When Intention to Suicide Is Rational

Sarah Edelman, PhD

Clinical Psychologist
President, Dying With Dignity NSW
Background
- DWD societies (in each state)

- Exit (Phillip Nitschke)
Bills to legalise assisted dying

- South Australia
- NSW
- Tasmania
- Victoria
- Federal
Common view: Suicidal behaviour is symptomatic of mental illness

Can the intention to suicide be rational?

Implications for our practice?
Information on Self-Delivery Methods
Case Study: ‘Robert’ 78 yrs

- Terminal cancer of the oesophagus
- Good relationship with GP. Imported Nembutal and planned to take it. Told his GP.
- GP called Insurer and asked for advice. Told to report the matter.
- 10 pm: CAT team arrived.
- CAT team returned the following morning with police.
- Involuntarily taken to Psychiatric Unit at Hospital. Assessed. Found to be of sound mind. Released.
- Entered a public hospital. Died a week later.
Most Health Professionals Believe Suicide Can Be Rational


- Ginn S, Price A, et al. Senior doctors’ opinions of rational suicide. J Med Ethics 2011; 37:723-726. 72% agreed, 17% disagreed. (Doctors who identified as being more religious were more likely to disagree).

What is rational suicide?

- Rational Suicide: Ending of one’s life for considered reasons, as opposed to emotional reasons.
- “Rationality requires logical consistency between one’s behaviours and first order desires or goals. The desire to hasten death may therefore achieve a higher order goal of reducing suffering.
- “People [without psychiatric illness] can freely desire a hastened death, based on carefully contemplated logical decision-making process”.
- “Mental illness does not automatically imply irrationality”.

### Child Mental Health tools and resources

- Resources and publications
- Websites
- Online discussion forums

### Suicide Prevention tools and resources

- Clinical Practice Guidelines
  - Clinical Practice Guidelines for the management of deliberate self-harm (adult and youth), RANZCP, 2012 and National Institute of Health and Clinical Excellence (NICE)
  - Working with the Suicidal Person: Clinical Practice Guidelines for emergency departments and mental health services, 2010 Victorian Government Department of Health.
  - Guidelines for the Assessment and Treatment of Child and Adolescent Suicidal Behaviour, 2001 American Academy of Child and Adolescent Psychiatry
  - The assessment and management of people at risk of suicide, 2003 New Zealand Guidelines Group (NZGG) and Ministry of Health
  - Self-harm: longer-term management, 2011 National Institute of Health and Clinical Excellence (NICE), Also see Evidence Update, April 2013
  - Life Matters: Management of Deliberate Self-Harm In Young People, 2001 Office of the Auditor General, Western Australia
  - Guidelines for the management of deliberate self-harm in young people, 2000 Australasian College for Emergency Medicine (ACEM) and The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- Operational Guidelines
- Suicide risk assessment tools
- Screening tools
- Training and events
- Tip sheets and fact sheets
- References and articles
Training Programs

- Assist
- ATAPS
- NSW Health Guidelines
- Suicide Prevention Australia
- Beyond Blue
- Australian Defence Force Suicide Prevention Program.
APS Ethical guidelines

General Principle A: Respect for the rights and dignity of people and peoples:
Psychologists regard people as intrinsically valuable and respect their rights, including the right to autonomy and justice.
Standard B.3. Professional responsibility

3.4. Psychologists act with care and skill in responding to a client’s current and ongoing signs of suicide, which may include:

- i) **taking steps to attend to the client’s immediate safety**;
- ii) undertaking or arranging for a **thorough and specific assessment of suicide risk**; and
- iii) arranging appropriate psychological, medical, psychiatric and/or social care, and community response.
A.5.2. **Psychologists disclose confidential information** obtained in the course of their provision of psychological services only under any one or more of the following circumstances:

- (a) with the consent of the relevant client or a person with legal authority to act on behalf of the client;
- (b) where there is a legal obligation to do so;
- (c) if there is an immediate and specified risk of harm to an identifiable person or persons that can be averted only by disclosing information.
4.1. In situations where it has not been feasible to obtain the client’s consent to inform other persons, **then assessment of the degree of risk to the client** and others will determine whether to disclose client information.

**The immediate safety of the person at risk is paramount.**
Video: John Grayson
Reflect

- How do you respond, when you have a client like John, who is mentally competent, and tells you he plans to end his life next week?
- What factors influence the way you respond?
NON TERMINAL ILLNESS:

Advanced Neurological Illness
Video: Aina Ranke
Video: Loredana Mulhall
NON TERMINAL ILLNESS:

Multiple Complex Illnesses Associated with Old Age
Video: Beverly Broadbent

- peripheral neuropathy
- osteoarthritis
- loss of mobility and falls,
- ophthalmic migraines
- chronic pain
- early dementia.
Peter and Pat Shaw
“The Big Sleep”
A reasoned choice

JULIETTE Hughes asserts that “people only opt for death when they are desperate, lonely, depressed and in pain”. She is mistaken. There are thousands of us that plan to enter the Big Sleep at a time of our own choice. We are mostly not religious, but we are sensible, mature, perfectly in control, good and responsible citizens. Our reason for suicide may be anticipation of pain and incompetence, but quite likely just a sense of a life accomplished and coming to a conclusion.

We are not interested in palliative care, and strongly resent do-gooders placing obstacles in our way. Their activities are illegitimate interference with our liberty and autonomy in a matter most central to our life.

Peter Shaw, Brighton
NON TERMINAL ILLNESS:

Chronic Pain
Marieke Vervoort

Aristea and grandmother, Voula.

SBS: “Allow me to Die”
Reflect

- What are our legal obligations?
- What are our ethical obligations?
- Are current APS guidelines adequate?
Dementia
Conclusion

- Suicidal intent may not always be driven by mental illness, lack of rationality, or lack of mental capacity.
- APS Code of Ethics does not address situations where a client’s intention to suicide is rational.
- It is a difficult area, but one that should not be ignored.
“Overall, the therapeutic relationship between a suicidal patient and clinician has been emphasised as being critical to restoring a patient's sense of well-being and self-worth to address suicidality.

It is suggested that acting in the patient's best interests, rather than following rigid rules or guidelines out of context, will almost always lead to the best course of management”.

Angelo Ho