

The logo for SHiFT.. is located in the top right corner. It consists of the word "SHiFT.." in a bold, orange, sans-serif font, with two small white dots following the "T". The logo is set against a dark blue rectangular background.

SHiFT..

The background of the top two-thirds of the page is a blue-toned image of a human head in profile, facing left. A large, semi-transparent question mark is overlaid on the brain area. The image has a subtle grid or mesh pattern overlaid on it.

What's the story?

Reporting **mental health**
and **suicide**

A resource for
journalists and editors

'What's the Story?' is produced by Shift, the Department of Health-funded campaign to tackle the stigma and discrimination associated with mental illness. For more information about Shift and our work, visit our website: www.shift.org.uk

Electronic versions of this document can be found online at: www.shift.org.uk/mediahandbook

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Foreword



It's not often, as a journalist, that you can file a story - and save a life - all in a day's work.

But following the tips in this handbook could help you do just that - or at least make a real difference to the lives of millions of people and their families who live in the shadow of mental illness.

One in six people reading newspapers and watching the TV news have a mental health problem. The scale of this problem is truly enormous. Mental health problems are estimated to cost the UK economy over £77 billion a year through the costs of care, economic losses and premature death¹. Some 630,000 people in England alone are in regular contact with specialist mental health services². And tragically, nearly 6,000 people take their own lives every year in the UK³ - that's 16 families bereaved by suicide every day.

So mental illness and suicide are huge social problems, responsible for untold suffering, that affect every family in the land. None of us, least of all journalists, can responsibly ignore them.

Government and society are already rising to the challenge of this previously hidden problem. Politicians are waking up to the fact that the well-being of society is just as important as the economy. Schools are employing techniques rooted in psychological therapies to try to teach children the life skills to help them lead happy and productive lives. People with mental health problems are increasingly talking openly about their illnesses. The bravery of high-profile people, such as Stephen Fry, Gail Porter and Frank Bruno, speaking out about their experiences, reflects this change in public opinion.

The media hasn't caught up yet. We've been here before. Once the Press reported on black Britons not as people but as a threat to 'the rest of us'. Often the only time a black face appeared in a newspaper was as a picture caption to a story about violent crime. Now, quite properly, it reports on the lives of black people in their own right and racist stereotyping, linking black men with violence, has become off-limits.

But this is not a "finger-wagging" exercise in political correctness. It's an opportunity for journalists to be in the vanguard of change, making a difference to the lives of millions of people who are unfairly victimised and socially excluded. I urge you to make good use of this guide and the contacts listed within it.

What can you do? Simple – report accurately and fairly, looking at all sides of the story; get quotes from the horse's mouth – people with real experience of mental health problems; don't make the mistake of creating the impression that everyone with a mental health problem is a 'mad axeman'; give numbers of helplines, like Samaritans when writing about suicide; don't give details that can – and do – result in people killing themselves in copycat suicides. Simple steps like these avoid causing offence, change lives for the better – and can even save lives.

A handwritten signature in black ink that reads "Jon Snow". The signature is stylized and cursive.

Jon Snow

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Introduction

The handbook – what is it for?

This handbook is packed with useful facts, figures and contacts. It is designed to help you do your job when covering these stories, whether you're a print, broadcast or magazine journalist.

It is intended to help, not hinder - we do not want to stop stories like these being reported. Quite the contrary, we would like more coverage of these important public health issues. But we do also want to encourage fair, accurate and balanced reporting, as well as awareness of the repercussions of careless coverage.

So the handbook also contains tips on how best to avoid causing needless offence - or worse - to your many readers and viewers affected by mental health problems. They apply whether you are covering a murder, a suicide or in fact wherever mental health crops up in the news, which can be pretty much anywhere. Our aim is to help you cover these stories properly and, at the same time, improve public understanding and avoid adding to the problems faced by people with mental health problems.

What's the problem? – stigma and discrimination

People with mental health problems are one of the most excluded groups in society, their lives often blighted by stigma and discrimination. They are denied access to jobs, education and healthcare and, often shunned by neighbours and colleagues, from playing a full part in our communities.

Many fear disclosing their condition, even to family and friends⁴. People with mental health problems frequently say the barriers they face because of their diagnosis have an even bigger destructive impact on their lives than their symptoms. They say they can manage their symptoms, but fear, prejudice and discrimination take away the rights that others take for granted.

"This handbook raises some really thought-provoking issues about how media reporting can affect the one in six people that have mental health problems. They are a substantial proportion of the media's potential audience. The choice is simple for journalists - we can shore up the wall of stigma and silence that surrounds mental health, or we can help knock it down."



**Bob Satchwell, Executive Director,
Society of Editors**

"My mailbag is full of moving letters from readers struggling with mental health problems - not surprising since nearly all of us have a friend or family member who has run into this sort of difficulty at some time. When we're reporting and commentating about these very common problems, it makes a huge difference if we remember we're talking about 'us' and not 'them' - and that we all deserve to be treated with respect."



**Deidre Sanders, also known as Dear Deidre,
The Sun's Agony Aunt**

What's this got to do with the media? Room for improvement

Over the last few decades, media coverage of issues like race, sexuality and physical disability has changed significantly, reflecting changing public opinion. Discrimination, of course, still takes place in society in relation to these issues, but the media has helped millions of people play a full part in their communities and take their rightful place in mainstream society.

But for people with mental health problems stigma and discrimination remain rife. You are in a privileged position, able to help improve public understanding and demolish some of the tired, old misconceptions about mental illness.

There have already been dramatic improvements in how much the media covers mental health issues in recent years⁵. Depression, anxiety, stress, eating disorders, panic attacks, post-natal depression and obsessive-compulsive disorder – all these conditions and more are now widely reported on. We read in the health and news pages about these illnesses and watch documentaries on television about them. Celebrities are increasingly willing to talk publicly about their mental health problems. Common mental illnesses have entered into the general lexicon. This is in stark comparison to ten or twenty years ago when we heard next to nothing about them.

However, there is still a way to go, particularly with views about severe mental illness. Prejudiced attitudes towards those more severely affected remain deeply ingrained in our society and this is still reflected in media coverage.

At worst, headlines sometimes still carry the kind of derogatory language (for example 'nutter', 'maniac' or 'schizo') that would be unthinkable in relation to race or physical disability. More subtly, terminology and language can be inaccurate and mental health is often presented as a problem for society, not a major public health issue.

The linkage between violence and mental illness is exaggerated. A survey found 27% of coverage about mental health was about homicides and violent crime⁶. Millions of people have mental health problems – very few are violent. Only five out of a total of 600 homicides a year are random attacks on members of the public by someone with a mental health problem⁷.

By challenging these stereotypes, rather than reinforcing them, you can encourage more openness about mental illness. This will really improve the lives of all those affected and will encourage others to come forward to get the treatment they so desperately need.

It could be you...



I had a pretty spectacular nervous breakdown when I was a journalist at the Mirror. I was poached by Eddy Shah's Today when it launched. It was a disaster. I was over-promoted, I hit the bottle pretty hard, went completely manic and cracked up.

On the day it happened, I was doing a piece on Neil Kinnock in Scotland. It was like this piece of glass cracking in slow motion into thousands of pieces inside my head. I was struggling to hold it together but the harder I tried, the more the glass cracked, and I ended up with an explosion of sounds, memories and madness reverberating through my mind.

I got detached from the main press pack and was picked up by the police because I was behaving oddly, putting all my possessions into a little pile in the foyer of a building I'd wandered into.

I was in a psychiatric hospital for a few days, heavily drugged. I was treated for depression and was on medication for a few months. There are not many things as deadening as real depression, when you feel unable to move a muscle and you're incapable of getting out of bed, or speaking or thinking, or doing anything, and you can't see a way forward. But I got through it eventually.

I was really lucky. Fiona, my partner, was incredibly supportive. Richard Stott, who was editor at the Mirror, took me back. He gave me a chance and that was a huge thing for me, an act of support people often don't get when they become ill.

When Tony Blair asked me to work for him in 1994, I said "You do know about my breakdown don't you? You do know I still get depression." He said "I'm not worried if you're not worried." I said "What if I'm worried?" He said "I'm still not worried." I think that's an important signal for us to take on board – if a Prime Minister can take that attitude, we all can.

I suffered severe bouts of depression during my time at Downing Street. At times I was so depressed I'd wake up and couldn't open my eyes, I couldn't find the energy to brush my teeth. The phone would ring and I'd stare at it endlessly, unable to answer it.

I've wanted to be open about my mental health problems, because I know from my own experience how it helps to know there are other people out there who have been to the brink and come back again.

If it happened to me, it can happen to you – it will almost certainly happen to a friend, colleague or relative. Help encourage more openness about mental illness and challenge the stigma – don't reinforce it.

Alastair Campbell

...Or someone you love



"My sister Linda had schizophrenia. She had made threats to kill herself, but we really didn't expect her to do it. But she did – she burnt herself to death. I was working in Australia at the time and came back to England to be with her for the six weeks it took her to die.

"Trying to explain to people back in Australia why I'd dashed over here, without mentioning her mental illness, seemed not only to deny my sister's struggles but to deny her very existence. That's when I decided to tell people about the mental health problems in my family.

"Secrets and lies will destroy you every time. If I hadn't 'come out' safely to a journalist in Australia after I ended up in a psychiatric wing, I'd be tip-toeing around today coping with the added stress of secrets and lies.

"My sister had schizophrenia, but that wasn't what killed her - it was the stigma. With the stigma comes ignorance and fear and people have personal life choices taken away from them."

Channel Five talk-show host Trisha Goddard



"I loved my father, Ron, dearly but he was a manic-depressive, and his mood-swings cast a long shadow over my childhood. When he was 'low' he would take to his bed for days on end - crushed and inconsolable.

"When he was 'high' it was, for me, my brother and mother, like trying to cling

on to the tail of a comet.

"There was no rest for him - or us. He'd walk for miles until the blood came through his plimsolls. He painted our front door at midnight. He smashed every breakable item in the house. Lithium would stabilise his moods but it destroyed his internal organs. At 63 my father died of a heart-attack.

"I never considered my father 'mad'. He was not a 'loony'. And I was lucky that, good, generous and loving man that he was much of the time, nobody who knew him ever labelled him as such. But mental-illness has always been feared and its sufferers shunned or politely avoided. This is where the media must play its role. Mental illness must be discussed, debated – brought out in the open – with sensitivity, understanding and, above all, love. Because often it is the people closest to us who are silently suffering."

Martin Townsend, editor of the Sunday Express

Why else should you care?

These are some other reasons which reporting on mental health is so important and why it makes sense to take care about how you cover it:

- One in six of us - nearly 10 million people across the UK - will be experiencing a mental health problem at any one time⁸ and worldwide depression is predicted to be the second biggest cause of death and disability in the world⁹.
- Mental health is now an important issue, not just for readers and viewers, but for businesses, opinion formers and government. Some experts suggest a nation's success should not be measured in Gross Domestic Product but in terms of the overall emotional well-being of the nation¹⁰.
- Most people, 84% of the general public, think that people with mental health problems have been the subject of discrimination for too long¹¹.
- International evidence shows that taking care over how you report suicide can prevent copycat suicides and save lives.
- You can make a difference as a journalist by helping to reduce stigma - the number one factor in improving the lives of people with mental health problems¹².
- You can also help challenge the discrimination people with mental health problems face. With the highest rate of unemployment among people with disabilities, 34% have been unfairly sacked or forced to resign from a job¹³.
- It's a professional responsibility. All the major professional codes for the media, and many in-house guidelines, include strong guidance on accuracy, privacy and non-discrimination.
- There are lots of untold stories out there. A survey by Shift in 2006 found that only 6% of media coverage contained the voice of people with mental health problems¹⁴.
- Words like 'loony', 'schizo' and 'nutter', still appear in the press and cause offence to people with mental health problems. The use of equivalent words for issues like sexuality, disability or race is unacceptable – these terms also have no place in our media.

Interviewing people with mental health problems: the Shift 'Speakers Bureau'

Shift has set up a 'Speakers Bureau', a bank of people with mental health problems, who are willing to talk to the media about their extraordinary stories.

If you would like to interview a Speaker, please contact Ben Furner on 01273 463 461 or at ben@bf-pr.co.uk

Key facts about mental health

One in six people - about 10 million people in the UK - are affected by a mental health problem at any one time¹⁵.

Mental health problems are estimated to cost the UK economy over £77 billion a year through the costs of care, economic losses and premature death¹⁶.

Total economic due to lost work and absenteeism associated with depression and anxiety disorders is around £12 billion each year¹⁷.

Fewer than four in ten employers would consider employing someone with a history of mental health problems, compared to more than six in ten for candidates with physical disability¹⁸.

Only about 20% of people with severe mental health problems and around 50% of those with less serious problems are in paid employment, yet 80% want to work¹⁹.

About one in every 200 adults experience a psychotic disorder, like schizophrenia or bipolar disorder, in any one year²⁰.

People with serious mental health problems die on average 10 years younger than other people. This is because of the greater risk of physical health problems and poorer access to healthcare²¹.

70% of people affected by mental illness say they have experienced discrimination at some time because of it²².

Most people say they would not want anyone to know if they developed a mental illness²³.

Care in and out of the community

The basic facts about mental health problems and their treatment

What is mental illness and what causes it?

Feelings of sadness, anxiety and confusion are perfectly normal responses to the stresses and strains of life. They only become mental health problems when they significantly interfere with everyday life.

The causes of mental illness are complex and the subject of much debate, differing between illnesses and each individual. Often illness can be triggered by traumatic, stressful events such as bereavement and physical illness and by work, relationship or financial problems. Drug misuse can precipitate illness in vulnerable individuals, as can pregnancy and childbirth. Other times there is no obvious environmental cause. It is generally recognised that illness is the result of the interplay of genetic vulnerability and life experience. Scientists are seeking to establish what genes confer vulnerability to severe mental illnesses like schizophrenia, bipolar disorder and major depression. These conditions sometimes run in families, evidence of a genetic predisposition.

World Health Organisation declaration on mental health:

“There is no health without mental health ... mental health and mental well-being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens.”

Treatment

A visit to the GP is normally the first step to getting treatment. For most common mental health problems, such as anxiety or depression, a family doctor may provide lifestyle advice, such as reducing stress and taking more exercise, a prescription for anti-depressants or a referral to counselling or talking therapies.

A GP is likely to refer someone with more severe or chronic mental health problems to a specialist mental health services such as the Community Mental Health Team or a consultant psychiatrist. Specialist services exist for children and young people (Child and Adolescent Mental Health Services) and for older people.

The vast majority of people receiving help for their mental health problems live in their own homes or with their families. Some, with extra support needs, may live in residential care homes, hostels, supported housing or therapeutic communities.

Hospital admissions are mostly voluntary with only around one in ten patients being detained or ‘sectioned’ under powers under the appropriate section of the Mental Health Act. A small minority of those admitted to hospital need to receive care in secure settings for the safety of the patient or other people. Secure care services are provided in a number of hospitals around the UK.

Drug treatments are widely used for a range of illnesses, and are considered essential for treating more severe illnesses like bipolar disorder, schizophrenia and severe depression, although they sometimes have very unpleasant side effects.

Talking therapies include counselling, psychotherapy and Cognitive Behavioural Therapy (CBT), the most evidence-based talking therapy which involves challenging negative thinking patterns. Many patients benefit from a combination of medicines and talking therapies.

The changing face of services

Over the last decade, emergency admissions to in-patient wards have fallen because of a move towards community-based treatment. Patients increasingly treated in their own homes by 'crisis resolution' and 'home treatment' teams, which are available 24-hours a day. Every year almost 100,000 people are treated safely and successfully at home instead of at hospital.

The Government has also pledged to invest £170m by 2010 in talking therapies in England. This is expected to reduce average waiting times to see a therapist from 18 months to a fortnight. Most people with anxiety and depression want talking therapies, rather than anti-depressants. It is expected that this will enable 900,000 more people, who would otherwise mostly have only had the option of anti-depressant treatment, to receive talking therapies.

The NHS is also making Computerised CBT, therapy delivered by computer online and through a CD-Rom, available after the National Institute for Clinical Excellence and Health recommended it as a treatment for mild depression or anxiety.

The Mental Health Act 2007, applicable in England and Wales from October 2008, introduced supervised community treatment, a new way of managing the care of patients in the community rather than in hospital. Patients can be asked to keep to conditions, such as attending out-patient clinics to take medication under supervision, to help ensure they receive the treatment they need. They may be recalled to hospital for treatment if necessary.

Reporting mental health and violence

One of the most damaging public misconceptions about people with mental health problems is that they are dangerous and unpredictable - 34% of people in England think that people with a mental illness are likely to be violent²⁴.

"This handbook quite rightly doesn't ask reporters to ignore someone's mental health problems if they are pertinent to their involvement in a crime. But quite reasonably it does ask that these facts are set in context, so we don't create the impression that everyone who is mentally ill is a murderer. There's so much misunderstanding about mental illness, we do need to report it accurately and sensitively."



Jon Clements, Crime Reporter, Daily Mirror

Extensive coverage of rare but sensational murders carried out by small number of psychiatric patients tends to create the misleading impression that everyone with a mental health problem is a 'mad axeman'. The facts do not justify this interpretation. Research has established a 'modest' association between severe mental illness²⁵ and violence, but **mental illness accounts for a relatively small proportion of violent crime**²⁶.

It has been established that about 9% of homicides, just over 50 of the 600 homicides a year in England and Wales, are perpetrated by someone with a history of mental illness²⁷, but mental illness is not always a factor in all these cases.

Fear of mental illness is often based on the misconceived notion that people with a mental health problem are likely to attack a member of the public at random.

In fact stranger homicides - random attacks on members of the public by people with mental illness - are very rare. They account for about five a year, less than 1%, of the 600 homicides in England and Wales every year²⁸.

Most homicides committed by people with mental health problems, whether by a mother with post-natal depression or someone with schizophrenia, are sadly perpetrated against their own families, often when there has been a breakdown in the provision of care.

Schizophrenia does carry a slightly higher risk of violence than other mental illnesses. About 30 homicides in England and Wales, five per cent of the total, are carried out every year by people with schizophrenia²⁹ - again most of these crimes are against family or friends³⁰. But the public fear of 'schizophrenics' is out of all proportion to the real risks. Of course, the reality is that people with schizophrenia tend to be vulnerable and withdrawn when ill, struggling with symptoms often described as 'a living nightmare', and are far more likely to hurt themselves than others.

Martin Rukin, 49, a father-of-five, of Blackpool, is a former soldier, who served in Northern Ireland and has schizophrenia. He says:

"When I read about a 'paranoid schizophrenic' going 'psycho' in the papers, I just want to hide. I can't face going to the pub - they all know I've been ill and I know what they'll be thinking, even my mates. It's just so unfair. My voices are a pain in the backside, but they never tell me to harm anyone. And anyway, I'd never hurt a fly."



Of course, the media will always cover sensational murders or violent crimes, irrespective of whether they are perpetrated by people with mental health problems or not. But it is important when reports highlight mental illness as being a factor in a violent crime that it is seen in the context.

When covering homicides, seek comment from the Department of Health press office and leading mental health charities such as Mind and Rethink.

They will all stress that it is very rare for people with mental health problems to carry out homicides. Most people with a mental illness pose no threat to anyone.

Shift is also working with the police and the criminal justice system to ensure they emphasise these facts when talking to the media about these cases.

When reporting newsworthy child abductions, the media often stresses the rarity of this crime. This is to avoid creating public alarm disproportionate to the risk to any one family, which is of course very small. It would be fair and responsible to take the same approach when reporting mental illness and violence.

The dos and don'ts of covering violence

These are some recommendations for good practice when reporting on violent crime stories which may be linked to mental illness:

- Avoid using offensive expressions like 'psycho', 'schizo' and 'nutter'. They perpetuate the stereotypical ideas associating people with mental health problems with violence and unpredictability – and their use may breach the PCC code and other codes of practice (see the chapter on codes of practice for more information).
- Stick to the facts – don't speculate about someone's mental health being a factor unless the facts are clear.
- Include contextualising facts about how very few people with mental health problems are violent.
- You may wish to reflect the views of the perpetrator's family – often they are victims too, with compelling stories to tell.
- Seek comment from a mental health charity, a police spokesman or a psychiatrist from the Royal College of Psychiatrists, who can set the story in perspective. See Contacts section at the back for more details.

Like ink on paper, journalists prefer to see the world in black and white - right or wrong, good or evil, mad or bad. Our adversarial traditions of governance and justice embed this view and shape the stories we tell. But the workings of the human mind are infinitely more complex than this diametric model. The motives for our behaviour are rarely straightforward or rational. The welcome fact that mental health, 'well-being' in the new language of politics, is no longer taboo obliges journalists to confront these complexities in our reporting. It is a profound challenge. We must revisit our assumptions and adjust our vocabulary. We must ensure ignorance and prejudice do not undermine our rigour. This handbook offers just the kind of help we need.



Mark Easton, Home Editor, BBC News

Violence and mental illness – the facts

These are some of the surprising facts and figures about the link between mental illness and violence:

- The number of homicides committed by people with mental illness in the UK has remained stable since the 1950s, demonstrating that the introduction of 'care in the community' has not increased the risk to the public³¹, at a time when the overall rate of homicides has tripled.
- A very small number of people who have a combination of conditions such as a severe mental illness, anti-social personality disorder and an alcohol or drug abuse problem, pose a heightened risk. However, they contribute to a relatively small proportion of all violent crimes³².
- Alcohol and drug problems are associated with a much greater risk of violence than mental illness³³.
- The reality is that, at odds of 1 in 10 million, you are as likely to be struck by lightning as to be killed by a stranger who is mentally ill³⁴.
- People with severe mental illness are more likely to be the victims than perpetrators of violent crime³⁵. One study found one in four were attacked in the course of a year and were 11 times more likely to be victimised than the general population³⁶. This form of 'hate crime' is under-recognised by the police and authorities, unlike violence on religious or race grounds.

Jo Sullivan, 42, from Liverpool, is studying for a degree in Spanish and International Studies at the Open University and works part-time as an administrator for NHS mental health trust Mersey Care. She has schizo-affective disorder.



She says: "It's hard living with a diagnosis like mine because of the stigma. Just the word 'schizo-' is terrible – it sounds like 'psycho'. What's worst is when you read in the papers about a 'mental patient' killing someone. I feel so angry anyone could actually hurt someone like that.

"But I also feel it's really unfair and unjust that I can be categorised in the same bracket as someone like that – I would never do something like that. It makes me feel very, very self-conscious when I read a story like that because people know my diagnosis. The media is so powerful and I'm just one of 'Joe Public' – I feel powerless to defend myself."

Violence: the other side of the story

These two pieces below show the 'mad axeman' story from a different perspective. This first piece is an edited version of a feature from Good Housekeeping Magazine.

Good Housekeeping



Photographs: **Brian Moody**

When Lin Langford's son Stephen was diagnosed with a mental illness, she did all she could to help him. But then, as she tells Ellie O'Mahoney, the unthinkable happened

My son Stephen was always different from my other two children. He was quieter and more clingy than they were, but he was never any trouble.

However, in his early twenties Stephen changed. He had trained as a mechanic, but at the age of 21

he gave up his job for no reason and started to spend a lot of time alone in his bedroom, sometimes in the dark. I was concerned but he brushed it off, saying he didn't enjoy the work any more. So when a friend of his told me that he was worried about

some bizarre things Stephen had been saying, I was surprised – I'd just thought he was a bit low.

I realised something was very wrong one afternoon, as we were watching television together. He confided that he'd seen Hitler. He

told me matter-of-factly that he also believed that the cartoon character Scooby-Doo was real. Around the same time, he became obsessed with washing his hands and he'd laugh out loud at nothing at all. When I confronted him, he'd deny doing any of it.

Over a period of months, things got increasingly worse. Stephen had some library books that were overdue, but he refused to return them. When I asked him why, he looked at me straight-faced and said he was the King and owned the library, so didn't need to return them. One day he even pointed at me and said, 'Look at her, she's got horns.' A split second later, he was talking normally again.

Desperately concerned, I persuaded Stephen to go to the doctor. He referred Stephen to a psychiatrist, who visited us at home and diagnosed schizophrenia. After he left, I sat on my sofa gazing into space, wondering what this diagnosis would mean for Stephen.

Adamant that there was nothing wrong with him, Stephen refused medication, so the psychiatrist suggested he should be sectioned. I was desperate to keep him at home but knew deep down he needed help, so I reluctantly agreed.

Either my sister, who was close to Stephen, or I visited him nearly every day for six weeks with home-cooked food. Then, to our surprise, he was sent home, despite not seeming any better. We wrote a letter to his doctors expressing our grave concern that Stephen had been discharged so suddenly, without a care plan or information on how we should deal with him at home.

Telephoning Stephen's psychiatrist to find out more, we were informed Stephen had schizotypal disorder – a personality disorder that, unlike his initial diagnosis of

schizophrenia, couldn't be treated with medication. This baffled us. Not only had the psychiatrist not informed us himself but also, we had spoken to a mental health charity when Stephen was first sectioned and he seemed to fit the profile of someone with schizophrenia exactly.

But without any further information to go on, we were left thinking we simply had to accept Stephen the way he was. I did my best to communicate with his doctors, once resorting to creeping into Stephen's bedroom to photocopy his diary to take with me as evidence of his strange writings.

So when Stephen refused to go to his outpatient appointments despite our best efforts, we felt hopeless. He was left with no support when he was at home and, although I phoned and wrote letters to his doctors to update them on his health, as someone who had no previous experience of mental illness, how could I be sure that I was reporting to them everything I needed to?

Finally Stephen was assigned a social worker, who came to see him on the morning of 27 March 2002 – eight months after his last meeting with a doctor. Not long after, I heard the door slam as the social worker left. Surprised that the meeting had been cut short, I came into the sitting room to see Stephen pacing up and down, clearly agitated. 'I won't be seeing him again,' he muttered, and a couple of minutes later he left the house without saying where he was going. He returned about four hours later, noticeably calmer.

The following day, I had a phone call from my sister. The social worker had called her to say that during his

visit to our house the day before, Stephen had threatened to 'butcher' him and his family. I just couldn't believe Stephen would have said something like that.

Then a few days later, on the morning of Easter Sunday, I was awoken by the sound of banging. I looked out of the window to see the house surrounded by police officers. The police practically pulled the door off its hinges, ran up the stairs and marched Stephen down in handcuffs, saying it was

'I looked out of the window to see the house surrounded by police officers'

in connection with the murder of a 79-year-old local woman. The murder had happened on the day of the social worker's visit to our house. I couldn't stop crying.

I was forced to leave the house so the police could check it for evidence, and I went to stay at a friend's house for a couple of days. It felt as if the ground had fallen away beneath me. My son was in prison, I was being questioned by the police and I couldn't even sleep in my own bed.

When Stephen was charged with murder, I couldn't take it in. It was completely surreal. I just kept thinking they'd realise they'd arrested the wrong man. I was terrified of leaving the house, fearful of what people in our small village would say to me. But a couple of days later, a friend encouraged me to go to the local pub and it was the best thing I could have done. As I sat cowering in the corner, a neighbour came over and said, 'They must have got the wrong kid, Stephen would never have done that.'

I was refused contact with

Stephen for more than a month while the police questioned him. On my first visit to the prison, he was sitting on a cardboard chair behind a glass screen, so I couldn't even reach out and hug him. He felt so very far away. I didn't even mention the crime at that point – all I really wanted was to know that he was okay.



Stephen at 14, seven years before the first signs of mental illness appeared

Photo: Brian Moody

As we talked more and more in the months leading up to his trial, it became clear that Stephen had no recollection of the killing. He was still incredibly ill, and it was difficult to get any sense out of him. He was planning to plead 'not guilty', and I had to explain that all the evidence pointed to him.

Waiting for the case to start was difficult. I couldn't sleep, my mind would go blank and I forgot phone numbers I'd known for years.

On the first day of the trial, Stephen was brought to the dock and smiled when he saw me. I was so pleased he could see I was there and relieved that he wasn't handcuffed. All I could think of was the little boy Stephen

used to be.

At the back of my mind, I hoped they'd find evidence to prove Stephen hadn't done it and it had all been a big mistake. But on 17 February 2003 Stephen was found guilty of manslaughter by reason of diminished responsibility. He was to be detained indefinitely in a medium-secure unit.

We heard that when Stephen left the house on the morning of his social worker's visit, he had walked around the corner into the open house of the elderly woman and stabbed her to death. I sat crying in the public gallery, watching my son behind the glass screen and feeling as if it was all happening to someone else.

It sounds odd, but as I left the court I was relieved it was over and that Stephen was finally going to get the professional care I knew he really needed. All I could think about was the victim's family and what they were going through. So after we left court, I asked the family's liaison officer if they would accept a letter from me or agree to a meeting. I wanted to explain that I'd fought for Stephen to receive proper treatment. I imagined the family would say no to my request – I thought I'd be the last person they'd want to see – but to my amazement they agreed to meet.

A few days later, we met in a hotel. I was apprehensive about how they would react to meeting the mother of the man who had killed their loved one. When the victim's husband and two daughters walked in, I was surprised to recognise one of the women. We'd kept ponies together years before. We hugged and shook hands and sat and talked about what we'd been through. They were so understanding about Stephen's illness and, unlike a lot of people,

they realised that two families had been affected. Four years on, I'm still in contact with them. We've helped one another in many ways.

At the beginning, I would break down in tears after every visit to Stephen. Now, though, I'm happy with the treatment he's receiving. His doctors update us constantly and the medication has transformed him back to the Stephen he used to be. When he was ill we didn't have a lot to talk about, but conversations are now easier. We still don't talk about the crime. He's so sorry to think of what he has done to the victim's family, but I've told him it wasn't the 'normal' Stephen who did it. That's why, despite finding it hard to believe that he did what he did, I still love him very much.

He has since been correctly diagnosed with schizophrenia, which should have been treated years ago with medication. Since the inquiry into the case, I've seen Stephen's medical notes and was disgusted to find there were psychotic signs in him just two days before he left the hospital. In my opinion, he shouldn't have been allowed home, but I put my trust in the medical professionals because I assumed, as anyone would, that they knew what they were doing.

I've kept all Stephen's things in his bedroom – I can't bear to throw them away – but he won't be able to come back to it. The Home Office has ruled that my home is too close to the crime scene and that it would be insensitive to the victim's family, which I completely understand. He'll have to start again on his own, and carry around with him what he has done for the rest of his life.

I still don't sleep well and I still cry when I'm alone. People say I've coped so well, but I've had no choice. On the inside, I will never get over it. ■

This extract from a news story in the Daily Mirror shows how a man with schizophrenia who attacked a church congregation deeply regretted his actions after recovering from the illness.



EXCLUSIVE

By JON CLEMENTS

A MAN who wounded 11 churchgoers after going berserk with a samurai sword while mentally ill is backing the Mirror's campaign to get knives off the streets.

Eden Strang, 33, stripped naked and attacked the congregation in a frenzy because he believed they were demons who were trying to kill his wife and child.

But Eden, who has been released from a psychiatric hospital after successful treatment for paranoid schizophrenia, said he was supporting the knife crackdown because he appreciated the dangers better than most.

He said: "I fully support the knife amnesty. I know that it's very important to get knives off the streets.

"What I did was wrong and of course I know that now. I'm very sorry for what happened but I was ill then."

Eden was released from hospital in 2002 - less than two years after his rampage at St Andrew's Church, in Thornton Heath, South London.

He is now trying to rebuild his life at a Surrey housing estate after splitting from wife Michelle, 30, and their nine-year-old daughter Olivia.

Eden said one reason he supports the Government's knife amnesty, which is backed by the Mirror's Bin That Knife campaign, is that he too has been a victim. The softly-spoken computer programmer was stabbed on three separate occasions while he was growing up in Glasgow.

He added: "I've been a victim of knife attacks and also a perpetrator so I've seen it from both sides."

Eden's mental illness spiralled out of control after a troubled childhood that included the loss of both parents.

In November 1999 Eden stripped naked to be "clean and pure" before walking from his house to the nearby church, armed with the sword that had been hanging on his wall.

His first victim was 50-year-old Paul Chilton, attacked as he stood outside the church. One blow from the 3ft blade sliced through Mr Chilton's jaw and into the jugular.

He almost died, surviving only after a 20-pint blood transfusion. Mr Chilton also lost his right thumb and a right finger and suffered extensive nerve and muscle damage across his face and neck.

Another 10 people were seriously injured. The terrifying attack ended when an off-duty policeman floored Eden with an organ pipe.

Eden stood trial at the Old Bailey for attempted murder and assault but was cleared due to diminished responsibility.

Psychiatrist Dr Philip Joseph told the jury: "In my experience, you can't get much madder than he was at that time."

Eden was released after just 21 months. Scotland Yard officers and mental health experts ruled that he was a "low risk" after responding to treatments.

Tess McWilliams, who was among the congregation when Eden struck, said they had forgiven him. Tess, 78, added: "We prayed for Eden because he needed help. I hope he is still getting the help he needs.

"If I saw him I would say hello and ask him how he was."

Reporting suicide

Suicide is often newsworthy and is a legitimate subject for reporting. The fact an individual has deliberately chosen to end their life quite naturally attracts interest. The figures are shocking. Although suicide rates are generally falling, there are still more than 6,000 deaths a year in the UK - nearly twice as many people die from suicide as they do in road traffic accidents³⁷.

But stories about individual suicides should be presented with care. How you choose to report on it can potentially save lives. The terrible truth is that people who are already feeling suicidal sometimes take their own lives after seeing media coverage of other suicides.

Copycat suicides

Recent research from the UK and around the world has shown that media representations of suicide can and do lead to copycat behaviour³⁸. The most vulnerable appear to be young people and the risk seems to be greater when there is a feeling of identification, such as in the case of a celebrity death by suicide. It is potentially very dangerous to provide specific details of a suicide method as this can provide a suicidal person with the knowledge they need to take their own life.

This evidence resulted in the Press Complaints Commission amending the Code of Practice in 2006 to require journalists to avoid reporting excessive detail about methods used.

The dos and don'ts of covering suicide

These are some recommendations for good practice when reporting on suicide:

- Seek help from one of the organisations listed in this handbook for expert advice, information or to find professionals or individuals who have direct knowledge of suicide.
- Take care to avoid giving excessive details about the method of suicide used because it may result in copycat suicides.
- Always include details of an appropriate helpline, such as Samaritans - 08457 90 90 90.
- Suicide was decriminalised in 1961, so it is inaccurate to use the term 'commit suicide'. Use alternatives such as 'took his own life', 'die by suicide' or 'complete suicide'.
- Suicide is complex. People decide to take their own lives for many different reasons. It is misleading to suggest a simplistic cause and effect explanation.
- Avoid sensational headlines or language that glorify or romanticise the act of suicide.
- Don't use dramatic photographs, footage or images related to a suicide.

The Press Complaints Commission Code of Practice: a new sub-clause on suicide

"When reporting suicide, care should be taken to avoid excessive detail about the method used."

The PCC has since upheld a complaint under this new rule against a regional evening newspaper after it published an article that described in detail the method a depressed teacher used to electrocute himself.



Copycat suicide case studies

- Newspaper reports of suicide by the unusual method of antifreeze poisoning detailed how antifreeze had been mixed with lemonade and drunk in a field. In the month following the coverage there were nine cases of deliberate antifreeze self-poisoning compared with two per month previously³⁹.
- Newspapers widely reported that two people, who met via the internet, killed themselves in a suicide pact by lighting a tray of barbecue charcoal in their car. The technique had often been used in Hong Kong but it was believed to be the first it had been used in the UK. A few months later a mother and her five-year-old son died after she barricaded herself and her son into a small bedroom at their home and lit a disposable barbecue.
- An episode of the TV drama Casualty contained a storyline about a paracetamol overdose. Research showed that self-poisoning increased by 17% in the week following the broadcast and 9% in the following week. One in five of those patients said that it had influenced their decision to attempt suicide⁴⁰.

BBC Editorial Guidelines:



Suicide, attempted suicide and self-harm

Suicide ... should be portrayed with great sensitivity ... Care must be taken to avoid describing or showing methods in any great detail and content producers should be alert to the dangers of making such behaviour attractive to the vulnerable.

Both ... factual reporting and fictional portrayal of suicide, attempted suicide and self-harm may encourage others. The sensitive use of language is also important. Suicide was decriminalised in 1961 and since then the use of the term "commit suicide" is considered offensive by some people. "Take one's life" or "kill oneself" are preferable alternatives.

Consider whether to offer a helpline number or provide support material when output deals with such issues. The chief executive of Samaritans is happy to be consulted by content producers about the portrayal of suicide. [Editorial advice] should be taken on any proposal to broadcast a hanging scene, portray suicide, attempted suicide or self-harm.

Secrecy, shame and stigma

Suicide and suicidal thoughts often remain shrouded in secrecy and shame, making it hard for people to talk about. This stigma means that, tragically, many of these thousands of people who go on to take their own lives are too frightened and ashamed to ask for help. You can help change that by educating the public about suicide.

Some of the misconceptions to challenge, include:

- *“People who talk about feeling suicidal are unlikely to really try to kill themselves”* - people who take their lives will in fact have often given warning in the weeks before their death
- *“If someone wants to kill themselves there’s nothing you can do about it”* – offering appropriate help and emotional support can reduce the risk of a vulnerable person taking their own life
- *“Talking about suicide encourages it”* – on the contrary, giving someone the opportunity to talk about their feelings may help them realise they do have alternatives to ending their life

Sarah Turner, 46, a former BBC journalist, now a social worker, said:



“At one very difficult point in my life, I was looking for ideas for how to kill myself. I saw something on the TV news about two suicides – someone who had taken an overdose of pills and someone who’d tried to cut their throat with a piece of glass. This convinced me that it was possible. I tried both of these methods. I think coverage like this is dangerous and irresponsible. When you’re already in a vulnerable place, it serves as a prompt - you just think ‘why not?’”

Language and terminology

Getting it right: style guide

Words matter. The more contentious the issue, the louder the debates and disagreements about the right language to use. This section briefly sets out some of the preferred language to use about mental health.

- Avoid using offensive expressions like 'loony', 'psycho', 'schizo' and 'nutter' when referring to someone with a mental health problem. They stereotype and stigmatise – and their use may breach the PCC code and other codes of practice.
- Try to avoid writing 'the mentally-ill' – say mental health patients or people with mental health problems.
- Defining people by a diagnosis – 'a schizophrenic' or 'a depressive' – can cause offence. People are more than their mental health problem.
- 'A person with' is clear, accurate and preferable to 'a person suffering from'.
- 'Schizophrenic' should not be used to mean 'two minds' or to refer to a 'split personality' – this is an incorrect use of the term.
- 'Schizophrenia' has become the 'illness metaphor of choice' in the Press. It is used metaphorically to imply chaos and unpredictability 50 times more often than the term 'cancer', according to research⁴¹, reinforcing negative perceptions of the illness.
- Secure psychiatric hospitals are not prisons – residents are patients, not prisoners or inmates. When they leave, they are discharged, not released (see Press Complaints Commission Code guidance on the next page).

"We stand in relation to some aspects of mental health – particularly in the way we refer to mental illness, in the language that we use and misuse – roughly where we stood in relation to race 20 or 30 years ago. The least we can do is to accept that language used about mental illness is important and reflect this in the practice of our trade."



Ian Mayes, Associate Editor and former Readers' Editor, The Guardian

"I'm very conscious of the way we all abuse mental health terminology. It actually causes great discomfort to people when we use words like 'schizophrenic' as a metaphor in casual discourse about issues that have nothing to do with mental health."



Jon Snow, Channel 4 News

Industry codes of practice

Meeting the guidelines

Here is a selection of key extracts from and summaries of the relevant professional codes of practice and in-house guidelines.

The Press Complaints Commission's Code of Practice

Clause 12 about discrimination states that the press must avoid prejudicial or pejorative reference to a person's race, colour, religion, sex or sexual orientation, or to any physical or mental illness or disability. Details of an individual's race, colour, religion, sexual orientation, physical or mental illness or disability must be avoided unless genuinely relevant to the story. Clause 5 states that when reporting suicide, care should be taken to avoid excessive detail about the method used.

In a Guidance note, the PCC gives more detailed advice, making clear that people detained under the Mental Health Act are 'patients', not 'prisoners', so language like 'caged' or 'jailed' is inaccurate. It warns against the use of terms such as 'basket case' or 'nutter', which may breach clause 12. It states: "Not only can such language cause distress to patients and their families, by interfering detrimentally with their care and treatment, it can also create a climate of public fear or rejection."

The note can be found in full at the PCC website at www.pcc.org.uk/advice

"Discrimination on grounds of mental illness has no place in a modern society. Nor should it have a place in the media. Discriminatory or inaccurate descriptions of people with mental health problems can distress patients and contribute to a climate of public fear or rejection."



Sir Christopher Meyer, Chairman of the PCC

The National Union of Journalists' Code of Conduct

The code requires members to: produce no material likely to lead to hatred or discrimination on the grounds of a person's age, gender, race, colour, creed, legal status, *disability*, marital status, or sexual orientation.

For the full code go to www.nuj.org.uk

"Press guidelines and codes of practice make it very clear that discrimination, distortion and inaccurate language have no place whatsoever in responsible reporting. The media has made good progress in upholding those standards on all sorts of issues.

But when it comes to mental health, we all have a bit of catching up to do."



Jeremy Dear, General Secretary of the NUJ

OFCOM Broadcasting Code

The code warns against the use of discriminatory language and says that methods of suicide or self-harm must not be portrayed or described in programmes except where editorially justified.

For the full code go to www.ofcom.org.uk

Diagnoses

Anxiety disorders

Chronic anxiety, worry, fear and panic which is so severe it dominates and interferes with ordinary life. Someone with an anxiety disorder may feel excessively anxious in particular situations, such as in social situations, or they may be constantly anxious regardless of the situation.

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is the most common childhood-onset behavioural disorder. It greatly reduces the children's ability to maintain attention without being distracted, leads to impulsive speech and behaviour, as well as making them fidgety and restless.

Bipolar Disorder (also referred to as manic depression)

A condition where people have extreme swings in mood, from being very high (manic) to very low (depressed), in a cyclical pattern. People go from profound depression to being elated and hyperactive, becoming reckless and having an unrealistic sense of their own importance or abilities.

Dementia

Mental confusion, impaired memory, reduced mental and physical functioning and altered behaviour are characteristic of dementia. Prevalence increases with age, although younger people can experience dementia.

Depression

Everyone feels sad, fed up or miserable sometimes. But for some depression goes on for longer and becomes so severe that they find it hard to carry on with their normal lives. The symptoms of 'clinical' depression include loss of interest and motivation, anxiety, difficulty concentrating, feelings of worthlessness or guilt, reduced energy levels and an inability to carry out everyday tasks. People feel bleak, helpless and sometimes suicidal. There can also be physical symptoms like insomnia and reduced or increased appetite. There is a range of self-help techniques and support networks available, as well as professional help and medication, to successfully manage depression.

Dual Diagnosis

A term generally used to describe people with mental health problems who also misuse drugs and/or alcohol.

Eating Disorders

Anorexia nervosa (starving oneself) and bulimia nervosa (compulsive eating followed by purging) are both eating disorders. They are not 'slimmers' diseases' but reflect psychological or emotional problems. They affect both males and females.

Obsessive Compulsive Disorder (OCD)

People with OCD feel that they have no control over particular repetitive, irresistible urges. Repeated and ritualistic behaviours such as hand washing, door closing or counting or repeatedly carrying out a series of actions in a set order disrupt individuals' everyday lives.

Personality Disorders

A group of disorders involving long-standing attitudes, behaviours and ways of viewing the world which are outside socially accepted limits. Personality disorders, often caused by traumatic childhood experiences, cause distress and disruption to individuals and those around them, making daily life difficult.

Post-natal Depression

This condition is one of the most common complications of childbirth. The most frequent symptoms are depression, intense feelings of tiredness or irritation and loss of appetite, as well as a feeling of not being able to cope or to meet the new baby's needs.

Psychosis

This is a term used by mental health professionals to describe a state when an individual's thought processes become distorted to such an extent that they lose touch with reality. It is a symptom commonly associated with severe mental illness. A person may experience a single episode of psychosis or may experience repeated episodes. Schizophrenia and Bipolar Disorder are the most common psychotic illnesses. Someone experiencing psychosis should not be referred to as a 'psycho'.

Schizophrenia

A condition that affects emotions, thinking and perceptions, and can result in people losing touch with reality, experiencing delusions, hallucinations, paranoia and disordered thinking. Symptoms include hearing, seeing or smelling things which are not there and believing that someone or something else is controlling one's behaviour. People with schizophrenia sometimes describe it as a 'living nightmare'.

Schizoaffective Disorder

A condition in which someone experiences symptoms of both mood disorders, like depression or bipolar disorder, and of schizophrenia.

Self-harm

Deliberate harm done to one's own body, usually done secretly, often by younger people. Ways of inflicting self-harm include cutting, burning and scalding, and self-poisoning. Often it is considered to be a way of coping with and distracting from emotional and life problems. However, people who self-harm are a high-risk group for later going on to take their own lives.

Contacts

The press offices listed here can provide advice on covering mental health issues, as well as access to information, research, comment and spokespeople.

Organisations - general mental health

Department of Health

Aims to improve the health and well-being of people in England, and ensure that health and social services are high quality, fast, fair and convenient. Provides information on mental health policy and service delivery.

Contact: Sally Aldous, Senior Press Officer

Tel: 020 7210 5329

Email: sally.aldous@dh.gsi.gov.uk

Web: information about policy and government initiatives is available at www.dh.gov.uk/mentalhealth

Mental Health Foundation

Leading charity helping people to survive and recover from mental health problems, as well as preventing them, through research and community projects.

Contact: Simon Loveland, Press Officer

Tel: 020 7803 1130

Email: sloveland@mhf.org.uk or pressoffice@mhf.org.uk

Mind

Leading charity in England and Wales, providing information and support, campaigning to improve policy and attitudes and working in partnership with nearly 200 local associations to provide services.

Contact: Julia Lamb, Press Officer.

Tel: 020 8215 2239

Email: j.lamb@mind.org.uk

Press Office: 020 8522 1743 or press@mind.org.uk

Web: www.mind.org.uk

Moving People

An £18 million programme to challenge attitudes and tackle discrimination against people with mental health problems in England. Moving People (interim branding) is led by the charities Mind, Rethink and Mental Health Media and is funded by the Big Lottery Fund and Comic Relief.

Tel: 020 8215 2352

Email: info@movingpeople.org.uk

Web: www.movingpeople.org.uk

Rethink

Leading UK-wide mental health membership charity, helping people affected by severe mental illness, providing services and campaigning for greater awareness and understanding of mental health issues.

Contact: Katie Leason, Media Manager

Tel: 020 7330 9129 / 9149

Email: katie.leason@rethink.org or media@rethink.org

Web: www.rethink.org

Royal College of Psychiatrists

The professional and educational body for psychiatrists in the UK and Ireland. It sets standards for mental health care and improves understanding through research and education, supporting psychiatrists and working with patients and carers.

Contact: Deborah Hart, Head of External Affairs

Tel: 020 7235 2351 ext.127

Email: dhart@rcpsych.ac.uk

Web: www.rcpsych.ac.uk

Sainsbury Centre for Mental Health

Carries out research, policy work and analysis to improve practice and influence policy in mental health and other public services, with a focus on care in prisons and mental health and employment

Contact: Andy Bell, Director of Public Affairs

Tel: 020 7827 8353

Email: andy.bell@scmh.org.uk

Web: www.scmh.org.uk

Samaritans

Provide a confidential non-judgemental emotional support 24- hours a day for people experiencing distress or despair, including those which could lead to suicide.

Contact: Kate Redway, Press Officer

Tel: 020 8394 8342

Email: k.redway@samaritans.org

Web: www.samaritans.org

Young Minds

A charity dedicated to promoting mental health for children and young people through their services, a helpline for parents, campaigning and sharing best practice.

Contact: Lucinda Paxton

Tel: 07772 513 365

Email: press@youngminds.org.uk

Web: www.youngminds.org.uk

Shift

The Department of Health-funded campaign to tackle the stigma and discrimination associated with mental illness.

Contact: Robert Westhead, Project Manager

Tel: 020 7307 2447 / 0845 223 5447

Email: robert.westhead@csip.org.uk / shift@csip.org.uk

Web: www.shift.org.uk

Shift Speakers Bureau

A bank of people with mental health problems who are willing to talk to the media about their experiences.

Contact: Ben Furner

Tel: 01273 463 461

Email: ben@bf-pr.co.uk

Web: www.shift.org.uk/speakersbureau

Together

A leading national charity running services, campaigning, doing research and educating local communities about their mental health needs.

Contact: Vicky Kington, Communications Manager

Tel: 0207 780 7444

Email: victoria-kington@together-uk.org

Web: www.together-uk.org

Organisations - specific conditions

Anxiety and Phobias

First Steps to Freedom

Voluntary organisation offering help to those who suffer from phobias, panic attacks, general anxiety, obsessive compulsive disorders and tranquilliser withdrawal.

Tel: 0845 120 2916

Email: first.steps@btconnect.com

Web: www.first-steps.org

National Phobics Society

The largest anxiety disorders association in the UK, run by people with phobias and anxiety disorders and supported by a medical advisory panel.

Tel: 0870 122 2325

Email: info@phobics-society.org.uk

Web: www.phobics-society.org.uk

Depression and Bipolar Disorder

The Association for Post-Natal Illness

Charity offering support to mothers suffering from post-natal depression.

Tel: 020 7386 0868

Email: info@apni.org

Web: www.apni.org

Depression Alliance

Charity offering help to people with depression, run by people with experience of depression.

Tel: 0845 123 23 20

Email: information@depressionalliance.org

Web: www.depressionalliance.org

MDF The Bipolar Organisation (formerly Manic Depression Fellowship)

A user-led charity, with a network of self-help groups in England and Wales, for people with Bipolar Disorder (Manic Depression) and their carers.

Contact: Jeremy Bacon

Tel: 08456 340 540

Email: jeremy@mdf.org.uk or mdf@mdf.org.uk

Web: www.mdf.org.uk

Eating Disorders

Beat

Provides information, help and support across the UK for people whose lives are affected by eating disorders.

Tel: 0870 770 3221

Email: media@b-eat.co.uk

Web: www.b-eat.co.uk

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What's the story?

Reporting mental health and suicide: A resource for journalists and editors

Feedback questionnaire

To help us make sure that we provide people with the support and guidance that they need, we would like to hear your views about this handbook.

Please give us your feedback using the form below.

An electronic version of this form is also available at www.shift.org.uk/mediahandbook

What is your job title?

If you would like to be kept informed of Shift's latest work, please print your email address

.....

Please circle the appropriate number (1=lowest, 5=highest)

	not very				excellent
1 How useful do you think this handbook will be?	1	2	3	4	5
2 Do you find the sections easy to read?	1	2	3	4	5
3 Do you find the website easy to access and use?	1	2	3	4	5

(continues over the page)

What have you found most helpful?

What have you found least helpful?

Do you have any further comments or suggestions?

Please return completed forms to:
WTS, Shift, 11-13 Cavendish Square, London W1G 0AN



Shift believes that people with a history of mental health problems should have the same chances and opportunities as everyone else.

For more information about Shift and our work, visit www.shift.org.uk