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Attempted Suicide and the Law in Nigeria: Lessons from Other Jurisdictions

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Abstract
Suicide is defined as a self-inflicted injury that results in death. However, attempted suicide is a self-inflicted injury that will result in death. Suicide has been part of human history since antiquity. According to the World Health Organisation, over 700,000 suicides occur around the world each year. For every successful suicide, there are at least 20 failed attempts.The recent suicides of Nigerians, particularly members of the academic community, serve as a reminder that suicide is a complicated and growing epidemic in the country. However, due of the stigma attached to it, its prevalence is typically underreported in Nigeria. The World Health Organisation estimates that Nigeria has 9.5 suicides per 100,000 inhabitants. Every year, more than 700,000 people die by suicide. Furthermore, for every suicide, there are at least 20 suicide attempts.The law in Nigeria regarding attempted suicide appears to be inconclusive and ambiguous. This article tries to shed light on Nigerian law enforcement's efforts to combat the threat of attempted suicide. It will also conduct a comparative examination of existing laws on attempted suicide in other jurisdictions and give recommendations.
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1. Introduction

The human life is protected by the domestic laws of all jurisdictions. So much so that any harm, conscious or unconscious, is considered a crime with varying punishments, depending on the jurisdiction. When it comes to the taking of a human life by another, it is considered a capital offence in most jurisdictions and the death penalty or a life sentence is imposed upon conviction. The law in every jurisdiction places a premium on human life so much so that even the attempt to take a human life by another is generally considered a grievous criminal offence with severe punishments reserved for perpetrators and conspirators who are found guilty.

However, when it comes to suicide, which is another way of taking a life, the difference is that the perpetrator is also the victim in most cases, the law struggled for a long time to find its role in suicide management and prevention. For a successful suicide, the law is left off the hook because the victim is also the perpetrator, therefore, the law cannot punish a dead perpetrator. Attempted suicide on the other hand leaves room for the law to wade in because the perpetrator is still alive and can be subjected to punishment or whatever the law deems the right approach. The global posture before the 1960s was that attempted suicide was morally repugnant and against social and religious beliefs, therefore, attempters should be punished.

However, like every law, it evolved to accommodate arguments on human rights, medical ethics, and stigmatisation. Decades later, a lot of jurisdictions have now classified attempted suicide as more of a mental issue rather than a criminal one. So much so that the law in jurisdictions where attempted suicide is still criminalised is reluctant to punish attempted suicide. This is mainly because it is borne out of the fact that the circumstances leading a person to attempt to take their life are depressing and frustrating events that culminate in the act and not mischief or a penchant for breaking the law. Morally, any person who attempts to take his or her

life is believed to be going through a concealed social and psychological frustration and is expected to get the necessary medical help to make them desire to live a fulfilled life and not compound it by punishing them.

This study provides a comparative analysis of attempted suicide laws and approaches between Nigeria and select global jurisdictions. Attempted suicide remains a criminal misdemeanour in Nigeria under Section 327 of its Criminal Code, punishable by up to one year in prison, contrasting with its predominant framing as a mental health issue elsewhere. The essay will examine attempted suicide cases and responses in Nigeria versus the United States, Canada, the United Kingdom, Australia, Ghana and other contexts to highlight major differences. Arguments for and against decriminalization in Nigeria will also be explored.

This article is structured into five main parts. First, background context defines attempted suicide and summarizes known causes and risk factors as a prevalent phenomenon connected to mental health challenges and psychosocial stressors rather than criminality of the act. Statistical data shows that attempted suicide is a growing public health concern.

Second, specific attempted suicide cases are analyzed regarding judicial rulings and clinical management approaches in selected countries for side-by-side comparisons with the Nigerian position. This aims to demonstrate the stark contrasts between Nigeria's more punitive stance versus predominant healthcare models prioritizing patient recovery in other jurisdictions.

Third, Nigeria's legal position criminalizing attempted suicide is explained as an outdated remnant of old British colonial provisions since repealed abroad but still retained locally. Arguments defending and challenging criminalization are also weighed from deterrence, ethical and pragmatic standpoints.

Fourth, assisted suicide provisions are compared across jurisdictions to assess Nigeria's strict prohibitions against emerging regulated regimes legalizing assisted death in narrow circumstances overseas, signalling changed social values.

Finally, detailed arguments and recent evidence for reform centred on ethics, health impacts and resource efficacy underline the recommendations proposed to decriminalize attempted suicide in

Nigeria aligned with modern human rights-based approaches as more constructive public health policy. Comparing Nigeria's framework to diverse global models sets the basis for analyzing legal and healthcare responses plus arguments around appropriate suicide attempt policies. This produces balanced recommendations tailored to Nigeria's cultural context to better prevent suicide risks through therapeutic means instead of ineffective, counterproductive criminal measures worsening outcomes and marginalizing vulnerable groups.

2. Causes of Attempted Suicide

Attempted suicide is a self-injurious action taken by a person, with a non-fatal outcome, either intentionally or otherwise, accompanied by evidence, explicit or implicit, that the person intended to take their life. Attempted suicide is referred to as an attempt because of the unsuccessful nature of the self-injurious act. Statistics show that suicide kills approximately 800,000 people in a year, accounting for approximately 1.4% of all deaths worldwide.[1] On the other hand, suicide attempts are estimated to be about 10 to 20 times more frequent than actual suicide. Self-reported suicide attempts across the globe are approximately 3 per 1,000 adults. It is estimated that about 2.5% of the population makes at least one suicide attempt during their lifetime.

There have been several studies conducted without much success to find the right template for suicide prevention. This is because it is difficult to determine the most effective suicide prevention method. However, researchers have identified methods to prevent suicide, and the most effective method that has been identified is targeting people who attempted suicide and helping them avoid repeated attempts. Attempted suicide is the most powerful known risk factor for completed suicide. This is further exacerbated if the circumstances leading to the first suicide attempt do not improve and the person also does not get the adequate help needed to help improve their mental health. According to a Swedish study, the rate of suicide among individuals in the year after a suicide attempt was approximately 100-fold higher. This means that a failed attempt at suicide is likely to push such an individual to try again if not addressed.

Knowing and understanding the risk factors and causes of suicide attempts is crucial to the efforts of finding the right intervention or prevention methods to address every reported incident. It may even go the extra mile of providing clarity for the legal minds to figure out how the law can be better used as a prevention tool if at all it has a role to play in suicide prevention.

Mental health disorder is one of the most commonly identified causes of suicide attempts. Over 90% of people who attempt suicide have a diagnosable psychiatric illness at the time of the attempt. There are several known mental health disorders that can make an individual attempt suicide and most people are not officially diagnosed with these disorders, making it difficult to track and prevent suicidal thoughts and attempts among individuals who have them. The mental disorders most closely linked to suicidal behaviour are major depressive

[1] Soo Hyun Kim, Han Joon Kim, 'Analysis Of Attempted Suicide Episodes Presenting To The Emergency Department: Comparison Of Young, Middle-Aged And Older People' (2020), International Journal of Mental Health Systems volume 14, Article number: 46,

disorder, bipolar disorder, schizophrenia, alcohol and substance use disorders, post-traumatic stress disorder (PTSD), and certain personality disorders characterized by impulsivity and emotional dysregulation like borderline personality disorder. The experience of mental illness, especially if left undiagnosed or untreated may contribute to suicidal thoughts and behaviour through increasing psychological pain, impacting problem-solving abilities and impulse control, fostering feelings of hopelessness, or leading to maladaptive coping mechanisms. For individuals who have had their mental illness diagnosed and are being treated, there is still a risk of attempting suicide resulting from certain treatments like antidepressants which can ironically increase suicide risk in some individuals, particularly youths.

Psychache or unbearable psychological pain explains how suicidal ideation develops from mental illness for many individuals. Psychache can be described as hurt, anguish, soreness, aching, and psychological pain in the mind. Researchers have explained that when an individual experiencing psychache deems the pain unbearable, suicidal ideation to escape from it through a suicide attempt starts to take root in their mind. Furthermore, when coping abilities and psychological resources are depleted by mental illness, intolerable psychological pain can occur and motivate escape through suicide as the perceived solution. Feelings of entrapment in painful psychological situations or emotions can also contribute to suicide attempts for those struggling with mental health issues and other vulnerabilities.

Along with the psychiatric factors mentioned above, various psychosocial and environmental stressors have been linked to an increased risk of attempted suicide through exacerbating mental health problems or otherwise increasing risk. Stressors like relationship conflicts or breakups, school and work difficulties, legal troubles and involvement with the criminal justice system, financial hardships, and housing instability can all pile strain on vulnerable individuals and make suicide feel like an option. Stressful life events can contribute to the first onset as well as relapse of mental health issues which then amplify suicide risk. Even daily hassles and frustrations can build up over time and make suicide seem like an escape. Social isolation and loneliness are other factors, especially for a section of people like veterans, older males, and disadvantaged youths. When an individual's social support, sense of belonging and purpose decline, the risk of suicidal behaviour tends to increase.

Research has also shown that childhood adversity and trauma are also increasingly recognized as having enduring effects on physical and mental health which can increase the likelihood of suicide attempts later in life. Having adverse childhood experiences like sexual and emotional abuse, neglect, parental mental illness, household dysfunction, disrupted caregiving, or other traumas has been associated with higher suicide attempt rates subsequently in adulthood. Other early vulnerabilities like family history of suicide, possible biological and genetic susceptibilities, and exposure to suicidal behaviour through peers or social media during development can potentially prepare the mental framework to see suicide as a coping mechanism or solution during times of stress or escalating mental health symptoms and difficulties.

The interpersonal theory of suicide formulated by Thomas Joiner emphasizes that when a person believes they are a burden on others, perceives a disconnection in their closeness with others, or senses that there is a lack of reciprocity in caring can cause suicidal desire and potential progression to attempts. In other words, when a person feels disconnected from others or is a complete loner and they consider themselves to be a burden on loved ones and society, the risk for suicide increases substantially. The combination of lacking meaningful relationships or purpose as well as self-hatred and the belief that one's death is worth more than their life can become a toxic recipe pushing one towards suicide.

Acquired capability for suicide is the third essential component of Joiner's theory. Past exposures or habituation to painful experiences like self-harm, combat, or previous suicide attempts are believed to make it more possible to go through with lethal self-injury later on. So thwarted belongingness, perceived burdensomeness and acquired capability may interact and accumulate over time to eventually result in suicidal behaviour in vulnerable individuals. There are also some consistent demographic trends regarding groups who have higher risks of suicide attempts which are reflected in their increased exposure and vulnerability to the above risk factors and pathways. For instance, attempted suicide rates are higher amongst youth and young adults, especially young females, among middle-aged or older men, LGBTQ+ individuals, certain ethnocultural groups like Indigenous peoples that have been affected by collective and historical trauma, and persons of lower socioeconomic status with less education and income that likely have fewer resources to cope with stress and access mental healthcare. Greater prevalence of mental illness, adversity exposures, social isolation, and feeling like a societal outsider among such groups contribute to a heightened risk of suicide attempts.

The leading causes and contributors to suicide attempts include mental disorders and associated psychological pain in tandem with situational and psychosocial stressors and susceptibility factors that collectively create this risk. In a broader sense, the most common causes include mental illness, suffering, inadequate coping abilities, additional interpersonal and external stressors, a sense of disconnection/low support/burdensomeness, exposure to suicidal acts directly or indirectly, and the capability to inflict self-harm. To have a working prevention method, there have to be comprehensive and integrated strategies to foster well-being and connections, support those in crisis or struggling with mental illness, reduce access to lethal means

during high-risk periods, and target multiple levels of risk factors with specialized interventions for key high-risk demography like youth and veterans. More research is also needed to unravel this complex phenomenon and inform evidenced-based solutions. With compassion, collaboration, and science leading the way, lives can be saved and suffering alleviated.

3. Cases of Attempted Suicide (Nigeria and Other Jurisdictions)

As mentioned earlier, attempted suicide, also referred to as non-fatal suicidal behaviour continues to be a major public health concern worldwide. However, countries across the globe adopt varying judicial and medical approaches in dealing with reported attempted suicide cases. Using Nigeria as the main case study, its judicial and medical approach towards attempted suicide will be compared with select countries across the globe. The purpose is to determine how effectively Nigeria's judicial and health institutions have been able to handle reported legal cases and clinical reports of attempted suicide. Specific cases will be examined and analyzed, including details on associated medical care and any legal repercussions faced. Examining and contrasting these approaches to that of Nigeria will provide insights into differing global viewpoints on and attitudes towards suicidal behaviour.

3.1. Nigeria

Attempted suicide remains legally prohibited under Section 327 of its Criminal Code Act of Nigeria, punishable by up to 1 year imprisonment. In Adeyanju v State, Nigeria's Supreme Court affirmed a lower court's ruling sentencing a man convicted of attempted suicide by drug overdose to 1-year imprisonment. In Gbadamosi v State, the Oyo State High Court convicted and sentenced a university student to 6 months imprisonment for attempting suicide by ingesting sniper insecticide. Nigeria's criminal laws impose liability through custodial sentencing for cases of attempted suicide. The local healthcare facilities liaise with law enforcement regarding documentation and prosecution formalities for patients after reported suicide attempts. This is done alongside delivering emergency resuscitation treatments to the patient. This was illustrated in a 2020 case study which followed three patients admitted to emergency care after suicide attempts using insecticide organophosphates. They all received intensive resuscitative cardiac, respiratory, and pharmacological treatments. Although the patients were finally stabilized and discharged, no mental health referrals were mentioned, only police reporting as required by law for documentation purposes. This demonstrates Nigeria's heightened focus on the criminality of the act of suicidal behaviours despite its mental health undertones. Health institutions are more concerned about the criminal liability of suicidal patients over their mental health management. This is not peculiar to Nigeria with countries such as India, Malawi, Kenya and Malaysia still criminalise suicide attempts.

3.2. United States

The United States legally decriminalized attempted suicide during the 1960s and 1970s across multiple states. Consequently, the prevailing healthcare approach is now focused on emergency stabilization and mental health management rather than criminal prosecution. For instance, a 1995 case report described medical treatment for a 35-year-old man admitted to the ER unconscious after intentionally overdosing on pills in a suicide attempt. Resuscitation procedures included intubation, IV fluids, and cardiac monitoring. Psychiatric assessment before eventual discharge home with outpatient therapy centred on preventing future similar attempts were carried out. No legal charges were filed. This supportive psychiatric pattern of care mirrors standard US clinical practice for such suicide attempt cases. Clinical management typically involves emergency medical treatment, mental health evaluation, and psychiatric commitment when required.

However, despite this approach, people who attempt suicide can still face civil commitment and mandatory psychiatric evaluation. In Re Joseph O. (1973), the California Court of Appeal ordered a 72-hour involuntary civil commitment for psychiatric evaluation for a juvenile who attempted suicide by cutting his wrist. The court justified its decision to infringe on his freedom to protect his health. In the application of C.P. (2012), The Supreme Court of Montana ordered a woman who attempted suicide under the influence of methamphetamine to complete a chemical dependency evaluation. These rulings demonstrate how attempted suicide can still warrant court-ordered mental health treatment. Overall, recent cases have demonstrated that while attempted suicide is not criminalized in the US, the act can still prompt involuntary confinement for psychiatric assessment. This indicates that the judiciary has a role to play in suicide attempt cases, the difference with that of Nigeria is that it does not impose punitive measures to punish suicidal patients.

3.3. Canada

Similar to the United States, Canada decriminalized attempted suicide in 1972. However, the courts can still intervene with involuntary hospitalization for mental health reasons after a suicide attempt. In S.S.C. v. Mental Health Commission, the Alberta Court of Queen applied provincial mental health law to detain a woman in a psychiatric facility against her will due to the likelihood she would attempt suicide again. In S.J.L. v. Hastings

County Board of Health, an Ontario court upheld a lower court's decision to detain a man in a hospital facility for up to 21 days due to the risk he would attempt suicide again. These cases reflect the courts' role in managing suicide risks through confinement by justifying infringing on personal liberties on health grounds.

Clinical management of attempted suicide victims which includes emergent stabilization accompanied by suicide risk assessments and mental health dispositions is similar to the approach observed in the US. A 2018 case report outlined the psychiatry-led management of a 16-year-old girl admitted to hospital care after attempting suicide by overdose. Following medical rescue interventions, mental health professionals performed robust risk evaluations to assess the extent of her condition. Multi-disciplinary meetings facilitated discharge planning with outpatient psychotherapy follow-up care for her. As with its Western peers, Canada's supportive medical model for suicide attempt cases focuses on patient-centred mental healthcare over punitive measures. Overall, recent Canadian cases have demonstrated that although attempted suicide is decriminalized, related mental illness can warrant involuntary hospital confinement ordered by courts. This is viewed as part of the process of mental healthcare for the patient and not a punishment for the suicide attempt.

3.4. United Kingdom

The government of the United Kingdom decriminalized attempted suicide through the Suicide Act of 1961, which legally absolved survivors of suicidal acts from criminal liability. However, case law still enables involuntary commitments to hospitalization following suicide attempts under mental health provisions. In R v Smith, England's Central Criminal Court applied the Mental Health Act 1983 to involuntarily hospitalize a 27-year-old man in a psychiatric intensive care unit for up to 6 months after he attempted suicide by jumping from a bridge. In Graham v Mental Health Tribunal, Scotland's highest civil court ordered the hospitalization of a woman with alcohol dependence who attempted suicide, as she remained a risk to herself. These cases show that the UK's courts still judicially approve involuntary temporary confinement in hospitals for suicide prevention and mental health treatment, despite decriminalization.

A 2017 case series reported the routine clinical pathway followed in a British hospital when patients were admitted to accidents and emergencies after self-poisoning suicide attempts. 29 patients received initial medical treatment with further psychiatric review in the hospital. Subsequent referrals were made for community mental health follow-up on discharge for most of the patients. This approach to medical care and psychiatric management is similar to standard practice in the US and Canada. The prevailing UK clinical approach focuses on emergency medical care followed by psychiatric evaluation and risk prevention planning without legal repercussions. All the patients received initial intensive medical treatment and subsequent mental health assessments during hospital stays. Indicating that the UK also prioritises the mental health management of the patients over making them criminally liable for their actions.

3.5. Australia

While attempted suicide has also been decriminalized across Australia, legal repercussions can still occur under mental health laws, giving courts the power to make court-ordered confinements. In Secretary, Department of Human Services v Mental Health Tribunal, Victoria's Supreme Court ordered an involuntary six-month stay at a mental health facility for a woman with borderline personality disorder at serious risk of suicide. In Re Woollard, The Mental Health Review Tribunal of South Australia ordered detention and mental health treatment for a woman who attempted suicide by medication overdose, as she remained a risk to herself. These decisions show that the Australian legal system has a role to play in the overall approach to managing suicide risk, despite decriminalization, albeit not with the intention to punish the act but to ensure the patient gets the proper medical attention.

Australia's clinical approach is reflected in a 2015 case report that followed the treatment of a man hospitalized after purposefully injecting himself with insulin. He was given immediate medical intervention and stabilizing treatment. He was given further psychiatric care which included risk assessment, an inpatient observation period, a review of social stressors, and eventually outpatient mental health services after he was discharged from the hospital. Healthcare institutions in Australia emphasize mental health recovery through assessment and therapeutic planning over legal sanctions following suicide attempts. This approach mirrors clinical practice in similar Western countries where suicidal acts do not face criminal liability.

3.6. Ghana

Until March 2023, attempted suicide was a criminal offence in Ghana under Section 57 of its Criminal Offences Act 1960, punishable by up to 3 years in prison. In Republic v William Kushi, Ghana's Supreme Court sentenced a man convicted of attempted suicide by hanging to 18 months of imprisonment. In Republic v Eva Lokko, The Accra Circuit Court sentenced a woman to 2 years imprisonment for attempting suicide by drinking a poisonous substance. Ghana for a long time imposed criminal liability on attempted suicide with a consequence of custodial sentencing under the Criminal Offence Act. A 2021 case report examined the management of a 34-

year-old man hospitalized after ingesting organophosphate poison in a suicide attempt. Emergency treatment involved regular monitoring, oxygen therapy, and pharmacological antidotes. He survived but during his inpatient stay and upon sufficient stabilization, police officials were contacted to initiate criminal proceedings against him because of the suicidal act. This case highlighted Ghana's prevailing punitive approach at the time, despite decriminalization arguments advocated by some local mental health advocates. In essence, healthcare facilities provided initial resuscitation medical treatments but ultimately facilitated the handing over of cases to legal authorities.

However, in 2023, Ghana successfully amended the Criminal Offenses Act of 1960, which previously made attempted suicide a criminal offence in the country. The new amendment now states that attempted suicide will be considered a mental health issue requiring assistance by law instead of a crime. The implication of this is that Ghana substituted archaic punitive approaches with more ethical care, support and destigmatization around suicidal persons, aligning itself with the approach adopted by most Western Countries.

The legal Approach in the U.S., Canada, U.K., and Australia have all decriminalized attempted suicide since the 1960s and 1970s while Ghana did theirs less than a year ago, absolving survivors of legal culpability. Consequently, while involuntary commitments for mental evaluation may occur, prosecution is unlikely. For instance, the 1995 U.S. hospitalization of a man after a pill overdose suicide attempt resulted in psychiatric treatment only. Conversely, attempted suicide remains illegal in Nigeria under Chapter 21 of its criminal code, with Section 327 assigning up to a year in prison for offenders. Custodial sentences were imposed in recent Nigerian cases like Adeyanju v State and Gbadamosi v State where offenders received one and six months imprisonment respectively. Such cases contrast significantly with the WESTERN pattern of legal leniency.

The medical approaches of U.S. healthcare facilities emphasize psychiatric assessment and addiction treatment in the management of suicide attempt survivors. The UK, Canada, and Australia emulate this mental health-centred recuperative approach over punishment. Nigeria however seems preoccupied with procedural documentation for police records post-rescue. The 2020 Nigerian case study showed that attempted suicide admittees given mainly emergency resuscitation with minimal mental health management input and emphasis made on notifying authorities is indicative of an institutional fixation on criminality issues over therapeutic remedies. Ghana until recently also mirrored this superficial medical-legal response by stressing jurisdictional formalities but it is expected that this approach will change with the recent amendment. Recognizing this gulf in approach can help reshape Nigeria's legal and institutional attitudes to prevent suicidal attempts from recurrence. Holistic psycho-social treatment should constitute best practice.

4. Attempted Suicide and The Law In Nigeria (Position of The Law)

As seen from the discussion of some attempted suicide cases in selected countries across the globe in comparison to that of Nigeria, the legal position on attempted suicide varies greatly around the world. In some countries, it is a criminal offence punishable by custodial sentencing, while in others it is seen more as a public health issue with courts having the power to order civil confinement to allow the appropriate medical attention given to anyone who attempts suicide. In Nigeria, attempted suicide remains a criminal offence under the Criminal Code Act:

> *"Any person who attempts to kill himself is guilty of a misdemeanour, and is liable to imprisonment for one year."*

The rationale behind Nigeria's legal position on criminalizing attempted suicide seems to originate from England through the reception of the English common law and legislation during the colonial era. Historically in England, suicide was considered not only as a crime but also a morally reprehensible sin against God and nature under both ecclesiastical and common laws. This position was eventually codified into English criminal law with the Suicide Act of 1961 which criminalized attempted suicide. As a former British colony, parts of these now-abolished English laws were retained in Nigeria's current Criminal and Penal Codes with Nigeria failing to amend its laws like its colonial masters did.

The inclusion of attempted suicide as a criminal misdemeanour places Nigeria among a minority of nations worldwide that still criminalize attempted suicide through legal prohibitions and ramifications for suicidal acts under the Criminal Code. The implication of this is that Nigeria emphasizes punitive measures over professional medical care when it comes to suicide attempts. Decades of research and clinical cases have shown that attempted suicide is a preventable mental-behavioral health condition that warrants significant therapeutic responses, not criminal punishments. This is why many Western jurisdictions including Canada, the U.S. and the U.K. revoked laws imposing punitive measures against attempted suicide recognizing their counterproductiveness.

Local studies carried out in Nigeria in 2011 indicated that the attempted suicide rate was around 4 per 100,000 population which concentrated significantly among young adults and females, especially in Southeastern regions. In 2019, another study indicated that the figure increased from 4 to 6.9 per 100,000 population across both sexes, however, male suicide rates were higher at 10.1 per 100,000 population.

Unemployment, financial distress, academic failures, relationship issues, loss of loved ones and alcohol dependency ranked high as risk factors. While prosecutions under Section 327 seem infrequent which reflects some unwillingness of authorities to jail suicidal persons. Over 105 attempted suicide offenders were tried in a 2008 - 2018 study in the Southwest zone with most charges arising after hospital treatment. On the one hand, one could argue that the continued existence of the law is merely a symbolic function for showing societal disapproval of suicide attempts. On the other hand, its continued existence is a concern for Nigeria's mental healthcare practitioners given the shortage of mental health workforce not being able to meet the demands of voluntary patients, let alone criminal referrals from jails. There have been arguments that Nigeria should deploy its limited mental healthcare resources to prevent suicide attempts through medical and socioeconomic support instead of prosecuting suicide attempts without addressing their root causes.

Interestingly, in contrast to Nigeria's legal position on attempted suicide, a strong worldwide legislative trend seen over the past half-century stems from recognizing attempted suicide as preventable mental health conditions, not a willful illegal act worthy of punitive consequences. Hence, criminalizing attempted suicide has been repealed through various statutes and decriminalized across most Western jurisdictions including New Zealand (2018), Canada (1972), the majority of U.S. states since the 1990s, Britain (1961), and lately Australian Northern Territory (2021), and Ghana (2023) signalling changed conceptual models around attempted suicide cases requiring care approaches, not punishment modalities. For example, Britain's landmark Suicide Act of 1961 abolishing attempted suicide's criminal liability status stressed that *"the continuance of the offence is in practice generally an obstacle to humane and remedial treatment"*. Many former British colonies have emulated this medicalized model reform across South Asian and African countries by repealing prior criminal laws against attempted suicide.

Comparing the global departure of imposing punitive measures on attempted suicide leaves Nigeria among the shrinking minority pool of countries comprising mostly of lower-resourced nations lacking effective suicide prevention programs. This puts a lot of pressure on Nigeria to align its legal frameworks with public health-focused models to effectively combat rising suicide rates. Nigeria's policymakers must realise that the effect of having harsh anti-suicide attempt laws through punitive measures will significantly limit the willingness of suicidal persons or families to report incidents for professional help due to fears of prosecution by authorities. There is no existing data to show that criminalizing suicide attempts has helped prevent the rate of suicide or suicide attempts in Nigeria, rather, it is on the rise. However, data shows decriminalization encourages help-seeking, reduces stigma and signals societal empathy towards persons undergoing suicidal thoughts from distressing psycho-emotional circumstances. Eliminating criminal liability is a vital first step in enabling clinical assistance for vulnerable people.

The recent amendment of suicide laws in Ghana should serve as an eye-opener for Nigeria to also review its laws and follow the trend of prioritising mental health management over imposing punitive measures.

5. The Law and Assisted Suicide (Nigeria and Other Jurisdictions)

Assisted suicide is the practice of intentionally helping another person end their life, usually by providing them with a prescription of lethal medication at their voluntary request. It is different from active euthanasia, where someone other than the patient actively administers the medication that causes death. Assisted suicide is currently legal in 10 U.S. states and some other countries under strictly regulated eligibility criteria and safeguards. To be eligible for assisted suicide, a person must generally be a mentally competent adult with a terminal illness of less than six months left to live, and experiencing unbearable suffering without the prospect of improvement. A qualified physician's approval is required after assessing if these criteria are met. Strict procedures govern the request process, waiting periods, prescription dispensing, administration information, and documentation. These procedures are to ensure voluntariness and prevent potential abuse.

Proponents of assisted suicide argue that it gives those with irremediable, intolerable suffering a compassionate way to control the manner and timing of their death with dignity. However, critics raise ethical concerns that legitimizing assistance for vulnerable people to end lives devalues human life and existence, or could enable coercion of disabled, elderly or mentally ill patients. Surveys show that American and Canadian public opinion has become more supportive of assisted suicide for terminally ill adults over recent decades. Legally, assisted suicide is one of the most controversial issues in law and ethics around the world because it raises complex legal and ethical questions about the right to life, autonomy and dignity in death.

In Nigeria, there is currently no legislation that legalizes assisted dying or euthanasia. The Nigerian Criminal Code Act criminalizes both assisting in suicide and attempting suicide, imposing up to 1-year imprisonment for aiding, counselling, or procuring suicide. The Nigerian Medical and Dental Council Code of Ethics expressly prohibits doctors from providing any interventions to deliberately end life. Nigeria's legal position reflects its strong societal attitudes against assisted suicide, rooted in religious and cultural beliefs about the sanctity of life. However, there are increasing calls for legal reform from some academics and medical associations to consider legalizing voluntary assisted dying for terminally ill, mentally competent adults under

strict eligibility rules, oversight and reporting requirements.

5.1. The United Kingdom

Assisting a suicide remains illegal in the UK under the Suicide Act 1961, with up to 14 years imprisonment, but prosecutions require approval of the Director of Public Prosecutions (DPP). To determine if prosecution is in the public interest, the DPP considers factors like the victim's illness, level of coerciveness, the motive of the suspect and public concern. There have been high-profile cases of Britons travelling to Switzerland to access legal assisted suicide through Dignitas clinics. There is an ongoing public debate around legalization. Assisted dying is prohibited by the British Medical Association code of ethics, but surveys indicate most doctors and the general public support a reform. In 2015, the UK parliament rejected an Assisted Dying Bill to legalize assisted dying. The Scottish parliament is considering a bill to legalize assisted suicide in early 2024. Overall, while illegal, prosecutions are rare and momentum is building for future reform in the UK.

5.2. The United States

There is no federal law prohibiting assisted suicide in the US, so states determine their own legislation. Assisted suicide is explicitly legal in 10 states and Washington DC, but remains a criminal offence in most states. The first right-to-die law was passed in Oregon in 1994 through a ballot initiative, with strict criteria that the patient must be terminally ill with less than 6 months to live, assessed by two doctors, deemed mentally competent, and undergo waiting periods.

Washington followed in enacting similar legislation in 2008. Since then, assisted dying has been legalized in further states, most recently in New Mexico, Maine and New Jersey between 2021 - 2022. This trend reflects the gradual increase of public support for assisted dying in the US since the 1990s. Federal legislative attempts to either legalize nationally or expressly prohibit assisted suicide have not passed. Courts have generally upheld state laws, rejecting appeals that prohibiting assisted suicide violates constitutional rights or equal protection. Overall the state-by-state approach has led to a complex legal framework across America.

5.3. Canada

Assisted suicide and voluntary euthanasia have been legal across Canada since June 2016 under federal law, for adults with grievous, irremediable medical conditions causing enduring, intolerable suffering. Patients must be mentally competent, consent freely without coercion, have a medical assessment by two doctors and meet prescribed waiting periods. Oversight bodies review each reported case. The law aims to balance patient autonomy with safeguards against abuse. This followed a 2015 Supreme Court ruling that prohibiting assisted suicide deprived patients of life and security rights under the Canadian Charter of Rights and Freedoms. Court decisions initially legalized assisted suicide in fewer circumstances, but the current law takes a broader approach.

Surveys indicate over 70% of Canadians support it. However, ethical concerns remain about risks like determining genuine informed consent for mentally ill patients. Implementation varies between provinces and data suggests that assisted death accounts for over 2% of deaths in Canada. Canada's legal framework on assisted suicide can be used by other nations to influence the debate on the legal reform of their respective laws governing assisted suicide.

5.4. Australia

Assisted suicide and euthanasia remain illegal across Australia under various criminal laws in each state and territory which attract severe penalties. But in recent decades, assisted dying laws have been passed in Victoria (2017), Western Australia (2019) and Queensland (late 2022) through state government bills or inquiries, restricted only to terminally ill and mentally competent adults, with substantial safeguards modelled after the Canadian approach. Public support exceeds 75% but major churches, parts of the medical profession and disability advocates remain opposed. Court challenges arguing for a constitutional right to die have not overturned prohibitions but generated momentum for political reform. The Australian Medical Association officially opposes euthanasia but around half its members support law reform. The gradual state-by-state legalization, as seen in the US, has allowed local factors and safeguards to be considered rather than a 'one size fits all' federal law. But it risks unequal access. There are renewed calls for uniform national legislation on assisted suicide in Australia.

5.5. Ghana

Assisted suicide is criminalised under Section 58 of Ghana's Criminal Offences Act, attracting up to 25 years imprisonment. This strict prohibition reflects the strong sociocultural attitudes in Ghana opposing assisted death. Religious beliefs emphasizing the sanctity of human life remain deeply influential in Ghanaian healthcare ethics and law. However, there is almost no occurrence of prosecutions or case law under these assisted suicide provisions. There are no signs the law will reform to permit assisted dying. But it must balance cracking down

further on rare cases against respecting the World Health Organization guidance that governments should avoid criminalising suicidal people and assist their care needs instead. Overall Ghana's legal position starkly contrasts more permissive regimes emerging in similar post-colonial common law nations like Australia and Canada.

Looking at the cross-jurisdictional review of legal frameworks on assisted suicide reveals that despite assisted suicide remaining formally prohibited in most countries, there is a gradual shifts, especially in the Western secular liberal democracies towards legalizing voluntary assisted dying for mentally competent, terminally ill adults as part of a broader legal right to self-determination at the end of life. Yet substantial ethical concerns persist about risks of abuse and erosion of the absolute prohibition on intentionally ending human life. Most reforming regimes try to balance these tensions by enacting narrowly restricted eligibility and strict safeguards around medical assessment, psychological capacity, consent processes and oversight. Future research could assess how effectively such safeguards are implemented in practice. The trend towards allowing assisted death in European nations like Switzerland, and the Netherlands and permissive regimes in parts of Australia and North America contrasts starkly with the strict prohibitions maintained across Africa and much of Asia, often inflected by religious and cultural traditions emphasizing the intrinsic sacredness of human life at all costs. Even in the few African countries where suicide or homosexuality have been decriminalized like Angola, there is no indication assisted dying will be legally condoned soon. Globally, the laws remain split, but the expansion of legalized assisted death in an increasing number of jurisdictions makes arguments that prohibiting assisted suicide breaches human rights protections more salient over time, potentially influencing more cautious nations like Nigeria. One can only hope and expect that the gradual state-by-state legalisation of voluntary assisted dying for terminally ill adults spreading in parts of Australia, the US and Canada will influence the debate in Nigeria and cause a consequential review of its legal framework. Some European countries also allow assisted suicide in varying circumstances. This indicates a gradual public and political acceptance of assisted death within strict regulatory regimes that try to balance moral concerns about the sanctity of life with emerging legal conceptions of individual autonomy, dignity and 'choice' in death among secular populations. Yet across most of Africa, Asia and the developing world, strong religious and cultural taboos persist against suicide or assisting death which is reflected in prohibitive Penal Code provisions like Nigeria's. The trend towards allowing assisted death in some countries but not others raises equality and human rights issues. Ultimately the debate involves a balance of the complexities of medical positions, ethics, self-determination, care, harm minimization and the moral status accorded to human life by the varying sociocultural and religious traditions while navigating legal modernity and shifts in medical technology and capacities. These tensions seem likely to intensify along the evolving global position on legalizing assisted death.

6. Criminalization of Attempted Suicide In Nigeria (Arguments for and Against)

There are ongoing debates around the criminalization of attempted suicide which by many indications is tilting significantly to the side of the spectrum that supports the decriminalisation of suicide attempts. Arguments highlighting deterrence aims, morality issues and state paternalism are used to defend criminalization, while humanitarian, health-focused and resource allocation issues are widely cited to call for decriminalization within a public health framework. The prevalent global stance is that criminalization of attempted suicide is against global human rights standards as many countries have departed from imposing punitive measures to improving their medical response to any reported case of attempted suicide.

Those in support of the continued criminalisation of attempted suicide in Nigeria have contended that it acts as a deterrent and prevents people from attempting suicide in the first place. There is also the argument that having a law against suicide attempts induces a commitment to stay alive in vulnerable individuals. There are also suggestions that criminalization could prompt the intervention of law enforcement and facilitate access to mental health care for suicidal persons. Additionally, some religious arguments based on morality have been used to defend keeping attempted suicide as a punishable offence. Most religious and moral beliefs support the notion that human life is sacred thereby justifying using man-made laws to punish anyone who attempts to take a life which will include attempting suicide.

On the other side of the spectrum, many experts have highlighted reasons why attempted suicide should be decriminalized in Nigeria. A central argument is that criminalization worsens the stigma around suicidal behaviours and creates barriers to seeking help. The effect of stigma must also be recognised as it undermines suicide prevention efforts while perpetuating myths about suicide. Along the same lines, several studies indicate that the shame and stigma associated with criminalization increase the risk of further attempts and ultimate suicide mortality. There are also humanitarian arguments against criminalization, emphasizing that punishment is unethical considering attempted suicide often arises from mental health issues and extreme distress which most people do not have control over rather than criminal intention. Authors have further reasoned that law enforcement approaches could produce human rights violations, loss of autonomy and justice issues for vulnerable people if attempted suicide remains illegal.

In another vein, some scholars argue that decriminalization does not appear to increase the reported cases of

suicide attempts, countering the deterrence argument. A good example can be seen in the case of England where attempted suicide rates in England remained stable even after its declassification from a criminal to a medical issue. There are also debates around resource allocation. Some assert that criminalization and law enforcement interventions drain resources that could be better utilized for mental healthcare and suicide prevention programs.

Overall, recent global debates on this issue have further emphasized a public health and human rights-based approach to be a better option rather than a legal approach, indicating that attempted suicide may be better addressed as a mental health issue requiring compassionate medical care rather than a criminal justice matter requiring punishment. This paper aligns with this side of the spectrum. However, more investigations are still needed to inform legal policies and support systems addressing attempted suicide and underlying mental health challenges in Nigeria.

7. Conclusion and Recommendations

Attempted suicide is a concerning phenomenon warranting adequate attention, especially in a country like Nigeria where psychosocial stressors such as unemployment, and social and economic hardship are prevalent. As observed across jurisdictions, while risk factors encompass mental illnesses, psychosocial stressors, childhood adversities, and interpersonal disconnection, attempted suicide frequently represents a cry for help from those undergoing unbearable anguish without adequate resources or outlets for support.

The cases explored in Nigeria and abroad demonstrate the varying judicial and clinical responses different countries adopt. On one end, the prevailing legal model in Western nations views attempted suicide mainly as preventable mental health conditions necessitating care rather than willful criminal acts warranting punishments. Consequently, the law seldom intervenes with punitive measures but may enable involuntary commitments for psychiatric evaluations or lifesaving treatments if risks of repeated attempts persist post-rescue. The predominant medical priority lies in emergency care, mental health assessments, therapeutic planning and referrals to encourage the continuity of patient-centred recovery.

Conversely, Nigeria's legal framework criminalizes attempted suicide by imposing custodial sentencing rather than prioritizing mental health interventions in reported cases. Police procedural documentation trumps psychological counselling referrals for clinical management. Deterrence and religious objections seemingly override modern medical management leading to prosecuting and incarcerating highly vulnerable, distressed individuals at risk of reattempts and completed suicides without addressing core drivers. Such legalized marginalization and victim-blaming mentalities further isolate affected persons, and create barriers against help-seeking which worsens risks and wastes opportunities for early intervention.

7.1. Recommendations

This research work recommends that Nigeria take medical ethics, public health, resource efficiency and human rights considerations more seriously by decriminalizing attempted suicide. Specifically, it recommends the following steps:

7.1.1. Federal legislators should repeal Section 327 of the Criminal Code Act to fully decriminalize attempted suicide aligning Nigeria's legal framework with global human rights standards and public health models prioritizing mental health assistance over punishment. This will reduce stigma and promote help-seeking and responsible resource allocations towards community-based psychosocial support systems and national suicide prevention programs.

7.1.2. Healthcare policymakers must develop clear guidelines, multidisciplinary case management protocols and specialized interventions to compassionately treat rescued suicide attempters through robust risk screenings, therapeutic planning and appropriate referrals for outpatient mental healthcare without procedural discharge delays. This should include trauma-informed capacity building for healthcare practitioners across emergency, psychiatric, psychosocial and primary care settings nationwide.

7.1.3. Strategic community engagement programs via anti-stigma campaigns and peer networking can raise awareness of available assistance pathways while empowering affected people through collective healing to mitigate reattempt risks. Prioritizing psychosocial rehabilitation equally with emergency responses can enable continuity of care.

7.1.4. Proactive structural reforms to tackle broader mental health challenges and socioeconomic risk factors by enhancing social equity, economic opportunities, housing, anti-discrimination laws and access to addiction/psychotherapy services can alleviate situational triggers for suicide attempts among vulnerable populations.

Ultimately, Nigeria must overcome punitive mindsets and regressive laws undermining suicide prevention efforts. Embracing public health ethics mandating State protection, capability enhancement and caring assistance for vulnerable groups attempting suicide can help manage attempt rates. Legally transitioning attempted suicide from a criminal issue to a mental health condition necessitating compassion over punishment is vital for saving distressed lives.

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