INTERNATIONAL JOURNAL OF HUMAN RIGHTS LAW REVIEW
An International Open Access Double Blind Peer Reviewed, Referred Journal

Volume 4 | Issue 5 | 2025 Art. 12

Suicide, Law and Dignity: A Comparative Human Rights Study on the Law's Evolving view of Suicide

Rudrali Deshpande
Law Student,
2nd Year, BA.LL.B., New Law College, Pune

Recommended Citation
Rudrali Deshpande, *Suicide, Law and Dignity: A Comparative Human Rights Study on the Law's Evolving view of Suicide*, 4 IJHRLR 185-208 (2025).
Available at www.humanrightlawreview.in/archives/.

Suicide, Law and Dignity: A Comparative Human Rights Study on the Law's Evolving view of Suicide

Rudrali Deshpande
Law Student,
2nd Year, BA.LL.B., New Law College, Pune

Manuscript Received	Manuscript Accepted	Manuscript Published
20 Oct. 2025	22 Oct. 2025	24 Oct. 2025

ABSTRACT

Suicide is a global public health problem that also raises complex legal issues. The World Health Organization (WHO) estimates that more than 700,000 people die globally from suicide each year, which is roughly one in every 100 deaths . However, notwithstanding its prevalence, legal responses to suicide have oscillated between punishment and compassion over time. While most countries have decriminalized suicide attempts, around 23 countries still criminalize suicide, the majority in South Asia, Africa, and the Middle East .

This research examines the legal progression of suicide from a crime based on religious morality to a human rights and mental health issue, and with a focus on national comparison, including decriminalization in India with the Bharatiya Nyaya Sanhita 2023, the UK's Suicide Act 1961, US state level Death with Dignity statutes, and South Korea's prevention model. Ultimately, this paper argues that criminalization does not deter suicide and interferes with prevention, and suggests a human-rights based, mental health oriented legal framework instead.

***Methodology**: This study employs a comparative and qualitative doctrinal approach using statutory texts, judicial decisions, and international instruments as primary data, and WHO and UN reports as secondary sources. Thematic content analysis identifies global trends in decriminalization, public health reform, and human-rights integration.*

KEYWORDS

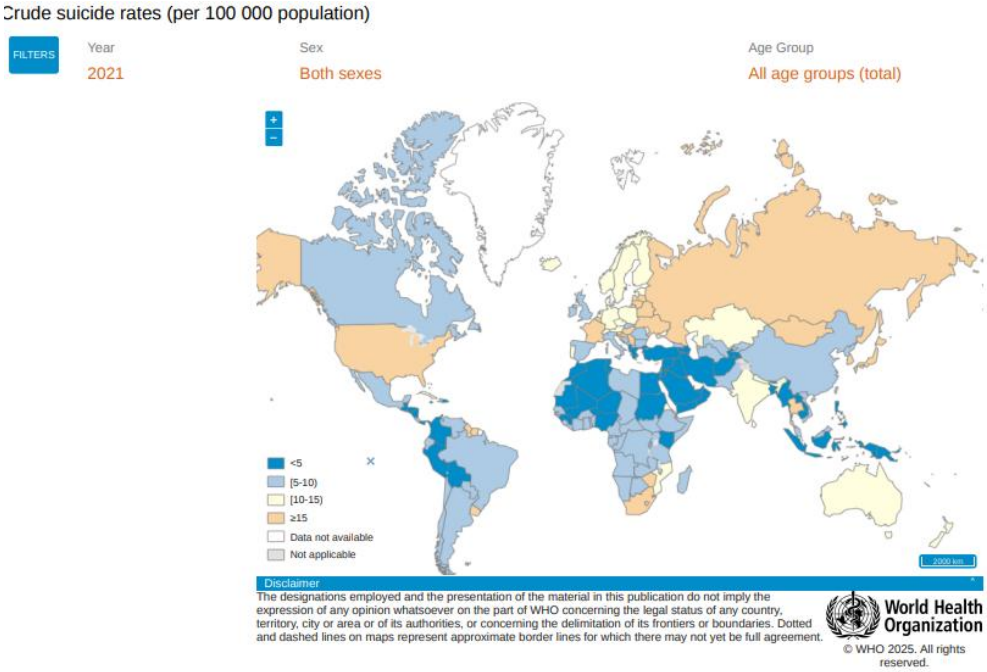
Suicide, Decriminalization, Human Rights, Mental Health, Global Epidemiology, Assisted Dying,

Comparative Law.

I. INTRODUCTION

For quite some time, suicide has been discussed in relation to morality, legality, and medicine. Today, it is seen not only as a social and health issue that warrants empathy and prevention, but not a crime. WHO data reveal that 73% of suicide takes place in low- and middle-income countries, with the most impacted demographic being those between the ages of 15-29[1] The UN and WHO both advocate for it to be decriminalized because it is very important to reducing stigma and ensuring access to mental health services.

Historically, law condemned suicide to punishment. In English common law, the offence was termed felo de se, which means a person is "a felon of himself." This included denial of a Christian burial and the forfeiture of the estate. Eventually, this moral perspective has changed to one of care and prevention. Current legal consensus acknowledges that penal sanctions do not deter suicide and do not align with the notions of human dignity and the protection of mental health.



II. HISTORICAL CONTEXT AND LEGAL EVOLUTION

[1] World Health Org. E. Mediterranean Region, *World Suicide Prevention Day 2025* (Sept. 10, 2025), https://www.emro.who.int/media/news/world-suicide-prevention-day-2025.html (last visited Oct. 10, 2025).

A. ORIGINS: RELIGIOUS DOCTRINE AND MORAL CONDEMNATION

The first legal and moral interpretation of suicide was developed out of religious cosmologies that viewed life as divinely owned. In Christian theology, life was seen as a sacred trust from God, and an act of self-destruction was treated as a defiance of God's authority. Both Saint Augustine and Thomas Aquinas denounced suicide as a mortal sin, arguing that it contravened both natural law and divine law. Aquinas wrote in the Summa Theologica that suicide "offends God, injures society, and puts an end to any chance of repentance."[2]

These theological foundations gave shape to European legal codes. Canon law in the medieval period-imposed bans on burial in consecrated ground to suicides, and in England, common law codified what had been a theological belief into punishment in a secular context. The estate of the deceased person would be forfeited to the Crown according to the doctrine of felo de se, which means the felon of himself, a legal concept that arose in the Year Books by the 13th century and was fully enforced under the Tudor monarchs.[3] The burial of the individual at crossroads with a stake through the body was designed to "pin" the soul, as punitive illustrations that showed the conflation of law and superstition.

In the 18th century, reformers of Enlightenment thought began to raise significant challenges to religious prohibitions on taking one's own life. Among some of the earliest, David Hume published his essay Of Suicide in 1757, where he contended that suicide was not an offense to God or society, but rather a rational choice when the circumstances of life became intolerable[4]. Hume's essay was never disseminated without censorship or financial fallout for the author, but Hume framed suicide in a rational way and introduced notions of autonomy and rational agency into Western considerations of suicide that eventually factored into modern forms of decriminalization.

B. THE COMMON LAW TRANSITION: FROM SIN TO OFFENSE

During the early modern era, the crime of suicide was still perceived as a felony under English law, but by the late 18th-

[2]Vincent Prigent et al., *Endothelial Colony-Forming Cells Dysfunctions Are Associated with Long-Lasting Adverse Effects of Intrauterine Growth Restriction on the Vascular System in Growing Male Rats*, 22 INT'L J. MOLECULAR SCIS. 10159 (2021).

[3] THOMAS AQUINAS, *SUMMA THEOLOGICA*, II–II, Q. 64, Art. 5 (Fathers of the English Dominican Province trans., Christian Classics 1981) (1265).

[4] 4 WILLIAM BLACKSTONE, *COMMENTARIES ON THE LAWS OF ENGLAND* 176–80 (1765).

century, that perception began to change, in a way that the courts would declare a verdict of non compos mentis, which means not of sound mind, to simplify recovery of family property. It was not uncommon for coroners and other jurors to provide a finding of mental incapacity to avoid serious or harsh outcomes, which represented a movement away from suicide as a moral event and instead represented an early recognition of suicide occurring as a medical event.

In any case, the change towards formal abolition was slow. It wasn't until 1961, through the Suicide Act, that the criminal status of suicide was abolished in England and Wales, where the law explicitly stated that "the rule of law whereby it is a crime for a person to commit suicide is abrogated." The passage of the statute represented the end of a long philosophical and legal journey over two centuries, changing from divine morality to secular compassion.

The Suicide Act 1961 also contained Section 2, which made it an offence to "aid, abet, counsel or procure" the act of suicide, which allowed for the state to still demonstrate an interest in preventing coercion or abuse, while allowing for self-determination to happen in the public domain. The next problem was distinguishing between self-determination and third-party facilitation of the act being the difference between those making the decision and those supporting.

C. COLONIAL TRANSPLANTATION OF CRIMINAL NORMS

British colonialism exported the felo de se principle across the empire. Colonial rule knew that the punishment for self-destruction was a central part of English penal logic, and colonial administrators integrated that logic into statutory codes aimed at imposing "moral discipline." Section 309 of the Indian Penal Code of 1860, the draft of Lord Macaulay, codified the suicide attempt as an offense punishable by up to one year imprisonment.[5]The application of section 309 of the Indian Penal Code of 1860 was largely unchanged for over 100 years and treated someone who was the survivor of a suicide attempt as a criminal, not a patient.

Section 309 was simply recreated in the penal codes of other colonies as well, including Malaysia and Singapore, Pakistan, Kenya, and Nigeria. All countries reflected paternalism and Victorian moralism in their inclusion of section 309 into their Penal Code[6]. The justifications for section 309 were based on deterrence of suicide and public order rather than. In the case of

[5] Indian Penal Code, No. 45 of 1860, § 309 (India) (repealed 2023).
[6] *Criminal Code Act, (Cap. C38) § 327 (Laws of the Fed'n of Nig. 2004).*

section 309, colonial courts and rulers often treated the act of suicide as evidence of "weak character" or "moral insanity," in keeping also with pre-existing psychiatric prejudices of the 19th century[7].

After independence, the penal statutes of the Commonwealth reflected the same, and many of the countries kept those same criminal laws against suicide, extending the criminalization of suicide into the 21st century. The continuation of those laws indicates how criminal laws in a colonial empire outlasted the empire itself.

D. POST-COLONIAL REFORM AND JURISPRUDENTIAL REALIGNMENT

The alignment between medicine, law, and rights gradually developed in the mid-20th century. With the establishment of the World Health Organization in 1948, as well as the Universal Declaration of Human Rights in that same year, the international conversation began to shift suicide from an expression of deviance to a public health issue connected to dignity. In India, Section 309 fell under constitutional challenge after constitutional challenge. The Delhi High Court (1985) was the first court to question the validity of Section 309, leading to the Supreme Court's ruling in P. Rathinam v. Union of India (1994), when the Court struck down the provision out of concern for Article 21, which protects the right to life, incorporating the right to die with dignity. However, that decision was reversed in Gian Kaur v. State of Punjab[8] (1996), when the Court held that Article 21 protected life, but did not protect its termination, even as the Court accepted suicide as an indicator of mental distress, rather than moral guilt.

This evolution in the common law made way for legislative reform. The Mental Healthcare Act 2017 kept in mind the assumption of "severe stress" in all suicide attempts, effectively decriminalizing the act of suicide, assigning care to the state. The subsequent Bharatiya Nyaya Sanhita 2023[9] repealed the penal provision altogether, formally signalling India's departure from a punitive colonial morality and toward a compassionate constitutionalism.

This legal advancement led to legislative reform. The Mental Healthcare Act 2017 provided for all suicide attempts to be presumed the result of "severe stress," thereby decriminalizing the act by shifting the accountability to the state for care. The

[7] *DAVID ARNOLD, COLONIZING THE BODY: STATE MEDICINE AND EPIDEMIC DISEASE IN NINETEENTH-CENTURY INDIA (Univ. of Cal. Press 1993).*
[8] *Gian Kaur v. State of Punjab*, A.I.R. 1996 S.C. 946 (India).
[9] *The Bharatiya Nyaya Sanhita*, 2023, No. 45, Acts of Parliament, 2023 (India).

Bharatiya Nyaya Sanhita, 2023 then removed the penal provision entirely, marking India's shift away from colonial punishment morality, to a more sympathetic constitutionalism[10].

Similar changes occurred in Canada (1972 repeal), New Zealand (1961), and Ireland (1993). Each legalization was developed from a changing idea of the individual as being more than a moral wrong-doer, but rather as a rights-bearing individual which the state owed care and a right to health care.

E. ANALYTICAL CONCLUSION

The discourse on suicide law signals more than mere changes in criminal law; it signals a change in human understanding about life, autonomy and moral responsibility. An act that started as something officially condemned by religion is, through social reform and centuries of philosophical commentary, now embraced by secular compassion. Each step of the way, starting with felo de se, then Section 309, and now, decriminalization shows a willingness to accommodate between the person's liberty and the social conscience. As such, the global movement toward decriminalization of suicide should be viewed as not merely a modernization of the law, but as a maturation of morality: that despair should be treated with compassion, and never punished.

III. GLOBAL EPIDEMIOLOGY AND DETERMINANTS

Suicide is still considered a public health emergency around the world, both for its legal and social consequences. The World Health Organization's Global Health Estimates (2021) state that approximately 727,000 people die from suicide every year, or about 1 person every 40 seconds[11]. Suicide accounted for 1.3% of all deaths globally, which is more than those caused by malaria, homicide, or war[12].

While suicide is a universal phenomenon, its distribution and determinants are extremely unequal. More than 73% of suicides take place in low- and middle-income countries (LMICs), which have the weakest mental health resources, data systems, and legal protections. The global age-standardized suicide rate is 9 per 100,000, with considerable variation regionally:

i. Africa: 11.2 per 100,000

[10] *The Mental Healthcare Act, 2017, No. 10, Acts of Parliament, 2017 (India).*
[11] WORLD HEALTH ORG., *Suicide Worldwide in 2021: Global Health Estimates* (2021).
[12] WORLD HEALTH ORG., *Global Health Observatory Data Repository—Suicide Mortality Rates* (last updated 2021), https://www.who.int/data/gho (last visited Oct. 12, 2025).

ii. Europe: 10.5 per 100,000
iii. South-East Asia: 10.2 per 100,000
iv. Americas: 7.1 per 100,000
v. Eastern Mediterranean: 6.4 per 100,000
vi. Western Pacific: 6.2 per 100,000

A. DEMOGRAPHIC AND GENDER PATTERNS

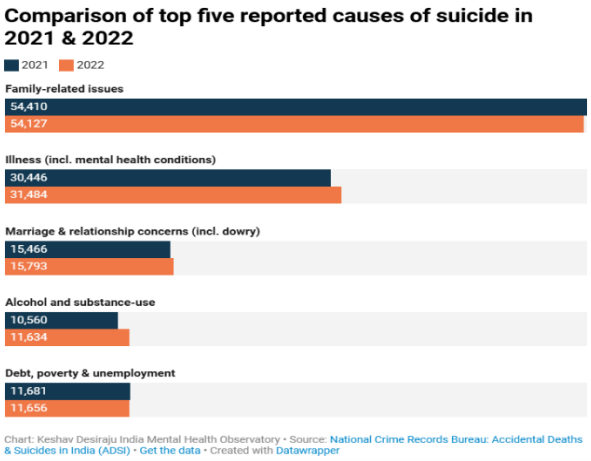
Globally, men account for nearly 75% of suicide deaths, while women attempt suicide more frequently[13]. In high-income nations, the male-female difference is larger, with boys committing suicide at rates two to four times higher than girls. In high-income countries, this is due to men's easier access to lethal means such as firearms and hanging, as well as women's likelihood to utilize mental health services when needed. Conversely, in some parts of Asia and North Africa, the gap is smaller and is likely due to stressors affecting both sexes, such as economic, social, and cultural factors.

Suicide is the fourth leading cause of death for young people aged 15 to 29 years, and it is the second leading cause among females aged 15 to 29 years on a global scale. In this age group, the numbers suggest a gap in early mental health interventions, or, perhaps more accurately, a gap in youth-oriented legal and policy measures to promote psychosocial wellbeing, mandating school counselling, workplace mental health codes, and juvenile health rights.

B. ECONOMIC AND SOCIAL CORRELATES

Financial strain is a recurring structural factor. Studies conducted by the WHO and the World Bank have reported a correlation between increasing suicide rates and unemployment, debt, and economic downturns[14]. In its report from the National Crime Records Bureau (2022), India's financial situation, family disputes, illness, and drug/alcohol misuse were the most common causes[15]. Similar trends have emerged in Europe post-recession, and in North America post-COVID-19. Recent spikes in suicide rates occurred after economic downturns.

[13] *CTR. FOR DISEASE CONTROL & PREVENTION, Suicide Data and Statistics (last visited Oct. 15, 2025),* https://www.cdc.gov/suicide/facts/data.html
[14] WORLD BANK, *Mental Health and Economic Inequality Report* 15 (2020).
[15] Tanya Fernandes, *Takeaways from the NCRB Data on Suicide for 2022: Insights from Six Charts*, CTR. FOR MENTAL HEALTH L. & POL'Y (Dec. 18, 2023), https://cmhlp.org/imho/blog/takeaways-from-the-ncrb-data-on-suicide-for-2022/ (last visited Oct. 13, 2025).



Social exclusion is also a contributing factor: individuals from vulnerable and marginalized groups, LGBTQ+, indigenous, refugees, and those who are incarcerated, have higher rates of suicide[16]. Inequality evidenced in differences in suicide rates is an intersection of law and discrimination, lack of protection from violence, and distinctions in access to mental health resources that expose these populations to higher rates of risk.

C. LEGAL DETERMINANTS: LAW AS A STRUCTURAL VARIABLE

The legal status of suicide has a direct effect on the accuracy of the information collected and on the performance of the methods used to prevent suicide. In countries where attempted suicide is criminalized (e.g., Nigeria, Pakistan, Bangladesh), persons may consider the suicidal behaviour to be an emergency for legal purposes and therefore the incident may be underreported or reported as an accident instead of a suicide, to prevent prosecution or stigma. WHO identifies this as a primary obstacle to surveillance, prevention, and intervention, stating that legal reform may enhance both reporting and interventions.

Legal statutes related to the accessibility of certain means of suicide - such as pesticides, guns, and prescription medications - act as a more insidious determinant of mortality. WHO, for instance, states that approximately 20% of all suicides globally result from pesticide poisoning, with this issue being more salient within agrarian economies. Thus, public health policy and environmental legislation operate in part as mechanisms of suicide prevention.

[16] Human Rights Council, *Decriminalizing Suicide Worldwide*, U.N. Doc. A/HRC/47/36 (June 28, 2021).

D. TEMPORAL TRENDS AND SDG ALIGNMENT

The suicide rate worldwide saw a decrease of about 36% from 2000 to 2021, from 12.5 to 9.0 per 100,000. That said, declines happened unevenly: the larger reductions took place in China and in certain European areas; while rates increased in the Americas and certain regions of Africa. These factors push many countries off target for Sustainable Development Goal (SDG) 3.4, which seeks to reduce premature mortality and, by association, suicide, by one-third by 2030[17].

The relationship between decriminalization and declines is contextual rather than causal: countries moving from punitive systems to public health systems tend to show better surveillance, better treatment access, and better community prevention systems[18].

IV. LEGAL FRAMEWORKS AND DECRIMINALIZATION TRENDS

A. GLOBAL LEGAL STATUS

The law on suicide resides at a volatile borderland between public health and criminal justice. Historically, suicidal self-destructive behaviours were criminal offences against the state, morality, or religion. In many jurisdictions, those rules (though often not enforced) have been repealed or abandoned, representing a shift from punishment to prevention in terms of humanitarian principles.

In its Policy Brief on Decriminalization of Suicide (2021), the World Health Organization reported that at least 23 countries continue to criminalize attempted suicide. Among those countries, the report lists Pakistan, Bangladesh, Ghana, Nigeria, Kenya, Malaysia, Myanmar, and jurisdictions in the Middle East influenced by a Sharia-style penal code. In any of those jurisdictions, a person who survives self-inflicted suicide may be imprisoned, fined, or incarcerated in a mental health facility.

Conversely, more than 100 countries have decriminalized suicide or legalized suicide attempts either via statutory enactments or via constitutional or parliamentary ruling. Many of these countries have retained separate criminal offences for abetment or assisting in suicide. This means, at a minimum,

[17] WORLD HEALTH ORG., *Progress Report on the Global Action Plan for Healthy Lives and Well-Being for All 2023* (2023).
[18] S. Kline & T. Sabri, *The Decriminalisation of Suicide: A Global Imperative*, 10 LANCET PSYCHIATRY 240, 240–42 (2023).

that while the death of a person as a result of self-inflicted suicide is no longer a crime, any encouragement or assisted suicide would still be subject to the criminal law principles of order of public policy and/or consent.

B. THEORETICAL FOUNDATIONS: AUTONOMY VS. STATE INTEREST

Contemporary legal thought on suicide hovers between two rival legal traditions:

i. Autonomy and Dignity: Based on the liberal tradition of human rights, this view holds that people are sovereign over their bodies, and have a right to make decisions about their lives. John Stuart Mill's On Liberty (1859) framed autonomy as "freedom of self-regarding conduct," although some modern thinkers have questioned whether suicide is truly a self-regarding act.
ii. State Interest in Preservation of Life: The state has a legitimate interest in the preservation of life, abuse prevention, and the protection of vulnerable persons, which provides a rationale for the continued existence of prohibitions against assisted suicide, even in liberal democracies.

The Gian Kaur v. State of Punjab (1996) decision in India established a middle ground between those two legal traditions, distinguishing between the "right to die" and the "right to die with dignity," and by extension, found that dignity could support passive euthanasia and therefore, could support active euthanasia.

C. DECRIMINALIZATION AS LEGAL REFORM

The United Kingdom pioneered modern reform with the Suicide Act 1961, which repealed the criminal offence of self-murder and stated that “the rule of law whereby it is a crime for a person to commit suicide is abrogated.” The Act also added Section 2 that criminalized the aiding, abetting, counselling, or procuring of another person’s suicide, in order to maintain a moral distinction between self-determination and assisted dying.

Following the British example, a number of Commonwealth countries (ex, Canada (1972); Australia (1990s); New Zealand (1961); Ireland (1993)) removed criminal liability. Each reform occurred alongside investment in public health and initiatives for the national suicide prevention strategy.

Two former colonies, India, Pakistan, and Nigeria, continued to rely on the Indian Penal Code (1860), specifically Section 309, which punished suicide attempt with up to one year imprisonment. The provision, which was originally justified as a deterrent to suicide, ultimately punished a person for a health issue and reduced overall reporting of suicidal behaviour.

The Mental Healthcare Act 2017 (India) dramatically redefined this construct, introducing in Section 115 that "any suicide attempt will be presumed to be in extreme stress," and therefore a person is not legally liable[19]. In effect, this further contributed to a medicalization of suicide, it is no longer a criminal act, it is a medical emergency, and represents the duty of care of the State. The Bharatiya Nyaya Sanhita, 2023, which replaces the IPC, finally repealed Section 309, completing the reorientation of legislation in India away from punishment for suicidal behaviours to a mental health focus.

D. JUDICIAL INTERPRETATION AND PROGRESSIVE JURISPRUDENCE

Courts across jurisdictions have advanced decriminalization through constitutional reasoning:

The development of the legal framework concerning end-of-life autonomy, has generated a global movement from a rigid adherence to the sanctity of life to an emerging recognition of personal choice and individual dignity. The trajectory in India began with the somewhat tumultuous appellate history regarding the decriminalization of attempted suicide, and then maintained pace with the conceptual separation made in Gian Kaur (1996) where both dignity and the right to die were accepted.

Most recently, in Common Cause v. Union of India (2018)[20], the legislative framework recognized passive euthanasia guidelines and an advance medical directive for a terminal patient to enhance autonomy, and was further updated in 2023. In 2002, the European Court of Human Rights, in Pretty v. United Kingdom[21], upheld the right to life while recognizing personal autonomy under the rubric of the right to private life, reflecting a more nuanced approach towards end-of-life choices than was taken in more absolutist legal jurisdictions.

[19] Mental Healthcare Act, No. 10 of 2017, § 115 (India).
[20] *Common Cause (A Reg'd Soc'y) v. Union of India, (2018) 5 S.C.C. 1 (India).*
[21] *Pretty v. United Kingdom, 35 Eur. H.R. Rep. 1 (Eur. Ct. H.R. 2002).*

Further demonstrating this divergence in jurisdiction, the Supreme Court of Canada undertook a stronger move in Carter v. Canada (2015)[22], where the court found physician-assisted dying lawful for competent adults who experience intolerable suffering, respecting patient autonomy and compassion for suffering. In the United Kingdom, courts were more cautious about decision-making in Nicklinson v. Ministry of Justice (2014)[23], ultimately considering it Parliament's role to consider matters of physician-assisted dying, while expressing additional opinion that Parliament should consider the topic in light of human rights implications. Taken together, these cases show a similar movement across jurisdictions: a movement from strict legal prohibition to a consideration of personal autonomy, dignity, and compassion weighed against society's interest in the preservation of life.

E. GLOBAL TREND ANALYSIS

The worldwide evolution of suicide law reflects three interconnected phases. The first phase, Criminalization (16–19th centuries), viewed suicide as a moral or religious crime. The felo de se used in England and Section 309[24] of the Indian Penal Code are case examples from this phase. In these situations, those who attempted or committed suicide were subject to some form of legal liability and social stigma, which reflected the mainstream view of suicide as a failure of fidelity to divine or social norms.

The second phase, Medicalization (from mid-20ths century) positioned suicide not as a crime but as a symptom of mental illness. The Suicide Act 1961 (UK)[25] is an example of this thinking. Medicalization recognized that many suicides and suicidal behaviours are initiated by some form of psychological distress or mental illness, and moved the focus of law, as it related to suicide, from punishing suicide and suicidal behaviour to treatment and prevention.

The third phase, Human Rights Reform (from late 20th–21st centuries), considers suicide as a public health and dignity issue. For example, India's Mental Healthcare Act 2017[26] and the questions raised in Carter v. Canada exemplifies a focus on protection, support, and respect for individual autonomy. As phase three develops further, it acknowledges the importance

[22] *Carter v. Canada (Att'y Gen.),* [2015] 1 S.C.R. 331 (Can.).
[23] *R (Nicklinson) v. Ministry of Justice,* [2014] UKSC 38 (appeal taken from Eng.).
[24] Indian Penal Code, No. 45 of 1860, § 309 (India) (repealed 2024).
[25] Suicide Act 1961, 9 & 10 Eliz. 2, c. 60 (U.K.).
[26] Mental Healthcare Act, No. 10 of 2017 (India).

of legal approaches to suicide aligned with human rights standards and public health goals.

F. ANALYTICAL REASONING

Reframing suicide away from a punitive toward a preventive approach reclassifies suicide away from a breach of law, toward an expression of suffering that is deserving of empathy and compassion. Decriminalization of suicide is a worthy first step, but is also insufficient. Legal change must accompany access to mental health services, social welfare protections, and stigma reduction.

The highest form of legal change will not be to simply take a legal penal clause away, but to put it into the context of self-preservation and dignity, from moral condemnation to structural and institutional empathy.

V. COMPARATIVE NATIONAL CASE STUDIES

A. INDIA: FROM COLONIAL CRIMINALITY TO MENTAL HEALTH REFORM

India's direction signifies the colonial legacy of criminalization and the slow transition toward a rights-based approach to mental health. Section 309 of the 1860 Indian Penal Code, enacted under British colonization, imposed criminal liability of simple imprisonment of up to one year for suicide attempts. The provision of attempted suicide within the IPC continued in effect long after the UK repealed the suicide statute in 1961, showing the persistence of colonial morality.

Challenges in the judiciary began in the 1980s. The Delhi High Court in State v. Sanjay Kumar Bhatia (1985) described Section 309 as "an anachronism unworthy of a humane society."[27]In P. Rathinam v. Union of India (1994), the Supreme Court held that the punishment for attempting suicide under Section 309 was unconstitutional under Article 21 (right to life) since the right to die is guaranteed under the broader right to personal liberty[28]. However, this legal status was returned to its previous discontinuity by Gian Kaur v. State of Punjab (1996) where the Supreme Court held life is protected under Article 21 only and "the right to die with dignity" may justify passive euthanasia.[29]

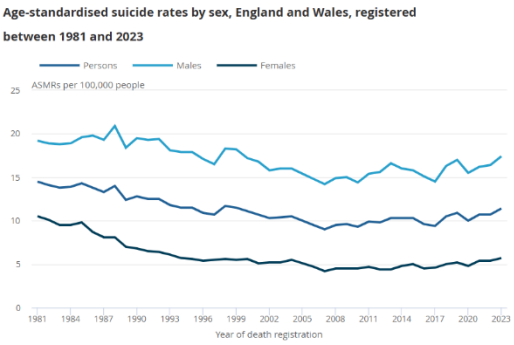
The legislative decriminalization began with the Mental

[27] *State v. Sanjay Kumar Bhatia,* 1985 Cri. L.J. 931 (Del. H.C.) (India).
[28] *P. P. Rathinam v. Union of India*, (1994) 3 S.C.C. 394 (India).
[29] *Gian Kaur v. State of Punjab*, (1996) 2 S.C.C. 648 (India).

Healthcare Act, 2017, under which Section 115 stipulates, "for all acts of attempt to die by suicide, the person shall be presumed to be in severe stress and shall receive care, not punishment."[30] This action, and the post-decriminalization statute of the Bharatiya Nyaya Sanhita, 2023 officially remove Section 309, and complete the decriminalization statute in India.

B. UNITED KINGDOM: THE HUMANITARIAN PIVOT

The Suicide Act 1961 (England and Wales) represents the modern beginning of decriminalization of suicide. It abolished criminal responsibility for the crime itself, but kept Section 2 in place, which makes assist suicide a crime punishable by up to 14 years in prison[31]. This was a compromise, reflecting a supposed balance between autonomy, the act of an individual, and protections by the state to mitigate against coercion or abuse.



Source: Suicides in England and Wales from the Office for National Statistics

Judicial developments also cemented the equilibrium. In Pretty v. United Kingdom (2002), the ECHR ruled Article 2 (European Convention on Human Rights) the right to life did not create a "right to die,"[32] but Article 8 (right to private life) recognized individual autonomy in making end-of-life decisions[33]. The Nicklinson case (2014) continued previous decisions to note that Parliament, not the courts, would create an assisted dying

[30] Mental Healthcare Act, No. 10 of 2017, § 115 (India).
[31] OFF. FOR NAT'L STAT., *Suicides in England and Wales: 2023 Registrations* (2024), https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2023 (last visited Oct. 14, 2025).
[32] Convention for the Protection of Human Rights and Fundamental Freedoms, art. 2, Nov. 4, 1950, 213 U.N.T.S. 221.
[33] Convention for the Protection of Human Rights and Fundamental Freedoms, art. 8, Nov. 4, 1950, 213 U.N.T.S. 221.

law, but recognized the need for reform.

The United Kingdom adds to its legislation a public health infrastructure, using national suicide prevention strategies (2012–2027), a National Suicide Prevention Alliance, and mandatory local action plans.[34] The national suicide rate is 10.5 per 100,000, with men between the ages of 45–54 at the highest risk. Thus, the law positions suicide prevention in a human-rights framework across sectors, not in the criminal law framework, but of the public health accountability.

C. UNITED STATES: FEDERAL SILENCE, STATE EXPERIMENTATION

Suicide is neither criminalized nor decriminalized by federal law in the United States; states are in charge of reconciling the legality of suicide. While most states previously adopted the common law position of England that recognized suicide as a felony, this had all but fallen away by the early twentieth century in favour of civil codes on mental health and assisted dying[35].

In terms of current U.S. law, a distinction exists between suicide, assisted suicide, and physician-assisted death. The first law authorizing medical aid in dying (MAiD) in the United States was Oregon's Death with Dignity Act (1997). Since that point, in states such as Washington, California, Colorado, Hawaii, Vermont, and New Jersey, authorized medical aid in dying exists under various strict requirements such as being a competent adult suffering from terminal illness making repeated voluntary requests[36].

That being said, beyond the established statutes, it is still illegal in most states to help someone die by assisted suicide. Specifically, the Supreme Court decided in Washington v. Glucksberg (1997)[37] and Vacco v. Quill[38] that laws banning assisted suicide did not violate the due process and equal protections owing to extra governmental interests, while states retained a legitimate interest in preserving life.

From a health perspective, suicide continues to rank as the

[34] DEP'T OF HEALTH & SOC. CARE (UK), *National Suicide Prevention Strategy for England: 2023–2028* (2023).
[35] CTRS. FOR DISEASE CONTROL & PREVENTION, *Suicide Data and Statistics* (2023), https://www.cdc.gov/suicide/facts/data.html (last visited Oct. 12, 2025).
[36] Or. Rev. Stat. §§ 127.800–.897 (2023).
[37] *Washington v. Glucksberg*, 521 U.S. 702 (1997).
[38] *Vacco v. Quill*, 521 U.S. 793 (1997).

12th leading cause of death in the United States (CDC, 2023) with 49,476 deaths at a rate of 14.1 per 100,000[39]. Inequities continue, for example, among males, rural citizens, and veterans who are at higher risk of dying from suicide. Legislative moves away from punitive laws, such as the National Suicide Hotline Designation Act, 2020[40], establishing the 988-emergency telephone line, where the law is reoriented toward prevention rather than punishment, demonstrate meaningful state interest in surveillance and access to proactive measures to avert the causes of suicide in the United States.

D. SOUTH KOREA: HIGH-INCOME, HIGH-RISK PARADOX

In South Korea, suicide represents the opposite case: a high-income nation and democracy with high suicide rates (23.6 per 100,000, nearly triple the global average)[41]It is the fifth leading cause of death and the first cause of death among people aged 10-39[42]. Interestingly, suicide was never a criminal offense under Korean laws, but stigma and potential economic strain continue to drive high suicide rates. The Mental Health Welfare Act, which was passed in 2016, and the Suicide Prevention Act, which was passed in 2011, provide the legal framework for famine prevention policy[43]. The Suicide Prevention Act mandates government oversight of suicide prevention, including establishing suicide surveillance, restricting access to means, and providing recovery care after someone attempts suicide.

Korea's crisis demonstrates that decriminalization alone to lower suicide is neither sufficient nor plausible; structural determinants (e.g., work culture, academic pressure, sensationalism by the media) require legislative intervention. The National Suicide Prevention Centre coordinates a suicide hotline that responds 24 hours a day, and outreach as part of a community mental health approach to suicide prevention. Courts have begun recognizing monetary liability in cases of suicide by claimants as a violation of government, labour law,

[39] CTRS. FOR DISEASE CONTROL & PREVENTION, *Deaths: Final Data for 2021*, 73 NAT'L VITAL STAT. REPS. 1 (2024).
[40] National Suicide Hotline Designation Act of 2020, Pub. L. No. 116-172, 134 Stat. 832.
[41] WORLD HEALTH ORG. REGIONAL OFFICE FOR THE W. PAC., *Health Statistics in the Western Pacific Region 2023: Monitoring Health for the SDGs* (2023).
[42] Ministry of Health & Welfare (S. Kor.), *National Suicide Report 2022* (2022).
[43] Act on the Prevention of Suicide and the Creation of a Culture of Respect for Life, No. 10698, Mar. 30, 2011 (S. Kor.).

and certain forms of occupational health injury[44].

E. ANALYTICAL REASONING

Comparative analysis produces three patterns:

Decriminalization does not mean decrease: While legal reform can enhance care and reporting, it does not automatically equate to a decrease in suicide rates. Structural and socio-economic determinants ultimately prove to be more significant.

New health of justice: In effective systems, legal reforms are accompanied by prevention infrastructures, the UK's national strategy, India's Mental Healthcare Act, and Korea's surveillance network.

Human rights as a framework: Countries that link suicide law with human dignity and access to care frameworks, made a better public trust and are open to data releases.

VI. PUBLIC HEALTH AND HUMAN RIGHTS INTERFACE

A. THE SHIFT FROM CRIME TO CARE

The convergence of public health and human rights represents the most substantial shift conceptually in suicide law. Suicide is no longer considered a moral and penal act; rather, suicide is now characterized as a public health crisis predicated upon structural injustices, social isolation, and mental distress. The World Health Organization (WHO) acknowledges that suicide prevention is a fundamental function of public health, placing an emphasis on the impediments to surveillance and treatment which punitive laws establish[45].

Decriminalization of suicide changes the interaction with law to a model of care as opposed to retribution. Survivors of suicide attempts, rather than being prosecuted and stigmatized, are now understood as patients with the right to rehabilitative and custodial care with dignity. The Mental Healthcare Act, 2017 (India), holds this position in Section 115, outlining in all instances the state's duty of treatment and, in all instances, a presumption of "severe stress".[46]This model has been cited by the United Nations Human Rights Council (UNHRC) as a standard by which human rights

[44] *Case Concerning Workplace Stress*, 2018GaHap13427 (Seoul High Ct. 2020) (S. Kor.).
[45] WORLD HEALTH ORG., *Preventing Suicide: A Global Imperative* (2014).
[46] Mental Healthcare Act, No. 10 of 2017, § 115 (India).

frameworks for suicide prevention can be developed[47].

B. HUMAN DIGNITY AS A FOUNDATIONAL PRINCIPLE

The concept of human dignity is a foundation of contemporary law around suicide. Article 1 of the Universal Declaration of Human Rights (UDHR) of 1948 states that "all human beings are born free and equal in dignity and rights." The dignity principle compels the state to respond with compassion instead of punishment to situations of human suffering[48].

In Gian Kaur v. State of Punjab (1996), the Supreme Court of India concluded that while the "right to die" is not otherwise part of Article 21, the "right to die with dignity" is a component of the right to life[49]. This is similar to the approach of the European Court of Human Rights (ECHR) in Pretty v. United Kingdom (2002) which held that personal autonomy and self-determination fall within Article 8 (private life) even though there was no legal recognition of assisted dying[50].

In this way, dignity connects health and law, compelling a state to apply evidence-based, compassionate options instead of coercive interventions. A human-rights lens changes the discussion around suicide from guilt of the individual to the responsibility of the state for the factors which contribute to suffering in the form of poverty, discrimination, or mental illness.

C. MENTAL HEALTH AS A LEGAL RIGHT

Mental health refers not only to a clinical phenomenon for an illness; it is also recognized as a legal right by a variety of international and domestic instruments. The right to "the highest attainable standard of physical and mental health" is enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the UN Special Rapporteur on the Right to Health (2017) specifically called on Member States to decriminalize suicide and to include suicide prevention in national health plans.

There are similar developments in domestic constitutional jurisprudence. In Shantistar Builders v. Narayan Totame (1990), the Supreme Court of India interpreted the right to life

[47] Human Rights Council, *Decriminalizing Suicide Worldwide*, U.N. Doc. A/HRC/47/36 (June 28, 2021).
[48] Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. Doc. A/810 (1948).
[49] *Gian Kaur v. State of Punjab*, AIR 1996 SC 946, 950 (India).
[50] *Pretty v. United Kingdom*, 35 Eur. H.R. Rep. 1 (2002).

as necessarily including the right to live with dignity, which means having access to basic conditions necessary to ensure mental well-being[51]. The Mental Healthcare Act, 2017 gives legislative effect to this right by requiring access to mental health services, the same access to health insurance as for any other medical condition and prohibits discrimination against individuals after a suicide attempt.

The World Health Organization (WHO) generated an important global shift, encouraging all countries to pledge to provide at least 5% of health service budgets for mental health in the Comprehensive Mental Health Action Plan 2013-2030[52]. However, as indicated in the WHO's 2023 Mental Health Atlas, more than 70% of low-income countries spend less than 1% of their health budget for mental health services; the structural neglect continues[53].

D. STRUCTURAL DETERMINANTS AND STATE OBLIGATIONS

Suicide prevention involves much more than public health and medicine, it involves obligations of the state, including addressing structural determinants such as poverty, inequality, and violence that affect access to health care. The WHO calls these "social determinants of mental health." Many states that criminalize suicide often share common patterns of underfunded health systems, structural social determinants like gender-based violence, and inadequate social welfare protections.

The UN Human Rights Council (A/HRC/47/36, 2021) has noted that such criminalization disproportionally affects women, LGBTQ+ people, and marginalized communities and violates the principles of non-discrimination under Articles 2 and 26 of the ICCPR. This perpetuates a feedback loop where stigma diminishes reporting leading to underreported data, which obscures knowledge about the magnitude of the problem, ultimately leading to insufficient policy responses and continued risk.

In occupational health settings that have decriminalized, the surveillance and engagement rates for early intervention have improved. The Suicide Prevention Implementation Report (2021, WHO) shows that following the decriminalization stay,

[51] *Shantistar Builders v. Narayan Totame*, AIR 1990 SC 630 (India).
[52] WORLD HEALTH ORG., *Comprehensive Mental Health Action Plan 2013–2030* (2021).
[53] WORLD HEALTH ORG., *Mental Health Atlas 2023* (2023).

voluntary reporting of mental health problems increased by 20-25% in the first five years. Both public health research and applications of law are implicated in determining the degree to which both epidemiologically accurate and ethically sound care for at-risk populations.

E. GENDER, YOUTH, AND INTERSECTIONAL RIGHTS

The entitlement to mental health is intertwined with gender equity and youth safety. Suicide is currently the second leading cause of mortality for females aged 15-29 and is generally associated with forced marriage, domestic violence, and economic dependency[54]. Under international law, states have an obligation to act on this through CEDAW (Convention on the Elimination of All Forms of Discrimination Against Women, 1979) to provide access, at a minimum, to reproductive, social and psychological health services[55].

Likewise, UNICEF (2023) draws attention to youth suicide as a rights crisis and advocates for national frameworks guaranteeing a safe school environment and access to mental health counselling[56]. For example, laws that mandate counselling cells in universities, as the government has made into law, in the UGC Mental Health Guidelines (2022) in India, or low-income workplace wellness regulations, such as in Japan, are rights-based interventions to promote mental health.

Thus, legal systems grow from managing conduct to securing conditions of well-being, shifting the focus of the state from deterrence to protection, and at-risk populations.

F. ANALYTICAL SYNTHESIS

Law and public health intersect most profoundly in understanding the role of criminalization, which kills by omission. When suicide is criminalized, people hide their suffering; when it is medicalized and dignified, people seek help. The law and legal context itself are a form of survival.

Decriminalization and a right to health become a virtuous cycle, less stigma, better data, better access, and more social empathy. But punitive institutions perpetuate trauma and structural discrimination. Therefore, the task is not only to

[54] WORLD HEALTH ORG., *Global Report on Adolescent Mental Health* (2022).
[55] Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13.
[56] U.N. CHILD.'S FUND, *The State of the World's Children 2023: Mental Health* (2023).

repeal these laws, but to institutionalize dignity, so that compassion is normed and legally organized, not exceptional.

VII. CONCLUSION AND POLICY RECOMMENDATIONS

A. SYNTHESIS OF FINDINGS

The worldwide transformation of suicide law demonstrates a fundamental change from morally socially condemned behaviour to a condition that recognizes the public health and human rights implications of taking one's life. In the past, taking one's life was criminalized as a blot against God or the state; now, it is understood as a consequence of social and psychological suffering that deserves empathy and care. Decriminalization is not enough on its own, but it is a legal base of prevention: it reduces the stigma associated with suicide, improves reporting, and provides a reconfigured understanding of state policies regarding human dignity.

Research from global institutions like the World Health Organization (2021) and national bodies like the National Crime Records Bureau (India, 2022) shows that countries working to develop more mental health oriented legislation for suicide show legitimate improvements in reporting and uptake of care.[57]But epidemiological evidence suggests that simply changing the law is not enough to decrease suicide rates; it must take place in conjunction with systemic changes to health and economy, and equity as part of societal change as well.[58]

B. PERSISTENT CHALLENGES

While normative gains have been made, there are still substantial gaps in legal policy and practice. These include:

i. Residual Criminalization: There are approximately two dozen countries that still punish attempts at suicide under penal codes, which maintain stigma and fear of punishment.
ii. Mental Health Systems Underfunded: More than 70% of low- and middle-income countries spend less than 1% of their health budgets on mental health.
iii. Data Gaps: Many jurisdictions do not operate robust vital-registration systems, limiting their ability for accurate surveillance and assessment of interventions.

[57] WORLD HEALTH ORG., *Suicide Worldwide in 2021: Global Health Estimates* (2021).
[58] WORLD HEALTH ORG., *Global Health Observatory Data Repository—Suicide Mortality Rates* (2023).

iv. Overlooked Populations: Gender-based violence, caste-based marginalization, and LGBTQ+ discrimination are still major factors when it comes to preventing suicide, yet few national legal systems pay explicit attention to these factors. These examples show that law is a necessary, but insufficient, condition to reduce risk. Its use will depend on the rules of administrative implementation, engagement towards building budgets and systems, and the civil society movement.

C. POLICY RECOMMENDATIONS

- Global Decriminalization: All states should repeal penal laws for suicide attempts. Criminalization violates obligations under the International Covenant on Civil and Political Rights (ICCPR) and the Universal Declaration of Human Rights (UDHR). The WHO and UNHRC have urged decriminalization in full by 2030 under Sustainable Development Goals (SDG) Target 3.4.
- Overlap of Legal Jurisdictions and Public Health Frameworks: States should embed suicide prevention into statutory mental health frameworks. The Indian Mental Healthcare Act, 2017, presumes significant stress and directs treatment. The Act is a good example for other national contexts. National action plans should also require helplines, early intervention systems, and layperson first aid personnel for response to suicide and suicidal behaviours.
- Regulation of Methods: Laws that govern the method of suicide, and especially access to lethal agents, should be prioritized. Laws that restrict access to lethal substances and particularly highly hazardous pesticides and unregulated guns, should be prioritized. The ban on class I pesticides in Sri Lanka reduced suicide rates by more than 70 percent in a decade.
- Rights-Based Health Context: Mental health should be treated as a justiciable right rather than a right to welfare. Legal provisions mandating mental health care parity would include provisions for coverage and anti-discriminatory provisions in insurance schemes. Courts and legislatures should embed the right to mental health within constitutional interpretation of the right to life.
- Community-Based Legal Education: Public legal education initiatives must promptly engage with the stigma of mental illness and suicide. Community policing and social welfare officers should be trained under rights-based suicide response protocols, which should focus on care not criminal inquiry.

- Data Modernization and Transparency: National governments should look to modernize death registration protocols to anticipate records that can link medical, legal and forensic databases to ensure reliable records of a suicide. Data reform is essential to go along with legal reform, as reform without data reform is purely symbolic change with little policy value.
- Ethical Regulation of Assisted Dying: Where assisted dying is being considered, however, states must seek to legislate through a transparent parliamentary process, reflective of examples in Canadian MAiD (2016) and Oregon (1997). Assisted dying should always be viewed through a lens that is distinct from decriminalizing suicide, grounded in the ethical principles of autonomy, competence, and informed consent.

D. CONCLUSION

The worldwide and comparative study of suicide law indicates that legal change is most impactful when developed within mental health and broader human rights frameworks. The literature confirms that international classification of the offense is significantly correlated with better reporting, increased access to care, and reduction of stigma; though the research does not infer an immediate present decline in suicide rate. Research in India, the UK, and Canada shows the extent of change in law, punishment to compassion, depends on a convergence of law, health policy, and public awareness. Prevention of suicide cannot exist solely in the realms of medicine or morality; suicide law and prevention must embrace the legal and ethical premise of a right to life and dignity. The future of suicide law lies in institutionalizing compassion, through legislation to protect, systems to heal, and authority to acknowledge despair as a condition that requires justice rather than judgment.