



MHCN mental health carers nsw

Monday, 30 September 2024

Law Reform Committee Members

Re: Media reporting of forensic and corrections patients and their families and carers

Dear Law Reform Committee Members,

Mental Health Carers NSW (MHCN) is the peak body for carers of people who experience mental illness in NSW. It is a community-based, non-government organisation that provides systemic advocacy, capacity development and education for the carers, family, friends and kin of those experiencing mental illness across NSW. We regularly engage carers in a range of different ways. Currently, we convene the *Carers of Forensic and Corrections Patients Network* meetings, held monthly in collaboration with Erika Ballance, Family and Carer Consultant, Justice Health and Forensic Mental Health Network, Ministry of Health. We also hold monthly peer led, engagement and advocacy meetings; the “*Mental Health Carer Connections Meetings*”.

We wrote the attached submissions to the Law Reform Commission in 2021 (Open Justice Review) and 2023 (Review of the Anti-Discrimination Act 1977 (NSW)) outlining our concerns about the practice of some media outlets writing and publishing sensationalist reports of tragic cases which involve an offence committed by a person due to serious and persistent mental health issues. We feel compassion for victims as well as families who also suffer when a person they have been unsuccessfully trying to get help for years finally hurts themselves or someone else.

The high level of unmet need for mental health services in many communities resulting in such tragedies is never reported as a context; reporting which might advance the public good by making the case for change. Instead, the sick person who could not manage their own risks and the family and carers who were not supported to help them to do so bear all the blame and vilification.

This cripples any impetus for social reform as well as often causing many serious personal repercussions for the person vilified and their family and carers, including serious harm to their mental health. These are the unacceptable results of the vilification of people who, it must be remembered, are unwell and deemed not responsible for their own conduct.

To these previous submissions, we would like to attach:

1. An article in the Sunday Telegraph, which is a recent example of reporting that uses sensationalist language and reveals names and other identifying details that renders persons vulnerable to ongoing harassment and retraumatisation.

2. Guidelines on language use that empowers and reflects lived and living experiences, and avoids further stigmatisation of a person experiencing mental health issues.

We draw attention to the appalling article in the Telegraph (which also vilified the Mental Health Review Tribunal) as an egregious example of the kind of reporting requiring action.

We renew our calls for action outlined in our attached submissions, broadly;

- to include vilification of people with experience of mental health issues (and their families and carers) in Anti-Discrimination Act, and
- to institute a regime to effectively suppress their identities in 'forensic' (criminal mental health) cases in the same manner as the identity of children is protected from salacious (or indeed any) press reporting of legal proceedings, in many circumstances, raising the priority of privacy and plugging the many holes in the current system.

In the interim we will continue to advocate that media reports adhere to better standards in language use that will improve and support recovery, as opposed to creating further harm and retraumatisation of vulnerable persons, and their families and carers.

Yours Sincerely,

Jonathan Harms, CEO MHCN

Cc NSW Human Rights Commission



Our words
matter: Guidelines
for language use



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An  EVERYMIND program

About these guidelines

Our words matter. The language we use to communicate about mental health and wellbeing, mental health concerns, suicide, and alcohol and other drugs (AOD) can have either a positive or negative impact. We have an opportunity to be more inclusive of people with diverse experiences and views, to reduce harm and stigma and to encourage more people to access and offer support through the words we choose.

We acknowledge that the language used in these guidelines may not reflect the views of all people living in Australia. While using consistent terms and language can have benefits in our public communication, people and communities must also be empowered to find their own way to put words to experiences.

Language evolves. The broad guidance given in this document is a snapshot at this point in time and may not necessarily reflect views of language in the future. These guidelines will continue to be updated to reflect the changes as language evolves, through the voice of people with lived and living experience and the latest research.

Our words matter: Guidelines for language use, was developed by Everymind with funding from the National Mental Health Commission. The resource builds on the most recent research and was developed in consultation with a diverse group of stakeholders in Australia. This included: people with lived and living experience of mental health concerns, suicide and AOD, media and other professional communicators, research experts and diverse community members. The work was steered by a Project Advisory and Research Leadership Group. Please refer to *Development of the guidelines* on page 34 for more information.

Key principles

These guidelines are founded on three principles: firstly, 'do no harm'; secondly, 'aim to do good' and finally, 'stay curious and be open to change'.

Some words and language that we use can be harmful, with the potential to increase distress, to reinforce stereotypes or to contribute to stigma and discrimination.

The 'do no harm' principle encourages us to reflect on the language we use, to avoid terminology that may reinforce harmful stereotypes or contribute to stigma, or that discourages connection and support.

The 'aim to do good' principle encourages us to use language that supports connection, promotes inclusion and acceptance of diverse experiences within our communities, and encourages people to seek help and offer support when it's needed.

The 'stay curious and be open change' principle reminds us that language is complex and evolving. Getting this right requires us to act on what the research tells us, listen to people with lived and living experience and continually adapt based on what we have heard.

The guidelines that follow provide best practice advice for how we can apply these principles in everyday communication.



Foreword

From the co-chairs of the Words and Images Project Advisory Group

The words and language we use matters. What we say and how we say it can either engage or alienate others. It can also break down or exacerbate stigma and harm.

For those of us with a personal or lived experience, the day-to-day reality can too often involve exposure to hurtful, stigmatising and thoughtless words and phrases that can dominate thoughts and derail individual and community wellbeing.

Language continues to change and evolve over time and so it is important that each of us pays attention to the words we use - in our personal and professional communication and in the material we produce.

We are grateful to each member of the project advisory group and to each person, community and organisation that contributed their expertise in the development of these guides and resources.

Please use them and champion their adoption with others, appreciating that what each of us considers to be preferred language will be different and may change over time.

STEFANI CAMINITI
FOUNDER AND CEO, THE INNER NINJA FOUNDATION

DR JAELEA SKEHAN OAM
DIRECTOR, EVERYMIND



I have, at times throughout my life, seen and felt the pain of words used by others and actively changed myself to ensure they were not said to me again, directly causing harm to my mental wellbeing.



STEFANI CAMINITI



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The guidelines

Whether we work in media or communication roles, as clinicians or service deliverers, in policy or programs, or are sharing our personal or community experiences, we all have a role as communicators. The choices we make when using language can have a huge impact.



Use language that empowers and reflects people's lived and living experiences



Adapt language to suit preferences or audience



Use language that is understandable



Avoid language that is sensationalised, including in headlines and titles



Consider the language you use as it can be helpful or harmful depending on the context

- Mental health and wellbeing
- Mental health concerns
- Suicide
- Self-harm
- Eating disorders
- Alcohol and other drugs (AOD).



Use language that empowers and reflects people's lived and living experiences

When we share stories of people with a lived and living experience, it can be powerful. These stories have been shown to reduce stigma, increase understanding and provide hope for others. Language can also empower and promote the ability of individuals and communities to live with complex experiences and enact positive change.

- When deciding on the language to use, it is important to consult with people who have lived and living experience, particularly those whose story you may be sharing.
- Person-first language should be used when describing someone's experiences to avoid defining or labelling a person by their experience.
- Unless a person uses the terms themselves, avoid words that suggest a lack of quality of life, such as 'victim' or 'suffering'.
- Use language that conveys messages of hope, recovery, and overcoming challenges. But take care not to apply this narrative if it doesn't align with an individual's personal experience or story.
- Care needs to be taken with terms that can imply judgments about a person accessing supports, e.g. 'treatment resistant', 'non compliant'.

Preferred

Ask a person how they would prefer their experience to be described

Someone who lives with suicidal thoughts; a person with a diagnosis of a mental illness

She lives with a depression; he has an experience of mental health concerns

Treatments have not alleviated their symptoms; they have survived a lot; there is hope

His needs are not being met; they are needing connection

Problematic

Using medical terms without asking if this is a person's preferred way to describe their experience

A suicidal person; a mentally ill person

She is a victim of depression; he is suffering from a mental illness

They are treatment resistant; they are a lost cause

He is manipulative; they are attention-seeking



If they see someone that they can identify with and go, "... that could be me". I think that's more powerful than anything else..



LIVED EXPERIENCE OF ALCOHOL AND OTHER DRUGS FOCUS GROUP PARTICIPANT



Adapt language to suit preferences and audience

The words we use are more likely to connect and engage with people when they reflect the preferences and needs of the audience.

Although consensus about the language we use is sometimes difficult to obtain, where possible, the words used to describe a person's experience should be aligned with their preferences. When sharing a person's story in the media, using their story in a policy or case study or having one-on-one discussions, we should seek clarification on preferred ways to describe their experience.

- Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse communities may have different beliefs or understandings when communicating about these challenges.

- Terms often used to describe mental illness or suicide may not exist or translate easily in other languages.
- Words used to describe a specific community or population group's experience should be aligned with their preferences.
- Language that acknowledges and honours the diversity of personal experiences, identities, sexualities, genders and bodies can be empowering or healing.

Preferred

Asking a person what words they would like used to describe their experience

Use of language guides or glossaries prepared by community groups or cultural organisations

Checking for updated guidance on a specific community or population group's language preferences

Problematic

Making assumptions or adding labels to a person's experience that they do not use

Assuming or applying medical or English-based terms that may not be accepted or used by particular communities

Using outdated language





Use language that is understandable

To increase understanding, we should use language that is non-judgemental and non-stigmatising, and avoid terms that may not be known or are confusing to a broader audience.

- Public communication should use simple, everyday language, rather than only using medical or clinical terminology, unless the medical or clinical terminology is widely understood and accepted within a particular audience.
- Some terms used in data collection, data releases and academic writing can be stigmatising when used in public communication and should be reworded.
- When presenting data, ensure use of descriptive terms such as 'significant' are consistent with the scientific meaning of the word.
- Care should be taken to use plain English terms to describe outcomes of research rather than research terms that can cause distress.



Preferred

Experiencing suicidal distress; thoughts of suicide

Suicide or self-harm

Further suicides; increase in suicidal behaviour following a suicide death

Comparing the likelihood of suicide between groups; impact of living with illness or injury

Impact of caring for someone who is experiencing mental health concerns

Measuring the years of life lost (YLL) due to premature death; years lived with a disability (YLD)

Where a person's day-to-day life, relationships with other people or the ability to work are impacted.

Problematic

Academic terms like suicidality; suicidal ideation

Intentional self-harm; deliberate self-harm

Coding or data related terms that can be stigmatising such as intentional self harm; deliberate self harm

Academic terms such as survival modelling; burden of disease; non-fatal burden

Academic terms like carer burden

Using only acronyms e.g. DLYs; YLLs; YLDs

Service related terms like psychosocial disability without defining them



Avoid language that is sensationalised, including in headlines and titles

Language should help to inform rather than alarm people. While elements of communication such as headlines or titles are designed to gain attention and encourage audiences to click-through or read further, engagement is not an excuse for sensationalised or alarming language.

- When presenting current data or data modelling of predicted distress or suicides, avoid sensationalist language and use more neutral terms.
- Avoid descriptions of behaviour that imply the existence of mental illness or are inaccurate. Focus instead on terms that more accurately describe individual behaviour.
- Where possible, opt to paraphrase quotes where people have used stigmatising or otherwise inflammatory language in relation to issues such as mental illness or suicide.
- When writing a headline, reflect on whether mentioning a person's diagnosis will sensationalise the issue and is therefore likely to reinforce stigma. Language selection of this kind may miss the key messages within the story, or simply generate an opinion based on the headline itself.

Preferred

Increased number of suicide deaths; high risk period; higher rates of suicide

Suicide rates predicted to rise unless action taken; action needed to prevent suicide deaths; town with high rates of suicide

Unusual behaviour

Predicted increases in mental distress

Area with high rates of drug use; area of concern

Person currently using methamphetamine; person seeking treatment for drug dependence

Problematic

Suicide epidemic; shadow pandemic; surge in deaths; rates skyrocket

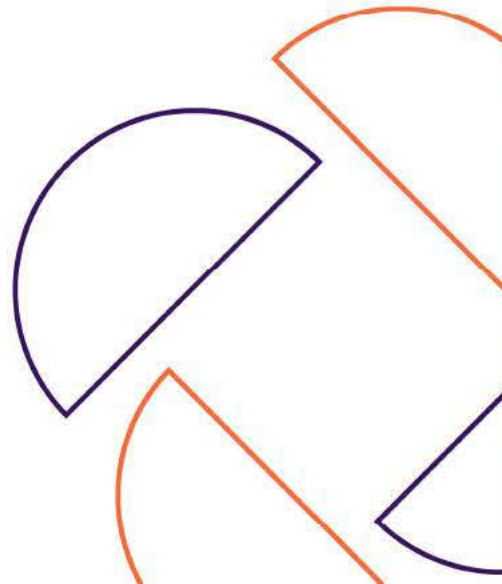
Sensationalist language like rates to soar

Labelling language like crazed; deranged; psychotic

Mental health time bomb

Alarmist language like drug affected town

Derogatory language such as meth head; junkie





Consider the language you use and ensure it is appropriate for specific contexts

Context matters. When communicating about these experiences, we need to consider the contexts in which words are used and the ways in which they may affect identity, understanding, attitudes or behaviours.

Mental health and wellbeing

The term 'mental health' should be used to describe a positive concept of wellbeing. We should take care to avoid using it interchangeably to describe mental illness or mental health concerns as these terms have different meanings.

- Avoid using language that implies mental health is a negative state or implies that mental health and mental illness are the same.

- The term 'social and emotional wellbeing' is the preferred term for Aboriginal and Torres Strait Islander peoples as well as some other groups or communities.

Preferred

Mental health and wellbeing; mental wellbeing; social and emotional wellbeing

Promote mental health; enhance wellbeing; prevent mental illness; respond early to distress; supporting people with mental health concerns

Problematic

Suffering from mental health

Prevent mental health; respond to mental health; the concerns of people living with mental health



The term 'social and emotional wellbeing' includes and goes beyond conventional concepts of mental health and mental illness. For Aboriginal and Torres Strait Islander peoples it is the preferred terminology to describe mental health. It is a holistic and whole-of-life view of health that incorporates the physical, social, emotional, cultural and spiritual wellbeing of individuals and their communities¹. Underlying this perspective is the interconnected nature of individual and community, with community a fundamental part of identity and concepts of self within Aboriginal and Torres Strait Islander cultures. "It also recognises the importance of connection to land, culture, spirituality and ancestry, and how these affect the individual."²

The language of distress

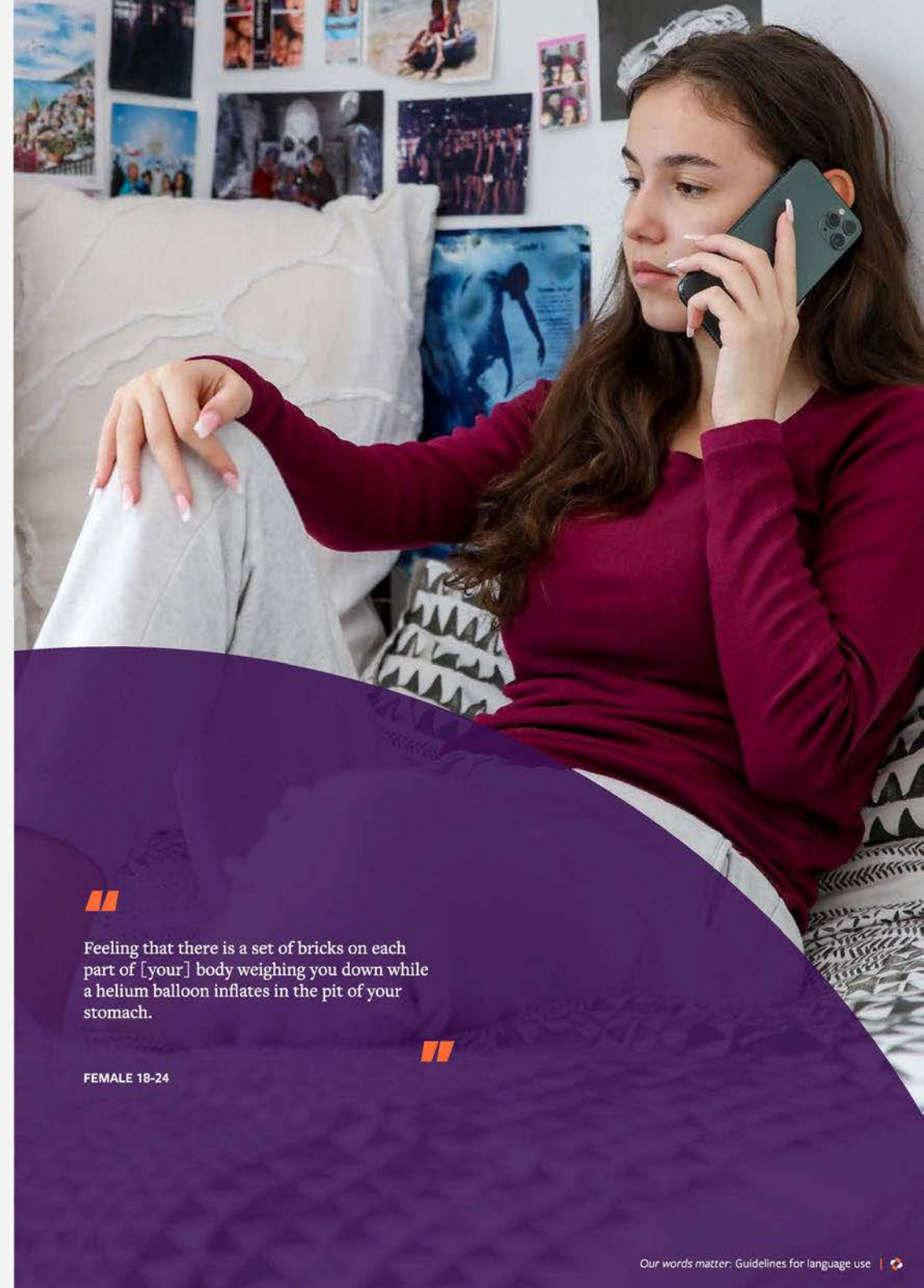
People use a range of words and terms to explain their own experience that may not align with common definitions or diagnostic terms³.

The language people use is often more descriptive of what it feels like or the impact of the experience.

When people with lived and living experience were asked to describe 'distress' they detailed intense physical and emotional experiences.

Despite the intensity of these experiences, distress is often seen as 'less serious' in the eyes of the broader community and the service system, creating a disconnect between people who experience distress and what the word indicates to health professionals and others.

Commonly used words	Emotional experiences	Physical experiences
Anxious	Rising panic; feeling of dread or impending doom	Being frozen or paralysed; breaking down in tears
Helplessness	Spiralling; feeling out of control or like everything is falling apart	A rock on my chest; churning stomach; heart racing
Pain	Internal emotional pain; intense emotion	Hands shaking; limb weakness; losing my voice
Unrelenting	Overload of emotions; persistent worry; racing thoughts	Can't focus or concentrate; lack of sleep



Feeling that there is a set of bricks on each part of [your] body weighing you down while a helium balloon inflates in the pit of your stomach.



FEMALE 18-24

Mental health concerns

To date, there is no common consensus on whether it is best to use general terms like ‘mental illness’, ‘mental ill-health’ or diagnostic terms (e.g. depression, schizophrenia) or terms that describe experiences, such as ‘distress’, ‘mental health concerns’ or ‘mental distress’ in our communication. However, when these terms are used, they should reflect current definitions (*Our words matter: Glossary of terms* mindframe.org.au/glossary-of-terms) and consider the context of the communication.

When we communicate about mental ill-health sensitively and accurately, we can change public misconceptions, challenge myths and encourage community discussion. However, when we use words that undermine a person’s experience or are stigmatising, this can have the opposite effect. Where possible, we need to choose language that describes a person’s experience of distress or trauma as this experience-focussed language can promote public empathy and understanding.

The current use of mental ill-health has been as an ‘umbrella’ term to describe mental health concerns and mental illness. This use has generally been in policy settings, in frameworks and strategy communications, and among some service providers. Increasingly, this term is not preferred by people who have a lived and living experience as it does not reflect or describe their own experience.

- Where possible, language that is being used to describe experiences should be defined or explained so that the audience is aware of the term’s meaning and why it is being used.
- Use person-centred language when describing a person who lives with a mental illness or is experiencing mental distress.
- Avoid using outdated and derogatory terms associated with mental illness.
- Use accurate terms to describe treatment and support for mental illness.
- Avoid using language that implies mental health services are similar to prisons (e.g. ‘discharged’ rather than ‘released’ from hospital).
- Avoid using diagnostic terms out of context.

Preferred

Mental health concerns; mental health challenges; mental health difficulties

A person living with mental health concerns

A person accessing support or treatment for, or living with, a mental illness

Has a diagnosis of schizophrenia; accessing treatment for anorexia; living with depression

Their behaviour was unusual

Antidepressants; psychiatrists; mental health workers; support services

Discharged from hospital

Clinical or medical terms used only within the correct context

Problematic

Using the term mental health as a negative state or to imply an experience of mental illness

Using labels, derogatory terms or slang that is offensive such as mentally ill; insane; mental patient; lunatic; psycho

Victim of; suffering from; afflicted with; hospitalised for

A schizophrenic; an anorexic; a depressive

Crazed; deranged; mad; psychotic

Derogatory terms such as happy pills; shrinks; nuthouse

Released from hospital

Psychotic driver; schizophrenic economy; bipolar weather



The old language about speaking about mental health concerns is so dark and negative and dead end, whereas with recovery-oriented language, there are elements of hope and a brighter future... that it’s part of the human condition to have mental health concerns from time to time.



LIVED EXPERIENCE FOCUS GROUP PARTICIPANT

Clinical terms

To date, there is little consensus on whether to use diagnostic terms in public communication about mental illness⁴.

It is more common for health professionals, including people working in the mental health and suicide prevention sectors, to suggest using diagnostic language. It is less common for peer workers or people with a lived and living experience to hold this view.

Those against using diagnostic language argue:

- The terms are stigmatised and can have negative consequences for those who are labelled with such diagnoses.
- The terms are not a useful way to describe a person's unique experience.
- The terms are associated with a health system where they may have experienced harm.

Those in favour of using diagnostic language argue that use of these terms:

- Increases visibility and understanding of less common, complex mental illnesses (such as schizophrenia and bipolar disorder).
- Reduces stigma associated with mental illness by framing it like physical and other illnesses.
- Provides 'shorthand' information for health professionals.

From both perspectives, there is a desire to reduce stigma and promote understanding and empathy towards people experiencing mental health concerns.

When we communicate about this issue, we should take time to consider which words may work best to achieve this goal at that time and in that particular context.



I have examples in my life where it's just appalling, the image people have of what you're capable of if you have a particular diagnosis. And I don't think we should presume that the public are knowledgeable, I think we presume the public have a limited capacity for this knowledge.

PEER WORKER



It's important to target that language, and also, just in the interest of normalising the terms themselves and ensuring that they're not these mysterious and scary labels.

HEALTH PROFESSIONAL



Suicide

Discussions surrounding suicide can cover a range of behaviours and impacts. This includes thoughts about suicide, suicide attempts, deaths by suicide and impacts experienced by caregivers and those bereaved by suicide. The language we use to communicate about each of these experiences has the potential to isolate people and reinforce stigma or it can engage and empower people to take action.

- Avoid using language that suggests suicide is a positive or desired outcome, or a 'solution' to problems or life stressors.
- Avoid using the word suicide out of context.
- Avoid using the term 'commit' in communication about suicide as the term's association with crime and/or sin can be stigmatising.

- Avoid giving details about the method or location of a suicide attempt or death.
- Avoid language that broadly relates to methods when discussing suicide or self-harm.
- Avoid labelling people who have attempted or died by suicide by the method used.
- There is conflicting evidence about the use of content advice, but if adding this advice, avoid phrases like 'trigger' or 'trigger warning'.

Preferred

Died by suicide; took their own life

Suicide attempt; attempted to end their life

Increased rates of suicide; higher rates of suicide

A person who attempted or died by suicide; he died by suicide

Tragic death; a tragedy

Refrain from using suicide out of context

Content advice; the content includes discussion of suicide

Problematic

Successful suicide; completed suicide; committed suicide

Unsuccessful suicide; failed suicide bid

Skyrocketing rates of suicide; suicide epidemic

Labelling terms associated with suicide methods

Set free; free from his demons; finally at peace; can rest at last

Political suicide; suicide pass/ball (in sports); suicide mission

Trigger warning



Self-harm

There are many different reasons why someone may harm themselves. The language we use to communicate about self-harm can help to normalise experiences, offer hope or encourage people to seek help and offer support. Other language may be distressing or harmful, making self-harm seem like a solution or helpful coping strategy for our problems or encouraging others to self-harm.

- Avoid using language that trivialises self-harm. Self-harm should always be taken seriously as it indicates underlying distress and the need for effective support.

Preferred

A person with a lived and living experience of self-harm; she self-harms; he is a person who self-harms

They have harmed themselves

Experiencing self-harm; self-harming

Avoid language that implies self-harm is manipulative or attention seeking.

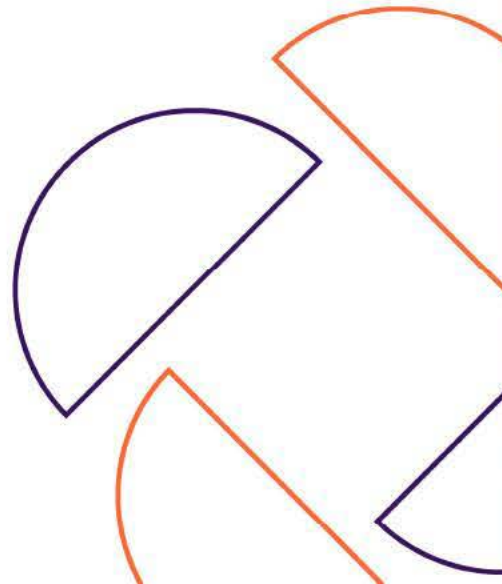
- Avoid language that gives details about the method of self-harm.
- Avoid labelling people who self-harm by the method used.

Problematic

Self-harmer; attempter; attention seeker

Any description of self-harm methods

Attention seeking; manipulating others; going through a phase



Eating disorders

The language we use to communicate about disordered eating and eating disorders can help to increase community understanding and encourage people to seek help or access support services when they need it. Other language may alienate members of the community, increase stigma, trivialise or sensationalise the issue or inadvertently contribute to disordered eating or eating disorders.

- Avoid using language that implies that all eating disorders are the same or all experiences are the same.
- Use person-centred language rather than labelling a person by their diagnosis.
- Use inclusive language. Eating disorders are experienced by all ages, demographics and genders, including men and gender diverse people.

- Always present eating disorders as a serious physical and mental illness and not a lifestyle choice.
- Avoid language that focuses on appearance, size, weight, shape or describing physical measurements.
- Use general terms (avoiding specifics that could be used as a 'how to guide') to describe behaviour without reference to the steps taken, frequency of behaviour or any implements used.
- Avoid language that presents eating disorders as glamorous or as an option for dealing with problems.
- Use plain terms to describe behaviour rather than adjectives or descriptions that imply a value judgement.

Preferred

A person with a lived and living experience of an eating disorder; a person with a diagnosis of bulimia nervosa; they are accessing treatment for anorexia nervosa

Using language that does not focus on appearance, size, weight or shape

If necessary, use general terms such as purging, bingeing, restricting

Simple language without value judgements

Problematic

An anorexic; bulimic; binge-eater

Describing people as thin, skinny, or giving specific weights

Detailed and specific information on how a person engaged in behaviours, or frequency of behaviours

Successful pursuit; unsuccessful attempt



Alcohol and other drugs (AOD)

Public attitudes and beliefs can have a significant impact on individuals who use AOD and have the potential to influence their ability to seek help or access support services. Some of the words we use can be stigmatising for people who use AOD, while more thoughtful language can accurately inform and positively influence community attitudes and lead to reductions in AOD use.

- A person should not be defined by their AOD use. Instead, use person first language and terminology that accurately describes a person's use of AOD.
- Use accurate plain language to describe AOD use rather than colloquial, informal or conversational terms.
- Avoid sensationalist language that may create or encourage moral panic within the community. This includes descriptive terms that may exaggerate facts. Instead, describe trends or patterns as an 'increase' or 'decrease' in use or prevalence.

- Avoid language that may glamorise AOD use, particularly pro-alcohol reporting as this can result in initiation or increased use, especially in young people.
- Avoid combat-related language and terms. General terms are preferred.
- Avoid outdated and derogatory terms associated with AOD use.
- Avoid terms that present people who use AOD as delinquent, violent and morally weak. Instead use language that reflects AOD use as a public health issue.
- Avoid describing someone who uses drugs or previously used drugs as 'dirty' or 'clean'. Instead use language such as 'person who uses or no longer uses drugs'.

Preferred

Person who uses drugs; has an addiction to alcohol; a person who uses cannabis

Person with a dependence on drugs; substance use

Person who no longer uses drugs; person who currently uses drugs

Respond to or address drug use in the community

Increased rates of crystal methamphetamine use; concerning rates of substance use

Problematic

Addict; junkie; crackhead; drunk; alcoholic; pot-smoker

Drug habit

Clean; dirty; fallen off the wagon

Fight or combat drugs; war on drugs

Ice epidemic



Development of the guidelines

Most people in Australia will be affected either directly or indirectly by mental health concerns, suicide, self-harm, disordered and eating disorders and AOD. These experiences are important and need to be discussed by and with the community. But how we communicate about them matters.

The language we use can have either a positive or negative impact on a person's life. Some language used to describe suicide, self-harm and eating disorders, for example, may encourage further harmful behaviours, while certain language around mental ill-health or AOD use can reinforce negative stereotypes and stigma^{5,6,7,8}.

Language is powerful and is an important tool. Incorporating these guidelines into our personal or professional communication, our work processes and practices, our policies and strategies, will help positively impact people's mental health and wellbeing, prevent harm and reduce distress and stigma.

The National Mental Health Commission funded Everymind to develop these guidelines focused on language related to mental health and wellbeing, mental ill-health, suicide, self-harm, disordered eating and eating disorders, and AOD.

This work was conducted within a research framework to ensure the scientific rigor of the approach, to build consensus and to support effective dissemination of the guidelines and supporting resources.

Everymind has ensured that consultation has included priority populations including people with lived and living experience, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse populations, LGBTIQ+ communities, men and young people.

The project was initiated through consultation with people with lived and living experience of mental

health concerns, suicide and AOD. Additionally, the Words and Images Project Advisory Group and a Research Leadership Group were established to inform project design.

The following activities also informed the development of the guidelines.

1. Scoping review of existing guidelines relating to language use, including guidelines used by media, sector stakeholders and governments in Australia.
2. Scoping review of language used on websites by member organisations from Mental Health Australia and Suicide Prevention Australia.

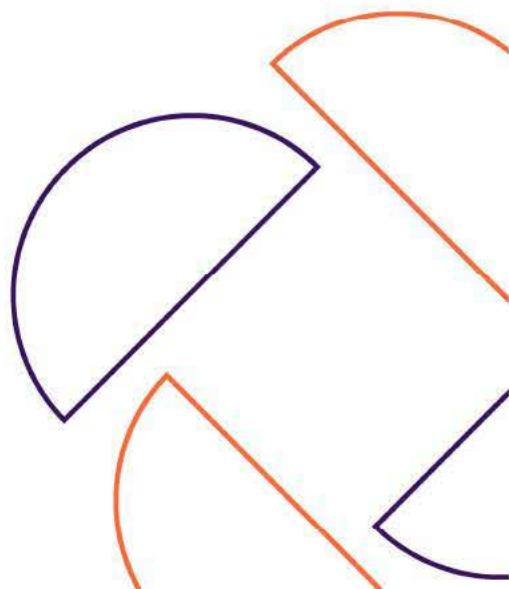


3. Consultation survey related to stigma, completed by media and professional communicators, sector organisations and people with lived and living experience.
4. Everymind worked with researchers at the University of Newcastle to conduct further consultation and a consensus study.
5. A series of 10 focus groups to further consult with key stakeholders, including people with lived and living experience and from priority population groups to explore their perceptions, attitudes, opinions and beliefs about safe, inclusive and non-stigmatising public representation of mental ill-health and suicide.
6. A Delphi survey to establish consensus between three expert groups (professional communicators including media, sector professionals, and people with lived and living experience) on guidelines statements.

To support these findings and delve further into language use, Everymind worked with researchers at the University of New England and the University of Melbourne to analyse two data sources^{3,4}.

Everymind acknowledges the support of all those involved in the development of these guidelines including members of the: Words and Images Project Advisory Group; Words and Images Project Research Leadership Group; *Mindframe* Media Advisory Group; *Mindframe* Journalism and Public Relations Educators Advisory Group; and participants in the roundtables, focus groups and surveys.

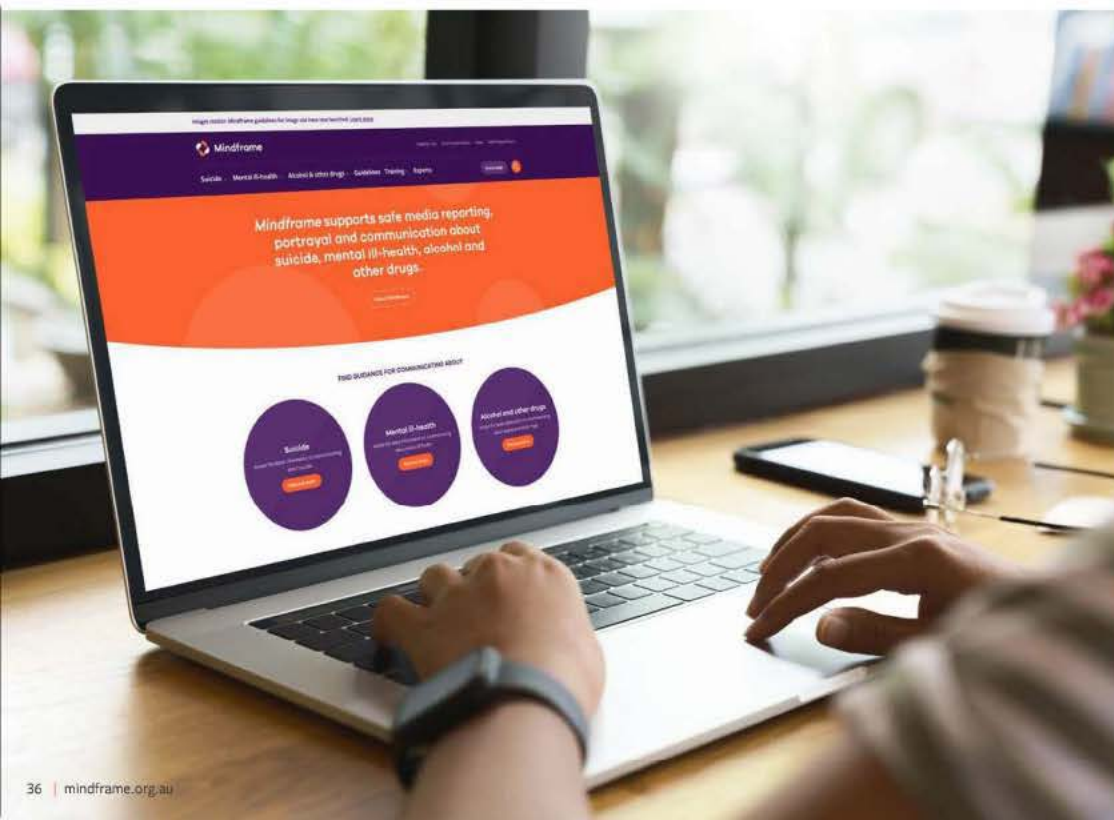
As part of these guidelines, collateral will continue to be created by Everymind through the *Mindframe* program, to support the implementation of the guidelines.



Supporting resources

A suite of supporting resources has been developed to complement these guidelines and aid in their implementation.

- *Our words matter* Guidance cards – quick-use cards designed to provide specific examples of problematic and preferred language so communicators can consider the impacts of their language selection.
- Quick reference guide for researchers – a quick-use guide designed to help researchers apply the advice provided in *Our words matter* to their research outputs, such as journal articles, reports or presentations.
- Quick reference guide for service providers – a quick-use guide designed to help service providers apply the advice provided in *Our words matter* in all areas of service delivery including providing individual or group support, clinical documentation, supervision, and professional development.
- Glossary of terms – this online glossary provides descriptions of broad terms that are currently in use or emerging as preferred terms. This glossary is designed to be updated as the words we use evolve.
- *Our words matter* language checklist - this checklist provides a quick-use overview of the guidelines.



Support services

Lifeline

13 11 14 | Text 0477 13 11 14 | lifeline.org.au

Suicide Call Back Service

1300 659 467 | suicidecallbackservice.org.au

StandBy Support After Suicide

1300 727 247 | standbysupport.com.au

Beyond Blue

1300 224 636 | beyondblue.org.au/forums

MensLine Australia

1300 789 978 | mensline.org.au

Butterfly Foundation

1800 334 673 | butterfly.org.au

Priority populations

Aboriginal and Torres Strait Islander

13YARN (13 92 76) | 13yarn.org.au

Lesbian, Gay, Bisexual, Trans, and/or Intersex

1800 184 527 | qlife.org.au

Culturally and Linguistically Diverse

embracementalhealth.org.au

Defence and Veterans

Defence and Veterans Open Arms – Veterans and Families Counselling

1800 011 046 (24/7) | openarms.gov.au

ADF All-Hours Support Line (ASL)

1800 628 036

Youth

Kids Helpline

1800 551 800 | kidshelpline.com.au

Headspace

1800 650 890 | headspace.org.au

ReachOut

au.ReachOut.com

Other resources

Head to Health mental health portal

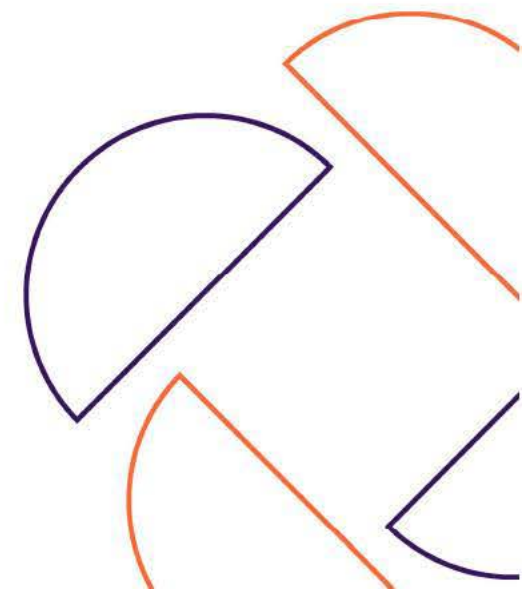
headtohealth.gov.au

Life in Mind suicide prevention portal

lifeinmind.org.au

SANE Australia online forums

saneforums.org



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3. Wayland, S. & Fatema, S.R. (2022) *Language data analysis for Everymind Words and Images Project*, Report for Everymind, Newcastle, Australia.
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