide is a preventable public health problem and a leading cause of death in the United States. More investment in suicide prevention, education and research will prevent the untimely deaths of thousands of Americans each year."*[i] Analysis by David Covington of data from the National Institute of Mental Health underscores the Foundation's conclusions.

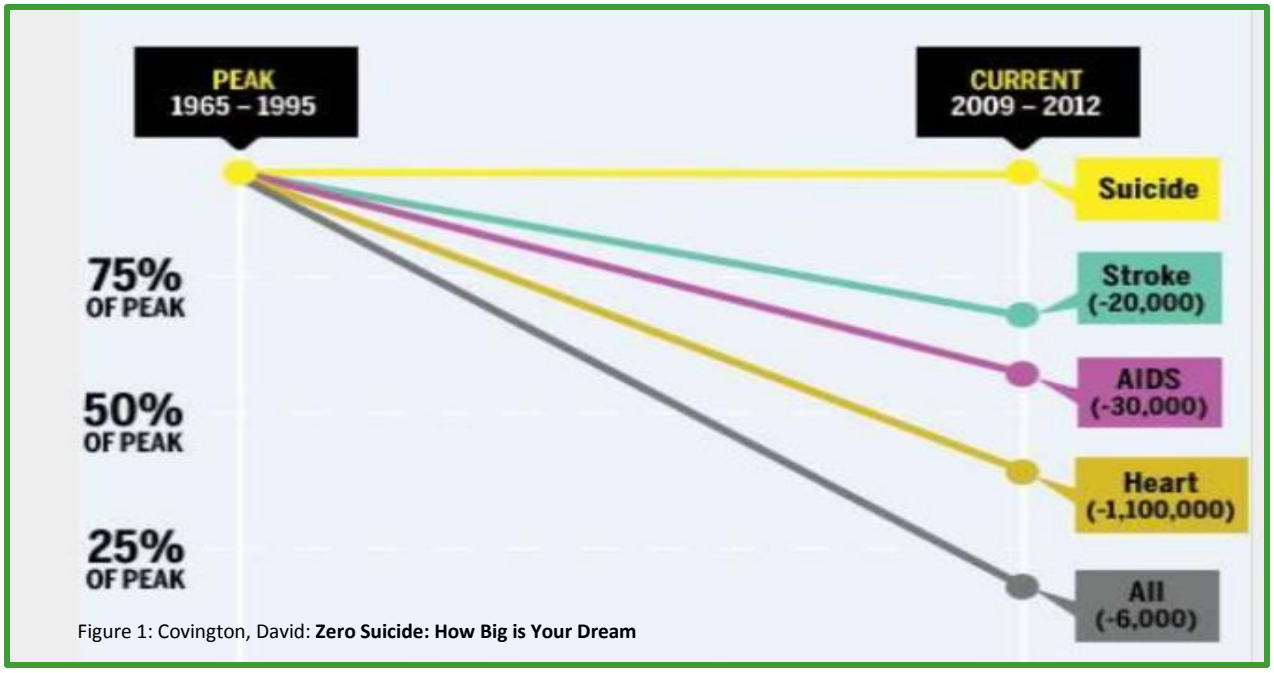

Figure 1: Covington, David: **Zero Suicide: How Big is Your Dream**

We see the media as an important partner to support individuals, their families and friends find resources for help and for the public to learn about mental health, mental illness and suicide prevention. We offer this *Toolkit* as a resource to the media and others communicating about these key public health issues.

Nationally, the data shows that the U.S. has achieved tremendous strides in preventing deaths and managing the lethality of diseases for several major threats to public health such as AIDS, heart diseases and strokes. Covington

Introduction

contrasts the negligible progress on preventing deaths by suicide as illustrated in figure 1.[ii]

Reductions in the rates of deadly diseases were accomplished through intentional focus and making reductions in these diseases a priority for research, education, treatment, advocacy, community action and resources.

comparison to other public health successes.

Oregon ranks thirteen among the fifty-two states for its rates of suicide. Overall it is the eighth leading cause of death in Oregon, based on 2015 data. Drilling down into the data, reported suicides are the second leading cause of death for people between 15 – 34 years of

The corollary efforts for suicide and mental health have are growing, which is good news. But those efforts have yet to share the same level of intention, collective effort, resources and results in

age and the third leading cause of death for youth between 10 – 14 and adults 35 – 44. According to the AFSP's analysis, people in Oregon are five times more likely to die from suicide than from homicide.[iii] And Oregon's rate of suicide

has been higher than the national average for three decades.[iv]

Thousands of Oregonians are impacted by suicide and mental illness[v]. They are major public health issues that are treatable and preventable. They rightly need and deserve our collective attention. The media is poised to be a significant ally in this effort.

First and foremost, the media can bring vital information to the public, promote awareness, encourage help seeking, and by providing information, help people access treatment and resources.

Additionally, media can influence cultural norms and contribute to increasing both understanding and inclusion, and assist in creating opportunities for people that lead to a better quality of life.

What's at stake? Untreated mental health issues and suicide have many costs and burdens for individuals, families, workplaces, and ultimately, our society.

Unfortunately, the media can also reinforce the stigma and discrimination associated with these treatable and preventable conditions. ***How*** the media "reports" on the issues is critical to positively impacting the "stigma of mental illness" in our midst.

As we said earlier, we have written the *Toolkit* to ***encourage communicating in such a way to stimulate hope, treatment-seeking and recovery.*** We want to be transparent with our "agenda" to help people and families get the help they need, so they can be in recovery and live full and fulfilling lives.

Much of the content of the *Toolkit* builds on the work of experts and organizations that have pioneered this work nationally and internationally, particularly in the last two decades. They represent the collective wisdom of members of our community with lived experience, as well as experts in the fields of mental health, public health, suicide prevention, the media—and, in some cases, the entertainment industry.

Examples of other, more comprehensive guides and resources are cited for your convenience; we applaud their work and impact. Because of these existing resources, the *Toolkit* is a summary and designed to be used in concert with the other more wide-ranging works available.

Introduction

We openly acknowledge that we are not media experts. We also recognize and appreciate that there have been many notable contributions by the media on these issues. Further, we respect that the media has the responsibility to report multiple viewpoints.

We created and invite use of this *Toolkit* because we are passionately committed to supporting and protecting people who are experiencing mental health issues and/or thoughts of suicide.

And we believe we share common values of building awareness and knowledge, improving our society and breaking down stigma that can surround the topics of mental health and suicide.

Mental Health Conditions and Suicide are Prevalent in the U.S. and Oregon; Many Do Not Seek or Have Care.

The National Institute of Mental Health estimates that over 43 million or nearly 18% of U.S. adults have experienced a mental health disorder of some kind; in Oregon, nearly 700,000 or over 22% of adults were impacted in 2015.[vi] The Centers for Disease Control and Prevention estimate that approximately 13 percent of children ages 8 to 15 had a diagnosable mental disorder within the previous year.[vii]

Less than half of the adults who experienced a mental illness in the past year received care (2014); almost 12 million Americans reported they had an "unmet need for additional mental health services;" and of those, over five million adults who didn't receive care but felt they needed it, reported they didn't receive it because they couldn't afford it.[viii] Affordability is one obstacle; in addition, "stigma in its various manifestations often serves as a barrier to care seeking."[ix]

Nationally, Oregon ranks in the top fifteen states with the high rates of suicide; the latest data (2015) ranks Oregon with the thirteenth highest rate and thirty-three percent higher than the national rate. Rates have increased over the last three decades.[x]

Statistically, vulnerable populations who die by suicide in Oregon include youth, veterans under 45 years of age, middle aged and older males among others; however, suicide impacts all walks of life, all cultures, races and economic

standing.[xi] Suicide attempts impact an even broader range of people.

Some media portrayals and news coverage emphasize stigma and myths around mental illness and suicide – this can discourage people from seeking help.

Stigma clouds efforts to reach people and connect them help. In some dictionaries, "stigma" is defined by example of the "stigma of mental disorder."

Research has demonstrated that "self-stigma" can create barriers for people acknowledging that they need help, and even if they know, prevent them from seeking help. Stigma fuels negative self-image, shame, worthlessness, exclusion and the burden of secrecy, all of which can be very disabling for people.[xii] Stigma further feeds reactions like fear and derision between people who have a mental illness and those that do not; it is the foundation for "social distance." Media portrayals can add to the myths equating mental illness with unpredictability, violence or incompetence that exist within popular culture.[xiii] Finally, stigma around mental health and suicide can lead to discrimination in the workplace, in housing and other social and economic consequences that impact opportunity and access.[xiv]

We plan to update this *Toolkit* periodically and we readily invite your feedback on the *Toolkit* content and usability. If you have comments or suggestions, please email Kathy Turner at kturner@clackamas.us.

Together we can continue the process of reshaping the public narrative around mental health and suicide, and in so doing, realize untapped potential and save lives in our communities.

Help us get the message of hope and recovery out to a broader audience. We look forward to working together with media and others communicating about these crucial public health issues. We thank you for your interest.

Guidelines:

Reporting on Mental Illness & Suicide

General Guidelines

Do's	Don'ts
Share information about where and how to get help.	Promote stereotypes and/or myths about people with mental health disorders or thoughts of suicide and sensitively consider how stories are framed and what images are used.[xv]
Encourage people to seek help.	Use headlines and photo captions that might inadvertently sensationalize the topic or promote stereotypes and/or myths.[xvi]
Emphasize that treatment can work and long-term recovery is possible. Emphasize the benefits of early intervention and prevention.[xvii]	Overlook managing online forums (e.g. message boards), monitoring comments from people in crisis or deleting posts that may contain content that could be harmful or dangerous to others.[xviii]
Share information about signs, characteristics and clues.	Portray the prevalence of mental illness and suicide sensationally; use terms like "growing," "increasing" and avoid terms like "alarming," "epidemic," "skyrocketing."[xix]
Clarify when it is appropriate to call 911 -- in the case of imminent danger to any person.	Portray a mental illness or thoughts of suicide as a permanent condition; with help and hope, recovery is often possible.
Emphasize there are many effective treatment options and regular innovations and advances in the field; medications are not the only options for treatment.[xx]	Express opinions about one form of treatment being more effective than others.
Encourage people to learn more.	
Thoughtfully share stories of recovery from people with lived experience.	

Guidelines:

Reporting on Mental Illness & Suicide

Specific to Reporting on Mental Health & Mental Illness

Do's	Don'ts
Share facts including that mental health disorders are prevalent for adults and children; building awareness can help "normalize" the topic of mental health.[xxi]	Associate a mental illness with a negative quality of life, e.g. "suffering with," "troubled by," "distressed with," or other terms that portray permanency or the person as a "victim."[xxii]
Emphasize that mental health is as important to a person's overall wellbeing as physical health.	Assume that what looks like strange or criminal behavior is automatically associated with a diagnosable mental illness.
Underscore that people can receive treatment, manage and/or recover from mental health disorders just like they can from physical illnesses like heart disease and asthma.[xxiii]	Include coverage of mental health or illness if it isn't relevant and/or central to the story.[xxiv]
Consult credible sources for symptoms, diagnoses, behaviors and treatments	Use phrases or jargon that are derogatory and can bolster stigma, e.g. "lunatic," "schizo," "mental," "loco," etc.[xxv]
Use "people-first language" when describing people. Generally, when any individual or group is defined by a condition, rather than as a person or people, it can tend to negatively marginalize them. In the case of a person with a mental illness, identify a person "as having "x" (e.g. an anxiety or bi-polar disorder) versus "He's schizophrenic."[xxvi]	Infer that a mental illness experienced by an older adult is only a function of age. If the content is central to the story, consult experts on physical conditions (such as dementia) versus mental health conditions (such as depression).[xxvii]

Guidelines:

Reporting on Mental Illness & Suicide

Specific to Reporting on Suicide

Do's	Don'ts
Because of the potential for contagion and suicide clusters, consider NOT covering individual suicides. If you do cover them, be sensitive about the placement of a story about individual suicides; consider placing stories below the fold and not on the front page of the paper or a section or a lead broadcast story.[xxviii]	Disclose specifics about the means and location, or publish pictures of the site, the remains and emergency personnel/vehicles.[xxix]
Be sensitive about seeking interviews with family, close friends, school or work associates or neighbors; particularly in the hours and days immediately following a death by suicide. They can be at risk themselves, inaccurately portray the context, or inadvertently say something that could trigger someone at risk.[xxx]	Publish pictures of memorials, funerals, anniversary tributes and people grieving, especially when a young person is involved.[xxxi]
Use terminology consistent with reporting on other causes of death (i.e. "died by suicide" or "died of suicide," rather than "committed suicide" or "successful suicide attempt."[xxxii]	Use terms that imply that suicide was the "desired" (successful/unsuccessful) outcome or a sin or a crime (committed). [xxxiii]
Distinguish between "death with dignity & assisted death" and a death by suicide.	Imply that a suicide by an older adult is to be expected. [xxxiv] The reasons are complex, but often undiagnosed and untreated mental health disorders such as depression can contribute to thoughts of suicide.[xxxv]

Guidelines:

Reporting on Mental Illness & Suicide

Specific to Reporting on Suicide

(continued)

Do's	Don'ts
Covering a death by suicide by a celebrity may be unavoidable. Because coverage of celebrities who have died by suicide have been demonstrated to be more likely to lead to replication, please be mindful about sensationalizing the details of their death, particularly the method. If there are mental health or substance abuse issues involved that can help educate others, please consider covering them sensitively. And please apply other safe reporting guidelines regarding location, etc. to stories. [xxxvi]	

Guidelines:

Tips for Interviewing

Interviewee's Needs & Preferences[xxxvii]	✓ Consult with the interviewee and/or their designated associate to set up the interview. ✓ Discuss the context of the reporting and the specific purpose of the interview; don't assume that they know that you are going to be asking about mental illness or suicide. ✓ Ask if the interviewee prefer someone accompany them to the interview. ✓ Provide ample time for the interview.
Cultural & Language Considerations[xxxviii]	✓ If the interviewee or their family is from a different culture and/or English is not their first language, arrange for a skilled cultural broker and interpreter and/or ask if the interviewee if they would like a cultural broker or interpreter present. ✓ It is important to consider the interviewee's cultural values, beliefs and background; consider asking the interviewee for a cultural broker of their choosing to be present to support accuracy and understanding. ✓ Attitudes, values, levels of acceptance and understanding about mental illness and suicide can significantly vary; [xxxix] prior research and consultation is recommended.
Other Interviewing & Reporting Tips	✓ Be sure that you clearly understand the interviewee's wishes about what information is included in the story. ✓ Come prepared with resources for the interviewee (i.e., Crisis Line Information, etc.) should the interviewee need follow up support. ✓ Exercise patience and listen. Be sensitive that a story may cause discomfort and be stressful to recount; and it may take longer for the person to relay it.

Guidelines:

Tips for Interviewing

Considerations When Interviewing a Minor[xl]	✓ Consider if there is another way to get the information rather than interviewing a minor. ✓ It is our recommendation that you **don't** conduct interviews with minors unless there is an adult present able to provide the appropriate support both during and after the interview. ✓ Having adolescents and young people share their stories of attempts can be unsafe – it may put the young person at higher risk and/or may influence other young people who are vulnerable. ✓ Seek legal advice and newspaper policy about interviewing minors. *Do you need written permission from a parent or guardian to interview or photograph? Do you need to disclose how the material will be used and what will be held confidential? Are you required to have a parent or a legal guardian present?* ✓ Make sure that the young person and their parent(s)/ guardian(s) understand that you are a reporter and the purpose of the interview. ✓ Ask the young person and their parent/guardian whether they want to keep their/family's identity confidential – going "public" can be met with negative consequences – by employers, landlords, friends, schools, etc. ✓ To protect individual and family identity, in addition to names, consider other items that could contribute to disclosing their identity – their school, their neighborhood, their friends, their hobbies, etc. ✓ In smaller communities and neighborhoods, keep in mind that community members are likely to be able to "figure out" who you are writing about even if you omit specific details (names, schools, etc.) ✓ Observe guidelines for safe reporting on suicide.

Guidelines:

Tips for Interviewing

Self-Care Considerations for Journalists	✓ Even the most experienced, objectively-minded journalists may experience emotional or physical reactions when exposed to traumatized people, tragedies or traumatic events[xli] that can surround stories about mental illness and suicide. These reactions are ***common, normal and to be expected***. ✓ Each person's response to trauma is different and most people are resilient, can cope and recover from the aftermath of experiencing a disturbing event, interviewing a survivor or the bereaved. [xlii] ✓ Some common reactions could include: ***reliving the event or flashbacks, nightmares, difficulty sleeping and/or strong emotions like fear, guilt, anger and sadness***.[xliii] Usually these reactions are short-lived and fade in a few days or weeks.[xliv] ✓ If you experience these or related impacts[xlv], self-care may help you manage symptoms. You may already practice self-care through exercise, meditation, yoga and relaxation. It can also be helpful to talk about your experiences with someone you trust and who cares about you.[xlvi] ✓ If emotional and physical reactions persist, professional help should be considered.[xlvii]

Mind the Story: Media & Mental Health Toolkit:

Resources for Help & Information

Metro Portland Mental Health & Suicide Crisis Lines:

- Clackamas County 503-655-8585
- Multnomah County 503-988-4888
- Washington County 503-291-9111

The crisis lines are open 24 hours a day and seven days a week.

State and National Suicide Lifelines:

- National Suicide Prevention Lifeline 800-273-8255
  www.suicidepreventionlifeline.org
  (24 hours – 150 languages)
- Veteran's Crisis Line 800-273-8255, press 1
  Text to 838255
  www.veteranscrisisline.net
- Oregon Youth Line 1-877-968-8491
  Text teen2teen 839863
  www.OregonYouthLine.org
- LGBTQ Youth 1-866-488-7386
  The Trevor Project
  Crisis Intervention & Suicide Prevention
  Text "Trevor" to 1-202-304-1200

Resources for Help & Information

Portland Metro Area Mental Health Urgent Care & Walk in Centers

Clackamas County:

Riverstone Mental Health Crisis and Urgent Walk-in Services is open seven days a week, from 9 a.m. to 8 p.m., Monday thru Friday and from 10 a.m. to 7 p.m. on Saturday and Sunday, located in the Ross Center near Clackamas Town Center at 11211 SE 82nd Avenue, Suite O, Happy Valley, 97086.
www.clackamas.us/behavioralhealth/riverstone.html

Multnomah County:

Cascadia Behavioral Healthcare's Urgent Walk-in Clinic is open from 7 am to 10:30 pm seven days a week, located at 4212 SE Division Street, Suite 100, Portland OR 97206.
http://cascadiabhc.org/

Washington County:

Hawthorn Walk-In Center is open 9:00 am to 8:30 pm seven days a week, located at 5240 NE Elam Young Parkway, Suite 100, Hillsboro, OR 97124. Walk-ins and appointments.
http://www.co.washington.or.us/hawthorn

Other Resources:

State of Oregon:

Get Help Page Addictions and Mental Health Services at Oregon.Gov
http://www.oregon.gov/oha/amh/Pages/gethelp.aspx

Emergencies:

In an emergency, call 911 or go to the nearest emergency room.

Mind the Story: Media & Mental Health Toolkit:

Resources for Help & Information

Quick References for Mental Health, Substance Use & Suicide:

- Where to find information on **specific mental health disorders** - https://www.samhsa.gov/disorders/mental
- Where to find information on **substance use disorders** - https://www.samhsa.gov/disorders/substance-use
- Where to find information on **suicide and suicide prevention** – https://www.samhsa.gov/suicide-prevention

Suicide Prevention & Mental Health First Aid Trainings:

To learn more and to register visit www.gettrainedtohelp.com

- Question, Persuade & Refer (QPR) – 2-hour introductory training
- Adult or Youth Mental Health First Aid (AMHFA or YMHFA) – 8-hour in depth training, 3-year certificate
- Applied Suicide Intervention Skills Training (ASIST) – 2- day in depth training, certificate
- Counseling on Access to Lethal Means (CALM) – 2.5- hour training for counselors, clinicians and first responders

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Mental health matters for all.

Mind the Story: Media & Mental Health Toolkit:

Resources for Help & Information

Sidebar Resources for Print Media

KNOW THE SIGNS & LEARN MORE:

Five signs someone may be experiencing a mental health issue:

- Personality change
- Moodiness, excessive fears, worries & anxieties, & hopelessness
- Disrupted sleep, change in appetite
- Withdrawal or isolation
- Poor self-care or risky behavior, inability to cope
- https://www.mentalhealth.gov/what-to-look-for/index.html

Five signs someone may be considering suicide:

- Talking about wanting to die, hopelessness, unbearable pain, or being a burden on others
- Increasing use of drugs and/or alcohol
- Extreme mood swings; displaying rage or talking about revenge
- Withdrawal or isolation
- Giving away prized possessions
- http://www.suicidepreventionlifeline.org/

FOR HELP, CONTACT:

- Clackamas County 503-655-8585
- Multnomah County 503-988-4888
- Washington County 503-291-9111

- National Suicide Prevention Lifeline 1-800-273-8255
  www.suicidepreventionlifeline.org
- Veteran's Crisis Line 1-800-273-8255, press 1
  Text to 838255
  www.veteranscrisisline.net
- Oregon Youth Line 1-877-968-8491
  Text teen2teen 839863
  www.OregonYouthLine.org

IF DANGER IS IMMINENT, DIAL 911

Endnotes

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Words matter when fighting the stigma of mental illness

http://www.dallasnews.com/life/healthy-living/2017/03/06/words-matter-fighting-stigmaof-mental-illness

Filed under Healthy Living at Mar 6, 2017

Thor Christensen, Special Contributor

When it comes to the language of brain disorders, society has come a long way from the days when "lunatics" and "imbeciles" lived in "madhouses" and "insane asylums."

But in some ways, we're still stuck in the lexicon of the Dark Ages. "Battling demons," for example, remains a common catchphrase for Hollywood, the media and the public when it comes to mental health issues.

As the vocabulary of the brain evolves, there's a growing effort to exorcise "demons," "inner monsters" and other outdated words that imply disorders are supernatural or immoral. Last November, the first-ever U.S. surgeon general's report on addiction asked the public to avoid good-vs.-evil morality judgments.

"It is not a moral failing, or evidence of a character flaw, but a chronic disease of the brain that deserves our compassion and care," Surgeon General Vivek Murthy told reporters after the release of the report, "Facing Addiction in America."

Care and compassion also need to be shown to people living with bipolar disorder, depression, schizophrenia and other mental illnesses, experts say.

"A term like 'demon' casts a negative light and subtly enforces a moral dimension that's implicit in a lot of stereotypes of mental illness," says Dr. Andy Keller, president of the Dallas-based Meadows Foundation Mental Health Policy Institute.

"People say, 'He needs to pull himself up by his own bootstraps,' or 'They need to overcome the demon of depression,' when in, reality, they need to get treatment for their illness," he says.

Do make readers aware of stigmatizing language related to mental health and mental illness. Do explain why the language is harmful.

Do cite reliable experts. Do make readers aware that mental illness is an illness, not an issue of character or morality.

Do discuss how language can be subtle and reinforce myths and discrimination. Do encourage seeking help.

In general, the language of mental illness has improved dramatically in recent years, according to Dr. Lynda Frost, director of planning and programs for the Austin-based Hogg Foundation for Mental Health, which issued the report "Language Matters in Mental Health."

"As people become more educated and less mystified about mental illness, the language has become more respectful," Frost says. "We try to use the best language that carries the least stigma."

Still, the demonization of mental illness and addiction persists. While reporters would never think of using the old comic catchphrase "the devil made me do it" to describe someone's brain disorder, they routinely trot out the phrase "he battled demons" to discuss suicide, addiction and a wide range of mental health issues.

Do increase awareness about phrases that can reinforce stigma

When Robin Williams died by suicide in 2014 after a long history of severe depression and addiction, many media outlets talked about his struggle with "demons." The New York Times, for example, used the word in a headline and several times in a story that said the actor "seemed to use work as a way to keep his personal demons caged."

More than one mental health expert took issue with the word "demons" when CNN reporter Nischelle Turner used it in her report on Williams' death. She later issued an on-air apology.

"A lot of times when we're doing live coverage ... we don't realize what we're saying. So I apologize for using the word 'demons,' because Robin Williams ... was battling a disease," Turner said.

Do "normalize" mental illness as a disease; do distinguish between illness and "demonic" possession.

Complicating the d-word issue is the fact that many people believe demons do, in fact, have the ability to control our bodies and our brains. A 2012 survey by the Pew Research Center discovered a majority of Americans believe in demonic possession, with the highest percentage of demon-believers (63 percent) in the age range of 18-29.

Other people use demons and monsters to describe brain disorders because it makes them more "tangible," says Toby Allen, an English artist whose "Real Monsters" paintings depict depression, anorexia and schizophrenia as a surreal menagerie of colorful beasts. (www.zestydoesthings.com/realmonsters)

"Mental illnesses are largely invisible to the sufferer and the outside world, but by giving them a face, it makes the subject a little more approachable and gives sufferers something to aim their angst at — a monster to slay," says Allen, who has an anxiety disorder.

"The words 'monster' or 'demon' do carry very negative meanings ... [but] with my work, I try to make a point of distancing the sufferer from the imagined 'monster' that causes the mental illness."

Former Olympic runner Suzy Favor Hamilton, author of Fast Girl: A Life Spent Running From Madness, says the public needs to be very careful with words that suggest people with mental illness don't have morals or religious beliefs.

"I was labeled a slut by people who didn't understand my illness," says Hamilton, a mental health advocate who says her bipolar disorder led her to a Doshort-lived career as a Las Vegas prostitute. (She speaks March 30 in Dallas at the Essential Energy Spring Reception.)

"People love to sit back and be judgmental, and their language can be very damaging," Hamilton says. "I don't think people are aware how their words can be cruel and hurtful, especially to someone who is unstable and isn't getting treatment or medication."

The way we talk about mental health — or avoid talking about it — continues to be a major obstacle in improving awareness and treatment, says Keller.

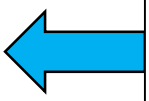
Last year, Keller and the Meadows Foundation Mental Health Policy Institute launched "Okay to Say," a grass-roots awareness movement designed to expand conversation and improve treatment. According to Keller, two-thirds of people with treatable mental illness never seek help, in part because our culture is overrun with misleading language.

Saying someone battles demons or "is a schizophrenic" implies their illness is "endemic to who they are. It implies it's a trait of that person, and you can't get better from it," he says.

"We're not trying to be the thought police or go around correcting people," Keller says. "But it's important to use more hopeful language and get rid of the stigmas and the false beliefs that these are not treatable illnesses."

Thor Christensen is a Dallas writer. Email thorchris2@yahoo.com

Do thoughtfully share stories from people with lived experience.



Do explain why people might avoid or delay getting help.

Do explain how stigma can lead people to believe that mental illness is not treatable.

Do encourage using more hopeful language.

http://laslatinitas.com/teens/redefining-mental-illness

Redefining Mental Illness

April 4, 2016 by Emily Hernandez

It's not physical, it's not easy to understand, and, most of the time, it's completely ignored or called "just a phase." I'm talking about mental illness. In the Latin@ culture, stigma often follows mental illness. Your "abuelita" may have tried to cure your anxiety with home remedies by rubbing an egg all over you to get "el malo ojo" out. Or your tía saying to "get over it" because it's only a phase. Deep down we know that it's not that easy to remove what we're feeling. Everyone has a battle to fight, but, chicas, you're not alone.

Do thoughtfully share stories of "lived experience" that are culturally specific.

Dealing with Depression

I experienced depression at a young age, but it became more evident in high school. I lost weight, I had no appetite, and I was becoming extremely introverted. The effects of all this led to more serious symptoms, bone pains, insomnia, and stomach cramps. My parents took me to various doctors to "fix" the problem, and the doctors would check my blood and do all kinds of crazy tests. To them, the problem wasn't there because it was in my head. Not once did they ask me how I truly felt. I had a boyfriend, I had great friends and a great family, but I just wasn't happy. I didn't see a purpose in life.

One day I was even taken to the emergency room due to serious joint pain and stomach cramps. Nothing was found, of course, except that I hadn't eaten in 2 days. Through frustration my father said it was "all in my head." His words hurt me, it hurt a lot. He didn't understand, but how could he? Growing up in Mexico meant that mental illness didn't "exist." I couldn't blame my parents for not understanding what I was going through.

Do include challenges that people with lived experience have had; others in similar situations can relate to them.

Depression followed me to college. Episodes happened, sleep was lost, and concentrating on my schoolwork was extremely hard. One day, through extreme insomnia, I made the decision

to see a specialist. It was really difficult for me to get to this step in my life, but I knew I had to do something.

I held my rose gold iPhone in my hand, Student Health Center's phone number on display, but all I could hear in my head was my Tía calling me crazy, saying it was all in my head, or saying this is a result from leaving to college. I was scared of the criticism, but I overcame it and finally made the phone call.

Do share stories of people seeking help, including thoughts or attitudes they have overcome to seek the help.

I was diagnosed with anxiety and depression, but I felt uneasy about the diagnosis. Self-doubt led to thinking if it was really in my head, and knowing what I had just made me feel more insecure! Luckily, my specialist, a very understanding Hispanic doctor, calmed by nerves by saying to "not feel insecure about this; mental illness is just like any other illness and it should not be considered any less. It's serious and I'm proud of you for coming in on your own to get help. That's brave.

Do "normalize" that mental illness is like other illnesses; do support help seeking behavior.

"He mentioned how anyone who feels something wrong should always look for help. I was prescribed medicine and I was given techniques for my anxiety. For once, I felt the feeling of being able to concentrate on schoolwork and I could breathe without a bad sigh.

Stigma within the Latin@ Community

Stigma regarding mental illness is fairly common within the Latin@ community. The National Alliance on Mental Illness found that lack and/or misunderstanding of information regarding mental health, language barriers, lack of health insurance and/or legal status, misdiagnosis, homeopathic remedies, privacy concerns, and religion are some of the leading causes that contribute to being resistant to mental health care, help, etc. In fact, Latinos are "less likely to seek mental health treatment." This poses a risk since Latinas have higher risks of depression and suicide. A study on depression and anxiety within the Latin@ community by the Albert Einstein College of Medicine of Yeshiva University found that "First-and second-generation Hispanics/Latinos were significantly more likely to have symptoms of depression than those born outside the U.S. mainland." Mental health is real, and it should not continue to be stigmatized and treated as if it's not.

Do increase knowledge about barriers and stigma; do share trends and risks.

Linda Eguiluz, a graduate from the University of Texas and now a graduate student at Lewis and Clark College, is familiar with dealing with mental health within the Latin@ community. As a graduate student, the pressures of school has led to dealing with anxiety.

"I think [being a Latina has] definitely affected the way I dealt with [anxiety] initially, and sometimes even now. There is no way to disassociate my ethnic identity from my mental illness, and it is a struggle to reconcile the cultural values placed upon me regarding mental health."

"I know it is not an easy task to confront our own mental illness when we come from a culture where we are automatically labeled as broken. Educating our loved ones is not our primary responsibility, so it is important to reach out to people that can advocate for you and can guide you through the process. Family is important for latin@ folk, and having that extra layer of support is incredibly important for our well being and progress through medication and psychotherapy," she adds.

So, chicas, please seek help if you feel that something isn't right. You are not alone in this, and there are so many people who would love to help you. Seek help from a teacher, counselor, an adult, or make the decision to seek professional help yourself. Mental illness is just like any illness and it is not a joke.

Do share cultural perspectives that people living with mental illness experience.

These cultural perspectives can break down isolation that a person can face.

Do recommend alternatives if family members are not (yet) supportive.

Do encourage people to seek help.

EDITION: UNITED STATES

REUTERS

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Veterans may face higher risk of suicide during first year home

http://www.reuters.com/article/us-health-veterans-suicide-idUSKCN12R2MT

By Lisa Rapaport

(Reuters Health) - Veterans may be more likely to commit suicide during the first year after they leave the military than after more time passes, a U.S. study suggests.

Avoid using "commit" when reporting on suicide. Use "die by suicide," or "suicide death."

Compared with people still on active duty in the military, veterans out of the service for up to three months were 2.5 times more likely to commit suicide, the study found. Veterans who had left the service from three to 12 months earlier had almost triple the suicide odds of current members of the military.

"Family members and community can be proactive to reach out to veterans if they recently experienced stressful events – not just limited to the stressful events we can capture in the data such as divorce or separation from the military," said lead study author Yu-Chu Shen, a researcher at the Naval Postgraduate School in Monterey, California.

"In addition, clinicians should be aware that deployments may increase suicide risk independently of underlying mental disorders, and so asking patients about deployment history is advisable," Shen said by email.

Do share information for providers, family and community members about people, such as veterans recently out of the service, who are at greater risk for suicide.

To assess how different types of experiences during military service and afterwards might influence suicide risk, researchers analyzed data collected on almost 3.8 million current and former service members from 2001 to 2011.

Overall, there were 4,492 suicides in the study population.

The strongest predictors of suicide were current or past diagnoses of self-inflicted injuries, major depression, bipolar disorder, substance abuse or other mental health conditions, researchers report in The Lancet Psychiatry.

Compared with service members who were never deployed, those who were currently deployed had a 50 percent lower risk of suicide, the study found.

However, in the first quarter following deployment, service members had a 50 percent higher risk of suicide than their peers who didn't experience deployment.

The study didn't examine why the suicide risk was lower during deployment than afterwards. But it's possible service members benefited from the positive psychological impact of belonging to a group with a shared mission during deployment, Shen said, then had more time to contemplate any negative feelings about their experiences when they were no longer on the mission.

When they left the military, the risk of suicide remained higher than for current service members for several years. Six years after leaving the military, veterans had a 63 percent higher risk of suicide than those still in the service, the study found.

One limitation of the study is that researchers lacked data on mental health disorders diagnosed after separation from the military, the authors note. They also lacked data on civilian experiences like divorce, unemployment, financial hardship or housing insecurity that could all influence mental health and the risk of suicide, the researchers point out.

The study also doesn't account for the frequency or intensity of combat experiences, noted Dr. Charles Hoge, a senior scientist at

Do share research information about suicide and risk factors.

Do share information a non-sensational way, using works like "higher risk" and "suicide risk was lower" rather than "skyrocketing, " "soaring," "epidemic," "sweeping, " etc.

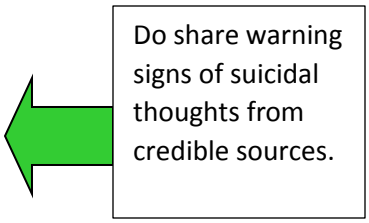
Do explain limitations to the research – unavailable data, etc.

the Walter Reed Army Institute of Research who wrote an accompanying editorial.

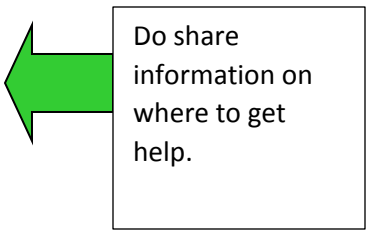
Still, the findings suggest that veterans may need mental health services long after they return home.

“Unfortunately, despite numerous efforts to reduce stigma and other barriers to care, stigma remains pervasive in society and many veterans still do not seek help when needed,” Hoge told Reuters Health by email.

“There are a number of warning signs for underlying mental health problems that may require treatment, such as withdrawal from family and friends, noticeable changes in functioning or behavior, talking about suicide or death, giving away belongings, increasing alcohol or substance use, or expressions of hopelessness or worthlessness,” Hoge added.



One immediate resource that is available 24/7 is the national suicide prevention lifeline 1-800-273-8255.



SOURCE: bit.ly/2dPXIi3 and bit.ly/2dMyc1G The Lancet Psychiatry, online September 30, 2016.