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IASP policy position on the decriminalisation of attempted suicide

Background Document

The criminal status of attempted suicide: current situation

> **"**At the beginning of the nineteenth century, most countries around the world had laws that provided for punishment, including jail sentences, for persons who attempted suicide. However, in the last 50 years the situation has changed significantly. Most, but not all, countries have decriminalized suicide" (WHO 2014: 51).

Reviewing criminal codes from 192 independent countries and states, Mishara & Weisstub (2016) found that suicide is currently illegal in 25 countries[1], which have specific laws and punishments for attempted suicide, and, in an additional 10 countries which follow Sharia law, people who attempt suicide may be punished. Legal penalties range from a small fine or short period of imprisonment to life imprisonment. Many countries with laws stipulating punishments do not, or infrequently prosecute people who attempt suicide. The WHO global report (WHO, 2014: 51) gives examples of the "complexities of the situation".

Arguments for and against decriminalisation of attempted suicide

There are three principal explanations for the practice of punishing suicide attempters (Mishara & Weisstub, 2016). The most common explicit explanation is that punishment is thought to have utilitarian value in reducing the repetition of an act that is socially sanctioned. The bulk of research to date supports the contention in the WHO global report that "… suicide rates tend to decline in countries after decriminalisation" (WHO 2014: 51). However, this conclusion must be tempered by the fact that when suicide attempts are considered to be punishable crimes, suicide attempts are often undeclared and deaths by suicide are more often classified as accidental or of undetermined cause. After decriminalisation, there may be more acceptance of identifying suicidal behaviours and reporting more openly on suicide deaths. For this reason, it might be expected that more suicides would be reported immediately after decriminalisation. Thus, a short term increase in official suicide rates after decriminalisation may actually reflect an increased openness to recognising suicidal behaviour. Despite the argument that suicide rates may show an increase after decriminalisation as a result of more complete reporting, the WHO global report (WHO 2014) finds no empirical support for the claim that decriminalisation results in an increase in suicides:

> "No data or case-reports indicate that decriminalization increases suicides; in fact, suicide rates tend to decline in countries after decriminalization" (WHO 2014: 51; Mishara & Weisstub 2016).

Studies which sought, but failed to uncover, a negative impact of decriminalisation on suicide incidence include:

- Osman et al. (2017) found that legalisation of suicide in Ireland in 1993 was not associated with a statistically significant increase in the subsequent rate of suicide deaths. (The study methodology includes adjustment for pre-existing trend in suicide incidence.) Undetermined deaths fell significantly after legalisation of suicide.
- Knipe et al. (2014) undertook an age-period-cohort analysis of suicide rates in Sri Lanka over the period 1975-2012. The suicide rate peaked between 1983 and 1998 (depending on sex and age group) and subsequently declined. There was no interruption to the downward trend following decriminalisation of suicide in 1998 in any age by sex group.
- Lester (1993) examined suicide rates in New Zealand in the 10-year period before and after decriminalisation of suicide in 1961. There was no increase in the suicide rate following decriminalisation.
- Lester (1992) examined suicide rates in Canada in the 10-year period before and after decriminalisation of suicide in 1972. The suicide rate increased at a slower pace after the legalisation of suicide than it did prior to legalisation. "… [C]hanging the legal status of suicide in Canada in 1972 was not associated with an increase in the rate of suicide…."
- Lindelius (1979) studied trends in suicide in Sweden 1749-1975. During this period there was a more than 10-fold increase in suicide. In 1864 punishment for suicide and attempted suicide was repealed and in 1908 all special regulations relating to suicide were repealed. The author asserts that "the increase in suicide [over the period under review] … is not a consequence of successive lenience in the legislation with regard to suicide…. Changes in the legislation have rather been an adaptation to the altered attitude to suicide which arose in the population…." (Lindelius 1979: 308).

The second explanation for criminal penalties for suicide attempts is that punishments can express a society's feelings of moral condemnation of certain behaviours. Expressive theories of punishment have been harshly criticised for not considering the usefulness of the practices, nor their negative impact on the health and wellbeing of vulnerable populations who are in need of help. One aspect of punishment is its use to publicly shame a person as an expression of social condemnation of certain behaviours. In countries where the bodies of suicide victims are beaten or otherwise "humiliated" before burial, and when people who attempt suicide are imprisoned, it is not only the victim or attempter who is shamed, but their entire family, by public affirmation. These practices of public shaming, both legal and in cultural traditions, inhibit people bereaved by suicide from getting much needed help and support, and they perpetuate practices where, rather than receiving mental health care and treatment, people at risk of suicide are left to hide their difficulties, thus increasing

the risk that they will die by suicide.

A third explanation for the punishment of suicide attempters is that this expresses the desire for retribution, so that justice is seen to be done and the person who commits a reprehensible or immoral act is punished. If killing oneself is considered to be tantamount to murdering another person, retribution may be thought necessary. However, this assumes that attempting suicide is an intentional act that a person consciously decides to do. Research indicates that people who attempt suicide generally suffer from a mental disorder that compromises their ability to make "rational" decisions; often they are under the influence of alcohol or drugs that limit their ability to make correct choices. Decriminalisation of suicide attempts will enhance opportunities for effective suicide prevention and interventions, thereby reducing the incidence of behaviours that may be considered to be reprehensible or immoral.

There a numerous benefits of decriminalisation of suicide attempts, including:

1 Decriminalisation improves measurement of the extent and characteristics of suicidal behaviour, which in turn enhances opportunities for effective suicide prevention and intervention. In order to prevent suicide, we need to have accurate data to identify who is at risk and how to best help them.

> "Suicide remains criminalized in many developing countries, and this is a major hindrance to collecting data and planning appropriate interventions" (Vijayakumar & Phillips 2016: 517).

Treating attempted suicide as criminal behaviour leads to an underestimation of the 'true' extent of suicidal behaviour and its (clinical, psychosocial and other) characteristics. This results from:

- concealment of behaviour by those who are determined to die by suicide
- concealment of cause of death (suicide) by relatives
- concealment of cause of death (suicide) by those responsible for certifying deaths, including coroners, family doctors, medico-legal authorities and law enforcement
- use of discretion by law enforcement to avoid criminal charge against those who survive a suicide attempt.

A more accurate understanding of the epidemiology and characteristics of suicidal behaviour increases the likelihood of developing a more appropriate and effective suicide prevention response.

2. As a result of decriminalisation, suicidal behaviour will be recognised and treated as a public health issue and vulnerable individual will be better able to obtain the help they need.

> "We conclude that in an overwhelming majority of cases it is most efficacious to treat suicidal behaviour as a psycho-social and mental health problem" (Mishara & Weisstub 2016: 58)

> "[W]hen a troubled individual tries to end his life, it would be cruel and irrational to visit him with punishment on his failure to die. It is his deep unhappiness which causes him to try to end his life. Attempt to suicide [sic] is more a manifestation of a diseased condition of mind deserving of treatment and care rather than punishment. It would not be just and fair to inflict additional legal punishment on a person who has already suffered agony and ignominy in his failure to commit suicide" (Law Commission of India 2008: 38).

Suicidal behaviour is, in major part, associated with a psychiatric or psychological problem. The suicide attempter is already traumatised. There is a societal obligation to help people with problems (mental [pain, emotional distress]), social, psychosocial and economic). Suicidal behaviour should be treated as a (public) health issue.

Mishara & Weisstub (2016: 57) note:

> "Although religious and cultural values are important to respect, countries with liberal values have already successfully decriminalized suicide by promoting the belief that suicide attempters have not intentionally gone against dominant religious precepts and cultural values."

3 Decriminalisation of attempted suicide will reduce stigma and increase help-seeking

> "The marginal status of suicide attempters in general and the lack of indications of any preventive effects of punishment of attempters indicate that the shaming impact of laws criminalizing suicide attempts do not have favourable outcomes and may … inhibit help seeking and use of suicide prevention and mental health services" (Mishara & Weisstub 2016: 57).

Decriminalisation of attempted suicide will reduce the public and felt stigma associated with the behaviour (and associated (mental) ill-health). Those who are most psychologically vulnerable and at risk of suicide will therefore be more willing to communicate suicidal thoughts and seek/receive the professional psychiatric/psychological help that they need.

4. Decriminalisation avoids the adverse mental health consequences of imprisonment

Incarceration exacerbates suicide risk because of harsh conditions and lack of, or inadequate, psychosocial and psychiatric support in prison. Ghana case studies (Mensah 2013) show that many suicide attempts occur during imprisonment. Harsh jail conditions need to be improved as a suicide prevention measure (including making

cells suicide-proof).

4.2 Aiding, abetting or encouraging suicide: a separate issue requiring even more careful handling

In their review of the legal status of suicide across the world, Mishara and Weisstub (2016) report that

> "… 142 [out of 192] countries have laws that stipulate punishments, including jail sentences, for assisting or encouraging a suicide" (p. 54).

They note that

> "[t]his remains a debated area, where trends to liberalize assisted suicide will inevitably clash with both ardent religious beliefs and advocates whose mission is to protect vulnerable populations" (p. 59).

They contend, however, that

> "[r]egardless of commitments to a specific set of values, be they religious beliefs, utilitarian oriented social environments, or western liberal ones, we contend that there is a broad consensus that aiding and abetting suicide is morally unacceptable and should bring legal sanctions" (p. 58).

IASP's policy position on the decriminalisation of attempted suicide explicitly excludes advocacy of removal of sanctions against aiding, abetting or encouraging suicide.

References

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