A call for empathy in the legalisation of assisted suicide

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For review

The continued criminalisation of assisted suicde is heartless. The government's moraity in this matter is, in my opinion, tantamount to evil. Legalised assisted suicide is a blessing for those suffering prolonged suicidal ideation. It is a merciful end to an awful life and a highly personal torture process.

What I'm arguing for is something like presumption of innocence in criminal justice. It is a pure axiom. The same is true of civility and empathy in the guarantee of a good death which is only made possible by the legalisation of assisted suicide. Choice and control over one's death should be protected like these freedoms are in life.

The current debate surrounds legalised assisted dying (assisted suicide for those who are going to die soon anyway) and the limitation to terminally ill patients which is of great sorrow to me. I have wished for my death for so long and my hope is I can die by assisted suicide rather than have to endure consistent but unfulfilled suicidal ideation day after day, year upon year. My last major attempt resulted in a coma for a few weeks but, sadly, I did not die. My deepest regret is I have not yet managed to kill myself.

I experience severe mental health problems and profound mental pain but my need to end my life is neither insane nor spurious. I want to escape the constancy of extreme suffering in my life. Suicidal thoughts are inherently the product of extreme suffering or fear of extreme suffering, suffering which is beyond survivable. They are also a personal torture process when unfulfilled, unmitigated suicidal thoughts persist. Various mental health professionals and their treatments over the years have failed to lift me out of the quagmire of suicidality (which I've known for years) so I am left in pain without hope of respite.

I recognise that I'm miserable but treatment has failed. My misery is the natural product of severe psychosocial disability and the actions of evil vermin but should not be devalued by considering it an illlness. My perspective resonates with the modern disability rights perspective and the compassion for the disabled which comes from experiencing disability. Disability in practice means poorer quality of life, fewer life chances, poverty, fewer good moments and many more bad moments which can cause someone to want to end their life. This is the tragedy of disability however it is only made worse by criminalising assisted suicide.

I want to die because living is akin to torture and has been for a long time. Good times are rare but profound misery and mental pain are constant as is my want of death to escape it all. I want no more tomorrows.

The legalisation of assisted suicide is a complex challenge but, in my opinion, there is a

simple principle which is the paramount reason for it: mercy. Mercy comes from humanity and empathy.

I appreciate this is a radical perspective given the status quo but I live through suicidal ideation and I would not want it endured by anyone who does not want to. IF you can imagine what it feels like to wake up day after day wanting to never see another day you might understand why I've chosen to support this radical position of empowerment of free choice. It is torture to live but want to die. It is hell on Earth.

Let me try and state my case. (Please be aware that I've heavily simplified the argument to a limited area and this is heavily weighted towards the needs/rights of the individual. There is more detail in the longer posts under the suicide tag and the Angel of the Abyss category at We Do Big Ideas. This document is not a typical proposal in terms of "do what I say." It's more "thinking about what you're doing" or "thinking different.")

Escaping excessive suffering, suffering so great it can not be endured any longer

Appreciation of the severity of pain which suicidal thoughts represent is fundamental to having empathy. It's a highly subjective experience but is always a pain too great for the individual themselves to handle and nothing else can solve it. Assisted dying and assisted suicide have this in common: they allow a person to avoid living through an unlivable life. This is what unites the spectrum of suicidal ideation from someone first experiencing suicidal ideation after breaking up with someone they love (which has happened to me) to enduring countless years of unfulfilled, unmitigated suicidal ideation (which is happening to me) to the suicidal feelings of the terminally ill.

Clearly there are many other differences between these examples but they're both mental states arrived at through intolerable pain or fear of intolerable pain. "Intolerable" is a personal assessment and need not conform to society's expectations. The state of feeling suicidal is also a personal hell irrespective of the reasons behind the feelings.

Some people feel the grief of lost love far more intensely and life without their object of affection would be abject misery. Suicidal feelings are felt for a short time then fade. The other example (chronic suicidal ideation) might start as part of grief over lost love or from a wide gamut of other reasons but it endures. Chronic suicidal ideation would also exist because of failed mental health treatment. Its constancy and unmitigatable qualities make it all the more awful than transitory suicidal feelings but these are still awful states of mental pain too. The quality of "unlivable" is unique and personal but it is how people arrive at the decision to die. Pain is pain.

This is where there's an abscence of empathy at the moment. In my mind the idea that a conscious mind would want to cease its existence is the primary tragedy of sucide and suicidal thoughts. It need not present like depression nor always be understandable to others but to the suicidal mind their suffering is profound. Suicidal thoughts come from

profound desperation and hopelessness. The end of living becomes the only hope to escape whatever hell is crushing the suicidal individual's will to live.

Suicidal ideation is a catastrophic mental state. Someone is suffering intensively by the time suicide becomes a rational option then becomes the only solution which could work. I'd suggest it's the worst mental state anyone can reach but my personal experience shows chronic, unfulfilled, unmitigated suicidal ideation is the worst mental state. It is a form of suffering beyond other sufferings. It is the product of a unique and personal torture process which makes life unlivable, and if it endures it is also a horribly torturing process.

I hope you now understand the nature and extreme severity of suffering in suicide. If you parse through the concise posts under the suicide tag at We Do Big Ideas you'll find other ways to communicate the sheer awfulness of suicidal ideation. It's an attempt to utilise my personal experience to convey what is, to me, very real and present: life is a living hell and death becomes the only hope.

Failed by life; failed by the mental health system

The untold tragedy in mental health is the lives of suicidal people whose suicidal feelings don't respond to current treatment approaches. This happens through a few factors (and I'm sure there's others but these are relevant to what I'm communicating here):

- There is no best practice or NICE clinical guidance for suicidal ideation. Specific mental health solutions for suicidal ideation are obviously necessary but there isn't enough scientific focus in psychiatric research. The treatment of suicidal ideation is included within depression and other mental health problem clinical guidance but I believe there's value to clinical guidance focusing solely on this single mental state.

- Drugs and psychotherapy don't work for everyone especially in fulfilling the vital objectives of reducing and stopping suicidal ideation. This is obvious of course but the consequence isn't fully appreciated. Failure of treatment for suicidal ideation means the profound suffering continues unabated.

  (Personally I don't feel asking for resilience to suicidal ideation is a compassionate treatment objective because of the profound nature of the pain. Whereas asking for resilience in mental distress might be reasonable it is unreasonable in suicide because resilience in suicidal ideation demands enduring a personal torture process. Cessation of suicidal ideation must be the primary goal of mental health treatments for suicide.)

- There is little high quality suicide directed research by psychiatry. Suicidal thoughts are a common sub-measure in scales used in psychiatric research

however it's not common to publish the effect of treatments purely on the suicidal ideation sub-measure. Success in terating suicidal ideation can be masked by the effect on other sub-measures in psychiatric research scales.

There is important suicidology (the science of suicide) research which is required to direct the lens of mental health research on this vitally important variable rather than multi-facetted phenomenon of the syndrome approach which is the basis of psychiatric research. Since randomised controlled trials using the suicide sub-measure are plentiful old data can be retrospectively used. Antidepressants (and other medication) can be compared to see which is best for reducing suicidal ideation as can psychological therapies. The 'apples and oranges' problem (is like being compared with like) is reduced so meta-analysis should have higher resolving power for a single measure which is already included in common psychpathology scales used in previous trials. (If this sounds like an unfeasibly large number of trials to review there is a review published in the British Journal of Psychiatry on publication bias in psychological therapies which uses data from a thousand trials.)

This focused suicide research using old studies is part of truly bringing science to the task of reducing suicidal ideation. This is the start of creating a high quality evidence base for designing clinical guidelines or best practice.

- Suicidology is woefully underfunded. This means clinicians don't have the best of what science can offer so will more often fail in their treatment of suicidal ideation.

- There is no best practice or cliinical guidance chronic suicidal ideation or suicidal ideation which is ended by conventional treatments. In the medical jargon this means "treatment resistant" suicidal ideation. Again, without the application of scientific focus this important best practice can't exist. This is awful but there's little clinicians can do about it without resorting to trial and error. There are no clinical guidelines for treatment resistant suicidal ideation because I doubt there's the evidence base to design them from.

  My last experience of therapy was that my request for therapy to help with suicide wasn't able to be fulfilled by the therapist. Instead I recieved CBT for psychosis which ended up making me worse. I waited 9 months to get this therapy experience which didn't meet my requirements and made me worse. (There are shades of the living hell of chronic suicidality.) I wanted to die all that time and longer.

- If you can empathise the suffering of suciidal ideation then you'll know that solutions need not be effective but also must be fast. Long waiting times for effective treatments mean patients are left to suffer in the extreme. Enduring untreated suffering of the intensity of suicidal ideation is, as I've stated earlier, a

personal torture process so this is simply unacceptable.

What's also tried should work fast to limit the duration of this torture as much as is possible and the right solution should be able to be selected first time so suicidal people shouldn't have to endure through trial and error.

This particular requirement of speed in the treatment of suicidal ideation is another important suicidology objective which is totally absent from current research and practice. Those who endure suciidal ideation suffer even more without this requirement that treatments should be designed to be swift in ceasing suicidal ideation.

- Without the option of a legal suicide (a guaranteed good death) many suicidal people go to their deaths without engaging with the mental health system. These unregulated suicides are perfectly legal and they'll continue to happen unless assisted suicide is legalised.

  There are several benefits for suicidal people from an assisted suicide: a reliable, painless death is possible without risking a worse quality life if the suicide attempt fails and they damage themselves, e.g. through liver failure after a failed overdose; they need not go to their deaths alone (it is one of the current undocumented horrors of modern life that suicidal people often die alone which is comprehended through lived experience); there is the opportunity to reduce the grief of those affected by the suicide because loved ones can enter into the process whereas unregulated suicides can happen without the their foreknowledge; they need not hide their intent for fear of coercive treatment by the mental health system.

  With the prospect of a good death at the end of the waiting period there will could be 100% engagement with the mental health system by suicidal people. There is no other option (that I can think of) which makes this possible other than the legalisation of assisted suicide. The substantial benefits for suicidal individuals above the current unregulated suicide situation make the quality of death much better too.

- I'm not sure it's that relevant but I'll mention it briefly. Doctors have a high occupational suiicide rate. This is another example of how little the medical profession understands about suicidal ideation.

As I see it the current system is an abject failure. The price of failure is paid dearly by those who suffer chronic suicidal ideation without managing to kill themselves. Without good science there are no good solutions; without good solutions there's just more suffering for the suicidal to endure. Without the mercy to legal assisted suicide there exist the evils of the unregulated suicide system.

This is totally unacceptable in a compassionate society but it is the accepted status quo today.

Assisted suicide is a mercy

I've asked for your empathy so I can beg for mercy. I've perhaps elucidated you on the hopelessness of relying on the mental health system to get things right and the monumental failure of the application of science to suicide.

What is, to me, the greater crime is the criminalising of assisted suicide. Assisted suicide guarantees the highest control over one's death and makes possible good deaths for those who want them. This is, in my fervent opinion, better than allowing people to suffer prolonged suicidal ideation because this is a personal torture which no one should endure. It brings the mercy which is currently absent in unregulated suicide.

Earlier in this document I used the contentious example of suicidal ideation caused by the grief of lost love. I expect some people might automatically dismiss the validity of this reason behind wanting to die. Some people might think it's shameful to admit to feeling suicidal because of lost love. Some people might think the reason for feeling suicidal isn't enough to validate a legal assisted suicide. This isn't true.

What I'm proposing is the main or triggering factor is not the target of assessment of the validity of suicidal ideation. Every reason has validity because of the unique and personal nature of everyone's experience of mental states. The pain some individuals suffer for lost love can be as brutal and intense as enduring the sort of physical pain which the legalisation of assisted dying allows to be escaped. Poets and writers have understood this but the understanding doesn't reach into the assisted suicide debate. Suicide is the escape from profound personal pain be it physical or mental in nature and understanding this is better understanding what it means to be human.

Society's expectations of suffering have underserved those who suffer chronic suicidal ideation. I believe that individuals remain the expert in their deaths. Judges, doctors, politicians and the public may all have their opinions on the matter but the individual's free will and release from a mental torture process should be paramount. External judgements are persecutory when they disregard and degrade the free will of the individual in this awful area of enduring suicidal ideation. Be it lost love, bereavement, financial catastrophe, other life catastrophe or anything else the key issue is their effect which is to drive a psyche beyond its limits. The onus should be on free choice, not meeting society's expectations of the right or wrong reason to want to die.

The suicidal individual should have as much control as possible in any legal assisted suicide system. The individual is the expert in their death. The framework which assesses which suicide is okay should be minimal and empower free decisions rather than curtail them . Assisted suicide can't be totally anarchic but it should (as much as

possible) favour the indiviudal in their choice to die.

Legalisation provides the mercy which is otherwise absent and this mercy should not (wherever possible) be witheld. This is based on the understanding of the sheer awfulness of suicidal feelings and protecting people from enduring pain beyond their capability to handle.

Criminalisation on the other hand is the product of a lack of empathy and understanding which forces people to live through wanting to die or to take their life by themselves. Suicidal people are forced to die alone, to risk lasting damage if their attempt fails and their desperate need to die is forced outside society. Criminalisation of assisted suicide also means some suicidal people go to their deaths without engaging with the mental health system whereas the legal option would ensure every person who wants to die will engage with the suicide system.

Criminalisation of assisted suicide ensures people like myself continue to live through an unlivable life, an unmitigated torture without hope of a good end. Criminalisation inherently says that society thinks there's something wrong with suicidal people and any desire to die is irrational.

Those who would show mercy and compassion are classed as criminal, a classificiation which is inappropriate given my arguments. Criminalisation denies this final mercy to the disabled and distressed because of a lack of understanding and the true compassion to do the hard thing.

Suicide is a tragedy but the tragedy is rooted in the suffering of the individual, suffering which death ends and criminalisation of assisted suicde prolongs. Those denied a good life are denied a good death which makes things all the worse.

Killing me is a mercy.

The End

These are just some additional thoughts on what precautions could be used (from my perspective).

What about the framework to decide whose suicide is okay?

It is unlikely a legal assisted suicide system would be wholly anarchic. As I found myself in my first experience of suicidal ideation (twenty years ago) the wish to die can fade even without treatment. Suicidal ideation can be a transient response which if acted upon immediately would be regretted by the suicidee. The prevention of these regrettable suicides is an important objective of any legal assisted suicide system

framework. Precaution however needs to be weighed against the principle I've written about which is the avoidance of the awfulness of enduring suicidal ideation of any kind.

The only rule system I'm suggesting is time between first making the decision to die and the final, fatal decison to die. This might be considered usefuly described as the length for suicide treatment to take effect but the minimisation of the length of the personal torture of suicidal ideation must also be considered.

A predefined length of time as part of the official assisted suicide framework is the most workable solution though my personal preference is for the predefined choice to be a personal one rather than an enforced standard. My thoughts on the key variable of the length of the precautionary waiting time are as follows:

- A very long length of time, e.g. two years, provides a high degree of protection against transient suicidal ideation resulting in a bad or regrettable decision. It is the maximum length of any psychological therapy on the NHS. As far as I am aware, Dialectical Behavioural Therapy is designed to take two years. It was designed to treat Borderline Personality Disorder, a diagnosis which includes a lot of people suffering enduring feelings of wanting to die. I'm not sure if it's generally offered because the cost is high not just because of the length of treatment but also the requirement for input from a second therapist.

  Two years is much too long though if the pain of unfulfilled, unmitigated suicidal ideation is appreciated. Remember, I'm proposing it is a personal torture process leading to both the suicidal ideation and profound suffering when it persists. Two years of such trauma can be extremely damaging and it is a suffering beyond other sufferings so such a long waiting period is unacceptable.

  It is, however, more than ample for certainty of the decision to die to be as high as possible. There is no way in which such a long felt decision is impulsive and the suicidal feelings are clearly, absolutely not transient.

- A very short time, e.g. a few days, guarantees the least distress for suicidal people but offers limited protection against transient suicidal feelings. It is also too small a window of time for any therapy to work if the individual chooses to engage with the mental health system. I'm sure it's much too short to be acceptable to suicide policy decision makers.

  However, for people who already experience chronic suicidal ideation and have endured it for more than, say, three months already I feel the shortest waiting period is most appropriate. They, like me, have endured enough already and their/my suicidal thoughts are not transient. The precautionary waiting period is unnecessary and would only serve to prolong their suffering without cause. I've wanted to die consistently (more days wanting death than not) for over a decade and in the last few years this feeling has been with me almost daily. I feel my

desperate desire to die is validated by what I've already endured and I don't need any more time nor do I want it.

- A medium length of time, e.g. a few months, is a much better balanced option which I hope is within the boundaries of acceptability by suicide policy decision makers. It is long enough for antidepressants or other medication to work and provides a decent window of time for high intensity psychological treatments to work. Talking therapies will need to be more intensive than the one session a week as is current for things like Cognitive Behavioural Therapy.

  Suicidal individuals are still forced to be resilient and endure their torture but it is not extensive. In fact a few months waiting seems unreasonable to me and I would err on the side of greater mercy, ie I'd prefer it to be shorter. A month perhaps. If you can imagine what it feels like to want to die day after day you'll understand why I feel this way I hope.

- A length of time decided upon by individuals. This purely democratic approach to assisted suicide would involve defining suicide criteria as part of psychosocial development. This solution is impractical because it requires a significant shift in society to include preparation for suicide in psychosocial development processes whereas a standard waiting period is easy to implement. However, with repect to the deeply challenging nature of determining the right standard length of time and the personal nature of suicide in general I believe this is also the best solution.

  This solution is possible if preparing for the possibility of experiencing suicidal ideation becomes part of standard psychosocial development through the education system, perhaps in mid teenage years. By educating people on the transient property of suicidal ideation and the awfulness of intransigent suicidal ideation the possibility of leaving end of life decisions solely with individuals is made practical in my opinion. It means any decision on enduring torture is a personal one, not one enforced by society. Since forcing someone to survive torture is against the ethics of modern society this is a worthwhile alternative solution to forcing suicidal people to endure their torture longer than they're willing to.

  Additionally, given the high lifetime prevalence of suicidal ideation - 1 in 6 (which is published in the Adult Psychiatric Morbidity Survey 2007) - the idea of including education about suicidal feelings in child development education is one which could actually be effective (in my opinion) against such a pervasive problem. At the moment there are no solutions which tacke the suicidal ideation epidemic until someone gets to the point where they feel like they want to die. It's like shutting the barn doors once the horse has bolted. What I'm proposing in terms of suicide education might or might not be preventative but at least people will be

more prepared to face this awful mental state. It could encourage resilience and while I'm against this being demanded by society it is something which individuals can decide for themselves.

The impetus is, as always, to show mercy for those suffering the most awful mental pain imaginable and not meet the demands of society or the collective which have already failed the suicidal individual. Suicidal individuals should be empowered as much as possible and not be slaves to moral insecurities which are derived from a lack of empathy as well as caution against 'inapppropriate' suicides.

What if the circumstances which cause suicidal dieation are solvable?

With transient suicidal ideation the precipitating situation can seem unsolvable when sometimes it isn't. This is true in assisted dying to a lesser extent because doctors don't always predict the prognosis accurately and new technologies are making miracles possihle in treating terminal illness. This doesn't apply in chronic suicidal ideation because circumstances don't change in quickly or at all or, as I've discovered, things just get worse.

It's important to provide protections against situation which drive suicidal feelings which are quickly and easily solvable. The question again is who is the expert in what's solvable and what that solution looks like. It may seem prudent to give the power to doctors or judges to enforce this precaution.

I disagree that doctors, judges or any other profession has the true expert knowledge to understand a suicidal individual's situation and the personal impact it has on the individual. Psychologists or people with lived experience of surviving suicidal ideation may be useful in educating a suicidal person about the transience possibility and the solvable possibility but I firmly believe the individual should remain the sole arbiter of this consideration. Mental health professions can provide education, guidance and (very rarely...) the right life wisdom but my belief is no one should rule over the personal plight of the individual.

A waiting period between decision to die and the assisted suicide is the sole protection necessary and the individual is the expert of their situation and their death. The individual's decision can be influenced during this waiting period but it should not be coerced.

I appreciate this is a radical perspective given the status quo but I live through suicidal ideation and I would not want it endured by anyone who does not want to because someone else invalidates their free will. IF you can imagine what it feels like to wake up day after day wanting to never see another day you might understand why I've chosen to support this radical position of empowerment of free choice and compassion through providing a good death. It is torture to live but want to die. It is hell on Earth.

Don't pity me. Find empathy and from there mercy. Kill me.