

# Care Not Killing Alliance response to the Health Select Committee call for evidence on suicide prevention (September 2016)

The Care Not Killing Alliance was initially established in 2006 to oppose Lord Joffe's Assisted Dying for the Terminally Ill Bill. We have been involved in the successful defeat of all subsequent legislation with the same aim in the House of Lords, House of Commons and Scottish Parliament.

The alliance holds that the proper response to end of life suffering is to address inequalities (based on age, diagnosis and location) in the provision of palliative care or support. Many people with terminal diagnoses are not receiving care for treatable conditions.

The principal message we wish to convey in presenting this evidence is that suicidal tendencies in people with terminal or incurable illnesses and disabilities should not be seen as different from those in other people. Euphemisms like 'assisted dying' have caused many to downgrade the significance of the wish of terminally ill people to end their own lives, but we urge the committee to take the view that suicide prevention must be for all, without discrimination on the basis of illness or disability. All people must be affirmed, cared for and protected until natural death.

- **The factors influencing the increase in suicide rates, with a focus on particularly at-risk groups**

We would contend that the well-publicised and well-funded campaign to legalise assisted suicide over the last ten years has fundamentally altered public perceptions about the 'acceptability' and 'reasonableness' of suicide.

Principally, this relates to how suicide for people with serious and incurable illnesses and disabilities should be viewed: euphemisms such as 'assisted dying', 'medical assistance in dying' and 'end of life choice' obscure the facts and have created an image of physician-assisted suicide as entirely different from 'normal' suicide.

We usually associate suicide with psychological strain and a loss of reason, with physician-assisted suicide being presented as a response to inescapable physical suffering. This is not the reality at all (see point 4 below) but this point has been entirely lost in the narrative of 'choice'. Despite repeated Parliamentary rejections of assisted suicide, there is an insidious perspective which divides suicides into those which are to be discouraged, and those which should be assisted.

This narrative, illustrated by hard cases (much publicised personal stories, such as that of the late Tony Nicklinson), has the additional effect of reducing the valuing of some people's lives: even spectacles like the Paralympics have failed in large part to alter the public perception that lives affected by disability or illness are somehow less worth living. When even people like the prominent athlete, commentator and Parliamentarian Tanni Grey-Thompson are told by strangers that they would not want to live with her level of disability<sup>1</sup>, we see how serious this has become.

We urge the Committee to consider what message would be sent to people vulnerable to suicidal tendencies if assisted suicide legislation were to be passed by Parliament. How would

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<sup>1</sup> <http://bit.ly/1tUuPaP> <https://youtu.be/j8rkkRxImcl>

suicide prevention be affected by Parliament saying that society no longer views all suicides as 'bad' – but only some? When such a message is based on an entirely arbitrary prognosis or level of disability, how much more difficult would it be to convey to people struggling to find the will to go on that suicide is not an answer?

- **The social and economic costs of suicide and attempted suicide**

We make no comment, beyond noting the appalling and long-lasting pain suffered by those left in the wake of a suicide. This pain is felt not just by families, but also by health and social care professionals who had been supporting the deceased, and is evident also in assisted suicides where these are legal<sup>2</sup>.

- **The measures necessary to tackle increasing suicide rates, and the barriers to doing so—in particular the Committee will consider the role of:**

- 1. Local authorities and partner organisations, including police, transport police, the rail industry, fire services, schools, youth services, and drug and alcohol services**

While the application of the Suicide Act (as amended) with regard to assisting suicide is subject to the DPP's published (and subsequently amended) prosecution guidelines, so as to express the greatest measure of compassion, it is nonetheless a firm deterrent against any 'act capable of encouraging or assisting the suicide or attempted suicide of another person'. Our purpose in noting this is to urge that the police and the Crown Prosecution Service remain resolute in investigating all suicides and being firm in prosecuting breaches of the law: prosecutorial discretion must not be allowed to be viewed as a disinclination to uphold a law designed to protect vulnerable people.

- 2. Mental health services and other parts of secondary care, including A&E and psychiatric liaison services**

We make no comment, beyond the observation that suicidal tendencies in people with terminal illnesses should never be viewed simply as a natural reaction to their condition; as the BMA's 2016 report on end of life care and physician-assisted suicide makes clear, depression in terminally ill people is common<sup>3</sup> and must be diagnosed and treated.

- 3. Primary care services**

One of the most positive aspects of the continuing trend towards larger GP practices is the pooling of specialties and sub-specialties, such that patients can be referred to more appropriate healthcare professionals (whether within or associated with the practice, the latter including district nursing) with respect to emerging needs. Efforts must continue to be made in terms of improving collaboration on tackling suicidal tendencies, but we would emphasise the need, in community based suicide prevention, to fully integrate palliative care in this regard. One of the most troubling outcomes of the ongoing public debate on physician-assisted suicide is that the will to end one's own life because of a serious, incurable or terminal illness or disability is seen by many as somehow more understandable or reasonable than because of psychiatric or psychological factors. This must never be reflected in the health service: all patients, regardless of prognosis, must benefit from the

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<sup>2</sup> [www.ncbi.nlm.nih.gov/pubmed/16676767](http://www.ncbi.nlm.nih.gov/pubmed/16676767)

<sup>3</sup> <http://bit.ly/2cbrGhr>

broadest sweep of experience and training within community healthcare to affirm life and confront suicidal tendencies.

#### **4. Referrals from non-statutory services - local support groups, faith groups, carers, friends and family**

Our particular interest is suicide prevention with regard to patients with terminal or incurable illnesses and disabilities. It is therefore pertinent to reflect on the reasons people access physician-assisted suicide where this is legal. In Washington in 2015<sup>4</sup>, the three most commonly cited concerns - dignity, autonomy and ability to engage in various activities - are existential in nature, while a majority (52%) still cite not wishing to be a burden on others as a reason for seeking assisted suicide. Barely a third (35%) cite inadequate pain control, while citations of financial implications of treatment returned to their highest level (13%). It is worth noting in this context that 53% of 2015 'participants' were widowed, divorced or had never married, the fifth year out of seven that participants who are married or in registered domestic partnerships have been in the minority. Academic studies have previously associated assisted suicide with 'situations that may indicate greater vulnerability such as living alone or being divorced'. All of this serves to illustrate the point that where suicidal tendencies relate to illness or disability, healthcare professionals may yet not be the best people to confront the problem. Where the will to die is founded on social isolation, financial strain or the wish not to 'burden' others, family, friends, local support groups, financial advice services and others able to support the patient socially may in fact be the key.

#### **5. Examples of best practice, including those from other countries**

We make no comment.

#### **• Media reporting of suicide, the effectiveness of guidelines for the reporting of suicide, and the role of social media and suicidal content online**

Depictions of assisted suicide in popular culture, notably television (e.g. Hayley Cropper in *Coronation Street*), run the real risk<sup>5</sup> of giving credence to dangerous myths about death and dying, such as:

1. The myth that people dying of cancer want to die. The overwhelming majority don't - they want good care and support
2. The myth that cancer pain cannot be controlled - in good hands it almost invariably can. This is why the pro-euthanasia lobby have essentially stopped using pain as an argument for changing the law
3. The myth that that effective pain relief produces confusion and is therefore to be avoided. Although sedation is sometimes necessary in order to help control severe pain in a dying patient this is in practice very rarely the case. After careful stepwise increases, patients with cancer pain can tolerate much larger doses of pain medication than usual and remain mentally alert

<sup>4</sup> [www.carenotkilling.org.uk/articles/wa-2015-new-highs-new-lows](http://www.carenotkilling.org.uk/articles/wa-2015-new-highs-new-lows) Full report: <http://bit.ly/2bXgYco>

<sup>5</sup> [www.carenotkilling.org.uk/articles/five-myths-about-death-and-dying](http://www.carenotkilling.org.uk/articles/five-myths-about-death-and-dying)

4. More serious is the myth that that the lives of some sick and disabled people are not worth living and that it is therefore reasonable for people with these conditions to kill themselves. This is profoundly discriminatory and demeaning and simply panders to ignorant prejudice. This is why disability rights activists are so strongly opposed to any change in the law on assisted suicide. They know they will be in danger from people who have made judgments about their lives
5. The myth that suicidal thoughts in sick and disabled people should be managed differently from similar thoughts in people who are not sick and disabled. People who choose to end their lives usually do so because of a perception that they are alone and that no one cares about them, because of a loss of meaning and purpose or because they perceive their lives to be a burden on others. It is much more about the person than the disease. People who are suicidal need love, support, care and professional help, not for us to accede to their requests. It is utterly illogical to offer a glass of barbiturate to someone who is terminally ill whilst offering protection and care to a person equally suicidal with a mental illness

The WHO's international guidelines on suicide portrayal<sup>6</sup> in the media refer to over 50 published studies, systematic reviews of which have consistently drawn the same conclusion, that media reporting of suicide can lead to imitative suicidal behaviours.

Bad media portrayals of suicide run the very real risk of putting the lives of very vulnerable people in danger. This phenomenon is variably termed suicide contagion, copycat suicide or the Werther effect.

Werther was the subject of an 18th century quasi-autobiographical novel by Goethe who killed himself after losing his lover. The book led to a spate of suicides amongst young people at the time, showing that fictional portrayals of suicide can be as dangerous as real stories.

The WHO guidelines specifically include the following:

- Avoid language which sensationalises or normalises suicide, or presents it as a solution to problems
- Avoid prominent placement of stories about suicide
- Avoid explicit description of the method used
- Take particular care in reporting celebrity suicides

Conversely, the Papageno effect refers to suicide portrayal which reduces suicide, usually by showing its detrimental effects on relationships and communities or by demonstrating how to overcome suicidal thoughts. The term comes from Mozart's *Magic Flute* and has been popularised in an article in the *British Medical Journal*<sup>7</sup>.

- **The value of data collection for suicide prevention, and the action necessary to improve the collection of data on suicide.**

We make no comment.

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<sup>6</sup> [www.who.int/mental\\_health/prevention/suicide/resource\\_media.pdf](http://www.who.int/mental_health/prevention/suicide/resource_media.pdf)

<sup>7</sup> [www.bmj.com/content/341/bmj.c5841](http://www.bmj.com/content/341/bmj.c5841)