REVIEW ARTICLE

IS IT TIME TO DECRIMINALIZE SUICIDE IN PAKISTAN? A CRITICAL REVIEW

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ABSTRACT

The issue of decriminalization of suicide in order to increase the access to mental health care has been gaining the attention of mental health professionals, authorities, law makers and policy makers in Pakistan. The bill to decriminalize attempted suicide has been once again presented in the Senate of Pakistan and the matter is now with standing committee of the National Assembly of Pakistan for further evaluation. Mental health professionals throughout the globe and especially in Pakistan have strongly advocated to repel punishment for attempted suicide however they have rarely considered this phenomenon in the wider context. This critical review has presented a divergent position and arguments in the light of inclusivity, epidemiological data, possible alternatives, and unanticipated consequences. We proposed rather than repelling punishment for attempting suicide, health care system should be legally liable to respond and to provide physical and mental health treatment to people who attempt suicide. Based on detail examination of this matter, the main problem lies in the lack of availability of treatment, lack of awareness and stigma associated with overall mental illness.

KEYWORDS: Decriminalization, Mental health, Pakistan, Suicide

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INTRODUCTION

Recent data suggested about 5552 cases of suicide were reported in Pakistan with an average of 3.1 incidences of suicide per 100,00 population [1]. Given the considerably higher rates attributed to suicide in Pakistan, governmental and various non-governmental organizations are putting their efforts to prevent suicide. Sindh Mental Health Authority (SMHA) has been actively playing its role in promoting mental health and is engaging in scientific research to devise an appropriate policy to mitigate suicide[2]. According to a five-year study done by the SHMA, 767 suicides occurred in Sindh between 2016 and 2020 and highest number of suicides were recorded in district Tharparkar[3]. Further on, in June 2021, the SMHA conducted a "psychiatric autopsy" to ascertain the reasons associated with suicide in Thar region. The study revealed that 24% of those who committed suicide in Tharparkar had mental illnesses. Furthermore, it was shown that 60 percent of those who committed suicide were in between 10 to 20 years of age. Lower income groups, those with untreated mental illness, and poverty were common reasons in the cohort. The research is useful in the development of suicide prevention policies[2,3]. After this report was publicized, many mental health experts and some policy makers in Sindh are advocating the abolishment of section 325 in Pakistan Penal Code (PPC)[4]. Section 325 PPC states,

"Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year, (or with fine, or with both)"

Those experts and policy makers argue that this law was a legacy left behind by British Raj and many countries including Britain itself have decriminalized the suicide. It has been contemplated that criminalization of suicide promote stigma therefore, it is a considerable barrier in provision of mental healthcare to people who attempt suicide[3]. In this regard, on occasion of Suicide Prevention Day, 2021, Chief Minister Sindh, has urged federal government to repeal the attempted suicide law[5]. Currently, a bill titled as "The Criminal Laws (Amendment) Bill, 2021" aims to decriminalize suicide is presented in Senate of Pakistan by Senator Shahadat Awan and this matter is now with standing committee of National Assembly of Pakistan for further evaluation[6]. This is the second time when a senator has moved a bill to decriminalize suicide in Pakistan. Prior to the current bill, the bill titled as "The Criminal Laws (Amendment) Bill, 2017" aims to decriminalize suicide was introduced by the Senator Karim Khawaja (present chairman of SMHA), which was approved by the standing committee on interior[7], however, the bill was not passed by the National Assembly, and eventually lapsed at the end of the last government's tenure.

Though, it is reasonable to consider that this law might be a barrier towards accessibility of the mental health care however, for few diligent reasons we believe that policy makers and experts working with SMHA have jumped to the conclusion without considering many facts. We believe that this matter has been extensively studied under the popular question "Why we should decriminalize suicide?" however, the questions and arguments in favour of "criminalization of suicide" have been rarely investigated.

POSSIBILITIES

We start with considering three possibilities pertaining to attempted and completed suicide. We believe that considering those possibilities are integral in making comprehensive understanding of why or how criminalization of suicide may or may not hinder access for mental health care. Suppose if a person commits a serious attempt of suicide and severely injured himself/ herself. Now what will his/ her relatives or people around him will do when they find it out? Will they let him/ her die because they fear that if they took him/ her to hospital then he/ she can be sentenced for imprisonment of one year or charged with fine? Logically speaking, in majority of cases relatives or friends or people around him/ her will try to take him to hospital because saving one's life is lot more important than saving him/ her from punishment or fine. And when they take him/ her to hospital then he/ she will be treated in emergency. Indeed, we agree that private hospitals might not entertain such cases and we do agree that any private and public health facility should have to respond to such cases without any delay, and it should be mentioned in law that any private or public hospital has to provide immediate treatment. But the basic assumption in favour of decriminalization of suicide seems unjustifiable which assume that people attempting suicide are afraid to go to health care facilities due to prosecution. It is clear that situation will compel the people around them to seek treatment urgently. Now if he/ she is being treated for any physical injury or health why can't he/ she be treated for mental illness given mental health services are available.

Now let's assume that a person has attempted a suicide, and this has resulted into minor injuries which may not require hospitalization. This injury has been informally managed at home. In this case we do agree that person attempting suicide or people around him at home or any other place will fear to go to hospital, however, this may not hinder the person access to mental health care due to two possibilities. One possibility is that if a person's suicide is a result of mental illness and he/ she was well aware of mental illness then he/ she should have consulted mental healthcare prior to his/ her suicide attempt. However, if we might assume that he/ she still don't access to mental healthcare due to severity of mental illness and suicidal thought and accessed mental health care in days following to his/ her suicide attempt then will mental health care providers are liable to report his/ her suicide attempt to law enforcement agencies when he/ she is seeking care for his/ her mental illness rather than suicide injury? And, are healthcare practitioners legally liable to report those cases in which attempt has been made a couple of days

before and where patient is seeking care for something other than suicidal injury? These questions indeed require a comprehensive dialogue and consultation between law professionals.

In case of completed suicide, it is reasonably correct to say that people in Pakistan are hesitant to report such cases due to socio religious factors. One of the prominent reasons for this is that some Islamic Scholars propose that in Islam, well known religious leaders in locality are not allowed to attend or to lead the funeral prayer of people died of suicide. Similarly, as this act is considered "forbidden" is Islam therefore, it is socially unacceptable. In this context, we contemplate that main issue lies in the lack of availability of mental health care and associated stigma.

WHOLISTIC APPROACH

Availability of the mental healthcare facilities have to be seen in a wholistic rather than a reductionistic approach in this context. World Health Organization Aims report on Pakistan indicated that resources including trained staff, outpatient and inpatient mental health facilities and budget allocated to mental health is insufficient to provide appropriate coverage to the disease burden associated with mental illness[8]. Similarly, stigma associated with mental illness is not limited for those who attempt/ commit suicide rather stigma is associated with all mental diseases. Due to the stigma, religious and cultural values, there is still a considerable proportion of people suffering from mental illness prefer to consult religious, traditional and faith healers rather than mental health professional. Therefore, accessibility towards mental healthcare has been limited in Pakistan for all mental health problems irrespective of suicide or self-harm history. An appropriate solution is to integrate mental health services in prison system without any discrimination. Islamic Ideological Council has recognized the importance of access to treatment for people attempting suicide with mental illness and stated:

"*If a person is diagnosed with specific mental illness after assessment, then punishment shouldn't be applied rather this person should be referred to rehabilitation center for treatment*"

This issue has also been exclusively addressed only for suicide and blasphemy accused in Sindh Mental Health Act 2015 (Amendment)[9]. However, we contemplate that mental health services shall be integrated in prison system without any discrimination to all prisoners. Hence, a wholistic approach providing a political, legal, and financial commitment to core remedies including capacity building, infrastructure building and integrating mental health awareness/ services in primary health care, workplace settings, basic and higher education institutions, prison system and religious institutions may be more suitable policy to increase the accessibility of mental health care.

DEFINING CRIMINAL BEHAVIOUR

It is imperative to consider that whilst defining a criminal behaviour, it should be defined independent of mental disorders. Otherwise, there are range of criminal behaviours which are associated with mental illness and assuming that person "who attempts suicide should not be considered as criminal because that person is suffering from mental illness rather it requires mental healthcare" would logically divert the criminal responsibility for all those who are accused with some crime and are mentally ill. We need to focus on the act itself and try to define the criminal behaviour with central focus on behaviour. However, we do acknowledge that one factor that single out suicide from other crimes is that it is a harm and aggression towards one own self compared to other crimes where harm or aggression is exerted towards others. The only reasonable and logical difference between suicide and other crimes in general is that suicide is an internalizing behaviour, however, other crimes are generally externalizing behaviours. Is this difference enough to decriminalize suicide? This matter has been rarely addressed through this approach.

POTENTIAL BARRIER

It has been strongly advocated by in Mental Health Action Plan to collaborate with traditional and faith healers in mental health care to increase the treatment accessibility in Lower Middle-

Income Countries. Data suggest that about 10 to 40 percent of people still consult traditional and faith healers in case of mental illness[10, 11]. One of the many barriers in developing a collaborative environment between faith healers and bio medical professionals is difference in explanation of mental illness where faith healers rely upon religious, spiritual, and magical explanation whilst medical professional rely on medical, disease and psychosocial model. It has been suggested to identify the common grounds, so that a trustful and implementable collaboration can take place. As majority of traditional and faith healers are influenced by Islamic principles, therefore, we believe that decriminalization of suicide might become another barrier in collaboration given the divergent positions on this issue.

INEVITABILITY

It has been advocated that involvement of medico-legal authorities and officers in the suicide case may occasionally result in exploitation. No consideration has been given to the fact that although role of medical and legal officers can be minimized in the context of suicide, but it cannot be eliminated given the plausibility of some other criminal offenses such as murder or attempted murder. In many developed countries postmortem is the routine practice after the unnatural death or suicide. It is also a matter of protection rights of deceased person, justice, and a responsibility of state, to make sure that an act of suicide was originally a suicide. In some cases, another person is injured or died as a result suicide attempt and due to this reason prosecution happens regardless of decriminalization of suicide. However, it depends upon the vicarious victim of suicide whether he/ she wants to take a plea in court and whether a person who attempted suicide had an adequate mental capacity or legal capacity determined through Forensic Mental Health Assessment. This issue has been discussed by Mishra and Weisstib[12] and argued that in many instances a person who commit suicide still face prosecution in regions where suicide is not criminalized:

"In countries where suicide attempts have been decriminalized, attempters may still face prosecution when another person is injured or dies as a result of their suicide attempt or where the attempter is a member of the military"[12]

Therefore, if criminalization of suicide is abolished there will still be the involvement of police and medical officers to rule out the possibility of any other criminal offense(s) and to ascertain the cause of the death.

INCLUSIVENESS

While amending or drafting new laws, acceptability of the laws to all stakeholders must be considered. It might be difficult to implement a law which has been developed without taking perspectives from diverse stakeholders in a wider context. Section 325 PPC is not an issue that is only related to mental health albeit it is related to wider stakeholders including legal and justice system, social norms, and religious values. Due to the popularity of Islam in Pakistan, Shariah and its laws has significant impact on the values and norms. In Islam, suicide is considered as a prohibited act, therefore, without any consultation with Islamic scholars (including popular religious leaders) and Shariah and Law experts, it may not be acceptable to various segments of population. It is also pertinent to consult legal professionals who might have a divergent position given that criminalization of suicide may be predominantly a preventative measure for suicide beside the barrier to mental health care[13]. Therefore, a rich, productive, and conclusive discourse is required between diverse stakeholders with divergent positions to address the counter narratives and to build a consensus.

SCIENTIFIC PRECISION

Importantly, the data presented in the "psychiatric autopsy report" and the issue pertaining to the criminalization of suicide are not directly related to each other, therefore, interpretation of the given data is not scientifically valid to support the abolishment of section 325 PPC. To support the argument that decriminalization of suicide can contribute to suicide prevention, ideally either 1) a comparative data is required in which rates of suicides have to be compared across jurisdictions with and without criminalization of suicide or 2) a longitudinal examination of the data where criminalization of the suicide is followed by the legalization.

It has been documented in WHO recent estimates that Eastern Mediterranean Region (EMRO) (including Pakistan, United Arab Emirates and Saudi Arabia, where suicide is considered as criminal act) have significantly lower rates of suicide with 4.3 per 100 000 population compared to the African (12.0 per 100 000), European (12.9 per 100 000), South-East Asia (13.4 per 100 000) regions and global average (10.5 per 100 000) in 2016[1]. To date, there is only one study which has identified the relationship of criminalization of suicide with rates of suicide indicating that suicide rates are higher in countries with anti-suicide laws only Human Development Index is lower, however, negative impact of criminalization of suicide-on-suicide rates were not found for countries with higher HDI[14]. Although, WHO propose that such comparisons are not justifiable since suicide is considered a criminal act and suicide deaths are unreported, thus giving the false impression that suicide rates are less common. We do agree that such comparisons are not sufficient to answer the effectiveness of decriminalization of suicide because it has been suspected that rates of suicide have been underreported and misclassified (as another cause of death) in many regions in the world especially in EMRO.

However, in addition to it, human rights fraternities believe that "*no data or case-reports indicate that decriminalization increases suicides"*. We argue that this statement is presented out of the context, rather than evaluating the effectiveness and to ascertain that decriminalization actually decrease the suicide rate, argument is twisted to demonstrate that discrimination don't increase suicide rates. The evidence until now indicates that decriminalization followed by the criminalization of suicide don't significantly decrease the registered/ reported cases of suicide in Ireland [15] rather some evidence suggest that these rates have been increased after decriminalization in seven countries including Canada (Decriminalized in 1972), England and Wales (Decriminalized in 1961), Finland (Decriminalized in 1910), Hong Kong (Decriminalized in 1967), Ireland (Decriminalized in 1993), New Zealand (Decriminalized in 1961), and Sweden (Decriminalized in 1864) [16]. The reduction in death rate was observed only for undetermined death causes, which is open to alternative factors especially in country (Ireland) where registration and reporting of suicide is better than many other regions in the world[15]. Therefore, a better conclusion to draw on existing evidence is that decriminalization neither increase nor decrease the suicide rate therefore, the effectiveness of such law is still uncertain.

Therefore, a straight away conclusion in favor of decriminalization without any consideration to suitable data and research method to ascertain the effectiveness of such action is indefensible.

EQUIVALENCY VS NON-EQUIVALENCY

The issue of non-equivalency between decriminalization and legalization is also topical. Where popular mental health professionals claim that decriminalization is not equivalent to legalization of the suicide rather it is to discourage the prosecution of those who attempt suicide. We argue that this idea represents the dominancy of psychiatric perspective, and it ignores the legal perspective at all. In law profession, it is a common saying that if any act is not explicitly prohibited under the law that action is considered as a legalized action. This was the exact interpretation and perspective of secretary interior during discussion on "Criminal Laws (Amendment) Bill 2017", he stated,

"*State could not allow its citizens under whatsoever circumstances to take their lives, punishment for suicide would act as deterrence and that omission of section 325 would be tantamount to legalizing suicide*"[7]

If this issue is interpreted with these lines, then decriminalization of suicide will lead to increase in suicide rate rather than prevention. In United States (US) several states have legalized Physician Assisted Suicide (PAS) and evidence is suggesting that legalization PAS has resulted in increased suicide rates[17]. However, the issue pertaining to the equivalency or non-equivalency between decriminalization of suicide and legalization of suicide cannot be concluded without extensive debate between mental health and law professionals and therefore left open for readers own interpretation.

IMPLEMENTATION ISSUE VS CHALLENGING BEHAVIOURAL PARADIGM

It has been widely accepted by mental health professionals and other stakeholders that section 325 has been rarely implemented. Further, the punishment model is embraced worldwide and has its origin in behavioural paradigm in social sciences with a considerable empirical and experimental support. Therefore, the argument stating that punishment don't work to prevent suicide in actual is a challenge to behavioural model, which has a long history and scientific rich evidence. The non-implementation of this laws in this context should also be considered, which might be the root cause of its apparent ineffectiveness.

CONCLUSION

Revisions in policies, laws and interventions in the modern era should not be prescriptive in nature rather they should be evolved through the process of consultation, inclusion, empirical evidence, and possible alternatives. However, we propose that rather than negating the section 325 PPC, policy and laws makers should take this issue as a process encompassing wholistic understanding of the phenomenon, consider the inevitabilities pertaining to the issue, give leverage to inclusivity and rigorous scientific evaluation to reach consensus. For mental health professionals, it is a reasonable idea to engage with diverse stakeholders to reach implementable and effective solution in a wider context. However, we do acknowledge that physical and mental treatment should be provided to people committing suicide and healthcare system (including public and private) should be legally liable to respond. Islamic Ideological Council had a same opinion where they acknowledged the role of availability of mental health treatment to people committing suicide rather than punishment.

REFERENCES

1. World Health Organization. 2019. Suicide in the world: global health estimates. World Health Organization.
2. Psychological Autopsy of Suicide Cases Registered at Tharparkar. 2021. [video] Karachi: Sindh Mental Health Authority. Retrieved from. https://www.youtube.com/watch?v=1K7xwxVj6rw
3. Saleem R. [Internet]. 2021 [cited 4 September 2021];. Available from: https://www.dawn.com/news/1644258
4. Pakistan Penal Code 1860. 325. Retrieved from https://www.ma-law.org.pk/pdflaw/PAKISTAN%20PENAL%20CODE.pdf
5. Siddiqui, T., 2021. [online] Available at: <https://www.dawn.com/news/1645460> [Accessed 10 September 2021].
6. The Criminal Law (Amendment) Bill. (2021, September 27). http://www.senate.gov.pk/uploads/documents/1632748909_568.pdf
7. Malik, A., 2017. *Report on the standing committee on interior*. [online] Senate of Pakistan, pp.1-10. Available at: <http://www.senate.gov.pk/uploads/documents/1511179317_271.pdf> [Accessed 3 November 2017].
8. World Health Organization. WHO-AIMS Report on Mental Health System in Pakistan. 2009. WHO Office, Islamabad: World Health Organization
9. Sindh Mental Health (Amendment) Act 2015. 49 Retrieved from http://www.pas.gov.pk/uploads/acts/Sindh%20Act%20No.XIX%20of%202015.pdf
10. Chaudhry MA, Butt AS, Khan EA, Latif AA, Kamran J, Khan MA, Rana MS. Health seeking behavior of psychiatric patients at an outpatient department of a tertiary care hospital in Lahore, Pakistan. Pakistan Journal of Public Health. 2017;7(3):137-41.
11. Ali S, Khan MA, Hussain MM, Qamar A, Bashir S. Evaluation of cisplatin induced genotoxicity in male Sprague dawley rats. Pakistan Journal of Physiology. 2019 Mar 31;15(1):21-4.
12. Mishara BL, Weisstub DN. The legal status of suicide: A global review. International journal of law and psychiatry. 2016 Jan 1;44:54-74.
13. Ahmed M. کیا خودکشی کی کوشش پر سزا ختم ہونی چاہیے؟ - ڈاکٹر محمد مشتاق احمد آوازہ. 2021 [Internet]. [cited 17 October 2021]. Available from: https://www.aawaza.com/dr-mushtaq-ahmed/17229/2021/

14. Wu, K. C. C., Cai, Z., Chang, Q., Chang, S. S., Yip, P. S., & Chen, Y. Y. (2020). Criminalization of Suicide and Suicide Rates in the World. *Available at SSRN 3564402*.
15. Osman M, Parnell AC, Haley C. "Suicide shall cease to be a crime": suicide and undetermined death trends 1970–2000 before and after the decriminalization of suicide in Ireland 1993. Irish Journal of Medical Science (1971-). 2017 Feb 1;186(1):201-5.
16. Lester, D. (2002). Decriminalization of suicide in seven nations and suicide rates. *Psychological reports*, *91*(3), 898-898.
17. Jones DA, Paton D. How does legalization of physician assisted suicide affect rates of suicide?. Southern medical journal. 2015 Oct 5;108(10):599-694.