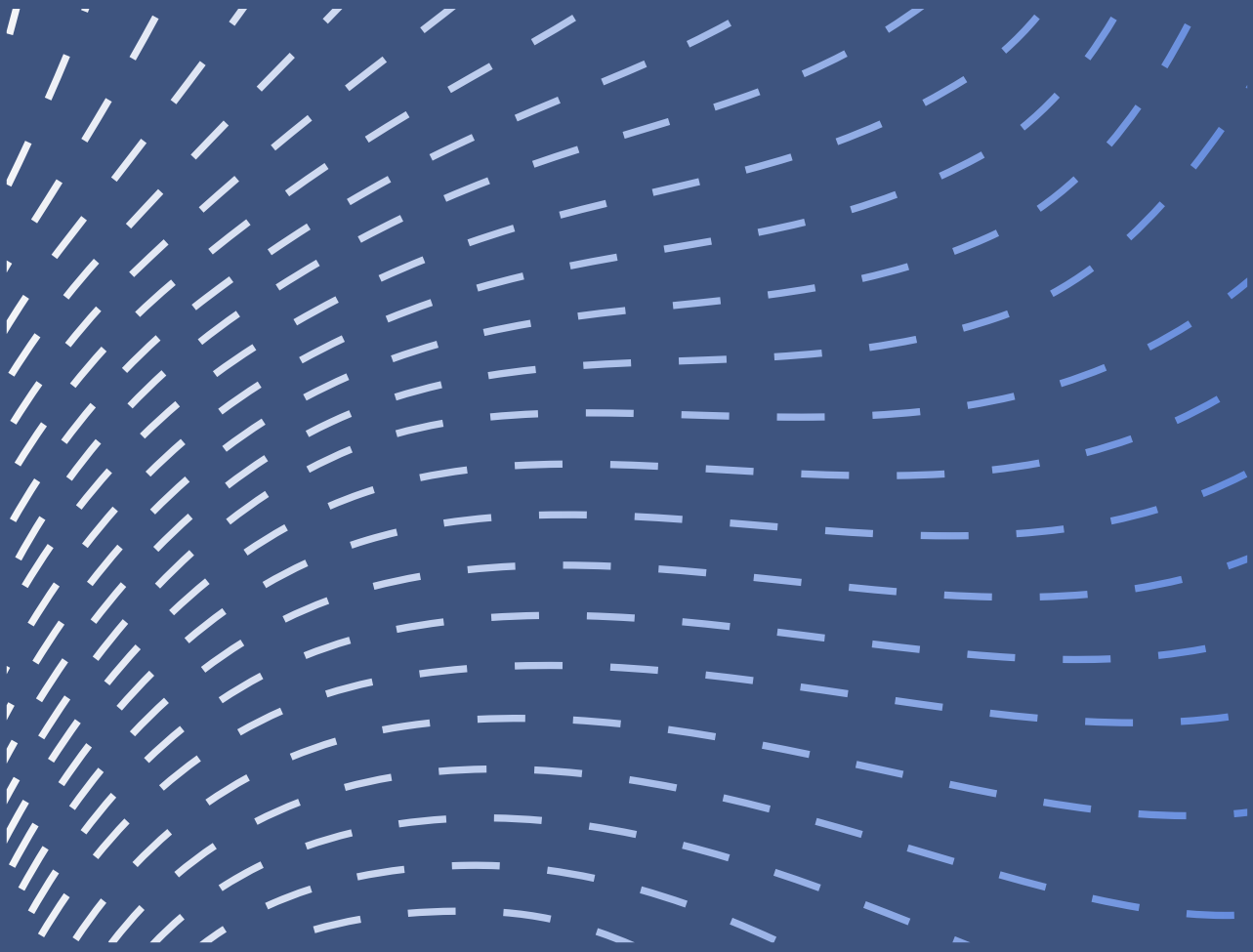
International Association for Suicide Prevention



Position Paper

Policy Position on the Decriminalisation of Attempted Suicide

Updated 2026 | Original document: July 2019

Policy position: Adopted May 2020

The International Association for Suicide Prevention (IASP) considers that the criminalisation of attempted suicide impedes the prevention of suicidal behaviour. IASP encourages countries where suicide attempts are currently illegal or punishable to develop and implement legislation that decriminalises suicide attempts.

Executive summary

This document sets out the evidence base for IASP's policy position, adopted in May 2020 and stated above. Attempting suicide remains a criminal or punishable offence in a number of countries, most of which retain provisions inherited from colonial-era penal codes or apply sanctions under religious law. These laws expose people in acute distress, many with mental health conditions, to arrest, prosecution, and penalties ranging from fines to imprisonment.

The evidence reviewed here supports decriminalisation on public health, human rights, and ethical grounds. There is no credible evidence that criminalisation deters suicidal behaviour; some studies associate it with higher national suicide rates. Criminalisation deters help-seeking, drives systematic underreporting, perpetuates stigma, and constrains governments from acting to prevent suicide. Decriminalisation has not been shown to increase suicide, and is identified by the WHO, the UN Sustainable Development Goals, and the WHO Comprehensive Mental Health Action Plan 2013 to 2030 as a critical step in prevention.

Since 2020, six countries have decriminalised attempted suicide, demonstrating that reform is achievable across diverse legal, cultural, and religious contexts. Experience also shows that legal reform is necessary but not sufficient: its benefits depend on concurrent investment in mental health services, surveillance, training, and stigma reduction, and reform must be actively protected through sustained coalition-building and advocacy.

IASP remains committed to advocating for decriminalisation globally and to supporting its members and partners in national reform efforts.

Contents

Introduction and purpose

This document provides the evidence base for the International Association for Suicide Prevention's (IASP) policy position on the decriminalisation of attempted suicide, adopted in May 2020. IASP considers that the criminalisation of attempted suicide impedes the prevention of suicidal behaviour. IASP encourages countries where suicide attempts are currently illegal or punishable to develop and implement legislation that decriminalises suicide attempts.

The original position paper (IASP, 2019) reviewed the global legal status of attempted suicide, the empirical evidence on the relationship between criminalisation and suicide rates, and the principal arguments for decriminalisation. This update retains that foundational evidence base and incorporates the substantial body of new research, policy guidance, and practical experience accumulated since 2020, in particular, the WHO Policy Brief on the Health Aspects of Decriminalisation of Suicide and Suicide Attempts (2023); reports by United for Global Mental Health (2021, 2024); LifeLine International's 'Decriminalise Suicide Worldwide' campaign (2023); and published research on recent legal reforms in Singapore, Pakistan, Guyana, Ghana, Malaysia, and India. Detailed country case studies and legal analyses are available in those companion documents; this paper focuses on the policy and evidence framework underpinning IASP's position.

The document is intended for IASP advocates, policymakers, international organisations, governments, and civil society.

The global legal landscape

At the beginning of the nineteenth century, most countries had laws providing for the punishment of persons who attempted suicide. The origins of many of these laws lie in British Common Law and in colonial-era penal codes, modelled on the Indian Penal Code of 1860, that were imposed across colonies in Asia, Africa, and the Caribbean. Many former colonies retained these provisions after independence, while the United Kingdom itself decriminalised suicide in 1961. The persistence of colonial-era anti-suicide laws in post-independence states has become increasingly recognised as an injustice in need of correction (Mishara & Weisstub, 2016; United for Global Mental Health, 2024).

In a landmark review of criminal codes from 192 countries and states, Mishara and Weisstub (2016) found that suicide was illegal in 25 countries with specific laws and punishments for attempted suicide, and that in an additional 10 countries following Sharia law, people who attempt suicide may be punished under religious legal provisions.

Since 2020, meaningful progress has been made, however, the same period has demonstrated that reform can be reversed: in May 2026, Pakistan's Federal Shariat Court issued a judgment reinstating criminal penalties for attempted suicide (see Recent Reforms). In addition, Jordan's 2022 amendment to its Penal Code, which introduced criminal penalties for attempted suicide in public spaces for the first time, carrying up to six months' imprisonment and a fine, and came into force in May 2022. Both these instances serve as a reminder that the global trajectory is not uniformly progressive, and that without sustained advocacy, countries may shift towards criminalising suicide.

The WHO Policy Brief (2023) estimated that at least 23 countries still criminalise suicide and suicide attempts in civil or criminal law. LifeLine International's 2023 campaign identified 52 countries where suicide is a crime or where the legal status remains unclear, representing approximately 1.2 billion people. In most criminalising countries, attempted suicide is a misdemeanour carrying one to three years' imprisonment and/or a fine. Even where laws are rarely enforced, their existence produces significant harms (as set out below). In some jurisdictions, the wills of those who die by suicide may be challenged or invalidated, survivors may acquire criminal records, and families face social and financial consequences beyond the immediate legal penalty (see United for Global Mental Health, 2024 for further information).

Regional advocacy has intensified since 2020. A Caribbean Regional Coalition for Decriminalisation of Suicide was launched in July 2024. In Sub-Saharan Africa, reform efforts are active in Nigeria, Malawi, Uganda, Kenya and Sierra Leone. In Kenya, the High Court declared the criminalising provision unconstitutional in January 2025, though statutory repeal remains before Parliament (as set out below). In Nigeria, the Federal Ministry of Health and Social Welfare inaugurated a National Taskforce on the Decriminalisation of Attempted Suicide in October 2024. In August 2026, Nigeria's Federal Executive Council approved a proposed amendment to the National Mental Health Act to decriminalise attempted suicide, currently an offence under Section 327 of the Criminal Code Act and Section 231 of the Penal Code, but the reform awaits National Assembly enactment and attempted suicide remains a criminal offence in law at the time of writing. Advocates in Uganda have also petitioned the courts to declare criminalisation unconstitutional.

The case for decriminalisation: arguments and evidence

Arguments advanced in support of criminalisation

Mishara and Weisstub (2016) identify three principal justifications historically cited for punishing suicide attempters: utilitarian deterrence (that punishment reduces the repetition of suicidal behaviour); moral and social condemnation (that punishment expresses societal censure); and retribution (that a morally reprehensible act deserves punishment). A related argument holds that decriminalisation will increase suicide rates by removing a legal deterrent. As ‘The Harms of Criminalisation’ sets out, these justifications are not supported by the available evidence. Additionally, theories of punishment have been broadly criticised for failing to consider the health and wellbeing costs imposed on the vulnerable populations (Mishara & Weisstub, 2016).

In some jurisdictions, anti-suicide laws also reflect religious doctrine that treats suicide as sinful; in such contexts, decriminalisation has required engagement with religious leaders as well as legislators (Lew et al., 2024).

What the evidence shows

- *Suicidal behaviour is a public health matter*

People who attempt suicide are in acute psychological distress. The majority have a mental disorder that affects decision-making capacity at the time of the attempt, and many are under the influence of alcohol or other substances (Mishara & Weisstub, 2016). A study of attempters in India found 93% to be psychiatrically unwell at the time of the attempt (Vadlamani & Gowda, 2019). Suicidal ideation tends to fluctuate over short periods, and the interval between the decision to act and the act itself is often less than ten minutes (Deisenhammer et al., 2009). Criminal liability presumes a person capable of weighing consequences. Suicidal crises are often moments when an individuals reasoning is diminished.

- *Criminalisation does not reduce suicide*

No study has identified a protective effect of criminalisation. Lew et al. (2022) examined age-standardised suicide rates over 2000—2019 in 20 countries that criminalise attempted suicide, compared against a matched sample of 20 that do not. They found no substantial evidence that criminalising countries had consistently lower suicide rates, and concluded that the evidence is inadequate to support the claim that criminalisation reduces suicide. They further raised the concern that fear of criminalisation may encourage the use of more lethal methods among those determined to die.

Wu et al. (2022), in an ecological study of 171 countries, found that laws penalising suicide were associated with higher, not lower, national suicide rates, with the association particularly pronounced among women in low Human Development Index (HDI), non-Muslim countries.

- *Decriminalisation does not increase suicide*

The central empirical concern about decriminalisation, that removing a legal deterrent will increase suicide rates, has been examined extensively and has not been borne out by the evidence. The WHO global report (2014) concluded that no data or case reports indicate that decriminalisation increases suicides, and that suicide rates tend to decline in countries after decriminalisation. Studies examining Ireland (Osman et al., 2017), Sri Lanka (Knipe et al., 2014), Canada (Lester, 1992), New Zealand (Lester, 1993) and Sweden (Lindelius, 1979) consistently found no increase in suicide rates following legal reform. In Ireland, deaths classified as of undetermined cause fell significantly

after decriminalisation, consistent with improved reporting accuracy rather than a genuine change in suicidal behaviour.

Detailed case studies for Singapore, Pakistan, Ghana, Malaysia, India and Guyana are available in the WHO Policy Brief (2023) and United for Global Mental Health (2021, 2024).

- *Interpreting the data*

When suicide attempts are criminalised, there are no means for systematically reporting them. Individuals conceal attempts, families misattribute deaths, and clinicians may classify suicides as accidental to protect families from legal consequences. A short-term increase in recorded suicide rates following decriminalisation may therefore reflect improved data quality rather than a genuine increase in suicidal behaviour, and should not be interpreted as evidence of harm from policy change (Mishara & Weisstub, 2016; WHO, 2014).

The harms of criminalisation: public health and human rights

How criminalisation undermines prevention

Criminalisation harms individuals, families, and public health systems through several interconnected mechanisms. The fear of arrest, prosecution, and imprisonment, or of social shame and stigmatisation, causes individuals in suicidal crisis to conceal their distress, avoid emergency services, and decline to seek mental health care. Families and carers may withhold care for the same reason. As Mishara and Weisstub (2016) concluded, the shaming impact of laws criminalising suicide attempts does not have favourable outcomes and may inhibit help-seeking and use of suicide prevention and mental health services.

Criminalisation produces systematic underreporting of suicidal behaviour and suicide deaths through concealment by individuals and families, misclassification by medico-legal staff, and law enforcement discretion not to charge survivors. As Vijayakumar and Phillips (2016) observed, suicide remains criminalised in many developing countries, and this is a major hindrance to collecting data and planning appropriate interventions. Without accurate data, it is not possible to identify who is at risk, monitor trends, or evaluate the effectiveness of interventions.

Where criminal sanctions are enforced, imprisonment exposes already vulnerable individuals to harsh conditions, limited mental health care, and elevated suicide risk. The WHO Policy Brief (2023) noted that the threat of legal sanction and actual imprisonment can exacerbate suicide risk, leaving those incarcerated even more vulnerable.

Beyond the individual, criminalisation constrains governments from taking positive action: developing a national suicide prevention strategy may be considered legally incompatible with a framework that treats suicidal behaviour as a crime (WHO, 2023). The harmful effects of criminalisation extend beyond formal prosecution to police conduct, institutional practice, and the dynamics of help-seeking, as demonstrated in Pakistan and Malaysia (Lew et al., 2024).

These harms fall disproportionately on those already facing discrimination and social exclusion, including LGBTQI+ individuals, indigenous peoples, refugees and migrants, prisoners, and people with mental health conditions (WHO, 2023; United for Global Mental Health, 2024).

Lived experience

The accounts of people who have survived a suicide attempt in a criminalising jurisdiction are consistent. Fears of arrest, of exposure and of a criminal record affect whether an ambulance is called, whether an injury is described honestly to a clinician, whether a family conceals what has happened, and whether a person returns for follow-up care. Testimony gathered through reform campaigns in, for example, Ghana and Kenya and elsewhere in The Commonwealth describe police attendance at hospital bedsides, detention while unwell, and lasting social consequences.

Criminalisation restricts instances where lived experience perspectives can be heard and included in any health or policy responses. People at risk of prosecution cannot speak safely. Lived experience evidence from criminalising jurisdictions is therefore limited in volume, and that limitation is a consequence of the law and not an indication that harm is absent. Lived experience evidence should be sought actively through anonymised and ethically governed ways.

International human rights obligations and the ethical case

The criminalisation of attempted suicide is incompatible with a range of international human rights obligations. The World Health Organization identifies criminalisation as a barrier to suicide prevention in Preventing suicide: a global imperative (2014) and in LIVE LIFE (2021), which includes decriminalisation among the foundational actions states should take. WHO's 2023 policy brief sets out the position in fuller terms: criminal sanctions deter help-seeking, distort national mortality data, and limit the capacity of governments to design and deliver prevention strategies. The brief also notes that criminalisation denies people fundamental human rights, including freedom from discrimination and the right to access health, social, and other services.

The UN Special Rapporteur on the right to health and the Special Rapporteur on torture have both found the criminalisation of attempted suicide inconsistent with the right to the highest attainable standard of health and, as applied to people in acute distress, with the prohibition on cruel, inhuman and degrading treatment.

The UN Convention on the Rights of Persons with Disabilities (CRPD) requires that persons with psychosocial disabilities access services free from coercion, fear of punishment, and discrimination – incompatible with criminal sanctions for suicidal behaviour. The right to the highest attainable standard of health (ICESCR, Article 12) requires states to remove obstacles to health care access; criminal sanctions that deter help-seeking directly undermine this right. The prohibition on cruel, inhuman, or degrading treatment (CAT; ICCPR) is engaged by the imprisonment of individuals in acute psychological distress following a suicide attempt.

At the level of global policy commitments, the UN SDGs include a target to reduce suicide mortality by one-third by 2030 (SDG 3.4.2), and the WHO Comprehensive Mental Health Action Plan 2013-2030 identifies decriminalisation as a critical step towards this target. By endorsing these frameworks, states have made binding political commitments to reduce suicide; commitments that are undermined by the continued criminalisation of those who attempt it.

The ethical case for decriminalisation rests on principles of autonomy, dignity, justice, and compassion. Punishing an individual in severe psychological distress for an act that reflects their suffering rather than their culpability is inconsistent with contemporary standards of justice and with the duty of care that society owes to its most vulnerable members. As Mishara and Weisstub (2016) noted, countries with liberal values have successfully decriminalised suicide by promoting the understanding that suicide attempters have not intentionally gone against dominant religious precepts and cultural values.

These positions have been upheld in national courts and legislatures. States that have decriminalised have done so on their own constitutional and ethical reasoning. The Law Commission of India (2008) concluded that it would not be just and fair to inflict additional legal punishment on a person who has already suffered agony and ignominy in failing to die by suicide. Section 115 of the India Mental Healthcare Act 2017 gave effect to this in law, establishing a presumption of severe stress and directing the state towards care rather than prosecution.

Singapore's Parliament repealed section 309 of its Penal Code in 2019, accepting that criminal sanction was an obstacle to help-seeking and that the state's role was one of intervention and support. The High Court of Ghana held the equivalent provision unconstitutional in 2023 as an affront to human dignity. Pakistan's Criminal Law (Amendment) Act 2022 followed similar reasoning, on the initiative of Parliament and with the support of the Pakistani clinical community.

Courts and legislatures in common law, civil law and mixed jurisdictions have reached the same conclusion: punishing a person for surviving a suicide attempt is inconsistent with human dignity and does not serve the state's interest in preventing suicide.

In addition, IASP adopted a formal position in support of decriminalisation in May 2020. That position is shared by the World Psychiatric Association, United for Global Mental Health and Lifeline International, whose Decriminalise Suicide Worldwide campaign has supported reform across the Commonwealth, and by national professional bodies, including the Pakistan Psychiatric Society.

Recent reforms: country experiences

Since 2020, six countries have decriminalised attempted suicide: Singapore (2020), Pakistan (2022), Guyana (2022), Ghana (2023), Malaysia (2023), and India abolished IPC 309 through the Bharatiya Nyaya Sanhita (2024). In Kenya, criminalisation was deemed unconstitutional by the High Court in 2025, with statutory repeal pending. In Pakistan, the reform has since been challenged through judicial proceedings. These cases collectively demonstrate that decriminalisation is achievable across diverse legal, cultural, and religious contexts and that the process of reform requires sustained coalition-building. Detailed country case studies, including legal reform pathways and implementation considerations, are available in the WHO Policy Brief (2023) and United for Global Mental Health (2021, 2024); a summary of key lessons is provided here.

Singapore (2020) decriminalised suicide through the Criminal Law Reform Act 2019. Following reform, police reoriented from enforcement to crisis support, and a 45% decline in suicide deaths was reported in the nine months after the change took effect. Singapore's model of retaining sanctions for those who abet or encourage another's suicide while treating those in crisis with compassion has been widely cited as a template for reform (WHO, 2023).

Guyana (2022) took a different route from the other reforming states. Rather than repealing a criminal provision in isolation, Guyana enacted the Suicide Prevention Act in November 2022, which decriminalised attempted suicide as part of a wider prevention framework. The Act repealed the relevant provisions of the Criminal Law (Offences) Act and established a National Suicide Prevention Commission, bringing together the Chief Medical Officer, Chief Psychiatrist, the Director of the Mental Health Unit, the Director of the Child Care and Protection Agency and the Chief Education Officer. Guyana has long recorded among the highest suicide rates in the world, and the reform was explicitly designed as a public health response rather than a purely legal correction. It was intended by the Ministry of Health to serve as a model law for the Caribbean, and it offers a direct illustration of the principle that legal reform is most effective when embedded in prevention infrastructure from the outset.

Pakistan (2022–2026) repealed Section 325 of the Pakistan Penal Code through the Criminal Laws (Amendment) Act 2022, following a sustained multi-stakeholder campaign involving faith leaders, mental health professionals, parliamentarians, and civil society.

As an Islamic Republic with a predominantly Muslim population, Pakistan's decriminalisation was regarded as a significant precedent for other Muslim-majority countries. However, in May 2026, the Federal Shariat Court issued a judgment reinstating criminal penalties, finding the 2022 amendment 'repugnant to the injunctions of Islam'. The judgment has been appealed before the Shariat Appellate Bench of the Supreme Court, and those proceedings are ongoing at the time of writing. Pakistan's experience illustrates both the importance of decriminalisation and the need, in jurisdictions where courts can review legislation for compatibility with religious law, to build broad, durable coalitions that include religious scholars and legal experts, and to embed reform within a comprehensive public health framework.

Ghana (2023) repealed Section 57(2) of the Criminal and Other Offences Act 1960 in June 2023. Malaysia (2023) unanimously removed Section 309 of the Penal Code in May 2023, simultaneously enacting a Mental Health Amendment Bill authorising crisis intervention officers to take individuals into care rather than custody. India formally completed decriminalisation through the Bharatiya Nyaya Sanhita (2024), building on the practical reform introduced by the Mental Healthcare Act 2017. India's experience is instructive: national suicide mortality did not increase after the 2017 reform, but less developed states saw higher rates attributed to inadequate accompanying investment in mental health services, highlighting how legal reform must be embedded in broader prevention infrastructure (Cambridge Prisms: Global Mental Health, 2024).

Kenya (2025) illustrates a distinct route to reform. Rather than legislative repeal, decriminalisation was achieved through constitutional litigation: in January 2025, the High Court held that Section 226 of the Penal Code, which made attempted suicide a misdemeanour punishable by up to two years' imprisonment, was incompatible with the constitutional guarantees of equality and freedom from discrimination, human dignity, and the right to health. The Court found that criminalising a mental health issue amounts to discrimination on the basis of health. The petition was coordinated by the Kenya National Commission on Human Rights together with the Kenya Psychiatric Association and the Brain and Mind Institute at Aga Khan University, demonstrating the effectiveness of coalitions linking national human rights institutions, professional bodies and academic partners.

Kenya's experience also shows that a favourable judgment is not the end of the process. Section 226 remains on the statute book pending the Penal Code (Amendment) Bill, and until it is repealed, the provision stays visible to police and health staff, with the risk of continued enforcement in practice. Judicial and legislative decriminalisation are complementary rather than alternative routes.

The distinct question of aiding, abetting, or encouraging suicide

The case for decriminalisation, set out above, concerns those who attempt to end their own lives. It does not extend to those who assist or encourage another person to do so. This distinction is frequently raised in legislative debate, and reform jurisdictions have generally addressed it by separating the two provisions rather than repealing both together. IASP's policy position explicitly excludes advocacy for the removal of criminal sanctions against aiding, abetting, or encouraging suicide. Mishara and Weisstub (2016) reported that 142 out of 192 countries have laws stipulating punishments for assisting or encouraging a suicide and contended that regardless of commitments to a specific set of values, there is a broad consensus that aiding and abetting suicide is morally unacceptable and should bring legal sanctions. Reform jurisdictions have retained such penalties, with the exception of Guyana; Singapore's revised Penal Code, for example, retains Section 306, which provides for up to 10 years' imprisonment for those who abet another's suicide.

The broader debate about medically assisted dying and euthanasia involves different considerations of autonomy and dignity and lies outside the scope of IASP's advocacy on decriminalisation. IASP's position should not be read as endorsing or opposing assisted dying in any form. IASP hold a separate policy position on medically assisted dying and euthanasia.

Implementation and effective reform

The evidence reviewed above demonstrates that decriminalisation is necessary but not sufficient. Its impact on suicide mortality depends on concurrent investment in mental health systems, data infrastructure, and public engagement. The following elements have been identified as essential complements to legal reform:

- A national suicide prevention strategy and action plan, developed in consultation with people with lived experience, mental health professionals, law enforcement, civil society, and faith leaders (WHO, 2014).
- A comprehensive surveillance system to monitor trends in suicidal behaviour and track the impact of reform over time (WHO, 2016).
- Education and training for law enforcement, healthcare providers, and emergency responders to reorient their role from enforcement to crisis support and referral.
- Investment in accessible, rights-oriented mental health and psychosocial services, including crisis support lines (LifeLine International, 2023).
- Public awareness and stigma reduction measures, recognising that legal reform and stigma reduction are mutually reinforcing.
- Engagement with religious, traditional, and community leaders in contexts where religious doctrine intersects with civil law.
- Meaningful participation of people with lived experience of suicidal crisis in the design and evaluation of decriminalisation measures and associated services.

It is also worth noting that sustaining these efforts beyond the moment of reform is what allows the benefits of decriminalisation to be fully realised. Decriminalisation is best understood as the beginning of a longer process rather than an endpoint, and continued investment in awareness, stigma reduction, and service implementation is what translates legal change into lasting improvements in prevention and care. Maintaining advocacy, funding, and political commitment over the long term ensures that the gains achieved through reform are consolidated and built upon.

The role of research and data: gaps and priorities

Why research matters for decriminalisation

Research and data are central to the case for decriminalisation. First, they provide the empirical foundation for advocacy: robust evidence that criminalisation harms individuals and systems, and that decriminalisation does not increase suicide rates, is essential for persuading legislators, governments, and publics, particularly where cultural, religious, or historical resistance to reform is significant. Second, research and data are themselves among the key benefits of decriminalisation: accurate surveillance of suicidal behaviour is only possible where individuals feel safe to seek care and where clinicians and officials have no incentive to misclassify deaths. Data informs the case for reform, and reform enables better data, in turn driving better prevention. Strengthening the evidence base is therefore both a precondition for achieving decriminalisation and a measure of its success.

Research gaps & opportunities

Data from low- and middle-income countries (LMICs) remains scarce. Over 73% of suicides occur in LMICs, yet the majority of evidence on decriminalisation outcomes comes from high-income countries or a small number of middle-income reformers. Generating robust data from LMIC contexts is essential for the relevance and credibility of the evidence base.

Qualitative evidence from lived experience is also limited, as highlighted above in this paper, and must be a priority for the research community.

Longitudinal evaluation of post-reform outcomes would provide opportunities for learning for other countries. Most existing evidence is cross-sectional, or based on limited pre-post comparisons. Robust longitudinal evaluations of recent reforms in Singapore, Ghana, Malaysia, Guyana, and India are needed to establish the scale and duration of any beneficial effects on suicide mortality, help-seeking, data quality, and service utilisation. In countries where reform has been contested or reversed, evaluations of the period following decriminalisation may also provide evidence of the harms that recriminalisation risks reinstating.

Equally, economic analysis quantifying the costs of criminalisation, including policing, prosecution, and imprisonment of survivors, compared with the costs and benefits of redirecting those resources into prevention and care would provide a further dimension to the advocacy case, but has not yet been undertaken.

A related gap concerns enforcement practices rather than legal status. Many countries with anti-suicide laws rarely prosecute, yet the law's deterrent and stigmatising effects operate through the threat of potential prosecution rather than through enforcement alone. Evidence on how the mere existence of a criminalising law affects help-seeking and data quality is needed to counter the frequently advanced argument that such laws are harmless because unenforced.

More broadly, intersectional impacts of criminalisation, including its differential effect by gender, sexual orientation, ethnicity, migration status, and socioeconomic position, are poorly understood. Wu et al. (2022) found the association between criminalisation and higher suicide rates particularly pronounced among women in low-HDI, non-Muslim countries; the mechanisms underlying this finding, and whether similar patterns apply to other marginalised groups, need further research attention.

Implementation science is needed to understand how legal reform translates into better outcomes: what forms of accompanying investment are most effective, at what scale, and in what sequencing. The India experience makes clear that decriminalisation without mental health infrastructure delivers uneven results. Research on training models for first responders, post-attempt care protocols, crisis line models, and community-based services, particularly in LMIC contexts where resources are constrained, would strengthen both prevention practice and future advocacy.

Finally, the relationship between criminalisation and the use of more lethal methods warrants investigation. Lew et al. (2022) raised the concern that individuals determined to die who are aware that survival may result in arrest and prosecution may seek more lethal means. This hypothesis has not yet been directly and systematically tested, and its implications for both public health and the deterrence argument are significant.

The role of data in sustaining reform

Research and data matter not only for achieving decriminalisation but for sustaining it. Decriminalisation opens up the possibility of establishing national monitoring and surveillance systems to inform post-reform policies. Post-reform monitoring of suicide rates, help-seeking behaviour, service utilisation, and public attitudes can demonstrate whether reform is delivering its anticipated benefits, identify where additional investment is needed, and generate evidence to support advocacy in countries that have not yet reformed. Where reform is contested or challenged, a strong post-reform evidence base is a critical tool for demonstrating its public health value. IASP encourages its members and partners to conduct and publish evaluations of decriminalisation in jurisdictions where it has recently been achieved, and to share that evidence through IASP's networks and publications.

Conclusion

The legal, normative, and empirical case for decriminalisation of attempted suicide has strengthened substantially since IASP adopted its Policy Position Statement in 2020. The evidence reviewed in this document supports five conclusions.

1. There is no credible empirical evidence that the criminalisation of attempted suicide deters suicidal behaviour. Research suggests criminalisation is associated with higher national suicide rates, particularly for women in low-income settings (Wu et al., 2022).
2. Criminalisation actively harms individuals, families, and public health systems through deterrence of help-seeking, systematic underreporting, perpetuation of stigma, adverse mental health consequences of incarceration, and constraints on government action to prevent suicide.
3. Decriminalisation is consistent with public health evidence, human rights obligations, and the international commitments that states have made to reduce suicide mortality. The WHO, the UN SDGs, and the WHO Global Mental Health Action Plan 2013—2030 all identify it as a critical step in suicide prevention.
4. Legal reform is necessary but not sufficient. Its impact depends on concurrent investment in mental health services, surveillance, training, and stigma reduction. The experience of Guyana and India demonstrates the importance of this complementarity; the experience of Pakistan demonstrates that reform must also be actively protected through broad coalition-building and sustained public health advocacy.
5. Important research gaps remain. Longitudinal evaluation of reform outcomes, qualitative evidence from lived experience, intersectional analyses, and implementation science research are priorities. Strengthening the evidence base is both a precondition for decriminalisation and a measure of its success.

The evidence reviewed here strengthens the basis for IASP's policy position. Since 2020, the empirical case has broadened: studies have included more countries, and the experience of six national reforms provides direct evidence. The human rights framing has been substantially reinforced, with the WHO Policy Brief, the UN Special Rapporteurs and wider bodies now addressing criminalisation explicitly. And finally, national experience has clarified what decriminalisation requires in practice, and that its benefits depend on accompanying investment in prevention strategy and infrastructure. IASP remains committed to advocating for decriminalisation globally, supporting its members and partners in national reform efforts, and contributing to the evidence base that informs compassionate and effective responses to suicidal behaviour worldwide.

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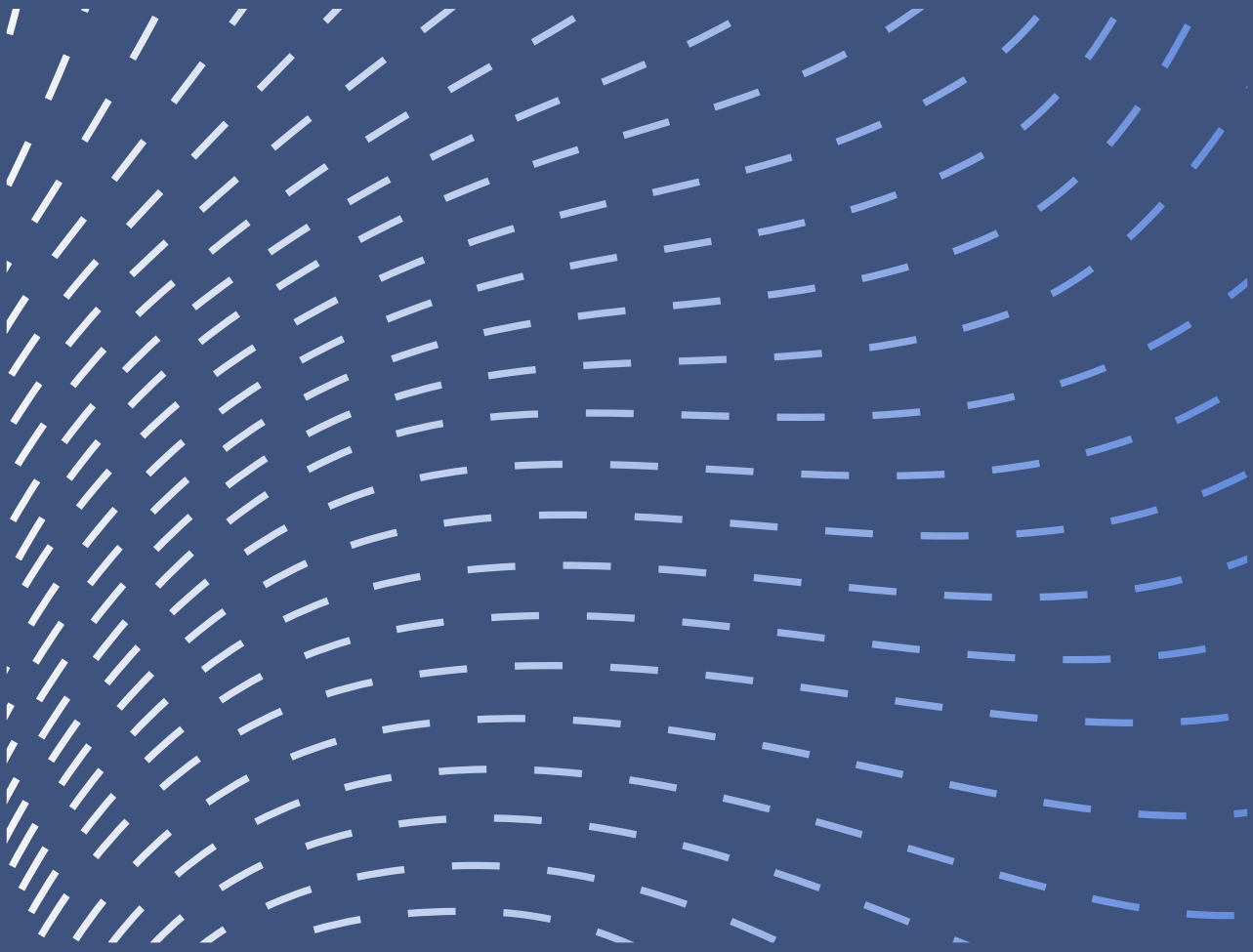

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