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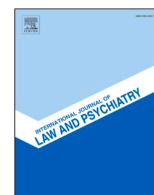

Perception of the criminality of attempted suicide in Nepal and its impact on suicide reporting

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ABSTRACT

In 2018–2019, according to the official statistics, 5754 people died as a result of suicide in Nepal. This is a high number for a country with a population of 29 million people. Experts believe that the actual rate is considerably higher and that many suicides are not reported. This underreporting of suicide is frequently blamed on the stigma and the criminality of attempted suicide. Yet, there has never been a criminal liability for attempted suicide in Nepal. This article discusses the reasons for the perception of the criminality of attempted suicide in the country, its consequences, and the ways of addressing them. We found that the involvement of the police at the initial stages of suicide investigation confirms public perceptions that attempted suicide is a punishable offense and this may reinforce the stigma of suicide. Recent criminalization of the abetment of suicide has contributed to this perception as the public may not be clear about the distinction between abetment of suicide and attempted suicide. Criminalization of suicide not in the laws but in minds discourages reporting and help-seeking behaviour and victimizes people who need support and services. We argue that decriminalization is more than removing the outdated legal clauses from the legal statutes, but also public awareness raising about the reasons for police investigation of suspicious deaths, sensitivity training, and education of government officials, policymakers, and police about suicide and its prevention. These are needed to dispel the myth of criminalization of attempted suicide in Nepal. Our findings could be of wider interest to scholars working on reducing the stigma of suicide and decriminalization of suicide attempts.

1. Introduction

Rapidly reducing the global suicide rate is the key to achieving the Sustainable Development Goals (SDGs) especially target 3.4 which directly relates to suicide prevention (United Nations General Assembly, 2015). Progress towards the achievement of this goal is hampered by the widely spread stigma of suicide resulting in underreporting, difficulties in surveillance, and lack of political will in formulating comprehensive suicide prevention strategies. In Nepal, there is a widely shared perception that suicide attempt is criminalized, although this has never been the case. Considering Nepal's high reported suicide rate, it is pertinent to discuss the perceived and factual legal status of suicide and attempted suicide, suicide reporting rules, their implementation, and their impact on the actual reporting.

2. Background

2.1. The problem of under-reporting and misclassification of suicide

According to the World Health Organisation (WHO), the availability and quality of data on suicide and suicide attempts globally are poor, with the majority of WHO members not being able to provide good quality mortality data (World Health Organisation, 2021a). While this problem is not unique to suicide, given the sensitivity of suicide and the illegality of suicidal behaviour in some countries, WHO notes that it is likely that under-reporting and misclassification are greater problems for suicide than for most other causes of death (World Health Organisation, 2021a). Potential reasons for misclassification are poor quality death certification procedures, poor vital registration data (or their

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absence), and classification of suicides as accidental or "undetermined" deaths (Rockett, Kapusta, & Bhandari, 2011; Snowdon & Choi, 2020). The reasons for under-reporting may include suppressing evidence of suicide by officials including the reluctance to reach a finding of suicide by doctors, police, and coroners (Tait & Carpenter, 2016), and friends and family due to the stigma and the fear of police investigation.

2.2. The evolution of the law and perceptions related to suicide

Ideas and perceptions of suicide are deeply rooted in culture, but the general disapproval of suicide is common (Colucci & Lester, 2013). Major religious traditions view suicide as a sin and an unacceptable act against God, based on the idea that every life is a gift of God and only he can take it away (Mendelson & Freckelton, 2013; Stefan, 2016). More specifically, Judea-Christian religious traditions share a general condemnation of suicide (Mishara & Weisstub, 2016; Wicks, 2010). In the West, these factors led to the criminalization of attempted suicide to discourage the taking of one's life and was frequently accompanied by property forfeiture to fill in the government's coffers (Barry, 1965; Tucker, 2015).

Hinduism and Buddhism also disapprove of suicide, but permit and even sanction religious or altruistic suicide under certain circumstances (i.e. actions rooted in selfless compassion for others) (Lamotte, 1987; Sharma, 2009; Wicks, 2010). While suicide is considered to be an act that produces bad karma and thus not an effective means to escape from suffering, altruistic suicide is believed to break the cycle of birth and can be seen as heroic. For example, in India, the practice of Jauhar (women's self-immolation before their men go to battle) was considered honorary (Wu, Chen, & Yip, 2012). Similarly, Hinduism's system of Sati - self-immolation of women after the death of their husband – was believed to guarantee the woman, her husband, and seven generations of the family direct access to heaven (Abrutyn, 2017).

With the Enlightenment, the views on suicide and attempted suicide changed in the West from being a crime to being a result of psychological illness, with survivors seen as needing help and support, not prosecution (Alexander, 2013; Healy, 2006). Suicide attempt was decriminalized in many European countries in the 19th century (Neeleman, 1996; Tait & Carpenter, 2016). In England and Wales, it was decriminalized considerably later in 1961 with the passage of the Suicide Act (Neeleman, 1996). This late decriminalization had an effect on the common law and the Commonwealth countries, some of which until recently retained or still retain the criminalization of suicide attempts in their laws (Neeleman, 1996). One of the examples is Indian Penal Code currently in force and drafted in 1860 during British rule. It states"whoever attempts to commit suicide and does any act towards the commission of such offense, shall be punished with simple imprisonment for a term which may extend to 1-year". The discussions about the repeal of this section started in the 1970s, when the Law Commission advised that attempted suicide warranted medical and psychiatric care and not punishment. In 1980, the Delhi High court decreed criminalization of attempted suicide "unworthy of society" (Behere, Rao, & Mulmule, 2015).

Illustrative of the changing attitudes towards suicide is the recommendation of the UK's Ministry of Health issued as a follow up to the Suicide Act 1961, advising all doctors and authorities that attempted suicide was to be regarded as a 'medical and social problem' (Sharma, 2009). As notable *R (on the application of Pretty) v Director of Public Prosecutions* judgement from the UK notes "Suicide itself (and with it attempted suicide) was decriminalized because recognition of the common-law offense was not thought to act as a deterrent, because it cast an unwarranted stigma on innocent members of the suicide's family and because it led to the distasteful result that patients recovering in hospital from a failed suicide attempt were prosecuted, in effect, for their lack of success" (*R (Pretty) v Director of Public Prosecutions in UKHL 61*, 2002).

With the deepened understanding of personal dignity, autonomy, and human rights the attitude towards suicide has further changed. Human beings became rights-bearers with autonomy to decide their fate and matters related to life and death (Wicks, 2010). Acceptance of a person's individual autonomy leads to the possibility to choose medically assisted suicide (MAID) or euthanasia in limited circumstances and following strictly defined rules (Mishara & Weisstub, 2005). States however still have a legitimate interest in preserving the lives of their residents (Utyasheva & Eddleston, 2021). Many states affirm this by adopting suicide prevention and mental health strategies, by placing restrictions on access to suicide means such as barriers on bridges, railway and train platforms, prescription sale of medicine, gun control rules, and the ban on highly hazardous pesticides used for self-poisoning (Gunnell et al., 2017; World Health Organisation, 2021b).

Although some countries retain the criminalization of attempted suicide, most do not in practice, prosecute, or punish suicide attempters (Adinkrah, 2016; Mishara & Weisstub, 2016; Naveed et al., 2017). A 2016 study showed that countries that punish attempted suicide do not have lower suicide rates than other countries (Mishara & Weisstub, 2016). This is despite the fact that reporting of suicide is usually lower where suicide attempts are illegal. Overall, there is no data supporting the belief that the threat of incarceration or fine has a preventative effect (Mishara & Weisstub, 2016).

As suicide and attempted suicide are decriminalized, aiding and abetting suicide remains a criminal offense in many countries. After the decriminalization of suicide in England and Wales, criminalization of the abetment of suicide remained in place (UK Public General Acts, 1961). An abettor is viewed as a perpetrator who uses the vulnerability of the victim to persuade them to kill themselves under pressure or following advice (Binder & Chiesa, 2019). Criminalization of abetment of suicide was introduced to protect vulnerable populations. The United Nations advises that legislation should criminalize any act of and attempts to intentionally advise, encourage, and abet or assist another in suicide (UN Women, 2011).

2.3. Attitudes to suicide across cultures and their relation to stigma and underreporting of suicide

Despite the change of the perception related to suicide globally, it remains culturally rooted. Noting the cultural differences in the epidemiology of suicidal behaviour in a range of countries, several authors point to the different suicide patterns in Asia as compared to Western countries (Keller et al., 2019; Shrivastava, Kimbrell, & Lester, 2012; Vijayakumar, 2017; Vijaykumar, 2007). For example, age distribution and male to female ratio are different: rates are higher in the elderly in the West and young people in Asia. In the West, the male to female ratio is greater at 3:1, whereas in Asia this ratio is 2:1 or lower with countries like India showing a similar ratio (1.4:1) (World Health Organization, 2014; World Health Organization, 2019). This shows higher suicide in women in Asia than in the West (Colucci & Lester, 2013; Vijayakumar, 2015; Vijayakumar, 2017). In India and Nepal, being female, living in rural areas, and holding strong religious beliefs may increase suicide risk compared to the same factors in the West (Marahatta et al., 2017; Pyakurel et al., 2015). On the other hand, being single or having a history of mental illness may be of less significance (Colucci & Lester, 2013; Vijayakumar, 2015).

After reviewing attitude to suicide among Italian, Indian and Australian youth, Colucci described Indian participants as having a more negative attitude towards suicide compared to their Italian and Australian peers (Colucci & Lester, 2013). In India, a young person who kills themselves is seen as having failed to face life's problems and as being weak and responsible for the act (and therefore blamed for it), as having brought shame to the family and created bad consequences for the survivor's lives. Colucci notes that suicide attempters are seen as having failed responsibilities towards society and their families (Colucci & Lester, 2013). Im and Park note significant stigma associated with suicide in South Korean society, where suicide was never considered illegal. However, it is believed to be a breach of the Confucian norms and

respect for family and elders. They point out that families may not “wish to acknowledge suicide for the fear of stigma and shame” (Im, Park, & Ratcliff, 2018).

The stigma associated with mental illness is another contributing factor to the underreporting of suicide (Im et al., 2018; Keller et al., 2019; Li et al., 2019). Stigma is defined as being discredited by society and condemned to an undesirable social status (Goffman, 1990) and is thought of as a social process that occurs within the broader socio-cultural environment that contributes to structural and institutional discrimination (Link & Phelan, 2001). Historically, mental illness was viewed not as a disease but as a manifestation of evil spirits (Dvoskin, Knoll, & Silva, 2020). In Nepal, mind-body division defects and the dysfunction of brain-mind (dimaag) are considered to be socially threatening and damaging. This, as well as seeking help from traditional healers (where many people go first) and psychiatrists, are associated with stigma (Kohrt & Harper, 2008). Mass media is another powerful cultural channel of influencing suicidal behaviour, contributing to the normalization of suicide as a response to common problems, sensational portrayal, or glorification of suicide (Sisask & Värnik, 2012; Wu et al., 2012).

Socio-cultural, economic, and religious contexts shape methods of suicide (Wu et al., 2012; Yip, 2008). For example, the easy availability of highly toxic pesticides to smallholder harmers in countries where a high proportion of the population is engaged in agriculture, makes pesticide one of the two most common means of suicide in Nepal, India, Sri Lanka, and other Asian countries (Ghimire et al., 2021; Karunarathne et al., 2020). Suicide by self-immolation in some Asian countries reflects the cultural connotation of fire, symbolizing protest against injustices. It carries the symbolic meaning of God and the purifier in Hinduism and thus plays a role in the practices of Sati and Jauhar (Wu et al., 2012).

The stigma associated with suicide hinders help-seeking behaviour and access to services for survivors, particularly for those from marginalized groups. The underreporting of suicide matters because the distorted suicide data do not correctly represent protective and risk factors associated with suicide and vulnerable groups, it also hinders designing cost-effective, meaningful, and successful interventions. Imprecision in recording and documentation does not only affect the figures for suicide. For every real case of suicide that is misrecorded as something else (e.g. accident), another mortality category will be unduly inflated, thus distorting the entire system of mortality records. Individual studies on the reliability of suicide mortality recording have indicated that the number of deaths may be underestimated by 30–200% (Bertolote, Fleischmann, Butchart, & Besbelli, 2006).

3. Methods

We collected qualitative data from a literature review and analyzed Nepal’s criminal law on suicide, attempted suicide, and abetment of suicide. We explored how suicide reporting is implemented by the authorities. Our literature review focused on the publications on suicide and suicide prevention and the discussions of the new Criminal code provisions on the abetment of suicide.

To discover public attitudes towards suicide, suicide attempt, and legal requirements for suicide reporting and its factual implementation, we conducted ten in-depth expert interviews, using a semi-structured questionnaire. The interviewees included nine *high caste* men and one Newari woman, and represented a diversity of professional opinion: lawyer, police officer, psychiatrist, medical toxicologist, forensic medicine specialist, general medical practitioner, policymaker, and agriculture expert, and retired civil servant. All interviews took place in Kathmandu. Eight interviews were conducted in English and two in Nepali. Oral consent was obtained from each interviewee for their participation. The experts were asked questions about whether suicide and attempted suicide were criminalized in Nepal, the procedures for suicide reporting, possible reasons for the underreporting, stigma associated with the act, and recommended ways for government to respond. Each set of data was reviewed with a theme analysis.

4. Results

4.1. Suicide in Nepal

Nepal’s health system consists of public and private health services (Constituent Assembly of Nepal, 2018). Nepal’s Ministry of Health and Population does not systematically collect nor report data on suicides (Gautam, 2016; Hagaman, Maharjan, & Kohrt, 2016). Although the national Health Management Information System (HMIS) includes variables on suicide reporting, they are not utilized, with data not being collected or reported within the health system (Government of Nepal and Ministry of Health and Population, 2013). Based on the current reporting mechanisms, collection and maintenance of data on suicidal deaths fall in the remit of three separate authorities: health, administration, and police (Marahatta et al., 2017). In the absence of one entity being responsible for coordinating the reporting of suicides, only police data are widely available and are used in media reports. Mental health legislation and a Suicide Prevention strategy have been proposed, but never adopted (Marahatta et al., 2017). In response to the Sustainable Development Goals, the Government of Nepal’s National Planning Commission has committed to reducing suicide mortality by 2030 and has designated the Ministry of Home Affairs to be responsible for the annual reporting (Government of Nepal, 2017).

In 2018–2019, 5754 people killed themselves in Nepal according to the official police statistics, representing an increase of 33% compared to 2014–2015 (Dhakal, 2019). It is believed that the state-generated official estimate of suicide is largely under-represented due to misclassification, stigma, and poor record-keeping (Hagaman et al., 2016). The WHO presents a wide range of estimates, both considerably higher and lower than the official statistics. In 2014, WHO modeled a 2012 predicted suicide rate, ranking Nepal 7th in the world at 24.9 per 100,000, the 3rd highest for women (20 per 100,000), and 17th for men (30.1 per 100,000) (World Health Organization, 2014). 2019 WHO’s Global Health Estimates indicated 2544 suicides, with 1176 (8.0) for females and 1368 (11.4) for males. It makes the suicide rate of 9.6 for both sexes, which is lower than the average global rate of 10.5 per 100,000 population (World Health Organisation, 2019) and lower than Nepal’s official figures. These significant discrepancies in estimated suicide rates show the unreliability of data and the need for better suicide recording and reporting (Pandey et al., 2020).

According to available records, the most used methods of suicide in Nepal are hanging and poisoning (Nepal Police Headquarters, 2019; Thapaliya, Sharma, & Upadhyaya, 2018). Many poisonings occur as a result of intentional ingestion of agricultural pesticides, especially highly toxic organophosphate insecticides. Another characteristic of suicide in Nepal is a lesser role of mental health concerns giving prominence to causative factors such as interpersonal relationship problems and life events (Thapaliya et al., 2018).

4.2. Legal provisions on suicide and abetment of suicide in Nepal

Although attempted suicide was never criminalized in Nepal, there is a perception of criminality associated with it (Hagaman et al., 2016; Marahatta et al., 2017). Opinions about attempted suicide being a punishable offense can be encountered in academic journals (Benson & Shakya, 2008; Rajit Bhakta Pradhananga and Kushang Lama, 2018), media (Hagaman & Rawat, 2015; Robertson, 2018), and even on a Wikipedia page (Wikipedia, 2020). Despite publications dispelling this myth (Hagaman et al., 2016; Marahatta et al., 2017), many stakeholders remain of the opinion that attempted suicide is a punishable offense and that survivors are subject to imprisonment and fines (Benson & Shakya, 2008; Shuvam, 2020). Misconceptions that attempted suicide is illegal are widely spread among health care workers (Marahatta et al., 2017). Legal specialists support this view. An article on the abetment of suicide

in the Prosecution Journal notes: "while the person who has completed suicide is beyond the reach of the law… when a person is unsuccessful in the commission of suicide or if the desired intention of the offender is not met in committing suicide he is within the ambit of the law" (Rajit Bhakta Pradhananga and Kushang Lama, 2018).

Nepal's new Criminal Code (2017) criminalizes the abetment of suicide. Section 185 Prohibition on Abetment of Suicide states: (1) "No one should provoke or generate a situation abate anyone to commit suicide or to create circumstances compelling someone to commit the same. (2) Anyone found guilty under the clause is liable to a five-year jail sentence and Rs 50,000 fine" (approx. $405 USD) (Nepal Constituent Assembly, 2017).

The introduction of the abetment of suicide into the law in Nepal was directly associated with the desire to protect vulnerable groups, particularly women, from violence and abuse. Before its introduction, the Domestic Violence (Offense and Punishment) Act of 2009 which punished domestic abuse, did not cover circumstances when the victim of abuse died by their own hand. If the victim died of suicide, no legal way existed to prosecute the abuser who drove the victim to suicide (Ghimire & Sharma, 2016). In several cases, the Supreme Court of Nepal ruled on the issue of suicide under pressure. In the case of *Binay Manandhar* vs *Government of Nepal*, the victim killed herself after experiencing domestic violence by her husband and his relatives (Ghimire & Sharma, 2016). Although it was presumed that domestic violence was the principal cause of suicide, there was no legal ground to prosecute the accused in the situation when the victim was dead. Similarly, in the case of *Government of Nepal* vs *Murari Dhamala* et al, the victim experienced domestic violence and psychological torment, as a result of the second (illegal) marriage of her husband. After her death, no legal ground to prosecute her husband for domestic violence remained (Ghimire & Sharma, 2016). These cases were cited as a reason for the need to introduce the new law to punish the abetment of suicide (Ghimire & Sharma, 2016). "The reason behind a suicide attempt is known only after investigation. If the suicide is found to be due to provocation or a situation created by someone, the individual found guilty of provocation will face legal action", said a spokesperson for Nepal Police in a statement (Paudel, 2019).

Since the introduction of this clause, the prosecutions and discussions of abetment of suicide in Nepal have become abound (Paudel, 2019; Satyal, 2019). According to the police, 27 people killed themselves in nine months of 2019 due to provocation (Paudel, 2019). Observers discussed several high-profile cases of abetment of suicide, expressing concern over the misuse of the law, noting that "thorough investigation is required". Mostly, such criticism arose when third parties were accused of aiding and abetting suicide after several prominent members of society (i.e. a member of parliament and a journalist) took their lives, blaming others for driving them to suicide by allowing injustice or human rights violations (Nribesh Nepal, 2019; Rai, 2019).

4.3. *Legal requirements to report suicide and suicide attempt*

Due to the gaps in the formal vital registration system and the fact that the Ministry of Health and Population does not collect comprehensive data on suicides (Thapaliya et al., 2018), the police remains the main actor involved in gathering the suicide statistics.

The Criminal Code 2017 in para 20, mandates police investigation in the case of death due to culpable homicide, accident, or suicide, or in any other suspicious circumstances. According to the rules, after examining the body, the investigating authority sends the body to a government-approved medical doctor or another expert designated by the government. If it does not appear from the initial examination of the body that death occurred as a result of an offense or in suspicious circumstances, the investigating authority may conclude that a post-mortem is not necessary. Then, the investigating authority can make a memorandum stating the reasons to close the case. When suicide is established, the case is closed, and there is no further action (KII 03, September 2019, on file with authors,).

According to the Government Cases Act (2049 (1992)), Sections 11 (1)–(3) if there is a suspicious death (i.e. homicide, suicide, or accident), a police inspector (or higher-ranking police officer) must visit the place immediately and prepare the formal preliminary investigation report (Muchulka) (Government of Nepal, 1992). This document is then sent to the prosecutor and the forensic department, with one copy kept for police records (KII 08, August 30, 2019, on file with authors). The police officer should then send the body for autopsy to a government approved medical practitioner or institution (Government of Nepal, 1999). The body is examined and a post-mortem report is done (Chapter 10(2)). The doctor who performs the autopsy hands over their report and samples for further laboratory investigation to a police inspector. It is then the police's responsibility to transport and deliver the sample to one of the forensic laboratories in Kathmandu. Only government-approved doctors are mandated to perform autopsies, even if they do not have any medico-legal training in forensic medicine (Subedi & Deo, 2015).

If a person survives and is admitted to the hospital after an attempted suicide, the hospital staff need to open a medical-legal case (MLC) and report the case to the police. The police usually will visit the hospital and relatives to collect information about the attempted suicide. It is noted that health care workers are unclear about the health system's role in reporting suicide because it is believed to be the responsibility of the police (KII 06, August 27, 2019, interview on file with authors). Clinicians believe that it is not "legal" for them to mark the cause of death as suicide as that is the responsibility of the police. Because of the nature of these medico-legal reports, it was believed that they "belonged to the police, and were not included in the HMIS (Hagaman et al., 2016). Confusion is highlighted as a concern due to the lack of legal clarity with MLCs, which hampers their management. The rules require a police presence in emergency rooms which contributes to the accusatory mode of suicide investigation (KII 06, August 27, 2019, on file with authors). Suicide statistics are reported by the police as a crime and appear as such in the crime section of the Central Bureau of Statistics annual reports (Fig. 1).

4.4. *The perception of criminalization vs reality*

Triangulation of the theme analyses of the literature review and the key informant interviews showed a misunderstanding of the legal status of suicide. In the statistical records, suicide is discussed as a crime and grouped together with other crimes (Shuvam, 2020) (Fig. 1). Further, there is a confusion between the concepts of abetment of suicide and attempted suicide even with legal experts talking of suicide and abetment of suicide as the same phenomenon (Rajit Bhakta Pradhananga and Kushang Lama, 2018). Publications on the abetment of suicide express concern over misapplication of the new legislation on the abetment of suicide for political purposes and to crush political enemies further complicating the issue of suicide reporting.

Our data analysis identified three themes that influence the perception of the criminality of attempted suicide. These are: the stigma of suicide reinforced by the criminalization of suicide in some neighbouring countries, the confusion between criminalization of aiding and abetting suicide and suicide attempt, and the characteristics of suicide documentation in Nepal (Fig. 2).

4.4.1. *Stigma and the criminalization of suicide in neighbouring countries*

The prevalent stigma of suicide in Nepal stems from the society where "suicide is viewed as a sin", and the society that blames and humiliates the family or/and the victim (KII 01, August 30, 2019, KII 05, August 26, 2019, KII 07, August 20, 2019) on file with authors). Suicide is associated with negative consequences to the family of the deceased or the survivor (Kohrt & Harper, 2008). The victim may be seen as having a defeated mentality (KII 03, September 3, 2019) and may be blamed for defaming the family and the community (KII 04, August 22). Stigma and community ostracism of survivors and their families also happen due to

17. MISCELLANEOUS
17.4 Number of Crime Committed by Types
2014/15 to 2017/18

— 398 —

Description	2014/15	2015/16	2016/17	2017/18
1. Dacoity with murder	1	1	1	2
2. Murder	597	558	616	628
3. Poison Case	0	0	0	0
4. Attempt to murder	664	584	646	728
5. Abortion	22	21	26	18
6. Suicide by				
a. Poision	1183	1075	1215	1363
b. Burning	30	21	24	15
c. Hanging	3374	3315	3761	3868
d. Weapon & instruments	13	14	15	9
e. Jumpping	65	66	71	50
f. Electric curent	3	0	4	1

Contd...

Fig. 1. Yearly crime reporting. Statistical Pocket Book of Nepal, Government of Nepal, 2018.

Fig. 2. The cycle of factors contributing to stigma and perception of criminality of suicide attempt in Nepal.

their association with mental illness (Kohrt & Harper, 2008; Luitel et al., 2017; Mahato et al., 2018; Regmi et al., 2004). "Stigma is very much prevalent in our society, especially in the rural areas" (KII 02, September 8, 2021, KII 04, August 22, 2019) on file with authors). Due to the negativity associated with the stigma, family members hesitate to report suicide and suicide attempts (Cousins, 2016; Licata et al., 2019) (Fig. 2).

The stigma of suicide is reinforced by the fact that several neighbouring countries criminalize attempted suicide (i.e. Bangladesh, Pakistan, Malaysia) (Mishara & Weisstub, 2016). The status of suicide in India is still ambiguous.

In 2017, the Indian government adopted the humanistic Mental Healthcare Act that states that a "person who attempts suicide should be presumed to have severe stress, and shall not be punished, to reduce the risk of a recurrence of the attempt to commit suicide" (Parliament of India, 2017). Section 115(2) of the Act mandates the government to provide care, treatment, and rehabilitation to a person who has severe stress and who has attempted to kill themselves. However, section 309 of the Indian Penal Code (IPC) that criminalizes attempted suicides (Imperial Legislative Council of India, 1860) has not yet been repealed.

4.4.2. The confusion between the criminalization of aiding and abetting suicide and suicide attempt

The perception of the criminality of suicide also stems from the recent criminalization of abetment of suicide. While the abetment of suicide is criminalized in many countries and is a legitimate way to protect vulnerable populations from abuse, the narrative in Nepal seems to confuse the issue. The abetment of suicide was criminalized in Nepal due to the risk of domestic violence, to eliminate the phenomenon of dowry deaths, and for the protection of vulnerable groups including the ill and the disabled (KII 06, August 27th, 2019). Domestic violence in Nepal and needs urgent attention is recognized as one of the key factors that increase the risk of suicide among women of reproductive age (Colombini et al., 2015; Cousins, 2016; Oates, 2003; Pun et al., 2020). However, the fact that public discourse links such issues as "aiding and abetting of suicide" and "domestic violence" with "suicide", creates the perception that suicide is criminalized and that it is done to protect women and other vulnerable groups (Ghimire & Sharma, 2016; Rajit Bhakta Pradhananga and Kushang Lama, 2018). All interviewed experts noted limited understanding of the law and suicide reporting procedures (KII 01–09, interviews on file with authors) (Fig. 2).

4.4.3. The way suicide is documented

The way in which suicide is documented and reported is perhaps the strongest contributor to the overall perception of criminalization and punishment around suicide and suicide attempt in Nepal. Suicide is recorded and documented by the police as a crime, which together with close police involvement in the investigation of all suspicious and unnatural deaths reinforces the perception of criminalization and unwanted legal and law-enforcement consequences.

While police investigation of all unnatural and suspicious deaths is warranted, in Nepal, we encountered evidence that police behaviour treats survivors and their families as criminals. As one responded pointed out, "there is a fear of police interrogation and harassment"(KII 08, August 30, 2019). The accusatory mode of police investigation of suicide/ attempted suicide cases sends a strong signal of possible repercussions and suppresses reporting and help-seeking behaviour. Police presence in emergency rooms reinforces this accusatory mode and instills fear in survivors and their families.

Furthermore, legal procedures on suicide reporting are not always clear to government workers and village administration (Hagaman et al., 2016). On the health care side, doctors avoid determining the cause of death, possibly out of fear of involvement with the police (Hagaman et al., 2016). As a result of the stigma and the fear of prosecution, many suicides and attempted suicides are reported as accidents or natural deaths or are not reported at all (Gautam, 2016) (Fig. 2).

5. Discussion

Suicide is a sensitive topic and measures designed to address it need to take into account cultural, legal, and historical contexts, and the underlying causes that affect public attitudes and societal prejudices. There is a strong case to be made against the criminalization of attempted suicide, and against their perceived association with police prosecution.

Nepal, where attempted suicide has never been criminalized, still experiences the negative impact of the stigma and fear of police prosecution. The perceived threat of police involvement and punishment deters individuals from seeking help and reporting suicides and attempted suicides. It reinforces the stigma already associated with suicide and suicide attempt. Even though attempted suicide is not punishable by law, widespread misperception makes it difficult to collect statistical data on suicide since families and survivors are unwilling to report suicide. If a person dies before being admitted to the hospital, families may complete the funeral without reporting suicide or even without reporting death. In addition to underreporting in statistics and epidemiological data on suicidality, it pushes the problem underground and impedes the provision of the necessary emotional and mental health support for survivors.

Changing the perception of criminality and removing the fear of prosecution will place survivors and their families in a better position to report suicide and suicide attempt and openly seek mental health care and other services after the incident. The improvement in suicide reporting and utilization of the HMIS indicators related to suicide are needed for effective suicide prevention. Awareness-raising about the reasons for the police investigation of all suspicious and unnatural deaths, together with treating survivors not as criminals but as witnesses in the investigation, are important first steps to dispelling the myth of criminalization. The government needs to raise awareness of the fact that no liability follows the initiation of the MLC during the death investigation. Sensitization of police, health officials, and communities of the complexities around suicide, including abetment of suicide, will lead to better data and the possibility of developing evidence-based interventions to tackle the problem (Fig. 3).

For the countries, that following the global recommendations (United for Global Mental Health, 2021) are planning to decriminalize attempted suicide, this study indicates that criminalization exists not only in the laws, but in the perceptions of society, decision- and policymakers, police, and health care workers. To effectively decriminalize suicide attempts, more than removal of relevant clauses from the laws is necessary.

6. Conclusion

Whether suicide is precipitated by mental illness or not, it is a sign of vulnerability and often is a cry for help. A person who attempted suicide needs assistance and help as much as any other person in need.

Globally, and in Nepal, to meet the targets set out by the Sustainable Development Goals to reduce suicide rates by 2030 by 30% (target 3.4), in addition to effective health and societal interventions to prevent suicide, the governments need to adopt urgent action to improve recording and documentation of suicide and decrease stigma and prejudice associated with it. This will make incidents of suicide and attempted suicide more visible, and create an enabling environment for much-needed support systems. Inter-sectoral cooperation across the government institutions, clear guidance on the reporting and adoption of suicide prevention strategies are the essential first steps in formulating a comprehensive response to suicide. Countries that criminalize attempted suicide need to consider the public health and legal consequences of criminalization with the view of treating suicide not as a criminal but societal and public health issue.

6.1. Limitations

The interviewee sample size was small and collected within a limited geographical area (Kathmandu), and hence study findings may not be representative of the entire Nepal, but rather, only those who were approached and consented to be interviewed.

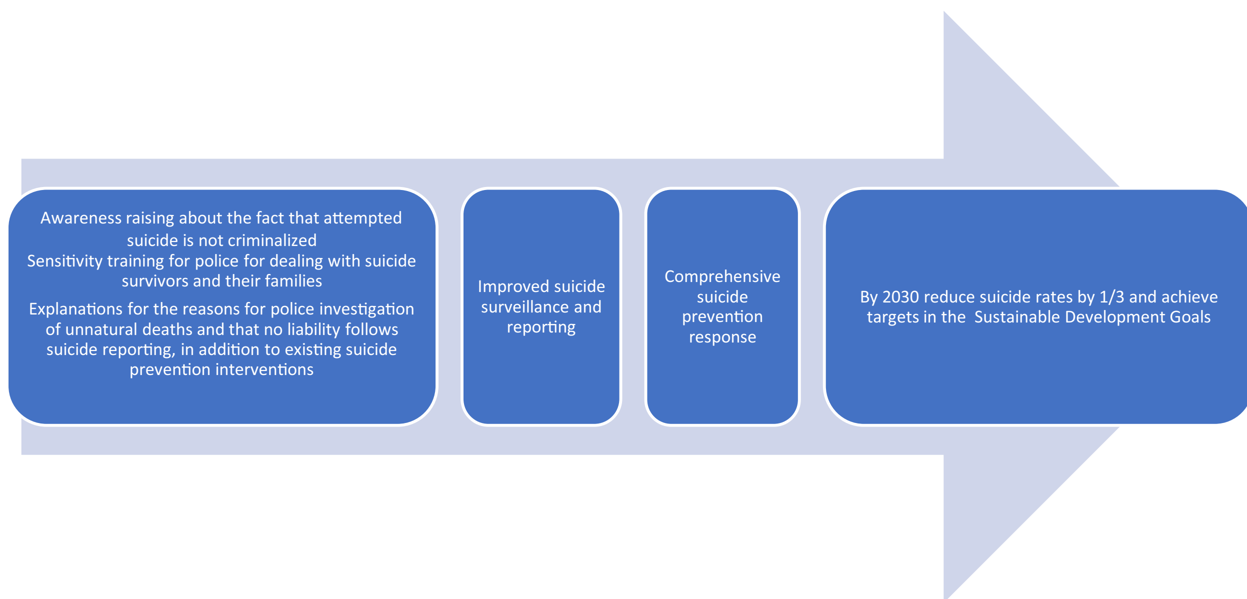

Fig. 3. Suggested interventions to address the perception of criminalization of suicide attempt and improve suicide response.

Ethical approval

Ethical approval was received from the Nepal Health Research Council on 24 January 2018 (Registration No 535/2017, Ref No. 2397).

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References

Abrutyn, S. (2017). What Hindu Sati can teach us about the sociocultural and social psychological dynamics of suicide. *Journal for the Theory of Social Behaviour, 47*(4), 522–539.
Adinkrah, M. (2016). Anti-suicide Laws in nine African countries: Criminalization, prosecution and penalization. *African journal of criminology and justice studies, 9*(1), 279–292.
Alexander, K. (2013). Saving "self-murderers": Lifesaving programs and the treatment of suicides in late eighteenth-century Europe. *Journal of Social History, 46*(3), 633–650.
Barry, J. V. (1965). Suicide and the law. *Melbourne University Law Review*, 5.
Behere, P., Rao, T. S., & Mulmule, A. (2015). Decriminalization of attempted suicide law: Journey of fifteen decades. *Indian Journal of Psychiatry, 57*, 122.
Benson, J., & Shakya, R. (2008). Suicide prevention in Nepal: A comparison to Australia-a personal view. *Mental Health in Family Medicine, 5*(3), 177–182.
Bertolote, J. M., Fleischmann, A., Butchart, A., & Besbelli, N. (2006). Suicide, suicide attempts and pesticides: A major hidden public health problem. *Editorials bulletin of the World Health Organization: The International Journal of Public Health, 84*(4), 260.
Binder, G., & Chiesa, L. (2019). The puzzle of inciting suicide. *American Criminal Law Review, 56*(65), 65–133.
Colombini, M., et al. (2015). Agenda setting and framing of gender-based violence in Nepal: How it became a health issue. *Health Policy and Planning, 31*(4), 493–503.
Colucci, E., & Lester, D. (Eds.). (2013). *Suicide and culture: Understanding the context. (H. Hjelmeland & B. C. B. Park, Collaborators)*. Hogrefe Publishing.
Constituent Assembly of Nepal. (2018). *The Public health services act in 2075/6/2. 2075*. Kathmandu, Nepal.
Cousins, S. (2016). Nepal's silent epidemic of suicide. *The Lancet (British edition), 387*(10013), 16–17.
Dhakal, S. (2019). Suicide cases increase by thirty-three percent. In *The Himalayan Times*.
Dvoskin, J. A., Knoll, J. L., & Silva, M. (2020). A brief history of the criminalization of mental illness. *CNS Spectrums, 25*(5), 1–13.
Gautam, B. R. (2016). *Civil registration and vital statistics: Policy and practices in Nepal*. Kathmandu: Department of Civil Registration: Babermahal.
Ghimire, K. J., & Sharma, N. P. (2016). And abetment of suicide: The need and relevance of its criminalisation. *Nepal Judicial Academy Law Journal, 10*(1).
Ghimire, R., et al. (2021). Intentional pesticide poisoning and pesticide suicides in Nepal. *Clinical Toxicology*, 1–7.
Goffman, E. (1990). Stigma : Notes on the management of spoiled identity / Erving Goffman. In *Penguin psychology*. London: Penguin Books.
Government of Nepal. (1992). *Government Cases Act* (2049).
Government of Nepal. (1999). *Government Cases Regulation* (2055).
Government of Nepal. (2017). *Sustainable Development Goals Status and Road Map 2016–2030, N. National Planning Commission, Editor*.
Government of Nepal and Ministry of Health and Population. (2013). *HMIS Indicators, 2070 D.o.H.S. (Nepal), Editor*. Teku, Kathmandu.
Gunnell, D., et al. (2017). Prevention of suicide with regulations aimed at restricting access to highly hazardous pesticides: A systematic review of the international evidence. *The Lancet Global Health, 5*(10), e1026–e1037.
Hagaman, A., & Rawat, K. (2015). *Pledge to save lives, in The Kathmandu post*. Kathamndu: The Kathmandu Post.
Hagaman, A. K., Maharjan, U., & Kohrt, B. A. (2016). Suicide surveillance and health systems in Nepal: A qualitative and social network analysis. *International Journal of Mental Health Systems, 10*(1), 46.
Healy, R. (2006). Suicide in early modern and modern Europe. *The Historical Journal, 49*(3), 903–919.
Im, J. S., Park, B. C. B., & Ratcliff, K. S. (2018). Cultural stigma manifested in official suicide death in South Korea. *Omega: Journal of Death and Dying, 77*(4), 386–403.
Imperial Legislative Council of India. (1860). *The Indian Penal Code, in Act No 45 of 1860*.
Karunarathne, A., et al. (2020). How many premature deaths from pesticide suicide have occurred since the agricultural green revolution? *Clinical Toxicology (Philadelphia, Pa.), 58*(4), 227–232.
Keller, S., et al. (2019). A look at culture and stigma of suicide: Textual analysis of community theatre performances. *International Journal of Environmental Research and Public Health, 16*(3), 352.
Kohrt, B. A., & Harper, I. (2008). Navigating Diagnoses: Understanding Mind–Body Relations, Mental Health, and Stigma in Nepal. *Culture, Medicine and Psychiatry, 32*(4), 462.
Lamotte, E. (1987). Religious suicide in early Buddhism. *Buddhist Studies Review, 4*(2), 105–118.
Li, F., et al. (2019). The influence of undetermined deaths on suicides in Shanghaix, China. *Social Psychiatry and Psychiatric Epidemiology, 54*(1), 111–119.
Licata, C., et al. (2019). Social and cultural factors leading to suicide attempt via organophosphate poisoning in Nepal. *Case Report Psychiatry, 2019*, 7681309.
Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology, 27*(1), 363–385.
Luitel, N. P., et al. (2017). Treatment gap and barriers for mental health care : A cross-sectional community survey in Nepal. *PLoS One, 12*(8), e0183223.
Mahato, P. K., et al. (2018). Qualitative evaluation of mental health training of auxiliary nurse midwives in rural Nepal. *Nurse Education Today, 66*, 44–50.
Marahatta, K., et al. (2017). Suicide burden and prevention in Nepal: The need for a national strategy. *WHO South East Asia J Public Health, 6*(1), 45–49.
Mendelson, D., & Freckelton, I. (2013). The interface of the civil and criminal law of suicide at common law (1194-1845). *International Journal of Law and Psychiatry, 36*(5–6), 343–349.
Mishara, B., & Weisstub, D. (2005). Ethical and legal issues in suicide research. *International Journal of Law and Psychiatry, 28*(1), 23–41.
Mishara, B., & Weisstub, D. (2016). The legal status of suicide: A global review. *International Journal of Law and Psychiatry, 44*, 54–74.

Naveed, S., et al. (2017). Suicide and its legal implications in Pakistan. *A Literature Review. Cureus, 9*.
Neeleman, J. (1996). Suicide as a crime in the UK: Legal history, international comparisons and present implications. *Acta Psychiatrica Scandinavica, 94*(4), 252–257.
Nepal Constituent Assembly. (2017). *Criminal Code of Nepal 2074 (2017), N.C. Assembly, Editor*.
Nepal Police Headquarters. (2019). In R. Ghimire (Ed.), *Annual suicide numbers*. Email communication.
Nribesh Nepal. (2019). *Journalist Pudasaini suicide case: Police arrest Rabi Lamichahane, in My Republica*. Kathmandu: My Republica.
Oates, M. (2003). Suicide: The leading cause of maternal death. *British Journal of Psychiatry, 183*(4), 279–281.
Pandey, A. R., et al. (2020). Mortality and risk factors of disease in Nepal: Trend and projections from 1990 to 2040. *PLoS One, 15*(12), Article e0243055.
Parliament of India. (2017). *The Mental Healthcare Act, in 10 of 2017, P.o. India, Editor*. New Delhi.
Paudel, N. (17 May 2019). *27 People Committed Suicide in Nine Months due to Provocation: Police Data Shows, in The Kathmandu Post*.
Pun, K. D., et al. (2020). 'Violence exists to show manhood': Nepali men's views on domestic violence – A qualitative study. *Global Health Action, 13*(1), 1788260.
Pyakurel, R., et al. (2015). Cause of death in women of reproductive age in rural Nepal obtained through community-based surveillance: Is reducing maternal mortality the right priority for women's health programs? *Health Care for Women International, 36*(6), 655–662.
R (Pretty) v Director of Public Prosecutions in UKHL 61. (2002). UK House of Lords.
Rai, B. (2019). *Everyone is talking about Rabi Lamichhane. here's what you need to know about the law that had him detained., in the Kathmandu post*. Kathmandu: The Kathmandu Post.
Rajit Bhakta Pradhananga and Kushang Lama. (2018). *An analytical study of culpable homicide (Kartabya Jyan) under the Miluki criminal (code) act, 2074 BS. Prosecution Journal* (p. 4). Nepal: Office of the Attorney General.
Regmi, S. K., et al. (2004). Nepal mental health country profile. *International Review of Psychiatry, 16*(1–2), 142–149.
Robertson, G. (2018). *Suicide and the media: A degree of caution is required, in the Himalayan times*. Kathmandu: The Himalayan Times.
Rockett, I., Kapusta, N., & Bhandari, R. (2011). Suicide misclassification in an international context: Revisitation and update. *Suicidology Online, 2*, 48–61.
Satyal, U. (2019). *Establishment of abetment to suicide no easy task, in the Himalayan times*. Kathmandu: The Himalayan Times.
Sharma, B. R. (2009). Is attempted suicide an offense? *Aggression and Violent Behavior, 14*(2), 139–145.
Shrivastava, A., Kimbrell, M., & Lester, D. (2012). *Suicide from a global perspective: Vulnerable Populations and Controversies*. Hauppauge: Nova Science Publishers, Incorporated.
Shuvam, D. (2020). *Suicide cases remain a challenge for law enforcement agency even during lockdown, in The Kathmandu Post*. Kathmandu.
Sisask, M., & Värnik, A. (2012). Media roles in suicide prevention: A systematic review. *International Journal of Environmental Research and Public Health, 9*(1), 123–138.
Snowdon, J., & Choi, N. G. (2020). Undercounting of suicides: Where suicide data lie hidden. *Global Public Health, 15*(12), 1894–1901.
Stefan, S. (2016). *Rational suicide, irrational laws: examining current approaches to suicide in policy and law*. New York: New York: Oxford University Press.
Subedi, N., & Deo, S. (2015). Status of medico legal service in Nepal: Problems along with suggestions. *Journal of College of Medical Sciences-Nepal, 10*(1), 49–54.
UK Public General Acts. (1961). *Suicide Act 1961, in c. 60 (Regnal. 9_and_10 Eliz_2)*.
Tait, G., & Carpenter, B. (2016). The continuing implications of the 'crime' of suicide: A brief history of the present. *International Journal of Law in Context, 12*(2), 210–224.
Thapaliya, S., Sharma, P., & Upadhyaya, K. (2018). Suicide and self harm in Nepal: A scoping review. *Asian Journal of Psychiatry, 32*, 20–26.
Tucker, J. (2015). The geometry of suicide law. *International Journal of Law, Crime and Justice, 43*(3), 342–365.
UN Women. (2011 March 01). Aiding and abetting suicide, 2011 [cited 2021 Feb 5]; Available from: https://www.endvawnow.org/en/articles/827-aiding-and-abetting-suicide.html.
United for Global Mental Health. (2021). *Decriminalising Suicide: Saving Lives, Reducing Stigma, I.A.f.S. Prevention, Editor*.
United Nations General Assembly. (2015). Resolution transforming our world:The 2030 agenda for sustainable development. In *A/RES/70/1*.
Utyasheva, L., & Eddleston, M. (2021). Prevention of pesticide suicides and the right to life: The intersection of human rights and public health priorities. *Journal of Human Rights, 20*(1), 52–71.
Vijayakumar, L. (2015). Suicide in women. *Indian Journal of Psychiatry, 57*(Suppl. 2), S233–S238.
Vijayakumar, L. (2017). Challenges and opportunities in suicide prevention in South-East Asia. *WHO South-East Asia Journal of Public Health, 6*(1), 30–33.
Vijaykumar, L. (2007). Suicide and its prevention: The urgent need in India. *Indian Journal of Psychiatry, 49*(2), 81–84.
Wicks, E. (2010). *The right to life and conflicting interests* (p. 260). Oxford; New York: Oxford University Press. xiv.
Wikipedia. (15 October 2020). Suicide in Nepal [cited 2020 November 10, 2020]; Available from: https://en.wikipedia.org/wiki/Suicide_in_Nepal.
World Health Organisation. (2019). Fact Sheet on Suicide, 2 September 2019 [cited 2020 11 June]; Available from: https://www.who.int/news-room/fact-sheets/detail/suicide.
World Health Organisation. (2021a). *Suicide, in Fact Sheet*. WHO.
World Health Organisation. (2021b). *Live life: An implementation guide for suicide prevention in countries*. Geneva: World Health Organization.
World Health Organization. (2014). *Preventing suicide: a global imperative*. Geneva: World Health Organisation.
World Health Organization. (2019). *Suicide in the world: Global Health estimates*. Geneva: World Health Organization.
Wu, K. C.-C., Chen, Y.-Y., & Yip, P. S. F. (2012). Suicide methods in Asia: Implications in suicide prevention. *International Journal of Environmental Research and Public Health, 9*(4), 1135–1158.
Yip, P. S. F. (2008). *Suicide in Asia: Causes and prevention*. Hong Kong: Hong Kong University Press.