When Is Suicide a Public Health Issue?

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Abstract

On 24 June 2025, the Australian Productivity Commission (PC) released an interim report evaluating the National Mental Health and Suicide Prevention Agreement. While the PC's recommendations are certainly important components of a robust national strategy for mental health and suicide prevention, they remain incomplete. A more fundamental question is when suicide is even a public health issue. We need to identify what is bad about suicide and articulate why and when it should be prevented. In this article, we will consider three possible approaches to suicide prevention: (1) suicide prevention as the prevention of death, (2) suicide prevention as the prevention of wrongful death and (3) suicide prevention as the prevention of bad death. We will ultimately demonstrate that only the third approach is adequately equipped to achieve what should ostensibly be the goals of a national suicide prevention scheme.

Introduction

On 24 June 2025, the Australian Productivity Commission (PC) released an interim report evaluating the National Mental Health and Suicide Prevention Agreement. The Agreement is a document that sets out the proposed shared intentions of all governmental bodies to work together to improve mental health services and reduce suicide for all Australians. It details specific commitments between State jurisdictions, including funding responsibilities. The PC's interim report paints a scathing picture of the current state of the Agreement. Key findings have been outlined in Box 1.

Box 1 Key findings from the PC interim report on suicide prevention

- **The mental health and suicide prevention system is fragmented and out of reach for many people.**
- **The actions in the Agreement do not advance system reform. Consumers, carers and practitioners report that services remain unaffordable and difficult to access and are not always able to respond to people's needs.**
- **Key commitments in the Agreement have not been delivered and should be completed as a priority.**
- **The current Agreement should be extended until June 2027 to allow sufficient time for co-design of the new policy architecture.**
- **The next agreement should formalise the role of the National Mental Health Commission as the entity responsible for independent assessment and reporting on progress.**

While the PC's recommendations are certainly important components of a robust national strategy for mental health and suicide prevention, they remain incomplete. A more fundamental question is when is suicide even a public health issue. With the advent of legislation in all Australian states to now *assist* suicide, suicide in and of itself should not be the target of public health interventions. Before it is possible to clearly and concretely formulate objectives, outcomes, and commitments, it is necessary to engage in a focused and explicit consideration of what the goals of a national suicide prevention plan should be. We need to identify what is bad about suicide and articulate why and when it should be prevented. As we will discuss in more detail further down, the assumption that all suicides can and should be prevented places limitations on support and care for people with treatment-resistant suicidal ideation. While our current focus is on Australia, as the catalyst of this piece as a current controversy issue, the arguments and conclusions presented here have global relevance. As we will go into below, the approach taken in Australia to suicide prevention is ubiquitous, and commonly adopted by many countries and global health organisations, including the USA and WHO. This approach to suicide prevention could end up being counterproductive. In this article, we will consider three possible approaches to suicide prevention, (1) suicide prevention as the prevention of death, (2) suicide prevention as the prevention of wrongful death, and (3) suicide prevention as the prevention of bad death. We will ultimately demonstrate that only the third approach is adequately equipped to achieve what should ostensibly be the goals of a national suicide prevention scheme.

Suicide prevention as the prevention of death

Currently, the dominant paradigm in terms of suicide prevention frames it as a matter of public health [1-2]. While there is ongoing disagreement concerning how public health should be defined, Verweij and Dawson helpfully point out some salient areas of overlap among various definition proposals. The authors suggest that matters of public health are public in two ways; firstly, in the sense that they affect communities on a population rather than an individual level in a way that can be recorded via epidemiological and statistical data, and secondly, that mitigation or prevention requires collective rather than individual action[3]. This is very much how suicide prevention is often framed, including by Verweij and Dawson themselves as an example of issues that have recently started to be thought of as

matters of public health[1-5]. Suicide is commonly viewed as a problem that both affects health at a population level, and requires some kind of coordinated collective action (in this case, by the government). This approach views suicide prevention as important because it constitutes the prevention of deaths. It is taken for granted that all deaths by suicide should be prevented, purely due to the fact that death should be prevented (similarly to how all deaths from cancer should be prevented) [4,6]. This approach to suicide prevention is reinforced through the use of language such as "epidemic" and "second leading cause of death" [1-2, 5]. The ubiquitousness of this view on suicide prevention is also reflected in what is called the Zero Suicide Model, which was developed in the United States by the National Action Alliance for Suicide Prevention in collaboration with several federal agencies, and which holds that every death by suicide is in theory entirely preventable, and therefore indicates a blame-worthy failure on the part of a healthcare professional [5]. Given that it is taken for granted that all suicides should be prevented as a matter of public health, this framework is fundamentally uninterested in the circumstances or context of individual cases of suicide. This framework and language surrounding suicide is also adopted by the PC in their reports evaluating the Agreement.

However, this approach to suicide prevention fails to acknowledge a key difference between suicide and other threats to public health and safety; the fact that suicide is a self-directed act that involves some level of choice. People do not choose to develop cancer in the same way that they choose to take their own lives, and this distinction raises important ethical questions that are unaddressed by the dominant approach to suicide prevention. Given the fact that a death by suicide is the result of an active choice, as opposed to something that has simply happened *to* the individual like an accident or other health condition, it is necessary to consider whether this could sometimes be a rational choice, that given the circumstances of the individual, death may be the preferable option. In fact, there is a widely acknowledged movement in moral philosophy and supporting empirical fields that argues that there is such a thing as rational suicide, or at least that the possibility of rational suicide cannot be precluded [7-12]. As David Benatar argues in a recent book chapter, all that is required to dislodge the notion that all suicides are irrational is to imagine a fate worse than death, which is not hard to do [13]. This, then, throws a major spanner in the works of the dominant approach to suicide prevention. If some suicides are rational and in fact the right choice for that individual, then it would appear that the view that all suicides should be prevented at all costs as a matter of public health is mistaken, and a more nuanced approach is required to establish the kinds of suicide that should be prevented.

Indeed, the euthanasia and assisted dying movements and legislation are premised on the existence of rational suicide or death. That is, in some cases life is no longer worth living because the suffering in it is too great or that living can no longer achieve the autonomous goals of the agent.

Suicide prevention as the prevention of wrongful death

A second possible way of approaching suicide prevention can be described as suicide prevention as the prevention of *wrongful* deaths. This approach acknowledges that indeed there are instances where suicide can be rational but argues that it, even so, might constitute a mistake. To explain this approach, it may be useful here to borrow a legal concept, namely that of the wrongful suicide. A wrongful suicide claim can be brought to court when there has been a suicide that would not have occurred if it were not for the actions or omissions of

the defendants [14-15]. In a more general sense, this approach to suicide prevention holds that while some suicides can be rational, most suicides would not occur if circumstances were (or were perceived to be) different for the individual, and it is these suicides that should be prevented. This approach is well illustrated by a 2011 article in which Pilpel and Amsel attempt to demonstrate that a suicide can adhere to all the requirements that would make it rational, but that it can still be a mistake, that suicide can still be interpreted as one "throwing her life away" for no good reason, even if it is technically rational [16]. Even Benatar himself issues a sober warning to those considering suicide to be especially careful that they are not making the wrong decision, as the finality of death means that suicide cannot be taken back [13]. While this approach successfully avoids the glaring problem with the dominant view on suicide prevention by conceding that there are some cases in which suicide constitutes the correct choice, it raises several others, two of which will be outlined now.

The first is a philosophical problem, namely the fact that concepts of regret and "having made a mistake" do not really work in the way they usually do when placed in the context of suicide or other end-of-life decision-making. For something to be considered a mistake, the individual who performed the action must be able to reflect on the action and, in hindsight, come to the realisation that they acted wrongly. This is not a possibility in the case of suicide, as the person who carried out the suicide is now gone and not experiencing any kind of mental state that would allow the required level of reflection on her actions. Concepts of regret and remorse simply do not function in the way they usually would following a mistake that the individual is conscious of in hindsight. Usually, the value in trying to prevent people from making mistakes is to save them from the consequences of actions they come to regret but must now live with. This is not to say that preventing ill-considered suicides is not an important or worthwhile endeavour, but it is equally important to acknowledge that the stakes are different than they usually are when trying to prevent people from making mistakes.

A further component of this philosophical problem is that if we concede that people can be mistaken about end-of-life decision-making, this would also imply that the decision to continue living may be a mistake. Interestingly, these cases would be more suited to concepts of regret, as this person would have access to the hindsight perspective and reflection required to realise they have made a mistake. However, worries about people making a mistaken choice not to take their own life are rarely observed, presumably due to the fact that suicide is final and irreversible. This asymmetry alludes to the complexity surrounding end-of-life decision-making (either in choosing death, or in choosing to continue living) being possibly understood as mistakes. While this topic is fascinating and relevant, it would easily merit further research unto itself and is sadly beyond the scope of this current paper.

The second is a practical problem. The view that a person experiencing suicidal ideation could be mistaken about their own experience and hypothetically may be able to return to a life that they consider worthwhile only holds for those individuals who have not yet undergone treatment or other forms of non-medical care that could improve their situation. In these cases, it is absolutely appropriate that prioritising care access is key and should be the first port of call, as deaths resulting from insufficient social and medical care would indeed be a grave matter of social injustice. However, this framework does very little in terms of caring for individuals experiencing treatment-resistant conditions that have suicidality as a symptom. A 2018 study showed that suicide risk is especially high among patients with treatment-resistant depression, regardless of which treatment was used [17]. The typical

components of a suicide prevention plan [1] are likely to be entirely ineffective and irrelevant for individuals who have already attempted all treatment pathways. Suicide prevention as the prevention of wrongful suicides therefore still insufficiently takes account of individuals for whom suicide is not a mistake, and counterproductively leaves these individuals to their own devices in a way that renders them more vulnerable to a potentially violent or otherwise distressing death.

Suicide prevention as the prevention of bad deaths

Our suggestion is to adopt an approach to suicide prevention that frames suicide prevention as the prevention of *bad* deaths. This approach would offer the individual extensive support and engagement, every effort should be made to improve the circumstances that have driven them to a place of suicidal ideation, but there should also be an explicit acknowledgement that sometimes suicide is the rational and most suitable choice. In these cases, it is essential that adequate end-of-life care is offered, allowing these individuals the opportunity to die safely and calmly instead of being forced to select potentially violent or otherwise distressing methods of ending their lives. This leaves the problem of determining when a suicide is the rational and correct choice and therefore should be assisted in a medically careful way rather than prevented altogether. An exhaustive account of how this should be established would require more space and research than is possible in this article. All we are arguing here is that this option should be considered as part of a nuanced and thoughtful suicide prevention scheme, exactly so that space and research into this question can be made possible. Suffice to say for now that this is not a new idea; philosophers have been writing about what is required for a suicide to be considered rational at least since Hume famously asserted: "I believe that no man ever threw away life, while it was worth keeping. For such is our natural horror of death, that small motives will never be able to reconcile us to it…" [18-19].

In her 2005 book, *Ending Life; Ethics and the Way we Die*, Margaret Battin presents the case study of Scott Ames, a 38-year-old television executive who was diagnosed with AIDS and was also found to have a severe brain tumour upon admission to psychiatric facility following an attempted suicide. The dilemma presented was between overriding Scott's wishes and force him to remain committed, and discharging him in the knowledge that another suicide attempt was highly likely. Battin suggests a third option that is particularly relevant for our current purposes; "Take Scott's interest in suicide as perhaps reasonable, certainly as an understandable choice for someone in his predicament, and work *with* him, not against him in planning for it" [20]. The measures she proposes in this case study involve facilitating final conversations with his loved ones, assigning a trusted nurse to talk with him about whether suicide in his parents' home is really what he wants for himself and for them, and offering him pharmaceuticals that might render the suicide easier and less stressful. When a wish to die has proven to be treatment-resistant, the individual is of sound mind, and she is able to demonstrate that this choice was based on rational and reasonable deliberation [19], taking a Zero Suicide attitude is in fact equivalent to throwing the baby out with the bathwater and exposing that individual to harm that could be avoided by, in the words of Margaret Battin, working with them. A Zero Suicide approach implies that every suicide can and should be prevented, which inherently imposes certain limitations on how much support and assistance can realistically be offered. Once the known mental health treatment pathways have proved ineffective, there is very little that can be done for those who still experience ideation, which may force them to select a method of death they would deem as non-ideal, much in the way Battin also alludes to in her case study [20].

Ultimately, this is what makes our approach importantly different from the paradigmatic public health approach. In that approach, it is taken for granted that there is a phenomenon that is affecting the health of a population in a way that is universally negative, and requires collective action for its mitigation or prevention. At first blush, it would appear that suicide fits this description; it is plausible to argue that death would negatively affect one's health, suicide is occurring on a scale that can be detected on a population level, and collective action certainly is required for its curtailment. Our argument, however, is that what makes suicide different from other things that are often thought of as public health concerns is that we do not think the effect of suicide is universally bad. Sometimes it can be a rational and appropriate choice, in a way that cannot be said of, for example, addiction or a severe epidemic. This distinction is what makes suicide unsuitable for a public health approach.

In summary, a thoughtful and considered suicide prevention strategy must acknowledge that sometimes, people's lives constitute a fate worse than death, and that those who have already unsuccessfully made every effort to render their lives worth living require help in avoiding a death they consider to be bad.

Conclusion

In this article, we have considered three possible approaches to suicide prevention on a national level. We have demonstrated that there are philosophical and practical problems with both approaching suicide as a public health concern – which is the dominant paradigm and also the approach currently adopted by the National Mental Health and Suicide Prevention Agreement, as well as the Productivity Commission – as well as approaching suicide prevention as the prevention of wrongful death. Given the advent of assisted suicide in all Australian states, there is a commonly accepted sensibility that sometimes suicide can be rational and should not necessarily be prevented. Our argument is that a national suicide prevention scheme that does not consider individuals with treatment-resistant suicidal ideation is inadequately equipped to achieve what should ostensibly be the policy goals of such a scheme. For these individuals, there should be an acknowledgement that their suicide is perhaps a rational choice, and there should be options to assist them in achieving a good death.

References

[1] Platt, S., Arensman, E., & Rezaeian, M. (2019). National Suicide Prevention Strategies – Progress and Challenges. *Crisis*, 40(2), 75–82. https://doi.org/10.1027/0227-5910/a000587

[2] World Health Organization. (2013). Global mental health action plan, 2013–2020. Geneva, Switzerland. Retrieved from http://www.who.int/mental_health/publications/action_plan/en/

[3] Verweij M, Dawson A. The meaning of "public" in public health. In: Dawson A, Verweij M, eds. Ethics, prevention, and public health. Oxford: Oxford University Press, 2007.

[4] Arensman, E., Scott, V., De Leo, D., & Pirkis, J. (2020). Suicide and Suicide Prevention from a Global Perspective. *Crisis*, 41(Supplement 1), S3-S7

[5] Sisti, D.A. & Joffe, S. (2018). Implications of Zero Suicide for Suicide Prevention Research. *JAMA*, 320(16), 1633–1634. doi:10.1001/jama.2018.13083

[6] Mayo, D. J. (2021). Rational Suicide?. In: *Loss and Trauma* (pp. 121-127). Routledge.

[7] Battin, M. (1999). Can suicide be rational? Yes, sometimes. In J. L. Werth (Ed.), *Contemporary perspectives on rational suicide* (pp. 13–21). Philadelphia: Taylor & Francis

[8] Cholbi, M. (2021). Schopenhauer, Suicide, and Contemporary Pessimism. In: *Schopenhauer's Moral Philosophy* (pp. 141-159). Routledge

[9] Clarke, D. (1999). Autonomy, rationality and the wish to die. *Journal of Medical Ethics*, 25(6), 457–462

[10] Gramaglia, C., Calati, R., & Zeppegno, P. (2019). Rational Suicide in Late Life: A Systematic Review of the Literature. *Medicina*, 55(10), 656. https://doi.org/10.3390/medicina55100656

[11] Humphry, D. (1987). The case for rational suicide. *Suicide and Life-Threatening Behavior*, 17(4), 335

[12] Richards, N. (2017). Old age rational suicide. *Sociology compass*, 11(3), e12456.

[13] Benatar, D. (2020). Suicide is sometimes rational and morally defensible. In: *Exploring the philosophy of death and dying* (pp. 217-223). Routledge.

[14] Dawson, K. (2024). The Argument for Wrongful Suicide: Iowa's Need for a More Comprehensive Approach for Liability in Suicide Cases. *Drake L. Rev.*, 71, 459

[15] Schlinsog Jr, A. (1990). The Suicidal Decedent: Culpable Wrongdoer, or Wrongfully Deceased. J. Marshall L. Rev., 24, 463.

[16] Pilpel, A., & Amsel, L. (2011). What is wrong with rational suicide. *Philosophia*, 39, 111-123.

[17] Bergfeld, I. O., Mantione, M., Figee, M., Schuurman, P. R., Lok, A., & Denys, D. (2018). Treatment-resistant depression and suicidality. *Journal of affective disorders*, 235, 362-367.

[18] Hume, D. (1986). Of Suicide. In P. Singer, ed. Applied Ethics. Oxford: Oxford University Press, p. 26

[19] Savulescu, J. (1994). RATIONAL DESIRES AND THE LIMITATION OF LIFE-SUSTAINING TREATMENT. Bioethics, 8, 191-222. https://doi.org/10.1111/j.1467-8519.1994.tb00255.x

[20] Battin, M. P. (2005). *Ending life: Ethics and the way we die*. Oxford University Press, p. 111.